BLMK

Joint Forward Plan

Appendices

CONTENTS

Appendix A

The Joint Forward Plan at Place

1.1 Bedford Borough

1. Opportunities and challenges for Bedford Borough

A growing population

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

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

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

Rising demand and increasing complexity

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

Population health

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

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

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

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

Several population health challenges have been identified for Bedford Borough:

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

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

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

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

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

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

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

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

2. Where are we now?

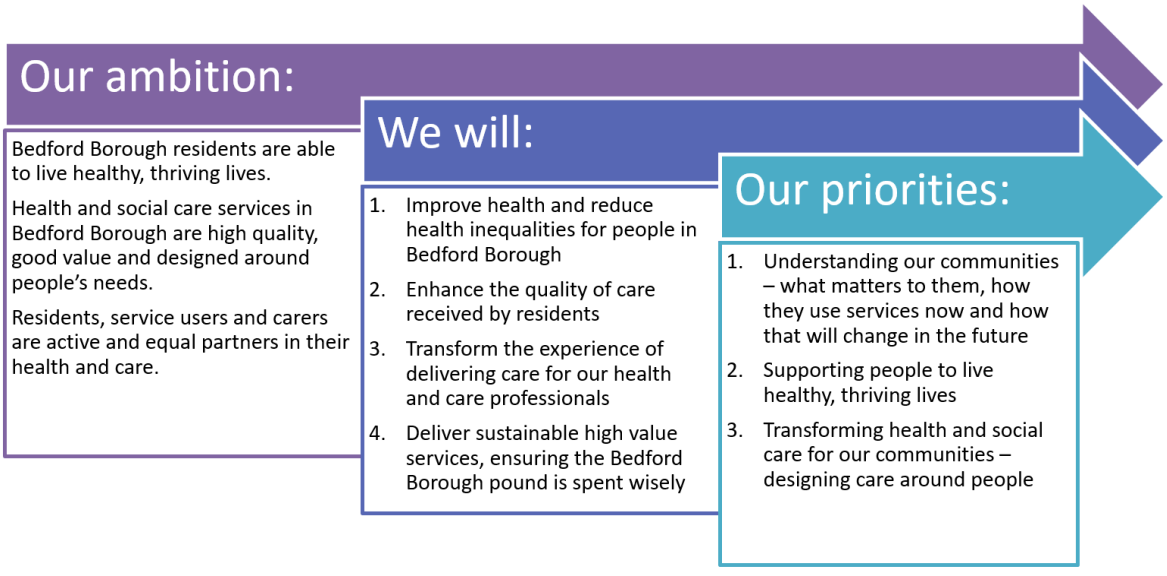
Bedford Borough Council has recently undergone a change in political leadership, with a new Mayor and a new Executive, whilst the Council as a whole has no overall control. Priorities for the new administration include ensuring that Bedford Borough is a great place to raise a family, and working with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

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

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

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

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



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

3. What have we achieved so far?

Priority 1: Understanding our communities and what matters to them

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

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

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

Priority 2: Supporting people to live healthy thriving lives

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

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

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

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

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

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

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

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

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

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

4. What's next?

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

1. Joint Local Health and Wellbeing Strategy

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

2. Primary Care Estates and Fuller Neighbourhood Teams

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

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

3. Excess weight

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

4. Managing complex health and care needs

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

5. Addressing health inequalities

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

Homepage - Bedford Borough Council

1.2 Central Bedfordshire

1. What are the challenges for Central Bedfordshire?

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

Population growth & demographic shift

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

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

Health needs and inequalities

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

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

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

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

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

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

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

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

2.The current landscape in BLMK

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

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

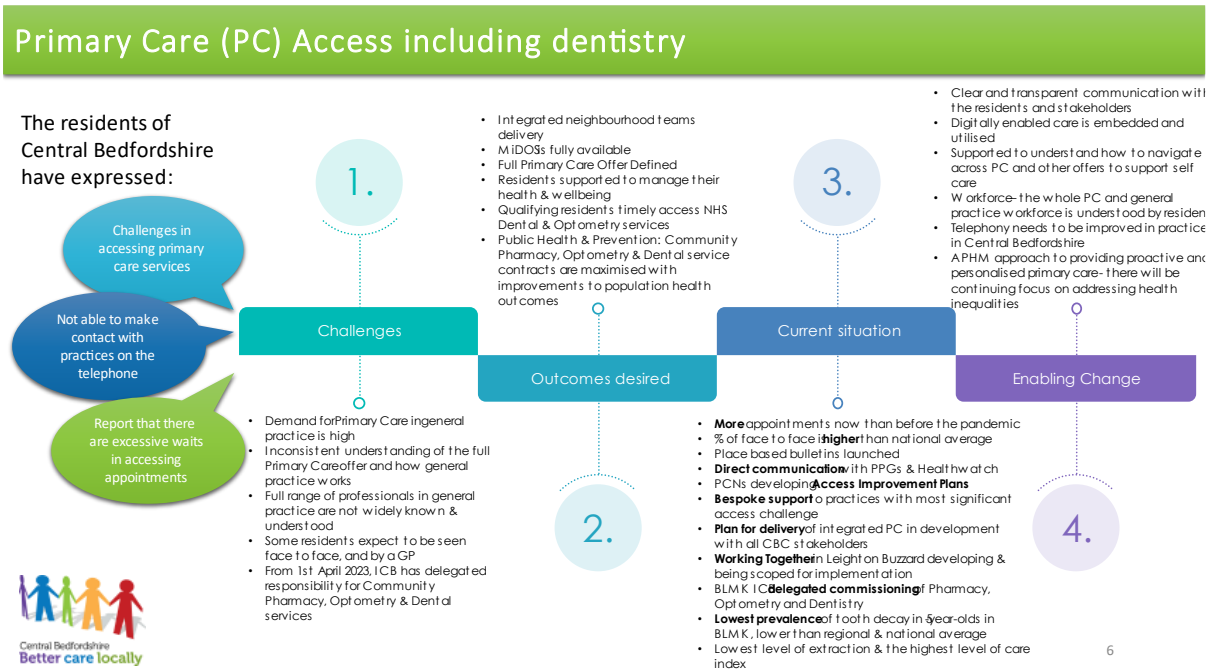
- **Living Well** - Improving access and supporting healthy choices.
- **Ageing Well** - Supporting independence for older people
- **Promoting Fairness and Community Cohesion** - Tackling inequalities and the wider determinants of health and wellbeing.

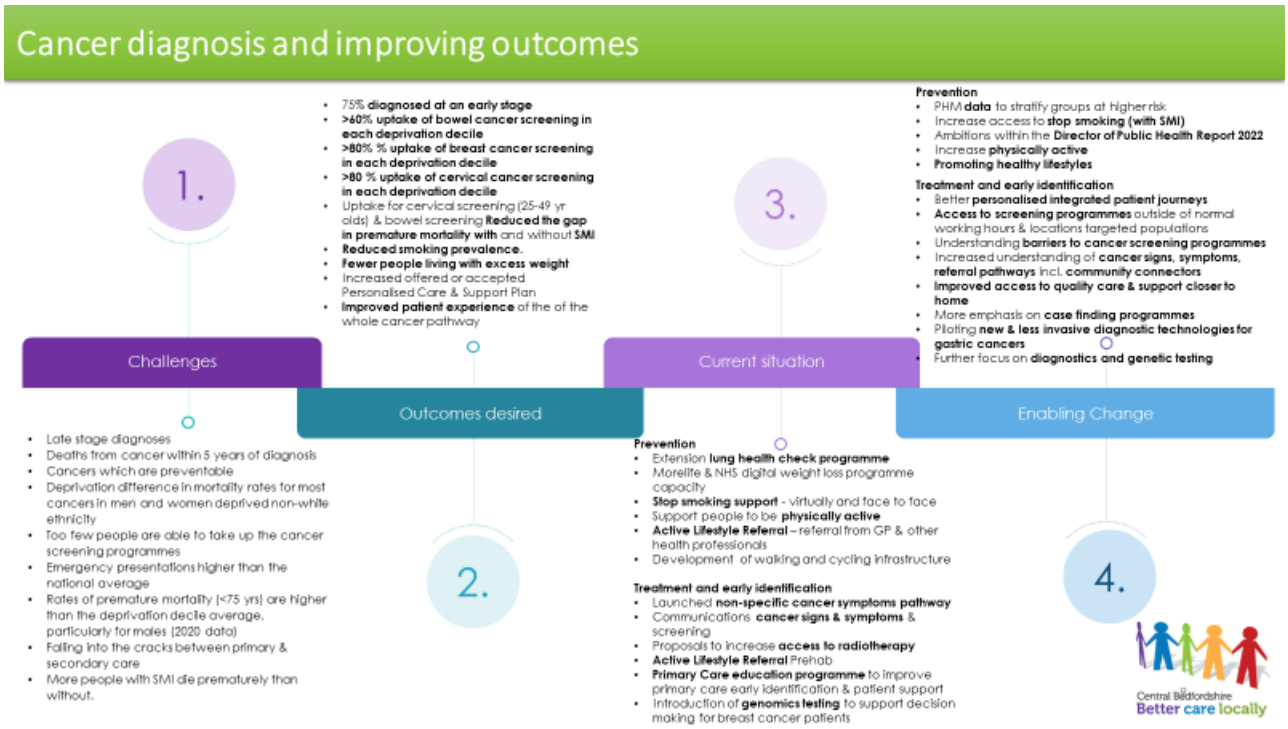
The Health and Wellbeing Board has agreed the priority outcomes for 2023-24 as follows:

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

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

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





Positive Mental Health and Well Being for Children and Young People

1.

Challenges

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

2.

Outcomes desired

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

3.

Current situation

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

4.

Enabling Change

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

Excess Weight

National & Local Issue:

Too many people living with Excess Weight:

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

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

and 66% of adults (20/21)

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

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

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

1.

Challenges

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

2.

Outcomes desired

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

3.

Current situation

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

Treatment and early identification
- Morelife & NHS digital weight loss programme increase with capacity

4.

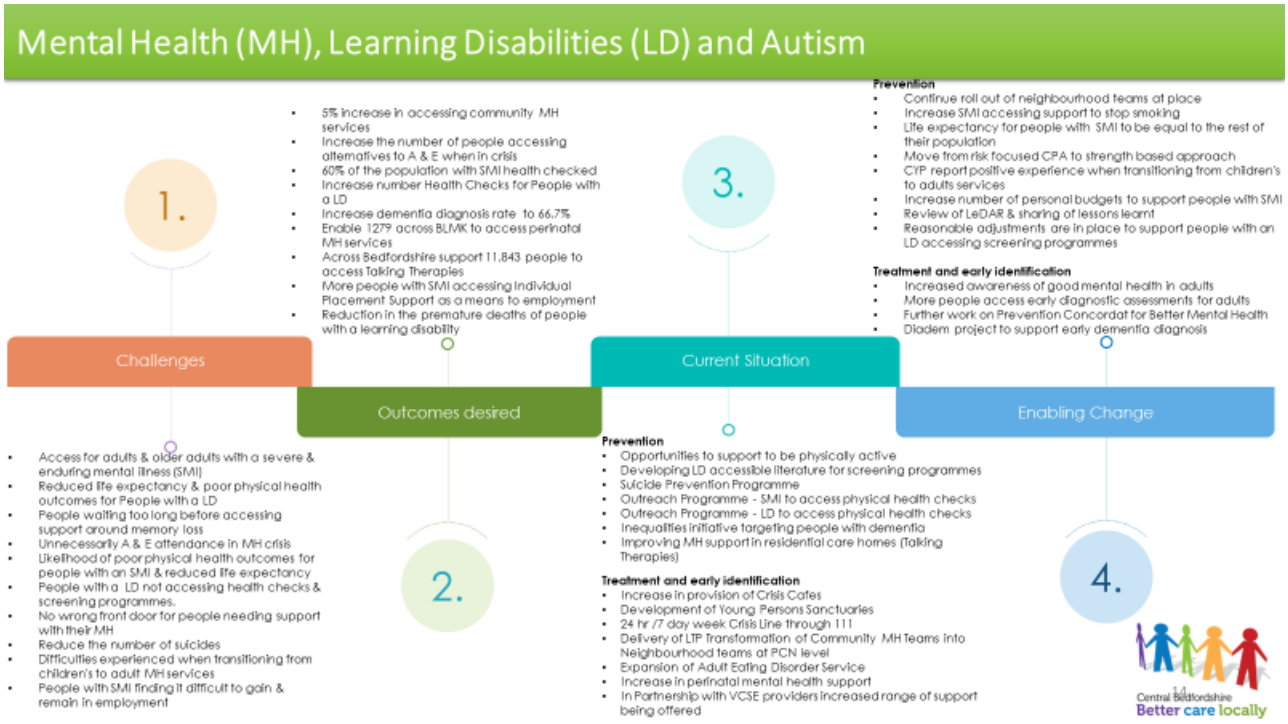
Enabling Change

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

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

12

Central Bedfordshire
Better care locally



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

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

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

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

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

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

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

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

What difference will this make?

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

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

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

Our Progress So Far…

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

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

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

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

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

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

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

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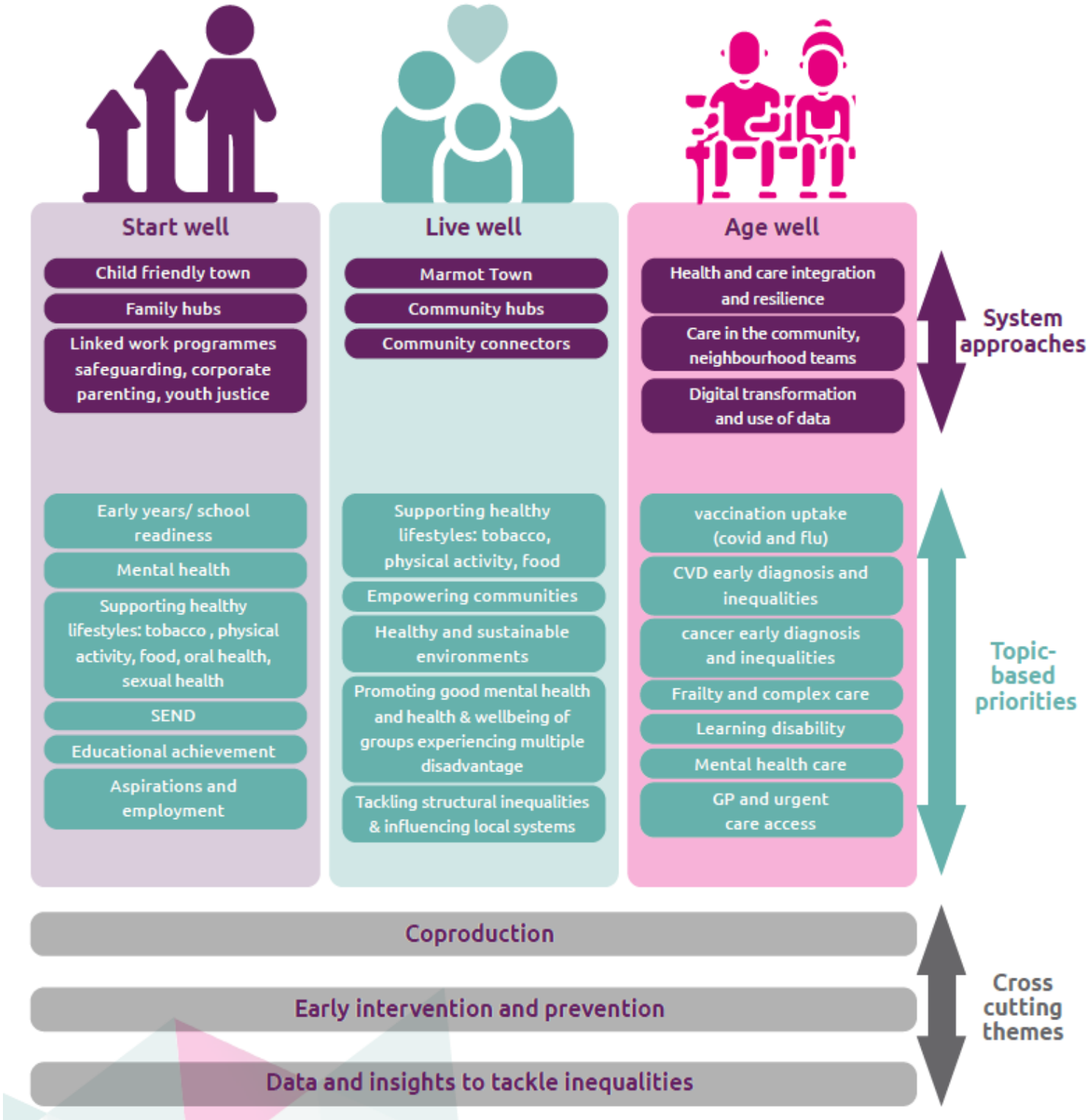
1.3 Luton

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

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

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

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


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

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

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

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

[Homepage - Luton Borough Council]

1.4 Milton Keynes

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

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

Population Growth

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

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

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

2. Current landscape in BLMK

Where are we now?

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

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

[1] Source: ONS, Census 2021

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

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

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

What have we achieved?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. What does good look like?

For System Flow, good looks like:

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

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

For Tackling Obesity, good looks like:

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

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

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

For complex care, good looks like:

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

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

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

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

How can be measure benefits/outcomes for residents

Improving System Flow metrics

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

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

Obesity Metrics

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

CYP MH Metrics

These are in development.

High level timeline

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

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

Interdependencies:

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

Other key dependencies are:

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

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Appendix B

The Joint Forward Plan & Provider Collaboratives

2.1 Bedfordshire Care Alliance

1. What is the purpose of the Bedfordshire Care Alliance

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

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

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

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

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

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

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

The Current Landscape

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

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

The populations of the 3 Boroughs are also very different:

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

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

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

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

The BCA currently has 3 strategic objectives:

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

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

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

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

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

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

Key Actions / Timelines to Deliver Objectives

These are as follows:

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

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

Principal Benefits sought from JFP High Impact Programmes

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

2.2 Mental Health, Learning Disability and Autism Provider Collaborative

1. What is the purpose of the BLMK MHLDA

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

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

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

The Current Landscape

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

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

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

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

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

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

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

Perinatal

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

Expanded perinatal service offer to increase access to psychological therapies

Service incudes offer for partners

Also available for patients up to 24 months post partum

CAMHS

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

Increasing access for CYP

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

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

NHS Talking Therapies

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

Long Term Condition services in place, including post Covid syndrome

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

Early Intervention

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

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

Community Mental Health Team

Embarked on the most ambitious programme of transformation of community mental health services in 20 years, building new community teams around neighbourhoods, working in a much more integrated way, with a real focus on broader psychosocial support, addressing inequalities, connecting people to communities, supporting more people into work and offering more physical health checks than ever before

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

Recovery college open in MK

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

Crisis

- New crisis pathways, with access to crisis support via 111, crisis teams that can visit people in their own homes as an alternative to hospital (24/)
- Alternative crisis offer via new crisis cafes across BLMK delivered in partnership with VCSE
- Mental health teams in our acute hospitals meeting national guidance and "core 24" standard

Dementia

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

Inpatient

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

Suicide Prevention

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

Other

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

Opportunities at Place

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

3. What does good look like in BLMK?

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

Case studies of achievements to date include:

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

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

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

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

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

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

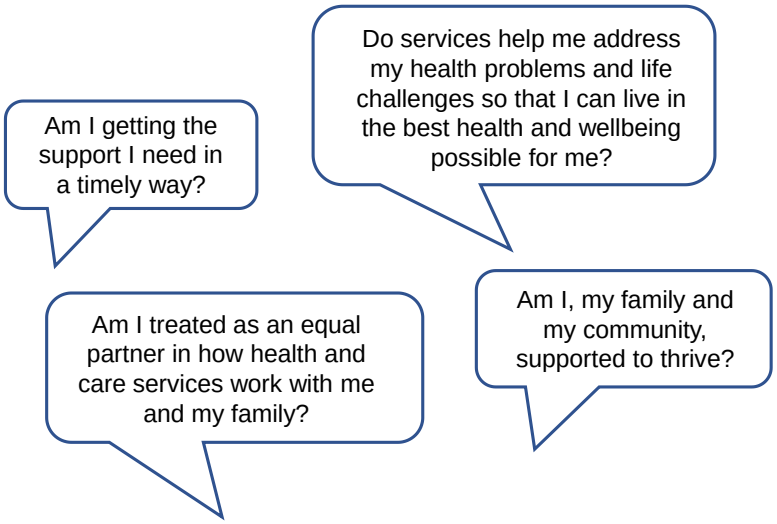
	Strategic Deliverables	High Impact Programmes	Key Partners
	• Supported independent living / crisis respite capacity within BLMK (CYP and adults)	• Intelligence-led Quality, Performance, Outcomes and Inequalities Improvement	• MHLDA providers • Local Authorities • ICB
Capital investment	• Release capital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

Appendix C

The Joint Forward Plan Enablers

3.1 Enablers to the High Impact Programmes

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



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

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

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

What do we need to do differently?

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

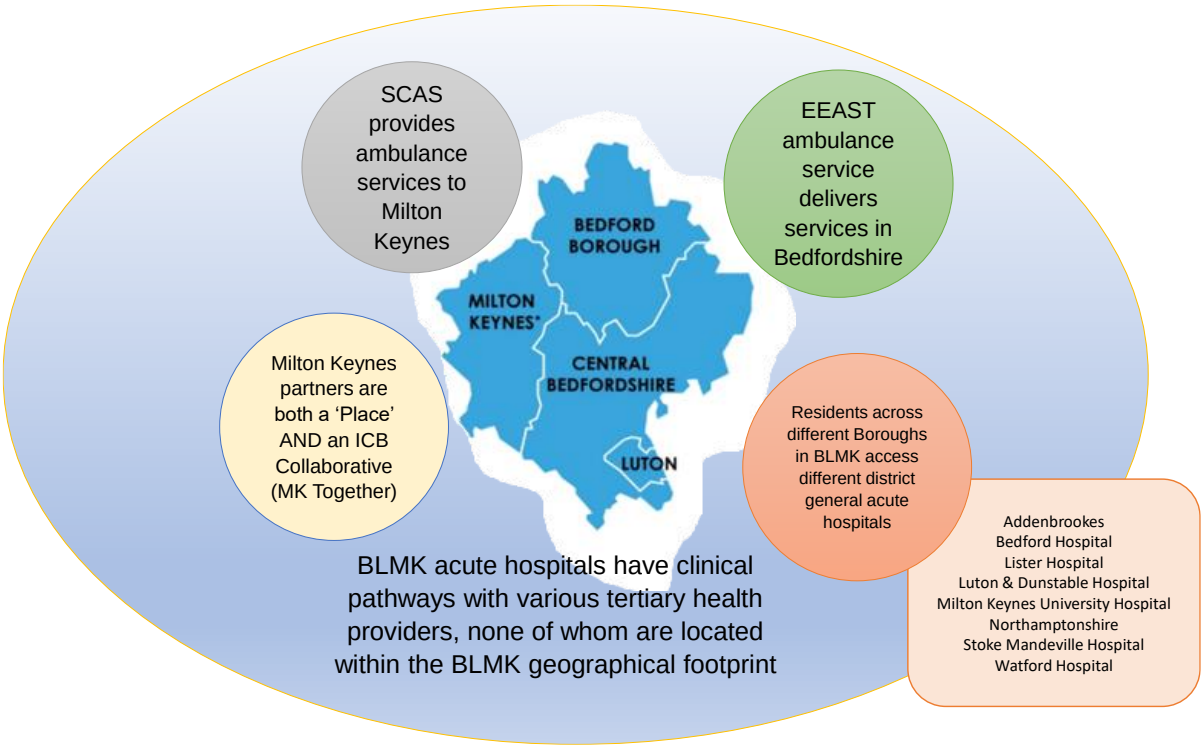
- More co-production with residents to support them to live more years in good health.
- Develop key aspects of our infrastructure, such as estates and technology, and tools, such as digital solutions, to enable improvements to care pathways.
- Offer more interventions earlier to limit the impacts of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

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

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

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

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



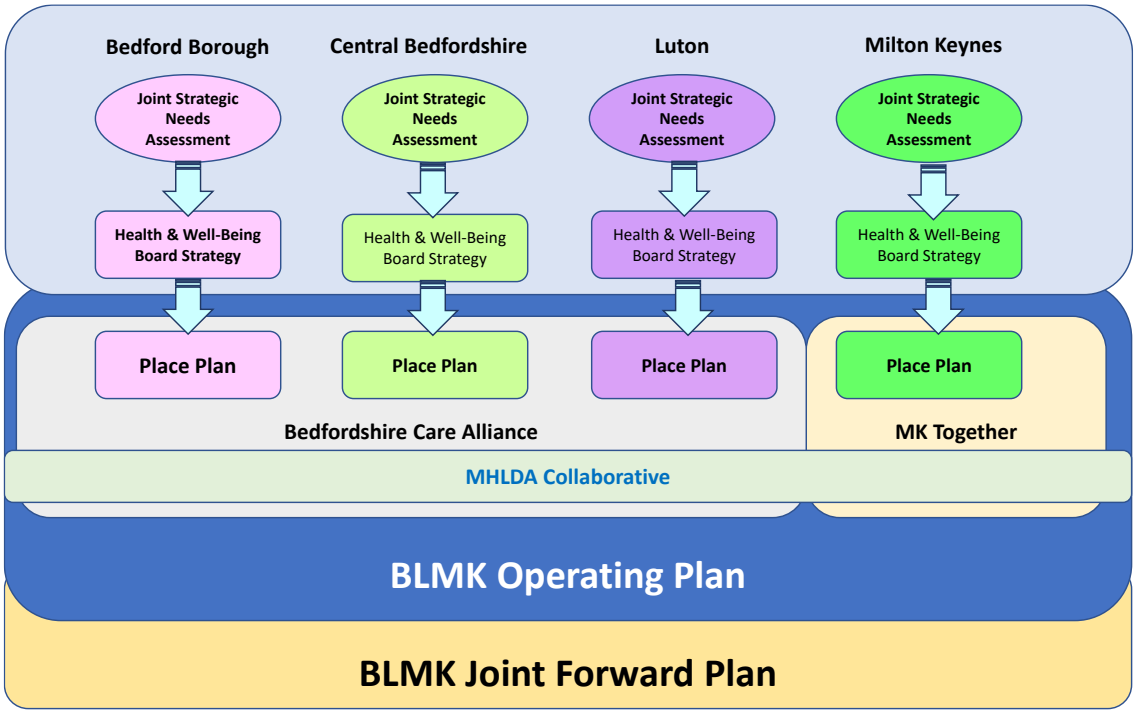
This means there are TWO reasons why a 'one size fits all' doesn't work for BLMK residents:

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

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

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

This relationship pan-BLMK is depicted below:



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

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

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

3.2 BLMK Health Services Strategy

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

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

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

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

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

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

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

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

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

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

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

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

3. Demand in primary care is continuing to rise.

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

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

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

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

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

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

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

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

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

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

BLMK Health services strategy will be developed by:

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

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

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

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

1.1 What will future health services look like?

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

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

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

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

Health product developer

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

Consumer-centric health community

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

Speciality care operator

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

Localised health hub

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

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

The potential of genomic medicine

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

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

Examples of Implementation in BLMK to date are:

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

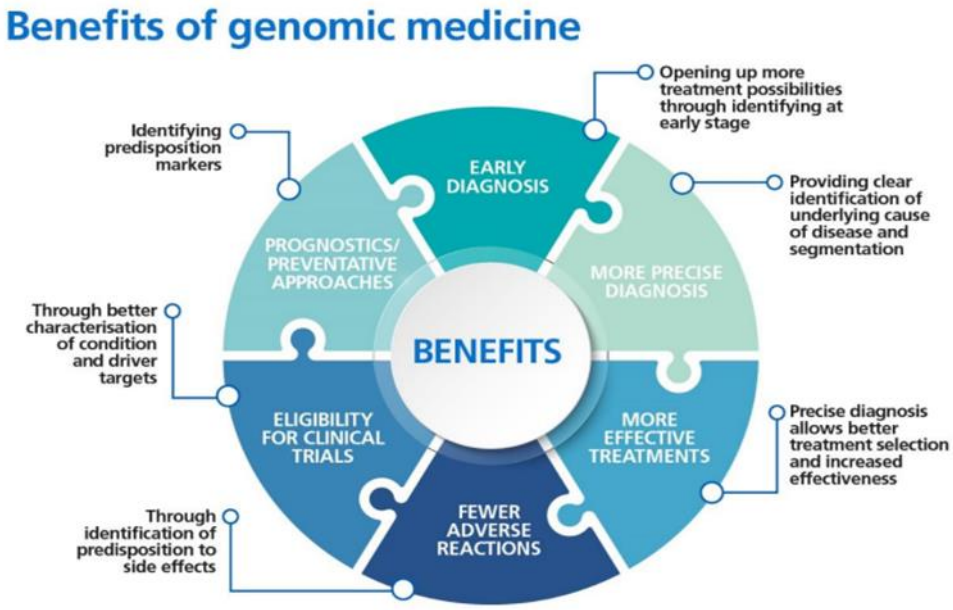
2. Virtual wards allow patients to get hospital-level care at home safely and in familiar surroundings, helping speed up their recovery while freeing up hospital beds for patients that need them most. Just as in hospital, people on a virtual ward are cared for by a multidisciplinary team who can provide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

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

4. **Genomics**

Genomics in cancer

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



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

1.2 What have we done so far?

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

Four questions were considered:

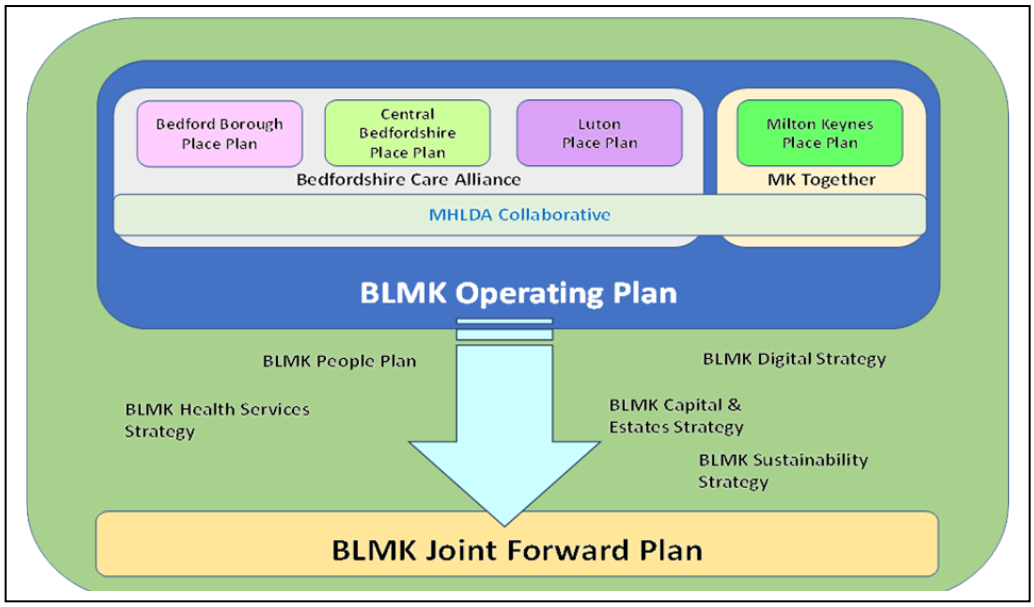
- Do we agree with the definition of the clinical services strategy?
- What must we consider in delivering an effective clinical services strategy?
- Which key deadlines or priorities from your place need to be linked to this work? What would be our top 3 priorities for year 1?
- Who should be involved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

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

The key themes identified with the responses is outlined below.

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

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



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

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

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

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

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

1.4 Why these programmes?

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

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

This programme is expected to run 2023- 2025.

1.5 Delivery Model

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

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

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

Collaboratives, productivity and effectiveness projects delivered within an organisation

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

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

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

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

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

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

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

2. Next Steps

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

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

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

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

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

List of appendices

Appendix A.1 – Long Term Plan Ambitions

Appendix B.2 – Upcoming New Technology

Appendix A.1

Long Term Plan Ambitions

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

Cardiovascular Disease

Milestones for cardiovascular disease

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

Respiratory diseases

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

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

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

Appendix B.2 – Upcoming New Technology

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

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

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

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

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

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

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

Acknowledgments:

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

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

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

1. What is the Purpose of this Enabler?

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

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

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

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

Our Shared Ambition

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

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

2. The current landscape in BLMK

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

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

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

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

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

Key challenges

Whilst these are addressed in some detail in the problem statement set out above, we consider the overall current capacity of VCSE organisations to be a barrier which the ICB has a responsibility to work to address. Furthermore, commissioning processes designed for large VCSE organisations and, NHS planning does not historically best enable VCSE participation and longer-term funding tied up in long term contracts with big providers limits our ability to invest strategically in the sector. A more practical challenge is the coordination of engagement activity across geographies and populations, especially amongst a rapidly growing population.

ICB Mandated Responsibilities

These are set out principally in the Health and Care Act 2022 and the ICS' VCSE guidance

The Act requires NHS organisations to plan and deliver services in partnership and work closely with local authorities, VCSE organisations and communities themselves to improve population health. The VCSE sector is a vital cornerstone of a progressive health and care system. ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving, and delivering services and developing and delivering plans to tackle the wider determinants of health.

Our VCSE partnership should be embedded as an essential part of how the system operates at all levels. ICBs are expected to have developed a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level.

There are further "must-dos" established by our BLMK ICB Memorandum of Understanding arrangement, as set out below:

- We will hold each other to account, live our values and regularly review our working relationship.
- We will collaborate to maximise on the opportunities and share the risks to achieve the best possible outcomes for individuals, communities, and our organisations.

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

Opportunities

There are countless opportunities afforded by a stronger working relationship with VCSE partners, including: Benefits statement - By working in partnership with the VCSE sector in BLMK, we will gain a better understanding of our diverse communities, derive more value from co-producing services and projects; and deliver more and better improvements in health and wellbeing for our residents.

We see particular opportunities for VCSE involvement in support action across the system to address support for everyday living, prevention services, driving forward the green agenda, social action, community development and tackling health inequalities.

What have we achieved

The "Where we are Now" section above goes some way to setting out the considerable progress made so far on establishing a new and strategic partnership with the VCSE for the benefit of local residents. Other notable achievements include the involvement of VCSE organisations in the Denny Review – a major, local study into health inequalities where, often for the first time, we were able to hear views from seldom heard communities including homeless people and individuals from the Roma communities.

Further notable examples of VCSE collaboration include support from the Bedfordshire Rural Communities Charity to support patients from rural areas upon their discharge from hospital, and innovative partnerships with partners like the MK Dons Football Club whose work supporting young people is a key part of supporting health development and developing skills. Milton Keynes University Hospital emergency department is supported by a volunteer scheme delivered by MK YMCA and Thames Valley Police, providing comfort and advice to individuals who may be particularly vulnerable.

Mental health is an area where there are a number of excellent examples of our work with the VCSE, including suicide prevention, bereavement support, dementia support, rough sleeping initiatives, support with winter pressures and a number of digital developments which have been mobilised with partner organisations. A particularly exciting area of development are VCSE mental health alliances, which form part of the community mental health transformation plans.

3. What does good look like – learning from others

The model that works for each ICS in terms of its relationship with VCSE organisations is of course dependant on the specific characteristics of the place. There are nevertheless a number of innovative models in areas like Yorkshire and Devon that we are seeking to understand further.

Devon ICS has development a business case to invest in the infrastructure required for enable more effective VCSE participation within workstreams and governance; they have delivered a buddying scheme between the NHS and VCSE leaders to bring about a better understating of each other's sectors; and using transformation funding to invest in the VCSE as part of a system response with co-designed solutions.

Humber and North Yorkshire HCP has agreed an annual budget to support VCSE collaboration. They have been working to simplify processes for grant agreements and contract variations and shifting language that recognises support for longer term development of the VCSE is an investment. West Yorkshire and Harrogate HCP has a well-developed place-based approach to working with the VCSE, with and annual budget to support collaborative activity. The development of VCSE commissioning vehicles is also being investigated.

NHSE is also developing a Quality Tool to support ICBs with self-assessment of how the VCSE partnerships is developing locally. The key elements are listed below, and we will use the final version of the tool monitor and evaluate the development of the BLMK VCSE Partnership.

- Understanding the value of the VCSE sector
- Building and strengthening VCSE infrastructure for collaborative working
- Embedding the VCSE as an equal partner in ICS governance and decision making
- Sustainable investment for VCSE alliances
- Designing and commissioning effective, innovative, and sustainable services
- Harnessing data and intelligence
- Measuring the impact of the VCSE as a key strategic partner
- Investing in leadership and relationship development
- Working with the VCSE sector to address the wider determinants of health

Case Studies like the mental health crisis cafes and support for young people overleaf bring to life how our relationship with the VCSE is transforming lives.

What difference will this make, and how will we measure it?

Much of the value the VCSE delivers in in the area of prevention and we recognise that measuring success requires further development. Prevention can be considered through a variety of lenses, and we will need to work with partners to better define how we measure it in terms medical, social, public health, economic and environmental. We will need to work with partners to understand how and where these are measured, for example within workstreams or at a strategic level.

There NHSE quality tool will enable us to measure improvements in a range of areas, operationally and strategically. The MoU also provides an opportunity to understand how the partnership with the VCSE is developing against the commitments outlined. This area of work is also supported by a programme plan and a related outcomes framework is progressing.

Several measures will be worked up further under each of the benefits outlined in the benefits statement above:

- Gain a better understanding of our diverse communities
  - Reach of VCFE into Core20Plus5 population
  - Completion of the asset mapping work and providing link to MiDoS directory of services tool in 23/24
  - Annual sentiment survey measure
- Derive more value from co-producing services and projects.
  - We will need to identify specific schemes which will use a co-production approach to develop this further
  - We will also work with procurement colleagues to develop the approach to measuring social value
- Deliver improvements in health and wellbeing for our residents.
  - These will need to be defined within specific workstreams, but examples include, distance travelled for individual clients e.g., before and after ONS4, Campaign to End Loneliness Tool, and similar wellbeing improvement measures

4. Delivery of this Enabler to Support the High Impact Programmes of the BLMK Joint Forward Plan

The MOU will be delivered by programme plan, the key elements are outlined below. Governance will occur via the VCSE Strategy Group. The NHSE quality tool and outcomes framework for the programme will track improvements and monitor progress.

Mobilisation in 2023-5

There are key actions underway as part of Place and Provider Collaborative's Delivery Plans and the ICB's NHS operational plan delivery to further embed partnership with the VCSE into the High Impact Programmes in our Joint Forward Plan.

These include:

- **Raise awareness of the VCSE and bring about a shared understanding of the sector's impact across a range of areas** - programme of engagement and co-production activity to support multiple workstreams at system and place; mechanisms for the VCSE to collaborate effectively at Place, amongst themselves and with other partners
- **Involve VCSE in operational and strategic planning processes through Places and Provider Collaboratives** - enhance VCSE involvement through delivery of ICB VCSE procurement strategy; strengthen VCSE involvement in relevant ICB governance; develop staff volunteering programme
- **Develop strategic investment case for VCSE infrastructure, and partnership development and maintenance** - complete mapping exercise; identify external and internal sources of investment to support VCSE infrastructure
- **Define outcomes, impact, and benefits** – this will be enabled through implementation of the Population Health Intelligence Unit, BLMK digital connectivity programme and pan-BLMK commitment across all partners to embed quality improvement methodologies to improve health outcomes and tackle inequalities

3.4 BLMK Infrastructure Strategy

1. What is the purpose of this Enabler?

In the context of significant population growth, the financial constraints facing the system, and our ambitious transformation and service improvement plans, we need to adapt our estate to ensure it enables new and more cost-effective models of care.

Our key estates priorities within BLMK include:

- Maintaining a safe, compliant and fit-for-purpose estate in the context of a constrained capital funding position.
- Enabling delivery of the system's clinical strategy and service improvement plans.
- Reducing inequalities by ensuring the alignment of estates prioritisation to local health and infrastructure needs.
- Planning for the future, including in areas of high levels of housing and population growth.
- Achieving measurable progress towards our Net Zero Carbon targets; and,
- Ensuring a cost-effective and affordable estate that is fit for the future.

The challenge for all public sector partners in BLMK is how best we tackle the inter-connected and complex issues for estates and capital investment:

- **Balancing need for backlog maintenance of aging estate vs. increased capital and revenue costs of new and more 'fit for purpose' buildings** in the context of extremely constrained NHS capital funding
- **Targeted investment in key capital estate to tackle 'pinch points' where lack of capital investment is the direct cause of inequitable outcomes for residents** and / or increased clinical risks and revenue costs within existing constrained provision
- **Making best use of mobile and digital technology to bring services closer to residents** whilst reducing reliance on purpose-specific buildings where volume of demand does not support expensive but low utilised capital investment
- **Finding innovative sources of capital funding to address the gap between need and resource availability** through traditional capital investment sources (primary care capital fund, section 106 etc)
- **To maximise benefit of capital investment through bringing together civic and NHS functions** into integrated accommodation to reduce capital and revenue costs to the taxpayer

2. The current landscape in BLMK:

The health services within BLMK operate from three main acute hospital sites, approximately 120 community/mental health settings, and over 130 primary care premises. This is in addition to the civic, education and social care settings and vast range of properties operated by our Local Authority partners.

Our key challenges to 2040 are:

- **Capital funding constraints**, which will make it increasingly challenging for us to maintain and replace our buildings and equipment
- **Significant housing growth**, not matched by adequate additional funding for civic and health infrastructure raised through traditional routes

- **Rising demand for services** and our continued recovery programme, requiring additional capacity across many services
- **Capital investment required to deliver new medical technical innovation** - implementing advances in research to improve health outcomes for our residents
- **Variation in the condition, capacity and energy efficiency of our facilities**
- **The need to enable new models of care**, to better meet the needs of residents, and tackle inequalities in access, outcomes and inequalities

Addressing these challenges will require joined-up efforts across system partners, harnessing the principles of One Public Estate, to maximise our opportunities to collectively plan for and deliver our future estate. By working together, we have greater ability to deliver flexible strategic estates solutions and to access a wider range of funding solutions.

As a system, we have made progress with the delivery of some of our most pressing estates challenges:

- Delivery of the Urgent Treatment Centre and Cauldwell Medical Centre projects on the Bedford Hospital site, which helped to streamline urgent care services in Bedfordshire, and provided essential primary care capacity in an area of high need.
- Delivery of a range of recovery schemes post-Covid to enhance the capacity of key services within both local Hospital Trusts
- Full Business Case (FBC) approved and redevelopment underway for the Luton & Dunstable Hospital site, which will provide fit-for-purpose accommodation for services, improve patient experience, and enable significant clinical and efficiency benefits.
- Delivery of the Maple Unit within Milton Keynes Hospital, which has helped to streamline urgent care services.
- Funding secured for the redevelopment of the Milton Keynes Hospital site under the second phase of the national Health Infrastructure Plan (HIP2 Programme), Strategic Outline Case (SOC) completed, and Outline Business Case (OBC) in development. The programme will help to future-proof hospital services against a backdrop of major population growth.
- Delivery of the Whitehouse Hub and Brooklands facilities in Milton Keynes, providing essential primary care services within areas of high housing growth.
- Delivery of Grove View Integrated Health & Care Hub in Dunstable, enabling joined-up working and additional capacity for a wide range of primary care, community, mental health, social care and hospital-led services.
- FBC approval and delivery mobilisation for the North Bedford Primary Healthcare Programme on the Bedford Health Village site, enabling consolidation of the largest GP practice in BLMK (40,000 list size).
- Approval of business cases for Community Diagnostic Centres (CDC) in Bedford and Milton Keynes, and delivery in mobilisation. In line with the national programme, these centres will provide additional diagnostic capacity away from the main hospital sites.
- Capital secured to build a new Mental Health inpatient unit on the Bedford Health Village site.
- Delivery of a range of smaller scale primary care premises schemes, and completion of a comprehensive Primary Care Estates Prioritisation Process across BLMK. The ICB has identified an additional £1.95m per annum to be made available to support primary care

estates, which represents a 22% increase in the investment in primary care facilities. This additional funding will enable twenty-three local projects to progress by 2025/26, with benefits for a wide range of communities across Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.

3. What does good look like?

The capital estates strategy and plan are dependent on our Place Plans and the outputs of key strategies such as our health services strategy and our digital integration strategy.

We also need to complete the critical mobilisation action of our BLMK Joint Forward Plan – detailed population growth and detailed demographic change modelling for each of our 4 Boroughs. The ONS estimate for population growth across BLMK is inaccurate due to the local plans to build circa 6,000 new homes every year until 2040. More accurate population growth modelling is an essential precursor to predicting changes in civic, care and health need and demand – and the resulting implications for our infrastructure.

We also need to ensure that as we build for our future that we do not plan capital estates investment predicated on old models of care. Digital integration and advances in medical technology enable us to bring joined-up care much closer to residents with reduced need for dedicated (low utilisation) buildings. In contrast, investment in specific estate to enable new models of care (for example, the Milton Keynes Cancer Centre and Bedfordshire Mental Health Hospital) will each improve access and outcomes for residents across our Place and enable delivery of NHS Constitutional Standards.

Within our operational planning we will need to continue to work closely with NHSE Regional colleagues to find targeted capital funding solutions to the remaining capital projects required to unblock existing flow bottlenecks which continue to have a material and deleterious impact on urgent emergency care and elective performance, and resultant patient waits and clinical outcomes.

Without clarity on the future / best-practice models of care and on the gap between demand and capacity at a local level, there is a significant risk that we will not use public capital investment to best effect for our residents.

The BLMK Infrastructure Strategy will need to address the following:

- Sustainable affordability (capital and subsequent revenue costs)
- Tailor investment to local need and demand – improving access, especially where health outcomes and / or inequalities have a detrimental impact on our communities' ability to thrive
- Based on evidence-based best practice in our models of care to ensure we have the right resources in place to improve health outcomes and the wider determinants of health
- Make best use of technology and sustainable resources to optimise benefits whilst minimising cost to the public purse and the environment
- Deliver clear 'return on investment' (capital and revenue) in meeting need and demand for residents, and delivering NHS Constitutional Standards sustainably

4. BLMK Timeline to Complete the BLMK Infrastructure Strategy

There are several actions in place to deliver this:

a. Modelling of population growth and demographic changes across all 4 of our Places to 2040 (based on best knowledge to date)

b. Work is underway to support many of the PCNs across BLMK to refresh their Clinical Strategies and their Estates plans, in line with the national PCN Estates Toolkit. This work will have a prime focus on maximising the utilisation of the system's existing collective estate, ensuring that we are planning the right infrastructure to meet future needs and planned models of care, and working towards delivery of our Green Plan intentions.

c. Mapping and review of 'one public estate' in each of our Boroughs, exploring the possibilities for optimised utilisation and targeted investment across civic, emergency, education and NHS buildings

A programme is in mobilisation, with a view to achieving sign-off of the BLMK Infrastructure Strategy in December 2023. This work will need to align to our Health Services Strategy and is interdependent on the ICS Digital Strategy and BLMK People plan.

5. Unmitigated Risks to Delivery

There are 3 aspects of NHS capital allocation policies that are significant risks to delivery of safe, sustainable estates to deliver NHS Constitutional Standards for all residents in BLMK:

a. **Lack of primary care premises strategic development capital funds**. This prevents strategic investment in major new developments in primary care to meet growing population need

b. **Short-term / fragmented and over-specified capital funding regime, meaning that systemic gaps in infrastructure cannot be adequately addressed** (causing poorer access and treatment outcomes, but also sub-optimal use of capital and revenue resources)

c. **NHS capital is allocated to each provider's 'home' ICB**. For BLMK ICB, where 3 of the 5 NHS Trusts have their 'home' in an ICB beyond BLMK (Cambridgeshire Community Services, East London NHSFT and Central North NHSFT), this results in a significant under-investment of NHS capital allocation for BLMK residents

BLMK will continue to work with regional and national policymakers to influence and seek resolution to these issues.

3.5 BLMK People Plan

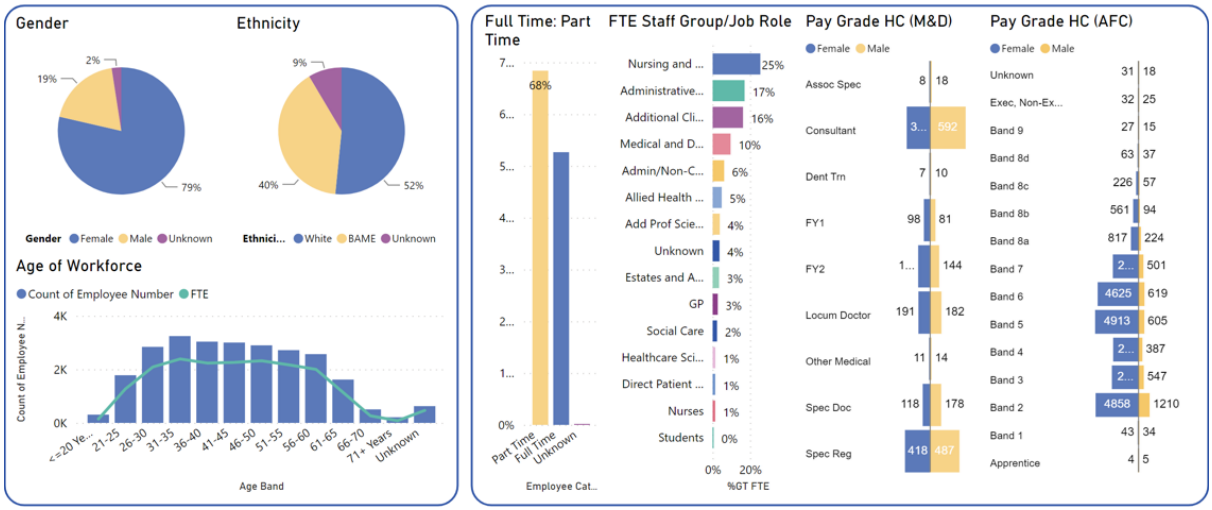
1. What is the Purpose of this Enabler?

Our health and care workforce is a key enabler to ensure delivery of the BLMK ICB strategy to enable all residents to live more years in good health. The BLMK workforce strategy builds upon the work that has already started to tackle workforce pressures.

2. The Current Workforce Landscape in BLMK

The BLMK Provider Trust workforce shows an aging workforce with 4904 within 10 years of retirement. We have a predominately female workforce, making up 79% of the workforce profile. We have a decreasing trend in our rolling 12-month sickness rate, currently 4.31%. We have a voluntary turnover rate, currently at 14.91% and a decrease over the last 2 years in staff engagement scores.

Across the BLMK Provider Trusts, there are currently 25,345 WTE staff in post with the following composition:



We have a 12.37% vacancy rate, 2155 WTE. The highest vacancy levels (above 10%) are in the following roles:

- Additional Professional, Scientific and Technical – 21.5%
- Admin and Estates – 12.34%
- Allied Health Professionals – 12.11%
- Health care Scientists – 24.86%
- Nursing and Midwifery Registered staff – 14.22%

Primary Care

BLMK has 515 GPs in post (including trainees) and a further 40 vacant GP posts. There are 264 Practice Nurse roles, with circa 10% vacancy rate, with a further 254 direct patient care roles within practices (mostly healthcare assistants).

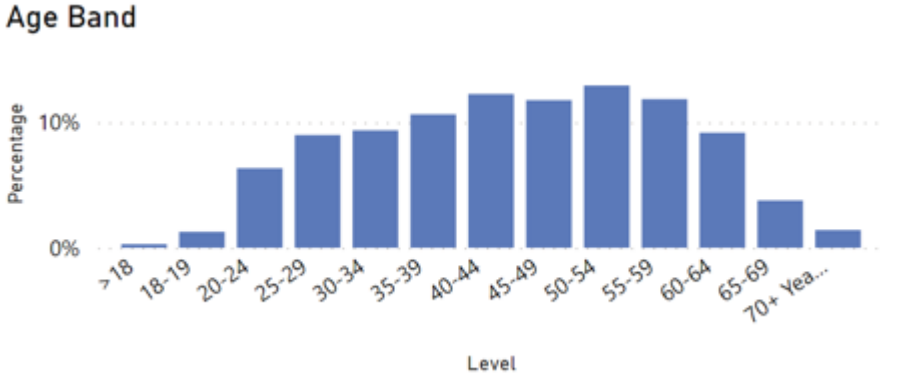
BLMK primary care networks have made good progress in recruiting to Additional Roles Reimbursement Scheme roles (ARRS – a range of multi-dicisplinary clinical roles bringing a range of expertise to the primary care team), with 354 in post to date.

The number of GPs working within BLMK is steadily increasing and we are seeing GPs move into BLMK from out of area to take up our New to Practice Programme. We are supporting nurse recruitment and retention through Legacy Nurse support, Senior Nurse Leadership development and International Recruitment in partnership with Cambridgeshire Community Services. Direct Patient Care roles and the multi-professional roles recruited at PCN level via the ARRS continue to increase significantly with our multi-professional clinical leads supporting with FCP supervision, Road Map navigation and peer support. Specific and bespoke local initiatives to grow, recruit and retain our workforce include;

- GP Recruitment Programme comprising of recruitment Master Classes, vacancy matching and GP Careers Fairs
- Clinical expansion programme, including growing the pool of Educators, Supervisors and Learning Organisations
- GP Fellowships – third year of Educator Fellowship attracting new GPs into Training Programme Director career pathway
- New to Practice Programme, New to Partnership Programme, Supporting Mentor Scheme, Flexible Pool Scheme (promoting the benefits of flexible working)
- Bespoke local initiatives to support our GP Educators and GP trainees including VTS away days bringing together 120 GP trainees
- 3 PCNs approved as Learning Organisations, 12 PCNs awarded funding to grow PCN Training Teams
- Digital Student Nurse placements expanding across BLMK into placements for other professions
- Student Pharmacist Summer Placements – year three expanding to 15 placement and leading across EOE
- Nursing Associate Apprenticeship Programme – 15 trainees in training
- Shine Project – 30 practices implementing innovative digital mental health programme improving health & wellbeing & retention of staff as well as improving patient access and care
- Bespoke 121 Health & Wellbeing & Organisational Development sessions at practice and PCN level

Social Care

The social care workforce in BLMK has a vacancy rate of 12.6%, with 2,000 vacancies and a turnover rate of 31%. Similarly to health partners, there is an aging workfcorce



Given the expected growth in the overall population in BLMK (with associated increase in demand for health and care provision), our workforce will need to grow whilst also transforming with new skill mixes, new roles, multi-disciplinary working models and portfolio careers to address the pending challenges.

Challenges

The summary workforce challenges for BLMK Partners' to deliver our Joint Forward Plan are:

- Low unemployment in some localities means that reducing vacancy rates and turnover in key workforce groups (care workers, administration) is a common strategic challenge across many BLMK partners
- Staff have experienced reduced opportunities for training and development during COVID; this together with the need to embed new ways of working is challenging in the current operating context
- We need to develop sustainable entry and career progression pathways into key workforce groups to encourage our population to choose careers in health and care
- We need to have targeted and innovative recruitment, development and retention strategies in place for professional roles where there are national workforce shortages (for example, qualified social workers, healthcare scientists)
- To deliver care sustainably within affordability of resources, all organisations face the challenge of reducing agency and locum workforce through effective reduction of vacancies in substantive posts

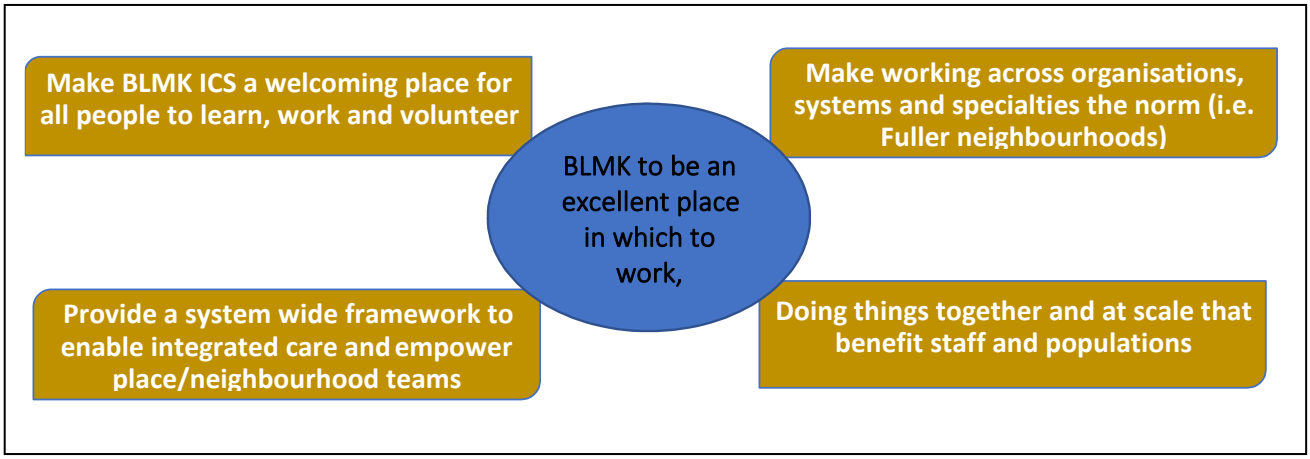
Opportunities

In addressing these challenges, there are opportunities to enable our staff to thrive and develop their careers, including;

- New roles and career pathways will be developed as new models of care to enable integrated neighbourhood working, and achieve the outcomes sought through the MHLDA collaborative plans, the strategic objectives to enable our children and young people to thrive, and our health services strategy
- Staff will be supported to work in multi-disciplinary teams that centre on residents' needs (and span traditional organisational silos) – this will improve resident outcomes and experience, and support greater staff satisfaction
- Primary Care Workforce will continue to diversify, expanding the number of multi-disciplinary teams functioning at practice & PCN level, with the largest growth in PCN roles via the Additional Role Reimbursement Scheme as well as increases in GP numbers.
- Population growth will support our Place-based actions to support our communities to thrive through increased employment opportunities
- Digital integration and technological solutions will support staff to provide joined-up care, and reduce duplication of effort

3. What does Good Look Like in BLMK?

Our BLMK People Strategy outlines our aims to develop and support our workforce in delivering our strategic aim for all residents to live more years of life in good health.



The BLMK People Strategy outlines a vision of an integrated workforce that delivers excellent personalised healthcare to the population of the ICS locality. We have adopted an integrated approach to workforce across our NHS Trusts, Primary Care, Social Care and voluntary sector organisations, working closely with finance and performance to ensure workforce plans are realistic, triangulated, and fundamentally aligned.

1- Make BLMK ICS a welcoming place for all people to learn, work and volunteer. We will do this by reducing health inequalities in staff experience across health and care, creating clear and diverse career pathways, recruiting diverse candidates, improving workforce flexibility and wellbeing, improving inclusivity, and increasing understanding of our workforce.

2 - Make working across organisations, systems, and specialities the norm. We will do this by embedding system values in leadership training, making CPD activities team-based (not organisation-based), improving OD capacity and co-production for transformation, and creating new roles, placements and apprenticeships across health and care.

3 - Provide a system-wide framework to enable integrated care and empower place and neighbourhood teams. We will do this by reducing barriers to integration by introducing digital staff passports, facilitating cross-organisational recognition of statutory/mandatory training and CPD, facilitating temporary staffing and role profiles, and producing guidance on MDT set-up and management.

4 - Doing things together and at scale that benefit staff and populations. We will make best use of international recruitment, integrated workforce planning, Robotic Process Automation (RPA), careers outreach and attraction to the system, talent management, sustainability, workforce transformation, and creating new apprenticeship and degree pathways to support the new ways of working and creation of new roles.

Staff will operate under a 'One Workforce' approach that will enable place and neighbourhood multidisciplinary teams, which will comprise staff from multiple organisations. Staff will have careers that span both health and social care, and in so doing, will gain a broad understanding of how we can work differently as a system to deliver integrated services.

The ICS will act as a framework to enable place-based and organisation/provider-level action in bringing about a flexible and integrated workforce, by means of:

- Digital Staff passport arrangements between healthcare and social care organisations to enable a mobile and agile workforce that is able to move around the system effectively with minimal cost offering additional opportunities for talent development supported by effective processes that enable this to happen
- Utilising digital solutions for information sharing.

- Organisational Development support and guidance to support the establishment of multidisciplinary teams. Ensure effective education and training programmes are in place to deliver future models of care, new roles, and new apprenticeships
- Support place-based recruitment and attraction initiatives maximising our opportunity as Anchor Institutions to support the local population into employment and the associated impact on the wider determinants of health.
- Develop the BLMK system value proposition and place-based value propositions to ensure we can attract and retain the workforce
- Create a strong climate and culture, reflective of the differing wants of our different generations within our organisations
- Ensure accurate and relevant workforce information across health and care, using this information and intelligence to support and make informed choices in workforce transformation and redesign.
- Undertake and develop effective workforce planning to support new models of care, and support transformation and redesign where we have hard to recruit roles
- Develop a workforce planning function, which will provide the evidence base for directing investment in transformation activity that meets the need of integrated services and the new models of care enabling us to understand the impact of service redesign on our workforce
- Integrating workforce planning with population health management to create a system-wide, shared approach to workforce planning derived from a single workforce data set
- Integrate workforce planning with population demographics and planned growth to ensure we reflect changes to services and the workforce required to deliver these.

4. Delivering the BLMK People Strategy

Mobilisation

The key mobilisation actions to deliver the BLMK People Strategy will be completed during 2023-4. These are:

	Collaborative Workforce Action	Delivery by:
1.	Integrate social care workforce into pan-ICB workforce planning & monitoring	December 2023
2.	Map pan-BLMK workforce data against updated population growth modelling and indicative service growth pressures	March 2024
3.	Deliver shared international recruitment target for nursing	December 2023
4.	Deliver shared international recruitment target for social workers	March 2024

The purpose of these mobilising actions are:

- To provide a single line of sight across health and care workforce, enabling collaborative workforce planning, role development and evaluation / benefits of actions taken to be measured
- To address immediate shared and stubborn workforce challenges that can be addressed at scale

By March 2024, the following wider mobilisation actions to deliver the BLMK Joint Forward Plan will be completed:

- Population growth and demographic changes will have been re-modelled based on projected housing growth in each Borough in BLMK
- BLMK Infrastructure strategy will be completed – this will inform / be informed by population growth and associated growth in health demand
- Health Services Strategy methodology confirmed, and first end-to-end clinical pathway reviews completed.
- The detailed delivery plans for years 2-5 of the High Impact Programmes (including impact / outcome metrics) will be completed. This will inform workforce planning to develop new roles and workforce projections to deliver new models of care outlined in the High Impact Programmes

5. Interdependencies with the BLMK High Impact Programmes

The BLMK People Strategy is a key enabler in every one of the BLMK High Impact Programmes, reflecting the nature of health and care provision. However, there are key dependencies with specific programmes:

High Impact Programme	Key Deliverables
Advancing Equity & Equality	• Workforce delivery of key improving health outcomes / tackling inequalities programmes, such as Maternity • Embedding Quality Improvement methodology across teams •
Efficiency & Effectiveness Programme	• Utilisation of technology to enable smarter working, such as robotic programme automation • Productivity programmes based on national best practice, for example Getting It Right First Time (GIRFT)
Enabling our Children & Young People to Thrive	• Developing recovery-focused models of care for our children and young people with the most complex needs
Improving Access & Treatment	• New roles and ways of working arising from clinical innovation and integrated pathway redesign

High Impact Programme	Key Deliverables
Improving Outcomes for MHLDA	• Delivery of mental health investment standards to increase clinical capacity in context of rising demand • New roles arising from enhanced pathways of care, for example community crisis and recovery, reducing out of area placements for people with very complex needs
Integrated Neighbourhood Working	• Ongoing delivery of integrated neighbourhood teams • Development of primary care roles and capacity
Intelligence-led Quality, Performance, Outcomes and Inequalities Improvement	• Embedding co-production as a core quality improvement tool across teams
ICB Target Operating Model	• Implementation of ICB target operating model 2023-5
Thriving Ecosystems & Prosperous Communities	• Embracing opportunities for Anchor Institute actions across organisations at Place, i.e., supporting those furthest away from employment into training and employment

3.6 Co-Production

1. What is the purpose of this Enabler?

We are ambitious for the people who live in Bedfordshire, Luton and Milton Keynes. We want everyone in our city, towns, villages and communities to live longer lives in good health and we know that working with and empowering local people is central to helping us achieve that.

Our population is culturally diverse – there are more than 100 different languages spoken in just one of our towns. The people that live in our four local authority areas come from a range of different backgrounds and ethnicities, making ours one of the most vibrant areas in the country.

To deliver these priorities for local people, in the context of the challenges we face it has never been more important to refresh how we engage so that we can break down barriers, improve access, support local people to make healthy life choices and work together to shape the health and care services that residents need now, and in the decade ahead. Our strategy is focused on delivering this through a range of approaches including co-production, consultation, engagement and continuous conversations with residents.

Engaging for the future

We know from our work during the Covid pandemic and through co-production we have undertaken with residents and service users that working in partnership with local councils, Healthwatch, the VCSE and residents delivers greater results than working alone.

If we are serious about helping people to live longer, healthier lives, we need to listen to what local people need and work together to design solutions to health and care and break down the barriers to good health that people face.

Prior to the establishment of the Bedfordshire, Luton and Milton Keynes Health and Care Partnership, all partners worked independently, engaging with and co-producing with residents and service users on a range of service changes. There was little alignment in in policy, processing or decision making and insights from residents were not shared extensively with partners, leading to engagement fatigue amongst those whose opinions were regularly sought.

The pandemic highlighted that seldom asked groups had started to disengage from the system, which was deepening health inequalities and the agencies best placed to engage with these communities, as trusted advocates including Healthwatch and the VCSE were insufficiently funded, did not have the resource to support our work and were not integral to the planning process.

This means that insights from residents did not always reach decision makers or effect meaningful change.

Following the establishment of the Integrated Care Partnership and a programme of extensive engagement with partners and consultation, engagement and co-production leads from local authorities and NHS organisations, steps have been taken to redress this balance and a new Working with People and Communities strategy was published in November 2022, which set out a new approach to working with residents.

This has led to the development of closer working relationships with elected members of local authorities and MPs as well as Foundation Trust Governors and Non-Executive Members. It has also seen the development of a new root and branch review into health inequalities, led by Reverend Lloyd Denny from Luton and the alignment of policies and processes to create a new

co-production framework for all health and care partners in Bedfordshire, Luton and Milton Keynes.

2. The current landscape in BLMK

The Integrated Care Board is required by law to involve local people in decision making in the development of health and care services, in accordance with Section 14Z44 of the Health and Care Act, 2022.

Following publication of the Working with People and Communities strategy, the ICB has been working to discharge this duty by:

- **Establishing a system wide engagement forum** designed to bring together co-production and engagement leads from across the system to share insights and develop a new framework for co-production to ensure there is consistency across our area.

- **Focusing on continuous conversations** to ensure that resident voices are included in decision making. While our ambition is to co-produce with residents, there are times when co-production in its truest sense is not possible and consultation, engagement or co-design might be more appropriate. We have adopted the ladder of participation and are working with partners to ensure we're clear with residents and service users how we will engage so that we can build trust and participants understand how their feedback is influencing decision making.

- **Embedding a culture of co-production** by working with the Consultation Institute to deliver a programme of training for those involved in designing health and care services locally. More than 300 people, including the Board of the ICB have received training in co-production and are working to embed a culture of co-production across the system. A series of webinars and community of practice events have also been established to share best practice and insights from across the area.

- **Putting involvement at the centre of our constitution and governance processes** by establishing a Working with People and Communities policy which sits at the centre of our constitution and created a formal sub-committee of the ICB to scrutinise and provide guidance on all involvement work, to provide assurance to the Board.

- **Engaging Healthwatch and the VCSE** in discussions to create strategic partnerships to support advocacy and engagement with local people.

While good progress has been made in delivering objectives for year one, there have been some key challenges to overcome, including establishing new working relationships with Healthwatch and the VCSE to facilitate closer engagement with local communities. Scarce resources and a lack of funding to support our work has meant that working at pace to deliver change has been challenging.

Uncertainty over funding for strategic partners and a lack of a policy to remunerate participants for co-production, in line with the policies of some other NHS Trusts in the system has also created barriers to progress in the first year of operation.

Despite these challenges however, there is a coalition of willing partners committed to delivering change locally and there is an opportunity through the Denny Review into health inequalities and

the Working with People and Communities strategy to work differently. Listening to insights from seldom asked people through trusted advocates and developing a participation and co-production network across the system to support the new approach to involving residents in decision making.

What have we achieved?

Since establishing the Working with People and Communities strategy, we have worked hard to establish strategic partnerships and re-engage with people who have lost trust with health and care services.

In November, we held a workshop with health and care professionals, Healthwatch, the VCSE and residents to listen to the experience's children, young people and their families had experienced of health and care in our area.

One of the key findings to come from the workshop was that some transgender and non-binary young people had experienced unconscious bias in health and care settings, which had created a barrier to them accessing care. This experience was also shared as part of findings from the Denny Review into health inequalities, where people referenced adverse experiences in both primary and emergency care which had led them to disengage, often resulting in poor health outcomes.

To respond to this, we have worked with partners in East London Foundation Trust (ELFT) and Rainbow Bedfordshire to design and deliver a series of transgender workshops aimed at health and care professionals to help them better understand the needs of transgender people, so that we can remove barriers to good health for transgender and non-binary people.

This has been well received by participants and has been requested as a training course for primary care Protected Learning Time events.

In addition, following engagement with deaf people in Bedford Borough in February, we have also established training for primary care practitioners to help them better support deaf patients coming into their practice. New software called 'Recite me' has also been applied to the BLMK Health and Care Partnership website to support deaf people in accessing information about services in their area.

3. What does good look like?

Bedfordshire, Luton and Milton Keynes are fortunate to have many examples of good practice of co-production within its partnership, and in the last twelve months, we have worked with colleagues in Wigan and Islington to learn from best practice and how councils are working to co-produce with their communities to deliver their 'deals' and 'Fairness Charters'.

Closer to home, the 'Talk, Listen, Change' work undertaken by Luton Council and the University of Bedfordshire has led to the development of a Fairness Charter being established in the town where residents, councillors, officers and VCSE organisations meet regularly to discuss how they can work together to make Luton a fairer town and help residents thrive.

This methodology has been applied to the Denny Review into health inequalities, which is considered best practice by NHS England nationally. The review, which includes representatives from across the system has commissioned a literature review form the University of Sheffield, which pulled together data on the health inequalities experienced by residents and highlighted those who experienced the greatest inequalities in four places.

This has been followed up with an engagement exercise led by Healthwatch and the VCSE to gather insights from seldom asked communities including Gypsy, Roma Traveller, homeless people, people from ethnic minorities that live in deprived communities, people who experience sexual violence including forced marriage, LGBTQ people and people with physical and learning disabilities. This exercise has generated significant insights which will be incorporated into our Joint Forward Plan and shared with partners and the Board in June, together with a series of recommendations that we can take forward to make a difference to the experience people face when accessing health and care in our area.

The Local Maternity Services co-production team in BLMK is also a great example of best practice. Following feedback from women who had experienced sexual violence and abuse, discussions on consent during pregnancy and birth were discussed with health and care professionals and new working practices were adopted across the system before being rolled out across the Eastern region and then country wide.

Measuring feedback

Measuring the success of the working with people and communities' strategy could take some time, as new working practices are embedded, and participants can see their influence shaping decisions. However, in our first year of operation, we have established a sentiment benchmarking survey to monitor perceptions of residents and stakeholders and set a baseline from which we can track perceptions and measure improvement annually.

The survey will ask residents and stakeholders their experience of co-producing locally and whether they feel their involvement has effected change in their area.

In addition to monitoring performance formally through the sentiment survey and baselining exercise, we are also working with strategic partners including Healthwatch, VCSE, residents and elected members to listen to feedback on the work we're doing and build on approaches. This has received support in meetings including support from elected members that are members of the Integrated Care Partnership Joint Committee.

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

The Working with People and Communities Strategy and Implementation Plan for year one was approved and was delivered in 2022/23, as below.

Description	Implementation	Outcome
Source new infrastructure for the development of a system wide insight bank	April 2023	We tested the market for new infrastructure, but current models did not deliver to the specification required or provide value for money. We will review in 2023/4.
Embed working with people and communities into the ICB's constitution and governance.	July 2022	Working with people and communities' policy established in constitution Working with people and communities committee established and embedded.
Embed co-production across the system by creating new engagement forum, rolling out training	April 2023	Training has been rolled out to more than 300 people across the system. A community of practice has been established which is driving shared

Description	Implementation	Outcome
and establishing a community of practice		policy making around participation and remuneration. Best practice webinars are held bi-monthly.
Build a network of trusted people to support engagement by developing a Memorandum of Understanding with VCSE and Healthwatch partners.	June 2023	An MOU has been agreed with the VCSE and we are currently developing an MOU with Healthwatch.
Engage in a continuous conversation with residents by undertaking extensive community engagement.	July 2023	Extensive engagement has been undertaken with seldom asked residents as part of the Denny Review into health inequalities. Engagement has also taken place with people from the D/deaf community and victims of abuse. A summer engagement programme is scheduled to begin in May and will run until October.
Establish community connectors	July 2023	Work is underway. We have established community connectors as part of the cancer alliance, Roma Community, LGBTQ people in Luton and homeless people via the YMCA in Milton Keynes.

Going forward, work needs to be undertaken to determine the implementation plan for year two of the working with people and communities' strategy. Engagement work with partners and residents has started to inform this plan with areas for consideration including:

- The development of a system wide participation network of lived experience
- Development work with system wide information governance and finance leads.
- Co-production with communities around key transformation programmes including Denny Review II and Fuller neighbourhoods.

Further engagement work to inform the Joint Forward Plan and the Operational Plan will be undertaken from May – October 2023 and give local people from different backgrounds and communities the opportunity to discuss the things that are most important to them.

Interdependencies for this Enabler	High Impact Programmes	Key stakeholders
Place Plans	• Integrated Neighbourhood Working • Enabling our Children & Young People to Thrive • Improving Outcomes for MHLDA	• Residents • VCSE • Place Partners • MHLDA provider collaborative
Inequalities programmes	• Advancing Equity & Equality, including Maternity programme	• Residents • VCSE •
Health services strategy	• Improving Access & Treatment	• NHS Providers • Residents • VCSE • Population Health Intelligence Unit •
Digital and population health management strategy & investment	• Intelligence-led quality, Performance, Outcomes & Inequalities Improvement	• Residents • VCSE • Local authority, NHS partners and wider public sector • Population Health Intelligence Unit
Staff training in co-production	• ICB Target Operating Model • BLMK People Plan	• Residents • VCSE • ICB • Local authority, NHS partners and wider public sector

3.7 Digital Integration, Business Intelligence & the Population Health Intelligence Unit

1. What is the Purpose of this Enabler?

There are key themes that repeat across the BLMK Joint Forward Plan and its High Impact Programmes that this Enabler is crucial in addressing. These include:

- **Focus on population health**, and our responsibility as ICB partners to improve health outcomes and tackle inequalities as 2 of our 4 core responsibilities as an ICB
- The need to better integrate data and provide technology to our teams to enable them to work more effectively across organisations to **provide joined up care to our residents**, and manage need and demand within constrained resources
- **Our commitment as a learning ICB** – using quality improvement methodology to evaluate, adjust and retest our improvement actions to maximise the benefit to our residents

These require fully connected digital solutions to generate an intelligence-led partnership across health, care and civic functions, with the level of analytic capability to measure and evaluate the impact of our actions on the health and well-being of specific communities across BLMK.

This approach is core to improving health outcomes and tackling inequalities – it shifts our peer- and self- assurance from considering impact in the round (the average experience of those who did access our services) to a position of challenging ourselves whether we are effective in supporting ALL our residents and their communities to thrive.

The 3 inter-related partnership components in this enabler to achieve our ICB strategic ambitions are:

1. Data connectivity and digital maturity across Partners
2. Population health management accessible and owned at Neighbourhood and Place
3. Business intelligence and analytics capability and capacity to inform and evaluate the impact of our High Impact Programmes

2. The Current Landscape in BLMK

There is a mixture of good progress, clear funded deliverables, and currently unmitigated residual risk in BLMK in our implementation of these 3 objectives.

Collaboration across health and Borough partners to integrate our care and treatment records and develop population health management has consistently been proactive over recent years. This means that BLMK is in a good position to achieve many of our objectives in this Enabler by 2025. This includes:

- Digital connectivity with each of our 4 Boroughs to create a shared ‘view’ of care and treatment plans for residents
- Joint procurement of a shared data platform to integrate and automate much of this connectivity to support Neighbourhoods and Places to deliver joined up care
- Bringing together our Public Health functions with our NHS population health management capability to create a single Population Health Intelligence Unit to drive our programmes to tackle inequalities and improve health outcomes across all our communities

- Re-scoping our NHS performance reporting to consider population health as well as performance for residents who have accessed healthcare:
    - Local feedback loops to identify under- and over-referrals to secondary care to inform local pathway improvement actions and improve access for residents who experience the most barriers
    - Use of quality improvement methodology and reporting to highlight evidence-based and statistically sound trends in need / demand and performance / outcomes across our Places
    - Provide more frequent and better automated reporting to teams on their delivery against evidence-based standards (for example, Getting It Right First Time, Sentinel Audit, Cancer prevalence and outcomes reporting)

- Engage with national partners such as NHS England in its development of the Foundry, the Office of National Statistics and NHS Benchmarking to influence future data analysis and reporting to inform health services strategy, for example delegation of specialised commissioning

However, there are immediate areas of moderate to significant risk in this field, including:

- **Digital Maturity** - Bedfordshire Hospitals NHSFT's plan to deliver increased digital maturity through the creation of this Trust across 2 sites has been significantly delayed and hampered by COVID. This means that the Trust is almost at level 3 of HIMSS digital maturity (Healthcare Information and Management Systems Society benchmarking), with plans to reach level 5 by 2025. This has a current and anticipated impact to residents and teams on integrating digital records to support integrated care across settings. All other NHS Trusts in BLMK are at level 5 or 6, with Milton Keynes Universities Hospital NHSFT nearly at HIMSS level 6.

- **Access to Capital** – capital funding to progress digital requirements in the NHS is piece-meal and short-term. There is also a significant gap in capital funding for primary care to embed required technology improvements, for example telephony, which are adversely impacting areas such as patient access.

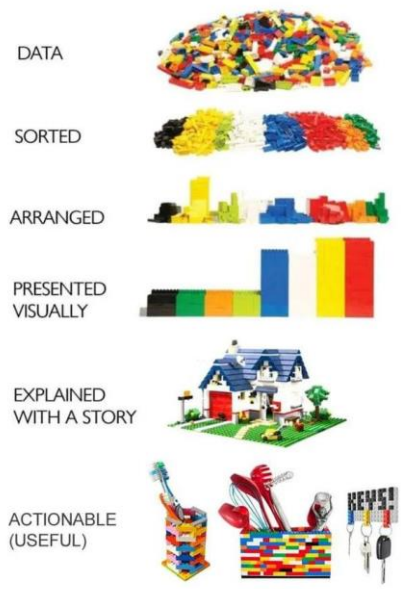
- **Analytics capability and capacity** – the current provider of business intelligence / analytics for the NHS in BLMK currently works to a 'commissioner' specification of analytics and reporting. This current contract is due to expire in June 2024. Work is underway to specify the future requirements for business intelligence for the NHS; how best to integrate with population health management / public health analytics where appropriate, and what is the cost-effective delivery of this service (including enhanced analytics capability) in the context of all ICBs' requirement to reduce running costs by 30%

- **Productivity and Effectiveness Challenge** – linked to the affordability risk above, there is insufficient capacity and revenue funding to systematically introduce digital innovation across existing software, for example robotic process automation. This limits the benefits of digital advances in reducing duplication of effort for our teams and leaves residual risk of manual transcribing across our patient / client electronic records.

3. What does Good Look Like in BLMK?

The challenge for partners of the BLMK ICB is how we translate the morass of data we individually collect to inform care and treatment to our residents into intelligence that can help us to improve health outcomes and tackle inequalities, as well as improve the effectiveness of our pathways to offer best value to the taxpayer.

A visual representation of this is depicted below:



This illustration highlights the challenges we need to address:

- Secure data connectivity (reduce duplicate and separate data sets)
- Software platforms that can draw data from original sources and arrange it in ways that give us insight
- The need to data to be understood in context (data quality and meaning of the data)
- Linked information at a resident-specific level to provide a single, integrated view of the person's relevant care and treatment to aid clinical decision-making, and reduce the number of times a resident has to repeat their story
- Robust and agreed analytics to provide intelligence and insight into what improvements we need to make to improve health outcomes and tackle inequalities
- Agreed metrics based on health population (not existing access to healthcare) to measure the impact of our improvement actions

a. Data and Digital Connectivity

The partners of BLMK we have a vision to use data and digital technologies to help inform service led transformation, to monitor and track codesigned health and care pathways and monitor outcomes to refine interventions and engagement with our residents where possible.

Data powers effective decisions at every stage of care which needs to remain personal to the resident.

Decision-making should happen as close to the resident as possible

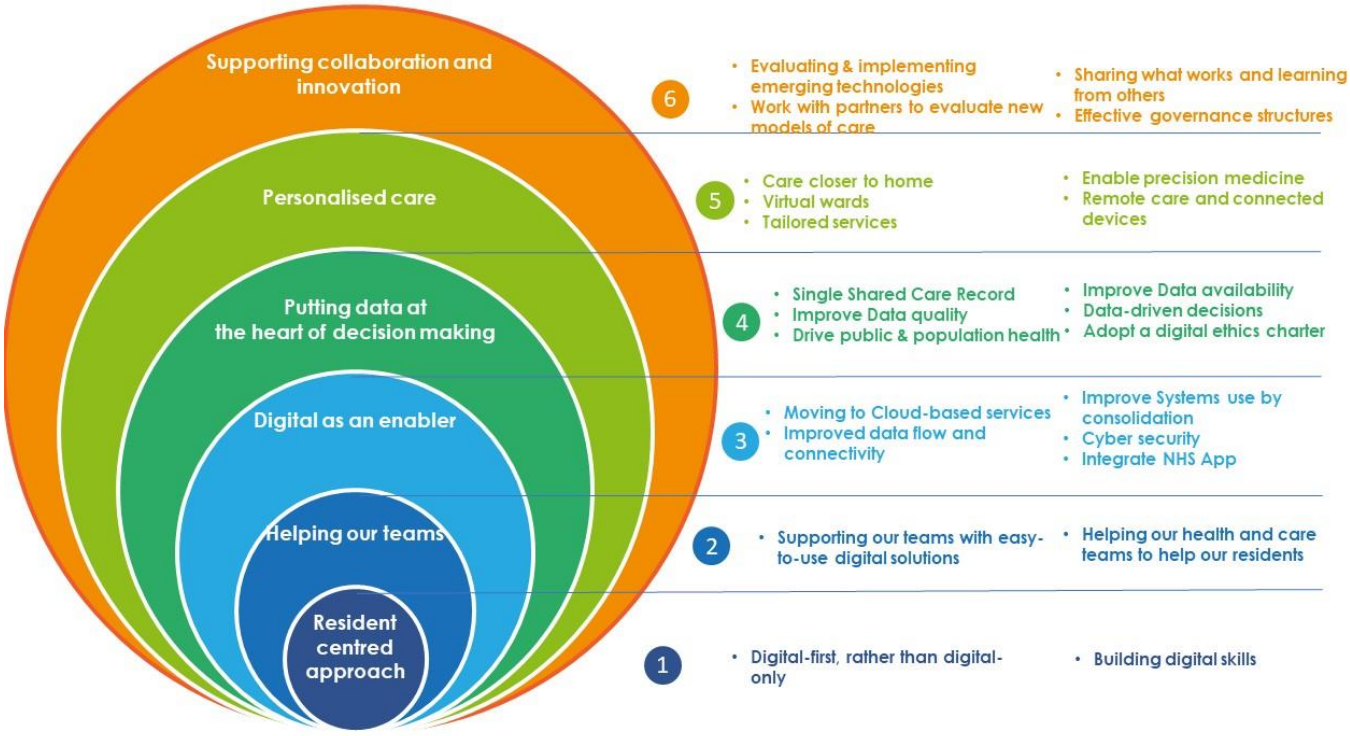
Access to the residents own health and care data helps to inform their lifestyle choices

Residents must be empowered to manage their own self-care by having access to their data

Data should be seen as a key enabler to support the reduction of inequality

This requires all the partners to be part of the same digital vision, and our journey started in 2020 with the delivery of a full System population health management strategy, followed by the data strategy in 2021, our digital strategy in 2022. We are now working towards the development of a 'single version of the truth' in 2023 where all relevant data is secured, curated and made available as appropriate.

For this vision to be realised, we must have joined-up and secure access to all our relevant data and ensure we have the correct quality controls in place for this to be the basis of our decisions. Our System partners are developing our data ethics policy to assure the residents we serve on how data is being used for their benefit.



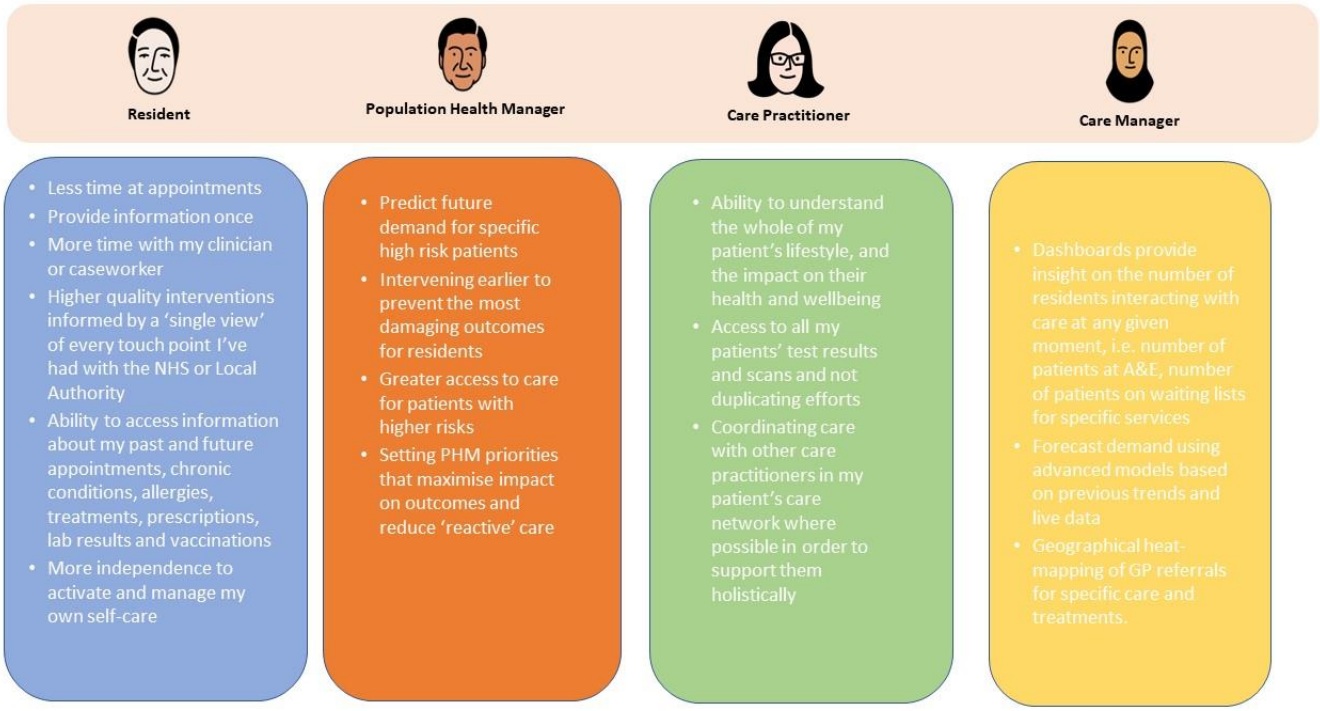
Our Digital Future

Our digital plans have been co-designed with partners and approved in 2022. This sets a clear roadmap for everyone into a digital era by the adoption of strong standards that enabled seamless integration though adoption of cloud-based technologies.

As highlighted, data is a key component of this Digital Strategy. With all the System partners we have deliberately aligned our digital and data strategies, which are available here: https://blmkhealthandcarepartnership.org/our-priorities/data-and-digital/

As the Digital Strategy evolves in the coming years, we will ensure that the data strategy alignment remains intact thereby preserving the ability for data and digital technologies to meet the needs of our residents and partners.

This means that the same, secure data (held by owner organisations) can be used in multiple ways to improve residents' experience of integrated care and treatment:



Our vision is to design a system which utilises and, links near real time data, analytics, and insights by building multi-disciplinary, cross-organisational intelligence functions that provide an actionable intelligence approach to insights to inform care design and delivery.

Our intelligence function is paramount in transformation of service design, providing timely and robust evidence, and routinely equipping teams with intelligence that drives improvements in performance. The intelligence function will pull and link data intelligence from across new, traditional organisational and contractual boundaries to progressively provide both qualitative and quantitative insights. These insights will be to be multi-dimensional, providing clinical, performance and financial intelligent intelligence, as well as contextual information on the wider determinants (or 'building blocks') of health, the demographics and the health outcomes of our communities.

These insights will be provided at the most appropriate geographical level, be that system, place, ward, neighbourhood, or provider catchment at place, ward, pathway. Variation and inequity will be highlighted. This journey has commenced utilising longitudinal datasets (including primary, secondary, mental health, social care, VCSE's, police and community data) to enable population segmentation, risk stratification and population health management (PHM).

b. Population Health Management

Population Health Management (PHM) involves using data to design new models of proactive care and deliver improvements in health and wellbeing whilst make the best use of the collective resources of the Integrated Care System. PHM starts by using shared data to identify a group of people with shared characteristics, who could benefit from more proactive or joined-up support, and then co-designing an intervention to meet their needs. The focus of PHM often involves targeting resources at individuals and population groups who typically experience poorer health outcomes or are under-served by the health and care system. Testing interventions, measuring their impact and then acting on the learning is crucial to the success of PHM.

BMLK ICS has a well-established multi-agency collaborative group that oversees the development and implementation of PHM, and the ICS has invested £2m in setting-up place-based PHM work programmes. Integrated Care Systems have been encouraged to plan PHM development in terms of the 'infrastructure', 'intelligence', 'interventions' and 'incentives'. BLMK progress is set out in those terms below.

BLMK has the leadership, governance and information governance **infrastructure** in place to oversee and enable PHM activities. Linked data is available through the AGEM GEMIMA platform, including acute hospital, primary care, community and mental health and social care.

Data Analytics and 'Super-user' Groups oversee the development of new population health **intelligence** products and PHM tools, which have included risk stratification and population segmentation tools and an interactive health inequalities dashboard.

A range of PHM **interventions** are being developed in BLMK. Primary Care Networks in Bedford Borough are using a Diabetes Warning & Alerts tool to identify patients and improve their care, whilst linked data has enabled detailed population profiles to be developed for neighbourhoods in Milton Keynes and Central Bedfordshire. In Luton the Council is linking data from across the local authority and health to improve outcomes for people with severe mental illness.

The enthusiasm and engagement of professionals and communities is necessary for PHM but not sufficient. Resources like time and money are scarce so it is important where possible to align the system **incentives** to encourage and support PHM initiatives. In Bedford Borough for example, Primary Care Networks (PCNs) were critical to the identification and invitation of residents who were eligible for a 'Warm and Well Assessment'. The pathway was co-designed with PCN leads, and as a result steps were taken to minimise the administrative burden on primary care – completing tasks centrally where possible and reimbursing GP practices for their time.

The next steps for the BLMK PHM Collaborative include: (1) ensuring that existing PHM tools and approaches are being used as widely and as effectively as possible; (2) to work with system and place leads to ensure that PHM is being used to address the issues that matter most to our residents and our ICS partners; (3) to ensure that the PHM strategy is aligned to and supporting a range of clinical transformation programmes, as well as prevention, health inequalities and sustainability; and finally (4) to ensure that PHM functionality is a key consideration in the development of the ICS Strategic Data Platform.

c. Performance Reporting

The core focus of our Integrated Care System is on working with partners to transform health outcomes for our population. We understand that this necessitates additional ways of measuring and monitoring our performance in addition to the traditional ways in which NHS performance is already currently managed.

Because so much of what impacts an individual's health is outside of the direct control of the health system – and in the gift of our partner organisations – we have been working, through the Improving Performance Task and Finish Group, to design a new way of measuring our performance that better tells us how the work we are doing as a system is making a difference for our residents.

The Framework we are developing, based on the ONS Health Index, reflects both health and non-health policy related indicators that affect the health of us all and our Places.

There are three categories:

- **Healthy People** – this covers core health outcomes like mortality, and the impact of physical and mental health conditions.

- **Healthy Lives** - this covers risk factors for health that relate directly to individuals< and social factors that cannot always be controlled by individuals but affect the population at the individual level.

- **Healthy Places** – this includes social and environmental risk factors that affect the population at a collective level. They often cannot be addressed solely at the individual level.

We will be working closely with partners and expert colleagues to develop this work during 2023/24, including areas such as data frequency and presentation, and look forward to onward collaborating with ONS to develop this.

Our aim is that it will provide us with insight at Neighbourhood, Place and pan-BLMK ICB to understand the impact to residents' health and well-being of the High Impact Programmes of our Joint Forward Plan.

4. Interdependencies with our High Impact Programmes

This Enabler is crucial to all our High Impact Programmes, and its importance in helping the BLMK ICB partners to deliver the '4 pillars' of our ICB responsibilities (improve health outcomes, tackle inequalities, offer good value for money to the taxpayer, and support local growth) cannot be over-stated.

Consistent and medium-term access to capital and project revenue costs to deliver this at scale is crucial to achieving our aims to enable all our communities to thrive.

3.8 Inequalities

1. What is the Purpose of this Enabler?

The Boroughs in BLMK – Bedford Borough, Central Bedfordshire, Luton and Milton Keynes are some of the fastest growing in the UK. We have diverse populations, and each Borough has strong plans to grow local economies, build housing and support our communities to thrive.

We also have some of the starkest inequalities in this country. Too many of our children live in poverty, and we know that our most deprived populations are experiencing the greatest challenges in accessing healthcare, and poorer health outcomes than the national average.

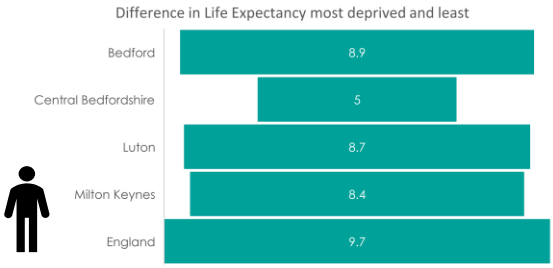
All ICBs have a fundamental duty to improve health outcomes and tackle inequalities. In BLMK, our Integrated Health and Care Partnership Strategy is centred on one over-arching and audacious goal – to improve the years lived in good health for ALL our residents.

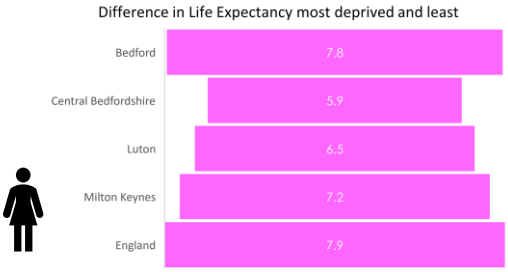
This Enabler sets out the approach we are taking to ensure that:

- We have dedicated and population-centred actions in each of our Places to tackle the inequalities experienced by residents
- We co-produce our efforts to positively impact the wider determinants of health in partnership with residents and our voluntary sector partners ('doing with', not 'doing to')
- We make use of data-intelligence to understand the needs of our population; and to measure the impact of our actions to improve residents' health & well-being
- We equip our teams with quality improvement tools and access to integrated data to enable them to lead local improvement

2. Current Landscape in BLMK

The variation in health outcomes and inequalities experienced across our population can be seen in the variation in life expectancy across our Boroughs;





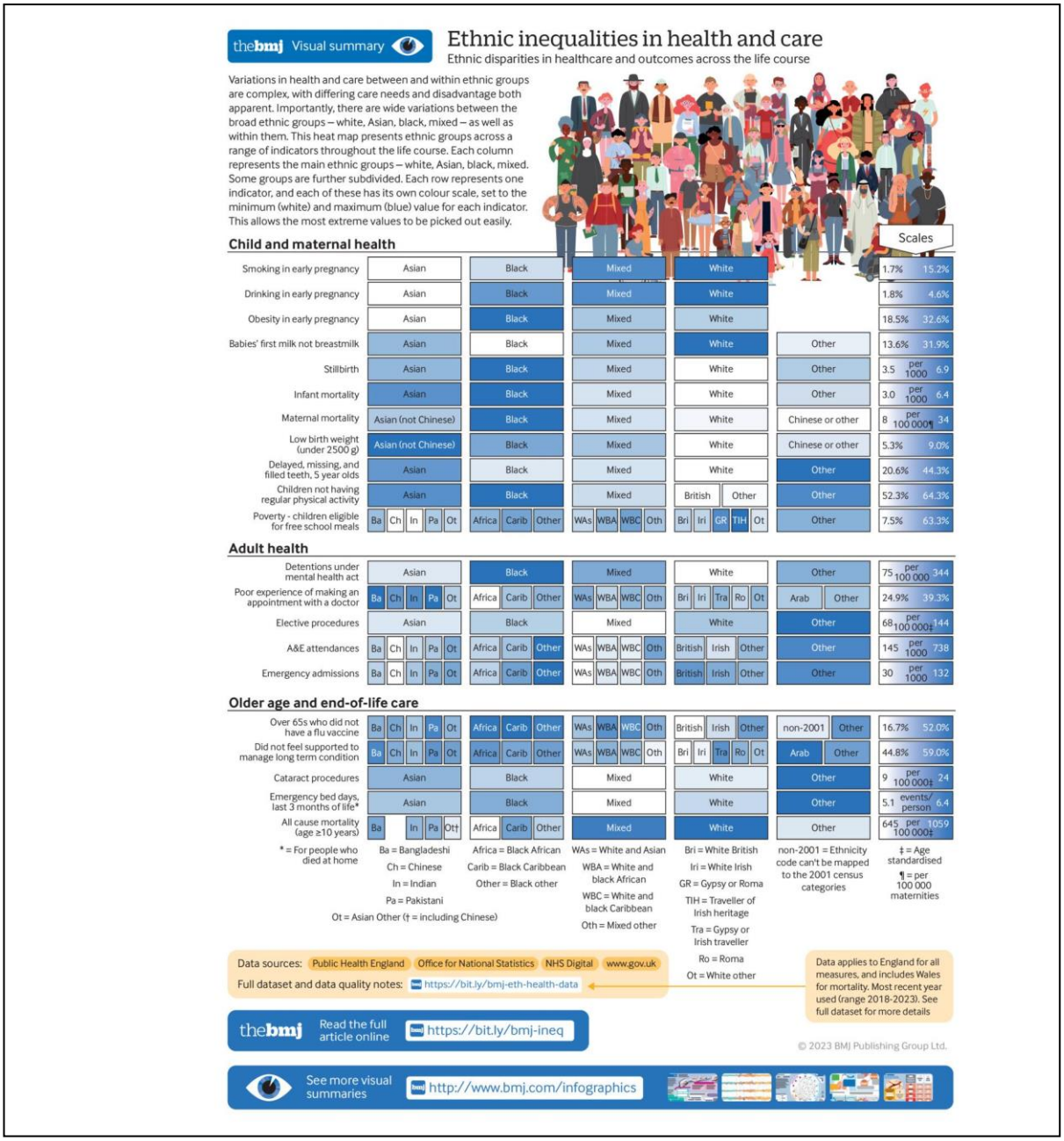
Data shows that people who experience health inequalities are more likely to need help and support from health services as their conditions become more complex. Breaking down barriers to access and removing health inequalities has the potential to prevent poor health, help people live longer lives in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

Across BLMK we know that:

- There are more low birth weight babies than the England average
- Uptake of childhood vaccinations is low, and falling
- We have variation in uptake to screening linked to deprivation

- People with learning disabilities & / or autism are less likely to attend for screening, wait longer for treatment, & are likely to die up to 14 years earlier than their peers
- Referrals to mental health services have increased since COVID, especially for children and young people
- The number of people registered as carers has doubled since 2019

Across the diversity of our population in BLMK, we also recognise the variation in access to health experienced by people of different ethnicities. COVID has laid stark the inter-dependencies between life disadvantages and ethnicity in this country; the health consequences are severe, as depicted in the graphic below from the British Medical Journal;



Based on their Joint Strategic Needs assessments and their Health and Well-being Strategies, each of our Boroughs have priorities identified in the Place Plans to tackle key inequalities experienced by their local communities:

- **Luton** is a Marmot town, with an overarching aim to eradicate poverty across its communities by 2040
- **Milton Keynes** health organisations have formed a collaborative called Milton Keynes together – its first priorities to address in collaboration are obesity, children with complex needs, urgent and emergency care flow, and children and young people's emotional well-being
- **Central Bedfordshire** has 6 priorities in its Place Plans – primary care access, improving early cancer diagnoses and outcomes, health checks for people (all ages) with severe mental illness, learning disabilities and / or autism spectrum disorders, improving emotional well-being in children and young people, prevention and rehabilitation in neighbourhoods, reducing excess weight
- **Bedford Borough** has 3 priorities in its Place Plans – primary care access, improving emotional well-being in children and young people, reducing obesity (all ages)

The Denny Review

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

We propose to allocate health inequalities funding to deliver recommendations set out within the report and costs associated with communicating the findings in line with the feedback we have heard from the report – for instance using video, translations, accessible documents to communicate how we are implementing feedback from people and communities.

The Denny Review has made several recommendations, which include:

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

More information on the Denny Review can be found at the end of this chapter.

The ICB has (through Health Education England funding) awarded £3million to University of Bedfordshire to develop our shared Research & Innovation Hub, focusing on tackling inequalities and developing our workforce.

3. What does Good Look Like?

Working with the Institute of Healthcare Improvement (IHI)

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

A partnership has been developed to build capacity and expertise to support BLMK's improvement journey. Working with the Institute for Healthcare Improvement will provide BLMK ICS with valuable expertise, resources, and a collaborative platform to address inequalities in

healthcare effectively. By leveraging the IHI's knowledge and methodologies, BLMK ICS can make significant strides in improving health equity and enhancing the well-being of their population.

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

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

Mental Health and Maternity programmes

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

4. Delivery & Implementation

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

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

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

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

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

5. Interdependencies across the BLMK Joint Forward Plan

BLMK High Impact Programmes

BLMK High Impact Programmes	Key Objectives that tackle Inequalities
Enabling our Children and Young People to Thrive	• Innovation in models of care to maximise prevention and early interventions to support children to thrive • Use of digital technology to enable independence for children and young people with long term conditions • Innovation to support children and young people to develop emotional resilience • Innovative models of care to support children and young people with very complex needs to thrive
ICB Target Operating Model	• BLMK People Plan – developing competencies and confidence for our staff to participate in co-production and use quality methodology to tackle inequalities and track impact
Improving Access & Treatment	• Health services strategy, including specialised services • Use of digital integration to improve access and outcomes in clinical pathways
Improving Outcomes for MHLDA	• Innovation in new models of care to tackle inequalities, and improve access and outcomes for residents • Place-led focus on maximising uptake of physical health checks and screening
Intelligence-led Quality, Performance, Outcomes & Inequalities Improvement	• Implementation of the Population Health Intelligence Unit • Ongoing connectivity of data to enable joined-up care for residents, & evaluation of benefits • Digital integration to enable technological innovation to support people to live more years in good health
Thriving Ecosystems and Prosperous Communities	• Place-led programmes to support those furthest from training and employment • Use of technology to enable thriving and sustainable ecosystems

6. Denny Review Update March 2023

a) Background

In 2020 at the height of the pandemic, residents from Bedford Borough's Windrush generation wrote to the Chief Executive of the then Clinical Commissioning Group asking for health inequalities to be addressed in the area – as evidence highlighted that more people from black and minority backgrounds were more severely affected by the virus. Believing this to be because of economic deprivation, senior leaders from the health system were invited to attend meetings to listen to the views of local people.

The lived experiences of this community were incorporated into the Covid vaccination programme and steps were taken to break down the barriers people experienced in accessing the vaccine. Venues were selected based on feedback from community leaders and clinics were set up in 'trusted places' with 'trusted people in attendance.

With the establishment of the Integrated Care Board and the inequalities priority, it was agreed that work should be undertaken to interrogate population health data and understand:

- Which communities experienced greater health inequalities,
- What the barriers are
- What the lived experience of health inequality is, and
- What we could do to address it.

b) Establishing the Denny Review

The Reverend Lloyd Denny from Luton and former public participation Lay Member for Luton Clinical Commissioning Group was asked to lead a review into health inequalities and a steering group was established. Paul Calaminus, Chief Executive of ELFT was appointed as Senior Responsible Officer (SRO) and a group was set up which included:

- Public Health representatives from all 4 local authorities
- Population Health lead Integrated Care Board
- Healthwatch Bedford Borough, Central Bedfordshire, Luton and Milton Keynes
- The University of Bedfordshire
- East London Foundation Trust
- A local GP with responsibility for inclusion

A plan was agreed which was to:

- Undertake a literature review to understand what had been written to date on health inequalities in Bedfordshire, Luton and Milton Keynes
- To engage with residents who experience health inequalities to listen to their lived experiences, and
- Work together to agree a series of recommendations, which would be taken forward to remove barriers to equality.

c) What did we learn from the literature review?

A procurement exercise was undertaken earlier this year to appoint an academic partner to deliver a literature review, which would set the benchmark and provide a framework for the review. The University of Sheffield was appointed and following a four-month desktop exercise, the literature review was published in June 2022.

It highlighted that the people most affected by health inequalities were people from ethnic and minority groups including:

- Gypsy, Roma and Traveller communities,
- People living in deprived neighbourhoods,
- People living in deprived neighbourhoods with disabilities,
- People experiencing homelessness,
- Migrants
- People from the LGBTQ+ community

The report also highlighted that those experiencing unfair distribution and impact of wider determinants affecting their access to services related to:

- Socio-economic, cultural and environmental, e.g., income, employment, education, access to green spaces
- Living and working conditions, e.g., housing, homelessness, overcrowding, high-risk professions, racial discrimination at the workplace
- Lifestyle and behaviours, e.g., physical activity, smoking, alcohol
- Access to and uptake of health services, e.g., language barriers, perceptions about 'ill health', beliefs and traditions, lack of knowledge about services, culturally inappropriate services
- Social capital, networks, communities and engagement, e.g., neighborhoods with a concentration of people with the same ethnicity, spiritual and faith beliefs
- The impact of Covid-19

Key considerations outlined also included the importance of intersectionality, which helped to understand how different factors can shape people's experiences.

The report recommended that work into health inequalities focused on the following areas:

- Making services more accessible to disadvantaged groups
- Targeting specific groups such as the homeless, the housebound, LGBTQ+ and ethnic minority groups living in deprived neighbourhoods
- Exploring better quality language and interpretation services and the delivery of information via trusted sources
- Targeting communication strategies at different groups
- Supporting for the VCSE to help communities navigate the health and care system
- Developing the cultural competency of staff to understand different needs and how services can services can meet these
- Considering the impact of social exclusion, racism, discrimination and socio-cultural barriers on the involvement of communities in decision making and service delivery.
- Strengthening collaborative working with the VCSE, including faith-based associations and centres
- Undertaking further research on what 'intersectionality' means in BLMK responding to complexity and not treating the 'community' as a homogeneous group

A Task and Finish Group, which included engagement and co-production leads from providers and local authorities across the system was established to interrogate the report. Using population health data and the recommendations of the report as a framework, the group was able to identify priority populations where engagement could be undertaken to listen to lived experiences and either validate or challenge the findings of the literature review and population health data.

d) How are we taking this work forward?

The Task and Finish Group agreed that the literature review should form the framework for the engagement and that the communities should be prioritised:

- Gypsy, Roma, Traveller
- People from ethnic minorities living in deprived areas
- People with a learning or physical disability living in deprived areas
- Homeless people
- Migrants
- LGBTIQ+ community

There was agreement that intersectionality needed to be considered as part of this exercise, to ensure that people were not heard as part of a homogenous group, to allow for richer and more authentic information to be shared.

The literature review highlighted that communications and culture were creators of health inequalities and it was agreed that these themes should be explored through the lens of health literacy, community languages, disabilities and cultural barriers including religion and race.

Learning from work that has been place across the system by local authorities and providers, it was agreed that engagement work with these communities should be undertaken by trusted people within the communities, to ensure that difficult conversations were managed sensitively and appropriately, and that people felt able to 'open-up' about their experiences.

The Task and Finish group agreed that:

- **Healthwatch Bedford Borough** would undertake engagement with the Gypsy/Traveller community in Bedford which included two settled Irish Traveller communities.
- **Healthwatch Milton Keynes, YMCA and MK Action** would engage with people from an ethnic minority living in deprived areas in Milton Keynes.
- **Bedford Borough Healthwatch** would work with local organisations to hear the experiences of women from ethnic minorities that have experienced forced marriage, FGM and domestic abuse.
- **Healthwatch Central Bedfordshire, the Disability Resource Centre and Community Dental Services (CIC)** would work together across Bedfordshire, Luton and Milton Keynes to listen to the experiences of people who have learning disabilities and physical disabilities in deprived areas.
- **Healthwatch Luton** would undertake engagement with people who are from an ethnic minority background and also part of the LGBTIQ+ community.
- **The Integrated Care Board** would undertake work with the Roma Trust in Luton, who would engage with the Roma community to ensure that those who are known to experience the greatest health inequalities were also included in the review.

Work is also underway with the Milton Keynes Homeless Partnership, who are currently putting together a proposal on how we can hear the voices of homeless people in the city; and Central Bedfordshire Healthwatch is developing a proposal with sex workers to ensure we hear from a previously silent community within our area.

e) How will this work be undertaken?

It is important that trusted people lead on this engagement work and organisations have been selected for their existing connections. Discovery interviews will be undertaken with residents and a series of questions have been developed which includes:

- What do you want from your health and care services? What do you aspire to?
- What does prevention mean to you? How do you think you could improve your own health and wellbeing?
- How can we communicate better with you?
- What could we be doing in health and care services to make it easier for you to access care?

f) Finalising the engagement exercise

The themes and reports of the engagement was received back in January 2023. The next stages is for the members of the steering group to come together to reflect on the themes and to agree on the next phase of the project. This will include taking a structured approach under the Triple Aim, Quality Improvement framework, strengthening projects that are already in place against the recommendations and identifying some continued engagement work with the communities of interest to ensure trust continues to build. All the work will be underpinned by quality improvement methodology and co-production with our stakeholders and residents. The report is due to be signed off in June 23 at the ICB Board.

3.9 Quality Improvement & Safety: Reducing Harm and Maximising Effective safeguarding across the BLMK

1. What is the Purpose of this Enabler?

50% of all harm in all healthcare is preventable. Around one in 20 residents are exposed to preventable harm in our healthcare system both in primary and secondary care. Harm to our residents and staff (we include staff because in nearly every case there was no intention of harm from the staff involved) can be devastating.

The focus for our system is for all healthcare providers to develop systems for learning and improvement to reduce harm. Within this, it is crucial that we ensure that people already experiencing disadvantages in life do not disproportionately experience harm through healthcare.

Harmful patient incidents are also a major financial burden. It is estimated that 10-15% of healthcare expenditure is consumed by the direct sequelae of healthcare-related resident harm. Harm in healthcare can have various causes, such as medication errors, adverse events, or negligence but it is a direct result of something in our healthcare system has not worked/happened/been acted upon rather than a recognised complication.

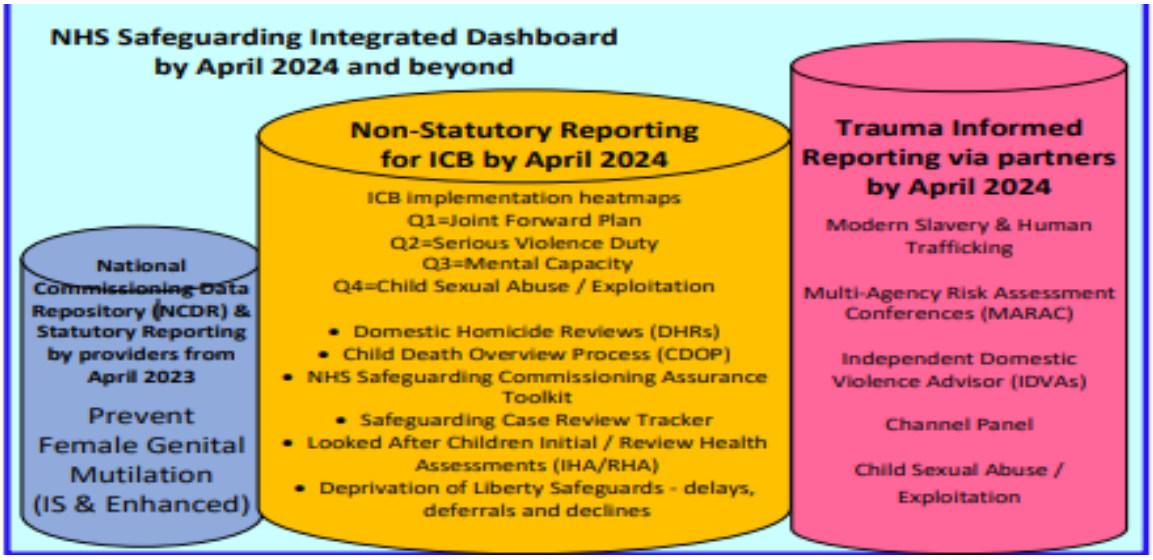
Who is responsible for safeguarding?

The responsibility of safeguarding is not one agency alone. In repeated national recommendations to provide a comprehensive picture of how several agencies work there continues to be a lack of real true shared partnership working. Safeguarding is protecting a citizen's health, wellbeing, and human rights; enabling them to live free from harm, abuse, and neglect. It is an integral part of providing high-quality care in any setting. Safeguarding children, young people and adults is a collective responsibility which we share across all BLMK partners.

Those most in need of protection include:

- Children and young people, especially children whose lives include any of the following: are looked after, are displaced from their usual communities (e.g., asylum seekers), are carers themselves, those whose lives reflect multiple Adverse Childhood Experiences
- Adults at risk, such as those receiving care in their own home, people with physical, sensory, and mental impairments, and those with learning disabilities
- Children and adults experiencing domestic abuse, displacement, and those whose lives are disrupted by crime and its consequences

All staff, whether they work in a hospital, a care home, in general practice, or in providing community care, and whether they are employed by a public sector, private, or not-for-profit organisation, have a responsibility to safeguard children and adults at risk of abuse or neglect in BLMK. The diagram below shows how we will try and integrate our data for learning and improving in our proactive actions to limit harm:



Inequalities is a cause of preventable harm

When people already negatively affected by unfavourable social determinants of health seek care, healthcare itself may exacerbate health inequalities rather than mitigate them. One way in which this occurs is when patients experience disproportionate levels of harm from the healthcare they receive. For example, a 2022 review in the UK found that ethnic minority women's experiences of poor communication and discrimination during interactions with healthcare staff may explain some of the stark inequalities observed in maternal health outcomes. Healthcare may therefore be less safe for some patients than others.

We see the consequence of this in our own population – for example, the infant mortality rate in Bedford and Luton is significantly higher than the East of England (EOE) and national rates (EOE 3.4 per 1000 live births and nationally 3.9 per 1000 births) with Luton sitting at 5.7 per 1000 births and Bedford at 4.9 per 1000 births.

One of the consequences of the COVID-19 pandemic has been to illuminate far-reaching health and socioeconomic inequalities in many countries. The pandemic's impact has fallen disproportionately on the most vulnerable individuals and communities, and along racial, ethnic, occupational, and socioeconomic lines. Inequalities in people's protection from and ability to cope with this pandemic and its tremendous societal costs stress the importance and urgency of the societal changes needed to protect population health and wellbeing in the future.

Disproportionate harm from healthcare experienced by our most disadvantaged residents further compounds the consequences of existing social or economic disadvantage. Viewing health inequalities through the lens of patient safety presents an avenue for tangible action on health inequalities for which healthcare professionals and systems have a clear responsibility.

2. Current focus and Required Development in BLMK

A shift towards improvement away from assurance and the journey of discovery together residents and staff and treat all of us with kindness and compassion.

In partnership with the inequalities current and future work the shift towards a quality improvement approach focusing on culture, behaviour, tools and techniques is key, without diminishing the need to maintain quality assurance in service provision. BLMK to will focus on three pillar of quality assurance, quality improvement and quality planning and a relentless focus on inequality reduction and ensuring all feel valued and are valued.

This requires all of us in BMLK to jointly working to pursue better health for well-defined populations (including citizens, healthcare providers at all levels, councils or municipalities, businesses, schools, fire services, voluntary sectors, housing associations, social services, and police) will benefit from having a shared method that includes a common language and tools and can be applied across four areas:

1. defining the system
2. describing shared aims
3. the work required to achieve them
4. measuring systematically over time and acknowledging that change happens.

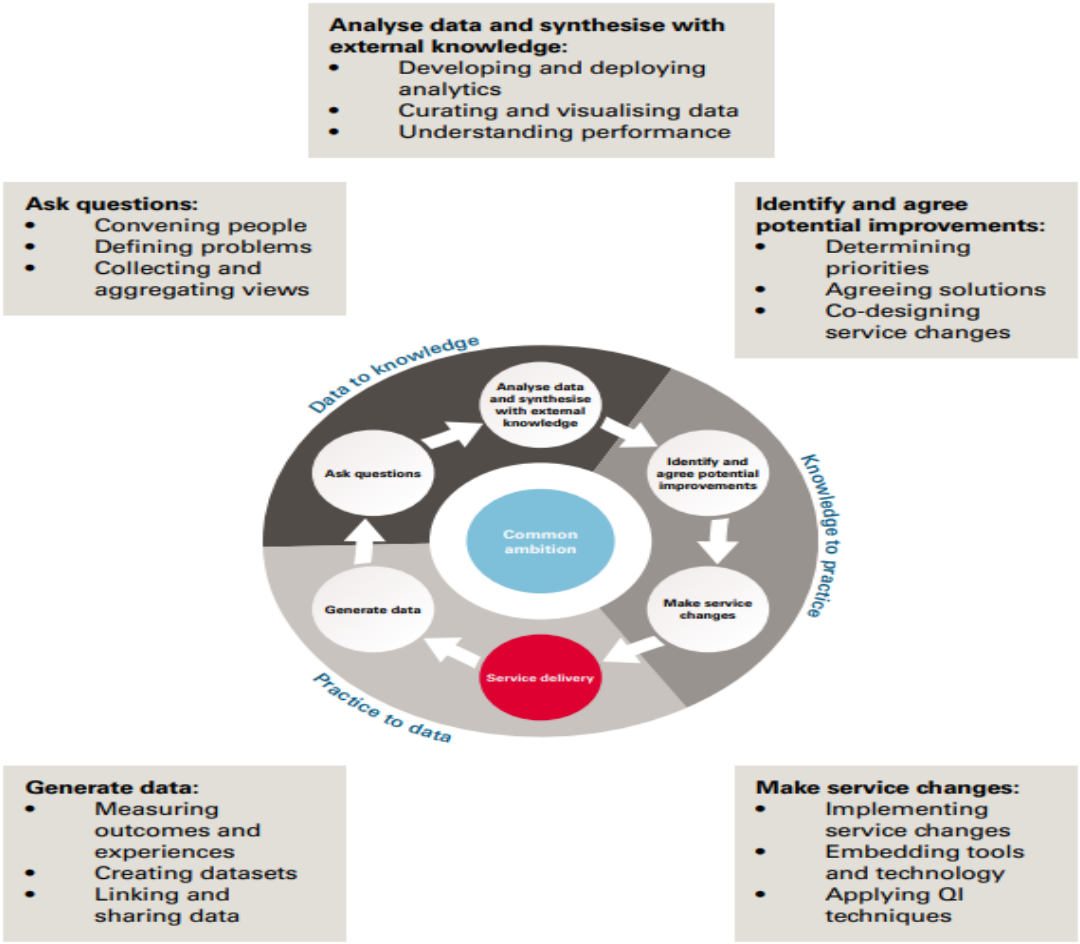
Capacity and capability for the staff and residence to learning how to improve

The Institute for Healthcare Improvement (IHI) is a globally recognised organisation dedicated to improving health and healthcare around the world, with a focus on quality improvement and patient safety. A partnership has been developed to build capacity and expertise to support BLMK's improvement journey. Working with the Institute for Healthcare Improvement will provide BLMK ICS with valuable expertise, resources, and a collaborative platform to address inequalities in healthcare effectively. By leveraging the IHI's knowledge and methodologies, BLMK ICS can make significant strides in improving health equity and enhancing the well-being of their population

To increase the capability of all our staff we will train our health and social care workforce & residents in quality improvement which in turn will provide all key stakeholders with the tools and empowerment to run their own quality improvement projects. There will also be a dedicated team of staff with expertise in improvement science to sit alongside all system transformation programmes in the form of Improvement Advisors (IA).

Data for Learning and Improving pan-BLMK

A learning health system (LHS) is a system such as the ICB that, working with a community of stakeholders, can develop the ability to learn from the routine care it delivers and improve as a result – and, crucially, to do so as part of business as usual. Done right, LHSs are not a separate agenda, but about embedding improvement into the process of delivering health care and social care. The diagram below shows the benefits of a LHS and how it might be used. BLMK is working on scoping the gaps in our system and the partnership working with the population health intelligence unit alongside the interoperability across health and social care and the timelines. This is an essential function for the ICB into to demonstrate measurable deliverable improvements.



Source: The Health Foundation's Insight & Analysis Unit

Statutory and regulatory functions and recent changes in focus:

- **Joint Targeted Area Inspection** (JTAI) is an inspection framework for evaluating the services of vulnerable children & young people. It is conducted jointly by Ofsted, Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Probation (HMIP). This is an important step forward for inspection.
- Following consultation, the new **'area SEND (Special Education Needs and Disability) inspection and framework'** has been published by Ofsted and the Care Quality Commission. The new framework and handbook come into use from 2023 and will be used to inform judgements on the efficacy of local areas' arrangements for children and young people with SEND. The new framework aims to strengthen accountability by:
    - Introducing an ongoing cycle of inspections with three inspection outcomes
    - Annual "engagement meetings" in all areas
    - Boosting the response where Ofsted has concerns via monitoring inspections and/or early re-inspections
    - More transparency and improving services by asking local areas to update and publish "visible strategic SEND plans" within 30 working days after full inspections
    - All strategic plans to be fully accessible to children and young people with SEND as well as parents and carers
    - A focus on how alternative provision is commissioned and overseen
    - An updated to the inspection team to be more multidisciplinary, involving health, education, and social care inspectors

The new 8 CQC Inspection quality statements for Integrated Care Systems from 2024 – Evidence of 'Safe' Care

- **Learning culture:** we have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
- **Safe systems, pathways, and transition**: We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored, and assured. We ensure continuity of care, including when people move between different services.
- **Safeguarding:** We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm, and neglect. We make sure we share concerns quickly and appropriately.
- **Involving people to manage risks:** We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.
- **Safe environments:** We detect and control potential risks in the care environment. We make sure that the equipment, facilities, and technology support the delivery of safe care.
- **Safe and effective staffing:** We make sure there are enough qualified, skilled, and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.
- **Infection prevention and control:** We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.
- **Medicines optimisation:** We make sure that medicines and treatments are safe and meet people's needs, capacities, and preferences by enabling them to be involved in planning, including when changes happen

Delivery 2023-2030: Continuously Reviewing, Learning and Reshaping

All delivery of programmes, including all system programmes will be through the lens of quality improvement and inequality reduction via direct support from improvement advisors, improvement coaches and access for all residents and staff to resources and training.

The infrastructure to deliver harm reduction and inequalities through continuous improvement will be the patient safety incident response Framework (PSIRF), the 3-year maternity plan and all the Core 20 plus 5 programmes for adults, children & young people and maternity. The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

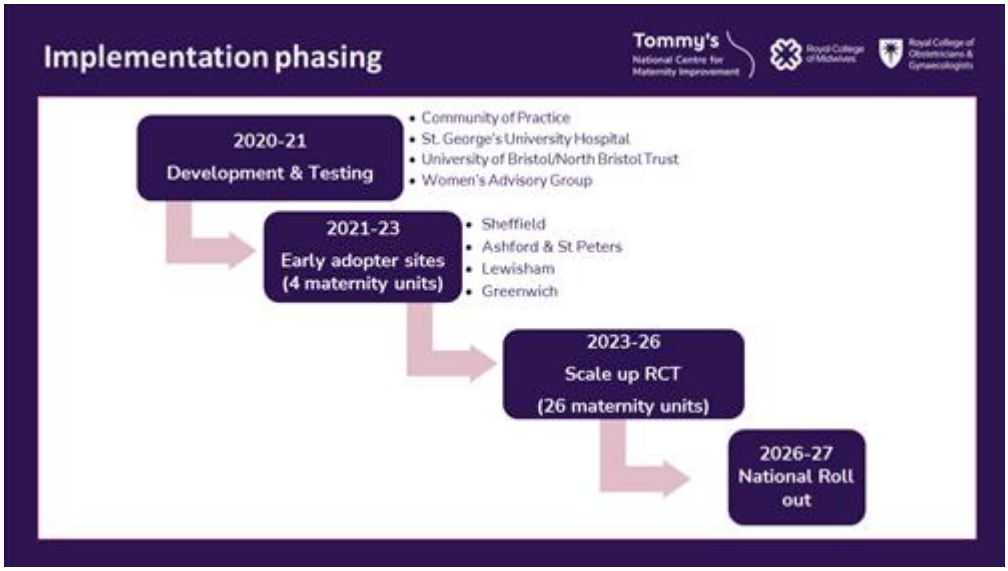
The three-year maternity plan 2023 and Core 20 plus 5 in Maternity has been launched the plan's aim to make care safer, more personalised, and more equitable by:

1. Listening to women and families with compassion which promotes safer care
2. Supporting our workforce to develop their skills and capacity to provide high-quality care plans
3. Developing and sustaining a culture of safety to benefit everyone
4. Meeting and improving standards and structures that underpin our national ambition

Alongside the PSIRF and the 3-year Maternity there are direct links with inequalities programme and the Inequalities leadership group for BLMK.

Relentless focus on selected solutions to reduce inequalities in patient safety through action by us all in BLMK

- **More routine involvement of advocates from patients' communities in healthcare interactions** to reinforce communication and ongoing support in care. Purposeful consideration of how the social background of a patient may dictate risk of harm from healthcare, and adjust management and follow-up plans accordingly
- **Use of culturally and linguistically appropriate shared decision-making tools** to empower involvement of marginalised patient groups in their care and safety
- **Support a diverse healthcare leadership** that pushes these issues into the consciousness of the workforce and mobilises the system towards meaningful action us this as a proactive recruitment focus. Health and care staff as full representation at all levels/grades as a clear representation of the local population. Include this into board and place-based board representations.
- **Race conscious approaches to healthcare education** with greater emphasis on racism and discrimination (rather than race) as determinants of disease
- **Systematised co-design of clinical services and clinical information with members of marginalised patient communities**
- **Strengthen capabilities for stratified analysis of patient safety event reports according to important patient characteristics** and the translation of these data into tangible action
- **Clinical trials must recruit an appropriately diverse cohort**, report relevant social determinant characteristics, and conduct relevant stratified analyses that determine effectiveness and safety of drugs and devices
- **Avoid using systematically biased clinical prediction tools and algorithms unless clear empirical justification for race adjustment has been established**. For example, **The Tommy's Pathway application enables midwives and doctors to assess each woman and birthing person's needs more accurately during pregnancy and to personalise their care.** Early in pregnancy, the tool can identify each person's chance of preterm birth or of developing problems with the placenta which may lead to stillbirth. It supports healthcare professionals to offer care recommendations in line with national clinical guidelines for best practice maternity care to help lessen the chance of these complications developing. This aims to reduce the variation in care across the NHS and ensure that each person is offered the right care at the right time, no matter where they live. BLMK ICB hopes to be in the 2023 scale-up randomised control trials for the national roll-out of this initiative.



Interdependencies across the BLMK Joint Forward Plan

The Partners of BLMK ICB are together committed to improving Quality and Safety as part of Business as Usual and in all our High Impact Programmes. The shift in tone of the national Safety Improvement Programmes, together with the move to PSIRF (tackling the system-wide root causes of harm) support our ICB's commitment to enable ALL our residents to live more years in good health (BLMK Integrated Health and Care Partnership Strategy).

Actions to enable all our communities to thrive will be explicitly highlighted in each of our High Impact Programmes, drawing specific attention to those populations whose health outcomes are worst and the inequalities that promulgate these. Specifically:

- Our Place Plans (built upon our Boroughs' health & well-being board strategies) will provide local focus and delivery of integrated services to improve health outcomes and tackle inequalities
- Evaluation of the impact of our High Impact Programmes will be assessed on the benefits to all residents, with specific attention to those residents who experience the most barriers to accessing care and treatment.
- The embedding of co-production (with residents and the VCSE organisations who link most closely with local communities) in our ICB Target Operating Model will embed our residents' view in the design, implementation, and evaluation of our improvement actions.
- The systematic use of health population data as part of understanding NHS access and outcomes will build on the lessons learned through COVID about finding and reaching out to those communities who do not come forward for screening or early diagnosis; whilst our BLMK health services strategy will ensure that improving health outcomes of all our residents is central to service and clinical pathway redesign and development
- Our BLMK People Plan sets out our collective actions to support residents into education, training, and employment

3.10 Research and Innovation (R&I) across Bedfordshire Luton Milton Keynes (BLMK) Integrated Care System (ICS)

1. What is the Purpose of this Enabler?

The challenges of an ageing population with complex healthcare needs, workforce pressures and health inequalities drive a pressing need to embed Research and Innovation (R&I) into programmes of work across ICSs. This will enable the system to cultivate transformative and targeted health care solutions for residents. The latter ambition has been further heightened by The Health and Care Act 2022 commitments stipulating the legal duties for ICBs to facilitate and deploy R&I into planning, reporting and decision-making. Successful implementation will enable systems to improve care-co-ordination, engage patients, address population health needs, drive service delivery innovations, facilitate evidence-based decisions, evaluation, and optimisation.

Research and innovation play a crucial role in supporting BLMK ICS to meet our strategic aim to increase the number of years lived in good health for all residents. This includes the following:

1. **Evidence-based decision-making:** Research provides ICSs with the necessary evidence to make informed decisions about the design and implementation of integrated care. It helps identify best practices, effective interventions, and areas for improvement. By using evidence-based approaches, we can optimise their resource allocation, service delivery, and overall performance.

2. **Improving care coordination:** Research and innovation contribute to enhancing care coordination within ICSs. This involves developing new models, technologies, and tools that facilitate seamless information sharing and communication among different healthcare providers.

3. **Enhancing patient engagement:** Research and innovation helps us engage patients and their families as active participants in their own care. By leveraging technologies like mobile applications, wearable devices, and patient portals, individuals can access their health information, communicate with healthcare providers, and participate in shared decision-making. This increased engagement leads to better health outcomes, improved patient satisfaction, and more efficient use of healthcare resources.

4. **Addressing population health needs**: Research supports us in identifying and addressing the health needs of their populations. By analysing health data, conducting epidemiological studies, and monitoring health trends, we can develop targeted interventions and preventive strategies. Research also informs the development of population health management approaches, such as risk stratification models and predictive analytics, to identify high-risk individuals and proactively manage their health.

5. **Innovating service delivery:** Research and innovation enable us to explore new approaches to service delivery, such as new care models, technologies, and processes. For instance, virtual wards to expand access to care, especially in underserved areas. Robotic-assisted surgeries, artificial intelligence applications, and precision medicine contribute to improved treatment outcomes and personalised care. These innovations can increase efficiency, reduce costs, and enhance the overall quality of care across BLMK ICS.

6. **Evaluating and optimising performance**: Research provides BLMK ICS with tools and methodologies to evaluate their performance, identify gaps, and measure outcomes. It helps us assess the effectiveness, efficiency, and equity of integrated care interventions. Research also supports continuous quality improvement efforts by providing feedback on implemented initiatives and suggesting refinements based on empirical evidence.

2. The Current Landscape in BLMK

Where we are now?

- BLMK ICS has a diverse population, where the benefits to maximising research into practice, and driving research and innovation will have demonstrable benefits to residents
- BLMK ICB consists of 2 health 'eco-systems' (Bedfordshire and Milton Keynes) and 4 Boroughs. It is a 'nexus' ICB, with strong relationships across multiple health and civic partnerships within and beyond the BLMK administrative boundary. This means that we are well-placed to influence and draw upon a rich diversity of research and innovation to benefit our residents
- BLMK partners have embedded relationships with several higher education institutes, research and innovation networks and global business partners based in our patch. This gives us great opportunities to expand and apply our research and innovation through partnership.
- The partners of BLMK ICB are already partners in a range of clinical trials, research and innovation, giving us a strong foundation to embed research and innovation in our collaborative High Impact Programmes to support our communities to thrive
- The ICB has (through Health Education England funding) awarded £3million to University of Bedfordshire to develop our shared R&I hub work on tackling inequalities and developing our workforce

Key challenges:

We need now to

- **Synthesise our existing R&I programmes across partners with our strategic ambitions and High Impact Programmes to create a pan-BLMK R&I strategy** that builds on existing practice, and delivers enhanced benefits to our residents
- **Standardise (as needed) our R&I governance processes to ensure we bid effectively and have the right infrastructure to deliver our R&I strategy**
- **Develop the skills and confidence of our staff to participate in R&I**, including research into practice
- **Grow our combined reputation in our research capabilities** to attract and influence the right R&I opportunities into BLMK with our partners

The actions to deliver this are:

1. **Collaboration and partnerships:** Foster collaboration between researchers, healthcare providers, policymakers, and other stakeholders within ICSs. This collaboration ensures that research and innovation efforts are aligned with the needs and priorities of the system.

2. **Establish research networks:** Create research networks or consortia within ICSs to facilitate knowledge sharing, collaboration, and joint research initiatives. These networks can include multiple healthcare organisations, universities, and research institutions working together to address common research questions and challenges.

3. **Dedicated funding:** build the sustainable resourcing for a shared R&I infrastructure across the ICB partners. This funding can support research projects, innovation initiatives, and the development of research infrastructure.

4. **Data sharing and interoperability:** Promote data sharing and interoperability across different healthcare organisations within BLMK. This enables researchers to access comprehensive and integrated data, facilitating population health research, outcome evaluations, and performance assessments. Implement standards and technologies that support secure and seamless exchange of data.

5. **Research governance and ethics:** Develop robust research governance frameworks and ethical guidelines specific to integrated care, that enable us to work in partnership in this field

6. **Capacity building and training:** Invest in building research and innovation capacity across ICB partners.

7. **Knowledge translation and dissemination:** Facilitate the translation of research findings into practice within BLMK. Develop mechanisms for disseminating research outputs and best practices to healthcare providers, policymakers, and other relevant stakeholders.

8. **Continuous evaluation and learning:** Implement a culture of continuous evaluation and learning within BLMK. This is part of (not separate to) our shared commitment to embed quality improvement methodology across our services to improve health outcomes, tackle inequalities and maximise efficiencies and effectiveness.

3. What have we achieved so far:

Some examples of how our use of research and innovation has benefitted our residents already are:

- Technologies that have been proven to be effective, cost saving and affordable (MedTech Funding Mandate) have been implemented across BLMK. Examples include less invasive procedures for urology and new non-drug treatment for migraines and cluster headaches.
- Work is currently underway to review the care for people with sickle cell and the access they have to Spectra Optia Apheresis (red cell exchange).
- In 2022, BLMK successfully bid for funding for NHS England's Innovation for Healthcare Inequalities Programme (InHIP). This funding will support the optimisation of self-management and treatment of CVD through proactive outreach in GP practices and will include evidence-based lipid lowering therapies.
- Technology to improve mobility, GaitSmart will be piloted across BLMK in 2023/2024. The impact of this technology on the residents will be evaluated, hoping to improve independence and quality of life.

New technology across social care in BLMK is helping people to stay independent, improve the well-being and support the health and social care workforce. Innovations have focused on three key areas of greatest need

  - Health monitoring
  - Falls prevention

- Digital records

A Bedford care home started using the Whzan blue box in May 2020. They remain enthusiastic advocates for this all-in-one telehealth kit.

"Before we had this equipment we often had to wait until the residents got really sick before we could get help. Now we can act more immediately because we can get observations – like blood pressure and oxygen saturation – and give these to the GP. This gives us the help we need for our residents much more quickly."

Raizer chairs to enable people to be assisted up following a fall have been introduced to care homes across BLMK. Care home managers have reported

- *'We couldn't live without the Raizer Chair now – it's amazing.'*
- *'The Raizer Chair is easy to use and kind to the person who is being assisted by it. Possibly the best piece of equipment to come into the care sector for years.'*

Following the success in care homes, Raizer chairs are going to be introduced to domiciliary care providers.

Further exciting work is planned in partnership with social care to expand remote monitoring which includes MiiCare. This digital tool uses telecare sensors to monitor different aspects of the individual's environment or check for movement and falls. This enables the individual to remain safely in their own home for as long as possible, with the reassurance that issues can be detected and investigated. There will be greater focus on the benefits of innovations to the health and well-being for our local residents. We will continue to work in partnership with Oxford and Eastern Academic Health science Networks (AHSN) to support evaluation and adoption of innovation and grow our relationship with academic partners.

4. How will we Develop our ICB Research and Innovation Strategy?

By March 2025, we aim to have developed a shared research and innovation strategy across our ICB partners that builds on our strong foundations to ensure that we have a comprehensive programme of research and innovation to help us achieve our strategic ambitions.

This is expected to include:

SHORT TERM GOALS

1. **Identify research and innovation priorities:** Conduct a comprehensive assessment of the ICS's research and innovation needs and priorities. Engage key stakeholders, including healthcare providers, researchers, patients, and policymakers, to identify areas where research and innovation can have the most significant impact on the ICB's goals and objectives. Prioritisation of areas we want to focus with R&I.

2. **Integration into the planning process:** Ensure that research and innovation are integral components of the ICB's Joint Forward Plan. Incorporate specific goals, strategies, and actions related to research and innovation within the overall plan. This demonstrates a commitment to advancing evidence-based practices and leveraging innovation to achieve the ICB's strategic objectives.

3. **Establish research and innovation governance:** Develop a governance structure for research and innovation across the ICB. This includes establishing clear roles and responsibilities, processes for decision-making, and mechanisms for monitoring and

evaluation. Define ethical guidelines and review processes to ensure that research activities adhere to ethical standards and regulatory requirements.

Tangible outputs/ actions include:

- Development of an R&I Board (Collaborative) that includes all stakeholders across BLMK ICB
- Formation of R&I ICB Community of Practice
- Clearly defined governance framework for R&I
- Prioritisation exercise on where we will focus on R&I to meet BLMK ICB strategic partnership priorities

MEDIUM TERM GOALS

1. **Dedicated funding and resources:** Develop sustainable funding sources to deliver the supporting infrastructure for collaborative research and innovation in BLMK. This ensures that there is adequate support for research projects, innovation initiatives, and the necessary infrastructure. Advocate for sufficient funding from relevant stakeholders, such as government agencies, research funding bodies, and private sector partners.

2. **Collaboration with research institutions and experts:** Forge or continue strengthening partnerships with all research institutions, universities, and experts in relevant fields across BLMK and beyond. Collaborate with academic researchers, clinical experts, and other knowledge partners to enhance the research and innovation capabilities of the ICB. Engage these partners in the planning process and leverage their expertise to inform the development of research and innovation framework.

3. **Knowledge exchange and translation:** Prioritise knowledge exchange and translation as part of the research and innovation strategy. Establish mechanisms to disseminate research findings, best practices, and innovative approaches within the ICB and beyond. Encourage the uptake of evidence-based practices and support the translation of research findings into actionable recommendations for healthcare providers and policymakers. Utilise various communication channels such as publications, conferences, workshops, and online platforms to share research findings effectively.

Tangible outputs/ actions include:

- Protected funding to take forward agenda through sustainable funding sources
- Development of a BLMK R&I framework followed by BLMK R&I strategy
- Establish a model of ‘Hubs’ that will take forward identified R&I priorities

LONG TERM GOALS

1. **Capacity building and training:** Invest in building research and innovation capacity across ICB partnerships. Provide training and professional development opportunities for health and care professionals, researchers, and innovation champions. This includes enhancing research skills, fostering innovation mindset, and promoting the use of evidence in decision-making. This builds a culture of research and supports the development of a skilled workforce. Develop policies and guidelines that support the

integration of research and innovation within our ICB, including services and partners which impact the wider determinants of health.

2. **Monitoring and evaluation:** Develop a robust monitoring and evaluation framework to track the progress and impact of research and innovation initiatives within BLMK Joint Forward Plan. Establish key performance indicators (KPIs) and metrics to measure the effectiveness and outcomes of research and innovation activities. Regularly review and assess the progress, adjust strategies as needed, and share the results to promote transparency and accountability.

3. **Continuous learning and improvement:** Foster a culture of continuous learning and improvement across ICB partnerships. Encourage feedback from stakeholders, including patients, health and care providers, and researchers, to inform future research and innovation efforts. Regularly assess the impact and outcomes of research and innovation initiatives. Utilise evaluation findings and lessons learned to refine strategies, identify new opportunities, and drive innovation within the ICB.

Tangible outputs/ actions include:

- Identify or create R&I training to support the multi-professional workforce
- Develop a robust monitoring and evaluation framework
- Finalise BLMK R&I strategy and publish recommendations

5. Interdependencies of the R&I Enabler programme with our Joint Forward Plan High Impact Programmes

Our ambition is for research and innovation to inform, underpin and enable our delivery of our strategic shared ambitions as partners in BLMK ICB. As such, by 2040 we aim for R&I to be embedded in all our strategic partnership programmes.

However, there are key interdependencies between our BLMK R&I ambitions and specific High Impact Programmes, as summarised below:

BLMK High Impact Programmes	Key Objectives underpinned by R&I
Advancing Equity & Equality	• Embedding existing R&I programmes on inequalities across our High Impact Programmes (e.g., Denny Review and Bedford University Research partnership)
Enabling our Children and Young People to Thrive	• Innovation in models of care to maximise prevention and early interventions to support children to thrive • Use of digital technology to enable independence for children and young people with long term conditions • Innovation to support children and young people to develop emotional resilience • Innovative models of care to support children and young people with very complex needs to thrive
ICB Target Operating Model	• BLMK People Plan – developing competencies and confidence for our staff to participate in research and innovation

BLMK High Impact Programmes	Key Objectives underpinned by R&I
Improving Access & Treatment	• Health services strategy, including specialised services • Use of digital integration to improve access and outcomes in clinical pathways
Improving Outcomes for MHLDA	• Innovation in new models of care to tackle inequalities, and improve access and outcomes for residents
Intelligence-led Quality, Performance, Outcomes & Inequalities Improvement	• Implementation of the Population Health Intelligence Unit • Ongoing connectivity of data to enable joined-up care for residents, & evaluation of benefits • Digital integration to enable technological innovation to support people to live more years in good health
Thriving Ecosystems and Prosperous Communities	• Place-led programmes to support those furthest from training and employment • Use of technology to enable thriving and sustainable ecosystems

3.11 Specialised Commissioning Delegation: Pharmacy, Optometry and Dental Delegated Commissioning

1. What is the Purpose of this Enabler?

The delegation of Pharmacy, Optometry and Dental (POD) commissioning from NHS England to the ICB offers an opportunity to help to address inequalities by greater joint working towards locally agreed priorities, with focused prevention initiatives that are co-produced. In parallel, we will be able to build better relationships with POD providers at neighbourhood level help to develop community solutions to local issues.

Dental access is an area of particular focus for the ICB given that there are significant challenges nationally and locally around workforce and contracts. We regularly receive feedback from Healthwatch and complaints from individuals that access to NHS dental care is a significant issue locally, and we are developing ways to capture data on the scale of unmet need.

The opportunity that the ICB has to address these challenges is limited as the contracts are nationally negotiated, but we will have the chance to work with local providers to maximise the impact of prevention and focus the resources where they are needed most in the local population. Oral health is an indicator of broader determinants of health and wellbeing, and we will be working across the system to explore how we can maximise the impact that improved access to dental care can have to people and communities.

2. The current landscape in BLMK:

Across all POD providers

POD commissioning is different to the way we commission other services. They are all nationally negotiated contracts, and the contracting and assurance function is very light touch. Providers can decide whether or not they want to deliver NHS service and therefore our approach needs to be collaborative and supportive, improving the appetite for providers to engage.

The work programme across POD will look for ways to work differently with our local providers, improving engagement and ensuring that they are an integrated part of place development. We plan to work on:

- Making every contact count to maximise prevention
- Build awareness of local options and referral points
- Maximise options for approach to immunisations and vaccinations
- Improve signposting for the local community
- Case finding and screening in more settings

Community Pharmacy

Community pharmacy is a well-established partner within the neighbourhood working and there are many good examples of pharmacies working closely with GP practices to improve access and outcomes. We have already implemented the Community Pharmacy Consultation service and hypertension screening and will be looking for ways to build on the successes of this. We will also work with local pharmacies to give more of them access to GP records to provide more seamless care and ensure that there are mechanisms to follow up community pharmacy findings. This is alongside the national initiatives that are included in the Primary Care Recovery Programme which will see Community Pharmacy play a stronger role in providing care to patients.

We have a Community Pharmacy Transformation Lead who will be working with the POD contracting team, Public Health, Local Pharmaceutical Committees, local providers and the Medicines Optimisation Team to develop a roadmap for community pharmacy which will help maximise their role and further strengthen the partnership working that is already in place.

Optometry

The contract for providing NHS optometry services is nationally negotiated. BLMK has a good network of optometrists providing this service and there is reasonable access. We have started initial discussions with Local Optometry Committees and are developing an understanding of the local context, provider landscape, access issues and contracts. These conversations have highlighted that there are national negotiations already underway around a review to the rates of reimbursement, and the ICB will monitor this to understand the local impact of any changes.

In addition to the core national contract the ICB commissions Optometrists Community Urgent Eye Service which offers an alternative to A&E and links directly with the local hospitals. The service will be reviewed for effectiveness and to ensure that the opportunity it offers is being maximised. Local optometrists work closely with our acute hospitals and have direct referral routes for relevant conditions. We will look to build on making every contact count.

Dental

BLMK has a relatively high incidence of dental decay in 5-year-olds compared to the rest of the East of England region but is about the same as the national level. Within BLMK there are inequalities, with Luton having the highest prevalence of experience of dental decay in 5-year-olds. Central Bedfordshire has the lowest prevalence and the lowest mean number of teeth with experience of dental decay. However, across BLMK there is evidence that oral health is improving with decreasing prevalence across the last four Office for Health Improvement and Disparities surveys which collects these annual snapshots of oral health.

We are working closely with Public Health colleagues to understand how we can use this, and other data collected to develop a clear picture of the local priorities in terms of need, access and unmet demand and inequality and will be developing a local dental strategy supported by the regional Local Dental Network and the development of a BLMK Dental Network. We will also review and maximise other initiatives that are underway such as the dental care home initiative and prevention activities within schools to reduce the need for dental treatment.

The limitations of the national contract have been highlighted by the Hewitt Report and NHS Confederation as factors which need addressing at a national level to improve uptake of NHS work by dental providers, therefore improving access to NHS dental care. We will monitor the developments with the national contract and look for ways to maximise existing contracts in the meantime in relation to prevention and access to urgent dental care. We will also be reprocuring our Community Dental Service which will give us the opportunity to co-design a solution which meets the needs of our population and helps to address some of the current barriers to access for the population.

3. What does good look like?

Across all POD providers

- Access to information and signposting which is consistent and supports the public to make the right choices
- Opportunities to engage patients in conversations around their broader health and wellbeing are routine, and where other needs are highlighted that the patient is supported to navigate the appropriate pathway

- POD providers are engaged in conversations at place which offer an opportunity for them to maximise their contribution to improving the health and reducing the inequalities of our populations

Community Pharmacy

All community pharmacies have access to the information that they need to provide the best proactive care to patients that they can. Opportunities for health screening and case finding are maximised and patients feel supported by pharmacies as part of the front door for health services. Where they are able to help address more urgent health needs without the patient needing to access GP or acute services they do, and where patients need onward referral that this is seamless. This will maximise the impact of community pharmacies in the broader NHS and reduce the demands on GP and acute services where this is possible.

Optometry

The role of community optometry is maximised with patients able to access their local service for relevant conditions. The availability of this as an alternative pathway is tied in to local urgent and routine care which ensures that patients are able to access the relevant service with ease. Where onward referral is required, this is done seamlessly. Opportunities to discuss broader prevention issues are maximised and case finding is routine with clear onward referral routes.

Dental

Prevention opportunities are maximised, and we have fewer children that experience dental decay. Inequalities are reduced and prevention initiatives are focussed on where they can have the biggest impact, combined with addressing the wider determinants of health. People are able to better access NHS dental care, including urgent dental care. The workforce feels supported with a more effective contract and as a result we have more dentists that are willing to offer NHS services which increases the capacity. People are able to access care at an earlier stage and therefore treatment is more effective which improves overall oral health. Broader determinants of health and wellbeing are considered in every contact with patients and there is access to effective information and signposting to other services.

4. Delivery

As the contracts transferred on 1st April 2023, we are in the relatively early stages of understanding the issues, benefits and opportunities that POD delegation presents. We are therefore planning for use 2023/24 as a year of STABILISATION to:

- Embed NHSE teams in to ICB and refine existing and new processes
- Monitor budget and develop a detailed understanding of spend and activity
- Develop relationship with POD contractors and improve understanding of issues

2024/25 will focus on ACCESS to work on:

- Public Health and data driven approach to informing improvement plan
- Work with providers to create joint improvement approach
- Track improvements to access and explore additional initiatives

2025/26 will see us beginning to TARGET INEQUALITIES through:

- Public Health inform planning to highlight areas of inequality and related population health outcomes
- Working with providers, set out a strategy to address priority areas
- Track improvements and change in population health outcomes e.g., reduction in incidence of diabetes, improvements in mental health

During 2023/24 we will work with stakeholders to develop our approach and methodology ensuring that we maximise opportunities for co-production.

3.12 Sustainability & Growth: Thriving Ecosystems & Prosperous Communities

1. What is the Purpose of this Enabler?

The health of individuals and communities is determined by much more than the healthcare they access and receive. Research[2] suggests 80% of health is due to the **"wider determinants of health"** – this includes the ecosystems –environments in which we live, the opportunities we have, the things we choose to do in our lives, and the way we do them, as shown below;

Adapted from Robert Woods Johnson Foundation / University of Wisconsin County Health Rankings Model

Thriving ecosystems and prosperous, fair communities are fundamental to a healthy, equal community – without these, health will worsen, health inequalities will widen, and demand for health and care services will only increase.

Therefore, if we tend to our ecosystems and community prosperity, we can have a direct, positive impact on the health of our populations whilst addressing some of the other challenges the health and care system faces – such as quality of care, inequalities in outcomes, demand for services, workforce recruitment and retention, and financial stability. The fourth pillar of BLMK ICS is to support the social and economic development of its population.

Furthermore, the healthcare system has a statutory duty to pay due regard to climate change. The climate emergency is a health emergency – we know that environmental pollution and degradation has a negative impact on human health and the ecosystems in which we live.

The impact of environmental degradation is felt throughout life for example including:

Start well - Children Growing up need a healthy environment:

- Air pollution affects children's development, before and after birth (RCP, 2016), including:
- Lower birth weights
- Incidence of asthma and allergy
- Attainment levels in schools.

Live well - Natural environments are restorative and protective

- Access to greenspace is much lower for those in most deprived areas
- Natural environments can enhance wellbeing, social contact and community cohesion

[2] The Robert Woods Johnson Foundation / Wisconsin County Health Rankings model

- Tree-cover can result in lower surface temperatures of up to 20°C (Hesslerová et al, 2013)
- High-carbon diets contribute to weight-gain, diabetes and other health issues.

Age well - Environmental impacts are highest for the most vulnerable

- Long-term exposure to air pollution has been associated with dementia, heart disease, stroke and some cancers (PHE, 2018)
- Heatwaves result in excess deaths, particularly in the more vulnerable

2. The current landscape in BLMK:

Environmental Sustainability in BLMK

Healthcare contributes to climate change and pollution, particularly through energy, travel, medicines, equipment, its supply chain, and waste (such as single-use plastic). For the NHS in BLMK:

- we annually emit the equivalent of driving more than 47,000 times around the world.
- we emitted 324,540 tCO2e in 2019/20; to remain on-track to meet national targets requires that this drops by 50% by the end of the decade.

A Health Impact Assessment of the BLMK ICS Green Plan, was published in January 2023 indicating:

- ~40 excess deaths in 2022 due to the heatwaves
- More than 400 deaths per year attributable to air pollution
- More than 200 bowel cancer cases caused through “high-carbon diets”

Environmental sustainability should be threaded throughout everything we do, and we can use the lens of environmental sustainability and net zero to also help achieve our wider goals, such as:

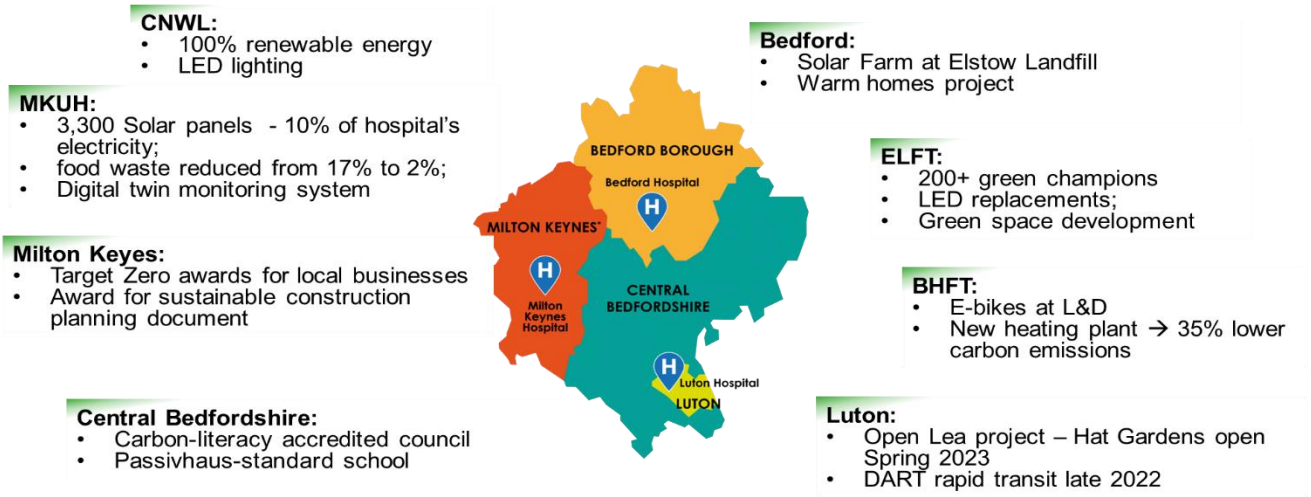
- There are clear links between access to the natural world and our physical and mental health
- In additional to staff wellbeing, there is some evidence that recruitment and retention is enhanced for companies taking sustainability seriously
- Ensuring good disease control, reducing polypharmacy, and using alternatives such as green social prescribing can reduce spend on medicines and associated emissions
- Healthier lifestyles, such as increasing activity levels through active travel, and healthier diets, can reduce risks of CVD, respiratory illness, diabetes, stroke and other conditions, as well as reducing emissions from vehicles and food supply chains.
- Reprocessing of equipment and recycling waste can introduce savings and even income streams whilst redirecting waste from landfill or incineration. Virtual and digital care can improve access, reduce demand for healthcare and give more control to patients in their care, while reducing the need to travel.

BLMK ICS and its constituent organisations have been working on environmental sustainability for several years. All NHS and local authority partners have published sustainability strategies in place, and the ICS as a whole has produced its three-year green plan, setting out high-level ambitions for addressing its impact on the climate and local environment. The progress already made progress across the ICS includes:

- A Health Impact Assessment was published in 2023, outlining the potential health risks and benefits and emissions likely if we were to achieve those ambitions set out in the Green Plan.
- Carbon literacy training for staff in primary care, secondary care and ICB

- System-wide healthcare adaptation task & finish to begin in May 2023
- Fuel poverty projects in Luton and Bedford Borough winter 2022/23
- Virtual ways of working (care delivery and office work)
- ICB Workforce – appraisal objectives and JD statements drafted for inclusion for all
- Social value – 10% weighting in all procurements.
- Sustainability impact assessment / checklist being trialled
- Inhalers – reduction in mean carbon emissions per non-salbutamol inhaler from 98th percentile to 59th in 12 months.

Examples of sustainability already embedded across BLMK Partners include:



Sustainable Economic Growth

As the diagram in section 1 shows, 40% of a person's health is related to their socio-economic situation.

- Around 120,000 (13%) of people in BLMK are living in areas of highest deprivation
- ~55% of UK households were predicted to be in fuel poverty by January 2023 (>80% for large families, lone parents, and pensioners).
- Long-term sickness is the cause of 43% of economic inactivity in Central Bedfordshire
- 20.7% (6,100) of economically inactive people in Milton Keynes want a job
- Bedford Borough (3.9%) and Luton Borough (5.5%) have above-average out-of-work benefit claimants

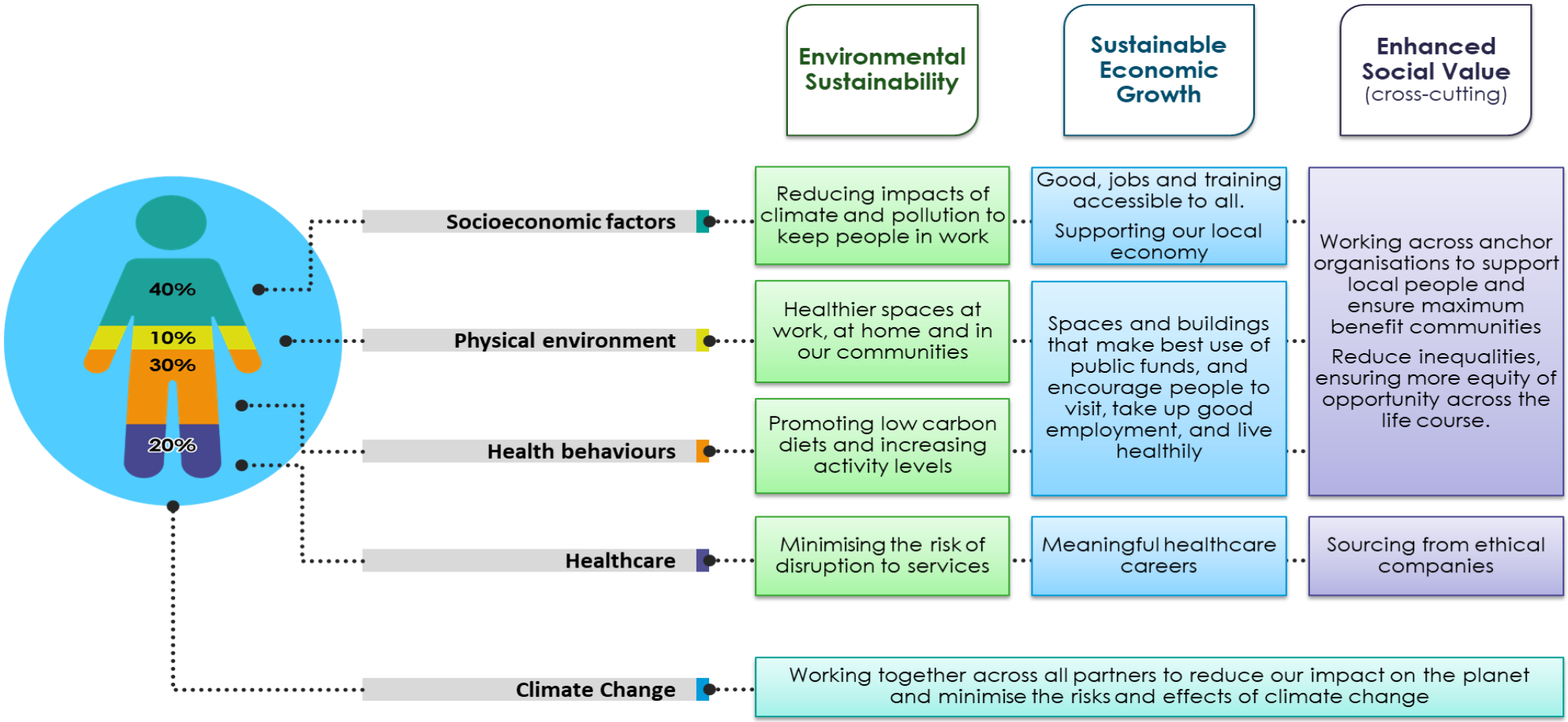
BLMK is one of the highest areas of population growth in the UK (almost 17%, 2011-2021 according to the UK Census 2021). Unlike much of the UK, the younger generations are growing alongside older generations. This means an increase in both working-age and economically-dependent resident cohorts – without appropriate, good quality jobs, we risk increasing unemployment and economic inactivity.

Supporting local social and economic development is one of the biggest opportunities for BLMK ICS to improve health, for example by addressing:

- Economic inactivity
- Poor quality jobs
- Barriers to employment, including in healthcare, particularly for those furthest from employment
- Insufficient good quality housing
- Inefficient use of public assets

3. What does good look like in BLMK?

BLMK ICB Partners will work together to help build the economy and support sustainable growth, focusing on the different wider determinants of health as outlined below;



Every decision will be driven by short- and long-term consideration of the environment and a circular economy:

Area	Example activities	Evidence / best practice	Measures and impact
Leadership, capability and embedding	• Working towards 100% of staff being "Carbon Literate" • Right tools for staff (e.g., sustainability checklist, Green Theatre checklist, Green impact toolkit, ICS Clean Air framework); • "Carbon" considered alongside quality and finance • Review and align whole Joint Forward Plan against Reduce-Renewable-Reuse-Reprocess-Recycle	• County Durham and Darlington NHS FT – 86%+ of staff undertook the free e-LfH basic carbon literacy course over 12 months • Carbon Literacy Project suggests that 5-15% of carbon emissions could be reduced with increased employee awareness	• Staff retention • Decisions made on the basis of environmental and related concerns
Focus on intersections with health	• Increase activity levels for children • Lower-carbon diets • Green social prescribing • Air pollution awareness and reducing exposure	• Nature-based interventions (e.g., green social prescribing) demonstrate effective improvement affective mental health disorders • Higher activity levels and healthier lifestyles significantly reduce incidence of diabetes (20%), stroke (27%), and cardiovascular disease (15%)	• Incidences of stroke, diabetes asthma, allergy, obesity, medicines use • Social value-add
Reduce	• Virtual commuting; virtual healthcare • Health promotion / illness prevention • System-wide procurement opportunities, including making our own consumables • Shift to lower-carbon alternatives e.g., anaesthetics	• Driving 1 mile in a diesel car in a congested urban area results in 12 minutes of life lost cf. 30s for an EV (Berners-Lee, 2021)	• Lower business and patient miles travelled • Lower use of resources
Renewable	• Energy generation at system- and organisational-level • Use natural environment to improve climate resilience of services	• MKUH is aiming for 15% of its electricity and a return on investment of 3-4 years from its solar panels • EoE doing a feasibility study of on-site renewables	• Energy mix • Incidence of over-heating buildings
Reuse	• Reduce single-use devices and consumables e.g., regional Gloves-Off campaign	• GOSH saved 21 tonnes of plastic and £90k through their gloves-off campaign	• Equipment used • Carbon emitted • Spend • Waste diverted
Reprocess	• Device reprocessing schemes	• In 12 months, Leeds Hospitals diverted 102kg of waste, and saved 69kg CO2 and £25k through device remanufacture	
Recycle	• System-wide recycling schemes (e.g., walking aids)	• Sterimelt machines from TCG are being used by several hospitals across the UK to recycling 100,000s of single-use masks into reusable Polypropylene.	

4. Our Approach to Delivery in our Joint Forward Plan

Environmental Sustainability in BLMK

The ICB must embed environmental sustainability in every process, programme, policy and strategy, including:

- **Reduce**: Step up public health, prevention and early-intervention to reduce resource use.
- **Reuse**: move away from mentality of single use
- **Repair**: stop throwing things away when they are broken.
- **Renewable**: avoid virgin materials and non-renewable sources of energy
- **Reprocess**: strip down equipment, clean up, and use the parts or whole again
- **Recycle**: break down end-of-life things to produce useful, usable raw materials

(as adapted from NHS England Central Commercial Function)

The ICS also has an opportunity to support these must-dos through capability-building, supporting ICS partners to deliver, share ideas and learning, collaborate to improve efficiency and effectiveness of common services and assets (e.g., estates, procurement and supply chain), and embedding a culture of innovation and quality improvement so new ideas can flourish. Threading environmental sustainability throughout our work is not without challenge, needing particular attention to be paid to:

- Behaviours and knowledge – helping staff to understand what they need to do, giving them the right tools and permission to act within their own sphere of influence, and supporting them to lead by example and challenge their peers and leaders.
- Perceived tension between sustainability and other pressures – climate change may be seen as a long-term issue, being resolved at a political level or "by the sustainability team". This might mean that decisions are made on one of the other measures – performance, quality, and finance, to the detriment of the environment in the short- and long-term. We will need to move to a situation where the impact on the environment becomes equally weighted in the "triple bottom line" framework (social, financial and environmental).
- We do not yet have all the answers and in order to move to a fully circular economy we will need to test and embed innovative solutions to some sources of carbon.
- "If you can't measure it, you can't improve it" (Deming) – carbon footprinting information is not always sufficiently detailed to allow us to know what are to target and whether we are having an impact. We are currently using proxy measures and focusing on those areas where the evidence is clearer (such as travel, inhalers, energy and plastics).

Sustainable Economic Growth

BLMK recognises that economic development needs to be planned and delivered over the same timescales as population and demographic change. BLMK ICS will develop short-, medium- and long-term plans over 20 years to:

- use healthcare services as a means to address socio-economic development;
- support local authority ambitions for economic growth.

We will **embed environmental sustainability** and the **concept of circularity** into **all of our work** – it's not a separate concern, but part of supporting healthy lives, and preventing harm and ill health through the delivery of services.

Mobilisation plan:

Area	Activities	Indicative timeframe
System leadership and alignment	Board development in environmental sustainability – training, seminars, briefings	2024
	Agree full-system and place-based collaborations – what are the things that we can only do, or make most sense to do across a larger footprint (e.g., air pollution, medicines, primary care, renewable infrastructure, estates, waste and recycling, reprocessing)	2023 and 2024
	Support development of local strategies (e.g., Local Plans and Local Travel Plans) to maximise opportunities for sustainability and health	2022 onwards
	Develop strategies and implementation plans for place- and system-wide initiatives	April 23 – April 25
Embedding sustainability in ICB and ICS organisations and work	Apply environmental sustainability checklist in all work of the ICB. Encourage similar within NHS providers.	April 2024
	Work with VCSE partnership to identify mutual benefit and additional value add in sustainability	April 2023 onwards
	Review methods for embedding environmental considerations within work across ICS partners	April 2024
	Align commitments (and potentially methods) across all anchor organisations	April 2025
Supply chain	Social value – mandatory environmental sustainability elements and supplier carbon reduction plans in all tenders	April 2023
	Social value – ensuring effectiveness through training, monitoring, measurement and evaluation mechanisms – alignment across system	2023/24 onwards

Area	Activities	Indicative timeframe
	Market development in collaboration with ICS partners (e.g., for reprocessing, local supply)	2024 onwards
Resident participation	Coproduction of long-term plan (8, 12 years and 22 years)	Q3 2023/24 – April 2025
	Develop mechanisms to ensure resident's views and ideas on environment are incorporated into all service redesign work	2025
Progress against Green Plans and LA sustainability plans	Support Trusts to develop and implement their own plans, incl. innovations	April 2022 onwards
	Identify synergies with local authority plans to support progress at place	April 2022 onwards
	Develop and implement ICS Green Plan thematic ambitions	April 2022 onwards

Appendix D

Assurance Matrices

4.1 The BLMK Joint Forward Plan and NHS England Operating Targets Assurance

	Area	NHSE Targets	Current BLMK Position	2023-4 BLMK Operational Plan Actions	Joint Forward Plan Actions
1	Urgent and Emergency care	Improve A&E Waiting Times – delivery of the '4hr wait' standard delivery in year, with further improvement in 2024-25	Steady performance over year starting at 66% ending in M12 with 62% We aim to improve to 76%	• BCA Winter plan in implementation • MK Together Flow plan in progress • Link with VCSE, social prescribers to support flow through Place	• Capital investment required to address known Flow 'pinch points' in UEC pathways, for example primary care estates capacity, infrastructure to facilitate admission avoidance pathways • MKUH - new hospital build to increase inpatient capacity to meet population growth • Increased partnership working with all partners to increase prevention (stay well at home), alternatives to acute admission where appropriate and use of technology and innovation to enable care at home
2	Urgent and Emergency care	Improve the 'category 2' ambulance response times in year and work towards pre-pandemic levels in 2024-25	Both SCAS & EAST have improved position over the year We aim to improve to 30 minutes	• Implementation of a new Unscheduled Care Hub (Bedfordshire) that incorporates the Community Urgent Care Response Teams (UCRT), Access to the 999 Stack, Call Before You Convey for frontline Ambulance clinicians, and the Silver Frailty Line	
3	Urgent and Emergency care	Reduce G&A bed occupancy equal to or below the optimum %	We aim to reduce occupancy to or below 92%	• 64 additional G&A beds at MKUH 2023-4 (UEC monies) • Patient flow programmes for Milton Keynes and also for Bedford/ Central Bedford/ Luton.	
4	Urgent and Emergency care	Routinely meet or exceed the 2hr UCR standard Aim to Meet or exceed 70%	CNWL – average of 93% ELFT ave. 86%* (*April 22 to Nov 22)	• Operationalise single pan-Bedfordshire response model	N/A
5	Urgent and Emergency care	Reduce unnecessary GP appointments and improve patient experience via streamlined direct access & referrals	Introduced direct patient access for urgent MH needs via 111 Personalised care planning of patients with palliative care needs with direct access to community teams	• MSK service out to tender pan BLMK – FCPs to reduce demand on GPs • Personalised care planning at a neighbourhood/PCN level for residents/patients with complex needs	• The BLMK health services strategy will identify where care can be provided closer to home, and how acute, community and primary care providers can collaborate to deliver this configured to meet local population needs
6	Primary Care	100% of patients needing routine appointments to be seen within 2 weeks	Less than 20% achieved- a steady improved position, supported by BLMK's delivery plan for recovering access to Primary Care	• Implement the new delivery plan for recovering access to primary care including the current 47 to 93 achieving full coverage by 2025. • Supporting PCNs to maximise the recruitment of ARRS staff utilising the full budget • Work with PCNs and community pharmacies to consider innovative ways of utilising ARRS staff.	• Capital funding stream required to increase primary care capacity to meet rapidly growing population; & provide clinical space for trainees and ARS roles
7	Primary Care	Urgent GP contacts assessed same or next day depending on need	Steady improved position with focused BLMK delivery plan for recovering access to Primary Care		

	Area	NHSE Targets	Current BLMK Position	2023-4 BLMK Operational Plan Actions	Joint Forward Plan Actions
8	Primary Care	Meet trajectory to deliver BLMK % of 50m more GP appointments by end of 2023-24	On track and delivering increased primary medical service appointments year on year.	• Promote and increase the number of community pharmacies offering the CPCS scheme and ensuring that general practice is trained to make the referrals. Build on this over the next 12-18 months community pharmacy provision of blood pressure monitoring scheme, • Ensure pharmacy is included in our ICB prevention and health inequalities plan as a system partner	*As above*
9	Primary Care	Deliver ambition to recruit BLMK % of 26k additional roles reimbursement scheme (ARRS) by end of 2023-24	On track to deliver		
10	Primary Care	Recover dental activity to pre pandemic levels	2023/24 is the transition and consolidation year following delegation of dental contracts.	• The priority is to stabilise existing contracts, understand contracts, performance, activity and review a dental needs assessment to help plan future dental provision to pre pandemic levels • Ensure that dental (pharmacy & optometry) is included in our prevention and health inequalities programme • Develop working with PH system partners to review and enhanced current provision and develop a system oral health strategy.	Pending national dental contract review
11	Elective Care	Zero waits over 65weeks by end of year excluding patient choice and/or specific specialities	On track but high risk to delivery due to impact of industrial action. At 21/05/ 2023 Bedford Hospital had 905 patients waiting and MKUH had 459.	• Implementation of community diagnostic hubs to reduce diagnostics bottleneck • Effectiveness and Productivity actions – particularly Theatre Utilisation and Day Case • Expansion of PIFU offer to deliver 5% target • Referral Optimisation • Adherence to NHS Choice guidelines following recent national focus • Independent Sector Utilisation	
12	Elective Care	Deliver agreed activity plans as per operational plan	This will be monitored in year through performance v. plan dashboards	• Top Decile Programme to improve efficiency and effectiveness • Outpatient Productivity (inc FUP efficiencies) • Repatriation of out of area Elective activity • Referral and Diagnostic Optimisation – identifying outliers based on population health and taking actions to increase presentations (low referrers) or manage needs locally without onward referrals (high referrers)	

	Area	NHSE Targets	Current BLMK Position	2023-4 BLMK Operational Plan Actions	Joint Forward Plan Actions
13	Cancer	Reduce number of over 62 week wait patients: BHT target – 201, MKUH target - 108	BHT - current is 402 MKUH - current is 167	• Implementation of community diagnostic hubs to reduce diagnostics bottleneck • Effectiveness & productivity actions • Workforce training for one-stop diagnostic pathways (e.g. nurse led for gynae and urology biopsy). • Working towards Q2 milestone of 70% by September 2023 • System committed to compliant Q4 position of 75% by March 2024. • Expand principles of addressing poor cancer outcomes to rest of BLMK taking the learning from Luton Cancer Outcomes project	• Mount Vernon hospital) re-provision – to reduce inequity of access for Luton residents • MKUH cancer centre • Increased uptake in clinical trials • Develop strategic plan to expand on current genomics offer as default treatment as national programme
14	Cancer	Meet faster diagnostics within 28 days standard for all 2ww suspected cancer cases to rule it in or out Delivery target of 67.5% by June 2023	BLMK performance over past year, with an average of 71% against a 75% target – MKU average has been 77%, BHT average has been 68%		
15	Cancer	Increase % of stage 1 & 2 cancer cases being diagnosed - as per 75% faster diagnosis ambition by 2028 All cancer patients offered care plan in agreed specialties (Breast, Colorectal, Prostate, Gynaecology)	May 2021 (latest data) 46%, third lowest month in preceding 12months Latest data suggest we are at 56.7% as a system based on 2018 data. Care plans are offered but there is significant variation across providers No robust data collection – work in progress to upgrade IT systems to enable this	• The introduction of Lung Health Check programme, improved GP education will have improved the 2018 position but we do not have access to that data yet (with confidence) • Improve public & primary care awareness of signs & symptoms of cancer • Developing plans for more proactive assessment and interactions with patients for specific cancers (e.g. prostate, liver, pancreatic). • Improve staging recording. • Further roll out of targeted lung health check programme across BLMK • Participate in roll out of GRAIL blood test during 23-24. • Supporting PCNS with implementing the Cancer Primary Care DES. • Use of genomics and genetic testing/familial history to identify high risk patients before symptoms present	• Integrated cancer care delivery across primary, community and secondary care as more people live with and beyond cancer (personalised care)
16	Diagnostics	Improve DM01 diagnostics within 6 weeks performance working towards 95% by March 2025 Aim splitting to 2.5% improvement over 23/24	Through 2022/23, remained at or around average. of 32% all year. Currently: • BLMK - 68% • BHFT - 64% • MKUH - 77%	• Implementation of community diagnostic hubs • Effectiveness and Productivity actions, CDS rollout, DNA Improvements • Ongoing support from insourced and outsourced diagnostic provision (MRI, Echo, Ultrasound), particularly in support of challenges services • Ongoing validation of waiting lists and optimisation of vetting procedures to reduce demand and effectively utilise capacity • Implementation of workforce strategies • Implementation of electronic referrals and an improved workflow of data for echo (MKUH specific) • GP Direct Access – launch iRefer	There are known gaps in diagnostic capacity to meet patient need, improve health outcomes and sustainably deliver elective recovery: • Need for investment in endoscopy at L&D to maintain JAG accreditation, and reconfigure estates to maximise productivity and flow • Diagnostic capacity required in Luton to tackle waiting times in elective recovery and address health inequalities and outcomes experienced by this population
17	Diagnostics	Deliver agreed diagnostic activity levels to support elective and cancer backlog reductions and DM01	34,748 in March 2023 compared to 29,403 in April 2022		

	Area	NHSE Targets	Current BLMK Position	2023-4 BLMK Operational Plan Actions	Joint Forward Plan Actions
	Diagnostics	BLMK Overall Performance for 22/23 was 99% against the 120% target.	Variable Performance at modality and provider level.	• Pathology Improvement - develop a system Pathology Collective	Mount Vernon reprovision to improve access to radiotherapy for Luton residents is crucial to improve 1 year cancer survival rates for this population
18	Maternity	Improve performance by reducing stillbirths, neonatal & maternal mortality, and serious intrapartum brain injury Deliver the 3 year maternity plan All external reports Kirk, Ockenden etc into clear deliverable CNST (Clinical negligence schemes for trusts) compliance	Refresh the LMNS (local maternity and Neonatal system) in light of ICB go live from July 2022. Introduction of Maternity core 20 plus 5. Introduction of Qi methodology to the 3-year maternity programme. Refresh relationship and responsibilities with the regional maternity team and handover 'extra support measures for Bedford hospital'	• Joint forward plan focus the delivery of the 3 year maternity plan broken down into four theme areas: Listening to and working with women and families, with compassion - cultural programmes and measurement of kindness and compassion for staff and women/families, human factors training, Growing, retaining, and supporting our workforce – achieved large international recruitment – overrecruited and Bedford, Improved at Luton and MKUH. Current vacancy rate approx. 14% (improved from 30%) Aim to focus on a joy in work programme Developing and sustaining a culture of safety, learning, and support – PSIRF to launch in maternity Standards and structures that underpin safer, more personalised, and more equitable care – Tommy's App research	
19	Maternity	Increase workforce fill rates against funded establishments	Significant achievement on international recruitment for midwives, with internationally recruited midwives included in the BLMK International Recruitment Forum	• See points above	• BLMK Maternity Strategy being developed as part of the 3 year delivery plan.
20	Use of Resources	Deliver balanced net system financial position in year	Balanced position agreed but some of this is non-recurring funding	• ICB has internal cost improvement programme in place, supported by move to the target operating model to reduce running cost allowance by 30% • Providers have comprehensive cost improve plans in place, with governance and oversight of delivery	• Joint Forward High Impact Programme will oversee pan-BLMK programme (Improving Effectiveness and Efficiency) to identify areas where there is unwarranted variation that we can improve to optimise outcomes for residents (increase prevention & early diagnosis) and reduce avoidable spend (working within agreed clinical protocols) • 2023-4 will focus initially on variation in clinical support functions (prescribing and pathology)

	Area	NHSE Targets	Current BLMK Position	2023-4 BLMK Operational Plan Actions	Joint Forward Plan Actions
	Use of Resources				• Establish technology solutions to enable clinical teams to be informed on their variation (feedback loops) • The health services strategy will focus on areas where there is high variation between need / demand / resources / best practice, and identify further areas to be addressed through the Improving Effectiveness and Efficiency
21	Workforce	Improve retention and attendance rates	Turnover Rate is 14.91% Sickness Rate is 3.85%	• Retention Strategy and Retention plan in place overseen by the People Board • Delivery of the 50k nursing programme	• One of the strategic objectives for BLMK is Growth & Sustainability. Within the Joint forward Plan, we will work in partnership at Place to maximise opportunities to support our growing population into training and employment
22	Mental Health	Increase access for Children and Young People– the BLMK % share of national ambition equates to 345,000k more 0-25 year olds accessing services	Ambition for 2023-24 is 17614 Overall increase over the year ending in 17,570 (M11 data)	• Recommissioning of VCSE provision to increase access with a focus on MK. • SNOMED coding and cleansing exercise to improve MHSDS submission data from MK • Work to increase access is being driven by co-producing with the young people's Better Days BLMK programme.	• Our JFP High Impact Programme 'Supporting our Children and Young People to Thrive' has clear actions to improve access to resources to emotional well-being via Place Plans • Our JFP High Impact Programme 'Improving Outcomes for people with mental health, learning disabilities and autism' will develop and implement plans with Places to provide more local capacity for children and young people with the most complex needs
23	Mental Health	Increase number of older people accessing IAPT treatment	Ambition for 2023-24 is 26,250 (minimum number to be starting IAPT to be 28,269* all ages)	• Develop our IAPT LTC Pathways in: Diabetes, COPD, Cardiovascular, Musculoskeletal, Medically Unexplained Symptoms, Cancer, Stroke, Gastrointestinal Problems, Post-Covid syndrome • Further expand access to IAPT for adults and older adults	• Embed expanded talking therapies offer into our Integrated Neighbourhood Working High Impact Programmes in each Place to tackle inequalities. This aligns with our personalisation agenda, and our commitment to tackle the root cause of inequalities, and support all our communities to thrive
24	Mental Health	5% growth in number of adults and older people supported by community MH services Plan for 2023-24 is 12,816.	Latest available data Feb 2023: 11,038	• Ensure that adults and older adults with Serious Mental Illness (SMI) can access new and integrated models of primary and community mental health (ensuring a range of support services are included) • Move away from the Care Programme Approach (CPA).	• Review of our community services urgent / emergency care and recovery model is a core deliverable through our MHLDA collaborative, working closely with partners to embed best practice from GIRFT, personalisation and Right Care, Right Person

	Area	NHSE Targets	Current BLMK Position	2023-4 BLMK Operational Plan Actions	Joint Forward Plan Actions
	Mental Health			• Expand EIP provision to include support for people experiencing At-Risk Mental State (ARMS) in Milton Keynes.	• Our strategic plans with each Plan to develop the right capacity and care model to support residents with the most complex needs locally (section 117) will enable more people to continue to reside in BLMK (reduce OOA placements) with enhanced community support
25	Mental Health	Work towards eliminating adult acute out of area placements 2023/24 is 133 Occupied Beds Days (OBD) in a rolling quarter in relation to inappropriate out of area placements (OAPs).	Not yet being achieved. Latest data as of February 2023: 815 OBD in relation to inappropriate out of area placements.	• Continue investment in improving the therapeutic offer to improve outcomes and experience from inpatient care, and • work to decrease long lengths of hospital stay, with a focus on reducing the number of working age adults in acute care with a stay over 60 days and the number of older adults with a stay over 90 days. • Work to implement the Getting It Right First Time (GIRFT) programme which reviews adult crisis and acute mental health care	• Bedfordshire MH hospital health village build • Community crisis and recovery pathway developments with Place is a core objective of the MHLDA Collaborative • JFP High Impact Programme 'Improving Outcomes for people with mental health, learning disabilities and autism' will develop market strategy with each Place to explore sustainable and local solutions to provide section 117 care to residents within the BLMK geography
26	Mental Health	Recover dementia diagnosis rate to 66.7% for 2023/24 is achieving and maintaining the dementia diagnosis rate (of 66.7%) and improving post-diagnostic support (6667 with an estimated prevalence of 9995).	In March 2023 we achieved 66.8%	• Implementation of a Dementia Intensive Support Team in Bedfordshire which has expanded provision in Luton. • Memory Navigation Telephone Service in place in Bedfordshire to help people worried about their memory or living with dementia, and carers. • New specialist dementia diagnosis service for care home residents set up by ELFT in Central Bedfordshire as part of a national NHS pilot. This project is working well and leading to an increase in referrals from care homes, the majority of which resulted in a diagnosis.	• Population growth modelling by Borough during mobilisation of the JFP, to ensure that we have good understanding of increases in older people / adults experiencing the highest inequalities will change to 2040, enabling strategic demand / capacity planning • Diagnosing and supporting people with dementia will be led by the MHLDA Collaborative working with each Place to deliver local plans to sustain dementia diagnosis
27	Mental Health	Improve access to perinatal MH services National target for 23.24 requires BLMK to continue with FYFV figure (814) + an additional 464 - total 1,278	Year-end position for perinatal mental health activity showed that target was not met	Remedial action plan to address activity in the Bedfordshire and Luton service now agreed with the Mental Health Delivery Group.	Women and their partners will be able to self-refer to local perinatal mental health and maternal mental health services for speedy access to support, and evidence-based intervention.

	Area	NHSE Targets	Current BLMK Position	2023-4 BLMK Operational Plan Actions	Joint Forward Plan Actions
28	Learning Disability & Autism	75% of over 14 year olds on GP LD registers have an annual health check and action plan by end of the year Our 2023-24 ambition is to maintain the 75% target.	As of 2022/23 year-end the 2023/24 target is achieved at 75.4%. Completion of Health Action Plans (HAPs) in year for patients receiving an AHC was 96.7% in 2022/23	• Work to address health inequalities in health checks including: - Improved communication - Addressing Barriers - Development and training needed for PCNs/primary care - Advocacy support • To support maintaining the target to understand and support those who are declining a health check with information and providing reasonable adjustments and to ensure the quality of the Health Action Plans.	• The JFP High Impact Programme 'Integrated Neighbourhood Working' will lead our ongoing actions at Place to sustainably deliver this requirement
29	Learning Disability & Autism	Fewer than15 under 18 year olds are inpatients in a designated facility at the end of the year	By the end of 2022/23 we had met the target for adult services with 20 inpatients. (9 ICB inpatients and 11 Provider Collaborative.) We did not meet the target with services for under with 7 inpatients against a trajectory of 3.	Adults: • Local integrated offer for people with complex mental health and/ or learning disability needs, whose placement needs are currently met through contracting with independent sector providers. Milton Keynes: Complex Care • – focussing on improving the planning, assessment, commissioning, and case management for people who have the most complex needs. Mental health, Learning Disabilities and Autism Collaborative	• JFP High Impact Programme 'Improving Outcomes for people with mental health, learning disabilities and autism' will develop market strategy with each Place to explore sustainable and local solutions to provide section 117 care to residents within the BLMK geography
30	Prevention & Health Inequalities	77% of patients with hypertension treated to NCE guidance by the end of the year	Currently 58.15% and working to achieve national target	A well-established LTC programme as part of the neighbourhood (Fuller) work	
31	Prevention	Achieve 60% of 25 - 84 year olds with a CVD risk score of >20% being on lipid lowering therapies	Current position for 18 years and above is 58.96%	A well-established LTC programme as part of the neighbourhood (Fuller) work	
32	Health Inequalities	**Cancer Screening and Early Diagnosis** AIM: early diagnosis and treatment: • Improving early diagnosis and treatment in Luton so that 75% of cases are diagnosed at stage 1 or 2 by 2028 • Improving early diagnosis of cancer in Luton so that 75% of cases are diagnosed at stage 1 or 2 by 2028, recognising the role of secondary care.		• To embed a focus on health inequalities in how we hold systems to account for delivery • To particularly focus on equity of access, experience and outcomes for the most deprived 20% of the population and the five clinical areas of focus set out in 'Core20PLUS5' where we know we can make the greatest difference (maternity, severe mental illness, chronic respiratory disease, cancer and hypertension case-finding). • 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% • A change theory will be developed next with measurements in place.	

	Area	NHSE Targets	Current BLMK Position	2023-4 BLMK Operational Plan Actions	Joint Forward Plan Actions
	Health Inequalities	**Serious mental Illness** AIM: SMI health checks • Ensuring annual health checks for 60% of those living with SMI across BLMK (bringing SMI in line with the success seen in learning disabilities). **Maternity** AIM: Ensuring continuity of care for 75% of women from BAME communities and from the most deprived groups. • Reducing the rate of still births, neonatal, maternal and infant mortality in 20% most deprived. **CYP Core20+5** **Aim**: Ensure an enhanced focus on Core20+5 groups across key clinical areas to narrow the inequalities gap in CYP across BLMK. Increasing access to all primary care services, with a focus on health inclusion groups and 20% most deprived across BLMK.		**Mental health** BLMK learning disabilities and autism steering group set up. Weight management, comorbid mental illness.3-part data review is underway Governance structure is complete which reports to MH and LD board. CYP social prescribing inequalities project in place through the inequalities funding **Maternity** Preconception inequalities project in place. (Mothers or expectant mothers from ethnic minority backgrounds or deprived areas). Engagement event started to explore assets and needs and governance structure emerging. Driver diagram in draft where measures will be embedded. **Cancer Luton Outcomes project – (**People with cancer in Luton, with particular focus on high-risk groups including ethnic minority communities, deprived communities and others.) Extensive research completed into assets and needs and a cross-system programme meet monthly. 4 workstreams feed into this regularly and then into cancer board. A change theory is in progress where a specific aim for overall programme and measurements will be complete and tested **Denny Review –** Literature review commissioned to pull out what population groups are experiencing the greatest health inequalities, to engage with those population groups and set some recommendations for BLMK ICS to take forward.	

4.2 The BLMK Joint Forward Plan and our ICB Statutory / Mandatory Responsibilities

Area	ICB Statutory / Mandatory Targets	Current BLMK Position	Ops Actions Underway	Longer term actions for Joint Forward Plan
Complex Placements, including children's continuing care, CHC and section 117	• Timeliness of assessment & review • Quality of care & placements • Affordability to public purse	• Summary of cost pressures • Market issues • Quality concerns • Outcomes for residents (i.e. out of area)	• Section 117 market review underway • Planning in Place with Boroughs on CCC sustainable options • Exploring CHC partnership across ICBs	• Capital investment strategy to accommodate more complex placements within BLMK • Clinical strategy to develop recovery-focused models of care, and ensure workforce supply and competence to deliver • Market management strategy to co-ordinate across Boroughs and ICB for commissioned placements
NHSE People Plan	• Looking after our people • Belonging in the NHS • New ways of working and delivering care • Growing for the future	• BLMK ICS staff survey score of 6 for 'We are safe and healthy'. Highest ICS score in EoE and above the National and Regional Benchmark • Place based teams becoming established and will drive transformation and new ways of working • 14.91% turnover rate and workforce plans showing 2.1% workforce growth 2023/24. Workforce Planning and supply workstream in place	• Delivering an OD Framework to enable new ways of working within the NHS and cross organisational collaboration • Deliver on Anchor ambition to ensure we can grow our workforce for the future and attract our local population into good work • Integrated workforce planning and innovative recruitment pathways to support growth and new ways of working • Delivery of the 'one workforce'	Developing our workforce is key to delivery of all the High Impact Programmes in our JFP. Key areas we will need to deliver to achieve our JFP are: • Delivery of the NHS Long-term workforce strategy to enable and support pipe-line workforce planning and retention based on population growth • Redistribution across ICBs / regions of junior doctor resources against population headcount – strategic plan with Deaneries for implementation in BLMK • Deliver the recommendations from the Beds university research on workforce and inequalities • Place plans for our responsibilities as Anchor Institutes in line with Borough growth plans • Aligning WF strategy to employment / training opportunities in Borough economic plans • Digital by default – enabling tools for our workforce to enable joined up care through EPR

Area	ICB Statutory / Mandatory Targets	Current BLMK Position	Ops Actions Underway	Longer term actions for Joint Forward Plan
Environmental Targets	• The NHS must pay due regard to targets under the Climate Change Act (net zero by 2050). Through statutory guidance under the Health and Care Act 2022, the NHS has set more stringent goals of being Net Zero by 2040 (NHS Carbon Footprint) and 2045 (NHS Carbon Footprint Plus. • Due regard must be paid to targets for England set under Environment Act (EA) 2021	• ICS Green Plan and NHS Trust Green Plans all aligned to NHS net zero ambitions, if not earlier • Local Authority sustainability plans in place aligned to or more stringent than UK target of being net zero by 2050. • Public sector organisations in BLMK will be bound by requirements for Biodiversity Net Gain due from November 2023.	• ICS Green Plan in delivery with local partners. • AD of Sustainability and Growth a board member of the Bedfordshire Local Nature Partnership which will oversee development of the Local Nature Recovery Strategy. • ICB reporting on environmental statutory responsibilities in its Annual Report.	• Embed environmental sustainability considerations into all processes within the ICB, and across ICS partners. • NHS guidance to be applied to relevant sectors, including Net Zero Building Standards, Social Value in procurements, supplier Carbon Reduction Plans, stopping the use of desflurane in anaesthesia, reducing N_2O waste, moving to renewable energy. • Educate staff in statutory responsibilities and activities that can be undertaken to support progress towards the targets.
Personalisation	• Personal Health Budgets (PHBs) mandated for: ○ CHC ○ Children in receipt of Continuing Care ○ Wheelchairs ○ People in receipt of Section 117 aftercare • Social Prescribing ○ Meet trajectory to deliver BLMK % of 1000 Social Prescribing Link Workers (national target) ○ Meet trajectory to deliver BLMK % 900,000 referrals to social prescribing (national target) • Personalised Care and Support Plans (PCSP's)	• PHBs are in place for all the mandated areas except Section117. S117 clients can currently access PHB's, but we need to implement a robust and efficient process to increase availability and uptake. Delivery of numbers of PHBs (as per 5 Year LTP) is on track for delivery by end of 2023/24. • Social Prescribing ○ BLMK have already exceeded the numbers of SPLW's as per 5 Year LTP ○ BLMK have already exceeded the number of social prescribing referrals as per 5 year LTP • BLMK have already exceeded the number of social PCSP's as per 5 year LTP	• **Personal Health Budgets** (PHBs) – Monies provided to ELFT to employ a Project Manager for 6 months to support implementation of PHB's in Section 117. • **Social Prescribing** - Ongoing work to develop ARRS roles (incl SPLW's) in line with Neighbourhood/Fuller recommendations • **Personalised Care and Support Plans** Work underway to increase capture of the data and to further promote use of PCSP's across pathways including Maternity and Palliative and End of Life Care • **PHB's** - Further development of the local PHB offer – consider implementation outside of the current mandated areas • **Social Prescribing** - Explore opportunities to involve/embed ARRS roles in pathways e.g. CHC Utilise multiple data sources/machine learning to support case finding Identify further methods for recording impact of social prescribing/personalisation interventions	Personalisation is a key enabler in all our strategic objectives (start well, live well, age well, tackle inequalities, support growth). As such it supports delivery in multiple JFP High Impact Programmes: • Advancing Equity • Supporting our children & young people to thrive • Integrated neighbourhood working • Improving access & treatment (for example in cancer survivorship) To embed personalisation in our JFP, we will develop a personalisation strategy that targets interventions to the populations where they will have most benefit, as seen through the population-centric stratification model (volume vs. complexity of need) To embed personalisation in our JFP, we will develop a personalisation strategy that targets interventions to the populations where they will have most benefit, as seen through the population-centric stratification model (volume vs. complexity of need) and via the lenses of PHM and risk stratification. The strategy will utilise personalisation to improve outcomes for individuals, mitigate system demand and concomitantly improve access.

Area	ICB Statutory / Mandatory Targets	Current BLMK Position	Ops Actions Underway	Longer term actions for Joint Forward Plan
Personalisation (cont)				We will: • Use the expertise and local knowledge of the ARRS Personalisation roles to provide better, bespoke care for the large number of citizens at the far left of the population-centric stratification model, intervening to improve well-being mitigate escalation of conditions and issues • Use the ARRS personalisation roles to address barriers to physical activity • Use the lens of personalisation to improve outcomes for the smaller number of citizens with complex needs (eg MH Crisis, Continuing Care for Children, CHC) by focussing on personalised care and support planning and "what matters to" the client Key areas for development include: - Pre-CHC personalised support planning using own and own network resources - Complex placements strategy for all ages (MH, LD and autism) - Integrated offer with expansion of talking therapies as per Place plans - Tackling obesity (priority for all 4 Place plans)
Public Engagement & co-production	• Health and Care Act 2022, Section 14Z45 – duty to involve residents – to include victims of abuse and children and young people. • NHSE Involvement duty in 13Q	• Working with people and communities strategy developed with commitment to co-production and involving residents. • Public Participation and Engagement policy developed in conjunction with partners and issued as part of the ICB's formal Constitution • Training has been undertaken with over 300 people to support implementation of co-production • VCSE Memorandum of Understanding has been developed to support involvement, participation and co-production.	• Engagement with Gypsy, Roma Traveller people is underway • Framework for co-production has been co-designed with partners • Policies for remuneration are being developed with partners. • Development of a Memorandum of Understanding with Healthwatch • The development of recommendations for the Denny Review • System wide community of practice has been established to align approaches to involvement and co-production across the system. • Engagement with seldom asked people incl those with Learning and physical disabilities, homeless people and LGBTQ people has been undertaken to inform the Joint Forward Plan • Engagement has been undertaken with children and young people and victims of abuse to ensure their lived experienced are included.	• Implementation of shared remuneration policies and principles across BLMK • Development with information governance and finance to support with the removal of barriers to co-production • Training with residents and health and care professionals delivered to embed co-production at Place will become a sustainable programme • The implementation of the Denny Review to breakdown health inequalities.

Area	ICB Statutory / Mandatory Targets	Current BLMK Position	Ops Actions Underway	Longer term actions for Joint Forward Plan
Quality	**Quality** • National Patient Safety strategy 2019 implementation • PSIRF implementation • LPSE • Quality improvement - NHS Impact • Leder Health checks • Inpatient MH safety Safety LMNS NHS quality board measures awaiting	• Quality and safety cord team linking to place boards • PSIRF launch Sept 2023 • LPSE account established • ICB plan for QI training for ICB staff • 75% of people aged 14 or over with a learning disability will have had an annual health check • Progression work on MH inpatient safety with local providers of care	• Introduce new Inequality improvement advisor team • Inequalities leadership group commenced • Performance reports reviewed and increased use of SPC charting and correct interpretation. • System quality group identified system risks • System investigation panel establishing for 2 or more providers harms	• Relentless focus on quality improvement capacity and capability across the system building on work done within ELFT and CNWL. • Agree contract with the IHI for 3 years and start working on population health inequalities • Learning system across the ICS connect with PSIRF implementation, CQC, LNMS, and JTAI/SEND agendas for all. • Single source of the truth programme over next 3-8 years – clear focus on improvement and inequalities. • Inequalities strategy devised and delivered.
Safeguarding	• Key areas of focus under the safeguarding system agenda for 2023 onwards • Mental capacity act amendment bill • Domestic abuse and violence bill • Sexual abuse in sports • Female genital mutilation information system • Contextual safeguarding and digital data • The National Network of Designated Healthcare Professionals for Safeguarding Children (NNDHP) • Looked After Children Clinical Reference Group (LAC CRG)	• Place based and provider/ primary care based safeguarding teams and meetings in place alongside statutory requirements • Shared child death review panel commenced • JTAI and SEND action plans being reviewed and escalated – evidence of more and more collaborative working needed.	• Develop a system wide health and social care escalation MDT for any age with any complex background for learning/support and senior decision making • Transformation programmes aligned to core 20 plus 5 for all • Reviewing meetings/processes in place since ICB a year old. • Regularly develop meetings,1.1 and joint with DAS's, DCS's and ICB leadership quality/safeguarding team • Director level involvement in Pan Beds and MK VRU violence reduction units.	• To have a clear system safeguarding strategy • To have agreed safeguarding training for health and social care. • ICB included in stator responsibility for serious violence reduction • Build in shared safeguarding information into health and social care digital documentation to support staff with shared understanding of needs and support required. • Build a learning system for all staff to access

Area	ICB Statutory / Mandatory Targets	Current BLMK Position	Ops Actions Underway	Longer term actions for Joint Forward Plan
Safeguarding (cont)	• Modern slavery human trafficking network • Safeguarding Adults National Network (SANN) • Child Protection Information Sharing (CP-IS) System • Working Together Implementation Group • Prevent			
GP Recovery	Contribute to growth in GP appointments. Improve access to same day appointments. To tackle the 8am rush and reduce the number of people struggling to contact their practice For patients to know on the day they contact their practice how their request will be managed.	To 22/23 from 19/20 appointments grew in BLMK by 10%. Face to face levels of activity are high in BLMK – better than rest of England. • Need to improve level of same day appointments – currently rank 35/42 (based on March 2023 data).	PCNs providing access improvement plans by 28 June to set out plans to improve access as specified • Implement neighbourhood working to improve access for the population	• Provide scaled models of same day and urgent primary care to support access for the population
Delegation to ICBs of Podiatry, Optometry and Dentistry ('POD' services)			• The action to stabilise contracts is twofold – the ICB will meet and greet contractors hosting an event for dentists in June and community pharmacies in July. Building on early communications to ensure contractors know who to contact within the ICBs for contract advice and support i.e. team transferred from NHSE and NHS BSA. - The ICB will do what it can to support contractors whilst we understand the financial and contractual implications of the newly delegated contracts and the challenges recruiting clinical staff. NB the ICB will be required to comply with national policy for e.g. dental year end contract management and where required claw back funding where contractors	

Area	ICB Statutory / Mandatory Targets	Current BLMK Position	Ops Actions Underway	Longer term actions for Joint Forward Plan
Delegation to ICBs of Podiatry, Optometry and Dentistry ('POD' services) (cont)			have not met their contacted activity. Funding claw back is used each year on a non-recurrent basis to commission additional activity, however in 2022/23 the financial clawback will be retained by NHSE and not transfer to the ICB making stabilising contracts more challenging	
Prevention	To deliver the NHS Long Term Plan (LTP) Treating Tobacco Dependency Programme by 23/24 in maternity services, acute inpatient settings and mental health inpatient settings.	• Recruitment within all areas is developing and will enable clinical and project leads to mobilise the programme in time for March 2023. • Support from local Tobacco Control & Stop Smoking services aligned to develop these roles. • A dedicated Prevention Programme Manager now working within the Integrated Care Board to provide ongoing leadership and support. • Collaborative working with Community Pharmacy Smoking Cessation Services to ensure choice of pathways post discharge from an acute hospital into pharmacy provision are in place. • Learning from best practice throughout regional teams. Continuous review of data using the Tobacco Dependence Programme Patient Level Dashboard.	• In spite of ongoing pressure on health system, we are establishing tobacco treatment services for three groups of patients (users of specialist MH services, pregnant women and their families, patients admitted overnight) in four different trusts within BLMK; Bedfordshire Hospitals Foundation Trust (Acute inpatients and Maternity), Milton Keynes University Hospital (Acute inpatients and Maternity), East London Foundation Trust (Mental health services in Bedfordshire) and Central and North West London Foundation Trust (Mental health services in Milton Keynes).	• To embed elements of the programme within wider BLMK prevention strategy and associated workstreams. We are on track to have these new tobacco treatment services established by the end of March 2024. We hope to continue these prevention pathways in the longer term reaching targeted communities to reduce health inequalities; this is subject to continued funding. • Further work is being undertaken to identify support for patients who are accessing services from other localities – to develop pathway with our Medicines Optimisation team.
Digital	Rollout and optimisation of **ICS level dashboards** to support capacity management and care planning	• Working with the national team directly to support the programme. Benefits from full integration not yet available from NHS E	• Digital team engaging with Trusts on all initiatives • Key deliverable for ICS, OPS to monitor, advise and support	Digital is a key enabler in all our strategic objectives (start well, live well, age well, tackle inequalities, support growth). As such it supports delivery in multiple JFP High Impact Programmes: • Intelligence-led quality, performance, outcomes and inequalities improvement • Advancing Equity

Area	ICB Statutory / Mandatory Targets	Current BLMK Position	Ops Actions Underway	Longer term actions for Joint Forward Plan
Digital (cont)	**Electronic Bed and Capacity Management System (eBCMS)** roll-out across acute trusts enabling live, real-time data on bed status and patient flow **Electronic Patient Record (EPR)** delivery and optimisation to support increased productivity, quality and safety Accelerating rollout of promising **AI** imaging tools to reduce diagnostic backlogs, save clinicians time and speed-up treatment	• eBCMS n place in one Site, in deployment on two further sites • EPR in place in one site, programmed for the other two • OBC for strategic data platform to be presented to F&IC in September, target date for initial contract go live q3 2024 • Part of strategic data programme	• Joint programme working with Lead Local Authority supporting all LAs and care home and domiciliary provision • Strategic Data Platform to support local, regional and national data feed • Shared Health and Care programme in final stages of deployment, Digitisation of Social Care planned through to 2026 • AI imaging piloting in two sites	• Supporting our children & young people to thrive • Integrated neighbourhood working • Improving access & treatment • Improving outcomes for people with MD, LD and Autism It also underpins delivery of much of our Effectiveness and Efficiency programme and supports our workforce plan's delivery. Through the health services strategy and research and innovation Enablers, we will challenge ourselves to embrace technology, including artificial intelligence to improve health outcomes and tackle inequalities for all our residents throughout the delivery of our JFP