

Meeting of the Integrated Care Board in PUBLIC

Date: 27 January 2023

Time: 09:00 – 12:15

Venue: Council Chamber, Bedford Borough, Borough Hall, Cauldwell Street, Bedford,
Beds MK42 9AP

No.	Agenda Item	Lead	Purpose	Time
Opening Actions				
1	Welcome, Introductions and Apologies	Chair	-	09:00
2	Core Purposes of Integrated Care Systems: <ul style="list-style-type: none"> • improve outcomes in population health and healthcare • tackle inequalities in outcomes, experience and access • enhance productivity and value for money • help the NHS support broader social economic development 	Chair	-	
3	Relevant Persons Disclosure of Interests	Chair	Note changes and approve	
4	Approval of Minutes and Matters Arising			
5	Review of Action Tracker			
6	Questions from the Public	Chair	Note	09:05
7	Chair's Report (verbal)	Chair	Note	09:10
8	Chief Executive Officer's Report	Chief Executive Officer	Note	09:15

No.	Agenda Item	Lead	Purpose	Time
Governance				
9	Corporate Governance update: <ul style="list-style-type: none"> ▪ Deputy Chair appt ARAC, ▪ ToRs amendment for H&CP ▪ H&C Senate rep to WWPAC ▪ ToRs amendment for WWPAC re quoracy ▪ Committee Chairs updates including from the extraordinary meeting of the PCCAC which was held on 11 January 2023. 	Chief of System Assurance and Corporate Services & Committee Chairs	Note and approve	9:20
10	Board Assurance Framework	Chief of System Assurance and Corporate Services	Note and discuss	9:30
Strategy				
11	Bedfordshire Care Alliance Update	David Carter, Chief Executive, Bedfordshire Hospitals NHS FT	Note and approve	9:40
12	People Strategy	Chief People Officer	Approve	09:50
13	Resident's Story in Relation to Inequality (verbal)	Chief of System Assurance and Corporate Services and Chief Nursing Director	Note	10:00
14	The Inequalities Journey – “Where are we going and where have we been?”	Chief Nursing Director	Note	10:15
15	Update on Strategy and Planning	Chief Transformation Officer	Note	10:25
16	Progress Report: Implementation of the Voluntary, Community & Social Enterprise and BLMK ICB Memorandum of Understanding	Chief of System Assurance and Corporate Services	Note	10:35
<i>Refreshment break – 10:45 – 11.00</i>				
17	Health & Care Senate Update	Chief Medical Director	Note and discuss	11:00
18	Green Plan Health Impact Assessment Report	Chief of System Assurance and Corporate Services	Approve	11:10

No.	Agenda Item	Lead	Purpose	Time
19	Luton Airport Proposed Development - Health and Community Impact	Chief Executive, Luton Borough Council <i>(Tim Simmance to co-present)</i>	Note	11:20
Operational				
20	Quality and Performance Report	Chief Nursing Director and Chief of System Assurance & Corporate Services	Note	11:30
21	Finance Report <i>November 2022 – Month 8</i>	Chief Finance Officer	Note	11:40
22	2022/23 Section 75 Agreements	Chief Finance Officer	Approve	11:50
23	Communications from the meeting	Chair	Discuss	12:05
24	Annual Cycle of Business – items for next meeting	Chair	Note	
25	Review of meeting effectiveness “Are Board members satisfied that items are put on the ICB agenda in a timely fashion for discussion and/or decision, and what else would they like to see in future”.	Chair	Discuss	
Closing Actions				
26	Any Other Business	Chair	-	12:10
	Date and time of next meeting: <ul style="list-style-type: none"> ▪ 24 March 2023, 9am (tbc) Milton Keynes Council Chamber, Civic Offices, 1 Saxon Gate East, Central Milton Keynes MK9 3EJ Deadline for papers will be: <ul style="list-style-type: none"> ▪ Noon, Monday 13 March 2023 	Chair	-	

Resolution to exclude members of the press and public

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

Report to the Board of the Integrated Care Board, 27 January 2023

3. Relevant Persons Disclosure of Interests

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input type="checkbox"/>	Workforce <input type="checkbox"/>	Ways of working <input type="checkbox"/>	Estates <input type="checkbox"/>
Communications <input type="checkbox"/>	Finance <input type="checkbox"/>	Operational and Clinical Excellence <input type="checkbox"/>	Governance and Compliance <input checked="" type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

What are the members being asked to do?

Approve <input checked="" type="checkbox"/>	Note <input type="checkbox"/>	Discuss <input type="checkbox"/>
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Report Author	Governance and Compliance Team
Date to which the information this report is based on was accurate	19 January 2023
Senior Responsible Owner	Chair

Executive summary

What is a conflict of interest?

A conflict of interest occurs where your ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest you hold. Conflicts of interest are inevitable, and it is how we manage them that matters.

Disclosures of interest should be made as soon as reasonably practicable and by law within 28 days after the interest arises (this could include an interest an individual is pursuing).

Further opportunities to make declarations include on application, on appointment, at meetings, when prompted to do so by the organisation or, on change of role.

What are the rules on Gifts and Hospitality?

- Never accept cash of any amount.
- You may accept promotional aids worth less than £6, even from suppliers / contractors.
- Gifts under £50 may be accepted, but not from suppliers / contractors (unless a promotional aid under £6).
- Gifts over £50 must be treated with caution and only accepted on behalf of an organisation, not an individual.
- Meals / refreshments under £75 may be accepted, except if they go beyond what the organisation might offer but offers from a supplier / contractor need particular caution and Executive Director approval.
- Offers of foreign travel and accommodation - offers of hospitality, including offers of foreign travel, that go beyond what the organisation might offer should be politely declined.

What are the available options?

To maintain accurate entries on the Registers of Interests

Recommendation/s

Members are asked to:

- Review the extract of the Register of Interests (as shown at appendix A) and confirm their entry is accurate and up to date.

All in attendance are asked to:

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

Key Risks and Issues

There are none identified.

Have you recorded the risk/s on the Risk Management system?

[Click to access system](#)

Yes

No

This is not applicable in this circumstance.

Are there any financial implications or other resourcing implications?
There are none identified.
How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
This is not applicable in this circumstance.
How will / does this work help to address inequalities?
This is not applicable in this circumstance.
The following individuals were consulted and involved in the development of this report:
Governance & Compliance Team
Next steps:
Should an individual declare an interest relating to items on the agenda, the minutes must include: <ol style="list-style-type: none"> 1. Individual declaring the interest. 2. At what point the interest was declared. 3. The nature of the interest (see descriptions below). 4. The Chair's decision and resulting action taken (i.e., will be required to leave the meeting for the item, can stay for the item but not involved in decision-making, etc.) <p>If applicable, the point during the meeting at which any individual/s retired from and returned to the meeting to be captured under the relevant agenda item: Start of item: xx left the meeting as agreed under item 2. - End of item: xx returned to the meeting. Following the meeting the Secretariat must forward a Declaration of Interest form to the individual to complete and return. The Register of Interests will then be updated by the Governance & Compliance Team.</p>
Appendices
Appendix A – Extract from Register of Interests

Type	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a decision.
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a decision, such as increasing their professional reputation or status or promoting their professional career.
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a decision.

Members & Participants 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 the Corporate Sec email address.

Extract from the Register of Conflicts of Interest - as at 18.1.2023

Surname	Forename	Position within or relationship with the ICB	Interests to Declare	Type of Interest			Details of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
				Financial Interest	Non-Financial Professional	Non-Financial Personal					
Blakeman	Andrew	Non Executive Member, Chair Audit & Risk Assurance Committee	Yes	N			Director, STRYDE International Ltd, a subsidiary of BP plc, Chertsey Rd, Sunbury-on-Thames, TW16 7BP, and previous directorships within the BP Group	01/01/1996	Ongoing	No actual conflict	15/06/2022
Borrett Bracey	Alison Michael	Non Executive Member Chief Executive, Milton Keynes Council	No Yes				Employee of Milton Keynes City Council	2009	Ongoing	None required	21/06/2022 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
Cartwright	Sally	Director of Public Health, Luton Council	No								22/06/2022
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		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	17/08/1987	Ongoing	I will excuse myself should an interest arise	14/06/2022
Gill	Manjjeet	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

Surname	Forename	Position within or relationship with the ICB	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
Gill	Manjeet	Non Executive Member	Yes	Y	Y			Managing Director, Chameleon Commercial Services Ltd, 12 St Johns Rd, LE2 2BL	09/09/2017	Ongoing	Regular 1-1s flag any issue and agenda items	27/09/2022
Graves	Stuart/Ross	Chief Strategy & Digital Officer, Central & North West London NHS Foundation Trust	Yes	Y	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	Y			Interim Chair, University of Buckingham	Apr-22	Oct 2022	Declare in line with conflicts of interest policy	16/05/2022
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
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y	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	Y			Trustee of NHS Confederation	2021	Ongoing	Declare in line with conflicts of interest policy	16/05/2022
Harrison	Joe	Chief Executive, Milton Keynes University Hospital	Yes	Y	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	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	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
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	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	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	Y			Member, National Association of Primary Care (NAPC) Council	01/10/2020	Ongoing	Declare conflict during discussions	08/09/2022
Kufeji	Omotayo	Primary Services Partner Member	Yes	Y	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	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	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

Surname	Forename	Position within or relationship with the ICB	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
Makarem	Rima	Chair, BLMK ICB	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 ICB	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 ICB	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	April 12019	Ongoing	Declare in line with conflicts of interest policy	15/12/2022
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				Chief Executive of Luton Council, an ICB Partner organisation	May-19	Ongoing	Declare in line with conflicts of interest policy	16/11/2022
Poulain	Nicky	Chief Primary Care Officer	No									30/06/2022
Roberts	Martha	Chief People Officer, BLMK ICB	No									04/07/2022
Shah	Maresh	Partner Member	Yes	Y				AP Sampson Ltd t/a The Mail 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	Maresh	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	Maresh	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	Maresh	Partner Member	Yes			Y		Gamlingay Pharmacy Ltd, 60a Station road, North Harrow, HA2 7SL, 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

Surname	Forename	Position within or relationship with the ICB	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
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
Stock	Tracey	Chair ICP	Yes				Y	Member of the East London Foundation Trust (ELFT) Council of Governors	15/12/2021	01/05/2023	None	05/07/2022
Taffetani	Maxine	Healthwatch Representative for Bedfordshire, Luton and Milton Keynes	Yes	Y				Employee of Healthwatch Milton Keynes	2017	Ongoing	Declare in line with conflicts of interest policy	14/12/2022
Westcott	Dean	Chief Financial Officer	Yes	Y				Chair of Board of Trustees - Association of Chartered Certified Accountants Pension Scheme	01/06/2021	15/11/2022	Completely outside of the NHS	14/06/2022
Westcott	Dean	Chief Financial Officer	Yes	Y				Board Advisor, London School of Commerce	01/12/2022	15/12/2022	Declare in line with conflicts of interest policy	13/12/2022
Westcott	Dean	Chief Financial 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				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			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
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				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
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes				Y	Daughter, Ellis Humberstone, registered on the Central & North West London Staff Bank	11/07/2022	30/08/2022	No further action required. My daughter holds a temporary admin role for summer 2022	14/07/2022

Surname	Forename	Position within or relationship with the ICB	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
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes	Y				Chair of Trustees for Arts for Health Milton Keynes (MK) a registered charity that is responsible for the art collection at MK University Hospital NHS Trust and provides art on prescription for MK residents. Address MK University Hospital, Standing Way, Eaglesstone, Milton Keynes MK6 5LD	2010	30/09/2022	Will be declared as relevant in meetings and will not be involved in any funding or other decisions where Arts for Health Milton Keynes may be a beneficiary. Standing down from role by 30/09/22.	14/07/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes	Y				Non-Executive Director and Deputy Chair of Northamptonshire Healthcare NHS Foundation Trust, St Mary's Hospital, London Road, Kettering NN15 7PW. NHFT provide prison health services to Yarlswood Immigration Removal Centre and Bedford Prison in BLMK. These services are not commissioned by BLMK ICB.	Nov-18	31/12/2022	Exclusion from involvement in related meeting or decision-making	14/07/2022
Wogan	Maria	Chief of System Assurance & Corporate Services	Yes		Y			I am a member of Inspiring Futures Through Learning Multi-Academy Trust which covers schools in 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 & 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

Date: 25 November 2022

Time: 10:00 – 13:00

Venue: Council Chamber, Luton Council, Town Hall, Luton LU1 2BQ

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

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

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

In attendance:		
Kim Atkin	Committee Governance & Compliance Office (minutes)	KA
Rachel Bickley	Co-Participation Lead (for item 8)	RB

In attendance:		
Gaynor Flynn	Governance & Compliance Manager	GF
Richard Fradgley	Executive Director of Integrated Care & Deputy Chief Executive, East London NHS Foundation Trust (ELFT) (in part, for item 13)	RF
Sonal Mehta	BLMK Partnership Lead, Voluntary Community & Social Enterprise (VCSE) (for item 9)	SM
Dominic Woodward-Lebihan	Incoming Deputy to Chief of System Assurance & Corporate Services (in part)	DW-L

Apologies:		
Andrew Blakeman -	Non-Executive Member (member)	AnBl
Cllr Tracey Stock	Chair, Bedfordshire, Luton and Milton Keynes Health and Care Partnership (participant member)	TS
Dr Sarah Whiteman	Chief Medical Director (member)	SW

No.	Agenda Item	Action
1.	<p>Welcome, Introductions and Apologies</p> <p>The Chair welcomed all to this Meeting of the Board of the Bedfordshire, Luton & Milton Keynes Integrated Care Board (ICB).</p> <p>In particular, the following were introduced:</p> <ul style="list-style-type: none"> • Sonal Mehta – VCSE Lead – for item 9; • Richard Fradgley – Director for Integrated Care & Deputy Chief Executive, ELFT - for item 13; and • Dominic Woodward-Lebihan, observing, Incoming Deputy to Chief of System Assurance & Corporate Services <p>Apologies were noted as above.</p> <p>As this was a Meeting in Public, members of the public were welcome to observe but their microphones were muted and their cameras turned off. No questions from the public had been received in advance of this meeting.</p> <p>It was confirmed that the meeting was quorate. The meeting was being recorded for the purpose of the minutes.</p>	
2.	<p>Core Purposes of Integrated Care Systems</p> <p>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:</p> <ul style="list-style-type: none"> • improve outcomes in population health and healthcare; • tackle inequalities in outcomes, experience and access; 	

	<ul style="list-style-type: none"> • enhance productivity and value for money; and • help the NHS support broader social economic development. 	
3.	<p>Relevant Persons Disclosure of Interests – Register of Interests</p> <p>Members had reviewed the Register of Interests and confirmed that entries were accurate and up to date.</p> <p>Attendees were asked to confirm that any offers of gift or hospitality received in the last 28 days, in relation to ICB business, have been registered with the Governance & Compliance Team. No submissions had been made.</p> <p>The Chair advised that NHS England (NHSE) had written to all ICBs regarding their policy and management of Conflicts of Interests and a response was due to them by 5 December.</p> <p>It was noted that there might be conflicts of interest for parts of the meeting, in the Private session, which would be highlighted.</p>	
4.	<p>Approval of Minutes and Matters Arising</p> <p>The Board approved the minutes were a full and accurate record of the meeting.</p> <p>There were no matters arising that did not form part of the meeting’s agenda.</p>	
5.	<p>Review of Action Tracker</p> <p>It was agreed to close action numbers 8, 16, 24, 25, 26, 27, 28, 29, 30 and 32. Action numbers 7, 9, 11, 23 and 32 are not yet due. Action number 15 is in progress.</p>	
6.	<p>Chair’s Report (Verbal)</p> <p>The Chair, Chief Executive and Associate Non-Executive Member had met with the Reverend Denny and some community leaders in Luton in November to discuss the role of the ICS. There had been interest and some enthusiasm, but also some cynicism as to whether things will be different this time around. Both positive and negative experiences were shared, with the top concern being access to GPs and dentists. They were keen for us to engage more and to make sure that we make best use of the VCSE sector and Healthwatch. There will be a further meeting in a few months’ time and we will also engage in other geographical areas in a similar vein.</p> <p>The Chair advised that Patricia Hewitt, Chair of Norfolk & Waverley ICB and a former Health Secretary, has been asked by the Secretary of State for Health and Social Care to review how things are working between ICSs and NHSE to support ICSs in their work. This is very encouraging and is an important piece of work. First thoughts need to be shared by Christmas, and it is hoped that this will lead to a more “peer support” than “top down” relationship with NHSE.</p> <p>The Board noted the verbal update.</p>	

7.	<p>Chief Executive’s Report</p> <p>The Chief Executive advised that the Royal College of Nursing Union has voted, in some trusts, to take industrial action. Although only nurses from two trusts within our geography will strike (South Central Ambulance Service and Cambridge Community Services), we may be impacted by strike action taking place in neighbouring ICBs. The situation is being managed through our Emergency Planning Resilience & Recovery (EPRR) programme and there will be testing through the Arctic Willow exercise in December. We will offer mutual aid wherever possible.</p> <p>Taking the report as read, the Chief Executive highlighted the following:</p> <ul style="list-style-type: none"> - “Moments that Matter” case studies were being developed and shared – in this month’s report there was a particular focus on our work with the VCSE with the Memorandum of Understanding (MOU) item on today’s agenda; - 100 day plan update – where all deliverables within the plan presented at the 1/7 Board meeting have been achieved; - The Research and Innovation Hub has been launched, which will see the University of Bedfordshire’s Institute for Health Research (IHR) and Institute of Applied Social Research (IASR) join forces with local health and social care professionals to work on a number of targeted projects over the next three years; - We continue to develop the underpinning of due diligence for specialised services and will soon be meeting with NHSE to take this forward in a much more ICB-led way as we move towards 2024; - We have been asked to support the specialised providers that are applying, on behalf of East of England (EoE) application, to become a Provider Collaborative; and - Following agreement in July, the Efficiency and Transformation Board has been set up, which will identify opportunities and decide whether each is best delivered at Place, through collaborative, or as a system. It was agreed that the remit of the group needs to be refined before core membership can be determined, which should include wider operational and clinical individuals. <p>It is key that we measure the impact of our actions compared to the starting baseline on case studies, and other work – and consider whether good examples could be replicated in other parts of our system.</p> <p>The Board noted the report.</p>	
8.	<p>Working with People & Communities (WP&C) Strategy – including a Resident Story</p> <p>The WP&C Strategy, which has been prepared with input from trusts, local authorities and Healthwatch, has been reviewed by the WP&C Committee for final review and is now brought to the Board for approval.</p> <p>The paper includes an implementation plan for the first year, so the focus is now on building up capability and information resources in this area, including the development of an insight bank and co-production training for colleagues in the ICB and the system.</p>	

To help bring the strategy alive, Rachael Bickley, Co-Production Lead and mother of a resident at the Milton Keynes YMCA, gave a presentation on a good example of co-production work between Milton Keynes YMCA and YMCA residents.

The aim of the YMCA project was to redress the power balance between residents and staff and to help young people negotiate and take a full part in a community in which they live. Rather than tell the residents what the YMCA was going to do, it shared what it wanted to achieve, engaged with residents, asking them to work on the project and supported them with their own development, honing their skills and improving their employability.

Residents and YMCA staff collaborated to develop a funding bid, worked their way through decisions around contractors and worked on the design of an app to support the mental health and wellbeing of YMCA residents which will be finalised in January. Through this collaboration, residents and staff alike have improved their problem solving, decision-making and conflict resolution skills, which has given them increased confidence in their own abilities. At the same time, a very helpful and supportive mental health resource will be made available to residents.

As part of our co-production development, we would like this type of project to be replicated in other parts of the system. Work is ongoing to fill the gaps in education and training and in our skill mix across BLMK. Co-production funding is key and a reward, recognition and reimbursement policy is being developed to support resident participants so that they are not out of pocket when participating.

There was a full discussion around co-production and it was considered that without a structural system of funding in place, this type of collaboration will not be sustainable. Real commitment needs to be shown to resident and VCSE co-production, but also to inequalities, with these elements being included in business cases from inception. Healthwatch can provide valuable co-production resources to the ICS but also needs sustainable resources over time to build relationships in the community.

The Chair thanked Rachael Bickley for sharing her story.

Some points from members:

- Need to make sure that we are making the most of the VCSE sector and Healthwatch who can often reach parts of the community that we find hard to reach and we must give our staff the support they need to do this;
- Must bring in key workers to potentially support cultural competence;
- Our strategy needs strengthening – needs to say more about BLMK having very dynamic and different communities and that ways of engaging will be different in different communities or areas;
- The strategy needs to be overt about the role and opportunities that we have – networks, knowledge of the partners around the ICB table, how local authorities and Healthwatch are embedded in communities; and
- The detail around quality and co-production is strong.

The Board **agreed** the Working with People and Communities Strategy subject to the strategy being amended to reflect the points above.

<p>9.</p>	<p>Memorandum of Understanding (MOU) with the Voluntary, Community & Social Enterprise (VCSE) Sector</p> <p>Sonal Mehta, VCSE Lead, presented the MOU with the VCSE sector, which sets out the strategic intent for the ICS working with the VCSE sector, and investing our resources to support the framework and achieve our core objectives.</p> <p>A BLMK Voluntary Sector Steering Group has been established to develop a more strategic approach to working with the VCSE as part of the ICS. Existing relationships are being developed and new ones formed, as we bring about some mutual understanding between all the partners about what a strategic partnership with VCSE can deliver.</p> <p>This enabling piece of work is fundamental to how we are going to work differently, together. We are mindful of existing networks and collaborations and have been working with Local Authority and VCSE colleagues to try to develop an architecture that enables VCSE to engage effectively at neighbourhood, Place and system level, but that also supports our approach to both internal collaboration within the sector and externally with partners.</p> <p>Next steps are to develop the strategic intent as set out in this MOU into something more tangible, identifying work streams where we can start to test the principles of the architecture and the MOU that we have developed. An update would then be brought to the meeting of the Board in January.</p> <p>A VCSE workshop with VCSE organisations across BLMK was held recently to discuss how to bring the MOU to life. There was a good discussion around evaluation of impact and how we can work together to support VCSE organisations to build that into their work and have the right measurables. This will be a key priority in the next year.</p> <p>It was recognised that the way certain voluntary sector groups and community groups view the ICS or larger anchor organisations varies and that some would not consider themselves to be “supporting” statutory services, so the language used needs to be carefully considered.</p> <p>The Board:</p> <p>a) approved the ICB and VCSE Memorandum of Understanding and authorised the Chair of the ICB to sign on the Board’s behalf and</p> <p>b) requested Place Boards to discuss how the Memorandum of Understanding is being implemented at Place at their next Place Board meetings.</p>	<p>Action: Place Linked Directors</p>
<p>10.</p>	<p>Fuller Programme – Update</p> <p>Nicky Poulain, Chief Primary Care Officer, highlighted some points from the Fuller Programme paper.</p> <p>The Fuller Programme is a system programme with the aim of anchoring transformation around our neighbourhoods using the Place Boards to implement the recommendations of the Fuller stocktake which was published in May 2022.</p>	

	<p>The programme is supported by the ICB Primary Care Team and the ICB PMO Team and framed using the following four pillars:</p> <ol style="list-style-type: none"> 1. The development of neighbourhood teams aligned to local communities; 2. The provision of streamlined and flexible access for people who require same day urgent care; 3. The provision of proactive personalised care and support for people with complex needs and comorbidities; and 4. An ambitious and joined up approach to prevention. <p>The BLMK Fuller Programme is accountable to the Primary Care Commissioning and Assurance Committee and will also be overseen by the ICB Fuller Programme Working Group and the BLMK Fuller Stakeholder Collaborative Group.</p> <p>The programme encompasses primary medical pharmacy, community pharmacy, dental and ophthalmology services.</p> <p>It was emphasised that this is everyone’s programme and that it is about working with our communities and residents to support the physical health, mental health and wellbeing of our residents, and to improve their access to services.</p> <p>The Chair advised that it is planned to have a deeper discussion on the programme in the next ICB Board seminar when we will take on board what we are hearing from residents. We will also consider how we can engage differently to maximise the contribution of partners, and in particular from the perspectives of mental health and local authorities.</p> <p>The Board noted the report and progress.</p>	
11.	<p>Integrated Care Partnership (ICP) and Integrated Care Board (ICB) Operational Delivery Planning Update</p> <p>The paper updated the Board on the development of its mandated Integrated Care Partnership (ICP) Strategy, the first publication of which is required by the end of December 2022, and how this is aligned with the requirement to produce the 2-year Operating Plan for the ICB by March 2023. The approach to producing the first iteration of the ICP Strategy has been developed in collaboration with Cllr Tracey Stock, Chair of the ICP.</p> <p>The ICP’s role is to hold the ICS to account to ensure that we are getting the best impact in terms of health outcomes and tackling inequalities, but also using the ICP’s connections with local communities to make best use of all of the assets and connections within these communities.</p> <p>The Chief Finance Officer (CFO) has worked with other system CFOs to look at how to simplify the process of planning and contracting, particularly with the increase in block contracts. The Chief Transformation Officer offered resources to work with partners at Place and in collaboratives on the impact that they need to make and how this can be done. NHS Planning Guidance is unlikely to be available until January, but we already have a strong sense of what we need to do and the inherent challenges. We know that funding will be a challenge and that we need to find a methodology where we focus on the key priorities.</p> <p>There was a comprehensive discussion with the following key points made:</p>	

	<ul style="list-style-type: none"> - This is a good example of what we want to locally vs what we have to do nationally; - When we mention “Core 20 + 5” we need to explain what it is; - We need not only to look at getting through this winter, but there needs to be continuous prevention work to mitigate pressures in winter 2023/24 and beyond; - We are committed to subsidiarity - Place based partners and Place communities can identify what they need to do to make a difference; - We must look at what our “wicked” challenges are and what our populations most need in terms of tackling inequalities and health outcomes, and support Places and collaboratives to deliver the best they can; - Due to the short timescales for preparing this initial ICP strategy, it has not been possible to have full engagement with all of the ICP members, but it is more a compilation of everything we have heard from people as we have been building the plans at Place since 2019; - A pragmatic approach has been taken in terms of developing the strategy due to the short timescales, which has been supported by the Health and Wellbeing Board Chairs of the local authorities. There will be a meeting the ICP on 14 December where members will be asked to approve this first iteration; - All ICBs and ICPs will be reviewing their governance arrangements and membership, how they are structured and how well they are working. The ICB will be audited on its Board/Committee Effectiveness by the end of the financial year. This will build on feedback collected on effectiveness during or after each meeting; - This work is a big ask on the local authorities within a short timescale, so there needs to be some flexibility; - It is recognised that the four Places are at different stages in their evolution, but they each need to make progress to demonstrate their focus on priorities; - There needs to be further communication on and clarification of what the asks are from Places; and - We need to be clear about what is within the remit of the Bedfordshire Care Alliance (BCA) and what is being done at Place. <p>Action: AnBr to collaborate with Places to establish what they are doing and the minimum that they need to do by next month and then identify next steps.</p> <p>The Board noted the proposed approach to development of this first ICP Strategy in the context of NHSE requirements, timescales to deliver and wider operating constraints.</p> <p>The Board approved the key actions and timescales for completion by identified Place/Collaborative/Neighbourhood teams to ensure explicit triangulation between the overarching aim to improve health inequalities and outcomes against the practical delivery plans outlined in the 2-Year Operational Delivery Plan.</p> <p><i>RF joined the meeting.</i></p>	AnBr
12	<p>Reports from Place Based Boards</p> <p>The four Place Based Board updates were taken as read and the following highlights given:</p>	

	<p>The Luton Board is working very closely with the PMO Team on the six objectives, many of which relate to the community voluntary sector. There is a 56,000 population in Luton’s Core 20, which has been an area of focus along with learning disabilities and mental health. Mary Seacole Housing Association and NOAH have helped immensely in the priority groups. Caroline Cook is taking the lead role as a spokesperson for the community voluntary sector for Luton.</p> <p>There is good engagement with PCNs in Bedford Borough where there is a strong focus around some of the access issues and the primary estate. Work continues with the ICS around health inequalities.</p> <p>The latest iteration of the Central Bedfordshire Place Plan was agreed yesterday.</p> <p>Good progress has been made with the “MK Deal” with a welcome exchange of letters with the ICB and MKC Chief Executive. There may now be a period of “creative conflict” between local partners, the Place and the ICB to work through the way forward.</p> <p>The Board noted the issues discussed by the Place Based Boards. The updates were very informative and help to focus the ICB on what is important at each Place.</p> <p><i>There was a break for refreshments.</i></p>	
13.	<p>Developing a BLMK Mental Health, Learning Disability & Autism Collaborative</p> <p>This item was co-presented by Richard Fradgley - Director of Integrated Care & Deputy Chief Executive, ELFT, and also Lead for BLMK Mental Health Programme, and Ross Graves – Chief Strategy & Digital Officer, Central & North West London Foundation Trust and ICB Partner Board Member for mental health.</p> <p>RF - Over the last few years, through the NHS Long Term Plan, there has been unprecedented focus on improving access and outcomes for people with mental health problems across our geography. The system now has the best early intervention in psychosis services in the region, with perinatal mental health services and work with schools on mental health issues significantly improved.</p> <p>There has been investment from the NHS Long Term Plan to support these initiatives, but one of the core reasons for our success is that we have created a single team approach across providers, who have provided talking therapy services in Luton and beyond. There is a common sense of purpose, a one team approach with trust and transparency, which has enabled us to work in a co-produced way.</p> <p>The aim of the proposal is to formalise this way of working and to address some of the “wicked” challenges, which include workforce, particularly in the light of increased demand for young people’s mental health services as a consequence of the pandemic, our accommodation care pathway for adults with serious mental illness and the mental health of people with long term conditions.</p> <p>In terms of opportunities, we will look beyond the Long Term Plan and think about what really matters to service users, carers and residents. This will be a core focus of our strategy, as will connecting our NHS planning with planning at Place</p>	

and linking more substantively with Health and Wellbeing Board priorities. There will be opportunities to work together with the Bedfordshire Care Alliance and BLMK Health and Care Partnership on areas such as mental and physical health, urgent and emergency care and long term conditions.

RG – This proposal is very much a strawman at this stage and the next stage of work will be to flesh out the detail, subject to the Board’s approval. It is intended to build on the work being done through ELFT and CNWL within each Place, recognising that each is different and that there are different partnership arrangements across BLMK. It is proposed that the Collaborative would be overseen by a committee of the ICB.

A key role for the Collaborative would be to navigate the tensions between system and Place in terms of priorities and support at a system level where things need to be done at scale or where more resilience is required.

Next steps would be a move into a formal planning phase from now until the end of the year, mindful that the plan needs to be fully validated and worked through and that it is happening during winter alongside other planned work.

It is planned to express interest to NHSE to gain “accelerator” status with NHSE’s Provider Collaborative Programme. Should the bid be successful, more support would be available to us which would help to capitalise on our work and potentially bring more resources into BLMK.

The Chair stated that she has been very impressed with the work of the Mental Health Board which has been active for a long time, and she felt that the collaboration that ELFT and CNWL have shown demonstrates to all partners what can be achieved through working together, even if their frontline work does not cover the same geographies within BLMK.

Population health metrics have significantly improved over the last 3-4 years but there is still a huge opportunity to develop the population health management infrastructure and expertise for a better focus on delivering good health outcomes for both physical and mental health.

There is an intention as part of the Fuller implementation plan to bring community and mental health services together around Primary Care Networks (PCNs) or ‘neighbourhoods’.

Places are integral and any proposals would be taken through the appropriate Place Boards, not least to understand and mitigate risk. There have already been some discussions with our respective Place Boards and with Milton Keynes Joint Leadership Team, and it is intended to communicate with the Health & Care Partnership on this proposal.

There are some significant opportunities where we can mobilise quickly to improve the quality of experience of people with serious mental illness living in supported accommodation and residential care through working together and ensuring that the Mental Health Investment Standard funding of £220m is spent where it can make the best impact.

There will be further engagement with stakeholders such as the Academic Health Sciences Network to understand why more people are being referred for autism or for ADHD.

	<p>The Board approved the proposals in the paper:</p> <ul style="list-style-type: none"> - that the direction of travel outlined in the paper be developed into a full proposal for further consideration with Integrated Care System partners; and - to explore whether the programme can gain 'accelerator' status with NHSE's Provider Collaborative Programme. 	
14.	<p>East Kent Maternity Report</p> <p>The Chief Nursing Director introduced the key findings from the Kirkup Report into East Kent maternity services, which had been published in October, and followed four earlier reports since 2018, including the two Ockendon reports.</p> <p>Assurance was given that there is a formal and thorough quality review process underway in BLMK to learn the lessons from this report for our residents. It is important that we support these residents who are in a complex situation, as well our staff. A further report on the outcome of this work will be presented in due course.</p> <p>The report was noted.</p>	
15.	<p>Quality and Performance Statement</p> <p>The Chief of System Assurance & Corporate Services advised that the Quality & Performance Report remains a work in progress in terms of ensuring that the right level of information is being brought to this Board and that information is not being duplicated elsewhere. Any feedback on the report structure from Board Members would be welcomed.</p> <p>This report includes an update on preparation for winter and our response to various national requirements for the system. Our approach has been to focus on the initiatives we believe will most benefit our residents and our workforce in terms of managing the winter pressures.</p> <p>Thanks was given to all the Trusts who form part of the Performance Delivery Group which meets fortnightly to review this. Very good initiatives are being put in place to reduce ambulance handover times support ambulance capacity including the community teams in Bedfordshire, taking calls directly from the ambulance 'stack' or work list which went live last week. Virtual wards are in place or coming online soon which should also help during the winter period.</p> <p>The Quality & Performance Committee will meet next week, which will dive deeper into this report, which will give assurance to the Board that there is more scrutiny in this forum.</p> <p>The Chief Nursing Director highlighted the following in relation to Quality:</p> <ul style="list-style-type: none"> - Following the Panorama and Channel 4 Dispatches programmes relating to mental health services, Claire Murdoch, NHSE's National Mental Health Director, has issued a letter to all Trusts and ICBs setting out the expectations to improve patient experience. CNWL and ELFT, who provide the majority of mental health and learning disability services across BLMK, are working up plans in response to the letter. Alongside this, the ICB is undertaking a review 	

	<p>of all other mental health, learning disability and autism patient services, including children and young people and Continuing Healthcare, across BLMK. Some of the behaviours and patient care that we have seen so far have been very good;</p> <ul style="list-style-type: none"> - An incident occurred in a local authority-commissioned residential home for people with dementia, Ridgeway Lodge, where one resident was physically attacked by another, resulting in fatal injuries. Safety visits of all BLMK HC ONE homes have been undertaken by the Quality and Safeguarding teams and support has been offered to the families of both residents. The family of the resident who died has been very supportive in helping with the improvement process in terms of Serious Incidents; - There were two Serious Incidents of severe harm and death which occurred as part of delays in ambulance handovers; - There has been a system wide deep dive into urgent and emergency care (UEC) and flow by the System Quality Group, with all participants taking away at least one improvement action; and - The national objective of the Patient Safety Incident Response Framework (PSIRF) Programme is a co-ordinated data-driven approach to patient safety incident response where investigations are done within a provider organisation, including hospices and primary care, and learnings shared across the system. This will be a significant cultural change towards systematic patient safety management. <p><i>Points from members:</i></p> <ul style="list-style-type: none"> - In relation to the Panorama programme, it was confirmed that ad hoc checks are undertaken on a regular basis by providers, including at night and on weekends; - Healthwatch independently visits homes and works alongside local authorities in relation to care homes. Maybe this could be better connected to support the work to quality assure resident experience in the independent /supported living sector; and - Research and evidence also shows that spending periods of time observing in an environment gives good insight into how it feels to be there. <p>The Board noted the concerns raised within the report and the revised format to reporting that will be given in future.</p>	
16.	<p>Finance Report – September 2022 – Month 6</p> <p>The Chief Finance Officer highlighted the following from the finance report for month 6, September 2022.</p> <ul style="list-style-type: none"> - The revenue position, for health, is showing a very small deficit year to date with the forecast of break even for the year end as per previous reports; - Efficiency plans of just under £56m are broadly on plan year to date and again forecast to deliver in full by the year end; - Trust pressures, as previously reported, relate mainly to agency and bank costs driven by levels of emergency activity, Covid, staff sickness and elective recovery; - The ICB position year to date is break even and we are forecasting a break even for the year, which includes the surplus that was reported at the previous meeting for the first three months of the year when we were a CCG; - The risks are included within the paper, but the key ones remain Covid, winter and inflationary pressures; 	

	<ul style="list-style-type: none"> - The risk of clawback on the Elective Recovery Fund for the system would appear to have receded. Although there has been no formal confirmation, we believe that there is no intention to claw back unless we are a significant outlier in terms of elective recovery – which we believe we are not; - Following the request at the last meeting, local authority positions have been added to the report; - For the four local authority areas, it is evident that all local authorities are facing pressures, with common themes in children’s services and inflationary pressures; - Three of the four local authorities are currently forecasting financial balance at year end, but generally by using contingencies and reserves; - One local authority is working towards that position; and - In terms of capital, we remain on track to balance the position, but this is being monitored on a monthly basis by system Finance Directors. <p>Since submitting the report, the Government’s Autumn Statement has been announced and we await the detail. We do know that, for the next two years, there is an additional £3.3bn per annum for the NHS, but there may be conditions attached to that in terms of operational targets and delivery. The key is to try to marry up the previously declared position from NHSE of a potential £7bn deficit going into 2023/24. The Centre have confirmed that the £7bn estimate was based on inflation running at 9% next year, whereas the autumn statement forecasts 4.5% inflation, so there is some level of risk in terms of the position.</p> <p>For the NHS, we are expecting the efficiency range based on this settlement to be 2.2% - 3% but that excludes any non-recurrent resources that NHS systems and organisations will have used to achieve financial balance in the current financial year.</p> <p>Pay awards will be a risk again this year, but these are outside NHSE’s control and remain subject to pay review body recommendations to Government. There is also additional social care funding nationally of circa £2.7bn next year and £4.8bn for the year after.</p> <p>The Board noted the report.</p>	
17.	<p>Board Assurance Framework (BAF)</p> <p>Following the Board Development workshop on 4 November, the BAF was presented to the Board for the first time. Following the deep dive into the workforce risk, the deep dive approach on risks will be continued. At the Audit & Risk Assurance Committee next week, there will be a deep dive on the climate change risk, to consider it as a system perspective in terms of mitigations in place.</p> <p>There has also been a meeting of risk leads from the NHS Trusts to formulate a process for the escalation and de-escalation of risks between the Trusts and the ICB.</p> <p>Since the last meeting, BAF 3, which relates to system pressure and resilience, has an increased risk score. There is also increased risk for system transformation, due to operational pressures.</p> <p>The report was noted by the Board.</p>	

18.	<p>Corporate Governance Update</p> <p>There are some further amendments to governance documents in the light of experience with regard to our Scheme of Delegation of Powers and Standing Financial Instructions.</p> <p>The Board approved the delegation for approval of arrangements for managing Individual Funding Requests (IFRs) to the Quality & Performance Committee – as defined in 2.1 of the report.</p> <p>The Board approved amendments to the following sections of the Governance Handbook:</p> <ul style="list-style-type: none"> • Scheme of Reservation and Delegation – as in 2.2 of the report; • Quality and Performance Committee Terms of Reference – as in 2.3 of the report; • Detailed schedule to operational / financial scheme of delegation – as in 2.4 of the report and the appendix A; and • Primary Care Commissioning and Assurance Committee Terms of Reference – as in 2.5 of the report. <p>The Board noted the following:</p> <ul style="list-style-type: none"> • Committee appointments – as in 2.6 of report; and • Committee Chairs updates and minutes – as provided in Appendix B. <p>Additionally, the Board appointed Mahesh Shah as Chair of the Exceptional Cases Review Panel for IFRs – a post that must be held by a Board member. Mahesh Shah was thanked for taking on this role.</p> <p>The Corporate Governance Update includes updates from Committee Chairs from meetings held since the last meeting of the Board, together with draft minutes of those meetings.</p> <p>SP added that, at the recent meeting of the Remuneration Committee, Manjeet Gill had been confirmed as Deputy Chair for that Committee. Possible strike action was also discussed in that forum.</p> <p>SP reported that, at the second meeting of the BCA Committee, it was decided to review the three major programmes of work that form part of the BCA plan. This brought out some interesting themes in terms of strong delivery to date but recognising that the programmes and projects within them are at different levels of maturity. It was felt that there would be some benefit from improving the formalisation of the programme and project management that underpins the delivery of those projects, in particular in relation to how we measure the effectiveness of delivery, the impact on our population health and how we communicate the benefits to the wider population.</p> <p>SP has plans to meet with all members of the committee to make sure that there is clarity around which projects and programmes need oversight at committee level and which should legitimately be run and overseen at Place. The BCA is working towards a dashboard of programmes to be sure that we are aligning projects and programmes to the BCA and ICS strategy and also to ensure that where there are requirements for the right support or mitigating actions affecting</p>	

	<p>delivery, the committee is aware of those and can address them or escalate as appropriate.</p> <p>In relation to the Working with People & Communities Committee, MG advised that it was agreed that the newly formed engagement collaborative should be a community of practice rather than a sub-committee of the Committee.</p> <p>There were no further updates from Committee Chairs. The reports and verbal updates from Committee Chairs were noted.</p>	
19.	<p>Communications from the meeting</p> <p>MW confirmed that a formal report would be produced for the Partners' Boards and governance meetings which would highlight key points from this meeting. A short summary of the meeting also be produced for inclusion in Partners' newsletters and stakeholder briefings.</p> <p>Action: MW to produce a short summary of the meeting for use in communications materials and a formal report from this meeting for ICS Partners' Board and governance meetings.</p>	
20.	<p>Annual Cycle of Business</p> <p>The Annual Cycle of Business had been shared for information and review. The following items have since been added for the January meeting:</p> <ul style="list-style-type: none"> - Health Inequalities (SS) - DCO Health Assessment (RP) - Hub Prioritisation (DW) - Delegation of Primary Care Services (NP) <p>The Annual Cycle of Business update was noted.</p>	
21.	<p>Review of meeting effectiveness</p> <p>Feedback was requested on the effectiveness of holding Board meetings in different places.</p> <p>It was generally agreed that holding meetings at different locations across our geography was the right thing to do and should be continued.</p> <p>A feedback questionnaire will be circulated after the meeting, which will include questions as to venues used and whether Friday is the best day of the week for members.</p> <p>Action: Governance Team to circulate feedback questionnaire. Action: MW/Governance Team to look at days of the week and see if there is a better day</p>	
22.	<p>Questions from the Public</p> <p>No questions had been received from the public.</p>	
23.	<p>Any Other Business</p>	

	There remains one GP vacancy on the Board and a recruitment process is underway to recruit a second GP. It is hoped to appoint to this post before the January Board meeting.	
24.	<p>Date and Time of Next Meeting:</p> <p>The next meeting of the Board will be held on Friday 27 January 2023 at the Council Chamber, Bedford Borough, Borough Hall, Cauldwell Street, Bedford, Beds MK42 9AP. Exact timings will be confirmed nearer the time.</p> <p>The deadline for reports will be noon on Monday 16 January 2023.</p>	

Approval of Minutes:		
Name	Role	Date

DRAFT

Integrated Care Board MASTER Action Tracker as at 6.1.23

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	COMPLETE - GREEN
Propose closure at next meeting (insert dd/mm/yyyy)	
CLOSED	Actions to be marked closed and moved to "Closed Actions" Tab once approved for closure at meeting.

Action No.	Meeting Date	Agenda Item	Action	Action Owner	Past deadlines (Since Revised)	Current Deadline	Current Position (latest update)	RAG
7	29/07/2022	Peer Accountability	To take forward peer accountability across the system at System Oversight Assurance Group and CEO Groups	Felicity Cox		31/03/2023	18/01/2023 December SOAG cancelled. To be discussed at next meeting on 3 February 2023. 17/8/2022: Individual discussions being held with each CEO and then discussion at CEO Forum in October. Approach will be tested and refined throughout the year. Next discussion at SOAG meeting in December. 14/12/2023 Strategy approved by Health and Care Partnership	In Progress
9	29/07/2022	ICB Strategy	To repopulate the strategy from existing work and to consider adding the word "happier" to our mission statement	Anne Brierley	30/09/2022	27/01/2023	11/11/2022: There is an update on the development of the strategy on the agenda. The strategy will be presented to the Health and Care Partnership on 14 December 2022. 30/9/2022 meeting: RM - below update suggests this is work in progress so can not be closed. MW - Action will be recommended for closure once the Integrated Health & Care Strategy is approved at the Health & Care Partnership on 14/12/2022. 14/9/2022: Strategy development is progressing well. We have been working with the Health and Care Partnership to identify key themes to include in the strategy. A core element of our this work to date has been a review of existing strategies and plans and insight from people and communities which will sit at the core of our final system strategy. We will be engaging with relevant stakeholder boards over in October and November to test the key themes emerging from this work. Having reviewed our mission 'happiness' is already part of our vision insofar as 'healthier' includes emotional wellbeing. The advantage of emotional wellbeing as our guide is that there are tools to measure this.	COMPLETE: Propose closure at next meeting (27/01/2023)
11	29/07/2022	Place Strategies	To reflect Place strategies in Integrated Care System Strategy review	Anne Brierley	30/09/2022	27/01/2023	11/11/2022: There is an update on the development of the strategy on the agenda. The strategy will be presented to the Health and Care Partnership on 14 December 2022. 30/9/2022 meeting: RM - below update suggests this is work in progress so can not be closed. MW - Action will be recommended for closure once the Integrated Health & Care Strategy is approved at the Health & Care Partnership on 14/12/2022. 13/9/22: It is our intention to reflect place strategies in the Integrated Care System strategy document and indeed deliver much of the strategy at place	COMPLETE: Propose closure at next meeting (27/01/2023)

Action No.	Meeting Date	Agenda Item	Action	Action Owner	Past deadlines (Since Revised)	Current Deadline	Current Position (latest update)	RAG
15	29/07/2022	Public comms - access	Plan immediate action in terms of priority comms to the public regarding access to services, following Fuller Stocktake	Maria Wogan / Nicky Poullain	30/09/2022	25/11/2022	<p>18/01/2023 Leaflets produced for each place and have been distributed electronically, these will be and updated monthly.</p> <p>25/11/2022 A leaflet has been designed which contains information about Primary Care. This is editable by practice. It is currently with Amanda Flowers for approval.</p> <p>An update to the Help Us Help You leaflet is also in design - to include the warm spaces and information on foodbanks and funding options for prescriptions - to help residents who are experiencing difficulty, as a result of the cost of living crisis.</p> <p>30/9/2022 RM - below update suggests this is work in progress so can not be closed. Update required for next meeting.</p> <p>A plain English leaflet is being developed with primary care which will show all the access points for primary care for local people. This will be shared with all partners across the system and local authority colleagues are being asked to support this through their channels, where messages are delivered at place. An access page will also be available on our website - which explains how people can access and the work we are doing to boost capacity and address the telephone issues people are facing. This is scheduled for distribution in October.</p>	COMPLETE: Propose closure at next meeting (27/01/2023)
23	29/07/2022	People Plan and Strategy	To bring revised People Plan & Strategy to the September meeting.	Martha Roberts	30/09/2022	27/01/2023	<p>6/1/2023: On 27 Jan agenda, so propose to close.</p> <p>11/11/2022: People Strategy to be presented to the Board on 27 January 2022.</p> <p>30/9/2022 meeting: People Plan on agenda. MW - Strategy to be presented January 2023. People Plan on agenda for 30/9.</p>	COMPLETE: Propose closure at next meeting (27/01/2023)
31	30/09/2022	Review of meeting effectiveness	Action: SF to use the Digital Strategy Report power point slides to create a template for future strategies being presented to the Board.	Sarah Feal		27/01/2023	<p>11/11/2022: Working with People and Communities Strategy has followed the approach of the Digital Strategy.</p>	COMPLETE: Propose closure at next meeting (27/01/2023)
33	25/11/2022	MOU with the VCSE Sector	Action: Place Linked Directors to discuss how the MOU is being implemented at Place at their next Place Board meetings	MW - Milton Keynes NP - Luton AnBr - Cbeds SS - Bedford		Next Place Board Meetings	<p>18/01/2023 A paper has been drafted and will go to Place board meetings in February/March</p>	In Progress
34	25/11/2022	ICP and ICB Operational Delivery Planning Update	Action: AnBr to collaborate with Places to establish what they are doing and the minimum that they need to do by next month and then identify next steps	Anne Brierley		End December 2022	<p>18/01/2023 Each HWB chair has been asked to bring place plans to the next meeting of the Health and Care Partnership in March</p>	In Progress

Report to the Board of the Integrated Care Board, 27 January 2023

8. Chief Executive Officer's Report

Vision: "For everyone in our towns, villages and communities to live a longer, healthier life"

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input checked="" type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input checked="" type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input checked="" type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input checked="" type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input checked="" type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input type="checkbox"/>	Workforce <input checked="" type="checkbox"/>	Ways of working <input checked="" type="checkbox"/>	Estates <input type="checkbox"/>
Communications <input checked="" type="checkbox"/>	Finance <input type="checkbox"/>	Operational and Clinical Excellence <input checked="" type="checkbox"/>	Governance and Compliance <input checked="" type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

Report Author	Georgie Brown, Chief of Staff
Date to which the information this report is based on was accurate	16 th January 2023
Senior Responsible Owner	Felicity Cox Chief Executive Officer

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

Maria Wogan, Chief of System Assurance & Corporate Services,
Anne Brierley, Chief Transformation Officer,
Michelle Summers, Associate Director, Communications and Engagement,
Sandra Vanreyk, Senior Programme Manager,
Martha Roberts, Chief People Officer,
Nicky Poulain, Chief Primary Care Officer

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

N/A

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

The members are asked to **note** the report

Executive Summary Report

1. Brief background / introduction:

This report provides a summary of corporate activities since the last Board meeting on 14th November 2022.

2. Summary of key points:

2.1 Winter

I would like to recognise the commitment, dedication and hard work of our people, clinicians, and partners over what has been an extremely challenging winter period to date. We know our residents have, at times, had to wait for long periods to receive the response, care and treatment they require and deserve, and this is not where we would want to be. As a system we recognise this and although extremely challenging, we have seen some real evidence and benefit of ICB partners, coming together, as a system to address immediate challenges and issues alongside identifying real opportunities for improvement. We are committed to embedding the immediate changes made and to embed the learning identified, ensuring we maintain this moving forward.

2.2 How we are working together to deliver improved health and care:

- **Warm Homes Bedford Borough:** Set up in partnership with Bedford Borough Council and the National Energy Foundation's warmth and wellbeing service, Warm Homes Bedford Borough is a scheme designed to support residents' whose health could be at risk from cold and damp conditions at home. More than 1,600 residents with health conditions were identified from GP records and sent a letter inviting them to contact Better Housing Better Health to apply for free support that could include draught-proofing for their home, loft and wall insulation, and more. Link: <https://blmkhealthandcarepartnership.org/warm-homes-bedford-borough-launched/>
- **Working Together Leighton Buzzard:** The WTLB programme is bringing together GP practices, mental health services and social care to better coordinate care across organisations. By working across organisations, the WTLB are able to coordinate responses to complex cases, helping to improve care and even avoid hospital admissions. Link: <https://blmkhealthandcarepartnership.org/working-together-for-a-dementia-patient-in-leighton-buzzard/>
- **Personal health budgets managed by Autism Bedfordshire:** Commissioned by the ICB, Autism Bedfordshire is managing the personal health budgets (PHBs) for children and young people in the area. PHBs are helping to improve young people's quality of life and their experience of care by helping them to have more choices about how their healthcare needs are met. Link: <https://blmkhealthandcarepartnership.org/personal-health-budgets-are-helping-children-and-young-people-to-have-more-choice-about-their-healthcare-in-luton/>
- **Keeping Well BLMK service:** This service provides wellbeing and psychological support to key workers including NHS staff and staff providing care to others in the community and in residential homes and voluntary sector organisations in the BLMK area. A recent case study shares the story of an NHS colleague who was close to resigning due to overwhelm at work, but who is back at work and "firing on all cylinders" after receiving "life changing" support from the service. Link: <https://blmkhealthandcarepartnership.org/bedford-nhs-staff-member-who-reached-out-to-keeping-well-shares-her-life-changing-experience/>

2.3. EPRR and Industrial Action

2.3.1 Industrial Action

Trade unions representing NHS staff advised the Secretary of State for Health and Social Care last year that they were in dispute over the 2022/23 pay award. A number of the unions balloted or are balloting their NHS members to take part in industrial action.

The Royal College of Nursing (RCN) carried out their first strike dates on 15th and 20th December 2022, in England, Wales and Northern Ireland at the NHS trusts or health boards that met the relevant legal requirements. In the Bedfordshire, Luton and Milton Keynes Integrated Care System, Cambridgeshire Community Services NHS Trust (CCS) and South Central Ambulance Service NHS Foundation Trust (SCAS), one of the ambulance services covering this area, was affected by the strike action.

Only a small number of staff in SCAS are members of the RCN and service delivery across BLMK was minimal impacted. CCS managed their derogations of services exempted from strike action resiliently and there was minimal impact of service delivery across both days of the strikes with all planned care going ahead as scheduled.

The RCN announced further strike dates on 18th and 19th January 2023, but no BLMK Trusts are participating in this industrial action.

The GMB carried out strike action on 21st December, in which 9 out of 10 ambulance Trusts in England and Wales participated in. SCAS put excellent arrangements in place on the day, including having senior teams on hand to support Hospital Liaison teams on site at the hospitals to maintain discharge and transfer flow. There was therefore minimal direct impact on services in BLMK from the strike action however, there was indirect impact on East of England Ambulance Services NHS Trust (EEAST) as the only Ambulance Trust in the country which did not strike. This resulted in significant handover delays experienced at L&D. Senior ICB leaders worked with the Trust to address the issues.

The planned strike by GMB ambulance workers on 28th December was suspended and rescheduled for 11th January.

On each of the strike days, the ICB had Command and Control in place and scheduled two Health Economy Tactical meetings which tied into the Regional Industrial Action meetings. There was also an open MS Teams channel throughout the day for urgent escalations between the Trusts and the ICB.

Martha Roberts, ICB Chief People Officer, the Senior Responsible Officer for Industrial Action, will continue to coordinate the system in response to the ongoing Industrial Action.

Debriefs with all partners were held after each day of strike action and a number of strengths and notable areas of good practice were identified:

- Both CCS and SCAS managed their derogations well with limited service disruptions. Both Trusts had a command cell in place and all planned care went ahead.
- The ICB's current format of open MS Teams channel for drop-in sessions and urgent escalation.
- The ICB distributed a Common Operating Picture to all internal and external stakeholders including Regional Teams (East of England and South East)
- Dedicated SRO throughout the planning and execution
- System working which has been supported by the relationship building in the Local Resilience Health Partnership (LHRP) Support Group
- Regional briefing meetings/touch points
- Effective stakeholder engagement

There are further dates for industrial action scheduled with the various trade unions and the ICB will continue to engage with and support system partners to minimise disruption to services for residents of Bedfordshire, Luton and Milton Keynes. Although managed well, a high percentage of staff voted

to strike, we must therefore be mindful of the feelings of our workforce re: pay, conditions and their ability to give care at a safe and acceptable standard.

2.3.2 Arctic Willow

Exercise Arctic Willow was a national exercise to support ICBs and health partners to explore the potential response to multiple incidents at the same time as operational winter pressures. Exercise Arctic Willow was designed to provide health and social care systems and organisations with an opportunity to explore their response to potential multiple, concurrent operational issues (e.g., industrial action, energy resilience, adverse winter weather) and winter pressures, as well as review the interdependencies with partners when responding to such pressures.

The scenarios were informed by planning scenarios developed by Cabinet Office and UK Health Security Agency (UKHSA). The exercise enabled participants to exercise the health system structures put in place by the Health and Care Act 2022, including the newly formed Integrated Care Boards (ICBs), focusing on system leadership at the local and regional level.

The exercise took place on 8th December with excellent representation from system partners and formed the basis of some of the actions that we took to prepare for the Industrial Action in December and going forward, such as:

- Collaboration, preparedness and communication
- System working and planning
- Importance of communication with all key stakeholders
- Shared understanding our responses and capabilities
- Openness and transparency with system partners

2.3.3 System Control Centre

All Integrated Care Boards were required to establish a System Control Centre (SCC) for their system, as part of preparations for winter 2022/23. Our SCC went live on 1 December.

The BLMK SCC is built on the existing arrangements put in place to support system partners, which have worked well in previous winters and Covid surges, with the aim of ensuring the safest and highest quality of care possible. Our control centre is just one part of our wide-ranging preparations we put in place for winter and is playing a vital role in the sharing and use of information to drive smarter decision-making by local NHS teams. By monitoring and responding to information and insights from provider services, the control centre is helping spread resources and make the best possible decisions for both staff and patients. It helps to identify which local NHS services have capacity, allowing teams to transfer patients or divert ambulances to a nearby hospital with more beds. It also supports the unblocking of issues that prevent acute flows resulting in ambulance handover delays.

The SCC operates from 8am to 8pm every day, supported by the Capacity and Flow and Organisational Resilience Teams, as well as clinical leadership within the ICB and within Trusts, as subject matter experts. On call arrangements are in place overnight, meaning there is support to the system 24/7, 365 days a year – including bank holidays. Initially established to operate “virtually”, from February the staff in the SCC will come together once a week in person to develop the SCC and ensure it develops and continues to add value to the system.

Since going live on 1st December, the control centre has received over 1000 contacts and has supported the following incidents, in addition to supporting ongoing system pressures:

- System pressure from Flu and Covid increases during December and January
- Ensuring adequate Mortuary Capacity, particularly over the Christmas and new year period
- Oxygen Cylinder Supply Shortages
- Strep A/iGas pressures
- Ambulance Handover Delays
- Minimising patient impact from Industrial Action

2.4 Primary Care Acute Respiratory Hub

To support the winter period, ICBs were asked to give active consideration for the provision of Acute Respiratory Infection (ARI) hubs to support same day assessment. The specification, published in October 2022, set out the requirement for systems to have in place additional capacity to adequately respond to acute respiratory infections during the 22/23 winter period. The model for ARI Hubs was to be locally designed but should build on the vision presented in the Fuller Stocktake report for the integration of primary care – provision of same day urgent response in primary care. In response to this we established:

- BLMK system wide collaborative group formed with PCN Clinical Directors and all system partners
- BLMK Standard Operating Procedure for ARI Hubs drafted and circulated
- BLMK Funding of £658,000 confirmed on 8.12.2022 for an ARI Hub model for 15 weeks (from 19.12.22) across 7 days

In Bedford Borough, from 4th January an initial 5-day service was mobilised, moving to 7 days by the end of January (subject to workforce availability). The service is provided from Shortstown Surgery.

In Central Bedfordshire a 5-day model, delivered by the PCNs;

- Chiltern Hills 28th December
- Leighton Buzzard 9th January
- Titan go live from 9th January
- Ivel Valley South TBC

Discussions are progressing with primary care providers regarding ARI provision for Hilton, Sandhills and the 4 managed practices and for all of Central Bedfordshire at the weekends

In Luton, a 7-day model from 3rd **January**, provided from **Gardenia and Marsh Farm Practices**.

In Milton Keynes, a 6 (to 7) day model from 9th January, delivered from the MK Urgent Treatment Centre.

2.5 Delegation of Primary Care, Optometry and Dental Services from NHSE

The contracting of Primary Care Pharmacy, Optometry and Dental (POD) services will be delegated from NHS England (NHSE) to the ICBs from 1st April 2023. This is part of a national strategy to enable more local decision making.

There are a number of opportunities resulting from Delegation including the opportunity to engage local providers more in primary care developments at place and ensure that the prevention elements of their contracts are contributing effectively to the BLMK Fuller programme and local place-based needs. There is an engagement and communication schedule in place to help build effective links with the community pharmacy, dental and ophthalmology providers as we move through Q4 2022/23 and Q1 2023/24.

The dental contracting function will transfer to the ICB with members of the current team transferring from NHS England which will support the transition. Due to the relatively small size of the current team and maximising staff efficiencies, the Pharmacy and Optometry contracting team will transfer to Hertfordshire and West Essex ICB and provide the function on behalf of all six ICBs in the region. An MOU has been developed to ensure that roles and responsibilities are clear.

The ICB has been partnering with the NHSE regional team to work through the practical steps necessary to facilitate a well-managed transition for the both the members of staff involved and the contractors. This has been monitored through a Safe Delegation Checklist process which is a two-way assurance process that has been supported by a Transition Team within the ICB. This Team is made up from subject matter experts representing key functions within the ICB including finance, quality, complaints, governance, information governance and IT.

The delegation process has highlighted some significant risks both in terms of the organisational resource within the ICB to take on any additional workload required to effectively manage the contracts, particularly in quality, complaints and finance, but more substantially, there are risks around the contract values and forecast spend. The risks were considered by the Executive Team at their meeting on 4th January 2023, and will be presented to the Board, but due to the current consultations with staff, this will be considered in their private session. A paper will be presented to the public Board meeting

on 24th March 2023 following consideration by the Primary Care Commissioning and Assurance Committee (PCCAC) on 17th March 2023.

2.6 Plan Development and Guidance

The Bedfordshire, Luton and Milton Keynes Health and Care Strategy was published on the 12th January. This first iteration of our strategy sets out our ambition to improve outcomes and tackle inequalities in each of our four places, to enable BLMK residents to live more years in good health. The strategy identifies the population challenges which will inform our planning and delivery at place and through provider collaboratives, with collective oversight and peer-accountability through the Integrated Care Board.

Guidance has now been published to inform the development of two-year operational plans for the NHS and a five year 'Joint Forward Plan' (JFP).

2.6.1 Joint Forward Plan

This guidance supports integrated care boards (ICBs) and their partner NHS trusts and foundation trusts (referred to collectively in this guidance as partner trusts) to develop their first 5-year joint forward plans (JFPs) with system partners. The draft Joint Forward Plan is expected by 31st March 2023. Engagement with partners (including with the public) is scheduled between March-May prior to final submission on 20th June 2023.

2.6.2 Operational Planning

The 2023/24 priorities and operational planning guidance reconfirms the ongoing need to recover our core services and improve productivity, making progress in delivering the key NHS Long Term Plan ambitions and continuing to transform the NHS for the future.

Operational Planning guidance for 23/24 recognises the shift to local decision-making at ICBs and place, with streamlined NHS targets for this period.

The Joint Forward Plan is expected to build on these plans into the medium term to support the delivery of longer-term enablers and our system priority actions. It is expected that both these plans will build on updated plans at place, due to be shared with the Health and Care Partnership at the end of March.

These will be included in the BLMK ICB Operational Delivery Plan for 2023-4, with final submission to NHS England by 31st March 2023.

1. Improve ambulance responses and A&E waiting times
2. Reduce elective long waits and cancer backlogs and improve core diagnostic performance
3. Ensure easier access to Primary Care services especially General Practice
4. Improve access to mental health for all age groups
5. Maximise preventative interventions, such as managing hypertension
6. 3 key diagnostic targets (cancer and non-cancer) to support earlier diagnosis
7. Health inequalities lens on all – reaching the patients with the poorest access / health outcomes

2.7 Publication of ICB Organogram

The ICB were requested, from the Secretary of State for Health and Social Care, Rt. Hon. Steve Barclay MP, to publish an organogram for our organisation together associated running costs. This shows the number of roles and associated costs of the people working in each of the ICB's directorates (as funded by the ICB's management cost allowance). The document is designed to give transparency and show our commitment to spending taxpayers' money wisely, whilst not providing personal information such as names, role titles or salary details, except in the case of the directors.

Roles have been grouped into grades and groups of at least five in number. This has been signed off through our Information Governance team and staff side have been kept informed of its development.

The document has been published on our website and you can view it using the link below.

<https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/what-we-do>

2.8 ICB Organisational Development

We are establishing our Organisational Development plan and approach for the ICB as part of the ICB year of transition. Our aim is to support staff to work in new ways across the ICB, focusing on delivery and improvement at scale, at place and through collaboratives. We will look at how we can work in new ways, sharing ideas and techniques to build the competency of our colleagues in areas like service improvement, coproduction and transformation whilst sharing the great work we are already doing in BLMK to deliver improved outcomes for our patients in line with our core aims.

This programme will commence with Staff Engagement Events in January and continue through the year.

2.9 Key Events December and January

On 7th December, the CEO co-Chaired an Executive-to-Executive Meeting with Bedfordshire Fire and Rescue Service (BRFS). The CEO had the opportunity to clarify with BFRS the purpose of an ICS and a positive conversation followed regarding the potential for collaborative working. The areas highlighted during the conversation were health inequalities, fall prevention, safeguarding and further areas where greater collaboration and joint working could take place to the benefit of local residents. The organisations felt that there was much to collaborate on, and planning is in progress for a joint away day to discuss this in more detail. This format of joint Executive meetings is being scheduled with other local partners to further explore collaborative opportunities.

2.9.1 NHS Trust NED and Governor Briefings

In November and December 2022, two briefing events were held for NHS Trust NEDs and Governors, to share information on the legislative changes for Integrated Care Systems, the BLMK system structure and the new ways of working. The sessions were co-designed with the NHS Chairs, governance leads and the ICB Chair and CEO and background information was circulated in advance of the meetings.

Over 40 people attended the NED briefing, from NHS Trusts and the ICB and the areas of discussions included system finance and how this was allocated to services, efficiency and effectiveness, how to involve wider partners e.g., Police, Fire service, the importance of prevention and how we cannot just keep doing more of the same, the interdependency of health and social care, the important role of anchor institutions and how organisations share appropriate information.

There were over 60 NHS Governors who attended the briefing in December with ICB colleagues. Areas of discussion included the establishment of the ICB as a statutory body that received the financial allocation for NHS services in BLMK and how this was allocated to services the planned delegation of the commissioning of additional primary care and specialised services, the ambition of BLMK to be a research ICS and how it is working with local Universities to achieve this, how we are enabling appropriate access to health and social care records of residents to provide holistic care, the expansion of personalised care is crucial, the regulatory framework we operate in, and how governors can provide valuable insight from patients and residents.

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

28 th November	<p>System Finance Away Day</p> <p>The CEO attended to present to finance staff from across the health system.</p>
7 th December	<p>Executive to Executive Meeting with Bedfordshire Fire and Rescue Service</p> <p>The ICB Executive Team met with the Bedfordshire Fire and Rescue Service to discuss areas for collaborative working. The meeting was positive and both organisations had ideas for working together to support our population and we have committed to hold a joint away day to progress ideas into plans.</p>
11 th December	<p>Hewitt Review meeting re Planning Guidance with Julian Kelly – the meeting tested possible issues arising from the now published planning guidance.</p>
14 December	<p>Royal Pharmaceutical Society King's Fund Vision for Pharmacy</p> <p>CEO attended the launch of this work which now moves to implementation by the profession and employers.</p>
9 th January 2023	<p>Quarter 4 Regional Review Meeting</p> <p>The ICB Executive team met with the NHSE Regional Executive Team for the formal quarterly review. This was an opportunity for us to discuss and show the good work and progress of the ICB and to raise our key issues, concerns and challenges to the regional team and to present to them how they could best support BLMK in these areas.</p>
12 th January 2023	<p>CEO met with Minister O'Brien to discuss primary care estate issues in Leighton Buzzard. Follow up meeting on the wider primary care estates issues being arranged.</p>
12 th January 2023	<p>ICB Chair and CEO Meeting with Minister</p> <p>Through December and January each ICB Chair and CEO were asked to meet with Government Minister to develop better relationships between ICBs and Ministers, and to get a sense of where challenges and opportunities are. BLMK Chair and I met with Minister Quince on the 12th January. We were also able to highlight some key constraints and barriers, including Primary Care funding and Community. This is likely to be the first of further such meetings.</p>
12 th January 2023	<p>Integration and Place WS - Hewitt Review – introductory meeting</p> <p>The CEO has been asked to Co-Chair this workstream with Tim Oliver. The meeting agreed possible membership and approach. This piece of work will happen weekly over the next four weeks and report to the Review at the end of February.</p>
13 th January	<p>East of England Specialised Services Provider Collaborative</p> <p>The CEO and Chief Transformation Officer met with Dr Susan Broster, Deputy Medical Director and Clinical Lead for Specialist Services Development and Integrated Care at Cambridge University Hospitals NHS Foundation Trust to discuss provider collaborative innovators.</p>
13 th January	<p>Vision for Community Pharmacy Steering Group</p> <p>CEO representing the views of ICBs regarding Community Pharmacy and how it might support population health and wellbeing going forward.</p>

2.10 Recently published ICB guidance

Since the last Board meeting on 14th November, the following guidance relevant to Integrated Care Systems has been published. Key guidance for the Board to note:

- **Guidance on developing the joint forward plan** (December 2023)

This guidance supports integrated care boards (ICBs) and their partner NHS trusts and foundation trusts (referred to collectively in this guidance as partner trusts) to develop their first 5-year joint forward plans (JFPs) with system partners.

[NHS England » Guidance on developing the joint forward plan](#)

- **2023/24 Priorities and Operational Planning Guidance**

The 2023/24 priorities and operational planning guidance reconfirms the ongoing need to recover our core services and improve productivity, making progress in delivering the key NHS Long Term Plan ambitions and continuing to transform the NHS for the future.

[NHS England » 2023/24 priorities and operational planning guidance](#)

3. Are there any options?

Not applicable.

4. Key Risks and Issues

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

Have you recorded the risk/s on the Risk Management system?

Yes

No

[Click to access system](#)

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

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

None

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

[Click to view Green Plan](#)

Not applicable

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

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

8. Next steps:

As described in report

9. Appendices

None

10. Background reading

None

Report to the Board of the Integrated Care Board, 27 January 2023

9. Corporate Governance Update

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

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

Enablers

Data and Digital <input type="checkbox"/>	Workforce <input type="checkbox"/>	Ways of working <input type="checkbox"/>	Estates <input type="checkbox"/>
Communications <input type="checkbox"/>	Finance <input type="checkbox"/>	Operational and Clinical Excellence <input type="checkbox"/>	Governance and Compliance <input checked="" type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

Report Author	Maria Wogan, Chief of System Assurance & Corporate Services Gaynor Flynn, Governance & Compliance Manager
Date to which the information this report is based on was accurate	16.12.2022
Senior Responsible Owner	Maria Wogan, Chief of System Assurance & Corporate Services

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

Maria Wogan, Chief of System Assurance and Corporate Services.
Committee Chairs.

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

None. The reports from Committees summarise the outcomes of the meetings of the Committees of the Board of the ICB.

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

The purpose of this paper is to outline the following and ask Members to:

- A) **Approve** the proposed amendments to the ICB's Governance Handbook in relation to:
- The Terms of Reference of the Health and Care Partnership Joint Committee – see 2.1 below.
 - The Terms of Reference of the Working with People and Communities Committee – see 2.2 below.
- B) **Note** the following:
- The appointment of a Deputy Chair for the Audit & Risk Assurance Committee – see 2.3 below.
 - The interim appointment of a representative from the Health and Care Senate to serve on the Working with People and Communities Committee – see 2.4 below.
 - The progress made to date with the ICB Annual Declaration of Interests Exercise – see 2.5 below.
 - Implementation of the ICB's Board Effect Platform – see 2.6 below.
 - Proposed dates for 2023/24 Meetings of the Board of the ICB – see 2.7 below.
 - Update on Primary Medical Services ICB Board Member Recruitment – see 2.8 below.
 - Committee Chairs Updates, provided in appendix A – see 2.9 below.

A link to the ICB's Governance Handbook can be found in section 9 below.

Executive Summary Report

1. Brief background / introduction:

As expected, there is a need to adjust some of the ICB's governance arrangements in the light of the first few months experience of operating the new organisation. Approval of amendments to the ICB's Governance Handbook is a power reserved to the Board of the Integrated Care Board.

2. Summary of key points:

2.1 Health and Care Partnership Joint Committee Terms of Reference

(See page 71 of the ICB's Governance Handbook)

The Terms of Reference were reviewed at the meeting of the Health and Care Partnership Joint Committee on 14 December 2022.

To avoid creating the impression that the Terms of Reference were not complete, it was recommended that the Board approve the removal of the following wording which makes up section 8 until such time as the ICB delegates authority to it:

8.1 The Bedfordshire, Luton and Milton Keynes Health and Care Partnership (Joint Committee) is authorised by the Integrated Care Board and the Councils of Bedford Borough, Buckinghamshire, Central Bedfordshire, Luton and Milton Keynes to:

2.2 Working with People and Communities Committee Terms of Reference

(See page 66 of the ICB's Governance Handbook)

It is recommended that the quoracy outlined in the Working with People and Communities Committee Terms of Reference be amended as follows:

From:

- "At least one Non-Executive Member.
- The Chief of System Assurance and Corporate Services or their nominated deputy.
- At least one of the non-voting members."

To:

- "At least one Non-Executive Member.
- The Chief of System Assurance and Corporate Services or their nominated deputy.
- At least one third of Committee members"

2.3 Appointment of a Deputy Chair for the Audit and Risk Assurance Committee

Alison Borrett was nominated as Deputy Chair of the Audit and Risk Assurance Committee and has accepted the role.

2.4 Interim appointment of a representative from the Health and Care Senate to serve on the Working with People and Communities Committee

The Health and Care Senate was asked for a nomination to serve as a Non-voting Member on the Working with People and Communities Committee, but no nominations were made. As an interim measure it was proposed that Dr Sarah Whiteman, who is Chair of the Health and Care Senate, undertakes this role until a nomination is made.

2.5 Annual Declaration of Interest Exercise

The ICB's Governance & Compliance Team commenced the ICB's annual Declaration of Interests exercise in December 2022. ICB Board and Committee Members were asked to review their previous declaration form and provide any updates. In addition, all 403 ICB staff (who are non-Board & Committee members) were asked to complete and submit a declaration form (including confirmation of nothing to declare) through the Microsoft Teams application.

To date 322 forms have been submitted to the Governance Team who will continue to chase outstanding responses and deal with queries.

2.6 Implementation of the ICB's Board Effect Platform

The Governance & Compliance Team has welcomed all ICB Board Members to the Board Effect platform. As implementation continues Board Members will have access to Meeting Packs for committees of the Board of the ICB via the Board Effect Platform. Additional functionalities of the platform will be explored and implemented in due course.

Questions regarding the use of Board Effect should be directed to the Governance & Compliance Team via the Corporate Sec email address.

2.7 Proposed dates for 2023/24 Meetings of the Board of the ICB

The outcome of the poll sent to Board Members regarding an alternative day of the week for Board meetings and 9am start time demonstrated the need for 'Board Day' to remain as Friday with a 9am start.

Dates for 2023/24 are proposed as follows. Calendar invitations to follow in due course with venues to be confirmed:

- 30 June 2023
- 29 September 2023
- 8 December 2023
- 22 March 2024

2.8 Update on Primary Medical Services (PMS) ICB Board Member Recruitment

The ICB undertook a recruitment process to appoint a PMS Board Member, unfortunately the process failed to recruit. A further recruitment process to appoint to this position will commence in due course.

2.9 Committee Chairs Updates

Updates from the following Committees of the Board can be found in appendix A:

Name of Committee	Meeting Held On
Audit & Risk Assurance Committee - Part 2 System Risk	2 December 2022
Bedfordshire Care Alliance Board Committee	17 November 2022
Finance & Investment Committee	9 December 2022
Health and Care Partnership	14 December 2022
Primary Care & Commissioning Assurance Committee (PCC&AC) in Public	9 December 2022
Primary Care & Commissioning Assurance Committee (Extraordinary) in Public	11 January 2023
Quality & performance Committee	2 December 2022
Working With People & Communities Committee	16 December 2022

3. Are there any options?

Approval of amendments to the ICB's Governance Handbook is a power reserved to the Board of the Integrated Care Board.

4. Key Risks and Issues

None identified.

Have you recorded the risk/s on the Risk Management system?

[Click to access system](#)

Yes

No

Not applicable as no risks identified.

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

None identified.

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

[Click to view Green Plan](#)

Not applicable.

7. How will / does this work help to address inequalities?
Not applicable.
8. Next steps:
The Governance Handbook will be updated and re-published on the Integrated Care Board website.
9. Appendices
Appendix A – Committee Chairs’ Updates
10. Background reading
The ICBs Governance Handbook - Microsoft Word - NHS BLMK ICB Governance Handbook Final v4.0

Appendix A – Committee Chairs Updates:

Audit & Risk Assurance Committee - Part 2 System Risk – 2 December 2022
Update to Board on key points
<p>Deep Dive – Climate Change Risk: Following a learning session held with the Local Health Resilience Partnership on last summer’s heatwave-induced mortality failures, the Audit and Risk Assurance Committee was asked to discuss the risk, the current mitigations, and actions to reduce the risk rating. Representatives from partner organisations within the ICS (local authorities and NHS Trusts) were invited to join the discussion.</p> <p>The core purpose of the discussion was to determine whether the climate change risk is appropriately captured, and whether appropriate mitigations are in place to address the risk as described. The current Board Assurance Framework (BAF) risk (no 7) rating is 16, with five mitigations listed against it within the system, taking it to a target risk score of 8.</p> <p>There was a full and robust discussion. Proposed next steps include:</p> <ul style="list-style-type: none">• Communicate the risk, its urgency, and what our staff and populations can do to support (for example, through an Integrated care System Green Plan engagement plan and carbon literacy strategy)• Develop a system-wide working group on adaptation in early 2023• Identifying assets within the system to contribute to the plan – understanding gaps in skills and knowledge and whether system partners can help address these.• Research best practice in adaptation in health and care nationally and internationally.• Research tools available to support decision-making that is sensitive to the needs of the system to adapt to climate change (e.g., carbon accounting tools).
Decisions for approval by the Board
There are none.

Bedfordshire Care Alliance Board Committee - 17 November 2022
Update to Board on key points
<ul style="list-style-type: none">▪ A digital update was provided which included the Shared Health and Care Record and progress against the ‘What Good Looks Like’ self-assessment.▪ A presentation on community services re-design was shared and identified the new ways of working. An update will be presented to the next meeting.▪ An update on the complex care and frailty programme was given.
Decisions for approval by the Board
There are none.

Finance & Investment Committee - 9 December 2022

Update to Board on key points

- The committee received and noted both the ICB and System Finance reports for month 7 and that the current forecasts are for year-end breakeven
- The committee received a presentation on the System Medium Term Financial Plan and noted the headline financial scenarios based on the key assumptions used. The committee noted that the model would be updated on receipt of the planning guidance and actual allocations
- The committee received a report on the ICB's Section 75 agreements for 2022\23. The committee recommended approval of the Section 75 agreements.
- The committee received an update on the planned procurement approach for the ICB strategic data platform and the governance processes. The committee approved the procurement of a strategic development partner.
- The committee received an update on the current key procurement and contracting issues.
- The committee 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 for 2022\23 as recommended by the Finance and Investment committee.

Health and Care Partnership - 14 December 2022

Update to Board on key points

- A report from the Directors of Public Health on the Joint Strategic Needs Assessment and Population health was presented. It included information on BLMK, '15 Facts about Health Inequalities'.
- A Place and Health and Wellbeing Board update was reported.
- The draft Health and Care Strategy was presented, and the Partnership made comments on its content that has been incorporated into the published strategy. It was requested that a follow up report is provided on the impact the strategy is having for our residents and this is planned for the autumn 2023.
- An update on the Fuller programme 'Delivering Integrated Primary Care' was provided and the importance of the role of local authority elected Councillors in communicating information with residents was stressed. It was noted that responsibility for dentistry, pharmacy and optometry is being delegated to the ICB from 1 April 2023 and a report will be made to the next meeting regarding this.

Decisions for approval by the Board

There are none.

Health & Care Senate - 8 December 2022

Update to Board on key points

Please refer to the item on the agenda

Decisions for approval by the Board

There are none.

**Primary Care & Commissioning Assurance Committee (PCC&AC) in Public
9 December 2022**

Update to Board on key points

The Committee noted and discussed the following:

- Confirmation of Mahesh Shah as the Deputy Chair of the Committee
- The ongoing work to progress the safe delegation of Community Pharmacy, Optometry and Dental (POD) contracts to the ICB; ICB expected to take delegation from 01 April 2023; the national timeline for NHS England (NHSE) to approve and ICB commissioned an internal audit for additional assurance of the ICBs readiness
- Actions being taken and contingency arrangements for The Village Medical Centre
- The deep dive review to take place in January at Cauldwell Medical Centre, Bedford further to whistleblowing complaint. Findings will be shared with the Primary Care Delivery Group to help inform assurance levels on quality of care and be considered when looking to invoke a potential two-year extension in April 2023. Assurance provided to ICB by East London Foundation Trust (ELFT) Medical Director and Executive Director that a review of the whistleblowing concern had been undertaken and mitigations put in place which will be reviewed as part of the deep dive
- The update and actions taken since previous meeting for Ashcroft Practice Luton further to inadequate Care Quality Commission (CQC) report. Remedial notice served 02.12.22. with 28-day turnaround. Assurance given that majority of actions required had been resolved or being actively worked through
- A branch closure form submitted for Ampthill Road Branch Surgery further to patient engagement and assurance this would not impact number of appointments available or service provided. Report to go to Primary Care Delivery Group Chairs Action Group for formal approval to close the site
- Applications to close lists received from Leagrave Surgery (Luton), Great Barford Surgery, Bedfordshire, Greensands (Ampthill) and Cobbs Gardens (Olney). Cobbs Gardens and Greensands applications will be presented to Primary Care Delivery Group Chairs Action Group in December. Assured that primary care policy guidance manual process was followed and both patient and practice engagement had taken place. Great Barford and Leagrave currently at application stage
- Discussed and noted payments and cashflow issues for practices and outlined actions taken by ICB
- Request for boundary change by Conway Medical Centre, Luton
- Application to incorporate and novate contract by Malzeard Road, Luton
- The current position across BLMK for refugees, evacuees and asylum seekers
- Updates on GP Alternative Provider Medical Services (APMS) Contracts Re-procurement:
 - re-procurement exercise for Brooklands Heath Centre, Milton Keynes and Kingsway Health Centre and Bramingham Park Medical Centre, Luton will be taking place from January 2023
 - plan to offer Neath Hill Health Centre and Kingfisher Surgery in Milton Keynes as branches with patient lists in the new year

- forward planning and ongoing contract monitoring for the other APMS contracts continues
- Status update of
 - (i) programme of work for the Universal Offer Personal Medical Services (PMS) reinvestment proposal and principles for 2022-24/2025;
 - (ii) phase 1 services implementation (January 2023) and
 - (iii) phase 2 in development implementation planned for April 2023
- Risks relating to the primary care directorate are being identified and managed appropriately. Risk registers presented separately for Digital and Estates. All risks logged and monitored in the 4Risk system
- The Primary Care Estates Report highlights:
 - Risk raised by King Street Surgery (Kempston) in relation to their premises, and the mitigating actions being considered/taken forward
 - Risk raised by the developer of Biddenham New Surgery that scheme may not be viable to go ahead due to increase in borrowing rates. Mitigation includes consideration of increase to the previously agreed rent reimbursement levels
 - An addendum to the North Bedford Hub Full Business Case was submitted to NHSE in line with end of November deadline previously reported to the Committee and the risk of approval delay by NHSE
- Estates Prioritisation Process highlights:
 - Outcome of the scoring to-date of the 53 current/proposed primary care estates schemes across BLMK
 - Review of affordability next step in the process (revenue and capital), risks and delivery factors, to agree a final list of schemes expected to be supported in 2022/23 and 2023/24, subject to individual business cases and that
 - Final list to be signed-off virtually by members of the Primary Care Delivery Group and ratification by chairs action from PCC&AC (see Extraordinary PCC&AC Chairs Report)
- Discussed under review of meeting effectiveness how as the Committee develops it can also provide assurance on patient experience rather than just outcomes
- Reviewed the annual business cycle.

Decisions for approval by the Board

There are none.

Primary Care & Commissioning Assurance Committee (extraordinary) in Public – 11 January 2023

Update to Board on key points

- An extraordinary meeting was held to review the outcome of the primary care estates prioritisation process as it relates to the primary care revenue budget and for the Committee to decide how best to take this work forward.
- The meeting was called at short notice to enable practices to proceed with their improvement work where possible.
- The virtual meeting was well attended with over 80 members of the public on the call, including MPs, local councillors, GPs and residents.
- Both the Mayor of Bedford Borough, and Andrew Selous, the MP for South-West Bedfordshire, were invited to ask questions at the start of the meeting and allowed follow up comments after the debate.
- The process for prioritisation and the outcomes of the process were explained and it was noted that the limited budget currently available to the ICB means that some schemes cannot currently be supported.

- The process has led to 23 schemes being supported across BLMK with 30 more still in the pipeline.
- It was recognised that this process was separate from the development of new premises and hubs which will need more in-depth engagement with partners and the public before decisions are made.

The Committee:

- **Received** the outcome of the primary care estates prioritisation process.
- **Approved** the recommended indicative budget of £1.95m to invest recurrently in primary care estates. £1.54m of this cost relates to schemes already committed / operational.
- **Supported** the alternative funding approach for the £1m revenue shortfall for the schemes as outlined by the Chief Financial Officer in the meeting and that primary care budget will be spent on primary care.
- **Approved** the recommended list of schemes to be supported in principle, including the schemes with marginal revenue impact, even though the scores for some of these were lower than others, noting that individual business cases are required for final approval to be given and should the revenue impact become higher than expected it may not be possible to ultimately approve the business case for these schemes.
- **Noted** that these proposals enable circa £468k and £472.5k of the Business As Usual capital to be directed towards primary care estates in 2022/23 and 2023/24 respectively (but note the risk that delays to concluding the prioritisation process may cause some slippage with capital spend between years).
- **Requested** the Board and Finance and Investment Committee of the ICB to consider making additional revenue available for primary care estates as part of the 23/24 resource allocation process, noting that a Board seminar on primary care and the development of Fuller neighbourhoods will include discussion of primary care estates as an enabler of neighbourhood working and is planned for 24 February 2023.
- **Recognised** that there are other primary care providers with estates needs who are not within the 23 and we are committed to working with them and system partners on their needs. Welcome the support and interest from all our partners in this issue and commit to working with all partners at a system and place level and we will continue to escalate the need for additional funding for primary care nationally.

Decisions for approval by the Board

There are none.

Quality & performance Committee – 2 December 2022

Update to Board on key points

- Urgent and Emergency Care (UEC) Risk – Deep Dive - pressures remain as significant high-risk areas. The Committee received a report following a system-wide deep dive on UEC, mitigations and the role of the system control centre were discussed. The deep dive gave a clear overview of provider/partner service pressures. All partners/providers recognised the need to strengthen and progress collaborative, open and transparent ways of working together. Milton Keynes Deal went live and has taken a leadership role in responsibilities for improving system flow.
- Patient Safety Incident Response Framework – workshops have been planned with training programmes for delivery of the new framework underway
- Inequalities – Quality Improvement projects have been identified against the Core20Plus5 Programme – training programmes are underway for priority areas, i.e., Children & Young People and hypertension, 2 of the highest impact projects against Core20Plus5. Memorandums of Understanding are being finalised for bespoke programmes of work with the Voluntary, Community & Social Enterprise (VCSE) sector.

- Transformation - A review of transformation programmes in line with quality improvement and inequalities is underway. All programmes of work and funding streams across the BLMK system will be coordinated.
- Maternity - Kirkup report will be reviewed along with Ockendon and other relevant reports with the aim of developing action plans to progress quality improvement and the inequalities work programmes for the BLMK Local Maternity Neonatal System. A workshop is planned for January 2023.
- Safeguarding – Further development needed to improve quality aspects and outcomes for children and young people across the BLMK system – Child Death Overview Panel Annual Reports - Work is underway to align data across the 4 local authorities to gain an overarching view of themes and trends in child deaths across BLMK, which will inform strategies for 22/23. Pathway for supporting families from the time of death notification to the outcome of the review will be strengthened.
- Clinical Policy - Committee considered and supported the Hyperhidrosis Clinical Policy
- Section 117 - NHS England advised all mental health, learning disability and autism service providers to take immediate actions to review their safeguarding systems for these in-patient placements. An assurance framework is being strengthened and further developed to ensure oversight and safeguarding of BLMK placements.
- Individual Funding Requests Policy – Delegation of approval requests and amendment to the Committee Terms of Reference were recommended to Board

Decisions for approval by the Board

There are none (Board approval to change to TOR was given at November Board).

Working With People & Communities Committee (WWPAC)

16 December 2022

Update to Board on key points

The committee

- noted that the WWPAC Strategy had been updated and approved by the Board
- asked the ICB to consider holding sessions to explain the roles of the ICB, Integrated Care Partnership (ICP) and how and where decisions are made for:
 - Healthwatch and Voluntary, Community & Social Enterprise (VCSE) sector.
 - VCSE trustees and board members
 - Local Authority elected councillors split by groups – specifically for members with health interests/portfolios and then in broader terms, how the ICP works, where decisions are made and how they can influence
 - leaders of the councils (as they do not all sit on the ICP)
- requested a progress report on the work from the Denny Review and recommended that the final report and recommendations be presented to the Health and Wellbeing Boards
- discussed transforming primary care by establishing neighbourhood teams. The conversation highlighted that discussions were needed at both neighbourhood, place and system level, and how ‘place-based’ boards should be empowered to take a leading role. Partners including the VCSE, community providers and pharmacies should be involved in developing neighbourhood teams. Following the discussion, the Primary Care Team agreed to review the feedback received and incorporate into their programme plan
- noted the engagement activity undertaken to support the Musculoskeletal (MSK) service re-design and procurement and supported the proposal to progress the work (noting that patient voice would continue to be heard throughout the procurement, mobilisation period and implementation of service)
- noted the co-production training plan and report
- noted and provided feedback on the draft BLMK Integrated Health and Care Strategy

Decisions for approval by the Board
There are none.

Report to the Board of the Integrated Care Board, 27 January 2023

10. Board Assurance Framework

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input checked="" type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input checked="" type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input checked="" type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input checked="" type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input checked="" type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input checked="" type="checkbox"/>	Workforce <input checked="" type="checkbox"/>	Ways of working <input checked="" type="checkbox"/>	Estates <input checked="" type="checkbox"/>
Communications <input checked="" type="checkbox"/>	Finance <input checked="" type="checkbox"/>	Operational and Clinical Excellence <input checked="" type="checkbox"/>	Governance and Compliance <input checked="" type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

Report Author	Ola Hill, Deputy Head of Organisational Resilience
Date to which the information this report is based on was accurate	10 January 2023
Senior Responsible Owner	Maria Wogan, Chief of System Assurance and Corporate Services

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

Maria Wogan, Chief of System Assurance and Corporate Services

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

Audit and Risk Assurance Committee – 2 December 2022 – Updated on Board Assurance Framework (BAF) & Climate Change deep dive
ICB Executive Team – 18 January 2023
Next Update to System Oversight and Assurance Committee – 3 February 2023 (meeting postponed in December due to system pressures)

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

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

- A) Progress against the Board Assurance Framework Workplan
- B) Current Board Assurance Framework
- C) Feedback from Audit & Risk Assurance Committee Deep-Dive into Climate Risk
- D) Next steps in the Board Assurance Framework Workplan

And **agree** if there should be any changes made to the Board Assurance Framework in terms of new risks or changes to risk scores and mitigating action plans.

1. Brief background / introduction:

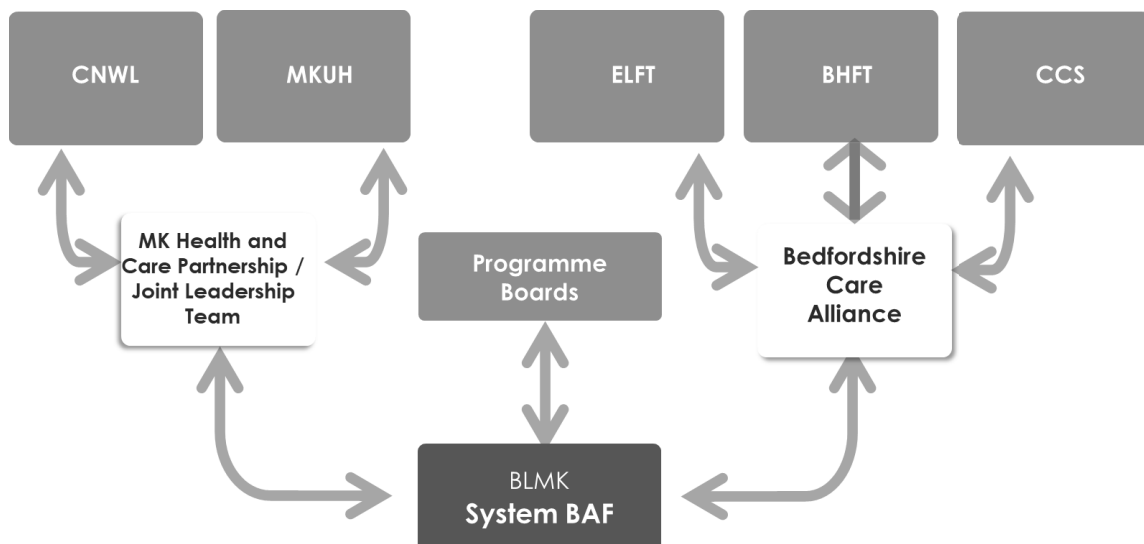
BLMK ICB's vision for risk management is for all decision makers to be fully informed of risk and that risks are effectively managed in the achievement of our objectives. Risk management benefits the ICB, our stakeholders and the local population by enabling new ideas to be explored and potential risks to be managed to minimise their impact. The approach is to utilise the ICB Board Assurance Framework (BAF) as the key tool to hold the strategic risks as defined by the ICB: the major risks that could prevent the ICB from fulfilling the objectives in its agreed strategy. These are strategic risks which pertain to the whole system as opposed to the ICB as a statutory organisation. Risks that pertain to the ICB as a statutory organisation are held on the ICB's corporate risk register and directorate sub-risk registers.

The development of the Board Assurance Framework is an iterative process engaging all the parts of the system to ensure that appropriate risks are identified and mitigated to support the ICB in achieving its objectives.

2. Summary of key points:

Progress with Board Assurance Framework Work Programme

Since the last meeting of the ICB Board, the System Risk Community of Practice met to scope the coproduction of the underpinning process for escalation and de-escalation of risks. The System Risk Leads have proposed the model below with the aim of ensuring that system risks are able to move through the system as appropriate to the BAF where a collaborative approach to strategic management and risk reduction is employed.



The proposed process ensures subsidiarity of risk with Trusts, Place and Neighbourhoods. The proposed process will be developed in two phases, first with Trusts and then to encompass the Bedfordshire Care Alliance, the MK Deal, the Place Based Boards and Programme Boards.

The Audit & Risk Assurance Committee carried out a deep dive into the Climate Change Risk on 2nd December, with sustainability leads from the system in attendance.

The Board Assurance Framework was also circulated to the members of the System Oversight and Assurance Group (SOAG) in December, but due to systems pressure, the meeting planned to discuss the BAF on 13th December was postponed until 3 February 2023. In February, the SOAG will consider whether a strategic risk of ‘failure to collaborate’ should be added to the BAF, in response to the output of the Board Development session on risk held on 4th November.

Current Board Assurance Framework

The Board Assurance Framework currently holds nine strategic system risks and there has been an increase to the risk rating of **BAF 5** has increased due to the pressure in the system reducing the capacity for transformation. There is now a revised completion date for the Joint Forward Plan as per the NHS Operating Plan Guidance. The risk rating for **BAF 9** has also increased due to the current economic climate increasing the cost of living.

A summary of the Board Assurance Framework is below and is attached in full at Appendix A.

Ref	Risk Title	Risk Description	Current Risk Rating	Change
BAF 1	Recovery of 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.	16	=
BAF 2	Developing suitable workforce	If system organisations within BLMK ICS are unable to recruit, retain, train and develop a suitable workforce then staff experience, resident outcomes and the delivery of services within the ICS, ICB People Responsibilities and the System People Plan are threatened.	20	=
BAF 3	System Pressure & Resilience	As a result of continued pressure on services from various factors (staff sickness, increased activity etc) there is compromised resilience in the system which threatens delivery of services across BLMK	20	=
BAF 4	Widening inequalities	There is a risk that inequalities in the system widen due to a range of factors leading to compromise to population health and increases in system pressure in the most deprived areas.	16	=
BAF 5	System Transformation	There is a risk that as a result of significant operational pressures, there will be decreased capacity to focus on strategic transformational change to deliver improved outcomes for our population.	16	↑
BAF 6	Financial Sustainability 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.	15	=
BAF 7	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	=
BAF 8	Population Growth	As a result of fast rate of population growth in BLMK, there is a risk that our infrastructure will not keep pace with the needs of our population, resulting in poor health and wellbeing for residents.	16	=
BAF 9	Rising Cost of Living	As a result of rising cost of living there is a risk that residents will not be able meet their basic needs resulting in deteriorating physical and mental health resulting in pressure on all public services	16	↑

Climate Risk Deep Dive – Audit & Risk Assurance Committee (2nd December)

Tim Simmance, BLMK ICB Associate Director of Sustainability and Growth, facilitated a deep dive into Climate Change risk with sustainability and adaptation leads from the system. The session was a very useful way to highlight a significant risk to the health of our population and to the provision of healthcare and provided a foundation for system collaboration on adaptation to mitigate this risk.

The core purpose of the discussion was to determine whether the climate change risk is appropriately captured, and whether appropriate mitigations are in place to address the risk as described. There was a full and robust discussion from all partners.

Although no further action has yet been taken, there was commitment from partners to convene early in 2023 to work through identified gaps in our mitigations, and to generate an adaptation plan and a programme of supporting work. The Green Plan Operational Working Group will be the forum overseeing progress of this. System partners attending the meeting agreed that it was beneficial to work together to develop the mitigation plans for this risk and acknowledged the limitations faced by individual organisations in mitigating the risk in terms of capacity, capability and impact.

The Committee agreed that that deep-dive approach to system risks was helpful in terms of providing assurance and identifying system-wide mitigation plans and agreed that this approach should therefore be taken in relation to all the risks on the BAF. A plan will be produced to facilitate deep dives into each risk during the year with the outcome being reported to the Audit and Risk Assurance Committee and the Board.

Next Steps in Work Programme

The System Risk Community of Practice will meet to further develop the first phase of the proposed escalation and de-escalation process for risks, working with Trusts.

The SOAG will consider the new risk around 'Failure to Collaborate' and agreeing the initial risk score and identifying a Risk Owner.

Further deep dives are planned for early 2023 on the transformation and inequalities risks.

3. Are there any options?

Not applicable

4. Key Risks and Issues

This report is wholly focused on risk

Have you recorded the risk/s on the Risk Management system?

Yes

No

[Click to access system](#)

The ICB Board Assurance Framework is wholly hosted on 4Risk.

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

There are no direct financial or resourcing implications arising from this report.

The ICB's Deputy Head of Organisational Resilience lead on strategic risk management as part of her wider Emergency Planning Resilience and Response portfolio equivalent to 0.5 WTE.

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

[Click to view Green Plan](#)

Climate change is a key strategic system risk on the Board Assurance Framework.

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

Reducing inequalities is a key strategic system risk on the Board Assurance Framework

8. Next steps:

- System Risk Community of Practice - February/March 2023
- Audit & Risk Assurance Committee – 3 March 2023
- System Oversight and Assurance Group – 3 February 2023

9. Appendices

Appendix A - ICB Board Assurance Framework

10. Background reading

BLMK ICB Board Assurance Framework

Report Date	10 Jan 2023
Risk Status	Open
Risk Area	0. ICB Board Assurance Framework
Comparison Date	In the past 3 Month(s)
Control Status	Existing
Action Status	Outstanding

Growth						
Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Action Required
BAF 6	Growth	Financial Sustainability & Underlying Financial Health Risk Owner: Dean Westcott Risk Lead: Stephen Makin Last Updated: 28 Oct 2022 Latest Review Date: 05 Jan 2023 Latest Review By: Abimbola Hill Last Review Comments: Reviewed by Stephen Makin	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.	I = 5 L = 3 To I = 5 L = 3 15	Monthly financial reporting to Finance & Investment Committee and Integrated Care Board - includes analysis of financial performance: revenue, capital, underlying financial performance plus risks & mitigations. System led financial oversight through SOAG, Performance & Delivery Group and System DoFs Update and development of system Medium Term Financial Plan for 2023/24 to 26/27. Includes scenario modelling of key variables and downsides.	Development and implementation of system transformation, improvement and efficiency programme covering for 2023/24 + across and between ICS partners Person Responsible: Anne Brierley To be implemented by: 31 Mar 2023
				N/A To I = 4 L = 2 6		
BAF 5	Growth	System Transformation Risk Owner: Anne Brierley Risk Lead: Last Updated: 06 Jan 2023 Latest Review Date: 06 Jan 2023 Latest Review By: Abimbola Hill Last Review Comments: Risk reviewed. Actions updated and progress updates added by Anne Brierley	There is a risk that sustained operational pressures and complexity of change, there will be reduced delivery and benefit from strategic transformational change to deliver improved outcomes for our population.	I = 4 L = 4 To I = 4 L = 4 16	Agreed strategic priorities across the system in place Chief Exec/SOAG - regular reviews of operational performance issues to agree mitigations EPRR Framework and System monitors and responds to incidents resulting from operational pressures to wider system Operational performance management process in place taking account of responses to operational pressures Performance & Delivery Group - manages immediate operational issues Same Day Urgent Primary Care Offer	Set clear timescales and expectations for place plans to deliver transformation for the population Person Responsible: Anne Brierley To be implemented by: 31 Mar 2023 Agree joint forward plan Person Responsible: Anne Brierley To be implemented by: 30 Jun 2023
				I = 4 L = 3 To I = 4 L = 4 16		

BLMK ICB Board Assurance Framework



Bedfordshire, Luton and Milton Keynes

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 2	Growth	<p>Developing suitable workforce</p> <p>Risk Owner: Martha Roberts</p> <p>Risk Lead: John Syson</p> <p>Last Updated: 03 Jan 2023</p> <p>Latest Review Date: 03 Jan 2023</p> <p>Latest Review By: John Syson</p> <p>Last Review Comments: National and regional workforce picture continues to be exceptionally challenging with industrial action affecting health providers as well as winter pressures. Turnover and sickness absences have seen increases in autumn and are expected to continue throughout winter. Cost of living pressures are also continuing to affect all organisations, particularly social care with competition from other sectors and employers</p>	<p>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.</p>	<p>I = 4 L = 5 20 To I = 4 L = 5 20</p> <p>==</p>	<p>EDI & Wellbeing: People Board Sub Group focussing on supporting the wellbeing of staff across the ICS. Also responsible for improving workforce inequalities relating to protected characteristics and development and implementation of initiatives e.g. 'no more tick boxes' to address recruitment inequalities.</p> <p>Education Partnership: People Board Sub Group responsible for development and co-ordination of CPD fund use & demand scoping for system as well as use of apprenticeship levy, school and university engagement and development of innovate courses and training courses across health and care workforce</p> <p>Leadership & OD: People Board Sub Group focussing on building the OD capacity and skills within the system to support workforce transformation across health and care. Development of leadership and development programmes for the ICB and system partner organisations in conjunction with regional and national bodies.</p> <p>People Board: ICS Executive Group with responsibility for People Plan delivery to meet ICS workforce priorities linked to BAF and People Board workforce risks. This enables delivery of ICS Strategic Objectives, ICB People Responsibilities and development of Workforce strategy</p> <p>Primary Care Training Hub supporting in recruitment, retention and training of primary care</p>	<p>I = 4 L = 5 20 To I = 4 L = 5 20</p> <p>==</p>	<p>Launch, assess and embed the Health and Wellbeing pilot: (Primary Care) Pilot a range of wellbeing support and interventions for primary care staff, assess their impact and embed those which represent value to the system.</p> <p>Person Responsible: Susi Clarke</p> <p>To be implemented by: 31 Mar 2023</p> <p>Rotational Apprenticeship: (Education Partnership) Pilot of level 3 HCA rotational apprenticeship between health and care providers in Bedfordshire to launch in 22/23 as proof of concept</p> <p>Person Responsible: Catherine Jackson</p> <p>To be implemented by: 31 Mar 2023</p> <p>50k Nursing Target: (linked to Workforce Modelling and Supply) System has a target to increase NHS system nurses WTE to in excess of 311.3WTE by March 2023. Sources range from international recruitment, apprenticeships to graduates and those recruited from other systems.</p> <p>Person Responsible: Marie Lambeth -Williams</p> <p>To be implemented by: 31 Mar 2023</p>	<p>I = 4 L = 3 12 To I = 4 L = 3 12</p> <p>==</p>

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					<p>Primary Care: People Board Sub Group focussing on workforce programmes as they relate to Primary Care Workforce. Wellbeing, career development, new roles (e.g. ARRS), international recruitment and workforce planning and OD</p> <p>Workforce Modelling & Supply: People Board Sub group focussing on the development of workforce strategy, recruitment, retention programmes and innovative role</p>		<p>Embed use of 'No more tick boxes' recruitment approach: (EDI & Wellbeing) To ensure that system organisations have implemented the key principals of the 'no more tick boxes' approach to recruitment in at least some recruitment episodes in 22/23</p> <p>Person Responsible: Martha To be implemented by: 31 Mar 2023</p>	

Live Well

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 9	Live Well	<p>Rising Cost of Living</p> <p>Risk Owner: Maria Wogan Risk Lead: Martha Roberts Last Updated: 10 Jan 2023 Latest Review Date: 23 Sep 2022 Latest Review By: Kathryn Moody Last Review Comments: requires further clarification in terms of actions required. To be worked through with RA.</p>	<p>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</p>	<p>I = 4 L = 4 16 To I = 4 L = 4 16</p> <p>==</p>	<p>Communications plan to support population access to support services</p> <p>Partner plans for managing increased costs due to inflation</p> <p>Partner support schemes for residents</p> <p>Partner Support Schemes for staff</p>	<p>I = 3 L = 4 12 To I = 4 L = 4 16</p> <p>↶</p>	<p>Understand and promote partner support schemes for residents</p> <p>Person Responsible: Maria Wogan To be implemented by: 31 Mar 2023</p> <p>[EDI] & Wellbeing People Sub-Group): Maximise support for staff across BLMK</p> <p>Person Responsible: Martha To be implemented by: 31 Mar 2023</p> <p>Agree medium-term financial plan with NHS partners</p> <p>Person Responsible: Dean Westcott To be implemented by: 31 Mar 2023</p>	<p>N/A To I = 3 L = 4 12</p> <p>==</p>

BLMK ICB Board Assurance Framework



Bedfordshire, Luton and Milton Keynes

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF7	Live Well	<p>Climate Change</p> <p>Risk Owner: Maria Wogan</p> <p>Risk Lead: Tim Simmance</p> <p>Last Updated: 07 Dec 2022</p> <p>Latest Review Date: 07 Dec 2022</p> <p>Latest Review By: Tim Simmance</p> <p>Last Review Comments: Risk description updated and confirmed with Audit and Risk Assurance Committee 2 Dec 2022. Risk controls reviewed, and additional actions added to support a more robust response to the risk.</p>	<p>=, 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.</p>	<p>I = 4 L = 4 16 To I = 4 L = 4 16</p> <p>=====</p>	<p>BLMK ICS Green Plan 2022-25</p> <p>Local Resilience Forum Adverse Weather Plans</p> <p>Partner Green Plans and Sustainability Plans. NHS other public sector bodies have plans to reduce their contribution to climate change, and put in place both business continuity and adaptation plans to address the impacts of climate change. The ICB will support NHS providers to implement their green plans and ensure adaptation plans are in place, and work in partnership with other public sector bodies and anchor institutions to mitigate the risks of climate change.</p> <p>Severe Weather Plan</p>	<p>I = 4 L = 4 16 To I = 4 L = 4 16</p> <p>=====</p>	<p>Develop and begin implementation of the delivery plan high impact elements of the BLMK ICS Green Plan (including supply chains, estates, medicines, care model transformation), linking with sustainability plans in partner organisations (including local authorities, NHS Trusts, other anchor organisations), to reduce the impact of healthcare on the climate and other environmental concerns.</p> <p>Person Responsible: Tim Simmance</p> <p>To be implemented by: 31 Jan 2023</p> <p>Identify a BLMK ICS lead, who will then oversee creation, approval and delivery of a BLMK system-wide, healthcare Adaptation Plan, outlining how the system and services will work to increase resilience to the effects of climate change.</p> <p>Person Responsible: Tim Simmance</p> <p>To be implemented by: 31 Mar 2023</p> <p>Support review of business continuity arrangements of ICS partners to ensure forward planning to manage climate change-related incidents.</p> <p>Person Responsible: Abimbola Hill</p> <p>To be implemented by: 31 Mar 2023</p>	<p>I = 2 L = 4 8 To I = 2 L = 4 8</p> <p>=====</p>

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 8	Live Well	<p>Population Growth</p> <p>Risk Owner: Anne Brierley</p> <p>Risk Lead:</p> <p>Last Updated: 06 Jan 2023</p> <p>Latest Review Date: 06 Jan</p> <p>Latest Review By: Abimbola Hill</p> <p>Last Review Comments: Risk reviewed. Actions updated by Anne Brierley</p>	<p>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.</p>	<p>I = 4 L = 4 16 To I = 4 L = 4 16</p>	<p>Local Authority Place Plans</p> <p>Oxford-Cambridge Arc</p>	<p>I = 4 L = 4 16 To I = 4 L = 4 16</p>	<p>Infrastructure plans (capital, estates, health services, workforce) will be addressed in the 5 year Joint Forward Plan, in line with Local Authority</p> <p>Person Responsible: Anne Brierley</p> <p>To be implemented by: 30 Jun 2023</p>	<p>I = 2 L = 4 8 To I = 2 L = 4 8</p>

BLMK ICB Board Assurance Framework



Bedfordshire, Luton and Milton Keynes

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 1	Live Well	<p>Recovery of Elective & Cancer Services</p> <p>Risk Owner: Anne Brierley</p> <p>Risk Lead: Michael Ramsden</p> <p>Last Updated: 01 Dec 2022</p> <p>Latest Review Date: 01 Dec 2022</p> <p>Latest Review By: Michael Ramsden</p> <p>Last Review Comments: Risk reviewed. One controlled switched from R.AIsop to Anne Brierley. Still remains a current risk</p>	<p>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.</p>	<p>I = 4 L = 4 16 To I = 4 L = 4 16</p> <p>=====</p>	<p>1. All Trusts have recovery action plans.</p> <p>2. Changes made to L&D Endoscopy service so referrals through one route (Referral Assessment Service) where clinical triage occurs.</p> <p>3. Change in national guidance for aerosol generation procedures leading to improvement in capacity</p> <p>4. Significant increase in Endoscopy capacity. However still a high number of patients waiting and cancer demand increasing.</p> <p>5. Clinical Prioritisation of wait list across BLMK. Reduction in Long waits with elimination of 104ww and 78ww in 22/23</p> <p>6. Cancer 62 day backlog recovery action plans and revised trajectory of improvement</p> <p>7. Waiting list validation and mutual aid programme</p> <p>An Elective Recovery Board has been convened to track recovery and instigate actions. The Board involves CEO/executive/senior stakeholders across commissioning, providers & NHSEI and is accountable for delivery of the Elective Transformation Programme and Elective Accelerator Programme in Bedfordshire, Luton and Milton Keynes. It sets the vision and change needs to deliver the programme objectives whilst assuring quality, safety and value for the BLMK</p>	<p>I = 4 L = 4 16 To I = 4 L = 4 16</p> <p>=====</p>	<p>Maintain oversight of the 22/23 Operational Plan delivery. All actions will support recovery of Elective performance and will be monitored through the Elective Collaboration Board</p> <p>Person Responsible: Michael Ramsden</p> <p>To be implemented by: 31 Mar 2023</p> <p>System wide transformation plan to increase productivity using GIRFT data); transform outpatients through advice and guidance, PIFU and virtual clinics; demand management actions such as clinical triage. All outlined in the 22/23 Operational Plan and delivery overseen by the Elective Collaboration Board</p> <p>Person Responsible: Michael Ramsden</p> <p>To be implemented by: 31 Mar 2023</p>	<p>I = 4 L = 3 12 To I = 4 L = 3 12</p> <p>=====</p>

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					<p>Monthly RTT report indicating size of waiting list and length of wait. Ongoing work with hospitals to optimise utilisation of ISP's</p> <p>Clinical Prioritisation (P1-6) review and shared decision making in place</p> <p>Monthly RTT report indicating size of waiting list and length of wait. Ongoing work with hospitals to optimise utilisation of ISP's</p> <p>Processes in place to ensure those with most urgent clinical needs are treated first.</p> <p>Quality - Supporting review of performance across service provision in particular Cancer services and associated Pathways & diagnostics. Triangulating information and soft intelligence such as serious incidents , complaints , HW engagement , Safeguarding partnership</p> <p>Safeguarding partnership information. Involvement in ICS board discussion for MH , Stroke , Cancer, safeguarding</p> <p>The actions and controls to support the Pandemic and System Pressures risk will support Elective Recovery, as, if there is strong demand management and flow, then the likelihood of emergency medical patients outlying to surgical ward (and concomitant elective cancellation) will be mitigated.</p>		<p>06/09/2022 - AGEM unable to forecast demand and capacity due to issues with the national tool. Significant delays therefore expected in 22/23. Work continues to develop a useful forecast for 23/24 planning round</p> <p>Demand and Capacity modeling. Working with AGEM CSU to develop a model.</p> <p>04/02/2022 - now to include the Strategic Planning Tool</p> <p>05/04/2022 - Deloittes have undertaken D+C analysis for BLMK. The draft report is being reviewed at the Elective Collaboration Board in April where further actions will be agreed. To remain open until report is signed off as accurate. D+C data will need periodic refreshes which will be undertaken by AGEM</p> <p>17.7.21 - Due to national issues with the Strategic Planning Tool, the Elective Board agreed to revert to a manual process for Demand and Capacity Modelling in 22/23. Further updates to be presented to the Executive Board throughout the year</p> <p>Person Responsible: Michael Ramsden</p> <p>To be implemented by: 31 Mar 2023</p>	

BLMK ICB Board Assurance Framework






Bedfordshire, Luton and Milton Keynes

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 3	Live Well	System Pressure & Resilience Risk Owner: Richard Alsop Risk Lead: Last Updated: 05 Jan 2023 Latest Review Date: 19 Oct 2022 Latest Review By: Abimbola Hill Last Review Comments: Current likelihood increased due to current system pressures.	As a result of continued pressure on services from various factors (staff sickness, increased activity etc) there is compromised resilience in the health and social care system which threatens delivery of services across BLMK. This may lead to poorer patient outcomes and reputational damage.	I = 4 L = 5 20 To I = 4 L = 5 20 =	BLMK engaged with regional critical care groups BLMK Performance & Delivery Group reviews performance on a bi-monthly basis and agrees system mitigations and actions BLMK Primary Care Access Program CCG officers review performance weekly via reset & restoration meetings Discharge To Assess process is being implemented in Bedfordshire (already in place in Milton Keynes) In line with escalation process, daily system calls in place for Bedfordshire Increased Patient Transport Services to facilitate swifter discharge Monthly reports are reviewed at the TIL T, Q&P and F&P meetings and the GB Reports are provided to the ICS CEO meeting regarding the performance issues and Covid position Revised escalation process in place to prompt system response across BLMK SHREWD being implemented across BLMK to enable real time resilience/flow data. Specific ICB focus on community bed management across Bedfordshire. The Exec Team reviews performance on a monthly basis	I = 4 L = 5 20 To I = 4 L = 5 20 =	Continued development and implementation of support/access improvement projects via BLMK Access Group and sub-groups Person Responsible: Nicky Poulain To be implemented by: 28 Apr 2023	I = 4 L = 4 16 To I = 3 L = 4 12

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					Winter Planning to include commissioning of further capacity (beds and care) across BLMK Work with Councils to review and redesign care pathways to release more therapy resource to focus on flow.			

Reduce Inequalities

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
BAF 4	Reduce Inequalities	<p>Widening inequalities</p> <p>Risk Owner: Anne Brierley</p> <p>Risk Lead:</p> <p>Last Updated: 06 Jan 2023</p> <p>Latest Review Date: 06 Jan 2023</p> <p>Latest Review By: Abimbola Hill</p> <p>Last Review Comments: Risk reviewed, Controls updated and action progress updated by Anne Brierley.</p>	<p>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.</p>	<p>I = 4 L = 4 16 To I = 4 L = 4 16</p> 	<p>Cross-ICS inequalities steering group and working group to coordinate inequalities activity across the ICS framed around the core20plus5 approach</p> <p>Developing Business Intelligence reporting to report key health outcomes/NHS constitutional standards by place and PCN. For example: uptake of cancer screening and early diagnosis of cancer and 62-day treatment standards to highlight populations with late cancer diagnoses and enable proactive case finding and community engagement.</p> <p>Health inequalities defined at place and PCN level</p> <p>ICS system inequalities lead appointed giving more capacity for this workstream</p> <p>Learning from incidents , safeguarding case review, Community partnership safety work</p> <p>Resource allocation for 22/23 to help to reduce inequalities and draw out learning for future investment</p> <p>Review to understand the impact of Covid on inequalities (Lloyd Denny) Literature review completed.</p> <p>Safeguarding partnership board priorities (Neglect , transition etc..) Working with providers and partners on access for seldom heard communities</p> <p>Supporting the workforce to deal with the impact of the pandemic being overseen by the BLMK Peoples Board.</p>	<p>I = 4 L = 4 16 To I = 4 L = 4 16</p> 	<p>Assurance and outcome metrics to be developed by Director of Contracting</p> <p>Person Responsible: Kathryn</p> <p>To be implemented by: 31 Mar 2023</p>	<p>I = 4 L = 3 12 To I = 4 L = 3 12</p> 

Risk Ref	ICB Priorities	Risk Title	Risk Description	Initial Score	Risk Control	Current Score	Action Required	Target Score
					<p>The new PCN Impact Investment Fund (criteria released 24.08.21) states that by 31 March 2022, PCNs will 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.</p> <p>Work with voluntary agencies e.g maternity Voices , parent carer forums SEND in coproduction of</p>			

Report to the Board of the Integrated Care Board, 27 January 2023

11. Bedfordshire Care Alliance Update

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input checked="" type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input checked="" type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input checked="" type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input checked="" type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input checked="" type="checkbox"/>	Workforce <input checked="" type="checkbox"/>	Ways of working <input checked="" type="checkbox"/>	Estates <input type="checkbox"/>
Communications <input checked="" type="checkbox"/>	Finance <input checked="" type="checkbox"/>	Operational and Clinical Excellence <input type="checkbox"/>	Governance and Compliance <input checked="" type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

Report Author	Peter Horne, Programme Director, Bedfordshire Care Alliance (BCA)
Date to which the information this report is based on was accurate	December 2022
Senior Responsible Owner	David Carter, Bedfordshire Care Alliance

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

Shirley Pointer
David Carter

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

N/A

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

The members are asked to:

- 1.1 Note the update and direction of travel for the BCA.
- 1.2 Agree the 'asks' that have been identified.

2. Brief background / introduction:

This report provides an update on the Bedfordshire Care Alliance (BCA). It covers the following areas:

- 2.1 Aims and current work programme for the BCA.
- 2.2 Areas for future development.
- 2.3 Asks of the ICB
- 2.4 Next steps.

3. Summary of key points:

- 3.1 The aim of the BCA work programme is to develop services in four areas:
 - 3.1.1 **Addressing unwarranted variation** in quality, access and outcomes of what people receive in different parts of Bedfordshire
 - 3.1.2 **Designing, planning and organising health services integrated with social care provision** in Bedfordshire
 - 3.1.3 Focussing on the **things that need to be done once** across Bedfordshire.
 - 3.1.4 **Supporting place priorities** with coherent engagement from providers covering larger footprint and tailoring where particular place population need requires it.
- 3.2 An outline of work programme is at Appendix A. In the second half of 2022/23, the main focus has been on programmes that will progress integration. Summaries are at Appendix B.
- 3.3 The key programmes highlighted in the report have been: Digital; Frailty and Complex care (includes D2A/Home First); Community Services redesign; Operational Leadership/Urgent and Emergency Care (UEC).
- 3.4 Learning from the past 6 months combined with the formalisation of the BCA as a Committee of the ICB offers an opportunity to develop the collaborative. Greater focus is needed in a few key areas for the next financial year to generate more traction and pace. Further work is planned in the following areas:
 - 3.4.1 Refreshing the governance for the BCA including fewer priorities and better coordination on decision-making.
 - 3.4.2 Securing resource to tighten the PMO function.
 - 3.4.3 Developing performance reporting to drive change.
 - 3.4.4 Development of a pilot scheme to test delegation of finances in 2023/24.
- 3.5 The BCA has specific requests of the ICB as follows:

3.5.1	A map of ICB projects and how they relate to the collaboratives and places.
3.5.2	Development of the ICB organogram to show the current roles and responsibilities of individuals in terms of collaboratives and place.
3.5.3	Commitment to provide an up-to-date picture of contracts, functions and management resource as the ICB moves from the transitional year to its new core structure and to supporting collaboratives and places.
3.5.4	Commitment to support from the ICS PMO function.
4. Are there any options?	
N/A	
5. Key Risks and Issues	
N/A	
6. Are there any financial implications or other resourcing implications, including workforce?	
N/A	
7. How will / does this work help to address the Green Plan Commitments?	
N/A	
8. How will / does this work help to address inequalities?	
Addressing inequalities is at the heart of the purpose of the BCA	
9. Next steps:	
See section 2 above	
10. Appendices	
Appendix A – Bedfordshire Care Alliance – Overview of Current Work Programme	
Appendix B – Bedfordshire Care Alliance – Summary of programmes as at Dec 22	
11. Background reading	

Introduction

1. The aim of the BCA work programme is to develop services in four areas:
 - 1.1 **Addressing unwarranted variation** in quality, access and outcomes of what people receive in different parts of Bedfordshire.
 - 1.2 **Designing, planning and organising health services integrated with social care provision** in Bedfordshire – making sure resources are in the right place for the best outcomes.
 - 1.3 Focussing on the **things we need to do once** across Bedfordshire – standardise where we can and it makes sense to do so.
 - 1.4 **Supporting place priorities** with coherent engagement from providers covering larger footprint and tailoring where particular place population need requires it.
2. An outline of work programme is at Appendix A. In the second half of 2022/23, the main focus has been on programmes that will progress integration across health and social care. Summaries are at Appendix B.

Overview of work

3. There is always a risk that the operational imperatives may dominate in a way that could impede progress. It is important, therefore, that a balance is maintained to be able to address both the short-term pressures as well as the longer-term solutions which take time to develop, implement and embed. The key programmes therefore have been Digital, Frailty and Complex care (includes D2A/Home First); Community Services redesign; Operational Leadership/UEC. The key points are:
 - 3.1 **Digital Shared Care Record for Bedfordshire.**
 - 3.1.1 All of the providers in BCA are on track to be connected to the Bedfordshire shared care record. Most will be completed by the end of Q4 2022/23 with the final implementation to be complete by the end of Q1 2023/24.
 - 3.1.2 In April 2023, there will also be connection to Herts and West Essex allowing data from the five acute hospitals (L&D, Bedford, Lister, West Herts and PAH) to be shared and Herts Urgent Care to be connected.
 - 3.1.3 All priority relevant data will be available in these timescales.
 - 3.2 **Frailty and Complex care.**
 - 3.2.1 **Development of interface services.**
 - 3.2.1.1 The 'Silver' phone service has been implemented and is now in place across the whole of Bedfordshire.
 - 3.2.1.2 Twenty-four-hour Same Day Emergency Care (SDEC) went live in Luton and Dunstable from December 2022.
 - 3.2.2 **Virtual Wards.** The ambition is to achieve 250 virtual ward beds by April 2024 focussing on frailty; respiratory; cardiology. Implementation is being phased with an initial priority on frailty and respiratory.
 - 3.2.2.1 Given the current system pressures, the current focus is on patients being discharged from acute care and this will expand in early 2023 to include patients being 'stepped up' from primary and community settings. The level of bed provision is on target with 67 beds for frailty and respiratory cohorts in operation.

3.2.2.2 Future work is concentrating on refining operating processes in a number of areas. The main ones being:

3.2.2.2.1 Considering short term solutions to increase capacity to bridge staffing gaps whilst permanent recruitment is underway.

3.2.2.2.2 Improving digital access to records from different clinical systems. Partners have enhanced the Multidisciplinary Team approach to ensure better coordination of care in parallel with the implementation of the shared care record.

3.2.2.2.3 Enhancing medication systems and processes

3.2.2.2.4 Development of existing processes in Primary Care to prepare for the provision of 'step up' capacity. Key to this is engagement with GPs locally.

3.2.2.2.5 Building the cardiology pathway.

3.2.3 **Discharge to Assess (D2A)/Home First.** This is a complex piece of work requiring agreement across multiple partners in order to ensure that safe and robust systems and processes are in place. Partners have reached a level of agreement on a number of aspects of the Home First/D2A pathway. However, there remain a number of areas that need to be resolved before a new complete pathway can be finalised and implemented. The main outstanding issues centre on decision thresholds and capacity/workforce availability.

3.3 **Community Services Redesign.** This is a fundamental area that needs significant focus in its planning and implementation. It is planned for a finalised project plan to be considered at the BCA Executive Forum in January 2023. Clarity will be provided on the current position including how community/neighbourhood teams are organised, how and where they are linked, whether they are linked to a particular primary care practice or local authority, delivery of community services and funding allocations thereby enabling discussion on a newly designed standardised model across the BCA footprint to meet the needs of the population for the future. It is anticipated that this work will be a priority for the next two to three years as it is key to improving population outcomes.

3.4 **Urgent and Emergency Care.**

3.4.1 **Discharge Escalation over Christmas and New Year 2022/23.** The multi-disciplinary discharge events in December and the Bedfordshire system escalation processes in place in recent weeks have worked effectively to ensure flow in the challenging post New Year period.

3.4.2 **Managing Ambulance Demand.** The urgent care response which is designed to support people where an ambulance conveyance may not be necessary has gone live. The initial focus has been on Community Services' staff taking referrals from the ambulance services dispatch database and attending where it is appropriate. It includes patients who are reported as fallen. Work is ongoing in developing greater consistency of response as staff become more accustomed to the change. An assessment of impact of this work will be conducted once more data is available in Quarter 4 22/23.

BCA Development.

4. The BCA has now been established as a formal committee of the ICB with an ICB Non-executive as Chair and a new Programme Director commenced in December 2022.

5. The BCA work programme is being refined to inject additional pace. The main areas are:

5.1 **Priorities.** Ensuring that priorities are clear and enable teams to focus on a few key areas. The experience of the past 6 months of operation indicate that the emerging priority should focus into a few projects that can accelerate integration.

- 5.2 **Governance.** Ensuring effective coordination between groups to reduce duplication of effort.
- 5.3 **Project Management Office function.** Ensuring that there is clarity on project progress and outcomes through a tightened PMO function. There have been initial discussions with ICB PMO lead to scope the level of support that is required. Main areas to be developed are:
 - 5.3.1 Mapping existing projects to inform priority setting for the BCA.
 - 5.3.2 Clearer project definitions: development of tangible outcomes and lead and lag indicators linked to trajectories to measure and monitor effectiveness.
- 5.4 **Intelligence and Information.** The BCA will need information and analytics expertise to support both planning and performance reporting.
- 5.5 **Preparation for Delegation of Commissioning and Budget Responsibilities.** A key element of the next phase of the BCA programme will be preparatory work in respect of delegation of commissioning and budget responsibilities to place and collaborative. It is proposed that a pilot area is agreed to go live from April 2023. Work is currently underway to identify a proposed area.

Next Steps

- 6. Further work is planned in the following areas:
 - 6.1 Refreshing the governance for the BCA including fewer priorities and better coordination on decision-making.
 - 6.2 Securing resource to tighten the PMO function.
 - 6.3 Developing performance reporting to drive change.
 - 6.4 Development of a pilot scheme to test delegation of finances in 2023/24.
- 7. **Asks of the ICB.** The BCA has the following asks of the ICB:
 - 7.1 A map of ICB projects and how they relate to the collaboratives and places.
 - 7.2 Development of the ICB organogram to show the current roles and responsibilities of individuals in terms of collaboratives and place.
 - 7.3 Commitment to provide an up-to-date picture of contracts, functions and management resource as the ICB moves from the transitional year to its new core structure and to supporting collaboratives and places.
 - 7.4 Commitment to support from the ICS PMO function.

Summary

- 8. This paper has provided an overview of the current work programme for the BCA. It has set out the key areas for development of the BCA and specified the key areas where commitment and endorsement from the ICB is required.

Appendix:

- A. BCA Work plan structure as at Q3 2022/23
- B. BCA Work plan summaries as at Q3 2022/23

BCA Work Plan - Structure

This sets out the structure that is responsible for taking forward elements of the BCA's work plan. It describes programmes that are more transformational in nature (concerned with significant, long term, sustainable change) and operational (dealing with here and now pressures and challenges in the system).

TRANSFORMATION ←

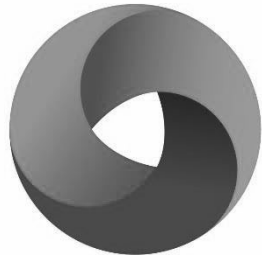
OPERATIONAL →

Planned Care Programme	Digital Programme	Community Services Redesign	Frailty and Complex Care Programme	Workforce Programme	Children and Young People	Cancer	Operational Leadership Group – UEC
<p>Priorities: MSK, referral optimisation, ENT, eye care, diagnostics, dermatology</p> <p>Governance: Beds Elective Delivery Group</p> <p>Leadership: SRO: Cathy Jones Lead: Tara Dear</p>	<p>Priorities: local implementation of data, digital and PHM strategies including shared care records</p> <p>Governance: Bedfordshire Digital Transformation Programme Board</p> <p>Leadership: SRO: David Carter Programme Lead: Mark Thomas</p>	<p>Review of community services building on community baselining exercise agreed at BCA CEs in June. Scoping paper to come to CEs in Q3 (SROs: Felicity Cox and Matthew Winn)</p>	<p>Priorities: Falls, end of life care, developing interface services (incl SDEC, silver phone), anticipatory care model, virtual wards</p> <p>Governance: Oversight Board monthly</p> <p>Leadership: SRO: Anita Pisani Clinical Lead: Tammy Angel Programme Lead: Amanda Flower</p>	<p>Priorities: Promotion of careers, pastoral support, international recruitment, apprenticeships, collaborative banks, employment EDI</p> <p>Governance: Beds Workforce Working Group</p> <p>Leadership: SRO: Liz Lees Programme Lead: Catherine Jackson</p>	<p>Priorities: SEND therapy provision, scoping child health hubs, maternity provision in family hubs, preparing for adulthood</p> <p>Governance: Pan Bedfordshire Children's Leadership Group (TBA), link to BLMIK Children's Trans Bd</p> <p>Leadership: SRO: TBD Sarah Breton, programme lead/Emma Hardwick (maternity)/Simon Hardcastle (preparing for adulthood)</p>	<p>Priorities: Mount Vernon re-provision, support after diagnosis, outcomes improvement</p> <p>Governance: Bedfordshire and Luton Cancer Action Group</p> <p>Leadership: SRO/clinical lead: James Ramsey Programme lead: Kathy Nelson</p>	<p>Priorities: Coordination across health and social care partners to respond to service pressures and challenges in urgent and emergency care and out of hospital pathway including Home First/D2A</p> <p>Governance: OLG monthly</p> <p>Leadership: Chairs: Anita Pisani, Kate Walker, David Carter</p>

Report to the BCA Executive Group and links to Clinical and Professional Leadership Group (senior clinical advice)

Work plan priorities – to be determined

Mental health: autism (Lorraine Rossati), S117 market shaping (Richard Fragley/Richard Macsorley), PHM co-morbidities



Bedfordshire Care Alliance

BCA Work Plan 2022/23 – Update on Progress, December 2022

4a. Transformation Programmes – Planned Care

Redesign of Community Musculo Skeletal Services

1. MSK improvement metrics agreed with BLMK and NHSEI. NHSEI have since shared regional targets
2. Agreement of action plans for MSK metric improvement are on track and there is SRO to support the emphasis on improvement (see measures)
3. Development of MSK Health Needs Assessment and recommendations are on track. There were Pop. Health Working Group and a Clinical Senate in September.
4. Whole pathway financial benchmarking across BLMK.
5. Progress on an MSK new care model is on track though there are risks around consultation and procurement.

Referral Optimisation

The Advice & Guidance (A&G) role is not sufficiently included in consultant job plans leading to a delayed response rate (E-referral) and reliance on the national network. The A&G review will look at the scope for speciality level preference for A&G provision.

1. Agreement of a Referral Optimisation Strategy is on track
2. A&G platform recommendation agreed and will be discussed at a Transformation Directorate meeting
3. Clinical pathway programme is being driven by the CIF (Clinical Interface Forum)
4. EBI policy education programme completed. This will improve awareness of policy thresholds and support patient discussions.
5. EBI 22/23 audit programme - completed (inc ISPs). Quarterly audits have been scheduled

Ophthalmology

Competing priorities and limited capacity are causing difficulties in terms of the time needed of clinical leads for this workstream. Wherever possible working groups will be used and the number of meetings minimised.

1. Eyecare improvement metrics are to be agreed regionally
2. Action plans for improving eyecare metrics are being developed and on track
3. Procurement of the CUES new care model has been scheduled
4. BHFT Eyecare Out of Hours go live

4a. Transformation Programme – Planned Care (cont)

ENT & Audiology

There is resistance to returning to pre-COVID job plans and clinic schedules which is impacting capacity. In response a whole pathway ENT transformation plan is to be developed

1. Development of a Referral Optimisation Action Plan
2. A Bedfordshire earwax removal proposal is in place
3. Identification of best practice ENT models is being facilitated by the Regional team who are producing a pack. A meeting with national ENT leads took place in Q3.
4. Service mapping and stocktake of Audiology provision is underway
5. A joint ENT transformation plan for ENT recovery and productivity is being finalised.

Dermatology

There is a significant increase in 2 week waits. Work is underway to scope alternative referral pathways to provide a more rapid access to non 2 week wait triage.

1. A clinical audit and evaluation of current Teledermatology provision has been completed and is now being finalised. Work to agree a future Teledermatology / A&G service model will follow.
2. A business case is being developed for a pilot Community Dermatology Diagnostics service
3. Work to pilot a non-2WW Advice & Guidance pathway is underway. Requirements and objectives have been scoped

Diagnostics

Competing priorities and limited available time are impacting the ability to support initiatives in this workstream. Wherever possible the number of working groups and meetings is being minimised.

1. A Phlebotomy Options Appraisal is in development
2. Work on a workforce plan and investment, is in development
3. An AQP Contract Review (NOUS, MRI and Audiology) is underway and is dependent on Community Diagnostic Centres.
4. Scoping for a business case for a Bedfordshire Diagnostics CDC Hub is underway.

SRO: Cathy Jones, DCE, BHFT Programme Lead: Tara Dear, Head of Planned Care, BLMK ICB

4b. Transformation Programmes – Digital Transformation

(The programme plan can be found at Appendix b)

The digital programme has three key elements:

- implementation of the **Shared Health and Care Record**.
- Local implementation for the **BLMK digital strategy** to empower residents
- Local implementation of the **BLMK population health management**

Planned activity

- Hospital records available to Primary Care
- MH records available in ShCR (Shared Care Record) Portal
- EEAST integration in ShCR in test
- Patient portal scoping – change of national guidance
- Raiser chairs in care homes
- Acoustic monitoring pilots in five care homes
- Bedford and Luton BCs connected to ShCR
- CCS connected to ShCR
- MK interconnector
- WGGL phase 1 underway
- WGGL phase 2 to start
- Resident engagement campaign started
- Guiding principles for inclusion campaign started
- 60% of care homes on digital system
- Frailty assessments by AI
- Trial minimal viable broadband in care homes

SRO: David Carter, CE, BHFT Programme Lead/ Deputy Chair: Mark Thomas, Chief Information Officer, BLMK ICB

4c. Transformation Programmes - Community Services

Ensuring high quality, equitable, integrated and sustainable community health services is a critical priority for the Bedfordshire Care Alliance (BCA). Terms of reference are being developed for a review of community health services and the development of the future model for delivery to be completed by March 2023. The BCA's work plan for 2022/23 proposed to use the information from the national community baseline mapping exercise that was done in the autumn 2021, to further understand the pattern of community health provision in Bedfordshire, and highlight variation in outcomes and quality, and overall gaps in provision. This will then inform work to design and deliver the future model of community health services in Bedfordshire.

This work is linked to the Fuller Stocktake Report (NHSE, 2022) which stressed the importance of community services delivering integrated services with primary care and other partners in neighbourhoods. It is envisaged that the BCA community health services framework will be a key enabler to the local implementation of the Fuller Report.

The outputs will also be used to support the modelling of required capacity and investment and determine the future model of provision.

This work is being scoped. High level terms of reference have been discussed at the BCA Executive Group in July and September 2022. More work is being done to define the objectives, timescale, interface with other pieces of work and resources required.

SRO: Felicity Cox, CEO, BLMK ICB/Matthew Winn, CE, CCS Programme Lead: Ann Brierley, Director of Transformation, BLMK ICB

4d. Transformation Programmes – Frailty and Complex Care

Priorities are:

1. **Falls:** The agreed falls offer now needs to be fully mobilised and integrated with new offers e.g. UCR (January 2023)
2. **Out of Hospital Support:** This describes a reframed priority for this group to reflect the more focussed and intensive work to develop UCR services, virtual wards and ensure sustainable Home First model (April 2023)
3. **Interface Services:** To continue development of services including consistent BHFT frailty model, silver phone, SDEC (June 2023)
4. **Anticipatory Care:** The envisaged work on anticipatory care and the delivery of the national specification will now be considered under the community health services review (see separate reference in the Work Plan)
5. **End of Life Care:** Ensure best possible experience for all residents requiring end of life care (June 2023)

SRO: Anita Pisani, DCE, CCS

Clinical Lead: Tammy Angel, CD, BHFT

Programme Lead: Amanda Flowers, Associate Director, BLMK ICB

4e. Transformation Programmes - Workforce

Deliverables: Ensuring sufficient supply of trained and engaged workforce to provide services to our population. Ensuring careers in health and social care are accessible, fair and equal and support people with their own mental and physical health. Innovating in the roles we offer, our flexibility in how they are done and embrace technology and data in how we plan our future workforce.

Overall project status update: Rotational apprenticeships across H&SC status is now amber which was due to start in 22/23. Pastoral support continues to have a due date to be confirmed, and has not started. The remaining 4 projects; promotion of H&SC careers to the BLMK population, collaborative banks, international recruitment and employment programmes as part of EDI work have a green status.

Milestone updates:

The Promotion of H&SC careers to BLMK population: The identification of careers fairs opportunities and pool of BCA partner staff identified to support careers activities continues to have an amber status, however the first careers fairs commenced in May, and organisational careers events have taken place. The consideration of IR for social care partners has now started.

Pastoral Support for Staff: Capacity to move this work on as a system is challenging. CCS and ELFT now have pastoral support roles in place. Issue being discussed at Beds Workforce Working Group.

Trajectory:

The Promotion of H&SC careers to BLMK population: The trajectory for number of hits on careers section of Work, Learn, Live website requires to be confirmed.

Risks and Issues:

Collaborative Bank/Reservist Model: A new issue has been added for the need to consider longer term funding options; BCA DoFs briefed as a starting point. Risks are logged on BLMK People Board risk register and monitored there. The documented risks in the report remain unchanged.

SRO: Liz Lees, Director of Nursing, BHFT

Programme Lead: Catherine Jackson, Senior Workforce Project Manager, BLMK ICB

4f. Transformation Programmes – Children and Young People

Children's Community Therapy Service (SEND)

Both the initial review and the final review and report have slipped by a month. Deadlines are now end December 2022 and end March 2023 respectively. In addition, a risk has been identified that, because of cost pressures, the recommended improvements cannot be afforded and implemented.

Progress

- Now a key priority in each LA Joint Commissioning Plan.
- Programme structure and resource in place to include joint commissioners from each LA.
- Launch event was planned for 12th Sept but delayed for national mourning. Rescheduled 1st Nov.
- Early discussions with Parent Carer Forums commenced and plans for co-design with young people in place.
- Agreed to focus on Speech and Language Therapy in phase one as the area of greatest pressure.

Planned activity

- Demand and capacity report to be completed.
- Detailed understand from JSNAs of future trends in demand.
- Analysis of current provision and funding to be undertaken
- Review of best practice to be completed.

Primary Care hubs for children and young people (Connecting Care for Children)

There is a high degree of interconnectivity involved, and ongoing development of many other hubs and service developments make the make the service configuration considerations highly complex. The November 1 launch event is an opportunity to engage and work across such dependencies.

Progress

- Early discussions with Imperial College London, and Connecting Care for Children webinars – looking at good practice.
- Discussions with Luton practices that are already piloting similar model.
- Funding identified to develop 'case for change'

Planned activity

- Work to consider interface with new LA Family Hub developments.

SRO: TBD Programme Lead: Sarah Breton



4f. Transformation Programmes – Children And Young People (cont)

Preparing For Adulthood

Feedback from parents and young people shows that many experience disjointed services, poor communication and service gaps when moving between children's and adult's services. A programme of activity will be undertaken to map system practices and challenges, and agree and implement system principles with the aim of Patient health and experience improvement, brought about by improved communication, co-ordination between services and with patients, advanced planning, and service alignment.

Progress

- Director of Quality and Strategy chairs Pan-Beds Transition in Safeguarding Steering Group
- Decision made for Pan-Beds Transition in Safeguarding Steering Group to continue in it's current form
- Initial scoping and mapping of PfA / Transitions information / guidelines / pathways / policies and procedures, locally, regionally and nationally completed

Planned activity

- PfA / Transition paper to be prepared outlining plans for establishing steering group and proposed actions
- Summit planned for late Autumn/Q3
- Complete mapping exercise of how current systems are addressing Preparing for Adulthood / Transition (Scope of mapping to include Safeguarding, LAC, CAMHS, SEND, Physical and Long Term Health, Adult Services, 0-25)
- Identify partners from across BLMK systems to be part of PfA / Transition Task and Finish Group
- Identify parent/carer and young people reps to co-produce.
- Identify priorities and action plan for BLMK

The Pan Bedfordshire Childrens Strategic Leaders Group have initially discussed these priorities and a proposal is being taken to them in December 2022 setting out more detail and proposing that they oversee this work.

SRO: TBD (will be considered at December 2022 Pan-Beds Childrens Board) **Programme Lead:** Sarah Breton



4g. Transformation Programmes – Cancer

Recovery and Restoration of cancer services update

Progress update:

BCA providers have fully recovered against the referrals and treatment metrics with over 100% of activity achieved each month when compared to pre-COVID. There is still some work to do on reducing the backlog for patients waiting over 62 days for treatment but there are plans in place to do this by March 2023 milestone.

Early Diagnosis

Progress update:

The Targeted Lung Health Check programme successfully expanded into South Bedfordshire
To manage the increasing demand on Breast Cancer services a new 2ww form has been rolled out across BLMK, this was led by clinicians at L&D and has resulted in improved GP education at the point of referral

Reducing variation and improving cancer outcomes

The Luton Cancer Outcomes Project seeks to understand the factors contributing to poor cancer outcomes in Luton. This is a collaborative project with BCA partners in Luton.

Progress update:

A case Study has been submitted to Kings Fund and an inequalities case study submitted to NHSE EoE.
£200k of inequalities funding has been secured to support relevant initiatives.
All workstreams now have a lead and clear actions
Successful Macmillan grant has enabled the recruitment of 4 community connector posts for 3 years. 2 of which were recruited in September 2022


Integration

Progress update:

Survey has been developed with Macmillan to seek views from Healthcare Partnership stakeholders on current service provision and ideas for improvement.

Planned Activity and Milestones

Planned activity includes recruitment to the remaining 'Community Connector' posts and planning for a 'Talk, Listen, Change' event.

SRO:  Barnesford AMD, BHFT

Programme Lead: Kathy Nelson, Head of Cancer Network, BLMK, ICB

BCA Work Plan 2022/23 – December 2022



Care Alliance

4h. Transformation Programmes – Mental Health

Market shaping for a range of people who need accommodation support,

A capital submission is now considered to be 'on the critical path' and will be addressed as a priority

Progress

- Programme Plan/ roadmap has been completed.
- Work on market shaping strategies' is being finalised in Q3 however, there has been a risk around robust data to underpin this work which needs to be explored.
- Provider and 3rd sector engagement plans being refined.
- Patient outcome targets will be finalised in December 2022.
- Further discussions with LAs during Q3 to confirm outline of strategic direction
- Development of expert knowledge of need and provider landscape is ongoing'. (Deadline tbc)

Autism review

Scope and deliverables: a review of the adult autism support available across BLMK, addressing the whole pathway, to understand the demand and prevalence, to then develop a gap analysis that will inform future commissioning priorities, and set recommendations including to reduce inequalities and adopt best practice.

Progress: The engagement phase has been completed with workshops delivered across BLMK using a hybrid model of face to face and online sessions, with an online questionnaire to reach a wider cohort of people. Insight has also been received through engaging with local services across health, SC and VCSE. The learning from the review has been written, including recommendations.

Next steps: The next steps are on track for September 22, to present the outcome of the review to the BLMK TCP delivery and the autism steering group, completing the review.

SRO: Richard Fradgley, Director of Integration, ELFT Programme Lead: Loraine Rossati, AD Mental Health and LD



5. Other BCA Work Plan Priorities – Home First/ Discharge To Assess

Home First/Discharge to Assess

The Bedfordshire Care Alliance worked as a partnership during the pandemic to collectively embed a Home First/Discharge to Assess approach to discharge from hospital. This work was supported by c.£10.8 million of central funding through the Hospital Discharge Fund (HDF). This funding was due to cease from 2022/23, and so partners engaged an independent consultancy, RSM, to work with them to review current system wide resource deployment, develop options and secure agreements amongst partners on how the system will ensure that the Home First approach is maintained, and the benefits realised. The final RSM report was published in May 2022. This contained high level financial modelling which articulated the financial gap to maintain the Home First model following removal of the national Hospital Discharge Funds. It also showed how the financial gap could be mitigated. This was through a combined approach including a shift in discharge pathways, admission avoidance and more efficient flow.

Overseen by the BCA CEs Group, this work is on-going with an expectation that a agreement on the future model and funding will be reached for implementation in 2023/24. In the meantime section 256 monies were transferred to each Local Authority at the end March 2022 to support discharge during 2022/23. This was to allow services to continue and make the necessary changes whilst work continued on the longer term funding position for 2023/24 beyond.

In order to take forward the service model changes as well as determining options for funding the service in the future, in June 2022 the BCA Executive Group agreed a series of actions. A report was presented to the BCA Executive in September 2022 which provided an update on these actions along with suggested next steps to resolve the issues that are outstanding. Even with the work in this report on improving discharge efficiency and introducing new elements to the model to mitigate the position, there is a residual funding gap of c£8m beyond 2023/24 which has not been resolved.

In September 2022, the BCA Executive agreed to develop terms of reference for a further piece of work:

- Develop a model for discharge looking at all elements of the pathway (not just Home First)
- Look at the total ICB resources to support this model, as well as the risks and priorities

SRO: Matthew Winn with input from Kate Walker, Julie Ogley, Maud O’Leary, Paul Calaminus, Richard Alsop/Jan Wood



5. Other BCA Work Plan Priorities

BCA Development Plan

The establishment of the BCA as a Committee of the ICB in 2022/23 was intended to:

- Test the partnership and ways of working
- Set up an infrastructure and reporting arrangements
- Begin migration of resources and responsibilities to the Bedfordshire footprint in line with the work plan.

The BCA has developed further during 2022/23 to meet the aspirations of partners, taking account of how the ICB develops and to meet Place requirements. Previously NHS partners have expressed the intention to pursue a lead provider arrangement to enhance service integration. This will be considered along with other options for improving collaboration during 2023/24.

Next Step

Led by the BCA Programme Director, it is proposed that the BCA takes stock of current working arrangements as well as future options with a view to making any changes to the BCA in 2023/24.

Stroke

In November 2022 the BCA agreed to support a proposal to address inequalities for stroke patients in Bedfordshire. This proposal included extending the existing Early Supported Discharge (ESD) service, provide access to a comprehensive health and social care assessment at 6-months post stroke, and to provide access to neuropsychology support in the ESD service. The comprehensive health and social care assessments started in June 2022 and have been offered to 339 people, with 78 reviews completed in the first three months. These have resulted in checks by GPs for blood pressure/medication, people starting smoking cessation services. The extended ESD service went live in July 2022 and has exceeded its target of 2.5 patients per month being supported at home, instead of going to an inpatient rehabilitation placement. The personal care element of this service has been provided via APT and MegaCare through the existing East London Foundation Trust (ELFT) contract, however this is due to end in March 2023. The neuropsychology support has been in place since the beginning of September 2022 with patients already being supported through the tiered model of treatment.



5. Others BCA Work Plan Priorities

Bedfordshire Hospitals NHS Foundation Trust are developing a framework for service integration.

As a first step, the Trust are working up a high level statement setting out the direction of travel. This will be the basis of conversations with system partners to inform further testing and modelling as proposals are refined. There will be some elements of the strategy which will require a partnership response under the auspices of the BCA, so it will be important to identify these areas as early as possible. For example there may be proposals for changes to services for which collaboration is fundamental.

Progress

There has been a discussion at the BCA Clinical and Professional Leadership Group in September presented by the Associate Medical Directors responsible for this work. This provided colleagues with a useful update and some suggestions for on-going partnership work where there are key interfaces. This needs to be fed into the BCA's future planning process.

Financial Opportunities

Individual organisations are developing cost improvement programmes for 2022/23. The work plan identified that there may be a number of areas which require a partnership approach to deliver. The plan suggested that work be undertaken by finance colleagues to understand related cost improvement plans and identify those (if any) which could benefit from a partnership approach to maximise opportunities.

Progress

To take this forward two Bedfordshire FD workshops have been held (June and Sept 2022) to look at collaborative opportunities including estates utilisation, minimising the financial pressures of workforce challenges, and the finance community supporting service transformation. A report has been prepared and will be considered by the BCA Executive Group.



Report to Board of the Integrated Care Board, 27 January 2023

12. People Strategy

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input checked="" type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input checked="" type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input checked="" type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input checked="" type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input checked="" type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input type="checkbox"/>	Workforce <input checked="" type="checkbox"/>	Ways of working <input type="checkbox"/>	Estates <input type="checkbox"/>
Communications <input type="checkbox"/>	Finance <input type="checkbox"/>	Operational and Clinical Excellence <input type="checkbox"/>	Governance and Compliance <input type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

Report Author	Martha Roberts, Chief People Officer (CPO) & John Syson, Associate Director of Strategy
Date to which the information this report is based on was accurate	December 2022
Senior Responsible Owner	Martha Roberts, Chief people Officer

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

People Board membership, People Board Subgroup leads, representatives from HEE, ICB (Finance, PCTH, WDA, VSE, C&YP, sustainability) Luton Borough Council, Central Bedfordshire Council, Bedfordshire Hospitals NHS Foundation Trust, Primary Care, Shirley Pointer, Anne Brierley, Innovate for Action team, Sandra Vanreyk

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

People Board on 12th January 2023

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

Members are asked to approve the People Strategy.

Executive Summary

Workforce is a key enabler for all five of the ICS’s strategic objectives, it is also the biggest risk/issue to their realisation. Having a unified People Strategy for the system will enable the co-ordination of priority activities such as recruitment, retention, wellbeing and training when needed and support individual organisations to align their activities to the realisation of the ICS’s strategic priorities.

The strategy has been developed with input from system partners, through People Board meetings in November 22 and January 23 as well as engagement sessions on 29th November 13th and 14th December 2022. In addition to this individual meetings and written feedback has been provided.

The strategy aligns with the ICS’s strategic approach, embedding the principal of subsidiarity in how activities are conducted and seeking to provide a single vision and source of the truth.

The strategy identifies four priority areas of action:

- Make BLMK ICS a welcoming place for all people to learn, work and volunteer
- Make working across organisations, systems and specialties the norm (i.e., Fuller neighbourhoods)
- Provide a system wide framework to enable integrated care and empower place/neighbourhood teams
- Doing things together and at scale that benefit staff and populations

A previous iteration of this paper was discussed and approved at the People Board meeting of 12th January 2023 with agreement on the: vision, approach, delivery and priorities.

Further development of the strategy will involve

- Determination of milestones, metrics and deliverables for priorities
- Amendment of People Board sub-groups and their responsibilities as required
- Continued engagement with stakeholders. Especially alignment with other strategies i.e., digital, clinical leadership and whether the language and approach speaks to the wider ICS.

1. Brief background / introduction:

The development of the People Strategy sits alongside the development of the ICS’s strategy. The strategy will inform the annual iterations of the system’s People Plan.

The strategy also contains elements of the National People Plan and guidance on the improvement of the People Profession and other national guidance.

We await a national workforce strategy and will amend and adjust this strategy to align with the anticipated national workforce strategy.

2. Summary of key points:

2.1 The document sets out the vision, approach, delivery and priorities for the People Strategy

2.2 It identifies four priority action areas

2.3 The next stage of development is to identify milestones, deliverables

3. Are there any options?

N/A

4. Key Risks and Issues		
Have you recorded the risk/s on the Risk Management system? Click to access system	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
<p>BAF4: IF system organisations within BLMK ICS are unable to recruit, retain, train and develop a suitable workforce THEN staff experience, resident outcomes and delivery of services within the ICS, ICB People Responsibilities and delivery of the system People Plan are threatened. Risk Score: 20.</p> <p>Linked risks are in the process of being transferred from the local People Board Risk Register to the 4Risk system</p>		
5. Are there any financial implications or other resourcing implications, including workforce?		
<p>Workforce is the single largest expenditure for the ICS. The changes to services bought about through greater provision of integrated care are likely to have far reaching effects on the types of roles required and team and organisational structures. Ensuring that we have a sustainable supply of engaged, valued and trained workforce will have significant financial, technological and estate impacts.</p>		
6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan		
<p>Environmental sustainability, through working practices, training and awareness are all elements of the current People Plan and are embedded in the strategy.</p>		
7. How will / does this work help to address inequalities?		
<p>As a key enabler for the services provided in the ICS and of its strategic priorities workforce is essential for reducing inequalities through the provision of excellent health and care services.</p> <p>Work is a factor in reducing health inequalities. Enabling our population to have access to varied, flexible and rewarding careers will support their wider determinants of health.</p>		
8. Next steps:		
<p>The People Strategy will continue to be developed by</p> <ul style="list-style-type: none"> • Determination of milestones, metrics and deliverables for priorities • Amendment of People Board sub-groups and their responsibilities as required • Continued engagement with stakeholders. Especially alignment with other strategies i.e., digital, health and care leadership and whether the language and approach speaks to the wider ICS. • Iteration following publication of national Workforce Strategy for health (expected March 2023) • Regular updates will be provided to the People and ICB Boards 		
9. Appendices		
Appendix A - People Strategy Summary		
10. Background reading		

People Strategy

ICB Board: 27th January 2023

People Strategy

Vision

BLMK to be an excellent place in which to work, volunteer, learn and live.

Why are we doing this?

Our services are our workforce. People are the key enabler of the delivery of the ICS's strategic objectives. Insufficient workforce is also the biggest risk to achieving the current and future needs of our population. Current system vacancy levels of XX%, turnover of XX% and sickness absence of XX%

What will our system be like the future?

- Our system **plans** its future workforce in a way that supports the ICS's strategic objectives and the wellbeing of staff and volunteers
- People are encouraged and supported **join** organisations through a variety of educational and direct entry routes.
- Careers in the system are **valued** and **popular** choices for our populations
- **Integrated, multi-organisational** teams with a **place focus** are normal and it is **simple for staff to move** between them.
- Staff can be their whole selves at **work**. They have **flexible roles, compassionate management** and their **wellbeing** is supported and prioritised.
- Staff can **progress** along **flexible** and **joined up career pathways** across **health and care** that fit with their needs.
- Staff **feel valued** and work in organisations that **represent them** and the communities we serve and that they **have a role** in the design and delivery of services
- As **Anchor Institutions** we have a role to play in improving the **economic, environmental** and **educational** capital of BLMK.

Our Approach

Our approach is aligned to that of the whole ICS:

- **The system is all organisations;** private social care, local government, higher and further education providers, the NHS, VCSE and other partners like fire and police.
- **Service users and staff** have a role in designing roles and services
- The Workforce elements of the JFP must help to deliver **the ICS's strategic priorities**
- **Inclusion, belonging** and the **reduction of inequalities** run through all our work
- **Subsidiarity:** doing things as close to those affected as possible and at scale when it can deliver maximum benefits to our population
- **One workforce:** implementing solutions that focus on outcomes for staff and residents and not organisations
- Access to **flexible and engaging** work is a key part of improving individual and population health
- The ICS has a key role to play in the **economic and environmental health** of BLMK ICS
- We will seek to **remove or reduce barriers to integrated system working**, taking action at neighbourhood, place or system level as required.
- We will look for **synergies** and **collaboration** beyond the ICS footprint
- Ensure we reflect **national guidance and objectives** in our plans

Delivery

1. The People Board will be responsible for the delivery of workforce elements of the Joint Forward Plan and System People Plan
2. The People Board will have a number of sub-groups with robust project management approaches to deliver actions
3. Metrics, linked to workstreams and actions will be developed and monitored by People Board
4. The JFP will inform the annual iterations of the System's People Plan and operational planning cycles

People Strategy: Subsidiarity

Examples of the level at which current/planned actions could occur.

Elements of activities may occur at all levels

Organisation

- Policies & procedures
- Some recruitment & retention activities
- Training specific to organisation
- Internal transformation activities
- Organisation level EDIB/career development/wellbeing
- **May establish bi-lateral/multi-lateral co-operation with other orgs for specific**

Place

- MDT composition depending on place needs
- Transformation activities at place level e.g. TUPE transfers between orgs
- Recruitment/outreach activities with other place partners
- Temp staffing collaboration

Alliance

- Activities relating to recruitment/wellbeing/career development across multiple places
- Workforce planning where plans affect alliance footprint

System

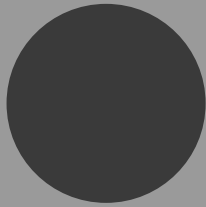
- Career development
- Creation of new roles/apprenticeships/academic pathways with system level reach
- Procurement of systems
- Provision of legal/professional frameworks for integrated working
- Commissioning placements
- Workforce planning

NHSE/Region

- Influencing national/regional policy e.g. housing policy.
- Assurance mostly at system level through People Board but some reporting up
- Guidance/instruction through national People Plan and legislation

Actions aligned to People Strategy, JFP & People Plan

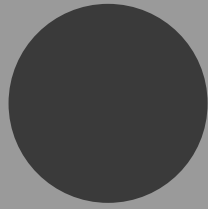
Examples



Health and Care Joint Working

Current and planned initiatives facilitated and or organised by the system which relate to care staff:

- **Care Home Champions & Coordinator:** Upskilling some care home staff to offer career development and improved care
- **Digital Directories of Care:** Searchable resource of LA accredited courses for social care staff
- **Personalised Care Training:** Digital directory produced and a personalised care workshop for all health and care staff in November 22.
- **Career Promotion:** Promotion of careers in health and care through careers fairs and Work, Learn, Live website
- **Wellbeing Support:** Wellbeing hub and other wellbeing support is available for all ICS staff
- **International Recruitment:** Engagement with social care providers to provide support and expertise in international recruitment
- **Rotational Apprenticeships:** Pilot being developed for HCSW rotational apprenticeship between health and care providers.
- **Health and Care Leadership Forum:** Development of leadership opportunities and training for health and care staff.



Workforce Integration

While workforce integration is happening across the system, examples include:

- Re-design discharge to assess process
- Introduction of virtual wards
- Admission avoidance through urgent community response
- Fuller Neighbourhood teams throughout the system

These initiatives and others require the development of new roles, ways of working, resolution of clinical and people governance issues. The workforce strategy seeks to create a framework to enable this work at neighbourhood/place/alliance level while identifying and delivering actions at a system level.

Next Steps

- Determination of: milestones, metrics and deliverables for priorities
- Amendment of People Board sub groups and their responsibilities as required
- Continued engagement with stakeholders. Especially alignment with other strategies i.e. digital, health and care leadership, Fuller Neighbourhood work and whether the language and approach speaks to the wider ICS.

Report to the Board of the Integrated Care Board, 27 January 2023

14. The Inequalities Journey – “Where are we going and where have we been?”

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input checked="" type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input checked="" type="checkbox"/>	Workforce <input type="checkbox"/>	Ways of working <input checked="" type="checkbox"/>	Estates <input type="checkbox"/>
Communications <input checked="" type="checkbox"/>	Finance <input checked="" type="checkbox"/>	Operational and Clinical Excellence <input type="checkbox"/>	Governance and Compliance <input type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

Report Author	Julia Robson, Inequalities Programme Lead Sarah Stanley, Chief Nursing Director BLMK
Date to which the information this report is based on was accurate	15/01/23
Senior Responsible Owner	Paul Calaminus, Chief Executive Officer (CEO) East London NHS FT and Senior Responsible Officer (SRO) for inequalities Sarah Stanley, Chief Nursing Director and ICB SRO for inequalities

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

Paul Calaminus and Sarah Stanley

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

None

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

The members are asked to note the following:

- A) Success in building a health inequalities dashboard to understand our local baseline data to plan 2023/24 data collection for improvement programmes already co-designed.
- B) Focus on leadership, programme design and engagement and national funding.
- C) Plans for 23/24 funding to enable stronger links with public health teams/shared roles and data/statistical expertise.

1. Brief background / introduction:

The NHS Long Term Plan placed tackling inequalities at the heart of NHS goals for this decade. The Covid-19 pandemic also shone a harsh light on some of the health and wider inequalities that persist in our society. The evidence based Core20 PLUS 5 framework defines key population groups and clinical focus areas for accelerated improvement in healthcare inequalities. BLMK are focusing on the following areas of focus against the Core20+5:

Core20: To tackle health inequalities in still births, neonatal, infant and maternal mortality. To improve the healthy life expectancy at birth in the 20% most deprived population and the rest.

Plus: People of all ages with mental health issues, including children with low emotional resilience. People with learning disabilities, health inclusion groups and people who have survived coronavirus infections including from BAME and other diverse communities.

Five National Areas of Focus: maternity, mental health, hypertension, chronic respiratory disease and cancer.

2. Summary of key points:

1. Progress has been made against each workstream which focuses mainly on setting up the infrastructure for the programme for example events, distribution of funds, recruitment of a quality improvement team, setting up quality improvement projects, setting up the governance for inequalities and developing metrics and dashboard to monitor performance and to understand where we are making improvements.
2. The inequalities programme would like to focus on the following in 23/24 – an evidence based and data driven programme of work and distribution of funds by working with public health teams, continuation of quality improvement projects and start testing ideas with each population group, developing action plans against the Denny Review and supporting each programme under the ICB with inequalities workstreams.

3. Are there any options?

4. Key Risks and Issues

The main risks for 22/23 is distributing the inequality funds before end of March 23. The finance and contracting department have supported the inequalities programme by working with each of the programme leads with their proposals which includes procurement routes and contracts.

Have you recorded the risk/s on the Risk Management system?

[Click to access system](#)

Yes

No

5. Are there any financial implications or other resourcing implications, including workforce?
Please see above
6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan
By improving on the quality of care and the services we provide through the inequality lens, we will be addressing the commitment to Sustainable models of care. By improving the access to services, we will in turn be supporting the digital transformation commitment. Within our Clinical Programme proposals, we wish to improve on priorities such as LTC and mental health, which could reduce emissions generated by the transport of medicines over the years.
7. How will / does this work help to address inequalities?
To reduce the gap in life expectancy in the 20% most deprived and vulnerable communities, prioritising on the 5 national areas of focus (maternity, mental health, hypertension, cardiovascular disease and cancer).
8. Next steps:
9. Appendices
Appendix A – “Where we have been and where are we going”
10. Background reading

Bedfordshire, Luton and Milton Keynes Inequalities journey

“Where we have been and where are we going?”

1.0 Background

1.1 What are health inequalities?

“Health inequalities are avoidable, unfair and systematic differences in health between different groups of people”

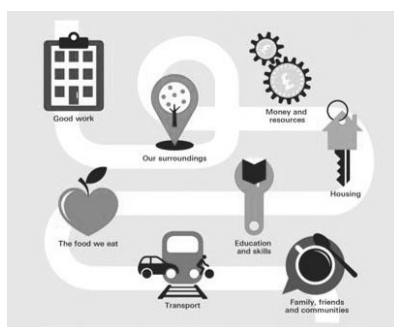
We often describe differences in terms of:

- socio-economic factors, such as income;
- where people live;
- Specific characteristics including those protected in law, such as sex, ethnicity or disability;
- socially excluded groups, for example, people experiencing homelessness.

We can measure health inequalities in terms of:

- Health outcomes e.g. life expectancy gap
- Men: Oakley ward vs Harpur ward – ~15 years
- Women: Kempston Rural vs Harpur - ~10 years
- Health risk factors e.g. overweight and obesity
- A Year 6 child living in urban wards in central Bedford >2x as likely to be living with excess weight than a child living in affluent rural areas
- Use and uptake of health services e.g. vaccination
- In BLMK, White British 75+ year olds were 4x more likely to have had a COVID-19 spring booster than people of Bangladeshi ethnicity

1.2 What causes health inequalities?



Health-related behaviours:

smoking and substance use, what we eat and drink, opportunity to live an active life

Access to, quality and experience of healthcare

1.3 What are the opportunities for BLMK to reduce health inequalities?

1.3.1 Reduce social inequalities – tackling “the wider determinants of health”

- Working on areas such as standards of housing, skills and work, community connections, access to healthy food and green space
- A lot of local council activity is in this space
- National policies have a large influence
- Complex, impact of changes slow
- Role for NHS organisations as anchor institutions and as point of contact with public.
- Work needs to be rooted in (and led at) Place – good understanding of local inequalities challenges, systems, strong Health & Wellbeing Boards and Place-based Boards. Areas of focus at Place, e.g.:
 - A. BBC – Fuel poverty
 - B. CBC – Fairness, community development in Houghton Regis
 - C. Luton – Marmot Town
 - D. MK – regeneration and MK Deal

1.3.2 Help people to live healthier lives

- Core part of public health activities - smoking/ tobacco, obesity, physical activity, alcohol consumption, mental wellbeing
- Not just “lifestyle” services (eg stop smoking) but system-wide strategies to address issues across policies (eg licensing)
- All of these risk factors have higher prevalence in poorer areas – contributing to inequalities in health
- Health and care services have key role in raising issues and having the right conversations, linking services and referring, early identification of risk factors.

1.3.3 Our role as HealthCare providers – to provide fair and accessible healthcare

Health and care services has an important role in tackling inequalities. Within the Inverse care law we understand the availability (or access?) of good medical care tends to vary inversely with the need for it in the population served.

The NHS has an important role in thinking about:

- Are services used by those that need them? If not why not? Do we have enough data to be able to say?
- Where services are placed
- Is information provided accessible? In the right languages?
- Opening times
- How bookings are made – digital access issues
- Cultural competence/ sensitivity of staff – language and words used
- Interpreters
- Do systems create barriers for people?
- Are pathways clear for professionals if they complex individuals present

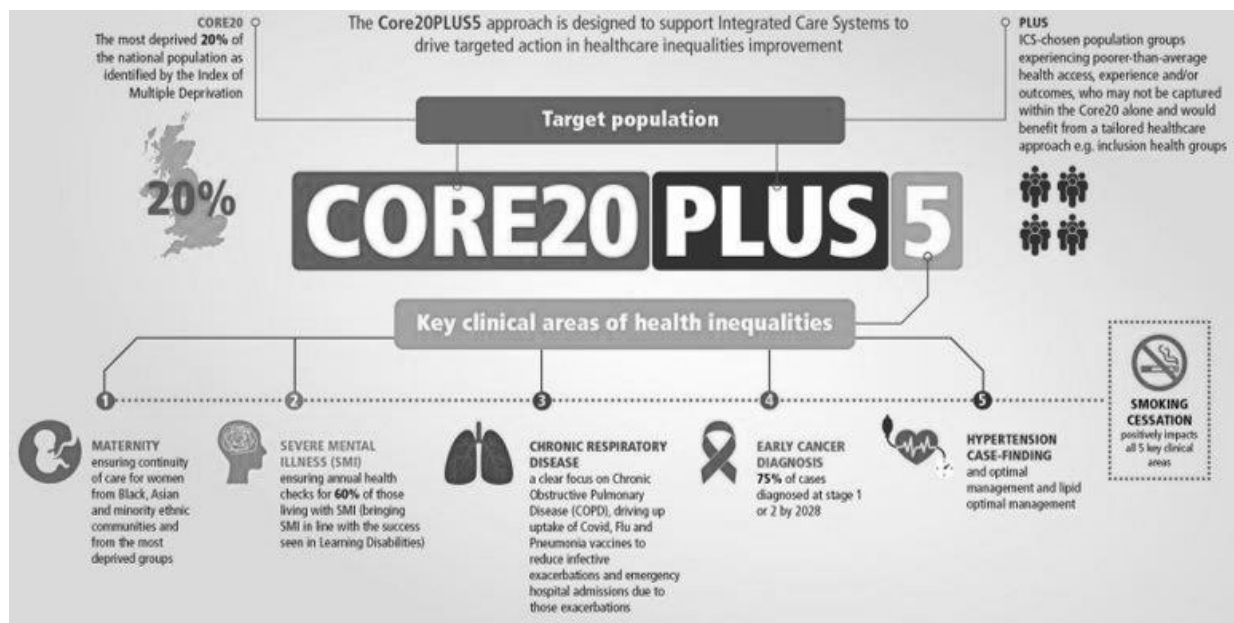
1.4 National Context

The NHS Long Term Plan placed tackling inequalities at the heart of NHS goals for this decade. The Covid-19 pandemic also shone a harsh light on some of the health and wider inequalities that persist in our society.

The national healthcare inequalities programme has identified five priorities:

- Restoring NHS services inclusively,
- Mitigating against digital exclusion
- Ensuring datasets are complete and timely
- Accelerating preventative programmes
- Strengthening leadership and accountability

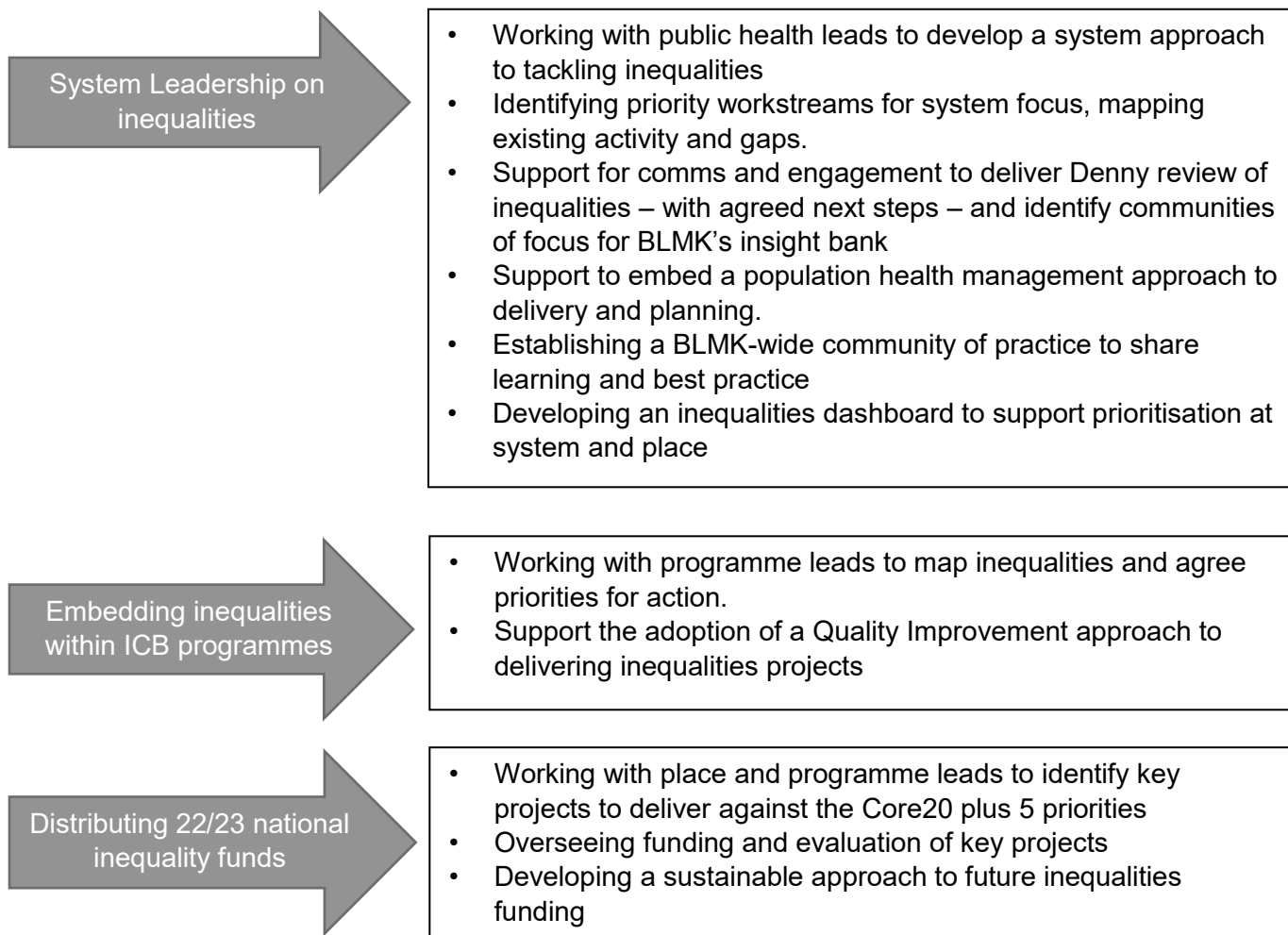
The evidence based Core20 PLUS 5 framework defines key population groups and clinical focus areas for accelerated improvement in healthcare inequalities.



2.0 Aims of the programme

The aim of our programme is to increase healthy life expectancy and close of the gap in healthy life expectancy including reductions in premature and infant mortality. The system SRO for this programme is Paul Calaminus, Chief Executive of East London Foundation Trust and member of the Integrated Care Board.

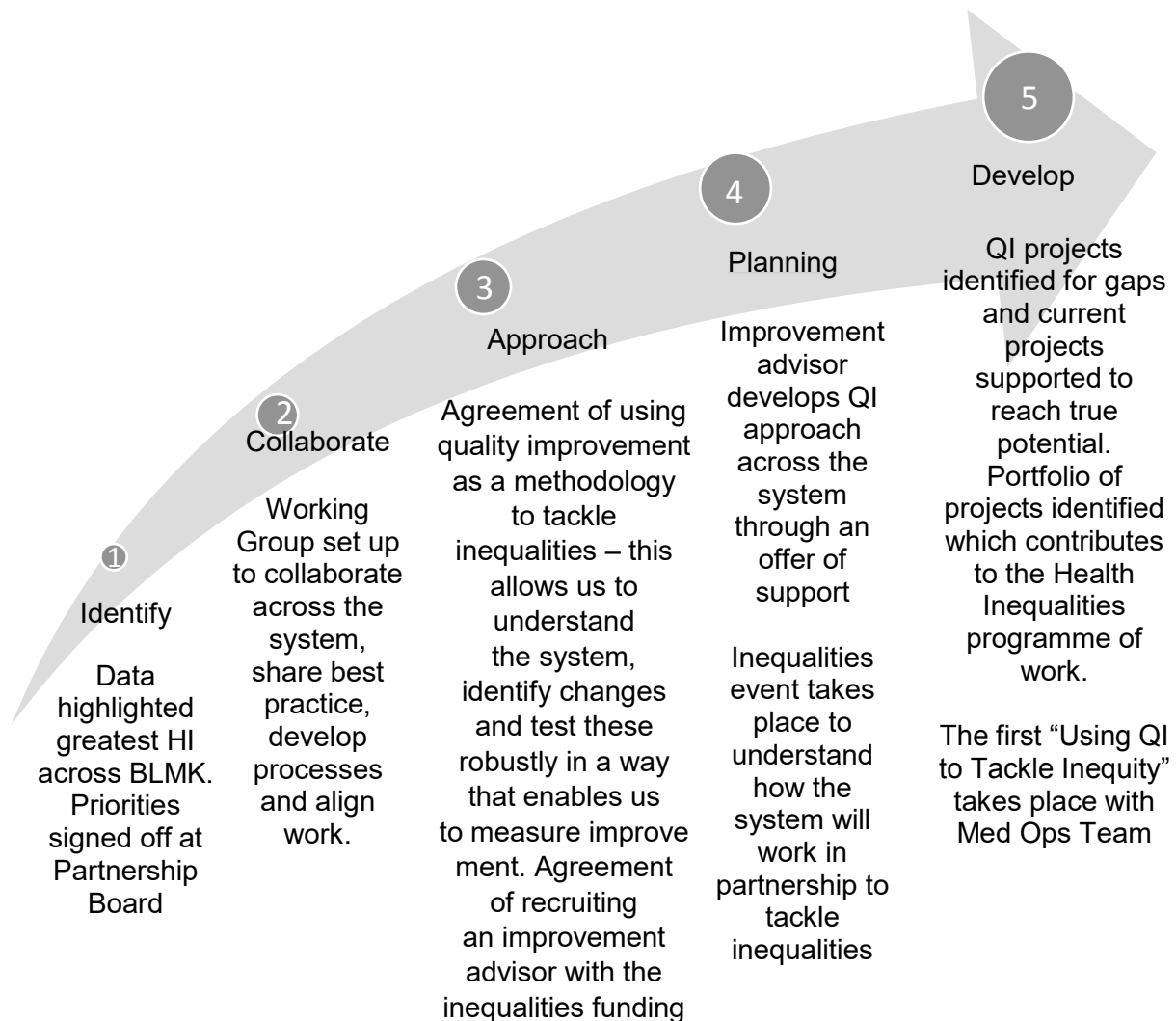
The three key strands of the inequalities programme in 2022/23 comprise:



2.1 The journey so far

The information provided below captures the inequalities journey so far, which takes into account the objectives against the programme aims, followed by next steps for 23/24

2.2 Core20+5 approach



Identify

2.2.1 Defining the BLMK population against the Core20+5

Core20

An evidence-based approach has been taken to define the population that will benefit from the national approach of CORE 20 plus 5. Analysis has been undertaken to identify communities and populations across Bedfordshire Luton and Milton Keynes who comprise our 20% most deprived population. There is evidence from our Joint strategic Needs Assessment across the 4 local authority areas that in our 20% most deprived population circulatory diseases forms a big burden. There is clear indication that amongst other long-term conditions there is a big gap between the least deprived and the 20% most deprived.

PLUS (derived from BLMK ICS priorities and population health data)

There is evidence available across Bedfordshire Luton and Milton Keynes to suggest that people with Mental Health substantially have higher prevalence of long-term conditions and

other co-morbidities, practically twice, than in the rest of the population. Across Bedfordshire Luton and Milton Keynes, people with Learning Difficulties have significantly higher prevalence for Diabetes and Obesity, and higher for Stroke and Dementia.

We are aware inclusion health groups include ethnic minority communities, coastal communities, people with multi-morbidities, protected characteristic groups, people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups. Our local information and work that we have undertaken over the pandemic has given us insight into the health needs of this population.

ONS analysis continues to show that people from a Black ethnic background are at a greater risk of death involving COVID-19 than all other ethnic groups. Covid -19 infections have also disproportionately affected people from diverse communities.

Five clinical areas identified nationally as a focus:

1. Maternity
2. Severe mental illness (SMI)
3. Chronic respiratory disease
4. Early cancer diagnosis
5. Hypertension case-finding

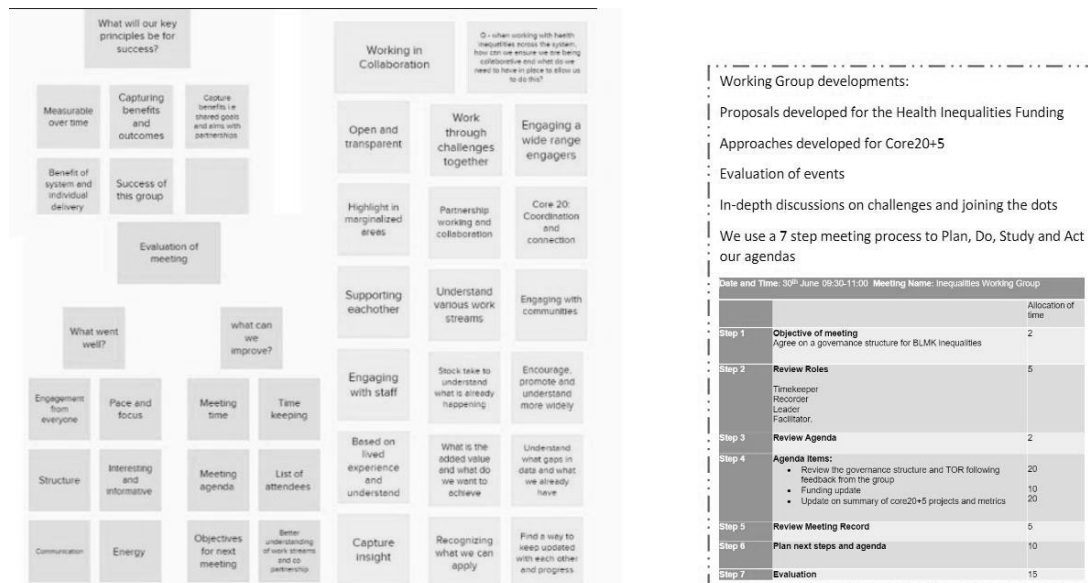
In Summary, BLMK are focusing on the following areas against the Core20+5

Core20		PLUS			
Tackle inequalities in: Still birth Infant Mortality Neonatal mortality Maternal mortality	Improve Healthy Life Expectancy at Birth in the 20% most deprived population and the rest.	People of all ages with Mental Health issues including children with low emotional resilience	People living with Learning Disabilities	Health Inclusion Groups	People who have survived C-19 infections including BAME and other diverse communities
5 National Areas of Focus					
<u>Maternity</u>	<u>Severe Mental Illness (SMI)</u>	<u>Chronic Respiratory Disease</u>	<u>Early Cancer Diagnosis</u>	<u>Hypertension Case-Finding</u>	
ensuring continuity of care for 75% of women from BAME communities and from the most deprived groups	ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)	a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations	75% of cases diagnosed at stage 1 or 2 by 2028	to allow for interventions to optimise BP and minimise the risk of myocardial infarction and stroke	

2.2.2 Collaborate

An inequalities working group was set up with people from across the system to collaborate and provide focus on the planning of the inequalities programme. Quality Improvement tools

have been used to share accountability, have all voices heard, improve on collective leadership and provide focus, such as the 7 step meeting process and Jamboard as shown below.



2.2.3 Approach

From the Inequalities working group, quality improvement was the chosen methodology for tackling inequalities. The benefits are adopting a systematic methodology for understanding the system, identifying changes and testing these robustly in a way that enables us to measure improvement. This approach will also enable involvement of people with lived experience and those with experience of caring for and supporting the population of interest throughout the work. The working group agreed to use some of the inequalities funding to recruit an improvement advisor, hosted by East London NHS Foundation Trust.

2.2.4 Planning

As part of the planning for the Core20+5 approach, the improvement advisor created a programme of work, including an offer of support which was advertised at the inequalities event in October 22.

What support can I get to tackle inequalities ?

4 WAYS

<p>01</p> <p>Improving Inequalities Learning Network</p> <p>A space for everyone in BLMK working on inequalities or interested in doing more to spread learning and collaborate</p>	<p>02</p> <p>Tackling Inequalities Workshop</p> <p>A practical workshop to explain what inequalities are, and introduce Quality Improvement tools to help tackle them</p>	<p>03</p> <p>Inequality Strategy Building</p> <p>Expert support for directorates or teams to develop a robust inequalities improvement strategy</p>	<p>04</p> <p>High-Impact Inequality Project Support</p> <p>Dedicated Quality Improvement coaching and project support for a select number of High-Impact Inequalities Improvement Projects</p>
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To find out more

Contact the BLMK Inequalities Team:
Julia Robson - julia.robson3@nhs.net - BLMK Inequalities Lead
Lorna Darknell - lorna.darknell@nhs.uk - BLMK Inequalities Improvement Advisor



The inequalities event that took place, focused on bringing system partners and those with lived experience together, to understand how we can be stronger together in tackling inequalities.



Some of the themes taken from this event were as follows:



The event has enabled us to develop a driver diagram which presents the system in which we wish to change; this will form part of the planning for 23/24.

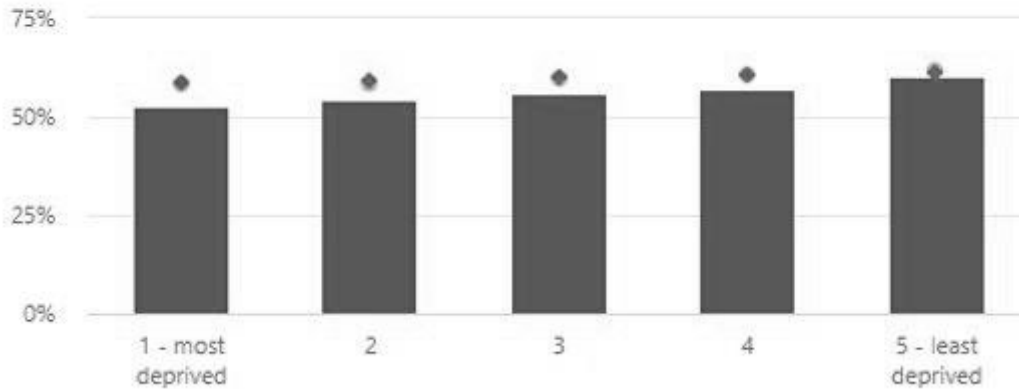
2.2.5 Develop

The Inequalities Programme supports a number of high-impact inequalities projects which support the Core20PLUS5 strategic aims through dedicated Quality Improvement (QI) coaching.

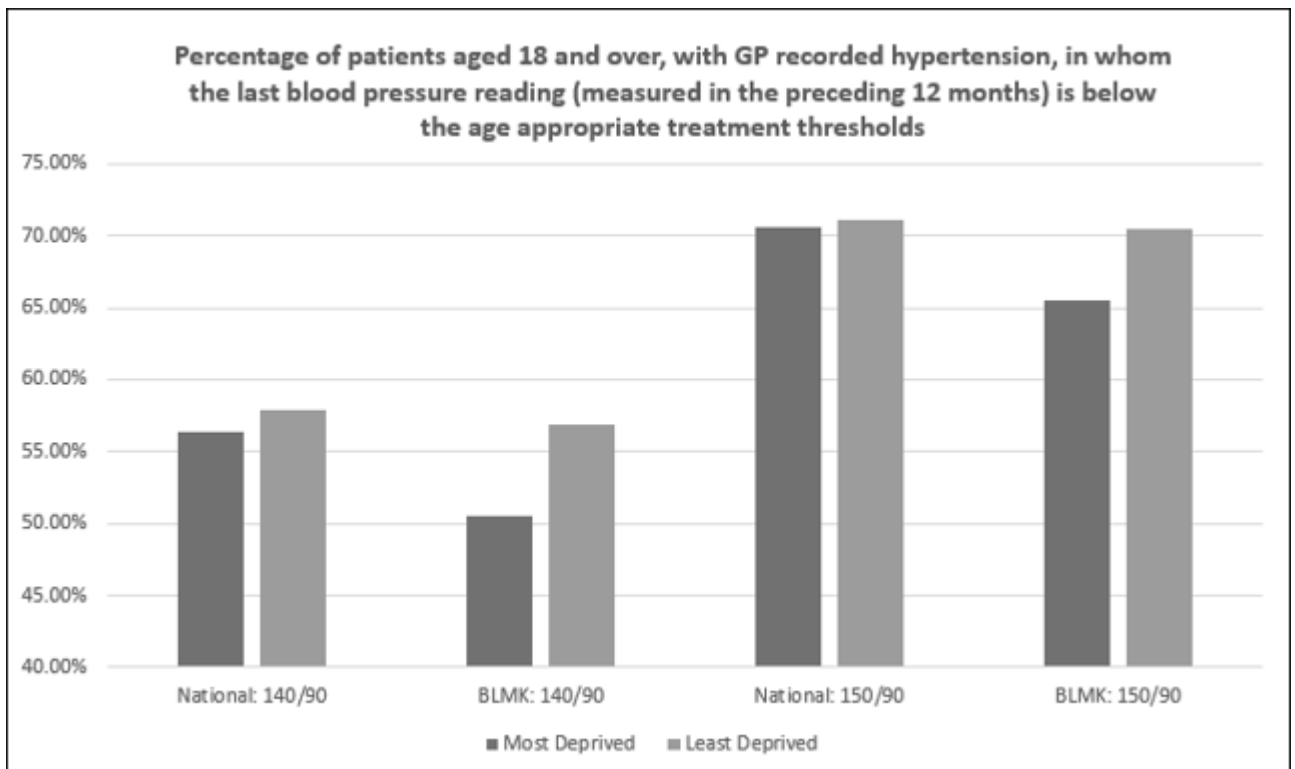
One of the high-impact projects aims to improve hypertension management for the most deprived communities; 7% gap between those treated to target between the most deprived and least deprived (please see below). While it may not sound a lot the gap between BLMK ICB treatment to target and the national average is about 3.5% and the gap between BLMK ICB (56.16% v 59.67%) and the best performing ICB in the region is also around 7% (56.16% v 63.97).

If the most deprived were treated to the same percentage as the least deprived it would equate to an additional 980 pts treated to target, potentially preventing 15 heart attacks and strokes in the next 3 years.

Deprivation Quintile



We also understand that there is a gap between the most deprived and the least deprived is significantly higher in BLMK than it is at a national level (3x higher, please see table below, which is broken down for those under 80 years and 80 years and over):



The gap is also worsening within BLMK, please see table below which shows national and BLMK gap between March 2020 and March 2022 (2021 missed out as COVID year and data not that reliable). As we come out of COVID and treated to target numbers go up, plus

work we will be carrying out as a system to improve HTN management, there is potential to worsen the gap if we don't have a targeted approach towards the most deprived groups

The project has brought together partners including primary care, pharmacy, and the Eastern Academic Health Sciences Network to collaborate on tackling the issue. For their next steps, the team are planning to undertake a number of interviews with primary care colleagues who directly interact with the hypertension pathway, to better understand the issue and where the opportunities are for improvement.

Another high-impact project, delivered by BLMK in partnership with Active Luton, provides a social prescribing offer for high-risk children and young people (CYP) with mild-moderate mental health issues. The project was initiated following feedback from GPs referrals for this cohort often 'fell through the net', with their mental health being deemed not severe enough for counselling or psychological support. In terms of eligibility, the team are focusing on CYP from deprived areas and a number of other criteria, such as young carer status, to ensure the service supports those who need it most. The social prescribing service was initiated in June 2022, and having obtained additional funding from Inequalities programme, the service will be extended into next year. The team opted to use QI methodology to focus on improving the number of referrals, the eligibility criteria and the current service offering for the next phase of the project. The team is currently looking at how to involve CYP more closely in development of the service and aim to include CYP as project team members in order to codesign the improvement work.

What is important to note is that the inequalities programme isn't starting from a blank sheet of paper, there are great pieces of work taking place across the system in many programmes of work, such as the Cancer Outcomes Project in Luton. The QI inequalities programme will help to consolidate some of these projects into a structured theory of change. Work should be undertaken with our PMO department to support programmes of work to understand where projects are not making an improvement and should discontinue, and therefore saving on resources to those projects that will make a difference to inequalities.

The improvement advisor facilitated the first "Using QI to Tackle Inequity" in November with the Med Ops Team; this is the first of its kind in BLMK ICB!





2.3 Denny Literature Review

The Denny Review was commissioned in 2020 in the aftermath of Covid 19 global pandemic. Within months it became clear that BAME people were contracting and dying disproportionately from the disease.

A literature review has taken place which aimed to retrieve and critically review the literature on the health inequalities between different social groups and communities of Bedfordshire, Luton and Milton Keynes and identify good practices to mitigate them. The literature review reported earlier this year and we have now moved into an engagement exercise via Healthwatch, the Disability Resource Centre and Community Dental Services (CIC). The report from this engagement will be drawn together in February 2023.

The final report will be submitted in summer 2023 and will contribute to our action plan for the Plus groups in the Core20+5.

2.4 Inequalities Funding

£200 million has been made available through 22/23 system allocations, targeted towards areas with the greatest health inequalities. BLMK has been allocated £3.197m of non-recurrent funding, intended to help systems to ensure that health inequalities are not exacerbated when they are seeking cost savings or efficiencies.

Our plan to distribute funding has been developed in collaboration with BLMK’s health inequalities working group and steering group and was approved by the ICB Executive and partner Chief Executives in August 2022.

It has been agreed that this funding will focus on the following:

1. Developing intelligence, engagement and programme support to build the inequalities programme
2. Funding for specific inequalities projects (vaccinations, Cancer, Mental Health, Maternity, Hypertension and Learning Disabilities)

NHSE planning guidance has been released and has confirmed that funding for inequalities is being made available in 23/24, therefore an approach is currently being developed and will be discussed at the inequalities steering group in January.

3.0 Where are we going?

To develop and summarise our objectives for 23/24 and beyond and to create a visual strategy of the system in which we wish to change, a driver diagram is being developed with system partners which will incorporate the new ICB strategy. An example of some of our objectives for 23/24 is as follows:

- **Imbedding our partnership working strategy**
Imbedding the plans for partnership working that were developed from the Inequalities Event in October 2022 – “how can we be stronger together in reducing inequalities”.
- **Quality Improvement**
The continuation of the quality improvement programme for the Core20+5 and beyond, such as the development of QI projects, a learning network and working with system partners for a more strategic and holistic approach to our strategy for tackling inequalities.
Ensuring that any improvements from QI projects are embedded into business as usual.
- **Funding**
Developing an evidence based and data driven approach for funding by working with our public health teams.
- **Supporting the ICB**
Developing a KLOE framework to improve on our ability to tackle inequalities outside of the Core20+5 framework, such as the development of our reporting frameworks and use of the new inequalities dashboard.
Working with our PMO department to ensure all programmes of work are supported to achieve maximum potential through QI and other programme management tools.
- **Denny Review**
Developing action plans from our engagement with our Plus communities with our VCSE and Healthwatch colleagues.

Report to the Board of the Integrated Care Board, 27 January 2023

15. Update on Strategy and Planning

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input checked="" type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input checked="" type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input checked="" type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input checked="" type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input checked="" type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input checked="" type="checkbox"/>	Workforce <input checked="" type="checkbox"/>	Ways of working <input checked="" type="checkbox"/>	Estates <input checked="" type="checkbox"/>
Communications <input checked="" type="checkbox"/>	Finance <input checked="" type="checkbox"/>	Operational and Clinical Excellence <input checked="" type="checkbox"/>	Governance and Compliance <input checked="" type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

Report Author	Anne Brierley ICB Chief Transformation Officer
Date to which the information this report is based on was accurate	10.01.23
Senior Responsible Owner	Anne Brierley ICB Chief Transformation Officer

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

ICB Executive Team – 18 January 2023

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

The BLMK Integrated Health & Care Partnership Strategy was reviewed and approved at the Health and Care Partnership Board meeting on the 14th December 2022 (pending minor corrections, which have been completed).

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

The report comprises of 3 inter-connected requirements of the BLMK ICB with respect to ICS strategy and planning:

1. Update on the approval of the BLMK Integrated Health & Care Strategy by the IHCP Board (14th December 2022), and the upcoming actions for Places and Collaboratives with respect of collective plans to improve health outcomes / inequalities for specific populations
2. Summary of NHS operational planning guidance, and what this means for Places, Collaboratives and NHS Trusts, including timeline for delivery
3. Update on revised timeline for development of the BLMK Joint Forward Plan (mandatory), and how this aligns to Place / Collaborative transformation, and delivers the impact in tackling inequalities and improving health outcomes as described in the BLMK Integrated Health and Care Strategy

The members are asked:

- A) **to note** the approval of the BLMK Integrated Health and Care Strategy by the BLMK Integrated Health & Care Partnership on 14th December 2022, and the actions now required by all Health and Care Partnership member organisations
- B) **to note** the NHS Operational Planning Guidance for 2023-4, and the key actions arising from this for Places, Collaboratives and NHS Trusts in line with Place Plans and the BLMK Integrated Health and Care Strategy
- C) **to support** the proposed approach to the development of the ICB 5 Year Forward Plan, and the revised submission date to NHSE of June 2023

1. Brief background / introduction:

The ICS' Strategy is owned by the BLMK Health & Care Partnership, who act as 'custodians for population health', supporting and enabling improvements to health outcomes and tackling inequalities as outlined in the strategy.

The strategy aims to:

- Reflect our 5 strategic priorities (Start Well, Live Well, Age Well, Growth and Tackling Inequalities)
- Include commitment to subsidiarity (to Place), with a focus on planning, decision-making and delivery as close to the resident as possible
- Emphasize our ambition to go further using our partnerships to support residents to live longer, and live more years in good health, and the central role played by VCSE partners in supporting residents to thrive
- Speaks to real examples that make a difference to local people

Building upon and 'having due regard to' the Strategy, there are two planning documents that need to be completed by the BLMK ICB in the coming months – the 2-year operational plan (due March 2023) and the Joint Forward Plan (due June 2023).

These plans have broadly the same remit but focus on differing time scales; the immediate operational delivery of integrated health and care at Place and Collaborative (including delivery of the mandated NHSE operating plan requirements); and the medium-term focus on developing and executing our strategic objectives to meet our ICB vision to support all our communities to thrive.

2. Summary of key points:

2.1 The Integrated Health and Care Partnership Strategy

This sets out the overall ambition of our ICB to tackle inequalities and improve health outcomes for all BLMK residents. The over-arching (and generational goal) is to improve years lived in good health for all residents, as well as positively impacting inequalities in mortality across our populations. This is an audacious goal, especially post-COVID and with the cost-of-living crisis affecting many households. But amid ongoing high demand pressures felt across all of our services, its purpose is to 'keep our eyes on the prize' – to challenge and encourage us to innovate and collaborate to achieve the best outcomes possible for our residents.

We need to consolidate our plans and efforts in two key areas to make progress towards this goal:

- **Consciously measure the impact of our 'business as usual services' on our populations, paying particular attention to the access and outcomes experienced by our most vulnerable / disadvantaged citizens.** This population health management approach means that we don't just measure the impact of our services to the people who currently use them – we also look for those with low uptake of prevention, screening, early diagnosis, and local support (such as emotional well-being support provided by the VCSE for children and young people).
- **Work together (at Place, Collaborative, across BLMK or beyond) to find new solutions to address long-standing wicked problems and tackle the root cause of these.** These may require fundamental changes in how we use our resources (people, money, and estates), and are not the quick fixes that any single organisation can achieve on its own. We will need to take advantage of the opportunities in our operating environment (increase in population, advances in technology etc) to optimise our impact in supporting our communities to thrive.

2.2 Two-year Operational planning

National NHS operational planning guidance was published on the 23rd December 2022. Recognising the shift to local decision-making at ICBs and Place, NHS England has published much-streamlined NHS targets for this period (32 key performance indicators, reduced from 241 in 2021-2). These cover key areas of health care:

1. Improve ambulance responses and A&E waiting times
2. Reduce elective long waits and cancer backlogs and improve core diagnostic performance
3. Ensure easier access to primary care services especially General Practice
4. Improve access to mental health for all age groups
5. Maximise preventative interventions, such as managing hypertension
6. 3 key diagnostic targets (cancer and non-cancer) to support earlier diagnosis
7. Health inequalities lens on all – reaching the patients with the poorest access / health outcomes

It is expected that the operational plan will also include the priority maximum impact interventions identified within updated Place Plans which will be presented to the Health and Care Partnership Board at the end of March 2023.

2.3 Joint Forward Plan

Systems have also been asked to develop five-year plans in line with [guidance](#) also published on the 23rd December. These 'joint forward plans' are expected to be developed across system partners, by 30th June 2023.

It is expected that these plans will build on Joint Strategic Needs Assessments, Health and Wellbeing plans and Place Plans, and will involve some element of public engagement.

This plan will support delivery of longer-term enablers, such as sustainable homecare workforce, increasing primary care access, and the development of community services to treat more people with frailty conditions without need for acute hospital admission.

The Joint Forward Plan will need to identify our key strategic objectives to address the changing needs of our population within the constraints of workforce and funding. To achieve this, we will need to fully utilise the current outputs of our digital integration, understanding the needs and changes in communities such as population growth and inequalities but also forward planning of health resources to improve health outcomes, and address variance in access and uptake of health interventions to reduce mortality and morbidity across our population. Crucially, this understanding will need to align with the 20 to 25-year approach to planning used by Local Authority partners – the infrastructure and workforce elements of this cannot be resolved over a five-year plan.

It is proposed that this evidence-based approach (making use of bench-marking data from public health and Getting It Right First Time – GIRFT – and Model Health System), will highlight key areas where BLMK is not achieving in the top decile of best performance / outcomes, or where there are integration / transformation opportunities to tackle inequalities and improve health outcomes whilst ensuring that we meet population need within our available resources. As discussed in previous ICB papers, the BLMK Transformation & Efficiencies Programme Board will oversee this review of delivery against 'best in class' and offer insights to Places and Collaboratives of key interventions that could be adopted.

In the first instance, this approach needs to be focused on tackling our 'wicked' challenges through our 2-year operational delivery plan – for example, meeting the increased care needs and complex frailty of our population post-COVID and maximising prevention, recovering elective long waits, supporting children and young people experiencing mental illness and acute emotional distress, and increasing primary care access and capacity through Fuller Neighbourhood teams. However, the way we use the collective opportunities available through our ICB partnerships will significantly influence our ability to address these challenges sustainably into the long term.

3. Are there any options?

All partner organisations within BLMK ICB are subject to the mandatory and statutory planning requirements and own governance relevant to the scope of their health or care provision. As such they are best placed on an individual / Place basis to make use of discretionary opportunities ('head-room') created by strong performance and delivery to date.

However, strong and sustained delivery of all such mandated requirements, including financial balance, will provide the requisite 'licence to practice' for the ICB, enabling headroom and autonomy to deliver innovation and transformation.

4. Key Risks and Issues

The key risk in the delivery of our strategy through our short and medium-term plans is that current operational pressures preclude us from achieving our shared ambition for our communities to thrive. Building focus on impact / outcomes to specific populations within our communities into our 'business as usual' performance and quality oversight is essential to ensure that we tackle inequalities and improve health outcomes for all our residents.

However, it is how we collaborate to address the significant challenges in our strategic 'enablers' (workforce, estates and use of technology and innovation) that will determine our strategic successes (or otherwise).

Our operational and strategic planning will need to factor in the risks and opportunities from delegated specialised commissioning for BLMK residents; Pharmacy, Optometry and Dental from April 2023 ('POD') and planned devolution of 66 specialised commissioning services lines, including cancer, neuro-rehabilitation and specialist dental (all ages) from April 2024.

<p>Have you recorded the risk/s on the Risk Management system? Click to access system</p>	<p>Yes <input checked="" type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>The principal risks are captured in the BLMK ICB BAF</p>		
<p>5. Are there any financial implications or other resourcing implications, including workforce?</p>		
<p>Our 2-year operational delivery plan and Joint Forward Plan will need to ensure that we use our resources effectively to achieve maximum benefits for our population within our available resources. Key to this will be new workforce models and commitment to 'grow our own' through training and apprenticeships, as well as innovative investment in our collective infrastructure to meet the increasing needs and volume of the BLMK population.</p>		
<p>6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan</p>		
<p>Growth and sustainability are a key strategic objective in the Health and Care Partnership Integrated Strategy for BLMK, and consideration of benefits / impact of both operational delivery and development of the medium-term plan will need to include these issues as core to all delivery by the ICB.</p>		
<p>7. How will / does this work help to address inequalities?</p>		
<p>This is fundamental to sustainable delivery of health and care in BLMK, and to enable us to achieve our ambition to support all communities to thrive.</p>		
<p>8. Next steps:</p>		
<p>There are a number of workstreams / actions that need to be brought together in the operational planning, contracting and Joint Forward Plan development by March 2023:</p> <ul style="list-style-type: none"> • Each Place to confirm its key collaboration actions from its Place Plan (and impact on specified population), for peer-review at the BLMK Health and Care Partnership Board on 7th March • Simplified NHS contracting round, starting the shift within individual provider contracts to reflect the 'new world' of a single system control target, streamlined NHSE operating plan targets and – crucially – the ambitions of Places and Collaborative to tackle inequalities and improve health outcomes for our local communities • Ask and Offer to VCSE within Places, building on existing Local Authority partnerships to maximise impact to residents through Fuller Neighbourhoods, and in supporting Stay Well at Home, and Home First • Development of a shared 'single source of truth' (BLMK population and health and care need/provision data benchmarked against best in class, and modelled over 20-25 years) to inform major strategic planning to deliver our strategic objectives sustainably within resources to meet the growing population of BLMK (workforce, estates, best-practice models of care, research and innovation) • Report on progress to Board of the ICB on 24 March 2023 		
<p>9. Appendices</p>		
<p>Appendix A – BLMK Health and Care Partnership Integrated Strategy (approved) Appendix B – NHSE targets for 23-4 Appendix C – 23-24 Financial Planning</p>		
<p>10. Background reading</p>		
<p></p>		

Bedfordshire, Luton and Milton Keynes Health and Care Strategy

January 2023

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- Our vision, purpose and ambition for population health
- Our partnership and how we will work together

Section 2: our population and health challenges

- Our local population, our health needs and challenges
- Where we will focus our efforts

Section 3: our system partners

- Our neighbourhoods and communities
- Our places and collaboratives

Section 4: what this means for me and my family

- Tackling inequalities in access, outcome and opportunity
- Supporting our population across the life course
- Building sustainable communities

Section 5: our approach

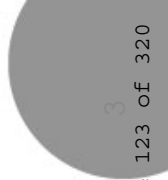
- Building our workforce
- Safe, excellent, health care, every time
- Managing our money and estates
- Using data and technology to improve outcomes



**Bedfordshire, Luton
and Milton Keynes**
Health and Care Partnership



WHO WE ARE



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

Your health and wellbeing matters to us.

We know that not everyone enjoys the same good health and opportunity across their lives. As the providers of public services, we also know that there is more we can do to support our residents to live longer, and live more of those years in good health.

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

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

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

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

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



Cllr Tracey Stock
Chair, Bedfordshire, Luton and Milton
Keynes Health and Care Partnership



Our purpose

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

The partnership is made up of local Councils, the NHS and voluntary, community and social enterprise (VCSE) sector partners in your area. We are looking to answer three questions to help us change services for the better:

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

This strategy sets out our ambition for improving health outcomes and reducing inequalities. It shows how we will work together, and what this will mean for people and communities across Bedfordshire, Luton and Milton Keynes.

The mandate of our Health and Care Partnership is to...

improve outcomes in population health and healthcare

tackle inequalities in outcomes, experience and access

enhance productivity and value for money

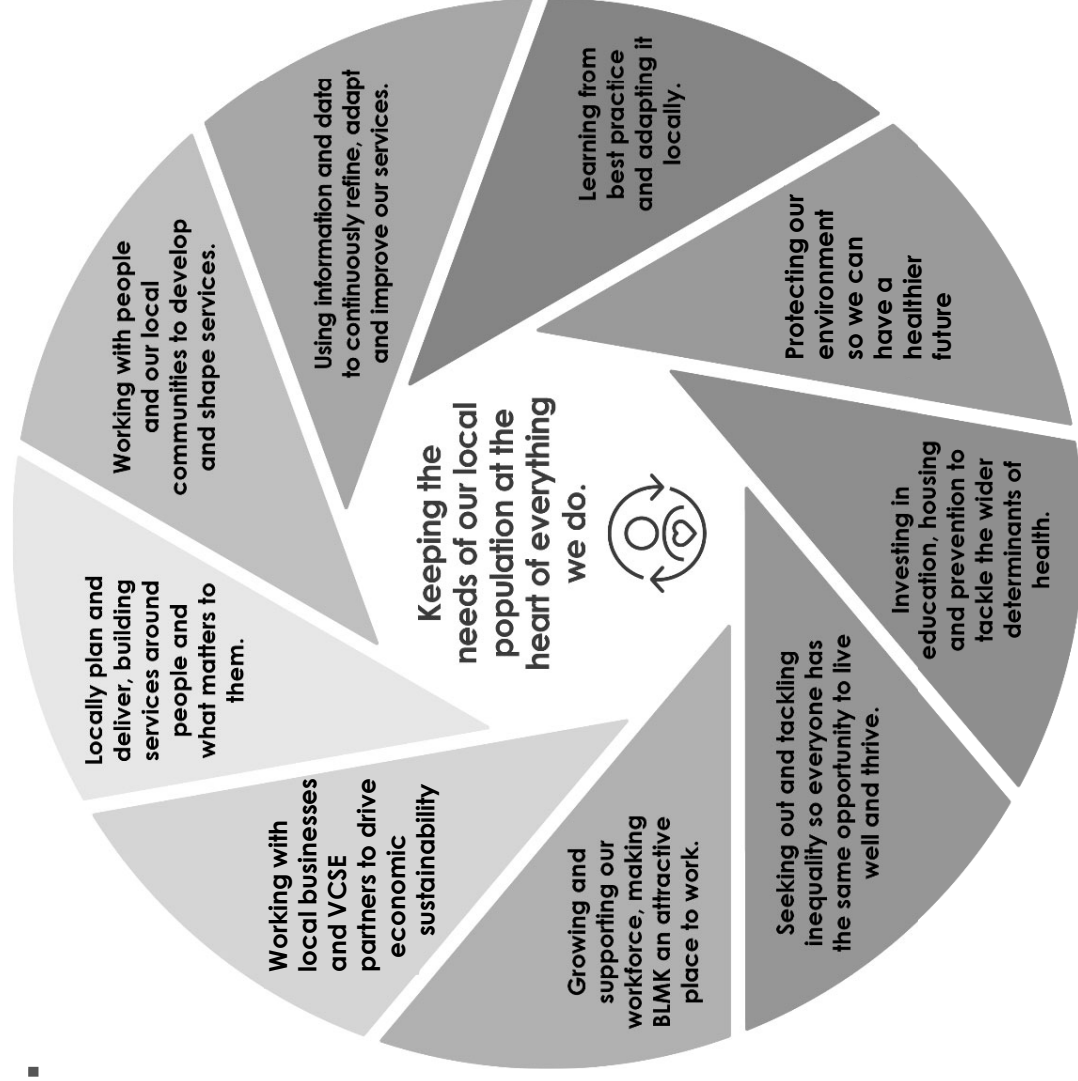
help the NHS support broader social economic development

Our overarching ambition is...

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

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

The only way to achieve our goal is by working together. Our Health and Care Partnership allows us to do more for residents than as separate organisations, keeping the needs and assets of our residents at the centre of everything we do.

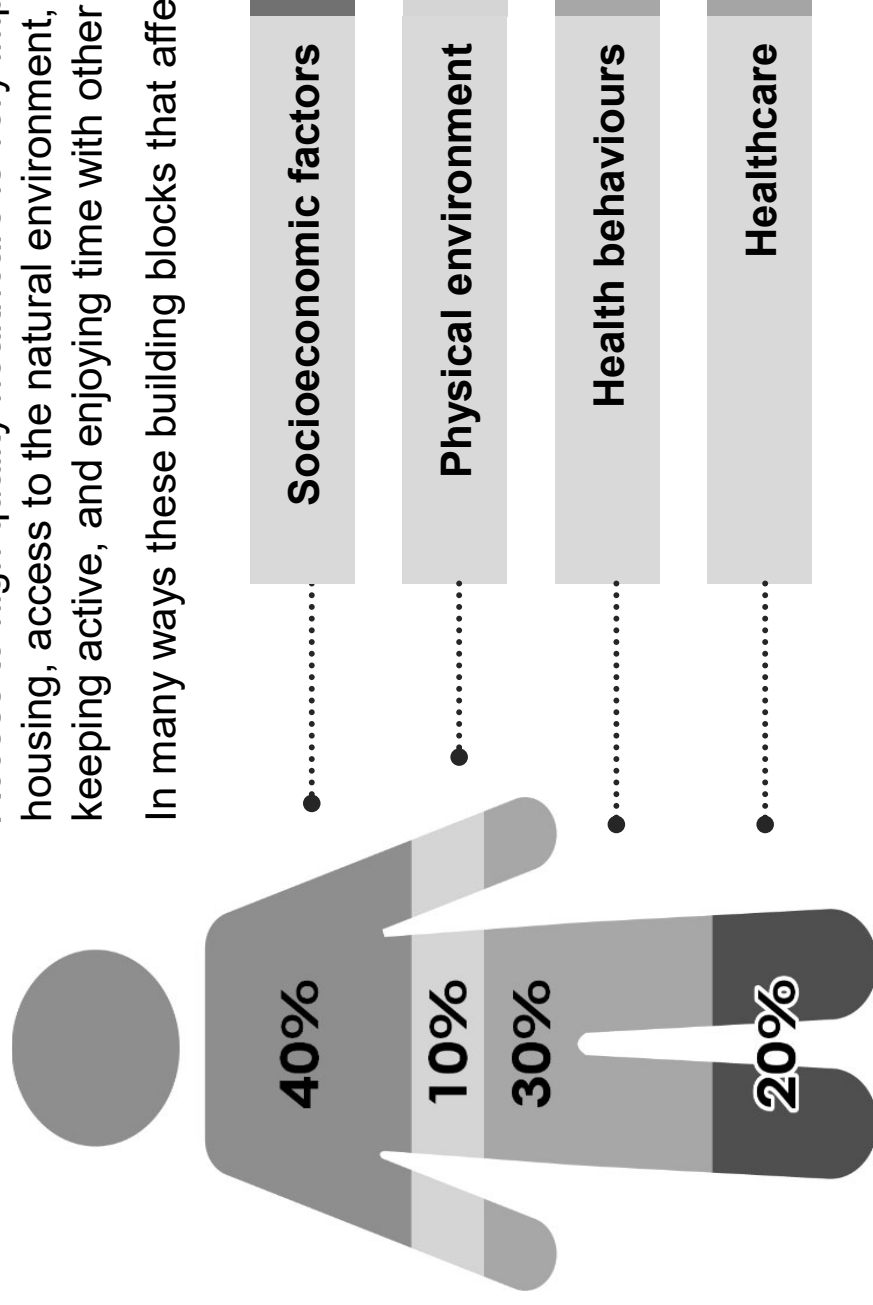


Supporting our communities to thrive

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

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

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



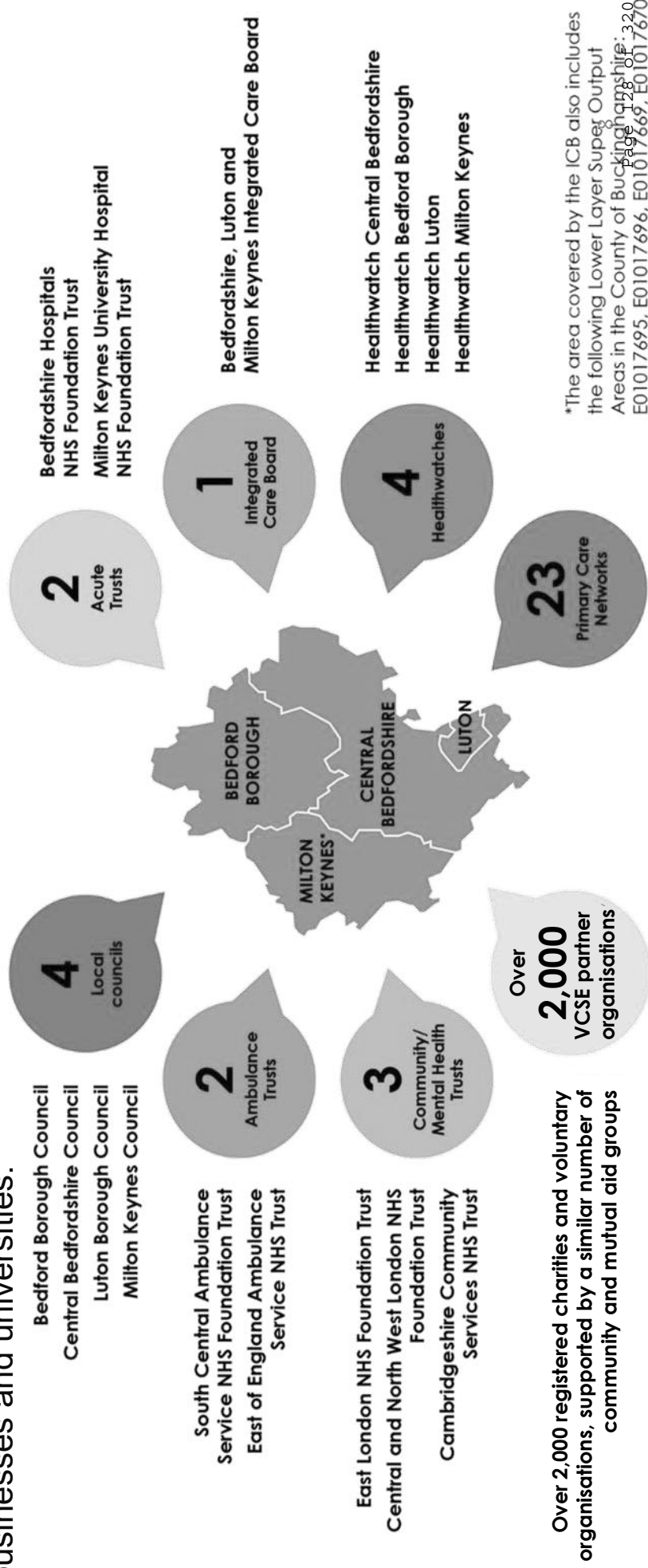
That's why we are developing closer and more collaborative ways of working with residents, communities, our Councils, our NHS and the charity and community organisations that make up the VCSE sector.

We also prioritising personalised and preventative care, to give people greater control over their own health, to stay well and live longer, healthier lives.

Our health and care partners

There are many organisations which make up our Health and Care Partnership. From local Councils and the NHS, to people providing education and housing, to the police and ambulance services, they all play a vital role. Our partners also include people living and working in our communities, our local businesses and universities.

Thousands of voluntary, charity and social enterprise (VCSE) organisations work to support and understand our population's needs, from directly providing prevention and care services to linking into our communities to help tackle inequalities.



*The area covered by the ICB also includes the following Lower Layer Super Output Areas in the County of Buckinghamshire: E01017695, E01017696, E01017669, E01017670

How our partnership will work together

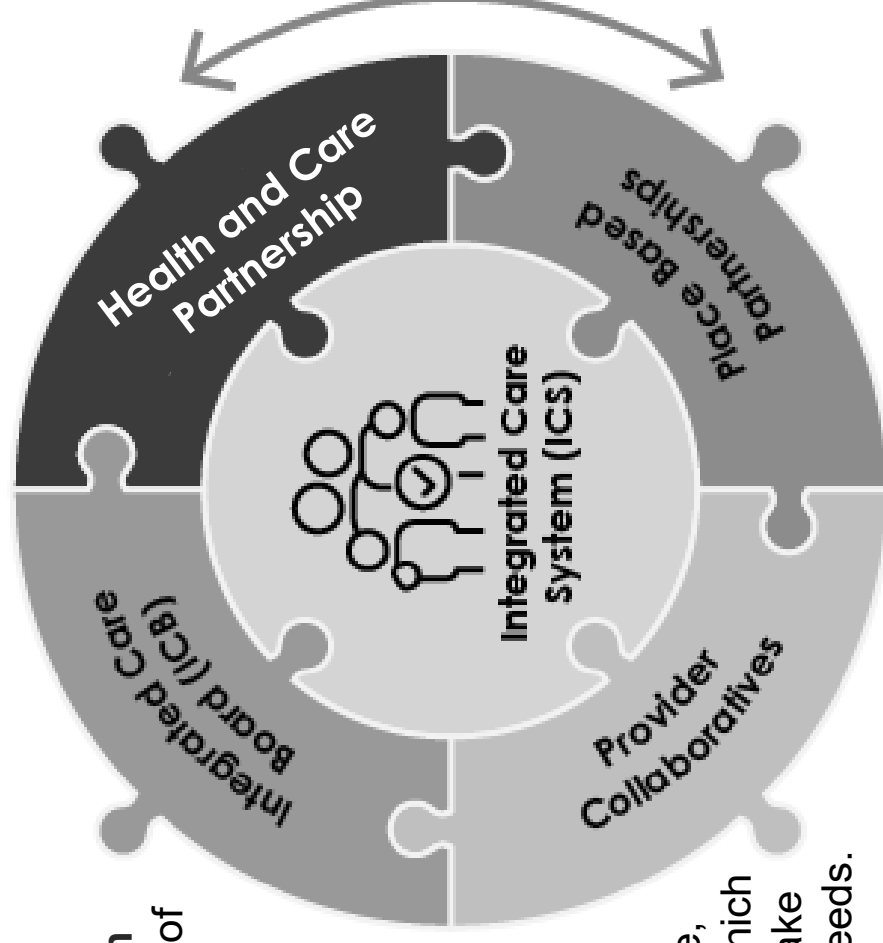
All partners, including Healthwatch and the VCSE sector, come together as the **Bedfordshire, Luton and Milton Keynes Health and Care Partnership** to oversee the development and delivery of our integrated care strategy.

Our **Integrated Care Board** brings together senior leaders from our Councils and NHS partners. The Board holds responsibility for actions to:

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

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

Provider collaboratives work together across a wider geography than at place. In our area this includes the Bedfordshire Care Alliance and the all-ages Mental Health, Learning Disabilities and Autism Collaborative. These are supported across the East of England by collaboratives for children and young people and specialised mental health.



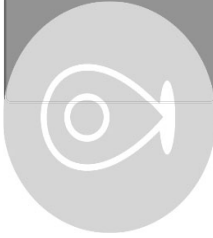


**Bedfordshire, Luton
and Milton Keynes**
Health and Care Partnership

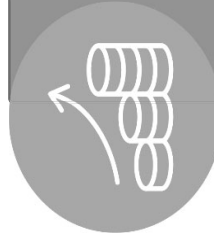


OUR POPULATION HEALTH CHALLENGES

Our local area



Our area covers four places **Bedford Borough, Central Bedfordshire, Luton and Milton Keynes City** – 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 resident population**. Of our population of one million people, 62% identify as White British, 15% Asian, 10% 'Other White' and 7% 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**.

Supporting our residents to live longer, healthier lives

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

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

Years difference in Life Expectancy: most vs. least deprived



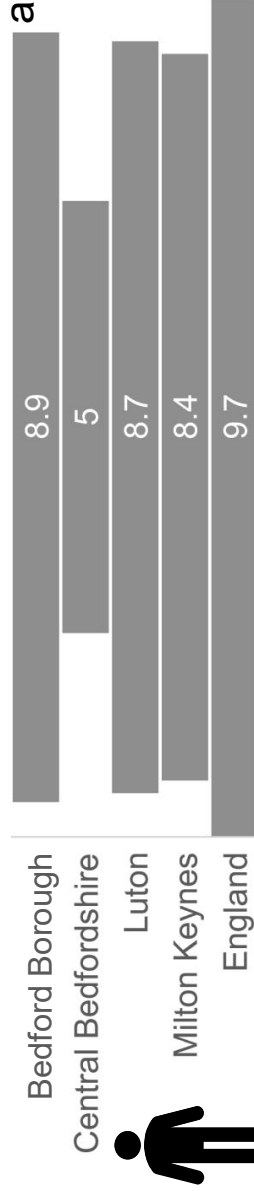
By looking at the factors which make up the building blocks of health we can start to understand why some of these differences exist.

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

Around 40% of children aged 11 are overweight or obese, and the percentage is higher in deprived neighbourhoods. This can lead to serious conditions like diabetes and asthma, and reduce life expectancy.

One in four UK households are living in **fuel poverty** and 25% of the coldest homes in the East of England are in our area. Living in a cold, damp house worsens airway and heart disease, risk of stroke and mental health.

Air pollution also has a significant impact on health and inequality, and is responsible for 6% of deaths in Bedfordshire, Luton and Milton Keynes.



Factors driving our health challenges


There are **more low birth weight babies** in our area than the England average. This increases death in childhood, asthma, infections, and diseases in adulthood.

The uptake of **childhood vaccinations is below target and falling**, increasing the risk of serious outbreaks.


Limiting face to face appointments in the pandemic was necessary, but now people are **waiting longer** and are more likely to have **conditions go undiagnosed**.

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

A child from the most affluent areas of BLMK



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



19% Percentage of adults who are smokers

A child from the most deprived areas of BLMK



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

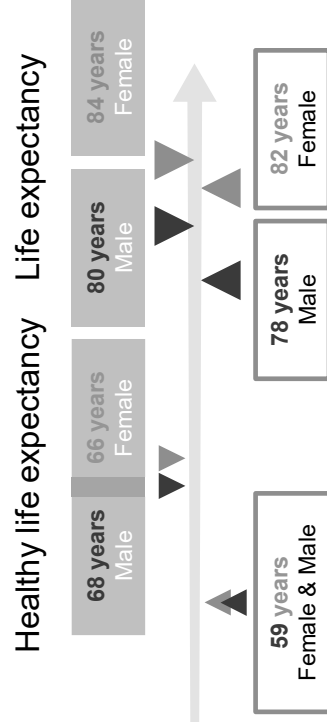


34% Percentage of adults in routine/manual occupations who are smokers

People with a learning disability or autism are less likely to attend screening, face long waiting times, and die on average 14 years before the rest of the population.

Cancer screening coverage varies and is lower in some population groups. Screening can reduce the risk of dying by 38% for breast cancer. 83% of cervical cancer deaths could be avoided if everyone attended screening.

Referrals to mental health services are increasing. **One in three** people with a long term condition also have mental health needs. People with a severe mental illness are more likely to die earlier, yet **40% did not receive their health check** across our area last year.



Tackling the causes of ill health

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

Prevention includes keeping people well, and supporting them to maintain independence for longer. Screening and early detection can help prevent advanced disease and improve outcomes for conditions such as diabetes and cancer.

We can also work to prevent mental ill health. By building resilience in young people and supporting families, we can help people to better understand their own mental health needs and how to get support when they are in crisis.

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

Things like good education and meaningful employment, a secure and warm home, strong family support, and a healthy environment all contribute to the building blocks of health.

Preventing long term conditions in Bedfordshire, Luton and Milton Keynes

Doctors have been looking for ways to support more people, particularly from the south Asian community, who are at risk of diabetes.

They used data to find out which people were most likely to be at risk, and test them for the condition.

One of these people was Nasreen, a young mother from Milton Keynes, who was diagnosed as pre-diabetic after blood was taken by her GP.

She is now taking part in a diabetes prevention programme. This has helped her understand how things such as her diet and exercise, can improve her health and avoid the complications associated with diabetes.

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



Our system challenges

In addition to the factors determining good health, we also have two significant challenges across our system.

Living Well is more difficult for everyone

- The cost of living has increased, and many families are struggling to pay their bills.
- Our local Councils, NHS, and our suppliers, are also feeling the pressure of rising costs and the need to manage greater demand within stretched budgets.
- Our staff are feeling the effect of their huge contribution during COVID. Vacancies have been increasing, and are now around 14% for staff in the NHS and 10% in adult social care, and this further affects staff morale.
- Environmental factors, including air pollution and access to green spaces, and climate change events such as heat waves, storms, floods, and pandemics are increasingly affecting our health and livelihoods.

Residents' health and care needs have changed over the pandemic

- Children and young people's lives have been disrupted. There are now more referrals to Councils for safeguarding, and to the NHS for conditions such as anxiety and eating disorders.
- Demands on primary care, especially GP and dental services, are increasing, and local people report access to a GP as one of their greatest concerns.
- People coming forward for support are more likely to have conditions diagnosed at a later stage or more than one condition, making care more complicated.
- More people are using our urgent care services and we need to work to reduce waiting times for planned care in the wake of the COVID pandemic.
- People who are discharged from hospital need more complex packages of care, requiring more staff time and more involvement from specialists.

Our strengths – what we are proud of

There is no doubt that improving health outcomes and tackling inequalities against the backdrop of increased demand for health and care services, the impact of COVID, and cost of living challenges is not easy. We will need to work together, and much smarter, to achieve a greater impact for our residents.

The Bedfordshire, Luton and Milton Keynes Health and Care Partnership has some real strengths we can draw on to help us achieve our shared vision. These include:

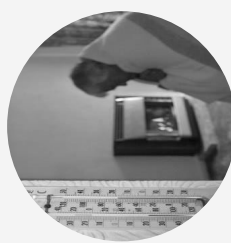
- **The commitment across Councils and our NHS to improve health outcomes and tackle inequalities**, reflected in our work to support residents to live longer, and live more years in good health.
- **Our VCSE organisations in all our communities**, who bring a wealth of specialist expertise in meeting the needs of our population, and boost investment in our system through charitable funding.
- **Strong partnerships between local Councils and NHS organisations**, demonstrating that we are willing to develop ways of working together to support our communities to thrive.

Supporting people with the cost of living crisis

With more people reporting increases in the cost of living having a negative impact on their health, we are working to find ways to support our residents.

Councils across Bedfordshire, Luton and Milton Keynes are using funding from the Health and Care Partnership to work with local VCSE organisations to provide warm spaces, where residents can get a hot drink and join in activities with others. Volunteers are also on hand to advise on issues from managing bills to homelessness and loneliness.

In Bedford Borough, GP services have invited over 1,500 people with health conditions that could be made worse by living in cold or damp houses to access advice and support from their local Better Housing Better Health scheme.



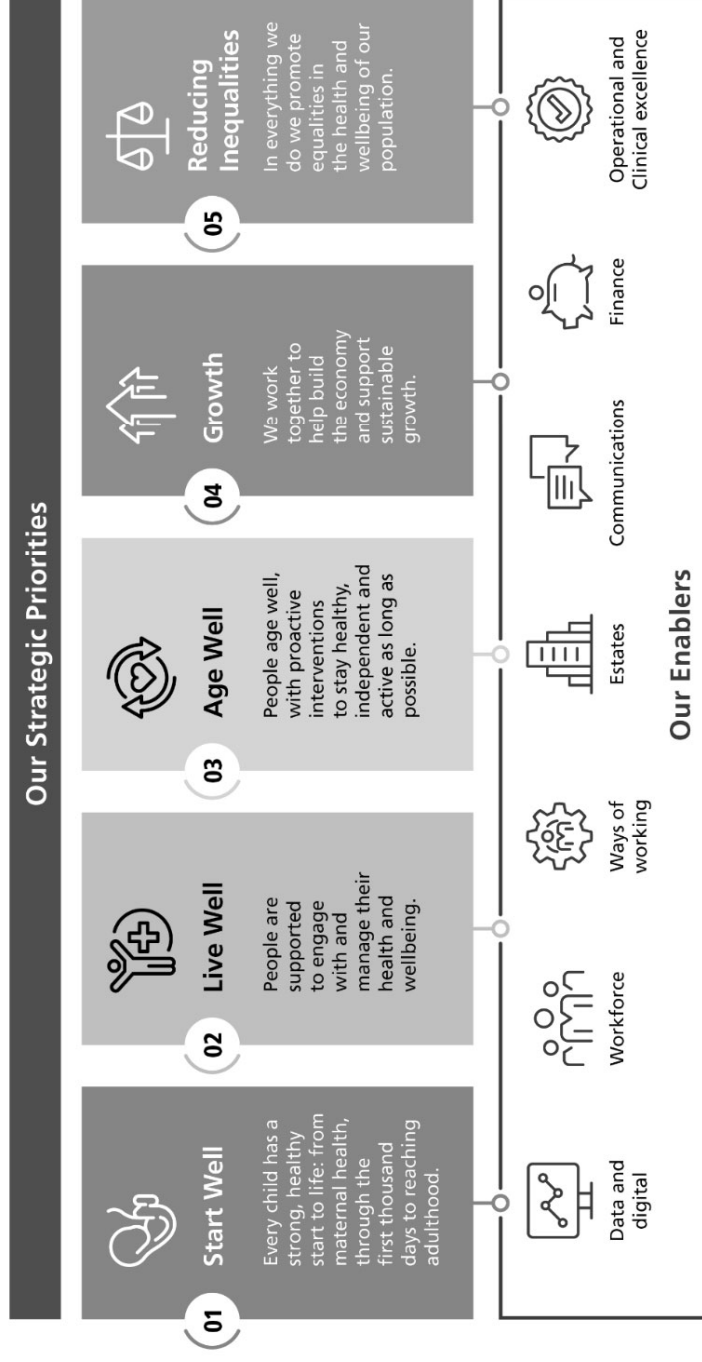
Where we* will focus our efforts

Our Health and Care Partnership has five priorities which inform our work. These focus on improving health outcomes and tackling inequalities for people of all ages.

They reflect the impact that growth and sustainability has on inequalities, on physical and mental health, and on social factors such as the environment, housing, employment and isolation.

These priorities are supported by seven enabler programmes, which will help us to make progress.

For each priority we will use what we know about our population health to help us understand where inequalities exist, and identify actions to address them. We will focus our actions through our partnerships at place.



* 'We' means our whole system: you, your families and friends, communities, councils and NHS; people working in the public sector, businesses, universities, charities and voluntary, community and social enterprise organisations.

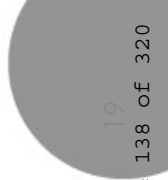


**Bedfordshire, Luton
and Milton Keynes**
Health and Care Partnership



OUR SYSTEM AND PARTNERS

Going further through partnership



Integrating care across our system

At the heart of our system are the new **Neighbourhood Teams**. These are NHS, local Council and VCSE sector teams working with a group of GP practices.

Much of the proactive and preventative care for residents is provided by these teams. This includes GP, dental, ophthalmology and community pharmacy services, VCSE service organisations, local authority services, community healthcare, and mental health and learning disability services.

They work together to serve a local population of 35,000 – 50,000 people and have four core aims:

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

The local partnerships shaping care for children and young people

Our system partners are already working together to support children and young people, with a focus on those who are most vulnerable or have complex care needs.

Across Bedfordshire, Luton and Milton Keynes there are over 1,300 'Looked After Children', and safeguarding referrals continue to increase. Councils, the NHS and VCSE partners work together across early years, education, children's centres, health, social care and youth justice to keep children safe and ensure their needs are met.

One in six children will have a special education need and/or disability. Support for these children often involves a number of public sector agencies and can sometimes be fragmented.

Work is underway across all our places to ensure all children can fulfil their potential, including:

- strong leadership at place to ensure care is joined up
- an early offer of support for parents and children
- speedy access to specialist support where needed.

It's all about you

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

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

We will engage and involve our staff and residents to get involved in designing and delivering care at every stage.

Our principles of co-production

Build Leadership that supports and promotes co-production.

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

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

Review and report progress: from 'you said, we did' to 'we said, we did'.

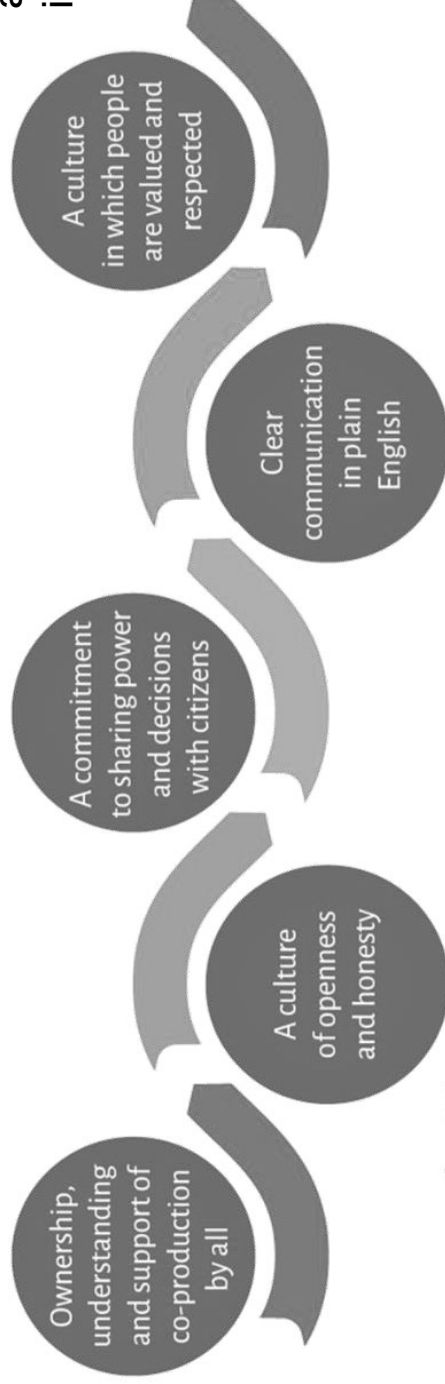
Reward and recognise people's contribution.

Embed co-production until it becomes 'how we work'.

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

Our principles of co-production recognise and value the lived experiences of people in our communities.

We will learn from and work with our four local Healthwatch organisations and VCSE partners who are experts in co-production and co-design and have good routes into our local communities.



Our places: Bedford Borough

Bedford Borough includes the vibrant urban area of Bedford and Kempston, surrounded by picturesque rural parishes. It has significant diversity, with 100 different community languages spoken and one of the largest concentrations of Italian immigrants in the UK.

The River Ouse runs through the town. The town has a rich heritage in the lace industry, brewing and aircraft building. Bedford Borough has an elected Mayor.

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 commits to:

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

Total population ≈ 185,300 in 2021

Age profile:

- one in six people are aged 65 years and over

Diversity:

- 64% White British, 10% Other White, 13% Asian, 5% Black

Deprivation:

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

Our places: Central Bedfordshire

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

Central Bedfordshire's strategic plan focuses on continuing to be a great place to live and work:

- Protecting the environment with sustainability plans
- Supporting the health and wellbeing of residents
- Building schools for the future to meet the needs of all our young people, including those with Special Educational Needs and/or Disabilities
- Delivering homes to meet the needs of all residents
- Delivering and improving services such as roads and transport.

The Central Bedfordshire place plan commits to:

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

Total population ≈ 294,200 in 2021

Age profile:

- almost one in six people are aged 65 years.
- Central Bedfordshire has the greatest number of over 65s in our area.

Diversity:

- four out of five people identify as White British

Deprivation:

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

Our places: Luton

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

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

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

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

The Luton place plan commits to:

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

Total population ≈ 225,300 in 2021

Age profile:

- one in nine people are aged 65 years and over

Diversity:

- most ethnically diverse population in our area (32% White British, 37% Asian, 11% Other White, 10% Black)

Deprivation:

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

Our places: Milton Keynes

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

Milton Keynes has the youngest population of all our places, with a quarter of the population under 18. It has excellent road and rail connections.

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

Called The 'Milton Keynes Deal', they are pioneering new inclusive ways of working.

The Milton Keynes Deal commits to:

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

Total population ≈ 287,000 in 2021

Age profile:

- 25% of people are under 18
- 14% of people are aged 65 years and over

Diversity:

- ethnically diverse population (62% White British, 12% Asian, 10% Black, 9% Other White)

Deprivation:

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

Provider collaboratives: mental health, learning disabilities and autism

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

- **Workforce** – training a new generation of mental health professionals to support our expansion in mental health services so that all people can get rapid and fair access to care.
- **Emotional wellbeing for young people** – responding to the increase in referrals since the pandemic, we are developing early support for young people in distress, joined up with family, schools and communities. Children and young people who need mental health inpatient support, will have access to a new unit from January 2023.
- **Supporting Adults with Autism** – supporting the high proportion of adults with autism who don't have a formal diagnosis to ensure these people can get access to support for them, their family, and from their employer.

Working in partnership to support people in crisis

The Mental Health Street Triage service supports patients experiencing a mental health crisis in Luton with fast access to care.



This team combines a police officer, a paramedic and a mental health professional in one car to respond to mental health crisis calls 365 days a year. Operating from 12pm-12am, the team acts where there is an immediate threat to life – to help someone in danger of self-harm, or suicide.

The team works with similar teams has a dedicated phone and is linked to both police and ambulance control rooms.

Provider collaboratives: Bedfordshire Care Alliance

Bedfordshire Care Alliance (BCA) is a provider collaborative, which spans the three places of Bedford Borough, Central Bedfordshire and Luton.

The BCA focuses on the aspects of integrated health and care that are best done for the whole of Bedfordshire. In particular, the BCA is looking at how to prevent ill health and deterioration and support people to stay well at home.

This will involve joining up the planning and delivery of care across social care, community, hospital, and primary care.

Some of the Alliance's priorities are:

- **Home First** – providing care at home to help people with frailty recover after a hospital visit.
- **Stay Well at Home** – providing a 'virtual ward' so people can access medical, nursing, therapy and care support at home instead of going into hospital.

Supporting people at home

The Bedfordshire, Luton and Milton Keynes Virtual Ward programme is building on strong partnerships to promote earlier discharge from hospital, and help people be cared for at home.

The Virtual Ward uses remote monitoring, and gives people access to treatments at home, home oxygen, and specialist palliative care, whilst allowing them to keep in touch with their clinical team.

The BCA is supporting the roll out of two new Virtual Ward schemes in Bedfordshire. These are designed to help people with frailty, or those with a severe respiratory illness, who would otherwise have to stay in hospital. By closer working across community, primary care and hospital teams, and better use of technology, these Virtual Wards both support individuals and help to free up much needed space inside our hospitals.

- **Ensuring communities have fair access to resources** – for Neighbourhood Teams, and to support Home First and Stay Well at Home plans.



WHAT THIS MEANS FOR ME & MY FAMILY

What can I expect to be different?

Equity in access – no one left behind

The way we provide services makes a big difference in how they are used by our residents, and how they impact on health and wellbeing. We are determined that across our partnership, services and support will be fair and accessible to all.

This applies to the NHS, providing universal healthcare for all, and services from your local Council including social care, public health, schools and education, planning and housing, waste and recycling, children's services, transport, roads and parking, leisure, environmental services, and community safety.

Tackling inequality in outcomes from heart disease

High blood pressure can increase the risk of heart attacks and strokes. Caught early, hypertension is easy to treat, but rates of detecting this are much lower in some populations.

GPs across Milton Keynes are working with pharmacies to identify people who are at risk of hypertension but may not be coming forward for treatment.

Community support to improve mental health

Community connectors have been integrated into local mental health teams across Bedford Borough to support people with emotional, social and practical needs.

With an in-depth knowledge of local VCSE and community services, these individuals are helping people access a range of local non-medical offers to improve confidence, social inclusion and independence, looking both at the building blocks of good health, as well as addressing specific mental health needs.

Our VCSE organisations also provide many of these services from prevention right through to specialist mental and physical health support. They are excellent at advocating for patients' and community members voices to be heard, and are experts at engaging and supporting communities that experience health inequalities.



Start well: Every child has a strong start in life

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

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

Transforming young lives in Milton Keynes

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

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

Luton's family partnership service

The family partnership service provides intensive support to vulnerable children, young people and their families.

This service has been built on the strong belief that children belong in natural networks with people they know and who love them and keep them safe.

The service takes several approaches to identify the right support for children and their families, including:

- Direct support by a family support worker
- Linking to services provided by other partners within community or specialist services.

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



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

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

Care is built around neighbourhood teams that deliver support in communities, with accessible primary care, and personalised care – using innovative ways to support the whole person.

Rapid mental health support, focused on prevention, including early intervention in psychosis and talking therapies, help people with mental health conditions to stay well.

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

Care is tailored to an individual's needs – for example, for people with Learning Disabilities, veterans, and people in end of life care.

Improving cancer outcomes in Luton

When Nam missed a routine smear test last year, because she didn't know she could request to see a female practice nurse, rather than her male GP, she didn't get her cervical cancer diagnosed until it was at a more advanced stage.

Once diagnosed, she was referred to Mount Vernon Cancer Centre for radiotherapy. But because Nam can't drive and her husband couldn't get time off work, she wasn't able to get the treatment she needed and is now in palliative care.

The Luton Cancer Outcomes project, led by the local Council, NHS and VCSE sector, is looking at how we can change this story in the future. Using information about who is missing out on treatment, and why, partners are working to find solutions that work for local people. This includes targeting people who are missing out on screening and providing support, including transport, to help people get the care they need.



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

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

Supporting people with dementia in Central Bedfordshire

When Dianne was diagnosed with dementia, her GP referred her to the Working Together Leighton Buzzard team (WTLB). This programme brings together GP practices, mental health services and social care to ensure care is joined up.

The team set up a visit from a district nurse and a social worker, who created a care plan for Dianne, with her husband. They referred her to an occupational therapist and ordered a new bed so she could safely sleep downstairs. Dianne's medication was reviewed and her husband, as the main carer, was also offered support.

By working together across organisations, the team prevented Dianne from having to go into hospital.

Preventing falls in Bedford Borough

Bedfordshire Fire Service offers Falls Prevention Checks in resident's homes. Officers check for trip hazards at the same time as advising residents of fire safety measures, such as smoke alarms.

The service also offers to refer people for advice on housing, and stopping smoking, to improve their safety and health.

Community services, including falls prevention, Virtual Wards and medication reviews, help **older people to maintain independence** and manage conditions, including dementia.

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

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

Growth and sustainability

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

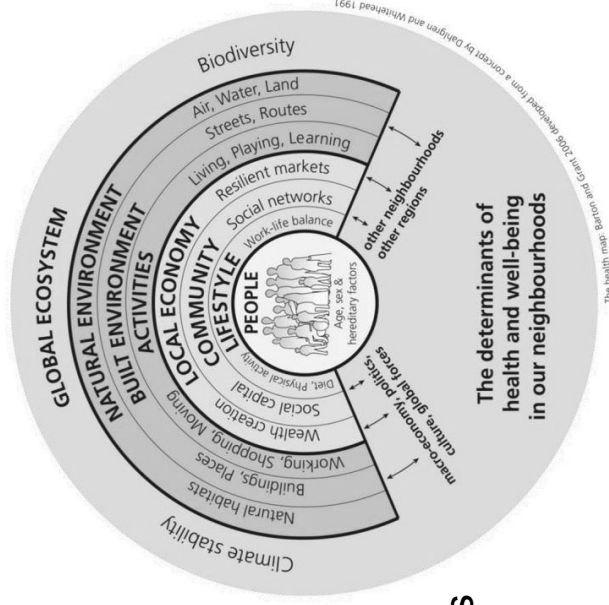
Environmental sustainability: with net zero carbon emissions by 2035, to work in harmony with our environment and reduce the risks of climate change.

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

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

- Creating a “circular economy” (reduce, reuse, repair, repurpose and recycle) with no waste.
- Building infrastructure (buildings, processes, transport) that helps us be sustainable.
- Making decisions with the future of our environment in mind.
- Increasing employment opportunities for local people and support to develop skills.

- Effective, efficient use of public assets.
- Investing in research and innovation.
- Supporting people to work and shop locally, and businesses to invest here.
- Keeping people healthy in their homes and communities.
- Nurturing partnerships across large, public-sector, and VCSE organisations, and local employers to improve the lives of our residents.





OUR APPROACH

How we will use our skills and resources differently

Our workforce

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

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

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

Keeping Well BLMK

This specially designed service provides wellbeing and psychological support for NHS staff, and those providing care in the community, residential homes, and in VCSE organisations.

Keeping Well practitioners run sessions tailored to an individuals' needs and issues to help them better manage physical and mental health both at home and at work.

Our leadership values:



People led



Collaborative



Integrated



Inclusive



Altruistic

Supporting our staff in primary care

People working in primary care have been under increasing pressure, and have reported an impact on their health and wellbeing.

Our Integrated Care Board wanted to help, introducing an app, called ShinyMind, specifically tailored to increase resilience and reduce stress in NHS staff.

Nine out of ten staff who have used the app report an improvement in wellbeing after using the programme, while seven out of ten said their job satisfaction had improved.

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

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

Support to provide excellent care, every time

Our **Clinical Services Strategy** will support and develop clinical and professional teams to work at the top of their game to achieve the best health outcomes for residents. A big part of this is learning from what we and others do. We will compare our care pathways with best practice and current evidence and adapt our approach accordingly. We will involve patients, carers and staff in co-design and co-production of pathways based on residents' need. By embedding ways of improving quality our health and care teams will provide excellent care, every time.

Promoting research across our system

Our newly created Bedfordshire Research and Innovation Hub will focus on research into health and social care inequalities. By building research capacity and capability, this hub will identify new ways of working to reduce inequalities. Priorities include building an inclusive workforce and resilience in the helping professions, and safeguarding children and adults with complex needs. This hub will help act as a catalyst for further investment in health and care research across the system.

Using innovative approaches to speed up diagnosis and care

When Margaret collapsed while walking her dog near her home she was rushed to Milton Keynes Hospital.

Doctors were able to view her CT scans instantly on their smartphones using new AI-powered software, analyse and identify any areas of the brain that may be damaged, and share images with colleagues in Oxford for expert advice.

Margaret was quickly diagnosed with stroke and transferred for treatment. The speed of this response allowed her to return home after a few days in hospital to recover from this serious illness.

We will promote research to find new and improved ways to support people. We will build our new research hub and work with Academic Health Science Networks to evaluate and spread innovation.

We will also work to prevent ill-health, and the causes of poor health, and maximise recovery after illness or injury.

Improving the safety of our care

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

The Patient Safety Incident Response Framework (PSIRF) is the new national way of improving patient safety in the NHS. It will help us to respond quickly and appropriately if and when we identify similar problems across patient pathways in different health settings, or where the same problem happens across a number of health settings. The principles which this framework supports are:

- 1. Kindness and respect to the person affected and their family, with honesty about what happened.** We will always listen, respect and involve all people who raise a safety concern.
- 2. Supporting our staff, and addressing the root causes of when things go wrong.** Avoiding a 'blame culture' where staff are blamed for issues beyond their immediate control. We will take responsibility for these factors, and work with clinical teams to address them.
- 3. We will identify the major quality improvement programmes needed in instances where we haven't got care right, and work together to make sure changes are sustained.**

Learning from others to improve our safety

Improving safety is about listening to people and learning from ourselves and others. One example of this is The Royal Free 'Keeping mothers & babies together' initiative, which provides knitted orange hats more vulnerable babies.

This helps the team easily identify which babies need extra care; allowing them to take timely observations, blood sugar tests and extra support to establish feeding so that mothers and babies can stay together.

- 4. We will work on quality improvements along with the whole health and care pathway, working to improve patient experience and outcomes as people move between different health settings.**

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- 3. We will identify the major quality improvement programmes needed in instances where we haven't got care right, and work together to make sure changes are sustained.**

Learning from the pandemic to improve our safety

To embed learning around infection control following the pandemic, care homes across Bedfordshire, Luton and Milton Keynes have been introducing a raft of measures to improve safety.

Regular care home forums allow staff to bring concerns and share good practice across our homecare network. Study days around frailty and the vulnerable person, linked to the risk of infections, are also in place. These will be rolled out to Learning Disability homes this year.

- 4. We will work on quality improvements along to the whole health and care pathway, working to improve patient experience and outcomes as people move between different health settings.**

Planning care around our population's needs

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

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

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

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

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

Using health intelligence to provide personalised care
90% of people who are socially vulnerable live on their own. They often rely on out of hours GP services or 999 for help, sometimes ending up in hospital unnecessarily.

To help improve care for some of these people, Titan Primary Care Network in Central Bedfordshire used linked primary and secondary care data to identify people who could benefit from being reviewed by their team.

Jane was one of those people. On visiting her home, a social prescribing practitioner found she wasn't managing her health and her home was in a bad state of disrepair.

Working with the local council, the team arranged improvements to her home, reviewed her medicines and helped her to better look after herself. She's now eating better, able to get out more and feeling less isolated.

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

Using technology to join up and improve care

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

This means using information in a smarter way. A single shared health and care record will join up information to help provide seamless care and help people to get the right care, every time.

Patients will be able to access information easily and technology will support Virtual Wards and help people to be cared for in their own homes.

Using information to get the right support, first time

The 'yellow bracelet' scheme for people in contact with homecare services in Bedfordshire, Luton and Milton Keynes, means professionals can access real-time data about a person's care package, their needs and the support they have at home.

This can speed up risk assessments, decision-making and ensure people get access to the right care, first time, and maintain independence at home.

So that patients can...

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

So that care practitioners can....

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

So that people planning care can...

- See how residents are using care at any given moment, for example the number of patients at A&E, or on waiting lists
- Forecast demand based on previous trends and live data
- Predict demand for high risk patients and provide pro-active care
- Intervene earlier to improve outcomes and reduce 'reactive' care
- Focus resources closer to the resident and their individual needs.

Managing our resources

Our health system has a budget of around £1.8 billion, managed by the Integrated Care Board. We will work collectively to allocate and spend this money as efficiently as possible to deliver better health outcomes for our population.

We will be working more closely between NHS, local Councils and VCSE partners to make sure that funding is targeted to have the greatest impact. Our place-based approach will help us make the right decisions to support our communities to thrive.

Giving people control of their care

People with Multiple Sclerosis and Epilepsy are being offered a new service, called Patient Initiated Follow Up (PIFU), which allows people to take control of their own care, reduces unnecessary hospital visits and improves waiting times.

This service provides an alternative to a regular scheduled follow-up appointment, and supports people to get help, review their medication, get test results and flag concerns without having to make an appointment with their GP.

Supporting carers in Central Bedfordshire

Primary Care Networks in Central Bedfordshire are working to ensure that carers are looking after their own health.

They have been contacting carers who have not been to see their GP in the last 12 months or who have a long-term condition, to give them a full health check and offer them a care plan personalised around their needs.

How we use our buildings has fundamentally changed since the pandemic. Much more healthcare is now delivered on-line or in places other than hospitals.

The move to more preventative and personalised care outlined in this strategy will mean this continues to evolve in the future. Our NHS and Councils are reviewing how we use our estates to provide integrated care at place.

Across our communities we also have other valuable resources in VCSE organisations, our networks and our communities. This includes thousands of informal carers, who work alongside our Councils and NHS to support our residents to live longer, healthier, lives.

Appendix B – list of NHSE National Priorities for 23-24

Urgent and emergency care	<p>Improve A&E waiting times so that no less than 76% of patients are seen within four hours by March 2024 with further improvement in 24/25</p> <p>Improve category 2 ambulance response times to an average of 30 minutes across 23/34 with further improvement towards pre-pandemic levels in 24/25</p> <p>Reduce adult general and acute (G&A) bed occupancy to 92% or below</p>
Community health services	<p>Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard</p> <p>Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathway for direct referrals</p>
Primary Care	<p>Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs and appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need</p> <p>Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024</p>
Elective care	<p>Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels</p> <p>Eliminate waits of over 65 weeks for elective care by March 2024 (except if patients choose to wait longer/specific specialities)</p> <p>Deliver the system specific activity target (agreed through the operational planning process)</p>
Cancer	<p>Continue to reduce the number of patients waiting over 62 days</p> <p>Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days</p> <p>Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028</p>
Diagnostics	<p>Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%</p> <p>Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition</p>

Maternity and neonatal	<p>Make progress towards the national safety ambition to reduce still birth, neonatal mortality, maternal mortality and serious intrapartum brain injury</p> <p>Increase fill rates against funded establishment for maternity staff</p>
Use of resources	<p>Deliver a balanced net system financial position for 23/24</p>
Workforce	<p>Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise</p>
Mental health	<p>Improve access to mental health support for CYP in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)</p> <p>Increase the number of adults and older adults accessing IAPT treatment</p> <p>Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services</p> <p>Work towards eliminating inappropriate adult acute out of area placements</p> <p>Recover the dementia diagnosis rate to 66.7%</p> <p>Improve access to perinatal mental health services</p>
People with a learning disability and autistic people	<p>Ensure 75% of people aged over 14 on GP learning disability register receive an annual health check and health action plan by March 2024</p> <p>Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12-15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit</p>
Prevention and health inequalities	<p>Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2023/24</p> <p>Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%</p> <p>Continue to address health inequalities and deliver on the Core20Plus5 approach.</p>

Appendix C: Financial Planning

The financial planning remains draft at the time of writing, however there are unlikely to be significant changes in the final guidance.

Business Rules

The finance business rules for the ICB and systems from 1 April 2023 are summarised in the table below:

Rule	ICB	System
Capital resource limit		Collective duty to act with a view to ensuring that the capital resource use limit set by NHS England is not exceeded
Revenue resource limit		Collective duty not to exceed the limit set by NHS England
Duties to break even / achieve financial balance	Duty to act with a view to ensuring its expenditure does not exceed the sums it receives	Objective to break even – i.e. duty to seek to achieve objective of system financial balance.
Financial apportionment	Revenue and capital resources of all trusts apportioned exclusively to a principal ICB	
ICB administration costs	Duty not to exceed the limit set by NHS England	
Risk management	Local contingency decision required to show how financial risks will be managed	
Prior years under and overspends		Maintain as a cumulative position
Repayment of prior years' overspends		All overspends are subject to repayment
Mental Health Investment Standard	Comply with standard to increase expenditure on mental health services by more than allocations growth	
Better Care Fund	Comply with minimum contribution as set out in relevant planning guidance	

Allocations

The guidance confirms that NHS England will issue two-year revenue allocations for 2023/24 and 2024/25. There is no real terms change in total ICB allocations. Additional funding of £3.3 billion in both 2023/24 and 2024/25 will be allocated to respond to pressures.

Core ICB funding grows by 4.62% against 2022/23 baselines. This is based on the following assumptions:

- The 2022/23 baselines now take account of in-year funding for pay and inflation, make additional health inequalities and maternity funding recurrent, and are adjusted to reflect the outcome of the baseline reset exercise to correct baseline contract funding between commissioners following the end of the Covid financial regime.
- 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)
- Growth funding is provided for inflation (updated for inflation forecasts), efficiency, and activity. This includes funding to deliver the Mental Health Investment Standard and increase investment in community services.
- Further resources are added to provide resources to maintain and expand capacity funding allocated for 2022/23 and distribute additional funding to support discharge which flows through the Better Care Fund.

The draft allocations for BLMK are in the table below.

	Programme	Delegated	Running Costs	Total
2022/23 Adjusted recurrent baseline (£k)	1,527,139	163,752	18,474	1,709,366
Growth (£k)	69,584	9,705		79,288
2023/24 Recurrent allocation (£k)	1,596,723	173,457	18,474	1,788,654
2023/24 COVID (£k)	6,771	0		6,771
2023/24 Additional elective funding (£k)	39,730	0		39,730
2023/24 Total allocation (£k)	1,643,223	173,457	18,474	1,835,154
2023/24 Total allocation growth (%)	4.06%	5.93%	0.00%	
2023/24 Additional discharge allocation (£k)	4,709			4,709
2023/24 Capacity funding (£k)	4,993			4,993
2023/24 Combined allocation (inc. COVID, additional elective, discharge, and capacity) (£k)	1,652,925	173,457	18,474	1,844,856

Elective recovery funding will be allocated to systems on a fair shares basis, and provider and system targets will be determined as part of the planning process.

The Health Inequalities allocation has been made recurrent and rolled into ICB baselines for 2023/24 onwards.

The in-year ICB allocations adjustment for charge exempt overseas visitors and UK cross-border emergency activity will be re-introduced.

ICBs will take on delegated responsibility for pharmaceutical services, general ophthalmic services, dental services (primary, secondary and community) and other primary care services. ICB allocations for services in scope for delegation and indicatively for 2024/25 are provided and will form part of the ICB financial plan. Where delegation is confirmed, ICBs will receive their allocation from 1 April 2023. Contracts for these services will be awarded by NHSE for 2023/24.

Revenue

The guidance states that delivery of an NHS wide balanced net system financial position whilst meeting the national objectives outlined will require systems to meet a 2.2% efficiency target. This is in addition to expectations of improved productivity.

There is an expectation that efficiency and productivity plans will be developed at system level with strong oversight and governance arrangements to drive delivery. To generate the required level of efficiency savings, systems must:

- Reduce agency spending across the NHS to 3.7% of the total pay bill in 2023/24.
- Reduce corporate running costs with a focus on consolidation, standardisation and automation to deliver services at scale across ICS footprints.
- Reduce procurement and supply chain costs via supply chain coordination limited (SCCL), and the specialised services devices programme.
- Improve inventory management by building an inventory management and point of care solution.
- Purchase medicines at the most effective price point through engagement with the commercial medicines unit and the national medicines value programme.

The NHS payment scheme sets out the basis for the inflation assumptions in the cost uplift factor applied to NHS payments and allocations, including relevant pay and non-pay assumptions.

The guidance raises an expectation that most planned elective care will be paid for at unit price for activity delivered. Activity targets should take account of the elective recovery funding included in ICBs baseline allocations, but the guidance also notes that where systems exceed agreed targets NHSE will cover additional costs.

Capital

Total capital resources for the NHS in England between 2022/23 and 2024/25 had previously been announced at a total of £23.8 billion. An additional £300 million will be made available nationally in 2023/24. Allocation of the additional funding will be prioritised for systems that deliver against agreed plans in 2022/23.

Planning timetable

The guidance states that ICBs are responsible for ensuring that system plans are signed off by the ICB, alongside the boards of partner trusts and foundations trusts by the end of March 2023. A draft financial plan will be presented to the Finance & Investment Committee for consideration when it meets on 9th March 2023.

Report to the Board of the Integrated Care Board, 27 January 2023

16. Progress Report: Implementation of the Voluntary, Community & Social Enterprise and BLMK ICB Memorandum of Understanding

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input checked="" type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input checked="" type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input checked="" type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input checked="" type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input checked="" type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input checked="" type="checkbox"/>	Workforce <input checked="" type="checkbox"/>	Ways of working <input checked="" type="checkbox"/>	Estates <input checked="" type="checkbox"/>
Communications <input checked="" type="checkbox"/>	Finance <input checked="" type="checkbox"/>	Operational and Clinical Excellence <input checked="" type="checkbox"/>	Governance and Compliance <input checked="" type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

Report Author	Sonal Mehta, Voluntary, Community & Social Enterprise (VCSE) Partnership Lead
Date to which the information this report is based on was accurate	18/01/2023
Senior Responsible Owner	Maria Wogan, Chief of System Assurance and Corporate Services

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

BLMK VCSE Strategy Group
 BLMK ICB Co-production Team
 Maria Wogan, Chief of System Assurance and Corporate Services
 Anne Brierley, Chief Transformation Officer
 Manjeet Gill, Non-Executive Member
 Lorraine Mattis, Associate Non-Executive Member
 Tim Simmance, Associate Director of Sustainability and Growth

ICB VCSE Task and Finish Group

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

BLMK VCSE Strategy Group – 17 January 2023

ICB Executive – 18 January 2023

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

This report provides an update on progress since the Board approved the Memorandum of Understanding (MoU) with the VCSE at its last meeting.

The Board is asked to **note** progress with development of the strategic partnership with the VCSE and for relevant Board members to **support** discussion of the MoU and the opportunities for greater partnership working with the VCSE at Place Boards in February.

1. Brief background / introduction:

MOU – Sign-off

A Memorandum of Understanding between the ICB and the Voluntary, Community and Social Enterprise (VCSE) in BLMK was approved at the ICB Board in November. This formalises our commitment to working together and describes our strategic intent for the relationship. The MoU sets out the way in which we will work together to build a sustainable and effective partnership. The MoU will continue to be developed by the ICB and VCSE over time, recognising we are in a transitional year for the ICB and are building on collaborative working. The MoU will be signed by the VCSE Co-Chair of the BLMK VCSE Strategy Group (when they are appointed next month), and by the ICB Chair..

Embedding VCSE in ICB Governance

The VCSE Strategy Group has been consulted on the development of the Integrated Care Strategy and has informed how to engage the VCSE “at place” in its further development. Going forward, the Strategy Group will be chaired by Manjeet Gill, ICB Non-Executive Member and a VCSE Co-Chair will be appointed in February. This, along with the VCSE representatives on the Working with People and Communities Committee (WWPAC), strengthens the role of the VCSE in our strategic governance. A process for engaging the wider VCSE sector in the work of the WWPAC committee has also been developed. Consideration is also being given to involving VCSE representation in the Health and Care Senate as described in another agenda item for the Board.

VCSE Involvement in Operational Planning and the Joint Forward Plan

At the BLMK VCSE Strategy Group in December, “15 Facts about Health Inequalities in BLMK” that was presented to the Health and Care Partnership Joint Committee in December, was shared and the potential VCSE contribution to addressing these inequalities was discussed as an area of focus for our work as a strategic partnership. Anne Brierley, Chief Transformation Officer facilitated a discussion of the following areas, which already have strong VCSE involvement, and could provide a framework for more detailed joint planning work:

- Isolation, weather surges, and support for everyday living
- Prevention services e.g., vaccinations, screening and early diagnosis
- Green agenda and sustainability
- Living your best life – thriving and flourishing
- Social action, community development and health creation

It was proposed that these areas are further explored with the VCSE as part of the operational planning process and a follow-up discussion was held with the VCSE Strategy Group on 17th January. It was also recognised that funding for the VCSE from statutory partners can be a lever to accessing further funding.

Improving ICB Processes to Support Partnership Working with the VCSE

A task and finish group has been set up within the ICB to look at internal processes that can be improved or developed to support better partnership working with the VCSE. Topics the group have identified as areas for improvement include contracts, procurement, standing financial instructions, mapping of VCSE spend by the ICB and local authorities, operational planning, communications & engagement, evaluation and impact assessment and identifying VCSE providers that are nearing the end of contract associated with non-recurrent spend. Similar themes have emerged from the VCSE Strategy Group and we will be setting up working groups comprised of VCSE and ICB colleagues to co-design improvements in these areas to strengthen our partnership.

Specific pieces of work have also been discussed within the task and finish group such as using a statutory partner in the ICS to undertake Disclosure and Barring Service checks for VCSE organisations, and to understand how work around winter pressures can contribute to the development of a year-round surge model.

VCSE and the BLMK People Plan

VCSE workforce (paid and voluntary) is integral to the BLMK People Plan and draft People Strategy. VCSE colleagues are part of our training and support offer including our Leading Beyond Boundaries course. The important role of volunteers in our workforce is recognised in our Plan and Strategy with a focus on 'volunteer to career' opportunities to strengthen our workforce in terms of capability, diversity and capacity.

VCSE and Working with People and Communities

Discussions have also been taking place with the ICB colleagues regarding the VCSE's role in co-production and engagement work. It is recognised that VCSE organisations can undertake a number of roles in this area, for example, understanding lived experience, or as a provider of services. Principles for resourcing the VCSE to carry out these different roles need to be agreed.

The VCSE Strategy Group has been engaged in the development of the ICB co-production strategy. The VCSE sector more broadly have been asked to help shape and participate in the ICB's co-production training, which is being rolled out over Jan-June 23.

The number and range of approaches from ICB colleagues to the VCSE to support engagement work have highlighted the need for a co-ordinated approach internally, and with the VCSE and local authorities. Planning of engagement work in the context of existing initiatives is required at place and system level. This is needed to mitigate the risk of

- a) VCSE groups being asked to work across a range of similar areas
- b) Duplicating work across places and system
- b) creating confusion and engagement fatigue in some groups that have already highlighted this concern through desk research in the first part of the Denny review.

The ICB funded the second stage of research for the Denny review, to be undertaken by VCSE organisations and Healthwatch organisations across BLMK. Engagement with people and communities who experience health inequalities, as well as organisations that work closely and support them, took place. The information gathered will help to create a clearer picture of the specific challenges faced by people and communities who experience health inequalities. This will help inform the BLMK health

inequalities plans at place and system and enable the development of tailored solutions based on real community needs and lived experience of local residents.

Benefits of the Strategic Partnership with the VCSE

Given the wide-ranging opportunities for a strategic partnership with the VCSE sector, we need to clearly define the most significant benefits delivered by the VCSE, how the MoU will enable the ICS to meet our goals and how we will measure success. An implementation plan is being developed. Early actions with some indicative timescales have been outlined below and a more detailed programme plan is in development.

The VCSE Strategy Group met on 17th January and began work to raise awareness of the benefits of working with the VCSE sector. This will help create a shared understanding of what a strategic partnership with the sector across BLMK can deliver and will provide the shared leadership and ownership in setting the foundations for an effective partnership.

Mapping VCSE assets and investment

It is recognised that partnership working, and delivery will be at neighbourhood and Place where VCSE has established networks and groups. Mapping of VCSE organisations and the local eco-system at Place is needed, including the forums that the ICB can work in partnership with, and the spend from the ICB, local authorities and external funders to VCSE through grants, commissioned services and infrastructure support are actions to be taken forward in Q4 of 2022-23. The mapping exercise will also help understand the challenges, opportunities and strengths that lie within the sector.

Additional resource is required to undertake mapping of VCSE organisations and is currently under discussion with the VCSE infrastructure organisations in BLMK. The Place Link Directors have a pivotal role in ensuring that the VCSE are connected with statutory partners at Place and involved in early discussions regarding community engagement, and the design and delivery of projects and services. The MoU will be presented to the Place Based Boards in February for discussion and local Board members are asked to support those discussions.

Key Actions for Q4 22/23

Action	Timescale
Create strategy to raise awareness of the VCSE and bring about a shared understanding of the sector's impact across a range of areas	Jan - Feb
Involve VCSE in operational and strategic planning processes through Places and neighbourhoods	Jan - June
Map VCSE at place, including existing forums. Please note the timescale is for a first run as mapping of the VCSE requires regular review and keeping up to date	Jan – Mar
VCSE Strategy group to develop decision making principles for allocating system funding for direct investment into the VCSE e.g., when NHSE offer funding for the VCSE	Jan - Mar
MoU to be presented and discussed at Place based boards	Feb
ICB Place link directors to hold discussions with respective local authorities and VCSE at place to understand the ecosystem	Feb - Mar
Map ICB, NHS and local authority investment into the VCSE – include commissioned services and infrastructure	Feb - Mar
Create a communications and engagement plan to include two-way communications between the VCSE and the ICB and improving understanding of the ICB. This will include some open briefing sessions for VCSE trustees and staff on the ICS.	Feb – Mar
Joint Co-production training	Jan-June

2. Summary of key points:

- 2.1 A Memorandum of Understanding between the ICB and the Voluntary, Community and Social Enterprise (VCSE) in BLMK was approved at the ICB Board in November. This formalises our commitment to building a sustainable and effective strategic partnership.
- 2.2 The sector is recognised as integral to understanding the dynamics of each of the Places within BLMK, and the BLMK VCSE Strategy Group are informing the development of the Integrated Care Strategy.
- 2.3 Strategic governance has been strengthened through VCSE representation on the WWPAC committee. Manjeet Gill, BLMK ICB NEM, is the chair of the VCSE Strategy Group.
- 2.4 A variety of discussions about future work are on-going between ICB and VCSE colleagues in a range of areas. These areas include, but are not limited to, action on health inequalities, prevention of ill health, system pressures, creating conditions for a good life, co-production and engagement work, and health creation.
- 2.5 An ICB task and finish has also been meeting to review barriers, challenges and solutions associated with internal processes such as contracting, finance, communications and engagement, and operational planning. The VCSE Strategy Group and the ICB will jointly explore these areas further.
- 2.6 Implementation of the MoU will need to run alongside the operational planning and joint forward planning process, and further development of the Integrated Care Strategy.
- 2.7 Early actions to support the development of a programme plan have been identified. This will include mapping of key assets in each of the Places to better understand how ICB resource can be repurposed, and determine what financial investment is needed into the VCSE to strengthen collaborative working at neighbourhood and place.
- 2.8 The Place link directors will have a key role in ensuring the VCSE sector is engaged early in discussions.
- 2.9 Measuring success will need to include the impact on residents, the VCSE sector and the system.

3. Are there any options?

Options are being developed as part of the MoU implementation plan which will be reported to the ICB Board in June 2023.

4. Key Risks and Issues

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

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

All of these factors are having a significant impact on sustainability, recruitment and retention, including that of volunteers. It also affects capacity within the sector to be able to effectively engage with the ICB.

Pressures within statutory organisations and NHS providers is also creating challenges. If the current financial environment leads to budget cuts and the VCSE sector is not recognised as a key partner within the system, valuable services may come to an end, and in some cases may lead to a VCSE provider closing for good.

Workplace pressures within the NHS mean that many colleagues are struggling with capacity. Difficulties in engaging them in the ICB's journey of transformation, to more integrated and preventative models of health and care, and the broader ambition of economic and social development risks a continuation of the approach that has gone before.

The development of this MoU and underpinning workplan seeks to mitigate some of these impacts.		
Have you recorded the risk/s on the Risk Management system? Click to access system	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
The Risk Management system is being updated.		
5. Are there any financial implications or other resourcing implications, including workforce?		
<ul style="list-style-type: none"> Each of the places would benefit from a Place based role with responsibilities for integrating the VCSE sector into collaborative activity at neighbourhood and place. This will be addressed as part of the alignment and re-purposing of ICB resources to place. Financial investment into the VCSE to support participation of the wider sector in the work of the ICB will be considered as part of 23/24 budget-setting and operational planning and will be informed by the mapping work of current investments by ICB, NHS and Local Authorities. A financial investment into the VCSE sector is required to enable mapping of the sector and ensure the variety of groups and networks that exist across BLMK can effectively engage with, and deliver work for the ICB. The scope, cost and funding source for this work is being explored. 		
6. How will / does this work help to address the Green Plan Commitments?		
Click to view Green Plan		
The VCSE will continue to be engaged as a key partner in this area. Their role in prevention and reducing demand for services will help meet our net zero commitments.		
7. How will / does this work help to address inequalities?		
The VCSE is an essential partner in our approach to reducing inequalities due to their trusted relationship and reach into communities more likely to experience health inequalities.		
8. Next steps:		
<ul style="list-style-type: none"> Development of BLMK statement of VCSE benefits to build shared understanding VCSE involvement in operational planning Jan-June 2023 Resourcing to be defined as part of alignment of staff resource and budget-setting process for 2023/24 Update report to Board June 2023 		
9. Appendices		
None		
10. Background reading		
The MOU agreed by the Board on 25 November 2022.		

Report to the Board of the Integrated Care Board, 27 January 2023

17. Health & Care Senate Update

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input checked="" type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input checked="" type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input checked="" type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input checked="" type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input checked="" type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input type="checkbox"/>	Workforce <input type="checkbox"/>	Ways of working <input type="checkbox"/>	Estates <input type="checkbox"/>
Communications <input type="checkbox"/>	Finance <input type="checkbox"/>	Operational and Clinical Excellence <input checked="" type="checkbox"/>	Governance and Compliance <input checked="" type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

Report Author	Dr Sarah Whiteman, Chief Medical Director
Date to which the information this report is based on was accurate	13 January 2023
Senior Responsible Owner	Dr Sarah Whiteman

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

None

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

None

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

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

- A) Terms of Reference
- B) Programme of work

Executive Summary Report

This report describes the role of the Health and Care Senate (HACS), the key issues it has addressed since the formation of the ICB on 1 July 2022, and the current membership.

1. Brief background / introduction:

The Health and Care Senate (HACS) is a non-statutory advisory committee to the Integrated Care Board (ICB). Its main purpose is to provide robust, evidence-based views and recommendations on care and health issues. HACS members are a diverse group of senior care and health professionals from a wide range of organisations within the BLMK Integrated Care System. The Senate meets quarterly with other meetings or on-line working arranged as required.

2. Summary of key points:

Agenda items have included:

- **14 July 2022** Percutaneous Coronary Intervention (PCI) services review – the outcome was presented to the ICB where support was recorded for a proposed hub and spoke model, with Oxford (OUH) as the hub and a spoke at Milton Keynes (MK). There is also a potential review of current Bedfordshire Hospitals Trust (BHFT) delivery over two sites.
- **6 October 2022** Musculo skeletal (MSK) health needs assessment - the outcome from HACS was to note the focus on:
 - 1. Inflammatory conditions
 - 2. Conditions of MSK pain
 - 3. Osteoporosis and fragility fracturesand the need to consider the re-procurement timescale (starting 1 April 23), the importance of exercise as a preventive measure, the use of digital technology and the importance of a multi-organisational system approach. The issues of falls prevention, polypharmacy and frailty were then discussed at the next meeting involving the Bedfordshire Fire Service, emphasising the importance of system-working and the iterative nature of the outputs from HACS.
- **6 October 2022** Head & neck cancer services for Milton Keynes (MK) patients - following some concerns about the current pathway that involves patients being referred to Northampton General Hospital (NGH), the proposal that consideration be given to an OUH hub with an MK spoke model was supported. HACS emphasised the need for additional factors to be considered that include mental health (MH) support for patients, speech and language therapy (SALT) provision and restorative dentistry. A letter to East of England Specialised Commissioning team was agreed and discussions are ongoing with OUH, Spec Comm teams from East of England, Midlands and South-East), MKH, NGH, BLM & Midlands ICBs.
- **8 December 2022** Falls prevention in collaboration with Bedfordshire Fire Service. HACS also heard about the Polypharmacy project, "Reconditioning the Nation" and the work of the Research & Innovation Hub in association with the University of Bedfordshire. This was linked to a presentation on the BLMK approach to transformation, the outcome of which is an ongoing discussion around key issues such as Children & Young People (CYP), MH, cancer,

long-term conditions (LTCs), ENT, ophthalmology waiting lists and Primary Care opportunities arising from incoming pharmacy, optometry and dentistry (POD) delegation.

Future meeting dates (tbc)

21 March, 15 June, 19 September and 12 December 2023.

Further Developments

- Exploring how best to include meaningful participation from VCSE and patient representatives.
- Identifying transformation and efficiencies, including to ophthalmology and other elective pathways where there are delays
- Working with partners to improve system flow.

Health and Care Senate Membership

The terms of reference for the Senate are set out in the Governance Handbook and the current membership includes a wide range of clinical professionals, as shown below.

Forename	Surname	Role or Organisation
Brown	Emma	ICB/AHSN
Bodalia	Pritesh	Chief Pharmacist BHT
Bunga	Yolanda	Chief Pharmacist, CCS
Cartwright	Sally	Public Health Representative, Luton
Chadwick	Helen	Chief Pharmacist MK
Chakrabarti	Sanhita	ICB
Chandratillake	Suraiya	Chief Pharmacist ELFT
Collins	Victoria	MKC
Glyn-Davis	Helen	AHP Council
Harrison	Mike	LMC
Head	Vicky	Public Health Representative, Beds & MK & Wellbeing Board Representative (DEPUTY CHAIR)
Howard	Kate	CCS
Jones	Emma	CNWL
Kufeji	Omotayo (Tayo)	GP, Milton Keynes - Primary Medical Services Member
Lees	Liz	Beds Hospitals
McKenna	Claire	ELFT MH
Nelson	Kathy	ICB
Ogley	Julie	Director of Social Care, Health and Housing, CBC
Pearson	Nina	Primary Care
Rayan	Anshu	Chief Pharmacist, CNWL
Reckless	Ian	MKUH

Ruttley	Angharad	ELFT
Smith	James	CNWL
Soyombo	Bola	Milton Keynes Local Dental Committee
Stanley	Sarah	ICB
Staten	Adam	MK GP Fed
Thornley	Janet	GP Nurse Strategic Lead
Tisi	Paul	BHFT
Vickers	David	Medical Director, CCS
Walker	Kate	BBC Officer
Watson	Rick	BHFT
Whiteman	Sarah	Chief Medical Director & Caldicott Guardian (CHAIR)
Williams	Nicky	LMC
Zeidman	Gerald	LPC

3. Are there any options?

Not applicable

4. Key Risks and Issues

Reputational risk if advice from HACS successfully challenged; mitigated by ICS governance structure that ensures decision-making is robust and defensible.

Have you recorded the risk/s on the Risk Management system?

Yes

No

[Click to access system](#)

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

No

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

[Click to view Green Plan](#)

Key to the importance of systems thinking and more integrated problem-solving, which is a fundamental tenet of the Green Plan.

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

All work and issues considered include consideration of the degree to which health inequalities are being addressed.

8. Next steps:

Constructive discussion around value and purpose of the Health & Care Senate with suggestions about what the Board considers its approach should be and what outcomes it should be looking to achieve.

9. Appendices

None

10. Background reading

Terms of Reference are included as appendix I of the Governance Handbook which is published on the ICB (<https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/our-publications/uncategorized/nhs-blmk-icb-governance-handbook/?layout=default>)

Report to the Board of the Integrated Care Board, 27 January 2023

18. Green Plan Health Impact Assessment

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input checked="" type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input checked="" type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input checked="" type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input checked="" type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input checked="" type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input checked="" type="checkbox"/>	Workforce <input checked="" type="checkbox"/>	Ways of working <input checked="" type="checkbox"/>	Estates <input checked="" type="checkbox"/>
Communications <input checked="" type="checkbox"/>	Finance <input checked="" type="checkbox"/>	Operational and Clinical Excellence <input checked="" type="checkbox"/>	Governance and Compliance <input checked="" type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

Report Author	Emily Loud, public health registrar Tim Simmance, Associate Director of Sustainability and Health, BLMK ICB
Date to which the information this report is based on was accurate	23/12/2022
Senior Responsible Owner	Maria Wogan, Chief of System Assurance and Corporate Services Marcel Coffait – Senior Responsible Officer (SRO) Strategic Priority 4 - Growth

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

Tim Simmance, Associate Director of Sustainability and Growth
Stella Cockerill, Regional Net Zero Engagement & Sustainability Lead, NHS England - East of England
BLMK Green Plan Operational Working Group – sustainability leads in provider organisations and local authorities in the system

East of England Greener NHS ICS Net Zero Forum – Integrated Care System (ICS) sustainability leads across the East of England

Marcel Coffait – SRO Strategic Priority 4 - Growth

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

ICB Executives Meeting – 21/12/2022

BLMK Green Plan Operational Working Group (sustainability representatives from provider organisations and local authorities) – 13/12/2022

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

The members are asked to:

A) **Note** the findings of the BLMK Green Plan Health Impact Assessment

B) **Approve** recommendations as set out at paragraph 2.2

C) **Discuss** and **suggest** coordinated ways to implement recommendations across ICS organisations, including areas of focus for 2023 in particular.

Executive Summary Report

1. Brief background / introduction:

Climate change and the carbon emitting activities that cause it already drive disease and health inequalities in BLMK and will likely worsen without proactive action; Green Plans therefore present a significant and urgent opportunity to improve health.

The ICS Green Plan was created with input from NHS, local authority, Voluntary, Community & Social Enterprise (VCSE) and academic partners in BLMK. It was published in April 2022, following discussion and endorsement at the ICS Partnership Board meeting in March 2022. The Green Plan gave the high-level ambitions for the ICS, with the intention to develop detailed delivery plans as our collective understanding and plans in the area developed.

The Green Plan Health Impact Assessment (attached in the appendix) was undertaken over a period of three months (Sept-Dec 2022) and is an initial attempt to connect BLMK's carbon reduction commitments with local health outcomes. The purpose is to help identify priorities for the Green Plan at the intersection between commitments in environmental sustainability and the impact on the health and wellbeing of our populations.

This is a challenging process due to uncertainty and limited data. The data used for the analysis was that which was publicly and readily available and was not always easily aligned to the way the Green Plan ambitions have been set. By improving ICS Green Plan governance and data collection now, and with further engagement with partner organisations, this connection – and the ability to demonstrate impact on health outcomes as well as environmental sustainability – will become clearer in future.

Current BLMK Green Plan commitments are not ambitious enough to take advantage of the opportunity to improve health and reduce inequalities. However, by following existing evidence and committing to integrating climate and health related outcomes into existing ICS population health work, BLMK will be able ensure that efforts in environmental sustainability have positive population health impacts and support staff wellbeing in the short and longer term.

2. Summary of key points:

2.1. Key findings included:

- The baseline data for carbon reduction commitments in the ICS Green Plan is limited, making the impact of these commitments on emissions uncertain.
- Based on scope and scale of interventions in the scientific literature, current ICS Green Plan commitments were not ambitious enough in scale or scope to measurably improve health for BLMK communities or staff. This was often due to a lack of specific target being outlined.
- Climate change, current emissions and the systems that generate them are damaging health and contributing to inequalities in BLMK now, notably across domains from air pollution to extreme heat, to travel and nutrition.

2.2. Recommendations were as follows:

- Refine Green Plan goals to be more specific and evidence based in scale and scope, using an annual action plan, for example, to focus on policies (such as reducing car use, active travel, increasing fruit and vegetable consumption, passive cooling techniques) that are most likely to reduce emissions and improve health in a time-bound and measurable way.
- Fill key information gaps, including through a deeper exploration of data available to ICS partner organisations, to enable improved monitoring and evaluation, particularly in relation to key baseline activities for theme areas across the ICS, staff health and travel patterns, supply chain and adaptation planning.
- Improve ICS Green Plan monitoring, communication and governance to enable more comprehensive information collection, particularly with local authority, care sector and primary care partners, which are where the data available was either not publicly available or not readily aligned to the elements of the Green Plan. Further detailed work, with local authority and care sector partners in particular, should be considered to build on and refine the findings of the Health Impact Assessment.
- Commit to evidence generation on commitments or policies to reduce carbon emissions and improve health, especially those where the policy translation into local setting is most complex e.g., air pollution.
- Clarify the ICB's role in bringing the system together towards cohesive, evidence-based policies to reduce carbon and improve health.
- Integrate climate and health outcomes into existing population health management work across the ICS, including health and wellbeing strategies and JSNAs, to ensure their contribution to health and inequalities is formally recognised, and reduce possible duplication.

2.3. Short-term suggested areas of focus (2023) could include:

Socialising the findings of the report and working at Place level to identify the intersections between the recommendations and existing priorities and programmes of work.

Working to improve data and expand workstreams related to air pollution, active travel, nutrition and adaptation planning by:

- Identifying quick wins at the intersection with other strategic priorities where the opportunity for health impact from environmental sustainability initiatives is strongest; for example, obesity, respiratory, cardio-vascular, diabetes, and mental health, particularly for those in more-deprived communities.
- Gathering data on and mapping ICS staff commute locations, public transport and safe walking and cycle routes to support organisational decision-making on commuting policies.
- Bringing together local authority transport teams and NHS Trust sustainability representatives to discuss the Local Cycling and Walking Infrastructure Plans and how these could support improved rates of active travel among health and care staff.

- Highlighting key areas of population health and strategy at ICS level under review or being established in 2023, where the intersection of climate and health could be formally included e.g., JSNAs.
- Piloting and evaluating active travel initiatives such as:
 - walk to school and walk to work schemes
 - e-bike or similar for staff visiting patients at home to reduce business miles and promote active transport (e.g. community trusts, district nursing)
- Nominating a lead for the food and nutrition theme.
- Baselining nutrition profiles of staff and patient food on offer at hospital and other relevant organisational sites, as well as pricing to include inequalities.
- Nominating a lead for the adaptation theme.
- Identifying a forum through which to discuss sustainability and adaptation issues with the care sector.
- Discuss sustainability and adaptation issues with the VCSE sector, commencing with sharing the report with the ICS VCSE Strategy Group.
- Committing to a timeline and engagement process for writing the ICS adaptation plan, identifying additional project resource to support with it.

3. Are there any options?

No formal options appraisal.

4. Key Risks and Issues

There is a risk that the Green Plan commitments are not ambitious or specific enough to reduce the risk of Climate Change (BAF risk 7), and the associated impacts to health and wellbeing. This can be mitigated by enacting the recommendations in the report.

There is a risk to enacting the recommendations relating to time and resource commitment from those already directly or indirectly involved in the relevant areas. Mitigation will involve identifying where the recommendations can align with priorities at place level, thus achieving co-benefits of sustainability and health impacts through existing work programmes.

Have you recorded the risk/s on the Risk Management system?

[Click to access system](#)

Yes

No

BAF Risk 7

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

Recommendations require possible reallocation or expansion of resources:

- At ICB level: to continue to provide PMO support to delivery of the Green Plan programme of work. Additional commitment of resource may be required in order to develop and deliver specific recommendations; at present this is envisaged to come from within existing ICB and partner resource; any future additional funding required would be subject to further request / business case.
- At ICS provider and partner organisation-level: to collect and share data, and to include climate related health outcomes in existing health and inequalities workstreams

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

[Click to view Green Plan](#)

The report directly supports achievement and enhancement of Green Plan commitments and health of staff and communities, in particular relating to setting ambitious and achievable goals for each of the themes within the Green Plan.

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

By identifying health inequalities connected to current carbon generation activities and climate change more generally, and connecting these to the ICS Green Plan, this report provides guidelines for how to reduce health inequalities and improve health while reducing carbon emissions.

8. Next steps:

1. Approve each recommendation in the report and commit to supporting its enactment
2. Resource additional work to build on the report and identify additional impacts towards developing a model and/or dashboard to understand the impact of individual environmental sustainability initiatives.
3. Review and refresh Green Plan on an annual basis

9. Appendices

Appendix A – Health Impact Assessment of the BLMK Green Plan Dec 2022:

10. Background reading

[BLMK ICS Green Plan](#)

<https://blmkhealthandcarepartnership.org/~documents/plans/blmk-green-plan-final-31st-march-2022-1>

Health impact assessment: estimating the health impacts of the BLMK ICS Green Plan (2022-25)

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December 2022 (amended January 2023)



Trust



Respect



Integrity



Accountability



Care

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Acronyms, abbreviations and technical terms

- Attributable fraction: proportion of cases in a particular risk group that can be attributed to (caused by) the risk factor which is present i.e. the proportion of cases in that group that would be avoided if the risk factor wasn't present.
- BLMK: Bedfordshire, Luton and Milton Keynes
- CO2e: carbon dioxide equivalent, which includes carbon dioxide and other greenhouse gas emissions suitably converted in order to be able to measure all gasses together.
- HIA: health impact assessment
- HR: hazard ratio, a measure of how often a particular event happens in one group compared to how often it happens in another group, over time. Can be interpreted as a risk ratio in some circumstances.
- ICB: Integrated Care Board, which is the commissioning organisation for the Integrated Care System, with a statutory responsibility covering NHS Trusts and primary care organisations in its geographical area, and a partnership relationship with local authorities within its area.
- ICS: Integrated Care System, which includes all the providers of health and care in a specific geographical area.
- PM2.5: particulate matter 2.5 microns (or less) in diameter, also known as fine particulate matter
- PM10: particulate matter 10 microns in diameter
- RR: risk ratio, also known as relative risk, the probability of a particular event/outcome in a group who have an exposure/ risk factor versus the probability in those who do not.
- WHO: World Health Organization

Key messages and executive summary

Key messages

Climate change and the carbon emitting activities that cause it **already drive disease and health inequalities in BLMK**, and will likely worsen without proactive action; Green Plans therefore present a significant and urgent opportunity to improve health.

This report is an initial attempt to **connect BLMK's carbon reduction commitments with local health outcomes**. This is a challenging process due to uncertainty and limited data but, by improving ICS Green Plan governance and data collection now, this connection – and the **ability to demonstrate impact** - will become clearer in future.

Although they lay a good foundation for future work, the current Green Plan commitments are not ambitious enough to take advantage of the opportunity to improve health and reduce inequalities. However, by following existing evidence and committing to **integrating climate and health related outcomes into existing ICS population health work**, BLMK will be able ensure that efforts in environmental sustainability has positive population health impacts and supports staff wellbeing in the short and longer term.

Executive summary

Context and aims

By April 2022, NHS Trusts and Integrated Care Boards had published their first round of Green Plans, adding to sustainability strategies already adopted in some local authorities. At the same time, the newly formed Integrated Care Systems have also taken on responsibility for population health management, supporting prevention and tackling inequalities. The link between these two areas of work has not yet been made formally or strategically at national or local levels. Bringing together relevant data on green policies and health should enable an approach to Green Plans that is evidence-informed and most likely to improve health locally. The aims of this project, supported by the regional East of England Greener NHS team, were therefore to:

- Identify the evidence base and data sources (and gaps) in relation to health and green policy areas.
- Enable the ICB and ICS organisations to better evaluate their plans and track their progress with environmental sustainability plans in relation to health impacts and co-benefits.
- Review scope and scale of current Green Plan commitments, and suggest opportunities to maximise population health while cutting carbon emissions.
- Inform a sharable health 'dashboard' that summarises available evidence and lays a foundation for future work in this area.

Key questions and methodology

After consulting local sustainability leads and ICB theme leads (those identified as leading on particular Green Plan ambitions), local data and reviews of the scientific literature were combined to answer the following key questions:

- What are the baseline emissions of current ICS activities and how likely are current Green Plan commitments to reduce them?
- What are the health impacts of existing emissions and how likely are current Green Plan commitments to reduce them?

Current carbon footprint of ICS – baseline data for commitments is limited

The high-level estimate from Greener NHS which estimated that BLMK ICS' 19/20 carbon footprint plus (including direct and indirect emissions) was 324,540 tonnes CO₂e per year – the equivalent of driving 805.5 million miles in an average-sized petrol car. However, in relation to the baselines for each of the Green Plan's commitments, there is very limited locally collected activity data. This meant that estimating each commitment's likely contribution to carbon reduction was difficult, and in some cases not possible at all. In addition, when compared to the scientific literature, some commitments focussed on areas that would not provide maximum carbon reduction or health benefits.

Most information was available for estates, medicines (both based on Greener NHS dashboard data) and also for staff commuting (which could be estimated using workforce and national information). The least information was available for supply chain and adaptation theme areas, which was significant as supply chain and procurement was the largest part of the carbon footprint (192,980 tonnes CO₂e), and adaptation planning has significant consequences for health in extreme weather scenarios.

Health impacts - current emissions and conditions are damaging health

Locally, key activities across the ICS that emit carbon currently are contributing to poor health and health inequalities among the communities we serve, and the staff we employ. Health issues related to four key areas were examined: air pollution, extreme weather, active travel and nutrition. The scientific evidence that climate change, carbon emissions and related activities are contributing to poorer health presently was strong. Air pollution was the area where the most significant damage to health was likely being done to staff and the wider community, with more than 460 deaths and 21% of all asthma cases in BLMK likely attributable to long term pollution. There is therefore a clear and urgent case for putting local health outcomes at the core of Green Plan work going forwards. There are global implications too; BLMK emissions from the single year 2019/20 are likely to cause between 73 and 325 excess deaths (depending on the model and scenario used) globally between 2020-2100.

Current ICS Green Plan commitments – not ambitious enough

The BLMK Green Plan outlines a number of high-level ambitions that provide a good foundation for future work. However, the evidence is that current commitments are neither specific nor ambitious enough to have significant local health improvements. This means that the local health and care sector risks continuing to contribute to damaging health and worsening health inequalities through carbon emissions and

related activities, particularly air pollution. However, there were some policy examples from the literature which evidenced or modelled significant improvements in health related to more ambitious policies, which mostly related to staff since this was where the best local data was available. These could be implemented as part of the Green Plan workstream to have a greater impact on health locally, and would intersect well with ICS organisations' roles as anchor institutions.

Areas of future focus – concentrate on win-wins, generate better evidence

Reducing private car use was a key evidence based policy for improving air quality and also facilitating health benefits to staff via active transport. Ensuring that canteen food complies with Eatwell guidance could improve health of staff and also cut carbon emissions from catering activities. For extreme weather, insulation and external passive cooling mechanisms were found to be helpful in reducing mortality during heatwaves, and so would need to be at the core of adaptation planning (which has not yet been done). However, it was worth noting that neither local data or policy implementation literature provided high quality evidence, so commitment to ongoing data collection, monitoring and evaluation to understand what works for BLMK is essential.

Recommendations for this and future Green Plan work

In order to maximise health impacts of commitments to reduce carbon emissions across the ICS, the following actions were recommended:

- Refine Green Plan goals to be more specific and evidence based in scale and scope, using an annual action plan, for example, to focus on policies (such as reducing car use, active travel, increasing fruit and vegetable consumption, passive cooling techniques) that are most likely to reduce emissions and improve health in a time-bound and measurable way.
- Fill key information gaps, including through a deeper exploration of data available to ICS partner organisations, to enable improved monitoring and evaluation, particularly in relation to key baseline activities for theme areas across the ICS, staff health and travel patterns, supply chain and adaptation planning.
- Improve ICS Green Plan monitoring, communication and governance to enable more comprehensive information collection, particularly with local authority, care sector and primary care partners, which are where the data available was either not publicly available or not readily aligned to the elements of the Green Plan. Further detailed work, with local authority and care sector partners in particular, should be considered to build on and refine the findings of the Health Impact Assessment
- Commit to evidence generation on policy measures, especially those where the policy translation into local setting is most complex e.g. air pollution.
- Clarify the ICB's role as a climate and health leader, bringing the system together towards cohesive, evidence-based policies to reduce carbon and improve health.
- Integrate climate and health outcomes into existing population health management work across the ICS, including health and wellbeing strategies and JSNA, to ensure their contribution to health and inequalities is formally recognised, and reduce possible duplication.



Trust



Respect



Integrity



Accountability



Care and Compassion

1. Context

Background and purpose of this project

Greener NHS East of England requested work to develop connections between Integrated Care System Green Plans and health outcomes on a regional level. The Bedfordshire, Luton and Milton Keynes Integrated Care System (BLMK ICS) volunteered to be the example setting for this work, which would then be shared and applied more widely.

This report aimed to:

- Identify the evidence base and data sources (and gaps) in relation to health and green policy areas.
- Enable the ICB and ICS organisations to better evaluate their plans and track their progress with environmental sustainability plans in relation to health and co-benefits.
- Review scope and scale of current Green Plan commitments, and suggest how efforts to maximise population health while cutting carbon emissions.
- Inform a sharable health 'dashboard' that summarises available evidence and lays a foundation for future work in this area.

The ultimate vision is to have a Green Plan that is evidence-based and actively improves local population health while reducing carbon emissions, and is well connected to ICS and provider activities that have similar goals.

Audiences for this report

This report and its accompanying materials are intended to support colleagues in both Integrated Care Boards and provider organisations across the East of England and beyond (including local authorities and non-NHS partners in the ICS), to assess likely health impacts of their green commitments. Although the NHS organisations and the Greener NHS Net Zero plan are featured heavily, local authority sustainability plans and data are also included where available, and these settings are recognised as crucial collaborators in reduction of carbon emissions and health outcomes.

NHS Green Plans

In 2022, NHS Trusts and Integrated Care Systems (ICSs) were mandated to submit their 'Green Plans' for the period of 2022 to 2025 in order to support the wider NHS ambition of achieving net zero carbon emissions by 2040¹. However, given the current competing priorities and strain that the NHS is under – from care backlogs, to COVID recovery, to staff shortages, to inflation and stretched budgets² – there is a danger that environmental sustainability is not prioritised. While there is public support for NHS action to reduce its carbon footprint, it is not seen as a top priority by the public, nor is it well known about by NHS staff³. Connecting green policies with their potential health outcomes (and inequalities) may therefore be essential to achieving meaningful change at this time, because it could improve motivation for action on environmental sustainability among relevant staff and management.

Statutory duties of Integrated Care Boards and Systems

Integrated Care Systems (ICS), formed in 2022 to take the role of place-based commissioning for health and care, have also taken responsibility for population health management, which emphasises prevention and the role of the wider determinants of health in shaping a person's health outcomes⁴. The Integrated Care Board (ICB) is also tasked with collaborating with NHS provider organisations and local authorities across the ICS to form system year plans, informed by and working with local joint strategic needs assessments and health and wellbeing strategies⁵. The ICB therefore has both the opportunity and wider responsibility to lead the way in tackling environmental determinants of health to improve local wellbeing.

Health impact assessment process

This report followed the five typical steps to a health impact assessment⁶, which are:

- Screening: would it be helpful, and how?
- Scoping: what data and health impacts should be considered? What methods should be used?
- Appraisal of evidence: what is the data telling us and where is the evidence strongest?
- Reporting and recommendations – what are our overall findings and how could health be maximised and harm minimised in the context of the ICS Green Plan?
- Monitoring and evaluation – how could these recommendations be supported and monitored going forward?

2. Screening

The screening process examines the question “could this proposal have an impact on, or implications for, people’s health and well-being or any factors which determine people’s health?” This question is answered below from a general standpoint of the issues at stake, and then applying this lens to the Green Plan in particular. This is meant to be high level, since detailed data appraisal follows if the health impact assessment is taken forward.

3.1. Climate change and health

Climate change is a public health issue globally, nationally and locally. The scientific consensus is that it is already affecting health in Europe and will continue to do so, through extreme weather events, changes to food and water systems, and shifting infectious disease landscapes⁷. There is also a serious risk that climate change will worsen existing health inequalities, with older and more deprived groups more like to suffer death and disability from extreme weather such as cold, heat and flooding⁸.

Carbon reduction measures and health co-benefits

Reducing carbon has the overall effect of making extreme consequences of climate change less likely for all people, globally, in the medium to long term. However, local systems work on local population health needs as well as national priorities, so it is necessary to understand the possible mechanisms for health impacts locally on a shorter term. This makes it essential to identify co-benefits of carbon reduction measures – those that reduce carbon and also benefit health. The most well explored of these include reductions in air pollution (reducing respiratory and cardiac diseases), increase in active transport (improving obesity and cardiac diseases), and changes to diet (primarily through reductions in meat consumption)⁹.

Adaptation and health co-benefits

The climate has already warmed by 1.1°C¹⁰ compared to pre-industrial levels (1850-1900), and harms to health are already occurring and will continue to escalate whatever our future emissions trajectory¹⁰. This makes adaptation to extreme weather a key strategy for protecting health over the short, medium and longer term. One of the main adaptation areas with potentially significant co-benefits for health concerns the delivery of health and social care services in extreme weather, specifically high temperatures and flooding, and changes to NHS and care infrastructure to support healthy patients and undisrupted care¹¹.

The NHS and climate change

The NHS is estimated to emit 25 mega tonnes of CO₂ equivalent per year¹² (carbon footprint ‘plus’), roughly equal to the emissions from the whole country of Sri Lanka¹³. This represents around 5% of the country’s emissions as a whole, and 40% of public sector emissions¹⁴.



Health inequalities and vulnerable groups

The health impacts of climate change are also not being felt equally. In the UK, age, pre-existing medical conditions and social deprivation are key factors that can increase exposure to the effects of climate change and so generate inequalities in health impacts¹⁵. This must be addressed in the ways the NHS works to achieve net zero, and should form a part of action to reduce growing health inequalities, which is a core task of all Integrated Care Systems¹⁶.

Limitations of connecting green policies and health benefits

While the health impacts of climate change are clear, the pathways and feedback loops between global warming and health outcomes are often complex and high level. Therefore, it can be difficult to evaluate strategies to improve health outcomes, and causal links between action and results can be difficult to draw¹⁷. Any reduction in carbon emissions should produce health benefits somewhere due to reduced global warming compared to not reducing emissions, and high level predictions estimating the global excess mortality associated with carbon dioxide equivalents (ranging from 1,000 tonnes¹⁸ to around 4,000 tonnes¹⁹ being sufficient to cause one premature death 2020-2100) can be helpful in conceptualising this. The challenge is that this type of health benefit is likely be separated in time and space from the people or organisation reducing their emissions, which is why drawing out local health impacts is important for catalysing change²⁰. However, it is important to recognise that this view is limited; by focussing on observable local health outcomes we may miss wider impacts for which the data is weaker or is less applicable to our local context. Therefore, this health impact assessment can only provide part of the picture, not the full overview.

3.2. Possible impact of the BLMK Green Plan

What the plan says

Over the three years from 2022 to 2025, the BLMK ICS has committed to various actions around nine key themes²¹. Based on the general evidence discussed above, their impacts on health have been graded as high to low based on whether there is a clear pathway to health impact and whether there is a clear evidence base on the degree to which health would be affected.

Theme	BLMK ICS Green Plan commitments (2022-25)	Possible local health implications
Workforce and system leadership	<ul style="list-style-type: none"> • Embed staff training on sustainability into all induction processes • Have staff sustainability champions within each team • Include sustainability in job descriptions 	Possible indirect and longer term support for the other commitments in the plan at team level, by promoting greater understanding of sustainability and health.
Sustainable models of care	<ul style="list-style-type: none"> • Reduce the distance to and frequency of appointments • Improve the efficiency of care delivered • Reduce length of stay in care facilities 	Reducing patient and clinician transport emissions leading to improved air quality with impacts on respiratory and heart disease. Promoting active transport contributing to improved air quality, with additional individual benefits around obesity, heart disease and mental health.
Digital transformation	<ul style="list-style-type: none"> • Increase the use of online services for patients • Digitise paper-based operations • Integrate sustainability into digital plans 	Fewer trips reducing emissions from transport, improving air quality with impacts on respiratory and heart disease.
Travel and transport	<ul style="list-style-type: none"> • Reduce the requirement to travel (reduce business miles by 10% each year by 2025) • Take measures to facilitate increased uptake of EVs • Encourage active travel through facilities for cycles (cycling infrastructure at 100% of feasible sites by 2025) 	Possible improvement in air quality through reduced transport emissions, also direct physical benefits to staff through active transport.

<p>Estates and facilities</p>	<ul style="list-style-type: none"> • Improve energy efficiency and decarbonise energy inputs across all estates • Improve biodiversity and green estates where possible • Reduce resource waste across all waste streams 	<p>Energy efficiency could improve temperature regulation of patients and staff in extreme weather, sources improved mental health and air quality through greening of estates, potentially improved air quality due to reduced incineration waste.</p>
<p>Medicines</p>	<ul style="list-style-type: none"> • Engage patients and staff in discussions about medicines optimisation and develop an approach to reduce emissions generated by inhalers and anaesthetics where clinically appropriate • Tackle waste generated by medicines and promote training and awareness for staff on recycling and medicine disposal • Reduce emissions generated by the transport of medicines 	<p>Reduction in medicines transport emissions could improve air quality.</p>
<p>Supply chain and procurement</p>	<ul style="list-style-type: none"> • Ensure suppliers are aligned with the NHS' green agenda • Switch to local suppliers where possible • Reduce the use of single-use plastic products 	<p>Possibility of indirect emissions reductions via local suppliers' alignment with Green Plan commitments and additional local employment.</p>
<p>Food and nutrition</p>	<ul style="list-style-type: none"> • Reduce food waste across our sites and facilities • Phase out plastic packaging • Provide more sustainable food choices for our workforce 	<p>Possible reduction in processed food consumption for workforce and patient/client groups, with direct benefits for healthy weight, heart disease and long term illness.</p>
<p>Adaptation</p>	<ul style="list-style-type: none"> • Develop risk assessment and progress monitoring mechanisms • Establish management and oversight practices • Increase risk mitigation efforts by developing the necessary emergency planning and preparedness strategies 	<p>Likely to reduce death and illness in extreme weather events (cold, hot, flood).</p>

3.3. Local views and gaps in health information

Other green plans

Green Plans (or a close equivalent e.g. net zero or carbon reduction plan) for 10 of the 11 main provider organisations were also identified (a Green Plan was not identified for South Central Ambulance Service NHS Trust, but a previous Sustainable Development Management Plan was referenced instead – [see below for complete list](#)). The NHS provider organisations (6 of the 10) all followed similar commitment theme areas, however the local authority plans (4 of the 10) were more varied in both scope and detail, since there is no national guidance equivalent to Greener NHS for them to follow. All provider plans generally recognised the importance of emissions reductions for health, and 8/10 plans gave one or more specific example of this. However, none directly quantified any possible health benefits in their plans.

Views from local stakeholders

The ICS ‘Green Operations Group’, comprised of sustainability leads from BLMK was consulted on the possibility of a health impact assessment in June 2022 before work began on the screening section of the project in earnest. The prospect of an evidence base linking health outcomes with sustainable actions was positively received.

In addition, a survey was shared with ICS theme leads and sustainability leads from NHS provider trusts, and Healthwatch representatives to get more detail on what they thought of the health impact assessment, and how they might be able to use the results. Twelve people responded (2 from the ICB, 8 from provider organisations and 2 from Healthwatch). Some key findings included:

- 6/12 said it was difficult to connect ICS level green policies with health impacts, with 3/12 saying it was neither easy nor difficult, and 3/12 saying it was easy.
- The main barriers to Green Plan policies were system coordination, and lack of time, capacity and resources.
- 9/12 of respondents said it would be useful to have a dashboard or toolkit to connect policies with their health impacts. Two people said it would possibly be useful and another said it was unlikely to be useful. Interestingly, those who were less sure it would be useful came exclusively from the ICB. Quotes from individuals responding to this question are displayed below:

“Clearer evidence between health outcomes and local action would better support engagement with residents and connectivity between residents/patients and the Green Plan. Clinicians discussing medicine’s optimisation with patients must have the evidence to clearly communicate that changes to prescribing is based on what is best for the patient and supports the environment. VSE bodies must be able to relate the evidence to bids for resources to grow green initiative projects.” - **voluntary sector context**

“This would be helpful. This would be great to share with the Council’s Public Health team to show where the links lie and how the Council can assist in improving both health and reducing carbon emissions. It’s not always easy for people to connect the two.” – **council context**

“Possibly [this could be useful]. I think what would be more useful would be a toolkit letting orgs know how they might implement elements.” – **ICB context**

- Of the ICB and provider responses, 3 people weren't tracking anything currently. The remaining 7 from this group were tracking a combination of process measures like meetings or progress on plan related actions, as well as utilities and energy use.
- For those who thought that having clearer evidence on health would be useful, the health topics they suggested they would like to see tackled included: respiratory issues and air pollution, staff well being, mental health, protection against extreme weather, active travel, and reduced health inequalities.
- There was no consensus on what level of geography or what timescale it would be most helpful to have health effects, with one respondent saying 1-2 years would be helpful for sharing with clinicians, and another citing longer term periods such as 8 years.

3.4. Conclusions

To conclude, a health impact assessment is required because the Green Plan represents a major policy instrument for the integrated care system, which is likely to have an impact on population health, and whose overall stakeholders support the strengthening of links between health impacts and sustainable actions. This was therefore be done as a concurrent health impact assessment (since the Green Plan has already been formulated and published). Methods combined desktop and comprehensive types of health impact assessment, which means that a small number of participants were be consulted for expertise, combined with longer term research drawing on scientific and grey literature.

4. Scoping

4.1. Setting the scope of the health impact assessment

Geographical boundaries

This impact assessment only included impacts within the area of the integrated care system across the local authorities of Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. The estimated population of around a million residents²² has mixed ethnic groups and levels of deprivation, with a population that is growing faster than average²³.



Figure 1: Map of BLMK geography²⁴.

Governance and steering group

The HIA project group, which meets weekly, includes Tim Simmance (BLMK ICS Associate Director of Sustainability and Growth), and Stella Cockerill (Regional Net Zero Engagement and Sustainability Lead, NHS England - East of England). Activities were reported back on an intermittent basis to Maria Wogan (Chief of System Assurance and Corporate Services).

The work was also regularly reported back to the BLMK ICS Green Operational Group whenever it meets, which includes sustainability representatives from organisations across the Integrated Care System. More widely, informal updates were shared with the East of England net zero leads group and the stakeholders who were surveyed at the start of the screening process. Once results were available, a summary of them was shared publicly across the ICS.

Key stakeholders

The ICS also covers a wide range of organisations providing health and care in the area, who are the key stakeholders for the ICS Green Plan and so also for this health impact assessment. Some of the main provider organisations in the ICS include:

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

Other important parts of the ICS include:

- Healthwatch: Milton Keynes, Luton, Central Bedfordshire and Bedford Borough
- All local primary care networks and the 96 GP surgeries they cover²⁵
- BLMK Integrated Care Board

Health issues

According to the overview of evidence and feedback gathered as part of the screening stage, the four main areas where health harms and benefits will be assessed are:

- Air pollution
- Physical activity
- Diet
- Extreme weather

Within each health issue, it will also be essential to discuss particularly vulnerable groups and health inequalities, wherever adequate information is available.

Emissions considered

Emissions will be considered based on availability of information, but are likely to focus on scope 1 and 2 level emissions:

- **Scope 1 emissions** are the emissions an organisation has direct control over. That is why they are also called direct emissions. They include emissions released due to energy use (apart from electricity), vehicle tail pipe emissions if the vehicle is owned by the business and, for the NHS, anaesthetic gases.
- **Scope 2 emissions** are indirect emissions associated with an organisation's electricity use which are released during the generation of electricity.

- **Scope 3 emissions** covers all other indirect emissions. They are a consequence of the activities of an organisation, but occur from sources not owned or controlled by the organisation, for example, emissions which are embedded in the supply chain. These emissions may occur upstream or downstream. For example, manufacturing products and well-to-tank emissions (WTT) are upstream scope 3 emissions. Whereas the use of sold products and disposal of waste are downstream emissions.

4.2. Scoping research questions and data sources

Overall research question: what health impacts could achieving targets in the ICS green plan have, and how could that progress be tracked?

To answer this question, evidence will be gathered and appraised in three stages:

- 1) **Measurement and monitoring:** what is existing best practice for measuring and linking carbon emissions and health outcomes in a health and care context?
 - *Local data:* targets articulated in the green plan and by theme leads, local context from other ICSs in the region.
 - *Academic and external data:* literature review of existing tools / dashboards/methodologies to support the connection of emissions and health related impacts to ensure these are combined in the most meaningful way.
- 2) **Current activities and emissions:** what are the baseline emissions of current ICS activities and how likely are current Green Plan commitments to reduce them?
 - *Focus:* use high level data to establish likely emissions from the ICS.
 - *Local data:* baseline activities from ICS theme leads and provider green plans, combined with standard carbon emissions datasets such as the BEIS emissions factors database²⁶ to estimate their current contribution by each theme area in the green plan. A hybrid approach to carbon footprinting (a combination of bottom up and top down, depending on what information is available) was used.
 - *Academic and external data:* if activity data is not available at a high level, then it will be estimated by reviewing the literature from comparable settings.
- 3) **Health effects:** what are the likely health impacts of existing emissions and how likely are current Green Plan commitments to reduce them?
 - *Focus:* connections between emissions and policies related to the most likely health issues covered in the green plan: air pollution, active travel, dietary change, and extreme weather in UK context.
 - *Local data:* input from the ICS on overall patients and staff involved in ICS activities each year; exposure and prevalence of relevant health conditions to be established via Fingertips, Defra and other public-facing government sources.
 - *Academic and external data:* review of systematic reviews and meta-analysis from Google Scholar and Pubmed for systematic reviews and meta-analysis literature providing a likely effect size on health for each issue of concern.

Full methodologies (including search terms) are detailed in the appendix. Once evidence for these three areas has been gathered and appraised, the following section will consider recommendations about how health impacts could be optimised and estimates could be improved in future.

In all cases, estimates on emissions and their health impacts will be computed using a combination of local data and information from scientific literature and relevant case studies if possible. However, it is likely that local information on emissions (from ICS theme leads and provider calculations, for example) will be limited since the ICS Green Plan was only published in 2022 and no formal carbon footprinting has yet been conducted. In this situation, high level estimates from the scientific literature, comparable settings, and reference emissions data will be computed so that more locally specific data can be calculated at a later date.

4.3. Appraisal of evidence

Conclusions for each section will be appraised along four main dimensions:

- **Current activities and emissions** – how much information is there on current activities and carbon emissions, and is it sufficient for us to estimate their current and future health effects?
- **Strength of scientific evidence** – how high is the quality of evidence for the link between the emissions reducing policy and health benefits / the emissions and damage to health in the wider literature? High quality evidence would be defined as:
 - A systematic review and meta-analysis in a high impact journal
 - Large scale observational studies from a UK context that clearly account for risks of bias in a high impact journal
- **Policy translation of evidence** – is there evidence of what kinds of policies can bring about these health improvements in real-life?
- **Impact of ICS commitments in light of evidence** – how well do ICS commitments match the scale or content of the evidence and policy findings?

The ratings will be marked on three levels:

- Strong – good quality evidence, sufficient data to make a judgement.
- Moderate – some evidence or data, but it may not be from local sources, a judgement can be made but it is quite uncertain.
- Weak – very little evidence or data, any judgement will be very uncertain.

4.4. Stakeholder engagement

Ongoing stakeholder engagement was key in order to shape the health impact assessment and its recommendations. It was also essential to establish current levels of knowledge around Green Plans and their equivalents, as well as to understand the levels of monitoring and data gathering was already happening.

This importance and interest matrix shapes how and how often different groups are involved in this process.

High interest	Satisfy - <i>Keep informed with what is happening and review their involvement regularly.</i> Sustainability leads from provider organisations ICS leads from East of England	Manage closely - <i>Key stakeholders who should be fully engaged and involved.</i> Tim Simmance – Sustainability Lead, ICS Stella Cockerill – NHS England, East of England Net Zero lead
Low interest	Monitor - <i>Keep informed</i> Healthwatch and the wider public, policy organisations and others around the country doing similar work, Greener NHS, ICS governance structures	Keep informed - <i>Review their engagement and involvement.</i> Maria Wogan / ICS governance and ICB theme leads
	Low influence / impact	High influence / impact

In terms of reporting to wider ICB leadership and committees, this work was reported back to relevant meetings, including all the stakeholders listed here. A full log of stakeholder engagement meetings (both scheduled and completed) can be found in the appendix.

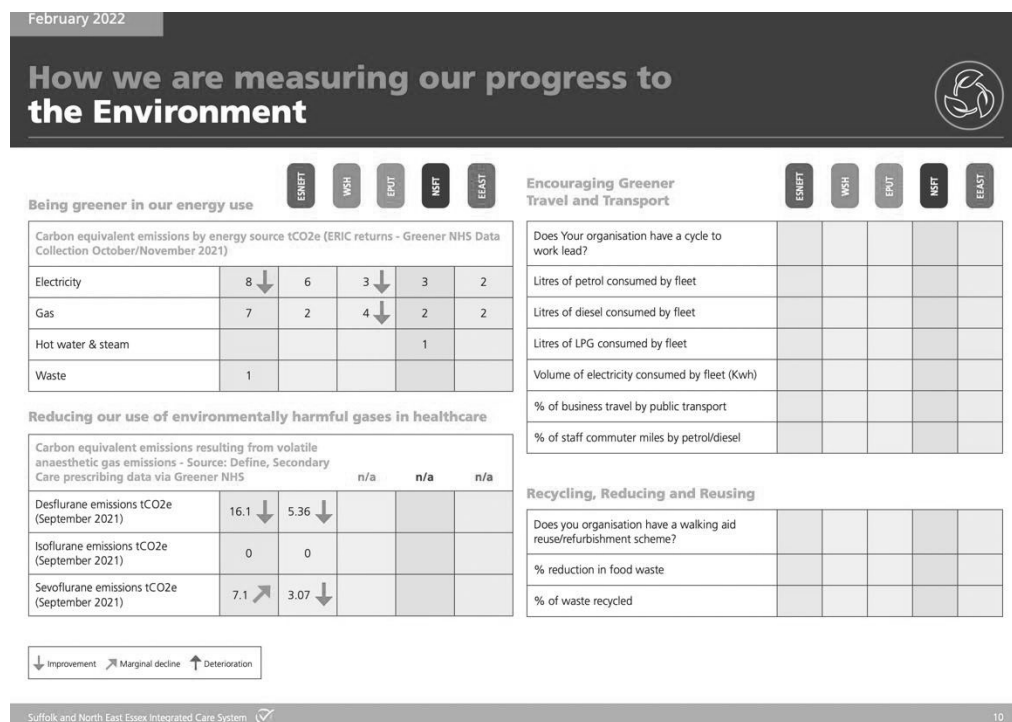
5. Appraisal of evidence and results

5.1. Measurement and monitoring

The aim of this section is to highlight existing approaches to measuring impact of green plans, specifically in relation to health, to ensure available tools are used, and the conclusions of HIA are up to date and not duplicating existing work.

5.1.1. Local approaches

In the East of England region, there is no directly similar tool or project currently underway. However, there is significant and potentially overlapping work ongoing on NHS trusts as ‘anchor institutions’, which are ‘large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve’²⁷. In particular the Suffolk & North East Essex Integrated Care System has been advancing its work on anchor institutions²⁸ by developing a dashboard that covers relevant social and environmental indicators. This includes some emissions and Green Plan related activity data, but is not currently complete; this presents an opportunity for tracking health outcomes of green policies in future.



In addition, previous work by students at the local Cranfield University modelled improvements in air quality against COVID-19 infection rates²⁹, which could have relevance in the context of Green Plan policies that could improve air quality.

It is also important to consider the work done in the ICSs, both in the East of England and across the UK. After enquiring with national NHS colleagues, they were not aware of other ICSs who were conducting work similar to this analysis. However, contact was made with Sussex ICS, who are in the early stages of a health and equalities impact assessment of their Green Plan.

5.1.2. National approaches and examples from literature

A key tool of note is the Greener NHS Dashboard (NHS Organisations), developed alongside the Green Plans, which monitors:

- Carbon equivalent emissions associated with NHS activity
- Policy and contractual levers which support a Net Zero NHS

This tracker is internally facing and takes measurements on a quarterly and annual basis. It tracks emissions by estates, anaesthetic gases, nitrous oxide and associated waste, and fleet. It is organised by NHS Trusts, not currently by ICS. Additionally, not all trusts have reported against each metric. There is another (unrelated) tool which helps GP surgeries calculate their carbon emissions – the GP carbon calculator³⁰. None of these tools currently include health outcomes, but could be useful sources of activity and emissions data.

In addition, prior to the creation of Trust and ICS level Green Plans, Greener NHS provided ICS level estimates of carbon emissions. This was calculated using a mix of top down and bottom up information, and so was quoted alongside other calculations for context. More recent estimates were given where information was sufficient. However, it was not clear the extent to which local authority emissions were included.

An adaptation focussed tool from the University of Exeter looks at climate forecasts for a local area and how adaptation policies might affect it³¹. At the time of citation, this was only available for the Cornwall area, but there are plans for a national version in the near future.

Sustainable Development Assessment Tool (SDAT) was a self-assessment tool previously supported by the NHS' Sustainable Development Unit (now Greener NHS), and well used by Trusts in previous sustainability planning. It enabled trusts to mark their progress against various domains. It seems unlikely to have included health outcomes based on public facing examples of its use³², but is no longer available online so it cannot be directly assessed. A similar tool for Green Plans specifically is apparently in progress, which would support this work directly going forward.

Additionally, the 'Health Outcomes of Travel' tool³³ was developed by the Sustainable Development Unit to model possible impacts of changes to travel methods in terms of Quality Adjusted Life Years (QALYs). Although it has not been updated since 2019, it contains helpful information that will be directly relevant to this exercise. A local authority air pollution and healthcare costs tool³⁴, and an older one for mortality³⁴ were also both previously developed by Public Health England (now UKHSA) to link air quality and health outcomes.

Future sources of information relevant to this exercise should also be considered, since they present the opportunity to update conclusions on health impacts as Green Plans progress. These include the new UKHSA Centre for Climate and Health³⁵, and the joint venture from the Office for National Statistics and the Wellcome Trust³⁶. The ONS and Wellcome programme intends to gather and publish health data

related to climate change, which could include co-benefits of mitigation strategies, but this does not appear to be the initial focus. Meanwhile, the UKHSA centre intends to ‘mobilise the evidence base to inform the design and implementation of climate change policies across local and national government and with international partners’³⁷, which certainly seems likely to cover this remit in future, although the timeline is uncertain. Overall, national work in this area is ongoing so the purpose of this HIA is to fill the gap and support local action on the Green Plan until such a time as improved tools and information is available.

5.2. Emissions levels and baseline activities

In order to support the development of the Green Plan, Greener NHS provided an estimate of BLMK ICS’s carbon footprint for the year 2019/20. This is very high level, so it may be necessary to do some additional footprinting work to understand the possible effects of different policies, but this is also a helpful reference point for this health impact assessment exercise, particularly where newer information is available. This estimated that BLMK ICS’s carbon footprint (emissions BLMK directly generate) was 57,280 tonnes CO₂e per year, and our carbon footprint plus (emissions BLMK can influence) was 324,540 tonnes CO₂e per year. Below, this estimate is broken down by Green Plan theme area.

Category	Tonnes CO ₂ e
Medicines total	17,130
Anaesthetic gases	4,700
Metered dose inhalers	12,430
Estates total	30,510
Coal	0
Gas	14,870
Electricity	12,650
Heat and steam	0
Oil	130
Waste	2,370
Water	490
Travel and transport total	44,780
Business travel	8,370
NHS fleet	1,270
Patient travel	20,510
Visitor travel	5,990
Staff commuting	8,640
Supply chain total	192,980
Business services	32,570
Medicines and chemicals	66,670
Medical equipment	28,930
Construction and freight	24,510
Non-medical equipment	40,300
Food and nutrition total	24,200

Other total: commissioned health services outside NHS	14,930
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5.2.1. Workforce and system leadership

Reminder of ICS Green Plan commitments in this area

The workforce and leadership commitments from the ICS green plan, and their required baseline activity levels, are:

- Embed staff training on sustainability into all induction processes (KPI: % of staff participation on sustainability e-learning modules)
- Have staff sustainability champions within each team (KPI: successful creation of cross-organisation working groups on sustainability, % of staff reached via communications channels on sustainability messaging)
- Include sustainability in job descriptions (KPI: none)

Available baseline information

Workforce and leadership activities are unlikely to have a direct contribution to reducing carbon emissions and having knock on health effects themselves, but should instead act as enablers to other types of action by increasing knowledge, engagement and willingness to act. This is because lack of knowledge is often cited as a barrier to action in a healthcare context³. However, the size and behaviours of the workforce also has a large influence on the carbon emissions of the ICS, so it is also important to understand this as a baseline measure.

Size of workforce

NHS Digital provides information on staff employed in the Trusts active across the ICS as of June 2022³⁸. For the providers that also work outside of BLMK, employee numbers were scaled down in order to better represent numbers present within our area. These proportions were requested from each organisation, but where they were not confirmed or verified, estimates are followed by an asterisk (*).

In addition, in their Green Plans, Bedfordshire Hospitals NHS Foundation Trust specified they also had 500 volunteers, and East of England Ambulance Trust 1,500. For the GP workforce, NHS Digital also provides the number of employees in general practice across BLMK for August 2022³⁹. Numbers for all local authority employees (including those in education) were obtained via the LG Inform platform⁴⁰, dated to quarter 2 (April-June) of 2022. Adult social care numbers were taken from a recent Skills for Care analysis⁴¹. This may be an underestimation, as it also doesn't include children's care workers.

Organisation	Headcount
Bedfordshire Hospitals NHS Foundation Trust - employees	7,844

Bedfordshire Hospitals NHS Foundation Trust – volunteers	500
East of England Ambulance Service NHS Trust – employees (15% applied to overall number for BLMK estimate)*	836
East of England Ambulance Service NHS Trust – volunteers (15% applied to overall number for BLMK estimate)*	225
Milton Keynes University Hospital NHS Foundation Trust	3,786
NHS Bedfordshire, Luton and Milton Keynes ICB	361
Cambridgeshire Community Services NHS Trust (37% applied to overall number for BLMK estimate)	1025
Central and North West London NHS Foundation Trust (15% applied to overall number for BLMK estimate)*	1,157
East London NHS Foundation Trust (27% applied to overall number for BLMK estimate)	1,795
South Central Ambulance Service NHS Foundation Trust (10% applied to overall number for BLMK estimate)*	447
All GPs	642
All GP nurses	379
All other patient facing staff at GP practices	349
All GP administrators	1,595
Bedford Borough Council	3,784
Central Bedfordshire Council	2,841
Luton Borough Council	5,680
Milton Keynes Council	4,063
Adult social care (independent sector)	18,000
Total employment footprint	55,308

If we take the average UK carbon footprint (4.85tCO₂e per person⁴²) and apply it to the staff estimate above, the ICS Green Plan and plans of all the organisations with in it could be influential over 268 kilotonnes CO₂e, excluding possible impact on the wider households of these employees. This is a significant number of people who could contribute personally and professionally to reducing carbon emissions, and benefit from policies to improve their health at the same time.

Other baseline activities

After meeting with theme leads for workforce and system leadership, it was evident that there was no further baseline information on sustainability champions, training or job descriptions across the system. Other helpful information for the calculation of co-benefits, in terms of sustainability awareness, employee travel patterns and occupational health data were not available, so would need to be based on national averages.

No evidence about whether including sustainability in job descriptions or having sustainability champions would decrease emissions was found. Although training is not a prerequisite for pro-environmental behaviour⁴³, weak evidence from the Carbon Literacy Project suggests that 5-15% of carbon emissions could be reduced with increased employee awareness (which includes pledges at the end of training), which are mostly via energy savings⁴⁴. It is not clear whether this would be at work or at home. Applying the 5% level to the ICS carbon footprint plus of 324,540 tonnes CO₂e per year, and assuming 25% of staff took this training and its effects did not wane, this could be a saving of around 4 thousand tonnes CO₂e per year in a professional context. However, this evidence is vague and uncertain, so gains such as these cannot be guaranteed following training.

Appraisal of data and evidence on current activities and emissions

- There was weak evidence on carbon footprint of current area.
- There was weak evidence on how commitments might reduce emissions.

Further information required on current commitments:

- Ambition on proportion of the workforce that should undergo sustainability training (beyond induction), and the behavioural results expected from this.
- Understanding of what adding sustainability to job descriptions would look like and how this could influence behaviour and emissions.

Areas missing from commitments:

- What system leadership across the ICS for Green Plans and sustainability more broadly might involve or look like.

5.2.2. Sustainable models of care

Reminder of ICS Green Plan commitments in this area

- Reduce the distance to and frequency of appointments (KPI: average distance to receive care, % reduction year on year).
- Improve the efficiency of care delivered (KPIs: average number of avoidable visits / care episodes, referrals per 1000 population/specialty and PCN and follow-up appointments)
- Reduce length of stay in care facilities (KPI: average length of stay in hospital (by type of illness/treatment)).

Available baseline information

After discussing with the digital lead, it was established that no local baseline information was available for average distance to care, frequency of appointments or length of stay in care locally. This means that national data and average were used in place of local baselines.

Distance to care and frequency of appointments

The few studies that do exist on mode of transport to care show that the majority of appointments are made by car, with one 2012 study from Yorkshire estimating that 75% of journeys were completed by car for GP appointments⁴⁵, and another randomised controlled trial conducted a travel survey as part of a health economics assessment also found 75% of people attended both GP and outpatient appointments by car⁴⁶.

Average car journey time (2019)⁴⁷ according to the Department for Transport is available for hospitals and GPs by local authority. Given the relatively short times on display, it would indicate that people often drive locally for their NHS care appointments. Taking an average of the Department for Transport's average road speeds⁴⁸ for motorways, A and B roads, local and minor streets, a driving speed of 39.9km/hr can help to provide a rough estimate of the equivalent distance travelled.

LA	Driving time to hospital (mins)	Estimated distance (km)	Return journey (km)	Driving time to GP (mins)	Estimated distance (km)	Return journey (km)
Bedford	16	10.6	21.2	9	6	12
Central Bedfordshire	23	15.3	30.6	9	6	12
Luton	17	11.3	22.6	7	4.7	9.4
Milton Keynes	14	9.3	18.6	8	5.3	10.6
Overall average BLMK	17.5	11.6	23.2	8.25	5.5	11

These average estimates can then be combined with data on the numbers of in person appointments in the year 21/22^{49, 50} to understand overall activity and emissions levels:

Type	Number of attended, in person appointments 21/22 (BLMK)
General practice	3,709,496
Hospital outpatient	993,495

A limitation of this methodology is that it does not include community appointments or home visits. However, face to face remains the main method of appointment for GP and outpatient appointments, so this does capture the majority of activity. In addition, while this methodology overall does include various levels of assumptions, it is similar to one used by NHS Midlands and Lancashire Commissioning Support Unit to calculate the economic and environmental case for virtual appointments⁵¹.

Combining the BLMK average distances calculated above with the number of in person appointments can provide estimates of emissions by appointment type. Assuming that 75% of journeys were made by car and 3% of those cars were electric⁵², with the others using average emissions factors from BEIS (including well-to-tank):

- Hospital outpatient appointments: 3.7 kilotonnes CO2e per year, average 3.7kg per appointment
- GP appointments: 6.6 kilotonnes CO2e per year, average 1.8kg per appointment

It is unclear what an appropriate reduction in distance to and frequency of appointments would be, and the Green Plan does not set a specific reduction target. However, national targets are to reduce outpatient appointments by 25% against 2019/20 activity levels by 2023⁵³. Although the composition of in-person and remote appointments has changed, the overall activity of attended outpatient appointments in BLMK is roughly the same in 2021/22 as it was in 2019/20⁵⁴. If we assume that remote appointments remain the same proportion (19.4%, see below), this would represent a 20.4% reduction in face to face appointments and the associated travel emissions, saving around 2.2 kt CO2e per year.

Efficiency of care

There appears to be no generally accepted definition of an avoidable admission⁵⁵, and to come up with one that would be practical and clinically appropriate for BLMK is beyond the scope of this report. Therefore, there is more work required ICS-wide to define what specifically the commitments around efficiency would mean in practice.

Length of stay

For the BLMK area, the mean length of stay in hospital for 21/22 was 4 days, with a median of 1 day, for a total of 280,965 admissions and 696,555 bed days⁵⁶. If the average emissions per day in hospital is 37.9kg CO2 e/bed day⁵⁷, then the carbon footprint for inpatient hospital stays for a year in BLMK is 26.4kt CO2e. Neither the ICS Green Plan, nor those from hospital providers have set any targets around

reduction in length of stay. However, the NHS Long Term Plan set an initial target of reducing the number of patients who experience a long stay (21+ days) by 25%, and then 40%⁵⁸. One snapshot from 2022 put the proportion of beds occupied by those medically fit to leave at 13%⁵⁹, so a 40% reduction in this area could represent an overall reduction of 5.2%. This could bring bed days down to 660,334 per year and save 1.4kt CO2e.

Appraisal of data and evidence on current activities and emissions

- Moderate evidence on carbon footprint of current area.
- Moderate evidence on how commitments might reduce emissions.

Further information required on current commitments:

- Local information on patient commuting patterns and distances to appointments, for GPs, community appointments and acute care.
- Verification of realistic appointment volume targets.
- Local agreement on what an avoidable admission looks like and how we can measure them (and progress against them) locally.
- Clarification around practical targets for length of stay reductions and relevant local data to baseline and track this, particularly around those staying 21+ days.

Areas missing from commitments:

- Understanding of how sustainable models of care could apply to local authority services e.g. social care.

5.2.3. Digital transformation

Reminder of ICS Green Plan commitments in this area

- Increase use of online services for patients (KPIs: NHS and other organisations staff working remotely, % of outpatient activity delivered remotely, data on impact virtual wards have on; reducing emergency admissions, emergency readmissions and length of stay, and reduced travel through digital/remote working and delivery of care)
- Digitise paper-based operations (KPIs: % of devices recycled / reused, % of paper based operations digitised)
- Integrate sustainability into digital plans (KPI: annual reporting on improved digitisation and impact on carbon footprint)

Available baseline information

Use of online services for patients

In BLMK, 28.8% of GP appointments for April 21-22⁴⁹ were via telephone or video consultation. For BLMK outpatient appointments (those based in Bedford, Luton and Dunstable and Milton Keynes Hospitals), 19.4% of attended appointments were conducted remotely in 2021-22⁵⁰. One recent UK-based study of epilepsy appointments found that, at its upper estimate (using a PC rather than laptop or phone, which are more energy efficient), a remote consultation would emit 148g CO₂e per hour of consultation⁶⁰. Given any consultation is unlikely to be longer than 30 mins, this could be reasonably halved to 74g for the highest emissions and longest likely duration of a hospital appointment, and 37g for a likely duration of a GP appointment. When paired with the per appointment emissions calculated in the [sustainable models of care section above](#), this would make remote consultations 2.5% the travel emissions of a face-to-face appointment for a hospital, 2.6% of the emissions for a GP appointment.

In terms of possible savings from increased use of remote consultations, NHS England has set a target of 25% of outpatient appointments being delivered remotely⁶¹. Applying this relatively modest increase in remote consultations to activity levels for 21/22 this would reduce CO₂e to 2.7 kt per year.

Paper based operations

Amanda Prichard shared in 2021 that 20% of NHS Trusts still “largely” paper based⁶². Both of the hospital Trusts in BLMK have some measure of electronic patient record in place^{63, 64}, with some evidence of East of England Ambulance Trust⁶⁵ and East London Foundation Trust⁶⁶ engaging in similar workstreams. Equivalent information was not uncovered for the other Trusts operating in BLMK. Overall, it is therefore difficult to estimate both the current status of paper-based operations and also the possible carbon savings associated with this policy commitment. While there are many benefits to digitisation, and it may save carbon emissions, this is not guaranteed and depends quite a lot on behaviour and recycling rates⁶⁷.

Digital plans

The Director of Digital Delivery at the ICB indicated that integration of sustainability into digital plans would happen at provider level via sustainability champions. However, given there is no baseline measure of sustainability champions, this makes this commitment equally difficult to baseline. In addition, there remains a missed opportunity to lead in this area with the ICB's digital strategy, which currently has no mention of sustainability or baseline for digital operations⁶⁸. The digital plans commitment is therefore not sufficiently developed to analyse.

Appraisal of data and evidence on current activities and emissions

- Moderate evidence on carbon footprint of current area.
- Moderate evidence on how commitments might reduce emissions.

Further information required on current commitments:

- Current level of paper use across ICS organisations, and a reasonable estimate about whether or by how much electronic systems are likely to reduce emissions.
- Theory of change about how digital plans could reduce emissions and what good practice would look like in this area.

5.2.4. Travel and transport

Reminder of ICS Green Plan commitments in this area

- Take measures to facilitate increased uptake of electric vehicles (KPI: NHS staff switching to low carbon travel options including: electric vehicles, public transport, fleet transition to low carbon options)
- Reduce the requirement to travel (KPI: reduced travel through digital/remote working and delivery of care)
- Encourage active travel through facilities for cycles (KPI: NHS staff switching to low carbon travel options including: active travel)

Available baseline information

The 2019/20 Greener NHS estimate for BLMK travel and transport was 44,780 tonnes CO₂e /year (including business travel, NHS fleet, patient travel, visitor travel, staff commuting). This roughly corresponds with the following high level estimate for 2020/21. NHS associated travel is estimated to account for 3.5% of all road travel in England, contributing around 14% of NHS' total emissions⁶⁹. In 2021, there were 4.4 billion road miles driven in BLMK⁷⁰, which means 155 million miles per year are likely to have been associated with the NHS in our area. Using this high-level metric, and assuming 3% electric car use, this would equate to 41.3 kilotonnes CO₂e per year.

This could be added to two of BLMK's councils, which already calculated their emissions footprint associated with travel and transport:

Organisation	Year	Emissions
Bedford Borough Council	2018/19	2,159 tonnes CO ₂ e for owned transport (fleet and social care) 164 tonnes for business travel (scope 3 indirect, inc. air, rail)
Central Bedfordshire Council	2018/19	4,098 tonnes CO ₂ e for transport

This would come to 52.6 kilotonnes of CO₂e (both direct and well to tank emissions), not including estimates from Luton and Milton Keynes local authorities (which weren't available) or from social care.

Workforce travel – commuting and electric car use

The high level estimates above do not enable analysis by emissions component, which is required for estimating possible impacts of different policies. Instead, the burden of commuting can be calculated from the following information:

- The average commuting distance from National Travel Survey (2021) was 817 miles per person per year⁷¹.
- 72% people used car as main mode of commuting according to a past NHS staff survey⁷².
- Car ownership by fuel type is 3% electric, 32% diesel, 64% petrol according to the National Travel Survey⁷³, and average emissions per mile can be taken

from the Department for Business, Energy, and Industrial Strategy database²⁶.

With an estimated workforce of 55,225, these data points provide an estimated annual commuting emissions of 8.7 kilotonnes of CO₂e per year. Although employers often don't control vehicle types for commuting, if electric car use rose to 10% from 3% and overall miles did not increase, there would be a reduction of around half a kilotonne (477 tonnes) CO₂e per year. However, this is just an example, and the current ICS Green Plan does not specify the proportion of electric car use among staff it would be looking to support.

Workforce travel – fleet

Fleet information from provider Green Plans, the Greener NHS Dashboard and an FOI request⁷⁴:

Organisation	Fleet type	Number of vehicles	Fuel compositions	Emissions calculations (if calculated)
EEAST	Rapid response vehicles and non-ambulance	1043	3% ZEV, LEV 85%	21.2 ktCO ₂ e
CNWL	Lease vehicles	74	85% petrol	
CCS	Lease vehicles	160	Unknown	
BBC	Fleet (excluding tractors and related vehicles)	211	Unknown	2.2 ktCO ₂ e
BHFT	Fleet (vans only, tug vehicles excluded)	9	10% ZEV, LEV 60%	
Total identified		1497		

As with previous calculations by Trust, this is complicated by the fact that Trusts such as EEAST are very large and work well beyond the boundaries of BLMK in addition to covering our area.

Using available information, the largest fleets with the biggest carbon emissions are the ambulance trusts such as EEAST. For example, if they were to swap the remaining 12% of their fleet (which presumably is petrol) with zero emissions vehicles, they could reduce emissions by 1.2 kilotonnes CO₂e per year (once WTT and electricity emissions are also accounted for). However, for other organisations with small fleets like Bedfordshire Hospitals Foundation NHS Trust, the emissions from staff commuting are likely to be much larger than their fleet emissions. In this case, the BHFT fleet is 9 vehicles (70% of which are low emissions), compared to an estimated 1.6 kilotonnes CO₂e per year for staff commuting.

Business miles

Business miles were not widely reported in provider Green Plans, except for SCAS, which reported 500,000 miles claimed per year. For an organisation with this level of

business miles, assuming the same fuel compositions of vehicles as used above, would result in 169.6 tonnes CO₂e per year. Reducing business miles by 10% as SCAS has pledged to do (assuming this is equally split across vehicles of all fuel types) would reduce emissions by 17 tonnes CO₂e per year.

Active travel

Little local data on active travel is available, but in 2022, according to Bedfordshire Hospitals Foundation Trust's green action plan, 15-20% of the capacity at the Luton and Dunstable Hospital cycle hub is estimated to be used. According to a survey of NHS staff nationally in 2017, 2% reported cycling as their main mode of transport for commuting, and 4% reported walking or running⁷². Although we do not have comprehensive information in this area, we can still reasonably conclude that active travel among BLMK staff is starting from a low base.

Appraisal of data and evidence on current activities and emissions

Moderate evidence on carbon footprint of current area.

Weak evidence on how commitments might reduce emissions.

Further information required on current commitments:

- Current commuting modes and active travel habits of staff (rather than relying on old information which may not be representative), ideally by organisation.
- Annual business miles, by provider.
- Full fleet information (numbers and fuel types) for each organisation.
- An estimation of car miles associated with the local authority and care sectors, since we only have some information for BBC and CBC.



5.2.5. Estates and facilities

Reminder of ICS Green Plan commitments in this area

- Improve energy efficiency and decarbonise energy inputs across all estates (KPIs: emissions data published quarterly, annual and seasonal energy use, sources of energy, waste produced, water use)
- Improve biodiversity and green estates where possible (KPI: access to green space on site, for both employees and patients).
- Reduce resource waste across all waste systems

Available baseline information

Overall, estates and facilities make up about 15% of the NHS Carbon Footprint plus⁶⁹, due to energy use. The 2019/20 Greener NHS estimate for BLMK energy use and waste was: 30,510 tonnes CO2e per year. The calculations below give a more recent estimate from 2020/21.

Estates' energy use

	Gas (kt CO2e)	Electricity (kt CO2e)	Totals (or not disaggregated)
Bedfordshire Hospitals Trust*	10	6	16
Milton Keynes University Trust*	4	3	7
East of England Ambulance Trust [^]	1.7	1.8	3.5
CNWL*	3	1	4
ELFT*	2	2	4
Cambridgeshire Community Services**	-	-	0.9
Bedford Borough Council [^]	-	-	5
Central Bedfordshire Council [^]	-	-	15.8
	20.7	13.8	56

Sources: Greener NHS Dashboard (20/21)* Green plan or equivalent[^] -

**estates footprints for key treatment buildings, but only one of these (Luton Treatment Centre) was within the BLMK area.

No public information was found for estates emissions from SCAS, Luton Borough Council or Milton Keynes Council. Without this information, the known annual emissions estimate is 56.2 kt CO2e. For organisations where the breakdown was available, gas was a larger contributor to emissions than electricity. Ground source heat pump systems are an alternative to gas (and being considered by EEAST⁷⁵), and at least one has been installed in an NHS hospital⁷⁶, with the organisation claiming that it would reduce the site's carbon footprint by 60%. Assuming this reduction applies only to the disaggregated estates and facilities gas footprint, and that it is transferrable to our contexts, similar actions across BLMK could reduce annual emissions by 12.4 kt CO2e. At provider level, some Green Plans included other initiatives to reduce energy use, such as:

- LED light replacement (estimated to reduce Bedfordshire Hospitals Trust⁷⁷ energy use by 576 tonnes/year).
- Solar panel installation was being considered by EEAST⁷⁵, although the carbon savings had not yet been identified.
- Energy efficient building standards, particularly BREEAM (Building Research Establishment Environmental Assessment Method), were identified by many providers, but again the energy savings associated with these were not quantified.

Biodiversity

One site in BLMK is recorded as being an NHS Forest site, but the only activity dates back to 2012 and the planting of a single tree⁷⁸, indicating that at one point there was local intention to do more on biodiversity, but this has not been meaningfully followed through. In addition, there is no evidence of biodiversity being considered in relation to key redevelopment of secondary care sites in BLMK⁷⁹. It is therefore safe to assume that the baseline for biodiversity is that it currently is not contributing to the overall balance of carbon emissions for NHS organisations within the ICS. By contrast, tree planting is more advanced in local authority organisations, with Bedford Borough⁸⁰ planting thousands and Milton Keynes Council⁸¹ hundreds of trees, and Central Bedfordshire⁸² and Luton⁸³ offering tree planting to communities or residents. It could be important for NHS organisations to learn from them, given the biodiversity net gain targets coming into force in 2023⁸⁴.

Initiatives like NHS Forest do not advise using tree-planting directly to offset emissions since benefits may take a long time to emerge and absolute carbon reductions may be small⁸⁵. However, the Greener NHS acknowledges that offsetting will be required⁸⁶, and meaningful action biodiversity, green estates action and nature based solutions are likely to be a key part of that^{87, 88}. In order to calculate any benefits to carbon offsetting or health, specific targets will need to be articulated across organisations.

Waste

On the Greener NHS dashboard, the total ICS area has 1 kilotonne of CO₂e listed as our 20/21 waste output. This compares to the Greener NHS estimate of 2.37 kilotonnes in 19/20. This could relate to a real terms decrease, but it could also be a methodological difference, since some waste streams are likely to have grown during COVID-19 due to increased procurement of single use plastic for personal protective equipment⁸⁹, for example. It is also estimated to be around 0.1% of the overall NHS carbon footprint⁹⁰, so likely to be a relatively small part of the picture.



Appraisal of data and evidence on current activities and emissions

Moderate evidence on carbon footprint of current area was provided by Greener NHS dashboard data.

Weak evidence on how commitments might reduce emissions, although more specific suggestions from provider organisations show possible ways forward.

Further information required on current commitments:

- Greener NHS Dashboard only contained secondary care estates emissions data, and evidence from the Green Plans was highly variable, leading to an incomplete picture of energy and waste.
- No data at all was available from SCAS, Luton Borough Council or Milton Keynes Council.

Areas missing from commitments:

- Reduction of energy use was not an explicitly stated goal in the ICS commitments.
- Link with adaptation and passive heating / cooling by using building technology and green estates, was not made.

5.2.6. Medicines

Reminder of ICS Green Plan commitments in this area

- Engage patients and staff in discussions about medicines optimisation and develop an approach to reduce emissions generated by inhalers and anaesthetics where clinically appropriate (KPI: patient feedback on medicines optimisation efforts, staff surveys to evaluate effectiveness of increased training)
- Tackle waste generated by medicines and promote training and awareness for staff on recycling and medicine disposal (KPI: obtain carbon footprint data from wholesalers for medicines, successful partnership-working across the system.)
- Reduce emissions generated by the transport of medicines (KPI: complete an audit of medicines transportation to identify opportunities to reduce travel)

Available baseline information

Medicines account for 25% of the NHS's emissions⁶⁹, and so have been a substantial focus nationally. The 2019/20 Greener NHS estimate for BLMK medicines (anaesthetics and inhalers) was 17,130 tonnes CO₂e per year. A more up to date estimation is made below.

Inhalers and anaesthetics

Information from the Greener NHS dashboard provides the following information on current anaesthetic and inhaler emissions in BLMK:

Emissions source	Total in secondary care
Desflurane emissions (annual rolling average, Jul 22)	8tCO ₂ e
Sevoflurane (annual rolling average, Jul 22)	11.8tCO ₂ e
Nitrous oxide (annual emissions 21/22)	3,504 tCO ₂ e
Total	3523.8 tCO₂e

Inhaler type	Number prescribed BLMK (June 2022)	Emissions BLMK (June 2022)	Annual equivalent (estimated)
MDI	52,597 (77%)	1055 tCO ₂ e	12,600 tCO ₂ e
DPI/SMI	16,058 (33%)	11 tCO ₂ e	132 tCO ₂ e
Total	68,655	1066 tCO₂e	12,732 tCO₂e

This comes to annual estimated total of 16.3 kilotonnes CO₂e per year from these two groups of high emissions medicines. The inhalers are by far the more emitting of the two groups, and if the target of 50% of prescribed inhalers being MDI that was set by the House of Commons Environment Audit Committee in 2018⁹¹ were met (the current level in BLMK is 76.7%), our area could save 4.2 kilotonnes in carbon

emissions each year. Other improvements, such as increased prescription of salbutamol inhalers that have a lower footprint (e.g. BLMK's average salbutamol inhaler decreased from 25 kg CO₂e in 2018 to 22 in 2022⁹²) have been enacted, but the scale of change for this is much smaller than switching to DPI/SMI inhalers.

Medicines waste

The Greener NHS dashboard details that Bedfordshire Hospitals Foundation NHS Trust has set up a multi-disciplinary team to deal with nitrous oxide waste, but provides no detail on further progress. No further local information on medicines waste was available. Nationally, a 2015 report estimated that £300 million of prescribed medications are wasted each year⁹³. Further, NICE guidance on medicines optimisation estimated that, if their guidelines on optimisation were followed then 202 tonnes CO₂e per 100,000 population⁹⁴ could be saved per year.

Medicines transport

No local information on medicines transport was available. One example from Oxford was found to have reduced emissions from medicines by introducing cycle couriers, but this was only by 10 tonnes CO₂e (a relatively small reduction) and the baselines were not provided for use by other areas⁹⁵.

Appraisal of data and evidence on current activities and emissions

Strong evidence on carbon footprint of current area was provided by Greener NHS dashboard data, but information on medicines transport and waste was very weak. Overall, level of data was therefore moderate.

Weak evidence on how commitments might reduce emissions, due to specific targets not being articulated.

Further information required on current commitments:

- Confirmation of whether the <50% MDI inhalers target is being worked towards locally.
- Benchmarks for medicines waste and transportation emissions.

Areas missing from commitments:

- Reduction and unnecessary prescribing could be added to medicines waste remit.

5.2.7. Supply chain and procurement

Reminder of ICS Green Plan commitments in this area

- Ensure suppliers are aligned with the NHS' green agenda (KPI: proportion of tenders with sustainability questions included, proportion of tenders which meet Government Buying Standards, number of suppliers with scope 1 and 2 emissions reduction plans in place)
- Switch to local suppliers where possible
- Reduce the use of single-use plastic products (KPI: number of ICS services with waste monitoring systems in place, data on waste redirected from landfill.)

Available baseline information

The 2019/20 Greener NHS estimate for BLMK's supply chain (including business services, medicines and chemicals, medical equipment, construction and freight, and non-medical equipment) was 192,980 tonnes CO2e.

Suppliers and the green agenda

Based on information for the ICS theme leads in this area, few 'green' questions were included historically in tenders. Those that were included previously were not given significant weighting as part of the decision-making process. It may therefore be safe to assume that no current tenders are fully compliant with the commitment that suppliers be aligned with the green agenda. However, they confirmed that since the NHS standard contract now includes green agenda questions⁹⁶, and the national procurement guidance PPN 06/20 and PPN 06/21 requires 10% net zero and social value weighting⁹⁷, this is what would be followed for all future tenders. Although the PPN 06/21 specifies that suppliers must commit to becoming net zero by 2050 at the latest, it only applies to contracts over the value of £5 million⁹⁸. The success of this notice would depend on the correct application of the weighting, the implementation and timeline of these commitments, the location of the supplier, and the extent to which offsetting is used in place of emissions reduction, among many other unknown factors. Impact would also depend on ICS organisations applying the weighting correctly; a recent example of BLMK procurement put social value and net zero weighting at 4%, not 10%. It is therefore unclear how much the use of these PPN guidance notices⁹⁹ would support reduced carbon emissions in the short to medium term. In addition, the PPN notice only applies to NHS contracts and central government, and so does not currently cover local authority or care system suppliers and procurement.

Local suppliers

There was no universal definition for a local supplier, but it was informally felt to be a supplier from the same or neighbouring counties. However, more importantly, theme leads explained that under the current legal frameworks they are not able to prioritise locally based providers or suppliers, so instead must rely on the social value and net zero requirements, which could favour local suppliers due to shorter transportation distances. In addition, they noted that many local suppliers are small businesses, whose ability to meet a formal sustainability agenda may be limited.

Waste management and single use plastic

The status of current waste monitoring and levels of landfill waste and recycling was unknown at provider and ICS level. Instead, the NHS standard contract⁹⁶ would be relied upon going forward, which details:

“The Provider must have in place clear, detailed plans as to how it will contribute towards a ‘Green NHS’ with regard to Delivering a ‘Net Zero’ National Health Service commitments in relation to:

- 18.3.3 single use plastic products and waste, and specifically how it will take action:
- 18.3.3.1 to reduce waste and water usage through best practice efficiency standards and adoption of new innovations;
- 18.3.3.2 to reduce avoidable use of single use plastic products;
- 18.3.3.3 so far as clinically appropriate, to cease use at the Provider’s Premises of single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics;
- 18.3.3.4 to reduce the use at the Provider’s Premises of single-use plastic food and beverage containers, cups, covers and lids; and
- 18.3.3.5 to make provision with a view to maximising the rate of return of walking aids for re-use or recycling, and must implement those plans diligently.”

However, even if this is implemented in future, it would not cover the non-NHS providers within the ICS system.

Appraisal of data and evidence on current activities and emissions

■ Weak evidence on carbon footprint of current area from high level Greener NHS estimate.

■ Weak evidence on how commitments might reduce emissions, due to specific targets not being articulated and no specific baseline information being identified.

Further information required on current commitments:

- Understanding of how many suppliers are currently aligned with the green agenda. Estimate of how much carbon could be saved from the supply chain through PPN compliance
- Definition of a local supplier and understanding of how local suppliers could help reduce carbon footprint (e.g. transport of goods).
- ICS and provider level baselines for current single use plastic consumption, recycling and landfill rates.

Areas missing from commitments:

- Expanding the NHS “green agenda” to cover procurement by others in the ICS system, namely local authorities.
- Commitments related to reusable items and supporting a circular economy.

5.2.8. Food and nutrition

Reminder of ICS Green Plan commitments in this area

- Reduce food waste across our sites and facilities (KPIs: number of food waste recycling points and disposal facilities, amount of household waste reduction, % of food sourced locally)
- Phase out plastic packaging (KPI: amount of plastic packaging reduction)
- Provide more sustainable food choices for our workforce (KPI: annual reporting on workforce nutritional conditions)

Available baseline information

The Greener NHS 2019/20 estimate of the footprint for food and nutrition in BLMK was 24,200 tonnes CO₂e. More recent estimates in this area are very high level, due to lack of current ICS theme lead and also some providers not including commitments on this as part of their Green Plans. Nationally, in 2018-19 £634 million was spent on hospital food, representing 140 million patient meals and approximately 6.7% of the total costs of running the NHS estate¹⁰⁰. It also makes up around 6% of the NHS' carbon footprint plus⁶⁹.

Food waste

No local data was found on levels of food waste in organisations across the ICS. However, literature reviews have found that food waste in healthcare facilities can be up to 50%¹⁰¹. It is therefore very important to understand the local picture on food waste, since it could represent a significant part of the carbon emissions associated with this area.

Local procurement and plastic packaging

While procuring local food can be beneficial for social and economic reasons (and a Nottingham based Trust defined this as being within 30 miles¹⁰²), only around 5.5% of food's emissions come from transportation, with a similar amount coming from packaging¹⁰³. This means that choice of food is more impactful for emissions than where it comes from or its packaging. This doesn't mean there are no carbon savings to be found here, only that they are much smaller; for example, reducing plastic packaging by 10% (as promoted by the Plastics Pact¹⁰⁴) could reduce overall emissions by 0.05%, which could be around 2 tonnes CO₂e annually for BLMK's patient meals.

Sustainable food choices

A recent study found a possible 17% reduction in carbon emissions if meals were to comply with the Eatwell guide¹⁰⁵, compared to the average UK diet, which could equate to 4,114 tonnes CO₂e per year for BLMK patient meals. This therefore could be the area of food and nutrition in which the greatest carbon reductions can be made.

Appraisal of data and evidence on current activities and emissions

- Weak evidence on carbon footprint of current area
- Moderate evidence on how commitments might reduce emissions, thanks to external estimates for two out of three commitments.

Further information required on current commitments:

- Baseline levels of food waste, local food procurement and food related plastic packaging were not found.

Areas missing from commitments:

- Measures such as composting food waste where appropriate were not included.



5.2.9. Adaptation

Reminder of ICS Green Plan commitments in this area

- Develop risk assessment and progress monitoring mechanisms (KPI: evaluation of risk assessment and progress monitoring efforts)
- Establish management and oversight practices (KPI: suitability of management and oversight approaches, level of engagement with local stakeholders)
- Increase risk mitigation efforts by developing the necessary emergency planning and preparedness strategies (KPI: progress made on the development of climate mitigation plans, and subsequent assessment of such plans).

Available baseline information

Information in this area is currently limited due to lack of current ICS theme lead, and no current adaptation plan at ICS level. In addition, at provider level, most commitments under adaptation were focussed on identifying risks.

However, national guidance about adaptation planning in relation to healthcare does exist.

Climate change is listed as a risk on BLMK ICB risk register as follows: “due to climate change, there is a risk of increased pressure on health and care services, and deteriorating population health outcomes”.

In addition, it also is featured in National Security Risk Assessment (NSRA) guidance used by Local Resilience Forums to plan for emergency situations. The NSRA is official sensitive, but its public facing counterpart the National Risk Register¹⁰⁶ covers flooding (responses include warnings, flood defences and construction resilience) and extreme weather (responses include providing alerts and advice).

According to national Greener NHS guidance, adaptation measures should look to the long term (not simply emergency response) and also not increase emissions¹⁰⁷, but there is no current way of assessing this without an official adaptation plan against which to benchmark.

The Local Health Resilience Partnership (which is made up of ICB and provider leads) is currently reflecting on longer term adaptation responses to heatwaves scenarios based on 2022 impacts, but primary responses being considered were expansion in air conditioning units. Compared to passive cooling strategies, this risks increasing energy use substantially¹⁰⁸ and therefore counteracting Green Plan goals.

Appraisal of data and evidence on current activities and emissions

- Weak evidence on carbon footprint of current area.
- Weak evidence on how commitments might reduce emissions, with the danger that adaptation measures could actually increase carbon footprint.

Further information required on current commitments:

- Baseline levels of food waste, local food procurement and food related plastic packaging were not found.

Areas missing from commitments:

- Clear commitment to long-term green adaptation, minimising additional carbon emissions wherever possible.

5.3. Health impacts

At a high level, using the range of mortality estimates associated with current carbon emissions, we can say that 324,540 tonnes of CO2 equivalent emitted in 2020 is likely to cause 73-325 excess deaths before 2100^{18, 19}. However, we cannot say these will be local deaths (in fact, this may be unlikely), so a closer look at more immediate impacts in time and geography is required.

5.3.1. Air pollution

Air pollution refers to gasses or particles that are generated by road traffic, manufacturing, agriculture and energy industries among others. They can form part of the air we breathe in different concentrations, and some have severe consequences for human health. The main pollutants of interest are typically nitrogen dioxide and particulate matter (PM) of various sizes. Key health conditions associated with air pollution primarily include asthma, respiratory disease, coronary heart disease, stroke, and lung cancer³⁴. According to the World Health Organization, air pollution is carcinogenic, and recommended annual exposure limits should be 5 µg/m³ for PM2.5, and 10 µg/m³ for nitrogen dioxide¹⁰⁹.

Scientific literature – health factors

Issue and study authors	Definition of air pollution	Health effects - how much do cases increase or decrease in different pollution scenarios?
All-cause mortality meta-analysis from Chen and Hoek (2020) ¹¹⁰	Per 10 µg/m ³ of PM _{2.5}	Risk Ratio (RR) for all-cause mortality was 1.08 (95%CI 1.06, 1.09)
Asthma meta-analysis from Khreis et al (2017) ¹¹¹	Black carbon (BC): Nitrogen dioxide (NO ₂), Nitrogen oxides (NO _x): Particulate Matter < 2.5 µm in diameter (PM _{2.5}): Particulate Matter < 10 µm in diameter (PM ₁₀):	Relative risk of developing childhood asthma with traffic pollution exposure: 1.08 (1.03, 1.14) per 0.5 × 10– 5 m– 1 1.05 (1.02, 1.07) per 4 µg/m ³ 1.48 (0.89, 2.45) per 30 µg/m ³ 1.03 (1.01, 1.05) per 1 µg/m ³ 1.05 (1.02, 1.08) per 2 µg/m ³
Asthma and COPD meta-analysis based on London, Evangelopoulos et al (2022) ¹¹²	PM 2.5 per 10 µg/m ³ increase NO ₂ per 10 µg/m ³ increase	3.2% (1.9-4.5%) increase in asthma hospital admissions in 0-14s 3.93% (1.06-6.89%) increase in asthma/COPD hospital admissions for 65+ 3.9% (1.5-6.4%) increase in asthma hospital admissions in 0-14s

		1.42% (1.07-1.76%) increase in asthma/COPD hospital admissions for 65+
COPD meta-analysis from Park et al (2021) ¹¹³	10 µg/m ³ increase in PM _{2.5}	Increased incidence of COPD HR 1.18, (95% CI 1.13–1.23)
Coronary heart disease and stroke cohort study from Wolf et al (2021) ¹¹⁴	10 µg/m ³ increase in NO ₂ 5 µg/m ³ increase PM _{2.5}	Model 3 (fully adjusted models), hazard ratios Stroke incidence 1.08 (95% CI 1.04–1.12) Coronary heart disease incidence 1.04 (1.01–1.07) Stroke incidence 1.10 (1.01–1.21)
Stroke meta-analysis, Shah et al (2015) ¹¹⁵	PM _{2.5} (per 10 µg/m ³ increment) NO ₂ (per 10 ppb increment) PM ₁₀ (per 10 µg/m ³ increment)	Relative risk of stroke: Incidence 1.011 (1.011 to 1.012) Hospital admission 1.011 (1.010 to 1.012) 85 Mortality 1.012 (1.011 to 1.012) Overall incidence 1.014 (1.009 to 1.019) Hospital admission 1.012 (1.005 to 1.018) Mortality 1.016 (1.007 to 1.023) Overall incidence 1.003 (1.002 to 1.004) Hospital admission 1.002 (1.000 to 1.003) Mortality 1.003 (1.002 to 1.004)
Lung cancer cohort study from Raaschou-Nielsen et al (2013) ¹¹⁶	PM ₁₀ per 10 µg/m ³ For PM _{2.5} per 5 µg/m ³	Lung cancer, statistically significant hazard ratio: 1.22 [95% CI 1.03–1.45] 1.18 [95% 0.96–1.46]
Compilation of meta-analyses on preventable causes of cancer Brown et al (2018) ¹¹⁷	Air pollution – all types combined	Population attributable fraction for all cancers in England: 1% Population attributable fraction for cancer of lung, bronchus and trachea in England: 8.2%

Local data

Local exposure to unhealthy levels of air pollution and the burden of disease to which that contributes, according to the Fingertips tool from the Office for Health Improvement and Disparities¹¹⁸:

Local authority	Fine particulate matter (total concentrations of PM2.5) - 2020	Proportion of mortality (aged 30+) attributable to air pollution - 2020
England	7.5	5.6%
East of England	7.8	5.8%
Bedford	7.6	5.5%
Central Bedfordshire	7.6	5.7%
Luton	8.2	6.2%
Milton Keynes	8.2	6.1%

A 2014 Public Health England report estimating local burdens of disease from air pollution calculated that 354 deaths can be attributed to air pollution per year in the BLMK area¹¹⁹. Based on the attributable mortality from OHID above and the Office for National Statistics' mortality data¹²⁰, this was 465 deaths in 2020. In terms of the specific harms that are associated with air pollution, our local baselines are displayed in the table below. Using the relative risks provided by the literature review above and the Public Health England methods¹¹⁹ and estimates from the research above, we can also calculate the attributable fractions for air pollution for each condition – the proportion of cases that would not occur if air pollution was not present.

	England	BLMK	BLMK attributable fraction % (cases)
COPD count (% prevalence)	1,170,437 (1.9%)	16,549 (1.6%)	PM2.5: 12.3% (2,028)
Asthma Prevalence – all Prevalence – under 19s**	3,629,071	60,739 (6.2%) 23,055 (9.1%)	PM2.5: 20.8% (12,649)* (4,801)
Coronary heart disease Count (%prevalence)	1,850,657 (3.0%)	27,120 (2.6%)	NO2: 7% (1,901)
Stroke (annual, 20/21) Prevalence Admissions Mortality	1,093,593 (1.8%)	14,511 (1.4%)	NO2: 13% (1,928) PM2.5: 14% (2,029)
Lung cancer incidence (annual 2020)	37,237	490	All air pollution: 8.2% (40)

**Childhood asthma population attributable fraction extrapolated to all asthma cases as lifetime risk ratios were not found. This is why childhood numbers were also included.*

***Local numbers for under 19s were unavailable, so figures from Asthma UK/NHS England were extrapolated to BLMK's 2021 under 19 census population.*

Exposure to air pollution for the ICS workforce and for patients seeking health care is also high. The SHAPE Atlas tool¹²¹ overlays the UKHSA air pollution vulnerability indicator (UKHSA's pilot indicator to of population level vulnerability to air pollution at LSOA level) for PM2.5 and NO2 onto local maps, showing that all three of BLMK's highest volume sites (Luton and Dunstable Hospital, Bedford Hospital and Milton Keynes University Hospital) are in the highest scoring areas. This indicates high vulnerability to air pollution from the communities living around the hospital sites (see appendix 3 for the maps).

In addition, we know that average air pollution exposure at the hospital sites, and across BLMK counties more generally, is excessive. Two of the main hospital sites (Luton and Bedford) are also either in or bordering an Air Quality Management Area^{122, 123}. More specifically, we can quantify exposure at BLMK's main hospital sites¹²⁴, and average roadside exposures¹²⁵ across the two main sources of air pollution harm:

Site	PM2.5 exposure (annual average)	NO2 exposure (annual average)
Bedford Hospital MK42 9DJ	11.53 µg /m3	18.40 µg /m3
Luton and Dunstable Hospital LU4 0DZ	10.80 µg /m3	17.86 µg /m3
Milton Keynes Hospital MK6 5LD	11.41 µg /m3	15.62 µg /m3
Bedford Borough – average roadside (2021)	7.6 µg /m3	17.6 µg /m3
Central Bedfordshire - average roadside (2021)	7.6 µg /m3	16.6 µg /m3
Luton – average roadside (2021)	8.2 µg /m3	21.4 µg /m3
Milton Keynes - average roadside (2021)	8.2 µg /m3	18.5 µg /m3

Examples of policies that have reduced exposure to air pollution

Mapping connections between policies and reduced exposure to harmful air pollutants is challenging because emissions are only one element of exposure; weather is also a powerful influence on how dispersed or concentrated pollutants might be. There are also several sources of PM (exhaust and non-exhaust e.g. tyres, brakes), and they and their effects may also overlap (COMEAP)¹²⁶. In addition, road transport is not the only source of these pollutants; it is estimated to make up 13% of PM2.5 pollution and 68% of NO2 pollution^{127, 128}. All of this means that policy

predictions are likely to be relatively uncertain initially, but can be improved with localised data collection. Below are some examples of research where reductions in exposure have been measured.

Policy description	How much were pollutants reduced?	Any health benefits associated?
Comparing NO ₂ and PM _{2.5} exposure in London and asthma admissions in 2016 compared to 2019. During this time the T-charge (2017), which then became an ultra low emissions zone, (2019) was implemented. Source: Evangelopoulos et al (2022) ¹¹²	Median population-weighted average concentrations reduced: -2.5 µg m ⁻³ for PM _{2.5} -7.9 µg m ⁻³ for NO ₂	20-30% reduction in asthma admissions attributable to air pollution
UK traffic volume and pollutants were compared between spring 2020 (during initial lockdown) and averages from 2017-19. Source: Jephcote et al (2021) ¹²⁹	Monthly-average daily traffic counts in April-2020 fell by 69% compared to April-2019. NO ₂ and PM _{2.5} concentrations fell respectively by 38.3% (8.8 µg/m ³) and 16.5% (2.2 µg/m ³).	None investigated
Modelled comparisons between 2016 levels of air pollution in London and two others, one based on ULEZ and London Environment Strategy (LES) scenarios for 2050. Source: Webber (2020) ¹³⁰	Unclear what the specific reductions being modelled are. Possible numbers offered by the ULEZ consultation are 13.6% reduction in PM _{2.5} , 6.9% reduction in NO _x from road transport ¹³¹ .	ULEZ: 29% reduction in total new cases of disease attributable to air pollution in London LES: 35% reduction in total new cases of disease attributable to air pollution in London.
De-weathered and de-trended air pollution concentrations in Oxford 2016-19 compared to lockdowns 1 and 2 in 2020. Source: Singh et al (2022) ¹³²	Lockdown 1: 69% reduction in traffic volume, associated with -28.2% NO ₂ at roadside and -17% NO ₂ and -12% PM _{2.5} at urban background locations. Lockdown 2 : 38% reduction in traffic volume, no significant change in	
A modelled approach, looking at levels of PM _{2.5} in 2010 in Adelaide, Australia, and co-benefits	Shifting 40% of private car kilometres to alternative transport (10% cycling, 30% public	40% alternative transport scenario was modelled to prevent 542 deaths.

to shifting transport habits by 2030. Source: Xia et al (2014)	transport) over 20 years was modelled to reduce PM 2.5 by 26%. Alternatively, shifting 10% of private car kilometres to cycling would generate a reduction of 8.6% PM2.5.	10% cycling scenario prevent 326 deaths
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Possible impacts of Green Plan policies on air pollution and health

Combining the population attributable fractions for air pollution, proportions of road traffic attributable to each air pollutant, and the high-level figure that NHS activity accounts for 3.5% of journeys in England¹³³, can give us an idea of the impact of local NHS transport emissions. Local NHS travel and transport (not capturing the impact of the care and local authority sectors) could therefore be responsible for:

- 2 deaths per year attributable to PM 2.5
- 58 cases of asthma due to PM 2.5, or 292 cases of asthma due to NO2
- 1 case of lung cancer
- 9 cases of COPD
- 46 strokes per year due to NO2, or 9 strokes due to PM2.5

If we take the average annual exposure at the three key hospital sites as an example, the reductions required to bring PM2.5 to WHO guidance levels of 5 µg /m3 and NO2 to 10 µg /m3 (displayed below) would be higher than any of the real or modelled reductions in the literature above.

Site	% PM2.5 reduction required to reach WHO standard	% NO2 reduction required to reach WHO standard
Bedford Hospital MK42 9DJ	-56.6%	-45.7%
Luton and Dunstable Hospital LU4 0DZ	-53.7%	-44%
Milton Keynes Hospital MK6 5LD	-56.2%	-36%
Bedford Borough – average roadside (2021)	-34.2%	-43%
Central Bedfordshire - average roadside (2021)	-34.2%	-40%
Luton – average roadside (2021)	-39%	-53%
Milton Keynes - average roadside (2021)	-39%	-46%

The scale of action required to see differences both at health and care sites, and across BLMK, depends on the extent to which we can attribute emissions at these sites to NHS activity. However, the largest modelled PM2.5 reduction (-26%) comes

from the Australian study, which requires a 40% swap from private car miles to active and public transport. It is therefore likely that at least this level of action would be required to see a meaningful difference.

The ICS Green Plan has set no specific target for reduction in private car use, and the only provider to set a specific aim for this is Milton Keynes University Hospital, which committed to a 10%-point decrease in the number of employees commuting alone and a 10%-point increase in the number of people car sharing, using public transport and active modes. While there are other commitments related to increasing share of electric vehicles among business, lease and commuter fleets, this is unlikely to have significant impacts on PM2.5 levels (although it would reduce NO2 and carbon emissions)¹³⁴. This means that overall there is not likely to be sufficient action in this area to come close to reducing air pollution in a way that is likely to reduce air pollution and produce meaningful health benefits at present.

More specific, and much greater, commitments to get staff out of private cars wherever possible are therefore required in order to reduce the health impact of travel and transport associated with health and care. As for how to do this, suggestions from the literature include ensuring that public transport and active travel are the same price or cheaper than driving and parking for staff¹³⁵.

Inequalities and vulnerable groups

Overall, we know that patients, those who live nearby, and members of staff are currently exposed to high levels of pollution around key hospital sites in BLMK, and also that overall concentrations across our local authorities are at unhealthily high levels. These exposures are likely to be felt unequally, with research concluding that highest pollution exposures in the UK are experienced by the poorest 20% of households¹³⁶ and those with the highest numbers of young children¹³⁷, despite contributing least to emissions. Unequal exposure leads then to unequal outcomes, with air pollution compounding conditions already made more likely by deprivation^{138, 139}. Therefore, not actively and ambitiously reducing the NHS' local contribution to air pollution would continue to contribute to ongoing health inequalities, contradicting work in other areas, especially as it relates to the poorest 20% of the population and those with chronic respiratory disease (which are both key targets for reducing inequalities in the CORE20PLUS5 framework¹⁴⁰).

Appraising the evidence on health: air pollution

- Strong evidence that generation of pollutants through ICS activity harms health locally currently (through travel-produced pollutants).
- Moderate evidence of relevant policy interventions that could reduce this harm.
- Weak evidence that ICS green policy commitments are aligned with scientific and policy evidence, and therefore likely to improve health locally.

5.3.2. Extreme weather

According to the Office for Health Improvement and Disparities, the main current and future risks of climate change and weather in the UK include heatwaves, flooding, wildfire, storms and drought⁸. A previous review of the impacts of extreme weather on the health and care system listed heatwaves, coldwaves and flooding as their primary areas of concern¹⁴¹, so these are the issues highlighted by the literature below.

Scientific literature – health factors

Study type and authors	Definition of extreme weather	Health effects
Systematic review and meta-analysis, Cruz et al (2020) ¹⁴²	Flooding in the UK	Pooled prevalence of mental health conditions 12 months after experiencing a flood: Anxiety: 19.78% Depression: 21.35% PTSD: 30.36%
Systematic review and meta-analysis, Liu et al (2022) ¹⁴³	Heat exposure, per 1°C increase above the reference temperature (definition unclear, but Met Office threshold is 25-28°C ¹⁴⁴)	Cardiovascular mortality in high income countries RR 1.020, 2.1% increase
Ecological study combining UK admissions and weather data, Rizmie et al (2022) ¹⁴⁵	Plotted effects from -5°C to 30+°C	Incidence risk ratio of emergency hospital admissions by disease area (significant ones listed only) for 30+°C compared to 10-15°C: Infectious diseases: 21.1% increase Metabolic diseases: 28% increase Respiratory diseases: 9.2% increase Injuries: 6.0% increase For -5°C compared to 10-15°C Respiratory diseases: 8.9% Injuries: 20.9%

Local information

Heatwave data for 2022 is not currently available on a regional level, but the ONS reports that there were 3,271 excess deaths across England and Wales from June to August 2022 over 5 heatwave periods¹⁴⁶. For those over 65, excluding COVID-19, this amounted to 2,803 excess deaths, which is the highest since the heatwave plan was introduced in 2004¹⁴⁶. If this was proportional to the over 65 population of BLMK, this would be equivalent to 40 deaths for this year alone. However, it is possible that our region experienced more excess deaths than this since the East of England (along with parts of the south) is one of the most vulnerable areas of the UK to adverse heat weather events¹⁴⁷; a previous estimate for the annual mean deaths in the wider East of England region put the number at 78 per year¹⁴⁸. Without

sufficient adaptation measures, this could grow to a mean of 110 and highs of 195 deaths per year in BLMK by 2050¹⁴⁹, depending on population growth levels. As part of their analysis of the 2022 heatwaves, the ONS also notes that deaths in care homes in particular were above average on heat period days¹⁴⁶, so these settings should receive specific consideration in future adaptation planning.

In addition, after attending the Local Health Resilience Partnership meeting, the leads for emergency preparedness and response across BLMK confirmed that the 2022 heatwaves period had interfered with delivery of care in several significant ways, including (but not limited to):

- Mortuary failure at two hospitals
- Air conditioning and air handling unit failures, leading to rising internal temperatures in staff and patient areas
- Medicines and devices becoming unusable due to very high temperatures in community staff vehicles.

Although the effects of climate change may mitigate the effects of cold, this type of adverse weather still contributes to mortality¹⁵⁰. A recent study estimated that there were 6414 annual mean deaths due to cold in the East of England¹⁴⁸.

Nationally, 4,630 properties were also flooded in England in 2019/20¹⁵¹. Although there was significant regional flooding reported in BLMK (Bedford in 2022 and 2020¹⁵², and Milton Keynes in 2021¹⁵³) no local data about the number of people affected locally each year were found.

Local levels of the health-related conditions mentioned in relation to heat, cold and flood above (as extracted from Fingertips¹⁵⁴) include:

Condition	BLMK	England
Depression – new diagnoses 20/21	7,815 (1.1%)	671,799 (1.4%)
Mortality from all cardiovascular disease (aged 65+) 2020	1,345	107,215
Emergency hospital admissions for respiratory disease (20/21)	7,120	407,719

Examples of policies to reduce effects of extreme weather on health

Study type and authors	Adaptation policies	Health effects
Literature review from Cheng et al (2013) ¹⁵⁵	Adaptation strategies that increase social capital (buddy systems, community outreach targeting vulnerable populations)	Decreased heat-related illnesses Improved overall health status due to increase capital, independent of other predictors of health
	Adaptation strategies that influence urban design	Increased physical activity, decreased cardiovascular and

	(increasing green spaces, reducing concrete surfaces, building more bicycle and walking paths)	respiratory diseases, thermal comfort, improved mental health
Modelled analysis of heat island adaptation measures on health outcomes from Taylor et al (2018) ¹⁵⁶	Energy efficiency upgrades to housing stock: insulation of floors, roofs and walls, triple glazed windows. Installation of external shutters or shading on housing stock (used between 9am-6pm in summer).	External shutters could reduce heat attributable deaths by 30-60%. Shutter installation and energy efficiency retrofit together could reduce mortality by 52%
Narrative report from Jay et al (2021) ¹⁵⁷	<p>Landscape and urban scale: water bodies, green space, shading, trees, urban ventilation, reducing vehicle density, active transport infrastructure, electric vehicles.</p> <p>Building scale: reflective coatings on walls, roofs and streets, insulation, glazing systems, external window shading</p> <p>Individual scale: fans, self-dousing, evaporative coolers, cold water ingestion, reducing activity, optimising clothing</p>	<p>Lower temperature and carbon emissions at the same time, can also have additional benefits related to physical activity and mental health.</p> <p>Reduce risks of indoor overheating and need for active cooling</p> <p>Can reduce body temperature, but only up to certain thresholds, and are also dependent on humidity.</p>

Possible impacts of Green Plan policies on extreme weather and health

Given the current lack of long-term adaptation planning in the ICB and ICS provider organisations, it is difficult to assess what action might be taken on this topic and any impact it might have. There is also some significant overlap with biodiversity strand in the estates and facilities theme, since lack of green space is a key risk for urban heat islands¹⁵⁸, which is also starting from a baseline of no visible action. The other guidance documents which are followed in place of an adaptation plan – the National Risk Register¹⁰⁶ and Heatwave Plan for England¹⁵⁹ – focus on emergency response rather than longer term actions, which are the majority of recommended methods detailed in the literature above. Meanwhile, the National Adaptation Plan¹⁶⁰ focusses on delivery of health and social care services in adverse weather, rather than any longer term prevention strategies for health services. All this considered, it is unlikely

that any of the health effects of adverse weather will be reduced in any way without a plan that goes above and beyond existing adaptation guidance.

Inequalities and vulnerable groups

Older people are at much higher risk of heat related morbidity and mortality, due to reduced temperature control above around 26 degrees centigrade^{161, 162}. This is also true for those with existing co-morbidities. Several studies also found that those who were more socio-economically deprived were at higher risk of harm from extreme weather brought on by climate change^{15, 148}, so ongoing inaction risks compounding existing health inequalities in BLMK.

Appraising the evidence on health: extreme weather

- Moderate evidence from national estimates that current state of affairs, and ICS (in)activity in terms of adaptation harms health locally.
- Moderate evidence of relevant policy interventions that could reduce this harm.
- Weak evidence that ICS green policy commitments are aligned with scientific and policy evidence, and therefore likely to improve health locally.

5.3.3. Active travel

Active travel, defined as making journeys by physically active means (like walking or cycling)¹⁶³, is associated with many positive health benefits, including strong associations between reduced overall mortality, cardiovascular disease, lower rates of type 2 diabetes, reduced musculoskeletal issues, reduced cancer rates and improved mental health¹⁶⁴. It is also crucial for cutting carbon and related emissions since it can replace private car journeys.

Scientific literature – health factors

Study type and authors	Definition and dose of active transport	Health effects
Systematic review from Jarrett et al (2012) ¹⁶⁵	2.5h per week of moderate physical activity	Type 2 diabetes: RR 0.81, 50% of effect achieved in 3.2 years Dementia: RR 0.89, 50% of effect achieved in 17 years Cerebrovascular disease (stroke): RR 0.77, 50% of effect achieved in 2 years Breast cancer: RR 0.87, 50% of effect achieved in 17 years Colorectal cancer: RR 0.92, 50% of effect achieved in 17 years Depression: RR 0.93, 50% of effect achieved in 2 years Ischaemic heart disease: RR 0.77, 50% of effect achieved in 2 years N.B. also increased incidence of injury
Prospective cohort study from Welsh et al (2020) ¹⁶⁶	1000 participants changing their commute to include cycling for 10 years (mixed or exclusive) from private car	15 fewer first cancer diagnoses (HR 0.89) 4 fewer cardiovascular events (HR 0.79) 3 fewer deaths (HR 0.88) 23 more injuries requiring hospital stay of <1 week 3 more injuries requiring hospital stay of >1 week
Retrospective cohort study from Patterson et al (2020) ¹⁶⁷	Usual commute by private motorised transport compared to public transport, walking and cycling from 1991-2016.	Analysis adjusted for age, sex, housing, marital status, ethnicity, education, car access, population density, socioeconomic classification, long term illness found: All cause mortality: bicycle HR 0.8 Cardiovascular mortality: bicycle HR 0.76 Cancer incidence: bicycle HR 0.89, walking HR 0.93 Cancer mortality: bicycle HR 0.84

Local data

Across BLMK, around two thirds of adults are classed as physically active¹⁶⁸, but very few use walking as their commute method and even fewer cycle to work. Common health consequences of insufficient physical activity range from overweight to heart disease, depression¹⁶⁹ and cancers, whose rates in BLMK are laid out below:

	England	East of England	BLMK*
% physically active adults	65.9%	65.7%	65.4%
% walking for travel 3+ days per week (19/20)	15.1%	13.8%	10.9%
% adults cycling for travel 3+ days per week	2.3%	2.4%	2.2%
Overweight or obese	63.5%	64%	66.7%
Obesity	25.3%	25%	28.5%
Coronary (ischaemic) heart disease	3%	3%	2.6%
Hypertension	13.9%	14.3%	13.2%
Diabetes 20/21 prevalence	7.1%	6.9%	7.2%
Depression (18+)	12.3%	11.3%	11.3%
Stroke prevalence 20/21	1.8%	1.8%	1.4%
Stroke hospital admissions (annual) 20/21	88,255	-	945
Cancer prevalence 20/21	3.2%	3.3%	2.7%

*population weighted average used where BLMK rate was not provided by Fingertips.

In addition, given there is a sickness absence rate of about 5% in NHS organisations across the East of England¹⁷⁰, and obesity is associated with higher rates of sickness absence¹⁷¹, it is likely that staff activity levels have consequences for operational performance.

Examples of policies to improve active travel in healthcare staff

There was not a wealth of studies on successful active travel policies or interventions in healthcare or similar staff groups, or employees more generally. A review of the evidence from 2016 concluded that the evidence on effectiveness on reducing driving behaviour was not strong¹⁷². However, a more recent review looking at

population-level interventions concluded that those balancing incentives (“carrots”) with disincentives (“sticks”) were more likely to have an impact on transport behaviour¹⁷³.

Possible impacts of Green Plan policies on active travel and health

While it’s possible that policies to encourage active travel could affect the wider BLMK population through infrastructure and the households of employees, the most direct avenues to impact would be through changing the commuting patterns of the health and care staff themselves.

However, language in the ICS Green Plan and in all but one of the provider plans is vague around encouraging active travel, with no specific targets outlined. The exception is Milton Keynes University Hospital, which commits to increasing the proportion of staff who commute by active means by 10%. If we take the 3.5% cycle commuting of the Milton Keynes area as typical, then this would represent 133 of their staff. Increasing cycle commuters by 10% would therefore be an increase of only 13 – far from the 1000 used as a benchmark in the Welsh et al study.

Instead, a more impactful ambition could be to aim to have 10% of those currently commuting by private car commuting by bicycle. Based on population rates of disease and scientific literature discussed above, this could have the following health benefits:

Condition	Expected number of cases in BLMK workforce	Reduction in cases if 10% currently commuting by car cycled	Timeline over which health gains would occur
Diabetes	3937 (7.2%)	75	50% in 3.2 years, all in 6.4 years – Jarrett et al
Ischaemic heart disease	1455 (2.6%)	33	50% of effect achieved in 2 years – Jarrett et al
Cerebrovascular disease (stroke)	773 (1.4%)	10	50% of effect achieved in 2 years – Jarrett et al
Depression	6240 (11%)	50	50% of effect achieved in 2 years– Jarrett et al
Any cancer	1491 (2.7%)	16	Over 15 years – Patterson et al.

Inequalities and vulnerable groups

Given that diabetes¹⁷⁴, heart disease¹⁷⁵, stroke¹⁷⁶, depression¹⁷⁷ and cancer¹⁷⁸ are all to some extent common among more deprived individuals, who are also less

likely to be physically active¹⁷⁹, any proactive policies that support greater active travel and generate improved health outcomes in these domains could have a greater impact on lower paid staff groups. However, any policies of this kind would also need to be inequalities sensitive to ensure that this is the case, by using “low-agency” rather than opt-in approaches, since these are more equitable¹⁸⁰.

Appraising the evidence on health: active travel

- Moderate evidence from national data that baseline NHS activity (travel and transport patterns) is likely to be harming health of staff locally.
- Weak evidence of relevant policy interventions that could reduce this harm.
- Weak evidence that ICS green policy commitments are aligned with scientific and policy evidence, and therefore likely to improve health locally.

5.3.4. Nutrition

Diets high in salt, sugar, saturated fat and red and processed meat, but low in fish, fruit, vegetables and fibre increase the risk of high blood pressure, cardiovascular disease, type 2 diabetes and some cancers¹⁸¹. Food consumption is also something that we all do every day that can contribute to a lesser or greater extent to carbon emissions, so the scope for co-benefits is large.

Scientific literature – health factors

Study authors	Definition of low carbon diet	Health benefit
Jarmul et al. 2020 – systematic review	Vegan diet: 81% reduction in GHGs Flexitarian diet: 46.1% reduction in GHGs	Significant reductions found for: Nutrition related chronic diseases: -12% [-19.8 to -4.28] Diabetes: -19.3% [-36.1 to -2.54] Cardiovascular disease -15.1% [-26.1 to -3.93] Significant reduction in cardiovascular disease: -1.75% [-2.65 to -0.84]
Milner et al. 2015 – modelling study in UK population	Compliance with WHO recommendations, which would reduce GHGs by 17%	The switch would save almost 7 million years of life lost prematurely in the UK over the next 30 years and increase average life expectancy by over 8 months
Columbo et al. 2021	Fruit – 100g increase per day Vegetables – 100g increase per day Legumes – 50g increase Red meat – 100g decrease Processed meat – 50g decrease	Ischemic heart disease RR 0.86 (0.79-0.95) [over 10 years] Ischemic stroke RR 0.65 (0.55-0.79) [over 10 years] Tracheal, bronchus, and lung cancer RR 0.93 (0.89-0.97) [over 30 years] Oesophageal cancer RR 0.87 (0.78-0.97) [over 30 years] Type 2 diabetes RR 0.91 (0.84-0.98) [over 10 years] Ischemic heart disease RR 0.86 (0.78-0.94) [over 10 years] Ischemic stroke RR 0.87 (0.79-0.97) [over 10 years] Ischemic heart disease RR 0.76 (0.65-0.89) [over 10 years]

		Colorectal cancer RR 0.86 (0.76-0.97) [over 30 years] Type 2 diabetes RR 0.8 (0.68-0.97) [over 10 years]
		Ischemic heart disease RR 0.56 (0.39-0.97) [over 10 years] Colorectal cancer RR 0.85 (0.79-0.91) [over 30 years] Type 2 diabetes RR 0.58 (0.47-0.76) [over 10 years]

Local data

The local context for obesity, heart disease and stroke (displayed above in 5.3.3) is challenging. In addition, local estimates show that dietary quality is also poor, with data from Fingertips showing just over half of people getting five fruits and vegetables per day¹⁸².

	England	East of England	BLMK*
% adults getting 5 a day (2019/20)	56.80%	56.70%	54.5%
Overweight or obese	63.50%	64%	66.7%
Obesity	25.30%	25%	28.5%
Coronary (ischaemic) heart disease	3%	3%	2.6%
Hypertension	13.90%	14.30%	13.2%
Diabetes 20/21 prevalence	7.10%	6.90%	7.1%

From calculations in the food and nutrition section (5.1.8) we know that BLMK is a provider of a significant volume of patient meals each year. What is less known, is the numbers of staff who also consume meals in their health and care workplaces. One general estimate (not from a UK setting) was that around 30% of employees eat at a work canteen¹⁸³, whereas another estimated that 44% of doctors ate in their hospital restaurant settings¹⁸⁴.

Another local unknown is the current nutritional quality of meals for patients, staff and visitors in the BLMK region where they are provided. Recent reviews of food from South-East England found that the majority of lunch meals in the canteen had “an unfavourable nutrient profile, and regular consumption of such meals may increase the risk of noncommunicable diseases”¹⁸⁵, and previous NHS staff surveys have revealed that 39% of staff think that catering provision is poor¹⁰⁰.

Examples of policies to change nutrient consumption in health and care context

Very few examples of health or care based interventions to improve nutrition in a climate and health sensitive way were found. However, one systematic review of policies to improve consumption of healthy food by healthcare staff in high income countries concluded that the most effective interventions were around reducing availability of low quality food¹⁸⁶, not simply labelling, for example. Another review concluded that implementing existing guidelines was associated with an improved hospital food environment and decreased availability of unhealthy food¹⁸⁷. However neither of these reviews reported quantitative health outcomes associated with these policies.

Possible impacts of Green Plan policies on nutrition and health

Existing commitments in the ICS Green Plan cover food waste, local providers and reducing packaging. In provider plans, where they exist on food and nutrition, they tend to focus on similar issues, although sometimes (in the ELFT plan, for example) plant based food is mentioned.

However, these will not have any tangible impacts on the health of staff, patients or visitors. The focus should be instead on meal composition, decreasing red and processed meats, increasing fruits and vegetable consumption in line with the Eatwell and WHO guidelines¹⁸⁸.

Using staff numbers from the BLMK hospital sites only (11630), and the lower 30% estimate of staff eating at the canteen (3489), we can calculate possible health effects of changing the composition of canteen food. Assuming that BLMK baseline levels of disease can be used for this staff group, and the changes could be achieved via one daily meal at the canteen, some of the possible health effects over 10 years for this hypothetical group of 3489 staff could be as follows:

Diet intervention (from Columbo et al.)	Health effects on 3489 staff over 10 years
Fruit +100g per day	13 fewer cases of ischaemic heart disease 22 fewer cases of diabetes
Vegetables +100g per day	13 fewer cases of ischaemic heart disease
Legumes +50g per day	22 fewer cases of ischaemic heart disease
Red meat -100g per day	49 fewer cases of diabetes
Processed meat -50g per day	40 fewer cases of ischaemic heart disease 104 fewer cases of diabetes

From this review of possible shorter term health impacts of canteen changes, the impactful intervention would be to reduce (or remove) consumption of processed meat. It is also possible that combining the interventions could enable individuals to reach their '5 a day' target, as the average UK diet in the Columbo et al. study was estimated to contain 140g of vegetables and 88g of fruit per day, a total of 228g of the 400g minimum advised by both WHO and the NHS¹⁸⁹.

Inequalities and vulnerable groups

Similarly to the considerations around active travel, healthy eating is much less affordable or common for those on lower incomes¹⁹⁰, leading to obesity becoming more prevalent at lower income levels¹⁷⁹. This is likely to be exacerbated by the ongoing cost of living crisis. Therefore, subsidising healthier and more sustainable food on offer to staff and patients could make policies around food and nutrition more equitable, with greater health benefits felt by those on lower incomes. However, this would only be effective if those on lower incomes are using organisational catering services, and we do not have good data on this locally for BLMK at present.

Appraising the evidence on health: nutrition

- Moderate evidence from national sources that baseline activity (food provision) is likely to be harming health (particularly of staff) locally.
- Weak evidence of relevant policy interventions that could reduce this harm.
- Weak evidence that ICS green policy commitments are aligned with scientific and policy evidence, and therefore likely to improve health locally.

6. Recommendations and reporting

6.1. Reporting: assessing emissions and health impacts

Available information for baselining of carbon reduction commitments was poor, and carbon reduction potential therefore was uncertain

In many of the ICS' Green Plan commitment areas, information on the current baseline level of activities and carbon emissions was not available to the degree that would enable a reliable forecast of how much emissions would be reduced as result of the commitment being fulfilled. Commitments were often also not specific, well-defined, or time-bound, which added to this difficulty. Although estimates using scientific literature were offered as part of this report, they were limited by a lack of local data. Therefore, the extent to which current Green Plan commitments will meaningfully cut carbon emissions is uncertain.

Current commitments were not plausibly sufficient to improve health

Current ICS level Green Plan commitments are not specific or ambitious enough to realistically improve health for BLMK communities or staff. Often the types of actions outlined within commitments were in the right area, but lack of specific targets made it impossible to say that they would live up to any health improving potential.

Climate change, carbon emissions and related activities are contributing to poor health and health inequalities in BLMK now

Air pollution

In BLMK in 2020, more than 460 deaths could be attributed to air pollution and 21% of asthma cases may be attributable to long term exposure. NHS associated activity could be responsible for 16 deaths and 443 asthma cases annually. The poorest communities are most likely to be exposed to high air pollution and suffer the consequences. Levels of PM2.5 and NO2 are also well above WHO recommended limits for key BLMK hospital sites and roadsides across all counties.

Extreme weather

Around 48 deaths for individuals over 65 years old in BLMK were attributable to the 2022 heatwaves. It is not known how many of these occurred in health and care settings. This weather also contributed to mortuary failures and high temperatures in health facilities and cars of health workers; the damage to care has not yet been quantified, but it is likely to have impacted quality of care and outcomes.

Active travel

The small amount of available evidence indicates that the health and care workforce are not likely to be involved in active travel, and many of them will not be meeting recommended levels of physical activity. This has consequences for obesity, heart disease and sickness absence.

Nutrition

If their health corresponds to that of BLMK as a whole, almost half of health and care staff are not getting 5 fruits and vegetables per day, and two thirds are overweight or obese. Although local data was lacking, evidence from elsewhere indicated that many staff in settings such as hospitals where there is a canteen are likely to eat in

it, and the quality of the food available there is likely to have an unfavourable nutrient profile.

Updated Green Plan policies could increase likelihood of improving health

Based on the data available now, updated commitments could improve the likelihood of maximising health gains and cutting carbon by focussing on the following types of actions.

Air pollution

Reducing private car use was likely to be the most effective method for improving air quality in relation to PM2.5 and NO2. In relation to travel and transport, reducing private vehicle use from commuting was also the most effective way of reducing carbon emissions for many organisations (except ambulance trusts), although this may change if fleet data is improved in future.

Extreme weather

BLMK ICS currently has no long term plan about how to adapt to high temperatures, minimise morbidity and mortality during heatwaves, and do this while reducing energy use and carbon emissions (e.g. not simply relying on air conditioning). Energy efficiency (insulation and triple glazing) paired with external shutters and shading for organisational and housing stock could reduce deaths 30-60%, whilst also lowering energy use in non-heatwave periods. Outside shading with trees could also lower the external temperatures and reduce the risk of urban heat island effects around key health and care facilities.

Active travel

Reducing private car use was also the most impactful option for improving health via active travel routes. However, health benefits for staff could be shown at lower levels of reduction than required for improving air quality. Across all BLMK staff, 10% staff swapping their private car commute for a bicycle could avert 75 cases of diabetes, 33 of heart disease, 10 strokes and 50 cases of depression, with effects seen within 2-3 years.

Nutrition

Changing the profile of available food was the intervention most likely to produce health outcomes. Reduction or elimination of certain meats had the greatest health effects; when modelled for a group of around 3500 staff over 10 years, 100g less red meat per day resulted in 49 fewer cases of diabetes, and 50g less processed meat per day resulted in 40 fewer cases of ischaemic heart disease and 104 fewer cases of diabetes. There were similar but smaller health gains for increasing consumption of fruit, vegetables and legumes. Providing a healthier diet in line with Eatwell guidance was also the most impactful choice from a carbon reduction perspective, and could save around 4 thousand tonnes of carbon dioxide equivalent per year compared to BLMK's 19/20 baseline.



6.2. Recommendations: monitoring and evaluation of health impacts moving forwards

In order to implement the measures detailed above and improve the ICS's ability to demonstrate health impact via Green Plan measures in future, the following changes were recommended:

Refine Green Plan goals to be more evidence based in scale and scope

Use the information gathered in this report to refine the ICS Green Plan commitments into SMART goals, including targets based on maximising health co-benefits. This could be done as an annual action plan, which is a tool that has been used in other ICSs and Trusts to improve pace and detail of Green Plan reporting.

Fill key information gaps to enable improved monitoring and evaluation

Working with ICS partners, the ICB should support direct information gathering on the health impacts of climate change in order to better capture current and future damage and co-benefits. This should include firstly basic activity data such as:

- Staff travel and commuting patterns
- Staff occupational health data
- Annual business miles by Trust
- Staff canteen use and meal quality/contents
- Patient and care home statistics and meal quality/contents
- Information on challenges faced by care homes, local authority and primary care in the recent heatwave.

Areas of the Green Plan missing most baseline information:

- Granular supply chain information e.g. levels of local procurement, in order to be able to establish how net zero guidance might shape outcomes via suppliers within BLMK.
- An adaptation plan with commitments, against which progress can be measured.

This could also extend to directly collecting health impact related information such as:

- Pollution levels at major health and care sites as measured by an air pollution monitor so peaks and troughs can be recorded rather than modelled.
- Temperature monitors from major health and care sites to profile vulnerability to extreme weather via indoor air temperature.
- Patterns of admissions and service demands during the 2022 heatwave (and previous similar events) to help forecast future challenges and inform adaptation planning.

Improve ICS communication, assurance and governance to enable better information collection

In order to build momentum around the Green Plan, improve its impact and ensure better data is collected in future, governance should be strengthened, including measures such as:

- Board level commitment to regular (e.g. quarterly) review of commitments, data and progress related to the ICS Green Plan.
- Board level commitment to identifying theme leads for each area in the Green Plan, and resourcing them if relevant teams do not have sufficient capacity.
- Reconvening of the ICS wide sustainability leads group in order to facilitate peer governance, networking and standardisation of approaches where possible.
- Consider using project management resources and setting up performance dashboard so that progress can be easily monitored and that there are adequate resources to drive Green Plan work forwards. This is what Norfolk and Waveney ICS have done¹⁹¹.
- Engage primary care and adult social care more formally to understand what their plans are in this area.
- Further engage local authorities (including linking in with active travel, planning and public health teams where possible) to ensure they are aware of NHS Green Plan processes, can share their expertise in making progress in this area where they are more advanced than NHS Trusts (BBC, CBC) and support others to catch up (MK Luton), working towards eventually having data that is broadly comparable and aggregable from local authorities and NHS organisations.

Commit to evidence generation on policy measures

Although the evidence on connections between climate change, carbon emissions generation, and health impacts is strong across the board, there was not a wealth of evidence around policies in health and care settings to reduce these impacts. This means that evidence generation about what works in our context is crucial for success in this area going forward. This is particularly necessary if we are to move beyond estimating health impacts on staff, and have more reliable estimates for the wider BLMK communities. Academic partners could be approached for support in this domain.

Clarify the ICB's role as a climate and health leader

In order to clarify leadership and scope of the ICS Green Plan, further work should be done to specify how provider plans and ICS plans overlap, and ensure that responsibility for each area is clear so that no areas are neglected. In areas where the ICB does not have authority or direct influence, a theory of change should be developed as to how it will support providers throughout the ICS to take action. A helpful vision of ICS leadership in this area could be borrowed from the Norfolk and Waveney ICB, which defines itself as “driving consistency and ensuring best practice is shared and adopted”¹⁹¹, and specifically lists different tasks in this area that ICB is responsible for and what the provider organisations should do, to promote clarity in this area.

Integrate climate and health outcomes with existing population health work

Ultimately, the ICS is responsible for improving population health, and the Green Plan provides a clear opportunity to do so, both for our own staff and the communities we serve. Therefore, climate and health indicators as explored in this report should be included in future versions of the BLMK PHM strategy¹⁹². Work should go forward to develop population health datasets across the ICS, to ensure they are embedded in this significant workstream moving forwards and not seen as



fringe because they are linked to environmental sustainability. It would also make sense to ensure that these indicators are embedded within other major health strategy work across the ICS, such as the Joint Strategic Needs Assessment and the local Health and Wellbeing strategy. This would be a coherent approach, since the health impacts of climate change and carbon emissions are currently contributing to health inequalities, and reducing carbon emissions in a health conscious way is also a prime opportunity to increase workforce wellbeing.

6.3. Next steps

6.3.1. Dissemination and feedback

This report and its findings will be shared with key stakeholders for feedback and input, specifically around the recommendations and the practicality of implementing them. As of December 2022, this has involved sharing and presentation to the following groups:

- ICS Green Operational Group (which involves net zero leads from all provider organisations)
- ICB executives group
- East of England net zero leads group

Further dissemination to contacts outside of the East of England will also be considered for early 2023, in order to gain feedback, share learning and support similar assessments elsewhere.

6.3.2. Toolkit

In order to ensure this work is a first step towards improved policies to maximise health benefits and reduce carbon emissions, a spreadsheet containing all the evidence and calculations made in this report has been produced in order to share it with provider organisations. This will enable them to better understand why better information collection is required and could build an appetite for them to appraise the health impacts of their own plans as well.

6.3.3. ICB actions

Once dissemination has been completed and feedback collated, the ICB should take the following next steps to begin implementation of recommendations (provided no serious objections are raised during dissemination):

- Start drafting a Green Plan action plan specifying key actions and deliverables for 2023.
- Draft a proposal around resource implications of recommendations, particularly governance, monitoring and data collection.
- Discuss recommendations with the population health management collaborative at ICS level.

Appendix 1 – record of engagement

Log of engagement meetings:

September 2022	Survey shared with 35 key stakeholders across the system.
October 2022	4 October – discussed with Helen Haumann, ICB Digital Lead 13 October – presented plan and progress to ICS net zero lead group 17 October – discussed with Luke McGeogh, Health Foundation 28 October – discussed James Bate Regional NHS England South
November 2022	1 November – discussed with supply chain and procurement ICB leads, and workforce ICB team (separately) 4 November – presented overview to Greener NHS National Leads 14 November – discussed with Paul Lomax, ELFT sustainability lead, separately with Helen Codd Sussex ICB Green Plan Lead 17 November – participated in adaptation discussion at Local Health Resilience Partnership meeting
December 2022	15 December - East of England Green Operational Group meeting 21 December – ICB executives meeting

Appendix 2 – methodological notes

5.1. Search for tools and monitoring approaches

Methodology:

- Sharing information locally, meeting with ICS partners and asking about related projects
- Literature review (“health outcomes” “green policies”, pubmed [0 results] and Google scholar [189 results], Google [“health outcomes” “green policies” tool uk nhs] [857 results, first 5 pages]). Post 2010
- Snowballing

5.3.1 Air pollution

- Literature review (impacts of air pollution on health meta-analysis uk, Google Scholar and pubmed[40])
- asthma air pollution meta analysis [pubmed 143]
- COPD air pollution meta analysis[pubmed 41]
- Stroke air pollution meta analysis [pubmed 33]
- coronary heart disease air pollution meta analysis [pubmed 15]
- lung cancer air pollution meta analysis [pubmed 80]

- Inclusion criteria: meta-analysis, most recent
- Exclusion criteria: doesn't provide a health effect tied to a specific increase in air pollution e.g. 1mg/m³
- Of chosen studies, only significant findings reported

5.3.2. Extreme weather

- green adaptation climate change health
- green adaptation climate change health uk
- green adaptation climate change health nhs uk
- health impacts extreme weather climate change [pubmed 8]
- health impacts heat climate change uk [pubmed 2]
- health impacts flooding uk climate change [pubmed 45]

5.3.3. Active travel

- active travel health benefits meta-analysis uk [pubmed 15]
- active travel health benefits meta-analysis uk [google scholar 4,310]
- active travel nhs staff interventions uk [google scholar]

5.3.4 Diet

- diet "climate change" carbon emissions meta analysis health outcomes
- climate change diet health outcomes meta analysis uk
- Low carbon diet health outcomes – 7 results pubmed
- climate change diet health outcomes meta analysis uk – 2 results pubmed
- policies to improve health patient and staff meals nutrition nhs – Google Scholar

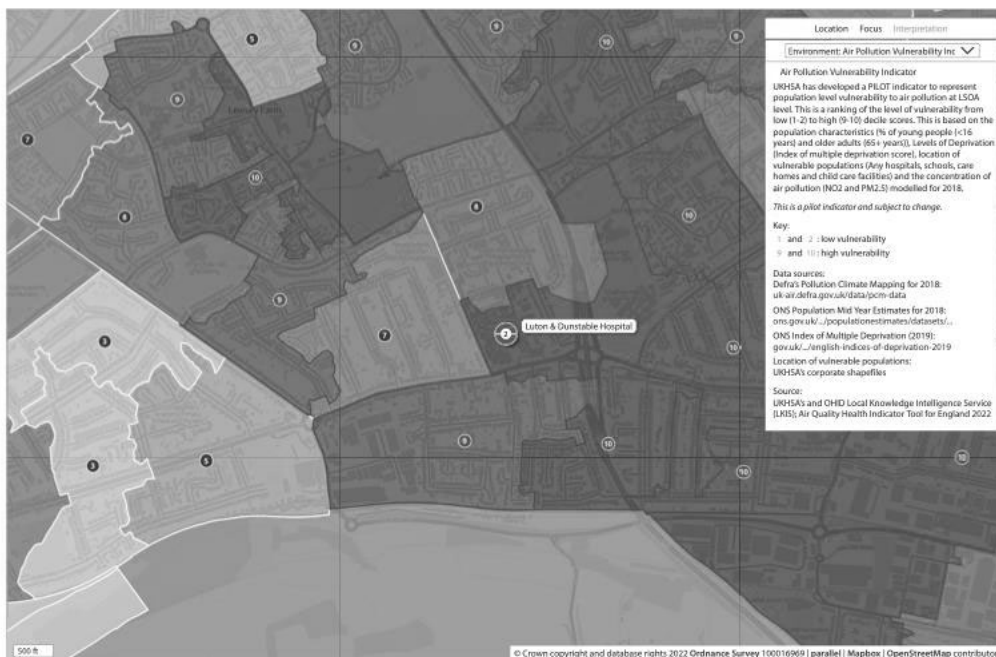
Appendix 3 – air quality maps around BLMK hospital sites

Source: ATLAS Shape Tool: <https://app.shapeatlas.net>

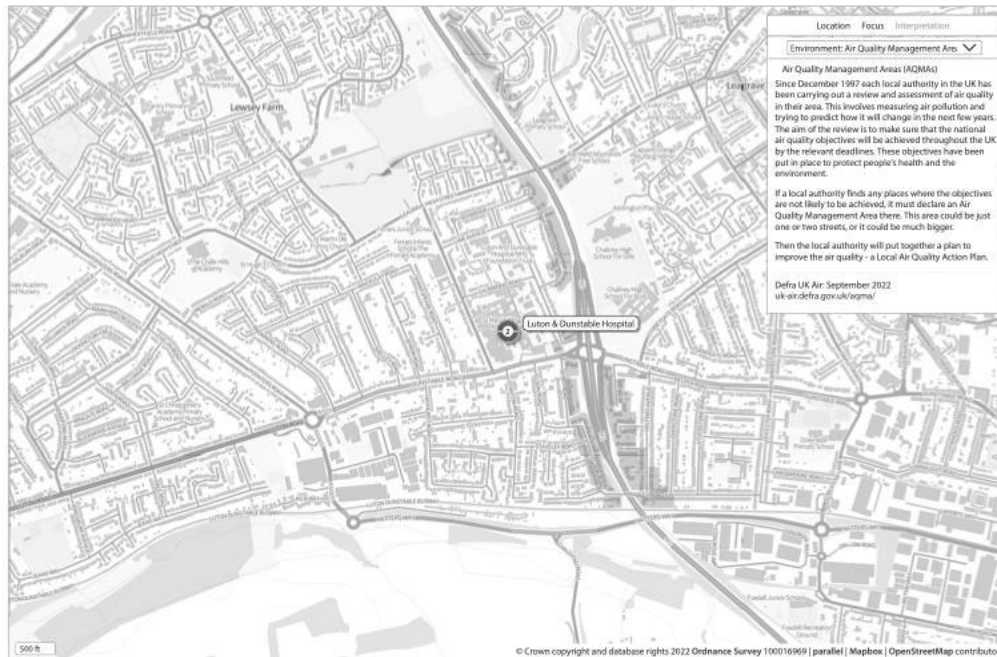
Luton and Dunstable Hospital – PM2.5 vulnerability indicator



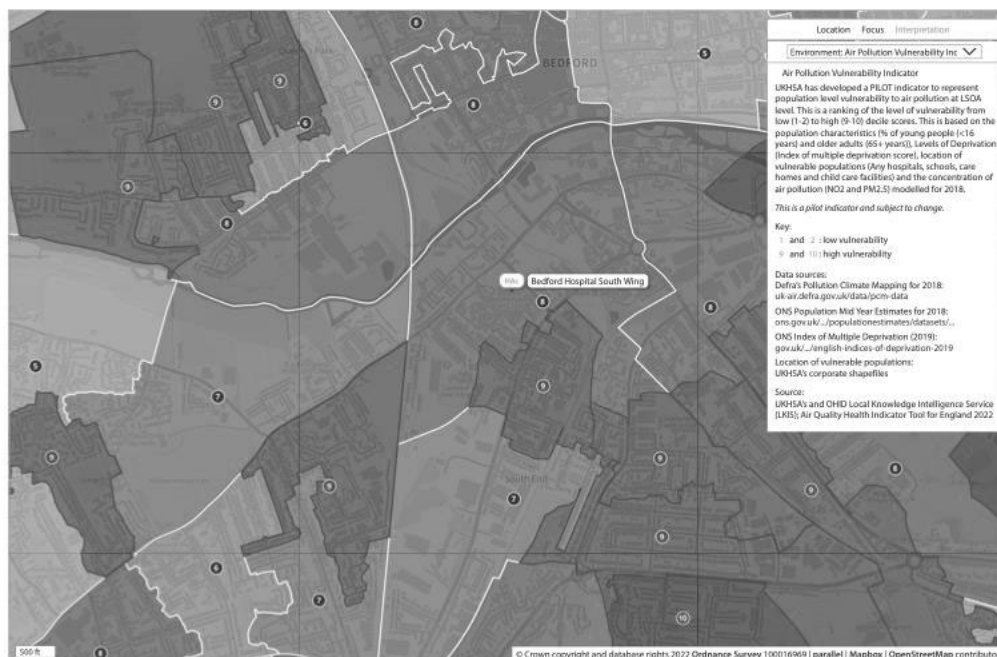
Luton and Dunstable hospital – NO2 vulnerability indicator



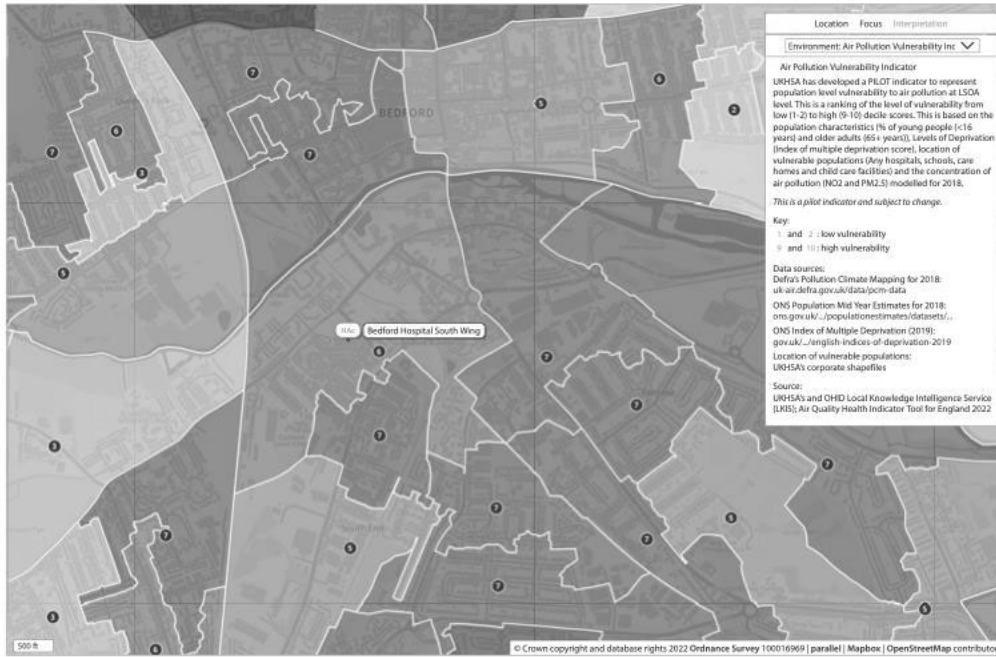
Luton – Air Quality Management Area 2



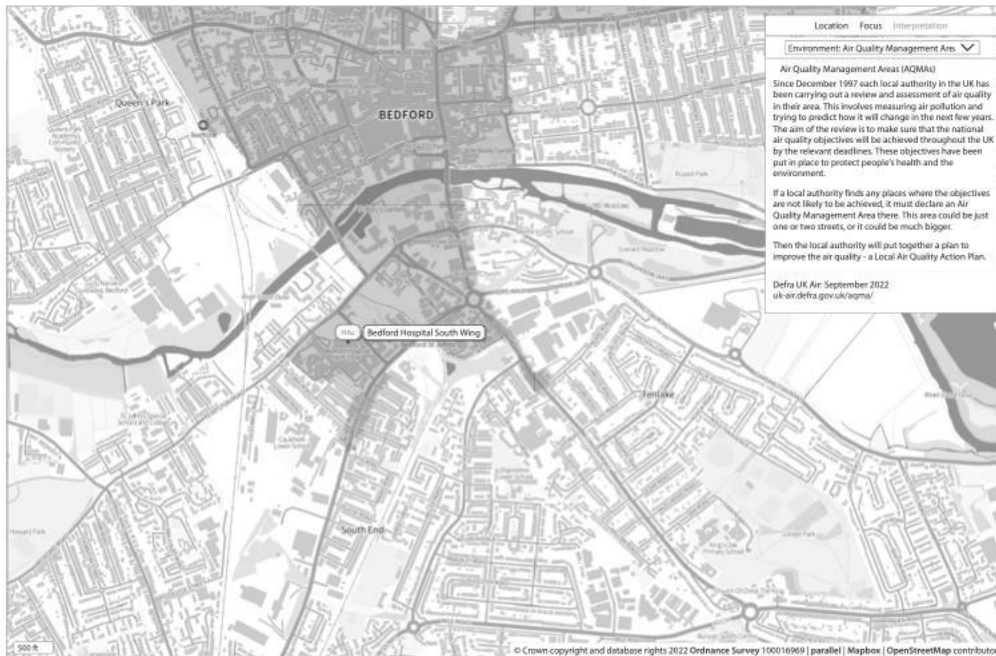
Bedford Hospital – PM2.5 vulnerability indicator



Bedford Hospital – NO2 vulnerability indicator



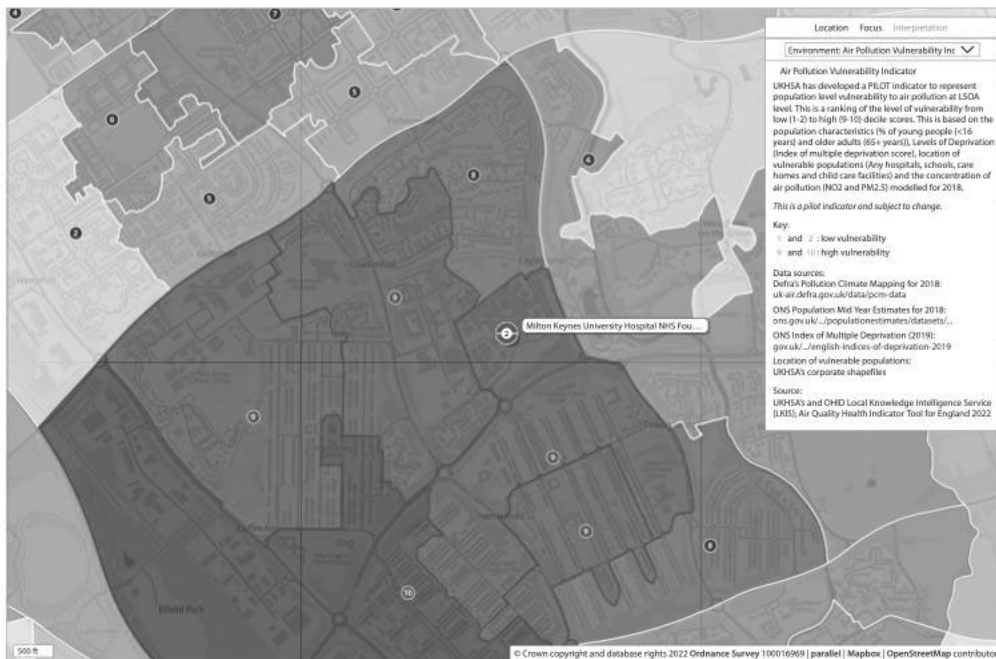
Bedford – Air Quality Management Area



Milton Keynes – PM2.5 vulnerability indicator



Milton Keynes – NO2 vulnerability indicator



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Report to the Board of the Integrated Care Board, 27 January 2023

19. Luton Airport Proposed Development - Health and Community Impact

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input checked="" type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input type="checkbox"/>	Workforce <input type="checkbox"/>	Ways of working <input type="checkbox"/>	Estates <input type="checkbox"/>
Communications <input type="checkbox"/>	Finance <input type="checkbox"/>	Operational and Clinical Excellence <input type="checkbox"/>	Governance and Compliance <input type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

Report Author	Robin Porter, Chief Executive, Luton Borough Council Antony Aldridge, Head of DCO Programme, Luton Rising
Date to which the information this report is based on was accurate	16 January 2023
Senior Responsible Owner	Robin Porter, Chief Executive, Luton Borough Council

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

A range of stakeholders, including members of the public, community organisations, health and public health organisations, and technical experts, were consulted in creation of the Preliminary Environmental Information Report (PEIR), and this document has been subject to public consultation in early 2022. Full details are included within the PEIR documentation, available at <https://virtualengage.arup.com/luton-airport-expansion/pei-report/>

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

None

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

- A) The Board is asked to **note** the process undertaken in creating the Health and Community report.
- B) The Board is asked to **consider** the assessed likely impact and mitigations of the proposed development, and **note** the overall positive contribution that the proposal seeks to achieve for the health and well-being of the local population
- C) The Board is asked to **note** the findings of the impact assessments with regards to health and community, and in doing so, the Board is asked to **signal its support** for the Development Consent Order (DCO).

1. Brief background / introduction:

Luton Rising (a business and social enterprise owned by a sole shareholder, Luton Council, and whose largest asset is London Luton Airport), is proposing to increase the future capacity of London Luton Airport, over a number of years, to 32 million passengers per annum. The plan includes expansion of the current terminal and construction of a new terminal and associated facilities. No additional runway is included in the proposal.

A Development Consent Order (DCO) application for the development is being finalised. A DCO is the planning application that is required for all nationally significant infrastructure projects; it forms part of the process introduced under the Planning Act (2008) to streamline the decision-making process for major infrastructure projects, making it fairer and faster for communities and applicants.

As part of the development of the DCO, the proposer is required to undertake a statutory consultation. As part of this pre-application consultation phase, a Preliminary Environmental Information Report (PEIR) has been produced, outlining the impact the proposals will have on various elements.

The consultation period ran during 2022. All documents pertaining to the consultation can be found at <https://lutonrising.org.uk/consultation/#group-section-Documents-Vault-CdLnZ89PYQ>, and in particular the PEIR documents at <https://virtualengage.arup.com/luton-airport-expansion/pei-report/>. These documents also include the Green Controlled Growth (GCG) mechanism which sets legally binding limits to ensure that the growth of the airport minimises the negative impacts of the Airport on the planet. Through GCG and other commitments within the DCO, London Luton Airport will position itself as a leading proponent at the forefront of the push to sustainable aviation alongside its established position as the most socially impactful airport in the country. GCG is explained below.

The Environmental Statement (ES), which will accompany the DCO, and is based on the findings of the PEIR and the consultation feedback, is currently in draft. The Health and Community section of the Environmental Statement contains the same material findings as the PEIR.

This report summarises the content and findings of a number of chapters from Volume 2 of the PEIR relevant to the health and community aspects of the proposal. Most of the information comes from Chapter 13 (Health and Community), but also refers to content in Chapters 7 ([Air quality](#)), 9 ([Climate Change Resilience](#)), 11 ([Economics and Employment](#)), 12 ([Greenhouse Gases \(GHGs\)](#)), and 20 ([Water Resources](#)). It also draws on additional detail in the draft Environmental Statement (ES); as this has yet to be published, these elements are specifically referenced.

The statutory consultation period regarding the development was completed in 2022. This paper is being brought to the ICB Board by the CEO of Luton Borough Council in recognition of the BLMK system-wide impacts of the proposal, and as part of the statutory role of the ICB with regards to the health and wellbeing of the population.

The content of this report to the ICB contains no additional assessment or analysis of the findings within the PEIR or ES – it seeks to summarise those findings to allow for the board to consider and discuss the particular impacts on health and wellbeing.

The board of the ICB is asked to review the resultant findings in the Health and Community chapter of the PEIR, and confirm its support for the DCO. Board members should be mindful of the core purpose of ICSs to help the NHS support broader social economic development and the ICB's strategic priority for growth 'We work together to help build the economy and support sustainable growth'.

2. Summary of key points:

2.1 Process and Scope

The PEIR Volume 2 Chapter 13 (Health and Community) assessed:

- a) Health effects due to:
 - i. access to open space, recreation, and physical activity
 - ii. access to services
 - iii. employment and income
 - iv. housing
 - v. increased population exposure to air pollutants
 - vi. neighbourhood quality
 - vii. aircraft noise
 - viii. perception and uncertainty, and
 - ix. social capital.

- b) impacts on community resources including residential properties, schools, community facilities, open spaces, and leisure and recreation facilities.

Elements out of scope of the assessment include the following, which have been assessed in line with relevant legislation and guidance:

- electromagnetic interference (EMI), due to the lack of any new EMI-producing equipment within 15m of "sensitive receptors" (those that might be susceptible to risk of EMI)
- ground and water contamination – in the separate PEIR chapter on water quality (Chapter 20), it has been assessed that contamination will be reduced due to mitigations, and the treatment of a former landfill site
- increased flooding risk – the Flood Risk Assessment did not identify any additional flood risk from the development
- cultural heritage, as no impacts on heritage sites were considered to have an impact on health and wellbeing
- major accidents and incidents, due to there being a low probability of occurrence and no available method for assessing the potential health outcomes (even though potentially and wide-ranging and severe), and
- impacts on individual business owners or operators – overall the development is assessed as increasing opportunities for employment.

Assessment of all elements was undertaken with the following key steps:

- 2018 Health and Community technical stakeholder workshop to gain feedback on scope and local issues

- 2019 Community workshop to gain further information on local resources, concerns and aspirations
- Spring 2019 – first open space surveys
- December 2019 – discussions with Director for Public Health at Luton Borough Council
- Workshops in December 2020 and July 2021 with a Health and Community working group (consisting public health representatives, local health and community groups, local authorities, the Luton CCG and Public Health England).
- Completion of the PEIR by competent experts (outlined in the Health and Community chapter of the PEIR), taking into account additional feedback from stakeholders including the CEO, Chief Medical Director and members of the ICB.
- The second Statutory Consultation on the proposals ran from February to April 2022. Feedback from this is being used to contribute to the creation of the final Environmental Statement as part of the DCO.

The magnitude of the impact within each topic was assessed as being High, Medium, Low or Very Low, depending on the scale (real or perceived) and duration of the effect. Similarly, the sensitivity of “receptors” (those perceiving the health and community impacts) was assessed as being High, Medium, Low or Very Low, depending on the proportion of people in the population vulnerable to the element in consideration. Impact and sensitivity were combined in a matrix to determine the overall impact (section 13.4.19).

The Board is asked to note the process used to create the PEIR.

2.2 Health and Community impacts

Airport expansion is a major employment contributor. As owner of the airport, Luton Rising works with the airport operator to deliver against the Luton Council 2040 agenda to eradicate poverty in Luton, modernising and improving the current and future operation of the airport and ensuring social justice and good employment. As part of this ongoing work, the airport operator has already committed to ensuring that all jobs at the airport are paid at Luton living wage levels. Expansion of the airport presents the real opportunity to modernise all aspects of the operation of the airport, and measures set out in the DCO will deliver significant social, economic and environmental improvements.

The expansion proposal is expected to have an overall positive health and community benefits, due to direct and indirect economic growth, employment and skills opportunities for local residents, and improved access to green space. The proposal sets out initiatives and mitigations (supported by legally enforceable limits) to ensure air pollution, noise, and any other potential negative community impacts are prevented or minimised.

Below is a summary of the impacts as assessed in Chapter 13 (Health and Community) of the PEIR. Full details are included in the documents available in the links at the end of this report.

2.2.1 Perception and Uncertainty

Although the evidence for links between perception and uncertainty and health are weak, this has been assessed as a moderate adverse temporary effect on mental wellbeing, which is deemed to be a significant impact. This is due to concerns regarding the perception and uncertainty surrounding the potential impacts on health and wellbeing from noise, air quality, traffic, greenhouse gas (GHG) emissions, and impacts on communities.

The report and assessments consider that there will either be low or no impact of some of these elements (traffic levels, air pollution), or that mitigations (for noise, community impacts and GHG emissions) will be

sufficient - Surface Access (traffic), air quality, noise and greenhouse gas emissions are all controlled through Green Controlled Growth (GCG) proposals, with limits set at acceptable levels.

Green Controlled Growth is a unique new framework developed by Luton Rising to make sure that throughput related environmental limits are observed as the airport grows. These limits would be legally binding and overseen by an independent body and if not observed can lead to passenger growth being stopped. It should incentivise the airport operator to work closely with airlines and other key stakeholders to ensure that Luton is at the forefront of measures to decarbonise aviation and work to encourage a greater take-up of sustainable travel modes for those using the airport.

Public perceptions of these impacts will be addressed through provision of further information.

2.2.2 Employment and income

The proposal will result in a large number of jobs created, both during construction and through the operation of the airport following expansion. Local employment is likely to be in lower-skilled roles, reflecting the tendency for those in lower paid roles not to commute as far as those in higher-skilled and managerial roles. Whilst this might mean that employment into higher-skilled roles will likely come from further afield, the Employment and Training Strategy (<https://lutonrising.org.uk/wp-content/uploads/2022/02/Draft-Employment-and-Training-Strategy.pdf>) will seek to develop skills within the local population to address any imbalance. It is also worth noting that currently a significant proportion of the higher-level roles are undertaken by residents of other local boroughs, including Bedfordshire and Milton Keynes. As of 2019, 58% of all direct employees were resident in Luton and Bedfordshire, with this figure rising to 77% residing within the immediate area of Bedfordshire, Hertfordshire and Buckinghamshire.

Whilst the expansion may have some negative impacts on health (see further details below), the benefits of increased opportunities for employment and income are likely to be overall positive, particularly for those whose wellbeing is compromised by their employment status.

2.2.3 Air Quality

Since 2019, the airport has been monitoring a wider range of air pollutants than any other UK airport, and continues to expand its air quality monitoring programme, with several local schools added to this monitoring in 2022.

The result of the air quality assessment indicates that the size of the population, and the magnitude of the increases in pollutant concentrations would be small (nitrogen dioxide, NO₂) or negligible (PM_{2.5} and PM₁₀ - particulate matter with sizes of up to 2.5µm and 10µm respectively). The Environmental Statement will include calculations of the likely increase in health burden, rising over the years until 2043 where it is expected for there to be:

- up to 0.06% increase in all-cause mortality from NO₂ and PM_{2.5} air pollution
- up to 0.0005% increase in emergency admissions due to cardio-vascular disease, and
- up to 0.0005% for emergency admissions or respiratory disease.

The PEIR chapter 13 notes that “individual residents at affected properties may experience a change in air quality” and identifies two sites that could be affected by small increases in NO₂ levels, but overall, the changes in air quality are considered to be below the level where effects on population respiratory health could be quantified.

As previously noted, air quality will be one of the limits set through the Green Controlled Growth proposal, preventing growth if it were to impinge on those limits, until mitigations are put in place.

2.2.4 Aircraft Noise

The noise assessment has been performed qualitatively for this PEIR, with a quantitative assessment undertaken for the full Environmental Statement. The impact has been assessed as moderate adverse, with effects on physical and mental health were there to be no mitigations put in place.

Modelling shows that, even with growth of the airport, aviation noise is less at each of the assessment years (2027, 2039 and 2043), than that experienced by residents in 2019, due to improvements in aircraft technology. The Environmental Statement will include the modelled figures and will demonstrate that lost Disability-Adjusted Life Years (due to Annoyance, Sleep Disturbance and Acute Myocardial Infarction), and lost Quality-Adjusted Life Years (for Stroke and Dementia), whilst lower than the 2019 baseline, will be increased due to noise pollution compared to the likely impact if no airport expansion were to take place.

The Green Controlled Growth commitments set legally binding limits on noise such that the airport will not be allowed to grow if it is unable to provide a plan which shows that noise will remain within these limits. This will be monitored and enforced by a new, independent body.

Mitigations will include quieter aircraft and the offer of full noise insulation for residential and public buildings falling within either the day time- or night time-SOAEI (significant observed adverse effect limit) levels, at no cost to the owner, as well as providing substantially greater contributions to properties affected by noise at much lower levels than any other UK airport (54dB vs 60dB-63dB); this will increase the number of properties potentially eligible for noise insulation from 2,000 to more than 11,000. The Environmental Statement will state *“the provision of additional compensatory mitigation measures in the form of noise insulation to qualifying properties, where accepted, could help reduce the significant adverse health effect inside properties due to air noise from the Proposed Development”* – this mitigation is expected to reduce the significance of the effect from “moderate adverse” and significant, to minor adverse and not significant.

2.2.5 Wigmore Valley Park

The development will result in the loss of a portion (41.6ha) of the Park. A greater area (48.3ha) of replacement open space will be provided on nearby land, before the loss of the space in the Park. The assessment states that the replacement land will be focused *“on the establishment of natural habitats, delivering areas of meadow grassland, native shrub planting, broadleaf woodland, and mixed-species hedgerows with hedgerow trees, as well as several surfaced footpaths to upgrade connections to the surrounding rights of way network.”* This should also improve access for those who are mobility impaired and those with pushchairs and cycles, in comparison to the existing access routes.

Although the new park area will take time to mature, the overall impact is considered to be beneficial.

2.2.6 Access to Services / Day Nursery

The only significant impact noted for this theme is the demolition of a Day Nursery, with equivalent alternatives more than 1.5km away. Whilst the land in question will not be required for several years, and no agreement has yet been reached as to an alternate site, discussions are ongoing with the owner and potential sites for relocation and/or re-provision of the spaces. Alternative mitigations are also being explored to maintain the existing level of provision. This remains a potentially major adverse permanent effect, deemed as significant, however Luton Rising remains confident that full mitigation will be achieved.

2.2.7 Climate Change

Chapter 9 (Climate Change Resilience) sets out the likely impacts on the development. Higher temperatures, extreme heat and cold, drought, days with high precipitation, and storms, whilst considered as increasingly likely to occur, were assessed as having a low impact on air quality, noise, soils, water resources, flooding, agricultural land, biodiversity, or landscape, even under a worst-case scenario. This

assessment took into account embedded and good practice mitigation measures that will be required as part of the DCO.

Both Luton Borough Council and the Bedfordshire, Luton and Milton Keynes ICS have set out ambitions to reach net zero earlier than the UK Government target; any additional emissions as a result of the expansion would therefore need to be counteracted through carbon reduction measures.

The DCO contains a commitment to airport operations being net zero by 2040 (specifically, the operation of the airport (the buildings, ground fleet, equipment etc.), excluding aviation emissions). Aviation emissions are considered at the national level and included in the section below about the Government's 2050 target). Luton Rising has also included in the DCO a commitment to Surface Access being net zero by 2040.

Green Controlled Growth sets hard limits on GHG emissions; growth of the airport will be dependent on emissions remaining within these limits.

In relation to aviation emissions (which are considered on a national and international level, rather than locally), Chapter 12 (Greenhouse Gas emissions), states that *"whilst emissions from the Proposed Development are estimated to be significant, they will not be so significant as to materially impact the Government's ability to meet its 2050 carbon reduction targets, including carbon budgets."* It also suggests that additional carbon efficiencies can be reasonably expected, over and above those considered within the assessment.

It is therefore assumed in the PEIR that the contribution from the expansion of the airport towards climate change will be negligible and accommodated within existing or likely interventions and mitigations at a national level.

As a result, Chapter 13 (Health and Community) states that the only "in-combination climate change impact" (ICCI) of relevance to this expansion proposal is a small risk of increased occurrence of high summer temperatures, humidity and heatwaves, which would manifest itself as a risk to health due to the replacement of a portion of Wigmore Valley Park (where mature natural shade would be replaced with immature tree cover) with a newly planted green space – until the new tree cover matures, there would be a reduction in available shade. The report assumes that people will make a choice to find alternative shade until the new land's tree cover matures.

The Board is asked to consider the assessed likely impact and mitigations of the proposed development, and to approve the findings of the PEIR with regards to health and wellbeing; in doing so, the Board is asked to signal its support for the DCO.

3. Are there any options?

Do nothing – not proceeding with the expansion proposal would prevent the realisation of the expected benefits, including direct and indirect economic growth and the impact this will have on the prosperity, health and wellbeing of the local population. It would also mean that interventions and mitigations as set out in the DCO, such as the noise insulation proposal (which goes beyond the current offer), expansion and improved access to green space, and the Community First fund (see below) would not be put in place.

4. Key Risks and Issues

The proposal is relevant to ICS BAF Risk 7 (Climate Change). The DCO and the relevant assessments in the Environmental Statement outline commitments and mitigations such that the proposal seeks to be in

line with or better than nationally and locally set decarbonisation targets. Assuming these mitigations and ambitions are met locally and nationally, the DCO intends to avoid any additional contribution to the Climate Change risk		
Have you recorded the risk/s on the Risk Management system? Click to access system	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
BAF 7		
5. Are there any financial implications or other resourcing implications, including workforce?		
There are no implications for the ICB regarding funding or resourcing		
6. How will / does this work help to address the Green Plan Commitments? Click to view Green Plan		
<p>Expansion of the airport represents an additional source of greenhouse gas emissions, as outlined in Chapter 12 of the PEIR. Whilst the majority of these will come from increased air traffic (and thus considered nationally and internationally, rather than locally), mitigations have been outlined including development of more fuel-efficient aircraft, reduction in private vehicle traffic associated with use of the airport (staff and travellers), options for renewable energy generation, and strategies to offset any losses of vegetation and habitat; this is in order to meet the commitments in the DCO for surface access and airport operation to be net zero by 2040</p> <p>Other environmental impacts are either considered low or have mitigations in place.</p> <p>The preliminary assessment concluded that whilst [additional] <i>“emissions would be significant, the Proposed Development would not materially affect the UK’s ability to meet its carbon reduction targets, including carbon budgets”</i>. The relevant updated chapter of the Environmental Statement will set out that the forecast trajectory for GHG emissions as a result of airport growth is in line with the Government’s latest (Jet Zero) High Ambition trajectory for reducing aviation GHG emissions.</p> <p>The Integrated Care System Green Plan sets out the ambition to be net zero by 2035, for emissions where the NHS has direct control. The national NHS ambitions are to be net zero by 2040 (for emissions it directly controls) and 2045 (for indirect emissions). Luton Borough Council, the sole shareholder of Luton Rising (owner of Luton Airport) has a goal to be net zero by 2040, in line with the NHS target.</p> <p>The DCO and the relevant assessments in the Environmental Statement outline commitments and mitigations such that the proposal seeks to be in line with or better than nationally and locally set decarbonisation targets. Assuming these mitigations and ambitions are met locally and nationally, the DCO intends to avoid any additional contribution to the Climate Change risk and seeks to contribute to other elements such as improving access to high quality green space.</p>		
7. How will / does this work help to address inequalities?		
<p>The wider determinants of health, which often have a more significant impact on those in more-deprived communities, include elements pertaining to economic development. The expansion of Luton airport is expected to have a significant positive benefit in terms of the overall prosperity in the local economy, including opportunities for employment and skills development, including for those in more-deprived neighbourhoods.</p> <p>The DCO also contain the Community First proposal, which will provide up to £14m per year to fund projects aimed at tackling deprivation or decarbonisation (with up to £8.4m of this being ring-fenced for</p>		

Luton). This is in addition to mitigations set out within the proposals, and additional to the circa £7m Luton Rising already puts into local community causes every year.

Whilst there are potential impacts on communities in terms of health and community, as outlined in Chapter 13 of the PEIR these are expected to be either low or sufficiently mitigated.

8. Next steps:

The programme team will be completing the Environmental Statement, including impacts on Health and Community, for submission with the DCO, for approval from the planning inspectorate.

9. Appendices

Appendix – All documents referenced within this report can be sourced at the links listed below in Background reading.

10. Background reading

It is recommended that Board members read Chapter 13 (Health and Community) from the PEIR documents.

All documents can be found at the following links.

- Luton Rising Consultation Home page: <https://lutonrising.org.uk/consultation/#section-Home-W2qnn48Zm8>
- Document Vault: <https://lutonrising.org.uk/consultation/#group-section-Document-Vault-CdLnZ89PYQ>
- PEIR documents: <https://virtualengage.arup.com/luton-airport-expansion/pei-report/>

Report to the Board of the Integrated Care Board, 27 January 2023

20. Quality and Performance Report - January 2023

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input checked="" type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input checked="" type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input checked="" type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input checked="" type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input checked="" type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input checked="" type="checkbox"/>	Workforce <input checked="" type="checkbox"/>	Ways of working <input checked="" type="checkbox"/>	Estates <input type="checkbox"/>
Communications <input checked="" type="checkbox"/>	Finance <input checked="" type="checkbox"/>	Operational and Clinical Excellence <input checked="" type="checkbox"/>	Governance and Compliance <input checked="" type="checkbox"/>
Other <input type="checkbox"/> (please advise):			

What are the members being asked to do?

Approve <input type="checkbox"/>	Note <input checked="" type="checkbox"/>	Discuss <input type="checkbox"/>
-------------------------------------	---	-------------------------------------

Report Author	Sarah Stanley - Chief Nurse, Maria Laffan – Deputy Chief Nurse, Maria Wogan, Chief of System Assurance and Corporate Services, Anne Brierley – Chief Transformation Officer, Carol Davies, Head of Performance Reporting and Analysis
Date to which the information this report is based on was accurate	Latest available data as at 16/1/23
Senior Responsible Owner	Sarah Stanley, Chief Nurse and Maria Wogan, Chief of System Assurance and Corporate Services

Executive summary

This paper summarises key areas of quality and performance by exception across the Bedfordshire, Luton and Milton Keynes system. Based on a risk-based assessment of overall quality and performance across the system, this report focusses on winter and elective performance as well as providing an exception report in relation to other areas of performance. Regular performance and quality reports are presented to the ICB Executive, the System Quality Group, the System Performance and Delivery Group and the ICB's Quality and Performance Committee, which last met on 2 December. The System Oversight and Assurance Group meeting (which comprises CEOs of all partner organisations) was postponed on 13 December due to system winter operational pressures; this meeting has been re-organised to take place on 3 February 2023.

A quarterly review meeting for the ICB with NHSE Regional Leadership Team was held on 9 January at which the development and overall performance of the ICB and ICS was discussed. At this meeting BLMK ICB was advised that the ICB continues to be rated as SOF 2 (on a development journey but demonstrates many of the characteristics of an effective ICB). No significant concerns about performance or quality were raised at this meeting. The process and approach to NHSE review and regulation for ICBs is being developed for 2023/24 and will be reported to the Board in March, when confirmed.

Positive developments since the last report

- Appointments in primary care are 12.8% higher than pre-pandemic (November 2022 vs November 2019) with 79% delivered face to face (87% in November 2019)
- Acute Respiratory Infection (ARI) hubs – additional primary care capacity has opened in the four places in BLMK in response to the significant increase in demand related to respiratory infections. This additional capacity was stood up within 6 weeks with excellent support from primary care colleagues and details are given later in the report. This is a good example of primary care's responsiveness, flexibility and ability to collaborate across primary, community and secondary care and work at scale. This additional capacity should reduce pressure on the systems A&Es and enable people to be seen close to home.
- System Control Centre – virtual control centre now in place to support the system with management of operational pressures. Over 1000 contacts have been received since the centre opened in December.
- Patient Safety Incident response framework (PSIRF) implementation is on track. The ICB Patient safety specialist lead has implemented a "community of practice" for all provider PSIRF implementation leads across the system, the patient safety specialist network is well established and BLMK have just held their second PSIRF workshop co-hosted and supported by Eastern AHSN. In addition, discussions are progressing on potential for system wide training. BLMK is developing processes for Patient safety investigation system panels to review where harm may have been attributed across system partners touchpoints.

Areas of concern/risk:

- Winter operational pressures and impact on residents – this report provides a summary of the actions we have taken to manage the significant operational pressures during December and January.
- Elective waiting list – this report provides a summary of the current position on the elective waiting list for our residents and describes the actions being taken to mitigate harm and delays for residents. The specialities where residents are waiting the longest are Ophthalmology, Trauma and Orthopaedics, Gynaecology and Ear, Nose and Throat.

- Industrial Action – Trade unions representing NHS staff have advised the Secretary of State for Health and Social Care that they are in dispute over the 2022/23 pay award. There are no Trusts in BLMK taking part in the RCN strikes (18th and 19th January) and only South Central Ambulance Service GMB members took part in GMB strike on 11th January. As in December, SCAS ran a command cell throughout the industrial action on both dates. EEAST showed significantly poorer performance during the days that other ambulance services were on strike in December. For the strike on 11th January, although EEAST staff did not participate, planning and preparation was in place as if they were.
- Dementia Diagnosis Rate – The ICB is below the planned target levels of 64.4% by end of Q2, predominantly due to a lower rate in Central Bedfordshire of 57.6%. A new specialist dementia diagnosis service for care home residents is being set up by ELFT in Central Bedfordshire as part of a national NHS pilot.
- Open Referrals for Suspected Autism – Adults and Children – A workshop took place on 5th December to review the current pathways and explore opportunities to reduce demand and support children’s needs at the right time in the right place. Recommendations will be presented to the Children & Young People Transformation Board in Feb 2023.
- Children and Young People Mental Health - Tier 4 provision Child & Adolescent Mental Health Services - The new 8-bed inpatient unit providing specialist short-term care for ages 13-17 with severe or complex mental health difficulties is now due to open mid February and staff are being onboarded onto alternative wards prior to the opening. Further capacity will still be required to meet current demand. This is subject to a capital estates bid where CDEL limits for ELFT and CNWL being held outside the BLMK ICS is a barrier to progress which we have escalated regionally.
- Eating Disorders – As part of the national Community Mental Health Transformation programme there are on-going developments with expanding the Community Eating Disorder Services across BLMK focussing on delivering timely, effective, evidence-based treatment which is aimed to address the increased demand for support in this area.
- Review of Patient Experience on Mental Health Wards - BLMK Quality teams are working closely with main providers ELFT and CNWL on establishing a position of assurance regarding safety on inpatient wards. A patient safety leadership and culture shift ambition is clearly a priority for main organisations to support this ongoing assurance piece. A task and finish group is in development for wider areas of provision where people may be placed in other inpatient service including patients under Section 117. This is a large piece of work across BLMK and will be updated on a quarterly basis.

What are the available options?

As described in relation to individual items in the paper.

Recommendation/s

The Board is asked to review the quality and performance report, **note** the areas of improvement and concern and **agree** any additional actions required to manage risk in the system.

Key Risks and Issues

Key risks are included within the report.

Have you recorded the risk/s on the Risk Management system?

Yes

No

Risks are identified and included on the Board Assurance Framework. The primary risks that relate to this report are as follows:

BAF 1 – Recovery of Elective & Cancer Services – Current risk rating 16

BAF 3 - System Pressures and Resilience – Current risk rating 20

The BAF is a separate item on the Board’s agenda.

Are there any financial implications or other resourcing implications?

BLMK adult social care discharge fund allocation for BLMK:

	ICB allocation	LA allocation	Total
Luton	£1.103M	£656,771	£1,759,771
Bedford Borough	£0.902M	£517,343	£1,419,343
Central Beds	£1.519M	£721,643	£2,240,643
MK	£1.395M	£765,732	£2,160,732
Bucks	£0.034M		

An additional £3.2M funding for BLMK winter operational pressures was announced by the Government on 9 January 2023. This will be allocated to places on the same basis as the above funding to support discharge initiatives and supporting people to be cared for out of hospital.

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

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

How will / does this work help to address inequalities?

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

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

Members of the System Quality Group and the Performance and Delivery Group

Next steps:

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

Appendices

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

1) Managing Winter/Urgent and Emergency Care

Summary of position and mitigations

We continue to see challenged performance in meeting urgent and emergency care standards, access and quality. Our population is experiencing long waits to access emergency care both in our emergency departments and ambulance response times. A&E attendances in December have increased by 11.73% on the same time in 2019, with all Trusts seeing record numbers of attendances over the last two months. Hospitals have been operating with high levels of bed occupancy 95.9% (December to 10th January) and the pressure on hospitals has seen ambulance handover delays. Although our system has relatively good performance it is not the standard of care we want to provide for our residents.

Ambulance Handovers week ending 15/01/2023 - Regionally by Trust, BHFT ranks 3rd for 30-60 mins and 5th for >60 mins; MKUH ranks 2nd for both 30-60 and >60 mins

	Ambulance Arrivals	% Delayed 30-60 mins	% Delayed >60 mins
Bedford Hospital South Wing	325	8.0%	10.5%
Luton & Dunstable Hospital	387	16.0%	11.1%
Milton Keynes Hospital	445	11.0%	1.3%
BLMK	1157	11.8%	7.2%
East of England Regional Average	6988	19.6%	17.7%

As an ICB we are reviewing areas of patient harm across our system. Where it is evident that there are other areas of potential impact/harm (e.g. delay in care due ambulance delay/offload) we are planning system review panels to ensure shared system wide learning and areas for improvement.

Hospitals have seen significant demand with attendances of all ages, inclusive of respiratory, falls and frailty. There continues to be ongoing challenges due to Strep A. Table below shows covid-19 and flu inpatients up to week ending 8th January.

Trust	Occupied Beds	W/E 25/12/2022	W/E 01/01/2023	W/E 08/01/2023
Bedford Hospital South Wing	Beds occupied by Covid-19 patients (Weekly average)	33	35	20
	Beds occupied by Flu patients (Weekly average)	31	44	29
Luton & Dunstable Hospital	Beds occupied by Covid-19 patients (Weekly average)	53	25	44
	Beds occupied by Flu patients (Weekly average)	45	71	41
Milton Keynes Hospital	Beds occupied by Covid-19 patients (Weekly average)	20	37	48
	Beds occupied by Flu patients (Weekly average)	33	24	26
BLMK	Beds occupied by Covid-19 patients (Weekly average)	106	97	112
	Beds occupied by Flu patients (Weekly average)	109	139	96

For W/E 01/01/2023 - Flu figure is a daily snapshot of 28/12/2022

We are expecting that pressures will continue as we plan for potential concurrent incidents of high respiratory infection rates (including COVID) and ill-health exacerbated by the cost of living crisis. The position is likely to be further impacted by challenges with resources, due to both the existing high vacancy factor across the health and care sector, high sickness absence and the potential for industrial action across multiple staff groups.

Partner organisations across health and care in both the Bedfordshire and MK areas have worked well together to manage the unprecedented demand and acuity levels and to mitigate the risk of patient harm. Key mitigating actions have included admission avoidance schemes, virtual wards, the maximum use of escalation beds in all three hospital trusts which has had an impact on elective activity and patient experience. The impact is more severe in the Bedfordshire system which relies more heavily on elective capacity such as catheterisation labs and endoscopy for escalation space than MKUH which has been able to maintain more elective activity due to the opening of the Maple Unit Same Day Emergency Care unit.

The Adult Social Care Discharge Fund has been used to support discharge from hospital in the four local authority areas and excellent joint work at place has been evident between health and care partners. The key challenges in relation to discharge are the lack of availability of the domiciliary care workforce in areas of full employment, particularly Central Bedfordshire and Bedford Borough and challenges returning and placing residents in care homes due to infection prevention and control concerns about covid and flu.

An additional £3.2M funding for BLMK winter operational pressures was announced by the Government on 9 January 2023. This will be allocated to places on the same basis as the above funding to support discharge initiatives and supporting people to be cared for out of hospital.

The ICB has established a system-wide care home cell (previously operational during Covid pandemic). The intention of this cell is to review some of the current challenges that are impacting flow and safe transition of patient across acute/care services. This work will include the current support from ICB infection control team and care home improvement nurses to work with care homes to support discharge and provide support on infection prevention control and other areas of concern/blockages.

The MK Deal (improving system flow) and the Bedfordshire Care Alliance mechanisms have enabled improved system working this winter and are also supporting the embedding of improved ways of working that will give sustained benefits. Place working is key to securing effective flow through our hospitals and tailoring our response to different place contexts and provider arrangements is essential. The ICB system approach has been to support and facilitate the four places to respond to the challenges and strengthen working arrangements. The recent procurement of intermediate care beds which becomes operational on 1 April 2023 will also support more appropriate use of intermediate care and better outcomes for our residents after an admission to hospital. We are working with partners on how to make most effective use of the recently allocated additional £3.2M to support hospital discharge.

In the longer-term, to improve our resilience to manage surges in demand and to give an improved patient experience we need to:

- Expand Urgent Community Response, SDEC and virtual ward provision to manage all frailty patients at home who have sub-acute illness
- increase the bed capacity at BHT (2 additional wards required) – this will help to mitigate the impact on elective capacity and improve patient experience
- work with wider partners to build up the domiciliary care workforce
- continuously improve our support for care homes, including expanding rehabilitation and nursing support to care homes for post-acute patients
- implement the Fuller neighbourhood approach and support primary care in terms of funding, estates and workforce to provide care outside hospital
- increase our investment in prevention and fully utilise the skills of the voluntary sector to help people stay well at home by tackling the two major determinants of poor health in the elderly (isolation and deconditioning)
- continue to strengthen place-based working and support the Bedfordshire Care Alliance to integrate services and reduce fragmentation.

UEC Quality and Performance - Detail

Snapshot of Performance – 6 key metrics

“The Next Steps in Increasing Capacity and Operational Resilience in Urgent and Emergency care ahead of Winter” letter set out 6 metrics that NHSE and ICBs will use in each system to provide assurance for the provision of safe effective urgent and emergency care. Latest performance against these 6 metrics is shown below (17/1/23) and is local data from providers which is unvalidated and therefore subject to change.

SYSTEM PRESSURE INDICATORS - DAILY SNAPSHOT

Unless otherwise stated, the previous position is for the day prior to the latest data period

Latest Data Period	Bedford Hospital South Wing			Luton & Dunstable Hospital			Milton Keynes Hospital																																																												
	Previous	Latest		Previous	Latest		Previous	Latest																																																											
Adult G&A Bed Occupancy - system ambition 92%	17/01/2023	98.51%	97.37%	↑	97.14%	95.25%	↑	98.74%	99.37%	↓																																																									
Patients with no criteria to reside with LoS 7+ Days - local ambition 22%	15/01/2023	58.52%	51.42%	↑	Figures to the left relate to Bedfordshire Hospitals NHS Foundation Trust			51.19%	26.61%	↑																																																									
% Beds Occupied by patients with no criteria to reside and LoS 7+ Days - local ambition 22%	15/01/2023	15.58%	16.10%	↓				8.29%	5.52%	↑																																																									
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Key:

Achieving ambition		Within 5% of ambition		More than 5% from ambition	
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Mitigating Actions Being Taken:

There is a significant system focus on reducing **Ambulance Handover Delays** - A whole system approach is being taken to reduce ambulance handover delays and the position is reviewed at the Performance and Delivery Group and in daily operational meetings in Bedfordshire and MK.

For Bedfordshire Hospitals Trust the Luton and Dunstable's performance is impacted by divers from other areas, 'Intelligent Conveyancing' and on occasion, batching of ambulances and Bedford Hospital's performance is linked to challenge around discharge and flow.

A number of new initiatives are underway to mitigate system pressures including the new Same Day Emergency Care unit at MKUH. Community services in Bedfordshire are now taking calls from the EEA ambulance service 'stack' of calls which is aimed at reducing ambulance conveyances. In Milton Keynes a different approach is being implemented as the South Central Ambulance Services system does not support access to the stack in the same way. Central North West London NHS Trust and SCAS initial referral pathway is for people who have fallen.

Acute Respiratory Hubs: the whole system has worked together to build on existing services. Principally a primary care function, acute consultant advice and review is available:

- Bedford Borough: **BEDOC (Shortstown Surgery)** mobilised a 5 day service from **4/1/23**. 7 day service will be stepped up over the coming days subject to workforce availability.
- Central Bedfordshire: a 5 day model will be **delivered by PCNs** to their population. Chiltern Hills live from 28/12/22. Other CB/PCN go live dates TBC. Discussions are progressing with primary care providers regarding ARI additional capacity on days 6 and 7 for CB.
- Luton: **Evexia** launched a 7 day model for **Luton** from **3/1/23** from **Gardenia and Marsh Farm Practices**.
- Milton Keynes: **MKUCS** working up a 6 (to 7) day model for **Milton Keynes from MK Urgent Treatment centre**. Go live date 9/1/23.

Demand & Capacity Beds: There are 4 schemes in place to deliver additional bed capacity in acutes, care homes, SDEC and virtual wards. The first allocations have been transferred to the acute Trusts in line with plan. Total beds expected 174 and 106 have been delivered to date.

Falls Support - community and care homes provision has been reviewed and additional support implemented where needed. we have reviewed our falls support including to care homes and implemented additional support where needed. We are rolling our Razer chairs 90 in place, with training and poster guidance delivered, 35 in progress

System Control Centre: operational since 1/12/22. It is a virtual control centre to support the system with management of operational pressures. It is staffed from 8am to 8pm every day with on call arrangements overnight, providing system support 24 hours a day, 365 days a year. Over 1000 contacts have been received since the centre opened.

Discharge: All services work 7 days a week, but private providers will not accept 7 day entrants/admissions – new procurement from 1 April 2023 will address this issue for commissioned NHS beds and local authorities are working on this with other providers. In response to system pressures the care home system escalation meeting chaired by the Deputy Chief Nurse has been reinstated to look at measures that could support system flow for care home discharge pathways. A number of issues were identified with respect to communication, relationship management and support for care homes staff and residents, particularly during the out of hours period and at times of system escalation, these include: medication safety, support from IPC, primary care and community teams, completion of capacity tracker, transfer of resident information to and from hospital and CQC requirements. Several of these issues are longstanding and will be taken forward with monthly meetings of the care home escalation group members to support progress.

Care home Cell: System wide Care home cell discussion re-established in January. Focused area of work on areas of improvement to support safe flow of patients from acute into care home provision.

Innovations: Delirium Recovery Pathway: consultant led pathway selected patients who suitable and safe for home based 24 hour live in care. We were able to reduce care within 7 days, often within 72 hours. In 7 cases, we reduced care to wellbeing calls and visits only. Now a mainstream service. MK all step down beds in private providers and rehabilitation unit as **one Community Virtual Hospital**, the Seacole Unit. This enabled single clinical management, single bed management and flow processes. As acuity increased during Covid and into present day, we have added in senior clinical resources, both directly and by accessing some acute services, e.g., Dietitian, Geriatrician etc.

Primary Care - There were 507,245 General Practice appointments offered across BLMK in November 2022 compared to 449,713 in November 2019 (pre-pandemic), an increase of 12.8%. 79% of appointments were delivered face-to-face compared with 87% in November 2019. To support Primary Care Networks the ICB has a 2022-23 plan to recruit to 456 roles under the Additional Roles Reimbursement Scheme (ARRS) which provides funding for additional roles to create bespoke multi-disciplinary teams in PCNs with 274 recruited as at September.

Digital support currently in place:

- 316 residents supported at home through Doccla remote monitoring
- 372 devices iPads in care homes to provide care professional support via VC or access to loved ones for contact
- 108 Whzan kits for NEWS monitoring active (84% of homes covered, 16% underway)
- 219 bedroom actively using acoustic monitoring to support falls prevention in care homes
- 29% of care homes with proxy access to primary care information (exceeding target of 25%)

Mental Health Admissions - To support flow through the system and minimise bottlenecks, private and step-down beds have been procured. Cost of living crisis and homelessness are impacting factors that contribute to extended lengths of stay in inpatient units. Work is ongoing on Alternatives for Admission with plans to expand existing provision across BLMK being worked up for 2023/24.

Mental Health Crisis Management – Crisis Cafes across BLMK currently see 750 people a year with over 3,500 contacts. Over 90% of people attend due to being in a mental health crisis and require help and support. 42% reported they would have gone to A&E had the crisis cafes not been open. Activity in Bedfordshire and Luton has not been as high as in Milton Keynes as the services are not as integrated into the crisis pathway as in Milton Keynes.

ELFT are working with BLMK MIND to embark on a programme to embed peer support workers into the 111 Option 2 service and ELFT clinicians will attend Bedfordshire and Luton Crisis Cafes to increase uptake.

Mental Health Nurses are embedded into both Ambulance service control rooms and help triage mental health calls in the control room and support ambulance crews on the ground. We do not have specific data from SCAS or EEAST. The same applies to the Street Triage service with Thames Valley police.

BLMK Winter Assurance Framework

In December there has been a significant increase from our original submission with 68.75% (35.42% November) key lines of enquiry (KLOE) being fully completed, 12.50% are partially completed and 18.75% still require updating.

Of the 12.50% partially completed there are 5 now overdue with original timescales of between September and November;

- Quality Improvement Support to Practices - ongoing
- Primary Care Technology – Ongoing, awaiting winter pressures funding
- Mental Health Specialist Vehicles – capital bid submitted to NHSE/I in mid December
- Specialty inreach in 60 minutes – Ongoing with the Bedford site
- 24/7 urgent mental health helplines – ongoing

There are 4 new KLOE's that have been updated in readiness for submission which relate to the establishment of the Acute Respiratory Hubs.

As an addendum to the winter plan NHSE have asked for each ICB to undertake a further review to reflect the demand pressures predicted over the next three months and the likely impact on elective capacity and this return has been submitted to NHSE.

Winter communications plan

We have a week-by-week schedule for planned communications activities, including news releases, staff briefing materials and stakeholder bulletins. Our social media presence – Twitter, Facebook and Instagram – continues to share these key messages.

Given the unprecedented pressure on NHS and social care services this winter, we have been particularly keen to encourage residents to use NHS services appropriately over the Christmas period and the first half of January. This includes heavy promotion of the symptom checker at 111 Online and the role of community pharmacy. We also have an updated version of *Your guide to local health services* (previously known as *Help us help you*), which incorporates a guide for parents of poorly children. Vaccination messages continue to feature heavily as the COVID and flu outreach campaigns are set to restart in January, and these will be supplemented by flu vaccination reminder toolkits for schools and nursery settings. Multilingual resources on Strep A have now been published by UKHSA, so we have also shared these with the local authorities and the third sector, who continue to assist us in reaching all demographics.

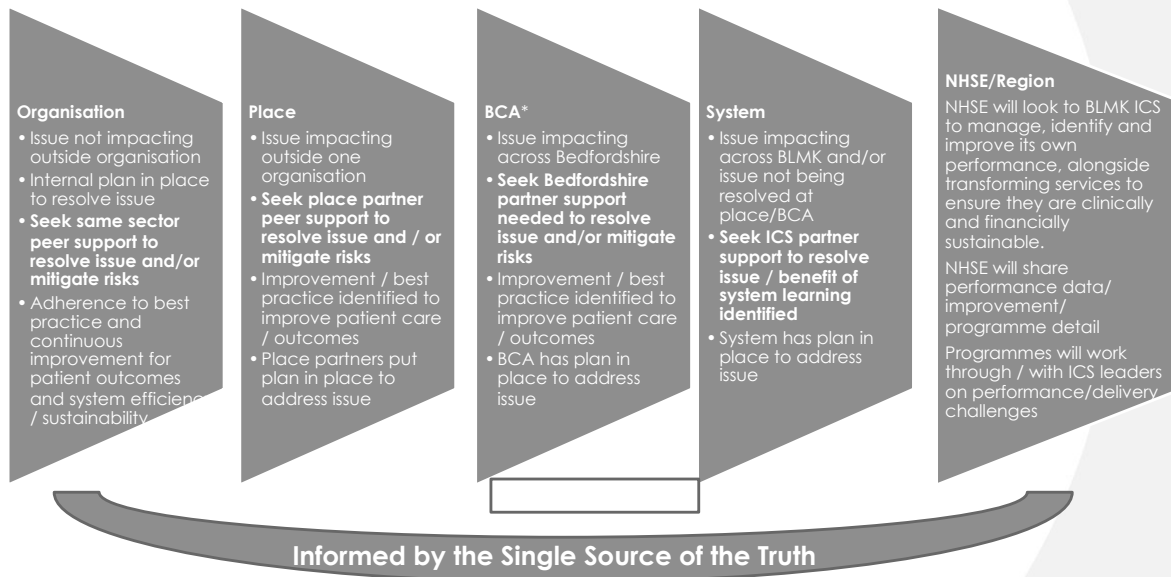
2) Elective Care – Reduction of Waiting Times for People

The Prime Minister has made 'cutting NHS waiting lists' one of his five key priorities for 2023 and this has been a long-standing part of our plans, however, the use of elective capacity to manage system pressures over winter has had an impact on elective performance and period to these pressures there were some specialities were particularly challenged in terms of waiting times.

ICB Strategic – Approach of Peer Accountability and Support

As an ICB, our role is to support the system to address performance challenges and we have been developing an approach based on peer accountability and support which is described below and which we will discuss further with partners at the System Oversight and Assurance Group on 3 February. This approach is based on subsidiarity and offering the appropriate support from all levels of the system. It recognises that a performance challenge in one area of the system have impacts across the whole system and can benefit from system-wide action to deliver improvement. The diagram below illustrates the concept and the slides that follow illustrate how this could be applied to one of our most challenged areas, ophthalmology by assessing the impact and then looking at possible sources of support to drive improvement. Further detail on ophthalmology actions is given later in the paper.

An approach to peer support based on subsidiarity

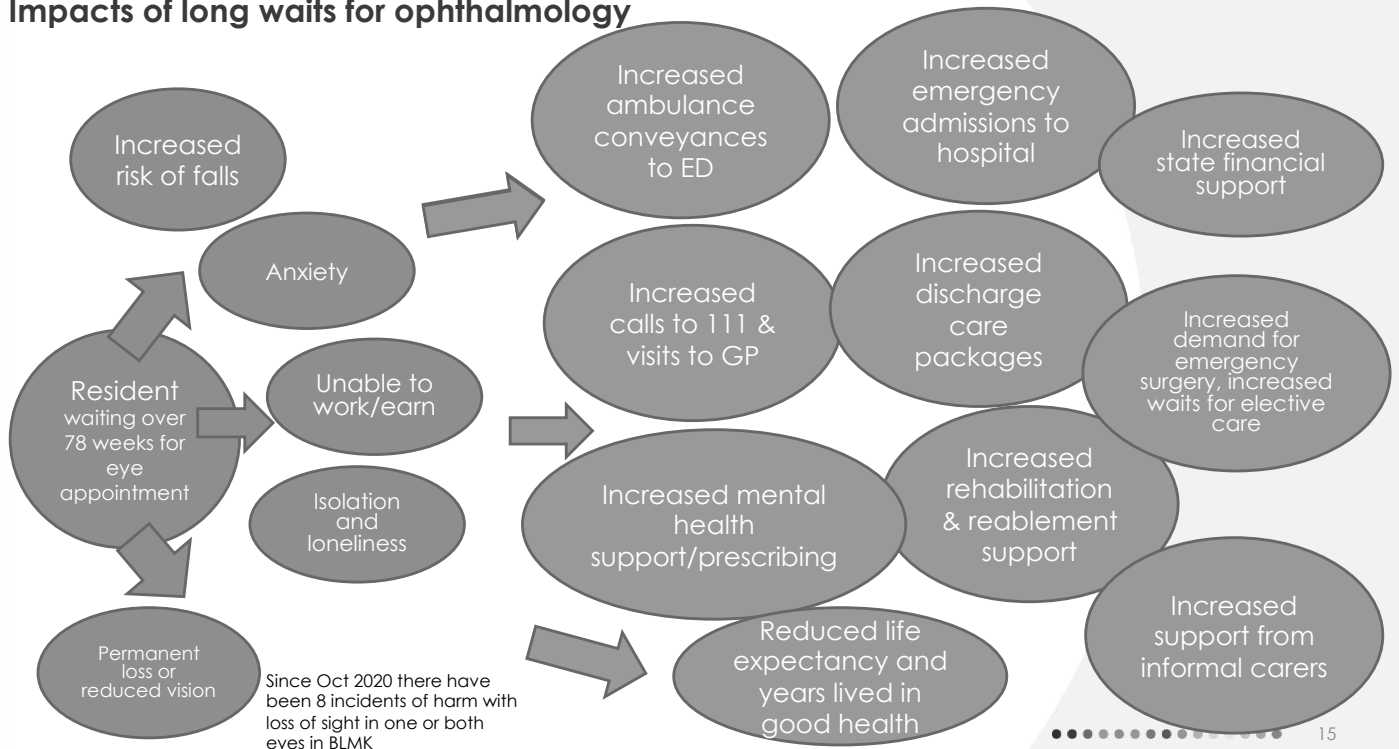


Bedfordshire, Luton and Milton Keynes Health and Care Partnership

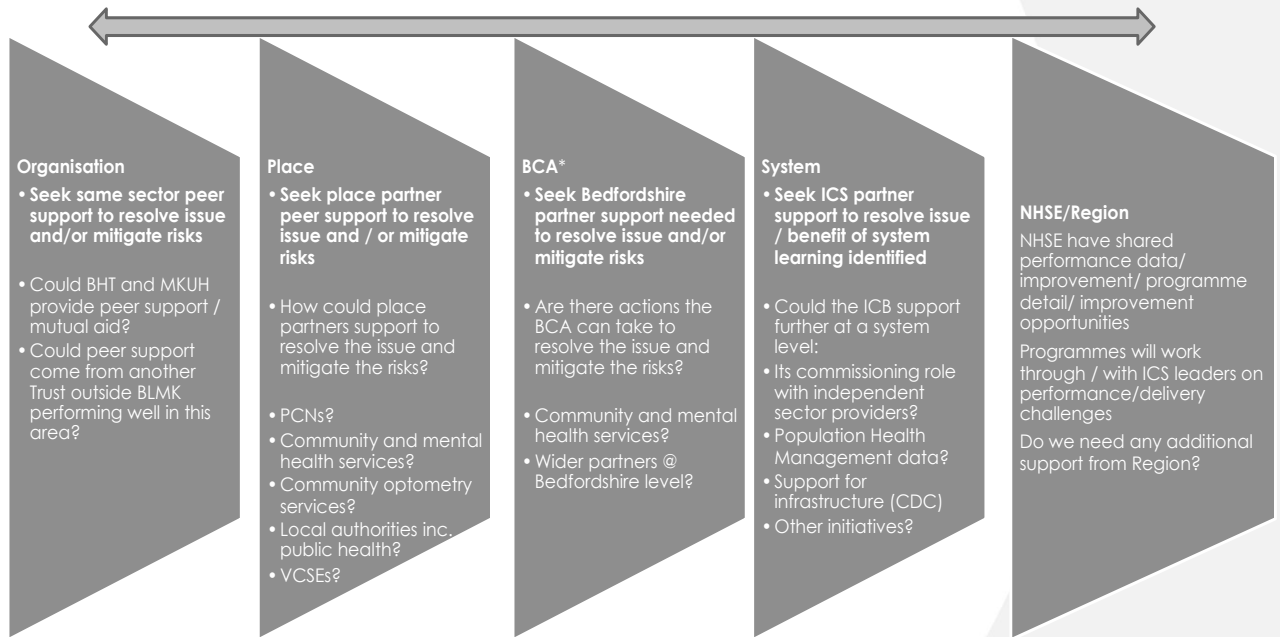
In all that we do we live our values

- Trust
- Respect
- Integrity
- Accountability
- Care & Compassion

Impacts of long waits for ophthalmology



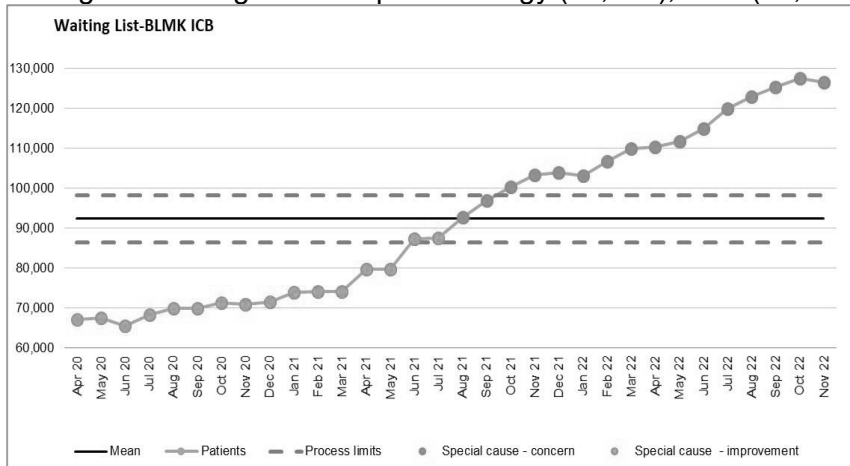
Ophthalmology - opportunity for peer support and improved outcomes



Bedfordshire, Luton and Milton Keynes Health and Care Partnership

The performance challenge:

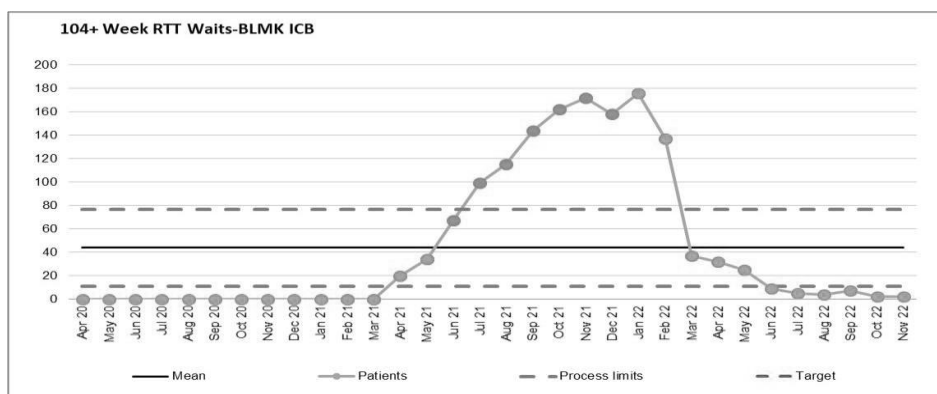
In November there were 126,531 BLMK patients on an RTT waiting list. 72,212 were at Bedfordshire Hospitals, 33,315 at Milton Keynes Hospital and 2,328 at local independent sector providers (Blakelands Hospital, Manor Hospital, Saxon Clinic and SpaMedica Bedford). The top 3 specialties with the highest waiting list are Ophthalmology (18,101), ENT (12,324) and Gynaecology (10,796).



People with Extended Waits

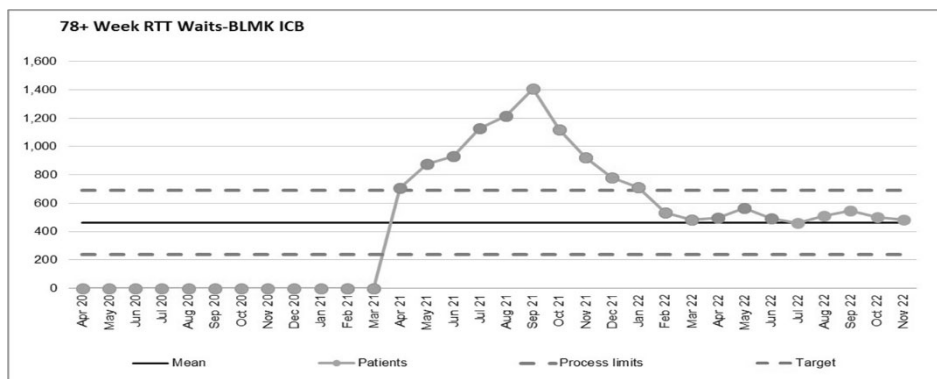
The ambition is to have zero in system 104+ week waiters and this is being achieved however there continue to be small number of people waiting over 104 weeks outside of the system. Each system leads on the reduction of 104+ and 78+ week waiters with providers (acute and independent sector) within their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

104 Weeks - There are currently 2 people waiting more than 104 weeks for treatment, one at East and North Herts in Gastroenterology and one at Leicester Hospital in General Surgery.

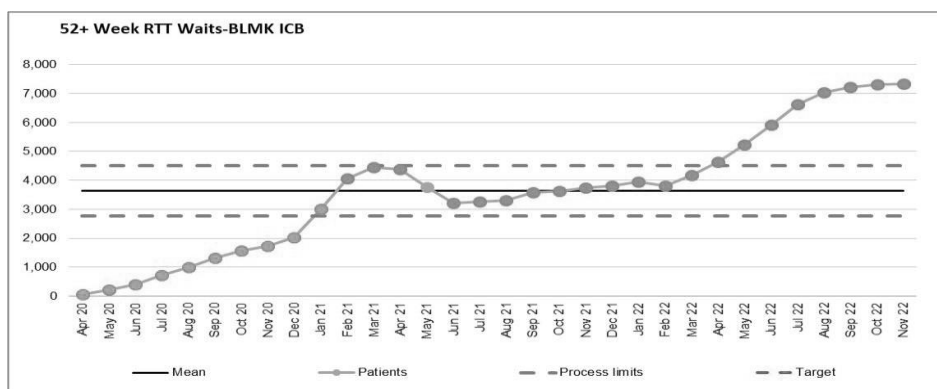


78 Weeks - There are 483 waiting more than 78 weeks. The top 3 specialties are Ophthalmology (212), Trauma and Orthopaedics (T&O) (69) and ENT (30).

The ICB and the acute provider trusts are required to reduce the number of patients at risk of breaching more than 78 weeks for their treatment from the dates of referral to zero by 31st March 2023. Both Trusts are committed to achieving this requirement and are working hard to address the impact of non-elective pressures on this target. There is a risk to non-delivery if non-elective pressures are sustained but every effort is being made to achieve the March ambition with further initiatives being implemented. Weekly oversight and assurance processes are in place.



52 Weeks – There are currently 7,338 waiting more than 52 weeks. The top 3 specialties are Ophthalmology (2,254), Ear, Nose and Throat (892) and Trauma and Orthopaedics (828). Providers are planning to achieve zero 52week waiters by end March 2025 although this ambition remains challenging due to demand levels. In line with the 23/24 planning guidance, eliminating 65 week waiters or going beyond this will be a priority in 2023/24 and will be a significant challenge.



What we are doing to reduce our long waiting patients

Ophthalmology continues to be the specialty with the highest number of 78week waiters with the majority at BHFT. As Ophthalmology is less sensitive to non-elective pressures, the Trust remains confident these patients will be treated by the end of March but the non-elective pressure pose a risk to this ambition. A longer-term system ophthalmology strategy is being developed ahead of a Getting It Right First Time (GIRFT) deep dive in March. Ophthalmology will be a system priority in Qtr 4 and 2023/24.

Health inequalities analysis has indicated significantly higher care gaps in Ophthalmology for Luton and Milton Keynes LTLAs, compared to Bedfordshire and EoE region. Although appointments for people living in Luton appear to have almost returned to pre covid expectations, for MK residents weekly appointment numbers are still almost half what would be expected. As a result, Luton and Milton Keynes will need to further increase activity to address the backlog and eyecare risk.

Trauma and Orthopaedics: the system has a small number of 78ww (72) with the majority at MKH. The Trust has recently ringfenced T+O beds to maintain elective activity but this remains a challenging position with the non-elective pressures. The long term provision of community MSK services is in preparation with a procurement exercise likely to start in early 23/24.

Independent Sector Providers (ISP)

- Work on the coding anomalies with **SPA Medica** continues and next steps will be addressed in the next contract meeting with SpaMedica. Long waits continue to be monitored with the ISPs and validation assurance is being sought from The Manor Hospital for 3 patients waiting 86-90 weeks.
- **Circle (Saxon Clinic)**, one of two providers in the Milton Keynes locality has suspended the pain service for new NHS patients. The ICB has now received formal notice to withdraw provision. Commissioners are working through patient pathways with Circle MSK to ensure patients are not lost to follow-up. A further alternative provider is being explored within the area. An action plan is in place.

Ear Nose and Throat has the second highest wait list behind Ophthalmology, although the number of 78ww are low. Demand management initiatives are being implemented to improve referral triage and ensure access to community micro-suction is equitable across BLMK. Demand and capacity analysis is also being given to a MK community provider to aid the wait list recovery.

Cancer Long Waits - There continues to be a focus on cancer long waits of 104 days and 63 days. Performance against the 63 day backlog continues to improve with BHFT now moving out of Tier 1 status. Pressures remain in a number of key specialities (urology, colorectal and gynaecology) and action plans are in place to address these. The ICB is awaiting formal feedback from NHSE following additional funding requests to support increased imaging and pathology capacity, waiting list initiatives and data analytics support, however we have been successful in a bid for additional capital to purchase equipment to support the cancer recovery plan. There has been some improvement in MRI/CT performance which support improved cancer 62 day performance. Both BHFT and MKUH are outside of the worst performing top 20 list nationally. Serious Incidents and patient experience are monitored on a regular basis to ensure that we are considering patient safety alongside our recovery efforts. Progress continues to be made, governance and oversight of performance continues with strong system engagement through the ICS Cancer Board.

In November - long Waiters on the 62 day Standard Pathway remain high with 28, a slight reduction from the 33 in Oct. Detailed analysis has been undertaken by pathway. Harm reviews continue to unfortunately flag issues which have been seen previously and which have been discussed at Cancer Board and is being reviewed at the Performance and Delivery Group on 19th January. The significant number of breaches on the non-standard pathway will be further discussed with the Cancer Managers in the Trusts.

Diagnostics - Community Diagnostic Centres will help to achieve earlier diagnoses for patients through more direct access to a range of diagnostic tests. MKUH/BHFT and the ICB have co-developed two business cases proposing 4 Community Diagnostic Centre (CDC) spokes covering a range of diagnostic modalities and these were submitted to NHSE and considered on 13th December. A resubmission is required for consideration by the national panel on 19th January following advice to amend the business case allowing for a Hub in Bedfordshire.

3) System Oversight Framework

Following the recent quarterly review meeting with the NHSE East of England Region the ICB continues to be rated as SOF 2 (on a development journey but demonstrates many of the characteristics of an effective ICB) and there were no significant concerns raised around our performance or quality of our services.

An overarching dashboard has been developed for use by ICBs which demonstrates performance against the SOF indicators, including a ranking within the 42 systems. Once indicator changes have been made and residual data quality issues addressed, BLMK's performance against these indicators will inform our future SOF rating. The framework is made up of 4 domains, 73 indicators: Leadership and capability; People; Preventing ill health and reducing inequalities and Quality of care, access and outcomes.

- Across all SOF indicators the ICB ranks in the highest quartile for 15 indicators
- Across all SOF indicators the ICB ranks in the inter quartile range against 40 indicators
- Across all SOF indicators the ICB ranks in the lowest quartile for 18 indicators

As an ICB we are working to establish how we best use the SOF indicators, accountability and improvement focus. We are also working with the regional team to understand the data where we have poor performance so that we can develop appropriate improvement plans as a system.

Indicators where the ICB is ranked in the highest quartile

Aggregation Score	Indicator	Rank
Sub ICB	S053a % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	4/42
ICB	S012a Cancer – Proportion of patients meeting the faster cancer diagnosis standard	5/42
ICB	S007a Total elective activity undertaken compared with 2019/20 baseline	6/42
Provider	S009b RTT Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	10/41
Provider	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	1/41
Sub ICB	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	4/42
Provider	S013b Diagnostic activity levels: Physiological measurement	2/41
Sub ICB	S013b Diagnostic activity levels: Physiological measurement	3/42
ICB	S029a Inpatients with a learning disability and/or autism per million head of population	10/42
ICB	S081a Access rate for IAPT Services	3/42
ICB	S084a Number of children and young people accessing mental health services as a % of population	6/42
ICB	S085a Proportion of people with severe mental health illness receiving a full annual physical health check and follow up interventions	10/42
ICB	S086a Inappropriate adult acute mental health placement out of area placement bed days	7/42
ICB	S032a Personal Health Budgets	5/42
ICB	S107a Percentage of 2-hour Community Response referrals where care was provided within two hours	4/42

Indicators where the ICB is ranked in the lowest quartile

Aggregation Score	Indicator	Value	Rank
ICB	S060a Aggregate score for NHS staff survey questions that measure perception of leadership culture	6.75/10	35/42
ICB	S074a FTE doctors in General Practice per 10,000 weighted patients	5.44/10,000	33/42
ICB	S63c Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	29.2%	35/42
ICB	S067a Leaver rate	9.8%	32/41
ICB	S051a Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	13.9%	37/42
Sub ICB	S053b % of hypertension patients who are treated to target as per NICE guidelines	57.0%	37/42
Sub ICB	S055a Number of referrals to NHS digital weight management services per 100k head of population	19.5/100,000	35/42
Sub ICB	S047a Proportion of people over 65 receiving a seasonal flu vaccination	64.0%	35/42
Sub ICB	S050a Cancer – cervical screening coverage: % females aged 25-64 attending screening within the target period	69.3%	34/42
Sub ICB	S013a Diagnostic Activity Levels: Imaging	99.8%	32/42
Provider	S013c Diagnostic Activity Levels - Endoscopy	67.2%	40/41
Sub ICB	S013c Diagnostic Activity Levels - Endoscopy	66.7%	39/42
ICB	S101a Outpatient follow up activity levels compared with 2019/20 baseline	107.8%	40/42
ICB	S037a Percentage of patients describing their overall experience of making a GP appointment as good	45.9%	42/42
Provider	S041a Clostridium difficile infection rate	155.6%	41/42
Sub ICB	S041a Clostridium difficile infection rate	124.8%	37/42
Provider	S042a E Coli Blood stream infection rate	153.3%	42/42
Sub ICB	S042a E Coli Blood stream infection rate	115.7%	38/42

4) Covid-19

Cases - In the 7 days to 11th January the number of new cases was 216, which is a 68% decrease over the last 4 weeks and a 60% decrease on the previous 7 days.

	11/01/2023	Change over last 7 days	7 day rate per 100,000
Bedford	70,936	+37	37.2
Central Bedfordshire	108,786	+75	53.7
Luton	81,214	+58	32.2
Milton Keynes	106,701	+46	32.2
BLMK Totals	367,637	+216	
East of England	2,249,008	+1,957	53.7
BLMK as a % of Total Cases in EoE	16.35%	11.04%	

Covid – Autumn Boosters - As of 09/01/2023 there have been 242,750 Covid-19 Autumn Boosters given to patients registered with a BLMK GP Practice and this equates to 90.13% of the expected population. Nationally bookings remain at a low level and this is mirrored across BLMK. Over the last 4 weeks we have seen a reduction in boosters done from 1,922 w/e 19/12/22 to 1,377 w/e 09/01/23. In response to the national decline in uptake all systems were asked to model activity through to Q4; approval to proceed was received 22/12/22 and we are now proceeding to plan this delivery.

Mass vaccination centres closed on 14th December following a national decision to withdraw funding for these vaccination outlets. Vaccinations remain available through PCNs, community pharmacies and some outreach work.

BLMK ICB	Autumn Booster - Eligible Population				
	Eligible Population	Expected Population	Done - 09/01/23	% Expected Population Done	To Vaccinate
Care Home Residents aged 65+	3,676	3,308	3,236	97.82%	72
Health and social care workers	5,315	3,721	2,778	74.66%	943
Age 75y and over	67,774	47,442	58,660	123.65%	-
Age 50 to <75y	250,466	175,326	160,088	91.31%	15,238
Age 05 to <50y + immunosuppressed contact	524	367	279	76.02%	88
Age 16 to <50y + at risk	52,063	36,444	16,452	45.14%	19,992
Age 16 to <50y + carer	2,597	1,818	891	49.01%	927
Age 05 to <16y + at risk	1,298	909	366	40.26%	543
Total	383,713	269,335	242,750	90.13%	26,585

Flu Vaccination Programme 2022-23 - As of 09/01/2023 there have been 291,665 Flu vaccinations given to patients registered with a BLMK GP Practice compared to 289,531 in the previous week. Over the last 4 weeks we have continued to see a reduction in vaccinations done from 4,217 w/e 19/12/22 to 2,134 w/e 09/01/23. Nationally, there remains a low level of flu vaccine uptake for 2 and 3 year olds against last year, this is mirrored in BLMK although we have seen a small improvement. We have an enhanced communications and engagement programme beginning from 16th January.

SystemOne Data to 09 January 2023

BLMK ICB	Flu Vaccine - Eligible Population				
	Eligible Population	Expected Population	Done - 09/01/23	% Expected Population Done	To Vaccinate
Age 65y and over	157,644	128,890	125,478	97.35%	3,412
Age 50 to <65y not at risk	130,319	65,094	43,553	66.91%	21,541
Age 6m to <65y + clinical risk - All *	116,100		61,030	52.57%	
Age 11y to <15y not at risk (Secondary school)	55,391	18,312	2,464	13.46%	15,848
Age 04y to <11y not at risk (Primary school)	98,207	46,098	48,343	104.87%	-2,245
Age 02y + 03y (Childhood ES) not at risk	23,948	17,322	10,797	62.33%	6,525
Total	465,509	275,716	230,635	83.65%	45,081

Flu - Achievement:
Achievement for Flu vaccinations is shown as a percentage of the target population for each group. Where the number of people vaccinated in that group is higher than the target population the achievement will be more than 100%

* The Age 6m to <65y + clinical risk cohort was not measured in the previous year programme, achievement is shown against eligible population. This line is excluded from the Totals

5) Quality and Safety Issues – by exception

- a) **Maternity** - Progress continues re compliance with the immediate and essential actions from the Ockenden reports. Workforce remains the priority issue in maternity services. However, improvement in vacancy rates is expected particularly across Bedfordshire Hospitals as a result of the successful international recruitment of midwives. Roll out of Midwifery Continuity of Carer remains suspended until safe staffing levels have been reached. The ICB is also focussing on addressing recommendations from the recent publication of the East Kent / Kirkup report on Maternity Services and awaiting the Single Delivery Plan which will set out national requirements around Ockenden and East Kent.
- b) **Dementia Diagnosis Rate** - In October is 64.73% compared to the England average of 62.6%. The planned target level by the end of Q3 is 66.02%. There continues to be a lower rate in Central Bedfordshire at 60.2%. A new specialist dementia diagnosis service for care home residents is being set up by ELFT in Central Bedfordshire as part of a national NHS pilot.
- c) **Autism** - A Children & Young People Autism/Attention Deficit and Hyperactivity Disorder workshop took place on 5th December to review the current pathways and explore opportunities to reduce demand and support children's needs at the right time in the right place. Recommendations will be presented to the Children & Young People Transformation Board in Feb 2023. Pre-diagnostic support has also been commissioned across BLMK for adults on the waiting list that enables people to access support while they wait to be assessed.
- d) **Children and Young People**

Tier 4 provision Child & Adolescent Mental Health Services - Pressure on acute hospital wards to admit children continues in Milton Keynes but shows an improving picture in Bedfordshire with joint working between the acute Trust and East London NHS Foundation Trust (ELFT) crisis teams. Good multi-agency working remains in place to assess young people and ensure they are in a safe environment and an increase in capacity of community home treatment teams has seen a positive impact in getting children discharged home with intensive support. The new 8-bed inpatient unit providing specialist short-term care for ages 13-17 with severe or complex mental health difficulties has a planned opening date of mid-February and staff are being onboarded onto alternative wards prior to the opening. Further capacity will still be required to meet current demand.

Children and Young People (CYP) Eating Disorders - Referrals remain higher than pre-pandemic. In the 12 months to Q1 2022/23 there were 277 CYP starting treatment following a routine referral and 14 following an urgent referral, compared to 94 routine and 17 urgent in the 12 months to Q1 19/20 (pre-pandemic). The publication of Q2 data was affected by a cyber-incident and ICB breakdowns were removed from the publication as they are inaccurate. Local provider data from ELFT (Bedfordshire and Luton) for Q2 shows 100% of routine referrals started treatment within 4 weeks and there were 0 urgent referrals in quarter. Local provider data from CNWL (Milton Keynes) shows 100% of urgent referrals started treatment within 7 days, and 100% of routine referrals started treatment within 4 weeks. Recruitment has been positive and a high intensity team has been mobilised in 2022/23. As part of the national Community Mental Health Transformation programme there are on-going developments with expanding the Community Eating Disorder Services across BLMK focussing on delivering timely, effective, evidence-based treatment.

- e) **Serious Incidents (SIs)** – In December 2022, 18 Serious Incidents of which one never event have been reported to BLMK ICB. This is a slight decrease to the usually reported number of SIs per month but a known end of year trend. Bedfordshire Hospitals – 9 SIs and 1 Never Event, Milton Keynes Hospital – 2 SIs, East London Foundation Trust – 2 SIs and Other providers - 4 SIs.

6) Month 8 – BLMK Performance Summary Report

Area	BLMK ICB	Threshold	Frequency	Latest Data	Achievement	Trend	YTD	Ranking	Regional Average (ICB position vs region)	What does good look like
Elective Recovery	RTT - % Patients Waiting 18 Weeks or less	92%	M	Nov-22	55.04%	↓	●	5 / 6	56.62%	High is good
	RTT - Number of 104+ Week Waits	n/a	M	Nov-22	2	↑		1 / 6	11	Low is good
	RTT - Number of 78+ Week Waits	n/a	M	Nov-22	483	↑		1 / 6	783	Low is good
	RTT - Number of 52+ Week Waits	n/a	M	Nov-22	7,338	↓		3 / 6	9,412	Low is good
Cancer Care	Diagnostics Tests - 6 Week Waits	≥1%	M	Nov-22	29.86%	↑	●	2 / 6	30.37%	Low is good
	Cancer -2 Week Waits Standard	93%	M	Nov-22	87.57%	↑	●	1 / 6	70.47%	High is good
	Cancer - 28 Day Faster Diagnosis Standard	75%	M	Nov-22	73.43%	↑	●	1 / 6	66.89%	High is good
	Cancer - 62 Day GP Referral	85%	M	Nov-22	67.30%	↑	●	2 / 6	62.39%	High is good
	Cancer - 104+ day waits	0	M	Nov-22	42	↓	●			Low is good
	Ambulance - 30 minute Handover Delays (Daily Average)	n/a	M	Dec-22	49.96	↓				Low is good
Urgent Emergency Care	% ED Attendances that result in emergency admission	n/a	M	Dec-22	25.15%	↑			26.02%	High is good
	Appointments in GP Practice - % Face to Face	75%	M	Nov-22	79.08%	↑	●	1 / 6	72.05%	High is good
Primary Care	72-Hour Follow Ups	80%	M	Nov-22	80.67%	↑	●			High is good
	SMI Healthchecks (12m rolling)	Q2: 4300	Q	Q2 2022/23	4,239	↑	●			High is good
	Dementia Diagnosis Rate	Q3: 66.02%	M	Oct-22	64.73%	↑	●	1 / 6	60.37%	High is good
	IAPT Access	Q3: 2183	M	Oct-22	2,325	↑	●			High is good
Adult Mental Health	IAPT Moving to Recovery	50%	M	Oct-22	47.19%	↓	●			High is good
	Early Intervention in Psychosis (EIP)	60%	M	Nov-22	80%	↓	●			High is good
	Inappropriate Out Of Area Bed Days	58	Q	Q2 2022/23	265	↑				Low is good
	Learning Disability Healthchecks	Q3: 19,95%	M	Nov-22	37.10%	↑	●			High is good
	Number of CYP accessing mental health services (12m Rolling)	Q1: 16,325	M	Q1 2022/23	17,440	↑	●			High is good
	CYP Eating Disorders - Routine (12m rolling)	95%	Q	Q1 2022/23	83.03%	↑	●	2 / 6	63.17%	High is good
	CYP Eating Disorders - Urgent (12m rolling)	95%	Q	Q1 2022/23	78.57%	↑	●	2 / 6	49.42%	High is good
	Perinatal Mental Health Access (year to date)	Q3: 960	M	Oct-22	645	↑	●			High is good
	Children's Wheelchairs - % received in 18 weeks	Q2: 76.32%	Q	Q2 2022/23	73.87%	↓	●			High is good
	Urgent Community Referrals - 2 hour Standard	70%	M	Nov-22	96.43%	↑	●			High is good
Community Services	Urgent Community Referrals - Responses within 2 hours	Nov-22: 699	M	Nov-22	135	↓	●			High is good
	Serious Incidents	0	M	Nov-22	24	↑				Low is good
Quality & Safety	Infection Control - C-Difficile	12	M	Nov-22	14	↑	●	4 / 6	9.57	Low is good
	Infection Control - MRSA	0	M	Nov-22	3	↓	●	6 / 6	0.5	Low is good

Key
Trend Arrows
↑ Improving
↓ Deteriorating
↔ No change
Achievement RAG
● On Track
○ Off Track
YTD
● YTD On Track
○ YTD Off Track
Regional RAG
● ICS vs Regional Average
○ ICS vs Regional Average

It is currently not possible to get an ICB-level position in the published Mental Health Services Monthly Statistics after June 2022. Local provider data is shown for 72-Hour Follow Ups and Early Intervention in Psychosis but it is not possible to get a 12-month rolling figure for CYP mental health access from the local data.

The publication of Children and Young People Eating Disorder data for Quarter 2 was affected by a cyber-incident and ICB breakdowns were removed from the publication as they are inaccurate. Efforts to resolve issues are on-going with NHS England and Providers and NHS England. It is not possible to get a 12 month rolling figure for CYP Eating Disorders from local data.

Appendix A

Updated 20 December 2022

BLMK ICS System Oversight Framework - December 2022

Domain	Area	Aggregation Score	Indicator	Value	Rank
Leadership and capability	Leadership	ICB	S060a Aggregate score for NHS staff survey questions that measure perception of leadership culture	6.75/10	35/42
People	Belonging in the NHS	Provider	S071a Proportion of staff in senior leadership roles who are from a BME background	19.30%	20/42
People	Belonging in the NHS	ICB	S072a Proportion of staff who agree that their organisation acts fairly with regard to career progression (promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age)	55.30%	25/42
People	Growing for the future	ICB	S074a FTE doctors in General Practice per 10,000 weighted patients	5.44/10,000	33/42
People	Growing for the future	ICB	S075a Direct patient care staff in GP practices and PCN's per 10,000 weighted patients	5.1/10,000	23/42
People	Looking after our people	ICB	S63a Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	10.7%	15/42
People	Looking after our people	ICB	S63b Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	18.8%	19/42
People	Looking after our people	ICB	S63c Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	29.2%	35/42
People	Looking after our people	ICB	S067a Leaver rate	9.8%	32/41
People	Looking after our people	ICB	S068a Sickness absence rate	5.74%	15/42
People	Looking after our people	ICB	S069a Staff survey engagement theme score	5.53%	25/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	ICB	S051a Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	13.9%	37/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	Sub ICB	S053a % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	91.9%	4/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	Sub ICB	S053b % of hypertension patients who are treated to target as per NICE guidelines	57.0%	37/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	Sub ICB	S053c % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	56.7%	18/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	Sub ICB	S055a Number of referrals to NHS digital weight management services per 100k head of population	19.5/100,000	35/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	ICB	S115a Proportion of diabetes patients that have received all eight diabetes care processes	46.80%	22/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	ICB	S116a Proportion of adult acute inpatient settings offering tobacco dependence services	0%	15/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	ICB	S116b Proportion of maternity inpatient settings offering tobacco dependence services	0%	13/42
Preventing ill health and reducing inequalities	Prevention and long term conditions	Provider	S117a Proportion of patients who have a first consultation in a post covid service within six weeks of referral	58.2%	12/24
Preventing ill health and reducing inequalities	Screening, vaccination and immunisation	Sub ICB	S046a Population vaccination coverage – MMR for two doses (5 years olds)	86.7%	28/42
Preventing ill health and reducing inequalities	Screening, vaccination and immunisation	Sub ICB	S047a Proportion of people over 65 receiving a seasonal flu vaccination	64.0%	35/42
Preventing ill health and reducing inequalities	Screening, vaccination and immunisation	Sub ICB	S050a Cancer – cervical screening coverage: % females aged 25-64 attending screening within the target period	69.3%	34/42
Quality of care, access and outcomes	Cancer	ICB	S010a Cancer - Total patients treated for cancer compared with the same point in 2019/20	107.10%	19/42
Quality of care, access and outcomes	Cancer	Provider	S011a Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	11.0%	26/42
Quality of care, access and outcomes	Cancer	ICB	S012a Cancer – Proportion of patients meeting the faster cancer diagnosis standard	74.3%	5/42
Quality of care, access and outcomes	Elective Care	ICB	S007a Total elective activity undertaken compared with 2019/20 baseline	105.3%	6/42
Quality of care, access and outcomes	Elective Care	ICB	S007b Elective Activity: Completed pathway elective activity growth	99.6%	22/42
Quality of care, access and outcomes	Elective Care	Provider	S009a RTT Waiting lists - Total patients waiting more than 52 weeks to start consultant led treatment	6,504	18/41
Quality of care, access and outcomes	Elective Care	Sub ICB	S009a RTT Waiting lists - Total patients waiting more than 52 weeks to start consultant led treatment	7,315	23/42
Quality of care, access and outcomes	Elective Care	Provider	S009b RTT Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	384	10/41
Quality of care, access and outcomes	Elective Care	Sub ICB	S009b RTT Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	499	15/42
Quality of care, access and outcomes	Elective Care	Provider	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	0	1/41
Quality of care, access and outcomes	Elective Care	Sub ICB	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	2	4/42
Quality of care, access and outcomes	Elective Care	Provider	S013a Diagnostic Activity Levels: Imaging	101.4%	30/41
Quality of care, access and outcomes	Elective Care	Sub ICB	S013a Diagnostic Activity Levels: Imaging	99.8%	32/42
Quality of care, access and outcomes	Elective Care	Provider	S013b Diagnostic activity levels: Physiological measurement	220.5%	2/41
Quality of care, access and outcomes	Elective Care	Sub ICB	S013b Diagnostic activity levels: Physiological measurement	187.5%	3/42
Quality of care, access and outcomes	Elective Care	Provider	S013c Diagnostic Activity Levels - Endoscopy	67.2%	40/41
Quality of care, access and outcomes	Elective Care	Sub ICB	S013c Diagnostic Activity Levels - Endoscopy	66.7%	39/42
Quality of care, access and outcomes	Elective Care	Provider	S013d Diagnostic Activity Levels - Total	102.1%	29/41
Quality of care, access and outcomes	Elective Care	Sub ICB	S013d Diagnostic Activity Levels - Total	100.4%	30/42
Quality of care, access and outcomes	Learning disabilities & autism	ICB	S029a Inpatients with a learning disability and/or autism per million head of population	321/000,000	10/42
Quality of care, access and outcomes	Learning disabilities & autism	ICB	S030a Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	25.0%	27/42
Quality of care, access and outcomes	Maternity and children's health	ICB	S022a Maternity – number of stillbirths per 1,000 total births	3.62/1,000	31/42
Quality of care, access and outcomes	Maternity and children's health	ICB	S104a Neonatal deaths per 1,000 total live births	1.27/1,000	13/42
Quality of care, access and outcomes	Mental health service	ICB	S081a Access rate for IAPT Services	89.2%	3/42
Quality of care, access and outcomes	Mental health service	ICB	S084a Number of children and young people accessing mental health services as a % of population	115.6%	6/42
Quality of care, access and outcomes	Mental health service	ICB	S085a Proportion of people with severe mental health illness receiving a full annual physical health check and follow up interventions	84.0%	10/42
Quality of care, access and outcomes	Mental health service	ICB	S086a Inappropriate adult acute mental health placement out of area placement bed days	230	7/42
Quality of care, access and outcomes	Outpatient transformation	ICB	S101a Outpatient follow up activity levels compared with 2019/20 baseline	107.8%	40/42
Quality of care, access and outcomes	Personalised care	ICB	S031a Rate of personalised care interventions	66.25/1,000	22/42
Quality of care, access and outcomes	Personalised care	ICB	S032a Personal Health Budgets	3,241,000	5/42
Quality of care, access and outcomes	Primary care and community services	ICB	S001a Number of general practice appointments per 10,000 weighted patients	5,141.9	29/42
Quality of care, access and outcomes	Primary care and community services	ICB	S106a Available virtual ward capacity per 100k head of population	7.6/100,000	29/42
Quality of care, access and outcomes	Primary care and community services	ICB	S107a Percentage of 2-hour Community Response referrals where care was provided within two hours	96.3%	4/42
Quality of care, access and outcomes	Primary care and community services	ICB	S108a Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a general practice	32.8/100,000	18/42
Quality of care, access and outcomes	Primary care and community services	ICB	S108b Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from NHS111 per 100,000 population	74.2/100,000	14/42
Quality of care, access and outcomes	Primary care and community services	ICB	S109a Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	74.1%	14/42
Quality of care, access and outcomes	Safe, high quality care	ICB	S037a Percentage of patients describing their overall experience of making a GP appointment as good	45.9%	42/42
Quality of care, access and outcomes	Safe, high quality care	Provider	S040a Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	4	17/42
Quality of care, access and outcomes	Safe, high quality care	Sub ICB	S040a Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	21	31/42
Quality of care, access and outcomes	Safe, high quality care	Provider	S041a Clostridium difficile infection rate	155.6%	41/42
Quality of care, access and outcomes	Safe, high quality care	Sub ICB	S041a Clostridium difficile infection rate	124.8%	37/42
Quality of care, access and outcomes	Safe, high quality care	Provider	S042a E Coll Blood stream infection rate	153.3%	42/42
Quality of care, access and outcomes	Safe, high quality care	Sub ICB	S042a E Coll Blood stream infection rate	115.7%	38/42
Quality of care, access and outcomes	Safe, high quality care	Sub ICB	S044a Antimicrobial resistance: appropriate prescribing of antibiotics and broad spectrum antibiotics in primary care	93.8%	28/42
Quality of care, access and outcomes	Safe, high quality care	Sub ICB	S044b Antimicrobial resistance: appropriate prescribing of antibiotics and broad spectrum antibiotics in primary care	8.81%	23/42
Quality of care, access and outcomes	Safe, high quality care	ICB	S121a NHS Staff Survey compassionate culture people promise element sub-score	7.2/10	12/42
Quality of care, access and outcomes	Safe, high quality care	ICB	S121b NHS Staff Survey raising concerns people promise element sub-score	6.5/10	21/42
Quality of care, access and outcomes	Urgent and emergency care	Provider	S123a Adult general and acute type 1 bed occupancy (adjusted for void beds)	97.1%	16/42
Quality of care, access and outcomes	Urgent and emergency care	Provider	S124a Percentage of beds occupied by patients who no longer meet the criteria to reside	15.3%	25/42

BLMK ICS System Oversight Framework - December 2022

Theme	Aggregation Source	Indicator	Period	Value	National Value	Target	Change from previous period	Quartile range
GP	ICB	S001a Number of general practice appointments per 10,000 weighted patients	10/2022	5,141.9	5,201.7		Improvement	29/42
	ICB	S007a Total elective activity undertaken compared with 2019/20 baseline	09/2022	105.3%		104%	Improvement	6/42
Elective Care	ICB	S007b Elective Activity, Completed pathway elective activity growth	10/2022	99.6%		110%	Improvement	22/42
	Provider	S009a RTT - Waiting lists - Total patients waiting more than 52 weeks to start consultant led treatment	10/2022	6,504	363,694		Deterioration	18/41
	Sub ICB	S009a RTT - Waiting lists - Total patient waiting lists waiting more than 52 weeks to start consultant led treatment	10/2022	7,315	352,560		Deterioration	23/42
	Provider	S009b RTT - Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	10/2022	384	43,839		Deterioration	10/41
	Sub ICB	S009b RTT - Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	10/2022	499	42,107		Improvement	15/42
	Provider	S009c RTT - Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	10/2022	0	1,532	0	Improvement	14/11
Cancer	Sub ICB	S009c RTT - Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	10/2022	2	1,683	0	Improvement	4/42
	ICB	S010a Cancer - Total patients treated for cancer compared with the same point in 2019/20	10/2022	107.1%		100%	Deterioration	19/42
Diagnostics	Provider	S011a Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	w/e 04/12/2022	11.0%	10.3%		Improvement	26/42
	ICB	S012a Cancer - Proportion of patients meeting the faster cancer diagnosis standard	10/2022	74.3%	68.6%	75%	Improvement	5/42
	Provider	S013a Diagnostic Activity Levels: Imaging	10/2022	101.4%	109.5%	120%	Improvement	30/41
	Sub ICB	S013a Diagnostic Activity Levels: Imaging	10/2022	99.8%	104.3%	120%	Improvement	32/42
	Provider	S013b Diagnostic activity levels: Physiological measurement	10/2022	220.5%	105.5%	120%	Deterioration	2/41
	Sub ICB	S013b Diagnostic activity levels: Physiological measurement	10/2022	187.5%	100.8%	120%	Improvement	3/42
	Provider	S013c Diagnostic Activity Levels - Endoscopy	10/2022	67.2%	96.5%	120%	Deterioration	40/41
	Sub ICB	S013c Diagnostic Activity Levels - Endoscopy	10/2022	66.7%	90.1%	120%	Deterioration	39/42
	Provider	S013d Diagnostic Activity Levels - Total	10/2022	102.1%	108.2%	120%	Improvement	29/41
	Sub ICB	S013d Diagnostic Activity Levels - Total	10/2022	100.4%	102.9%	120%	Improvement	30/42
Maternity	ICB	S022a Stillbirths per 1,000 total births	2020	3,621,000	3,291,000		Deterioration	31/42
Learning disabilities & autism	ICB	S029a Inpatients with a learning disability and/or autism per million head of population	22-23 Q2	321,000,000	421,000,000	301,000,000	Improvement	10/42
	ICB	S030a Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	22-23 Q2	25%	27.90%	100%	Improvement	27/42
Personalised Care	ICB	S031a Rate of personalised care interventions	22-23 Q1	66.25/1,000	75.33/1,000		Improvement	22/42
	ICB	S032a Personal Health Budgets	22-23 Q1	3,241,000	1,451,000		Improvement	5/42
	ICB	S037a Percentage of patients describing their overall experience of making a GP appointment as good	2022	45.9%	56.2%		Deterioration	42/42
Safe, and High Quality Care	Provider	S040a Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	10/2022	4	260	0	Improvement	17/42
	Sub ICB	S040a Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	10/2022	21	753	0	Deterioration	31/42
	Provider	S041a Clostridium difficile infection rate	10/2022	155.6%	115.9%	100%	Deterioration	41/42
	Sub ICB	S041a Clostridium difficile infection rate	10/2022	124.8%	110%	100%	Deterioration	37/42
	Provider	S042a E. Coli Blood stream infection rate	10/2022	153.3%	109.1%	100%	Deterioration	42/42
	Sub ICB	S042a E. Coli Blood stream infection rate	10/2022	115.7%	108.9%	100%	Deterioration	38/42
	Sub ICB	S044a Antimicrobial resistance: appropriate prescribing of antibiotics and broad spectrum antibiotics in primary care	09/21 - 08/22	93.8%	88.9%	<-7.1%	Deterioration	28/42
Vaccination	Sub ICB	S044b Antimicrobial resistance: appropriate prescribing of antibiotics and broad spectrum antibiotics in primary care	09/21 - 08/22	8.81%	8.38%	<-10%	Improvement	23/42
	Sub ICB	S046a Population vaccination coverage - MMR for two doses (5 years olds)	22-23 Q1	86.7%	84.4%	>95%	Deterioration	28/42
Prevention and long term conditions	Sub ICB	S047a Proportion of people over 65 receiving a seasonal flu vaccination	10/2022	64.0%	65.4%	85%	Improvement	35/42
	Sub ICB	S050a Cancer - cervical screening coverage: % females aged 25-64 attending screening within the target period	21-22 Q4	69.3%	70.8%	75%	Improvement	34/42
	ICB	S051a Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	22-23 Q2	13.9%	32.5%		Deterioration	37/42
	Sub ICB	S053a % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	2021-22	91.9%	89.0%	90%	Improvement	4/42
	Sub ICB	S053b % of hypertension patients who are treated to target as per NICE guidelines	2021-22	57.0%	60.4%	80%	Improvement	37/42
	Sub ICB	S053c % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	03/2022	56.7%	56.9%	45%		18/42
	Sub ICB	S055a Number of GP referrals to NHS digital weight management services per 100k head of population	22-23 Q2	19.5/100,000	63.8/100,000		Improvement	35/42
	ICB	S60a Aggregate score for NHS staff survey questions that measure perception of leadership culture	2021	6.75/10			Improvement	35/42
	ICB	S63a Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	2021	10.7%			Improvement	15/42
	Workforce	ICB	S63b Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	2021	18.8%			Improvement
ICB		S63c Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	2021	29.2%			Deterioration	35/42
ICB		S067a Leaver rate	09/2022	9.8%	9.1%		Improvement	32/41
ICB		S068a Sickness absence rate	07/2022	5.74%	6.20%		Deterioration	15/42
ICB		S069a Staff survey engagement theme score	2021	5.53/10			Improvement	25/42
Provider		S071a Proportion of staff in senior leadership roles who are from a BME background	2021	19.3%	1152.10%	12%	Improvement	20/42
ICB		S072a Proportion of staff who agree that their organisation acts fairly with regard to career progression/proportion regardless of ethnic background, gender, religion, sexual orientation, disability or age	2021	55.3%			Improvement	25/42
Mental Health	ICB	S74a FTE doctors in General Practice per 10,000 weighted patients	09/2022	5,441/10,000	5,881/10,000		Improvement	33/42
	ICB	S075a Direct patient care staff in GP practices and PCNs per 10,000 weighted patients	22-23 Q1	5,110/10,000	4,981/10,000		Improvement	23/42
	ICB	S081a Access rate for IAPT Services	09/2022	89.2%		100%	Improvement	3/42
	ICB	S084a Number of children and young people accessing mental health services as a % of population	06/2022	115.6%		100%	Deterioration	6/42
	ICB	S085a Proportion of people with severe mental health illness receiving a full annual physical health check and follow up	09/2022	84.0%	74.5%	100.0%	Improvement	10/42
	ICB	S086a Inappropriate adult acute mental health placement out of area placement bed days	06/22 - 08/22	230		0	Improvement	7/42
Quality of Care, access and outcomes	ICB	S101a Outpatient follow up activity levels compared with 2019/20 baseline	10/2022	107.8%		75%	Deterioration	40/42
	ICB	S104a Neonatal deaths per 1,000 total live births	2020	1,271/1,000	1,511,000		Deterioration	13/42
	ICB	S105a Available virtual ward capacity per 100k head of population	11/2022	7,641/100,000	13,717/100,000	40/100,000	Deterioration	29/42
	ICB	S107a Percentage of 2-hour Community Response referrals where care was provided within two hours	09/2022	96.3%	82%	70%	Improvement	4/42
	ICB	S108a Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a general practice	03/2022	32.8/100,000			Improvement	18/42
	ICB	S108b Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from NHS111 per 100,000	03/2022	74.2/100,000			Improvement	14/42
	ICB	S108c Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	09/2022	74.1%	70.2%	100%	Deterioration	14/42
	ICB	S110a Access rates to community mental health services for adult and older adults with severe mental illness	05/2022	97.3%		100%	Deterioration	13/42
	ICB	S115a Proportion of diabetes patients that have received all eight diabetes care processes	21-22 Q4	46.8%	46.7%		Improvement	22/42
	ICB	S116a Proportion of adult acute inpatient settings offering smoking cessation services	08/2022	0.0%	8.16%	100%	Deterioration	15/42
	ICB	S116b Proportion of maternity inpatient settings offering smoking cessation services	08/2022	0.0%	13.9%	100%	Deterioration	13/42
	Provider	S117a Proportion of patients who have a first consultation in a post covid service within six weeks of referral	11/2022	58.2%	46.4%		Deterioration	12/24
	ICB	S121a NHS Staff Survey compassionate culture people promise element sub-score	2021	7.2/10				12/42
	ICB	S121b NHS Staff Survey raising concerns people promise element sub-score	2021	6.5/10				21/42
Provider	S123a Adult general and acute type1 bed occupancy (adjusted for void beds)	10/2022	97.1%	95.9%		Improvement	16/42	
Provider	S124a Percentage of beds occupied by patients who no longer meet the criteria to reside	11/2022	15.3%	15.3%		Deterioration	25/42	

KEY for Quartile Range

	Highest performing quartile
	Interquartile range
	Lowest performing quartile

Link to NHS System Oversight Framework Dashboard 2022/23
<https://tblanalytics.data.england.nhs.uk/#/views/NHSSystemOversightFramework/Cover>

BEDFORDSHIRE HOSPITALS TRUST System Oversight Framework - December 2022

Theme	Indicator	Period	Value	National Value	Target	Change from previous period	Quartile range
Elective Care	S007a Total elective activity undertaken compared with 2019/20 baseline	09 2022	104.1%		104%	Improvement	41/137
	S007b Elective Activity: Completed pathway elective activity growth	10 2022	78.9%		110%	Deterioration	125/137
	S009a RTT Waiting lists - Total patients waiting more than 52 weeks to start consultant led treatment	10 2022	4,087	363,694		Deterioration	109/135
	S009b RTT Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	10 2022	278	43,839		Improvement	98/135
	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	10 2022	0	1,532	0		1/135
	S010a Cancer - Total patients treated for cancer compared with the same point in 2019/20	09 2022	114.8%		100%	Improvement	45/137
	S011a Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	w/e 04/12/2022	11.2%	10.3%			92/132
	S012a Cancer - Proportion of patients meeting the faster cancer diagnosis standard	10 2022	72.9%	68.6%	75%	Improvement	52/137
	S013a Diagnostic Activity Levels: Imaging	10 2022	96.9%	109.5%	120%	Improvement	112/135
Diagnostics	S013b Diagnostic activity levels: Physiological measurement	10 2022	230.7%	105.5%	120%	Deterioration	3/126
	S013c Diagnostic Activity Levels - Endoscopy	10 2022	78.4%	96.5%	120%	Deterioration	91/124
	S013d Diagnostic Activity Levels - Total	10 2022	98.4%	108.2%	120%	Improvement	110/135
	S022a Maternity – stillbirths per 1,000 total births	2020	3.69/1,000	3.29/1,000		Deterioration	84/119
Mortality	S034a Summary Hospital level Mortality Indicator	07 2022	2				16/121
	S035a Overall CQC rating	11 2022	3 - Good				14/136
CQC	S038a Consistency of reporting patient safety incidents	04/22 - 09/22	100%		100%		1/137
	S039a National Patient Safety Alerts not declared complete by deadline	04 2022	1		0		101/137
	S040a Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	10 2022	1	260	0	Improvement	44/137
	S401a Clostridium difficile infection rate	10 2022	136.2%	115.9%	100%		104/137
	S042a E Coli Blood stream infection rate	10 2022	135.9%	109.2%	100%	Improvement	120/137
Leadership	S059a CQC well-led rating	11 2022	3 - Good				17/136
	S60a Aggregate score for NHS staff survey questions that measure perception of leadership culture	2021	6.63/10				107/137
Workforce	S63c Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	2021	28.6%			Deterioration	95/137
	S067a Leaver rate	09 2022	9.65%	9.07%		Improvement	104/137
	S068a Sickness absence rate	07 2022	5.76%	6.20%		Deterioration	46/137
	S069a Staff Survey engagement theme score	2021	6.85/10			Deterioration	73/137
	S071a Proportion of staff in senior leadership roles who are from a BME background	2021	12.4%	1152.10%	12%	Deterioration	32/137
	S071b Proportion of staff in senior leadership roles who are women	09 2022	52.6%		62%	Improvement	120/136
	S071c Proportion of staff in senior leadership roles who are disabled	2022	3.2%		3.2%	Deterioration	56/137
	S072a Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	2021	53.6%			Improvement	97/137
	S104a Neonatal deaths per 1,000 total live births	2020	1.79/1,000	1.5/1,000		Improvement	86/115
	S105a Proportion of patients discharged from hospital to their usual place of residence	10 2022	96.1%	92.7%		Improvement	20/137
Quality of Care, access and outcomes	S121a NHS Staff Survey compassionate culture people promise element sub-score	2021	7.1/10				68/137
	S121b NHS Staff Survey raising concerns people promise element sub-score	2021	6.3/10				95/137
	S123a Adult general and acute type 1 bed occupancy (adjusted for void beds)	10 2022	97.3%	95.9%		Improvement	49/124
	S124a Percentages of beds occupied by patient who no longer meet the criteria to reside	11 2022	15.4%	15.3%		Deterioration	74/134

Highest performing quartile
Interquartile range
Lowest performing quartile

MILTON KEYNES TRUST System Oversight Framework - December 2022

Theme	Indicator	Period	Value	National Value	Target	Change from previous period	Quartile range
Effective Care	S007a Total elective activity undertaken compared with 2019/20 baseline	09 2022	105.6%		104%	Deterioration	34/137
	S009a RTT Waiting lists - Total patients waiting more than 52 weeks to start consultant led treatment	10 2022	2,407	363,694		Deterioration	88/135
	S009b RTT Waiting lists - Total patients waiting more than 78 weeks to start consultant led treatment	10 2022	106	43,839		Deterioration	71/135
	S009c RTT Waiting lists - Total patients waiting more than 104 weeks to start consultant led treatment	10 2022	0	1,975	0		1/135
	S010a Cancer - Total patients treated for cancer compared with the same point in 2019/20	09 2022	133.7%		100%	Deterioration	49/136
	S011a Cancer - Percentage of patients on the waiting list who have been waiting more than 62 days	w/e 04/12/2022	10.3%				81/132
	S012a Cancer - Proportion of patients meeting the faster cancer diagnosis standard	10 2022	76.9%	68.6%	75%	Improvement	30/137
	S013a Diagnostic Activity Levels: Imaging	10 2022	119.8%	109.5%	120%	Deterioration	26/135
	S013b Diagnostic activity levels: Physiological measurement	10 2022	189.8%	105.5%	120%	Improvement	61/126
Diagnostics	S013c Diagnostic Activity Levels - Endoscopy	10 2022	0.38%	96.5%	120%		123/124
	S013d Diagnostic Activity Levels - Total	10 2022	117.0%	108.2%	120%	Deterioration	27/135
	S022a Maternity – stillbirths per 1,000 total births	2020	3.36/1,000	3.29/1,000		Deterioration	64/119
Maternity Mortality	S034a Summary Hospital level Mortality Indicator	07 2022	2				16/121
	S035a Overall CQC rating	11 2022	3 - Good				14/136
Safe, High Quality Care	S038a Consistency of reporting patient safety incidents	04/22 - 09/22	100%		100%		1/137
	S039a National Patient Safety Alerts not declared complete by deadline	08 2022	3		0		22/28
	S040a Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	10 2022	3	260			100/137
	S401a Clostridium difficile infection rate	10 2022	235.7%	115.9%	100%	Deterioration	135/137
	S042a E Coli Blood stream infection rate	10 2022	192.9%	109.1%	100%	Deterioration	135/137
	S059a CQC well-led rating	11 2022	3 - Good				17/136
	S60a Aggregate score for NHS staff survey questions that measure perception of leadership culture	2021	6.98/10				28/137
	S63a Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	2021	9.96%			Deterioration	27/110
	S63b Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	2021	19.5%			Deterioration	50/107
Workforce	S63c Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	2021	29.6%			Deterioration	110/137
	S067a Leaver rate	09 2022	10.2%	9.1%		Improvement	121/137
	S068a Sickness absence rate	07 2022	5.67%	6.20%		Deterioration	43/137
	S069a Staff Survey engagement theme score	2021	7.21/10			Deterioration	16/137
	S071a Proportion of staff in senior leadership roles who are from a BME background	2021	6.98%	1152.10%	12%	Improvement	62/137
	S071b Proportion of staff in senior leadership roles who are women	09 2022	62.1%		62%	Improvement	63/136
	S071c Proportion of staff in senior leadership roles who are disabled	2022	5.5%		3.2%	Improvement	16/137
	S072a Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	2021	55.0%			Deterioration	79/137
	S104a Neonatal deaths per 1,000 total live births	2020	0.28/1,000	1.5/1,000			2/115
	S105a Proportion of patients discharged from hospital to their usual place of residence	10 2022	94.5%	92.7%		Improvement	44/137
	S117a Proportion of patients who have a first consultation in a post covid service within six weeks of referral	11 2022	58.2%	46%		Improvement	22/65
	S121a NHS Staff Survey compassionate culture people promise element sub-score	2021	7.4/10				30/137
	S121b NHS Staff Survey raising concerns people promise element sub-score	2021	6.8/10				24/137
	S123a Adult general and acute type 1 bed occupancy (adjusted for void beds)	10 2022	96.8%	95.9%		Deterioration	61/124
S124a Percentage of beds occupied by patients who no longer meet the criteria to reside	11 2022	15.10%	15.3%		Improvement	70/134	

Highest performing quartile
Interquartile range
Lowest performing quartile

Report to the Board of the Integrated Care Board, 27 January 2023

21. Finance Report November 2022 (Month 8)

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input checked="" type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input checked="" type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input checked="" type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input checked="" type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input checked="" type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input type="checkbox"/>	Workforce <input type="checkbox"/>	Ways of working <input type="checkbox"/>	Estates <input type="checkbox"/>
Communications <input type="checkbox"/>	Finance <input checked="" type="checkbox"/>	Operational and Clinical Excellence <input type="checkbox"/>	Governance and Compliance <input type="checkbox"/>
Other <input type="checkbox"/>			

What are the members being asked to do?

Approve <input type="checkbox"/>	Note <input checked="" type="checkbox"/>	Discuss <input type="checkbox"/>
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Report Author	Finance Department
Date to which the information this report is based on was accurate	23/12/2022
Senior Responsible Owner	Dean Westcott, Chief Finance Officer

Executive summary

This paper sets out the 2022/23 BLMK ICS financial position at month 8 (November 2022) for revenue and capital spend.

NHS organisations hosted within the system are reporting a £0.3m favourable Income & Expenditure variance to plan at Month 8; the forecast remains delivery of a breakeven position.

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

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

What are the available options?

Not applicable

Recommendation/s

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

- 1) the month 8 and forecast position for revenue and capital
- 2) the risks to the financial forecast

Key Risks and Issues

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

- The delivery of efficiency and productivity plans.
- Inflationary pressures over funding levels.
- The impact of the pay settlement for NHS staff not being fully funded.

Have you recorded the risk/s on the Risk Management system?

Yes

No

Are there any financial implications or other resourcing implications?

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

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

[Click to view Green Plan](#)

How will / does this work help to address inequalities?

The finance plan reflects operational plans that include a focus on addressing inequalities.

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

BLMK Directors of Finance

Next steps:

Appendices

1.0 Introduction

1.1 The purpose of this paper is to report the Integrated Care System (ICS) financial position at month 8 (November) for those NHS organisations that form part of the Bedfordshire, Luton and Milton Keynes (BLMK) ICS financial control total. These organisations are:

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

A commentary on the current financial position of Local Authority partners is included in Appendix A. It reflects the latest available publicly available information of partners.

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

2.0 System Income & Expenditure Position

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

Surplus / (Deficit)	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	FOT	Variance
	£m	£m	£m	£m	£m	£m
Bedfordshire Hospital NHS FT	0.0	0.3	0.3	0.0	0.0	0.0
Milton Keynes NHS FT	(4.0)	(4.0)	0.0	0.0	0.0	0.0
BLMK CCG/ICB	0.0	0.0	0.0	0.0	0.0	0.0
Intra ICS Organisations	(4.0)	(3.7)	0.3	0.0	0.0	0.0

2.2 The ICS is reporting a year-to-date surplus to plan of £0.3m and forecasting breakeven by the end of the year.

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

Bedfordshire Hospital NHS Foundation Trust

A summary financial position at month 8 for Bedfordshire Hospital NHS Foundation Trust is set out in the table below:

Income & Expenditure	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	467,168	482,735	15,567	700,757	718,336	17,579
Pay	(301,592)	(310,849)	(9,257)	(452,338)	(466,338)	(14,000)
Non-Pay	(165,597)	(171,540)	(5,943)	(248,419)	(251,998)	(3,579)
SURPLUS / (DEFICIT)	(21)	346	367	0	0	0

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

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

Milton Keynes University NHS Foundation Trust

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

Income & Expenditure	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	216,370	224,014	7,644	326,996	339,018	12,022
Pay	(140,506)	(148,277)	(7,771)	(208,207)	(220,229)	(12,022)
Non-Pay	(79,883)	(79,721)	162	(118,789)	(118,789)	0
SURPLUS / (DEFICIT)	(4,019)	(3,984)	35	0	0	0

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

- Income – additional income re: wage award and contract performance with Buckinghamshire and Northamptonshire systems.
- Pay – wage award backpay and higher than expected temporary staffing costs
- Non-Pay – no material variance

Integrated Care Board

Clinical Commissioning Groups (CCG) remained as statutory organisations between 1 April 2022 to 30 June 2022. The full year 2022/23 Integrated Care Board allocation has been reduced by the resources consumed by Bedfordshire, Luton and Milton Keynes CCG in the first three months of the year. Therefore, at the point of establishment, the ICB received the remaining funding for the balance of the financial year.

At the end of quarter 1 there was a surplus of £9.3m in BLMK CCG. CCG allocations were adjusted by NHSE to bring all CCGs to breakeven and any surplus or deficit compared to the quarter 1 allocation was rolled forward into the new ICB. The difference of £9.3m has been carried forward into the ICB allocation for the remainder of the year.

The table below shows combined CCG and ICB performance against key financial performance indicators. At month 8 the ICB is delivering and forecasting full achievement of these metrics.

Performance Measure	Year To Date - Month 8			Forecast		
	Target	Actual	Variance	Target	Actual	Variance
Revenue Resource Limit	£1,175.3m	£1,175.3m	£0.0m ✓	£1,803.0m	£1,803.0m	£0.0m ✓
Capital Resource Limit	£0.8m	£0.8m	£0.0m ✓	£2.4m	£2.4m	£0.0m ✓
MHIS Expenditure	£103.7m	£104.5m	£0.8m ✓	£155.5m	£156.3m	£0.7m ✓
Efficiency Savings	£9.9m	£10.1m	£0.2m ✓	£15.4m	£15.6m	£0.2m ✓
BPPC	>95%	95%	0% ✓	>95%	95%	0% ✓

The ICB is reporting a breakeven YTD against a planned breakeven position and is forecasting a breakeven financial position. The position by commissioning programme as at month 8 is set out in the table below:

PROGRAMME AREA	YEAR TO DATE M04-M08			FORECAST OUTTURN		
	Budget £000	Actual £000	Variance £000	Budget £000	Forecast £000	Variance £000
Acute Services	417,879	414,715	3,164	742,453	739,456	2,996
Mental Health Services	80,540	80,708	(168)	144,804	144,601	203
Better Care Fund	12,863	13,234	(371)	23,132	23,819	(687)
Other Community Services	62,733	61,650	1,084	112,442	112,131	310
Continuing Care Services	31,213	32,011	(799)	55,855	57,150	(1,296)
Primary Care Co-Commissioning	67,746	67,676	70	122,875	123,753	(878)
Prescribing	57,588	61,069	(3,481)	104,645	110,594	(5,950)
Other Primary Care Services	13,583	12,595	989	23,695	23,347	348
Other Programme Services (Incl Reserves)	(3,407)	7,390	(10,797)	31,103	38,333	(7,229)
Total Commissioning Budget	740,738	751,046	(10,308)	1,361,003	1,373,184	(12,181)
Running Costs	7,909	6,895	1,014	14,175	12,482	1,693
Surplus / (Deficit)	9,294	0	9,294	9,294	0	9,294
Total ICB Net Expenditure	757,941	757,941	0	1,384,472	1,385,666	(1,194)
Expected Allocation from NHSE for ARR's roles	0	0	0	1,194	0	1,194
Total Net Expenditure after NHSE Allocation	757,941	757,941	0	1,385,666	1,385,666	0

The key variances from budget are highlighted below:

Acute is showing an underspend of £3.2m with a year-end forecast of £3.0m under plan.

The financial position for NHS contracts is a year-to-date underspend of £3.5m and a forecast underspend of £3.5m. The main driver of this underspend in the year-to-date and forecast is Elective Recovery Funding where funding was not received until Q2, this is offset by £2.9m overspend in the legacy CCG where expenditure was accounted for by the CCG in Q1 where there was no funding source. After adjusting for this the net underspend across the full financial year is £0.7m year-to-date and £0.6m in the forecast.

Non-contracted activity is overspent year-to-date by £0.7m, due to low volume activity (LVA) and independent sector activity.

Mental Health at Month 8 is an underspend of £0.2m and a forecast of £0.2m underspend. The key contributors towards the underspend relate to a reduction in complex placements.

These are partly offset by continued pressures in S117 care, although growth has significantly reduced since last year. It should be noted that the challenging level of S117 efficiencies will need to be met to ensure the position does not deteriorate.

There is continuing collaborative work in Bedfordshire to deliver efficiencies and manage timely reviews in the S117 workstream. The responsibility for spend within Bedfordshire and Luton and the financial risk is currently held by the ICB. In Milton Keynes S117 budgets are devolved to the CNWL. CNWL has seen a continued significant increase in specialist high-cost placements and S117 costs from Milton Keynes.

Expenditure on the main mental health NHS providers, CNWL & ELFT, is agreed by block contract and no variance is expected. Although the S117 pressures being incurred by CNWL should be noted above.

The Mental Health Investment Standard target is set by NHSE to ensure growth in mental health spend is protected. This is closely monitored by NHSE together with the additional development funds targeted for mental health. The current MHIS forecast is £0.7m above target.

Continuing Care Services is reporting a £0.8m year-to-date overspend with a year-end forecast of £1.3m.

Adult CHC and Funded Nursing Care (FNC) is reporting a YTD overspend of £0.8m which has increased by £0.2m from month 7 and driven by both activity and costs. However, the overspend is forecast to increase to £1.3m by year end. Further work is underway to assess the risks to the plan and available mitigations.

Primary Care Co-Commissioning The year-to-date is breakeven, being a combination of overspends against additional roles reimbursement scheme (ARRS), premises and locum costs offset by prior year benefits released, particularly Investment and Innovation Fund payments to practices that were less than expected.

The forecast is net overspend of £0.9m mainly due to the continuing monthly ARRS run rate being above baseline allocation. ARRS workforce is forecast to be £1.2m above allocation having factored in current ARRS staffing and potential further recruitment planned by PCNs by year end. The ARRS overspend is recoverable from the monies that NHSE hold centrally for such purposes.

Prescribing this is an area where estimation is required due to the timing of data flows. Information is provided two-months in arrears and there can be some volatility in the cost of medicines due to national and international supply issues.

Prescribing reports a year-to-date overspend of £3.5m and a forecast overspend of £5.9m. There has been a significant increase in costs associated with No Cheaper Stocks Available (NCSO drugs) in quarter 3, which is being forecast to continue throughout the remainder of the financial year.

Other Primary Care Services report an underspend of £1m year-to-date and forecast to be £0.4m underspend by year end. Locally commissioned services and other GP commissioned schemes are underspent with activity volumes lower than planned. This is offset by urgent treatment centre activity which higher than planned and expected to continue through winter and to year end.

3.0 NHS Financial Performance of Inter ICS NHS Organisations (organisations who provide services in BLMK but are hosted in other systems)

3.1 Intra ICS NHS Providers are reporting year to date deficit of £5.6m and a forecast deficit of £10.2m against a planned deficit of £0.5m for services delivered within BLMK. The table below shows the position by organisation:

	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m
CNWL	0.0	(1.3)	(1.3)	0.0	(3.7)	(3.7)
ELFT	(0.3)	(4.3)	(4.0)	(0.5)	(6.5)	(6.0)
CCS	0.0	0.0	0.0	0.0	0.0	0.0
Inter ICS Organisations	(0.3)	(5.6)	(5.3)	(0.5)	(10.2)	(9.7)

CNWL

The forecast deficit of £3.7m splits to £3.3m for MK Mental Health and £0.4m for MK Community Health.

The main drivers are the level of spending on agency staff due to the difficulties in recruiting staff. The Trust has been able to reduce the level of nursing vacancies through locally focused recruitment events. Recruiting doctors to medical posts in the current environment remains exceptionally challenging, and agency cover for these roles is very expensive.

CNWL are working with BLMK ICB on the demand pressures for complex placements, which are symptomatic of the wider demand pressures and increased acuity of patient presenting for mental health treatments across Milton Keynes, driven by both population growth and changing demographics

ELFT

The forecast deficit of £6.5m is driven by the following factors:

- Year-to-date overspend on temporary staffing includes £1.2m for medical staff, £0.2m on nursing staff and £0.2m on allied health professionals. These overspends are partially offset by vacancies.
- Community Health Services YTD expenditure overspends are on the Home Team £0.6m, CCS £0.4m and Wheelchairs £0.2m.
- Adult MH expenditure overspends have increased due to placements at Independent Sector Providers of £0.9m some of which had previously been classified as CYP and on non-pay £0.3m.

CCS

Costs are forecast to be in line with contract value.

4.0 System Efficiency Plans

- 4.1 The system financial strategy includes delivery of an efficiency plan of £55.6m (for in-system NHS partners).
- 4.2 The ICS is reporting savings of £34.4m year to date, £0.2m above plan. The forecast remains to deliver the full plan by the end of the year.

	Year-to-date				Forecast Outturn			
	Plan	Actual	Variance		Plan	Actual	Variance	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
ICB - Recurrent	5,160	7,470	2,310	45%	8,214	11,561	3,347	41%
ICB - Non recurrent	4,748	2,633	(2,115)	-45%	7,227	4,094	(3,133)	-43%
Subtotal - ICB	9,908	10,103	195	2%	15,441	15,655	214	1%
BHFT - Recurrent	15,972	15,972	0	0%	23,951	23,951	0	0%
BHFT - Non recurrent	2,800	2,800	0	0%	4,200	4,200	0	0%
Subtotal - BHFT	18,772	18,772	0	0%	28,151	28,151	0	0%
MKHFT - Recurrent	4,658	1,873	(2,785)	-60%	9,049	4,060	(4,989)	-55%
MKFT - Non recurrent	900	3,685	2,785	309%	3,000	7,989	4,989	166%
Subtotal - MKFT	5,558	5,558	0	0%	12,049	12,049	0	0%
Total Efficiencies	34,238	34,433	195	1%	55,641	55,855	214	0%

4.3 In-year plans include non-recurrent elements, 26% of the total - this is an issue for the system going into future financial years and will form part of the work being undertaking to refresh the medium-term financial strategy of the system.

5.0 System Financial Risks

5.1 The system financial plan set out several risks to plans which are under constant review. Mitigations to offset these risks and other emerging risks continue to be developed. The current risks are set out below:

Risk Title	Risk Description (Cause & Effect)	Risk Control	Action Required
Delivery of Efficiency Programme	As a result of the efficiency plan not being delivered there is a risk that the ICS will not breakeven at the end of 2022/23	Regular meetings with scheme leads to update on progress and ability to stretch, plus any actions required if deviations from plan identified Presented to Performance & Delivery Group and to Finance & Investment Committee	Ongoing monitoring and early escalation of any scheme deviating from plan Continued scanning for further opportunities to add to plan to mitigate any shortfalls
Increase in operational and winter pressures	As a result of an increase in operational pressures and winter pressures, there is a risk that additional costs will be incurred that cannot be met from existing resources, resulting in the ICB not breaking even at the end of 2022/23.	Signed contracts in place for all services. Engagement with local authority partners via s75 / BCFs agreed System capacity to enable appropriate discharge to and from step down beds	All contracts to be agreed and signed for acute, 999 and Out of Hours /111 services Prescribing forecast and profile to be regularly reviewed to identify level of operational pressure ABI / Stroke and s117 budget pressures to be monitored
Inflation	As a result of inflation being higher than funded via tariff and allocations, there is a risk that providers will face additional costs that they cannot manage and look to the ICB for financial support, and the ICB will		Monthly monitoring of spend against budget Review of non-recurrent opportunities within 2022/23 available to mitigate inflation

Risk Title	Risk Description (Cause & Effect)	Risk Control	Action Required
	see its own costs increase		
Management / Running Costs	As a result of the pay award being higher than budgeted, and unfunded, which is a real-terms cut in Running Costs, there is a risk of a reduction in ICB staffing and capacity to support establishing the new organisation and ways of working,	Vacancy control process NHSE business case completed for interim staff and consultancy spend	Pay award to be modelled and impact understood on each budget Agree approach to managing individual budget pressures with Executive budget holder
Covid	As a result of a new variant of covid or an increase in infections and hospitalisations, costs may increase whilst the covid allocation that was issued to cover these additional costs, has reduced	Reporting of spend against covid allocation monthly to identify early any pressures on funding	Monitoring of covid expenditure within ICB and across ICS

5.2 The system plan is underpinned by full receipt of Elective Recovery Fund (ERF) income. Funding for the first six months of the financial year has been confirmed, and full funding is now expected for the second half of the financial year. The in-year risk has therefore been reduced.

6.0 System Capital

6.1 BLMK ICS has a capital expenditure limit (CDEL) which it cannot breach. This limit applies to those organisations which form part of the BLMK ICS financial control total. Currently capital for East London NHS Foundation Trust (ELFT), Central and North West London NHS Foundation Trust (CNWL) and Cambridgeshire Community Services (CCS), who provide community and mental health services in Bedfordshire, Luton and Milton Keynes, is held within their lead systems.

6.2 ICS organisations may also receive other capital funding from ringfenced national sources to support key priorities including the Government's New Hospitals Programme and capital to support elective recovery, digital, community diagnostics etc...

6.3 The table below shows the year-to-date and forecast financial performance of intra system providers against CDEL and other capital funding sources. The system annual CDEL is £43.3m and at month 8 providers are forecasting that they will deliver a break-even position against this limit. The ICB does not have a CDEL limit.

Capital Plan - Provider Based	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Charge against capital allocation (CDEL)	26,903	29,425	(2,522)	43,341	43,339	2
Other funding streams	38,005	25,428	12,576	96,776	109,196	(12,420)
Total	64,908	54,853	10,055	140,117	152,535	(12,418)

6.4 The ICS is expecting an increase to the CDEL limit to offset the impact of the implementation of

financial reporting standard IFRS 16. New leases or modifications of existing leases from 1 April 2022 will count against the capital departmental expenditure limit (CDEL) and limits will need to be increased to manage the impact of the implementation of the new standard.

- 6.5 The table below shows the year-to-date and forecast position for the intra-ICS NHS organisations across all capital funding streams (CDEL and national sources). There is a currently a £12.4m forecast overspend across the intra-ICS organisations - this reflects a timing issue relating to the allocation of funds for non-CDEL national capital programmes and is expected to be amended in future periods, resulting in a breakeven financial forecast.

	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m
Bedfordshire Hospital NHS FT	55.3	43.5	11.8	116.7	127.7	(11.0)
Milton Keynes NHS FT	9.6	11.3	(1.7)	23.5	24.9	(1.4)
BLMK ICB	0.0	0.0	0.0	1.6	1.6	0.0
Intra ICS Organisations	64.9	54.8	10.1	141.8	154.2	(12.4)

- BHFT is reporting a £11.7m underspend year to date, mainly due to outside of envelope schemes. The Trust is forecasting an overspend on capital against the original plan by £11.0m. This is due to approval of the additional theatre on the Bedford site, funded from the Targeted Investment Fund. As above additional national funding is anticipated to cover the forecast position. Performance against CDEL limit is forecast to be breakeven.
- Milton Keynes Hospital is reporting a year-to-date overspend, which is due to the timing of the Maple Centre. The Trust is forecasting this will become a £1.4m deficit by the end of the year and relates to donated capital, which is excluded from CDEL. Performance against CDEL limit is forecast to be breakeven.
- The ICB has been allocated capital funding of £1.6m to support GP IT and corporate capital. The Integrated Care Board is reporting no spend year-to-date but forecasts to spend this allocation in full. Capital expenditure on GP IT is capitalised by NHS England rather than the Integrated Care Board. All ICB capital is therefore subject to NHS England business case processes and only released when business cases are approved.

7.0 Recommendations

7.1 The Integrated Care Board is asked to:

- Note the year-to-date financial position of the ICS at month 8 and forecast position for revenue and capital
- Note the risks to the financial forecast

Appendix A

Financial Position of ICS Local Authority Partners

A summary of the latest publicly available financial position of Local Authorities is set out below.

Bedford Borough Council: The authority faces a wide number of challenges to the provision of its services in the current year resulting in a forecast overspend position of £6.5 million by the end of the financial year.

Services are being delivered against a backdrop of significant inflationary pressures (upward pay pressures, energy/ commodity prices and wider contract inflation) resulting from the war in Ukraine and wider geopolitical issues affecting supply chains. There are specific financial pressures in Children's Services. This is due to an increase in numbers of children's placements, particularly in residential care, together with an increase in the complexity of their needs. The demand and cost of school transport is also impacting on the financial position. Further pressures also exist in relation to housing and the supply of temporary accommodation.

The Authority is taking steps to manage and minimise the overspend in so far as is possible, to reduce the overspend by the end of the financial year.

Central Bedfordshire Council: As at the end of September, forecasting a gross overspend of £10.7m.

The main drivers of the overspend are in Children's Services, being the cost of education transport and the cost of individual placements (fostering and adoption etc) and the effects of Covid in terms of social work cases coming through and the impact on leisure income and car parking.

However, after application of budget contingency and Covid and financial hardship related grants, the Council is forecasting achievement of a balanced outturn position.

Luton Borough Council: Forecast overspend of £10.1m indicated for General Fund Services at the first Quarter's monitoring, after the use of the general contingency budget and some specific reserves.

The adverse position reflects the impact of price inflation, the enduring impact of covid and delivery risks regarding the budgeted savings programme.

Recovery actions have been put in place with the aim to reduce the current forecast overspend to a balanced position by the end of the year and for improving the prospects for the 2023/24 Budget.

Milton Keynes: At the end of September 2022, the Council was forecasting an overspend of £2.8m. The key pressures are within:

- Adult Services with Adult Social Care forecast to overspend by £1.8m;
- Children's Services with Children's Social Care is forecast to overspend by £2.2m;
- Environment and Property - forecast overspend of £0.9m, including rising inflation £1.2m for utilities, including street lighting and highways contract £0.4m and our Environmental Services Contract of £0.4m;
- Increased pay award (now agreed) has added an additional £3.9m to the overspend compared with the 2% allowance that was included in the budget;
- Overspends have been partly reduced through increased investment income (higher interest rates) of £3.7m, parking income of £1.25m and additional grant income of £0.5m.

After all corporate items including the use of full contingency, the overspend is projected at £2.785m, which is being funded from uncommitted earmarked reserves.

Glossary of commonly used terms in Finance reports

Acronym	Name	Description
BHFT	Bedfordshire Hospitals NHS Foundation Trust	
CCS	Cambridge Community Services NHS Trust	Provides community services in Luton and Bedfordshire
CDEL	Capital Department Expenditure Limit	Each department of Her Majesty's Treasury (HMT) has a departmental expenditure limit (DEL) which can be separated into capital and revenue DEL. The government controls overall expenditure by deciding each department's DEL. The Department of Health and Social Care (DHSC) sets a capital departmental expenditure limit (CDEL), which covers the capital spend of NHS trusts and is used by DHSC and HMT to monitor and manage capital expenditure within the sector.
CNWL	Central and North West London NHS Foundation Trust	Provides Community and Mental Health Services in Milton Keynes.
ELFT	East London NHS Foundation Trust	Provides Community and Mental Health Services in Bedfordshire and Luton.
ERF	Elective Recovery Funds	The ERF is designed to support systems to work collaboratively to restore elective services against the backdrop of unprecedented demands on the service because of Covid. It ensures that the marginal costs of delivering extra activity to tackle a lengthening waiting list can be met.
H1 or H2	Half Year	H1: Covers April-September H2: Covers October-March
HDP	Hospital Discharge Programme	Details the discharge requirements for all NHS trusts, community interest companies, private care providers of acute, community beds and community health services and social care staff in England. The guidance, based on successful discharge to assess principles, aims to ensure that all individuals are discharged from hospital in a safe, appropriate and timely way. Funding was provided by NHS England to support HDP in 2020/21 and 2021/22
ICS	Integrated Care System	ICs are partnerships between the organisations that meet the health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
MHIS	Mental Health Investment Standard	MHIS is the requirement for ICBs to increase investment in Mental Health services in line with their overall increase in allocation each year.
MKUHFT	Milton Keynes University Hospital NHS Foundation Trust	
NHSE	NHS England	
SDF	System Development Funds	Resource allocations for specific programme activities deemed a priority by NHSE for 2022/23.
YTD	Year-To-Date	

Report to the Board of the Integrated Care Board, 27 January 2023

22. 2022/23 Section 75 Agreements

Vision: “For everyone in our towns, villages and communities to live a longer, healthier life”

Please state which strategic priority and / or enabler this report relates to

Strategic priorities

<input checked="" type="checkbox"/>	Start Well: Every child has a strong, healthy start to life: from maternal health, through the first thousand days to reaching adulthood.
<input checked="" type="checkbox"/>	Live Well: People are supported to engage with and manage their health and wellbeing.
<input checked="" type="checkbox"/>	Age Well: People age well, with proactive interventions to stay healthy, independent and active as long as possible.
<input checked="" type="checkbox"/>	Growth: We work together to help build the economy and support sustainable growth.
<input checked="" type="checkbox"/>	Reducing Inequalities: In everything we do we promote equalities in the health and wellbeing of our population.

Enablers

Data and Digital <input type="checkbox"/>	Workforce <input type="checkbox"/>	Ways of working <input type="checkbox"/>	Estates <input type="checkbox"/>
Communications <input type="checkbox"/>	Finance <input checked="" type="checkbox"/>	Operational and Clinical Excellence <input checked="" type="checkbox"/>	Governance and Compliance <input checked="" type="checkbox"/>
Other <input checked="" type="checkbox"/> (please advise):	Contracting and Procurement		

Report Author	Kathryn Cragg, Head of Acute and Strategic Contracts
Date to which the information this report is based on was accurate	5 th January 2023
Senior Responsible Owner	Anne Brierley, Chief Transformation Officer

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

Commissioning colleagues within the ICB and local authorities
 ICB Contracting leads
 Finance colleagues within the ICB and local authorities
 Information Governance colleagues within the ICB
 Governance colleagues within the ICB

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

Finance and Investment Committee in December 2022

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

The members are asked to approve the following:

- a) Approve the proposed 2022/23 S75 agreements for signature

1. Brief background / introduction:

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).

Section 75 of the NHS Act 2006 states as follows:

The Secretary of State may by regulations make provision for or in connection with enabling prescribed NHS bodies (on the one hand) and prescribed local authorities (on the other) to enter into prescribed arrangements in relation to the exercise of—

(a) prescribed functions of the NHS bodies, and

(b) prescribed health-related functions of the local authorities,

if the arrangements are likely to lead to an improvement in the way in which those functions are exercised

Within BLMK, the legacy CCGs all held S75 agreements with their local authority to enable the discharge of this duty. These agreements required updating where expired for 2022/23, and agreement was made that this should be a light touch approach to enable a more streamlined and focused approach for 2023/24 following the inception of BLMK ICB.

In line with BLMK ICB SFI's the Finance and Investment Committee are recommending to the ICB Board approval to sign all S75 agreements for 2022/23.

2. Summary of key points:

This paper sets out the key areas for 2022/23 with each of the 4 local authorities within the BLMK system, and the proposed approach for 2023/24. The full agreements are available for Board members in the Resource Library on BoardEffect for information.

Milton Keynes City Council

We are proposing three S75 agreements between Milton Keynes City Council (MKCC) and BLMK ICB for 2022/23, in line with the previous year. The proposed S75 agreements have been jointly developed and agreed between MKCC and BLMK ICB colleagues, and these are progressing through MKCC's governance process simultaneously. The services and total value of pooled funds are set out below:

S75 Agreement	Summary	Value
Better Care Fund (BCF)	This agreement has been updated to reflect the agreements within the BCF plan. The S75 includes pooled funding arrangements for both BCF and iBCF (Improved Better Care Fund), whilst also setting out governance requirements, risk share arrangements and process for overspends.	£27,593K
Learning Disabilities	<p>There are a number of services jointly commissioned for adults with Learning Disabilities that are funded via pooled budget arrangement between BLMK Integrated Care Board (formally with Milton Keynes Clinical Commission Group) and Milton Keynes City Council. These include:</p> <ol style="list-style-type: none"> 1. Joint Learning Disability Service 2. Community Team for Adults with Learning Disabilities 3. Day services 4. Supported living <p>This service is critical to our delivery of learning disability services to our population in Milton Keynes.</p>	£28,244K
Community Equipment	<p>The current Integrated Community Equipment Service within Milton Keynes is a joint health and social care service funded via a pooled and non-pooled budget. It enables the Council and the ICB to provide equipment that:</p> <ol style="list-style-type: none"> 1. supports the care of people within their own homes, enabling them to maximise their independence 2. reduces hospital admissions and facilitates prompt hospital discharge 3. reduces the requirement for Service Users to enter long-term care 4. reduces the demand on domiciliary care through reduced care packages, double handed care, and 5. enables access to the curriculum and care at home for children with a range of health and social care needs. <p>This service is a critical element of the health, education and social care economy in Milton Keynes through maximising independence and improving wellbeing for the local community.</p>	£1,037K

Luton Borough Council

We have proposed one S75 agreement between Luton Borough Council (LBC) and BLMK ICB for 2022/23, 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 £83,187,520.

In line with the governance requirements in LBC the S75 and schedules have been approved by the Joint Strategic Commissioning Group and, Health and Wellbeing Boards. Agreement between Executive leads was made to sign and seal this S75 in November to meet the requirements of LBC.

The services and total value of pooled funds are set out overleaf:

S75 Schedule	Summary	Value
Integrated Children's and Young People's Commissioning	<p>The aligned budgets, service commissioning and provision set out in the schedule are set out below:</p> <ol style="list-style-type: none"> 1. London Road Resource Centre with variable contribution from Health & Social Care depending on the demand 2. Children with complex needs including out of borough placements and tripartite funding, variable funding from health & Social care depending on the demand 3. Integrated disability services including SENDIASS and SEND joint resource budget (2022/23) to deliver the written statement of action with fixed share of funding from health & Social care. 4. Contract Carers service with Fixed contribution from Health and Social Care 5. Supporting children 's inequalities and dental health needs fixed share 	£4,083K
Commissioning Integrated Mental Health & Wellbeing	<p>The commissioned services covered by this schedule are:</p> <ol style="list-style-type: none"> 1. East London NHS Foundation Trust contract 2. Complex mental health placements 3. Section 117 Aftercare MHA 4. MH non-contractual activity 5. GPs (Mental Health Act Assessments) 6. Total Wellbeing (Turning Point) 7. Mental health floating support within wider universal floating support 8. Penrose STEPS 	£43,647K
Integrated Strategic Learning Disabilities Commissioning and Learning Disabilities Service Provision	<p>The Integrated Strategic Learning Disabilities Commissioning schedule outlines the joint commissioning functions and joint working arrangements. It sets out the remit to plan, develop and support local and regional plans that have a single care pathway and point of access for adults with a learning disability, their families and carers. The pooled funds support the following:</p> <ol style="list-style-type: none"> 1. Adults Commissioning Team function 2. Integrated Community Learning Disability Team function <p>The Learning disabilities provision (aligned budget) and joint ways of working included within this schedule are for the following areas:</p> <ol style="list-style-type: none"> 1. Day care 2. Supported Living 3. Residential & nursing 	£9,651K
Better Care Fund and the Improved Better Care Fund	<p>This schedule provides an overview of pooled fund allocations. 95% of the BCF and iBCF funding for Luton has been allocated to core service provision with the remaining 5% allocated to the following schemes:</p> <ol style="list-style-type: none"> 1. Enhanced Health in Care Homes 2. The Falls Service 3. Ageing Well 4. End of Life 	£25,807K
Joint Commissioning Arrangements and Governance	<p>The schedule sets out the governance and joint working arrangements for leadership. This includes the functions of the Joint Strategic Commissioning Group and associated sub-groups and the remit of jointly funded roles (pooled fund).</p>	Non-Financial

Financial Agreements	The Schedule sets out financial contributions to the S75 and the arrangements within, including: <ol style="list-style-type: none"> 1. Risk Share 2. Pooled Fund Management 3. S75 Overspend Position 4. S75 Underspend Position 5. Financial Management Systems 6. Timely Invoice Dispute Resolution 7. Timely settlement of invoices and backing data 8. Open and Transparent S75 Reporting 	Summary of above schedules
UKGDPR	The Schedule sets out the requirements of processing, personal data and data sharing	Non-Financial
The Luton At Place Board Partnership	The Schedule sets out the remit of the Place Board, the governance arrangements, values and approach to whole system working. Currently there is no pooled or aligned budget but option exists to include ICS monies allocated to Place.	Non-Financial

Bedford Borough Council

In line with previous years, we are proposing one S75 agreement for 2022/23 between Bedfordshire Borough Council (BBC) and BLMK ICB. The schedule has been updated in line with the agreed BCF plan. The service and total value of pooled funds are set out below:

S75 Agreement	Summary	Value
Better Care Fund	This agreement has been updated to reflect the agreements within the BCF plan. The S75 includes pooled funding arrangements for both BCF and iBCF, whilst also setting out governance requirements, risk share arrangements and process for overspends.	£17,507K

A schedule for Personal Health Budgets already exists and is part of a 2-year agreement from 2021/22, this will be updated for 2023/24 when the schedule expires.

Central Bedfordshire Council

In line with previous years, we are proposing 1 S75 agreement for 2022/23 between Central Bedfordshire Council (CBC) and BLMK ICB. The agreement has been jointly developed and CBC are currently passing through their own internal governance process for sign off simultaneously to us. The service and total value of pooled funds are set out below:

S75 Agreement	Summary	Value
Better Care Fund	This agreement has been updated to reflect the agreements within the BCF plan. The S75 includes pooled funding arrangements for both BCF and iBCF, whilst also setting out governance requirements, risk share arrangements and process for overspends.	£34,419K

A schedule for Personal Health Budgets already exists and is part of a 2-year agreement from 2021/22, this will be updated for 2023/24 when the schedule expires.

Approach for 2023/24

Given the emphasis on place working we are proposing that each place has an overarching S75 agreement in line with the Bevan Brittan model which will then include generic schedules for areas such as Information Governance and Conflicts of Interest, with more specific schedules in accordance with place level priorities and requirements.

A S75 programme board has been established and work is underway with local authority colleagues to ensure S75 agreements and schedules are finalised no later than March 2023.

3. Are there any options?

N/A

4. Key Risks and Issues

N/A

Have you recorded the risk/s on the Risk Management system?

Yes

No

[Click to access system](#)

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

Values of the pooled funds are set out in the paper and S75 agreements.

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

[Click to view Green Plan](#)

Through appropriate contracting in-line with operational plan requirements which reflect green plan commitments.

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

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.

8. Next steps:

Following approval from the ICB Board the S75's will be put forward to the ICB Chief Executive for formal signature and recording.

9. Appendices

10. Background reading

Available in the Resource Library in BoardEffect for Board members

- MKCC/BLMK ICB Better Care Fund S75
- MKCC/BLMK ICB Community Equipment Service
- MKCC/BLMK ICB Learning Disabilities S75
- LBC/BLMK ICB S75
- CBC/BLMK ICB Better Care Fund S75
- BBC/BLMK ICB Better Care Fund S75

ICB in PUBLIC - Annual Cycle of Business

Subject	Accountable Person (name on agenda)	Author/s	31/03/2023
Strategy			
Reports from Place Based Boards: <ul style="list-style-type: none"> • Bedford Borough • Central Bedfordshire • Luton • Milton Keynes 	Local Authority CEOs		✓
Fuller Stocktake - after 29/7 quarterly update on implementation	Chief Primary Care Officer (CPCO)	CPCO	✓
Delegation of Pharmacy, Optometry and Dentistry	Chief Primary Care Officer		✓
Health & Care Senate	Chief Medical Director		
Health Inequalities	Chief Nursing Director	Sarah Stanley	
Operational			
Quality & Performance Statement/Report	Chief Nursing Director (CND)	Performance Team Team/CND	✓
Finance Report	Chief Finance Officer	Stephen Makin	✓
2022/23 S75 Agreements for sign off	Chief Finance Officer ?		
Resident's Story	Chief of System Assurance & Corporate Services	tbc	✓
Governance			
Board Assurance Framework	Chief of System Assurance & Corporate Services		✓