Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Meeting of the Board of the Integrated Care Board in Public - 30 June 2023 - 09:00 to 12:00

Agenda

09:00	**1. Meeting opening** Chair	
	1.1 Apologies	Note
	1.2 Quoracy	
	1.3 Disclosure of Interests	Update
	1.4 Minutes (from 24 March 2023) and Matters Arising	Approve
	1.5 Action Tracker	Update
09:05	**2. Chair's Report – verbal** Chair	Note
09:10	**3. Chief Executive Officer's Report** Chief Executive Officer	Note
09:20	**4. Questions from the Public** Chair	
09:25	**5. Resident Story**	
	6. SYSTEM STRATEGY	
09:40	**6.1 Denny Review** ICS PARTNER: Reverend Lloyd Denny, the Author of the Denny Review and Paul Calaminus, CEO ELFT. ICB EXECUTIVE: Chief of System Assurance and Corporate Services & Chief Nursing Director	Approve
10:20	**6.2 2023/24 Inequalities Funding – proposed allocation and governance** ICS PARTNER: Vicky Head, Director of Public Health, Bedford Borough, Central Bedfordshire & Milton Keynes and Sally Cartwright, Director of Public Health, Luton Council. ICB EXECUTIVE: Chief Nursing Director	Approve
10:35	**REFRESHMENT BREAK**	
10:45	**6.3 BLMK Joint Forward Plan 2023-2040** ICS PARTNER: Partner Member Chief Executive Officers ICB EXECUTIVE: Chief Transformation Officer	Approve
11:05	**6.4 Memorandum of Understanding with Healthwatch**	Approve

ICS PARTNER: ICB Member Healthwatch ICB EXECUTIVE: Chief of System Assurance and Corporate Services

7. OPERATIONAL

11:15

7.1 Quality and Performance Report
Note

ICS PARTNERS: All Partner Members ICB EXECUTIVE: Chief Nursing Director and Chief of System Assurance and Corporate Services

11:25

7.2 Finance Reports

7.2.1 - BLMK ICS and ICB Financial Plans 2023/24
Approve

ICS PARTNER: All Partner Members ICB EXECUTIVE: Chief Finance Officer

7.2.2 - BLMK ICS Finance Report (May 2023)
Note

ICS PARTNER: All Board Members ICB EXECUTIVE: Chief Finance Officer

11:35

7.3 Section 75 Agreements
Approve

ICS PARTNER: Local Authority Chief Executive Officers ICB EXECUTIVE: Chief Transformation Officer

11:40

8. GOVERNANCE

8.1 Decision Planner
Note

ICS PARTNER: All Partner Members ICB EXECUTIVE: Chief of System Assurance and Corporate Services

8.2 Update from Place Based Partnerships
Note

ICS PARTNERS: Members of Place Based Partnerships ICB EXECUTIVE: Place link directors

- Bedford Borough
- Central Bedfordshire
- Luton
- Milton Keynes

8.3 Board Assurance Framework
Note

ICS PARTNER: Partner Members ICB EXECUTIVE: Chief of System Assurance and Corporate Services

8.4 Corporate Governance Update and Report from Committees
Approve

ICS PARTNER: Committee Chairs ICB EXECUTIVE: Chief of System Assurance and Corporate Services

11:55

9. Meeting closing
Chair

9.1 Communication from the Meeting

9.2 Meeting Evaluation

9.3 Any Other Business

Next meeting
Date: Friday 29 September 2023
Time: 09:00 to 15:00 (to include ICB Annual General Meeting)
Venue: Luton Council Chamber

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

Register of Conflicts of Interest
(Board Members and Participants as at 16.6.2023)

Surname	Forename	Position within, or relationship with the Integrated Care Board	Interests to Declare	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect	Details of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Borrett	Alison	Non Executive Member	No									21/06/2022
Bracey	Michael	Chief Executive, Milton Keynes Council	Yes	Y				Employee of Milton Keynes City Council	2009	Ongoing	None required	21/11/2022
Carter	David	Chief Executive, Bedfordshire Hospitals Foundation Trust	Yes	Y				Chief Executive of Bedfordshire Hospitals NHS Foundation Trust	08/05/2017	Ongoing		18/05/2022
Carter	David	Chief Executive, Bedfordshire Hospitals Foundation Trust	Yes				Y	Wife employed by NHS England Eastern Region	2019	ongoing		18/05/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes	Y				Bedford Borough Council, Commissioner of Public Health and Social Care Functions	05/10/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes		Y			East of England Local Government Association - Chief Executive lead on health inequalities	01/12/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Church	Laura	Chief Executive, Bedford Borough Council	Yes				Y	Ian Turner (husband) provides consultancy services to businesses providing weighing and measuring equipment to the NHS	05/10/2021	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Coiffait	Marcel	Chief Executive, Central Bedfordshire Council	Yes	Y				I am the Chief Executive of Central Bedfordshire Council which is an may be commissioned to work on behalf of the ICB	01/11/2020	Ongoing	Declare in line with conflicts of interest policy	27/05/2022
Cox	Felicity	Chief Executive, BLMK ICB	Yes		Y			I am a registered pharmacist with the General Pharmaceutical Council (GPC) and a member of the Royal Pharmaceutical Society	17/08/1987	Ongoing	I will excuse myself should an interest arise	14/06/2022
Gill	Manjeet	Non Executive Member	Yes		Y			Non Executive Director, Sherwood Forest NHS Hospitals Foundation Trust	11/11/2019	Ongoing	Would flag any conflict in agendas	27/09/2022
Gill	Manjeet	Non Executive Member	Yes		Y			Managing Director, Chameleon Commercial Services Ltd, 12 St Johns Rd, LE2 2BL	09/09/2017	Ongoing	Regular 1-1s flag any issue and agenda items	27/09/2022
Graves	Stuart Ross	Chief Strategy & Digital Officer, Central and North West London Foundation Trust	Yes		Y			Chief Strategy & Digital Officer CNWL NHS Foundation Trust, 350 Euston Road, London NW1 3AX	May-20	Ongoing	Declare in line with conflicts of interest policy	15/11/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Chief Executive Officer, NHS Milton Keynes University Hospital	2013	Ongoing	Declare in line with conflicts of interest policy	21/11/2022

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Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Chair NHS Employers Policy Board	2021	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Trustee of NHS Conferation	2021	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Council Member - National Association of Primary Care	2020	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Keele University - Lecturer	2016	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				Advisor to Alphasights, MM3 Global Research, Silverlight and Stepcare	2018	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Chair, Clinical Research Network Thames Valley & South Midlands Partnership Group Meeting		Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes		Y			Member, Oxford Academic Health Science Network		Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes				Y	Spouse, Samantha Jones, Expert Advisor to the Secretary of State for Health & Social Care	Nov-22	Ongoing	Declare in line with conflicts of interest policy	23/11/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes				Y	Sister, Ruth Harrison, Director of Durrow Ltd	Circa 2012	Ongoing	Declare in line with conflicts of interest policy	21/11/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y				National Director for Digital Channels	Jan-23	Ongoing	Declare in line with conflicts of interest policy	01/02/2023
Head	Vicky	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes.	No									27/06/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			The Bridge Primary Care Network Clinical Director	01/04/2021	Ongoing	May need to be excluded from decisions regarding Primary care Networks	11/05/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Member, NHS Confederation Primary Care Network	07/07/2019	Ongoing	Declare conflict during discussions	08/09/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Member, National Association of Primary Care	01/10/2020	Ongoing	Declare conflict during discussions	08/09/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Trustee, Arts for Health Milton Keynes	01/04/2020	Ongoing	Declare conflict during discussions	08/12/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			Trustee, Milton Keynes Christian Centre	01/10/2019	Ongoing	Declare conflict during discussions	08/12/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes		Y			GP partner, Newport Pagnell Medical Centre	01/02/2004	Ongoing	May need to be excluded from decisions regarding Primary Care Networks	08/12/2022
Makarem	Rima	Chair, BLMK Integrated Care Board	Yes		Y			Chair of Sue Ryder (non remunerated)	01/05/2021	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Makarem	Rima	Chair, BLMK Integrated Care Board	Yes	Y				Chair of Queen Square Enterprises Ltd (remunerated)	01/11/2020	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Makarem	Rima	Chair, BLMK Integrated Care Board	Yes	Y				Lay Member of General Pharmaceutical Council	Apr-19	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Mattis	Lorraine	Associate Non Executive Member	Yes	Y				Director - Community Dental Services Community Interest Company	Nov-17	Ongoing	Declared in line with conflicts of interest policy	10/01/2023
Pointer	Shirley	Non-Executive Member, Chair Remuneration Committee	Yes		Y			Bpha (a not for profit Housing Association). Non-Executive Director and Chair of the Remuneration Committee	Apr-19	Ongoing	Declare in line with conflicts of interest policy	15/12/2022

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Pointer	Shirley	Non-Executive Member, Chair Remuneration Committee	Yes			Y		Pavilions Management Co Ltd, (residents management co), Director. This is a voluntary role which is not remunerated	Sep-20	Ongoing	Declare in line with conflicts of interest policy	15/12/2022
Porter	Robin	Chief Executive, Luton Borough Council	Yes	Y	Y			Chief Executive of Luton Council, an ICB Partner organisation	May-19	Ongoing	Declare in line with conflicts of interest policy	16/11/2022
Shah	Mahesh	Partner Member	Yes	Y				AP Sampson Ltd t/a The Mall Pharmacy, Unit 3, 46-48 George Street, Luton LU1 2AZ, co no 00435961, community pharmacy	Nov-88	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2011
Shah	Mahesh	Partner Member	Yes				Y	RightPharm Ltd, 60a Station Road, North Harrow, HA2 7SL, co no 08552235, community pharmacy, son & sisters	28/03/2014	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes				Y	Calverton Pharmacy Ltd, Ashleigh Mann 60a, Station Road, North Harrow HA2 7SL, co no 07203442, community pharmacy, son & sisters	03/04/2018	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes				Y	Gamlingay Pharmacy Ltd, 60a Sation road, North Harrow, HA2 7SL, no no 05467439, son & sisters	01/04/2021	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes		Y			Committee Member, Bedfordshire Local Pharmaceutical Committee	1984	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Shah	Mahesh	Partner Member	Yes		Y			Community Pharmacy PCN Lead, Oasis Primary Care Network, Luton	06/02/2020	Ongoing	Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	20/05/2022
Stanley	Sarah	Chief Nurse Director	No									08/09/2022
Westcott	Dean	Chief Finance Officer	Yes		Y			Board Advisor, London School of Commerce	01/12/2022	Ongoing	Declare in line with conflicts of interest policy	13/12/2022
Westcott	Dean	Chief Finance Officer	Yes				Y	Wife is Senior Mental Health Transformation Manager at West Essex CCB	01/06/2021	Ongoing	Declare in line with conflicts of interest policy	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes			Y		Civil partner, Advanced Nurse Practitioner (Walnut Tree Health Centre, Milton Keynes)	2013	Ongoing	No involvement in relation to decision making	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes		Y			Stonedean, Practice - Sessional GP/former partner	01/06/2007	Ongoing	No involvement in relation to decision making	14/06/2022

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Whiteman	Sarah	Chief Medical Director	Yes		Y			General Medical Council Associate	2012	Ongoing	Exclusion of self from involvement in related meetings, projects or decision-making	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				Akeso (coaching network) – coach – Executive and Performance Coach	01/04/2021	Ongoing	Open declaration, no monies received	14/06/2022
Whiteman	Sarah	Chief Medical Director	Yes	Y				NHS England – Appraiser	2001	Ongoing	Exclusion of self from involvement in related meetings, projects or decision-making relating to any relevant practitioners	14/06/2022
Cartwright	Sally	Director of Public Health, Luton Council	No									22/06/2022
Poulain	Nicky	Chief Primary Care Officer	Yes		Y			Registered nurse and midwife and a member of trhe RCN			Declare in line with conflicts of interest policy, exclusion from involvement in related meetings or discussions and/or decision making as guided by Governance Lead	17/02/2023
Roberts	Martha	Chief People Officer, BLMK Integrated Care Board	No									04/07/2022
Taffetani	Maxine	Healthwatch Representative for Bedfordshire, Luton and Milton Keynes	Yes	Y				Employee of Healthwatch Milton Keynes	2017	Ongoing	Declare in line with conflicts of interest policy	14/12/2022
Wogan	Maria	Chief of System Assurance and Corporate Services	Yes			Y		I am a member of Inspiring Futures Through Learning Multi-Academy Trust which covers schools in Milton Keynes (MK) and Northamptonshire. Address: Fairfields Primary School, Apollo Avenues, Fairfields, Milton Keynes MK11 4BA	2016	Ongoing	Will be declared in any relevant meetings.	14/07/2022
Wogan	Maria	Chief of System Assurance and Corporate Services	Yes	Y				I am a Director of Netherby Network Limited which is a consultancy company that has provided services to Milton Keynes Clinical Commissioning Group in the past. It does not currently provide any services for health or care clients. Address: 69 Midland Road, Olney, MK46 4BP	Mar-14	Ongoing	No actions required as the company is not trading.	14/07/2022

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 24 March 2023

Time: 10:00 – 13:00

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

Minutes of the: Board of the Integrated Care Board (ICB) in **PUBLIC**

Members in attendance:		
Dr Rima Makarem (Chair)	Chair	RM
Alison Borrett	Non-Executive Member	ABo
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
Ross Graves	Partner Member, NHS Trusts and Foundation Trusts	RG
Joe Harrison	Partner Member, NHS Trusts and Foundation Trusts - *part*	JH
Shirley Pointer	Non-Executive Member	SPo
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	ABr
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
Maxine Taffetani	Participant Member for Healthwatch within Bedfordshire, Luton and Milton Keynes	MT
Maria Wogan	Chief of System Assurance & Corporate Services	MW

In attendance:		
Tara Dear	Head of Planned Care (items 9-10)	TD
Sarah Frisby	Head of System Engagement, Communications	SFr
Geoff Stokes	Interim Programme Director – Governance	GS
Kim Atkin	Committee Governance & Compliance Office (minutes)	KA

Apologies:		
Michael Bracey	Partner Member, Local Authorities	MB
Manjeet Gill	Non-Executive Member	MG
Dr Omotayo Kufeji	Partner Member, Primary Medical Services	OK
Cllr Tracey Stock	Chair, Bedfordshire, Luton and Milton Keynes Health and Care Partnership (participant member)	TS

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed all to this meeting of the Board of the Bedfordshire Luton and Milton Keynes Integrated Care Board (ICB) and apologies were noted as above. As this was a meeting in public, members of the public were welcome to observe but their microphones should be muted and their cameras turned off. Three questions had been received from the public, and these would be answered under item 8 on the agenda. It was confirmed that the meeting was **quorate**. The meeting was being recorded for the purpose of the minutes.	
2.	**Core Purposes of Integrated Care Systems** The Chair highlighted the core purposes of the Integrated Care System (ICS) and stated that these should be borne in mind during discussions and when taking decisions: • **improve outcomes** in population health and healthcare; • **tackle inequalities** in outcomes, experience and access; • **enhance productivity** and value for money; and • help the NHS support broader **social economic development.**	
3.	**Relevant Persons Disclosure of Interests – Register of Interests** Members had reviewed the Register of Interests and entries were confirmed to be accurate. Attendees were asked to confirm that any offers of gift or hospitality received in the last 28 days, in relation to ICB business, had been registered with the Governance and Compliance Team. There had been none. The Chair asked that any conflicts of interests be declared during the meeting, if appropriate.	
4.	**Approval of Minutes and Matters Arising** The Board **approved** the draft minutes of the meeting held on 27 January 2023. There were no matters arising that did not form part of the meeting's agenda.	
5.	**Review of Action Tracker** Actions were followed through between meetings and the action tracker has been updated. This was presented for review with updates and proposed items for closure.	

	Item 33, the drafting of a Memorandum of Understanding (MoU) with the Voluntary Community and Social Enterprise (VCSE) sector is being discussed at Place Boards and it was proposed to close this action after the last Place Board meeting on 12 April. Item 37, in relation to the communication of the newly published Health and Care Partnership Strategy for residents, is in progress. The two action updates were **noted** and all other actions were **agreed** to be closed.	
6.	**Chair's Report** The recruitment of a second GP partner member is underway. Due to the unfortunate resignation of Andrew Blakeman, Non-Executive Member (NEM) and Audit and Risk Assurance Committee (ARAC) Chair, due to ill health, a replacement NEM and Audit Chair will be recruited. A Chair for East of England Ambulance Trust has recently been appointed but the name cannot yet be announced. As part of the Hewitt Review, the Chair attended a round table event with Lord Markham about capital expenditure. There is a lot of creative thinking at ministerial level as to how to get more capital funding into the NHS nationally. The ICB's new Chief Pharmaceutical Officer, Shabina Azmi, will be developing a Research and Development (R&D) Group for the system and will be liaising with partner organisations to pull together system Research and Innovation (R&I) needs. With a view to reshaping both the ICB and Integrated Care Partnership (ICP) meetings, the Chair is having a series of individual meetings with each partner member of the ICB to obtain their feedback. The Board **noted** the Chair's report.	
7.	**Chief Executive Officer's (CEO's) Report** Taking the report as read, the CEO gave the following updates: The ICB is working through the implications of the ICB's running costs allowance reduction by 30% although further detail is awaited. The CEO will be talking to all partners once that is available. The final report from the Hewitt Review is expected to be released very soon. The first junior doctors' strike took place last week. There has been a rapid "wash up" both clinically and in terms of emergency preparedness resilience and response (EPRR) issues. The next strike will take place over the Easter holidays which could prove more difficult. There was a productive meeting this week with Cambridge and Peterborough ICB and BLMK ICB executives to consider if any back office functions can be shared with a view to reducing running costs. The CEO's meetings with members of Parliament (MPs) are proving useful, both in terms of an exchange of knowledge and views, but they are also giving us insights into what they are hearing in their surgeries.	

	The CEO attended a round table meeting on the digital contribution to population health with Tim Ferris, National Director of Transformation, NHS England. BLMK ICB is doing well in this area both in terms of how we are connecting systems together and the work that is going on within trusts in relation to digital. The Board **noted** the Chief Executive Officer's report.	
8.	**Questions from the Public** Three questions had been received from members of the public in relation to: • bad diet, poor health epidemic and environmental issues; • the closure of Ivel Medical Centre and Biggleswade Primary Care; and • the Chief Executive being requested to meet with Living Age Foundation in relation to health inequalities. The questions were read out to the meeting and verbal responses were given to all questions. The questions and full answers will be made available on the internet. **Action: MW – Communications Department to make Questions from the Public and answers available on website following the meeting.**	MW
9.	**Resident's Story** A Milton Keynes resident and patient, Roxy, joined the meeting to tell the story of how she had been bounced around in the musculoskeletal (MSK) pathway and how the lack of support with weight management had impacted her MSK condition. Roxy shared her back pain journey and the impacts on her quality of life in terms of her physical and mental health, work, relationships and financially. The members showed their appreciation for Roxy's willingness to share and took on board the issues that had been highlighted. The Chair thanked Roxy for taking the time to attend the meeting and for sharing her experiences. **Action: Chief Nursing Director to arrange a multidisciplinary discussion to include primary and secondary care to formulate a personalised care plan for Roxy.**	SS
10.	**Integrated Muscoloskeletal (MSK) and Pain Services** *Presented by Tara Dear, Head of Planned Care* David Carter, Chief Executive, Bedford Hospitals Foundation Trust (BHFT), declared an interest in relation to this item but it was considered that he could remain for the item. Contracts for community MSK services will expire on 31 March 2024 which has presented an opportunity to look at the delivery of MSK services in BLMK. By establishing the BLMK MSK Collaborative in July 2021 and by undertaking a number of patient engagement events, the ICB has worked with BLMK partners and patients to define a standardised model of care which supports the whole person. A Joint Health Needs Assessment (JHNA) for MSK has been developed with public health to understand the population needs and lifestyle factors that drive an increase in MSK and also look at improving prevention opportunities. There has been collaboration with other systems to understand their models of care and learn from best practice. It should be noted that there is already some best practice and innovation within our existing services which would be included in the future model.	

Opportunities from the review are detailed in the paper, which include the shift from reactive to more productive care, with a more holistic and personalised offering to individuals including services from voluntary care services, which are expected to deliver health improvements and a better patient experience. It will also enable individuals to live more independently, work safely and enjoy an improved quality of life.

A business case will be presented to the Finance and Investment Committee on 19 May. The timeline presented within the paper is indicative and may be subject to change as a result of market feedback and further planning needs. Following approval of the business case, the ICB will undertake a competitive procurement process to secure future services.

There was a full and robust discussion with the following key points being made:

- Delay in MSK support may occur where a resident visits a physiotherapist and mentions, e.g. that they have chest pain – the resident would then be escalated to cardiology before any other support is given;
- There should be clinical triage points across the MSK pathway where "red flags" that could complicate care services are considered;
- People need to be encouraged to come forward and there is work to improve access so that patients are not reliant on a GP appointment, but can self-refer to a service, which could reduce some of the pressure on GP appointments;
- Patients also have access to apps and other digital platforms and materials that can support them;
- Signposting is key and should include community practitioners including pharmacists, dentists and optometrists, as appropriate;
- Soft market testing went live a few days ago and will last four weeks. It is too early to determine the formal market appetite but the results will be shared with the Board;
- As these services have a direct correlation to primary care access, the paper will also be taken to Place Boards;
- In the procurement, it is important to address the fragmentation on the MSK pathway to the acute hospitals, which is due to the number of clinicians involved, the nature of MSK conditions and the overlap with pain services and potentially mental health services; and
- The JHNA identified unmet needs across the pathway where patients have disengaged and more work must be done to encourage use of preventative opportunities.

The Board **noted**:

- the content of the report, including the process and outputs in developing the case for change.
- that Integrated MSK and Pain Business Case will be presented to the Finance and Investment Committee on 19 May 2023 for approval, prior to competitive procurement; and
- the further engagement activities that are planned with both patients and with each of the four places via the Place Boards.

The Board **supported** the approach to Place based partnerships for MSK and that each local authority member is asked to nominate a representative (public health or social care) by 6 April 2023 to work in partnership with the ICB to identify new MSK provider arrangements from 1 April 2024.

Action: LA representatives to nominate a representative (public health or social care) by 6 April to work in partnership with the ICB to identify new MSK provider arrangements from 1 April 2024.

MB
LC
MC
RP

11.	**BLMK Fuller Programme – Outcome of Table Discussions from ICB Workshop** *Presented by Nicky Poulain, Chief Primary Care Officer* It was valuable to have representation from primary care networks from the four Places and from the local authorities at the ICB workshop on the BLMK Fuller Programme. There were discussions around what a neighbourhood is, what is meaningful to our populations, the access needs in each neighbourhood and how to address them. The outcome from the seminar has been shared with Place boards, and the following updates were given: **Luton –** *Sally Cartwright* Initial work is underway to identify neighbourhood geographical boundaries. This will then be shared with Place boards for wider discussion to identify what this means and next steps. **Milton Keynes** – *Maria Wogan* The Milton Keynes Health and Care Partnership (MK H&CP), which is the MK Place Board, has agreed to ask the Joint Leadership Team (JLT) to look at "locality working" – how it is referred to in MK - building on the Fuller work. This was agreed on 22 February before the Board Seminar and at the JLT meeting on 9 March, the notes from the Board Seminar were taken on board. All partners are committed to support locality working and see it as a priority area that could potentially be built into the MK Deal going forward. A draft action plan for a pilot of an area will be taken to the JLT meeting next week to agree next steps. There is good progress in MK and governance will be provided by the JLT and the MK H&CP. **Bedford Borough** – *Laura Church* Work had already started on how the local authority (LA) can respond to Fuller neighbourhoods. This has been taken to the Senior Leadership Team and there is good commitment across partners to look at this opportunity and see how the LA can engage productively with primary care networks and the extended teams that they offer for Bedford Borough. Some of the conversations are being shaped around the wider estates issue and the opportunity for primary care networks in particular to take all the Fuller neighbourhoods' opportunities. **Central Bedfordshire** – *Marcel Coiffait* The collaborative Fuller Forum has just met where all four Places were represented and there is much to be learned from what has been done in Leighton Buzzard. Due to a senior management change, a more detailed update will be given later. Across the four Places, it was acknowledged that this is all about helping our residents to help themselves and to understand the "art of the possible". It is also important to include all types of mental health services, which will link into the Mental Health and Learning Disability Autism (MHLDA) Collaborative. The Chair was pleased to hear of good progress in all four Places and hoped, within a few months, better to understand action plans, timescales and where Places might be struggling. The Board **noted**: • the feedback report from the ICB Board Seminar with the priority for each of the four Local Authority (LA) areas to define neighbourhoods that are meaningful to residents; and • that the ICB will support work at Place, with wide stakeholder engagement through the Collaborative Stakeholder Group, to develop well-functioning and diverse integrated neighbourhood teams that meet residents' needs.	

12.	**Core 20+5 for Children and Young People** *Presented by Sarah Stanley, Chief Nursing Director* Core 20+5 is a national NHS England (NHSE) approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies five focus clinical areas considered nationally to require accelerated improvement. This approach, which initially focussed on health inequalities experienced by adults, has now been adapted to apply to children and young people. This gives the ICB a clear framework with which to focus inequalities work for the population of children and young people, building on existing work at Place and identifying where working across BLMK will add value in terms of reducing inequalities. Existing pathways such as asthma, diabetes, epilepsy and mental health are already in place, in various forms, across the system. Oral health is likely to be an area of focus with the delegation of dentistry to the ICB. It was proposed to identify, with the support of population health data, a population group initially to focus on, to seek to solve some of the issues. It is likely that fixing some of the issues for this group would also benefit other residents. The Board **agreed** the proposed approach to focus on a population group and define the pathway around this. *There was a short refreshment break.*	
13.	**Managing Conflicts of Interest in Procurement** *Presented by Anne Brierley, Chief Transformation Officer* This policy expands on the existing Conflicts of Interest Management and Standards of Business Conduct Policy that the ICB approved in July 2022. It focusses on the procurement of large strategic clinical services such as MSK where there will need to be a full and proper procurement process, and where partner members may potentially be bidders. The paper sets out how the ICB manages any potential conflict of interest in each step of the procurement process. The Board: • **noted** the risks, issues and proposals within the paper; and • **confirmed** its agreement to the recommended ways of working.	
14.	**Transition of Delegated Community Pharmacy, Optometry and Dental (POD) Contracts to the ICB** *Presented by Nicky Poulain, Chief Primary Care Officer* The paper was taken as read and the Board: • **Noted** the work ongoing to progress the safe delegation of community pharmacy, optometry and dental (POD) contracting from NHS England to the ICB from 1 April 2023; • **Approved** a recommendation from Primary Care Commissioning and Assurance Committee (PCCAC) to accept delegation from 1 April 2023; • **Noted** the outstanding risks and view of internal audit, and support the recommendation of a side letter to the Delegation Agreement which sets out the ICB's concerns and limitations in relation to the readiness for delegation; • **Noted** the new governance arrangements for POD from 1 April 2023;	

	• **Approved** a recommendation to delegate pharmacy regulatory decisions to Pharmaceutical Services Regulatory Committee (PSRC), which is a designated statutory committee for decisions in relation to the pharmaceutical regulations; and • **Approved** the Memorandum of Understanding (MoU) and associated Standard Operating Procedure (SOP) with Hertfordshire and West Essex ICB for the management of pharmacy and optometry contracts and hosting the staff that will continue to support the six ICBs.	
15.	**Proposed Approach: BLMK ICS Joint Forward Plan (JFP)** *Presented by Anne Brierley, Chief Transformation Officer* Every ICB is required to prepare a Joint Forward Plan, with first submission being due by the end of June 2023. As discussed at the recent Board Seminar, BLMK ICB's ambition is to go beyond the specified five years and to be less NHS-driven and focused, with input from Health and Wellbeing Boards (HWBs). This would have to link into the Workforce Plan and capital and estates strategies. The JFP is about how to bring to life the strategy. The proposal is to focus on the most complex issues that are shared across health, civic and care partners that can only be resolved through partnership working. The intention is to look at the end to end pathway, but also step back and take a strategic view of services that may not previously have been viable, with the opportunities from POD delegation and new innovation in the digital area. There would be particular focus on health inequalities and prevention. The JFP will build on Place and collaborative provider plans that are already in place. Over the next few months, the key issues and resolution timelines for each partner provider will be identified. In particular, there needs to be an understanding of how many new homes will be built in the different areas across BLMK, the rate at which the populations are growing and how the demographic will change, all of which will affect health and care needs. Engagement is also very much at the core of this work with a draft of this JFP. A draft has already been shared with HWBs and an updated version will be shared in June. It is also being socialised with the VCSE network. There will then be further public engagement via the website. The Working with People and Communities Committee (WWPAC) has given support to the engagement plan. A report will be prepared on the JFP which can be taken to NHS trust organisations' Board meetings in May. It was confirmed that the Deputy Medical Director is working closely with the Chief Transformation Officer's team in relation to the clinical services strategy in parallel to the JFP work. *JH left the meeting.* The Board: • **approved** the approach to the BLMK development of the JFP; • **committed** to the proposed targeted public engagement work to ensure that there is a comprehensive and consistent approach to ensuring residents, including the VCSE community, have the opportunity to contribute to the development of the final Joint Forward JFP; • **considered** options to mitigate risk on timescales for Health & Wellbeing Board engagement (required) given the local elections; and	

	• **committed** to an action to confirm governance/approval within sovereign organisations (Councils and Trusts) before multi-agency review at Place Boards/ Health & Wellbeing Boards/ Provider Collaborative Boards.	
16.	**BLMK ICS 2023/24 Financial and Operating Plan** *Presented by Anne Brierley, Chief Transformation Officer and Dean Westcott, Chief Finance Officer* Recognising the shift to local decision-making at ICBs and Place, NHSE has tasked systems with a more streamlined, though still stretching, suite of 32 specific objectives which are measured against a set of standards, as well as balancing the finances. After a good start this year, with inflation a significant cost pressure, there has been good progress across all partner providers. The ICB is committed to having the maximum impact with the best use of its resources, aided by population health management tools. The Board: • **Noted** progress with the development of the Operating Plan 2023/24; and • **Agreed** for the final, submitted, plan to be approved by the ICB Chief Executive Officer following a meeting of system CEOs on 29 March 2023.	
17.	**Place Plans, Health and Wellbeing Board Updates and Guidance for Health and Wellbeing Boards and Integrated Care Boards** Written reports were taken as read and the Chair also asked local authority representatives to be prepared to give verbal updates at meetings going forward. **Milton Keynes Health & Care Partnership (MK H&CP) –** *Maria Wogan* A paper was delivered by public health on the Stop Smoking Service and Obesity Strategy. It was agreed to initiate the third priority in the MK Deal which is children and young people's mental health which is now underway. There was a good discussion around locality working. **Luton Health and Wellbeing Board (LH&WB**) – *Sally Cartwright* The Population Wellbeing Strategy is being refreshed, which will set the strategic direction for each of the sub-Boards. There was a discussion in relation to how updates and progress on Place Plans and H&WB updates would be shared going forward. A template is being prepared as a guideline for Place and HWB updates to this Board, with suggestions of what might be included, including how the wider agenda is being translated into Place, also what is happening at Place that needs to be escalated to the ICB and an understanding of how the work is linking back to a local level. **Action: MW to discuss how best to manage this area and to ensure that a process is in place for the next Board meeting.** The Board **noted** the written reports and verbal updates given.	MW
18.	**Quality and Performance Report** *Presented by Maria Wogan, Director of System Assurance and Corporate Services and Sarah Stanley, Chief Nursing Director* The report was taken as read and the following highlights and updates were given:	

	• The target to achieve zero 78-week waits by the end of March is at risk due to industrial action by junior doctors in March. Trust colleagues and system partners have been working hard to reduce the breaches; • The zero 78-week wait target for April will also be impacted by planned junior doctors' industrial action in April – which is a similar position for all ICBs currently; • There was a deep dive into lessons learned from last winter at the recent Quality and Performance Committee (Q&PC) meeting. Planning is already underway in the Milton Keynes and Bedfordshire systems to plan for next winter; • Q&PC also reviewed elective recovery work, in particular ophthalmology, and the committee was assured that work is in hand to tackle this; • The ICB is ranked in the lowest quartile, particularly around C-difficile and E-coli, which is being challenged as this does not seem to be correct; • Work will be done to address poor patient experience of making a GP appointment; • There have been two maternal deaths which are being investigated, staff are being supported and Heads of Midwifery are involved in trying to establish what happened in these two cases; • There was also a death of a gentleman in the back of an ambulance while waiting to be offloaded, which is also being investigated; and • National advice is being sought in relation to women who are choosing not to have a health care professional at the birth of their baby and are asking for an NHS number, which they are legally entitled to, but at no stage has the baby been seen by a healthcare professional, which represents a safeguarding issue. The monthly report is being improved and will in future capture more information in relation to primary care, community health and mental health, and not be focussed solely on acute care. The Board **noted** the written and verbal reports.	
19.	**Finance Report – January 2023 Month 10** *Presented by Dean Westcott, Chief Finance Officer* The report was taken as read and the following verbal updates given: • The ICB and its partner organisations remain on track to break even; • The main pressures continue to be related principally to agency and bank costs and inflation, which are also impacting planning discussions for next year; • For the ICB, there are particular pressures in relation to prescribing and increased costs for placements in relation to Continuing Health Care (CHC); • The ICB is on track to deliver its efficiency plan, although it should be noted that of the £55m that will be delivered, £15m will be non-recurrent. This will need to be addressed going forward into 2023/24; • Regarding capital, it is forecast to achieve capital departmental expenditure limit (CDEL), although there could potentially be some movement in this at BHFT and work is being done within the system to mitigate this to meet the ICB target; • The positions of the LAs are detailed in the Appendix – the pressures in the main relate to common themes impacting all the LAs in our area. All are working towards balance through a mixture of mitigating actions. The Board **noted**: • the month 10 and forecast position for revenue and capital; and • the risks to the financial forecast.	

20.	**Board Assurance Framework (BAF)** *Presented by Chief of System Assurance and Corporate Services, Maria Wogan* The report presented an update on activity in relation to the BAF since the last Board meeting. • There had been a good discussion in relation to BAF risks at the System Oversight and Assurance Group (SOAG) meeting, with particular focus on the population growth risk. It was agreed that the risk score should be increased. The mitigation plan was reviewed following the Board Seminar in February; • The highest scoring risks currently are population growth, workforce and system pressures; • There is an additional risk to assess in relation to resident expectations and how the system works together; • SOAG requested that risk assessments are undertaken for two risks related to collaboration: are we collaborating on the right things or are we over collaborating and not getting value from collaborations; and one focussing on ICS collaborations for our residents; • At the Q&PC a review of the risks in relation to industrial action and the impacts therefrom was requested; • There was also a request to work with LA colleagues to understand how risks are managed within their organisations, the governance of that and how it links through to the ICB. The Board **noted** the updated Board Assurance Framework and verbal updates.	
21.	**Corporate Governance Update** *Presented by Maria Wogan, Chief of System Assurance and Corporate Services* **The Board:** - **Approved** the proposed amendments to the ICB's Governance Handbook in relation to: • The Terms of Reference of the Primary Care Commissioning and Assurance Committee; and • Cover arrangements following the resignation of a Non-Executive Member. - **Noted** the following: • the resignation of Non-Executive Member; the recruitment of a Non-Executive Member and Chair of Audit Committee; • the update on recruitment for a Primary Medical Services partner member on the Board of the ICB; • the plan for the development of the Annual Report & Accounts 2022/23; • the proposed date for Annual General Meeting 2023 (29 September, same day as Board); and • Committee Chairs' updates, provided in appendix B. The following additional Committee Chairs' verbal updates were given: **Quality & Performance Committee** – *Shirley Pointer, Chair* In addition to the items included in the Quality and Performance Report above, at the last meeting, there was a review of ophthalmology recovery arrangements and it is	

	intended for there to be a deep dive into recovery areas at each meeting going forward. **Bedfordshire Care Alliance (BCA)** – *Shirley Pointer, Chair* BCA has been looking at how the success and integration across the BCA is shared more widely, in particular where colleagues have worked across boundaries. The work plan for the BCA has been reviewed and slimmed down, to allow the BCA to focus on the key priorities for the whole of Bedfordshire. There is not currently a specific workforce workstream in the BCA and work is being done with the ICB Chief People Officer to understand what needs to be done by the BCA and local partners. ***Finance and Investment Committee (F&IC) –*** *Rima Makarem, Chair* The Finance and Investment Committee has met since the last meeting. There are no further updates other than the papers presented to Parts 1 and 2 of this meeting.	
22.	**Annual Cycle of Business 2023/24** *Presented by Maria Wogan, Chief of System Assurance and Corporate Services* The Board **noted** the draft Annual Cycle of Business for 2023-2024. All members and participants were encouraged to proposed items for ICB meeting agendas. Any requests should be sent to the Chair.	
23.	**Communications from the meeting** It was **agreed** that the Communications Team would prepare a summary of updates from the meeting to share with partner members to include: • MSK and pain relief, including the Resident Story element; • Fuller Update; • Approach to Core 20+5 for children and young people; • Transition of POD Update; • JFP approach; and • Financial and Operating Plan. **Action: MW (Comms Team) to prepare a summary of updates from the meeting to share with partner members as above.**	MW
24.	**Review of Meeting Effectiveness** The Chair asked the question - "was the time allowed/taken on each agenda item sufficient?" All present considered that the timing scheduled for and given to agenda items had been good.	
25.	**Any Other Business** There was none.	
26.	**Date and Time of Next Meeting:** The next meeting of the Board is currently scheduled to be held on Friday 30 June 2023 at Central Bedfordshire Council Chamber, and there is also an Extraordinary Meeting on 23 June to approve the Annual Report and Accounts.	

	The Chair read the Resolution to exclude members of the press and public to part 2 of this meeting: The Board of the Integrated Care Board resolves that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest, Section 1(2), Public Bodies (Admission to Meetings) Act 1960. *The meeting closed at 12.37.*	

Approval of Draft Minutes:		
Name	Role	Date

APPENDIX

Three Questions from Members of the Public – meeting 24/3/23
With Answers

PQ1 - Relating to Bad Diet, Poor Health Epidemic and Environmental Issues

Board of the ICB – 24/3/2023

QUESTION	ANSWER
Do the members agree that bad diet (junk food, processed meats, red meats, cheese, refined foods, foods high in sugar, fats and salt, and low in fibre, fruit and vegetables) is causing an epidemic of poor health (heart disease, cancer, obesity, diabetes etc), as well as causing environmental problems?	Members agree that an unhealthy diet and lack of physical activity are leading risks to health, and adopting a healthy diet helps to protect against malnutrition in all its forms, as well as non-communicable diseases, including obesity, diabetes, heart disease, stroke and cancer. Members recognise that food needs to be grown, processed, transported, distributed, prepared, consumed, and sometimes disposed. All these steps create greenhouse gases that are contributing to climate change. Moreover, at current consumption levels, certain foods, particularly red and processed meat and dairy[1][2], are causing damage to our health and the planet. On the other hand, increasing our consumption of fruit, vegetables and legumes will reduce our risk of non-communicable diseases and help protect the environment. Ultimately, it is recognised that the current food system needs to adopt healthier, more equitable and more sustainable ways of producing and consuming food (Agroecology).
If so, do you see it as part of your responsibility to tackle this cause of ill health and planetary destruction, and not just to treat the symptoms (which is what the NHS does)?	In accordance with the government's food strategy, steps need to be taken to create a more prosperous agri-food sector that delivers healthier, more sustainable and affordable diets for all. The strategy identifies a number of measures to achieve this, targeting a variety of actors across the entirety of the food supply chain. In the Long Term Plan, the NHS recognises its role in supporting healthier diets, introducing healthier food options for staff and patients and improving nutrition training in health professional education. Furthermore, in 'Delivering a Net Zero NHS', the NHS recognises the contribution of food and catering

[1] https://www.lancetcountdown.org/data-platform/mitigation-actions-and-health-co-benefits/3-5-food-agriculture-and-health/3-5-1-emissions-from-agricultural-production-and-consumption

https://www.lancetcountdown.org/data-platform/mitigation-actions-and-health-co-benefits/3-5-food-agriculture-and-health/3-5-2-awaiting-data-diet-and-health-co-benefits

[2] https://www.thelancet.com/article/S0140-6736(22)01540-9/fulltext

QUESTION	ANSWER
	to its carbon emissions and acknowledges that the diet recommended by the government's EatWell plate is low-carbon as well as healthy. In the Bedfordshire, Luton and Milton Keynes Integrated Care System Green Plan, BLMK has identified food and nutrition as a key theme that will support the BLMK five priorities for health and social care and reduce its environmental impact. The councils have also noted the importance of improving locally sourced food options, providing more opportunities to grow food locally and reducing food waste in their climate action plans and food plans. • Bedford Borough Council – Carbon Reduction Delivery Strategy 2020-2030 • Central Bedfordshire Council – Sustainability Plan • Luton Borough Council – Climate Change Action Plan and Food Plan 2018-2022 • Milton Keynes Council – Sustainability Strategy 2019-2050 Luton Council has also developed a Climate Change Guide that provides advice on how to take action in different areas from making changes in your home to how you travel and the food you eat.
What are you prepared to do and what are you doing to promote plant-based foods and to help restrict meat, dairy, and junk foods?	Locally, our aspiration is to support the formation of Local Food Partnerships that bring together councils and partners from the public sector, voluntary and community groups, and businesses to reduce diet-related ill health and inequality, while supporting a prosperous local food economy. Councils are also exploring what policy levers are available to them in their capacity as local authorities to address their local food environments. The Bedfordshire, Luton and Milton Keynes Integrated Care System has committed to reducing food waste across our sites and facilities, phase out plastic packaging, and provide healthier, more locally sourced, and sustainable food choices. We will work with key stakeholders across the system to deliver these commitments. The NHS National standards for healthcare food and drink set requirements for healthy and sustainable meals for patients, staff, and visitors. All NHS organisations are required to meet these standards. More detailed local actions on food and nutrition are also specified

QUESTION	ANSWER
	in the Milton Keynes University Hospital and Bedfordshire Hospitals NHS Foundation Trust Green Plans.

PQ2 – Ivel Medical Centre, Biggleswade Closure / Board of the ICB – 24/3/2023

Board of the ICB 24/3/23

QUESTION

The Partners of the Ivel Medical Centre in Biggleswade have handed back their GMS Contract back to the Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB). Since this announcement, the ability to obtain a doctor's appointment has become even more difficult. What are the ICB actively doing to resolve the issue, including the hiring of additional staff to serve the increasing population of Biggleswade?

I know a new hub is being considered but this may be rejected, so what is the plan? These are difficult times for us all in Biggleswade, communication from the ICB on progress would be much appreciated.

ANSWER

The partners of Ivel Medical Centre resigned their General Medical Services (GMS) contract giving 6 months' notice. Their contract will terminate at midnight on 31 May 2023. The partners continue to be responsible for providing primary medical services during their notice period. We have written to all patients to confirm that we do not need them to take any action, and that we will keep them updated of any developments.

The most recent data confirms:

- The total number of appointments recorded at the practice is steady and the % of GP appointments has increased from 48% to 59%;
- Face-to-Face appointments each month are between 92-95%, (national average of 68%); and
- Appointments booked on the same day have increased to 57%.

There are weekly meetings with the practices to support the safe handover to a new provider, and the partners of the practice are working closely with the ICB to support and retain staff during the notice period. The employed staff are aware they will Transfer under Protected Employment (TUPE) rights to the new provider on 1 June 2023.

The ICB is providing additional dedicated management support to the practice to help to recruit to vacant posts. In the last week, the partners have confirmed they have successfully recruited an experienced receptionist who will transfer to the new provider on 1 June 2023.

The ICB has a responsibility to secure a new provider from 1 June 2023 and as such is currently undertaking a procurement process. Given the commercially sensitive nature of this process the ICB cannot provide further updates but expects to be in a position to announce the new provider in mid April 2023.

As regards new hub in Biggleswade, we continue to work with our health and care partners to develop proposals. No decisions have been made about new integrated health and care hubs in BLMK.

PQ3 – Living Wage Foundation Meeting – in relation to Health Inequalities

Board of the ICB – 24/3/2023

QUESTION

As BLMK work to reduce inequalities in everything they do, and are specifically looking to reduce systemic inequality, would Felicity Cox agree to meet with leaders from Citizens UK and a representative from the Living Wage Foundation to discuss the benefits of becoming Living Wage accredited. The real Living Wage rates are higher because they are independently-calculated based on what people need to get by.

Luke Larner, Priest, St Paul's Church Bedford
Catherine Butt, Vicar at St Frideswide's Church Bletchley
Rebecca Stockman, Affordable Housing Development Consultant, LivShare Housing

RESPONSE

Thank you, Father Larner, Reverend Butt and Ms Stockman.

We would be very pleased to meet with leaders from Citizens UK and the Living Wage Foundation to discuss the matter of the 'Living Wage' and to understand Living Wage accreditation. We are grateful for the contact you have made and look forward to meeting with you.

Integrated Care Board MASTER Action Tracker as at 12.5.23

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Key

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

Action No.	Meeting Date	Agenda Item	Action	Action Owner	Past deadlines (Since Revised)	Current Deadline	Current Position (latest update)	RAG
37	27/01/2023	Chief Executive's Report	MS and MT to discuss communication of the newly published strategy to residents	Michelle Summers and Maxine Taffetani	27/02/2023	30/06/2023	**26/04/23:** We are working with partners to book in slots for filming. This includes providing versions in BSL. **27/3/23**: This remains in progress. **7/3/23** The Health and Care Partnership Strategy has been published to the website. We are currently looking at how we provide accessible versions of the plan, including video to make this information easy to access for local people.	**COMPLETE: Propose closure at next meeting (30/06/2023)**
42	24/03/2023	Questions from the Public	Communications Department to make Questions from the Public and answers available on website following the meeting	Maria Wogan / Michelle Summers		30/06/2023	Completed after Board meeting.	**COMPLETE: Propose closure at next meeting (30/06/2023)**
43	24/03/2023	Resident's Story	Chief Nursing Director to arrange a multidisciplinary discussion to include primary and secondary care to formulate a personalised care plan for Roxy.	Sarah Stanley		30/06/2023	Discussions have taken place and support and advocacy has been arranged	**COMPLETE: Propose closure at next meeting (30/06/2023)**
44	24/03/2023	Integrated MSK and Pain Services	Local Authority representatives to nominate a representative (public health or social care) by 6 April to work in partnership with the ICB to identify new MSK provider arrangements from 1 April 2024	Tara Dear Michael Bracey Laura Church Marcel Coiffait Robin Porter		01/04/2024	MSK contract has been extended for one year, during which time engagement with Place will take place.	
45	24/03/2023	Place Plans, HWB Updates and Guidance for H&WB Boards and ICBs	To discuss how best to manage this area and to ensure that a process is in place for the next Board meeting	Maria Wogan		30/06/2023	**30/6/2023: Place report is included in the agenda for meeting**	**COMPLETE: Propose closure at next meeting (30/06/2023)**
46	24/03/2023	Communications from the Meeting	Communications Team to prepare a summary of updates from the meeting to share with partner members as above	Maria Wogan/ Michelle Summers		30/06/2023	**30/06/23: Communications from Board meetings are issued to partner members and reports to Council Health and Wellbeing Boards and NHSTrust Boards**	**COMPLETE: Propose closure at next meeting (30/06/2023)**

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

Executive Lead: Felicity Cox, Chief Executive Officer

Report Author: Georgie Brown, Chief of Staff

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

Item: 3 – Chief Executive Officer's Report

1.0 Executive Summary

1.1 This report provides a summary of corporate activities since the last Board Meeting on 24th March 2023.

2.0 Recommendations

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

3.0 Key Implications

Resourcing	
Equality / Health Inequalities	✓
Engagement	✓
Green Plan Commitments	

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

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

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

3.6 The following individuals were consulted and involved in the development of this report:
Anne Brierley, Chief Transformation Officer
Nicky Poulain, Chief Primary Care Officer
Martha Roberts, Chief People Officer
Maria Wogan, Chief of System Assurance and Corporate Services

4.0 Key Updates

4.1 **Target Operating Model (TOM):** The implementation of the Target Operating Model (TOM) continues, ensuring that between now and the end of 2025, we take 30% out of our running cost allowance. The TOM has been discussed with the whole Board, and through June, the CEO has met individually with system chief executives to share perspectives and discuss ideas. As part of this, the ICB will be going out to consultation with staff side and engaging staff in a future structure, this will start week commencing 26 June and run for 45 days. The ICB plans to make the reduction in running cost over two years, 20% by the end of March 2024 and a further 10% by the end of March 2025.

4.2 **Fuller:** The ICB continues to make progress with our partners to implement Fuller Integrated Neighbourhood Working across BLMK which will provide our residents with good access to

same day primary care, continuity of care where needed, and a preventative offer that supports more healthy years.

At place, defining neighbourhood footprints is progressing well with each place board or its equivalent, setting out plans for their footprints, and developing population profiles and mapping the stakeholders and assets that will be crucial to success. It is anticipated that most of the neighbourhood footprints will be defined by the 30th of June 2023.

The publication of the 'Delivery Plan for Recovering Access to Primary Care' provides further support to the work practices, PCNs and all primary care providers are doing to develop access for the population. The ICB primary care team are working closely with Practices and PCNs to ensure we make use of the Universal, Intermediate and Intensive support offers available through the General Practice Improvement Programme. Funding to move more practices onto Cloud Based Telephony (currently we have 46 practices on CBT in BLMK) is still being negotiated with regional teams and is an important aspect in how we improve our population's access to their registered practice. The PCN DES Access Improvement Plans are being drafted now by PCNs, with support from the ICB primary care team, and these will articulate how modern general practice access – at scale where appropriate - will be delivered across BLMK. The focus here will be on improving patient experience of contact, ease of access, demand management and accuracy of recording in appointment books which will ensure there is a true picture of demand and capacity in general practice for effective planning into the future.

4.3 **Mental Health Collaborative:** In September 2022, the BLMK ICB approved in principle for the two mental health providers in BLMK (Central and North West London NHSFT and East London NHS Foundation Trust) to form a provider collaborative that, over time, will take on increased delegation for NHS mental health, learning disability and autism services (MHLDA).

The purpose of the collaborative is to work with places to deliver our shared goals to improve access, experience and outcomes for BLMK residents living with mental illness, learning disabilities and / or autism spectrum disorders. This goes beyond the delivery of the NHSE mental health investment standards to tackle the challenges of rising need and demand for mental health services post-COVID (especially children and young people) to tackle inequalities experienced by these populations.

The development of the overarching transformation programme is under development. A series of co-production events with services users has been undertaken to understand what matters most to them in how these services are delivered; and work continues with our Boroughs, NHS providers and voluntary sector partners to ensure that we co-produce enhanced care pathways that meet the needs of our local populations. The collaborative transformation will focus on our shared strategic plans to provide recovery-focused complex placements for people with the highest needs; extending our community crisis support to offer local care to all people in crisis; working with the national Getting It Right First Time (GIRFT) team to develop our services to deliver in line with best practice, all of the time; and our shared medium-term workforce plan to deliver the additional clinical capacity funded through the NHSE mental health investment standards.

The providers will present these elements within the the MHLDA Provider Collaborative proposal to the BLMK ICB Board in September and the transition period to 'go-live' (pending final approval) which will run November 2023 to March 2024.

4.4 **Board Seminar 26th May:** The Board seminar focused on building trust to support our effectiveness as a Board and as an integral part of our approach to Quality Improvement and the notes have been circulated to Board members. Our next Board seminar is on 21 July, this will be a joint seminar with the ICP with a focus on supporting people with health issues to remain in or return to employment.

4.5 **MSK:** Following the ICB Board in March 2023, further factors arose necessitating the need to review the MSK procurement timetable. As a result of this review, the ICB will be enacting the one-year extension option within the current provider contracts to allow further market engagement, a robust competitive procurement and additional time to continue to engage with patients and residents. This decision was based on the following factors:

- Bedford Borough Council Overview and Scrutiny Committee recommendation
- Good market testing response, but the complexity of feedback along with potential bidders suggesting further early supplier involvement would enhance the partnership development needed to achieve all the benefits
- Opportunity to learn from Sussex ICB who plan to undertake a similar procurement exercise, learning from their approach to the finance and outcome measures
- The need to adjust other contracts to ensure components of the MSK specification are not duplicated elsewhere (maximise value and reduce repetition)
- Development of an MSK Estates Strategy to design locations based on need and footfall rather than historic arrangements

In the interim period, the ICB will continue to work with patients and existing providers to improve care, with a specific focus on the points raised in the patient engagement events.

4.6 **POD Delegation:** The delegation of the contracting of Pharmacy, Optometry and Dental (POD) from NHS England to the ICB took place as planned on 1st April 2023. The Dental contracting team transferred to the ICB, and the Pharmacy and Optometry contracting team transferred to Hertfordshire and West Essex ICB where they will continue to work on behalf of the six ICBs in the region. Engagement with the contractors has commenced through initial meetings with the representative Local Committees. There is already existing good partnership working with the Local Pharmaceutical Committee, and through the ICB Medicines Optimisation Team there are already a number of local initiatives planned and underway. A meeting took place on the 8th June 2023 to bring together the ICB's Primary Care team, the Medicines Optimisation Team, Pharmacy Transformation Lead and Chief Pharmacist to set out a joint work plan, and also discuss how to start to integrate Pharmacies in to the neighbourhood and Fuller workstreams, where they are not already. Next, we will engage with Public Health colleagues to develop and ensure inclusion of POD in the BLMK prevention and health inequalities programme.

On 29th June we engaged with local Dentists via a joint event with BLMK Local Dental Committees. This inaugural session introduced the ICB, setting out the opportunities and barriers to delegation, and planning how to work together, introducing neighbourhoods and Fuller and the contribution they can make at place level. We have had an initial meeting with the Local Optometry Committee and a follow up is planned to further explore how we can engage local Optometrists, building on the existing work that has been done on the Community Urgent Eye Service and pathway developments. Internally, the Primary Care Team are working with Finance colleagues to understand the budget and cost positions of these contracts, as well as establishing the activity and performance of the contracts. The limitations of the national contracts that we had identified as risks as we planned for delegation have been set out by the NHS Confederation in their report "From delegation to integration: lessons from early delegation of primary pharmacy, optometry and dentistry commissioning to integrated care boards" published on 3rd April 2023, and we have prepared a briefing which will be shared with key stakeholders to help us manage expectations around the pace of change. It very much reflects our position that 2023/24 needs to be a year of stabilisation rather than rapid change, and also highlights the need for a number of actions that need to be taken by NHS England at a national level to facilitate improvement as they are outside of the influence of ICBs. We will continue to monitor the national position closely as we work to develop and maximise the opportunities that delegation offered through local integration and direct links with the POD providers at ICB level.

4.7 **Specialised Commissioning:** NHS England has set out a timetable of due diligence for 59 services lines of specialised commissioning of health services currently commissioned by regional NHSE teams to be delegated to ICBs on 1st April 2024. This includes services such as cancer, neuro-rehabilitation, and specialised services including respiratory, renal and cardiovascular.

The process of due diligence to provide assurance to both regional NHSE and receiving ICBs is underway. BLMK, as the potential host of this on behalf of the East of England ICBs is leading the ICBs' due diligence. Using transition funds from NHSE for this purpose, BLMK has procured the services of an independent consultancy to undertake due diligence covering all areas of this delegation, including the risks and opportunities in quality, finance, resources and transition. The consultancy is engaging with each stakeholder, and a report with recommendations will be presented to ICB Boards in September 2023.

In parallel, NHSE East of England and ICBs have formed a Joint Committee, jointly chaired by Felicity Cox (on behalf of the ICBs) and Ruth Ashmore (Regional NHSE Executive for Specialised Commissioning). This is overseeing the existing specialised commissioning transformation plan, the process of mutual due diligence, and the development of proposals as to how delegation will function in the East of England. This includes joint oversight of the specialised commissioning service lines that will remain with the regional NHSE team.

4.8 **Operational Plan 23/24:** The ICB submitted a financially balanced and largely compliant plan in May 2023. There remains both a financial and delivery challenge for the system in the forthcoming year and there is a need for a focused approach to delivering the core requirements, which includes a system approach to the management of Urgent and Emergency Care. Delivery for 23/24 will work to ensure that, the GIRFT indicators and efficiency/productivity expectations are achieved towards top decile GIRFT performance. We will collectively need to work to an ambition/assumption to minimise as far as practicable, our reliance on escalation and surge areas, maximising alternatives to ED and admission and ensuring efficient and timely flow out of hospital. Further work will need to be done at place and alliance, ensure a sharing of the risk and joint accountability.

4.9 **ICB Forward Plan and Portfolio Tool:** Since the last Board Meeting in January, the ICB has been working to develop a clear Decision Planner for the Board for the forthcoming year, along with a portfolio of our key programmes of work. The aim is to ensure our timeline of activities, engagement, communications and decisions are mapped and planned to an agreed timeline.

4.10 **ICB Appraisals and Development:** ICB Chiefs have undertaken their annual appraisals through June, including 360 reviews. NEM appraisals are also being planned. We have spent time both as an Executive team, and with NEMs in their role as committee chairs, to develop our working relationships, practices and priorities. We look forward to continuing this development at our time together as a full Board in October.

4.11 **New Local Authority Councillors:** Following the recent local elections we have begun to meet with some of the new Councillors across BLMK, we are also pleased to be developing some information and briefings on the IC for new Councillors as part of their induction.

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

28 March	**NHS East of England Equality and Reducing Health Inequalities Programme Board** The CEO became the ICB Chief Executive Lead for health inequalities this month, undertaking Co-Chair responsibilities for the Health Inequalities Board alongside Aliko Ahmed, Regional Director of Public Health at NHS England.
30 March	**Living Wage Meeting with Citizens UK**

	The CEO and members of the ICB People Team met with representatives from Citizens UK to discuss how the ICS can contribute to improving continuity and quality of care by addressing staff shortages and through reducing working poverty.
31 March	**Executive to Executive with Central Bedfordshire Council** Focusing on key priorities, Primary Care Estates, Place arrangements
31 March	**BLMK Mental Health Summit** The Chair and CEO attended the event hosted by the two main providers of NHS mental health care for BLMK: East London NHS Foundation Trust (ELFT) and Central North West London NHS Foundation Trust (CNWL). The event brought together service users, carers and any members of the public who have accessed the area's primary or secondary mental health services to help shape mental health care planning and delivery across Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. The purpose of the event was to directly form the priorities for our mental health services in BLMK with an opportunity for people to share their views and experience about what is working well for mental health care and where it needs to improve.
3 April	**Leighton Buzzard Site Development Project Meeting** The inaugural meeting of this group, Chaired by Suki Joy, Commercial Finance Manager from the Department of Health and Social Care, with the aim of bringing stakeholders together to refine plans for the Leighton Buzzard site. The meeting was attended by representatives from the ICB, Central Bedfordshire Council, NHS Property Services and MKG Advisory Limited.
4 April	**Contributing to the implementation of Luton as a Marmot Town** The CEO joined a virtual meeting with Ramyadevi Ravindrane and Lee Watson from Luton Borough Council to provide input into the implementation of Luton as a Marmot Town. The ICB is supportive of this vision and shared with the meeting attendees how the ICB is tackling health inequalities in Luton.
5 April	**Visit to the Maple Centre at Milton Keynes University Hospital NHS Trust** John Blakesley, Deputy Chief Executive, provided the CEO with a guided tour of the Centre, which opened on the 31 October 2022 and provides dedicated space for both medicine and surgical Same Day Emergency Care (SDEC) pathways to the population of Milton Keynes.
25 April	**ICB Quarterly Review Meeting (Q1**) The ICB met with NHSE for the Quarter 1 review meeting. This focused on the Operational Plan for 23/24 and they key financial and operational position ahead of the ICB meetings with the National Team.
27 April	**ICB Roadshow with National NHSE Team** The Chair, Chief Executive, Director of Finance and Joe Harrison met with the national team on the 23/24 Operational plan and current position ahead of the final submission in May. This meeting focused on the financial position alongside the key challenged areas of UEC (inc discharge), Elective and Outpatients and Cancer.
10 May	**Executive to Executive with Bedfordshire Police**
7 June	**Virtual Meeting with Minister Neil O'Brien** - Primary Care Capital in Central Bedfordshire This meeting focused on Leighton Buzzard, Biggleswade and Cobbs Garden.
19 June	**Virtual Meeting with Minister Quince** - ICB Touchpoint and key performance issues attended by the Chair and Chief Executive

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

NHS England issued revised statutory guidance on delegation and joint working arrangements for ICBs, NHS trusts and foundation trusts. This supersedes guidance that was produced in September 2022. The guidance provides opportunities for changes to the way some NHS functions are carried out, although it defers implementation of the new arrangements until after 2023/24. The guidance only applies to delegation to other NHS bodies – delegation to local authorities remains covered by section 75 (NHS Act 2006). More information can be found here: Guidance for delegation and joint working arrangements

New guide launched to help ICSs increase public participation in research.
A new guide has been published by NHS England to support ICSs to increase the public's participation in research. It identifies the barriers to participating in research faced by groups and provides practical tips. The guidance sets out what good research practice looks like and supports integrated care boards in fulfilling their research duties. Download the guide here.

Other information published by NHSE for Board to note:

Health and Social Care Select Committee: Integrated Care Systems: autonomy and accountability. The Health and Social Care Select Committee (HSCSC) has published their inquiry report on integrated care systems: autonomy and accountability. The report considers similar themes to the forthcoming independent review of ICSs, led by Patricia Hewitt and puts forward recommendations for the government and NHS England to create the conditions that will enable ICSs to succeed. Read the full report here.

CQC: Our approach to assessing integrated care systems. The CQC has published interim guidance for assessing integrated care systems, which is awaiting government approval. To design the assessment, CQC has been working in partnership with ICSs, local government organisations, NHS England and others. They are also engaging with the Hewitt Review process and, once findings are published, will consider any important information for their approach that may results in amendments. Read the article here and view the interim guidance here.

NHS Confederation: Hewitt review: what you need to know. This briefing from NHS Confederation provides a summary and analysis of Patricia Hewitt's review into oversight, governance and accountability of integrated care systems. It suggests that, if fully implemented, the review's recommendations offer a step change in enabling ICSs to deliver their four main statutory purposes. Read the briefing here.

NHS Confederation: How have provider collaboratives been set up? This briefing from NHS Confederation unpacks the findings from engagement with provider collaborative leaders around establishing their governance arrangements. The outcomes reveal there is wide variation across the governance spectrum, with many collaboratives at the less developed stage. While it is suggested that the development end state is often undefined, a clear sense of the path leading towards more defined and formalised approaches is identified. Read the briefing here.

5.0 Next Steps

5.1 As described in this report.

List of appendices

None

Background reading

None.

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

ICS Partner: Reverend Lloyd Denny, the Author of the Denny Review and Paul Calaminus, Senior Responsible Officer (SRO) for Health Inequalities (at the time of writing the report)

ICB Executive: Maria Wogan, Chief of System Assurance and Corporate Services

Report Author: Michelle Summers, associate Director Communications and Engagement

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

Item: 6.1 - The Denny Review

1.0 Executive Summary

1.1 The Denny Review into Health Inequalities across Bedfordshire, Luton and Milton Keynes will be published in July this year.

1.2 This is a landmark study for the ICS that will, subject to the Board's approval, inform work over the next three years, with its findings embedded across everything the ICB does.

1.2 Over the last three years Reverend Lloyd Denny, a former Patient Participation Lay Member from Luton Clinical Commissioning Group (CCG) has been working with health and care partners and residents from across the system to undertake a root and branch review of health inequalities in Bedfordshire, Luton and Milton Keynes.

1.3 The Review sought to understand:

- Which communities experience the greatest health inequalities in our area;
- What the barriers are;
- What the lived experiences of health inequality are; and
- How we can remove barriers, improve experience and create good health in our population.

1.4 Using population health data, analysis and insights from residents who have lived experience of health inequalities, a series of tactical (short-term) and strategic systemic (medium-long-term) recommendations have been co-produced with residents and partners.

1.5 These recommendations go to the root of health inequalities and are designed to break down barriers to good health – a first step in helping people in Bedfordshire, Luton and Milton Keynes to live longer lives in good health.

1.5 This paper will report on what we have learned from the Denny Review and what recommendations, with Board approval, can be taken forward to make a positive change to the experiences and lives of the people and communities we serve.

2.0 Recommendations

2.1 The members are asked to:

1. Approve the proposal to publish the Denny Review and all its recommendations in July.

2. Endorse the proposals for implementing the short-term and medium-longer term recommendations from the Denny Review including the proposed communications, engagement and co-production activity to build on the work of the Review.
3. Share their particular sector perspectives on how the findings can be embedded in everything we do.

3.0 Key Implications

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

3.1 Resourcing - To date, the Denny Review has been delivered by a small team which includes the Associate Director of Communications and Engagement for the ICB, the Inequalities Lead for the ICB and a Programme Manager from ELFT. Should the recommendations in this report be approved, a team from the current ICB establishment should be assembled to implement this work at scale and support implementation of work through partners at place.

3.2 Health Inequalities - This paper is focused on achieving health equality in Bedfordshire, Luton and Milton Keynes.

3.3 Engagement - Extensive engagement has been undertaken over three years, starting with the Descendants of Windrush in Bedford Borough before expanding to include seldom asked communities from different backgrounds in our area. It is important to note that the insights from this engagement have been incorporated into the Joint Forward Plan for 2023/24.

3.4 Green Plan Commitments – While this paper is not focused on the commitments from the green plan, engagement with seldom asked communities means that there are routes to communities of interest to support future co-production and engagement.

3.5 Before being submitted to the Board, this paper has been shared with:

- Reverend Lloyd Denny, the Author of the Review,
- Paul Calaminus, Senior Responsible Officer (SRO) for Health Inequalities,
- Julia Robson, Health Inequalities Lead for BLMK ICB,
- Maria Wogan, ICB Chief of System Assurance and Corporate Services,
- Dominic Woodward-Lebihan, ICB Deputy Chief System Assurance and Corporate Services,
- Manjeet Gill, Chair of the Working with People and Communities Committee
- Members of the ICB's Working with People and Communities Committee
- The Health Inequalities Steering Group,
- Chief Executives of Healthwatch Milton Keynes, Healthwatch Bedford Borough, Healthwatch Central Bedfordshire and Healthwatch Luton.

3.6 GPs and practice teams have also had the opportunity to share their views on the findings of the report, following a seminar for primary care on 21 June 2023.

4.0 Report

4.1 Over the last three years Reverend Lloyd Denny, a former Patient Participation Lay Member from Luton CCG has been working with health and care partners from across the system to undertake a root and branch review of health inequalities in Bedfordshire, Luton and Milton Keynes.

4.2 The Review sought to understand:

- Which communities experience the greatest health inequalities in our area;
- What the barriers are;
- What the lived experiences of health inequality are; and
- How we can remove barriers, improve experience and create good health in our population.

4.3 Partners from local authorities, public health, Healthwatch, the VCSE, University of Bedfordshire and the NHS came together to form the Health Inequalities Steering Group (known as the Denny Review Group) and agree the basis of the study.

4.4 The Review team commissioned a Literature Review from the University of Sheffield to compile and analyse all the data that had been written about health inequalities in our area.

4.5 While the data showed that health inequalities lead to disease like diabetes, cancer, cardiovascular disease and hypertension, the University of Sheffield advised the Group to consider intersectionality as the foundation in the methodology of the study, rather than looking at homogenous groups.

4.6 The Literature Review highlighted that the people most affected by health inequalities were:

- Gypsy, Roma and Traveller communities
- People who live in deprived neighbourhoods,
- People with learning and physical disabilities
- Homeless people/rough sleepers,
- Migrants and;
- LGBTQ people.

4.7 Based on this insight, population health data was used to map where the health inequalities were most prevalent in our four local authority areas and discussions were undertaken with four Healthwatch organisations and the VCSE to understand which organisations had the most trusted relationships with the communities of interest to undertake engagement and discovery interviews.

4.8 Engagement was undertaken with individuals and communities from August – December 2022 and the findings from interactions were shared with the Denny Review Steering Group in March 2023.

4.9 Using a Quality Improvement approach, workshops were held with partners, and this has since been widened to include health and care professionals including GPs and practice teams to enable us to review and consider the recommendations for improvement from the engagement process and the Literature Review.

4.10 From the interviews and surveys undertaken, the following feedback was provided:

- People do not know how to access health services
- People are struggling to access services
- Language barriers mean that people rely on partners, family members or friends for interpretation and sometimes this is inappropriate

- People feel they are not listened to
- Some female refugees feel uncomfortable seeing a male doctor and they do not know they can ask for an alternative
- The care given in practices is not tailored to the needs of a person
- Virtual appointments can create barriers for those with physical and learning disabilities and failure to attend appointments either in hospital or with their surgery can result in people being removed from waiting lists
- Traditional hours of access do not suit everyone
- LGBTQ people feel outed every time they make an appointment
- Racism and unconscious bias are prevalent in our system
- People feel they cannot trust health and care professionals
- Long waits for treatment can impact a person's mental health
- Wider determinants including housing concerns have a detrimental impact on wellbeing, anxiety and mental health.
- There is a 'one size fits all' approach applied to health and care which makes people feel that services are not for them.
- Communication must come in different forms to break down barriers.

4.11 While the report exposed many different lived experiences, there were some common themes including:

- Accessibility of services provided
- Culture and culturally inappropriate language, imagery
- Poor communication in terms of language, literacy, mode and frequency.
- Cultural competency within organisational settings
- Unconscious bias and racism

4.12 The most important insight to come from the Literature Review and the engagement process was that failure to take a person-centred approach to health and care is widening and entrenching health inequalities as people feel that services are 'not for them', and they disengage.

4.13 As one resident explained: "I've given up on myself. No one cares, why should I?"

4.14 Another person told us "Language barrier, culture, age. I am old. I am not a priority anymore."

4.15 Both tactical (short term change) and strategic systemic change is needed to address the concerns residents have about health and care services in Bedfordshire, Luton and Milton Keynes.

4.16 There is no magic bullet to solving health inequalities, but timely and sustained action in the next three years will help us to improve the lived experiences people have and start the long process of building trust and breaking down barriers to good health with communities.

4.17 This can be achieved by implementing recommendations including (but not exhaustive):

4.18 Tactical (short-term-change):

- Asking patients how they wish to be communicated with and providing choice e.g video messaging, email, text, letters.
- Training for transgender awareness, deaf awareness etc.
- Roll out of female only clinics – in all female settings (delivered through a PCN) at weekends.

- Refresh of all Patient Participation Groups and mandating PPGs in GP contracts to ensure co-production is embedded in all surgeries.
- Accessible communications produced and a campaign run to explain how to access health and care services.
- Flagging system introduced on SystmOne to highlight individual needs before a patient attends an appointment to provide person-centred care.

4.19 Strategic systemic change (medium-long-term change):

- The introduction of a system wide translation service
- Introduction of 'Access Champions' across the system to support individual access needs
- Extended and improved access delivered through our approach to Fuller Neighbourhoods
- Embedding the requirement of co-production and EDS2022 into the contracting and contract management process
- Investment in advocates at place to continue to engage with communities of interest to help them stay involved/influence and break down barriers
- Involvement from anchor institutions, housing officers and mental health professionals in settings to support hidden communities for example homeless people/ those with learning disabilities.
- Introduction of a flagging system to highlight personal needs before a resident enters the system.
- Mandatory training for all health and care professionals.
- Review of all communications materials and imagery in our area and promoted nationally to influence change.

4.20 While these recommendations have been put forward by residents and partners following the Quality Improvement process, more work is needed with health and care professionals to respond to the feedback we have heard.

4.21 An initial meeting with GPs was held on 21 June, but further work should be undertaken with community pharmacists, dentists, optometrists, NHS Trusts and local authorities to determine how recommendations can be implemented and performance monitored to determine whether the recommendations are delivering the scale and impact of the change required.

4.22 £300k has been identified from the health inequalities funding to deliver the recommendations in this plan, pending approval from the Board. We envisage this will be driven through Healthwatch and the VCSE at place, with systemic work at scale, regional and national level being influenced and undertaken by the ICB.

4.23 Should the Board approve the recommendations identified in this paper (and the delegation of funding as requested in the health inequalities funding paper on the Board agenda), we will proceed to writing and publishing the Denny Review. We have identified 31 July 2023 as the preferred date for publication.

4.24 Following publication, we propose to hold a series of Denny workshops and breakfasts across the system to share the insights and co-design any further solutions with partners, health and care professionals and communities of interest to roll out across the system.

4.25 A communications and engagement plan will also be developed to share the findings of the report extensively.

4.26 Accessible communications will be at the centre of this approach, and we plan to engage with MPs, Councillors and other partners as we work to implement these recommendations.

4.27 Leader articles and profile pieces in key titles e.g., HSJ and other national and local media will be prioritised to share the findings of the report. This will be led by Felicity Cox, Chief Executive BLMK, ICB, Reverend Lloyd Denny and Paul Calaminus, SRO of the Review.

Risks and issues

4.28 Failure to implement the recommendations from this Review has the potential to further deepen the lack of trust between health and care organisations and seldom asked groups.

4.29 Health inequalities will continue to exacerbate the percentage of people requiring treatment for complex care needs will grow if steps are not taken to improve access, break down barriers and deliver a person-centred approach to delivering health and care.

4.30 The reputation of the NHS and other health care organisation will be tarnished by a failure to act.

5.0 Next Steps

5.1 If this paper is approved the Board, we will arrange a series of workshops to take the findings into the system and look to build on the work already begun.

5.2 Should funding be agreed for implementation, we will work with partners to fully cost and commission partners to deliver this work at place.

List of appendices

None

Background reading

The Literature Review and engagement reports from Healthwatch are available in the Background Reading Pack. The Literature Review highlights several seminal texts on health inequalities which were used to inform the methodology of this study.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

ICS Partner: Vicky Head, Director of Public Health (Bedford Borough, Central Bedfordshire and Milton Keynes) and Sally Cartwright, Director of Public Health (Luton)

ICB Executive: Sarah Stanley, ICB Chief Nursing Director and Senior Responsible Officer for Inequalities

Report Author: Julia Robson, ICB Inequalities programme lead

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

Item: 6.2 – 2023/24 Inequalities Funding – proposed allocation and governance

1.0 Executive Summary

1.0.1 This paper has been developed by the ICS Health Inequalities System Leadership Group and provides the Board with an overview of the health inequalities funding that has been made available to Bedfordshire, Luton, and Milton Keynes to tackle health inequalities in our area.

1.0.2 It sets out a series of recommendations as to how we propose to allocate this funding to help residents to live longer, healthier lives and the governance processes we will put into place to manage the funding through the system.

1.1 Background and introduction

1.1.2 Data shows that people who experience health inequalities are more likely to need help and support from health services as their conditions become more complex. Breaking down barriers to access and removing health inequalities has the potential to prevent poor health, help people live longer lives in good health and reduce the burden on the public purse.

1.1.3 Nationally, NHS England has made £200 million available in 2023/24 to support Integrated Care Systems with the greatest health inequalities in their populations. £3.197m of recurrent funding has been allocated to Bedfordshire, Luton, and Milton Keynes Integrated Care System to deliver a programme of system wide improvement.

1.1.4 Administered by the Integrated Care Board, we have worked closely with partners to co-design how the funding will be allocated across the system and a Health Inequalities Systems Leadership Group has been established, which is chaired by the Chief Nursing Director for the ICB and co-chaired by Directors of Public Health from all four local authorities.

1.2 System leadership and governance

1.2.1 An ICS Health Inequalities System Leadership Group (officer group) has been established to review and agree on the design of the BLMK Inequalities Strategy. As well as to provide advice and guidance and inform decision makers on how to allocate the inequalities funding. Members also provide advice and guidance to shape the priorities and work programme of the shared Population Health Intelligence Unit.

1.2.2 The Terms of Reference and Membership of the group has been provided in the Background Reading pack.

1.3 Governance and delegated authority

1.3.1 Following the learning from last year's allocation of inequalities funding, where there was no clear governance in place to guarantee a timely sign off process, it is proposed that delegated authority is given to the chair of the ICS Health Inequalities System Leadership Group – the ICB's Chief Nursing Director – to make decisions on the allocation of inequalities funding based on expert advice from the Group.

1.3.2 This approach:

1. Allows subject matter experts who have a deep understanding of the local context and specific needs of the communities across BLMK to advise the Chief Nursing Director for the ICB. These individuals are often closer to the ground, having direct contact with the residents and service providers in the area. This local knowledge enables more effective targeting of funds towards areas with the greatest need.

2. Empowers local decision-makers to respond promptly and flexibly to emerging challenges and changing circumstances. Each area within the ICS may have unique requirements, priorities, and demographics. Delegating authority enables these decision-makers to allocate funds in a way that is most appropriate for their specific population and respond swiftly to emerging health and social care needs.

3. It can enhance the efficiency of resource allocation. Local decision-makers, who are familiar with the intricacies of the local health and social care system, can identify areas where funds can have the most significant impact and make strategic decisions accordingly. They can allocate resources to initiatives that are proven to be effective within the local context, ensuring that the funds are utilised optimally.

4. Encourages active involvement and collaboration among various stakeholders within the ICS. Local decision-makers can engage with service providers, community organisations, patients, and residents to gather insights, receive feedback, and involve them in the decision-making process. This participatory approach fosters ownership, transparency, and accountability, leading to better outcomes and stronger partnerships. Overall, taking the above approach enables a more tailored, responsive, and efficient allocation of resources. It leverages local expertise, encourages collaboration, and promotes accountability, ultimately leading to improved health and social care outcomes for the communities involved.

1.4 Funding plan recommendations for 23/24

1.4.1 Our plan to distribute funding has been developed in collaboration with Health Inequalities System Leadership Group, as follows (more detail is available in Annex 2 in the Reading Room).

1.4.2 Place Allocation

It is recognised that some of the inequalities work programme needs to have a balance of activity across BLMK and at Place. There is a need for BLMK system leadership, infrastructure, and actions, as well as actions at place level, where more specific actions to address place-based inequalities and population needs will have greater impact.

It is proposed that an allocation of £500k is directed to each place.

The rationale for this even split across places is that when factors such as deprivation, as well as age structure and population size have been accounted for in initial simple modelling, the difference in amounts between the four places have been minimal. It is therefore suggested that an equal split gives a pragmatic approach that allows us to move forward in a timely way, ensuring funding is directed to place as quickly as possible to allow for agile working in-year.

Once funding is allocated to Place the governance for developing this proposal will fall under the Place Boards, with advice and guidance from Director of Public Health on population need and impact, however the final decision will be with the Chair of the Place Board. This funding is intended to help reduce the inequalities gap in healthy lives lived and is intended to support the system at place. The funding should be aligned against local place priorities that will maximise achievement of that aim. All members of the place board will be able to put forward ideas, proposals including inequality reduction work within acute/community providers, primary care and VCSE.

1.4.3 Sustainable Inequalities programme support

There is system recognition that the inequalities programme is a complex and vital programme. Currently there is little resource to take the programme to a more evidence based, data driven and integrated approach, whilst also taking some key projects through a system of learning. It is key to build on the themes that we developed last October at the BLMK Inequalities event, which brought in the ambition to be "stronger together to tackle inequalities." The themes captured were:

- Co-production with our staff and our communities
- Working with our trusted sources, such as the VCSE
- Building on our community assets (we are not starting from a blank sheet of paper!)
- Understanding what works and scaling up
- Sharing our data to inform us as we go

To drive forward the above approach, the following infrastructure is proposed to support the inequalities programme in a more sustainable, integrated, and impactful way:

- Four Inequality Improvement Advisors aligned to Place
- An Inequalities Programme Manager
- Head of Quality and Inequalities

Details of the above posts can be found on slide 5 in the Background Reading pack.

1.4.4 Working with the Institute of Healthcare Improvement (IHI)

The IHI is a globally recognised organisation dedicated to improving health and healthcare around the world, with a focus on quality improvement and patient safety.

A partnership has been developed to build capacity and expertise to support BLMK's improvement journey. Working with the Institute for Healthcare Improvement will provide BLMK ICS with valuable expertise, resources, and a collaborative platform to address inequalities in healthcare effectively. By leveraging the IHI's knowledge and methodologies, BLMK ICS can make significant strides in improving health equity and enhancing the well-being of their population.

1.4.5 Increasing capabilities across the system to provide a new system of learning

To train our health and social care workforce & residents in quality improvement which in turn will provide all key stakeholders with the tools and empowerment to run their own quality improvement projects. The training provided would give "pocket QI" training for all, followed by leadership and coaching training for individuals wishing to take their learning to the next stage. This would provide key projects, both system-wide and at Place, with trained project leads and coaches where appropriate.

1.4.6 Denny Review

The Denny Review is one programme of work that will be delivered using the health inequalities funding. The Review was launched in 2020 and over a period of three years has sought to understand the data and lived experiences of people who have been seldom heard in conversations around health and care.

We propose to allocate £300k of health inequalities funding to deliver recommendations set out within the report and costs associated with communicating the findings in line with the

feedback we have heard from the report – for instance using video, translations, accessible documents to communicate how we are implementing feedback from people and communities.

The Denny Review is a substantial item for Board discussion on 30 June and will provide more details on the recommendations proposed, which includes:

- The creation of a system wide translation service
- The development of 'Access Champions' to help people with additional needs to navigate the health and care system
- The development of SystemOne to flag the needs of patients
- Mandatory training for front line health and care professionals to eradicate unconscious bias and racism (led by advocates and residents)
- Process changes to include EDS2022 in contract management
- Review of Patient Participation Groups to ensure there is representation at place to support co-production.

1.4.7 22/23 Mental Health and Maternity programmes

In 2022/23, as part of the inequalities funding that was signed off at the CEO Group in August 22, the system agreed to provide each clinical area against the Core20+5 with funding to target their biggest priority areas. Maternity chose a preconception programme and Mental Health chose Serious Mental Illness and Dementia.

As these two programmes have been previously agreed, they have been rolled forwards into 23-24 budgets. Details of these submissions can be found in appendix 2.

A summary of the above recommendations can be found in appendix 2, slide 2.

A summary of costs for the above proposals can be found on the below table:

	Amount (£3.197k)
Mental health and maternity 22/23 late submissions to be funded from 23/24	£39,712 maternity £98,628.03 mental health **£138,340**
Staffing structure, IHI support and Qi training to support the inequalities programme	**£550,000**
Denny Review – place and system wide working from recommendations	**£300,000**
Allocation to Place as an equal split to develop proposals, against some agreed principles	**£500,000 each** **= £2m**
Underspend – TBC and for discussion at future inequalities meetings	**£145,660**

2.0 Recommendation

2.1 The members are asked to:
Approve the proposed allocation of inequalities funding described in this paper and summarised at paragraph 1.3.6 and **agree** to delegate authority to the ICB Chief Nursing Director, to make **future** decisions on the allocation of inequalities funding, with the members of the ICS Health Inequalities System Leadership Group being advisors to her on these decisions.

3.0 Key Implications

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

3.1 Delegating authority to the Chief Nursing Director on advice from the ICS Health Inequalities System Leadership Group, mitigates the risk that late decision making will occur which may result in BLMK losing funding that should be spent on targeting inequalities.

3.2 The only source of funds for the inequalities programme is the national inequalities funds that is described in this paper.

3.3 Improving the access, experience, and outcomes for the residents of BLMK, to reduce the gap in life expectancy and increase the number of healthy years that our residents live.

3.4 The following have contributed to this report or seen the report who are all members of the ICS Health Inequalities System Leadership Group:

- Sarah Stanley, Chief Nursing Director, BLMK ICB
- Sally Cartwright, Director of Public Health, Luton
- Vicky Head, Director of Public Health, Beds, Central Beds and Milton Keynes
- Ross Graves, Chief Strategy and Digital Officer
- Simon Edwards, Deputy Chief Medical Officer
- Sonal Mehta, VCSE (Voluntary Community and Social Enterprise) Partnership lead
- Sanhita Chakrabarti, Deputy Chief Nursing Director
- Ian Brown, Head of Population Health Intelligence Unit and Chief Officer for Public Health
- Paul Calaminus, CEO East London Foundation Trust, and SRO Inequalities Lead
- Tim Simmance, Growth and Sustainability Lead
- Maria Laffan, ICB Deputy Chief Nurse
- Anne Brierley, ICB Chief Transformation Officer
- Maria Wogan, Chief of System Assurance and Corporate Services

3.7 Reducing inequalities is interconnected with the Growth and Sustainability agenda, such as reducing over prescribing and work with our anchor institutions. If we focus on our prevention agenda, we hope to reduce the need for primary care services and medicines for our resident in the future.

4.0 Next Steps

4.1 The ICS Health Inequalities System Leadership Group will develop the final criteria and timeline for proposals for the inequalities Place allocations and the funding will be allocated to all Local Authorities, for utilisation across the system at Place, by 1st July 2023.

4.2 Recruitment to roles in accordance with ICB management of change process.

4.3 Quality improvement training will start in September 2023 provided by Central Northwest London (CNWL) and East London NHS Foundation Trust (ELFT).

4.4 Commence 3 year contract with Institute of Healthcare Improvement (IHI) Provisional start date 1st July 2023.

4.5 Purchase Orders have already been raised for the maternity programme so funding to those organisations is imminent. The Mental Health contracts are signed, and purchase orders are due to be raised before the end of June.

4.6 Between the months of August to October, ideas for implementing the Denny Review recommendations will be coproduced, with measurements attached.

4.7 Any final underspends will be transferred from the ICB from months November to December.

List of annexes (available in the Background Reading Pack)

Annex 1 System Leadership Group ToR - FINAL.docx

Annex 2 Funding options 23-24 for inequalities updated 14th June.pptx

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

ICS Partners: Participants in Integrated Health & Care Partnership & Integrated Care Board members & attendees

ICB Executive: Anne Brierley, Chief Transformation Officer

Report Author: Anne Brierley, Chief Transformation Officer

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

Item: 6.3 - BLMK Joint Forward Plan 2023-2040

1.0 Executive Summary

1.1 All Integrated Care Boards (ICBs) and their local Trust partners have a duty to develop and publish a forward plan to NHS England, partners and the public by the end of June 2023.

1.2 The purpose of the Joint Forward Plan (JFP) is to bring together all the operational and strategic plans for the partners of the ICB to:

- Deliver our Integrated Health and Care Strategy to improve health outcomes and tackle inequalities;
- Deliver our strategic objectives in accordance with the statutory requirements of ICBs, including supporting our partner NHS and Local Authority organisations to deliver their own mandates;
- Deliver the health service's objectives set out by NHS England; and
- Provide a medium-term view of how these will be delivered, for a minimum of five years.

1.3 The BLMK Joint Forward Plan has multiple sections

- The BLMK Joint Forward Plan
- Appendix A – the Joint Forward Plan at Place (Bedford Borough, Central Bedfordshire, Luton & Milton Keynes
- Appendix B – the Joint Forward Plan and Provider Collaboratives
- Appendix C – Joint Forward Plan Enablers
- Appendix D – NHSE Assurance Matrices (not included in this pack but part of submission to NHSE)

1.4 This Board Cover paper summarises:

- the ethos behind the BLMK 'Joint Forward Plan' (JFP) – our approach, development and engagement activity that has taken place to inform it
- the structure and content of the JFP
- key points to note
- alignment with the plans of our partners - including with BLMK's Health and Wellbeing Boards (HWBBs)

1.4 and asks the Board to approve the Plan, and its publication; and submission to NHSE.

2.0 Recommendations

2.1 The members are asked to:

- **Note** the views of the Health and Wellbeing Boards on the draft Joint Forward Plan

- **Approve** the BLMK Joint Forward Plan 2023-2040 for publication and submission to NHSE; and,

- **Note** plans for widespread engagement activity with partners and residents through the Summer and Autumn of 2023 to feed into the next iteration of the Plan.

3.0 Key Implications

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

3.1 **Resourcing:** It is a requirement of our Plan that we include information about how we will use our available resources to meet the health needs of our communities and service needs. This includes the use of both financial and other resources.

3.2 **Health equality assessments** – the whole Joint Forward Plan is focused on the areas where we will collaborate to improve health outcomes, and tackle inequalities in our communities. Specific health equality assessments will be completed will be undertaken for individual projects within the JFP's High Impact Programmes and Enabler Projects in accordance with ICB policy.

3.3 **Green Plan commitments**: a requirement of the Plan is that it explains how an ICB will discharge its responsibilities in relation to climate change and achieving a 'net zero' NHS. Our plans and approach towards such commitment are outlined in one of the high impact programme areas described in section 7 of the Plan

4.0 Report

4.1 **The Joint Forward Plan Requirements**

4.1.1 Before the start of each financial year, an integrated care board and its partner NHS trusts, and NHS foundation trusts must prepare a plan setting out how they propose to exercise their functions in the next five years. For the first year of ICB existence the Plan is to be published by end June 2023. Given the timing of this Board meeting, the BLMK system has approval to submit its Plan to NHSE on 3 July 2023.

4.1.2 The plan must, in particular:

- describe the health services for which the integrated care board proposes to make arrangements
- explain how the integrated care board proposes to discharge its wider duties (including financial duties) as defined by legislation
- set out any steps that the integrated care board proposes to take to implement any local joint local health and wellbeing strategies to which it is required to have regard
- set out any steps that the integrated care board proposes to take to address the particular needs of children and young persons under the age of 25; and
- set out any steps that the integrated care board proposes to take to address the particular needs of victims of abuse.

4.1.3 Within this framework, ICBs have discretion as to the format and content of the Plans, though NHS England publish Guidance for planning. The NHSE guidance aims to set out a flexible framework for Joint Forward Plans to build on existing system and place strategies

and plans in line with the principle of subsidiary. The minimum requirements for the ICB JFP are centred on 3 principles:

- **Principle 1**: the plan is aligned with the ambitions of the wider system partnership;
- **Principle 2:** the plan supports subsidiarity, building on existing local strategies (including Joint Strategic Needs Assessments and Health and Wellbeing strategies) and reflect universal NHS commitments; and
- **Principle 3**: the Plan is delivery-focused, including specific objectives and milestones as appropriate.

4.1.4 At a minimum the JFP should describe how the ICB Partners intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include delivery of:

- Universal NHS commitments (set out in operational planning guidance and the NHS Long Term Plan (LTP));
- The ICS's four core purposes;
  - 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.
- Legal requirements (specifically those set out in the NHS Act 2006, the Public Sector Equality Duty, second 149 of the Equality Act 2010).

4.2 Our BLMK Approach and Ethos

4.2.1 The Joint Forward Plan is the medium-term, over-arching Plan that sets out how ICB partners will work together to support our communities to thrive. The housing plans for the four Places in our area means that around 6,000 new homes are expected to be built across Bedfordshire, Luton and Milton Keynes every year until 2040. Therefore, there is a critical need to accurately model how the population will grow and the demographics will change for each of our four Places up to 2040, and so the Joint Forward Plan aims to focus on the needs of all residents at Place and extend to 2040.

4.2.2 The Joint Forward Plan does not replace individual organisations' own strategic and operational plans. It covers areas where ICB partners need to work collaboratively with our communities to deliver the core responsibilities of ICBs to achieve our collective long-term goal to enable all residents to live more years in good health (BLMK Integrated Health & Care Partnership Strategy). This Plan sets out our most complex, important, and stubborn challenges and how we plan to tackle them together to make a real difference to our communities and help us to deliver services within our available resources.

4.2.3 In line with the principle of subsidiarity, the BLMK Joint Forward Plan is informed by and aligned to the priorities identified at Place and by Health and Wellbeing Boards' strategies (which are based on Boroughs' Joint Strategic Needs Assessments). This is highlighted in Appendix A, where each Place has set out its priorities and actions in relation to the needs of its local population.

4.3 Engagement

4.3.1 Close engagement with partners and residents has been and remains essential to the development of the JFP. This has included working with:

- the Integrated Care Partnership (BLMK Health and Care Partnership);
- Primary Care providers;
- Local Authorities and each relevant Health and Wellbeing Board;
- other ICBs in respect of providers whose operating boundary spans multiple ICSs;
- NHS trusts, collaboratives, networks and alliances;
- the voluntary, community and social enterprise sector (VCSE); and
- people and communities that will be affected by specific parts of the proposed plan, or who are likely to have a significant interest in any of its objectives.

4.3.2 The draft Joint Forward Plan has been shared with the Boards of all seven of our NHS Partner Trusts and with the five Health and Wellbeing Boards who make up our Integrated Care Partnership. Trusts' Boards and Borough Health and Wellbeing Boards have been supportive of the draft plan and have provided comments which will be reflected in the final version of the Joint Forward Plan. In addition, all of the Health and Wellbeing Boards were asked to confirm that the JFP had taken proper account of their Health and Wellbeing Strategies and at the time of writing this confirmation had been received from Bedford Borough and Milton Keynes Health and Wellbeing Boards, as well as Chair's Approval from the Central Bedfordshire Health and Wellbeing Board, pending a meeting of that Board scheduled for 12 July 2023. An update on the position of the remaining Health and Wellbeing Boards will be given at the ICB Board meeting.

4.3.3 In developing the first iteration of the BLMK Joint Forward Plan we were mindful to avoid engagement fatigue with residents who have been subjected to numerous consultations on health in recent years. We took a decision to reflect on what we had heard from conversations on the NHS Long-Term Plan in 2019 and cross reference the data with more up to date information from Healthwatch reports on primary care access and elective care, so that we could understand the issues resident felt were most important to them now.

We built on existing data by adding insights from the Denny Review into health inequality and feedback from interviews and focus groups with children and young people and 'victims of abuse', which were undertaken in April 2023. This approach provided us with a solid foundation and detailed feedback, which has been incorporated into the Joint Forward Plan.

4.3.4 Resident insights from the engagement undertaken verified what we had heard in recent years, but perhaps more powerfully made in the aftermath of the pandemic, which has exacerbated existing concerns particularly around access to health care. Access (in primary care, secondary care, mental health and community care) remains a real issue for local people. Residents report struggling to access appointments, and this was reported as a particular challenge for people with physical and learning disabilities, the homeless/people in temporary accommodation, or those for whom English is a second language.

Poor communication was another issue high up on the list of concerns for residents with some people reporting that long waits for treatment with little or no communication has led to increased anxiety and mental health issues. This is certainly an area that has worsened following COVID and recent industrial action where elective care has been delayed.

One of the key messages from our engagement, was that residents are seeking a more inclusive and personalised approach from health and care services that understands, welcomes and responds to the wide-ranging diversity of our population and tackles the barriers to access to healthcare experienced by our communities already most disadvantaged.

Residents who did not feel included in health and care messages and services reported disengaging from looking after their own wellbeing and from services to support them which will widen health inequalities.

The Joint Forward Plan gives us an opportunity to review the actions that can be taken to address feedback from residents and engage in quality improvement in the year ahead, with further changes being made as our partnership matures.

4.3.5 It is a NHSE requirement that Joint Forward Plans will be updated annually. In line with our ethos and approach, the level of detail included in the first iteration reflects the current maturity of our partnership and of development of responses to our key priorities for improvement.

4.3.6 Recognising the need to review and reinforce this plan, the ICB has already planned a major engagement programme. 'The Big Conversation' is planned to take place from June to October 2023. This will give residents the opportunity to share their experiences and

aspirations for health and care services post pandemic. It will allow the ICB to test and validate what we have heard from previous engagement. The Big Conversation will include a series of events and workshops across the four places together with a resident facing survey, which will give people who are unable to attend events the opportunity to share their views.

4.4 **The structure of the JFP**

4.4.1 In keeping with our ethos and approach to medium term planning, the Joint Forward Plan comprises of two main parts:

- Our 'core' BLMK Joint Forward Plan – this sets out the need, scope and approach of our ICB Partners to work with residents to tackle the strategic, complex and stubborn challenges that require collaboration to achieve our strategic objectives
- Comprehensive appendices (as per section 1.3 above) – these reflect the wealth of effort and system maturity & co-ordination required in delivery of our Joint Forward Plan to achieve the benefits sought for all our residents

4.5 **Key points from the JFP**

The BLMK Joint Forward Plan is our ICB's plan to tackle the most important – and difficult – aspects of healthcare and the wider determinants of health and well-being that really will make a difference to our communities. It is bold in its aspirations and scope, especially given our current operating environment, with the legacy of COVID felt across our residents and our teams and the challenges of the global economy.

It is bold for this very reason – we cannot keep doing more of the same and expect different outcomes. If we want positive change to support all our communities to thrive, we need to enable that change.

There are 4 themes throughout this Plan which will be critical factors in determining the success of our endeavours:

1. **We need to collaborate differently** – to embed co-production with our communities, voluntary, community and social enterprise partners and across our teams in all our business. And understand the impact of our Plan from the perspective of the residents, as well as our statutory requirements.

2. **We need to focus on the 'left shift**' - even (especially) amid operational pressures to deliver our services, we must keep our orientation towards prevention and early diagnosis and intervention. As part of this we must be disciplined in excluding low-benefit 'must-do's' from our operational plans; and ensure our delivery is good value to the taxpayer.

3. **We need to continue to develop mature subsidiarity**, enabling more decisions about health and care to be made as close to the resident as possible. We will need to invest together in the relationships, governance and programme infrastructure to underpin this.

4. **We need to manage together the risks and challenges that are beyond the direct control of the ICB Partners** – influencing development of clinical / professional research and innovation as well as the national policies that shape our operating environment. We will need to be co-ordinated and evidence-based to ensure that the diverse needs of all our residents are heard and addressed.

The BLMK Joint Forward Plan sets out at a high level what we plan to deliver in the medium-term, and crucially, why this is important for our residents. During this year the move to the new ICB Target Operating Model will underpin the collaborative programme infrastructure and metrics we will need to adopt consistently across our organisations to enable delivery of our Plan.

Our Joint Forward Plan also sets out how we, as leaders of the organisations that form our ICB, will work in partnership to achieve our long-term strategic goals. As the ICB Board, in

approving this Plan we will act as exemplars of collaboration wherever it benefits our residents.

4.6 Key Risks

The key risks to delivery of our strategic goals in our Joint Forward Plan are set out against the principal risks in our ICB Board Framework in section 9 of the Plan.

Key risks to delivery of NHSE operating target plans to 2028 that are beyond the direct control of the BLMK ICB Partners relate to finance:

- consistent medium-term capital investment to reflect the growth of the BLMK population
- the need to invest in core digital and estates infrastructure to tackle quantified barriers to access and delivery
- Medium-term funding to tackle revenue pressures in Local Authorities related to increasing social care need for children, young people and adults

There is also a shared operational risk in transition to the ICS' new target operating model and mobilisation of the Joint Forward Plan 2023-5 during sustained operational delivery pressures, recovery of waiting times (all NHS providers) and managing cost pressures.

5.0 Next Steps

5.1 Subject to Board approval, the Joint Forward Plan will be submitted to NHS England on the 3rd July 2023, and a programme of engagement with residents will take place over the summer to inform next year's updated version of this Plan.

5.2 Design work is ongoing for the 'core' Joint Forward Plan. Once the final version of the BLMK Joint Forward Plan has been approved by the June ICB Board, it will be published on our ICB website, together with a short and accessible summary version. ICB Board members are asked to ensure that their own organisational websites highlight links to these documents, as well as the BLMK Integrated Health and Care Partnership Strategy, which has informed the development of this Plan.

5.3 Population growth and demographic shift modelling which reflects our Borough's housing plans to 2040 will be led by the BLMK Population Health Intelligence Unit during Quarters 2 and 3 2023-4. This will provide a more robust understanding of population changes that will need to be factored into our medium- to long- term planning in our High Impact Programmes.

5.4 Detailed programme / project planning – including impact metrics – will be incorporated into the next iteration / prioritisation of the BLMK High Impact Programmes and Enablers. This needs to be developed in alignment with the move to the BLMK ICB new Target Operating Model to ensure that the resources and scheduling of these programmes align. This is planned to be completed during Quarter 4 2023-4, for approval with the BLMK NHS Operating Plan no later than March 2024.

List of Documents

BLMK Joint Forward Plan
Appendices A-C (as listed in section 1.3 above)

NHSE Assurance documents (Appendix D):
To Follow:

- Joint Forward Plan & NHS England Operating Plan Targets
- Joint Forward Plan and ICB Statutory / Mandatory Responsibilities

Background reading

Bedfordshire, Luton and Milton Keynes Health and Care Partnership Strategy

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Living a longer, healthier life

Bedfordshire, Luton and Milton Keynes Joint Forward Plan

This document has been produced in collaboration with partners from across the BLMK health and Care Partnership.

All the Health and Wellbeing Boards in BLMK have agreed that the JFP is a fair representation of the Health and Wellbeing Strategies.

Bedford Borough Council
Central Bedfordshire
Luton
Milton Keynes City Council
Cambridgeshire Community Services NHS Trust
NHS East of England Ambulance Service NHS Trust
NHS Bedfordshire Hospitals NHS Foundation Trust
NHS Central and North West London NHS Foundation Trust
NHS East London NHS Foundation Trust
NHS Milton Keynes University Hospital NHS Foundation Trust

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Contents

Foreword from BLMK ICB Accountable Officer

Welcome to the Bedfordshire, Luton, and Milton Keynes Integrated Care Board Joint Forward Plan.

The BLMK Joint Forward Plan is the start of the journey we must make together if we are to enable more people to stay well throughout their lives.

Our aim is to increase the years of healthy life that every one of our residents have – adding life to years, not just years to life.

To achieve this, we must **change how we work**. We need to collaborate and co-ordinate with all our partners. That starts with Bedfordshire, Luton and Milton Keynes residents. It includes community networks, the voluntary sector, employers and all our public services. The result should be that no matter where you live in our area, you see and feel the benefits of health and care services which are working together to deliver better services.

The NHS was created 75 years ago to help people who have ill health. We still do that, but we now need to do more, focusing on preventing people becoming unwell in the first place.

Prevention means working in a way that fits with people's lives, making sure that the services we offer are as easy as possible to navigate. They need to be effective and efficient, offering the right support at the right time. To do this we need to work with other services, especially our local council partners and our residents, to address the 80% of things which affect everyone's health, not just the 20% which are affected by the NHS.

We are at the start of this way of working, and we are excited about its potential. This Plan outlines our approach and the change that we as partners in the ICB want to make. In the NHS, long-term tends to mean 5-10 years. However, we believe that this work should look to 2040 and beyond, and this is reflected in our plans.

In this document, you will find what we are doing in collaboration to help keep you healthy. We set out our longer term, strategic programmes and the things that make them happen.

This Plan is based on the health of the whole person, rather than specific organisations or clinical specialities. Our commitment is to work as close to residents as possible, something we call subsidiarity. That means building change together with you, co-producing services so that residents' voices are heard, and acted upon, every step of the way. That can only be a good thing.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

We will measure how interventions have better enabled residents to live fulfilling lives. This is all about measuring how you are and your health outcomes. This work should result in fairer access and outcomes across the population.

The changes involve both how we work and what we are trying to deliver. It promises better outcomes for residents across Bedfordshire, Luton and Milton Keynes, and that's what really matters.

In the Plan you will find out more about the issues we are trying to tackle, how we intend working with our partners to keep people healthier, and how we want to improve outcomes for residents. We give a big-picture overview of what we are intending to do. We will, over the rest of this year, work with residents and partners to set out further detail on how, together, we will achieve these ambitious changes.

Finally, your involvement matters so much. If you want to get involved in our ongoing work, please contact blmkicb.communications@nhs.net. We would love to hear from you.

Dr Rima Makarem
Chair - BLMK Integrated Care Board

What is a Joint Forward Plan?

Every Integrated Care Board (ICB) in England is required to develop a Joint Forward Plan. It must set out how the Councils, NHS, wider public sector and voluntary organisations intend to arrange or provide our services to meet their population's physical and mental health needs, and tackle inequalities.

The purpose of the Plan is to bring together all the operational and strategic plans for the partners of the ICB to:

- Deliver our Integrated Health and Care Strategy to improve health outcomes and tackle inequalities;
- Deliver our strategic objectives in accordance with the statutory requirements of ICBs, including supporting our partner NHS and Local Authority organisations to deliver their own mandates;
- Delivery the health service's objectives set out by NHS England; and
- Provide a medium-term view of how these will be delivered, for a minimum of five years.

The Joint Forward Plan is the medium-term, over-arching Plan that sets out how ICB partners will work together to support our communities to thrive.

Our four pillars

Every ICB has four core purposes, which we call our pillars. These are:

- Improving outcomes in population health and healthcare;
- Tackling inequalities in outcomes, experience and access;
- Enhancing productivity and value for money; and
- Helping the NHS to support broader social and economic development.

Helping to overcome difficult challenges

The Joint Forward Plan does not replace individual organisations' own strategic and operational plans. It covers areas where we need to work together to overcome difficult challenges. If we can do that, we will better deliver the outcomes to enable our residents to live more years in good health.

This Plan sets out our most complex, important, and stubborn challenges. We need to tackle them together to make a real difference to our communities and help us to deliver services with our available resources. It brings the direct voice and experiences of residents too, particularly through the Healthwatch and elected councillors. Our Joint Forward Plan also summarises how the ICB partners will adapt to deliver our shared Target Operating Model – that's how we organise ourselves together as a partnership.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

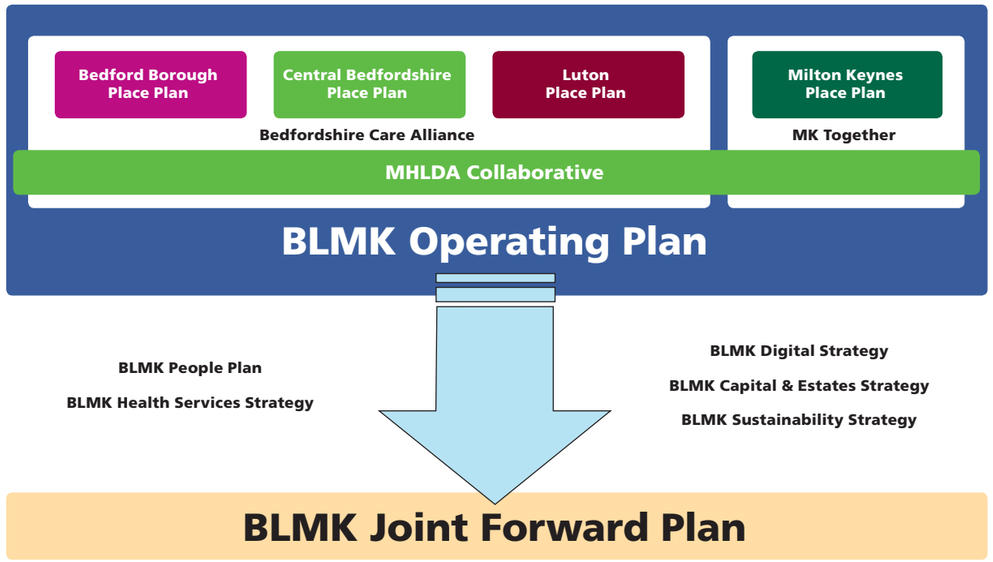
Putting residents at the heart of our Plan

We are committed to making sure the voice of the resident is heard, and that's why we've been listening to residents across BLMK to inform what this Plan presents. Our Joint Forward Plan is centred on the resident. Our focus is on the needs of our communities in each of our four Places. These are Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.

The Integrated Health and Care Partnership

The Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Health and Care Partnership is made up of locally elected councillors, NHS and council chairs, Healthwatch, Voluntary, Community and Social Enterprise Organisations and wider public sector partners, such as police, fire and criminal justice representatives. It brings together the needs of all our residents, as identified in each Borough's Joint Strategic Needs Assessment, with the strategic priorities of each Place's Health and Wellbeing Board. As our ICB matures, the role of the Integrated Health and Care Partnership will be to hold us account.

The Joint Forward Plan is a medium to long-term strategic Plan. As such it integrates several other strategies and operational plans. This is a complex relationship, summarised below:



The experience of residents

With so many relationships between organisations, it is no surprise that some residents find health and care services to be fragmented. Residents rightly express frustration at having to repeat their story to different health and care professionals. This health and care landscape means that some of our most disadvantaged residents can experience the worst access to healthcare – something the Denny Review of Health Inequalities makes clear, and which is explained further in the Enabler section of this Plan.

Residents are also clear that they find it difficult to access primary care, and the real stress of the "8am rush" for an appointment. Residents are worried about backlogs for elective surgery - they want to move on with their lives, recover, and reach their full potential. Residents also tell us about the interaction with many professionals in different organisations which results in residents reporting that they feel like a set of individual symptoms rather than a whole person and important aspects of their care are missed. We understand this, and addressing these issues now is vital to our future success as a system.

Our Integrated Health and Care Strategy says "No-one left behind". A big part of our collaborative efforts is to tackle unfairness and the root causes of poor health and wellbeing for all our residents.

Our focus

We need to meet population growth and changing needs of residents within the resources we have. We must work together to tackle our most difficult an important shared challenges so that our communities can thrive. Specifically, our Plan will:

- **Focus on working together to meet changing population needs**;
- Develop our **processes and partnerships to build an integrated system**
- **Develop and deliver infrastructure strategies** to tackle inequalities, improve health outcomes and reduce avoidable costs.

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Our population

The people of Bedfordshire, Luton & Milton Keynes

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

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

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

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

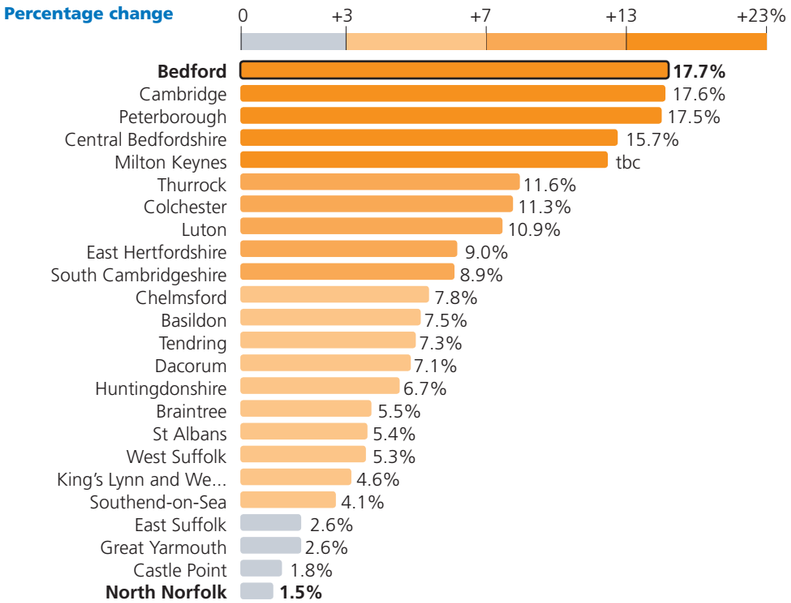
The four Places within Bedfordshire, Luton and Milton Keynes are diverse, and all have rapidly growing population. Over the last 10 years, around 5,000 homes were completed per year across our area. This is likely to increase. Local plans and housing strategies from our Borough Councils suggest around 6,000 new homes will be built each year to 2040.

This is significantly more than population projections from the Office for National Statistics (ONS) which assumes growth of around 2,400 homes per year; new housing built in our area is likely to be 2.5 times higher than official, national estimates.

We have one of the fastest growing populations in the UK, and this trend is expected to continue.

Not only will there be more residents in the area over the next 15-20 years, but the demography, health needs and demand of our population will change significantly.

Population change of selected local authority areas in the East of England between 2011 and 2021



Under 18	18-39	40-64	65-74	75+
+13%	+10%	+14%	+33%	+25%

All of our Boroughs have strong plans to grow housing, employment opportunities and prosperity in a sustainable way, focused on the needs of specific communities.

This Joint Forward Plan is clear that we cannot do more of the same with our resources to meet this growing and changing population need.

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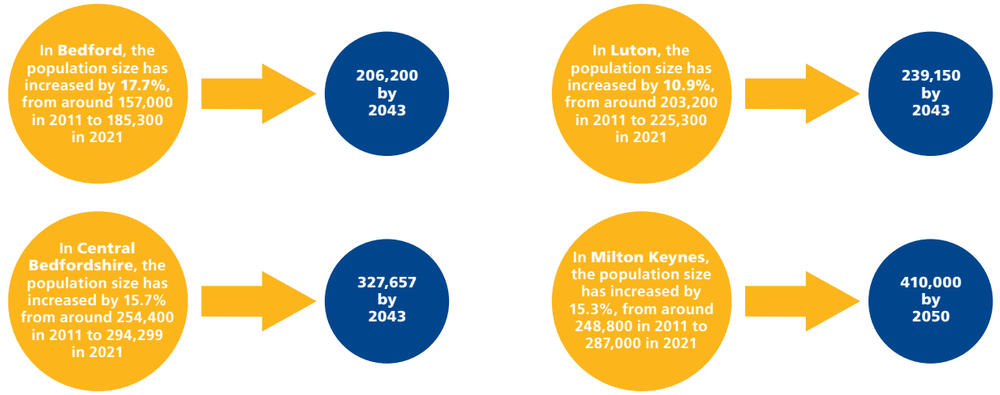
The most difficult issues which this Plan addresses

The known and shared complex, critical and stubborn issues for BLMK are:

- Rapid population growth and demographic shifts, specific to each Place



- Challenges accessing core primary care, including GP and dental services;
- Life challenges experienced by people in our communities including poverty, poor education and other things that may make a person vulnerable to inequalities as set out in the Denny Review;
- Impact of COVID on residents, including:
  - Deconditioning of people with frailty
  - Increased safeguarding and mental health issues for children and young people
  - Delays in accessing routine elective surgery;
- Cost of living crisis affecting families; and
- Poor health of the population including obesity and long-term conditions.

SECTION TWO: Medium-term affordability

Making sure we can afford the services residents need

The ICB developed a medium-term financial planning model in 2022 for the period 2023-24 to 2026-27.

The outputs show a potential 'do-nothing' scenario deficit across NHS partners hosted within the ICS (the ICB, Bedfordshire Hospitals NHS Foundation Trust and Milton Keynes University Hospitals NHS Foundation Trust) **of around £580m by end 2026-27**.

As part of future development, we will be seeking to incorporate the medium-term financial forecasts for the local authorities within the ICB boundary.

The key financial pressures for the NHS in BLMK in the medium term are as follows:

Revenue

- Demand for services;
- Inflationary costs;
- Significant levels of efficiencies needed;
- Achieving elective recovery targets;
- Reduction in ICB running cost allowance of 30% by 2024-25; and
- Impact of delegation of pharmacy, ophthalmology and dental services and future delegation of specialist commissioning.

Capital

- Overall affordability of plans within the Capital Departmental Expenditure Limit (CDEL)
- Ensuring capital allocations are equitably and fairly distributed; and,
- Investment to increase capacity in the primary care estate

To manage these pressures the ICB will need to work in partnership to improve performance and productivity. It will also need to explore alternative and innovative funding mechanisms.

The ICB is currently developing a health services strategy. It will likely lead to the redevelopment of specific clinical pathways across the system. The strategy will consider future population growth and demographic changes. It will look at our population's health needs and how these will be delivered in the future given technological advancements and digital delivery. This work will drive and inform financial strategies going forward.

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Local authorities' affordability challenges

All four of our unitary councils are under substantial and sustained financial pressures. If they are not addressed, these pressures will total many millions over the next five years.

The main drivers of these pressures are increasing demand (especially in adults and children's social care and homelessness), inflation and a sustained reduction in central Government financial support for services. A fundamental challenge for local government partners is the short-term nature of the finance settlements which makes planning difficult.

Mitigations

This Joint Forward Plan sets out an ambitious range of High Impact Programmes (Section 7). These are designed to tackle our shared, complex problems to better meet the needs of our residents with our available resources .

One of the High Impact Programmes is the efficiency and effectiveness programme which includes the following programmes that span multiple organisations.

- **Clinical peer-to-peer productivity challenges** (sharing best practice to maximise productivity in clinical services, and reduce waiting times)
- **Multi-agency pathway redesign** - reducing the number of steps in clinical pathways to treat people who need it more quickly)
- **Maximising the effectiveness of clinical support and corporate functions** – in areas such as pathology, prescribing, procurement and agency spend
- **Cross-sector innovation** – for example, introduction of a digital app to monitor epilepsy in children
- **Intra-region (ICB)** – working with other ICBs to share functions and reduce costs
- **ICB internal efficiencies** – for example, continuing health care (CHC), non-pay costs.

Outstanding risk

There are three key risks to affordability over the medium-term:

- Revenue does not keep up with rapid population growth, and the increase in need and demand;
- Having sufficient financial headroom to facilitate transformation of services; and,
- The short-term nature of the finance settlements which makes planning difficult.

This applied a range of inputs and assumptions in respect of funding, inflation, and demand for NHS services. The plan is being updated for final resource allocations published for the period 2023-24 to 2024-25 and will be estimated for later financial periods. Each ICB partner organisation has its own effectiveness and efficiencies programme designed to improve quality, outcomes and reduce avoidable costs. These are overseen by each organisations' own governance and accountability structures and further information.

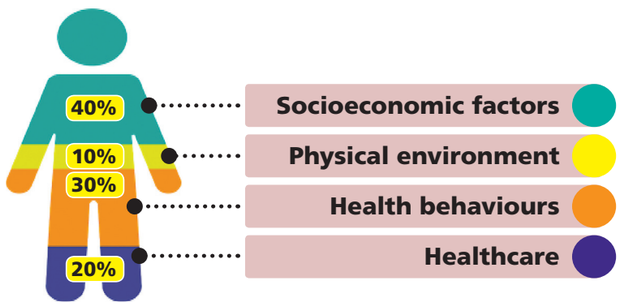
SECTION THREE: Our strategy

Our BLMK ICB strategy sets out our ambition for improving health outcomes and reducing inequalities. Our goal is for everyone in our city, towns, villages, and communities to live a longer, healthier life. It means increasing the number of years people spend in good health and reducing the gap between the healthiest and the least healthy in our community.

Our strategy set out three questions which we will answer by working in partnership:

1. Are we doing the right things to improve health outcomes and tackle inequalities for our residents?
2. Are we making the best use of partnerships between public services, voluntary, community and social enterprise (VCSE) partners and local communities?
3. Are we working with our people and communities to understand what matters to our residents and co-designing and co-producing sustainable solutions?

The benefit of working in partnership is the opportunity this affords us to look at all the factors that affect our chances of living a longer, healthier life.



Our Joint Forward Plan is firmly grounded in this understanding of what matters to our people and communities, our Joint Strategic Needs Assessments, Health and Wellbeing Strategies and emerging priorities at Place.

SECTION FOUR: A Joint Approach – maximising benefit to residents

Our Joint Forward Plan highlights the shared complex, critical and stubborn issues. These are where an innovative, collaborative approach is needed to deliver outcomes for all residents to 2040 and beyond.

As such the Plan is built on a strong shared ethos between all partners in the ICB as to how best to achieve this sustainably:

1. **Prevention and earlier intervention** – preventing or reducing things that have a negative impact on people's health and well-being

2. **Local interventions that meet the needs of residents at a Neighbourhood, Place or System-level** – based on the demographic and health needs of local communities

3. **Right Care, First Time**, especially for those residents who have the:
   a. Worst outcomes, highest risk factors or the greatest inequalities;
   b. Highest and most complex needs, or unmet needs driving high volumes of interaction with health, care and public sector services, e.g. police;
   c. Highest volume, lowest complexity demand for health care, including elective and same day urgent care.

4. **Co-production with local communities** – working with (not doing to) our residents to design and deliver services and support that enable communities to thrive

5. Leverage the inter-dependencies and interfaces across health and care services to:

a. Make every contact count – build opportunistic prevention, and support for residents to self-care, into existing pathways of care;

b. Reduce low value and repeat interventions for residents; and

c. Optimise use of resources, including our workforce, estates and finance.

6. Optimise the operating environment for health, care and civic services – across traditional service and organisational boundaries to:

a. Tackle inequalities;

b. Stimulate local employment and economic development;

c. Support the sustainability and green agenda;

d. Develop the workforce over long term; and,

e. Invest in the digital and estates assets.

There are significant differences between existing local authority and NHS planning approaches. The NHS is focused on short-term delivery, with a three-year funding cycle and a one-year operating plan. Local authority plans for infrastructure and population growth are over a 15-20 year period. NHS operating objectives are focused on the standards that clinical services must achieve for the patients who access these services. In contrast, local authorities consider the whole population living in a specific geographical area.

All health and local authority partners in ICBs have a shared responsibility to the populations they serve in their use of public money.

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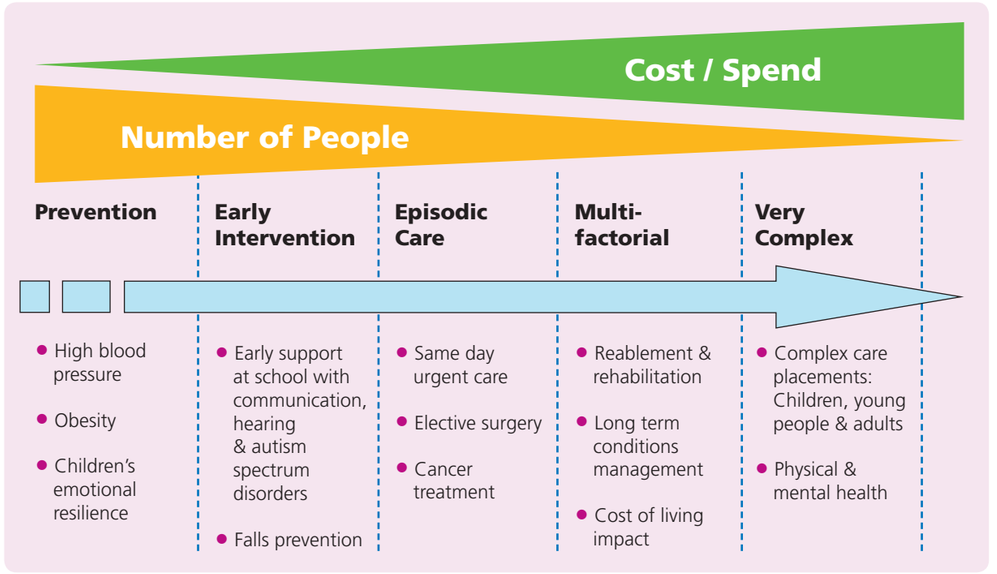
SECTION FIVE: Our approach

Addressing our shared, major challenges will require a systemic approach, split into different levels, as shown below:



This will shift our focus from: 'What can we afford to do?' to 'Can we afford NOT to do it?'

When the question is changed like this the focus is different. It becomes much more about the people living in BLMK, and how best we tackle inequalities and improve health outcomes. We will focus on:

1. Developing a consistent approach to framing and investigating our shared complex, critical and stubborn issues. The focus will be on defining our target population, supporting co-production and personalisation and using collective resources;

2. Ensuring interventions are evidence-based. Challenging ourselves to achieve and sustain performance within the top 10% of ICBs. Drawing on and contributing to research and innovation, and applying learning from best practice; and

3. Taking an approach to improvement which can adapt according to different circumstances. Measuring outcomes as well as activity and considering both the impact of our actions and the impact on the health and care system or wider society if we fail to act.

Examples of this approach could include:

a) Earlier intervention for children and young people who would benefit from:

- Speech and language help at a younger age or at a lower threshold of need;
- Autism spectrum disorder support and diagnosis at a lower threshold of need; and
- Occupational therapy input for children identified above to support their communication and social interaction at home and school.

The rationale for this earlier intervention would be to support children to meet their earlier developmental and education milestones, rather than delay intervention until the special educational needs and disability (SEND) threshold is met later in childhood.

b) Local integrated offer for people with complex mental health or learning disability needs, whose placement needs are currently met through contracting with independent sector providers. This could include:

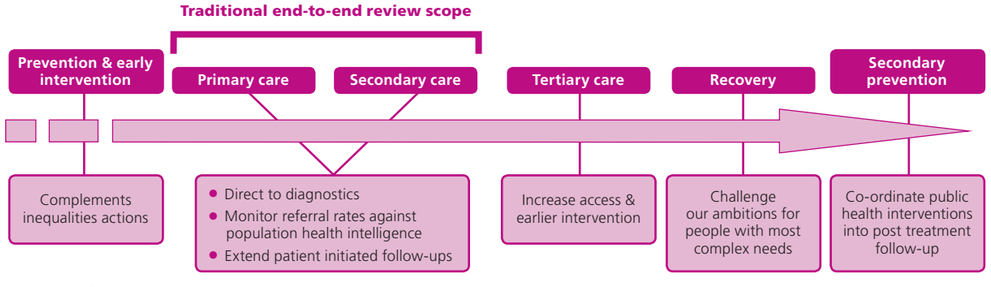
- Creating sufficient supported independent living accommodation within local authority areas to meet local need;
- Extended capacity to bring crisis support to the individual at times of highest need. This would reduce Emergency Department attendance and acute psychiatric admission unless clinically required; and
- An approach which supports the individual to address root causes, manage distressing emotions and achieve their potential.

This population are some of the most disadvantaged in our society. This approach sets out how our whole system can come together to support residents to thrive.

c) Elective clinical pathways review

An end-to-end clinical pathway review typically spans looks at the full journey a resident would take when seeking health and care support. This would start in primary care, when a resident first sees a healthcare professional, to secondary care, if specialist support is required, and the return to primary care for those who access healthcare.

Adopting a truly end-to-end clinical pathway review could better tackle inequalities and improve health outcomes, as shown below:



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Anchored in Places, this approach will:

- Identify populations whose risk profile or barriers to access indicates they are at higher risk and require support at a neighbourhood or council ward level;
- Provide engagement tailored to the residents' different needs, such as health promotion and uptake of screening programmes;
- Provide oversight for Place partners – giving a clear view and feedback on managing unwanted variation in services.
- Reduce bureaucracy for GPs in the referral processes. It will encourage greater autonomy for providers of acute care to determine the right clinical pathway
- Inform decision-making on how best to use specialised clinical pathways, known as tertiary care. These are currently under-used in BLMK,
- Allow residents to get the best public health interventions for them

The outcomes sought from this approach are two-fold:

1. To ensure timely access that maximises health outcomes for all residents
2. To manage demand and cost through more effective, targeted interventions based on population need.

d) Partnership in 'Fuller' Neighbourhoods to support residents to tackle the root causes of their need and not just manage symptoms.

The development of Fuller Neighbourhoods is based on a report by Dr Claire Fuller which sets out the future vision for Primary Care services.

It sets out how by bringing together all the professionals who can support residents in specific neighbourhoods with primary care needs we can better sustain delivery of;

- Same day access for urgent care
- Support to people living with long term conditions
- Working with communities and our voluntary sector partners to help people improve their health & well-being
- Working with our partners in emergency services, education and civic functions such as libraries and leisure centres to enable people to access urgent support for mental health crises when they need

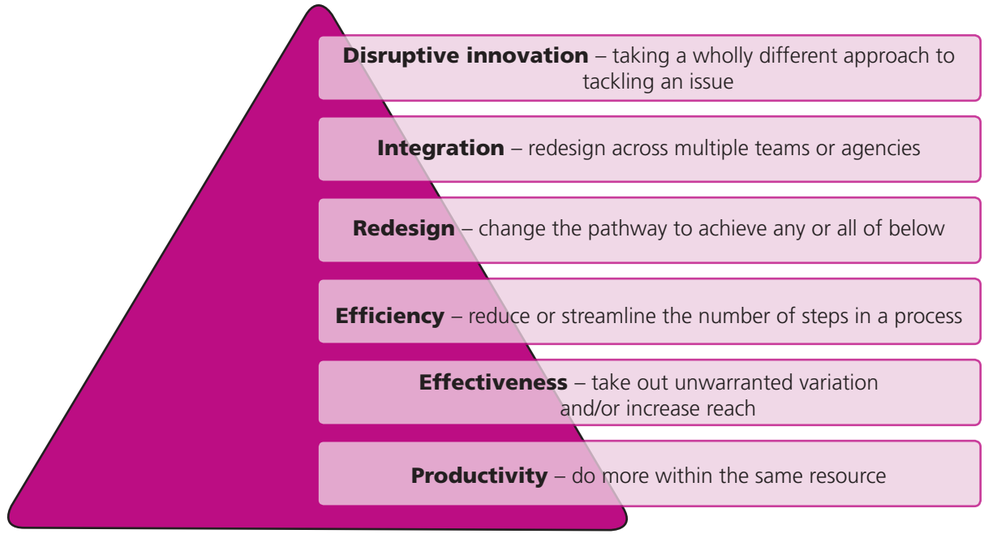
These four examples demonstrate how, when we collaborate to the benefit of specific residents, we can improve outcomes for the individual and reduce avoidable costs.

As illustrated in these examples, the Joint Forward Plan will aim to move us away from the traditional way we deliver care, which is often not joined up. We will be able to:

- Define our goals by the needs of our population at Place rather than episodes of care or care pathways;
- Move resource to improving prevention and early intervention, to benefit residents and reduce future need and cost; and
- take a long-term view wherever possible.

We will deliver this through quality improvement interventions that are locally owned. They will make it easier for our teams to do the right thing for the resident, first time.

Based on population growth and need we will deploy a range of actions in delivery of the elements of the Joint Forward Plan:



We are excited about growing this work together with our partners and the major impact it will have on residents' lives across BLMK

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SECTION SIX: Mobilising the Joint Forward Plan

There are several key actions that need to be completed for the Plan to be delivered to maximum effect, and to enable us to measure the difference are we making for our residents.

Population growth and change

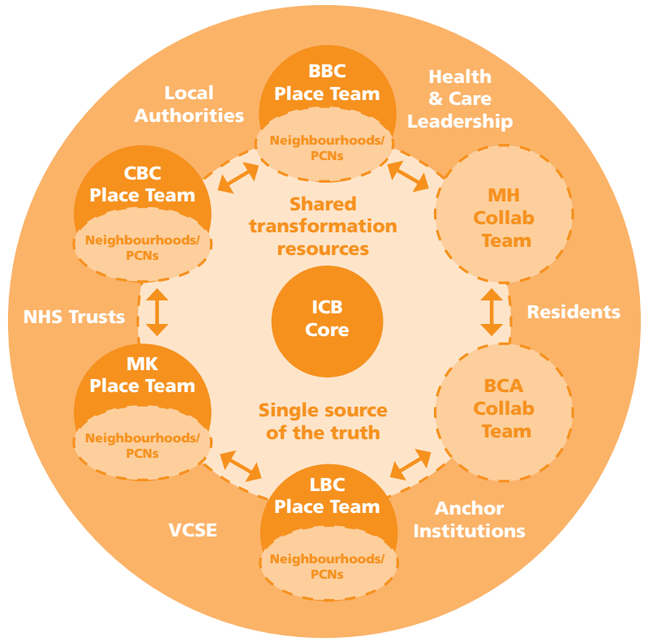
There is a critical need to accurately model how the population will grow and the demographics will change for each of our four Places up to 2040. At the same time, the demographic make-up of each Place is changing, with each one specific to its local population. Changes to the numbers of people of different ages, for examples, will have an impact on the services required.

We cannot build, deliver, and assess the impact of a Joint Forward Plan without clear future modelling scenarios of our population size, demographic, and likely future health and civic needs. The new Population Health Intelligence Unit will lead this work on behalf of the four Places and the ICB. It will give enable us to test the benefits to residents of our High Impact Programmes. This initial work is expected to be completed by December 2023.

Implementation of the Integrated Care System Target Operating Model

The ICB will implement a new Target Operating Model during 2023-25. This reflects its role as a system convenor, bringing together different services to address difficult challenges, and its' own organisational requirement to reduce its own running costs by 30% by 2025. this will reduce the number of staff employed directly with the ICB. It involves changes in ways of working and extending the responsibilities of Place and Provider Collaboratives to improve health outcomes and tackle inequalities.

The Target Operating Model is shown below. It shows that, by 2025/26, there will be a core ICB team, four Place teams working with neighbourhoods and Primary Care Networks, a shared transformational resource, and Provider Collaborative teams. This model presents a way of working which is more flexible and responsive, with a focus on convening and working with a wide range of partners to deliver improvements for our residents.



The diagram of the TOM is illustrative and not drawn to scale.

SECTION SEVEN: High Impact Programmes

We – and our partners – must work differently together to achieve our ICB core aims and NHS England Operating Plan targets This includes, crucially, improving health outcomes and reducing inequalities for our residents.

The effects of the COVID pandemic, cost of living crisis and rapid projected population growth means this is a significant challenge. It will require a fundamental shift in how public sector and VCSE services engage and support residents.

ICB partners recognise that we need to take steps to tackle the root causes of poor health outcomes and inequalities. Section Five summarised the approach the ICB will take to achieve this shift towards a focus on prevention of health issues. Section Six described the actions we need to take.

In this section we set out our BLMK High Impact Programmes. These are programmes which ICB partners will deliver in collaboration to realise our Integrated Care Partnership strategy and ICB objectives.

The below therefore sets out:

- The 'problem statements' outlining the root causes we are tackling;
- The short, medium, and long-term outcomes we are seeking for residents; and
- The projects within each of the High Impact Programmes.

The following sections of the Plan will:

- Clarify how these overarching programmes will come together and enable the delivery of our medium-term Place plans, based on population needs;
- Describe the emerging role of our provider Collaboratives to shape and lead delivery of clinical and professional-focused programmes;
- Provide a summary of our key enabler programmes, such as the People Plan or Digital Strategy;
- Detail how this Joint Forward Plan will deliver the standards and targets of the NHS England Operating Plan; and
- Describe the extent to which the Joint Forward Plan will mitigate the risks outlined in the ICB's Board Assurance Framework, and key risks currently beyond the direct control of ICB partners.

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Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

The ICB High Impact Programmes are those interventions where we can only achieve the outcomes sought for our residents through collaboration, partnership and innovation.

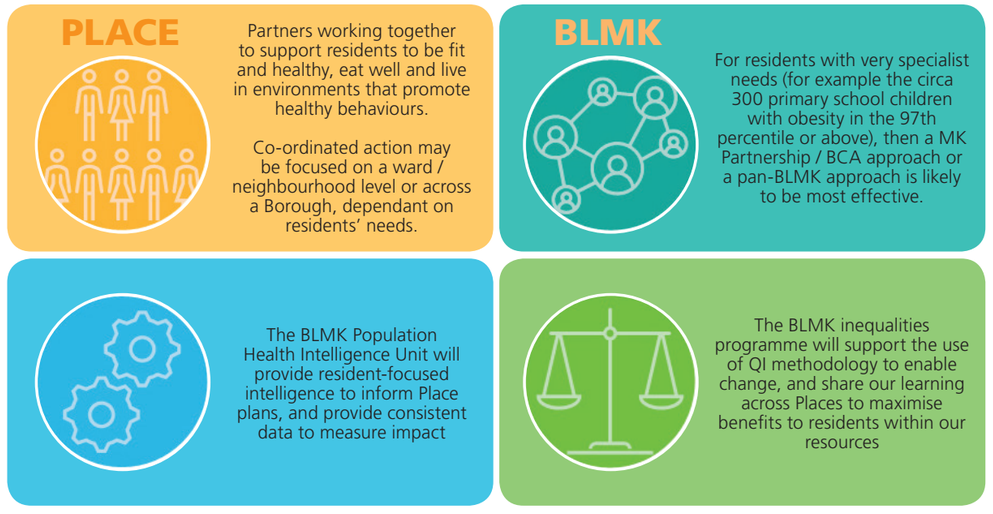
The ICB's governance and ways of working are based on the principle of **'subsidiarity'**. This means that decisions and responsibility for delivering agreed changes sit as close to the resident as possible.

This principle determines who needs to be involved in leading which aspects of our High Impact Programmes. For example:

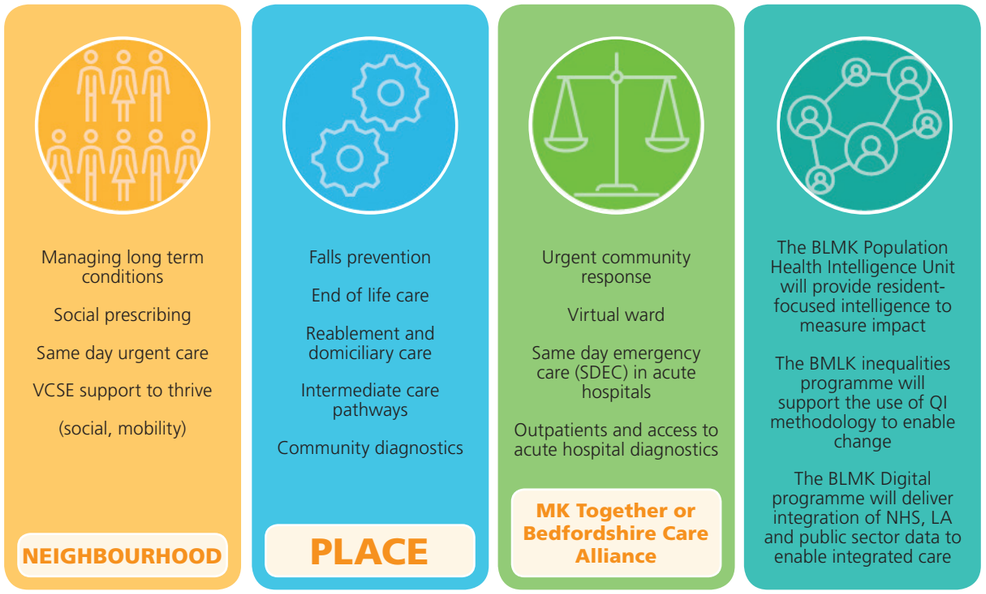
- A single organisation and managed within that organisation's own governance;
- Across partners working together at Place;
- A Collaborative of different health and care Providers and
- Where there is high complexity, acute need and very low numbers of residents, an approach across the whole of our area may deliver the best outcomes

Focusing on residents' needs, rather than the service or intervention required, allows subsidiarity to function effectively.

Example 1 – Obesity



Example 2 – Frailty



So, what are our High Impact Programmes?

1. Advancing Equity, (reducing harm and promoting safety through the introduction of quality improvement methods and tools)

- Supporting all system partners to develop a population health management approach to tackle the socio-economic and environmental disadvantages in life, and improving the access, experience and outcomes for all our residents
- Adoption across BLMK of consistent Quality Improvement tools to enable all staff to identify, tackle, test and measure improvements in access, outcomes and experience across our NHS and civic services
- Support to system partners in working to support patient safety by maximising the things that go right and minimising the things that go wrong in health care provision, improving effectiveness and patient experience. Delivering a system supported collaborative approach to new framework for patient safety and reducing harm (NHS patient safety incident response framework- PSIRF)
- continue to deliver on statutory function to keep people safe from abuse and neglect and look to use quality improvement approach to learn lessons and improve the circumstances of vulnerable people.

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Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

2. Efficiency & Effectiveness Improvement Programme

- Rolling programme to identify and reduce unwarranted variation in clinical and integrated health and care pathways, tackle inequalities and to reduce unnecessary cost
- Focus on multi-agency pathways and clinical support / corporate delivery (local productivity & improvement is overseen within organisation-specific and Place governance)
- Shared oversight of all efficiency and effectiveness programmes (organisation-specific, issues in common, multi-agency and ICB) to assure overall delivery of required impact / benefits and mitigate unintended consequences of inter-intra-dependency
- Establish digital / automated feedback loops to empower local teams to deliver best practice and address unwarranted variation as close to the service as possible

3. Enabling our Children and Young People to Thrive

- Earlier intervention to support children and young people to thrive (education, long term conditions and mental health and well-being)
- Sustainable recovery-focused strategy for complex needs / placements
- Preparing for adulthood
- Focus on children and young people experiencing the poorest outcomes / most disadvantaged: looked after children, children living in poverty, children who are displaced or experiencing abuse

4. Improved Access and Treatment

- Delivery of elective and emergency care recovery through integration and innovation
- Development of diagnostics and screening to address inequalities of access and outcomes
- Focus on ensuring that our most disadvantaged populations have parity of access and health outcomes, for example those living in deprivation, displaced people, vulnerable children and adults
- Promoting digital innovation to improve diagnostic and elective accessibility whilst safeguarding against digital exclusion.
- Make best use of capacity across all health care sectors and promoting choice where applicable
- Prioritising care for those with the most urgent clinical need ensuring equity between both children and adults.

5. Improving Outcomes for people with Mental Illness, Learning Disabilities and / or Autism Spectrum Disorders (MHLDA)

- Development of sustainable early intervention and crisis and recovery pathways for children, young people and adults
- Develop capacity to deliver early local diagnosis and support for people with autism spectrum disorders
- Development and implementation of sustainable recovery-focused models of care for people with complex needs, including shift to default of complex placements being delivered within BLMK
- Capital development in core services, for example mental health inpatients
- Improving physical health access and outcomes for people with severe mental illness, learning disabilities and autism spectrum disorders

6. Integrated Neighbourhood Working

- Delivery of 'Fuller' Neighbourhoods – proactive multi-disciplinary teams focused on local populations to provide same day urgent care and support to manage long term conditions
- Acceleration of prevention and support to tackle the wider determinants of health (falls prevention, optimised end of life care at home, rehabilitation, reablement and recovery post-health crisis, supporting people furthest from employment or training)
- Optimise delivery and outcomes from delegated primary care services (optometry, dental and community pharmacy)
- Continued delivery of the GP recovery plan – together with Place-based strategies to expand primary care capacity to meet population growth

7. Intelligence-led Quality, Outcomes, Performance, & Inequalities Improvement

- Implementation of the Public Health Intelligence Unit and outcomes-based reporting based on specific populations
- Sustainable re-development of business intelligence and analytics capability / capacity to shift performance reporting (i.e. NHS Operating Plan Targets) to be viewed through the lens of impact on local communities
- Digital integration strategy – integration of NHS, LA and public sector data to enable integrated care and embedding digital solutions in care pathways

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8. Integrated Care System Target Operating Model

- Structuring ICB staff to focus on core ICB / Place & Collaborative / pan-BLMK / pan-East of England region statutory & mandated responsibilities and delivery of high impact programmes (and deliver required ICB running cost allocations efficiencies)
- Development of Place / Health & Well-being Boards and their relationship with NHS and LA organisational governance
- Evolution of Integrated Health & Care Partnership Board
- Developing ICB Leadership roles and responsibilities to deliver the Target Operating Model
- Develop training to embed the new ways of working
- Due diligence and mobilisation of delegation of specialised commissioning for BLMK population

9. Thriving Eco-systems and Prosperous Communities

- Embed environmental sustainability into decision-making at all levels of the health and care system, to achieve the co-benefits of health improvement, whilst reducing the impact on our ecosystems and the negative impact on people's health and wellbeing.
- Deliver the BLMK ICS Green Plan to achieve a net zero health system, working with partners, VCSEs and residents.
- Establish a collaborative of anchor institutions
- Develop pathways for those furthest from stable employment due to their health to obtain, return to, and stay in work.
- Grow our own workforce across all health and care careers in partnership with educational institutions
- Ensure inward investment through supply chains
- Implement the BLMK Research Hub at the University of Bedfordshire, and build the system Research and Innovation portfolio across all our institutions.

Delivering the Benefits of our High Impact Programmes

'So what?' This is the question we in the ICB have challenged ourselves to focus on when developing our High Impact Programmes.

Each of our High Impact Programmes have clearly defined problem statements. These are focused on our population's needs rather than how services are currently delivered.

This shift in focus is crucial to enable the ICB to:

- Support the health and wellbeing of our residents, using local assets to enable communities to thrive;
- Make best use of resources within current and future constraints; and
- Embed sustainable solutions to chronic and growing gaps between demand and capacity. This includes urgent and emergency care, care at home or in residential care, elective demand, special educational needs and complex needs placements.

What is the problem we are trying to solve?

The problem statements for each of our High Impact Programmes are summarised below:

BLMK High Impact Programme	Problem Statements
1. Advancing Equity	• Too many BLMK residents live in poverty, which is the single biggest predictor of inequalities and poorer health & well-being • Maternity inequalities- poorer outcomes for BAME communities – higher risks mortality in this cohort in pregnancy. Higher risks of still birth, maternal, neonatal and infant mortality in 20% most deprived. • Health promotion challenges – smoking in pregnancy – more to understand current numbers – digital data collection • Residents, including health inclusion groups such as homeless, Roma and Gypsy travelling communities and migrants, experience inequalities in access to health services, impacting health outcomes • Obesity affects over a third of our population, especially those living in deprived areas with constrained income / poorer access to healthy food • Core20+5 highlights populations in BLMK with poorer access / uptake / outcomes in key health areas • Safeguarding numbers and complexity of presentation have increased for example, self-neglect, alcohol related issues, increase in domestic abuse and violence • Sustained improvement in health outcomes and reducing inequalities is complex and takes time to achieve
2. Efficiency & Effectiveness Improvement Programme	• The cost of continuing to provide services in the current configuration for our growing population exceeds the available resources • There are chronic workforce gaps (mirroring national picture) increasing pay costs and limiting effectiveness. • There are insufficient feedback loops for local teams to monitor compliance with best-practice and assess impact of improvement initiatives • Productivity in key health and care interventions is below top decile in specific services in BLMK
3. Enabling our Children and Young People to Thrive	• Too many of our children in BLMK live in poverty • Over a third of children in BLMK are overweight – this is a key risk in for future health & well-being • Not all children and young people have early key interventions during primary school years to enable them to thrive (communication, diagnosis and support for dyspraxia, autism spectrum disorders, emotional resilience) • There is more we can do to support transition to adulthood for young people with complex needs • BLMK has insufficient 'recovery & thrive' capability and capacity to meet the needs of our most complex children's placements within the patch • There is more we can do to prevent and proactively manage long term conditions for children & young people • Children and young people are waiting too long to access mental health and well-being services
4. Improving Access & Treatment	• Patients are waiting too long for routine elective interventions, compromising health & well-being • Barriers to accessing screening & early diagnosis are adversely impacting the health outcomes of some residents • Cancer diagnostic and treatment capacity in key modalities is insufficient given the increase in demand, and difficult to access for some populations • Urgent & emergency care pathways have higher demand than capacity, adversely impacting patient experience and increasing clinical risk • Uptake of very specialist clinical services in East of England is lower than national average, compromising health outcomes • Delays in paediatric elective treatments can have an impact on development and educational progress. • Traditional face to face elective care delivery models are inflexible and no longer meet the societies work and lifestyle expectations, leading to missed treatment opportunities and poorer outcomes. • There is more we can do to enable greater choice about how and where people access healthcare, especially for those with the poorest access currently

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Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

BLMK High Impact Programme	Problem Statements
5. Improving Outcomes for MHLDA	• People in acute mental crisis / distress are not consistently able to access rapid mental health support in their local community • Crisis pathways are focused on immediate safety with insufficient recovery provision • People with severe mental illness and / or learning disabilities are more likely than the general population to die early due to long term conditions • BLMK has insufficient 'recovery & thrive' capability and capacity to meet the needs of our most complex mental health, learning disabilities and ASD placements within our geography • Current Bedfordshire adult inpatient mental health services estate is insufficient for modern models of care and local need / demand
6. Integrated Neighbourhood Working	• Population growth in specific geographies will exceed primary care capacity (dental, pharmacy and primary medical) without transformation of the current service model. • There is more we can do to help connect people together within the community to address isolation, loneliness including those with caring responsibilities • Our approach to health screening (including cardio-vascular, respiratory, diabetes and cancer screening) needs to adapt and be agile to deliver an acceptable offer to our diverse population • There is more we can do by working with our voluntary sector to help residents live a happy life and to help them to confidently manage their long-term conditions • Seldom heard communities need a bespoke in-reach community offer to increase vaccination rates • The proportion of residents living in a care home with complex care needs continues to increase requiring multidisciplinary proactive anticipatory care to enable residents to be safely managed in an out of hospital setting • There is more we can do to support people/communities to address the root causes of their problems including the wider determinants of health to and reduce reliance on health care or medical interventions • We do not consistently use opportunities to promote wellbeing and physical activity or to sign post residents to community events or activities that support prevention of poor health.
7. Intelligence-led Quality, Performance, Outcomes, and Inequalities Improvement	• Not all health & care data is digitally integrated, causing gaps, duplication and delays in treatment – and requiring residents to repeat their story • There is more we can do to embed population health view into NHS metrics to identify inequalities in access, outcomes and experience; and assess the impact of actions to improve health outcomes and tackle inequalities • There is more we can do to enable residents to manage their health and wellbeing using digital technology • Duplication of reporting has an adverse impact on staff productivity & morale
8. Integrated Care System Target Operating Model	• Our current ways of working don't always make it easy to provide joined-up care for residents • There is more we can do to work with communities to enable them to thrive • There is more we can do to work in partnership with our VCSE to optimise experience and well-being for residents • Our governance will need to adapt as the ICB matures to optimise the impact of Health & Well-being Boards, and ensure collaborative and sovereign governance aligns • We have yet to explore the opportunities to conduct core ICB functions at scale across the East of England Region
9. Thriving Eco-systems and Prosperous Communities	• Environmental concerns are not yet seen as a core part of delivery of services to improve health and reduce avoidable illness. • Climate change and environmental pollution are not bound by geography, sectors, or organisational footprints, and have the greatest impact on those in the most-deprived communities. • We need to better understand accountabilities and responsibilities for delivering thriving ecosystems and prosperous communities across the different partners, organisations and sectors (public, private, VCSE) within the ICS, and develop appropriate governance and sensitive measurement systems to oversee progress. • We need to develop innovative approaches to health improvement, employment, procurement and estates with partners in all sectors, whilst working within the parameters of legislation.

Outcomes of our High Impact Programmes

This section summarises the benefits of High Impact Programmes to residents and to the sustainable delivery of NHS and local authority services. This is a shift from traditional reporting against performance targets, with a focus on volume and waiting times. Though these remain crucial to monitor the experience of our residents, this approach does not give assurance that we are improving the years lived in good health for all our residents.

The ICB is committed to understanding our performance data against key NHS and local authority standards and targets, with a focus on the local population's health and wellbeing. This shifts the assessment of our impact from 'are we working hard enough to meet demand?' to 'are we doing our best to improve health outcomes and tackle inequalities for all our residents?'

Here is an example of why this population perspective is so important.

Luton radiotherapy example:

Cancer performance is Luton was generally above average before the pandemic but there was a perplexing contradiction in terms of health outcomes for residents. There was a long-standing question as why the cancer outcomes for residents in Luton were poorer than other areas of the country.

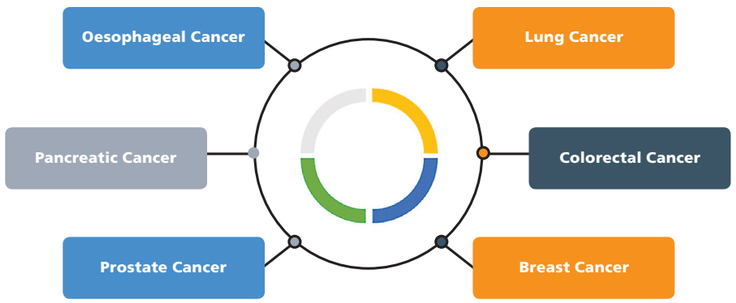
The Luton Cancer Outcomes project was set up to identify the main factors – **medical, behavioural, social and others** – which contribute to variations in cancer outcomes amongst the residents of Luton and make recommendations for improving cancer outcomes.

The project looked at four key **outcome measures**:

1. Stage at diagnosis 2. Emergency presentation 3. One year survival, and 4. Five year survival

And focused on the **six cancers** with the greatest levels of premature mortality for Luton in 2019:

We asked residents of Luton what the barriers were to accessing cancer services and one of the stories we heard was so powerful it formed our driver for change. Nam's story illustrates the complexities that lack of knowledge around how and when to seek help, services able to meet needs of their local population and access to transport or other economic factors can shift patient decision making and therefore patient outcomes.



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Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Patients and carers from Luton have told us about geographical, cost, transport, cultural and socio-economic factors that make accessing care difficult.

For example:

- We have heard about women unable to travel to an appointment without their husband, unable to see a male doctor, or unable to travel very far from home, and whose diagnosis or treatment is delayed as a result.
- We have heard about single parents who cannot afford childcare support and have no one to babysit whilst they attend appointments – the further away those appointments are, the more impossible this becomes.
- We have repeatedly heard about journeys of 90 minutes each way to the current cancer centre and stories of patients who have decided not to have treatment because of the current lengthy travel times or complicated journeys.

The project worked in 4 key workstreams looking at health inequalities, health outcomes data patient experience and strategic factors such as resources, workforce, partnership working. These workstreams developed a set of recommendations which are now in implementation phase.

Key learning

- The factors contributing to poor cancer outcomes in Luton are complex and wide ranging;
- Patients and carers told us about geographical, cost, transport and socio-economic factors that made accessing care difficult
- Barriers to accessing cancer screening are likely to be linked to ethnicity and culture, but barriers to accessing treatment are likely linked to wider determinants such as access to transport and being able to take time off work.
- Prostate cancer diagnosis has been impacted by COVID with men not seeking help early on, we need to reach these men in a different way.
- Patient experience is generally good but we are not hearing from all communities
- People are still presenting late with cancer symptoms and this will continue to have an impact on survival rates if not addressed
- There are opportunities to make small but significant changes to cancer pathways - specifically between Luton & Dunstable and Mount Vernon - to improve experience and outcomes

This example illustrates how working together a on a shared problem can help us deliver a solution that addresses the issues that matter most to our residents.

The table overleaf sets out the outcomes we expect our High Impact Programmes to achieve:

BLMK High Impact Programme	JFP Mobilisation / Operating Plan Actions 2023-5	Summary of Outcomes: JFP Delivery 2025 - 2030	Summary of Outcomes: JFP Delivery 2031 - 2040
Advancing Equity	• Detailed population growth & demographic shift modelled for BLMK to 2040 • Population health intelligence unit established • Shared Quality Improvement approach embedded across BLMK services • Inequalities targeted funding is aligned to Place JSNA priorities, with clear actions and metrics to evaluate benefit to residents	• Slow or reduce obesity in population • Improved Maternity & neonatal outcomes • Reduced variation in health outcomes, plus increasing access to services, especially for those who are most disadvantaged / have poorest outcomes • BLMK spread of Better Lives campaign of 0-25 year-olds	• Outcome measures demonstrate more residents spending more years of life in good health • Reduce incidence of still births, neonatal, maternal and infant mortality • Reduce smoking rates in our most deprived population • Increase in activity resulting in reduction in obesity in 11-16 year-olds
Efficiency & Effectiveness Improvement Programme	• Programme pipeline established – identification of opportunity • Governance established (organisation-specific, issues in common, pan-BLMK, ICB) • Effective impact metrics established to ensure sustainable shift in use of resources	• Programme supports improvement in health and outcomes and reductions in inequalities through effective use of resources • Programme has sufficient impact to enable local LA and NHS to deliver within resources • Teams will routinely have access to feedback loops highlighting variation to make it easier to ensure treatment pathways are delivered within best practice clinical guidelines	• Investment in our services and infrastructure is configured to anticipate future need as well as current population demand • We can evidence across our services that we are spending public money wisely and achieving optimum outcomes for residents • Our research and innovation is driving improvements in health outcomes, reducing inequalities and delivering sustainable resources
Enabling our Children and Young People to Thrive	• Working jointly with Councils at Place and wider to develop affordable and sustainable placements and/or capacity for children with the most complex needs. • Working at Place to support families to prevent and intervene early for overweight children. • To develop multi-disciplinary pathways of care that provide evidence based, resourced early intervention for children in their early years – to include, hearing, communication, sensory. • Roll-out national pathways for asthma, epilepsy and diabetes to improve outcomes for children and prevent avoidable admissions and deaths. • Provide free, universal, digital mental health support offer for all young people in BLMK Options evaluation with each Borough on sustainable model for complex needs placements completed and plan agreed	• Developing a market management strategy that plans and predicts what will be needed for children with the most complex needs over the next decade. • Speedy access to family support and evidence-based programmes to reduce excess weight in children and manage those requiring specialist services. • Develop place-based pathways of support on a multi-agency basis with a single 'local offer' that is easily accessible for all children and families. • Drive quality improvement through focus on reducing inequalities in the 20% most deprived families (deep-dive practices) • Continue to build early intervention services so that mental health services are focusing on those children with diagnosable mental health problems, providing speedy access and sustained follow-up where appropriate.	• There is sustainable infrastructure for local provision of complex needs placements • Local services work together to prevent, intervene, and manage obesity in children in line with international best practice • An online 'local offer' of services and support, including self-referral ensures developmental needs are addressed at the earliest opportunity. • Readmissions to hospital are reduced and preventable mortality in children is eradicated. • Children and young people know how to access support for their emotional wellbeing and where specialist services are required they can access them within days. This will reduce the number of young people being admitted to mental health beds.

Living a longer, healthier life

Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

BLMK High Impact Programme	JFP Mobilisation / Operating Plan Actions 2023-5	Summary of Outcomes: JFP Delivery 2025 - 2030	Summary of Outcomes: JFP Delivery 2031 - 2040
Improving Access & Treatment	• Earlier and faster cancer diagnosis • Health services strategy methodology agreed & implemented • End-to-end pathway reviews and peer-productivity challenges embedded • Community diagnostic centres completed • Flow programmes reduce preventable admissions and delays waiting for discharge	• Cancer infrastructure accessible to all as population grows. Cancer services at point of diagnosis and after treatment are integrated • Access and health outcomes are improved, especially for those currently most disadvantaged • People with frailty are supported to remain well at home or recover better after acute hospital admission • Waiting time for routine hospital and community health treatments are at / close NHS Constitutional standards	• Outcome measures demonstrate more residents spending more years of life in good health • Impact of life's disadvantages on health outcomes has reduced • Cancer survival rates at 1 and 5 years are at / above national mean, including those people who are most disadvantaged • Respiratory and cardiovascular outcomes are at or above national average outcome measures, with systemic attention to prevention, long term conditions management and preventing avoidable admissions
Talk about people with Mental Health, Learning Disabilities and ASD.	• Community crisis and recovery pathways developed and implemented • Options evaluation with each Borough on sustainable model for complex needs placements completed and plans agreed • Implementation of capital investment to increase crisis capacity in Bedfordshire and Milton Keynes	• People in crisis have prompt access to local support to keep them safe and support recovery • Adults requiring inpatient admission can be treated within BLMK • More adults with severe mental illness, learning disabilities and autism spectrum disorders are supported into employment • Increased access to diagnosis and support for people with autism spectrum disorders	• There is sustainable infrastructure for local provision of complex needs placements • We have significantly redressed the poorer long term physical health outcomes experienced by people with severe mental illness, learning disabilities and autism spectrum disorders • All residents in mental health crisis can access local community-based support quickly and easily
Integrated Neighbourhood Working	• Co design meaningful neighbourhoods across the 4 places and put in place the appropriate infrastructure and support for neighbourhood working • A system-wide approach for integrated urgent care to guarantee access for people who require same day primary care services • LTC transformation programme via multi agency groups for diabetes/respiratory/ CVD using bespoke outcome measures (including patient reported outcomes, clinical measures and health inequality metrics)	• All residents of BLMK have access to wellbeing facilities and can access same day primary care services with confidence • Residents and families impacted by long term conditions have access to prevention, advice and support to help them stay well at home • Stay well at home initiatives with local voluntary sector are supporting older people to stay warm, and reduce loneliness and isolation	• We have sustainable primary care capacity to meet population needs (same day urgent care access, support to manage long term conditions) • We will be able to demonstrate the benefit to residents of integrated neighbourhood working based on the things that matter most to residents; and in key health outcome measures

BLMK High Impact Programme	JFP Mobilisation / Operating Plan Actions 2023-5	Summary of Outcomes: JFP Delivery 2025 - 2030	Summary of Outcomes: JFP Delivery 2031 - 2040
Intelligence-led Quality, Performance, Outcomes and Inequalities Improvement	• Business intelligence / analytics solution identified & delivered • Population Health Intelligence Unit established • NHS performance reporting is routinely split by Place, and understood in the context of health population needs • Benefit measures underpinning transformation quantify the changes in health outcomes and in reducing inequalities – the wider determinants of health (as well as NHS performance, access and value for money)	• High Impact Programmes and QI are driven by integrated data highlighting inequalities and variation in outcomes • NHS and social care data is digitally integrated, enabling more joined up care for residents • Integrated Neighbourhood teams and Place Boards will have intelligence to understand who is not accessing health interventions in a timely way, and tools to engage with residents to ensure that those who find health services most difficult to access are not disadvantaged in their health outcomes	• Residents can manage their long-term conditions with digital support • Population health management intelligence routinely informs service development; and evidences benefit to residents of quality improvement actions • Integrated data enables multi-disciplinary working across settings and organisations to provide seamless, joined-up care for residents • Strategies to support communities to improve their health and well-being are bespoke to local population needs
Integrated Care System Target Operating Model	• Transformation Programme for ICB – including 30% reduction in running costs. • Place based boards established • Compact with VCSE & Healthwatch agreed • ICB approach to contracting with VCSE in place • Denny review report agreed and recommendations implemented • Co-production training delivered • Remuneration approach for co-production implemented • Big conversation delivered to develop our joint forward plan April 24 • Investment in VCSE infrastructure agreed	• Integrated workforce planning to enable planning at a system and place level • Integrated working and shared QI approaches enable staff to work across organisations & settings • Evidence of co-production as part of High Impact Programmes and delivery of Place Priorities • Evidence of positive impact on resident outcomes from VCSE work • VCSE playing a larger role in service delivery and co-production • VCSE partners integral to ICB and place planning and delivery • Evidence of transfer of power to residents via co-production approach	• Joint working across neighbourhood and place supporting organisation models like collaboratives in providers to deliver joined up resident focussed services. • As anchor institutes, all YP & adults furthest from employment have access to support • Improve health outcomes for population groups most affected by health inequalities • Increased resident and stakeholder satisfaction in annual sentiment surveys • Improved sustainability and resilience in VCSE sector • Evidence of transfer of power to residents via co-production approach has supported improved health & well-being for residents
Thriving Eco-systems and Prosperous Communities	• Embed sustainability checklist and environmental literacy into leadership, change-management and governance processes • Delivery plans for Green Plan themes • Establish anchor coalition • Resident co-production of future environmental sustainability strategy • Procurement systems developed to maximise social value and inward investment opportunities • Build on employment and employability pathways, with existing organisations and the proposed MK STEM university • Maturation of the Research and Innovation Hub	• Reduced carbon-equivalent emissions from all sources, with NHS achieving ~48% reduction against 2019/20 baseline by 2032 • Focus on improving health and environment as co-benefits (e.g. air pollution, active travel, diet, and severe weather events) • Barriers to employment within health and care are reduced • Supply chain delivering greater social value benefit for BLMK residents	• NHS is net zero on Scopes 1 and 2 carbon emissions, with overall emissions >80% lower than 2019/20 • Realisation of health co-benefits relating to the environment such as air pollution, active travel, diet, and severe weather events • The healthcare workforce is more representative of the local population, with a greater proportion coming from within BLMK • Within legal frameworks, a greater share of goods and services in the health and care supply chain come from BLMK-based businesses, through improved knowledge, skills and capacity of those businesses to successfully bid for tenders.

Living a longer, healthier life

Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Improving health services quality, access, and outcomes for our population

Our population health view focuses on the resident and how services are benefiting our residents. It means that we are committed to understanding the quality, performance, and outcomes of our NHS services as it relates to local populations.

Addressing all the determinants of health

Research shows that health services play only a small part in what supports people and communities to thrive. It is estimated the NHS directly impacts only 20% of what determines an individual's health. The other 80% is determined by wider factors like access to green spaces, educational attendance, attainment and skills, and crime rates.

We are therefore designing a new way of measuring our performance that is solely NHS-focused and more about how we as a system are together improving health outcomes for our population.

At the heart of this new performance framework are three distinct categories or domains, based on the Office for National Statistics (ONS) Health Index:

Healthy People – this domain covers health outcomes that include mortality, and the impact of physical and mental health conditions;

Healthy Lives – covers risk factors for health that relate directly to individuals. This includes factors that can be changed by individuals, and social factors that cannot always be controlled by individuals but can affect them; and

Healthy Places – includes social and environmental risk factors that affect the population at a collective level. These relate to circumstances that can influence health outcomes and risk factors. However, they often cannot be addressed solely at the individual level.

If we were to apply the Health Index framework in Bedfordshire, Luton and Milton Keynes, an example of the cross-cutting measures forming part of this approach is set out below.

Health Index		
Healthy People	**Healthy Lives**	**Healthy Placess**
Difficulties in Daily Life • Disability • Frailty	**Behavioural Risk Factors** • Alcohol Misuse • Drug Misuse • Healthy eating • Physical Activity • Sedentary Behavious • STIs • Smoking	**Access to Green Space** • Private Outdoor Space
Mental Health • Children's and Young Peoples' MH • Mental Health Conditions • Self Harm • Suicide	**Children and Young People** • Early Years Development • Pupil Absences • Pupil attainment • Teenage pregnancy • Young People in Edu/Emp	**Access to Services** • Distance to GP surgeries • Distance to pharmacies • Distance to sport/leisure facilities • Internet access • Patients offered acceptable GP appointments
Mortality • Avoidable Mortality • Infant Mortality • Life Expectancy • Mortality from all causes	**Physiological Risk Factors** • High Blood Pressure • Low Birth Weight • Overweight/Obesity in Adults • Overweight/Obesity in Children	**Crime** • Low level crime • Personal crime

Health Index		
Healthy People	**Healthy Lives**	**Healthy Placess**
Personal Wellbeing • Activities in Life are Worthwhile • Feelings of Anxiety • Happiness • Life Satisfaction	**Protective Measures** • Cancer Screen Attendance • Child Vaccination Coverage	**Economic and Working Conditions** • Child poverty • Job realted training • Unemployment • Workplace safety
Physical Health Conditions • Cancer • Cardiovascular • Dementia • Diabetes • Kidney and Liver disease • MSK • Respiratory		**Living Conditions** • Air pollution • Household overcrowding • Noise complaints • Road safety • Rough sleeping

Partner organisations within the ICB will continue to be responsible and accountable for their own delivery through their statutory governance arrangements.

SECTION EIGHT - Place and Provider Collaborative Key Objectives

There are four Places within the ICB area: Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. Each has a Place plan, identifying local priorities that partners can work on together to improve the health and wellbeing of local residents.

These are summarised as below:

BEDFORD BOROUGH COUNCIL

Bedford Borough's vision is to thrive as a Place that people are proud of, want to live in and move to. Local plans recognise a growing and strong local economy and an active response to climate change as two important factors in achieving this. From this foundation residents will be able to thrive and realise their potential, supporting and celebrating Bedford Borough's diverse and inclusive communities.

The Bedford Borough Place plan has been developed by the Health and Wellbeing Board and commits to:

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

The priority partnership actions identified in Bedford Borough are:

- Tackling obesity; and
- Improving access to primary care.

Central Bedfordshire

The Central Bedfordshire Place Plan includes three over-arching ambitions:

- **Promoting fairness and social inclusion** – identifying and tackling underlying inequalities in social and wider determinants of health, promoting better, equitable access to services;
- **Living well** – so everyone has the right and opportunity to live their best life, with the required support and infrastructure to make healthy choices and maximise wellbeing; and
- **Ageing well** – to provide support and services required to meet the needs of an ageing population, adapting to changing demands and new models of care.

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Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Given the breadth of the ambition, the Board has identified five initial priorities of focus which are:

1. **Cancer** – prevention, early detection and reducing premature mortality;
2. **Children and Young People's Mental Health** – delivering the ambitions to promote positive mental health and wellbeing;
3. **Mental health, learning disability and autism** – reducing stigma, improving the experience of care and physical health of people with these conditions and access in a crisis;
4. **Primary care access, including dentistry** – developing the Fuller plan for integrated care and developing new models of care; and
5. **Developing a one team approach to intermediate care services** – ensuring more joined-up and timely care.

Luton

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

This is supported by:

- **A town built on fairness** – tackling inequality;
- **A child-friendly town** – investing in young people; and
- **A carbon neutral town** – addressing the impact of climate change.

The Luton Place Board has developed a Place plan which commits to:

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

The key priority actions identified to deliver this in Luton are to work in partnership to build:

- **Community hubs** and healthy places;
- Improved **mental health services** and interventions to tackle the causes of poor health;
- The Luton **digital programme**, connecting health and care services and helping people to stay independent at home; and
- Capacity across the **VCSE sector**.

The Milton Keynes Health and Council partners have formed **MK Together**. It formalises the commitment of the main local NHS partners in Milton Keynes and the City Council to work more closely together, with a focus on:

- **Improving system flow** – targeting urgent and emergency care services for older, frail or complex service users;
- **Tackling Obesity** – helping people lose weight and maintain a healthy weight through easily accessible weight management programmes, use of technology, pharmacological therapies, and education and prevention work;
- **Children and young people's mental health** – good mental health in children and young people helps build resilience, develop healthy relationships and lays the foundation for better mental and physical health and wellbeing throughout their whole lives. Early intervention is key for lifelong wellbeing. 75% of adult mental health issues are present by the age of 24; and
- **Complex Care** – focussing on improving the planning, assessment, commissioning, and case management for people who have the most complex needs
- MK has started a research phase on a Bletchley Pathfinder project to develop integrated neighbourhood working

Bedfordshire Care Alliance

The Bedfordshire Care Alliance is a Provider Collaborative. It aims to ensure that, where scale and complexity requires us, to provide standardised care across the three Bedfordshire boroughs.

The Alliance has agreed an initial focus on four priority areas:

- **Supported discharge** – improving rehab, reablement and recovery outcomes;
- **Alternatives to acute admission** – stay well at home;
- **Digital infrastructure** – to enable integrated pathways of care across Bedfordshire; and
- Support to Places to optimise **care closer to home**.

Living a longer, healthier life

Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Mental Health, Learning Disability and Autism Spectrum Disorder Collaborative

The Mental Health, Learning Disability and Autism Collaborative is a collaboration between several ICB partners - Central and North West London NHS Foundation Trust, East London NHS Foundation Trust and the ICB. It aims to improve outcomes, quality, value, and equity for residents.

The initial vision of the Collaborative will be developed with input from service users, carers and system partners. It will put the service user's voice and a focus on Place at its heart. In doing so, it will refocus efforts on addressing inequalities and unwarranted variation and working at scale where it makes sense to do so.

Specific areas where the Collaborative will add value will include:

a. Development of sustainable early intervention and crisis and recovery pathways for children, young people and adults;

b. Develop capacity to deliver early local diagnosis and support for people with autism and autistic spectrum disorder;

c. Development and implementation of sustainable recovery-focused models of care for people with complex needs. This includes complex placements being provided within the ICB area as standard;

d. Capital development in core services, for example mental health inpatients; and

e. Improving physical health access and outcomes for people with serious mental illness, learning disability and autism.

SECTION NINE: BLMK ICB Principal Risks

The BLMK ICB Joint Forward Plan is designed to deliver the core objectives of the ICB for our residents. As such it aims to tackle within the High Impact Programmes and Enablers all the most critical risks the BLMK Partners face in delivering our core services, and our collaborative plans to improve health outcomes, tackle inequalities, provide value for money and support growth in our local economies.

Our key risks are held in the ICB Board Assurance Framework & overseen by the ICB Board.

The extent to which our High Impact Programmes & Enablers mitigate these known principal risks - and the outstanding risk which cannot be mitigated locally – is summarised below:

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Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

BAF Prefix	Strategic Priority	Risk Detail	Risk Mitigations in Joint Forward Plan Programmes & Enablers	Outstanding Risks
BAF0001	Live Well	**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 and Urgent and Emergency Care pathway related pressures, workforce constraints or demand led pressures. This may lead to poorer patient outcomes and reputation damage.	**Improving Access & Treatment** • Health services strategy • End-to-end pathway review & peer productivity challenges to improve effectiveness & productivity • Implementation of community diagnostic hubs • Cancer programme Integrated Neighbourhood Working • Place-based plans to increase prevention & early diagnosis • Increasing primary care & neighbourhood capacity	Capital investment required in targeted areas to: • unblock existing acute flow bottlenecks in urgent emergency care and elective capacity • ensure diagnostic capacity aligns to population need • accommodate sufficient primary care capacity as population increases
BAF0002	Growth	**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.	**Improving Access & Treatment** • Health services strategy **Improving Outcomes for MHLDA** • Workforce strategy to deliver mental health investment standard **Intelligence-led quality, performance, outcomes & inequalities** • Use of digital technology, quality improvement & tackling inequalities skills to support effective pathways of care **Integrated Care System Target Operating Model** • Staff to move to Integrated Care System Target Operating Model • Delivery of co-production training across teams	National training pipeline shortages in key speciality roles, including; • Histopathology • Midwifery • Primary Care • Social Care Impact of long-term sickness absence from wider workforce across all employers, including public sector employers e.g. treatments and operations delayed, impacts public service delivery & slows economic growth Impact of the anticipated NHSE Long Term Workforce Strategy is not yet known.
BAF0003	Live Well	**System Pressure & Resilience** As a result of continued pressure on services from various factors 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.	**Delivery over the medium-term of the 'left shift':** • Increasing prevention and early diagnosis • Integrated Neighbourhoods proactive intervention to help older people stay well at home • Children & Young People – actions to improve long term conditions management, and reduce avoidable admissions • MHLDA – crisis and recovery pathway development to support more people to stay well in the community	Multiple reporting requirements at times of peak / sustained pressure will divert from efforts to deliver the sustainable 'left shift'

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Bedfordshire, Luton, and Milton Keynes Integrated Care Board Joint Forward Plan

BAF Prefix	Strategic Priority	Risk Detail	Risk Mitigations in Joint Forward Plan Programmes & Enablers	Outstanding Risks
BAF0004	Reduce Inequalities	**Widening inequalities** There is a risk that inequalities and outcomes for specific demographic groups within BLMK population will widen compromising our ICS purpose to improve outcomes and tackle inequalities.	Focus on health population & impact of all High Impact Programmes & Enablers is core to all our delivery. This is enhanced by: • Implementation of the population health intelligence unit, and NHS performance reporting by local population need • Specific actions to tackle inequalities & improve health outcomes • Co-production & working with VCSE to maximise access to our most deprived populations	Revenue funding shortfalls to core Local Authority functions such as adult & children's social care & SEND to support our most vulnerable populations
BAF0005	Growth	**System Transformation** 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.	BLMK ICB transformation is enabled by: • Subsidiarity to Place & Provider Collaboratives • Shift to Integrated Care System Target Operating Model • Streamlined reporting & performance management regime • Operational plans at Place / Provider Collaborative to address UEC demand pressures • Capital investment in key areas such as diagnostics capacity Transformation across all High Impact Programmes & Enablers is targeted to deliver the greatest benefit to residents through effective use of our resources	Risk that multiple requirements from central policy-makers will divert attention from BLMK population-centric key deliverables – and compromise efforts to improve health outcomes, reduce inequalities & deliver sustainable services that are value for money for our residents Need for joined-up medium-term capital and revenue investment in digital and business intelligence capacity & capability to enable transformation of care
BAF0006	Growth	**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.	This is supported by: • Enhanced digital capability to reduce duplication of effort • Effective Infrastructure and People strategies • Health services strategy and Research & Innovation to improve outcomes within resources • Focus on prevention and early diagnosis to support residents' health & well-being, and slow increases in population need & demand • Effectiveness & efficiency programme to tackle unwarranted variation & thus reduce avoidable cost	Condition of BLMK estates & infrastructure requires significant investment to maintain the status quo Requirement for ongoing cost improvement delivery in the context of rising operational pressures may not be fully deliverable

Living a longer, healthier life

Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

BAF Prefix	Strategic Priority	Risk Detail	Risk Mitigations in Joint Forward Plan Programmes & Enablers	Outstanding Risks
BAF0007	Live Well	**Climate Change** 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; ii) new health challenges iii) extreme weather events resulting in harm; iv) disruption to day-to-day healthcare provision; and v) a deterioration in population health outcomes.	Clear strategy in our Joint Forward Plan to maximise our collective impacts on sustainability & growth, supported by: • Place Plans • BLMK People Strategy, including our actions as anchor institutes Our Infrastructure strategy will highlight key areas of risk caused by infrastructure fragility most likely to compromise sustained delivery of health, care and civic services contingent to delivery of our ICB shared objectives.	Fragility of some key infrastructure means that service interruption is more frequent as weather variation becomes more extreme Cost of sustainable products is prohibitive to the public purse Challenges in achieving sufficient capital to meet increased health need due to population growth
BAF0008	Live Well	**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, which will exacerbate widening inequalities and outcomes.	Joint Forward Plan will be based on modelling of population growth & demographic shift generated by our local housing plans. This will enable more accurate & strategic demand / capacity modelling. Delivery of future services is informed by our health services strategy, MHLDA and children & young people's plans and our People strategy	Challenges in achieving sufficient capital and revenue to meet increased health need due to population growth
BAF0009	Live Well	**Rising Cost of Living** 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	Our 4 Boroughs all have strong plans to support people into training & employment; grow the local economy and enable our communities to thrive. Our Joint Forward Plan High Impact Programmes & Enablers ensure that our efforts improve the years lived in good health by all our residents. Our collective focus on health outcomes improvements and tackling the wider determinants of health are crucial to ensure we tackle the inequalities experienced by our most disadvantaged communities	

BLMK

Joint Forward Plan

Appendices

CONTENTS

Appendix A

The Joint Forward Plan at Place

1.1 Bedford Borough

1. Opportunities and challenges for Bedford Borough

A growing population

Bedford Borough includes the urban area of Bedford and Kempston, surrounded by rural parishes. It has rich heritage and significant diversity with over 100 different community languages spoken. 12.5% of the population identify as Asian or Asian British (mostly Indian, Pakistani and Bangladeshi); 11.6% as White non-British; and 5.2% as Black or Black British.

Between 2011 and 2021 the population grew by 17.7% to 185,300, which was the fastest population growth in the East of England. The largest increases were seen among working-age adults 30-39 and 50-59.

Population projections produced by the Office for National Statistics (ONS) in 2020 (prior to the 2021 Census) indicated that the population of Bedford Borough would grow by a further 20,000 by 2040, with the largest increases among those aged 60 years and over, including a doubling of the population aged 90 and over. The ONS projections however do not fully account for all the growth seen between 2011 and 2021, or for the housing growth anticipated in the Borough. According to the Local Plan 2040 an estimated 1,355 new dwellings will be required every year until 2040, and as a result population growth over that period could be up to three times the ONS projection. The growth in the number of families with children is particularly prone to underestimation, as housing growth tends to attract this demographic.

Rising demand and increasing complexity

The growing and aging population will place additional demands on local services, including health and social care services. Increasing complexity of individual cases is already being experienced by Adults' and Children's services, and since April 2021 the average number of primary care contacts in Bedford Borough has risen by almost 40%.

Population health

Continuous improvements in life expectancy have stalled since 2014, and potentially reversed in the last couple of years. Over the last 10 years the average number of years lived in good health has fallen by 8.4 years in women (to 59.3) and 5.4 years in men (to 62.3). Bedford Borough has the largest life expectancy gap in BLMK between the least and most deprived areas. Life expectancy at birth for females ranges from 78.2 years in Harpur to 88.9 years in in Kempston Rural; for males it ranges from 72.1 years in Harpur to 86.6 years in Oakley. The largest causes of the gap in life are COVID-19, cardiovascular diseases (especially in males), cancer (particularly lung cancer in females) and dementia.

Healthcare is important for good health but it only accounts for about 20% of what makes us healthy. Health behaviours (e.g. diet and exercise) account for around 30%, while socioeconomic factors (e.g. education, employment, income) and the physical environment we live in (e.g. housing, access to amenities, green spaces) make up the remaining 50%. These socio-economic and environmental factors are also known as the building blocks of health, and they are mainly responsible for the geographical and demographic inequalities we observe in rates of disease and death.

The cost of living crisis remains a significant threat to health and wellbeing in Bedford Borough. In 2021/22 it was estimated that after housing costs had been taken into account 1 in 4 children (10,800) were living in poverty. The national impacts of rising costs have included increased reliance on food banks and crisis support, and rising levels of fuel poverty. Official figures for Bedford Borough show that in 2020 an estimated 9,598 (13.8%) households experienced fuel poverty. More recent data is not available but since then average energy costs have more than doubled, so the number of residents affected is likely to be much higher.

Another impact of the cost of living crisis is the ability for people to afford stable and good quality housing. The number of households in temporary accommodation in Bedford Borough has increased by 64% in the last 12 months, from 377 to 620.

Several population health challenges have been identified for Bedford Borough:

- Childhood immunisations
- Excess weight
- Cardiovascular disease
- Cancer
- Mental health

High coverage of **childhood immunisations** is vital to prevent outbreaks of dangerous vaccine-preventable diseases including measles, meningococcal disease and cervical cancer. Childhood immunisation rates have mostly fallen over the last couple of years, in part due to changes in provision and uptake during the COVID-19 pandemic. The proportion of the eligible population who have received two doses of the Measles Mumps and Rubella (MMR) vaccine by the age of 5 has fallen to 89.5% which is well below the 95% level which makes it difficult for outbreaks to spread. Population coverage of the HPV vaccine (offered to 12-13 year olds) which prevents cervical cancer and the meningococcal ACWY vaccine (offered to 14-15 year olds) have also fallen below national targets of 90%.

Excess weight can lead to a range of health conditions including diabetes, cardiovascular disease, cancers and mental ill health. Living with excess weight is associated with higher healthcare use, including up to 140% higher prescription costs, 60% more primary care contacts and a 30% higher hospitalisation rate. In Bedford Borough the proportion of primary school Year 6 students with obesity or severe obesity increased from 21.0% in 2019/20 to 24.3% in 2021/22. Across the Borough there is a three-fold difference in the proportion of year 6 students with excess weight: in Castle and Harpur wards more than 50% of year 6 students have excess weight, whilst in Oakley it is less than 20%. Two in three adults in Bedford Borough are living with either overweight (34%) or obesity (29%).

Cardiovascular disease is the single largest cause of the life expectancy gap in Bedford Borough – mainly due to heart disease and strokes. Premature mortality from cardiovascular disease is between 1.7 and 2.8 times higher than expected in Castle, Cauldwell and Harpur wards. To a large degree CVD is avoidable due to modifiable risk factors such alcohol use, tobacco use, physical activity, excess weight, high blood pressure, high cholesterol and diabetes. Whilst it is important to address the building blocks of health and make it easier for people to live healthier lives, there is also more that can be done to engage residents in behaviour change services (e.g. Stop Smoking and Weight Management services), and detect and treat conditions like high blood pressure and diabetes earlier and more effectively. Adults aged 40-74 are eligible for a NHS Health Check every 5 years, which

includes blood pressure, cholesterol and diabetes checks as well as the opportunity for advice and referral to behaviour change services where appropriate. In 2022/23 1,638 NHS Health Checks were carried out in primary care, which was only 16.5% of the target.

Cancer is another major cause of the life expectancy gap in Bedford Borough, contributing to 11% of the gap in males and 16% in females. Lung cancer is the largest contributor to the gap overall, accounting for 4.6% and 11.1% in males and females respectively, and whilst smoking prevalence in Bedford Borough has fallen to below 10% of the population for the first time, it is much higher among some groups, for example three times higher among routine and manual workers and four times higher among adults with severe mental illness. The number of people successfully quitting with the help of the Stop Smoking Service has fallen since the COVID-19 pandemic, largely due to the slow recovery of stop smoking specialist support in primary care.

With the exception of bowel cancer screening, screening uptake has generally decreased since the pandemic, and remains for most neighbourhoods and most screening programmes below the national target of 80%. Unvalidated local data indicates that uptake of cervical screening is higher among white British compared to Black, Asian and White 'other' ethnic groups. 57.2% of cancers in Bedford Borough were diagnosed at stages 1 or 2 in 2020. The NHS target is for 75% of cancers to be diagnosed at stages 1 or 2 by 2028. One of initiatives that will contribute to reaching this target is lung health checks which will start later this year in one Bedford Borough Primary Care Network.

Good **mental health** – being able to cope with the normal stresses of life, get on with the things we want to do, and look after ourselves and others – is essential to our wider wellbeing. When our mental health is not so good a range of supportive services are available to help, including self-help guides, text message services, talking therapies, community mental health teams and crisis response. Demand for services has increased significantly since the COVID-19 pandemic, with Child and Adolescent Mental Health Service (CAMHS) referrals doubling between 2018/19 and 2021/22 and CAMHS crisis referrals tripling since 2019/20. Adult Community Mental Health Team referrals have increased by 66% from pre-pandemic levels. There is presently a lack of inpatient mental health care in the Borough. Residents with severe mental illness (SMI) are more than twice as likely to die prematurely of cardiovascular disease as people without SMI, and they are more than six times as likely to die prematurely of liver disease or respiratory disease.

2. Where are we now?

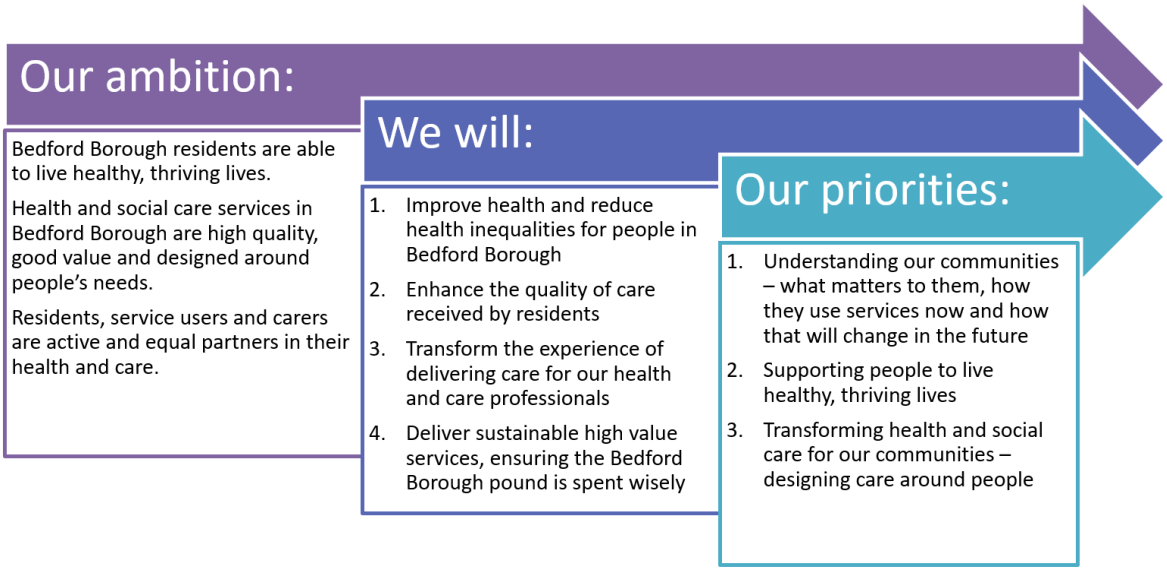
Bedford Borough Council has recently undergone a change in political leadership, with a new Mayor and a new Executive, whilst the Council as a whole has no overall control. Priorities for the new administration include ensuring that Bedford Borough is a great place to raise a family, and working with local NHS partners to proactively plan for the growing demand for healthcare.

The **Bedford Borough Joint Local Health and Wellbeing Strategy** (JLHWS) is due to be refreshed in 2023, in consultation with residents and elected members. The JLHWS will highlight the role that public sector organisations have in improving the building blocks of health and tackling health inequalities, and by doing so will help to support families and address demand for healthcare.

In 2022 the Council published its **Children, Young People and their Families Plan 2022-2027**. Written by children and young people, the plan identifies six themes that are important

to them. Local partners including the NHS were involved in developing the plan, and all our partners including schools and colleges are being asked to consider these themes in their own plans and demonstrate how they are working to improve things for children, young people and their families. The six themes are set out below.

In 2019 each local authority 'place' in BLMK was asked by the ICS to develop a 'place based plan' for health and care transformation, and in 2022 our partnership at place reviewed and refreshed the **Bedford Borough Place Based Plan 2019-2024**. The plan describes our ambition for Bedford Borough, what we will do together and our priority actions. The plan includes a detailed set of short and medium-term actions for each priority, and priority 3 'Transforming health and social care for our communities' includes separate actions for children and young people, working age adults and older people. The plan recognises the need to seek to reduce health inequalities in everything we do, give equal prominence to mental and physical health, and protect our most vulnerable residents from abuse.



The **Executive Delivery Group** is an officer sub-group of the Health and Wellbeing Board that was established to oversee delivery of the place-based plan. The EDG includes senior officers from the council, BLMK ICB, Primary Care Networks, East London NHS Foundation Trust (ELFT), Bedfordshire Hospitals NHS Foundation Trust, the VCSE and the Bedfordshire Care Alliance. The EDG has considered the population health challenges in Bedford Borough and has proposed a specific focus on two areas: primary care estates and tackling obesity.

3. What have we achieved so far?

Priority 1: Understanding our communities and what matters to them

We are in the process of refreshing our whole approach to the Joint Strategic Needs Assessment (JSNA), with a new JSNA website due to go live this summer. As well providing in depth needs assessments for a range of topics, the new JSNA will be a repository for local public health reports and will include interactive maps and charts that enable the user to explore what the data says about their community.

The Public Health team commissioned peer-led research into the impacts of COVID-19 on communities and groups that were disproportionately impacted by the pandemic. Local people were recruited and trained to undertake the field work and analyse the findings, which were presented to the Health and Wellbeing Board and will now be translated into an action plan.

The Council has strengthened its engagement with communities and the voluntary sector through the creation of a dedicated Community Engagement Officer role. A regular Community Network Event has been established in partnership with CVS Bedfordshire. Building on work done to address vaccine inequalities during the COVID-19 pandemic the Public Health team has established an outreach team, which is working with Healthwatch, VCSE partners and community groups to enable more people to access preventative services.

Priority 2: Supporting people to live healthy thriving lives

Our partnership at place has responded to the cost-of-living crisis with a range of measures, and ICS funding has been used to provide additional short-term support to the VCSE sector; tackle fuel poverty and support the creation of a warm spaces network.

The **Community Cost of Living Grant Fund** was set-up to provide additional short-term support to local VCSE organisations supporting Bedford Borough residents with the cost of living and related inequality issues including housing, mental wellbeing, access to healthcare and support for carers. Thirty-seven applications were received and following an evaluation process thirteen grants of between £5,000 and £22,000 were awarded to a diverse range of VCSE organisations. A review of the impact of the grant scheme will be undertaken over the next few months, but early indications are that VCSE organisations have been able to use this funding effectively to support more people than would otherwise have been possible during a particularly challenging period.

Warm Homes Bedford Borough was established to support residents who were at increased risk of the health impacts of cold and damp homes as a result of a long term health condition. We identified eligible residents through an innovative population health management (PHM) approach, combining primary care data with other information on potential vulnerabilities, and via referral from frontline professionals. Between December 2022 and April 2023 a total of 246 Warm and Well Assessments were completed, leading to a range of interventions including energy company switching advice, inclusion on the Priority Service Register, and applications to the Warm Homes Discount and national energy efficiency schemes. Following a detailed assessment of need a total of 54 households received funded installations including boiler replacement, heating controls and loft insulation. An evaluation is now underway to measure the impact of the scheme on health and wellbeing, carbon reduction and healthcare utilisation.

The **Warm Spaces Network** was established in late Autumn last year to ensure that there were places across Bedford Borough where residents could go where they could stay warm, enjoy some company and get a hot drink. Along with support from the Mayor's Climate Change Fund, ICS funding helped the organisations providing Warm Spaces to meet their additional costs. Over 40 venues offered a Warm Space and together they recorded more than 1,400 attendances, although not all have reported this information so the total figure supported is likely to be much higher.

Priority 3: Transforming health and social care through effective partnership working

A strong area of partnership working has been for young people and their families living with special educational needs and disabilities (SEND). Our partnership at place was issued a written statement of action in 2018 and was revisited in 2020 with improvements and significant progression of outcomes noted for young people and their families living with SEND. The improvement journey has continued with good engagement across health, social care, education and public health, and co-production in everything we do with representatives from the local Parent Carer Forum (PCF).

In January 2022 concerns were raised at our SEND Improvement Board about the increased demand for **Speech and Language Therapy** (SaLT), the high numbers of requests for advice into Education Health & Care Plans (EHCPs), and the high caseloads across the service. Following consultation with the PCF a plan was proposed to commission 'Talking Success' training and fund a post within the Youth Offending Service (YOS) and Pupil Referral Unit (PRU), along with additional funding to support 3 objectives: (1) ensure that all schools received a visit from a link therapist to review their clinical needs; (2) improve the timeliness of responses to ECHP requests; and (3) ensure all children with termly or annual reviews in their EHCP were seen. By April 2023 all three objectives had been achieved and the SaLT post was established within the YOS and the PRU. The SaLT caseload was reduced from 500 to 264 and waiting times for initial assessment were reduced from 40 weeks to 28 weeks.

Additional central government funding has enabled us to develop a **Rough Sleeper Drug and Alcohol Treatment Team** which provides specialist drug and alcohol support to people at risk of or currently rough sleeping. Jointly staffed by the ELFT P2R drug and alcohol treatment service and the SAMAS peer mentoring support service, the team includes specialist doctors and nurses, a support worker and a peer advocate. The team takes a highly skilled multi-agency approach to complex cases, working with people out in the community, including in supported accommodation settings. In the first year 108 people engaged with drug and alcohol treatment, 31 accessed mental health support, and all are now registered with a local GP. Twenty-two are in stable accommodation and 57 are in temporary accommodation.

Both Bedford Borough Council's Reablement Team and ELFT Community Health Services' Primary Care Home team support people home from hospital through one of the **'discharge to assess' pathways**. Both services are focused on providing rehabilitation and reablement support, working with each individual to maximise their independence and reduce their reliance on formal long-term care. The teams work jointly and meet daily to review all referrals offering patients/service users the most appropriate and timely support while ensuring the best use of resources across the health and social care services. This has been effective, with the teams "holding work" for each other and it has removed the traditional "hand off" boundaries, giving the flexibility to manage demand and capacity with the positive that this is unseen by our service users.

Increasing collaboration between system partners has seen our primary care colleagues working with public health and the ICS digital team to identify vulnerable patient groups using a PHM approach and undertake work that is focussed on addressing inequalities in health care. Work in 2022/23 identified patients with obesity and hypertension and focused on both improving management of their long-term conditions as well as more holistic support for prevention and proactive referral to services to support care such as smoking cessation, weight loss services and our community wellbeing teams.

4. What's next?

We will continue to work to the priorities identified in the Place Based Plan, regularly checking progress against the actions and periodically ensuring that the plan remains fit for purpose in light of changing needs and circumstances. Five areas of focus have been identified for the next 12 months:

1. Joint Local Health and Wellbeing Strategy

We will consult on and publish a new Joint Local Health and Wellbeing Strategy, highlighting the role that public sector organisations have in improving the building blocks of health, including education, inclusive employment, the local food environment, housing and active travel.

2. Primary Care Estates and Fuller Neighbourhood Teams

The ICB has allocated funding to support the development of the Outline Business Cases (OBCs) for Kempston Hub and the Great Barford Surgery. This is the next stage of the work, following on from the Strategic Outline Case for Kempston which set out possible options for a site and the need for a new health facility in Kempston, as well as the new facility in Great Barford. A joint team from BLMK ICB and Bedford Borough Council has been set-up to oversee the project and work is underway to appoint the necessary expertise to take these OBCs forward, which will involve the development of detailed requirements for the premises, as well as initial design work.

We will contribute to the development of Fuller Neighbourhood Teams in Bedford Borough – mapping 'Fuller Neighbourhoods' and ensuring that there is a strong focus on supporting and enabling primary and secondary prevention within our Fuller Neighbourhood Teams.

3. Excess weight

We will help more people with excess weight to access weight loss support, with a particular focus on providing support to families to prevent unhealthy weight gain early in life, and on those at higher risk due to their socio-economic circumstances and/or physical and mental health conditions. We will tackle the stigma associated with excess weight/obesity, and we will seek to improve access to healthy, affordable food at home, school, at work and when using health and care services. We will continue to explore the use of local policy levers to help shape the environment in Bedford Borough to make it easier for people to maintain a healthy weight.

4. Managing complex health and care needs

We will work together to provide better care and support for people with complex health and care issues, building upon the successful ‘between teams’ protocol. We will ensure that everyone with complex health and care needs get the support they are eligible to, through the most appropriate funding streams available. We will focus on developing the partnership with our community and mental health services.

5. Addressing health inequalities

We will build on the learning from the Community Cost of Living Grant Scheme and the fuel poverty interventions to inform our future investment to address health inequalities in Bedford Borough. We will focus on building our partnership with the VCSE sector and taking a neighbourhood approach to working with local communities to address our population health challenges.

Homepage - Bedford Borough Council

1.2 Central Bedfordshire

1. What are the challenges for Central Bedfordshire?

The key problem for Central Bedfordshire as a 'Place' within the Integrated Care System is that given the challenges of significant population growth and demographic shift, the increasing health needs and wide-ranging inequalities of this population presents considerable resource challenges of money, workforce and infrastructure to deliver effective, efficient and sustainable health and care services for our current and future population.

Population growth & demographic shift

Central Bedfordshire is an area of significant economic opportunity with planned housing and employment growth and is a desirable place to live. It is the 11th largest Unitary Council area in the country, predominantly rural in character and one of the least densely populated. While this dispersed, rural identity is what makes Central Bedfordshire an attractive place to live, it also poses challenges for getting around and accessing shops, services and jobs close to home.

Central Bedfordshire population is currently around 295,000 with further growth expected. The local plan for Central Bedfordshire states a need for 32,000 new dwellings by 2035. Currently, the largest household group in Central Bedfordshire is new families, reflecting the growing amount of new housing stock. However, since 2011, the population aged 65+ has grown 1.6 times faster than England average. Growth is set to be fastest among older people. Where 27,800 (56%) residents aged 65+ are expected by 2035. Largest growth rates have been in populations aged 70-74 (55%) and those aged 90+ (43%). All age bands over 70 have grown by at least 28% since 2011.

Health needs and inequalities

The ageing population coupled with changing patterns of disease, with more people living with complex, multiple long-term conditions and rising public expectations pose important challenges.

Although, a relatively affluent area with life expectancy greater than the national average, there are significant challenges resulting from an ageing population and pockets of urban and rural deprivation. There are areas of deprivation particularly within Houghton Regis, Dunstable and Flitwick East, but importantly there are smaller pockets of rural deprivation, often in stark contrast to affluence within the same village or town. 10% of residents claim housing benefits, and 11.3% of children are living in poverty.

While Central Bedfordshire scored well in the social mobility index for adults, it scored poorly for education indicators with an overall decile of 30-40% and 7 poorly performing indicators (of 16).

The number of people with long term conditions is expected to increase significantly by 2030. 61% of adults are considered overweight and/or obese, and one-in-five adults report that they are physically inactive. Around a third of 10- to 11-year-olds are overweight.

Our vision is for the people of Central Bedfordshire to have access to good quality, safe, local health and social care across its towns and rural areas. We want every child to have high aspirations, reach their potential, make friends and build strong relationships with their

family. We want to prevent people from becoming ill and reliant on institutions such as care homes and hospitals, encouraging health, wellbeing and independent lives.

Rurality has implications across service areas, from providing services such as domiciliary care to accessing community services as well as challenges of rural isolation across all ages. Central Bedfordshire does not have a hospital within the administrative boundary. Residents access multiple hospitals across several Integrated Care Systems for acute care. The adult social care market in Central Bedfordshire is under pressure and sustainability, particularly the Home Care market remains a concern. There are significant workforce capacity issues across all providers of health and social care both in terms of carers.

We want a sustainable health and care system, that sees a real shift in the balance of care from acute hospitals and institutionalised care to a more community-based focus, organised around the needs of the people by integrating primary, community and social care to deliver seamless physical and mental health care services. Aside from our publicly funded services we wish to work with individuals and our local communities to promote an asset-based approach and build on networks of support and capacity in our communities. Our ambition is for an all systems partnership which includes housing, wider Council services, as well as with Independent, Private and Voluntary organisations.

2.The current landscape in BLMK

Central Bedfordshire's population distribution and its relation to secondary care providers make it important that the primacy of an integrated health and care approach is sustained in local communities so that services are more accessible to people, especially in predominantly rural areas, and meets the requirements for delivering health and care services to an expanding and ageing population. Securing locally based centres of excellence for providing proactive and preventative care for adults and children with complex health needs is a key priority for Central Bedfordshire as a 'Place'.

A 'Place Plan' which reflects the ambitions of the Joint Health and Wellbeing Strategy and informs the ICS's Integrated Care Strategy, has been published. The Plan is informed by the JSNA and population health information and sets out the priority health and wellbeing outcomes for the local population. It commits to 3 key high-level priorities for:

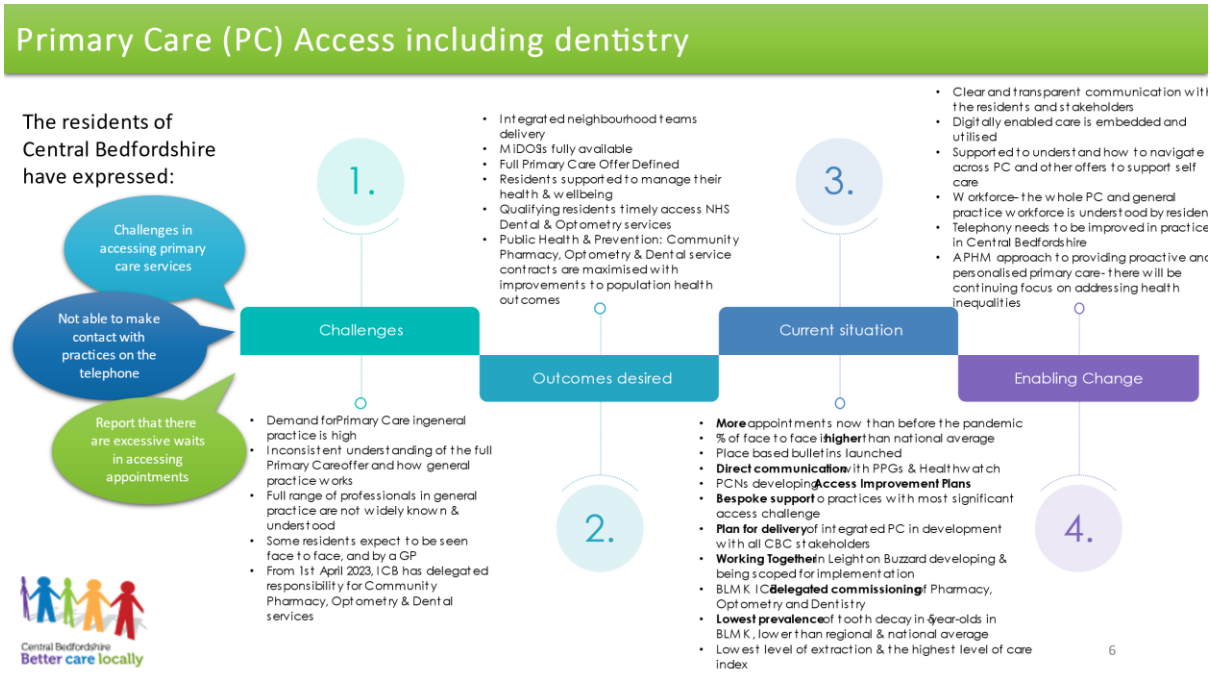
- **Living Well** - Improving access and supporting healthy choices.
- **Ageing Well** - Supporting independence for older people
- **Promoting Fairness and Community Cohesion** - Tackling inequalities and the wider determinants of health and wellbeing.

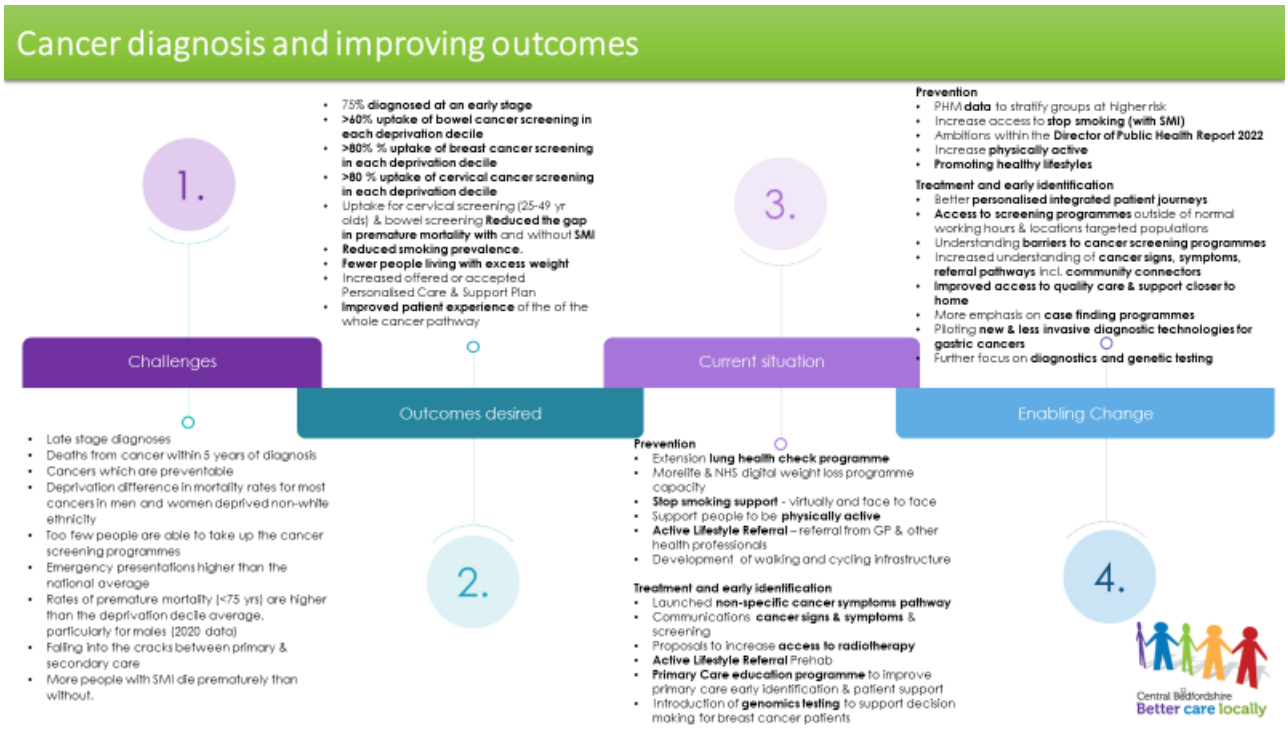
The Health and Wellbeing Board has agreed the priority outcomes for 2023-24 as follows:

- Primary Care Access including dentistry.
- Cancer diagnosis and improving outcomes.
- Mental Health, LD & Autism (All Age).
- Children Mental Health and emotional wellbeing for children
- Excess weight
- Working Together 'One Team approach' Intermediate care services

With housing growth, in which the largest household group is new families, meeting the needs of Children and Young People with complex mental health and care needs as well as redesigning services to ensure children and young people have access to the right health and care placements is key.

These challenges, desired outcomes and enablers for each of the six areas above are set out in the Place Plan Delivery framework for 2023-24.





Positive Mental Health and Well Being for Children and Young People

1.

- Increasing early intervention and prevention by strengthening community offer
- Increasing Mental Health Support for schools' teams
- Update and relaunch emotional/mental health wellbeing toolkit
- Accessible mental health support for children and young people with SEND
- Expanding support for young people with eating disorders
- Development of local leisure services to promote self care
- Launch of emotional health and well being online hub
- Co-production is embedded in everything we do

3.

- Reduced referrals into CAMHS single point of entry (SPOE) - % of referrals accepted, % of referrals signposted
- Reduced CAMHS referral to assessment time – 12-week KPI
- Reduced CAMHS referral to treatment time – average time
- Increased uptake of CHUMS provision –
- CYP open to CAMHS with SEND
- SHEU Survey findings demonstrate improved mental health and wellbeing of student population
- Emotional & behavioral health of children in care – decreased average SDQ score.
- Number of Central Bedfordshire education settings who have a mental health lead
- Reduced number of CYP accessing urgent care through emotional well-being and mental health needs (A&E 111*2)

Challenges

- Improve children & young people's emotional & mental health and wellbeing
- Services are integral in education
- Supporting celebration of who they are: build confidence, resilience & providing a sense of belonging.
- Five pathways across the THRIVE framework.
- Sufficient services and resources that empower children and young people.
- Up-to-date, easily accessible information for children, young people and their families
- Children with complex needs through timely multi-agency collaboration and effective targeted and specialist services, preventing crisis

Outcomes desired

2.

Current situation

- KPIs review incl. SMART targets for Children & Young Peoples Plan
- CYPP will be reported on quarterly to the Children and Young People's Strategic Alliance (CYPSA).
- System conversation in March 2023 focused in on what needs to be different to effectively support children and young people with complex care and mental health needs including step down placements from Tier 4 provision
- Work underway to look at a system review of the pathway for these children
- CYPSA have agreed to be the Sponsor for this work

Enabling Change

4.

Excess Weight

National & Local Issue:

Too many people living with Excess Weight:

17% of 4-5 year olds (academic year 21/22)

34% of 10-11 year olds (21/22)

and 66% of adults (20/21)

Excess Weight increases the risk of **chronic diseases** incl. cardiovascular disease, type 2 diabetes, cancer & osteoarthritis

Excess body fat is a **factor** in nearly a **quarter of deaths** among people aged over 45 and now contributes to more deaths in this age group than smoking. Moderate obesity **reduces life expectancy** by about 3 years and severe obesity can shorten a person's life by 10 years. This 10 year loss is equal to the effects of lifelong smoking.

The NHS spends around **£6.5 billion a year** (close to 4% of its 22/23 budget) on treating the consequences of obesity. This is forecast to rise to £9.7 billion by 2050. The annual cost to society, including wider economic costs, is around £54 billion, roughly equal to 1-2% of GDP or the total annual funding allocated to schools in England.

1.

- Fewer people living with excess weight
- Reduce rates of excess weight in children were highest in areas of higher deprivation
- Lower prevalence of type 2 diabetes & cancers
- Easier access to healthy food
- Increase physically activity
- More people living with excess weight accessing services to support them
- More professionals feeling confident to talk to people about their weight in a supportive, non-stigmatising way

Challenges

Obesity was a factor in nearly 4,800 **hospital admissions** in Central Bedfordshire in 2019/20. Obesity-related admissions in the most deprived areas of England are 2.4 times greater than in the least deprived areas.
Excess weight carries significant **economic costs** for Central Bedfordshire, including lost working days and economic inactivity, increased benefits payments and costs associated with NHS treatment and care.

Outcomes desired

2.

3.

Prevention

- Public sector driving production and supply of healthier food options
- Lower density of fast food outlets
- Support for voluntary & community organisations to increase access to healthier foods
- Uptake of healthy start scheme
- Strengthen Design Guide & Local Transport Plan
- Limit the marketing, placement, advertising & sponsorship of unhealthy foods
- Encourage schools & wrap around care to provide healthy options
- Opportunities to be more physically active

Treatment and early identification

- Easier access to integrated services support behaviour change (SPOC)
- Increase confidence of frontline professionals raise excess weight & offer brief advice
- Delivery of a 2 –year specialist programme for people with a learning disability

Current situation

Prevention

- A wide range of opportunities to support people to be physically active
- Active Lifestyle Referral – referral from a GP and other health professionals for smoking/inactivity/weight management
- Development of walking and cycling infrastructure Design Guide encouraging active travel in new housing developments
- Healthy Start Scheme
- Green social prescribing, Community Gardens & allotments and volunteering
- Early years programmes such as Healthy Movers and Physical Activity and Nutrition Coordinators

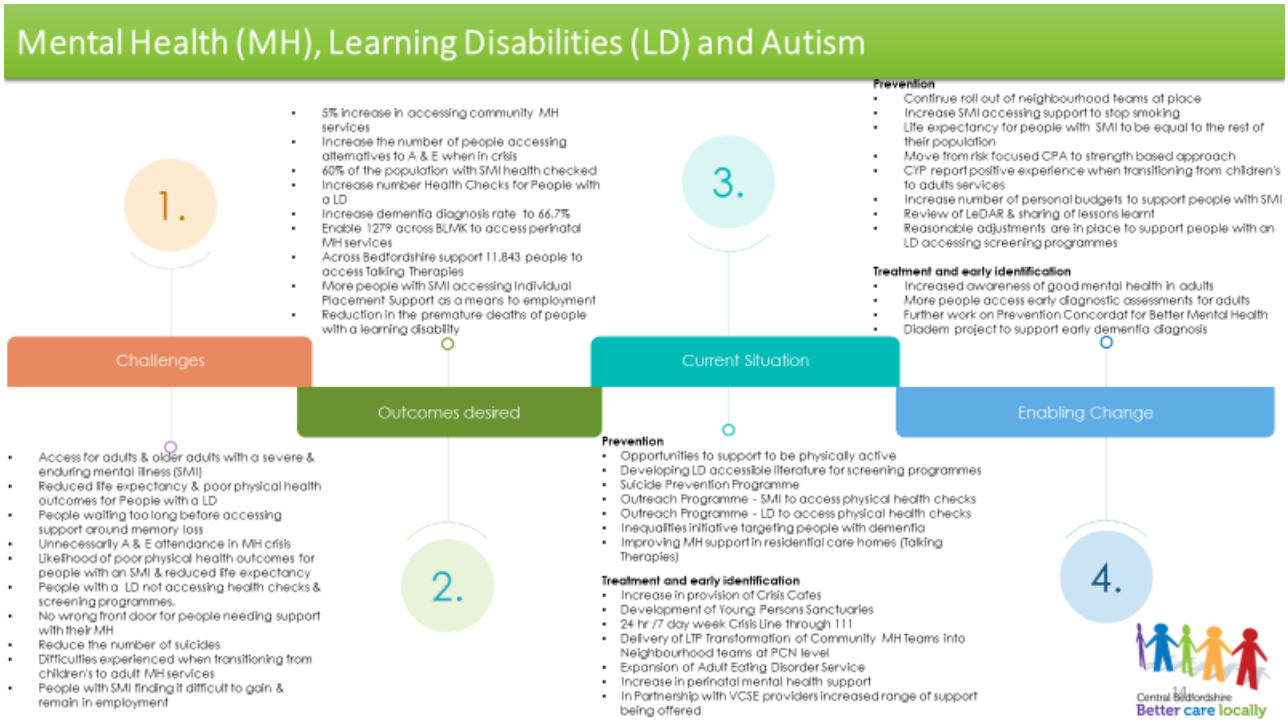
Treatment and early identification

- Morelife & NHS digital weight loss programme increase with capacity

Enabling Change

4.

12
Central Bedfordshire
Better care locally



The strategic challenges we must address in the BLMK Joint Forward Plan are:

- Work with the Health and Wellbeing Board to **tackle the social determinants of health** e.g., social isolation, poor housing, education, and employment.

- **Primary care capital infrastructure and workforce to create additional capacity** to meet the needs of our rapidly growing population

- **Sustainable strategy for residents with complex needs placements** (children, young people, mental health, learning disabilities and autism, adult continuing care) to provide more care and better outcomes which are financially sustainable within Central Bedfordshire
- Further integration of health, care, civic and VCSE support to individuals to **maximise prevention, early intervention, and local urgent care access to meet their needs**
- Co-ordinated strategy and new models of care to **provide more interventions earlier for children and young people to support them to thrive in primary school and beyond**
- **Consistent access to diagnostics and acute services that reflects the rural nature of the Borough**, and the number of acute hospitals residents' access, and tackles existing variation in early diagnosis of cancers, dementia diagnosis, waiting time for elective health care
- **Reduce incidence of excess weight in our population** - co-ordinated actions to improve people's living environments and access to healthy food, and support to individuals to live well
- Facilitate the **delivery of mental health transformation plans to reduce variations in access and outcomes** for Central Bedfordshire residents.

3. What does good look like for Central Bedfordshire Residents?

Using the principles of **Integrated Neighbourhood Working**, we wish to secure transformational change across health and social care based on integrated and seamless care pathways at locality levels. With an emphasis on person-focused approach with prevention and support for maintaining and maximising independence at its core. This should be underpinned by the following principles:

- Care coordinated around the individual.
- Decisions made with, and as close to, the individual as possible.
- Care should be provided in the most appropriate setting; and
- Funding flowing to where it is needed.

Local people will have access to more joined-up health and care services closer to home. People will experience real improvements in primary care and community-based support when it is needed.

What difference will this make?

The changes and outcomes we want to achieve, which are set out in the Joint Health and Wellbeing Strategy, Children and Young People Plan and our Place Plan include:

- Seamless access to a timely, coordinated offer of health and care support.
- Reduced variations in care with improved outcomes.
- Access to a wider range of support to prevent ill-health, with increased emphasis on early interventions supported by voluntary, community and long-term condition groups, enabling them to stay healthier for longer.

- Support to remain independent with primary care led community multidisciplinary teams with integrated rehabilitation and reablement services that will avoid or minimise the need to rely on residential or nursing home care.
- Improvements in access to services, evidenced through improved waiting times.
- Access to mental health services that are integrated with physical health and social care services, through acute, primary, community and specialist teams and aligned to lifestyle Hubs.
- Improvements in mental wellbeing and outcomes for our residents including admissions to hospital for self-harm in young people.
- Support for carers that is timely, and person centred with an integrated response.
- Person-centred, highly responsive and flexible services, designed to deliver the outcomes important to the individual.
- Ensuring that children, young people and adults have timely access to an appropriate level of high-quality support and care - that there is no wrong door.
- Improvement in measures of wellbeing including resilience in our young people.
- Effective transitions for vulnerable children to adult services, that put the person transitioning at the heart of decision making.
- Make the best use of community assets and promote these, for example, through social prescribing.
- Investment and increased access to modern, state of the art leisure facilities for residents, particularly in areas of deprivation.
- Ensure that growth delivers improvements in health and wellbeing for current and future residents by:
    - creating places that promote health,
    - improving access to affordable housing, and
    - providing appropriate housing for people with specific health and mobility needs.

Our Progress So Far…

- Collaboration in the **development of our Children and Young People Plan**.
- **Working Together in Leighton Buzzard** as a precursor to Fuller Neighbourhoods
- Continuing to build on the collaborative multidisciplinary approach to create **'one integrated team' across a Primary Care Network/neighbourhood footprint** and refining a model for delivering integrated outcomes for people.
- Developed an Integrated Care System and action plan to **improve the discharge process and flow of medically fit residents from Acute Trusts**.
- **Investment to improve the mental health of vulnerable young people in Central Bedfordshire**, taking a Population Health Management approach to target evidence-based interventions to young people aged 16 to 25 years most in need of mental health support.
- **Continued investment for community referral (social prescribing)** using Community Wellbeing Champions in alignment with the Primary Care Networks social prescribing link workers.
- There has been early progress in the **development of a multi-disciplinary approach for co-located services, focused on management of frailty, long term conditions and mental health issues in children and young people**,

using a population health approach to cover the Chiltern Hills primary care network (population circa 55,000).

- **A social prescribing pilot scheme for vulnerable children and young people** aged 11 to 18 years old with a particular focus on reducing mental health inequalities is in place in one of our Primary Care Networks (Titan). The social prescribers support children and young people with low-level mental health needs below specialist Children and Adolescent Mental Health Services threshold and those at high risk of developing a mental health disorder. This service is particularly focused on supporting children and young people in the most deprived areas.
- **The Grove View Integrated Health and Care Hub** was completed in March 2023, provides an update to date fit for purpose estate for primary care and additional services for Priory Gardens Surgery and wider PCN services for Dunstable and surrounding towns and villages. It provides accommodation for an extended and integrated multidisciplinary workforce in a purpose-built facility designed to support new ways of working and has the flexibility to meet demands from future growth.
- Central Bedfordshire Council carried out a **spatial modelling exercise plan for an increasing population which has informed the Leisure Facilities Strategy** which includes investment in a programme of replacement and modernisation of Leisure Centres.
- **Deployment and expansion of technology-enabled care to support people to live safely and independently in their own homes for as long as possible**, self-manage long term conditions and have remote access to specialist care when needed.
- The Digitisation Programme in its first year achieved the requirement for **60% of Adult Social Care Providers to have a Digitised Care Management System**.
- **Communities coming together and supporting each other through local action, neighbours helping neighbours, charity groups** (Good Neighbour Schemes, for example) and other voluntary, community and charity responses. There is a great opportunity to build on these strong foundations to support healthier and more resilient communities.
- **Further investment in the Voluntary Sector to support residents**.

4. What Does Central Bedfordshire Place need from ICB Partners to deliver our ambitions for residents?

- Ongoing development of the concept of 'Place' within the Integrated Care System and the interface with the wider agenda across Central Bedfordshire around Place shaping with the ICB as a key partner.
- Joint capital infrastructure strategy across NHS and civic partners to meet growing population need and demand.
- Shared strategy and delivery plan for sustainable, recovery-focused placements for Central Bedfordshire residents (children, young people, mental health, learning disabilities and autism, adult continuing health care)
- Secure parity and delegation of resources for Central Bedfordshire that reinforces the principles of subsidiarity and supports the delivery of place priorities (A 'Central

Bedfordshire Deal' to drive improvements in population health and improvements in the quality and efficiency of the health and care services)

- Clear understanding of pan-BLMK and pan-Bedfordshire Care Alliance system risk issues, implications for Central Bedfordshire and plans to address them.
- Ensure that the voice of local people is heard and supports the modelling and implementation of this strategy by engaging with patients to ensure the views of our residents are considered, especially when redesigning pathways.

Homepage - Central Bedfordshire Council

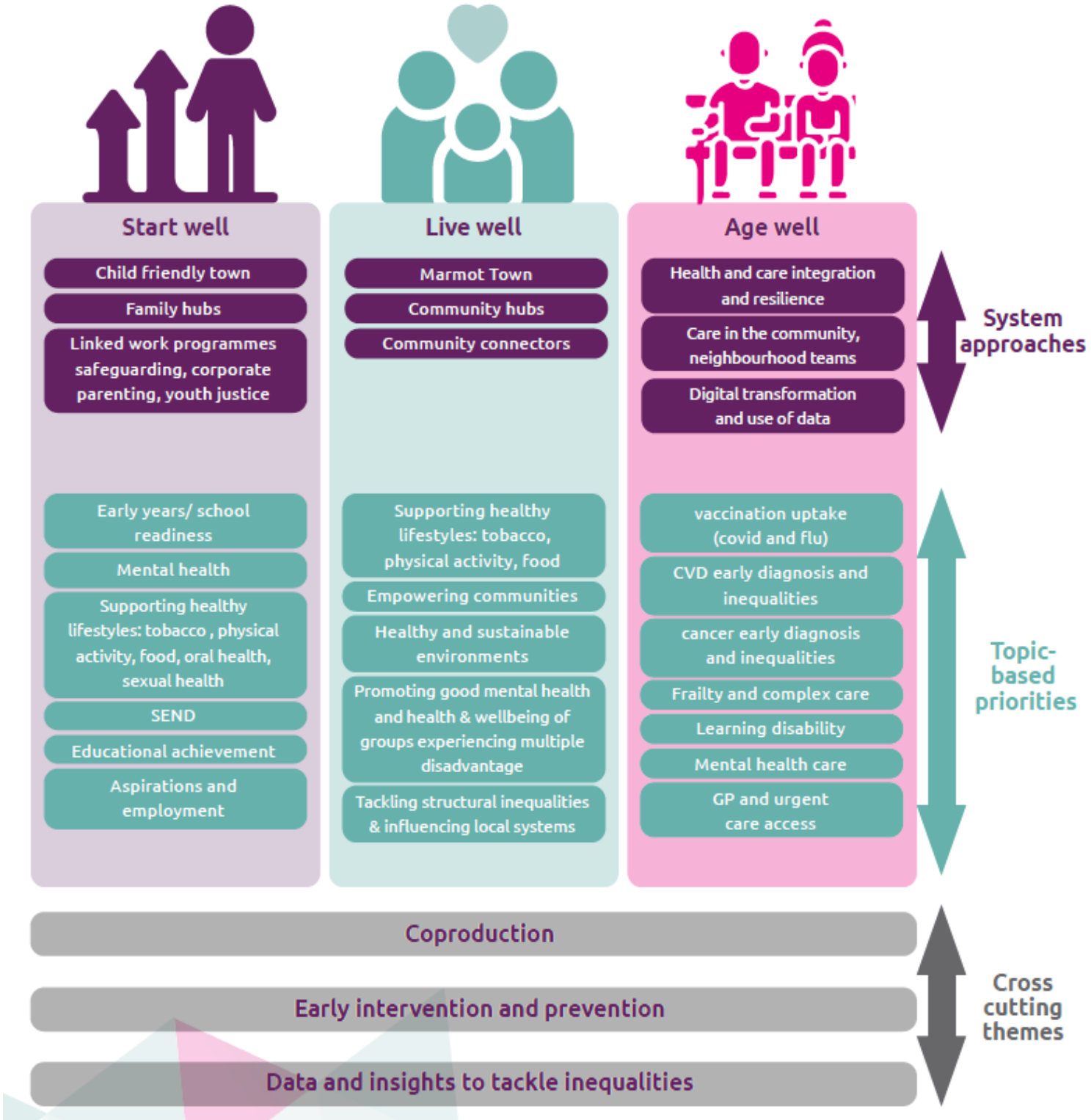
1.3 Luton

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

The vision is built around five priorities, each of which contributes to achieving our overall vision for the town:

- **Building an inclusive economy that delivers investment to support the growth of businesses, jobs and incomes.**
- **Improving population wellbeing and tackling health inequalities to enable everyone to have a good quality of life and reach their full potential.**
- **Becoming a child friendly town, where our children grow up happy, healthy and secure, with a voice that matters and the opportunities they need to thrive.**
- **Tackling the climate emergency and becoming a net zero town with sustainable growth and a healthier environment.**
- **Supporting a strong and empowered community, built on fairness, local pride and a powerful voice for all our residents.**

1. Key to delivery of this in addressing the health and wellbeing of the population, and addressing inequalities, is the population wellbeing strategy. The strategy is a health and care system-wide approach to improving health and wellbeing and tackling health inequalities. It takes a life-course approach, laying out actions across the system in the three pillars of Start well, Live well, and Age well.


Start well
Child friendly town
Family hubs
Linked work programmes safeguarding, corporate parenting, youth justice
Live well
Marmot Town
Community hubs
Community connectors
Age well
Health and care integration and resilience
Care in the community, neighbourhood teams
Digital transformation and use of data
System approaches
Early years/ school readiness
Mental health
Supporting healthy lifestyles: tobacco , physical activity, food, oral health, sexual health
SEND
Educational achievement
Aspirations and employment
Supporting healthy lifestyles: tobacco, physical activity, food
Empowering communities
Healthy and sustainable environments
Promoting good mental health and health & wellbeing of groups experiencing multiple disadvantage
Tackling structural inequalities & influencing local systems
vaccination uptake (covid and flu)
CVD early diagnosis and inequalities
cancer early diagnosis and inequalities
Frailty and complex care
Learning disability
Mental health care
GP and urgent care access
Topic-based priorities
Coproduction
Early intervention and prevention
Data and insights to tackle inequalities
Cross cutting themes

Luton 2040 ambition for population wellbeing: Improving population wellbeing and tackling health inequalities to enable everyone to have a good quality of life and reach their full potential.

	Year 1		Year 2		Year 3	
	Actions	**Outcomes**	**Actions**	**Outcomes**	**Actions**	**Outcomes**
Start well	Launch of family hubs offer and communicated across system Child Friendly Town working group and roadmap established Obesity taskforce develops robust pathways for obesity prevention and referrals Refresh partnership approach oral health Refresh health in schools programme for obesity, tobacco, mental health, and substance misuse Lead mental health strategy actions Engage with PCNs to support improvement in childhood imms uptake Collaborative development of SEND strategy Education strategy developed with focus on early intervention and school readiness NEET strategy re-invigorated	Child healthy weight and oral health actions and roles clear across the system Clarity on early years offer through Family Hubs – system knowledge of offer System-wide agreement on mental health, NEET, and education strategies strategy Improvement seen in childhood imms uptake	Develop and deliver next phase of family hubs programme Child friendly town engagement and voice of young person programme of activity Continue to work with partners to embed CHW & oral health actions Continue to build on work in schools across Revise tobacco prevention actions including midwives and schools Evaluate YP hub for impact on D&A	Decreasing % DMFT Slowing increase in obesity Increased % school readiness Improvement in childhood imms Decreasing SATOD Reduction self harm admissions SEND improvement measures… Education inequalities measures	Review of key strategies across partnerships – what more can we be doing? What has impact been	Continuing improvement across indicators Halted rise in CYP obesity Decreasing smoking prevalence
Live well	Systematic approach to delivery of Marmot Town - Agree indicators, communicate to public, develop planned actions across the system on employment and businesses, housing, and community and voluntary sector, and community advice and guidance Building on marmot recs, development of community hubs offer across Luton Building on Marmot, evaluate housing strategy for health and equity impact Marmot and health equity event held to showcase Marmot Town ambition and activity Develop evidence based work plans for those with complex vulnerabilities, linking to town centre strategy group Develop strategic plan for temporary accommodation and tackling homelessness Mapping of community connectors roles across Luton and understanding of support offer to community. Fairness taskforce and community funds strategic plans developed Complete drug and alcohol needs assessment and delivery plan for Combatting Drugs Strategy Development of perpetrator and prevention programme for domestic abuse Physical activity strategy starting to be mobilized across borough Renewed tobacco control strategy delivery plan across borough Refresh of food strategy Recommissioned sexual health ensuring focus on HIV diagnosis and prevention Clarity on actions for mental health prevention workstream	System wide partnerships across Combatting Drugs partnership,, tobacco, physical Activity, Food plan System indicators for Marmot agreed System ownership of Marmot Town, with clear links to Fairness Taskforce as shared ambitions Reduction in in temporary accommodation and street homelessness Clear town centre complexity pathway established Perpetrator and prevention programme delivered Tobacco and physical activity strategies start to deliver process outputs	Recommission D&A service with more focus on prevention, learning from pilots. Continue to embed targeted tobacco prevention work Review impact and actions of domestic abuse strategy, and physical activity strategy Embed system actions across food plan Stocktake and review of Marmot delivery and actions – including employment, housing, and community actions	Halting increase in smoking prevalence Increasing physical activity rates & Slowing rise in obesity prevalence Reduction in alcohol admissions Reduction in HIV late diag and prev Decreasing prev domestic abuse Seeing reduction in Mental health crisis	Review impact of focused areas – what more could we do? Develop new actions	Continuing improvements across measures Reducing smoking prevalence.
Age well	Embed cancer inequalities work across pathways Work via place board to develop actions based on PCN profiles and inequalities – LTCs, falls, screening. Embedding of PHM approach to develop actions. Embed mental health strategy across system, focusing on inequalities Develop LD strategy, and review demand and need for accommodation Establish Fuller taskforce to challenge and develop further neighbourhood model in Luton system Develop system plan for social prescribing, linking to new community connector models Adapt vaccination strategy to meet needs – focusing on flu ASC fair cost of care review and market stability analysis / market position statement and actions	System wide work plan led by Place Board Clear strategies on vaccination post-covid, mental health, LD, LTCs for Luton	Embed refreshed social prescribing strategy and workplan, linked to mental health strategy and TLC Review impact mental health strategy Embedding neighbourhood teams to have prevention focus System review of place board – are we having an impact? Should we be doing more?	Improvement in cancer outcomes and screening uptake Improvement in social isolation rates, ASC waiting lists, carers support Reduction in admissions for falls Improved mgmt. LTCs, health checks MH Increased uptake in mental heath services from BAME groups Seeing impact of PHM project to learn from and embed further	Strategic review of PHM approach Strategic review across pathways – what is impact, where do we focus?	Continuing improvement across measures, social isolation improving

Underpinning the approach to tackling health inequalities is Luton's approach to being a Marmot Town – a town that prioritises health inequity, and system actions to address issues impacting on health inequity.

[Homepage - Luton Borough Council]

1.4 Milton Keynes

1. What is the problem we are trying to solve?

Milton Keynes is one of the most successful cities in the country. The population growth is exceptional. The challenge for the health and social care family in the city is to keep pace with this growth. To do that, stronger local partnerships will need to be forged, services will need to be re-designed and re-sized and better integrated, and facilities extended to meet current and future demand including a stronger focus on prevention. Given the very buoyant labour market, high employment rates and limited local education and training provision, there are also significant workforce problems to address.

Population Growth

Population growth between 2011-2021 was calculated to be 15.3% by the Office of National Statistics[1], making Milton Keynes one of the fastest growing places in the country. This growth is expected to continue. The ONS projects that the population will reach 410,000 by 2050, but this is likely to underestimate the impact of housebuilding and local forecasts suggest the population could grow to around 460,000 by this date.

The majority of MKUH's patient population comes from MK (80%) with 89% coming from within BLMK. MKUH is therefore impacted by population and demand growth from neighbouring boroughs Central Bedfordshire, Buckinghamshire and Northamptonshire where there has also been significant housing growth.

The East expansion zone is a significant area of new housing growth in MK (estimated 5000 new homes with development expected to start in 2024) and in line with MKCC's approach to investment through the Housing Infrastructure Fund and the MK Tariff, plans are being progressed to build a community health hub in the area early in the development of the new housing. This hub is planned to accommodate primary care and other integrated health and care provision with wider community services and facilities. The City Council, the ICB and health partners have established joint working arrangements to plan for and respond to housing growth.

2. Current landscape in BLMK

Where are we now?

To respond to these challenges, the MK Health and Care Partnership and the ICB agreed the MK Deal in October 2022. The Deal is the first of its kind across Bedfordshire, Luton and Milton Keynes (BLMK) and is a formal agreement between the Milton Keynes Health and Care Partnership and the BLMK Integrated Care Board. It has three central aims:

- **Closer working:** The MK Deal formalises the commitment of the main local NHS partners in MK and the city council to work more closely together. This includes forming and sustaining a Joint Leadership Team. The Joint Leadership Team, or JLT for short, reports directly into the MK Heath and Care Partnership. It has been in place for a year

[1] Source: ONS, Census 2021

and widened its membership to include the ICB Place Link Director in October 2022. After initially meeting fortnightly, the JLT now meets every three weeks and the relationship between the partners has matured into one where they assist and encourage each other by providing candid and constructive support and challenge.

- **Drive forward change in key local priorities:** The MK Deal focuses on priorities which the local area wants to improve, as endorsed by the MK Health and Care Partnership and fully in line with the BLMK Health and Care Partnership's strategic priorities. It's informed by evidence of population health needs and a pragmatic assessment that the areas are ones where progress can be made.

- **Establish a clear remit and resourcing:** The MK Deal sets out the remit and resources that the ICB agrees to pass to the local partners in the MK Health and Care Partnership to both help with the delivery of the specifically agreed improvement areas and to the general effective running of the local health and care system. Over the last five months we have achieved a good awareness of the MK Deal and, in turn, our shared local commitment to taking more responsibility and accountability. As part of the development of the Deal each of the agreed priorities identified existing capacity and resourcing which could be allocated to place from the ICB.

What have we achieved?

Improving System Flow – This priority went live on 1 December 2022. Improving system flow (ISF) focuses on urgent and emergency care services for older and/or frail and/or complex service users. An ISF Steering Group was established in December to provide strategic oversight with senior clinical and managerial members from across health and social care providing their time. All parties recognise that large scale transformation of Urgent and Emergency Care services, if it is to be successful and sustained, must take place at a local level with providers working together to reshape demand, and the delivery of care.

A core project team made up of staff seconded from MKCC, MKUH, CNWL and the ICB is now in place to ensure there is sufficient dedicated staff capacity to deliver the assessment, planning, securing services and review process. Established in time for the busy winter period, an operational focus group leads the ongoing operational management of urgent and emergency care services. Mapping of existing hospital admission avoidance and hospital discharge schemes has been completed with this review showing complexity of the current system and the opportunities offered by the new Same Day Emergency Centre (SDEC) opened at MKUH in 2022, enhancement of the virtual ward offer, and development of a MK Care and Therapy Academy. The development of the business case for an integrated multi-disciplinary team 'without walls' is in production and is due to brought for review to JLT shortly. This workstream also links to City-wide work on same day access to primary care being led by Dr Jon Walter.

The development of two Community Diagnostic Centres in MK (Whitehouse and Lloyds Court) and a radiotherapy unit at MKUH will also improve access and reduce waiting times for MK and BLMK residents by providing additional capacity and care closer to home. Lloyds Court will enhance the number of diagnostic tests available by 44%, and Whitehouse by 12%. In

response to the significant demand and population growth on MKUH, it has been included in the national New Hospitals Programme and is awaiting a decision on funding approval from the national team. The new hospital will deliver a world class elective surgery centre and imaging centre combining new clinical space with state-of-the-art facilities and equipment. MKUH is established as a leading Trust for pioneering use of new digital and robotic surgery techniques, and this new facility will enable MKUH to become a centre of excellence in certain treatments and specialities ensuring the Hospital attracts and retains the best talent. The plans include a new Women and Children's Hospital which will co-locate maternity and paediatric services to transform the care offered to families. The ISF programme is a key contributor to mitigating the demand impact on MKUH to ensure that the additional capacity from the new hospital is sufficient.

Tackling obesity also went live as an MK deal priority on 1 December 2022. Jointly led for JLT by Vicky Head, Director of Public Health and Dr Omotayo Kufeji, a local GP and a Primary Care Network (PCN) Director, this priority is focused on helping people lose weight through easily accessible weight management programmes and use of technology, alongside system working to build a healthier food and physical activity environment in MK.

The workstream is focused on increasing referrals and engagement with existing weight management services by streamlining the referral process for healthcare professionals. This process will be in place by August 2023. This is the first step towards developing a referral hub for weight management and smoking cessation services as part of a more integrated behaviour change service.

In addition, a local training package has been developed utilising expertise from public health colleagues and primary care GP registrars to increase awareness on national and local weight management services, focusing on increasing confidence in discussing weight, cultural humility training, active lifestyle and physical activity. This is being delivered as a phased approach with the first session being delivered to Primary Care clinicians in July 2023. Further sessions will be rolled out of the year across secondary, community services including community pharmacies. A 'train the trainer' package is being created with a plan to engage community champions in hard-to-reach communities across MK who would promote key messages and signposting to national and local weight management options. This piece of work will be undertaken in conjunction with MK Community Action and will start in December 2023.

A review on the provision of Tier 2 plus services for Children and Young People and Tier 3 services for Adults will commence in July 2023. The review will focus on identifying current gaps and explore options for improving access and support and will be led by MKUH consultants, supported by public health colleagues and other subject matter experts.

Running alongside the above programme of work is the digital incentive scheme which consists of three components: a wrist worn watch; a phone app that monitors physical activity, sets physical activity goals tailored to the individual and provides nudges and tips to increase activity; and a set of vouchers as a reward for being physical active (worth up to £200 per year). This is being conducted as a randomised trial (2 years) to establish whether it is effective and will be complemented with focus groups or interviews with a small number of participants to understand people's experience of the scheme as well as enablers and barriers to engagement. Approval from the National Institute for Health & Care Research is expected in June 2023 and engagement with Primary Care GP's will commence in July 2023 with the

trial commencing in September 2023, i.e., first patient recruited. A final report based on 24 months data will be produced in the Autumn of 2026.

We are also seeking to create a societal shift in eating habits and physical activities by changing cultural, social and economic and environmental factors. JLT members have supported this approach and 'a call to action' proposal is being developed for system partners to make specific commitments within a focused timescale.

Children's Mental Health – This priority went live on 1 April 2023 and is therefore in its infancy. The JLT lead is Jane Hannon, Managing Director of the Diggory Division at CNWL. The four key themes of this priority are closer working, getting help and advice, neurodevelopmental pathways and crisis response. Closer working between system partners including sharing data, prioritisation and exploring co-location of teams has made good progress. Development of the local 'getting help' offer in Milton Keynes is underway and will provide appropriate community-based support, including more face-to-face options.

Complex care Work to initiate this workstream is underway. It will focus on developing an integrated approach to improving the planning, assessment, commissioning and case management for people who have the most complex needs, initially focussed on the 14-25 client group.

Neighbourhood working – In addition to the four areas agreed in the MK Deal, the JLT is also undertaking scoping work to determine how integrated neighbourhood working can improve outcomes for local residents, incorporating the learning from the Fuller Report. Recognising the high levels of need in the area, Bletchley is being explored as a potential pathfinder project to bring a wide group of local partners and residents together to develop work to:

- Provide more proactive, personalised care and support to people through a multi-disciplinary team approach
- Help people to stay well for longer as part of a stronger focus on prevention of ill-health.

Subject to agreement by the MK HCP, the background work (June-Sept 23) includes completing a workforce survey, looking at options for multi-disciplinary teams, looking at data to identify support needs and make greater use of local assets including the VCSE and developing potential governance for the work.

3. What does good look like?

For System Flow, good looks like:

- All parties recognise that large scale transformation of Urgent & Emergency Care services, if it is to be successful and sustained, must take place at sub-system level with providers working together to reshape demand, and the delivery of care. Together we are seeking to transfer clear responsibility for system flow to the MKHCP with partners working together to:
- Deliver better outcomes, with local people able to live healthier independent lives
- Get people home as quickly as possible after a hospital or community bedded stay is completed, in order to maintain people's independence and minimise decompensation

- Reduce average lengths of stay in hospital and other bedded care removing barriers to early discharge, and focusing on reablement from the point of admission
- Better integrate discharge services to avoid duplication and maximising opportunities to resolve issues creating unnecessary admissions and attendances
- Reduce reliance on long term care caused by delay and decompensation
- Ensure people are seen in the right place for their condition, with attendances, conveyances and admissions to hospital reduced from currently projected levels by services
- Secure system capacity to support these aims
- Reduce overall system costs in relation to the provision of urgent and emergency care, in order that a) that MK and wider ICS are financially sustainable AND b) provide headroom for upstream investment in prevention and out of hospital care.
- Review Better Care Fund schemes to ensure coherence with the aims of the MK Deal: value for money and effectiveness
- Utilise S256 funding in a way that maintains discharge and flow in the short term, while the system transforms

For Tackling Obesity, good looks like:

- Clear and accessible support for individuals in MK who want to lose weight, with a BLMK system responsibility to ensure an equitable service offer in order to address inequalities, particularly for people at higher risk due to socio-economic circumstances and physical and mental health conditions that make it harder to maintain a healthy weight.
- Delivery of the national and local digital weight management offers are optimised within the local system, alongside increasing access and provision to Tier 2 plus services for children and young people and Tier 3 services for adults; Effective and appropriate use is made of community voluntary and social enterprise capacity
- Increased access to healthy food in MK, including while using health services.
- Improvements to the environment in MK to make it easier for people to maintain a healthy weight
- Over time. a reduction in the proportion of people aged over 18 with BMIs over 25.
- Over time. a reduction in the proportion of Reception and Year 6 children who are overweight or obese.

For Children and Young People's Mental Health, good looks like:

- Leading Health & Care Partnership-based work plans to improve outcomes for children and young people's mental health.
- Interfacing with the ICB Mental Health Transformation Programme to ensure join up for key deliverables and recovery plans.
- Ensuring that plans will address inequalities across MK.
- Providing assurance as required to NHSE
- identifying and deciding the services necessary to meet the needs of the population including design of new pathways, services, working with finance, contracting, primary care and quality colleagues to ensure this is done to provide high quality care at best value.

For complex care, good looks like:

- Agree a shared definition of complex needs to identify potential opportunities for integrated systems.
- Conduct a high-level review of the ways the budget is spent with a view to identifying medium to long term efficiencies in any placement and/or support costs, agreeing to stop doing things that do not have evidence of positive impact.
- Agree with the ICB how funding for complex needs including CHC decision-making and funding will be managed in Milton Keynes focussed on delivering a robust, simplified approach.
- Develop proposals to achieve a jointly coordinated approach to early identification and support, management, and review of people 14-25 years with complex needs. To include people funded by social care, health or jointly between health and social care.
- Reduce the use of placements outside of Milton Keynes (out of area placements) by using the data and intelligence we have across the system to identify and decide the services necessary to meet the needs of the population including support 'closer to home'.
- Introduce an integrated case management approach for children, young people and adults, 14-25 years who have complex needs.
- Provide headroom for upstream investment in prevention and early intervention. For example, reducing waits for autism and attention deficit hyperactivity disorder (ADHD) followed by pro-active intervention where these are needed.
- Explore the opportunities for market development for complex needs provision within Milton Keynes (or a wider footprint for highly specialist care and support)
- Ensure that links to the MK Deal work for Child and Adolescent Mental Health Services are maintained to reduce duplication of effort and capitalise on potential opportunities.
- Secure system capacity to support these aims

4. What do we need to do to create the JFP chapter for this workstream?

No further work on narrative required – the MK Deal is the place plan for MK. As part of the work to deliver the MK Deal, JLT oversees the ongoing work to develop and deliver:

- Workstream plans
- Workstream metrics including outcome measures
- Resource plans including agreeing with the ICB the allocation of sufficient ICB resources to respond to place priorities
- Workstream plans and timelines

How can be measure benefits/outcomes for residents

Improving System Flow metrics

- Percentage of patients in MKUH not meeting criteria to reside
- 78 week waits at MKUH for elective care
- Number of 30-minute ambulance handover delays at MKUH
- The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

- Percentage of two-hour Urgent Community Response referrals that achieved the two-hour standard

Obesity Metrics

- Prevalence of overweight (including obesity) among MK pupils of Reception age (Source: National Child Measurement Programme)
- Prevalence of overweight (including obesity) among MK pupils in Year 6 (Source: National Child Measurement Programme)
- 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)
- Adult prevalence of overweight/obesity (Source: Active Lives Adult Survey)

CYP MH Metrics

These are in development.

High level timeline

Workstream	2023/24	2024/25	2025/26	2026/27	2027/28
MK Deal	Q1 Decision on neighbourhood working (June) H2 Review Deal with ICB	Annual review of Deal	Annual Review of Deal	Annual Review of Deal	Annual Review of Deal
ISF	H1 Business Case for integrated team to JLT H1 Winter Plan agreed National decision on New Hospital Programme Q3 both CDCs open Q1 Planning permission for MK East Community Health Hub H2 Integrated Discharge Hub establishment commences (subject to approval)	Q1 – MKUH radiotherapy centre opens	MK East Community Health Hub opens (check)	New Hospital Opens subject to funding (check)	
Obesity	Q2 launch streamlined referral process Q2 1st phase of training starts in primary care Q2 review of provision starts Q3 community champions work starts Q3 digital incentive scheme starts		Q3 Review of digital incentive scheme		
CYP MH	Q2 deliver neurodiversity training H2 Decide on potential Co-location of CNWL and Council teams	Plan being developed			

Workstream	2023/24	2024/25	2025/26	2026/27	2027/28
	H2 – Respond to Independent Scrutineer report on getting help H2 – revise crisis pathways				
Complexity	Q2/3 Decision on Workstream initiation	Plan to be developed when workstream is initiated			
Neighbourhood working	Q1 Approval for background work June 23 H1 Background scoping work June-Sept H2 Decision on workstream initiation H2 Agree indicator of success metrics H2 18-month pilot starts Sept H1 City-wide Same Day Primary Care Access workstream starts	Q4 review of pilot and decision on next steps			

Interdependencies:

Delivery of the MK Deal ambitions is dependent upon the continuing commitment and resources of all MK Partners including agreements on the allocation of financial and staffing resources from the BLMK ICB via the MK Deal. There is therefore a dependency on the development and implementation of the BLMK ICB TOM.

Other key dependencies are:

- Approval of the New Hospitals Programme bid for MKUH by Central Government
- Funding for the radiotherapy centre
- Access to inequalities funding from the ICB to support local priorities including the Bletchley pathfinder for integrated neighbourhood working
- Investment in primary care estates – particularly in the East Community Health Hub
- National Institute for Health & Care Research approval for digital incentive scheme

Homepage - Milton Keynes Council

Appendix B

The Joint Forward Plan & Provider Collaboratives

2.1 Bedfordshire Care Alliance

1. What is the purpose of the Bedfordshire Care Alliance

The Bedfordshire Care Alliance (BCA) is a Provider Collaborative for all health and local authority partners in Bedfordshire and is a formal collaborative within the BLMK ICB.

It is chaired by a BLMK Non-executive Member, with executive membership from all partners.

Its over-arching purpose is to co-ordinate delivery at scale for the residents of Bedfordshire where a single / standardised approach will gain greater benefits / efficiencies than Place-based or single-organisations can achieve.

Pan-Bedfordshire complex and shared challenges centre on urgent and emergency care pathways. Although demand for secondary care is not higher than pre-pandemic, even with growth in primary care capacity, there are still challenges for some residents in accessing primary care (GP and dental in a timely way). Furthermore, the clinical complexity and care needs of our frail and multiple co-morbidities population has driven up lengths of stay in acute settings and increased intermediate care demand post-discharge.

From the residents' perspective this means that patients waiting to leave hospital experience delays and avoidable decompensation.

For services, this increases demand and cost in an environment where resources (workforce and finances) are constrained. It increases clinical / social care risk along the whole UEC pathway.

As the ICB matures, the BCA may take delegated functions for NHS service provision that is best delivered / co-ordinated at scale. This will support delivery of care closer to home and integrated neighbourhood working, based on the population needs of the 3 Boroughs in the BCA.

The Current Landscape

The BCA reflects the complex provider landscape in Bedfordshire which comprises of:

- **3 Local Authority Unitary Councils**, each with Place Boards delivering their Health & Well-being Strategy based on the needs of their residents – Bedford Borough, Central Bedfordshire and Luton)
- **2 community services providers** (Cambridgeshire Community Services and East London Foundation Trust)
- **1 mental health trust** (East London Foundation Trust)
- **1 acute trust**, with 2 hospitals which is in the process of delivering the benefits of a merger of these 2 sites (Bedfordshire NHS Hospitals FT)
- **1 ambulance service provider** (East of England Ambulance Service)

The populations of the 3 Boroughs are also very different:

- **Bedford Borough** – number of urban conurbations but also some rurality. Population will continue to grow faster than the national average due to Borough's housing plan. Some deprivation, and population is aging. Residents access multiple acute hospitals in and beyond Bedfordshire

- **Central Bedfordshire** – mostly rural population over a significant geography, though overall low deprivation. Rurality, however, presents challenges in tackling local deprivation and access to services, with no single large urban conurbation which can provide a focus for healthcare delivery at scale. Population growing very fast due to Borough's housing plan and has the highest proportion of older people in BLMK. Residents access both Bedfordshire acute trusts, as well as those in neighbouring ICBs.

- **Luton** – diverse and generally younger population, although high deprivation and the transitory living arrangements for a significant minority of the population means that health needs and inequalities are high and affect population at a younger age. Luton is a Marmot Town and has a partnership strategy to eradicate poverty by 2040. Some key services (such as radiotherapy) are accessed by residents in London acute hospitals, presenting challenges to access and thus patient outcomes.

2. What are the Outcomes we are working to achieve?

The BCA currently has 3 strategic objectives:

1. **Digital Integration** – to support BLMK programme of digital integration across health and care services in Bedfordshire (a key enabler of joined-up care and improving outcomes for residents)

2. **Improving Flow** – reducing delays in discharging patients from acute hospital into intermediate care pathways (reducing decompensation in frailty patients, and reducing clinical risk caused by high volume of acute surge beds, affecting elective recovery and concentrating clinical risk in acute settings)

3. **Extending Urgent Care at Home** – extending the virtual ward provision and urgent care response service to support more people to be treated at home (reduce avoidable ambulance conveyances, ED attendances and non-elective medical admissions)

These complement and co-ordinate with sovereign organisations' own improvements actions in these areas.

Each programme has / is completing clear deliverables and timescales, with benefits focusing on:

- Benefits to residents
- Operational metrics on productivity / flow
- Patient and carer experience
- Staff experience

Key Actions / Timelines to Deliver Objectives

These are as follows:

1. **Digital** – as per BLMK digital integration programme

2. **Improving Flow** – redesign of partnership working in intermediate care pathways, and associated enablers by October 2023
3. **Extending urgent care at home** – consolidation into single UCR service pan-Bedfordshire during 2023, including development of Bedfordshire UEC oversight hub. Continued expansion of scope and volume of virtual ward as per existing trajectories during 2023 and 2024-5

Principal Benefits sought from JFP High Impact Programmes

1. Delivery of ICB target operating model to move resource to support delivery of Place Plans and system-level transformation
2. Clarity and programme governance regarding projects delivered at Place / Provider Collaborative / ICB
3. Delivery of mental health (all ages) crisis and recovery pathways transformation – for example delivery of Right Care, Right Person to provide enhanced local crisis support to improve patient outcomes and experience, and reduce reliance on wider public sector provision (emergency departments, police ambulance) when these are not the best placed service to meet the person's needs
4. Integrated neighbourhood working – increased primary care same day urgent care access to meet growing populations, and more integrated working across local authority, voluntary sector and NHS partners to maximise prevention and support management of long-term conditions

2.2 Mental Health, Learning Disability and Autism Provider Collaborative

1. What is the purpose of the BLMK MHLDA

In September 2022, the BLMK ICB approved in principle for the 2 mental health providers in BLMK (Central and North West London NHSFT and East London NHS Foundation Trust) to form a provider collaborative that, over time will take on increased delegation for NHS mental health, learning disability and autism services.

The purpose of the Collaborative is to work with Places to deliver our shared goals to improve access, experience and outcomes for BLMK residents living with mental illness, learning disabilities and / or autism spectrum disorders. This goes beyond the delivery of the NHSE mental health investment standards to tackle the challenges of rising need and demand for mental health services post-COVID (especially children and young people) to tackle inequalities experienced by these populations.

The providers will present the MHLDA Provider Collaborative proposal to the BLMK ICB Board in September, outlining the overarching transformation plan, proposed governance of the provider collaborative and the transition period to 'go-live' (pending final approval) which will run November 2023 to March 2024.

The Current Landscape

The calls on our mental health, learning disabilities and neurodiversity services across all ages have increased significantly and show no sign of abating. Nationally, there has been a 44% increase in referrals to NHS mental health services between 2016-17 and 2021-22.

In BLMK, the number of referrals to mental health providers increased by 20% in BLMK from 2020/21 to 2021/22, with the largest increase (26%) among working age adults. Primary care registers for depression have increased year on year with a 33% increase between 2018/19 and 2022/23.

There has been significant demand and acuity increase in children's mental health and neurodiversity exacerbated by the pandemic - a 26% estimated proportion of 17- to 19-year-olds with a probable mental disorder in 2022, increasing from 10% in 2017. Significant local developments (e.g., comprehensive Home Treatment services; expanded intensive eating disorders treatment) are subject to non-recurrent funding, putting those services in jeopardy. Recent Children & Adolescent Mental Health Service (CAMHS) Deep Dive into Children and Young People (CYP) Specialist Mental Health Services details 75% of BLMK CYP with a probable mental health condition not having needs met; services processing c7,000 referrals per year.

Population increases in several of our places, projected aging population across BLMK and stand-still funding create the 'perfect storm' which means we need to re-imagine our offer to people with mental health needs, learning disabilities and neurodiverse conditions. The status quo is not an option.

The BLMK mental health programme has grown and matured since its inception in 2015. We have a "one team" approach across commissioners and providers and are currently working with an unprecedented level of collaboration, with much more transparency, trust, and with people working across our organisations in the interests of the population we serve.

- Consequently, we are delivering on improved outcomes, quality and value for residents of BLMK in several areas that have previously been "stuck", particularly Long-Term Plan ambitions.
- We are working collaboratively to tackle complex local issues (e.g., Section 117 Aftercare) and to improve outcomes for people using pathways that typically span multiple health and care providers and involve a multiplicity of stakeholders (e.g., urgent & emergency care, and perinatal mental health).
- Key challenges include workforce; the lack of specialist facilities for people with complex needs (e.g., for people with autism and mental health needs); an under-developed local accommodation market; cost pressures on the Mental Health Investment Standard linked to S117 Aftercare
- Opportunities include:
    - **Population health management**: using population health management to drive focus on the opportunities to achieve the triple aim for people with mental health problems and physical health co-morbidities
    - **Children & young people's mental health**: re-modelling our care offer considering demand pressures, fragile services, and developing our local Tier 4 beds, developing an iThrive model of support.
    - **Workforce:** developing and enacting a robust joint plan
    - **Integration:** continuing to test working in a more integrated way, with a clear focus on clinical leadership, people participation and quality improvement
    - **Sustainability:** Financial sustainability for mental health services across BLMK

2. Our Journey – What the MH Programme has achieved since 2018/19

Perinatal

More pregnant women and new mothers receiving perinatal mental health care than ever before and new maternal mental health services to support people who have sadly lost their baby or had a miscarriage

Expanded perinatal service offer to increase access to psychological therapies

Service incudes offer for partners

Also available for patients up to 24 months post partum

CAMHS

New community crisis teams, crisis sanctuaries for children and young people, and much greater capacity in our CAMHS services to support children, young people and their families

Increasing access for CYP

New mental health in schools teams, supporting hundreds of pupils and teachers

BLMK CAMHS Tier 4 inpatient unit due to open imminently - Evergreen

NHS Talking Therapies

Treating more adults with anxiety and depression in primary care talking therapies than ever before

Long Term Condition services in place, including post Covid syndrome

Continue to meet 50% recovery rate, 75% accessing within 6 weeks and 95% within 18 weeks

Early Intervention

Early intervention services that are the best quality in the whole of the east of England (as per national 2022/23 EIS audit)

Overachieve vs 60% target of patients requiring Early Intervention for Psychosis (EIP) receiving NICE concordant care within two weeks

Community Mental Health Team

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 a real focus on broader psychosocial support, addressing inequalities, connecting people to communities, supporting more people into work and offering more physical health checks than ever before

A range of new roles in place including peer support, drug and alcohol, primary care ARRS roles

Recovery college open in MK

Our Journey – What the MH Programme has achieved since 2018/19

Crisis

- 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 (24/)
- Alternative crisis offer via new crisis cafes across BLMK delivered in partnership with VCSE
- Mental health teams in our acute hospitals meeting national guidance and "core 24" standard

Dementia

- Memory assessment services expanded
- Above East of England and England average for Dementia diagnosis and just below national target (63.9% vs 66.7% target)

Inpatient

- UEC capital funds – for MK developing HBPoS this year. Next year developing Crisis Lounges
- Sensory – investment in to Campbell Centre to enhance therapeutic environmental internally and in the garden. Includes training for staff and new sensory equipment
- Developed case for change for Bedford Health Village and Stage 1 designs in development
- Demand remains a challenge but despite this 72 follow up and length of stay remains positive

Suicide Prevention

- Work to develop prevention initiatives well underway through the prevention concordat with local authorities, and a well-developed suicide reduction partnership and plan

Other

- Rough sleeping services in place – MK and Luton
- Establshing Gambling Service for the whole EoE region
- Established Keeping Well Service – Staff Support Hubs

Opportunities at Place

Through the mental health placed based partnership there will be an opportunity to focus on the local priorities that matter to residents. Working in partnership to plan and deliver MHLDA services against the local priorities set out in each placed based plan (Bedford Borough priorities used below as an example), including:

3. What does good look like in BLMK?

There are several innovations that have been implemented that demonstrate the benefits of co-production with service users and collaboration with partners to maximise outcomes and value for money.

Case studies of achievements to date include:

- Co-production approach to developing the **Evergreen Tier 4 CAMHS inpatient unit** in Luton: young people leading the way to design and deliver a therapeutic environment
- **Dementia diagnosis:** multi-agency collaboration to develop and implement new opportunities to drive up dementia diagnosis. BLMK is the only ICS in Eastern Region to have achieved the national target (Q4 22/3)
- **Talking Therapies Network:** our three providers (Turning Point, ELFT, CNWL) joined forces to drive improvement in access, staff training, recruitment and retention, use of digital opportunities, sharing resources

Our Joint Forward Plan will embed how we are doing things differently:

- Co-production will be the driver for change in BLMK. Service users, carers and citizens are central to the Collaborative's development and delivery – through setting our vision and values, designing at place and scale and holding the Collaborative to account for delivery. A service-user led summit was held 31 March, the outputs of which will form the basis of the MHLDA Collaborative's vision, values and outcomes.
- Mental health placed based partnerships in each borough will take responsibility for developing and delivering local plans, informed by a deep understanding of the needs and assets of the local population
- The Collaborative would carry the functions associated with the delegation into the BCA / MK Together and system executives via mental health placed based partnerships to ensure an integrated approach to whole population planning
- Local partners, including VCSE and general practice, will be central, with a significant opportunity to join up the commissioning of the future across the NHS and councils

Measuring success: through the Collaborative's co-production approach, agreed outcomes will form the basis of holding the Collaborative to account for delivering a new offer for local people of all ages.

4. What are the Strategic Challenges to tackle in our Joint Forward Plan

	Strategic Deliverables	High Impact Programmes	Key Partners
Prevention & early intervention	• Neighbourhood / Place teams to provide community access and support for people in escalating crisis, including support to tackle life causes • VCSE and education interventions to support children and young people to develop emotional resilience • Earlier assessment and support for people with ASD (all ages) • Maximise dementia diagnosis across all Places • Integrate memory clinics with falls prevention pathways • Support people furthest from training and employment into work	• Improving outcomes for MHLDA • Integrated Neighbourhood Working • Enabling our Children and Young People to Thrive • Intelligence-led Quality, Performance, Outcomes and Inequalities Improvement • Thriving Eco-systems and Prosperous Communities	• Partners at Place • Residents and services users • VCSE • MHLDA providers
Inequalities	• Maximise health checks for people with SMI, LD and complex needs • Maximise screening uptake for people with SMI, LD and complex needs •	• Advancing Equity and Equality • Integrated Neighbourhood Working • Intelligence-led Quality, Performance, Outcomes and Inequalities Improvement	• Partners at Place • Residents and services users • VCSE • MHLDA providers
Increased need and demand	• Extend and enhance community crisis and recovery capacity • Increase ASD assessment capacity • Increase step-down (post-acute) supported independent living capacity	• Improving outcomes for MHLDA • Intelligence-led Quality, Performance, Outcomes and Inequalities Improvement	• Partners at Place • Residents and services users • VCSE • MHLDA providers • Police • Ambulance services • Acute Hospitals
Integrated models	• Multi-agency crisis pathway (right person, right care) • Supported discharge / admission avoidance (acute hospitals) for people with dementia • Support for carers	• Improving outcomes for MHLDA • Intelligence-led Quality, Performance, Outcomes and Inequalities Improvement • Integrated Neighbourhood Working	• Partners at Place • Residents and services users • VCSE • MHLDA providers •
Complex needs	• Peer support networks for people with complex needs • Recovery-focused models of care	• Improving outcomes for MHLDA	• Residents and services users • VCSE

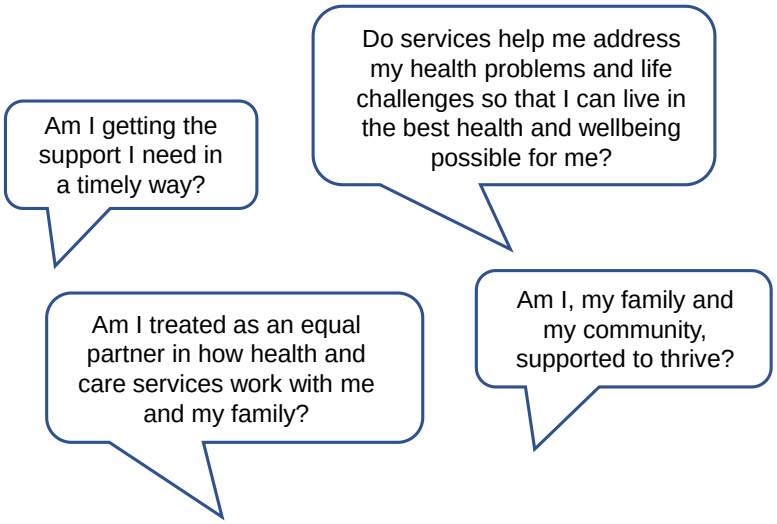
	Strategic Deliverables	High Impact Programmes	Key Partners
	• Supported independent living / crisis respite capacity within BLMK (CYP and adults)	• Intelligence-led Quality, Performance, Outcomes and Inequalities Improvement	• MHLDA providers • Local Authorities • ICB
Capital investment	• Release capital for Bedfordshire acute mental health hospital rebuild • Deliver capital plans for additional section 136 capacity, and crisis lounges • Capital plans to develop residential infrastructure for children, young people and adults with complex MH, LD and autism	• Improving outcomes for MHLDA • Efficiency & effectiveness programme (capital strategy)	• MHLDA providers • Local Authorities • ICB

Appendix C

The Joint Forward Plan Enablers

3.1 Enablers to the High Impact Programmes

Achieving the ambitious vision presented in this Plan requires a range of changes in how we work. To get this right, we need to answer the following questions from residents:



What we know, as partners in BLMK ICB, is that we cannot offer this to all residents all the time within our available resources IF we keep doing things in the same way that we are doing them now.

We also recognise it is difficult to change how we are doing things whilst in 'mid-flight' – we need to keep providing services and tackling the legacy of COVID whilst ALSO making these changes.

For our teams, this can feel like being asked to change the tires of their racing car whilst they are zooming around the racetrack. So, it's crucial that we co-ordinate the delivery of different elements of our High Impact Programmes to create 'pit-stops' where teams can engage with residents to develop, co-ordinate, and embed the changes in their own services.

What do we need to do differently?

The changes to how we will work together to deliver our BLMK Strategy include:

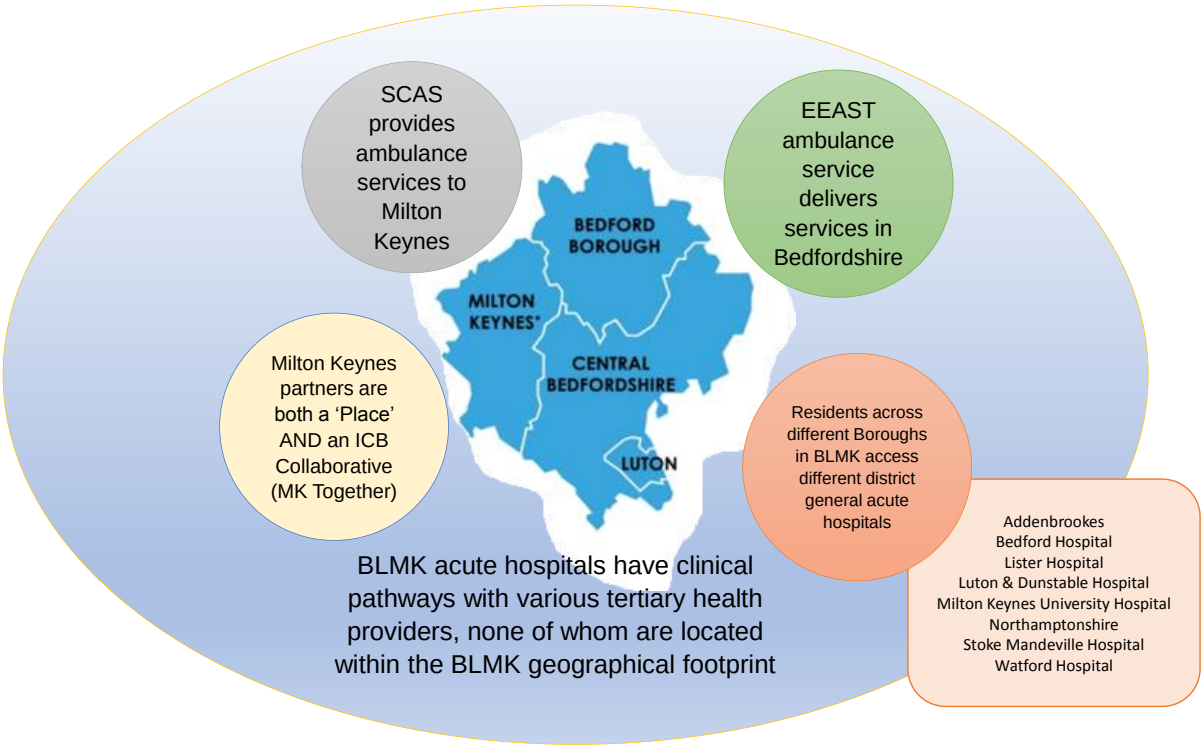
- More co-production with residents to support them to live more years in good health.
- Develop key aspects of our infrastructure, such as estates and technology, and tools, such as digital solutions, to enable improvements to care pathways.
- Offer more interventions earlier to limit the impacts of health conditions on residents' everyday lives.
- Better joining up local health, care, and civic support to residents.
- Strengthen our partnerships with VCSE, the wider public sector, including police, fire, and education. Strengthen partnerships with our communities and local

employers to better draw on the contribution they make to enable people and communities to thrive.

- Develop a shared approach using quality improvement methodology to make it easier for our staff to do the right thing for the resident, first time.
- Support the development of our staff to work in new ways, and work with local communities to train and recruit our workforce of tomorrow.
- Use population health management data intelligence to make sure that our most disadvantaged residents have fair access and outcomes of health and opportunities to thrive; and
- Measuring the impact of our High Impact Programmes focused on the benefits to residents – not just productivity, waiting times and value for money.

To achieve this, we need to take the next step in how we work together.

Key to our delivery is recognition of how residents in our Boroughs access their healthcare. BLMK ICB is a 'nexus' patch, outwardly looking to other healthcare systems in and beyond the East of England NHSE regional boundaries. Summarised, this is:



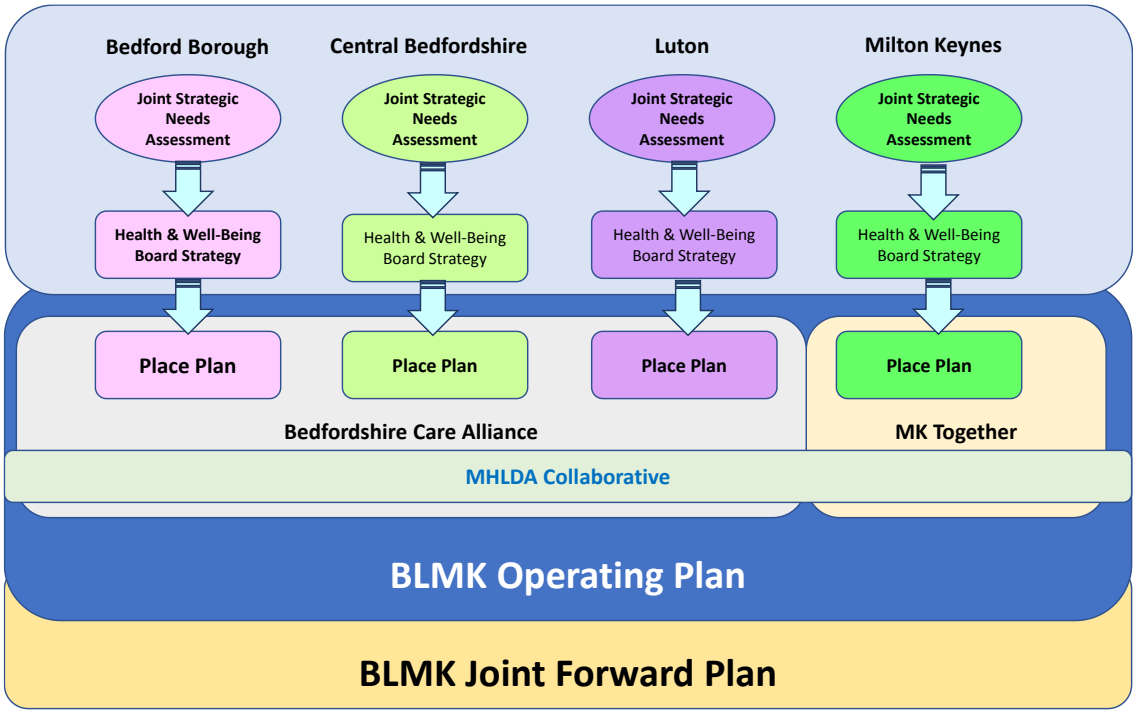
This means there are TWO reasons why a 'one size fits all' doesn't work for BLMK residents:

- The populations in each of our Boroughs are very different, meaning that health and care needs to be optimised to best meet the needs of different communities
- Each Borough has relationships with multiple health providers, not all of them within the BLMK geographical footprint

However, the standards of healthcare (access and treatment) should be the same for every

resident. Tackling the inherent disadvantages some communities experience means that we need to balance bespoke delivery to meet local needs with shared standards of outcomes.

This relationship pan-BLMK is depicted below:



The supporting changes we need to make are called **Enablers.**

How we deploy our Enablers to key to ensuring that we are consistently addressing poor health outcomes and tackling inequalities to support all our residents to live more years in good health.

This Appendix summarises all the enabling work the Partners in BLMK ICB are collaborating on to deliver our Joint Forward Plan.

3.2 BLMK Health Services Strategy

The BLMK Health Services Strategy is necessary to address the changing healthcare needs of the population and improve health outcomes. The existing health services have been evaluated at both national and local levels, and feedback from the population confirms the need for a different approach. Several factors support this need, including population growth, the prevalence of health conditions such as high blood pressure, diabetes, depression, increasing demand in primary care, rising mental health caseloads and the high demand for end-of-life palliative care.

The strategy aims to deliver services that prioritise illness prevention and early identification, focusing on population health outcomes and utilising evidence and a quality improvement approach. It will be developed through co-production with Place and Partners to ensure it aligns with the local population health needs and the NHS Long Term Plan ambitions.

The future of health services is expected to shift towards a focus on wellness rather than just healthcare. It will involve a shift from institution-centred care to person-centred care, driven by data connectivity, interoperable platforms and increases public engagement. New service delivery approaches may include health product developers, consumer-centric health communities, speciality care operators and localised health hubs. Geonomics, technology-enabled care services, virtual wards and community diagnostic centres are also anticipated to play significant roles in future healthcare.

The strategy development process has involved workshops and discussions with the BLMK Board, health and care leadership group and other key stakeholders. The scope and definition of the strategy have been refined based on feedback. Key priorities and deadlines have been identified and efforts will be made to ensure alignment with other strategies to avoid duplication.

The strategy will be informed by an evidence base, including population health data, the impact on elective recovery, pressures in urgent and emergency care and health-related issues. The prioritised clinical programmes aim to address high prevalence and poor outcomes in specific areas.

In order to deliver on place-based priorities, discussions will be conducted with various collaboratives and place-based boards. The strategy will contribute to advancing equality, improving efficiency and effectiveness, enabling the well-being of children and young people, improving early access to treatment and promoting integrated neighbourhood working.

Overall, the BLMK Health Services Strategy will provide a comprehensive and co-produced approach to transform health services, improve outcomes and ensure safety and sustainability. It will address the changing healthcare needs of the population and embrace innovations in technology, genomics and service delivery to deliver person-centred care and wellness.

1. Why do we need a BLMK health services strategy?

The health services we need in the future to improve outcomes for the population of BLMK need to look significantly different to what we have now. National as well as local evaluations of our existing health services have called out for a changed health care service offer. This has been further confirmed by feedback from our population across BLMK.

We also have hard facts that are suggesting that we need a different health service to what we have now. These are as below:

1. Total population increase - 991,800 (Census 2021) compared to 863,880 (Census 2011). Compared to the national average, BLMK has more young people aged 0-14 and a higher proportion of the population aged 30 to 49, there are fewer 55 - 90-year-olds. In BLMK over 65's has increased from 13% to 15% of the total population. The proportion of over 65-year-olds recorded has increased by 29% in census of 2021 compared to Census 2011.

2. The most **commonly recorded health conditions** by GPs are high blood pressure (range: 12% - 14%), diabetes (range: 6% - 8%) and depression (range: 8% - 13%). **Deaths** due to circulatory disease, cancer and respiratory disease contribute the most to the life expectancy gap seen between the most and least deprived neighbourhoods in each place. Covid-19 has also contributed to this gap. In women mental and behavioural disorders are also important contributory drivers of the life expectancy gaps. Across BLMK **30% to 42%** of children aged 10 to 11 years are overweight or obese and 11% to 20% of children live in low-income households. Smoking is more prevalent in routine and manual workers (21 to 31%) and among people with long term mental health conditions (21 to 33%).

3. Demand in primary care is continuing to rise.

4. Mental Health caseloads are rising across all age groups indicating growing pressures on services.

5. The segment with the highest health care demand across different services in BLMK is for End of Life / Palliative Care. In 2021/22, 0.29% of the population on an end-of-life care pathway resulted in 4.22% of total spend in healthcare. End of life pathways resulted in significant numbers of GP appointments and high numbers of elective and non-elective admissions.

6. Adults with low need Long Term Conditions (LTCs) and Mental Health (MH) conditions are only averaging 7 planned contacts per person per year. Adults with High Need LTCs are averaging around 18 contacts a year.

7. Current Labour Force Survey (LFS) data indicates 8.8m people aged between 16 and 64 who are economically inactive - **Of these 27% (2.4m) are inactive due to being long term sick, and a further 200k due to being temporarily sick**.

8. 11.8m adults in England reported waiting for a hospital appointment/test/start treatment through the NHS; **of which 3.3m adults in England are reporting to be economically inactive (not retired).**

9. Published HES first outpatient data suggests that around 57% of activity is of working age (16 to 64). **i.e., around 4.1m pathways on the [7.2m] waiting list size. Est. 3.2m working aged people on the RTT waiting list**

10. The Health Foundation's REAL Centre (research and economic analysis for the long term) high-level analysis points to an overall workforce supply-demand gap of around 103,000 FTE across the NHS HCHS and general practice in 2021/22 (around 7% of estimated FTE workforce demand). This gap is projected to increase to around 179,000 FTE by 2024/25 before declining gradually to a still substantial 156,000 FTE in 2030/31 (around 9% of projected demand).

The BLMK Health Services Strategy will describe how we will deliver services at scale and closer to residents' homes using evidence and a quality improvement approach that considers peoples' experiences, available resources and focusses on population health outcomes. Our health services strategy will prioritise illness prevention and early identification, in the context of those conditions where we can make most impact.

A comprehensive and coproduced strategy, the BLMK Health Services Strategy will work beyond service redesign and will look to future proof health services and help improve outcomes at a population level and make our health services safe and sustainable. Co-production with place-based boards as well as providers will help deliver on place-based ambition at place and at scale.

We have already established examples from BLMK Cancer Board where the strategy for cancer in BLMK was developed through the Cancer Board, with engagement from partners across BLMK with clear focus on local population health needs. Through engagement with communities and multi-professional stakeholder groups the Cancer strategy and has continued to develop over the years and has started to deliver on innovative solution to improve outcomes such as improved access to diagnostics. This has enabled a clear 10-year plan to be co-designed with partners taking into account the NHS Long Term Plan ambitions and The East of England Cancer Alliance strategy and the ambitions of our providers and patients.

BLMK Health services strategy will be developed by:

- **Delivering on commitments already made to improve the quality of the health service and its consistency via NHS operational plan and NHS long term plan**. See Appendix A for Long Term Plan commitments.
- **Responding to changing patient and public expectations**. Our public want us to deliver safe, high-quality treatment with fast access, an integrated, joined-up health system, comfortable accommodation services and a patient-centred services
- **Embedding advances in medical technologies**, including pharmaceuticals and genomics. For example, GRAIL, advanced genomics, and smart technology such as AI, and other digital aids are already showing promise in improving outcomes. See Appendix B – for all upcoming new technology
- **Responding to the changing health needs of the population**, including demography by proactively engaging with communities to promote wellbeing from early years
- **Responding to increased prices for health services resources**, including skilled staff, the level of productivity improvement which can be achieved by developing new models of care

The BLMK Health Services Strategy will embrace the following key principles already agreed across the system.

- Take Life course approach
- Emphasis on prevention (primary, secondary, tertiary)
- Evidence based
- Care as close to home as possible and at scale where that is likely to lead to better outcomes (enabled by the "Fuller Program")

- Improve access and health outcomes for our population
- Resident focussed
- Tackling inequity and inequality
- Resource efficient
- Multi-professional and all sectors
- Co-ordinated from a system perspective, aligned to others

1.1 What will future health services look like?

We anticipate that by 2040, health care as we know it today will no longer exist. There will be a fundamental shift from “health care” to “health.” While disease will never be completely eliminated - through science, data, and technology, we will be able to identify it earlier, intervene proactively, and better understand its progression to help our population more effectively and actively sustain their well-being. The future will be focused on wellness. Unlike today, we believe care will be organised around the person, rather than around the institutions that drive our existing health care system.

Driven by greater data connectivity; interoperable and open, secure platforms; and increasing public engagement, archetypes are likely to emerge and will replace and redefine today’s traditional life sciences and health care roles to power the future of health.

We anticipate modernised roles to be developed with health services. We also anticipate health services delivery to change radically.

We can see new service delivery approaches emerging, such as these below:

Health product developer

Health product developers will power the population by developing and manufacturing wellness and care products from applications to drugs and devices. Those products won’t be limited to pharmaceuticals and medical devices, they will also include software, applications, and wellness products.

Consumer-centric health community

Along with companies that develop health products, other organisations will provide the structure that supports virtual communities. Consumer-centric health players will provide virtual, personalised wellness and care to consumers; leverage community to encourage behaviour change; and drive consumer and caregiver education.

Speciality care operator

Two decades from now we will still have disease, which means we will still need speciality care providers and highly specialised facilities where those patients can receive care. Speciality care operators will provide essential speciality care and interventions when in-home wellness and care efforts are insufficient.

Localised health hub

While there will be some speciality care, most health care will likely be delivered in localised health hubs. Localised health hubs will serve as centres for education,

prevention, and treatment in a retail setting. Additionally, local hubs will connect consumers to virtual, home, and auxiliary wellness providers.

The potential of genomic medicine

The systematic application of genomic technologies has the potential to transform patients' lives by:

- Enabling a quicker diagnosis for patients with a rare disease, limiting the possibility of years of uncertainty, often referred to as the 'diagnostic odyssey'.
- Matching people to the most effective medications and interventions, reducing the likelihood of an adverse drug reaction.
- Increasing the number of people surviving cancer each year because of more accurate and early diagnosis and more effective use of therapies**.**

Examples of Implementation in BLMK to date are:

1. Technology enabled care services refers to the use of telehealth, telecare, telemedicine, telecoaching and self-care in providing care for patients with long term conditions that is convenient, accessible, and cost-effective. There is established evidence that these services transform the way people engage in and control their own healthcare, empowering them to manage their care in a way that is right for them. **Whzan technology is helping an increasing number of Trusts across the BLMK to embrace virtual wards**

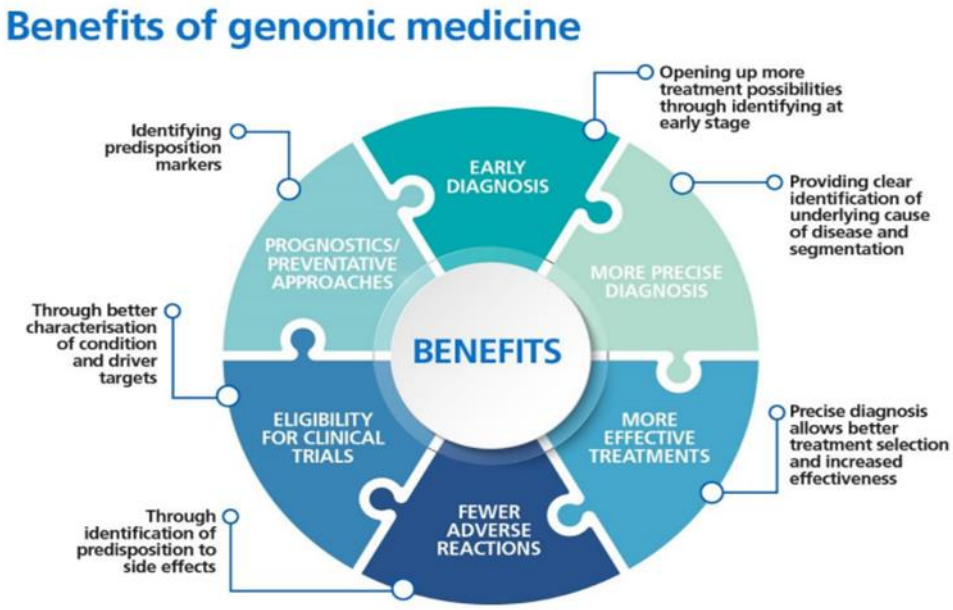
2. Virtual wards allow patients to get hospital-level care at home safely and in familiar surroundings, helping speed up their recovery while freeing up hospital beds for patients that need them most. Just as in hospital, people on a virtual ward are cared for by a multidisciplinary team who can provide a range of tests and treatments. This could include blood tests, prescribing medication or administering fluids through an intravenous drip. Patients are reviewed daily by the clinical team and the 'ward round' may involve a home visit or take place through video technology. Many virtual wards use technology like apps, wearables and other medical devices enabling clinical staff to easily check in and monitor the person's recovery. **BLMK is embracing virtual wards as part of our winter plans and ongoing patient flow strategy.**

3. Community Diagnostic Centres will allow patients to access planned diagnostic care nearer to home without the need to attend acute hospital sites. These services would be separate to urgent diagnostic scan facilities, which means shorter waiting times and a reduced risk of cancellation which can happen when more urgent cases take priority. Therefore, this would lead to improved patient experience and outcomes. **BLMK ICB has received capital funding for the following community diagnostic centres:**
    - North Bedfordshire CDC Hub (Gilbert Hitchcock House)
    - Milton Keynes CDC Spoke (Lloyds Court)
    - Milton Keynes CDC Spoke (Whitehouse Health Centre)

4. **Genomics**

Genomics in cancer

The NHS Long Term Plan aspires to offering more extensive genomic testing to patients who are newly diagnosed with cancers. We already make use of genetics testing in cancer as routine in Breast, Colorectal (Bowel) and Gynaecological cancers to assess familial history risk. The BLMK Cancer Board has included increased used of genomics for the purposes of targeting treatments and its use to detect cancers earlier as part of its 10-year plan for BLMK.



5. **Robotic Surgery -** This type of surgery has evolved into a global industry since the first, American-made, DaVinci® robot was installed in St Mary's Hospital, London back in 2001. More versatile models are now arriving on the market, offering a growing choice of technology and resulting in an increasing number of procedures being performed by robotic surgery in the NHS. **MKUHFT has been a pioneer in the country in promoting robotic surgery**

1.2 What have we done so far?

During the Board seminar on the 28th February, we discussed the scope of a BLMK wide Health Services Strategy (formerly known as Clinical Services Strategy).

Four questions were considered:

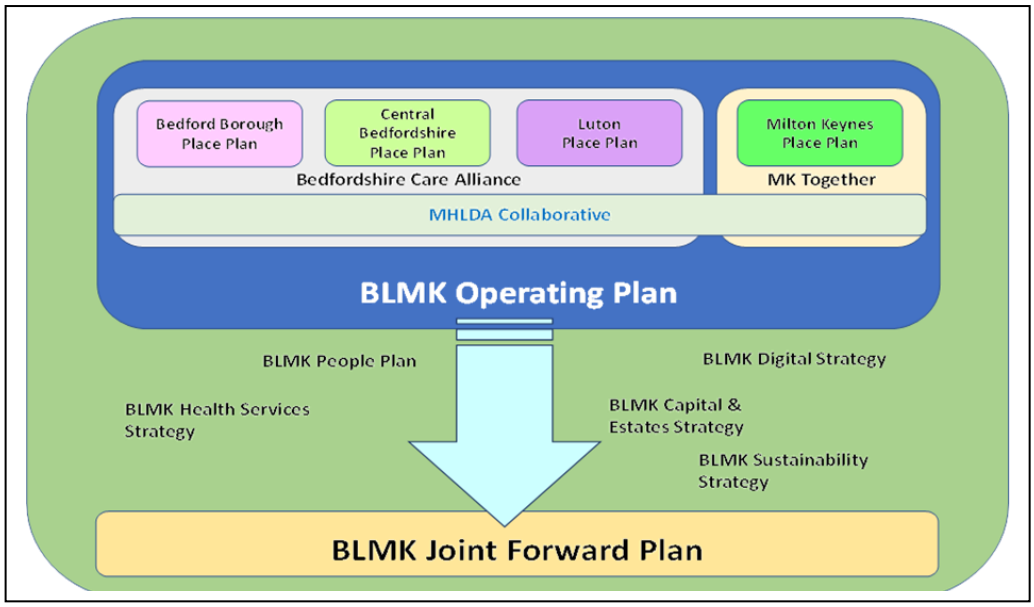
- Do we agree with the definition of the clinical services strategy?
- What must we consider in delivering an effective clinical services strategy?
- Which key deadlines or priorities from your place need to be linked to this work? What would be our top 3 priorities for year 1?
- Who should be involved in the work? (local residents, multi-professional voices) How can we collectively resource this work?

The feedback from the board was captured and changes were made as per feedback.

The key themes identified with the responses is outlined below.

1. **Sharpen definition and define scope** – altered definition is now incorporated
2. **How does this strategy link with other strategies and let's avoid duplication?**

We have this now as part of BLMK joint forward plan. The diagram below describes this:



In addition, each clinical programme area will support the High Impact Programmes identified within the BLMK Joint Forward Plan. Therefore, the health services strategy will help deliver on the ambitions around:

- **Advancing Equity** through helping to tackle inequalities and variance in health outcomes
- **Efficiency & Effectiveness Improvement** in each clinical programme by delivering on value and evidence-based approaches
- **Enabling our Children and Young People to Thrive** by taking a life course approach
- **Improving Access & Treatment** will be the underlying theme within the health services strategy
- **Integrated Neighbourhood Working** will be the key in delivering best outcomes for people with long term conditions

1.3 What evidence base has been used to get to the top programmes mentioned – why are others not included?

Pragmatic prioritisation using the following evidence base **has identified key areas that we need to focus in the next 5 years**. Prioritisation was based on:

- **Population Health data on mortality in under 75 years of age** and disability free life years
- **Elective recovery back log** – compromising life experience for our citizens and impacting on ability to work. We must tackle NHSE mandates to recover long waits for routine surgery to be able to progress to wider transformation
- **Pressures within urgent emergency care and primary care access**
- Health related issues that affect **our female population** where there are inconsistent pathways and access affecting well-being
- Issues that are not already being addressed at Place, Provider Collaborative or other BLMK High Impact Programme

1.4 Why these programmes?

The clinical programmes identified and the reason they have been prioritised is listed here:

- **BLMK has High prevalence and poor outcomes** compared to similar population; in **cardiovascular, respiratory disease and cancer**
- **Tackling obesity** - 70% of our population will be obese or overweight by 2030 – the role of the health services strategy will be to focus on interventions not best provided at Place
- **Eyecare –** Across BLMK we have high volume waits. We see significant variation in care for conditions that cause blindness in the elderly. Luton has a higher rate per 1,000 population on the waiting list for specialist input. Poor eyesight compromises life experiences and productivity in people.
- **Women's reproductive health strategy:** women comprise over 50% of the population across BLMK. Women's reproductive health impacts on experiences and productivity which impacts on health and wellbeing in the family. Currently fragmented provision is causing demand on hospital-based gynaecology services.

This programme is expected to run 2023- 2025.

1.5 Delivery Model

The key remit of the health services strategy is to critically review options for those areas of healthcare where we have a complex challenge (now and into the future) that is not being adequately addressed elsewhere in BLMK programmes.

It is recommended that a pragmatic approach to the number of programmes running simultaneously is undertaken:

- Resourcing implications for all partners considered in the scheduling of major health services strategy reviews. This may result in fewer programmes being undertaken at a time, with the expectation that this will allow for shorter, more concentred delivery
- Building on existing work within organisations rather than duplicating process
- Being clear what is already being addressed within other workstreams, for example prevention and integration at Place, redesign led by Provider

Collaboratives, productivity and effectiveness projects delivered within an organisation

- Making use of local expertise but also draw in evidence-base and learning from elsewhere to provide challenge to identify the most beneficial options to address issues (clinical, operational, workforce, financial) to improve health outcomes for all our residents

- Work with Place partners and the Population Health Intelligence Unit to ensure that local population need is clearly understood, and that the impact on different cohorts of residents is factored into the development of options

As part of confirming the detailed methodology for each Health Services Review, the governance process spanning clinical representation; population impact (health outcomes and tackling inequalities); affordability; workforce and wider resource implications will be managed through a review and approval process that:

1 Starts with sovereign organisations directly affected by proposals managing this through their own governance framework

2 Appropriate engagement / consultation with partners through Place and Provider Collaboratives

3 Clarity on the need for public and political engagement / consultation

4 Review / approval of any proposals supported thus far through shared ICB governance processes

2. Next Steps

2.1 Proposed Methodology and timeline to develop BLMK health services strategy:

Multi-professional stakeholder groups for the identified programmes will develop the terms of reference for the BLMK health services strategy. Multi-professional stakeholder groups will comprise clinical reference groups as well as other experts such has health economists and experts who can undertake modelling with scenarios.

The terms of reference will incorporate the following approach and methodology:

1. BLMK health services strategy will examine the technological, demographic and medical trends over the next two decades (with short-, medium- and long-term goals with 5-year running cycles) that may affect the health service across BLMK as a whole.
2. In the light of (1), to identify the key factors which will determine the financial and other resources required to ensure that the NHS services across BLMK can provide a publicly funded, comprehensive, high-quality service available based on clinical need and not ability to pay.
3. To report to the ICB board by March 2024 with an interim scope of all the identified programs. The scope will include suggested resourcing required from ICB and all partner organisations. We will aim to get first set of initial recommendations. We will also aim to get a report on where we are on ophthalmology in terms of pan-system redesign.

4. By March 2024 we will establish a multi-professional think tank to help with horizon scanning and drawing in the best evidence base to secure safe sustainable health services for the population across BLMK.
5. The strategy will take account of the place-based priorities across BLMK and clinical services strategies that have already been developed by providers across the BLMK.
6. The strategy will need to model recommendations based on projected financial and workforce projections and challenges
7. The strategy will build on learning from existing strategies and plans such as Cancer strategy and Mental Health strategy
8. The strategy will take into account all of the existing evidence signalling the need for a comprehensive, fully funded and long-term workforce strategy.

List of appendices

Appendix A.1 – Long Term Plan Ambitions

Appendix B.2 – Upcoming New Technology

Appendix A.1

Long Term Plan Ambitions

- **Cancer:** By 2028, 55,000 more people each year will survive their cancer for five years or more; and 75% of people with cancer will be diagnosed at an early stage (stage one or two).
- **Mental Health: Transform mental health care so more people can access treatment**
- Make it **easier and quicker for people of all ages to receive mental health crisis care**, around the clock, 365 days a year, including through **NHS 111**
- **Expand specialist mental health care for mothers** during and following pregnancy, with mental health assessments offered to partners so they can be signposted to services for support if they need it
- **Expand services, including through schools and colleges,** so that an extra 345,000 children and young people aged 0-25 can get support when they need it, in ways that work better for them
- **Continue to develop services in the community and hospitals**, including talking therapies and mental health liaison teams, to provide the right level of care for hundreds of thousands more people with common or severe mental illnesses.

Cardiovascular Disease

Milestones for cardiovascular disease

- The NHS will help prevent up to 150,000 heart attacks, strokes and dementia cases over the next 10 years.
- We will work with our partners to improve community first response and build defibrillator networks to improve survival from out of hospital cardiac arrest.
- By 2028 the proportion of patients accessing cardiac rehabilitation will be amongst the best in Europe, with up to 85% of those eligible accessing care.

Respiratory diseases

- Ensure more patients have access to testing, such as spirometry testing, so that respiratory problems are diagnosed and treated earlier
- Ensure patients with respiratory disease receive and use the right medication, including educating patients on the correct use of inhalers
- Expand rehabilitation services, including pulmonary rehabilitation and digital tools so that more patients have access to them and have the support they need to best self-manage their condition and live as independently as possible
- Improve the treatment and care of people with pneumonia.

NHS England's Elective Care Transformation Programme supports local health and care systems to work together to:

- Better manage rising demand for elective care services.
- Improve patient experience and access to care.
- Provide more integrated, person-centred care.

Appendix B.2 – Upcoming New Technology

NHS digital strategy is using technology to help health and care professionals communicate better and enable people to access the care they need quickly and easily when it suits them.

From websites and apps that make care and advice easy to access wherever patients are, to connected computer systems that give staff the test results, history and evidence they need to make the best decisions for patients.

The following areas of digital technology will transform health care services of the future.

Artificial intelligence - Advancements in computing and investment from a range of sources have resulted in an expansion of the capabilities of AI technology, but there are few examples of use in healthcare, with a focus on diagnostic testing.

Mobile computing Smartphone - use has continued to rise over the past 10 years, though use is unevenly spread across age and socio-economic groups. The Covid-19 pandemic has sped up the implementation of video and other digital technologies to replace back-office and traditional functions.

Personal and wearable technologies - Advances in the size and styling of wearable technologies have encouraged growth in the use of smartwatches and fitness trackers. Few examples in UK health services, some integration into insurance plans in the United States.

Internet of things - As computing technology gets smaller, more and more 'smart' devices are reaching the consumer market, most notably smart Shaping the future of digital technology in health and social care.

Acknowledgments:

The content from the following websites were used as inspiration and evidence to develop this paper:

1. https://www.kingsfund.org.uk/
2. https://www.health.org.uk/
3. https://www.england.nhs.uk/digitaltechnology/
4. https://www.longtermplan.nhs.uk/
5. https://www.england.nhs.uk/elective-care-transformation/
6. https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/future-of-health.html
7. Special thanks to BLMK Public Health Intelligence, Executive Place officers, AGEM BI and the BLMK Population Health Management team for place-based profile packs for population health data for BLMK.
8. Special thanks to Aliko Ahmed, Neil Wood & Joan Skeggs – from East of England regional team for providing data on **Health & Wealth: Supporting Social and Economic Development of Populations**

3.3 BLMK ICB's work with Voluntary, Community and Social Enterprise Organisations

1. What is the Purpose of this Enabler?

The population of BLMK is growing rapidly – three of our four places grew by more than 15% between 2011-2021. This growth is expected to continue, making the East the fastest growing region in England and, within this, BLMK as the fastest growing ICS areas. Meeting the inevitable growth in health and care demand and complexity is only possible if we work together in partnership with our colleagues in the Voluntary, Community and Social Enterprise Sector (VCSE). There are estimated to be 4000 such organisations in BLMK, bringing diverse expertise, insight, and a range of services to the area.

It's not just population growth that working with the VCSE helps to tackle. BLMK is an area of deep inequality, where your life chances and your health are often determined by a wide range of characteristics – including where you're born, your job, your employment and skills and your race and gender to name just a few. It is a central to our Integrated Care Board's strategy to tackle these health inequalities – a mission to which our partnership with the VCSE is of crucial importance.

Central to BLMK ICB's approach to delivering its strategic aim to enable all residents to live more years in good health – and support communities to thrive – is the recognition that its is the wider determinants of health that have the greatest influence on the health and well-being of our residents – 80% in fact. VCSE partners have a unique role in engaging, developing and delivering the community resources and networks that support each of us to tackle life's challenges.

However, whilst the VCSE is voluntary, it is not a free resource. The way that ICB partners work and resource our VCSE organisations is crucial to enable them to fulfil their potential. In BLMK, we are implementing a range of partnership approaches to ensure that statutory services engage and partner with VCSE in ways that support them to be sustainable.

Our Shared Ambition

We need more in prevention and early intervention to achieve our vision of supporting more people to live more years in good health. Understanding how we support different parts of the population to stay well or prevent further decline will be essential if we are to reduce demand for services in the longer term. Our partnership with the VCSE will enable us to address this problem and improve our understanding of how we define and measure outcomes.

The partnership aims to understand the significant contribution VCSE organisations make in local communities, supporting people to keep well, developing community resilience, and designing services that improve outcomes in groups with the poorest health. It will help us to understand where the VCSE has the potential to do more, to work differently with system partners, and how we overcome barriers in terms of their capacity and the way we (as a system) enable this to happen. The strategic partnership will put the VCSE and the community at the heart of our work as an ICS.

2. The current landscape in BLMK

At the centre of where we are now is our landmark Memorandum of Understanding, agreed by the Integrated Care Board in November 2022. This sets out how we work together, put our local

communities and residents at the heart of everything we do and establish the values on which our strategic partnership is founded.

The engine room behind our work, our VCSE Strategy Group, bring together key partners and is co-chaired by VCSE and ICB representatives.

We are working to develop a clear map of VCSE assets that will support our developed understanding of the resources across BLMK and, in turn, how we can signpost residents and patients accordingly. Our collection of Case Studies, including health & wellbeing coffee mornings, support for young people with a neurodiversity diagnosis and mental health crisis cafes are already helping us to bring to life to possibilities of local partnership working, backed by ICB funding.

We are also using our connections with VCSE partners to support earlier engagement on key work areas – including winter planning – where the VCSE have a vital role to play in supporting people in our of hospital settings. Where there is VCSE representation in the system there is more diverse expertise and insight, and this is born out on the Integrated Care Board, the Health and Care Partnership, the Working with People and Communities Committee and place boards.

Key challenges

Whilst these are addressed in some detail in the problem statement set out above, we consider the overall current capacity of VCSE organisations to be a barrier which the ICB has a responsibility to work to address. Furthermore, commissioning processes designed for large VCSE organisations and, NHS planning does not historically best enable VCSE participation and longer-term funding tied up in long term contracts with big providers limits our ability to invest strategically in the sector. A more practical challenge is the coordination of engagement activity across geographies and populations, especially amongst a rapidly growing population.

ICB Mandated Responsibilities

These are set out principally in the Health and Care Act 2022 and the ICS' VCSE guidance

The Act requires NHS organisations to plan and deliver services in partnership and work closely with local authorities, VCSE organisations and communities themselves to improve population health. The VCSE sector is a vital cornerstone of a progressive health and care system. ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving, and delivering services and developing and delivering plans to tackle the wider determinants of health.

Our VCSE partnership should be embedded as an essential part of how the system operates at all levels. ICBs are expected to have developed a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level.

There are further "must-dos" established by our BLMK ICB Memorandum of Understanding arrangement, as set out below:

- 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.

Opportunities

There are countless opportunities afforded by a stronger working relationship with VCSE partners, including: Benefits statement - By working in partnership with the VCSE sector in BLMK, we will gain a better understanding of our diverse communities, derive more value from co-producing services and projects; and deliver more and better improvements in health and wellbeing for our residents.

We see particular opportunities for VCSE involvement in support action across the system to address support for everyday living, prevention services, driving forward the green agenda, social action, community development and tackling health inequalities.

What have we achieved

The "Where we are Now" section above goes some way to setting out the considerable progress made so far on establishing a new and strategic partnership with the VCSE for the benefit of local residents. Other notable achievements include the involvement of VCSE organisations in the Denny Review – a major, local study into health inequalities where, often for the first time, we were able to hear views from seldom heard communities including homeless people and individuals from the Roma communities.

Further notable examples of VCSE collaboration include support from the Bedfordshire Rural Communities Charity to support patients from rural areas upon their discharge from hospital, and innovative partnerships with partners like the MK Dons Football Club whose work supporting young people is a key part of supporting health development and developing skills. Milton Keynes University Hospital emergency department is supported by a volunteer scheme delivered by MK YMCA and Thames Valley Police, providing comfort and advice to individuals who may be particularly vulnerable.

Mental health is an area where there are a number of excellent examples of our work with the VCSE, including suicide prevention, bereavement support, dementia support, rough sleeping initiatives, support with winter pressures and a number of digital developments which have been mobilised with partner organisations. A particularly exciting area of development are VCSE mental health alliances, which form part of the community mental health transformation plans.

3. What does good look like – learning from others

The model that works for each ICS in terms of its relationship with VCSE organisations is of course dependant on the specific characteristics of the place. There are nevertheless a number of innovative models in areas like Yorkshire and Devon that we are seeking to understand further.

Devon ICS has development a business case to invest in the infrastructure required for enable more effective VCSE participation within workstreams and governance; they have delivered a buddying scheme between the NHS and VCSE leaders to bring about a better understating of each other's sectors; and using transformation funding to invest in the VCSE as part of a system response with co-designed solutions.

Humber and North Yorkshire HCP has agreed an annual budget to support VCSE collaboration. They have been working to simplify processes for grant agreements and contract variations and shifting language that recognises support for longer term development of the VCSE is an investment. West Yorkshire and Harrogate HCP has a well-developed place-based approach to working with the VCSE, with and annual budget to support collaborative activity. The development of VCSE commissioning vehicles is also being investigated.

NHSE is also developing a Quality Tool to support ICBs with self-assessment of how the VCSE partnerships is developing locally. The key elements are listed below, and we will use the final version of the tool monitor and evaluate the development of the BLMK VCSE Partnership.

- Understanding the value of the VCSE sector
- Building and strengthening VCSE infrastructure for collaborative working
- Embedding the VCSE as an equal partner in ICS governance and decision making
- Sustainable investment for VCSE alliances
- Designing and commissioning effective, innovative, and sustainable services
- Harnessing data and intelligence
- Measuring the impact of the VCSE as a key strategic partner
- Investing in leadership and relationship development
- Working with the VCSE sector to address the wider determinants of health

Case Studies like the mental health crisis cafes and support for young people overleaf bring to life how our relationship with the VCSE is transforming lives.

What difference will this make, and how will we measure it?

Much of the value the VCSE delivers in in the area of prevention and we recognise that measuring success requires further development. Prevention can be considered through a variety of lenses, and we will need to work with partners to better define how we measure it in terms medical, social, public health, economic and environmental. We will need to work with partners to understand how and where these are measured, for example within workstreams or at a strategic level.

There NHSE quality tool will enable us to measure improvements in a range of areas, operationally and strategically. The MoU also provides an opportunity to understand how the partnership with the VCSE is developing against the commitments outlined. This area of work is also supported by a programme plan and a related outcomes framework is progressing.

Several measures will be worked up further under each of the benefits outlined in the benefits statement above:

- Gain a better understanding of our diverse communities
  - Reach of VCFE into Core20Plus5 population
  - Completion of the asset mapping work and providing link to MiDoS directory of services tool in 23/24
  - Annual sentiment survey measure
- Derive more value from co-producing services and projects.
  - We will need to identify specific schemes which will use a co-production approach to develop this further
  - We will also work with procurement colleagues to develop the approach to measuring social value
- Deliver improvements in health and wellbeing for our residents.
  - These will need to be defined within specific workstreams, but examples include, distance travelled for individual clients e.g., before and after ONS4, Campaign to End Loneliness Tool, and similar wellbeing improvement measures

4. Delivery of this Enabler to Support the High Impact Programmes of the BLMK Joint Forward Plan

The MOU will be delivered by programme plan, the key elements are outlined below. Governance will occur via the VCSE Strategy Group. The NHSE quality tool and outcomes framework for the programme will track improvements and monitor progress.

Mobilisation in 2023-5

There are key actions underway as part of Place and Provider Collaborative's Delivery Plans and the ICB's NHS operational plan delivery to further embed partnership with the VCSE into the High Impact Programmes in our Joint Forward Plan.

These include:

- **Raise awareness of the VCSE and bring about a shared understanding of the sector's impact across a range of areas** - programme of engagement and co-production activity to support multiple workstreams at system and place; mechanisms for the VCSE to collaborate effectively at Place, amongst themselves and with other partners
- **Involve VCSE in operational and strategic planning processes through Places and Provider Collaboratives** - enhance VCSE involvement through delivery of ICB VCSE procurement strategy; strengthen VCSE involvement in relevant ICB governance; develop staff volunteering programme
- **Develop strategic investment case for VCSE infrastructure, and partnership development and maintenance** - complete mapping exercise; identify external and internal sources of investment to support VCSE infrastructure
- **Define outcomes, impact, and benefits** – this will be enabled through implementation of the Population Health Intelligence Unit, BLMK digital connectivity programme and pan-BLMK commitment across all partners to embed quality improvement methodologies to improve health outcomes and tackle inequalities

3.4 BLMK Infrastructure Strategy

1. What is the purpose of this Enabler?

In the context of significant population growth, the financial constraints facing the system, and our ambitious transformation and service improvement plans, we need to adapt our estate to ensure it enables new and more cost-effective models of care.

Our key estates priorities within BLMK include:

- Maintaining a safe, compliant and fit-for-purpose estate in the context of a constrained capital funding position.
- Enabling delivery of the system's clinical strategy and service improvement plans.
- Reducing inequalities by ensuring the alignment of estates prioritisation to local health and infrastructure needs.
- Planning for the future, including in areas of high levels of housing and population growth.
- Achieving measurable progress towards our Net Zero Carbon targets; and,
- Ensuring a cost-effective and affordable estate that is fit for the future.

The challenge for all public sector partners in BLMK is how best we tackle the inter-connected and complex issues for estates and capital investment:

- **Balancing need for backlog maintenance of aging estate vs. increased capital and revenue costs of new and more 'fit for purpose' buildings** in the context of extremely constrained NHS capital funding
- **Targeted investment in key capital estate to tackle 'pinch points' where lack of capital investment is the direct cause of inequitable outcomes for residents** and / or increased clinical risks and revenue costs within existing constrained provision
- **Making best use of mobile and digital technology to bring services closer to residents** whilst reducing reliance on purpose-specific buildings where volume of demand does not support expensive but low utilised capital investment
- **Finding innovative sources of capital funding to address the gap between need and resource availability** through traditional capital investment sources (primary care capital fund, section 106 etc)
- **To maximise benefit of capital investment through bringing together civic and NHS functions** into integrated accommodation to reduce capital and revenue costs to the taxpayer

2. The current landscape in BLMK:

The health services within BLMK operate from three main acute hospital sites, approximately 120 community/mental health settings, and over 130 primary care premises. This is in addition to the civic, education and social care settings and vast range of properties operated by our Local Authority partners.

Our key challenges to 2040 are:

- **Capital funding constraints**, which will make it increasingly challenging for us to maintain and replace our buildings and equipment
- **Significant housing growth**, not matched by adequate additional funding for civic and health infrastructure raised through traditional routes

- **Rising demand for services** and our continued recovery programme, requiring additional capacity across many services
- **Capital investment required to deliver new medical technical innovation** - implementing advances in research to improve health outcomes for our residents
- **Variation in the condition, capacity and energy efficiency of our facilities**
- **The need to enable new models of care**, to better meet the needs of residents, and tackle inequalities in access, outcomes and inequalities

Addressing these challenges will require joined-up efforts across system partners, harnessing the principles of One Public Estate, to maximise our opportunities to collectively plan for and deliver our future estate. By working together, we have greater ability to deliver flexible strategic estates solutions and to access a wider range of funding solutions.

As a system, we have made progress with the delivery of some of our most pressing estates challenges:

- Delivery of the Urgent Treatment Centre and Cauldwell Medical Centre projects on the Bedford Hospital site, which helped to streamline urgent care services in Bedfordshire, and provided essential primary care capacity in an area of high need.
- Delivery of a range of recovery schemes post-Covid to enhance the capacity of key services within both local Hospital Trusts
- Full Business Case (FBC) approved and redevelopment underway for the Luton & Dunstable Hospital site, which will provide fit-for-purpose accommodation for services, improve patient experience, and enable significant clinical and efficiency benefits.
- Delivery of the Maple Unit within Milton Keynes Hospital, which has helped to streamline urgent care services.
- Funding secured for the redevelopment of the Milton Keynes Hospital site under the second phase of the national Health Infrastructure Plan (HIP2 Programme), Strategic Outline Case (SOC) completed, and Outline Business Case (OBC) in development. The programme will help to future-proof hospital services against a backdrop of major population growth.
- Delivery of the Whitehouse Hub and Brooklands facilities in Milton Keynes, providing essential primary care services within areas of high housing growth.
- Delivery of Grove View Integrated Health & Care Hub in Dunstable, enabling joined-up working and additional capacity for a wide range of primary care, community, mental health, social care and hospital-led services.
- FBC approval and delivery mobilisation for the North Bedford Primary Healthcare Programme on the Bedford Health Village site, enabling consolidation of the largest GP practice in BLMK (40,000 list size).
- Approval of business cases for Community Diagnostic Centres (CDC) in Bedford and Milton Keynes, and delivery in mobilisation. In line with the national programme, these centres will provide additional diagnostic capacity away from the main hospital sites.
- Capital secured to build a new Mental Health inpatient unit on the Bedford Health Village site.
- Delivery of a range of smaller scale primary care premises schemes, and completion of a comprehensive Primary Care Estates Prioritisation Process across BLMK. The ICB has identified an additional £1.95m per annum to be made available to support primary care

estates, which represents a 22% increase in the investment in primary care facilities. This additional funding will enable twenty-three local projects to progress by 2025/26, with benefits for a wide range of communities across Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.

3. What does good look like?

The capital estates strategy and plan are dependent on our Place Plans and the outputs of key strategies such as our health services strategy and our digital integration strategy.

We also need to complete the critical mobilisation action of our BLMK Joint Forward Plan – detailed population growth and detailed demographic change modelling for each of our 4 Boroughs. The ONS estimate for population growth across BLMK is inaccurate due to the local plans to build circa 6,000 new homes every year until 2040. More accurate population growth modelling is an essential precursor to predicting changes in civic, care and health need and demand – and the resulting implications for our infrastructure.

We also need to ensure that as we build for our future that we do not plan capital estates investment predicated on old models of care. Digital integration and advances in medical technology enable us to bring joined-up care much closer to residents with reduced need for dedicated (low utilisation) buildings. In contrast, investment in specific estate to enable new models of care (for example, the Milton Keynes Cancer Centre and Bedfordshire Mental Health Hospital) will each improve access and outcomes for residents across our Place and enable delivery of NHS Constitutional Standards.

Within our operational planning we will need to continue to work closely with NHSE Regional colleagues to find targeted capital funding solutions to the remaining capital projects required to unblock existing flow bottlenecks which continue to have a material and deleterious impact on urgent emergency care and elective performance, and resultant patient waits and clinical outcomes.

Without clarity on the future / best-practice models of care and on the gap between demand and capacity at a local level, there is a significant risk that we will not use public capital investment to best effect for our residents.

The BLMK Infrastructure Strategy will need to address the following:

- Sustainable affordability (capital and subsequent revenue costs)
- Tailor investment to local need and demand – improving access, especially where health outcomes and / or inequalities have a detrimental impact on our communities' ability to thrive
- Based on evidence-based best practice in our models of care to ensure we have the right resources in place to improve health outcomes and the wider determinants of health
- Make best use of technology and sustainable resources to optimise benefits whilst minimising cost to the public purse and the environment
- Deliver clear 'return on investment' (capital and revenue) in meeting need and demand for residents, and delivering NHS Constitutional Standards sustainably

4. BLMK Timeline to Complete the BLMK Infrastructure Strategy

There are several actions in place to deliver this:

a. Modelling of population growth and demographic changes across all 4 of our Places to 2040 (based on best knowledge to date)

b. Work is underway to support many of the PCNs across BLMK to refresh their Clinical Strategies and their Estates plans, in line with the national PCN Estates Toolkit. This work will have a prime focus on maximising the utilisation of the system's existing collective estate, ensuring that we are planning the right infrastructure to meet future needs and planned models of care, and working towards delivery of our Green Plan intentions.

c. Mapping and review of 'one public estate' in each of our Boroughs, exploring the possibilities for optimised utilisation and targeted investment across civic, emergency, education and NHS buildings

A programme is in mobilisation, with a view to achieving sign-off of the BLMK Infrastructure Strategy in December 2023. This work will need to align to our Health Services Strategy and is interdependent on the ICS Digital Strategy and BLMK People plan.

5. Unmitigated Risks to Delivery

There are 3 aspects of NHS capital allocation policies that are significant risks to delivery of safe, sustainable estates to deliver NHS Constitutional Standards for all residents in BLMK:

a. **Lack of primary care premises strategic development capital funds**. This prevents strategic investment in major new developments in primary care to meet growing population need

b. **Short-term / fragmented and over-specified capital funding regime, meaning that systemic gaps in infrastructure cannot be adequately addressed** (causing poorer access and treatment outcomes, but also sub-optimal use of capital and revenue resources)

c. **NHS capital is allocated to each provider's 'home' ICB**. For BLMK ICB, where 3 of the 5 NHS Trusts have their 'home' in an ICB beyond BLMK (Cambridgeshire Community Services, East London NHSFT and Central North NHSFT), this results in a significant under-investment of NHS capital allocation for BLMK residents

BLMK will continue to work with regional and national policymakers to influence and seek resolution to these issues.

3.5 BLMK People Plan

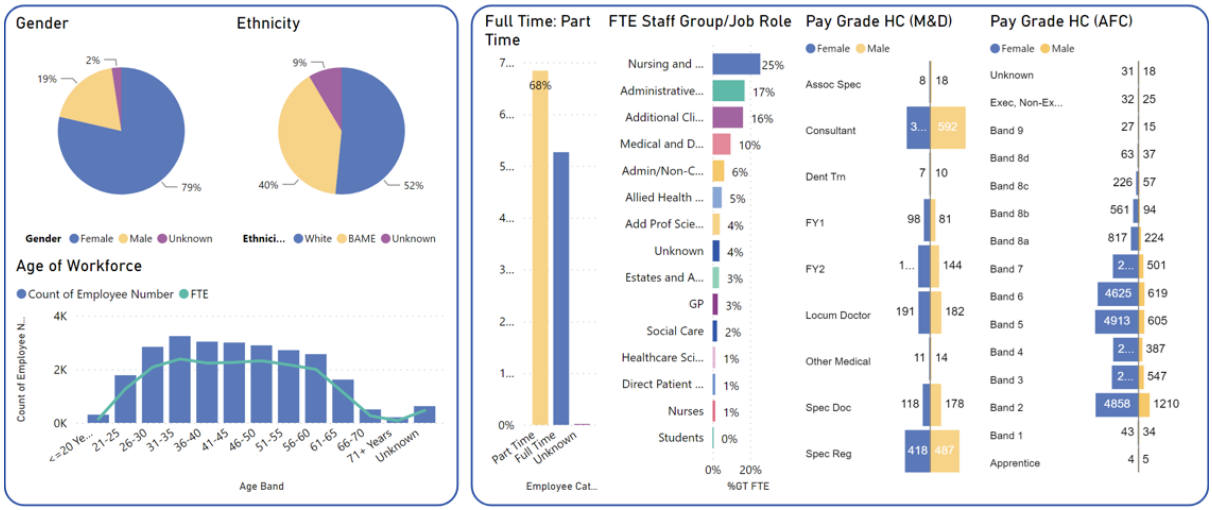
1. What is the Purpose of this Enabler?

Our health and care workforce is a key enabler to ensure delivery of the BLMK ICB strategy to enable all residents to live more years in good health. The BLMK workforce strategy builds upon the work that has already started to tackle workforce pressures.

2. The Current Workforce Landscape in BLMK

The BLMK Provider Trust workforce shows an aging workforce with 4904 within 10 years of retirement. We have a predominately female workforce, making up 79% of the workforce profile. We have a decreasing trend in our rolling 12-month sickness rate, currently 4.31%. We have a voluntary turnover rate, currently at 14.91% and a decrease over the last 2 years in staff engagement scores.

Across the BLMK Provider Trusts, there are currently 25,345 WTE staff in post with the following composition:



We have a 12.37% vacancy rate, 2155 WTE. The highest vacancy levels (above 10%) are in the following roles:

- Additional Professional, Scientific and Technical – 21.5%
- Admin and Estates – 12.34%
- Allied Health Professionals – 12.11%
- Health care Scientists – 24.86%
- Nursing and Midwifery Registered staff – 14.22%

Primary Care

BLMK has 515 GPs in post (including trainees) and a further 40 vacant GP posts. There are 264 Practice Nurse roles, with circa 10% vacancy rate, with a further 254 direct patient care roles within practices (mostly healthcare assistants).

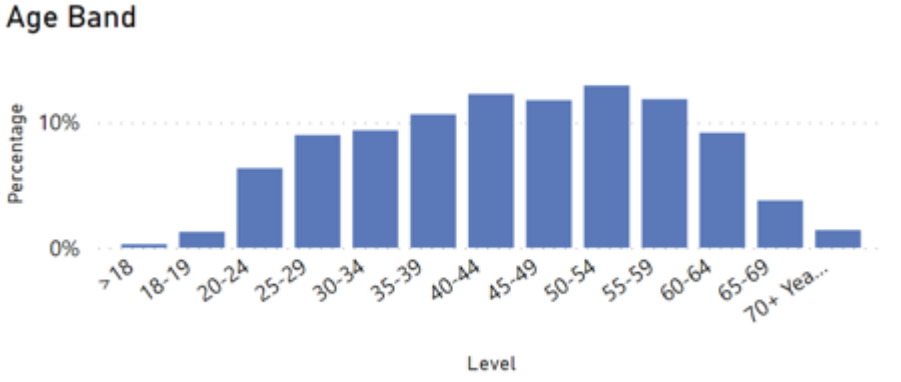
BLMK primary care networks have made good progress in recruiting to Additional Roles Reimbursement Scheme roles (ARRS – a range of multi-dicisplinary clinical roles bringing a range of expertise to the primary care team), with 354 in post to date.

The number of GPs working within BLMK is steadily increasing and we are seeing GPs move into BLMK from out of area to take up our New to Practice Programme. We are supporting nurse recruitment and retention through Legacy Nurse support, Senior Nurse Leadership development and International Recruitment in partnership with Cambridgeshire Community Services. Direct Patient Care roles and the multi-professional roles recruited at PCN level via the ARRS continue to increase significantly with our multi-professional clinical leads supporting with FCP supervision, Road Map navigation and peer support. Specific and bespoke local initiatives to grow, recruit and retain our workforce include;

- GP Recruitment Programme comprising of recruitment Master Classes, vacancy matching and GP Careers Fairs
- Clinical expansion programme, including growing the pool of Educators, Supervisors and Learning Organisations
- GP Fellowships – third year of Educator Fellowship attracting new GPs into Training Programme Director career pathway
- New to Practice Programme, New to Partnership Programme, Supporting Mentor Scheme, Flexible Pool Scheme (promoting the benefits of flexible working)
- Bespoke local initiatives to support our GP Educators and GP trainees including VTS away days bringing together 120 GP trainees
- 3 PCNs approved as Learning Organisations, 12 PCNs awarded funding to grow PCN Training Teams
- Digital Student Nurse placements expanding across BLMK into placements for other professions
- Student Pharmacist Summer Placements – year three expanding to 15 placement and leading across EOE
- Nursing Associate Apprenticeship Programme – 15 trainees in training
- Shine Project – 30 practices implementing innovative digital mental health programme improving health & wellbeing & retention of staff as well as improving patient access and care
- Bespoke 121 Health & Wellbeing & Organisational Development sessions at practice and PCN level

Social Care

The social care workforce in BLMK has a vacancy rate of 12.6%, with 2,000 vacancies and a turnover rate of 31%. Similarly to health partners, there is an aging workfcorce



Given the expected growth in the overall population in BLMK (with associated increase in demand for health and care provision), our workforce will need to grow whilst also transforming with new skill mixes, new roles, multi-disciplinary working models and portfolio careers to address the pending challenges.

Challenges

The summary workforce challenges for BLMK Partners' to deliver our Joint Forward Plan are:

- Low unemployment in some localities means that reducing vacancy rates and turnover in key workforce groups (care workers, administration) is a common strategic challenge across many BLMK partners
- Staff have experienced reduced opportunities for training and development during COVID; this together with the need to embed new ways of working is challenging in the current operating context
- We need to develop sustainable entry and career progression pathways into key workforce groups to encourage our population to choose careers in health and care
- We need to have targeted and innovative recruitment, development and retention strategies in place for professional roles where there are national workforce shortages (for example, qualified social workers, healthcare scientists)
- To deliver care sustainably within affordability of resources, all organisations face the challenge of reducing agency and locum workforce through effective reduction of vacancies in substantive posts

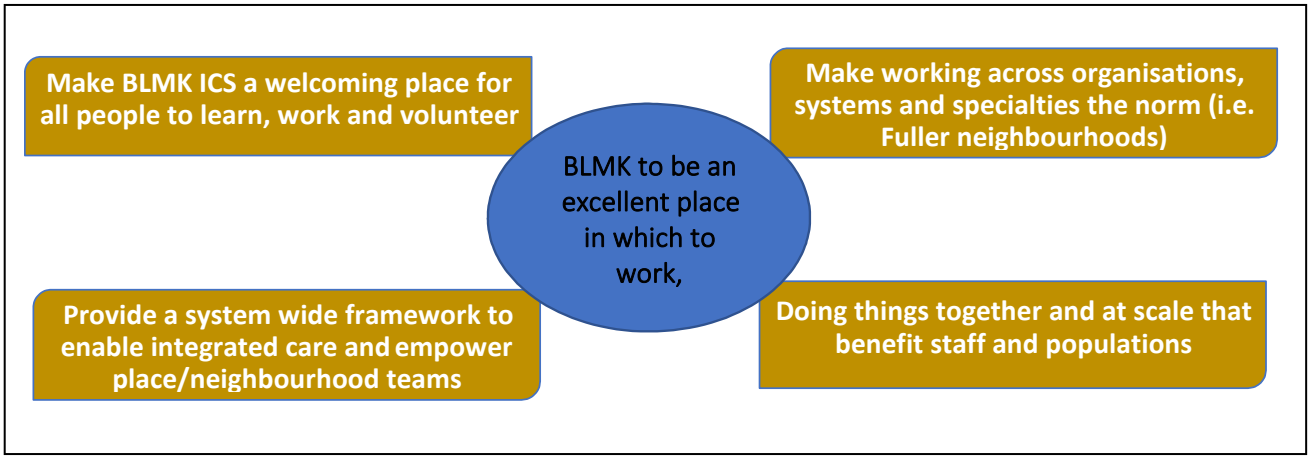
Opportunities

In addressing these challenges, there are opportunities to enable our staff to thrive and develop their careers, including;

- New roles and career pathways will be developed as new models of care to enable integrated neighbourhood working, and achieve the outcomes sought through the MHLDA collaborative plans, the strategic objectives to enable our children and young people to thrive, and our health services strategy
- Staff will be supported to work in multi-disciplinary teams that centre on residents' needs (and span traditional organisational silos) – this will improve resident outcomes and experience, and support greater staff satisfaction
- Primary Care Workforce will continue to diversify, expanding the number of multi-disciplinary teams functioning at practice & PCN level, with the largest growth in PCN roles via the Additional Role Reimbursement Scheme as well as increases in GP numbers.
- Population growth will support our Place-based actions to support our communities to thrive through increased employment opportunities
- Digital integration and technological solutions will support staff to provide joined-up care, and reduce duplication of effort

3. What does Good Look Like in BLMK?

Our BLMK People Strategy outlines our aims to develop and support our workforce in delivering our strategic aim for all residents to live more years of life in good health.



The BLMK People Strategy outlines a vision of an integrated workforce that delivers excellent personalised healthcare to the population of the ICS locality. We have adopted an integrated approach to workforce across our NHS Trusts, Primary Care, Social Care and voluntary sector organisations, working closely with finance and performance to ensure workforce plans are realistic, triangulated, and fundamentally aligned.

1- Make BLMK ICS a welcoming place for all people to learn, work and volunteer. We will do this by reducing health inequalities in staff experience across health and care, creating clear and diverse career pathways, recruiting diverse candidates, improving workforce flexibility and wellbeing, improving inclusivity, and increasing understanding of our workforce.

2 - Make working across organisations, systems, and specialities the norm. We will do this by embedding system values in leadership training, making CPD activities team-based (not organisation-based), improving OD capacity and co-production for transformation, and creating new roles, placements and apprenticeships across health and care.

3 - Provide a system-wide framework to enable integrated care and empower place and neighbourhood teams. We will do this by reducing barriers to integration by introducing digital staff passports, facilitating cross-organisational recognition of statutory/mandatory training and CPD, facilitating temporary staffing and role profiles, and producing guidance on MDT set-up and management.

4 - Doing things together and at scale that benefit staff and populations. We will make best use of international recruitment, integrated workforce planning, Robotic Process Automation (RPA), careers outreach and attraction to the system, talent management, sustainability, workforce transformation, and creating new apprenticeship and degree pathways to support the new ways of working and creation of new roles.

Staff will operate under a 'One Workforce' approach that will enable place and neighbourhood multidisciplinary teams, which will comprise staff from multiple organisations. Staff will have careers that span both health and social care, and in so doing, will gain a broad understanding of how we can work differently as a system to deliver integrated services.

The ICS will act as a framework to enable place-based and organisation/provider-level action in bringing about a flexible and integrated workforce, by means of:

- Digital Staff passport arrangements between healthcare and social care organisations to enable a mobile and agile workforce that is able to move around the system effectively with minimal cost offering additional opportunities for talent development supported by effective processes that enable this to happen
- Utilising digital solutions for information sharing.

- Organisational Development support and guidance to support the establishment of multidisciplinary teams. Ensure effective education and training programmes are in place to deliver future models of care, new roles, and new apprenticeships
- Support place-based recruitment and attraction initiatives maximising our opportunity as Anchor Institutions to support the local population into employment and the associated impact on the wider determinants of health.
- Develop the BLMK system value proposition and place-based value propositions to ensure we can attract and retain the workforce
- Create a strong climate and culture, reflective of the differing wants of our different generations within our organisations
- Ensure accurate and relevant workforce information across health and care, using this information and intelligence to support and make informed choices in workforce transformation and redesign.
- Undertake and develop effective workforce planning to support new models of care, and support transformation and redesign where we have hard to recruit roles
- Develop a workforce planning function, which will provide the evidence base for directing investment in transformation activity that meets the need of integrated services and the new models of care enabling us to understand the impact of service redesign on our workforce
- Integrating workforce planning with population health management to create a system-wide, shared approach to workforce planning derived from a single workforce data set
- Integrate workforce planning with population demographics and planned growth to ensure we reflect changes to services and the workforce required to deliver these.

4. Delivering the BLMK People Strategy

Mobilisation

The key mobilisation actions to deliver the BLMK People Strategy will be completed during 2023-4. These are:

	Collaborative Workforce Action	Delivery by:
1.	Integrate social care workforce into pan-ICB workforce planning & monitoring	December 2023
2.	Map pan-BLMK workforce data against updated population growth modelling and indicative service growth pressures	March 2024
3.	Deliver shared international recruitment target for nursing	December 2023
4.	Deliver shared international recruitment target for social workers	March 2024

The purpose of these mobilising actions are:

- To provide a single line of sight across health and care workforce, enabling collaborative workforce planning, role development and evaluation / benefits of actions taken to be measured
- To address immediate shared and stubborn workforce challenges that can be addressed at scale

By March 2024, the following wider mobilisation actions to deliver the BLMK Joint Forward Plan will be completed:

- Population growth and demographic changes will have been re-modelled based on projected housing growth in each Borough in BLMK
- BLMK Infrastructure strategy will be completed – this will inform / be informed by population growth and associated growth in health demand
- Health Services Strategy methodology confirmed, and first end-to-end clinical pathway reviews completed.
- The detailed delivery plans for years 2-5 of the High Impact Programmes (including impact / outcome metrics) will be completed. This will inform workforce planning to develop new roles and workforce projections to deliver new models of care outlined in the High Impact Programmes

5. Interdependencies with the BLMK High Impact Programmes

The BLMK People Strategy is a key enabler in every one of the BLMK High Impact Programmes, reflecting the nature of health and care provision. However, there are key dependencies with specific programmes:

High Impact Programme	Key Deliverables
Advancing Equity & Equality	• Workforce delivery of key improving health outcomes / tackling inequalities programmes, such as Maternity • Embedding Quality Improvement methodology across teams •
Efficiency & Effectiveness Programme	• Utilisation of technology to enable smarter working, such as robotic programme automation • Productivity programmes based on national best practice, for example Getting It Right First Time (GIRFT)
Enabling our Children & Young People to Thrive	• Developing recovery-focused models of care for our children and young people with the most complex needs
Improving Access & Treatment	• New roles and ways of working arising from clinical innovation and integrated pathway redesign

High Impact Programme	Key Deliverables
Improving Outcomes for MHLDA	• Delivery of mental health investment standards to increase clinical capacity in context of rising demand • New roles arising from enhanced pathways of care, for example community crisis and recovery, reducing out of area placements for people with very complex needs
Integrated Neighbourhood Working	• Ongoing delivery of integrated neighbourhood teams • Development of primary care roles and capacity
Intelligence-led Quality, Performance, Outcomes and Inequalities Improvement	• Embedding co-production as a core quality improvement tool across teams
ICB Target Operating Model	• Implementation of ICB target operating model 2023-5
Thriving Ecosystems & Prosperous Communities	• Embracing opportunities for Anchor Institute actions across organisations at Place, i.e., supporting those furthest away from employment into training and employment

3.6 Co-Production

1. What is the purpose of this Enabler?

We are ambitious for the people who live in Bedfordshire, Luton and Milton Keynes. We want everyone in our city, towns, villages and communities to live longer lives in good health and we know that working with and empowering local people is central to helping us achieve that.

Our population is culturally diverse – there are more than 100 different languages spoken in just one of our towns. The people that live in our four local authority areas come from a range of different backgrounds and ethnicities, making ours one of the most vibrant areas in the country.

To deliver these priorities for local people, in the context of the challenges we face it has never been more important to refresh how we engage so that we can break down barriers, improve access, support local people to make healthy life choices and work together to shape the health and care services that residents need now, and in the decade ahead. Our strategy is focused on delivering this through a range of approaches including co-production, consultation, engagement and continuous conversations with residents.

Engaging for the future

We know from our work during the Covid pandemic and through co-production we have undertaken with residents and service users that working in partnership with local councils, Healthwatch, the VCSE and residents delivers greater results than working alone.

If we are serious about helping people to live longer, healthier lives, we need to listen to what local people need and work together to design solutions to health and care and break down the barriers to good health that people face.

Prior to the establishment of the Bedfordshire, Luton and Milton Keynes Health and Care Partnership, all partners worked independently, engaging with and co-producing with residents and service users on a range of service changes. There was little alignment in in policy, processing or decision making and insights from residents were not shared extensively with partners, leading to engagement fatigue amongst those whose opinions were regularly sought.

The pandemic highlighted that seldom asked groups had started to disengage from the system, which was deepening health inequalities and the agencies best placed to engage with these communities, as trusted advocates including Healthwatch and the VCSE were insufficiently funded, did not have the resource to support our work and were not integral to the planning process.

This means that insights from residents did not always reach decision makers or effect meaningful change.

Following the establishment of the Integrated Care Partnership and a programme of extensive engagement with partners and consultation, engagement and co-production leads from local authorities and NHS organisations, steps have been taken to redress this balance and a new Working with People and Communities strategy was published in November 2022, which set out a new approach to working with residents.

This has led to the development of closer working relationships with elected members of local authorities and MPs as well as Foundation Trust Governors and Non-Executive Members. It has also seen the development of a new root and branch review into health inequalities, led by Reverend Lloyd Denny from Luton and the alignment of policies and processes to create a new

co-production framework for all health and care partners in Bedfordshire, Luton and Milton Keynes.

2. The current landscape in BLMK

The Integrated Care Board is required by law to involve local people in decision making in the development of health and care services, in accordance with Section 14Z44 of the Health and Care Act, 2022.

Following publication of the Working with People and Communities strategy, the ICB has been working to discharge this duty by:

- **Establishing a system wide engagement forum** designed to bring together co-production and engagement leads from across the system to share insights and develop a new framework for co-production to ensure there is consistency across our area.

- **Focusing on continuous conversations** to ensure that resident voices are included in decision making. While our ambition is to co-produce with residents, there are times when co-production in its truest sense is not possible and consultation, engagement or co-design might be more appropriate. We have adopted the ladder of participation and are working with partners to ensure we're clear with residents and service users how we will engage so that we can build trust and participants understand how their feedback is influencing decision making.

- **Embedding a culture of co-production** by working with the Consultation Institute to deliver a programme of training for those involved in designing health and care services locally. More than 300 people, including the Board of the ICB have received training in co-production and are working to embed a culture of co-production across the system. A series of webinars and community of practice events have also been established to share best practice and insights from across the area.

- **Putting involvement at the centre of our constitution and governance processes** by establishing a Working with People and Communities policy which sits at the centre of our constitution and created a formal sub-committee of the ICB to scrutinise and provide guidance on all involvement work, to provide assurance to the Board.

- **Engaging Healthwatch and the VCSE** in discussions to create strategic partnerships to support advocacy and engagement with local people.

While good progress has been made in delivering objectives for year one, there have been some key challenges to overcome, including establishing new working relationships with Healthwatch and the VCSE to facilitate closer engagement with local communities. Scarce resources and a lack of funding to support our work has meant that working at pace to deliver change has been challenging.

Uncertainty over funding for strategic partners and a lack of a policy to remunerate participants for co-production, in line with the policies of some other NHS Trusts in the system has also created barriers to progress in the first year of operation.

Despite these challenges however, there is a coalition of willing partners committed to delivering change locally and there is an opportunity through the Denny Review into health inequalities and

the Working with People and Communities strategy to work differently. Listening to insights from seldom asked people through trusted advocates and developing a participation and co-production network across the system to support the new approach to involving residents in decision making.

What have we achieved?

Since establishing the Working with People and Communities strategy, we have worked hard to establish strategic partnerships and re-engage with people who have lost trust with health and care services.

In November, we held a workshop with health and care professionals, Healthwatch, the VCSE and residents to listen to the experience's children, young people and their families had experienced of health and care in our area.

One of the key findings to come from the workshop was that some transgender and non-binary young people had experienced unconscious bias in health and care settings, which had created a barrier to them accessing care. This experience was also shared as part of findings from the Denny Review into health inequalities, where people referenced adverse experiences in both primary and emergency care which had led them to disengage, often resulting in poor health outcomes.

To respond to this, we have worked with partners in East London Foundation Trust (ELFT) and Rainbow Bedfordshire to design and deliver a series of transgender workshops aimed at health and care professionals to help them better understand the needs of transgender people, so that we can remove barriers to good health for transgender and non-binary people.

This has been well received by participants and has been requested as a training course for primary care Protected Learning Time events.

In addition, following engagement with deaf people in Bedford Borough in February, we have also established training for primary care practitioners to help them better support deaf patients coming into their practice. New software called 'Recite me' has also been applied to the BLMK Health and Care Partnership website to support deaf people in accessing information about services in their area.

3. What does good look like?

Bedfordshire, Luton and Milton Keynes are fortunate to have many examples of good practice of co-production within its partnership, and in the last twelve months, we have worked with colleagues in Wigan and Islington to learn from best practice and how councils are working to co-produce with their communities to deliver their 'deals' and 'Fairness Charters'.

Closer to home, the 'Talk, Listen, Change' work undertaken by Luton Council and the University of Bedfordshire has led to the development of a Fairness Charter being established in the town where residents, councillors, officers and VCSE organisations meet regularly to discuss how they can work together to make Luton a fairer town and help residents thrive.

This methodology has been applied to the Denny Review into health inequalities, which is considered best practice by NHS England nationally. The review, which includes representatives from across the system has commissioned a literature review form the University of Sheffield, which pulled together data on the health inequalities experienced by residents and highlighted those who experienced the greatest inequalities in four places.

This has been followed up with an engagement exercise led by Healthwatch and the VCSE to gather insights from seldom asked communities including Gypsy, Roma Traveller, homeless people, people from ethnic minorities that live in deprived communities, people who experience sexual violence including forced marriage, LGBTQ people and people with physical and learning disabilities. This exercise has generated significant insights which will be incorporated into our Joint Forward Plan and shared with partners and the Board in June, together with a series of recommendations that we can take forward to make a difference to the experience people face when accessing health and care in our area.

The Local Maternity Services co-production team in BLMK is also a great example of best practice. Following feedback from women who had experienced sexual violence and abuse, discussions on consent during pregnancy and birth were discussed with health and care professionals and new working practices were adopted across the system before being rolled out across the Eastern region and then country wide.

Measuring feedback

Measuring the success of the working with people and communities' strategy could take some time, as new working practices are embedded, and participants can see their influence shaping decisions. However, in our first year of operation, we have established a sentiment benchmarking survey to monitor perceptions of residents and stakeholders and set a baseline from which we can track perceptions and measure improvement annually.

The survey will ask residents and stakeholders their experience of co-producing locally and whether they feel their involvement has effected change in their area.

In addition to monitoring performance formally through the sentiment survey and baselining exercise, we are also working with strategic partners including Healthwatch, VCSE, residents and elected members to listen to feedback on the work we're doing and build on approaches. This has received support in meetings including support from elected members that are members of the Integrated Care Partnership Joint Committee.

4. What do we need to do to create the JFP chapter for this workstream?

The Working with People and Communities Strategy and Implementation Plan for year one was approved and was delivered in 2022/23, as below.

Description	Implementation	Outcome
Source new infrastructure for the development of a system wide insight bank	April 2023	We tested the market for new infrastructure, but current models did not deliver to the specification required or provide value for money. We will review in 2023/4.
Embed working with people and communities into the ICB's constitution and governance.	July 2022	Working with people and communities' policy established in constitution Working with people and communities committee established and embedded.
Embed co-production across the system by creating new engagement forum, rolling out training	April 2023	Training has been rolled out to more than 300 people across the system. A community of practice has been established which is driving shared

Description	Implementation	Outcome
and establishing a community of practice		policy making around participation and remuneration. Best practice webinars are held bi-monthly.
Build a network of trusted people to support engagement by developing a Memorandum of Understanding with VCSE and Healthwatch partners.	June 2023	An MOU has been agreed with the VCSE and we are currently developing an MOU with Healthwatch.
Engage in a continuous conversation with residents by undertaking extensive community engagement.	July 2023	Extensive engagement has been undertaken with seldom asked residents as part of the Denny Review into health inequalities. Engagement has also taken place with people from the D/deaf community and victims of abuse. A summer engagement programme is scheduled to begin in May and will run until October.
Establish community connectors	July 2023	Work is underway. We have established community connectors as part of the cancer alliance, Roma Community, LGBTQ people in Luton and homeless people via the YMCA in Milton Keynes.

Going forward, work needs to be undertaken to determine the implementation plan for year two of the working with people and communities' strategy. Engagement work with partners and residents has started to inform this plan with areas for consideration including:

- The development of a system wide participation network of lived experience
- Development work with system wide information governance and finance leads.
- Co-production with communities around key transformation programmes including Denny Review II and Fuller neighbourhoods.

Further engagement work to inform the Joint Forward Plan and the Operational Plan will be undertaken from May – October 2023 and give local people from different backgrounds and communities the opportunity to discuss the things that are most important to them.

Interdependencies for this Enabler	High Impact Programmes	Key stakeholders
Place Plans	• Integrated Neighbourhood Working • Enabling our Children & Young People to Thrive • Improving Outcomes for MHLDA	• Residents • VCSE • Place Partners • MHLDA provider collaborative
Inequalities programmes	• Advancing Equity & Equality, including Maternity programme	• Residents • VCSE •
Health services strategy	• Improving Access & Treatment	• NHS Providers • Residents • VCSE • Population Health Intelligence Unit •
Digital and population health management strategy & investment	• Intelligence-led quality, Performance, Outcomes & Inequalities Improvement	• Residents • VCSE • Local authority, NHS partners and wider public sector • Population Health Intelligence Unit
Staff training in co-production	• ICB Target Operating Model • BLMK People Plan	• Residents • VCSE • ICB • Local authority, NHS partners and wider public sector

3.7 Digital Integration, Business Intelligence & the Population Health Intelligence Unit

1. What is the Purpose of this Enabler?

There are key themes that repeat across the BLMK Joint Forward Plan and its High Impact Programmes that this Enabler is crucial in addressing. These include:

- **Focus on population health**, and our responsibility as ICB partners to improve health outcomes and tackle inequalities as 2 of our 4 core responsibilities as an ICB
- The need to better integrate data and provide technology to our teams to enable them to work more effectively across organisations to **provide joined up care to our residents**, and manage need and demand within constrained resources
- **Our commitment as a learning ICB** – using quality improvement methodology to evaluate, adjust and retest our improvement actions to maximise the benefit to our residents

These require fully connected digital solutions to generate an intelligence-led partnership across health, care and civic functions, with the level of analytic capability to measure and evaluate the impact of our actions on the health and well-being of specific communities across BLMK.

This approach is core to improving health outcomes and tackling inequalities – it shifts our peer- and self- assurance from considering impact in the round (the average experience of those who did access our services) to a position of challenging ourselves whether we are effective in supporting ALL our residents and their communities to thrive.

The 3 inter-related partnership components in this enabler to achieve our ICB strategic ambitions are:

1. Data connectivity and digital maturity across Partners
2. Population health management accessible and owned at Neighbourhood and Place
3. Business intelligence and analytics capability and capacity to inform and evaluate the impact of our High Impact Programmes

2. The Current Landscape in BLMK

There is a mixture of good progress, clear funded deliverables, and currently unmitigated residual risk in BLMK in our implementation of these 3 objectives.

Collaboration across health and Borough partners to integrate our care and treatment records and develop population health management has consistently been proactive over recent years. This means that BLMK is in a good position to achieve many of our objectives in this Enabler by 2025. This includes:

- Digital connectivity with each of our 4 Boroughs to create a shared ‘view’ of care and treatment plans for residents
- Joint procurement of a shared data platform to integrate and automate much of this connectivity to support Neighbourhoods and Places to deliver joined up care
- Bringing together our Public Health functions with our NHS population health management capability to create a single Population Health Intelligence Unit to drive our programmes to tackle inequalities and improve health outcomes across all our communities

- Re-scoping our NHS performance reporting to consider population health as well as performance for residents who have accessed healthcare:
    - Local feedback loops to identify under- and over-referrals to secondary care to inform local pathway improvement actions and improve access for residents who experience the most barriers
    - Use of quality improvement methodology and reporting to highlight evidence-based and statistically sound trends in need / demand and performance / outcomes across our Places
    - Provide more frequent and better automated reporting to teams on their delivery against evidence-based standards (for example, Getting It Right First Time, Sentinel Audit, Cancer prevalence and outcomes reporting)

- Engage with national partners such as NHS England in its development of the Foundry, the Office of National Statistics and NHS Benchmarking to influence future data analysis and reporting to inform health services strategy, for example delegation of specialised commissioning

However, there are immediate areas of moderate to significant risk in this field, including:

- **Digital Maturity** - Bedfordshire Hospitals NHSFT's plan to deliver increased digital maturity through the creation of this Trust across 2 sites has been significantly delayed and hampered by COVID. This means that the Trust is almost at level 3 of HIMSS digital maturity (Healthcare Information and Management Systems Society benchmarking), with plans to reach level 5 by 2025. This has a current and anticipated impact to residents and teams on integrating digital records to support integrated care across settings. All other NHS Trusts in BLMK are at level 5 or 6, with Milton Keynes Universities Hospital NHSFT nearly at HIMSS level 6.

- **Access to Capital** – capital funding to progress digital requirements in the NHS is piece-meal and short-term. There is also a significant gap in capital funding for primary care to embed required technology improvements, for example telephony, which are adversely impacting areas such as patient access.

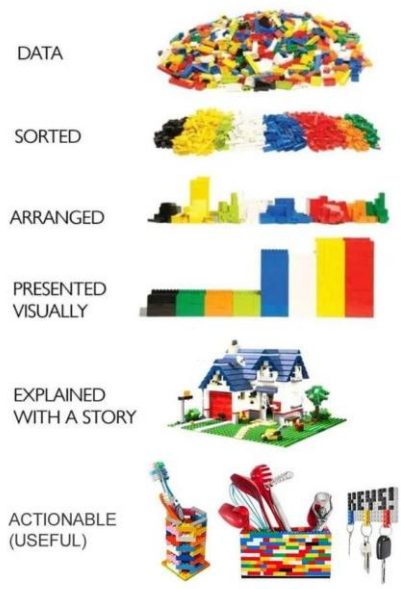
- **Analytics capability and capacity** – the current provider of business intelligence / analytics for the NHS in BLMK currently works to a 'commissioner' specification of analytics and reporting. This current contract is due to expire in June 2024. Work is underway to specify the future requirements for business intelligence for the NHS; how best to integrate with population health management / public health analytics where appropriate, and what is the cost-effective delivery of this service (including enhanced analytics capability) in the context of all ICBs' requirement to reduce running costs by 30%

- **Productivity and Effectiveness Challenge** – linked to the affordability risk above, there is insufficient capacity and revenue funding to systematically introduce digital innovation across existing software, for example robotic process automation. This limits the benefits of digital advances in reducing duplication of effort for our teams and leaves residual risk of manual transcribing across our patient / client electronic records.

3. What does Good Look Like in BLMK?

The challenge for partners of the BLMK ICB is how we translate the morass of data we individually collect to inform care and treatment to our residents into intelligence that can help us to improve health outcomes and tackle inequalities, as well as improve the effectiveness of our pathways to offer best value to the taxpayer.

A visual representation of this is depicted below:



This illustration highlights the challenges we need to address:

- Secure data connectivity (reduce duplicate and separate data sets)
- Software platforms that can draw data from original sources and arrange it in ways that give us insight
- The need to data to be understood in context (data quality and meaning of the data)
- Linked information at a resident-specific level to provide a single, integrated view of the person's relevant care and treatment to aid clinical decision-making, and reduce the number of times a resident has to repeat their story
- Robust and agreed analytics to provide intelligence and insight into what improvements we need to make to improve health outcomes and tackle inequalities
- Agreed metrics based on health population (not existing access to healthcare) to measure the impact of our improvement actions

a. Data and Digital Connectivity

The partners of BLMK we have a vision to use data and digital technologies to help inform service led transformation, to monitor and track codesigned health and care pathways and monitor outcomes to refine interventions and engagement with our residents where possible.

Data powers effective decisions at every stage of care which needs to remain personal to the resident.

Decision-making should happen as close to the resident as possible

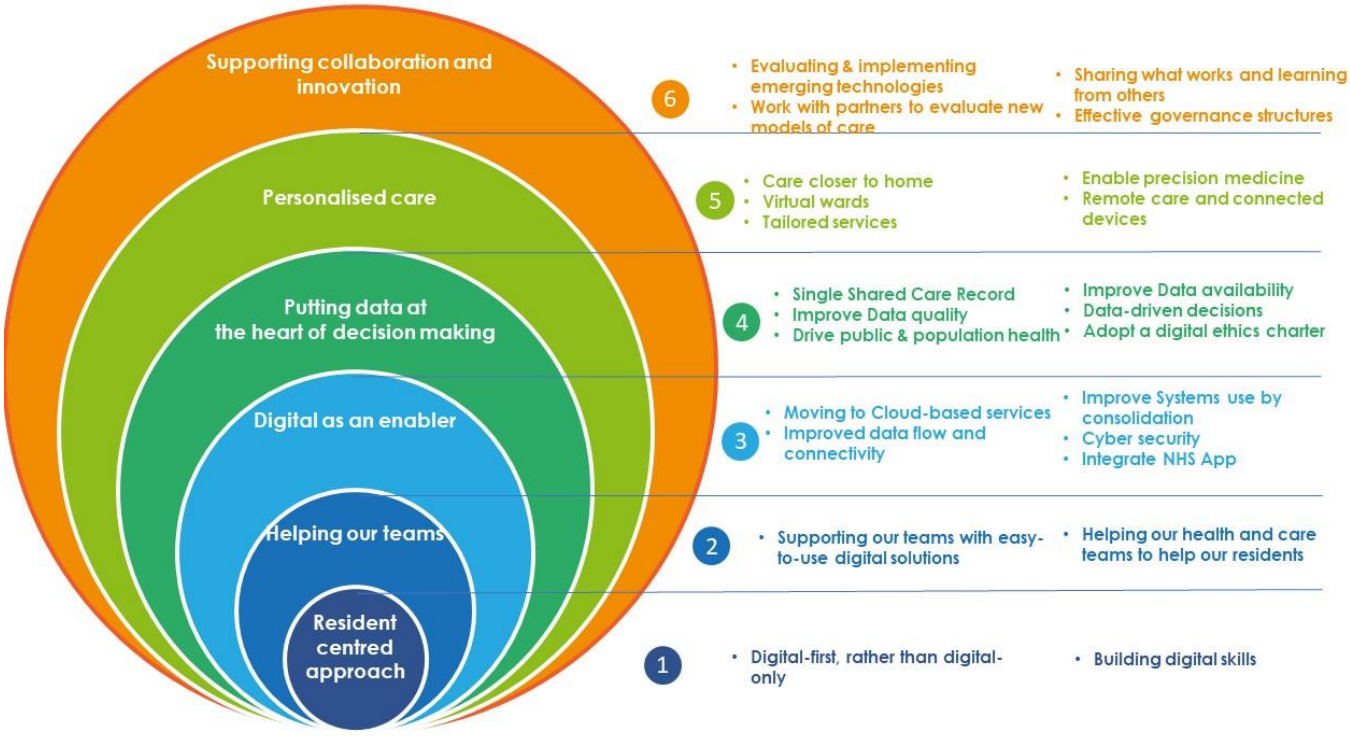
Access to the residents own health and care data helps to inform their lifestyle choices

Residents must be empowered to manage their own self-care by having access to their data

Data should be seen as a key enabler to support the reduction of inequality

This requires all the partners to be part of the same digital vision, and our journey started in 2020 with the delivery of a full System population health management strategy, followed by the data strategy in 2021, our digital strategy in 2022. We are now working towards the development of a 'single version of the truth' in 2023 where all relevant data is secured, curated and made available as appropriate.

For this vision to be realised, we must have joined-up and secure access to all our relevant data and ensure we have the correct quality controls in place for this to be the basis of our decisions. Our System partners are developing our data ethics policy to assure the residents we serve on how data is being used for their benefit.



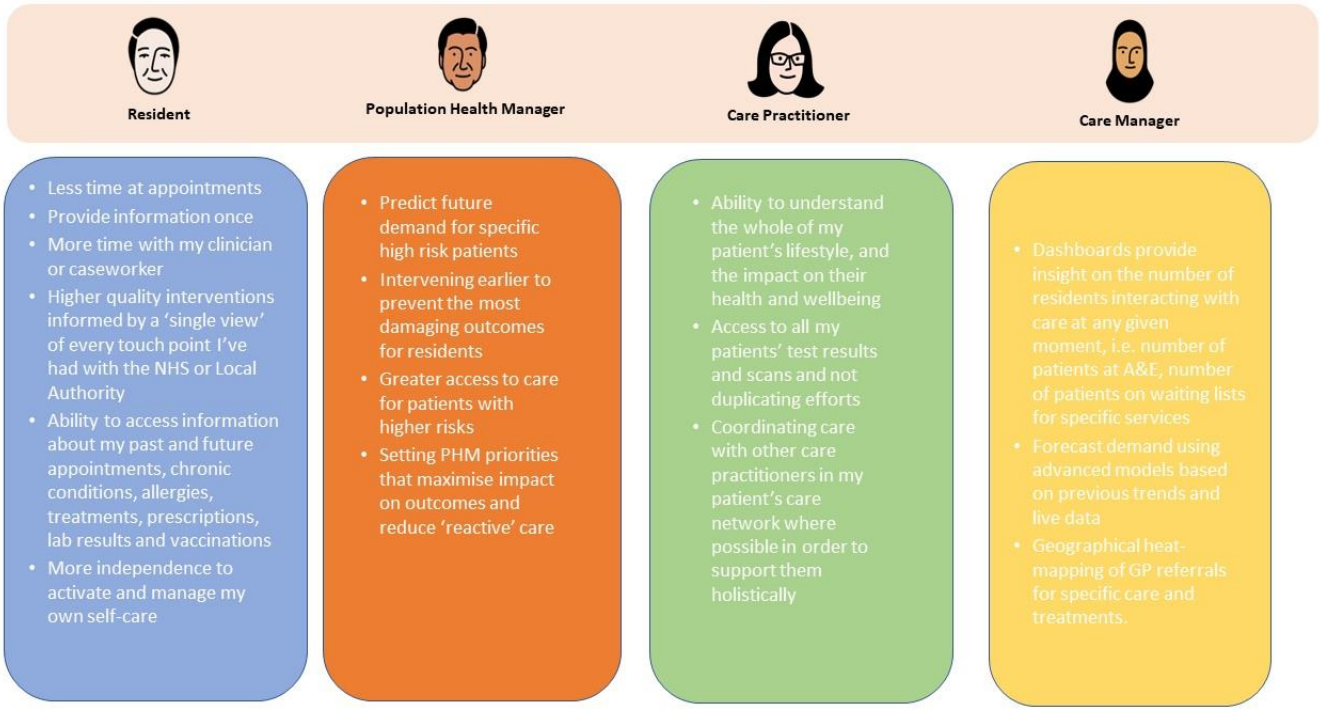
Our Digital Future

Our digital plans have been co-designed with partners and approved in 2022. This sets a clear roadmap for everyone into a digital era by the adoption of strong standards that enabled seamless integration though adoption of cloud-based technologies.

As highlighted, data is a key component of this Digital Strategy. With all the System partners we have deliberately aligned our digital and data strategies, which are available here: https://blmkhealthandcarepartnership.org/our-priorities/data-and-digital/

As the Digital Strategy evolves in the coming years, we will ensure that the data strategy alignment remains intact thereby preserving the ability for data and digital technologies to meet the needs of our residents and partners.

This means that the same, secure data (held by owner organisations) can be used in multiple ways to improve residents' experience of integrated care and treatment:



Our vision is to design a system which utilises and, links near real time data, analytics, and insights by building multi-disciplinary, cross-organisational intelligence functions that provide an actionable intelligence approach to insights to inform care design and delivery.

Our intelligence function is paramount in transformation of service design, providing timely and robust evidence, and routinely equipping teams with intelligence that drives improvements in performance. The intelligence function will pull and link data intelligence from across new, traditional organisational and contractual boundaries to progressively provide both qualitative and quantitative insights. These insights will be to be multi-dimensional, providing clinical, performance and financial intelligent intelligence, as well as contextual information on the wider determinants (or 'building blocks') of health, the demographics and the health outcomes of our communities.

These insights will be provided at the most appropriate geographical level, be that system, place, ward, neighbourhood, or provider catchment at place, ward, pathway. Variation and inequity will be highlighted. This journey has commenced utilising longitudinal datasets (including primary, secondary, mental health, social care, VCSE's, police and community data) to enable population segmentation, risk stratification and population health management (PHM).

b. Population Health Management

Population Health Management (PHM) involves using data to design new models of proactive care and deliver improvements in health and wellbeing whilst make the best use of the collective resources of the Integrated Care System. PHM starts by using shared data to identify a group of people with shared characteristics, who could benefit from more proactive or joined-up support, and then co-designing an intervention to meet their needs. The focus of PHM often involves targeting resources at individuals and population groups who typically experience poorer health outcomes or are under-served by the health and care system. Testing interventions, measuring their impact and then acting on the learning is crucial to the success of PHM.

BMLK ICS has a well-established multi-agency collaborative group that oversees the development and implementation of PHM, and the ICS has invested £2m in setting-up place-based PHM work programmes. Integrated Care Systems have been encouraged to plan PHM development in terms of the 'infrastructure', 'intelligence', 'interventions' and 'incentives'. BLMK progress is set out in those terms below.

BLMK has the leadership, governance and information governance **infrastructure** in place to oversee and enable PHM activities. Linked data is available through the AGEM GEMIMA platform, including acute hospital, primary care, community and mental health and social care.

Data Analytics and 'Super-user' Groups oversee the development of new population health **intelligence** products and PHM tools, which have included risk stratification and population segmentation tools and an interactive health inequalities dashboard.

A range of PHM **interventions** are being developed in BLMK. Primary Care Networks in Bedford Borough are using a Diabetes Warning & Alerts tool to identify patients and improve their care, whilst linked data has enabled detailed population profiles to be developed for neighbourhoods in Milton Keynes and Central Bedfordshire. In Luton the Council is linking data from across the local authority and health to improve outcomes for people with severe mental illness.

The enthusiasm and engagement of professionals and communities is necessary for PHM but not sufficient. Resources like time and money are scarce so it is important where possible to align the system **incentives** to encourage and support PHM initiatives. In Bedford Borough for example, Primary Care Networks (PCNs) were critical to the identification and invitation of residents who were eligible for a 'Warm and Well Assessment'. The pathway was co-designed with PCN leads, and as a result steps were taken to minimise the administrative burden on primary care – completing tasks centrally where possible and reimbursing GP practices for their time.

The next steps for the BLMK PHM Collaborative include: (1) ensuring that existing PHM tools and approaches are being used as widely and as effectively as possible; (2) to work with system and place leads to ensure that PHM is being used to address the issues that matter most to our residents and our ICS partners; (3) to ensure that the PHM strategy is aligned to and supporting a range of clinical transformation programmes, as well as prevention, health inequalities and sustainability; and finally (4) to ensure that PHM functionality is a key consideration in the development of the ICS Strategic Data Platform.

c. Performance Reporting

The core focus of our Integrated Care System is on working with partners to transform health outcomes for our population. We understand that this necessitates additional ways of measuring and monitoring our performance in addition to the traditional ways in which NHS performance is already currently managed.

Because so much of what impacts an individual's health is outside of the direct control of the health system – and in the gift of our partner organisations – we have been working, through the Improving Performance Task and Finish Group, to design a new way of measuring our performance that better tells us how the work we are doing as a system is making a difference for our residents.

The Framework we are developing, based on the ONS Health Index, reflects both health and non-health policy related indicators that affect the health of us all and our Places.

There are three categories:

- **Healthy People** – this covers core health outcomes like mortality, and the impact of physical and mental health conditions.

- **Healthy Lives** - this covers risk factors for health that relate directly to individuals< and social factors that cannot always be controlled by individuals but affect the population at the individual level.

- **Healthy Places** – this includes social and environmental risk factors that affect the population at a collective level. They often cannot be addressed solely at the individual level.

We will be working closely with partners and expert colleagues to develop this work during 2023/24, including areas such as data frequency and presentation, and look forward to onward collaborating with ONS to develop this.

Our aim is that it will provide us with insight at Neighbourhood, Place and pan-BLMK ICB to understand the impact to residents' health and well-being of the High Impact Programmes of our Joint Forward Plan.

4. Interdependencies with our High Impact Programmes

This Enabler is crucial to all our High Impact Programmes, and its importance in helping the BLMK ICB partners to deliver the '4 pillars' of our ICB responsibilities (improve health outcomes, tackle inequalities, offer good value for money to the taxpayer, and support local growth) cannot be over-stated.

Consistent and medium-term access to capital and project revenue costs to deliver this at scale is crucial to achieving our aims to enable all our communities to thrive.

3.8 Inequalities

1. What is the Purpose of this Enabler?

The Boroughs in BLMK – Bedford Borough, Central Bedfordshire, Luton and Milton Keynes are some of the fastest growing in the UK. We have diverse populations, and each Borough has strong plans to grow local economies, build housing and support our communities to thrive.

We also have some of the starkest inequalities in this country. Too many of our children live in poverty, and we know that our most deprived populations are experiencing the greatest challenges in accessing healthcare, and poorer health outcomes than the national average.

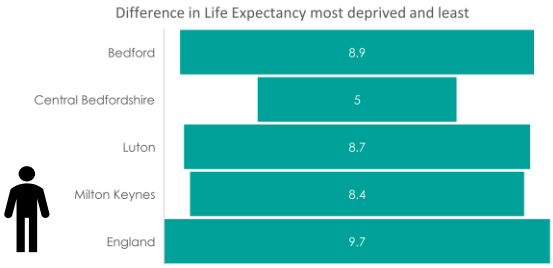
All ICBs have a fundamental duty to improve health outcomes and tackle inequalities. In BLMK, our Integrated Health and Care Partnership Strategy is centred on one over-arching and audacious goal – to improve the years lived in good health for ALL our residents.

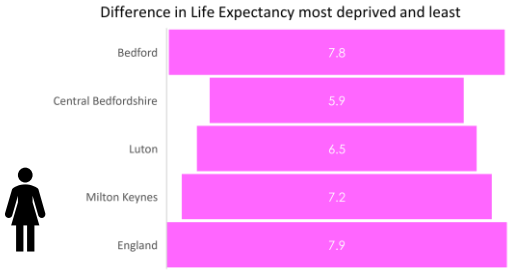
This Enabler sets out the approach we are taking to ensure that:

- We have dedicated and population-centred actions in each of our Places to tackle the inequalities experienced by residents
- We co-produce our efforts to positively impact the wider determinants of health in partnership with residents and our voluntary sector partners (‘doing with’, not ‘doing to’)
- We make use of data-intelligence to understand the needs of our population; and to measure the impact of our actions to improve residents’ health & well-being
- We equip our teams with quality improvement tools and access to integrated data to enable them to lead local improvement

2. Current Landscape in BLMK

The variation in health outcomes and inequalities experienced across our population can be seen in the variation in life expectancy across our Boroughs;





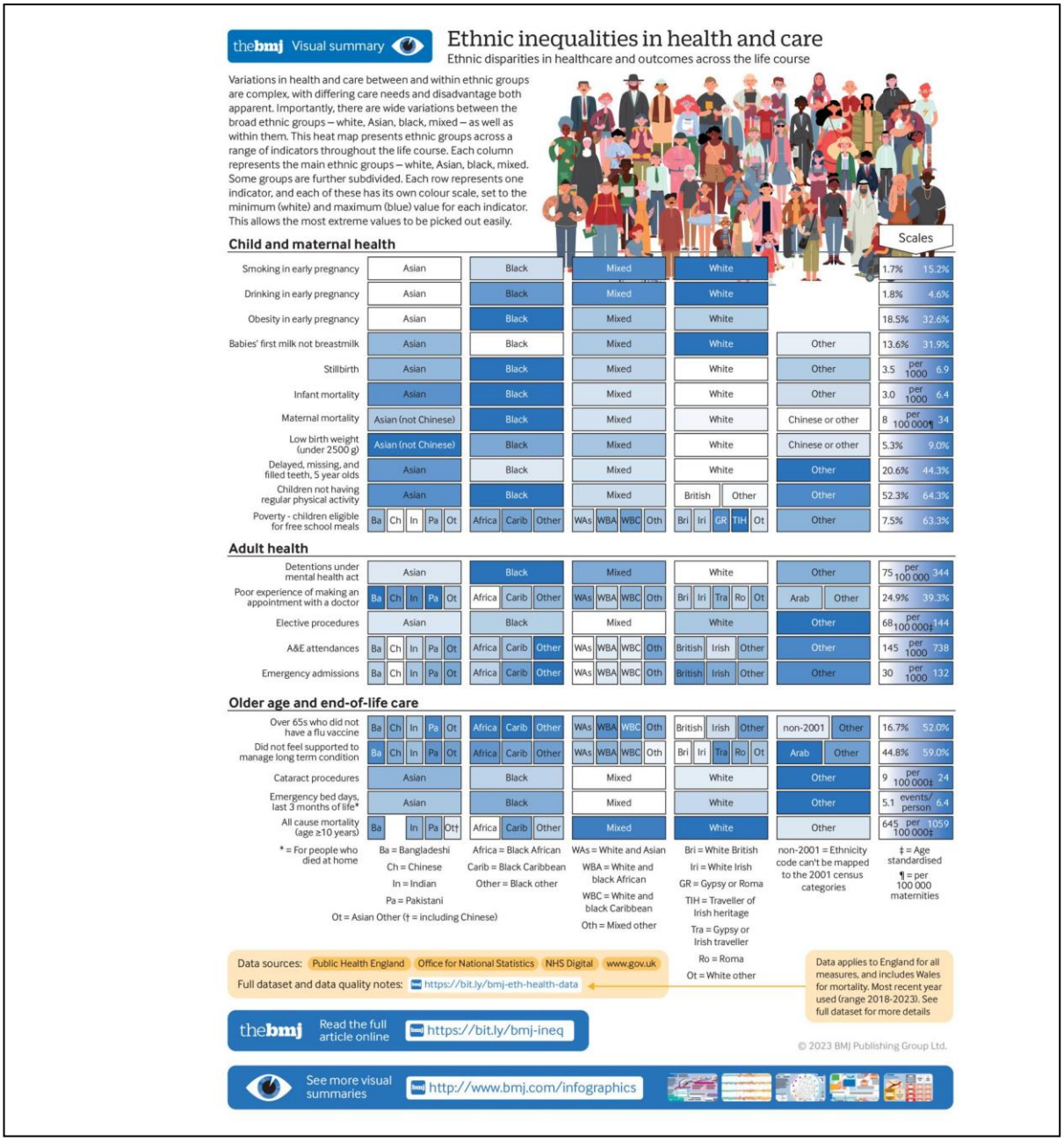
Data shows that people who experience health inequalities are more likely to need help and support from health services as their conditions become more complex. Breaking down barriers to access and removing health inequalities has the potential to prevent poor health, help people live longer lives in good health and reduce the burden on the public purse.

Across BLMK we know that:

- There are more low birth weight babies than the England average
- Uptake of childhood vaccinations is low, and falling
- We have variation in uptake to screening linked to deprivation

- People with learning disabilities & / or autism are less likely to attend for screening, wait longer for treatment, & are likely to die up to 14 years earlier than their peers
- Referrals to mental health services have increased since COVID, especially for children and young people
- The number of people registered as carers has doubled since 2019

Across the diversity of our population in BLMK, we also recognise the variation in access to health experienced by people of different ethnicities. COVID has laid stark the inter-dependencies between life disadvantages and ethnicity in this country; the health consequences are severe, as depicted in the graphic below from the British Medical Journal;



Based on their Joint Strategic Needs assessments and their Health and Well-being Strategies, each of our Boroughs have priorities identified in the Place Plans to tackle key inequalities experienced by their local communities:

- **Luton** is a Marmot town, with an overarching aim to eradicate poverty across its communities by 2040
- **Milton Keynes** health organisations have formed a collaborative called Milton Keynes together – its first priorities to address in collaboration are obesity, children with complex needs, urgent and emergency care flow, and children and young people's emotional well-being
- **Central Bedfordshire** has 6 priorities in its Place Plans – primary care access, improving early cancer diagnoses and outcomes, health checks for people (all ages) with severe mental illness, learning disabilities and / or autism spectrum disorders, improving emotional well-being in children and young people, prevention and rehabilitation in neighbourhoods, reducing excess weight
- **Bedford Borough** has 3 priorities in its Place Plans – primary care access, improving emotional well-being in children and young people, reducing obesity (all ages)

The Denny Review

The recommendations from the Denny Review will be delivered using the health inequalities funding. The Review was launched in 2020 and over a period of three years has sought to understand the data and lived experiences of people who have been seldom heard in conversations around health and care.

We propose to allocate health inequalities funding to deliver recommendations set out within the report and costs associated with communicating the findings in line with the feedback we have heard from the report – for instance using video, translations, accessible documents to communicate how we are implementing feedback from people and communities.

The Denny Review has made several recommendations, which include:

- The creation of a system wide translation service
- The development of 'Access Champions' to help people with additional needs to navigate the health and care system
- The development of SystmOne to flag the needs of patients
- Mandatory training for front line health and care professionals to eradicate unconscious bias and racism (led by advocates and residents)
- Process changes to include EDS2022 in contract management
- Review of Patient Participation Groups to ensure there is representation at place to support co-production.

More information on the Denny Review can be found at the end of this chapter.

The ICB has (through Health Education England funding) awarded £3million to University of Bedfordshire to develop our shared Research & Innovation Hub, focusing on tackling inequalities and developing our workforce.

3. What does Good Look Like?

Working with the Institute of Healthcare Improvement (IHI)

The IHI is a globally recognised organisation dedicated to improving health and healthcare around the world, with a focus on quality improvement and patient safety.

A partnership has been developed to build capacity and expertise to support BLMK's improvement journey. Working with the Institute for Healthcare Improvement will provide BLMK ICS with valuable expertise, resources, and a collaborative platform to address inequalities in

healthcare effectively. By leveraging the IHI's knowledge and methodologies, BLMK ICS can make significant strides in improving health equity and enhancing the well-being of their population.

Increasing capabilities across the system to provide a new system of learning

To train our health and social care workforce & residents in quality improvement which in turn will provide all key stakeholders with the tools and empowerment to run their own quality improvement projects. The training provided would give “pocket QI” training for all, followed by leadership and coaching training for individuals wishing to take their learning to the next stage. This would provide key projects, both system-wide and at Place, with trained project leads and coaches where appropriate.

Mental Health and Maternity programmes

In 2022/23, as part of the inequalities funding that was signed off at the CEO Group in August 22, the system agreed to provide each clinical area against the Core20+5 with funding to target their biggest priority areas. Maternity chose a preconception programme and Mental Health chose Serious Mental Illness and Dementia.

4. Delivery & Implementation

There is system recognition that the inequalities programme is a complex and vital programme. Currently there is little resource to take the programme to a more evidence based, data driven and integrated approach, whilst also taking some key projects through a system of learning. It is key to build on the themes that we developed last October at the BLMK Inequalities event, which brought in the ambition to be “stronger together to tackle inequalities.” The themes captured were:

- Co-production with our staff and our communities
- Working with our trusted sources, such as the VCSE
- Building on our community assets (we are not starting from a blank sheet of paper!)
- Understanding what works and scaling up

Nationally, NHS England has made £200 million available in 2023/24 to support Integrated Care Systems with the greatest health inequalities in their populations. £3.197m of recurrent funding has been allocated to Bedfordshire, Luton, and Milton Keynes Integrated Care System to deliver a programme of system wide improvement.

Administered by the Integrated Care Board, we have worked closely with partners to co-design how the funding will be allocated across the system and an Inequalities Systems’ Leadership Group has been established, which is chaired by the Chief Nursing Director for the ICB and co-chaired by Directors of Public Health from all four local authorities.

An Inequalities System Leadership Group has been established to review and agree on the design of the BLMK Inequalities Strategy. As well as to provide advice and guidance and inform decision makers on how to allocate the inequalities funding. Members also provide advice and guidance to shape the priorities and work programme of the shared Population Health Intelligence Unit.

5. Interdependencies across the BLMK Joint Forward Plan

BLMK High Impact Programmes

BLMK High Impact Programmes	Key Objectives that tackle Inequalities
Enabling our Children and Young People to Thrive	• Innovation in models of care to maximise prevention and early interventions to support children to thrive • Use of digital technology to enable independence for children and young people with long term conditions • Innovation to support children and young people to develop emotional resilience • Innovative models of care to support children and young people with very complex needs to thrive
ICB Target Operating Model	• BLMK People Plan – developing competencies and confidence for our staff to participate in co-production and use quality methodology to tackle inequalities and track impact
Improving Access & Treatment	• Health services strategy, including specialised services • Use of digital integration to improve access and outcomes in clinical pathways
Improving Outcomes for MHLDA	• Innovation in new models of care to tackle inequalities, and improve access and outcomes for residents • Place-led focus on maximising uptake of physical health checks and screening
Intelligence-led Quality, Performance, Outcomes & Inequalities Improvement	• Implementation of the Population Health Intelligence Unit • Ongoing connectivity of data to enable joined-up care for residents, & evaluation of benefits • Digital integration to enable technological innovation to support people to live more years in good health
Thriving Ecosystems and Prosperous Communities	• Place-led programmes to support those furthest from training and employment • Use of technology to enable thriving and sustainable ecosystems

6. Denny Review Update March 2023

a) Background

In 2020 at the height of the pandemic, residents from Bedford Borough's Windrush generation wrote to the Chief Executive of the then Clinical Commissioning Group asking for health inequalities to be addressed in the area – as evidence highlighted that more people from black and minority backgrounds were more severely affected by the virus. Believing this to be because of economic deprivation, senior leaders from the health system were invited to attend meetings to listen to the views of local people.

The lived experiences of this community were incorporated into the Covid vaccination programme and steps were taken to break down the barriers people experienced in accessing the vaccine. Venues were selected based on feedback from community leaders and clinics were set up in 'trusted places' with 'trusted people in attendance.

With the establishment of the Integrated Care Board and the inequalities priority, it was agreed that work should be undertaken to interrogate population health data and understand:

- Which communities experienced greater health inequalities,
- What the barriers are
- What the lived experience of health inequality is, and
- What we could do to address it.

b) Establishing the Denny Review

The Reverend Lloyd Denny from Luton and former public participation Lay Member for Luton Clinical Commissioning Group was asked to lead a review into health inequalities and a steering group was established. Paul Calaminus, Chief Executive of ELFT was appointed as Senior Responsible Officer (SRO) and a group was set up which included:

- Public Health representatives from all 4 local authorities
- Population Health lead Integrated Care Board
- Healthwatch Bedford Borough, Central Bedfordshire, Luton and Milton Keynes
- The University of Bedfordshire
- East London Foundation Trust
- A local GP with responsibility for inclusion

A plan was agreed which was to:

- Undertake a literature review to understand what had been written to date on health inequalities in Bedfordshire, Luton and Milton Keynes
- To engage with residents who experience health inequalities to listen to their lived experiences, and
- Work together to agree a series of recommendations, which would be taken forward to remove barriers to equality.

c) What did we learn from the literature review?

A procurement exercise was undertaken earlier this year to appoint an academic partner to deliver a literature review, which would set the benchmark and provide a framework for the review. The University of Sheffield was appointed and following a four-month desktop exercise, the literature review was published in June 2022.

It highlighted that the people most affected by health inequalities were people from ethnic and minority groups including:

- Gypsy, Roma and Traveller communities,
- People living in deprived neighbourhoods,
- People living in deprived neighbourhoods with disabilities,
- People experiencing homelessness,
- Migrants
- People from the LGBTQ+ community

The report also highlighted that those experiencing unfair distribution and impact of wider determinants affecting their access to services related to:

- Socio-economic, cultural and environmental, e.g., income, employment, education, access to green spaces
- Living and working conditions, e.g., housing, homelessness, overcrowding, high-risk professions, racial discrimination at the workplace
- Lifestyle and behaviours, e.g., physical activity, smoking, alcohol
- Access to and uptake of health services, e.g., language barriers, perceptions about 'ill health', beliefs and traditions, lack of knowledge about services, culturally inappropriate services
- Social capital, networks, communities and engagement, e.g., neighborhoods with a concentration of people with the same ethnicity, spiritual and faith beliefs
- The impact of Covid-19

Key considerations outlined also included the importance of intersectionality, which helped to understand how different factors can shape people's experiences.

The report recommended that work into health inequalities focused on the following areas:

- Making services more accessible to disadvantaged groups
- Targeting specific groups such as the homeless, the housebound, LGBTQ+ and ethnic minority groups living in deprived neighbourhoods
- Exploring better quality language and interpretation services and the delivery of information via trusted sources
- Targeting communication strategies at different groups
- Supporting for the VCSE to help communities navigate the health and care system
- Developing the cultural competency of staff to understand different needs and how services can services can meet these
- Considering the impact of social exclusion, racism, discrimination and socio-cultural barriers on the involvement of communities in decision making and service delivery.
- Strengthening collaborative working with the VCSE, including faith-based associations and centres
- Undertaking further research on what 'intersectionality' means in BLMK responding to complexity and not treating the 'community' as a homogeneous group

A Task and Finish Group, which included engagement and co-production leads from providers and local authorities across the system was established to interrogate the report. Using population health data and the recommendations of the report as a framework, the group was able to identify priority populations where engagement could be undertaken to listen to lived experiences and either validate or challenge the findings of the literature review and population health data.

d) How are we taking this work forward?

The Task and Finish Group agreed that the literature review should form the framework for the engagement and that the communities should be prioritised:

- Gypsy, Roma, Traveller
- People from ethnic minorities living in deprived areas
- People with a learning or physical disability living in deprived areas
- Homeless people
- Migrants
- LGBTIQ+ community

There was agreement that intersectionality needed to be considered as part of this exercise, to ensure that people were not heard as part of a homogenous group, to allow for richer and more authentic information to be shared.

The literature review highlighted that communications and culture were creators of health inequalities and it was agreed that these themes should be explored through the lens of health literacy, community languages, disabilities and cultural barriers including religion and race.

Learning from work that has been place across the system by local authorities and providers, it was agreed that engagement work with these communities should be undertaken by trusted people within the communities, to ensure that difficult conversations were managed sensitively and appropriately, and that people felt able to 'open-up' about their experiences.

The Task and Finish group agreed that:

- **Healthwatch Bedford Borough** would undertake engagement with the Gypsy/Traveller community in Bedford which included two settled Irish Traveller communities.
- **Healthwatch Milton Keynes, YMCA and MK Action** would engage with people from an ethnic minority living in deprived areas in Milton Keynes.
- **Bedford Borough Healthwatch** would work with local organisations to hear the experiences of women from ethnic minorities that have experienced forced marriage, FGM and domestic abuse.
- **Healthwatch Central Bedfordshire, the Disability Resource Centre and Community Dental Services (CIC)** would work together across Bedfordshire, Luton and Milton Keynes to listen to the experiences of people who have learning disabilities and physical disabilities in deprived areas.
- **Healthwatch Luton** would undertake engagement with people who are from an ethnic minority background and also part of the LGBTIQ+ community.
- **The Integrated Care Board** would undertake work with the Roma Trust in Luton, who would engage with the Roma community to ensure that those who are known to experience the greatest health inequalities were also included in the review.

Work is also underway with the Milton Keynes Homeless Partnership, who are currently putting together a proposal on how we can hear the voices of homeless people in the city; and Central Bedfordshire Healthwatch is developing a proposal with sex workers to ensure we hear from a previously silent community within our area.

e) How will this work be undertaken?

It is important that trusted people lead on this engagement work and organisations have been selected for their existing connections. Discovery interviews will be undertaken with residents and a series of questions have been developed which includes:

- What do you want from your health and care services? What do you aspire to?
- What does prevention mean to you? How do you think you could improve your own health and wellbeing?
- How can we communicate better with you?
- What could we be doing in health and care services to make it easier for you to access care?

f) Finalising the engagement exercise

The themes and reports of the engagement was received back in January 2023. The next stages is for the members of the steering group to come together to reflect on the themes and to agree on the next phase of the project. This will include taking a structured approach under the Triple Aim, Quality Improvement framework, strengthening projects that are already in place against the recommendations and identifying some continued engagement work with the communities of interest to ensure trust continues to build. All the work will be underpinned by quality improvement methodology and co-production with our stakeholders and residents. The report is due to be signed off in June 23 at the ICB Board.

3.9 Quality Improvement & Safety: Reducing Harm and Maximising Effective safeguarding across the BLMK

1. What is the Purpose of this Enabler?

50% of all harm in all healthcare is preventable. Around one in 20 residents are exposed to preventable harm in our healthcare system both in primary and secondary care. Harm to our residents and staff (we include staff because in nearly every case there was no intention of harm from the staff involved) can be devastating.

The focus for our system is for all healthcare providers to develop systems for learning and improvement to reduce harm. Within this, it is crucial that we ensure that people already experiencing disadvantages in life do not disproportionately experience harm through healthcare.

Harmful patient incidents are also a major financial burden. It is estimated that 10-15% of healthcare expenditure is consumed by the direct sequelae of healthcare-related resident harm. Harm in healthcare can have various causes, such as medication errors, adverse events, or negligence but it is a direct result of something in our healthcare system has not worked/happened/been acted upon rather than a recognised complication.

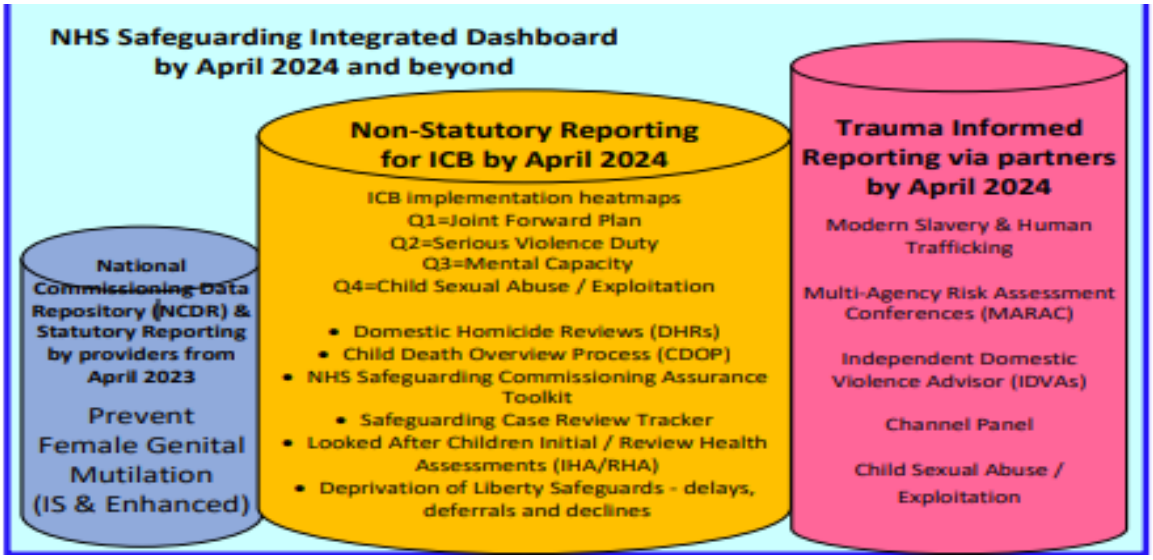
Who is responsible for safeguarding?

The responsibility of safeguarding is not one agency alone. In repeated national recommendations to provide a comprehensive picture of how several agencies work there continues to be a lack of real true shared partnership working. Safeguarding is protecting a citizen's health, wellbeing, and human rights; enabling them to live free from harm, abuse, and neglect. It is an integral part of providing high-quality care in any setting. Safeguarding children, young people and adults is a collective responsibility which we share across all BLMK partners.

Those most in need of protection include:

- Children and young people, especially children whose lives include any of the following: are looked after, are displaced from their usual communities (e.g., asylum seekers), are carers themselves, those whose lives reflect multiple Adverse Childhood Experiences
- Adults at risk, such as those receiving care in their own home, people with physical, sensory, and mental impairments, and those with learning disabilities
- Children and adults experiencing domestic abuse, displacement, and those whose lives are disrupted by crime and its consequences

All staff, whether they work in a hospital, a care home, in general practice, or in providing community care, and whether they are employed by a public sector, private, or not-for-profit organisation, have a responsibility to safeguard children and adults at risk of abuse or neglect in BLMK. The diagram below shows how we will try and integrate our data for learning and improving in our proactive actions to limit harm:



Inequalities is a cause of preventable harm

When people already negatively affected by unfavourable social determinants of health seek care, healthcare itself may exacerbate health inequalities rather than mitigate them. One way in which this occurs is when patients experience disproportionate levels of harm from the healthcare they receive. For example, a 2022 review in the UK found that ethnic minority women's experiences of poor communication and discrimination during interactions with healthcare staff may explain some of the stark inequalities observed in maternal health outcomes. Healthcare may therefore be less safe for some patients than others.

We see the consequence of this in our own population – for example, the infant mortality rate in Bedford and Luton is significantly higher than the East of England (EOE) and national rates (EOE 3.4 per 1000 live births and nationally 3.9 per 1000 births) with Luton sitting at 5.7 per 1000 births and Bedford at 4.9 per 1000 births.

One of the consequences of the COVID-19 pandemic has been to illuminate far-reaching health and socioeconomic inequalities in many countries. The pandemic's impact has fallen disproportionately on the most vulnerable individuals and communities, and along racial, ethnic, occupational, and socioeconomic lines. Inequalities in people's protection from and ability to cope with this pandemic and its tremendous societal costs stress the importance and urgency of the societal changes needed to protect population health and wellbeing in the future.

Disproportionate harm from healthcare experienced by our most disadvantaged residents further compounds the consequences of existing social or economic disadvantage. Viewing health inequalities through the lens of patient safety presents an avenue for tangible action on health inequalities for which healthcare professionals and systems have a clear responsibility.

2. Current focus and Required Development in BLMK

A shift towards improvement away from assurance and the journey of discovery together residents and staff and treat all of us with kindness and compassion.

In partnership with the inequalities current and future work the shift towards a quality improvement approach focusing on culture, behaviour, tools and techniques is key, without diminishing the need to maintain quality assurance in service provision. BLMK to will focus on three pillar of quality assurance, quality improvement and quality planning and a relentless focus on inequality reduction and ensuring all feel valued and are valued.

This requires all of us in BMLK to jointly working to pursue better health for well-defined populations (including citizens, healthcare providers at all levels, councils or municipalities, businesses, schools, fire services, voluntary sectors, housing associations, social services, and police) will benefit from having a shared method that includes a common language and tools and can be applied across four areas:

1. defining the system
2. describing shared aims
3. the work required to achieve them
4. measuring systematically over time and acknowledging that change happens.

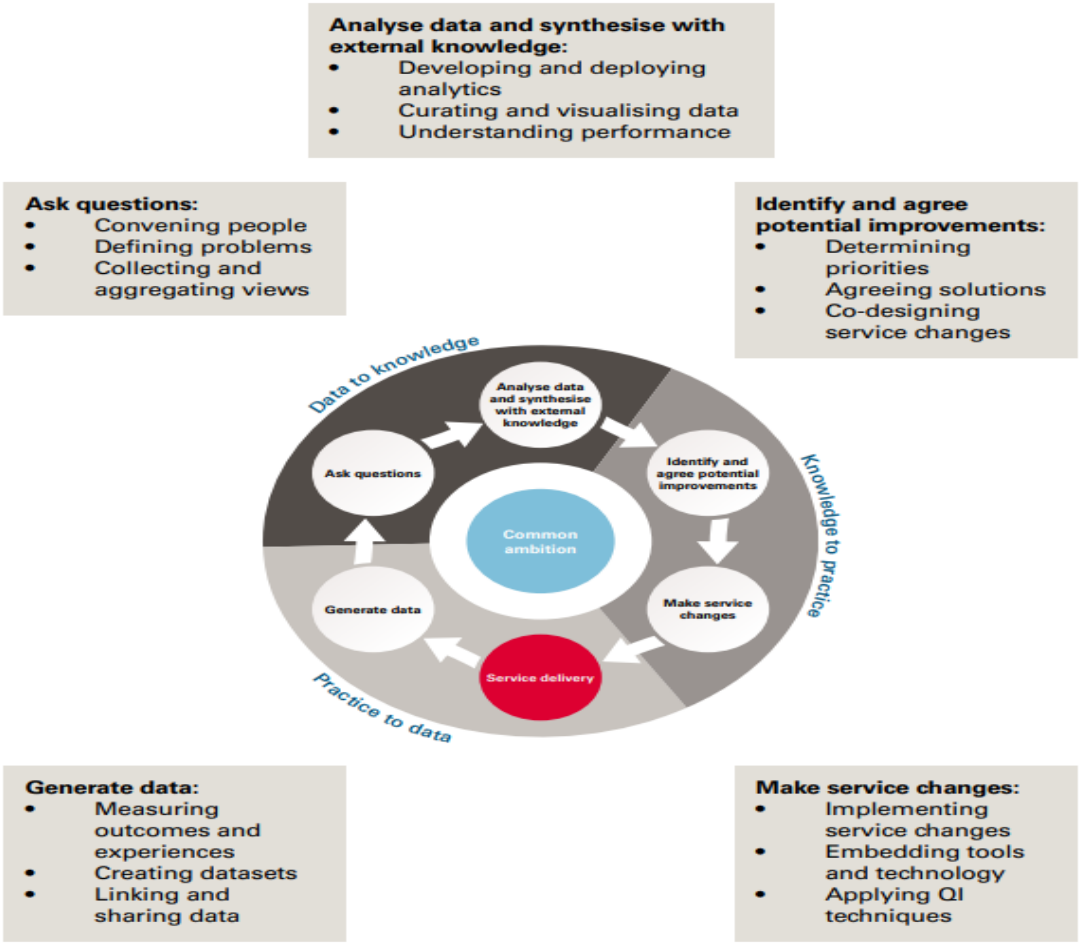
Capacity and capability for the staff and residence to learning how to improve

The Institute for Healthcare Improvement (IHI) is a globally recognised organisation dedicated to improving health and healthcare around the world, with a focus on quality improvement and patient safety. A partnership has been developed to build capacity and expertise to support BLMK's improvement journey. Working with the Institute for Healthcare Improvement will provide BLMK ICS with valuable expertise, resources, and a collaborative platform to address inequalities in healthcare effectively. By leveraging the IHI's knowledge and methodologies, BLMK ICS can make significant strides in improving health equity and enhancing the well-being of their population

To increase the capability of all our staff we will train our health and social care workforce & residents in quality improvement which in turn will provide all key stakeholders with the tools and empowerment to run their own quality improvement projects. There will also be a dedicated team of staff with expertise in improvement science to sit alongside all system transformation programmes in the form of Improvement Advisors (IA).

Data for Learning and Improving pan-BLMK

A learning health system (LHS) is a system such as the ICB that, working with a community of stakeholders, can develop the ability to learn from the routine care it delivers and improve as a result – and, crucially, to do so as part of business as usual. Done right, LHSs are not a separate agenda, but about embedding improvement into the process of delivering health care and social care. The diagram below shows the benefits of a LHS and how it might be used. BLMK is working on scoping the gaps in our system and the partnership working with the population health intelligence unit alongside the interoperability across health and social care and the timelines. This is an essential function for the ICB into to demonstrate measurable deliverable improvements.



Source: The Health Foundation's Insight & Analysis Unit

Statutory and regulatory functions and recent changes in focus:

- **Joint Targeted Area Inspection** (JTAI) is an inspection framework for evaluating the services of vulnerable children & young people. It is conducted jointly by Ofsted, Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Probation (HMIP). This is an important step forward for inspection.
- Following consultation, the new **'area SEND (Special Education Needs and Disability) inspection and framework'** has been published by Ofsted and the Care Quality Commission. The new framework and handbook come into use from 2023 and will be used to inform judgements on the efficacy of local areas' arrangements for children and young people with SEND. The new framework aims to strengthen accountability by:
    - Introducing an ongoing cycle of inspections with three inspection outcomes
    - Annual "engagement meetings" in all areas
    - Boosting the response where Ofsted has concerns via monitoring inspections and/or early re-inspections
    - More transparency and improving services by asking local areas to update and publish "visible strategic SEND plans" within 30 working days after full inspections
    - All strategic plans to be fully accessible to children and young people with SEND as well as parents and carers
    - A focus on how alternative provision is commissioned and overseen
    - An updated to the inspection team to be more multidisciplinary, involving health, education, and social care inspectors

The new 8 CQC Inspection quality statements for Integrated Care Systems from 2024 – Evidence of 'Safe' Care

- **Learning culture:** we have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
- **Safe systems, pathways, and transition**: We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored, and assured. We ensure continuity of care, including when people move between different services.
- **Safeguarding:** We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm, and neglect. We make sure we share concerns quickly and appropriately.
- **Involving people to manage risks:** We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.
- **Safe environments:** We detect and control potential risks in the care environment. We make sure that the equipment, facilities, and technology support the delivery of safe care.
- **Safe and effective staffing:** We make sure there are enough qualified, skilled, and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.
- **Infection prevention and control:** We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.
- **Medicines optimisation:** We make sure that medicines and treatments are safe and meet people's needs, capacities, and preferences by enabling them to be involved in planning, including when changes happen

Delivery 2023-2030: Continuously Reviewing, Learning and Reshaping

All delivery of programmes, including all system programmes will be through the lens of quality improvement and inequality reduction via direct support from improvement advisors, improvement coaches and access for all residents and staff to resources and training.

The infrastructure to deliver harm reduction and inequalities through continuous improvement will be the patient safety incident response Framework (PSIRF), the 3-year maternity plan and all the Core 20 plus 5 programmes for adults, children & young people and maternity. The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

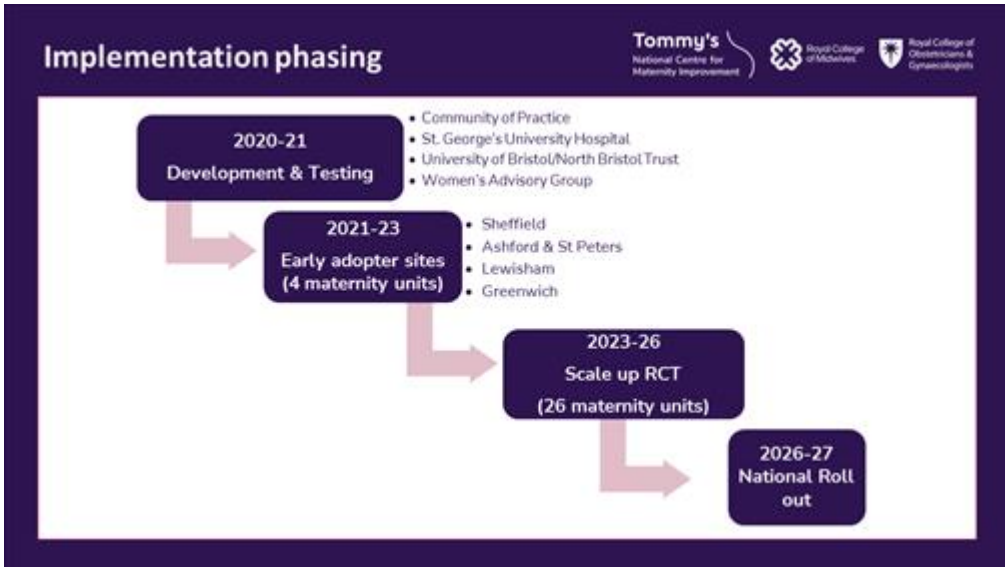
The three-year maternity plan 2023 and Core 20 plus 5 in Maternity has been launched the plan's aim to make care safer, more personalised, and more equitable by:

1. Listening to women and families with compassion which promotes safer care
2. Supporting our workforce to develop their skills and capacity to provide high-quality care plans
3. Developing and sustaining a culture of safety to benefit everyone
4. Meeting and improving standards and structures that underpin our national ambition

Alongside the PSIRF and the 3-year Maternity there are direct links with inequalities programme and the Inequalities leadership group for BLMK.

Relentless focus on selected solutions to reduce inequalities in patient safety through action by us all in BLMK

- **More routine involvement of advocates from patients' communities in healthcare interactions** to reinforce communication and ongoing support in care. Purposeful consideration of how the social background of a patient may dictate risk of harm from healthcare, and adjust management and follow-up plans accordingly
- **Use of culturally and linguistically appropriate shared decision-making tools** to empower involvement of marginalised patient groups in their care and safety
- **Support a diverse healthcare leadership** that pushes these issues into the consciousness of the workforce and mobilises the system towards meaningful action us this as a proactive recruitment focus. Health and care staff as full representation at all levels/grades as a clear representation of the local population. Include this into board and place-based board representations.
- **Race conscious approaches to healthcare education** with greater emphasis on racism and discrimination (rather than race) as determinants of disease
- **Systematised co-design of clinical services and clinical information with members of marginalised patient communities**
- **Strengthen capabilities for stratified analysis of patient safety event reports according to important patient characteristics** and the translation of these data into tangible action
- **Clinical trials must recruit an appropriately diverse cohort**, report relevant social determinant characteristics, and conduct relevant stratified analyses that determine effectiveness and safety of drugs and devices
- **Avoid using systematically biased clinical prediction tools and algorithms unless clear empirical justification for race adjustment has been established**. For example, **The Tommy's Pathway application enables midwives and doctors to assess each woman and birthing person's needs more accurately during pregnancy and to personalise their care.** Early in pregnancy, the tool can identify each person's chance of preterm birth or of developing problems with the placenta which may lead to stillbirth. It supports healthcare professionals to offer care recommendations in line with national clinical guidelines for best practice maternity care to help lessen the chance of these complications developing. This aims to reduce the variation in care across the NHS and ensure that each person is offered the right care at the right time, no matter where they live. BLMK ICB hopes to be in the 2023 scale-up randomised control trials for the national roll-out of this initiative.



Interdependencies across the BLMK Joint Forward Plan

The Partners of BLMK ICB are together committed to improving Quality and Safety as part of Business as Usual and in all our High Impact Programmes. The shift in tone of the national Safety Improvement Programmes, together with the move to PSIRF (tackling the system-wide root causes of harm) support our ICB's commitment to enable ALL our residents to live more years in good health (BLMK Integrated Health and Care Partnership Strategy).

Actions to enable all our communities to thrive will be explicitly highlighted in each of our High Impact Programmes, drawing specific attention to those populations whose health outcomes are worst and the inequalities that promulgate these. Specifically:

- Our Place Plans (built upon our Boroughs' health & well-being board strategies) will provide local focus and delivery of integrated services to improve health outcomes and tackle inequalities
- Evaluation of the impact of our High Impact Programmes will be assessed on the benefits to all residents, with specific attention to those residents who experience the most barriers to accessing care and treatment.
- The embedding of co-production (with residents and the VCSE organisations who link most closely with local communities) in our ICB Target Operating Model will embed our residents' view in the design, implementation, and evaluation of our improvement actions.
- The systematic use of health population data as part of understanding NHS access and outcomes will build on the lessons learned through COVID about finding and reaching out to those communities who do not come forward for screening or early diagnosis; whilst our BLMK health services strategy will ensure that improving health outcomes of all our residents is central to service and clinical pathway redesign and development
- Our BLMK People Plan sets out our collective actions to support residents into education, training, and employment

3.10 Research and Innovation (R&I) across Bedfordshire Luton Milton Keynes (BLMK) Integrated Care System (ICS)

1. What is the Purpose of this Enabler?

The challenges of an ageing population with complex healthcare needs, workforce pressures and health inequalities drive a pressing need to embed Research and Innovation (R&I) into programmes of work across ICSs. This will enable the system to cultivate transformative and targeted health care solutions for residents. The latter ambition has been further heightened by The Health and Care Act 2022 commitments stipulating the legal duties for ICBs to facilitate and deploy R&I into planning, reporting and decision-making. Successful implementation will enable systems to improve care-co-ordination, engage patients, address population health needs, drive service delivery innovations, facilitate evidence-based decisions, evaluation, and optimisation.

Research and innovation play a crucial role in supporting BLMK ICS to meet our strategic aim to increase the number of years lived in good health for all residents. This includes the following:

1. **Evidence-based decision-making:** Research provides ICSs with the necessary evidence to make informed decisions about the design and implementation of integrated care. It helps identify best practices, effective interventions, and areas for improvement. By using evidence-based approaches, we can optimise their resource allocation, service delivery, and overall performance.

2. **Improving care coordination:** Research and innovation contribute to enhancing care coordination within ICSs. This involves developing new models, technologies, and tools that facilitate seamless information sharing and communication among different healthcare providers.

3. **Enhancing patient engagement:** Research and innovation helps us engage patients and their families as active participants in their own care. By leveraging technologies like mobile applications, wearable devices, and patient portals, individuals can access their health information, communicate with healthcare providers, and participate in shared decision-making. This increased engagement leads to better health outcomes, improved patient satisfaction, and more efficient use of healthcare resources.

4. **Addressing population health needs**: Research supports us in identifying and addressing the health needs of their populations. By analysing health data, conducting epidemiological studies, and monitoring health trends, we can develop targeted interventions and preventive strategies. Research also informs the development of population health management approaches, such as risk stratification models and predictive analytics, to identify high-risk individuals and proactively manage their health.

5. **Innovating service delivery:** Research and innovation enable us to explore new approaches to service delivery, such as new care models, technologies, and processes. For instance, virtual wards to expand access to care, especially in underserved areas. Robotic-assisted surgeries, artificial intelligence applications, and precision medicine contribute to improved treatment outcomes and personalised care. These innovations can increase efficiency, reduce costs, and enhance the overall quality of care across BLMK ICS.

6. **Evaluating and optimising performance**: Research provides BLMK ICS with tools and methodologies to evaluate their performance, identify gaps, and measure outcomes. It helps us assess the effectiveness, efficiency, and equity of integrated care interventions. Research also supports continuous quality improvement efforts by providing feedback on implemented initiatives and suggesting refinements based on empirical evidence.

2. The Current Landscape in BLMK

Where we are now?

- BLMK ICS has a diverse population, where the benefits to maximising research into practice, and driving research and innovation will have demonstrable benefits to residents
- BLMK ICB consists of 2 health 'eco-systems' (Bedfordshire and Milton Keynes) and 4 Boroughs. It is a 'nexus' ICB, with strong relationships across multiple health and civic partnerships within and beyond the BLMK administrative boundary. This means that we are well-placed to influence and draw upon a rich diversity of research and innovation to benefit our residents
- BLMK partners have embedded relationships with several higher education institutes, research and innovation networks and global business partners based in our patch. This gives us great opportunities to expand and apply our research and innovation through partnership.
- The partners of BLMK ICB are already partners in a range of clinical trials, research and innovation, giving us a strong foundation to embed research and innovation in our collaborative High Impact Programmes to support our communities to thrive
- The ICB has (through Health Education England funding) awarded £3million to University of Bedfordshire to develop our shared R&I hub work on tackling inequalities and developing our workforce

Key challenges:

We need now to

- **Synthesise our existing R&I programmes across partners with our strategic ambitions and High Impact Programmes to create a pan-BLMK R&I strategy** that builds on existing practice, and delivers enhanced benefits to our residents
- **Standardise (as needed) our R&I governance processes to ensure we bid effectively and have the right infrastructure to deliver our R&I strategy**
- **Develop the skills and confidence of our staff to participate in R&I**, including research into practice
- **Grow our combined reputation in our research capabilities** to attract and influence the right R&I opportunities into BLMK with our partners

The actions to deliver this are:

1. **Collaboration and partnerships:** Foster collaboration between researchers, healthcare providers, policymakers, and other stakeholders within ICSs. This collaboration ensures that research and innovation efforts are aligned with the needs and priorities of the system.

2. **Establish research networks:** Create research networks or consortia within ICSs to facilitate knowledge sharing, collaboration, and joint research initiatives. These networks can include multiple healthcare organisations, universities, and research institutions working together to address common research questions and challenges.

3. **Dedicated funding:** build the sustainable resourcing for a shared R&I infrastructure across the ICB partners. This funding can support research projects, innovation initiatives, and the development of research infrastructure.

4. **Data sharing and interoperability:** Promote data sharing and interoperability across different healthcare organisations within BLMK. This enables researchers to access comprehensive and integrated data, facilitating population health research, outcome evaluations, and performance assessments. Implement standards and technologies that support secure and seamless exchange of data.

5. **Research governance and ethics:** Develop robust research governance frameworks and ethical guidelines specific to integrated care, that enable us to work in partnership in this field

6. **Capacity building and training:** Invest in building research and innovation capacity across ICB partners.

7. **Knowledge translation and dissemination:** Facilitate the translation of research findings into practice within BLMK. Develop mechanisms for disseminating research outputs and best practices to healthcare providers, policymakers, and other relevant stakeholders.

8. **Continuous evaluation and learning:** Implement a culture of continuous evaluation and learning within BLMK. This is part of (not separate to) our shared commitment to embed quality improvement methodology across our services to improve health outcomes, tackle inequalities and maximise efficiencies and effectiveness.

3. What have we achieved so far:

Some examples of how our use of research and innovation has benefitted our residents already are:

- Technologies that have been proven to be effective, cost saving and affordable (MedTech Funding Mandate) have been implemented across BLMK. Examples include less invasive procedures for urology and new non-drug treatment for migraines and cluster headaches.
- Work is currently underway to review the care for people with sickle cell and the access they have to Spectra Optia Apheresis (red cell exchange).
- In 2022, BLMK successfully bid for funding for NHS England's Innovation for Healthcare Inequalities Programme (InHIP). This funding will support the optimisation of self-management and treatment of CVD through proactive outreach in GP practices and will include evidence-based lipid lowering therapies.
- Technology to improve mobility, GaitSmart will be piloted across BLMK in 2023/2024. The impact of this technology on the residents will be evaluated, hoping to improve independence and quality of life.

New technology across social care in BLMK is helping people to stay independent, improve the well-being and support the health and social care workforce. Innovations have focused on three key areas of greatest need

  - Health monitoring
  - Falls prevention

- Digital records

A Bedford care home started using the Whzan blue box in May 2020. They remain enthusiastic advocates for this all-in-one telehealth kit.

"Before we had this equipment we often had to wait until the residents got really sick before we could get help. Now we can act more immediately because we can get observations – like blood pressure and oxygen saturation – and give these to the GP. This gives us the help we need for our residents much more quickly."

Raizer chairs to enable people to be assisted up following a fall have been introduced to care homes across BLMK. Care home managers have reported

- *'We couldn't live without the Raizer Chair now – it's amazing.'*
- *'The Raizer Chair is easy to use and kind to the person who is being assisted by it. Possibly the best piece of equipment to come into the care sector for years.'*

Following the success in care homes, Raizer chairs are going to be introduced to domiciliary care providers.

Further exciting work is planned in partnership with social care to expand remote monitoring which includes MiiCare. This digital tool uses telecare sensors to monitor different aspects of the individual's environment or check for movement and falls. This enables the individual to remain safely in their own home for as long as possible, with the reassurance that issues can be detected and investigated. There will be greater focus on the benefits of innovations to the health and well-being for our local residents. We will continue to work in partnership with Oxford and Eastern Academic Health science Networks (AHSN) to support evaluation and adoption of innovation and grow our relationship with academic partners.

4. How will we Develop our ICB Research and Innovation Strategy?

By March 2025, we aim to have developed a shared research and innovation strategy across our ICB partners that builds on our strong foundations to ensure that we have a comprehensive programme of research and innovation to help us achieve our strategic ambitions.

This is expected to include:

SHORT TERM GOALS

1. **Identify research and innovation priorities:** Conduct a comprehensive assessment of the ICS's research and innovation needs and priorities. Engage key stakeholders, including healthcare providers, researchers, patients, and policymakers, to identify areas where research and innovation can have the most significant impact on the ICB's goals and objectives. Prioritisation of areas we want to focus with R&I.

2. **Integration into the planning process:** Ensure that research and innovation are integral components of the ICB's Joint Forward Plan. Incorporate specific goals, strategies, and actions related to research and innovation within the overall plan. This demonstrates a commitment to advancing evidence-based practices and leveraging innovation to achieve the ICB's strategic objectives.

3. **Establish research and innovation governance:** Develop a governance structure for research and innovation across the ICB. This includes establishing clear roles and responsibilities, processes for decision-making, and mechanisms for monitoring and

evaluation. Define ethical guidelines and review processes to ensure that research activities adhere to ethical standards and regulatory requirements.

Tangible outputs/ actions include:

- Development of an R&I Board (Collaborative) that includes all stakeholders across BLMK ICB
- Formation of R&I ICB Community of Practice
- Clearly defined governance framework for R&I
- Prioritisation exercise on where we will focus on R&I to meet BLMK ICB strategic partnership priorities

MEDIUM TERM GOALS

1. **Dedicated funding and resources:** Develop sustainable funding sources to deliver the supporting infrastructure for collaborative research and innovation in BLMK. This ensures that there is adequate support for research projects, innovation initiatives, and the necessary infrastructure. Advocate for sufficient funding from relevant stakeholders, such as government agencies, research funding bodies, and private sector partners.

2. **Collaboration with research institutions and experts:** Forge or continue strengthening partnerships with all research institutions, universities, and experts in relevant fields across BLMK and beyond. Collaborate with academic researchers, clinical experts, and other knowledge partners to enhance the research and innovation capabilities of the ICB. Engage these partners in the planning process and leverage their expertise to inform the development of research and innovation framework.

3. **Knowledge exchange and translation:** Prioritise knowledge exchange and translation as part of the research and innovation strategy. Establish mechanisms to disseminate research findings, best practices, and innovative approaches within the ICB and beyond. Encourage the uptake of evidence-based practices and support the translation of research findings into actionable recommendations for healthcare providers and policymakers. Utilise various communication channels such as publications, conferences, workshops, and online platforms to share research findings effectively.

Tangible outputs/ actions include:

- Protected funding to take forward agenda through sustainable funding sources
- Development of a BLMK R&I framework followed by BLMK R&I strategy
- Establish a model of ‘Hubs’ that will take forward identified R&I priorities

LONG TERM GOALS

1. **Capacity building and training:** Invest in building research and innovation capacity across ICB partnerships. Provide training and professional development opportunities for health and care professionals, researchers, and innovation champions. This includes enhancing research skills, fostering innovation mindset, and promoting the use of evidence in decision-making. This builds a culture of research and supports the development of a skilled workforce. Develop policies and guidelines that support the

integration of research and innovation within our ICB, including services and partners which impact the wider determinants of health.

2. **Monitoring and evaluation:** Develop a robust monitoring and evaluation framework to track the progress and impact of research and innovation initiatives within BLMK Joint Forward Plan. Establish key performance indicators (KPIs) and metrics to measure the effectiveness and outcomes of research and innovation activities. Regularly review and assess the progress, adjust strategies as needed, and share the results to promote transparency and accountability.

3. **Continuous learning and improvement:** Foster a culture of continuous learning and improvement across ICB partnerships. Encourage feedback from stakeholders, including patients, health and care providers, and researchers, to inform future research and innovation efforts. Regularly assess the impact and outcomes of research and innovation initiatives. Utilise evaluation findings and lessons learned to refine strategies, identify new opportunities, and drive innovation within the ICB.

Tangible outputs/ actions include:

- Identify or create R&I training to support the multi-professional workforce
- Develop a robust monitoring and evaluation framework
- Finalise BLMK R&I strategy and publish recommendations

5. Interdependencies of the R&I Enabler programme with our Joint Forward Plan High Impact Programmes

Our ambition is for research and innovation to inform, underpin and enable our delivery of our strategic shared ambitions as partners in BLMK ICB. As such, by 2040 we aim for R&I to be embedded in all our strategic partnership programmes.

However, there are key interdependencies between our BLMK R&I ambitions and specific High Impact Programmes, as summarised below:

BLMK High Impact Programmes	Key Objectives underpinned by R&I
Advancing Equity & Equality	• Embedding existing R&I programmes on inequalities across our High Impact Programmes (e.g., Denny Review and Bedford University Research partnership)
Enabling our Children and Young People to Thrive	• Innovation in models of care to maximise prevention and early interventions to support children to thrive • Use of digital technology to enable independence for children and young people with long term conditions • Innovation to support children and young people to develop emotional resilience • Innovative models of care to support children and young people with very complex needs to thrive
ICB Target Operating Model	• BLMK People Plan – developing competencies and confidence for our staff to participate in research and innovation

BLMK High Impact Programmes	Key Objectives underpinned by R&I
Improving Access & Treatment	• Health services strategy, including specialised services • Use of digital integration to improve access and outcomes in clinical pathways
Improving Outcomes for MHLDA	• Innovation in new models of care to tackle inequalities, and improve access and outcomes for residents
Intelligence-led Quality, Performance, Outcomes & Inequalities Improvement	• Implementation of the Population Health Intelligence Unit • Ongoing connectivity of data to enable joined-up care for residents, & evaluation of benefits • Digital integration to enable technological innovation to support people to live more years in good health
Thriving Ecosystems and Prosperous Communities	• Place-led programmes to support those furthest from training and employment • Use of technology to enable thriving and sustainable ecosystems

3.11 Specialised Commissioning Delegation: Pharmacy, Optometry and Dental Delegated Commissioning

1. What is the Purpose of this Enabler?

The delegation of Pharmacy, Optometry and Dental (POD) commissioning from NHS England to the ICB offers an opportunity to help to address inequalities by greater joint working towards locally agreed priorities, with focused prevention initiatives that are co-produced. In parallel, we will be able to build better relationships with POD providers at neighbourhood level help to develop community solutions to local issues.

Dental access is an area of particular focus for the ICB given that there are significant challenges nationally and locally around workforce and contracts. We regularly receive feedback from Healthwatch and complaints from individuals that access to NHS dental care is a significant issue locally, and we are developing ways to capture data on the scale of unmet need.

The opportunity that the ICB has to address these challenges is limited as the contracts are nationally negotiated, but we will have the chance to work with local providers to maximise the impact of prevention and focus the resources where they are needed most in the local population. Oral health is an indicator of broader determinants of health and wellbeing, and we will be working across the system to explore how we can maximise the impact that improved access to dental care can have to people and communities.

2. The current landscape in BLMK:

Across all POD providers

POD commissioning is different to the way we commission other services. They are all nationally negotiated contracts, and the contracting and assurance function is very light touch. Providers can decide whether or not they want to deliver NHS service and therefore our approach needs to be collaborative and supportive, improving the appetite for providers to engage.

The work programme across POD will look for ways to work differently with our local providers, improving engagement and ensuring that they are an integrated part of place development. We plan to work on:

- Making every contact count to maximise prevention
- Build awareness of local options and referral points
- Maximise options for approach to immunisations and vaccinations
- Improve signposting for the local community
- Case finding and screening in more settings

Community Pharmacy

Community pharmacy is a well-established partner within the neighbourhood working and there are many good examples of pharmacies working closely with GP practices to improve access and outcomes. We have already implemented the Community Pharmacy Consultation service and hypertension screening and will be looking for ways to build on the successes of this. We will also work with local pharmacies to give more of them access to GP records to provide more seamless care and ensure that there are mechanisms to follow up community pharmacy findings. This is alongside the national initiatives that are included in the Primary Care Recovery Programme which will see Community Pharmacy play a stronger role in providing care to patients.

We have a Community Pharmacy Transformation Lead who will be working with the POD contracting team, Public Health, Local Pharmaceutical Committees, local providers and the Medicines Optimisation Team to develop a roadmap for community pharmacy which will help maximise their role and further strengthen the partnership working that is already in place.

Optometry

The contract for providing NHS optometry services is nationally negotiated. BLMK has a good network of optometrists providing this service and there is reasonable access. We have started initial discussions with Local Optometry Committees and are developing an understanding of the local context, provider landscape, access issues and contracts. These conversations have highlighted that there are national negotiations already underway around a review to the rates of reimbursement, and the ICB will monitor this to understand the local impact of any changes.

In addition to the core national contract the ICB commissions Optometrists Community Urgent Eye Service which offers an alternative to A&E and links directly with the local hospitals. The service will be reviewed for effectiveness and to ensure that the opportunity it offers is being maximised. Local optometrists work closely with our acute hospitals and have direct referral routes for relevant conditions. We will look to build on making every contact count.

Dental

BLMK has a relatively high incidence of dental decay in 5-year-olds compared to the rest of the East of England region but is about the same as the national level. Within BLMK there are inequalities, with Luton having the highest prevalence of experience of dental decay in 5-year-olds. Central Bedfordshire has the lowest prevalence and the lowest mean number of teeth with experience of dental decay. However, across BLMK there is evidence that oral health is improving with decreasing prevalence across the last four Office for Health Improvement and Disparities surveys which collects these annual snapshots of oral health.

We are working closely with Public Health colleagues to understand how we can use this, and other data collected to develop a clear picture of the local priorities in terms of need, access and unmet demand and inequality and will be developing a local dental strategy supported by the regional Local Dental Network and the development of a BLMK Dental Network. We will also review and maximise other initiatives that are underway such as the dental care home initiative and prevention activities within schools to reduce the need for dental treatment.

The limitations of the national contract have been highlighted by the Hewitt Report and NHS Confederation as factors which need addressing at a national level to improve uptake of NHS work by dental providers, therefore improving access to NHS dental care. We will monitor the developments with the national contract and look for ways to maximise existing contracts in the meantime in relation to prevention and access to urgent dental care. We will also be reprocuring our Community Dental Service which will give us the opportunity to co-design a solution which meets the needs of our population and helps to address some of the current barriers to access for the population.

3. What does good look like?

Across all POD providers

- Access to information and signposting which is consistent and supports the public to make the right choices
- Opportunities to engage patients in conversations around their broader health and wellbeing are routine, and where other needs are highlighted that the patient is supported to navigate the appropriate pathway

- POD providers are engaged in conversations at place which offer an opportunity for them to maximise their contribution to improving the health and reducing the inequalities of our populations

Community Pharmacy

All community pharmacies have access to the information that they need to provide the best proactive care to patients that they can. Opportunities for health screening and case finding are maximised and patients feel supported by pharmacies as part of the front door for health services. Where they are able to help address more urgent health needs without the patient needing to access GP or acute services they do, and where patients need onward referral that this is seamless. This will maximise the impact of community pharmacies in the broader NHS and reduce the demands on GP and acute services where this is possible.

Optometry

The role of community optometry is maximised with patients able to access their local service for relevant conditions. The availability of this as an alternative pathway is tied in to local urgent and routine care which ensures that patients are able to access the relevant service with ease. Where onward referral is required, this is done seamlessly. Opportunities to discuss broader prevention issues are maximised and case finding is routine with clear onward referral routes.

Dental

Prevention opportunities are maximised, and we have fewer children that experience dental decay. Inequalities are reduced and prevention initiatives are focussed on where they can have the biggest impact, combined with addressing the wider determinants of health. People are able to better access NHS dental care, including urgent dental care. The workforce feels supported with a more effective contract and as a result we have more dentists that are willing to offer NHS services which increases the capacity. People are able to access care at an earlier stage and therefore treatment is more effective which improves overall oral health. Broader determinants of health and wellbeing are considered in every contact with patients and there is access to effective information and signposting to other services.

4. Delivery

As the contracts transferred on 1st April 2023, we are in the relatively early stages of understanding the issues, benefits and opportunities that POD delegation presents. We are therefore planning for use 2023/24 as a year of STABILISATION to:

- Embed NHSE teams in to ICB and refine existing and new processes
- Monitor budget and develop a detailed understanding of spend and activity
- Develop relationship with POD contractors and improve understanding of issues

2024/25 will focus on ACCESS to work on:

- Public Health and data driven approach to informing improvement plan
- Work with providers to create joint improvement approach
- Track improvements to access and explore additional initiatives

2025/26 will see us beginning to TARGET INEQUALITIES through:

- Public Health inform planning to highlight areas of inequality and related population health outcomes
- Working with providers, set out a strategy to address priority areas
- Track improvements and change in population health outcomes e.g., reduction in incidence of diabetes, improvements in mental health

During 2023/24 we will work with stakeholders to develop our approach and methodology ensuring that we maximise opportunities for co-production.

3.12 Sustainability & Growth: Thriving Ecosystems & Prosperous Communities

1. What is the Purpose of this Enabler?

The health of individuals and communities is determined by much more than the healthcare they access and receive. Research[2] suggests 80% of health is due to the "**wider determinants of health**" – this includes the ecosystems –environments in which we live, the opportunities we have, the things we choose to do in our lives, and the way we do them, as shown below;

Adapted from Robert Woods Johnson Foundation / University of Wisconsin County Health Rankings Model

Thriving ecosystems and prosperous, fair communities are fundamental to a healthy, equal community – without these, health will worsen, health inequalities will widen, and demand for health and care services will only increase.

Therefore, if we tend to our ecosystems and community prosperity, we can have a direct, positive impact on the health of our populations whilst addressing some of the other challenges the health and care system faces – such as quality of care, inequalities in outcomes, demand for services, workforce recruitment and retention, and financial stability. The fourth pillar of BLMK ICS is to support the social and economic development of its population.

Furthermore, the healthcare system has a statutory duty to pay due regard to climate change. The climate emergency is a health emergency – we know that environmental pollution and degradation has a negative impact on human health and the ecosystems in which we live.

The impact of environmental degradation is felt throughout life for example including:

Start well - Children Growing up need a healthy environment:

- Air pollution affects children's development, before and after birth (RCP, 2016), including:
- Lower birth weights
- Incidence of asthma and allergy
- Attainment levels in schools.

Live well - Natural environments are restorative and protective

- Access to greenspace is much lower for those in most deprived areas
- Natural environments can enhance wellbeing, social contact and community cohesion

[2] The Robert Woods Johnson Foundation / Wisconsin County Health Rankings model

- Tree-cover can result in lower surface temperatures of up to 20°C (Hesslerová et al, 2013)
- High-carbon diets contribute to weight-gain, diabetes and other health issues.

Age well - Environmental impacts are highest for the most vulnerable

- Long-term exposure to air pollution has been associated with dementia, heart disease, stroke and some cancers (PHE, 2018)
- Heatwaves result in excess deaths, particularly in the more vulnerable

2. The current landscape in BLMK:

Environmental Sustainability in BLMK

Healthcare contributes to climate change and pollution, particularly through energy, travel, medicines, equipment, its supply chain, and waste (such as single-use plastic). For the NHS in BLMK:

- we annually emit the equivalent of driving more than 47,000 times around the world.
- we emitted 324,540 tCO2e in 2019/20; to remain on-track to meet national targets requires that this drops by 50% by the end of the decade.

A Health Impact Assessment of the BLMK ICS Green Plan, was published in January 2023 indicating:

- ~40 excess deaths in 2022 due to the heatwaves
- More than 400 deaths per year attributable to air pollution
- More than 200 bowel cancer cases caused through “high-carbon diets”

Environmental sustainability should be threaded throughout everything we do, and we can use the lens of environmental sustainability and net zero to also help achieve our wider goals, such as:

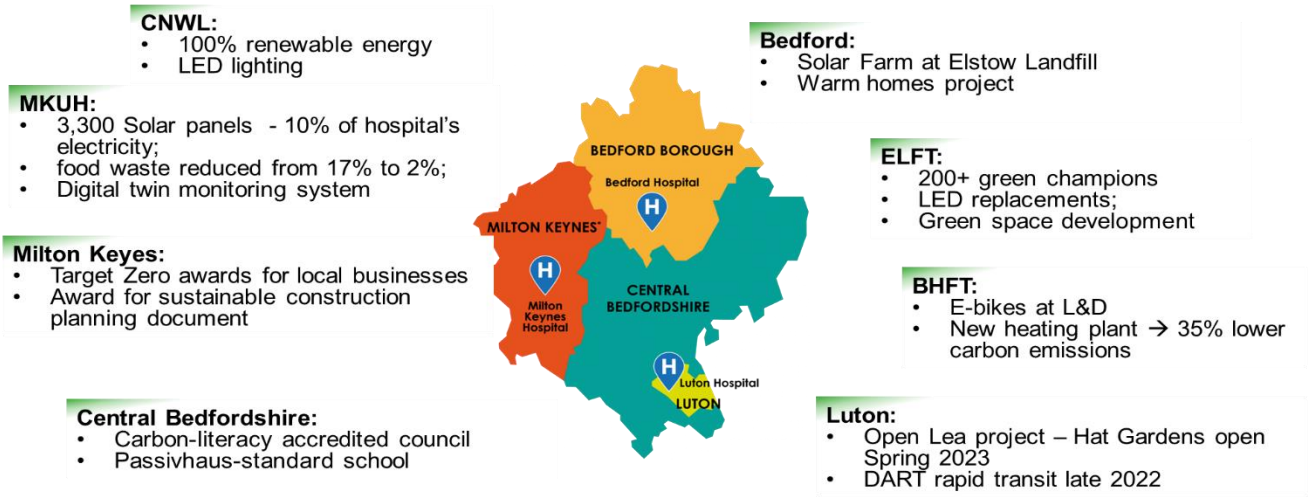
- There are clear links between access to the natural world and our physical and mental health
- In additional to staff wellbeing, there is some evidence that recruitment and retention is enhanced for companies taking sustainability seriously
- Ensuring good disease control, reducing polypharmacy, and using alternatives such as green social prescribing can reduce spend on medicines and associated emissions
- Healthier lifestyles, such as increasing activity levels through active travel, and healthier diets, can reduce risks of CVD, respiratory illness, diabetes, stroke and other conditions, as well as reducing emissions from vehicles and food supply chains.
- Reprocessing of equipment and recycling waste can introduce savings and even income streams whilst redirecting waste from landfill or incineration. Virtual and digital care can improve access, reduce demand for healthcare and give more control to patients in their care, while reducing the need to travel.

BLMK ICS and its constituent organisations have been working on environmental sustainability for several years. All NHS and local authority partners have published sustainability strategies in place, and the ICS as a whole has produced its three-year green plan, setting out high-level ambitions for addressing its impact on the climate and local environment. The progress already made progress across the ICS includes:

- A Health Impact Assessment was published in 2023, outlining the potential health risks and benefits and emissions likely if we were to achieve those ambitions set out in the Green Plan.
- Carbon literacy training for staff in primary care, secondary care and ICB

- System-wide healthcare adaptation task & finish to begin in May 2023
- Fuel poverty projects in Luton and Bedford Borough winter 2022/23
- Virtual ways of working (care delivery and office work)
- ICB Workforce – appraisal objectives and JD statements drafted for inclusion for all
- Social value – 10% weighting in all procurements.
- Sustainability impact assessment / checklist being trialled
- Inhalers – reduction in mean carbon emissions per non-salbutamol inhaler from 98th percentile to 59th in 12 months.

Examples of sustainability already embedded across BLMK Partners include:



Sustainable Economic Growth

As the diagram in section 1 shows, 40% of a person's health is related to their socio-economic situation.

- Around 120,000 (13%) of people in BLMK are living in areas of highest deprivation
- ~55% of UK households were predicted to be in fuel poverty by January 2023 (>80% for large families, lone parents, and pensioners).
- Long-term sickness is the cause of 43% of economic inactivity in Central Bedfordshire
- 20.7% (6,100) of economically inactive people in Milton Keynes want a job
- Bedford Borough (3.9%) and Luton Borough (5.5%) have above-average out-of-work benefit claimants

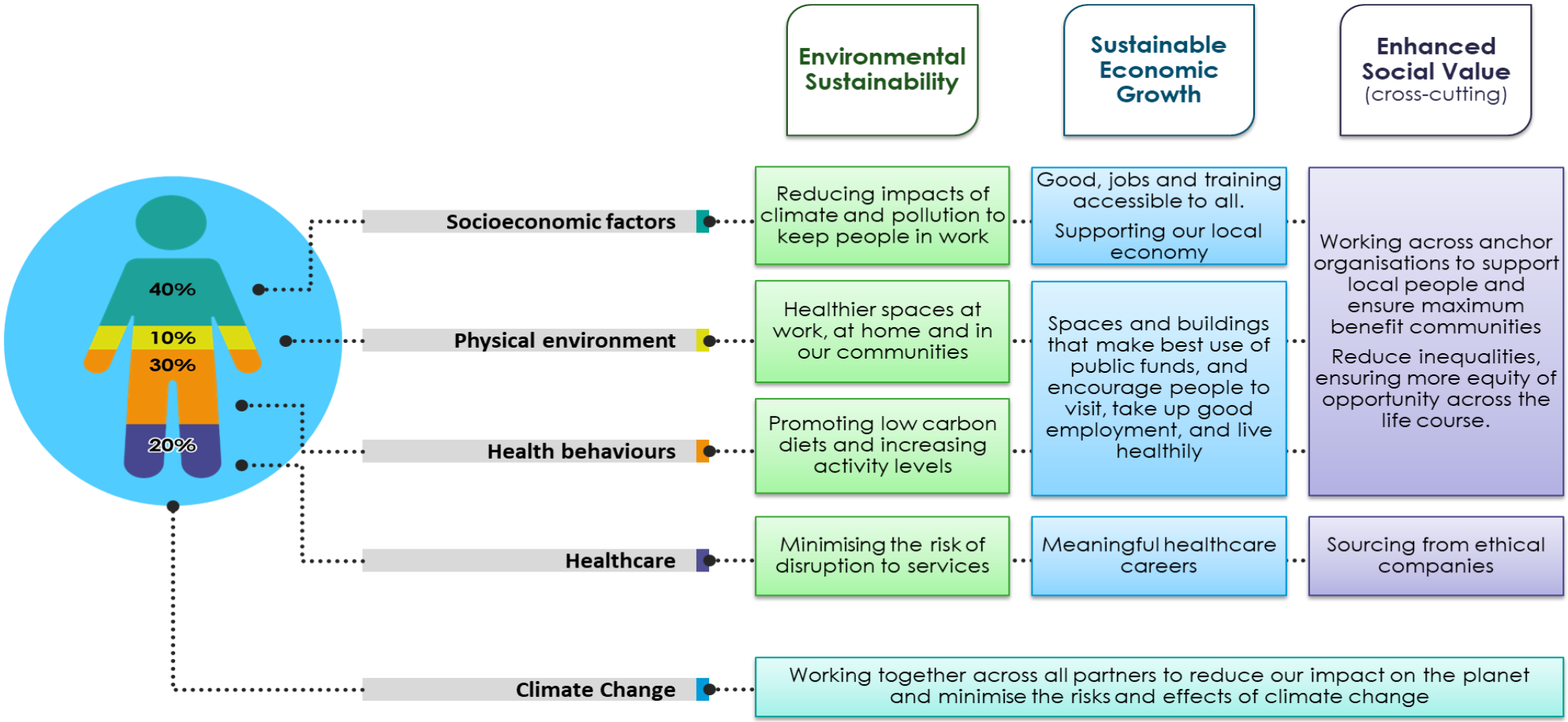
BLMK is one of the highest areas of population growth in the UK (almost 17%, 2011-2021 according to the UK Census 2021). Unlike much of the UK, the younger generations are growing alongside older generations. This means an increase in both working-age and economically-dependent resident cohorts – without appropriate, good quality jobs, we risk increasing unemployment and economic inactivity.

Supporting local social and economic development is one of the biggest opportunities for BLMK ICS to improve health, for example by addressing:

- Economic inactivity
- Poor quality jobs
- Barriers to employment, including in healthcare, particularly for those furthest from employment
- Insufficient good quality housing
- Inefficient use of public assets

3. What does good look like in BLMK?

BLMK ICB Partners will work together to help build the economy and support sustainable growth, focusing on the different wider determinants of health as outlined below;



Every decision will be driven by short- and long-term consideration of the environment and a circular economy:

Area	Example activities	Evidence / best practice	Measures and impact
Leadership, capability and embedding	• Working towards 100% of staff being "Carbon Literate" • Right tools for staff (e.g., sustainability checklist, Green Theatre checklist, Green impact toolkit, ICS Clean Air framework); • "Carbon" considered alongside quality and finance • Review and align whole Joint Forward Plan against Reduce-Renewable-Reuse-Reprocess-Recycle	• County Durham and Darlington NHS FT – 86%+ of staff undertook the free e-LfH basic carbon literacy course over 12 months • Carbon Literacy Project suggests that 5-15% of carbon emissions could be reduced with increased employee awareness	• Staff retention • Decisions made on the basis of environmental and related concerns
Focus on intersections with health	• Increase activity levels for children • Lower-carbon diets • Green social prescribing • Air pollution awareness and reducing exposure	• Nature-based interventions (e.g., green social prescribing) demonstrate effective improvement affective mental health disorders • Higher activity levels and healthier lifestyles significantly reduce incidence of diabetes (20%), stroke (27%), and cardiovascular disease (15%)	• Incidences of stroke, diabetes asthma, allergy, obesity, medicines use • Social value-add
Reduce	• Virtual commuting; virtual healthcare • Health promotion / illness prevention • System-wide procurement opportunities, including making our own consumables • Shift to lower-carbon alternatives e.g., anaesthetics	• Driving 1 mile in a diesel car in a congested urban area results in 12 minutes of life lost cf. 30s for an EV (Berners-Lee, 2021)	• Lower business and patient miles travelled • Lower use of resources
Renewable	• Energy generation at system- and organisational-level • Use natural environment to improve climate resilience of services	• MKUH is aiming for 15% of its electricity and a return on investment of 3-4 years from its solar panels • EoE doing a feasibility study of on-site renewables	• Energy mix • Incidence of over-heating buildings
Reuse	• Reduce single-use devices and consumables e.g., regional Gloves-Off campaign	• GOSH saved 21 tonnes of plastic and £90k through their gloves-off campaign	• Equipment used • Carbon emitted • Spend • Waste diverted
Reprocess	• Device reprocessing schemes	• In 12 months, Leeds Hospitals diverted 102kg of waste, and saved 69kg CO2 and £25k through device remanufacture	
Recycle	• System-wide recycling schemes (e.g., walking aids)	• Sterimelt machines from TCG are being used by several hospitals across the UK to recycling 100,000s of single-use masks into reusable Polypropylene.	

4. Our Approach to Delivery in our Joint Forward Plan

Environmental Sustainability in BLMK

The ICB must embed environmental sustainability in every process, programme, policy and strategy, including:

- **Reduce**: Step up public health, prevention and early-intervention to reduce resource use.
- **Reuse**: move away from mentality of single use
- **Repair**: stop throwing things away when they are broken.
- **Renewable**: avoid virgin materials and non-renewable sources of energy
- **Reprocess**: strip down equipment, clean up, and use the parts or whole again
- **Recycle**: break down end-of-life things to produce useful, usable raw materials

(as adapted from NHS England Central Commercial Function)

The ICS also has an opportunity to support these must-dos through capability-building, supporting ICS partners to deliver, share ideas and learning, collaborate to improve efficiency and effectiveness of common services and assets (e.g., estates, procurement and supply chain), and embedding a culture of innovation and quality improvement so new ideas can flourish. Threading environmental sustainability throughout our work is not without challenge, needing particular attention to be paid to:

- Behaviours and knowledge – helping staff to understand what they need to do, giving them the right tools and permission to act within their own sphere of influence, and supporting them to lead by example and challenge their peers and leaders.
- Perceived tension between sustainability and other pressures – climate change may be seen as a long-term issue, being resolved at a political level or "by the sustainability team". This might mean that decisions are made on one of the other measures – performance, quality, and finance, to the detriment of the environment in the short- and long-term. We will need to move to a situation where the impact on the environment becomes equally weighted in the "triple bottom line" framework (social, financial and environmental).
- We do not yet have all the answers and in order to move to a fully circular economy we will need to test and embed innovative solutions to some sources of carbon.
- "If you can't measure it, you can't improve it" (Deming) – carbon footprinting information is not always sufficiently detailed to allow us to know what are to target and whether we are having an impact. We are currently using proxy measures and focusing on those areas where the evidence is clearer (such as travel, inhalers, energy and plastics).

Sustainable Economic Growth

BLMK recognises that economic development needs to be planned and delivered over the same timescales as population and demographic change. BLMK ICS will develop short-, medium- and long-term plans over 20 years to:

- use healthcare services as a means to address socio-economic development;
- support local authority ambitions for economic growth.

We will **embed environmental sustainability** and the **concept of circularity** into **all of our work** – it's not a separate concern, but part of supporting healthy lives, and preventing harm and ill health through the delivery of services.

Mobilisation plan:

Area	Activities	Indicative timeframe
System leadership and alignment	Board development in environmental sustainability – training, seminars, briefings	2024
	Agree full-system and place-based collaborations – what are the things that we can only do, or make most sense to do across a larger footprint (e.g., air pollution, medicines, primary care, renewable infrastructure, estates, waste and recycling, reprocessing)	2023 and 2024
	Support development of local strategies (e.g., Local Plans and Local Travel Plans) to maximise opportunities for sustainability and health	2022 onwards
	Develop strategies and implementation plans for place- and system-wide initiatives	April 23 – April 25
Embedding sustainability in ICB and ICS organisations and work	Apply environmental sustainability checklist in all work of the ICB. Encourage similar within NHS providers.	April 2024
	Work with VCSE partnership to identify mutual benefit and additional value add in sustainability	April 2023 onwards
	Review methods for embedding environmental considerations within work across ICS partners	April 2024
	Align commitments (and potentially methods) across all anchor organisations	April 2025
Supply chain	Social value – mandatory environmental sustainability elements and supplier carbon reduction plans in all tenders	April 2023
	Social value – ensuring effectiveness through training, monitoring, measurement and evaluation mechanisms – alignment across system	2023/24 onwards

Area	Activities	Indicative timeframe
	Market development in collaboration with ICS partners (e.g., for reprocessing, local supply)	2024 onwards
Resident participation	Coproduction of long-term plan (8, 12 years and 22 years)	Q3 2023/24 – April 2025
	Develop mechanisms to ensure resident's views and ideas on environment are incorporated into all service redesign work	2025
Progress against Green Plans and LA sustainability plans	Support Trusts to develop and implement their own plans, incl. innovations	April 2022 onwards
	Identify synergies with local authority plans to support progress at place	April 2022 onwards
	Develop and implement ICS Green Plan thematic ambitions	April 2022 onwards

Appendix D

Assurance Matrices

4.1 The BLMK Joint Forward Plan and NHS England Operating Targets Assurance

[to follow]

4.2 The BLMK Joint Forward Plan and our ICB Statutory / Mandatory Responsibilities

[to follow]

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

ICS Partner: Maxine Taffetani, Chief Executive Officer Healthwatch Milton Keynes

ICB Executive: Maria Wogan, Chief of System Assurance and Corporate Services

Report Author: Michelle Summers, Associate Director Communications and Engagement

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

Item: 6.4 - Healthwatch Memorandum of Understanding

1.0 Executive Summary

1.1 Our intention is to sign a Memorandum of Understanding with Healthwatch organisations in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes in July, to cement Healthwatch's position as an important strategic partner to the BLMK Integrated Care Board.

1.2 This document is the culmination of six months co-design work to agree an approach that will work for all five organisations.

1.3 The document sets out proposed ways of working together and looks to address issues such as forward planning, funding, intellectual property, and dispute resolution processes – within the unique statutory framework that Healthwatch has within Integrated Care Systems.

1.4 This MOU is currently passing through the governance processes of all four Healthwatch organisations to secure support from their Boards for this approach. Any proposed amendments received after publication of this Board paper will be reported at the Board meeting.

1.5 Should the MOU receive approval from the five Boards, our ambition is to hold a signing event in July to mark this important partnership and the benefits this will bring to residents.

2.0 Recommendations

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

1. Memorandum of Understanding between the ICB and Healthwatch

3.0 Key Implications

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

Resourcing

3.1 The Memorandum does not have any resourcing implications for the ICB but paves the way for resource to be commissioned from Healthwatch organisations as required.

Equalities and Health Inequalities

3.2 Healthwatch in our four local authority areas are trusted advocates for local people and communities. Working with Healthwatch will provide greater access to seldom heard communities and help us to build trust with communities of interest.

Engagement

3.3 The MOU between the ICB and Healthwatch will support more meaningful engagement with people and communities and BLMK.

Green Plan Commitments

3.4 Engaging with Healthwatch as a strategic partner will support the ICB in co-producing with residents. Working with people at place will help us to deliver the carbon reduction targets outlined in the Green Plan.

4.0 Report

4.1 Healthwatch is an important statutory partner to the Integrated Care Board, with a role in amplifying the voice of people and communities.

4.2 Their main statutory functions are to:

- Obtain the views of people about their needs and experience of local health and social care services. Local Healthwatch make these views known to those involved in the commissioning and scrutiny of care services.
- Make reports and make recommendations about how those services could or should be improved.
- Promote and support the involvement of people in the monitoring, commissioning and provision of local health and social care services.
- Provide information and advice to the public about accessing health and social care services and the options available to them.
- Make the views and experiences of people known to Healthwatch England, helping us to carry out our role as national champion.
- Make recommendations to Healthwatch England to advise the CQC to carry out special reviews or investigations into areas of concern.

4.3 Since the formation of the BLMK ICB, the four Healthwatch organisations have been working together, agreeing which Healthwatch should take the lead on which committees and share information between themselves.

4.4 The Healthwatch's have formed a collaborative of the chief executives', and this led to the signing of a Memorandum of Understanding between the four Healthwatch, to ensure that they had mechanisms in place to support system wide working, whilst also continuing to deliver their statutory functions at place.

4.5 Building on this, approach and to provide clarity around the new ways of working between Healthwatch and the ICB, the communications and engagement team has worked with the chief executives of all four Healthwatch organisations to co-design a Memorandum of

Understanding that will allow for greater integration between the organisations whilst respecting Healthwatch's statutory place-based role, as the voice of residents.

4.6 The document is currently passing through the governance processes of all four Healthwatch for Board approvals. Pending the approval of the ICB Board, we will look to undertake an official signing in July 2023.

4.7 This will be followed by workshops with staff within the ICB to set out the levels of support available for us to commission work.

5.0 Next Steps

5.1 Following approval from the Board and the Boards of all four Healthwatch, we will schedule in a formal signing event in July.

List of appendices

Appendix A – Healthwatch MOU

DRAFT Memorandum of understanding between Bedfordshire, Luton and Milton Keynes Healthwatch Collaborative and Bedfordshire, Luton and Milton Keynes Integrated Care Board

1. Introduction

This is a Memorandum of Understanding between **Healthwatch Bedford Borough (HWBB), Healthwatch Central Bedfordshire (HWCB), Healthwatch Luton (HWL), Healthwatch Milton Keynes (HWMK) and Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB).**

The Bedfordshire, Luton and Milton Keynes Integrated Care Board is responsible for planning the delivery of NHS services to achieve the aims of the strategy to improve the health of the population of Bedfordshire, Luton and Milton Keynes (BLMK), including deciding how resources are allocated.

Healthwatch are local health and social care champions. Within the Bedfordshire, Luton and Milton Keynes Integrated Care System there are four local Healthwatch: Healthwatch Bedford Borough, Healthwatch Central Bedfordshire, Healthwatch Luton and Healthwatch Milton Keynes. As independent bodies with statutory functions, Healthwatch has powers to ensure system leaders and other decision makers listen to people's feedback and improve standards of care.

1.1 Background and context

This Memorandum of Understanding (MoU) sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health and wellbeing of the people of Bedfordshire, Luton and Milton Keynes. We serve a population of 991,800 (2021 figure). The area covered by the Integrated Care System faces several health and social care challenges, including:

- clear and widening health inequalities
- increasing demand on and access to health and social care services
- growing and retaining a workforce to meet the demand on services and support the increasingly complex needs of residents
- rising costs, and the need to manage greater demand within stretched budgets

In July 2022 NHS BLMK Integrated Care Board was established, inheriting commissioning functions at scale across Bedfordshire, Luton and Milton Keynes. The BLMK Health and Care Partnership, which is responsible for developing a system wide strategy to transform health and social care commissioning across Bedfordshire, Luton and Milton Keynes was also formed. The ICB's responsibilities include a duty to collaborate across the healthcare, public health, and social care and shift away from competition toward integration, collaboration and partnership.

HWBB, HWCB, HWL and HWMK are legally separate organisations providing the statutory Healthwatch functions within the four local authority areas in the BLMK ICS. We recognise that greater collaboration and collective use of our limited resources is required to support and monitor the development and execution of ICS strategies, to ensure that all residents across the ICS are equitably involved in large-scale commissioning and transformation work, and to deliver effective ICS wide engagement projects and activities that include all our people and communities.

HWBB, HWCB, HWMK and HWL have formed a collaborative agreement underpinned by a Memorandum of Understanding to support the Integrated Care System to effectively deliver its four key aims to improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, enhance productivity and value for money and help the NHS support broader social and economic development.

1.2 Purpose of the MoU

The purpose of this MoU is to formalise the ways of strategic partnership working between Healthwatch Bedford Borough, Healthwatch Central Bedfordshire, Healthwatch Luton, Healthwatch Milton Keynes and Bedfordshire, Luton and Milton Keynes Integrated Care Board for the benefit of the population of Bedfordshire, Luton and Milton Keynes.

1.3 Parties involved

This MoU is between:

Healthwatch Bedford Borough

Healthwatch Central Bedfordshire

Healthwatch Luton

Healthwatch Milton Keynes

Bedfordshire, Luton and Milton Keynes Integrated Care Board

1.4 Role of local Healthwatch

The vision for the BLMK Healthwatch Collaborative is to ensure that health and care leaders, policy makers, commissioners and providers design and deliver services that reflect the diverse needs of the communities of Bedfordshire, Luton and Milton Keynes and involve them at every level of decision making within the Bedfordshire, Luton and Milton Keynes Integrated Care System.

Our joint mission is for the BLMK Healthwatch Collaborative to be the independent champions for people in Bedfordshire, Luton and Milton Keynes providing a strong, collective voice and empowering our communities to influence the way health and social care services are designed and delivered.

Each Healthwatch within BLMK represents very different places and geographies, and has unique access, insight, and expertise within our communities. We use that insight to better understand the challenges facing our places, and the system, to make sure people's experiences improve health and care services for everyone. We also help people with the information and advice they need to make the right decisions and get the support they need.

The Local Government and Public Involvement in Health Act 2007, which was amended by the Health and Social Care Act 2012, outlines the main legal requirements of Healthwatch and our commitments, as a Healthwatch Collaborative

- Promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local care services.
- Enabling local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved.

- Obtaining the views of local people regarding their need for, and experiences of, local care services and importantly to make these views known to those responsible for commissioning, providing, managing or scrutinising local care services and to Healthwatch England.
- Making reports and recommendations about how local care services could or ought to be improved. These should be directed to commissioners and providers of care services, and people responsible for managing or scrutinising local care services and shared with Healthwatch England.
- Providing advice and information about access to local care services so choices can be made about local care services.
- Formulating views on the standard of provision and whether and how the local care services could and ought to be improved; and sharing these views with Healthwatch England.
- Making recommendations to Healthwatch England to advise the Care Quality Commission (CQC) to conduct special reviews or investigations (or, where the circumstances justify doing so, making such recommendations direct to the CQC); and to make recommendations to Healthwatch England to publish reports about issues.
- Providing Healthwatch England with the intelligence and insight it needs to perform effectively.

The authority and influence of the ICB plays a crucial role in ensuring local Healthwatch have opportunities to strengthen partnership working and access resources for activities at place and at Bedfordshire Care Alliance level, where ICS priorities and funding is delegated. In addition, where provided with sustainable system-level resourcing directly from the ICB, BLMK Healthwatch Collaborative can work with greater capacity at scale to deliver involvement and participation activities, support co-production activities with residents, support the development of patient representatives and patient participation groups (PPGs), as well as providing training.

1.5 Joint working

The ICB and the Healthwatch Collaborative will work in constructive partnership to ensure the views, experiences and needs of residents in the ICS sit at the heart of service design, transformation, delivery and evaluation.

The ICB and BLMK Healthwatch Collaborative agree to communicate proactively with each other and raise matters of concern within a spirit of partnership wherever possible.

The ICB recognises that Healthwatch follows a statutory reporting and publication framework that involves service providers and commissioners at appropriate points in reporting processes.

The ICB acknowledges the independence of Healthwatch and its ability to raise the issues the public feel is important. Healthwatch will look for those that align with the strategic priorities of the system, but there may be issues that Healthwatch raise because they come through strongly in the insights received from the public. This might include publishing reports with findings that may be uncomfortable for the system to have shared.

Healthwatch recognises that the ICB is required to follow legislation and take account of NHS guidance that shapes ways of working in a way that serves the local population. Where possible, the

ICB will share information with Healthwatch prior to publication of communications to allow Healthwatch to support residents where necessary and help to build a shared understanding of issues as they arise.

The ICB will share its forward plan of engagement and consultation with Healthwatch, and the Working with People and Communities Committee, where all four Healthwatch organisations are represented, to ensure they have visibility of all consultations and the opportunity to share their views in the formative stages of planning.

The ICB will ensure it makes opportunities for partnership appropriate, reasonable and realistic. The ICB should ensure it recognises, and where appropriate supports the often-limited resources of local Healthwatch. This will be demonstrated by actions such as giving local Healthwatch sufficient notice and clarity on the expectations of their involvement and resourcing local Healthwatch to undertake ICS wide activities.

The ICB and BLMK Healthwatch Collaborative will routinely discuss, prioritise, agree and review:

- Activities the ICS would like engagement support on from local Healthwatch.
- The sharing of insight to the ICB
- ICB Engagement approaches
- A resourced programme of engagement activities
- The effectiveness of communications

These discussions may take place in dedicated meetings embedded within appropriate Boards and Committees of the ICB. Specific agreements and resource allocations will be set out in a co-created annual plan.

2. BLMK Healthwatch Collaborative's Expectations of the ICB

Principle Expectations

BLMK Healthwatch Collaborative has agreed the following set of expectations with the ICB to ensure that the people and communities of Bedfordshire, Luton and Milton Keynes are listened to, represented and involved equally and equitably at a place and system level, unless broader representation is agreed by all four Healthwatch organisations, or where there is a logical case for engagement by the most appropriate Healthwatch.

Our principle expectations of the ICB are:

1. To ensure that all Healthwatch and the independent voices of our communities are equitably represented at a system level within the ICS.
2. Recognise the role of the Healthwatch Collaborative to monitor, challenge and as appropriate support the implementation of the 10 principles for how ICSs work with people and communities
3. Support a collective approach to working in strategic partnership with local Healthwatch at scale.
4. Recognise that local Healthwatch are licenced to operate within a local authority area and are publicly accountable. Local Healthwatch must be able to demonstrate the allocation of resources and activities at place, based on local priorities, plans and views/concerns raised by residents. Activities and membership to Boards and Committees that sit outside, or stretch this place-based remit requires appropriate funding.
5. Co-create a resourced and funded plan (refreshed annually) for representation at ICS Boards and Committees, and for delivering system wide insight and activities.
6. To communicate this MOU with all Directors, departments and clinical staff within the ICB.
7. Plan in sufficient time for the Healthwatch collaborative to discuss service specifications between each other, and with ICS project and contracting teams when developing proposals.
8. Work actively to ensure staff within the ICB have good knowledge of agreed activity plans with Healthwatch and how/who to raise queries with about additional activities.
9. Respond to local Healthwatch reports and recommendations in a timely manner. The ICB should be clear who the appropriate officers are to respond to and ensure they respond within statutory timescales. Where local Healthwatch provide insight reports and updates, the ICB will confirm how these have been used to improve services – "you said, we did".

Expectations regarding Membership of ICS Boards and Committees

The BLMK Healthwatch Collaborative consider it best practice and will seek to provide strategic level representation from all Healthwatch on Boards Committees and workstreams of the ICS. This is

to ensure senior level expertise in supporting community engagement communications and co-production.

The Healthwatch Collaborative recognise that membership to Boards and Committees may be limited. The ICB recognises that local Healthwatch may have insufficient resources to provide full place-level representation on Boards and Committees.

In such cases, BLMK Healthwatch Collaborative expects that the Chair/Lead of the relevant ICS Board or forum will contact the Healthwatch collaborative and explain the rationale for limiting Healthwatch membership from all Places.

The Healthwatch Collaborative will explore and address any concerns about limiting representation, agree solutions with the Chair/Lead and set out resourcing needs for Collaborative representatives.

The ICB recognises that if appropriate resourcing can't be provided, this will limit the capacity for the Healthwatch collaborative to support the aims and work of the ICS.

A current representation framework has been established between BLMK Healthwatch Collaborative and the ICB.

Expectations in discharging Healthwatch statutory functions

Strategic representation allows local Healthwatch to ensure public involvement in planning, commissioning and providing services. As described above this will be in a spirit of constructive partnership.

However, Healthwatch also need to hold commissioners, providers and system partners to account, representing the views of the public in areas such as:

- Appropriate use of public funds
- Ensuring safe and high-quality services
- Duty of candour for NHS organisations
- Transparent and ethical decision making
- Timely responses to recommendations and reports
- Compliance with law, guidance and policy (including feedback to CQC and other regulatory bodies)

We expect the ICB's full support in undertaking our independent statutory functions.

3. The ICB's Expectations of BLMK Healthwatch Collaborative

- The Integrated Care Board expects local Healthwatch, and the BLMK Healthwatch Collaborative to act as a strategic partner to support delivery of its statutory responsibilities, as outlined in Section 116ZB Health and Care Bill.
- Insights and lived experiences from places, as heard through local Healthwatch channels and events will be fed into the organisation to inform decisions both at place and at scale.

- Where appropriate, the ICS will ask for the support of local Healthwatch at place to engage with seldom asked communities and local people, where Healthwatch is a trusted advocate. This work will be built into the overall schedule for the ICB and resourced appropriately.
- The Integrated Care Board is committed to continuous conversations and will provide feedback to Healthwatch, and local communities through existing channels to demonstrate how feedback has impacted on decision making (you said, we're doing).
- ICB expects that local Healthwatch will promote the ICB's and wider system communications and publicly share progress with activities related to working with the ICS.

3.1 Overarching commitments

The ICB commits to working effectively with local Healthwatch and the BLMK Healthwatch Collaborative by:

- Acknowledging local Healthwatch's engagement expertise; the rich, unique insight and community connections they have built; and their role in scrutinising the involvement of people and communities at an ICS level.
- Recognising local Healthwatch's level of resourcing to support ICS work.
- Working with local Healthwatch on a monthly basis to discuss, align, prioritise and review the activities the ICS would like support with.
- At the start of any work, being clear about the level of influence local Healthwatch's insight and activities will have to shape the outcomes being sought.
- Providing clarity and articulating expectations of activities prior to agreeing them with local Healthwatch.
- Being timely in the provision of information for meetings or any other activity.
- Provide regular feedback quarterly basis as to how local Healthwatch support to the ICS has changed outcomes for local people and communities.
- Providing sufficient time for local Healthwatch to consider and respond to any additional requests outside the priorities agreed in this MoU.

3.2 Commissioning of and funding for local Healthwatch

- On agreement of work to be commissioned, a project service specification will be provided to all four Healthwatch organisations for them to consider. Healthwatch will have two weeks to provide a fully costed proposal against the service specification for consideration. On approval of work, an MOU will be provided by the contracting team to formalise the agreement.
- Intellectual property belongs to the Healthwatch organisations delivering the work. Where work has been commissioned by the ICB, the copyright remains with the ICB and an agreed

date of publication of Healthwatch findings and reports will be set out within the project MOU. As independent statutory bodies local Healthwatch reserve the right to publish findings and reports by the date set out within the MOU.

- Purchase orders and payment for funded activities will be provided by the ICB within 30 days of receipt of a signed MOU. Payment agreements will be set out within MOUs and clearly state acknowledgement by the ICB that there will be no expectation for project initiation until payment has been received.

4.1 Reporting and insights

Quarterly meetings will be held between all four Healthwatch organisations and the ICB to review reports and insights heard from residents and to discuss work programmes being undertaken.

Reporting for specific programmes of work will be agreed on a project-by-project basis to ensure consistency of approach across the area.

4.2 Confidentiality

All four Healthwatch organisations and the ICB agree to respect the confidentiality of all individuals (including, but not limited to, clients, patients, carers, colleagues etc.), by not disclosing any information obtained, accessed or used in discharging our duties to anybody who does not have a legitimate reason to receive it.

4.3 Managing disputes and resolving disagreements

Partners in this agreement will attempt to resolve in good faith any dispute between them in line with the Principles, Values and Behaviours set out in this Memorandum.

Partners will apply a dispute resolution process to resolve any issues that cannot otherwise be agreed through these arrangements. The key stages of the dispute resolution process are:

1. The ICB's Executive Group and Healthwatch representatives will seek to resolve any disputes to their mutual satisfaction of each of the affected parties. If the Executive Group cannot resolve the dispute within 30 days, then the dispute should be referred to a mutually agreed panel of three independent members from the BLMK Integrated Care Partnership for resolution.
2. The ICP panels purpose will be to consider and resolve the dispute. The panel will agree its Terms of Reference and membership with the ICB and local Healthwatch.
3. The ICP panel will come to a majority decision and will advise the ICB and Healthwatch of its decision in writing. A majority decision will be reached by applying the Principles, Values and Behaviours of this Memorandum., taking account of the objectives of the Health and Care Partnership.
4. If the parties do not accept the panel's decision, or the panel cannot come to a decision, it will be referred to an independent mediator selected by the panel. The mediator will work with the ICB and Healthwatch to resolve the dispute in accordance with the terms of this Memorandum.

4.4 Managing conflicts of interest

The individual local Healthwatch and the BLMK ICB have agreed individually to manage any potential conflicts of interest to ensure that decisions will be taken without influence by external or private interest and do not affect the integrity of their decision-making processes. All parties will comply with their individual organisation's policies on conflicts of interest.

The parties will maintain registers of interest of:

- Roles held on all Boards and Committees of the ICB.

The registers of interest are published on the BLMK ICB Website.

Individuals should declare interests in line with their own organisation's policy for the management of conflicts of interest. All parties to this MoU must ensure that those representing their organisation declare any interest that is relevant to the functions described in this MoU.

4.5 Process for review and updating the MoU

This MOU will be reviewed between the ICB and BLMK Healthwatch Collaborative on an annual basis.

Where any issues are identified with the MOU, it made be revised sooner. The Boards of all local Healthwatch parties covered under this MOU and the ICB must approve any changes.

4.6 Key Contacts

Integrated Care Board:

- Maria Wogan, Chief System Assurance and Corporate Services Director.
- Dominic Woodward-Lebihan, Deputy Chief System Assurance and Corporate Services,
- Michelle Summers, Associate Director Communications and Engagement.

Place Link Directors:

- Maria Wogan, Chief System Assurance and Corporate Services and Milton Keynes Link Director.
- Sarah Stanley, Chief Nursing Director and Bedford Borough Link Director.
- Anne Brierley, Chief Transformation and Central Bedfordshire Place Link Director.
- Nicky Poulain, Chief Primary Care Officer and Luton Place Link Director.

Local Healthwatch:

- Maxine Taffetani, Chief Executive Healthwatch Milton Keynes
- Elizabeth Learoyd, Chief Executive Healthwatch Bedford Borough
- Diana Blackmun, Chief Executive Healthwatch Central Bedfordshire
- Lucy Nicholson, Chief Executive Healthwatch Luton.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

ICS Partner: All Partner Members

ICB Executive: Sarah Stanley, Chief Nurse and Maria Wogan, Chief of System Assurance and Corporate Services

Report Author: Dominic Woodward-Lebihan, Deputy Chief of System Assurance and Corporate Services

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

Item: 7.1 - BLMK Quality and Performance Report – June 23

1.0 Executive Summary

1.1 This report provides a system overview of our key quality and performance improvements. There are notable additions to this report, including a new section around Primary Care Access, more information on the System Oversight Framework (SOF) and an update on the development of the ICB's new Cross-Cutting Outcomes Framework. Note that the ICB's Quality and Performance Committee will be undertaking a deep dive on the SOF at its meeting on 07/07/23 and the outcome will be reported to the Board in September. Partners are welcome to join this deep dive. This Report provides a system overview of our key quality and performance improvements and challenges which were discussed by the System Oversight Assurance Group (SOAG) on 20 June.

2.0 Recommendations

2.1 Members are asked to:

(a) Note the proposed development of a new cross-cutting outcomes framework and support its onward development through the Population Health Intelligence Unit
(b) Note and discuss the areas of improvement and concern raised within the report
(c) Note and discuss the detailed report on the System Oversight Framework (SOF) metrics for BLMK ICS
(d) Agree any additional actions required to manage risk in the system

3.0 Key Implications

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

3.1 System workforce, finance, estates and digital resources impact all areas of performance and quality. Key risks are included within the report and described in the BAF elsewhere on the agenda.

3.2 Inequalities are considered in all aspects of transformational work as a part of the quality agenda, using the Equalities Impact Assessment Process. We are improving the way we analyse data to support us to have a better understanding of inequalities, for example by being able to cut data by population groups.

4.0 Report

4.1 Areas of Quality and Performance Improvement

4.1.1 **Annual Health Checks for People with Learning Disabilities and Serious Mental Illness**– In 2022/23 BLMK achieved 75.45% of people aged 14 years or over on the learning disability register receiving a health check against a national target of 75% and an East of England achievement of 73.30%. This is a significant improvement against the 67.14% achieved in 2021/22. In Q4 2022/23 (rolling 12 months) across BLMK 5,353 health checks for people with serious mental illness were carried out compared to 3,134 at the same time last year[1]. We are investigating why people either decline or do not attend their Health Checks appointments, and a Task and Finish Group meets fortnightly to drive this. The system is committed to continuing this improvement work to address life expectancy inequalities for people with learning disabilities and serious mental illness.

4.1.2 **Dementia Diagnosis Rate** – At the end of March 23 the ICB successfully achieved 66.8% and was the only ICB in the East of England to exceed against the national target of 66.7%.

4.1.3 **Community 2-hour response** - In March local data showed that 89% of Urgent Community referrals were responded to within 2 hours for ELFT, and 95.1% for CNWL against the national standard of 70%. This standard has successfully been delivered by both providers consistently over the last 12 months.

4.2 Areas of Performance and Quality Concern

4.2.1 **Industrial action -** Robust planning & support plans are in place with all system partners together with communication plans around access to services. Industrial action is however impacting performance across the system.

4.2.2 **Elective waiting list** – The waiting list has been increasing month on month since March 2021 and is currently at 128,278 (+1894 from February 23). Bedfordshire Hospitals Trust increased by 1,949 and Milton Keynes by 506. The top two specialties with the highest waiting list continue to be Ophthalmology with 16,113 and ENT 12,953 patients and there is continued system focus on reducing the waiting list in these specialties and exploring wider opportunities to improve patient outcomes. There was one 104-week waiter at MKUH within Ophthalmology (this patient has now been treated). Actions to address residents with long waits on the waiting list has been impacted by the Junior Doctors' Industrial Action and the system is working towards the new ambition of 0 residents waiting 78 weeks by end June except where a patient has chosen to delay their care. In March the ICB was rated in the highest performing quartile with a ranking of 6 compared to the 42 ICBs nationally. The SOAG signed-off the Elective Assurance Framework for the system on 20 June noting that elective performance could be improved if the system had access to greater capital funding. A review of long waits for children and young people was also underway across 3 pathways.

4.2.3 **65+ Week Waits** – From April 2023 the ICB and acute provider trusts are required to reduce the number 65 week waits as part of the 23/24 operational plan. Locally reported data as at 21/05 shows BHFT had 905 patients waiting and MKUH had 459. Weekly reporting and oversight in the Elective Leadership Group.

4.2.4 **Cancer 63-day backlog -** An increase since the end of March within BHFT due to continued challenges including histopathology turnaround times, gynaecology, and urology pathways. MKUH faces imaging capacity issues and additional waiting list initiatives are being utilised where appropriate, at MKUH and within histopathology at BHFT. The ICB is planning to undertake demand and capacity pathway analysis in conjunction with the Cancer Alliance, with a starting focus on gynaecology. Due to current backlog challenges, there is a risk of BHFT deterioration into tier one, to mitigate this, tier 2 meetings continue every other week

[1] Investigations into data quality issues in the SystmOne reporting for this indicator are currently being undertaken.

for BHFT, focusing on reduction of the overall backlog, improvement action plans and how to maximise regional support offers.

4.2.5 **NHS 111 – call abandonment** - <3% threshold – 6-week trend remains a deteriorating position across BLMK. This is primarily due to performance at HUC (Bedfordshire and Luton). During April and May call volumes across the system saw spikes because of Bank Holidays and Industrial Action. Productivity of call handlers increases with experience - both 111 providers have a significant number of Health Advisors with less than 12 months service. Attrition rates are reducing and both providers have welfare programs in place to retain staff, which should improve productivity, reducing call lengths with fewer 111 calls abandoned.

4.2.6 **CNWL – Willow Ward CQC Notice** - CQC notified the ICB that it has withdrawn its warning notification following receipt of evidence from the Trust. CNWL addressed initial concerns and have developed an action plan. Newly appointed clinical and service directors will be in post shortly to provide leadership and visibility across the organisation and undertake a leadership review. Work underway to support improved flow of people admitted with complex emotional needs in line with best practice guidelines. The ICB team, ELFT and local partners continue to offer support. Bi-weekly meetings to be established following an in-person site visit end of June.

4.2.7 **Primary Care Access, Urgent and Emergency Care and Winter Planning -** The national 'Delivery plan for recovering access to primary care' was published on the 9th May which sets out the commitment to tackle the '8am rush' and make it easier and quicker for patients to get the help they need from primary care. This launched a National General Practice Improvement Programme which provides a universal, intermediate, and intensive support offer to practices. The ICB primary care team are proactively engaging and recruiting practices in this support offer. In addition, the Delivery plan for recovering access to primary care has a focus on increasing the availability of Cloud Based Telephony (currently 46 practices in BLMK have this) to further improve the populations experience of contacting their practice. The Primary Care Networks (PCN) are currently drafting their Capacity and Access plans (due by the 30th of June 2023) which will focus on improvements across 3 areas as follows: patient experience of contact, ease of access & demand management and accuracy of recording in appointment books. The March 2023 data shows that practices are at least maintaining the same level of activity as last year. BLMK ranks well for appointments with a professional other than a GP (15/42) and less well for appointments offered on the same day (35/42) - this is an area we expect to see improvement in because of the actions described above.

4.2.8 On 19 June, both BHT and MKUH reported record attendances at A&E. BLMK has been identified as Tier 3 (requiring least support) for UEC by the national team and has refocused the system performance and delivery meeting to provide a forum for system UEC strategy development which will also address the national assurance requirements for UEC. Both BCA and MK are progressing well with their plans for winter 23/24 including investment and development of virtual ward offers. Further work is required on intermediate care bed provision across BLMK and SOAG agreed that cost comparisons between NHS and commissioned provision and benchmarking with other ICSs should be progressed.

4.2.9 **Prevention – Vaccinations and screening**

MMR uptake has suffered in recent years, with national performance for uptake of two doses at 85%. In Q3 2022/23 BLMK ICB performance was at 86.19%. The increased number of measles cases and the surrounding publicity has anecdotally driven an increase in demand for vaccines which may be reflected in figures for Q4 when they are published.

BLMK ICB performance for cervical screening is below the national target of 75% with Q3 performance at 67.78%. There are a number of factors influencing the uptake including residual impact of Covid-19 and people engaging with the programme.

4.2.10 **Proactive Care - Long-term conditions**
The proportion of people with diabetes receiving the eight care processes in primary care has seen an increase due to a local incentive scheme in place in the last financial year to promote this, however the figures mask a very wide variation in performance between individual practices. Work continues to address this variation with a continued focus on care process completion included in the newly launched (from April 2023) BLMK Universal Offer.

4.3 System Oversight Framework

4.3.4 The NHS Oversight Framework is currently underpinned by a set of 89 metrics aligned with the 2022/23 Planning Guidance. For 2023/24 NHSE are reviewing the approach to oversight aligned to the implementation of the new Operating Framework and the recommendations of the Hewitt review, including the proposed shift to fewer, outcomes-based targets and increased weight for locally set targets - The proposed changes will reduce the current metrics by over 40% from 89 to 54. Based on data released in May 2023 there were 14 indicators in the lowest quartile as detailed below for those indicators that continue in the 2023/24 framework.

4.3.5 **Flu vaccination uptake 65+ years** - Pressures in the last flu season were vaccine fatigue, the timing of covid campaign and influenza campaign meaning the opportunity to co-administer was lost and a lack of flexibility to book appointments. The intention is to bring Covid and flu vaccinations into the prevention delivery plan which will enable enhanced communications across primary care and at an ICS level, as well as improved processes for monitoring performance in near real time and supporting areas of low uptake.

4.3.6 **Workforce - Leavers** - The 12-month turnover rate has been consistently around 15% since August 2022, which is higher than the national target of 5%. The People Strategy outlines some key actions to support Retention within the system including the development if an ICS Retention Strategy and Plan including initiatives regarding flexible working, late and mid careers, career coaching and preceptorship programmes.

4.3.7 **Harassment Bullying and Abuse** - East of England Inclusion team has been recruited and commence June 2023. This team will lead the development and implementation of specific Equality, Diversity, and Inclusion (EDI) programmes. Each provider has its own equality and inclusion strategy and anti-racism strategy and share good practice through the system EDI working group.

4.3.8 **Leadership Culture** - The BLMK People Strategy has been launched with a workstream focused on Leadership, Talent Management and Organisational Development. The workstream aims to develop system leadership values, behaviours and training increasing OD capacity and supporting system transformation.

4.3.9 **Infection Control - MRSA** – There was 1 new MRSA bacteraemia recorded in March, giving a YTD total of 23. There is an increase in trend for most infections both locally and regionally. As an ICB we have exceeded trajectories and are above the regional average. It is our aim to explore the current data and identify how we will work to improve this situation.

4.3.10 **Clostridium Difficile** - 15 cases of C-Difficile were reported for the ICB in March giving a YTD total of 187 against a threshold of 149. Currently a C. diff work stream incorporating all BLMK system partners meets on monthly basis. The focus is on discussing trends, learning, patterns from all post infection review meetings held at all acute providers.

4.3.11 **E-Coli Bloodstream Infection Rate** - In March 50 cases of E. coli bacteraemia cases were recorded for the ICB giving a YTD of 490 against a thresh hold of 401. We continue to highlight current improvement plans in acute Trusts and a range of improvement projects taking place in local care homes.

4.3.12 **Cervical Screening** - Several challenges were identified within the younger women cohort and feedback included: Lack of awareness of cervical screening as a cancer test rather than perceived as only a sexual health test, improving access to appointments, increasing training for sample takers to be more sensitive towards cultural and personal barriers impacting those coming forward. The ICB worked to address these concerns and there is a work plan over the next year and the ambition is to move out of the bottom quartile in that period.

4.3.13 **Diagnostics** - BLMK Overall Performance for 22/23 was 99% against the 120% target. Whilst this is not achieving at an aggregate level, performance is variable at modality and provider level and the system is on an upward trend in terms of the overall amount of diagnostic activity that has been delivered throughout the last year (29,403 in April 22 compared to 34,748 in March 23). For 2023/24 the individual diagnostic activity indicators are being replaced with a single indicator to show compliance with the 6-week access across the 15 diagnostic tests. For March data the ICB ranked 25/42 – Interquartile range.

4.3.14 **Hypertension (HTN)** - There is a focus this year on addressing hypertension in primary care. An online meeting was held with 390 primary care colleagues about the importance of monitoring and managing blood pressure (BP) in this group of patients. Along with medicines optimisation colleagues, they also addressed how best to achieve and maintain target blood pressure. NHSE has set a target of 77% of people with HTN to be treated to their BP target by the end of the 23/24 financial year. To improve and reduce the variation in BP management for people with hypertension during the 23/24 financial year, BLMK has developed and launched a new HTN Management Pathway.

4.4 Planning/Productivity

Following the ICB's operational planning submission in May, we have received NHSE feedback and are working through the points raised. BLMK as a system is now firmly within the delivery stage of the process which will be achieved through existing services and pathways, monitored through routine reporting.

Areas of current risk and mitigation:

4.4.4 **Elective Recovery Fund (target 109%):** BLMK ICB is currently achieving 108.8% (value weighted activity) of 19/20 levels; Milton Keynes continues to be challenged around deliverability relating to insufficient physical capacity, infrastructure, and funding. Work is in progress to firm up productivity and efficiently plans and to optimise opportunities aligned to the "GIRFT" and Model Health data sets.

4.4.5 **Outpatient Follow Up target (target - 25%):** The system has been clear that is not planning to deliver the 25% reduction in follow ups over 2023/24 and continues to plan for an in-year focus on follow up reduction through increased utilisation of patient initiated follow up pathways (PIFU). Additional actions for outpatient transformation will be worked up across the system with productivity gains to be quantified for 23/24.

4.4.6 **65 week waits (Zero)** – The BLMK system plans to meet the zero-target excluding patient choice by March 2024, although this position remains predicated on the system putting in place alternatives to current/surge escalation beds. The system will continue to monitor and respond to UEC interdependencies and impact on elective activity. Speciality level trajectories and actions for delivery of 65w are being worked up to support delivery/governance in the delivery phase.

4.4.7 **Cancer 62 day waits (Reduction)** -Monthly trajectories and mitigation plans are in place to reduce waits to pre-pandemic levels by March 2024. BHT remains challenged due to high levels of backlog, however in support, the 28-day Faster Diagnosis Standard will be compliant and there is an improved diagnostic delivery position. Recovery actions, monitoring and support required will be managed through system tiering meetings held bi-weekly.

5.0 Next Steps for BLMK ICB's Performance Reporting

5.1 We are continuing to work up with partners a new Cross-Cutting Outcomes Framework, based on the ONS Health Index. Because so much of what impacts an individual's health is outside of the direct control of the health system, the new Framework will reflect the diverse nature of what determines population health. There are three categories:

- **Healthy People -** covers health outcomes that include mortality, and the impact of physical and mental health conditions.
- **Healthy Lives** - covers risk factors for health that relate directly to individuals. This includes factors that can be changed by individuals, and social factors that cannot always be controlled by individuals but affect the population at the individual level.
- **Healthy Places** - includes social and environmental risk factors that affect the population at a collective level. These relate to circumstances that can influence health outcomes and risk factors. However, they often cannot be addressed solely at the individual level. The draft Framework is shown below.

Proposed Cross Cutting Outcomes Framework, based on ONS Health Index Cross Cutting Outcomes Framework, based on ONS Health Index		
Healthy People	**Healthy Lives**	**Healthy Places**
Difficulties in Daily Life - Disability - Frailty	Behavioural Risk Factors - Alcohol Misuse - Drug Misuse - Healthy eating - Physical Activity - Sedentary Behaviour - STIs - Smoking	Access to Green Space - Private Outdoor Space
Mental Health - Children's and Young Peoples' MH - Mental Health Conditions - Self Harm - Suicide	Children and Young People - Early Years Development - Pupil Absences - Pupil attainment - Teenage pregnancy - Young People in Education/Employment	Access to services - Distance to GP surgeries - Distance to pharmacies - Distance to sport/leisure facilities - Internet access - Patients offered acceptable GP appts
Mortality - Avoidable Mortality - Infant Mortality - Life Expectancy - Mortality from all causes	Physiological Risk Factors - High Blood Pressure - Low Birth Weight - Overweight/Obesity in Adults - Overweight/Obesity in Children	Crime - Low level crime - Personal Crime
Personal Wellbeing - Activities in Life are Worthwhile - Feelings of Anxiety - Happiness - Life Satisfaction	Protective Measures - Cancer Screen Attendance - Child Vaccination Coverage	Economic and Working Conditions - Child poverty - Job related training - Unemployment - Workplace safety
Physical Health Conditions - Cancer - Cardiovascular - Dementia - Diabetes - Kidney and Liver disease - MSK - Respiratory		Living conditions - Air pollution - Household overcrowding - Noise complaints - Road safety - Rough sleeping

This approach will help significantly in shaping the ICB's strategy for performance improvement in determining the centrality of driving core NHS performance versus influencing partner organisations. We look forward to discussing further with partners, including Directors of Public Health (DPH), to shape the next iteration of this work and will bring an update to the Board in September.

List of appendices

Appendix 1 – Month 12 – BLMK Performance Summary Report. Appendix 2 – Primary Care Medical Services Dashboard
Appendix 3 – Trend Charts - Statistical Process Control Charts

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Appendix 1 - Month 12 – BLMK Performance Summary Report

Area	BLMK ICB	Threshold	Frequency	Latest Data	Achievement	Trend over last 6 data points	YTD	Ranking	Regional Average (ICB position vs region)	What does good look like
Elective Recovery	RTT - % Patients Waiting 18 Weeks or less	92%	M	Mar-23	53.96%	⇩	●	5 / 6	55.80%	High
	RTT - Number of 104+ Week Waits		M	Mar-23	2	⇩		3 / 6	4.50	Low
	RTT - Number of 78+ Week Waits		M	Mar-23	50	⇧		2 / 6	219	Low
	RTT - Number of 52+ Week Waits		M	Mar-23	6,562	⇧		3 / 6	8,254	Low
	Diagnostics Tests - 6 Week Waits	1%	M	Mar-23	28.74%	⇧	●	3 / 6	28.42%	Low
Cancer Care	Cancer - 2 Week Waits Standard	93%	M	Mar-23	83.35%	⇩	●	2 / 6	77.82%	High
	Cancer - 28 Day Faster Diagnosis Standard	75%	M	Mar-23	70.69%	⇩	●	3 / 6	70.62%	High
	Cancer - 62 Day GP Referral	85%	M	Mar-23	60.31%	⇩	●	4 / 6	62.34%	High
Urgent Emergency Care	Ambulance - 30 minute Handover Delays (Daily Average)		M	Apr-23	27.07	⇧				Low
	% ED Attendances that result in emergency admission		M	Apr-23	27.28%	⇧			28.27%	High
Primary Care	Appointments in GP Practice - % Face to Face	75%	M	Mar-23	81.08%	⇧	●	1 / 6	74.63%	High
Adult Mental Health	Care Progamme Approach patients followed up in 72-Hours	80%	M	Feb-23	79.00%	⇩	●			High
	SMI Healthchecks (Rolling 12 months)	5392	Q	Mar-23	5,353	⇧	●			High
	Dementia Diagnosis Rate	66.71%	M	Mar-23	66.80%	⇧	●	1 / 6	60.80%	High
	Number of people acessing IAPT Services	2331	M	Feb-23	2,185	⇧	●			High
	% of people moving to recovery following IAPT treatment	50%	M	Feb-23	49.39%	⇧	●			High
	Early Intervention in Psychosis (EIP) - % People starting treatment in 14 days	60%	M	Feb-23	78%	⇧	●			High
	Number of Inappropriate Out Of Area Bed Days in Mental Health Services	34	Q	Dec-22	935	⇩	●			Low
Learning Disability & Autism	Learning Disability Healthchecks (Cumulative)	31%	M	Mar-23	75.45%	⇧	●			High
Children and Young People (CYP) & Maternity	Number of Children & Young People accessing mental health services (Rolling 12 months)	16458	M	Feb-23	17,570	⇧	●			High
	Children & Young People with an Eating Disorder Waiting Times - Routine	95%	Q	Mar-23	83.40%	⇧	●	3 / 6	71.84%	High
	Children & Young People with an Eating Disorder Waiting Times - Urgent	95%	Q	Mar-23	69.23%	⇩	●	5 / 6	64.60%	High
	Number of women accessing Perinatal Mental Health Services (Cumulative)	1172	M	Feb-23	970	⇧	●			High
Community Services	Childrens Wheelchairs - % received in 18 weeks	74%	Q	Mar-23	53.97%	⇩	●			High
Quality & Safety	Infection Control - C-Difficile	13	M	Mar-23	20	⇩	●	4 / 6	11.07	Low
	Infection Control - MRSA	0	M	Mar-23	1	⇧	●	5 / 6	0.50	Low

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

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Appendix 2 - Primary Care Medical Services

Primary Care Dashboard																				
Indicator	Threshold	Frequency	Latest Data	BLMK ICB				Bedford Borough			Central Bedfordshire			Luton			Milton Keynes		
				Latest Position	Same time last year	6 Data Point Trend	National Ranking	Latest Position	Same time last year	6 Data Point Trend	Latest Position	Same time last year	6 Data Point Trend	Latest Position	Same time last year	6 Data Point Trend	Latest Position	Same time last year	6 Data Point Trend
Access - General Practice Access																				
Total GP Appointments per 1,000 list size (actual)		Monthly	Mar-23	456	454			456	452		492	492		425	420		446	448	
% of appointments on the same day		Monthly	Mar-23	40.24%	40.36%		35/42	39.90%	40.60%		40.85%	42.58%		40.26%	40.52%		39.81%	37.90%	
% of appointments with a healthcare professional other than a GP		Monthly	Mar-23	51.19%	49.49%		15/42	44.53%	45.19%		55.30%	47.83%		46.40%	52.14%		54.52%	51.82%	
Access - Urgent Primary Care																				
NHS 111 Total Calls per 1,000 pop		Monthly	Mar-23	123	125			28	28		31	29		38	41		26	26	
Number of calls in-hours per 1,000 pop		Monthly	Mar-23	63	61			13	13		16	14		22	23		12	12	
GP Out of Hours Activity - IN DEVELOPMENT																				
Personalised Care/Prevention - Vaccinations/Screening																				
Population vaccination coverage – MMR for two doses (5 years old)	95%	Quarterly	Q3 22/23	86.19%	86.70%		28/42	89.83%	89.30%		90.70%	90.95%		82.50%	82.30%		88.90%	88.30%	
Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage)	75%	Quarterly	Q3 22/23	67.78%	68.95%		34/42	67.61%	69.15%		75.28%	76.12%		57.89%	59.54%		66.13%	67.46%	
Pro-active Care - Health Checks																				
People with severe mental illness receiving a full annual physical health check and follow up interventions		Quarterly	Q4 22/23	5353	3134			2377	1254		Central Beds included in Bedford Borough figures			1674	1013		1302	867	
People aged 14 and over with a learning disability on the GP register receiving an annual health check	30.93%	Monthly	Mar-23	75.45%	67%			77.24%	79.90%		Central Beds included in Bedford Borough figures			79.08%	73.90%		69.47%	60.84%	
Pro-active Care - Long Term Conditions																				
Proportion of diabetes patients that have received all eight diabetes care processes		Monthly	Mar-23	48.35%				45.41%			Central Beds included in Bedford Borough figures			47.44%			54.12%		
Patients aged 18 and over with GP recorded hypertension, who have had a blood pressure reading within the preceding 12 months		Quarterly	Q3 22/23	80.20%	77.15%			77.08%	73.19%		82.15%	80.24%		81.43%	78.81%		80.77%	76.55%	
Patients with hypertension - % with most recent BP (within last 12 months) treated to target (<140/90 if aged 79 or under, <150/90 if aged 80 or over)	80%	Quarterly	Q3 22/23	58.15%	56.16%		37/42	55.80%	53.22%		60.76%	60.03%		58.96%	57.07%		56.45%	54.27%	
Respiratory Metrics - IN DEVELOPMENT																				

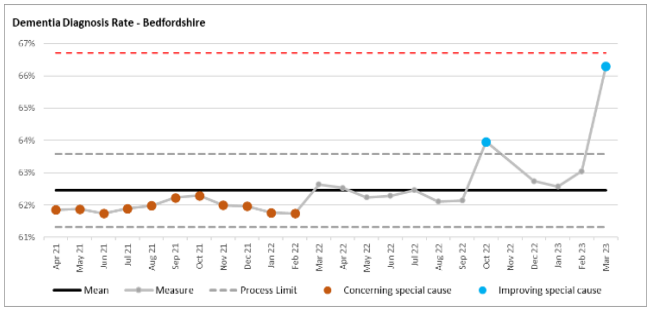
Key:

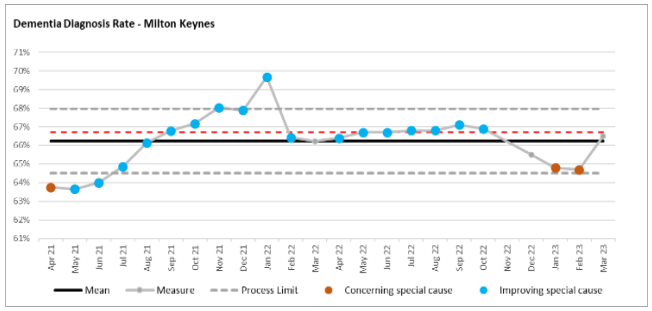
Achieving ambition	
Within 5% of ambition	
More than 5% from ambition	

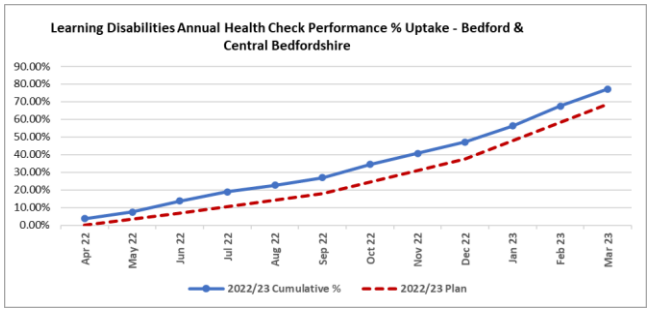
Where there is no ambition the latest position is ragged against previous position	Better than previous period	
	Within 5% of previous period	
	More than 5% from previous period	

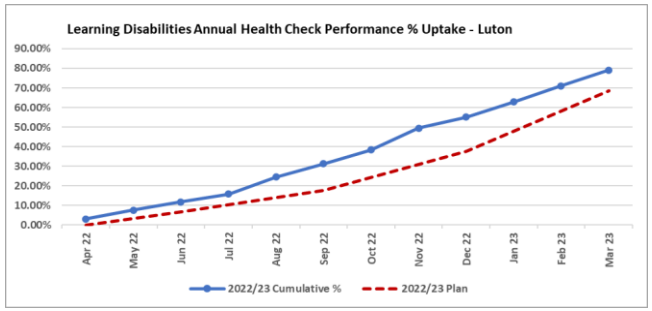
Appendix 3 – Trend Charts - Statistical Process Control Charts and other charts as appropriate. Where this is an area of concern the relevant section has been referenced next to the slide

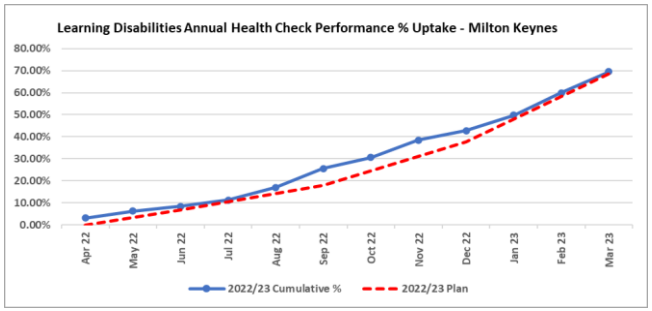
Mental Health

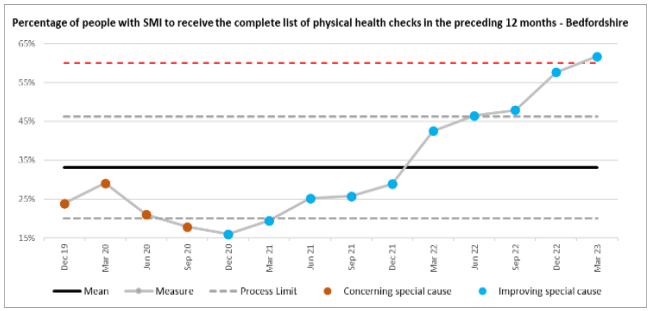


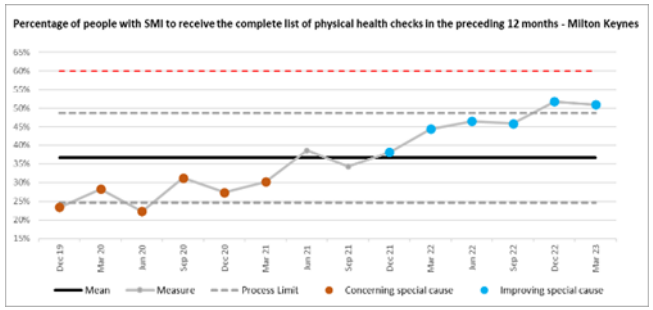




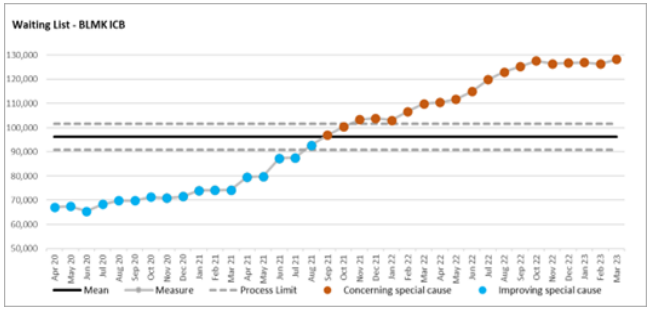


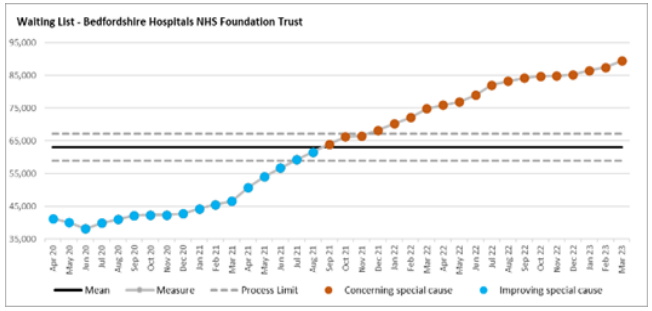


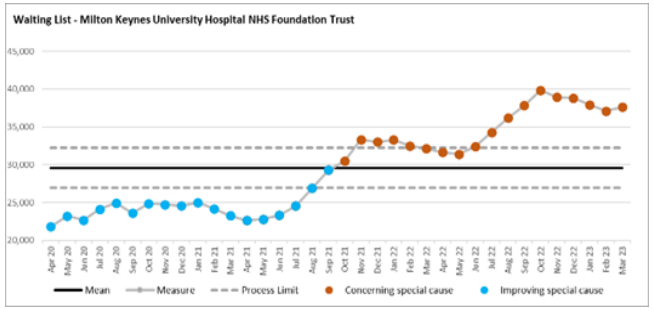


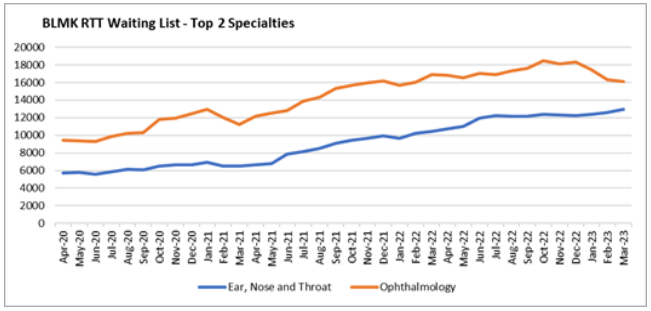


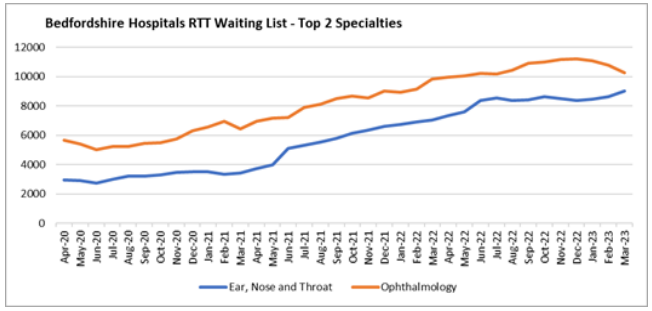
Elective Care

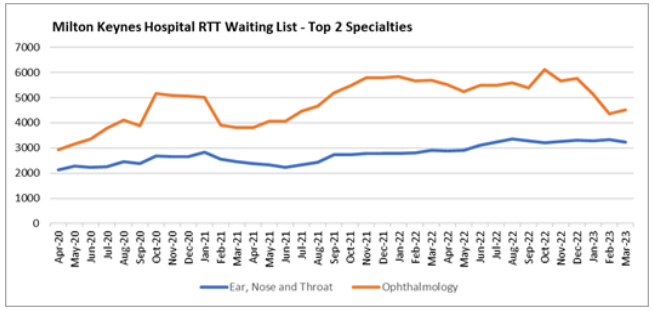






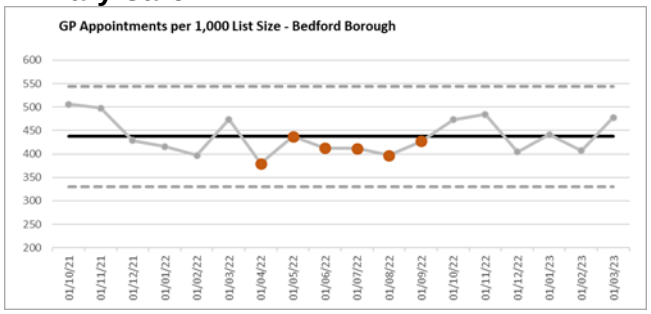


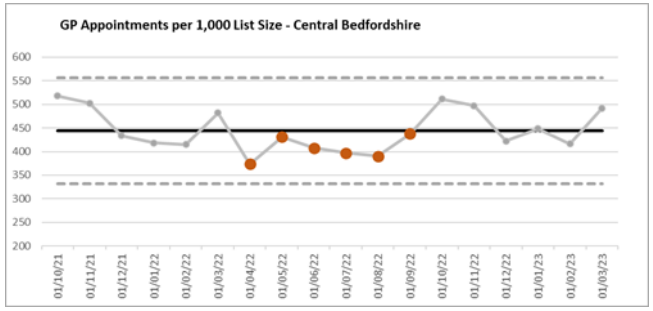


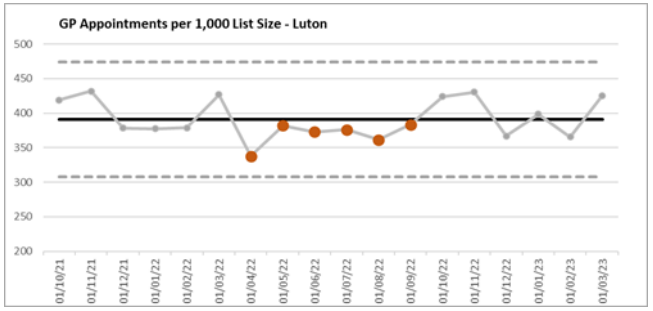


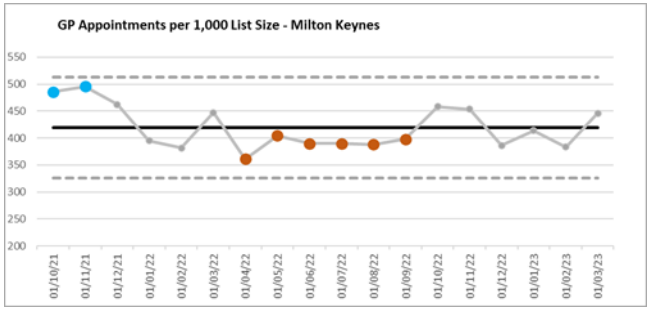
See section 4.2.2 for elective waiting list and long waiters

Primary Care

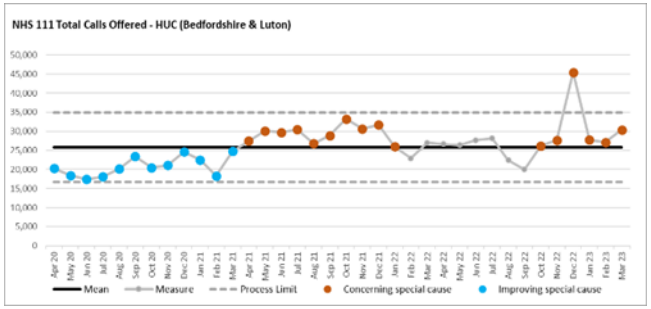


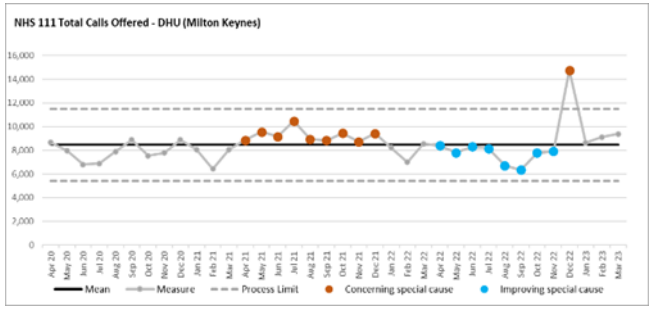




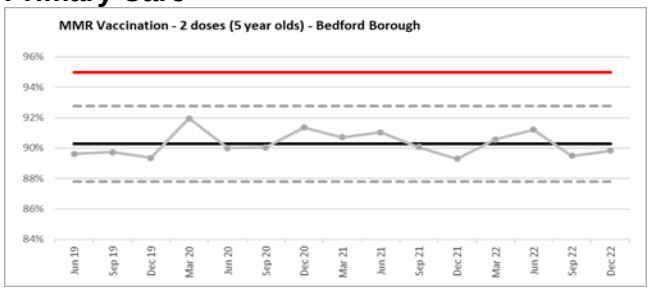


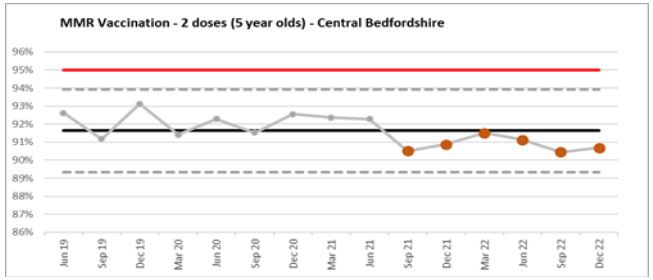
See section 4.2.4 for NHS 111 call abandonment rates: 4.2.7 for MMR vaccination uptake and cervical screening coverage

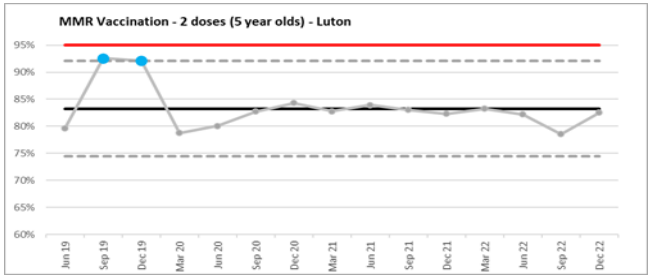


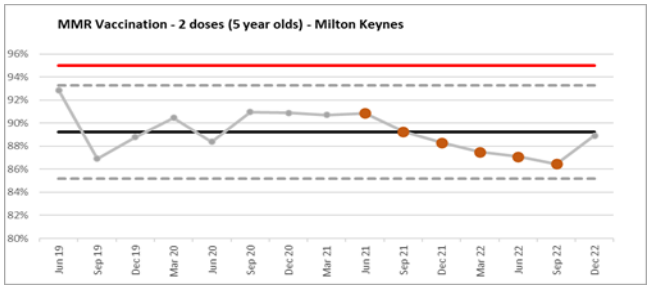


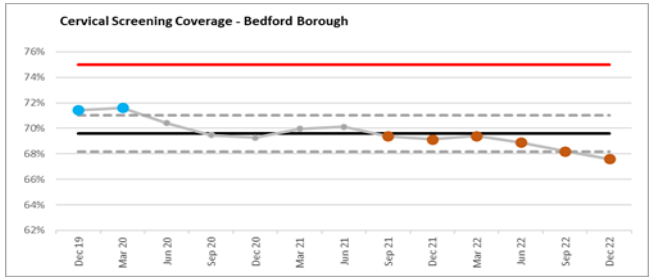
Primary Care

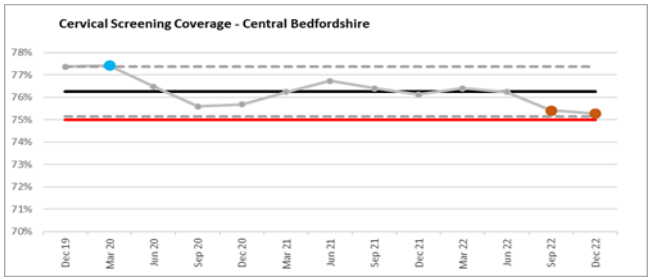


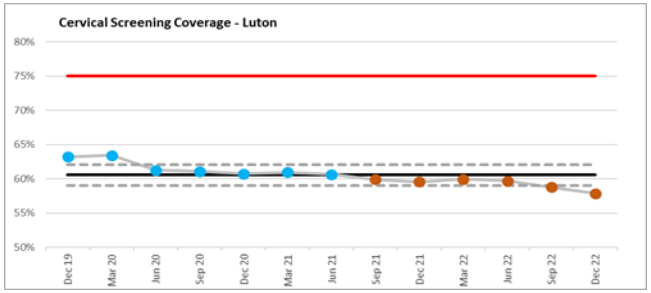


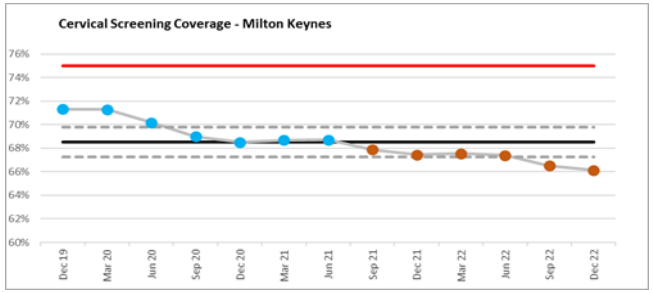






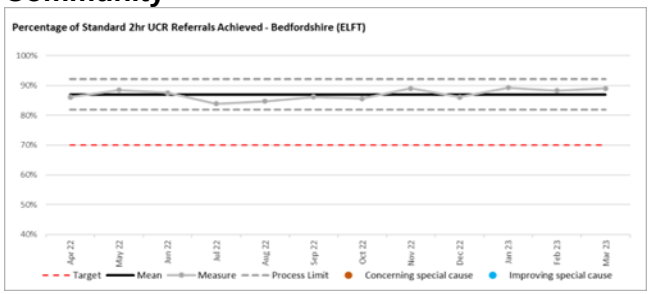


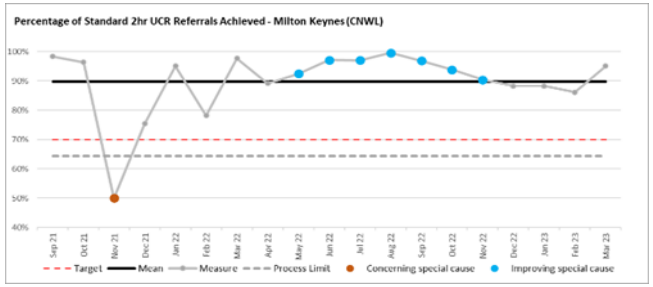




See section 4.2.7 for MMR vaccination uptake and cervical screening coverage

Community





Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

ICS Partners: All Partner Members

Executive Lead: Dean Westcott, Chief Finance Officer

Report Author: Finance Department

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

Item: 7.2.1 - BLMK ICS and ICB Financial Plans 2023/24

1.0 Executive Summary

1.1 The ICS is planning to deliver a break-even income and expenditure plan both as a system and in each constituent organisation.

1.2 The system capital plan is currently in excess of the available capital resource limit (CDEL). Discussions are taking place with NHS England, given that the level of CDEL resource available to BLMK is less that that generated through Trust depreciation. Subject to these discussions, further work is likely to be required within the system to align plans with the CDEL allocation.

1.3 The ICB financial plan is breakeven, after cost pressures and the application of efficiencies, that total £18.5m, of which one-third remain to be identified. Further work is required within the system and the ICB to fully identify efficiency plans.

1.4 The ICB underlying financial position is a £22m deficit and is not sustainable; it will need to be addressed in 2023/24 through the delivery of recovery actions and sustainable transformation. Further work is being undertaken to understand NHS Trust underlying financial positions and therefore the overall system position.

1.5 The ICB has identified risks of £15.6m that require mitigation, which is in addition to the current level of unidentified efficiencies.

1.6 The Board of the ICB is required to approve the annual budget.

2.0 Recommendations

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

- ICS Financial Plan including income & expenditure, efficiency, risks and capital
- ICB Financial Plan

3.0 Key Implications

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

3.1 The financial plan for the ICS and ICB contain significant risks which will need to be addressed and mitigated during the year. The ICB plan also includes an element of unidentified efficiencies, which is a further risk to both the ICB and ICS.

3.2 The ICS financial plan and draft ICB budget were presented to the Finance & Investment Committee in May 2023.

3.3 The finance plan reflects operational plans that include a focus on addressing the Green Plan Commitments and inequalities.

4.0 Report

4.1 The financial framework continues to support system collaboration and collective responsibility for financial performance, and as such systems continue to be the key unit for the purposes of allocations and financial planning.

4.2 The ICB and system finance business rules are clear that systems have a collective duty not to exceed the limit set by NHS England (NHSE), with an objective to breakeven i.e., a duty to seek to achieve the objective of system financial balance. Further, ICBs have a duty to act with a view to ensuring its expenditure does not exceed the sums it receives. This also includes specific duties in respect of running costs and capital.

System Funding / Allocations

4.3 The allocations methodology continues to move systems towards a fair share distribution of resource at the levels affordable within the Spending Review settlement.

4.4 ICBs have received the following funding allocations:

ICB programme allocations – ICB programme allocations are based on:

- Baseline adjustments to reflect recurrently the outcome of the baseline reset and full-year impact from the change in the employer national insurance contribution rate
- Net base growth to reflect underlying local demographic and non-demographic activity requirements; inflationary pressures, inclusion of the 1.1% efficiency, as set out in the NHS payment scheme
- A Convergence adjustment to move systems towards a fair share allocation

ICB delegated (from NHSE) primary medical care

ICB other primary care allocation (for agreed delegations) indicative budgets have been notified and form part of the system financial plan submission.

ICB running cost allocation – ICBs are asked to maintain running cost spending on a flat cash basis against the 2022/23 running cost allocation, which means that running costs will continue to fall in real terms.

ICB Covid allocation – This is transferred into core allocations reflecting that Covid is now an ongoing pressure on NHS services. Funding has significantly reduced from 2022/23 (£22m down to £7m).

Health Inequalities – an amount equal to the 2022/23 non-recurrent allocation has been rolled into the ICB baseline.

ICB elective recovery funding (ERF) – ERF has been separately identified in ICB allocations and distributed on a fair share basis. This additional elective funding has been allocated to commissioners to deliver 109% of 2019/20 levels of value-based activity.

Providers will also receive inflows from out of system commissioners, including other ICBs and directly commissioned services not included in the BLMK system allocation.

Service development funding (SDF) - Systems will continue to receive (SDF) allocations to support the delivery of the NHS Long Term Plan commitments.

Capacity Funding – Initial allocations for recurrent capacity funding for Physical and Virtual Ward capacity. Funding is apportioned nationally in line with 2022/23 plans.

Discharge Funding – A separate allocation has been received and this funding will be included in the Better Care Fund (BCF) minimum contributions schedule, in addition to the 5.66% uplift.

4.5 System financial funding for the full year is set out in the table below:

ICB Recurrent Allocation (confirmed)	£'000
ICB Programme Allocation	1,596,723
Primary Medical Care Services	173,457
Running costs	18,474
ICB Programme Allocation – Additional Funding	0
COVID Funding	6,771
Additional discharge allocation	4,709
Additional physical and virtual bed capacity funding	4,993
Total ICB recurrent Allocation (confirmed)	**1,805,127**

ICB Non-Recurrent Allocation (confirmed)	£'000
Elective Recovery Funding	39,730
COVID-19 Testing	2,382
COVID Funding	0
Service Development Fund (SDF)	25,726
UEC Capacity Funding	7,049
Total ICB Non-Recurrent Allocation (confirmed)	**74,887**

Total ICB allocation (confirmed)	**1,880,014**

System Income & Expenditure - Financial Plan Summary

4.6 NHSE has allocated £1.88bn to BLMK to commission NHS services for the population of BLMK in 2023/24. In-system (intra) acute providers receive operating income from BLMK ICB and other commissioners of service including other ICBs and NHSE. The summary plan is included in Appendix A.

4.7 The BLMK system and individual statutory organisations submitted a breakeven plan for the 2023/24 financial year.

4.8 The system plan includes efficiencies of £71.8m. This equates to an average 4.9% of operating expenditure in providers and 4.7% of adjusted (discretionary) spend for the ICB.

4.9 A summary of key financial plan metrics for the intra system organisations is set out in the table below:

KEY FINANCIAL METRICS		2023-24 Plan			
	Currency	ICB	BHFT	MKFT	Totals
Surplus / (Deficit)	£000s	0	0	0	**0**
Risks					
Risks	£000s	(15,560)	(37,000)	(24,800)	(77,360)
Mitigations	£000s	0	37,000	24,800	61,800
Net Risk	£000s	(15,560)	0	0	(15,560)
Efficiency					
Efficiency Actuals / Plan	£000s	18,478	36,032	17,334	71,844
Efficiency % of OpEx	%		4.8%	5.1%	
Efficiency % of ICB Discretionary Expenditure	%	4.7%			

4.10 Risks to the delivery of the system break-even position are assessed as:

- Elective Recovery Funding: provider plans are underpinned by the assumption of the full receipt of elective recovery fund income.
- Inflationary pressures over funding levels: inflation continues to be excess of the GDP deflator used in the calculation of NHS allocations.
- Sustained pressure on the urgent and emergency care (UEC) capacity.
- Costs of industrial action.
- The impact of the pay settlement for NHS staff not being fully funded.
- The delivery of efficiency and productivity plans.

System Capital - Financial Plan summary

4.11 Systems are responsible for managing their in-year operational capital CDEL expenditure within a CDEL (Capital Departmental Expenditure Limit) envelope. The allocation in 2023/24 is £35.1m. CDEL allocation is highly constrained and predominantly covers operational business-as-usual capital needs. Managing within the system CDEL allocation will be challenging in this financial year, particularly given the erosion in purchasing power arising from higher rates of inflation.

4.12 The capital plan is set out in the table below. The plan is non-compliant with the CDEL allocation, being £5.8m above the CDEL allocation (plus a bonus payment for 2022/23 performance) and £3.8m above the allocation including an allowable 5% plan over profile. Further work is required within the system to align plans with the CDEL allocation.

KEY FINANCIAL METRICS		2023-24 Plan			
	Currency	ICB	BHFT	MKFT	Totals
Capital Plans					
System Allocation	£000s				35,067
Fair Shares Prior Year Revenue Performance	£000s				4,840
Total Allocation	£000s				**39,907**
Total CDEL Allocation + 5% Overprofile	£000s				41,902
Current CDEL Plan	£000s		27,428	18,269	45,697
Variance to Allocation	£000s				(5,790)
Variance to Allocation + 5% Overprofile	£000s				(3,795)

4.13 In addition, £1.7m is available to the ICB in 2023/24 to support primary care IT and estates related schemes with funding administered by the ICB on behalf on NHSE (who will capitalise the expenditure).

ICB Financial Plan - Key Assumptions / Inputs

4.14 The ICB financial plan has been prepared in accordance with NHSE guidance. The following planning assumptions are included in the 2023/24 financial plan.

Mental Health Investment Standard (MHIS) - applies to ICBs and continues to be subject to an independent review. ICBs are required to increase spend on mental health services by programme allocation base growth before convergence plus SDF funding that is now part recurrent. This equates to an increase of 7%.

Acute & Community Services – NHS contracts have been uplifted in line with the nationally published net national tariff uplifts, activity growth and a share of the elective recovery funding (where applicable).

Primary Care - assumes that the allocation uplift is sufficient to fund the GP contract settlement. All investment in primary care is to be consistent with the national GP contract framework.

Prescribing - the plan includes an estimate for growth in line with historic trends and cost pressures associated with new technologies and therapeutics. The full year effect impact of cheaper stock price concessions is built into the underlying financial position. This is a critical driver of the underlying deficit.

Running Costs - the plan assumes that the spend will be within the running cost allocation.

ICB – 2023/24 Income & Expenditure Financial Plan

4.15 The ICB have submitted a breakeven for 2023/24 after the application of requirements in the planning guidance. A summary of the ICB plan is set out below.

Programme Area	2022/23 Forecast Outturn	Normalising Adjustments	Opening Budget	2023/24 Plan
	£000's	£000's	£000's	£000's
ICB allocations - programme	1,623,589	(96,450)	1,527,139	1,596,722
ICB allocations - running costs	18,793	(319)	18,474	18,474
ICB allocations - primary medical services	162,282	1,470	163,752	173,457
Total Allocations	**1,804,664**	**(95,299)**	**1,709,365**	**1,788,653**
Acute Services	976,471	(54,938)	921,533	959,612
Mental Health Services	193,201	(11,070)	182,131	195,907
Community Health Services	172,902	719	173,621	180,029
Continuing Care Services	75,961	332	76,293	80,254
Prescribing	145,637	(1,151)	144,486	143,092
Primary Care Services	30,603	(4,080)	26,523	27,832
Primary Care Co-Commissioning	160,793	2,959	163,752	173,457
Other Programme Services	32,135	(13,521)	18,614	9,996
Total Commissioning Services	**1,787,703**	**(80,750)**	**1,706,953**	**1,770,179**
ICB Running Costs	16,961	1,513	18,474	18,474
Total ICB Net Expenditure	**1,804,664**	**(79,237)**	**1,725,427**	**1,788,653**
In Year Underspend/(Deficit)	**0**	**(16,062)**	**(16,062)**	**(0)**

4.16 The delegation of Pharmacy, Optometry and Dentistry (POD) from NHS England is assumed to be fully funded and is not included within the ICB plan, in line with planning guidance.

4.18 The underlying deficit has deteriorated from a £16m underlying deficit to £22m, predominantly due to prescribing pressure. The underlying deficit is c1.2% of allocation and

has deteriorated by c£11m from that reported earlier in 2022/23. The underlying financial position is unsustainable and will need to be addressed in 2023/24 through the delivery of recovery actions and sustainable transformation.

4.19 The following are considered when developing the ICB financial plan:

Efficiency Plans: The plan is underpinned by the planned delivery of a £18.5m efficiency programme. Of the plan, £7.1m has been fully identified, a further £5.6m is reliant upon non-recurrent schemes / mitigation. In addition, the plan currently assumes the full delivery of £5.8m of schemes that are pipeline opportunities or are currently not fully identified – this requires rapid development.

Cost Pressures: cost pressures are defined as those costs that cannot be avoided e.g., contractual uplifts, pay awards, etc. Where possible, alternative sources of funding have been identified, e.g., MHIS, agreements with other partners, leaving a net cost pressure of £13.2m which has been built into plan.

Investments: No additional investments are assumed to be funded within the current plan. To fund any additional investment a source of funding would need to be identified.

Service Development Funding: £25.7m and is anticipated in the plan to be spent in full.

Elective Recovery Funding: £39.7m and is anticipated in the plan to be spent in full.

Discharge Fund: the allocation of the Discharge Fund needs to be agreed by partners. The plan assumes it is spent in full.

UEC Capacity Funding: the allocation of the UEC capacity funding needs to be agreed by partners. The plan assumes it is spent in full.

Contracts: although a number of contracts are still being negotiated, the ICB plan assumes they are agreed within current envelopes.

ICB Staff Consultation: no contingency in place to fund redundancies following the planned staff consultation.

ICB Risks and Mitigations

4.20 The ICB plan has unmitigated risks of £15.6m and include:

- Prescribing NCSO and Cat M pressure
- Inflation more than allocation growth
- Potential ICB redundancy / restructuring costs arising from 30% ICB Running Costs reduction targets. The impact of restructuring will not be supported by additional NHSE funding.

4.21 There are further risks not yet quantified or built into the plan:

- Financial risks associated with POD delegation
- Prescribing spend continues to increase in line with current upward trajectories and external funding / mitigation is not secured
- System financial position deteriorates and requirement for ICB to improve position to ensure overall balance

4.22 All risks will need to be fully mitigated through the development of an efficiency / transformation pipeline, non-recurrent mitigations, contractual management, slippage on investment, and additional controls on recruitment. Progress will be reported to the Finance and Investment Committee.

5.0 Next Steps

5.1 Internal for BLMK ICB

- Directorates to continue to identify cash releasing efficiencies and work with PMO to cost.
- Further review and management of inflationary and contractual pressures to manage downwards.
- Further mitigations to be identified.
- Work with NHSE regarding primary care prescribing.
- Work with NHSE to identify risks and opportunities arising from delegated POD services.

5.2 BLMK System

- Significant focus on the development of system and organisation efficiency / transformation programmes to manage current and unexpected risks.
- Further work is required within the system to align plans with the CDEL allocation.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

Executive Lead: Dean Westcott, Chief Finance Officer

Report Author: Finance Department

Report to the: Board of the Integrated Care Board

Item: 7.2.2 – BLMK ICS Finance Report (May 2023)

1.0 Executive Summary

1.1 This report sets out the 2023/24 BLMK ICS financial position at May 2023 (month two) for revenue and capital spend.

1.2 NHS organisations hosted within the system are reporting a £6.7m deficit against plan for Income & Expenditure at Month 2; the forecast remains delivery of a breakeven position.

1.3 Industrial action and continued emergency pressures have had an impact on provider expenditure. The ICB has a pressure on prescribing from 2022/23 where costs are not known when the accounts are closed, and the March position was higher than forecast.

1.4 System efficiency plans are delayed and there are significant non-recurrent plans, which are a risk to achievement of the system financial plan and the underlying financial health of the system.

1.5 The ICS submitted has a non-compliant capital plan – with planned expenditure currently greater than the available capital allocation. Capital expenditure is slightly above plan year to date but forecast to break-even.

1.6 Financial performance at month 2 has been identified as a significant risk. The system is focused on the actions required to ensure deliver of the financial plan.

2.0 Recommendations

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

3.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	
Engagement	
Green Plan Commitments	

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

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

4.0 Report

4.1 The purpose of this paper is to report the Integrated Care System (ICS) financial position at month two (May) for those NHS organisations that form part of the Bedfordshire, Luton and Milton Keynes (BLMK) ICS financial control total, covering both revenue and capital. These organisations are:

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

4.2 Where NHS organisations provide services within BLMK financial information is included within the report where available.

Intra System Income & Expenditure

4.3 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 2023/24 financial year. The table below shows the year-to-date position is an overspend of £6.4m spread across all three organisations, but forecast to recover this by the end of the year.

Surplus / (Deficit)	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m
Bedfordshire Hospital NHS FT	0.1	(1.5)	(1.6)	0.0	0.0	0.0
Milton Keynes NHS FT	0.2	(4.0)	(4.2)	0.0	0.0	0.0
BLMK CCG/ICB	0.0	(0.9)	(0.9)	0.0	0.0	0.0
Intra ICS Organisations	**0.3**	**(6.4)**	**(6.7)**	**0.0**	**0.0**	**0.0**

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

Bedfordshire Hospital NHS Foundation Trust

Income & Expenditure	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	125,828	127,234	(1,406)	754,959	763,405	(8,446)
Pay	(80,002)	(83,181)	3,179	(480,018)	(480,018)	0
Non-Pay	(45,764)	(45,578)	(186)	(274,941)	(283,387)	8,446
SURPLUS / (DEFICIT)	**62**	**(1,525)**	**1,587**	**0**	**0**	**0**

4.5 The key drivers for the variances are:

- Income – NHS income is ahead of plan
- Employee Expenses (Pay) – Higher levels of pay for medical and nursing staff due to impact of industrial action and continued emergency pressures into quarter one.
- Operating Expenses (Non-Pay) – pressures in non-pay offset by underspend on clinical services.

Milton Keynes University Hospital NHS Foundation Trust

Income & Expenditure	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	56,844	57,931	1,087	340,063	340,063	0
Pay	(36,017)	(39,602)	(3,585)	(215,575)	(215,575)	0
Non-Pay	(20,657)	(22,355)	(1,698)	(124,488)	(124,488)	(0)
SURPLUS / (DEFICIT)	**170**	**(4,026)**	**(4,196)**	**0**	**(0)**	**(0)**

4.6 The key drivers for the variances are:

- Income – Emergency care income recognised above plan to cover the ongoing cost of escalation.
- Employee Expenses (Pay) – Impact of junior doctors strike, continued use of temporary staff to cover escalation capacity and delayed CIP.
- Operating Expenses (Non-Pay) – Additional drugs and clinical supplies costs for escalation areas.
- Finance Costs – Increased interest received.

Integrated Care Board

4.7 The ICB is reporting a £0.9m deficit year-to-date against a planned breakeven position. At this early stage of the year the ICB is forecasting a breakeven financial position.

The table below shows the status against the key financial performance indicators for the year. At month 2 the ICB is forecasting full achievement of these metrics.

Performance Measure	Year To Date - Month 02			Forecast		
	Target	Actual	Variance	Target	Actual	Variance
Revenue Resource Limit	£324.3m	£325.2m	-£0.9m	£1,946.7m	£1,946.7m	£0.0m
MHIS Expenditure	£27.9m	£27.9m	£0.0m	£167.3m	£167.3m	£0.0m
Efficiency Savings	£2.1m	£2.1m	£0.0m	£18.5m	£18.5m	£0.0m
Better Payment Practice Code	>95%	97%	2%	>95%	95%	0%

4.8 The position by commissioning programme as at month 2 is set out in the table below:

PROGRAMME AREA	YEAR TO DATE			FORECAST OUTTURN		
	Budget £000	Actual £000	Variance £000	Budget £000	Forecast £000	Variance £000
Acute Services	168,515	168,574	(58)	1,011,093	1,011,093	0
Mental Health Services	35,088	34,967	121	210,527	210,527	0
Better Care Fund	5,557	5,557	0	33,344	33,344	0
Other Community Services	26,534	26,535	(1)	159,202	159,202	0
Continuing Care Services	13,497	13,500	(3)	80,980	80,980	0
Primary Care Co-Commissioning	29,195	29,172	22	173,457	173,457	0
Pharmacy, Ophthalmic & Dental Co-Commissioning	14,211	14,235	(24)	85,268	85,268	0
Prescribing	23,631	24,590	(959)	143,172	144,089	(917)
Other Primary Care Services	5,182	4,979	202	32,562	32,562	0
Other Programme Services (incl. Reserves)	(236)	298	(534)	(1,415)	(2,332)	917
Total Commissioning Budget	**321,174**	**322,408**	**(1,234)**	**1,928,190**	**1,928,190**	**0**
Running Costs	**3,079**	**2,762**	**317**	**18,474**	**18,474**	**0**
Total ICB Net Expenditure	**324,253**	**325,170**	**(917)**	**1,946,664**	**1,946,664**	**0**

4.9 The main pressure within the year to date and forecast is primary care prescribing for March 23, now that the position has been finalised. These pressures are due to increased scripts issued and medicine prices. It is currently expected that this pressure can be

mitigated, however prescribing price rises continue to be of major concern in relation to the run-rate and the underlying financial position of the ICB.

Inter ICS Financial Performance:

4.10 At the time of reporting information remains outstanding from ICS partners who deliver services in BLMK. System financial reporting will be updated to reflect the financial performance of partners as information is available.

Delivery of Efficiency Plans

4.11 The system financial plan includes delivery of £72m efficiencies for in-system NHS partners. Plans are £3.5m behind plan at month 2 but forecast to deliver in full by the end of the year. MKUH plans have slipped but the forecast remains delivery in full.

	Year-to-date				Forecast Outturn			
	Plan	Actual	Variance		Plan	Actual	Variance	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
ICB - Recurrent	1,078	1,078	0	0%	6,709	6,709	0	0%
ICB - Non recurrent	995	994	(1)	0%	11,769	11,769	0	0%
Subtotal - ICB	**2,073**	**2,072**	**(1)**	0%	**18,478**	**18,478**	**0**	0%
BHFT - Recurrent	2,838	2,198	(640)	-23%	17,028	17,028	0	0%
BHFT - Non recurrent	3,168	3,168	0	0%	19,004	19,004	0	0%
Subtotal - BHFT	**6,006**	**5,366**	**(640)**	-11%	**36,032**	**36,032**	**0**	0%
MKHFT - Recurrent	1,304	25	(1,279)	-98%	7,828	7,828	0	0%
MKFT - Non recurrent	1,584	0	(1,584)	-100%	9,506	9,506	0	0%
Subtotal - MKFT	**2,888**	**25**	**(2,863)**	-99%	**17,334**	**17,334**	**0**	0%
Total Efficiencies	**10,967**	**7,463**	**(3,504)**	**-32%**	**71,844**	**71,844**	**0**	**0%**

4.12 Non-recurrent efficiencies currently account for over half of the total efficiency plan and represent a challenge to the underlying financial sustainability of the system transformation.

4.13 Actions are in place both as a system and at organisational level, with the aim to manage both in-year delivery challenges and the recurrency of plans.

Workforce – Agency Cap

4.14 A cap on agency spend has been introduced by NHS England. The target spend for BLMK is c£26m. This is not applied to individual organisations, but the combined intra ICS NHS partners. The table below shows that the total spend was £3m above plan year to date and is forecast to continue to spend above plan at BHFT, but reduce significantly at MKUH by the end of the year.

Agency Spend	Year-to-date			Forecast Outturn		
	Actual	Cap - pro rata	Variance	FOT	Cap - pro rata	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Bedfordshire Hospital NHS FT	5,293	2,976	(2,317)	24,460	17,855	(6,605)
Milton Keynes NHS FT	2,308	1,398	(910)	5,425	8,386	2,961
Total	**7,601**	**4,374**	**(3,227)**	**29,885**	**26,241**	**(3,644)**

System Capital

4.14 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 ELFT, CNWL and CCS is held within their lead systems.

4.15 ICS organisations 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.

4.16 The system capital plan is currently more than the available capital resource limit (CDEL). The plan is £5.8m above the CDEL allocation (plus a bonus payment for 2022/23 performance) and £3.8m above the allocation including an allowable 5% plan over profile. Discussions are taking place with NHS England, given that the level of CDEL resource available to BLMK is less that that generated through Trust depreciation. Subject to these discussions, further work is likely to be required within the system to align plans with the CDEL allocation.

4.17 The table below shows the position for the intra-ICS NHS organisations, this is to breakeven against the overcommitted plan for the year although there is a slight variance to date.

	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m
Bedfordshire Hospital NHS FT	11.0	11.1	(0.1)	96.4	96.4	0.0
Milton Keynes NHS FT	8.0	7.5	0.5	46.8	46.8	0.0
BLMK ICB	0.0	0.0	0.0	1.7	1.7	0.0
Intra ICS Organisations	**19.0**	**18.6**	**0.4**	**144.9**	**144.9**	**0.0**

4.18 The ICB is allocated capital funding of £1.7m to support GPIT, primary care estates and corporate capital, which it plans to spend in full.

4.19 The table below shows capital spend for the ICS split between CDEL and other funding streams. These figures exclude the ICB which does not have CDEL.

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)	7,944	7,836	108	45,697	45,697	0
Other funding streams	11,074	10,729	345	97,498	97,498	0
Total	**19,018**	**18,565**	**453**	**143,195**	**143,195**	**0**

Financial Risks

4.18 The key risks to the financial plan are:

- Elective Recovery Funding: provider plans are underpinned by the assumption of the full receipt of elective recovery fund income.
- Inflationary pressures over funding levels: inflation continues to be excess of the GDP deflator used in the calculation of NHS allocations.
- Sustained pressure on the urgent and emergency care (UEC) capacity.

- Costs of industrial action.
- The impact of the pay settlement for NHS staff not being fully funded.
- The delivery of efficiency and productivity plans.
- Prescribing pressures continue from March into the new financial year at levels above plan
- Potential ICB redundancy / restructuring costs arising from 30% ICB Running Costs reduction targets. The impact of restructuring will not be supported by additional NHSE funding.

5.0 Next Steps

5.1 The level of overspend at the end of month two has been identified as a significant risk and there have been a number of meetings between partners to understand the drivers of the overspend and determine steps to be taken to manage the position back to breakeven by the end of the year.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

ICS Partner: Local Authority Chief Executive Officers

ICB Executive: Anne Brierley, Chief Transformation Officer

Report Author: Kathryn Cragg, Head of Acute and Strategic Contracts

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

Item: 7.3 - Section 75 Agreements

1.0 Executive Summary

1.1 This paper presents to the Board of the Integrated Care Board, the 2023/24 Section 75 agreements between the ICB and Luton Borough Council (LBC) and the 2023/24 Section 75 agreement relating to Community Equipment Services (CES) between the ICB and Milton Keynes City Council (MKCC).

1.2 The S75 agreements have been jointly developed between ICB and Local Authority colleagues and reviewed by the Joint Strategic Commissioning Groups.

1.3 These agreements have previously been reviewed by the ICB's Finance and Investment Committee where they were recommended for approval by the ICB Board in line with ICB Standing Financial Instructions. The agreements are available in the Background Reading pack.

2.0 Recommendations

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

1. 2023/24 S75 agreement between BLMK ICB and LBC
2. 2023/24 S75 agreement between BLMK ICB and MKCC for CES

3.0 Key Implications

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

3.1 The financial implications and details of each scheme are set out the agreements and subsequent schedules. For LBC the total value of all pooled funds is £87,510,929, and for MKCC the value of the pooled fund for CES is £1,037,000.

3.2 Through the management of contracts and pooled funds we can work together with local authority colleagues and providers to address inequalities across these services, tailored to the demography of place.

3.3 We will address Green Plan commitments through appropriate contracting in-line with operational plan requirements.

3.4 No engagement implications have been identified, and there are no risks to report in relation to the proposed S75 agreements.

3.5 Colleagues from across both the ICB and local authorities have been consulted during the development of the S75 agreements including Commissioning, Contracting, Finance, Information Governance and Governance colleagues.

4.0 Report

4.1 Section 75 (S75) agreements ensure that we are compliant with statute, but more crucially, that we are commissioning services in an integrated way through the use of delegation agreements and pooled budget arrangements, including the Better Care Fund (BCF).

4.2 We are proposing one S75 agreement between Luton Borough Council (LBC) and BLMK ICB for 2023/24, in line with previous years. This agreement includes governance arrangements between parties and multiple schedules for the various pooled funds to a total value of £87,510,929.

4.3 We are proposing three S75 agreements between Milton Keynes City Council (MKCC) and BLMK ICB for 2023/24, in line with the previous year. The agreement for Integrated Community Equipment Services has been recommended for signature by the Finance and Investment Committee with a value of £1,037,000

4.4 The remaining S75 agreements are in the process of being agreed, and in line with the deadline set by Government for full agreement by 31st October 2023 and will come to Board in September 2023.

4.5 The total amount to be paid via S75 agreements in 2023-24 is estimated to be £160,600K. This includes the Better Care Fund (BCF) and the Improved BCF (IBCF), Discharge Funding, Integrated Community Equipment Services (ICES), and integrated commissioning teams (learning disabilities, children, mental health and wellbeing).

A full breakdown is as below:

Category / LA	BCF/IBCF (£000s)	Discharge Funding (£000s)	ICES (£000s)	Integrated Commissioning (£000s)	Total (£000s)
LBC	26,568	-	-	60,943	87,511
MKCC	25,817	2,193	1,037	-	29,047
BBC	16,815	1,335	-	-	18,150
CBC	24,058	1,834	-	-	25,892
Total	93,258	5,362	1,037	60,943	160,600

4.6 As part of the ongoing requirement to ensure value for money, equity, and alignment to strategic place objectives, a review of the S75 agreements and the BCF needs to be undertaken during 2023-24 to ensure these are still fit for purpose in the context of the Joint Forward Plan (JFP) and deliver effective outcomes for the populations they encompass. Alongside this, the ICB needs to assure itself that the governance in place for approval and management of these funds is in alignment with current and future organisational and partnership structures, including the BLMK ICB Target Operating Model (TOM).

5.0 Next Steps

5.1 Following approval from the ICB Board the S75 agreements will be put forward to the ICB Chief Executive for formal signature and recording.

5.2 Discussions regarding the review of the BCF will be taken forward through Place Boards.

List of appendices

N/A

Background reading

As stated above, the following documents are available in the Board Effect Reading Room:

- FIC Paper seeking (and gaining) approval of the agreements as outlined above
- S75 agreement between BLMK ICB and LBC, approved at the FIC
- S75 agreement between BLMK ICB and MKCC for CES, approved at the FIC

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

ICS Partner: Partner Members

ICB Executive: Maria Wogan, Chief of System Assurance and Corporate Services

Report Author: Maria Wogan, Chief of System Assurance and Corporate Services

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

Item: 8.1 - Decision Planner for ICB decisions

1.0 Executive Summary

1.1 It is important that the Board of the ICB and the wider public are aware of forthcoming decisions that need to be taken by the ICB. This paper describes a mechanism for those decisions to be captured and published to enable greater transparency and accountability.

1.2 The first version of the Decision Planner is shown at appendix A

2.0 Background

2.1 As a public body responsible for a budget of nearly £2bn, it is important that decisions are well planned and that the decision making process is transparent and accountable.

2.2 Local authorities have had a statutory requirement to publish their forthcoming decisions for a number of years and this has informed the approach being taken by the BLMK ICB.

2.3 The Decision Planner will enable able cross-referencing to other documents, including to the engagement grid which will show what engagement and consultation activities are due to take place prior to decisions being made.

2.4 This version of the Decision Planner shows decisions up to December 2023, once the Joint Forward Plan is agreed and work programmes are developed in detail we expect the Decision Planner to be populated with items related to delivering the High Impact Programmes set out in the Joint Forward Plan.

3.0 Recommendations

3.1 The Board is asked to **note** this report and Board members are invited to notify the corporate governance team of any additional items for inclusion on the Decision Planner.

4.0 Key Implications

Resourcing	✓
Equality / Health Inequalities	
Engagement	✓
Green Plan Commitments	

4.1 The author has considered each of the areas above in relation to the report; identified the implications and described where applicable how these will be managed in the paragraphs shown.

5.0 Report

5.1 The Decision Planner will be managed by the Corporate Governance team, based on information from programme leads and other intelligence, including from the Programme Management Office (PMO) which maintains a schedule of all significant activity, much of which will lead to a decision being needed. There are no direct resourcing implications for the Corporate Governance team but there will be a reliance on information being provided by colleagues across the ICB and the wider ICS.

5.2 The development of the Decision Planner has involved a number of senior managers across the ICB including the Executive Group. The concept and design were also discussed at the Board Seminar on 26 May 2023 and partners were invited to propose any additional items for inclusion on the Decision Planner.

6.0 Next Steps

6.1 The Decision Planner will be maintained by the Corporate Governance team, regularly reviewed by the Executive Group and reported to each Board meeting. The latest Decision Planner will be uploaded to the website on a monthly basis.

List of appendices

Appendix A – Decision Planner as at 21 June 2023

Bedfordshire, Luton and Milton Keynes Integrated Care Board
Decision Planner

Status	Ref No.	Topic	Decision to be taken	Decision Taker	Scope	Date of Decision	ICB Board Sponsor	Contact Name
FUTURE	10070	Delegation of Specialised Commissioning	To make a go/no go decision on hosting following the review of due diligence. (NB extraordinary meeting may be needed).	Board of the ICB (Private)	BLMK	28 Jul 2023	Chief Transformation Officer	Kathryn Moody, Director of Contracting
FUTURE	10071	Integrated Urgent Care	To agree the strategy for the re-provision of integrated urgent care (111 service, clinical assessment services, GP out of hours) urgent treatment and walk-in centres.	Primary Care Commissioning and Assurance Committee	BLMK	15 Sep 2023	Chief Primary Care Officer	Amanda Flower, Associate Director - Primary Care Commissioning and Transformation Steve Gutteridge, Senior Primary Care Transformation and Commissioning Programme Manager – Integrated Urgent Care
FUTURE	10074	Specialist Community Dental Service (SCDS) Contracts	To agree the process for re-procurement of specialist community dental services contracts.	Primary Care Commissioning and Assurance Committee	BLMK	15 Sep 2023	Chief Primary Care Officer	Lynn Dalton, Associate Director - Primary Care
FUTURE	10075	111 Emergency dental services	To agree the process for re-procurement of emergency dental services accessible via 111.	Primary Care Commissioning and Assurance Committee	BLMK	15 Sep 2023	Chief Primary Care Officer	Lynn Dalton, Associate Director - Primary Care

Bedfordshire, Luton and Milton Keynes Integrated Care Board
Decision Planner

Status	Ref No.	Topic	Decision to be taken	Decision Taker	Scope	Date of Decision	ICB Board Sponsor	Contact Name
FUTURE	10076	Primary Care estates	Approve the process for any review of primary care estates programme (prioritisation list).	Primary Care Commissioning and Assurance Committee	BLMK	15 Sep 2023	Chief Primary Care Officer	Nikki Barnes, Head of ICB Estates
FUTURE	10077	Arden GEM Business Intelligence Support	To re-procure business intelligence support services from NHS Arden GEM CSU.	Board of the ICB	BLMK	29 Sep 2023	Chief Transformation Officer	Kathryn Moody, Director of Contracting
FUTURE	10078	Mental Health	Approve the establishment of a Mental Health, Learning Disability and Neurodiversity Collaborative Committee.	Board of the ICB	BLMK	29 Sep 2023	Chief Transformation Officer	Robin Campbell, Deputy Director of Integrated Care, East London NHS Foundation Trust
FUTURE	10079	Strategic Data Platform	To agree the approach to procuring a hosted ICS wide strategic data platform	Board of the ICB	BLMK	29 Sep 2023	Chief Medical Director	Mark Thomas, Chief Digital and Information Officer
FUTURE	10080	Business Intelligence Strategy	To approve the ICB Business Intelligence Strategy.	Board of the ICB	BLMK	29 Sep 2023	Chief Transformation Officer	Kathryn Moody, Director of Commissioning
FUTURE	10081	Target Operating Model	To note the outcome of the consultation with trade unions and staff on the revised structure for the ICB.	Board of the ICB	BLMK	29 Sep 2023	Chief People Officer	Emma Richards, Head of People, Change and Transformation
FUTURE	10082	VCSE Development	To agree an approach to grow the role of the VCSE in healthcare.	Board of the ICB	BLMK	29 Sep 2023	Chief Transformation Officer	Kathryn Moody, Director of Contracting
FUTURE	10083	Non-emergency patient transport	To agree the approach for the re-procurement of non-emergency patient transport services.	Board of the ICB	BLMK	29 Sep 2023	Chief Transformation Officer	Kathryn Moody, Director of Contracting

Bedfordshire, Luton and Milton Keynes Integrated Care Board
Decision Planner

Status	Ref No.	Topic	Decision to be taken	Decision Taker	Scope	Date of Decision	ICB Board Sponsor	Contact Name
FUTURE	10084	System recovery plans for access to primary care	To report progress on primary care recovery plans for reporting to NHS England.	Board of the ICB	BLMK	8 Dec 2023	Chief Primary Care Officer	Nicky Poulain, Chief Primary Care Officer
FUTURE	10085	ICS Infrastructure	To approve an ICS Infrastructure Strategy.	Board of the ICB	BLMK	8 Dec 2023	Chief Finance Officer	Nikki Barnes, Head of ICB Estates
FUTURE	10086	Data Ethics Strategy	To approve the ICS Data Ethics Strategy.	Board of the ICB	BLMK	8 Dec 2023	Chief Medical Director	Mark Thomas, Chief Digital and Information Officer
FUTURE	10087	Primary Care estates	Approve any changes to the prioritisation list for primary care estates schemes.	Primary Care Commissioning and Assurance Committee	BLMK	15 Dec 2023	Chief Primary Care Officer	Nikki Barnes, Head of ICB Estates Lynn Dalton, Associate Director - Primary Care
FUTURE	10088	Primary Care estates	Approve Kempston estate scheme business case (King St. GP practice reprovision).	Primary Care Commissioning and Assurance Committee	Bedford Place	Q1 2024/25	Chief Finance Officer	Nikki Barnes, Head of ICB Estates Lynn Dalton, Associate Director - Primary Care
FUTURE	10089	Equality, Diversity and Inclusion	To report on the Equality, Diversity and Inclusion improvement plan	Board of the ICB	BLMK	29/09/2023 (provisional)	Chief People Officer	Bethan Billington, Deputy Chief People Officer

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

ICS Partner: Members of Place Based Partnerships

ICB Executive: Maria Wogan, Link Director for Milton Keynes, Anne Brierley Link Director for Central Bedfordshire, Sarah Stanley Link Director for Bedford Borough and Nicky Poulain Link Director for Luton.

Report Author: Michelle Evans-Riches, Acting Head of Corporate Governance

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

Item: 8.2 – Update from Place Based Partnerships

1.0 Executive Summary

1.1 This provides an update on key issues from the four places in BLMK, Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.

2.0 Recommendations

2.1 The members are asked to note the update from the four Places in BLMK.

3.0 Key Implications

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

3.1 Each Place has identified specific priorities to meet the needs of local residents, to address health inequalities, the wider determinants of health and the green plan commitments.

3.2 The Chief Executives in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes have been consulted on the Place update contained at Appendix A.

4.0 Report

4.1 Since the last Board meeting in March 2023, partnership working continues to be strengthened in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. The Place update om Appendix A provides an update on areas of progress and key issues at Place and Health and Wellbeing Board meetings.

4,2 There have been local authority elections in each of the four Councils on 4 May 2023 and there have been changes in political leadership at Central Bedfordshire Council and Bedford Borough Council. As part of each Council's Members induction programme a session has been arranged on the role and responsibilities of the ICB and partnership working across the system and at Place.

5.0 Next Steps

5.1 Not applicable

List of appendices

Appendix A – Place update

Appendix A PLACE update for Board of ICB

1. Bedford Borough

The Borough's Health and Wellbeing Board met for the first time following the Local Government elections in May, and elected a new Chair, Cllr Martin Towler. At the Board's meeting on 7 June 2023, some of the items it considered were:-

Covid 19 Impact – Research Findings Community Engagement and COVID-19
Bedford Borough and Central Bedfordshire Councils commissioned NatCen and Community Regen to undertake a peer research investigation in 2022 to gain insights into how COVID-19 had affected local people, and in particular those who were disproportionately impacted, including residents from ethnic minority communities, those living in areas of higher deprivation and front-line health workers. Peer researchers from these groups were recruited and trained in research design, methods and practice.

The BLMK ICB Joint Forward Plan – the Plan for a Plan. The Board agreed that the Joint Local Health and Wellbeing Strategy was taken into account in the development of the Joint Forward Plan.

Better Care Fund – 2022-23 outturn and 2023-25 Plan
The Board considered the outturn from last year, and approved the Plan for 2023 -25. Further updates will be provided to the Board through the year.

The Bedford Borough Place Executive Delivery Group also reported to the Board on its work to support the delivery of the Place Based Plan, including:

- **The development of the Bedford Borough Family Hubs.**

The hub model takes a whole family approach to provide a single access point to family support services that is integrated across health (physical and mental health) and social care as well as voluntary and community organisations and education settings. There is a focus on bringing services together and changing the way family help and support is delivered locally. The model will be delivered in person and virtually. It was noted by the EDG that there are services which are not funded by the Family Hubs programme, which are expected to be part of the model. These include wider mental health services, midwifery, health visiting, oral and child health, early language support, SEND support, parenting programmes, debt and welfare advice, housing, reducing parental conflict, domestic abuse support, substance misuse support, family support, early childhood support, youth support, and youth justice.

- **Fuller Neighbourhood Teams.**

The EDG agreed to establish a group to lead on the development of options for neighbourhood mapping and the development of Neighbourhood Teams in the Borough, reporting to the EDG on progress.

- **Director of Public Health Annual Report – "Taking Local Action to Address Excess Weight in Bedford Borough"**

The EDG noted the role for partners in addressing issues relating to excess weight and obesity, including measures that they could take to improve the food offer in their premises and what they could do as employers to support staff. It was also noted that there were often other health and wellbeing issues that affected those with excess weight, and that a joined-up approach was needed to enable people to access support services.

2. Central Bedfordshire

- Change in administration following recent local elections. The new Chair of the H&WBB has been announced as Cllr Hares
- Feasibility Study considering the potential for additional health and care services in Leighton Buzzard was published on 18th May. We are working with our partners and residents to further consider need, affordability and scale of the options presented, and look forward to meeting with residents on the 13th June.
- The 6 Place Priorities for CBC 2023-4 have been confirmed, with shared action plans and outcome measures agreed:
    - Primary Care access, including dentistry
    - Increasing early cancer diagnosis and improving outcomes
    - Mental Health, Learning Disabilities and Autism – improving primary / secondary care interface, maximising physical health checks, increasing dementia diagnosis
    - Children & young people – maximising reach and uptake of emotional well-being support, graduated approach for children with SEND and place based care and wrap around family support for children with mental health concerns
    - Integrated neighbourhood working
    - Reducing excess weight – support to individuals and creating healthy environments
- Part of the pan-Bedfordshire programmes on:
    - Enhancing mental health community crisis and recovery pathways
    - Intermediate care – supporting people to recover

3. Luton

Verbal update as Luton Health and Wellbeing Board meets on 27 June 2023 – after papers for this meeting have been published.

4. Milton Keynes

MK Joint Leadership Team's key areas of focus have been:

- the development of a business case for the expansion of the virtual ward and the development of a single point of access to improve system flow and care for more residents in the community.
- Integrated working between the Council and CNWL with an initial focus on working better together to support Children in care
- Plans for a health and community facility in the Eastern Expansion Zone

The MK Health and Care Partnership met on 13 June and:

- reviewed the Draft Joint Forward Plan and agreed that subject to reflecting local projections on the level of population and housing growth it reflected MK's priorities
- reviewed progress on the delivery of the MK Deal priorities (improving system flow, tackling obesity and children and young people's mental health)
- agreed to commence the preparation phase for the 'Bletchley pathfinder' on locality/neighbourhood working and report back in September. This includes:
    - background research and test local appetite
    - a local workforce audit
    - pilot work on health and wellbeing coaching
    - developing proposed governance and leadership arrangements.
- The Bletchley pathfinder is aligned with city-wide work on streamlining access to care and advice

The ICB is requested to continue to support delivery of the MK Deal priorities with relevant staff resources and in particular to support the work on the Bletchley pathfinder which may become a 5th MK Deal priority in due course.

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

ICS Partner: All Partner Members

ICB Executive: Maria Wogan, Chief of System Assurance and Corporate Services

Report Author: Ola Hill, Deputy Head of Organisational Resilience

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

Item: 8.3 – System Board Assurance Framework

1.0 Executive Summary

1.1 This report emphasises the value of risk management for the ICB, stakeholders, and the local population by enabling the exploration of new ideas and effective mitigation of potential risks. The ICB utilises the Board Assurance Framework (BAF) as a key tool to identify and address strategic risks that may hinder the ICS from achieving its objectives.

1.2 Ongoing industrial action has been found to have a widespread impact on several risks outlined in the BAF. The ICB acknowledges this impact and emphasises the need for dynamic risk assessments that consider the interdependency of risk factors, including those related to industrial action.

1.3 The System Oversight and Assurance Group (SOAG – a meeting of system CEOs) has agreed to hold a risk assessment workshop to assess the potential risk/s related to collaborative working. This workshop will facilitate a shared understanding among partners and prioritise areas that require attention and mitigation. Also, in response to previous Board discussions, the report proposes a new risk for inclusion on the BAF in relation to partnership working.

1.4 Overall, the report emphasises the importance of risk management, acknowledges the impact of industrial action on the BAF risks, addresses new and pending risks, and highlights initiatives for climate change adaptation and collaborative working. The ICB and its partner organisations are committed to proactive risk assessment, mitigation, and collaboration to achieve system objectives and minimise risks effectively.

2.0 Recommendations

2.1 The Board is asked to review the BAF, note actions take to manage risks on the system BAF and agree any additional risks or mitigations that should be captured on the BAF.

3.0 Key Implications

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

3.1 There are finance and workforce risks on the BAF relating to the BLMK system, however there are no direct funding or workforce implications as a result of this report.

3.4 Widening inequalities is a strategic risk on the BAF which has implications across the BLMK system.

3.6 The BAF recognises Climate Change and subsequent adaptation as a key strategic risk from the BLMK system.

4.0 Report

4.1 Risk management benefits the ICS, ICB, our stakeholders and the local population by enabling new ideas to be explored and potential risks to be managed to minimise their impact. Our approach is to utilise the ICB Board Assurance Framework (BAF) as the key tool to hold the strategic risks as defined by the ICB working with ICS partners via the System Oversight and Assurance Group (SOAG) and the Board: the major risks that could prevent the ICS and ICB from fulfilling the objectives in its agreed strategy.

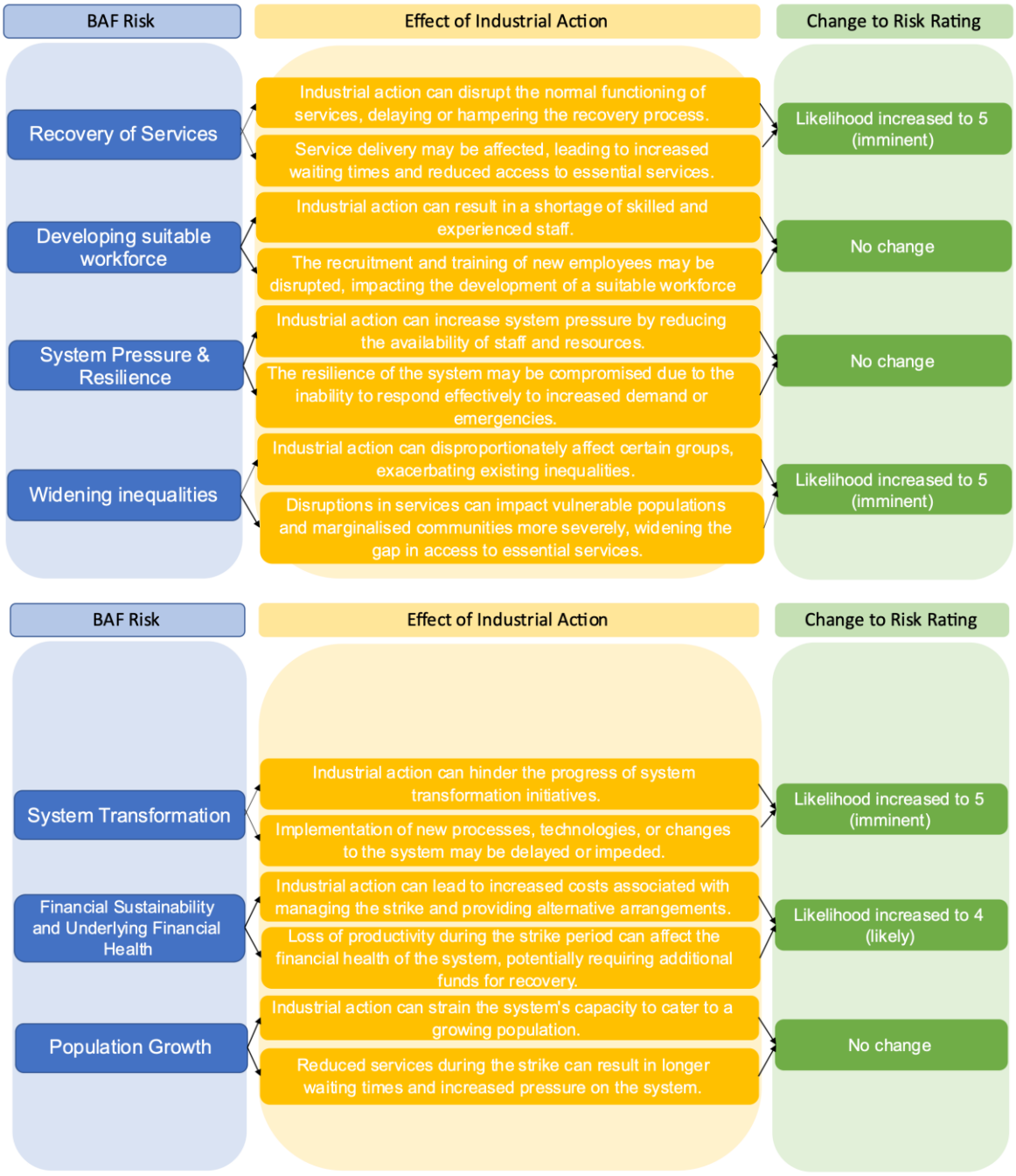
4.2 **Current BAF Risks**

There are currently ten risks on the BAF, BAF0010 is new following review by SOAG. Due to the impact of ongoing industrial action, there have been changes to the likelihood of a number of risks as illustrated below.

Ref	Risk Title	Risk Description	Current Risk Rating	Change
BAF0001	Recovery of Services	There is a risk that the NHS is unable to recover 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.	20	↑
BAF0002	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	=
BAF0003	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 system which threatens delivery of services across BLMK	20	=
BAF0004	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.	20	↑
BAF0005	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.	20	↑
BAF0006	Financial Sustainability and Underlying Financial Health	As a result of increased inflation, significant operational pressures, elective recovery 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.	20	↑
BAF0007	Climate Change	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.	16	=
BAF0008	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.	20	=
BAF0009	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	16	=
BAF0010	Partnership Working	There is a risk that the development of the ICS's public position on an issue is inconsistent with the public position of one or more partner member, resulting in a lack of clarity for the public and stakeholders	12	NEW

4.3 **Impacts of Industrial Action on BAF Risks**

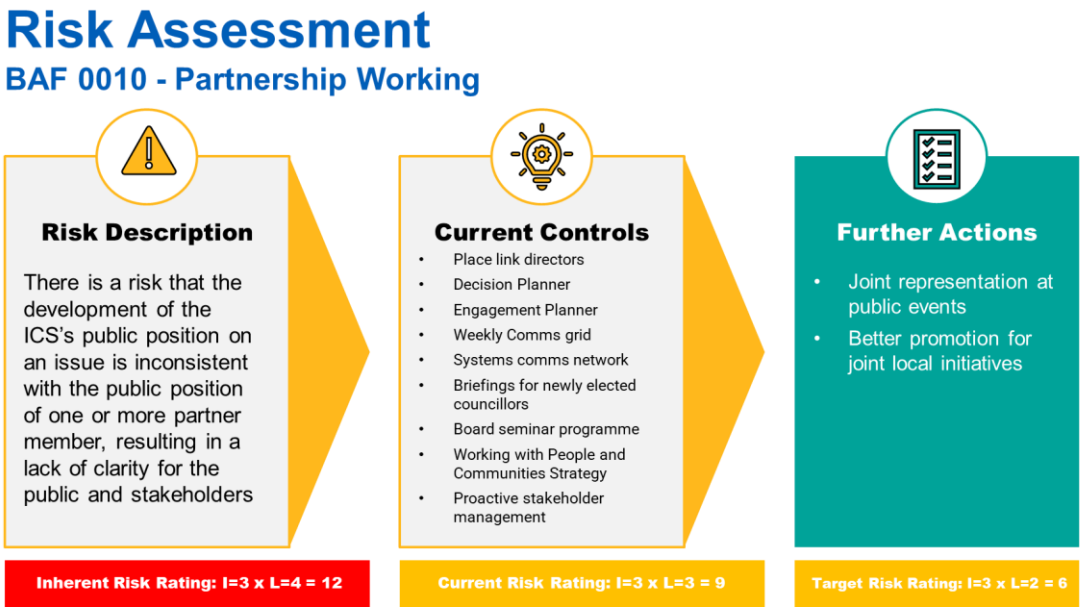
4.3.1 Following the last SOAG meeting, the ICB reviewed the impact of industrial action on the BAF risks and the ICB Executive Team acknowledges the widespread effect of the ongoing industrial action on a number of the system risks on the BAF as set out below:



4.3.2 The ICB and its partners need to ensure that they maintain dynamic risk assessments in response to a changeable risk environment, reflecting on the interdependency of risk factors across a spectrum of areas, as is the case with industrial action.

4.4 **New and Pending Risks**

4.4.1 Since the last meeting where there was a discussion about the reputational impact and risks arising from challenges facing the ICS such as the pressure on primary care estates and a risk assessment was undertaken on this area and a risk to '**Partnership working**' has been agreed by SOAG (see below).



4.4.2 The impact of the required 30% **reduction to ICB running costs** is an interdependency which prompts a further review of the BAF risks, which will be undertaken before the next SOAG in September.

4.4.3 A risk assessment workshop with partners is being arranged to deep dive into the potential **risk/s related to collaborative working**. As part of our work to further develop the system Target Operating Model and we progress with our work on the Mental Health, Learning Disabilities and Autism Collaborative, the Bedfordshire Care Alliance and our place based working arrangements, it will be helpful to share thinking on how we are managing the risks related to our collaborative work to maximise the opportunities collaboration offers and to accelerate progress with this work. By bringing together relevant stakeholders, the workshop will aim to foster a shared understanding of the potential risk and challenges related to it, promoting open discussions and knowledge exchange, enabling partners to gain insights from each other's experiences and expertise. Through collaborative discussions and assessments, partners will be able to collectively evaluate the likelihood and impact of the risks, enabling the identification of high-priority areas that may require immediate attention and mitigation.

4.4.4 The potential risk of poor collaboration between ICSs impacting outcomes for residents (particularly in relation to neighbouring ICSs) will be assessed by the ICB Executive Team in July and the outcome reported to the next SOAG.

4.5 **Actions following Deep-Dive – Climate Change**

4.5.1 Following the Deep-Dive on the Climate Change risk at the Audit & Risk Assurance Committee, we have established a System Operational Green Planning Group and an Adaptation Task and Finish Group to support the review of the ICB Adaptation Plan and the development of a system workplan for adaptation.

4.5.2 The group has highlighted concerns with regard to the inability to accurately ascertain outcome measures for climate adaptation and a lack of subject matter expertise in this area, particularly around the Green Plan and hence the group would be grateful for any support partners and anchor organisations can give in this regard. The Regional Team has agreed to support BLMK with this request and support access to expertise from the national team.

4.6 **BAF Work Programme**

4.6.1 As part of the BAF Work Programme, the ICB has been working to align BAF risks with Board Committees that can take ownership for strategic system risks that are relevant to their roles and remits. The committees will regularly receive relevant risks from the BAF at

their meetings and carry out at least annual deep dives into the respective risks involving appropriate system partners.

Ref	Risk Title	Risk Description	Proposed Board Committee
BAF0001	Recovery of Services	There is a risk that the NHS is unable to recover 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.	**Quality & Performance Committee**
BAF0002	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.	Quality & Performance Committee Finance & Investment Committee
BAF0003	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 system which threatens delivery of services across BLMK	**Quality & Performance Committee**
BAF0004	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.	**Quality & Performance Committee**
BAF0005	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.	Quality & Performance Committee Finance & Investment Committee
BAF0006	Financial Sustainability and Underlying Financial Health	As a result of increased inflation, significant operational pressures, elective recovery 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.	Finance & Investment Committee
BAF0007	Climate Change	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.	Audit & Risk Assurance Committee
BAF0008	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.	Finance & Investment Committee
BAF0009	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	Quality & Performance Committee Finance & Investment Committee

4.6.2 The ICB Quality and Performance Committee reviewed the list above and accepted its role in supporting deep dives into the risks as identified above. The ICB Finance & Investment Committee will be reviewing the above at its meeting on 1st September.

5.0 Next Steps

5.1 A risk assessment workshop will be held to assess the potential **risks related to collaborative working – partners are invited to nominate representative to participate in this workshop.**

5.2 The BAF will be next be presented to:

- Audit & Risk Assurance Committee – 14th July

5.3 The ICB Quality & Performance will receive the relevant risks at its meeting on 7th July and the ICB Finance & Investment Committee will review the relevant risks at its meeting on 1st September.

List of appendices

Appendix A – System Board Assurance Framework

System Strategic Risk Register (BAF)

Generated Date	15 Jun 2023 12:32
Risk Criteria	
Project	LIVE - Risk
Risk Area	ICB Board Assurance Framework

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

ICB Board Assurance Framework

Prefix	ICB Priorities	Risk Detail	Initial Priority	Controls Detail	Current Priority	Actions Action Details	Target Priority
BAF0010	Growth, Live Well	**Risk Title**: Partnership working **Cause**: There is a risk that the development of the ICS's public position on an issue is inconsistent with the public position of one or more partner member, resulting in a lack of clarity for the public and stakeholders **Risk Owner**: Maria Wogan **Risk Lead**: Dominic Woodward-Lebihan **Status**: Open	High (3:4=12)	Place link directors managing at Place Decision Planner Engagement Planner Weekly Comms grid Established comms network Briefings for newly elected councillors Partnership social media Live Well Newsletter Pre-briefing good practice to local leaders Chair and CEO quarterly session with local leaders Board seminar programme Working with Communities Strategy Media and Social Media Strategy	Medium (3:3=9)	**Detail**: Joint representation at public events **Assignee**: Dominic Woodward-Lebihan **Variable Target**: 29 Dec 2023 **Status**: Not Started **Detail**: Better promotion for joint local initiatives **Assignee**: Dominic Woodward-Lebihan **Variable Target**: 29 Dec 2023 **Status**: Not Started	Medium (3:2=6)

Prefix	ICB Priorities	Risk Detail	Initial Priority	Controls Detail	Current Priority	Actions Action Details	Target Priority
BAF0007	Live Well	**Risk Title**: Climate Change **Cause**: 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. **Risk Owner**: Maria Wogan **Risk Lead**: Tim Simmance **Status**: Open	High (4:4=16)	Partner Green Plans and Sustainability Plans. NHS organisations, local authorities and other public sector ... Local Resilience Forum Adverse Weather Plans BLMK ICS Green Plan 2022-25 Severe Weather Plan Green Plan Operational Working Group Climate Adaptation Task & Finish Group	High (4:4=16)	**Detail**: Identify a BLMK ICS lead, who will then oversee creation, approval and delivery of a BLMK system-wide... **Assignee**: Tim Simmance **Variable Target**: 30 Apr 2023 **Status**: Complete **Detail**: Implement recommendations from Green Plan Health Impact assessment. **Assignee**: Tim Simmance **Variable Target**: 30 Sep 2023 **Status**: Not Started **Detail**: Develop and begin implementation of the delivery plan high impact elements of the BLMK ICS Green Plan... **Assignee**: Tim Simmance **Variable Target**: 30 Jun 2023 **Status**: Not Started **Detail**: Support review of business continuity arrangements of ICS partners to ensure... **Assignee**: Abimbola Hill **Variable Target**: 30 Apr 2023 **Status**: Complete	Medium (2:4=8)

Prefix	ICB Priorities	Risk Detail	Initial Priority	Controls Detail	Current Priority	Actions Action Details	Target Priority
BAF0009	Live Well	**Risk Title**: Rising Cost of Living **Cause**: 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 **Risk Owner**: Maria Wogan **Risk Lead**: Martha Roberts **Status**: Open	High (4:4=16)	Delivery of ongoing communications to support population access to support services in partnership with Trusts and Local Authorities. Partner support schemes for residents Partner and national NHS financial plans for managing increased costs due to inflation Need for clinical and operational prioritisation of waiting lists...	High (4:4=16)	**Detail**: [EDI & Wellbeing People Sub-Group established]: Ongoing work plan for maximising support for staff across BLMK. **Assignee**: Martha Roberts **Variable Target**: 30 Jun 2023 **Status**: Not Started **Detail**: Develop and implement Population Health Intelligence Unit with Local Authorities... **Assignee**: Sarah Stanley **Variable Target**: 30 Jun 2023 **Status**: Not Started **Detail**: Understand and promote partner support schemes for residents **Assignee**: Maria Wogan **Variable Target**: 31 Mar 2023 **Status**: Complete **Detail**: Implementation of inequalities work programme to support the most vulnerable people... **Assignee**: Maria Laffan **Variable Target**: 30 Jun 2023 **Status**: Not Started **Detail**: Agree medium-term financial plan with NHS partners. As part of joint forward plan. **Assignee**: Dean Westcott **Variable Target**: 30 Jun 2023 **Status**: Not Started	High (3:4=12)
BAF0001	Live Well	**Risk Title**: Recovery of Elective & Cancer Services **Cause**: 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. **Risk Owner**: Anne Brierley **Risk Lead**: Michael Ramsden **Status**: Open	High (4:5=20)		High (4:5=20)	**Detail**: Weekly Waiting List monitoring - AGEM CSU working up process for weekly waiting list monitoring at ICS level **Assignee**: Michael Ramsden **Variable Target**: 01 Apr 2022 **Status**: Complete	High (4:3=12)

Prefix	ICB Priorities	Risk Detail	Initial Priority	Controls Detail	Current Priority	Actions Action Details	Target Priority
				The actions and controls to support the Pandemic and System Pressures risk will support Elective Recovery...		**Detail**: Elective Recovery Planning - High level plan to be completed August - September, with detailed plan in Oct-Nov. **Assignee**: Michael Ramsden **Variable Target**: 30 Nov 2021 **Status**: Complete	
				Processes in place to ensure those with most urgent clinical needs are treated first....		**Detail**: Negotiate H2 ISP contracts - Contracts to be negotiated to optimise utilisation of ISP capacity. **Assignee**: Michael Ramsden **Variable Target**: 30 Sep 2021 **Status**: Complete	
				An Elective Recovery Board has been convened to track recovery and instigate actions....		**Detail**: BLMK-wide Comms Plan is planned, but currently there is an embargo on waiting list related Comms... **Assignee**: Duncan McConville **Variable Target**: 03 Jun 2022 **Status**: Complete	
				Monthly RTT report indicating size of waiting list and length of wait....		**Detail**: Maintain oversight of the 22/23 Operational Plan delivery. All actions will support recovery ... **Assignee**: Michael Ramsden **Variable Target**: 31 Mar 2023 **Status**: Not Started	
				Monthly RTT report indicating size of waiting list and length of wait. ...		**Detail**: System wide transformation plan to increase productivity using GIRFT data)... **Assignee**: Michael Ramsden **Variable Target**: 31 Mar 2023 **Status**: Not Started	
				Independent Sector and community services use to support Trusts in their wait reduction...		**Detail**: 06/09/2022 - AGEM unable to forecast demand and capacity due to issues with the national tool... **Assignee**: Michael Ramsden **Variable Target**: 31 Mar 2023 **Status**: Not Started	
				1. All Trusts have recovery action plans....			
BAF0002	Growth	**Risk Title**: Developing suitable workforce **Cause**: 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	High (4:5=20)		High (4:5=20)		High (4:3=12)

Prefix	ICB Priorities	Risk Detail	Initial Priority	Controls Detail	Current Priority	Actions Action Details	Target Priority
		Responsibilities and the System People Plan are threatened. **Risk Owner**: Martha Roberts **Risk Lead**: Bethan Billington **Status**: Open		Frequent Director of Nursing and HEE discussion on nursing workforce and future planning /risks . Significant LMNS involvement and SRO ownership for maternity development - with focus on Midwifery workforce. EDI & Wellbeing: People Board Sub Group focussing on supporting the wellbeing of staff across the ICS... Active workstreams around increasing placement capacity, recruitment, retention... High risk areas for recruitment such as mental health, critical care and maternity have specific subgroups... Leadership & OD: People Board Sub Group focussing on building the OD capacity and skills within... Work ongoing to develop a workforce structure to deliver people plan and ICB workforce responsibilities Primary Care: People Board Sub Group focussing on workforce programmes as they relate to Primary Care Workforce... Triangulating information from Serious incidents , complaints , safeguarding ... Workforce Modelling & Supply: People Board Sub group focussing on the development... Primary Care Training Hub supporting in recruitment, retention and training of primary care workforce Operational plan for 21/22 submitted. People Board receives assurances around ongoing People Plan... People Board: ICS Executive Group with responsibility for People Plan delivery to meet IC... Education Partnership: People Board Sub Group responsible for development and co-ordination...		**Detail**: Mental Health Workforce plan re-fresh for EoE and BLMK (includes ongoing recruitment activity) **Assignee**: Michael Farrington **Variable Target**: 31 Mar 2022 **Status**: Complete **Detail**: Expansion of clinical placement capacity and quality **Assignee**: John Syson **Variable Target**: 30 Jun 2022 **Status**: Complete **Detail**: Rotational Apprenticeship: (Education Partnership) Pilot of level 3 HCA rotational apprenticeship... **Assignee**: Catherine Jackson **Variable Target**: 31 Mar 2023 **Status**: Not Started **Detail**: 50k nursing recruitment and retention project focusses increasingly on retention and later careers **Assignee**: Marie Lambeth-Williams **Variable Target**: 29 Apr 2022 **Status**: Complete **Detail**: Workforce Planning: Adequate integrated workforce planning approach linked to population... **Assignee**: John Syson **Variable Target**: 31 Mar 2023 **Status**: Complete **Detail**: Launch, asses and embed the Health and Wellbeing pilot: (Primary Care) Pilot a range... **Assignee**: Susi Clarke **Variable Target**: 31 Mar 2023 **Status**: Not Started **Detail**: H&W conversations and support via Wellbeing hub and provider OH services for staff to maintain resilience **Assignee**: John Syson **Variable Target**: 30 Jun 2022 **Status**: Complete	

Prefix	ICB Priorities	Risk Detail	Initial Priority	Controls Detail	Current Priority	Actions Action Details	Target Priority
						Detail: 50k Nursing Target: (linked to Workforce Modelling and Supply) System has a target to increase... **Assignee**: Marie Lambeth-Williams **Variable Target**: 31 Mar 2023 **Status**: Not Started **Detail**: Embed use of 'No more tick boxes' recruitment approach: (EDI & Wellbeing) ... **Assignee**: Bethan Billington **Variable Target**: 31 Mar 2023 **Status**: Not Started **Detail**: Launch of 2 cohorts of Leading Beyond Boundaries (LBB) in 22/23: (Leadership & OD)... **Assignee**: Martha Roberts **Variable Target**: 30 Dec 2022 **Status**: Complete **Detail**: Joint recruitment and advertising between health and social care partners **Assignee**: Catherine Jackson **Variable Target**: 30 Jun 2022 **Status**: Complete	

Prefix	ICB Priorities	Risk Detail	Initial Priority	Controls Detail	Current Priority	Actions Action Details	Target Priority
BAF0003	Live Well	**Risk Title**: System Pressure & Resilience **Cause**: 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. **Risk Owner**: Anne Brierley **Risk Lead**: Anne Brierley **Status**: Open	High (4:5=20)	BLMK engaged with regional critical care groups BLMK Primary Care Access Program SHREWD being implemented across BLMK to enable real time resilience/flow data. In line with escalation process, daily system calls in place for Bedfordshire Specific ICB focus on community bed management across Bedfordshire. Increased Patient Transport Services to facilitate swifter discharge Discharge To Assess process is being implemented in Bedfordshire (already in place in Milton Keynes and Luton) Monthly reports are reviewed at the TILT, Q&P and F&P meetings and the GB CCG officers review performance weekly via reset & restoration meetings 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 The Exec Team reviews performance on a monthly basis BLMK Performance & Delivery Group reviews performance on a bi-monthly basis and agrees system mitigations and actions Work with Councils to review and redesign care pathways to release more therapy resource to focus on flow. Winter Planning to include commissioning of further capacity (beds and care) across BLMK	High (4:5=20)	**Detail**: Meeting with Regional EPRR Leads (EoE and SE) to review current position and build ... **Assignee**: Geraint Davies **Variable Target**: 16 Sep 2021 **Status**: Complete **Detail**: Milton Keynes and Bedfordshire Care Alliance will confirm their winter plans for 23/24 **Assignee**: Anne Brierley **Variable Target**: 31 Mar 2023 **Status**: Not Started **Detail**: Continued development and implementation of support/access improvement projects via BLMK Access Group and sub-groups **Assignee**: Nicky Poulain **Variable Target**: 28 Apr 2023 **Status**: Not Started **Detail**: 2021/22 Winter Plan being produced **Assignee**: Richard Alsop **Variable Target**: 30 Sep 2021 **Status**: Complete **Detail**: H2 Plan being produced for service management & funding **Assignee**: Richard Alsop **Variable Target**: 30 Nov 2021 **Status**: Complete **Detail**: EPRR Lessons Learned Exercise built into future management of incident **Assignee**: Mark Meekins **Variable Target**: 30 Dec 2022 **Status**: Complete	High (3:4=12)

Prefix	ICB Priorities	Risk Detail	Initial Priority	Controls Detail	Current Priority	Actions Action Details	Target Priority
BAF0004	Reduce Inequalities	**Risk Title**: Widening inequalities **Cause**: 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. **Risk Owner**: Sarah Stanley **Risk Lead**: Sarah Stanley **Status**: Open	High (4:5=20)	Resource allocation for 22/23 to help to reduce inequalities and draw out learning for future investment Learning from incidents , safeguarding case review, Community partnership safety work 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. 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 Health inequalities defined at place and PCN level Supporting the workforce to deal with the impact of the pandemic being overseen by the BLMK Peoples Board. Work with voluntary agencies e.g maternity Voices , parent carer forums SEND in coproduction of outcomes Safeguarding partnership board priorities (Neglect , transition etc..) Working with providers and partners on access for seldom heard communities Developing Business Intelligence reporting to report key health outcomes/NHS constitutional standards by place and PCN... Review to understand the impact of Covid on inequalities (Lloyd Denny)...	High (4:5=20)	**Detail**: Action plan for 9 priority areas developed. Some elements still in early stages of implementation... **Assignee**: Nicola Kay **Variable Target**: 30 Apr 2022 **Status**: Complete **Detail**: Linking to Place plans, each place profile will highlight inequalities and agree appropriate actions... **Assignee**: Nicky Wadely **Variable Target**: 28 Oct 2022 **Status**: Complete **Detail**: Assurance and outcome metrics to be developed by Director of Contracting **Assignee**: Kathryn Moody **Variable Target**: 31 Mar 2023 **Status**: Not Started	High (4:3=12)

Prefix	ICB Priorities	Risk Detail	Initial Priority	Controls Detail	Current Priority	Actions Action Details	Target Priority
BAF0005	Growth	**Risk Title**: System Transformation **Cause**: 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. **Risk Owner**: Anne Brierley **Risk Lead**: Anne Brierley **Status**: Open	High (4:5=20)	Operational performance management process in place taking account of responses to operational pressures Performance & Delivery Group - manages immediate operational issues Chief Exec/SOAG - regular reviews of operational performance issues to agree mitigations Agreed strategic priorities across the system in place Same Day Urgent Primary Care Offer EPRR Framework and System monitors and responds to incidents resulting from operational pressures to wider system	High (4:5=20)	**Detail**: Establish delegation/migration programme to implement subsidiarity **Assignee**: Maria Wogan **Variable Target**: 30 Sep 2022 **Status**: Complete **Detail**: Agree BLMK integrated care strategy including key metrics for population outcomes **Assignee**: Anne Brierley **Variable Target**: 30 Dec 2022 **Status**: Complete **Detail**: Agree joint forward plan **Assignee**: Anne Brierley **Variable Target**: 30 Jun 2023 **Status**: Not Started **Detail**: Set clear timescales and expectations for place plans to deliver transformation for the population **Assignee**: Anne Brierley **Variable Target**: 31 Mar 2023 **Status**: Not Started	Medium (3:2=6)
BAF0006	Growth	**Risk Title**: Financial Sustainability & Underlying Financial Health **Cause**: 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. **Risk Owner**: Dean Westcott **Risk Lead**: Stephen Makin **Status**: Open	High (5:4=20)	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 Group. Update and development of system Medium Term Financial Plan for 2023/24 to 26/27. Includes scenario modelling of key variables and downsides.	High (5:4=20)	**Detail**: Development and implementation of system transformation, improvement and efficiency programme covering for 2023/24 + across and between ICS partners **Assignee**: Anne Brierley **Variable Target**: 31 Mar 2023 **Status**: Not Started	High (4:3=12)

System Strategic Risk Register (BAF)

Prefix	ICB Priorities	Risk Detail	Initial Priority	Controls Detail	Current Priority	Actions Action Details	Target Priority
BAF0008	Live Well	**Risk Title**: Population Growth **Cause**: 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. **Risk Owner**: Anne Brierley **Risk Lead**: Anne Brierley **Status**: Open	High (4:5=20)	Joint forward plan population trajectories Oxford-Cambridge Arc Local Authority Place Plans Partner Support Schemes for staff	High (4:5=20)	**Detail**: Primary Care estates strategy aligned with One public estates plan **Assignee**: Nicky Poulain **Variable Target**: 04 Dec 2023 **Status**: Not Started **Detail**: Infrastructure plans (capital, estates, health services, workforce) will be addressed.... **Assignee**: Anne Brierley **Variable Target**: 30 Jun 2023 **Status**: Not Started **Detail**: One public estates plan mapped against population growth for each borough **Assignee**: Dean Westcott **Variable Target**: 04 Dec 2023 **Status**: Not Started **Detail**: Develop and approve BLMK Health and Care Partnership Integrated Care Strategy **Assignee**: Richard Alsop **Variable Target**: 30 Dec 2022 **Status**: Complete	High (3:4=12)

Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 30 June 2023

ICS Partner: Non-Executive Members – Committee Chairs

ICB Executive: Maria Wogan, Chief of System Assurance and Corporate Services

Report Author: Michelle Evans-Riches, Acting Head of Corporate Governance

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

Item: 8.4 – Corporate governance update and report from Committees

1.0 Executive Summary

1.1 This report provides a list of key Corporate Governance points to approve or note as indicated below:

1.1.1 Executive lead roles within Integrated Care Boards – proposed amendment to the Governance Handbook Scheme of Reservation and Delegation (SORD)

1.1.2 Recruitment of Dr Sahadev Swain, Primary Medical Services partner member of the Board of the ICB.

1.1.3 Update on the recruitment of a Non-Executive Member (NEM) and Chair of Audit and Risk Assurance Committee.

1.1.4 Committee Chairs Updates.

2.0 Recommendations

2.1 The members are asked to **approve** the amendment to the Governance Handbook Scheme of Reservation and Delegation for the Chief Nursing Director;

2.2 That members are asked to **note**

2.2.1 The recruitment of Dr Sahadev Swain, Primary Medical Services partner member of the Board of the ICB and **agree** to his appointment as a member of the Quality and Performance Committee – see 4.2 below.

2.2.2 Update on the recruitment of a Non-Executive Member and Chair of Audit and Risk Assurance Committee – see 4.3 below.

2.2.3 Committee Chairs' updates, provided in appendix A – see 4.4 below.

3.0 Key Implications

Resourcing	
Equality / Health Inequalities	
Engagement	
Green Plan Commitments	

3.1 There are no resourcing, equality/health inequality, engagement or Green Plan commitments as a result of this report.

4.0 Report

4.1 **Executive lead roles within Integrated Care Boards**

In May 2023, NHS England published guidance (here) for each ICB Board to identify voting Board members with explicit responsibility for the areas listed in the table below. The table details the area of responsibility and the BLMK ICB Board member:

Area of Responsibility
Children and young people (aged 0 to 25)
Children and young people with special educational needs and disabilities (SEND)
Safeguarding (all-age), including looked after children
Learning disability and autism (all-age)
Down syndrome (all-age)

4.2 The Governance Handbook Appendix P Scheme of Reservation and Delegation (SORD) details the delegated functions of the Board, and it is recommended that the decision and functions delegated to the Chief Nursing Director on page 127 be amended as follows to reflect the roles required by the guidance

Individual Board member	Decisions and functions delegated to the individual or group
Chief Nursing Director Lead for:	• Children & Young People (aged 0 to 25), • Transforming Care, • Local Maternity & Neonatal System, • Children and Young People with Special Educational Needs & Disabilities (SEND), • Safeguarding (all-age), including looked after children; and: • Down syndrome (all-age)

4.2 Recruitment of Dr Sahadev Swain, Primary Medical Services partner member of the Board of the ICB

Following an appointment process, Dr Sahadev Swain has been appointed with effect from 5 June 2023 for a three-year term as a Primary Medical Services partner member of the Board. Dr Swain is also recommended for appointment as a member of the Quality and Performance Committee.

4.3 Update on the recruitment of a Non-Executive Member (NEM) and Chair of Audit and Risk Assurance Committee

The recruitment process for a NEM and Chair of Audit and Risk Assurance Committee is underway and, if successful, it is hoped the newly appointed NEM will commence in the summer/autumn. A verbal update will be given at the Board meeting.

4.4 Committee Chairs Updates

With three exceptions, updates from the following Committees of the Board can be found at appendix A. Verbal updates will be provided for the meetings where a written report is not available due to timing of the board agenda despatch – as indicated by a * below.

Note: the BLMK Health and Care Partnership has not met since the last Board meeting. The agenda setting group which comprises of the ICB Chair and Chairs of the local authority health and Wellbeing Boards are due to meet on 21 June 2023 to discuss the meeting arrangements for 2023-24.

Name of Committee	Meeting Held On
Audit and Risk Assurance Committee Part 1 ICB Business	12 May 2023
Audit and Risk Assurance Committee Part 2 System Risk	12 May 2023
Bedfordshire Care Alliance*	15 June 2023

Name of Committee	Meeting Held On
Finance and Investment Committee	16 May 2023
Health and Care Senate*	22 June 2023*
Primary Care Commissioning and Assurance Committee in Public	17 March 2023
Primary Care Commissioning and Assurance Committee in Public*	16 June 2023
Quality and Performance Committee	5 May 2023
Working with People and Communities	9 June 2023

*****Verbal updates will be provided at the Board.

5.0 Next Steps

5.1 The Governance Handbook Scheme of Reservation and Delegation will be amended following Board approval.

List of appendices

Appendix A – Report from Committee Chairs

Background reading

None

Appendix A – Committee Chairs Updates:

Audit and Risk Assurance Committee Part 1 ICB Business – 12 May 2023
Update to Board on key points
The Committee approved the external auditors' (Grant Thornton) **Audit Plan for the Annual Report and Accounts** for the period July 2022 to March 2023. There were no risks of significant weakness or weaknesses or emerging issues to report. **Internal Auditors** (BDO) presented: Internal Audit Progress Report, Conflicts of Interest Audit Report (outcome was moderate assurance), Pharmacy, Ophthalmology and Dentistry – readiness for delegation report, Equality, Diversity and Inclusion Maturity Report, ICB Governance Report, Internal Audit Follow up of Recommendations Report. The Committee approved the Draft Internal Audit Plan 2023/24. The BDO **Counter Fraud Specialist** presented the Progress Update Report – noting that the National Fraud Initiative data matching exercise is underway across the public sector and the Draft Review against NHS Counter Fraud Authority Standards 2022/23 – noting it to be positive and proposing a move from amber last year to green this year. The Deputy Chief Finance Officer confirmed that following independent audit by Grant Thornton, the Mental Health Investment Standards (MHIS) 2021/22 have been met. The Committee noted preparation for the submission of the Data Security and Protection Toolkit. The Chief of System Assurance and Corporate Services provided an update on the development of the annual reports and accounts for BLMK CCG Q1 and BLMK ICB Q2-4 and the Risk Management Update Report. The committee had a discussion under the Annual Review of Committee Effectiveness item.
Decisions for approval by the Board
None

Audit and Risk Assurance Committee Part 2 System Risk – 12 May 2023
Update to Board on key points
The committee received an update following the Climate Change deep dive session and a System Risk Management report. It was proposed that committees of the Board take ownership of risks which align to their remit, therefore assuring review of the risks, risk scores, existing controls, assurance, and further actions and carry out at least annual deep dives into its respective risks involving appropriate system partners. The role of A&RAC will be to get assurance that the system and processes of system risk management are working well rather than management of individual risks
Decisions for approval by the Board
None

Finance and Investment Committee – 16 May 2023
Update to Board on key points
Noted both the ICB and System Finance reports for month 12 noting the reported outturn for the year (subject to audit) and also the underlying position and pressures particularly with regard to prescribing costs. Received an update on the 2023/24 System Financial Plan and noted that whilst the plan is balanced, a significant efficiency programme is required and that risks to delivery exist, particularly with regards to on-going levels of inflation. The committee also noted that the current capital plan for the system remains non-compliant due to the discrepancy between the Trust depreciation estimates and the CDEL allocated. Received an update on the current key procurement and contracting issues including the planned procurement approach for the ICB strategic data platform and the governance processes. Received an update on the system capital position and progress on key projects.
Decisions for approval by the Board
Approval of the ICB's section 75 agreements for 2023/24 (paper on Board agenda)

Primary Care Commissioning & Assurance Committee in Public - 17 March 2023
Update to Board on key points
Noted (i) the ongoing work to progress the safe delegation of Community Pharmacy, Optometry and Dental (POD) contracting from NHS England to the ICB from 1 April 2023, (ii) the outstanding risks and view of internal audit, and supported a recommendation of a side letter to the Delegation Agreement which sets out the ICB concerns and limitations in relation to the readiness for delegation, (iii) the new governance arrangements for POD from 1 April 2023 Approved the recommendation to delegate pharmacy regulatory decisions to the Pharmaceutical Services Regulatory Committee (PSRC), which is a designated statutory committee for decisions in relation to the pharmaceutical regulations. Approved the Memorandum of Understanding (MOU) and associated Standard Operating Procedure (SOP) with Hertfordshire and West Essex ICB for the management of Pharmacy and Optometry contracts and hosting the staff that will continue to support the six ICBs Noted feedback from the ICB Board workshop on the delivery of integrated primary care, including the priority for each place to define their neighbourhoods and the importance of the Place Boards to drive local implementation . Noted the progress outlined in the primary care workforce highlight report Noted the updates and received assurance that the required contractual, governance, patient and practice considerations and actions had been followed and applied

Approved the extension of the Cauldwell Medical Centre contract for a further two years from April 2023 to March 2025.

Discussed and delegated to the Chair to take Chairs Action in regard to Ivel Medical Centre contract resignation on the recommendation for contract award to the preferred provider, assuming that they are above the bar on scorings and weightings and the ICB are confident under clinical management, performance and finance to make that recommendation.

Noted the progress update and next steps for Acute Respiratory Infection Hubs, the status update of the Universal Offer programme of work; provided support to proceed with services for inclusion at the price proposed within financial schedule and noted the next steps to achieve delivery of the Universal Offer.

Noted that risks relating to the primary care directorate are being identified and managed appropriately.

Noted the report from the Estates Working Group and the January 2023 primary care financial position.

Decisions for approval by the Board

To accept delegation of Community Pharmacy, Optometry and Dental contracting from NHS England to the ICB from 1 April 2023 and to delegate pharmacy regulatory decisions to the Pharmaceutical Services Regulatory Committee (PSRC), which is a designated statutory committee for decisions in relation to the pharmaceutical regulations and approved the Memorandum of Understanding (MoU) and associated Standard Operating Procedure (SOP) with Hertfordshire and West Essex ICB for the management of pharmacy and optometry contracts and hosting the staff that will continue to support the six ICBs. This was approved by the Board on 24 March 2023.

Quality and Performance Committee – 5 May 2023

Update to Board on key points

Board Assurance Framework and Risk Register – will be further refined to incorporate all identified quality risks, determining risk appetite, tolerance, appropriate ownership for management, review, and rationalisation for any changes. The link between workforce risks and quality was also discussed and supported this approach.

Inpatient Mental Health – LD & Autism - relationship building with providers is underway with plans to ensure/confirm appropriate clinical oversight, robust treatment plans and, where appropriate, discharge plans. Learning from a recent Learning Disability and Autism review will support this work. The mental health collaborative and East of England provider collaborative will also be approached for input. The committee was assured of appropriate priority and partner collaboration.

Joint Forward Plan - The joint forward plan is a work in progress with a focus on ensuring quality and inequalities are recognised as an integral part of the plan and embedded for the longer term. It was agreed Quality should not be considered a separate item in the plan and suggested an overview of all contributions for assurance that quality is fully incorporated in each submission.

Patient Safety Incident Response Framework (PSIRF) - An integrated system-wide overview of how the framework is working is planned, to determine whether implementation is meeting the tenets of the framework, and, that it is being delivered in the most efficient and effective way to ensure expected outcomes

Complaints – On 1 April 2023, responsibility for commissioning pharmaceutical, general ophthalmic services and dentistry (POD) was delegated to Integrated Care Boards; the team has started the transition to take on POD complaints. Main focus of complaints is what the ICB is doing to factor in population expansion and the infrastructure to meet increased

demand on services (Primary Care access). A thematic review will be developed to with a view to measuring outcomes and impact from recommendations and actions. **Quality and Performance Report –** the committee received a comprehensive overview of the report and System Oversight Framework. Areas of concern noted; the impact of industrial action across the system, pressures in Urgent and Emergency Care, cancer backlogs (histopathology, gynaecology, colorectal) and elective recovery; longest waits are in ophthalmology. High risks noted in the NHS 111 GP Out of Hours Service, workforce and vacancy rates; these areas are also monitored and tracked. Winter planning is underway with place-based plans being developed by providers and local authority partners. The Committee was assured of appropriate risk prioritisation and ongoing mitigations **Annual Review of Committee Effectiveness** - A governance overview and evaluation were completed on the work of this committee.
Decisions for approval by the Board
None

Working with People & Communities - 9 June 2023
Update to Board on key points
Denny Review - committee commended all the work that had been undertaken. They noted and supported all the recommendations made by the Health Inequalities Steering Group. The committee proposed that further work including report to Board include two or three actions relevant to each of the five priority groups identified as facing the most disadvantage. There was unanimous support for the board to approve the allocation of further funding which would enable implementation of the recommendations across the system. **Engaging with communities, roles of Healthwatch and VCSE sector** – A request was made by Healthwatch Luton for clarity around how the ICB would commission work from Healthwatch organisations and the VCSE – being mindful of the statutory function of Healthwatch. There was potential overlap and a proposal to facilitate a joint session between the four Healthwatch organisations and VCSE Strategy Group was supported. The committee recommended that work be undertaken to review how more mature systems work with Healthwatch and the VCSE to bring lessons to BLMK. **Joint Forward Plan** – Members noted the Joint Forward Plan and the engagement undertaken to support its development. They approved the 'Big Conversation' approach and recommended that disease specific groups be engaged with during the process. **Primary Care Same Day access** –It was agreed that a workshop will be arranged in July/August to enable a detailed discussion about primary care same day access, so there is a clear understanding of what can be influenced and the timeframes for engagement with residents. **Healthwatch Memorandum of Understanding (MoU)** – the committee were assured on the progress being made to develop a Memorandum of Understanding between the ICB and Healthwatch. The MOU is currently passing through Healthwatch governance processes, and a paper will be submitted to the ICB Board on 30 June for approval.
Decisions for approval by the Board
The Denny Review and Healthwatch MOU will be submitted to the Board for approval on 30 June.