Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

Health and Care Partnership

Date: 31 October 2023
Time: 14:00 to 16:00
Venue: Luton Borough Council Chamber, Town Hall, George Street, Luton LU1 2BQ

Agenda

No.	Agenda Item	Lead	Purpose	Time
Opening Actions				
1.	Welcome, Introductions and Apologies	Deputy Chair	-	2.00
2.	Appointment of the Chair	Chair	Approve	
3.	Relevant Persons Disclosure of Interests • Register of Interests	Chair	Note changes and approve	
4.	Approval of Minutes and Matters Arising			
5.	Review of Action Tracker			
6.	Health and Care Partnership Governance, Work Programme and Approach for 2023/24	Chief of System Assurance and Corporate Services	Approve	2:05
7.	Resident story - linked to Denny Review	Chief of System Assurance and Corporate Services	Note	2.15
8.	Delivering our Strategy at System and Place – Reports from the Health and Wellbeing Boards and ICB	Rima Makarem Cllr Martin Towler Cllr Rebecca Hares Cllr Hazel Simmons Cllr Peter Marland	Note	2.25
Strategy				
9.	Denny Review	Chief of System Assurance and Corporate Services	Discuss	2.45
10.	Health and Employment outline strategy framework	Chief of System Assurance and Corporate Services	Discuss	3.05
11.	Right Care, Right Person	Chief Transformation Officer CNWL/ELFT	Discuss	3.20
12.	NHS Operational Planning 2024/25	Chief Transformation Officer	Note	3.35

No.	Agenda Item	Lead	Purpose	Time
Governance				
13.	Communications from the meeting	Chair	Discuss	3.45
14.	Review of meeting effectiveness	Chair	Note	3.50
Closing Actions				
15.	Any Other Business	Chair	-	3.55
16.	Date and time of next meeting:	Chair	-	

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NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 31 October 2023

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

Report Author: Michelle Evans-Riches, Acting Head of Corporate Governance

Report to the: Integrated Care Partnership

Item: 2. Appointment of the Chair

1.0 Executive Summary

1.1 The

2.0 Recommendations

2.1 The members are asked to **approve** that Khtija Malik and Martin Towler are co-Chairs of the Integrated Care Partnership for a period of two years.

3.0 Key Implications

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

3.1 None as a result of this report.

4.0 Report

4.1 Tracey Stock was the former chair of the ICP, and stood down as a Central Bedfordshire Councillor at the local elections in May 2023.

4.2 Following the elections the Councils representatives on the ICP agenda setting group, Cllrs Khtija Malik, Martin Towler, Rebecca Hares and Peter Marland, were asked to seek nominations from their respective Councils to be the Chair of the ICP. The Council's nominated Khtija Malik and Martin Towler and it is recommended that they co-chair the ICP. The ICP Terms of Reference specify that the appointment will be for two years.

4.3 At the ICP meeting on 21 September 2022 Rima Makarem was appointed as the Deputy Chair of the ICP for a period of two years.

5.0 Next Steps

5.1 Please outline what will happen next including key dates.

List of appendices

None

Background reading

None

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

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

#NAME?

Extract from Register of Conflicts of Interest
BLMK Integrated Care Partnership
as at 17.10.23

				Type of Interest								
Surname	**Forename**	**Position within, or relationship with the ICB**	**Interests to Declare**	**Financial Interest**	**Non-Financial Professional**	**Non-Financial Personal**	**Indirect**	**Description of Interest**	**Date From**	**Date To**	**Actions to be taken to mitigate risk**	**Date Declared**
Barhey	Manraj ("Baz")	Primary Care Network Clinical Director, Luton	Yes		Y			Medics PCN Clinical Director	01/07/2019	Ongoing	Declare in line with conflicts of interest policy	13/03/2022
Barhey	Manraj ("Baz")	Primary Care Network Clinical Director, Luton	Yes		Y			GP Woodland Avenue Practice	01/04/1995	Ongoing	Declare in line with conflicts of interest policy	23/08/2022
Barhey	Manraj ("Baz")	Primary Care Network Clinical Director, Luton	Yes		Y			Member of Evexia - GP Federation	01/09/2021	Ongoing	Dedclare in line with conflicts of interest policy	23/08/2022
Barhey	Manraj	Primary Care Network Clinical Director, Luton	Yes		Y			GP with Interest in Dermatology and Skin Surgery	01/04/1995	Ongoing	Declare in line with conflicts of interest policy	23/08/2022
Blackmun	Diana	Chief Executive Officer, Healthwatch Central Bedfordshire	No									05/12/2022
Bradburn	Robin	Deputy Leader Milton Keynes City Council, member of Health and Care Partnership	No									03/01/2023
Cartwright	Sally	Director of Public Health, Luton Council	No									22/06/2022
Coiffait	Marcel	Chief Executive, Central Bedfordshire Council	Yes	Y				I am the Chief Executive of Central Bedfordshire Council which is an may be commissioned to work on behalf of the ICB	01/11/2020	Ongoing	Declare in line with conflicts of interest policy	27/05/2022

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Type of Interest: Financial Interest	Type of Interest: Non-Financial Professional	Type of Interest: Non-Financial Personal	Type of Interest: Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Cox	Felicity	Chief Executive, Bedfordshire, Luton and Milton Keynes Integrated Care Board	Yes		Y			I am a registered pharmacist with the General Pharmaceutical Council (GPC) and a member of the Royal Pharmaceutical Society	17/08/1987	Ongoing	I will excuse myself should an interest arise	14/06/2022
Cox	Felicity	Chief Executive, Bedfordshire, Luton and Milton Keynes Integrated Care Board	Yes		Y			I am a trustee of a charity as a member (and secetary) of the parochial church council of the Ecclesiastical Parish of Bushey	01/07/2023	Ongoing	We supply no services to the ICB	13/10/2023
Davis	Alison	Milton Keynes University Hospital,Chair and member of the Health & Care Partnership	Yes					Impact Mental Health Peer Support, 1 Brewer's Hill, Dunstable, Beds LU6 1AA (non Exec Chair)			No actions needed at present, unless funding from Local Authority discussed	01/02/2023
de Cartaret (Huggins)	Emma	Member and Trust Representative - East of England Ambulance Services NHS Trust	Yes			Y		Husband a BT manager	154/09/2019	Ongoing	Does not deal with any NHS contracts or processes	26/09/2022
de Cartaret (Huggins)	Emma	Member and Trust Representative - East of England Ambulance Services NHS Trust	Yes		Y			ICSA student member	01/01/2019	Ongoing	Does not deal with any NHS contracts or processes	26/09/2022
Elford	Mary	Cambridgeshire Community Services NHS Trust (Health and Care Partnership member)	Yes	Y				Chair, Cambridgeshire Community Services NHS Trust	01/04/2020	Ongoing	Declare in line with conflicts of interest policy	23/09/2022
Elford	Mary	Cambridgeshire Community Services NHS Trust (Health and Care Partnership member)	Yes		Y			Trustee and NED of NHS Providers	01/07/2021	Ongoing	Exclusion from involvement in related meeting or decision making	07/12/2022
Freda	Emma	Deputy CEP, Healthwatch Bedford Borough	No	Y				Employed by Healthwatch Bedford Borough, 21-23 Gadsby Street, Bedford, Beds MK40 3HP	01/10/2023	Ongoing	I will declare in line with the COI policy. I will remove myself from any decision that we have a conflict or perceived conflict in, if in agreement, and declare our specific interest at all appropriate meetings given the impending agenda item(s)	11/10/2023

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Type of Interest: Financial Interest	Type of Interest: Non-Financial Professional	Type of Interest: Non-Financial Personal	Type of Interest: Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Head	Vicky	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes.	No									27/06/2022
Hopkins	David	Elected member, Milton Keynes City Council	Yes					I am directed by the Director, Law & Governance at MK City Council to declare: Director Milton Keynes Development Partnership (wholly owned MKCC company)			Declare in line with conflicts of interest policy	12/01/2023
Hopkins	David	Elected member, Milton Keynes City Council	Yes					I am directed by the Direcdtor, Law & Governance at MK City Council to declare: Member of Woburn Sands Town Council and Member of and Chairman of Wavendon Parish Council			Declare in line with conflicts of interest policy	12/01/2023
Kibasi	Thomas	Chair, Central and North West London Trust	Yes		Y			Employed by Flagship Pioneering which conceives, creates and scales biotechnology companies, as Senior Vice President, Strategy	01/04/2021	Ongoing	Declare in line with conflicts of interest policy	20/09/2023
Kibasi	Thomas	Chair, Central and North West London Trust	Yes		Y			Director at UCL Health Alliance (linked to CNWL Chair role)	03/04/2023	Ongoing	Declare in line with conflicts of interest policy	20/09/2023
Kocen	Jane	Bedfordshire Care Alliance Member - Clinical Director for Caritas Medical Primary Care Network	Yes				Y	My Husband Dr Rory Harvey is a Consultant Gastroenterologist at Bedford Hospital (1999) , he is one of the clinical leads for integration and the clinical lead for general surgery across both hospital sites	Jun-05	Ongoing	Declare in line with conflicts of interest policy	09/12/2022
Macpherson	Angela	Integrated Care Partnership Board member, Deputy Leader, Buckinghamshire Council	No									22/09/2022
Makarem	Rima	Chair, Bedfordshire, Luton and Milton Keynes Integrated Care Board	Yes		Y			Expert on Independent Expert Panel evaluating for the Health and Social Care Committee the government's commitments to pharmacy services	Apr-23	July 23	Declare in line with conflicts of interest policy	26/04/2023
Makarem	Rima	Chair, Bedfordshire, Luton and Milton Keynes Integrated Care Board	Yes		Y			Chair of Sue Ryder (non remunerated)	01/05/2021	Ongoing	Declare in line with conflicts of interest policy	17/06/2022

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Makarem	Rima	Chair, Bedfordshire, Luton and Milton Keynes Integrated Care Board	Yes	Y				Chair of Queen Square Enterprises Ltd (remunerated)	01/11/2020	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Makarem	Rima	Chair, Bedfordshire, Luton and Milton Keynes Integrated Care Board	Yes	Y				Lay Member of General Pharmaceutical Council	Apr-19	Ongoing	Declare in line with conflicts of interest policy	17/06/2022
Makarem	Rima	Chair, Bedfordshire, Luton and Milton Keynes Integrated Care Board	Yes		Y			Trustee of LifeArc	June 2023	Ongoing	Declare in line with conflicts of interest policy	26/04/2023
Malik	Khtija	Co-Chair and Councillor, Luton Borough Council	Yes		Y			Governor on East London NHS Foundation Trust	2019	Ongoing	Declare in line with conflicts of interes policy	
Marland	Peter	Leader of a local authority	No									07/12/2022
Mehta	Sonal	Voluntary, Community and Social Enterprise Partnership Lead	Yes		Y			Honorary Associate, The Open University. Delivering talks and writing articles to support the Ageing Well project.	Jul-22	July 2024	Declare interest for any agenda items related to ageing.	07/12/2022
Mehta	Sonal	Voluntary, Community and Social Enterprise Partnership Lead	Yes	Y				Director, Catalyst Health Solutions CIC, 18 Station Terrace, Marsh Drive, Great Linford, Milton Keynes MK14 5AP The company offers training and consultancy services to organisations operating in th health, wellbeing and car sector	Feb-21	Ongoing	Remove myself from any decisions regarding commissioning of training or consultancy support	28/09/2022
Murphy	Mike	Executive Director of Strategy and Business Development, South Central Ambulance Service	No									26/09/2022
Nicholson	Lucy	Chief Executive, Healthwatch Luton	No									05/10/2022
Rammohan	Navaneetha	Clinical Director, Nexus Milton Keynes Primary Care Network/Integrated Care Partnership representative for Milton Keynes Primary Care Networks	Yes		Y			Oakridge Park Medical Centre, GP Partner	01/02/2018	Ongoing	To be excluded from meeting when discussing primary care issues	26/09/2022

Surname	Forename	Position within, or relationship with the ICB	Interests to Declare	Type of Interest: Financial Interest	Type of Interest: Non-Financial Professional	Type of Interest: Non-Financial Personal	Type of Interest: Indirect	Description of Interest	Date From	Date To	Actions to be taken to mitigate risk	Date Declared
Rammohan	Navaneetha	Clinical Director, Nexus Milton Keynes Primary Care Network/Integrated Care Partnership representative for Milton Keynes Primary Care Networks	Yes		Y			Nexus MK PCN - Clinical Director	01/07/2019	Ongoing	To be excluded from meeting when discussing primary care issues	26/09/2022
Sharp	Andy	Director, Social Care, Health & Housing, Central Bedfordshire Council	Yes	Y				Director, New Vista Homes	01/02/2023	Ongoing	Declare in line with conflicts of interest policy	12/09/2023
Sharp	Andy	Director, Social Care, Health & Housing, Central Bedfordshire Council	Yes	Y				Director, Care is Central	01/02/2023	Ongoing	Declare in line with conflicts of interest policy	12/09/2023
Sharp	Andy	Director, Social Care, Health & Housing, Central Bedfordshire Council	Yes	Y				Director, Central Bedfordshire Group	01/02/2023	Ongoing	Declare in line with conflicts of interest policy	12/09/2023
Taylor	Eileen	Acting Chair East London NHS Foundation Trust (substantive chair from 1/1/23)	Yes		Y			Chair Designate East London NHS Foundation Trust from Jan 1, 2023 (currently acting chair) 9 Alie Street London E1 8DE	Acting Chair 01/04/2022 To become substantive Chair 1/1/2023	30/09/2025	As appropriate	08/12/2022
Taylor	Eileen	Acting Chair East London NHS Foundation Trust (substantive chair from 1/1/23)	Yes		Y			Chair Designate North East London NHS Foundation Trust CEME Centre- West Wing Marsh Way Rainham Essex RM13 8GQ	01/01/2023	30/09/2025	As appropriate	08/12/2022
Taylor	Eileen	Acting Chair East London NHS Foundation Trust (substantive chair from 1/1/23)	Yes		Y			Non Executive Director MUFG Securities EMEA PLC 25 Ropemaker Street London	01/04/2019	Ongoing	As appropriate	08/12/2022
Walker	Kate	Adult Services, Bedford Borough Council	No									11/01/2023

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 07/03/2023

Time: 17.00

Venue: MS Teams

Minutes of the: Health and Care Partnership

Members:			
Surname	**Forename**	**Title**	**Initials**
Stock	Tracey	Chair	TS
Barhey	Baz	PCN Clinical Director Luton	BB
Cartwright	Sally	Director of Public Health, Luton	SC
Cox	Felicity	CEO BLMK ICB	FC
Davis	Alison	Chair Milton Keynes Hospital	AD
De-Carteret	Emma	Director of Corporate Affairs and Performance, East of England Ambulance	ED
Ekuban	Belinda	PCN Clinical Director, Central Bedfordshire	BE
Griffiths	Dorothy	Chair CNWL	DG
Head	Vicky	Director of Public Health Bedford Borough, Central Bedfordshire and Milton Keynes	VH
Hopkins	David	Councillor Milton Keynes Council	DH
Hussain	Javed	Councillor, Luton Borough Council	JH
Jackson	Louise	Chair of the Health and Wellbeing Board, Bedford Borough Council	LJ
Kocen	Jane	PCN Clinical Director Bedford	JK
Learoyd	Elizabeth	Healthwatch Bedford Borough	EL
Linnett	Simon	Chair Bedfordshire Hospitals	SL
Malik	Khtija	Public Health and Commissioning Luton Council Portfolio Holder	KM
Marland	Peter	Milton Keynes City Council, Leader	PM
Mehta	Sonal	BLMK VCSE Lead	SM
Nicholson	Lucy	Healthwatch Luton	LN
Ogley	Julie	Director of Social Care, Health and Housing, Central Bedfordshire Council	JO
Rammohan	Navaneetha	PCN Clinical Director, Milton Keynes	NR
Taylor	Eileen	Acting Chair, East London Foundation Trust	ET
Walker	Kate	Director of Adult Services, Bedford Borough Council	KW

In attendance:			
Surname	**Forename**	**Title**	**Initials**
Brierley	Anne	Chief Transformation Officer BLMK ICB	AB
Boosey	Jacqueline	Business Manager - Health & Wellbeing, Buckinghamshire Council	JB

In attendance:			
Surname	**Forename**	**Title**	**Initials**
Chakrabarti	Sanhita	Clinical Lead, BLMK ICB	SC
Dugmore	Catherine	Non Executive Director, ELFT	CD
Fradgley	Richard	Director of Integrated Care ELFT	RF
Graves	Ross	Chief Strategy and Digital Officer, CNWL	RG
Poulain	Nicky	Chief Primary Care Officer, BLMK ICB	NP
Stanley	Sarah	Chief Nursing Officer, BLMK ICB	SS
Summers	Michelle	Associate Director Communications & Engagement, BLMK ICB	MS
Tovey	Hilary	Interim Director, Strategy and Planning, BLMK ICB	HT
Wogan	Maria	Chief of System Assurance and Corporate Services	MW
Evans-Riches	Michelle	Programme Manager ICS Transition, BLMK ICB	MER

Apologies from members:			
Surname	Forename	Title	Initials
Blackmun	Diana	Healthwatch, Central Bedfordshire	DB
Elford	Mary	Chair Cambridgeshire Community Services	ME
Keech	Tracy	Healthwatch Milton Keynes, Deputy CEO	TC
Makarem	Rima	Chair BLMK ICB	RM
Simmons	Hazel	Leader, Luton Council	HS
MacPherson	Angela	Leader, Buckinghamshire County Council	AM

Two members of the public also attended

No.	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate.	
2.	**Relevant Persons Disclosure of Interests** Members were asked to declare any relevant interests relating to matters on the agenda and there were none declared.	
3.	**Approval of Minutes and Matters Arising** The minutes of the meeting held on 14 December 2022 were approved as a true record.	
4.	**Review of Action Tracker** **Action 15 Fuller Neighbourhood programme**	

	Local authorities to confirm support for onward communication with primary care bulletin. **Action 16 AOB – Smoking cessation and weight management self-referral** The Directors of Public Health confirmed that self-referral is available for BLMK residents to smoking cessation and weight management support.	**MER to follow up**
5	**Health and Care Strategy and Five Year Forward Plan** All integrated care boards are required by NHS England to produce a Joint Forward Plan which identifies what actions are going to be taken to deliver the Integrated Care Strategy. The Joint Forward Plan (JFP) is required to span a minimum of five years, however in BLMK we want to plan for a longer period of 15-20 years due to the proposed growth and the change in demographics in BLMK projected over the next 10-15 years. The focus of the JFP is to identify the 'wicked' issues that we can only address effectively in collaboration These actions build on the Place JSNA and Plans, the integrated care strategy to deliver our objectives to reduce inequalities and improve health outcomes. The plan needs to specify how we are going to meet NHS standards in areas such as timely cancer diagnosis and treatment, elective surgery, mental health, learning disabilities and autism spectrum disorder, children and young people's services, access to primary care and how we are implementing the Fuller neighbourhood's programme. The report outlined the plan for developing the Joint Forward Plan which will require engagement with partner organisations and residents. <u>Summary of Discussion:</u> • Importance of identifying the voice of the resident/patient in determining the "wicked" issues at Place to work collaboratively on and tackle inequalities. • Schematic on slide 4 needs to be altered to include local authority decision making bodies as well as the Trusts and Foundation Trusts. **ACTION** • The correlation between income and health, whereby as income levels increase so does the person's health needs to be included. • Welcomed the emphasis on Place and that the joint forward plan is being built from Place Plans recognising that Joint Strategic Needs Assessments will be refreshed over time. • Structured and planned co-production needs to be embedded in the delivery of the plan and this will be with groups and communities that are defined by the service/issue/area that is being worked on e.g. the relevant community will be self-defined. We need to recognise where we have information already from listening to residents and that Healthwatch has a wealth of information that provides valuable insight.	**ACTION 17AB**

	It is important that engagement is not duplicated. The Working with People and Communities Committee and the Engagement Collaborative have valuable insight and a key role in this area. • Co-production is defined in the Working with People and Communities strategy and this sits as part the ladder of participation, where approaches to participation are tailored appropriately to the piece of work. This can be described in the plan. • The support the system can provide to Place e.g. hub and spoke model, that enables system wide and local actions to be taken to address need. **ACTION: Case studies of how the methodology will be used for collective single delivery and how it can be used for bespoke actions for a community will be included in the plan.** • Correlation of Fuller neighbourhoods with this plan and the projected growth in population in BLMK which will increase demand on services. We need to define the resource requirements by defining the models of care and the workforce requirements to meet the needs of increasing demand. • The importance of defining outcomes and designing services that matter to residents is more important than defining community. The emphasis needs to be to design and delivery of programmes in areas that matter to residents. **Agreed: That the comments at the meeting will be incorporated in the next iteration of the joint forward plan that will identify the issues we are collectively trying to address and how population growth may affect these.**	**ACTION 18 AB** ACTION AB
6	**Place plans, Health and Wellbeing Board updates and Health and Wellbeing Board guidance** In addition to the Health and Wellbeing Board updates in the report, Cllr Louise Jackson provided the following update: **Update from the Bedford Borough Health and Wellbeing Board and Executive Delivery Group** • The last meeting of the Bedford Borough Health and Wellbeing Board was on 7 December 2022 • The Board received an update on the Better Care Fund including additional winter funding to support discharge from hospital. • The Board heard about Warm Homes Bedford Borough – a population health management initiative funded by BLMK ICS and delivered in partnership between the Council, the ICB and the National Energy Foundation, which is designed to identify and support people with health conditions that may be exacerbated by cold or damp conditions this winter, providing advice and practical support to help keep their homes warm and dry. • The Board received an update from the BLMK Cancer Lead, with a focus on cancer outcomes and system recovery. It was noted that there remained significant variation in screening uptake across BLMK, and that	

there was renewed focus with primary care colleagues on promoting symptom awareness to support earlier detection of cancer. A new pathway had been introduced for patients with non-specific cancer symptoms, and work was ongoing to reduce the number of patients waiting over 62 days for treatment. A concern was raised that Bedford Borough residents accessing cancer care at Addenbrooke's Hospital might be adversely affected by the proposed Cambridge congestion charging zone, and it was agreed that the Board would submit a response to the consultation accordingly.

- In an update on adult and children's mental health services the Board were advised that there has been a reduction in waiting times for appointments for talking therapies for adults, but Child and Adolescent Mental Health Services (CAMHS) were continuing to experience an increasing number and complexity of referrals, including crisis and eating disorder presentations. It was noted that a CAMHS Recovery college for those aged 12 and over was being introduced, that the Mental Health in Schools Teams were progressing well, and that an 8-bed inpatient CAMHS facility and a 'crisis sanctuary' for young people would be provided in the Borough from early 2023.
- The Chief Executive of Bedford Borough Council provided the Board with an update on the work of the Executive Delivery Group (EDG), which is an officer working group that was formed to drive forward the place agenda for health and care. Early discussions have included how to maximise the integrated neighbourhood teams as envisaged in the Fuller Report, working with the Primary Care Networks to support them with estates and workforce issues, and population health management approaches to identify and address health inequalities. The EDG is exploring the development of a Bedford Borough 'Deal' to focus the place partners' attention and resources on a small number of complex issues that require a system response. Potential areas of focus for a Bedford Borough 'Deal' are currently being scoped.

Buckinghamshire Council
Jacqueline Boosey, from Buckinghamshire Council added the information in the report that the Health and Wellbeing Strategy had been refreshed. It was clarified that 6,000 residents of Buckinghamshire Council are within the BLMK ICB geographical footprint and therefore, Buckinghamshire Council is a member of the BLMK Health and Care Partnership.

Central Bedfordshire Council
Central Bedfordshire Health and Wellbeing Board was meeting on 15 April and would be considering the refresh of the Health and Wellbeing Strategy 2023-28 and the Health and Wellbeing guidance issued in November 2022.

Agreed: That the following be noted:

A) The Place Plans for Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.
B) The reports from the Health and Wellbeing Boards.
C) The implications of the Health and Wellbeing Board guidance issued on 22 November 2022 and agree to take action as appropriate at place.

7	**Delegation of Dentistry, Optometry & Community Pharmacy** Nicky Poulain, Chief Primary Care Officer, BLMK ICB, provided an update on the delegation of responsibility of dentistry, optometry and community pharmacy to the ICB from 1 April 2023. As part of the delegation of responsibility from NHSE, the ICB will receive staff from NHS England who have expertise in planning and managing these services. It was noted that 2023/24 would be a transitional year with no visible changes to services. The ICB is building relationships with contractors and there are opportunities to explore how these services can help access to general practice e.g. NHS 111 service. There is already innovative work being undertaken e.g. dental professionals working with residents of care homes, which helps address inequalities and improves the nutrition of residents who may not be able to eat due to poor oral health. Dentistry is particularly challenging because of the national contract which limits the funding to undertake complex work. <u>Summary of discussion:</u> • Access to NHS dentists is a particular concern to residents. It has implications for general practice when a resident has to seek medical help for example for an infection and can exacerbate inequalities, as many dentists are no longer accepting NHS patients. • Prevalence of tooth decay in young children is high in BLMK and needs to be addressed. We have already started working with public health on prevention work with schools and colleges. • There is an opportunity to target activity at Place and work collaboratively especially with residents who do not use these services. • It was clarified that the Secretary of State for Health has responsibility for fluoridation of water which has proven benefits against tooth decay. • There is an opportunity to develop the community dentistry service and how we can procure services differently. Demand for community dentistry and waiting lists is increasing and there is a national workforce issue for this specialty. • Community pharmacies are experiencing financial difficulties due to rising costs of energy, cost of living and some medications. This is leading to some closures of local pharmacies. GP practices refer residents to community pharmacy for advice and treatment, and with closures of pharmacies this will increase pressure on general practice. • Community pharmacy also undertakes prevention work e.g. cardio vascular disease identification and it would be helpful to integrate digital systems so health professionals can see information that is recorded. • BLMK is working with Health Education England on training places and has reached out to dentist, community pharmacy and optometry on how we can work together to retain staff.	

	• The Hewitt Review has identified that the pharmacy, dentistry and optometry contracts are not fit for purpose and will be reporting on this. Support from ICB partners to lobby on this issue would be welcome. The contracts need to be flexible enough to enable it to meet local needs and encourage innovation. **Agreed that:** **1. The current position regarding the delegation of dentistry optometry and community pharmacy be noted.** **2. The ICB will continue to monitor the risks and implications of delegation as well as the opportunities to provide the assurance that is needed for a safe transition**	
8	**Mental Health, Learning Disability and Autism Collaborative** Richard Fradgley, Director of Integrated Care, ELFT and Ross Graves, Chief Strategy and Digital Officer, CNWL provided an update on the development of the mental health, learning disability and autism collaborative. The Mental Health Five Year Forward View was published in 2016 and additional funding had been provided through the Mental Health Investment Standard to enable changes and improvements to mental health services. Staff and teams across all partners, VCSE, police, NHS trusts, local authorities and primary care have worked together and the following progress has been made in BLMK: • Perinatal mental health teams support pregnant women and new mothers. Current provision is being expanded to 1.2k patients, four years ago this service was not in place. • Maternal mental health service supports families who have experienced miscarriage or baby loss. • Children and young people crisis support teams. • Evergreen, a young person's inpatient mental health facility, has been opened and was co-designed with young service users. It has a multi-disciplinary team that includes doctors, nurses, psychologists etc. Patients are being re-patriated from out of area placements, which enables them to have visits from friends and family more easily. • There are six mental health teams in schools and plans for five more. • 25k patients (2,000 per month) are accessing talking therapies, • Early intervention of psychosis - which is recognised as having the highest quality in East of England • New integrated mental health community teams that work at neighbourhoods with GPs, voluntary sector to offer broader psychosocial needs. • Increase in physical health checks for people with severe mental illness or learning disability, which have been delivered in partnership with primary care. • Crisis support via NHS111 with teams being able to visit patients in their own home and the provision of crisis cafes. • Street triage in Bedfordshire working with the Police. • Prompt dementia diagnosis that is the highest level in the East of England.	

	The Board of the ICB agreed to the proposed development of the mental health, learning disability and autism collaborative in November 2022, recognising the ambition to collaborate further and wider to improve services for residents. It recognised that there is a great deal of unmet need, using national modelling we are only seeing 35% of children and young people and 28% of adults. Growth of mental health illness has increased significantly since the pandemic and is putting additional pressure on urgent and emergency care. An area for enhanced collaboration is providing appropriate accommodation for people with mental health issues and illness and how we support them to move on to independent living. Bedford Health Village has a planned inpatient facility, although there is a challenge regarding capital funding. **ACTION: an update will be provided for Bedford Borough Council on the current position.** Despite seeing an increase in additional staff in mental health there continues to be workforce pressures and we need to work creatively to address this. With the longer-term population growth and the trends in severe mental illness, dementia and mental illness, we need to plan appropriately to meet demand. Inequalities are exacerbated for people with mental illness, learning disabilities and autism and their health outcomes are poorer. The service user voice is at the heart of all service design and the Evergreen inpatient project for children and young people is an example of this. It is recognised that service plans for people with learning disabilities and autism are not as advanced. All Place plans have mental health as a priority, and we will examine what can be done at scale and also what can be delivered locally to meet a specific need. The report contains an update on feedback from engagement that has taken place to date and what areas of focus service users are identifying. There is a service user summit planned for 28 March. All outputs will be used to develop the work plan for the collaborative. <u>Summary of discussion</u> • PCNs have undertaken health checks for people with learning difficulties and severe mental health which improves health outcomes, which has led to a significant improvement in the level of annual health checks being completed. • Signposting of residents to services is complicated and there is duplication with a number of service providers which is confusing. Community mental health teams are simplifying access by building around PCNs with social services and VCSE. A single page overview of the flow is being developed for children and adults.	**ACTION 19 RF**

	• It would be useful for primary care to be able to access ELFT clinical records for patients. **ACTION: To provide an update on timescale for the Shared Health and Care record to be connected to ELFT.** • Luton is developing a mental health strategy and discussions are taking place with the other Places in BLMK to see if they wish to use this model. • The mental health long term plan and mental health investment standard was prescriptive on investment and outcomes. It is believed that in future there will be more local flexibility to plan for local needs. Investment also needs to be sustainable especially with future population and demand growth. • Consideration has to be given on parity of esteem and leveraging in resource and effort to address demand for mental health services. • Workforce gaps, retention and recruitment is a priority for the ICB. **ACTION: a report on what is being done to address the workforce issues in health and social care will be reported to the next meeting.** • There is extensive collaboration with the Police, who are often first responders to people in mental health crisis. **Agreed: that the mental health, learning disability and autism collaborative update be noted including specifically the:** • **Progress made nationally in delivery of the NHS Long Term Plan for mental health** • **Progress made with improving mental health services in Bedfordshire, Luton and Milton Keynes over the past several years** • **Progress made with improving NHS commissioned services for people with learning disability & autism over the past several years** • **The context for the future** • **An outline of the opportunity for deeper collaboration across partners and places to drive improved outcomes, quality, value and equity for the people that we serve who have, or are at risk of, mental health conditions and/or learning disability and autism**	**ACTION 20: MER** **ACTION 21 MR**
9	**Community Engagement** Michelle Summers, Associate Director Communications and Engagement BLMK ICB, gave a presentation on the new partnership approach being taken to working with people and communities following the approval of the Working with People and Communities Strategy by the ICB Board in November 2022. The following was highlighted: • Pooling of resources in local authorities, NHS, Healthwatch and VCSE to reduce duplication. • Established principles of co-production, the Consultation Institute is undertaking co-production training with ICB and partners. • Engagement with residents on the joint forward plan. • Gathering information on what we have already heard e.g. from long term plan, Healthwatch, 'talk, listen change' in Luton and other Place engagement exercises.	

	• Denny review on health inequalities that was commissioned as a result of the Covid pandemic. A literature review has been undertaken which identifies significant barriers to accessing health and care. Local authorities, public health and seldom asked communities e.g. gypsy, Roma and travellers, have been listened to. As a result of feedback, a trans gender awareness training has been rolled out. • Through the inequalities workstream we are developing community connectors with Healthwatch and the VCSE as strategic partners. • A community of practice has been established which involves local authorities, NHS, police, fire and rescue, Healthwatch and the VCSE to have a shared approach to engagement campaigns. • We are considering with partners a system wide remuneration policy for participation. • A key element of this work is to have an insight bank for sharing information gathered by partners, however at present there is not a software system available on the market that meets the specification. • The Working with People and Communities Committee, which has membership from sectors across BLMK partnership is developing a workplan for the system. • We will evaluate resident feedback and there will be an annual benchmarking survey to monitor resident and stakeholder views which will report for the first time in July 2023. <u>Summary of discussion</u> • MKUH uses a patient experience platform that captures real time comments through social media. **ACTION: Information on the MKUH patient experience platform will be shared.** • **ACTION: Examples of how the voice of residents has changed services would be powerful.** • Ongoing sustainable funding for Healthwatch and VCSE to continue with engagement activity is required. An MOU is going to be developed between Healthwatch and the ICB with a subsequent work plan. • Residents need to be encouraged to go to another general practice site to access enhanced primary care services and communicating the additional roles in general practice is required. **Agreed: That the new partnership approach being taken to working with people and communities, sharing our engagement insights from local authorities through to NHS, Healthwatch and the VCSE to remove duplication be supported.**	**ACTION 22 MS/AD** **ACTION 23 MS** **ACTION 24 MS**
10	**ICB Update** Felicity Cox, CEO of BLMK ICB, provided the following update from the Board of the ICB which took place on 27 January 2023. • **Winter Pressures** - how well the system had worked collaboratively dealing with winter pressures. • **Governance –** approved the proposed changes to Health and Care Partnership Terms of Reference. • **BAF / System risk –** cost of living risk was discussed due to the increase in demand on services because more residents are experiencing hardship due to the cost of living crisis.	

	• **Bedfordshire Care Alliance update –** first progress report from the Alliance. • **People Strategy** was approved. • **Green Plan Health Impact Assessment –** recognition that we need to go further and work smarter to deliver change. • **Updates on inequalities, strategy and joint forward plan, performance and finance –** ICB forecast to break even at year end**.** **Noted**	
11	**Communications from the meeting** Key communications from the meeting are: • **Joint forward plan** - An update on the development of the joint forward plan which has Place plans as its foundation was presented. Case studies of how the methodology will be used for collective single delivery and how it can be used for bespoke actions for a community will be included. • **Workforce** pressures has been highlighted in a number of reports and an update will be provided at the next meeting on what the system is doing to retain and recruit staff. • **Place plans, Health and Wellbeing Board updates and Health and Wellbeing Board guidance –** Place plans and the local priorities were presented and key areas of discussion from the Health and Wellbeing Board meetings in Central Bedfordshire, Luton, Milton Keynes and Buckinghamshire Council was provided. Bedford Borough Health and Wellbeing Board is meeting on 15 March. Health and Wellbeing Board guidance that was published in November 2022 and the requirements it on the Health and Wellbeing Boards, ICBs and ICPs was noted. Health and wellbeing boards – guidance - GOV.UK (www.gov.uk) • **Delegation of dentistry, optometry & community pharmacy –** an update on the delegation of responsibility from 1 April 2023 to the ICB of dentistry, optometry and community pharmacy was provided. It was noted that 2023/24 would be a transitional year and provides an opportunity to build relationships with contractors. It was reported that there are significant challenges with the national contracts and partners supported the lobbying for change in contracts to enable more local flexibility. Access to NHS dentists was a real concern for residents and coupled with community pharmacy closures, increases the workload for GPs. • **Mental health, learning disability and autism collaboration –** information was shared on the progress that had been made in provision of mental health services since the Mental Health Five Year Forward view was published in 2016 and the investment through the Mental Health Investment Standard. There was an opportunity to have greater collaboration for people with mental illness, learning disabilities and autism and the Board had agreed the development of this collaborative. The report contained an update on feedback from engagement that has taken place and what areas of focus service users are identifying. • **Community engagement –** a presentation was given on the new approach of pooling partner resources to avoid engagement	

	duplication, agreeing co-production principles and highlighted areas of work e.g. the Denny review.	
9	**Health and Care Partnership Forward Plan** Items for the next meeting: • VCSE sector summary of activities in BLMK and actions taken on the ICB and VCSE Memorandum of Understanding • Children and young people – population health priorities, Place priorities and actions being taken, engagement with young people • Workforce – health and care workforce issues, what are we doing to retain and recruit staff	
10	**Any Other Business** **Vote of thanks:** 1. A vote of thanks was recorded for Tracey Stock, who is standing down as a councillor at the elections in May 2023. She was commended for her effective chairing of the BLMK Health and Care Partnership and her leadership in developing the partnership since its inception in July 2022. 2. This is the last Partnership meeting for a number of members of the Health and Care Partnership and the Chair thanked them on behalf of the partnership for their invaluable contribution, Dot Griffiths – CNWL Chair, Simon Linnett – Bedfordshire Hospitals Chair, Louise Jackson – Bedford Borough Health and Wellbeing Board Chair, and Julie Ogley Central Bedfordshire Council – Director of Adult Services.	
11	**Date and time of next meeting** ▪ 21 June 2023 5-8pm Venue to be confirmed	

The meeting ended at 19.57

Approval of Draft Minutes by Chair only:		
Name	**Role**	**Date**
Tracey Stock	Chair	17/03/2023

Meeting of the *Health and Care Partnership* - Action Tracker

Key

Escalated	**Escalated** - items flagged RED for 3 subsequent meetings - BLACK
Outstanding	**Outstanding** - no actions made to progress OR actions made but not on track to deliver
In Progress	**In Progress.** Outstanding - actions made to progress & on track to deliver due date -
Not Yet Due	Not Yet Due
COMPLETE: Propose closure at next meeting	**COMPLETE** - GREEN
CLOSED (dd/mm/yyyy)	CLOSED

Items to be moved to "closed actions" once closed

Action No.	Meeting Date	Item Title	Action	Responsible Manager (Enter full name)	Past deadlines (Since Revised)	Current Deadline	Current Position	RAG (Add date action is agreed closed)
5	14/12/2022	Health & Care Partnership Purpose and Governance	Terms of Reference be reviewed in six months time	Michelle Evans-Riches	22/06/2023	31/10/2023	Revised TOR on agenda (under item 6)	**COMPLETE: Propose closure at next meeting**
13	14/12/2022	Draft Health & Care Strategy	That case studies and resident feedback on how the strategy has made an impact be brought back to the Health and Care Partnership in six months.	Anne Brierley	22/06/2023	Mar-24	A 'stocktake' is to be brought as a substantive item to the March 24 meeting to include case studies and feedback.	**Not Yet Due**
17	07/03/2023	5 Year Joint forward plan	Schematic on slide 4 needs to be altered to include local authority decision making bodies as well as the Trusts and Foundation Trusts.	Anne Brierley		31/03/2023	Completed, JFP went to HWBs and appropriate LA decision making bodies	**COMPLETE: Propose closure at next meeting**
18	07/03/2023	5 year Joint forward plan	Case studies of how the methodology will be used for collective single delivery and how it can be used for bespoke actions for a community will be included in the plan.	Anne Brierley		31/03/2023	Completed. Examples were included in the final JFP	**COMPLETE: Propose closure at next meeting**
19	07/03/2023	Mental Health, Learning Disability and Autism collaborative	Update on Bedford Health Village be provided to Bedford Borough Council following option appraisal with architects	Richard Fradgley	31/03/2023	Mar-24	Due to cost inflation and other priorities for the New Hospitals Programme (and therefore no capital headroom allocated by NHSE), the scheme is being re-designed as a phased approach. Revised first stage plans are due to be completed in the next two months.	**Not Yet Due**
20	07/03/2023	Mental Health, Learning Disability and Autism collaborative	To provide an update on timescale for the Shared Health and Care record to be connected to ELFT	Michelle Evans-Riches			Shared Health and Care record is connected with ELFT RIO system	**COMPLETE: Propose closure at next meeting**
21	07/03/2023	Mental Health, Learning Disability and Autism collaborative	A report on what is being done to address the workforce issues in health and social care will be reported to a future meeting	Martha Roberts	21/06/2023	Mar-24		**Not Yet Due**
22	07/03/2023	Community Engagement	Information on the MKUH patient experience platform will be shared.	Michelle Summers/Alison Davis		31/03/2023		**Outstanding**
23	07/03/2023	Community Engagement	Examples of how the voice of residents has changed services would be powerful.	Michelle Summers	21/06/2023	Mar-24	A 'stocktake' is to be brought as a substantive item to March 24 meeting to include 'you said we did' examples.	**Not Yet Due**
24	07/03/2023	Community Engagement	Communication to encourage residents to visit other general practice sites to access specific services.	Michelle Summers	21/06/2023	Mar-24	Your guide to local NHS services' issued in spring 2023.	**Not Yet Due**

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 31 October 2023

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

Report Author: Michelle Evans-Riches, Acting Head of Corporate Governance

Report to the: BLMK Health and Care Partnership

Item: 6. Health and Care Partnership Governance, Work Programme and Approach for 2023/24

Supports: Ways of Working enabler

1.0 Executive Summary

1.1 This paper provides a briefing on the governance and work of the Health and Care Partnership for new members who have joined since the last meeting in March 2023 and proposes a new way of working for the Health and Care Partnership for 2023/24, based on learning from the experience of the first year of operation.

1.2 In December 2022, the BLMK Health and Care Partnership agreed the Health and Care Strategy for the population of BLMK. The statutory role of the BLMK Health and Care Partnership is to **develop, agree** and **monitor** the implementation of the Health and Care Strategy for Bedfordshire, Luton and Milton Keynes, building on Joint Strategic Needs Assessments, Health and Wellbeing strategies, Place plans, and the voice of people with lived experience, to achieve improved population health outcomes and reduced inequalities for people who live in BLMK.

1.3 To deliver on its statutory duty, based on learning from the first year of operation, it is **proposed** for 2023/24 that the Health and Care Partnership should:

- meet formally as a joint committee in public twice a year (October '23 and March '24); and
- convene joint seminars with the ICB three times in 2023/24, to involve wider partners and the voice of people with lived experience in the development and delivery of the five strategic priorities in the Health and Care Strategy.

1.4 This paper describes in more detail how the seminars will contribute to the development and delivery of the strategy and how the formal meetings will be used to approve any changes to the strategy and to track and monitor implementation of the strategy.

2.0 Recommendations

2.1 That the revised Health and Care Partnership Terms of Reference be **approved and local authority partners be requested to take these through their internal governance processes as appropriate**.

2.2 That the proposed way of working for the Health and Care Partnership be **agreed** for 2023/24, with the Health and Care Partnership meeting formally twice a year and jointly convening with the ICB, three system-wide seminars that focus on ICS strategic priorities.

3.0 Key Implications

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

3.1 The ICB provides the resource (staffing and associated costs) to hold the meetings and seminars of the Health and Care Partnership.

3.2 Reducing inequalities is one of the five strategic priorities of the ICS.

3.3 The Health and Care Partnership has a statutory duty to hear the voice of people with lived experience in doing its work. The ICB has agreed a Working with People and Communities Strategy to enable this. This Strategy is currently being reviewed and a refreshed version will be available in March 2024.

3.4 Sustainability and Growth is one of the five strategic priorities of the ICS and the Green Plan is one of the delivery plans for this strategic priority.

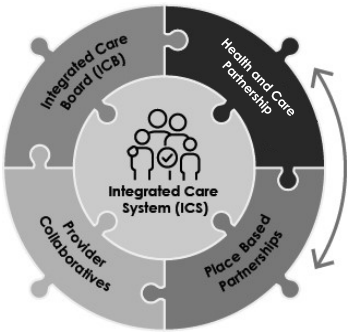
4.1 Governance

4.1.1 The Health and Care Partnership and the Integrated Care Board are the foundations of the BLMK Integrated Care System and were established on 1 July 2022. The Health and Care Partnership is a joint committee of the five local authorities that provide social care services to BLMK residents and the BLMK ICB. Integrated care systems are designed to bring partners together to deliver four core purposes:

- improve outcomes in population health and healthcare.
- tackle inequalities in outcomes, experience and access.
- enhance productivity and value for money.
- help the NHS support broader social and economic development.

4.1.2 The core purposes are delivered by different roles in the system as summarised below:

Building our partnership to deliver for our residents



All partners, including Healthwatch and the VSCE sector come together at the **Health and Care Partnership** to oversee our system strategy.

The **Integrated Care Board** brings together senior leaders from our Councils, the NHS and Healthwatch to support delivery against this strategy.

Our four **place based partnerships** bring together partners across a local Council area to agree priorities and take action to meet local needs.

Provider collaboratives work together to tackle specific issues. These include the Bedfordshire Care Alliance and the Mental Health, Learning Disabilities and Autism Collaborative, alongside the East of England children and young people and specialist mental health collaborative.

Memoranda of Understanding have been agreed with the VCSE and Healthwatch to support partnership working across the BLMK system.

5

4.1.3 The role and membership of the BLMK Health and Care Partnership is described in its terms of reference (appendix A). These terms of reference have been updated as part of a wider review of the Governance Handbook of the ICB.

The following changes have been made.

Para.	Change	Rationale
4.1	Change '… for the quorum to be established. At least one member ...' to '… for a quorum to be established including at least one member …'	To avoid ambiguity.
4.1	Delete '… must be present to make the meeting quorate.'	This phrase is now redundant.
5.1	Change 'four' to 'two' scheduled meetings	To enable space for joint seminars.
10.1	Delete 'when the minutes of the Joint Committee's meetings will be presented.'	A report is provided to all Place meetings so presenting the minutes is unnecessary (and out of date as they would need to be approved minutes).
11.0	Delete the empty table under 11.1.	There are no sub-groups of the H&CP

The Health and Care Partnership is asked to **approve the terms of reference and request local authority partners to take these through their internal governance processes as appropriate**.

4.1.4 Recognising that the way we work together is as important as the work we do, the Health and Care Strategy agreed the following values which underpin the work of the Health and Care Partnership and all partners in the system:

4.1.5 Agendas for meetings of the Health and Care Partnership are set with the Chairs of the Health and Wellbeing Boards and the Chair of the ICB in an agenda setting group. This year it is proposed that the Health and Care Partnership has co-chairs: Councillors Khtija Malik (Luton Borough Council) and Martin Towler (Bedford Borough Council) have agreed to be nominated for this role and this will be put to the meeting for decision on 31 October 2023.

4.2 Work Programme and Way of Working

4.2.1 In its first year, the Health and Care Partnership, chaired by former Councillor Tracey Stock of Central Bedfordshire Council, developed and agreed the BLMK Health and Care Strategy and has continually reviewed and monitored the following elements of the strategy and its priorities in more detail:

Strategic Priority/Enabler	Topic	Meeting
Ways of working	System values	March 2022
Start Well	Seminar on strategic priorities for children and young people	May 2022
Ways of working	Agreed & established governance	July 2022
All priorities	Agreed BLMK Health and Care Strategy	December 2022

Strategic Priority/Enabler	Topic	Meeting
All priorities & Inequalities	Reviewed Joint Strategic Needs Assessment and Population Health data for BLMK with a focus on inequalities	December 2022
Live well & Age well	Fuller Neighbourhoods / Integrated Neighbourhood Working	December 2022
All priorities	Reviewed draft Joint Forward Plan	March 2023
Live Well	Reviewed proposed establishment of Mental Health, Learning Disabilities and Autism Collaborative	March 2023
Communications	Reviewed progress on working with people and communities on strategy and service development	March 2023

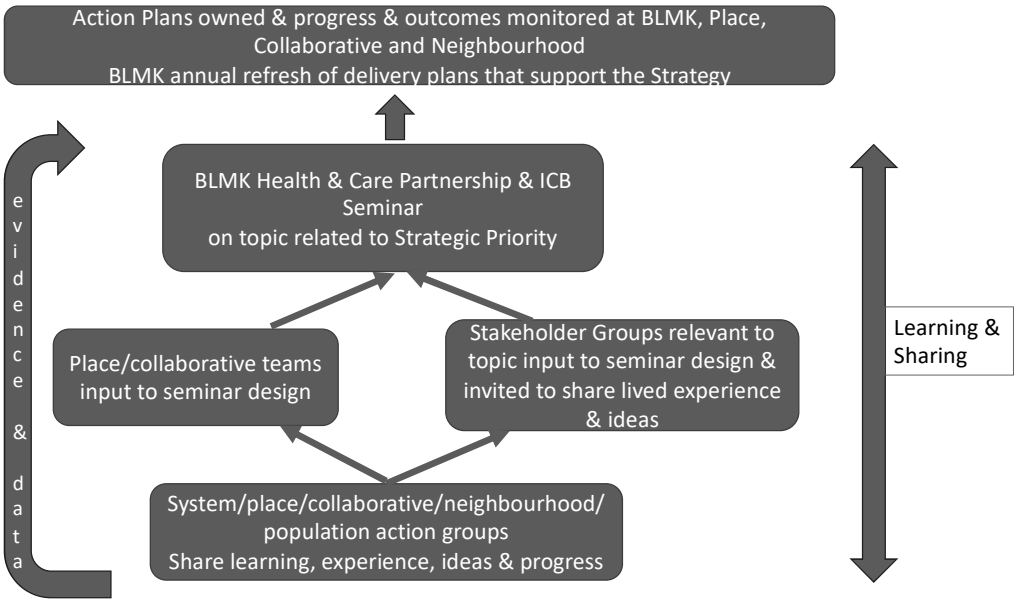
4.2.2 The initial ways of working for the Health and Care Partnership and the ICB were developed with local authorities and the ICB during 2021/22 in readiness for 'go live' on 1 July 2022. It was recognised that the initial year of operation of the ICB and ICP would test this way of working and may need to adapt as system working matured. As a result of this review, the ICB Board has moved from bi-monthly meetings to quarterly meetings to enable system seminars involving wider partners to be held on key issues that support the development and delivery of the Health and Care Strategy. Following discussions between the Chairs of the Health and Wellbeing Boards and the Chair of the ICB, it is proposed that for 2023/24, the Health and Care Partnership should meet formally twice a year and that there should be three seminars on the ICS's strategic priorities, which will be jointly convened with the Board of the ICB. The topics for these seminars are:

ICS Priority	Seminar Topic	Date
Sustainability & Growth	Health and Employment	21 July 2023
Start Well	Early Years	24 November 2023
Live Well/Age Well	Integrated Neighbourhood Working (TBC with agenda setting group)	16 February 2024

4.2.3 The first joint seminar took place on 21 July and focused on health and employment and more detail is provided in the report on this agenda at item 10. The next seminar is on 24 November and will be on early years and how we can support children and families earlier to meet their developmental milestones and thrive in the early years of school. Members of the Health and Care Partnership have been invited to this event which is taking place in Milton Keynes. The third seminar is planned for 16 February 2024, and it is proposed it will be focused the development of integrated neighbourhood working and how this supports delivery of the Live Well and Age Well strategic priorities. It is key that all members of the partnership support and present at the workshops so a wide perspective on the issues can be taken.

4.2.4 The partnership will be taking a population health and continuous improvement approach to the organisation of the seminars, which will be supported by the quality improvement training that is being rolled out across the system to staff, VCSE groups and residents. The seminars will be framed as learning and sharing events that will inform strategy implementation and facilitate initial action planning. This will enable BLMK to become a learning system (and part of a national and international learning system) by taking a systematic approach to iterative data driven improvement as part of our business-as-usual approach. This approach will enable the Health and Care Partnership members to hear the lived experience and improvement ideas coming from our residents and our front-line workforce in developing system strategy, implementation approaches and action plans, which is the statutory duty of the Health and Care Partnership, and which is difficult to fully achieve in a formal meeting.

4.2.5 Our approach is described in the diagram below:



BLMK Health & Care Partnership and ICB Model for Seminars

4.2.6 The SROs for the strategic priorities will work with the ICB team to develop each seminar programme and approach. Health and Care Partnership members, Place representatives, voluntary and community sector representatives, residents and local interested parties will be invited to take part in the seminars, with the invitations being tailored to the seminar topic. CEOs/Executives will play an important role in supporting resident or staff experts who come to speak to the seminar. The ICB takes responsibility for the organisation and resourcing of the seminars on behalf of the Partnership.

4.2.7 The outcome of the seminars will be reported to the Health and Care Partnership, ICB and Place based partnership and collaborative meetings in order for system-level, collaborative and place actions to be fully developed, agreed and incorporated in the appropriate system, collaborative and place delivery plans. Any changes to system-level delivery plans will be captured in an annual review of progress against plan by the Health and Care Partnership in March each year. Places and collaboratives will update their over-arching plans as appropriate to their own governance and planning processes.

4.2.8 Responsibilities for seminars and their outputs are described below:

Task	Lead Responsibility
Agree seminar topics and dates	Chairs of Health and Wellbeing Boards and Chair of ICB
Sign-off seminar scope, agenda, approach and invitations	SRO for strategic priority with support from Place teams via Place Link Directors
Sponsor residents and front-line staff to input their experience and ideas at seminar	SRO / Executives from all partner organisations
Organise, resource & write up learning and ideas from seminar	ICB with support from all members
Propose system response from seminar and report on delivery	ICB to draft for agreement by all members via Health and Care Partnership
Agree place or collaborative response to ideas /learning presented at the seminar and report on	Place Based Partnership or Collaborative (Bedfordshire Care

Task	Lead Responsibility
delivery. It is not an expectation that all actions/ideas discussed at the seminar are expected to be agreed by place/collaborative.	Alliance, Mental Health, Learning Disability and Autism Collaborative) as appropriate
Ensure feedback loop is closed with residents and front-line staff who have been part of the seminar	SRO / Executives from partner organisations
Provide reports to Health and Care Partnership and ICB on progress on achievement of strategic priorities and delivery of Joint Forward Plan	ICB PMO with inputs from Place and Collaborative, using Verto tool. Health and Care Partnership annually in March in March
Provide reports on achievement of agreed outcome goals	Population Health Intelligence Unit and ICB PMO

4.2.9 The Health and Care Partnership is asked to agree that the proposed way of working described in this paper be agreed for 2023/24, with the Health and Care Partnership meeting formally twice a year and jointly convening with the ICB three system-wide seminars that focus on ICS strategic priorities.

5.0 Next Steps

5.1 Confirm arrangements for seminars and meetings 2023/24

5.2 Develop standard report on progress against strategic priorities and outcome goals for partnership meeting in March 2024

5.3 Agree approach for 24/25 in March 2024

List of appendices

Appendix A – Health and Care Partnership Terms of Reference
Appendix B - Health and Care Partnership members

Background reading

Health and Care Partnership (Joint Committee) Terms of Reference

1.0 Introduction

1.1 The Bedfordshire, Luton and Milton Keynes Health and Care Partnership is the name of the system's Integrated Care Partnership (ICP) in accordance with the Health and Care Act 2022 and is established in accordance with NHS Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board (ICB) Constitution, and the Constitutions of the five local authorities in the system, as a Joint Committee of the Integrated Care Board and the local authorities of Bedford Borough Council, Central Bedfordshire Council, Buckinghamshire Council, Luton Borough Council and Milton Keynes Council.

2.0 Membership

2.1 The membership of the ICP shall include:

2.2 Core Members

Organisation	Role
NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board	Chair Chief Executive Officer
Bedford Borough Council	Health and Wellbeing Board Chair One or two further people appointed by the Council (suggest one member is from children's and one member is from adult services)
Buckinghamshire Council	One person as nominated by the Council
Central Bedfordshire Council	Health and Wellbeing Board Chair One or two further people appointed by the Council (suggest one member is from children's and one member is from adult services)
Luton Borough Council	Health and Wellbeing Board Chair One or two further people appointed by the Council (suggest one member is from children's and one member is from adult services)
Milton Keynes Council	Health and Wellbeing Board Chair One or two further people appointed by the Council (suggest one member is from children's and one member is from adult services)
Director of Public Health (2)	Bedford Borough, Central Bedfordshire and Milton Keynes Councils Luton Borough Council
Bedfordshire Hospitals NHS Foundation Trust	Chair
Milton Keynes University Hospital NHS Foundation Trust	Chair
Cambridgeshire Community Services NHS Trust	Chair
East London NHS Foundation Trust	Chair

Organisation	Role
Central and North West London Foundation Trust	Chair
South Central Ambulance Service NHS Foundation Trust	Chair or nominated deputy
East of England Ambulance Service NHS Trust	Chair or nominated deputy
Primary Care Networks a Clinical Director from:	Bedford Luton Central Bedfordshire Milton Keynes
Healthwatch A local representative from:	Bedford Luton Central Bedfordshire Milton Keynes
NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board's Health and Care Senate	A representative
Voluntary, Community and Social Enterprise	BLMK nominated representative

2.3 Regular Participants

2.3.1 The Joint Committee may invite specified individuals to be Participants at its meetings to inform decision-making and the discharge of its functions as it sees fit. Participants will receive advanced copies of the notice, agenda and papers for meetings. They may be invited to attend any or all the meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

2.3.2 The following individuals will be regular participants:

Organisation	Role
NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board	Non-executives, executives, primary care partner members – as relevant to agenda items
Local Authorities in BLMK	As requested by local authorities and as relevant to agenda items
NHS Trusts in BLMK	CEOs and others as relevant to agenda items
Bedfordshire Fire and Rescue Service	Nomination from Fire and Rescue Service
Buckinghamshire Fire and Rescue Service	Nomination from Fire and Rescue Service
Thames Valley Police	Nomination from Police
Bedfordshire Police	Nomination from Police
Housing	Relevant to agenda items
Education	Relevant to agenda items
Criminal Justice	Relevant to agenda items
Voluntary, Community and Social Enterprise leads	Relevant to agenda items
Community Groups	Relevant to agenda items
Carers Representative	Relevant to agenda items

2.3.3 The Joint Committee may invite any individuals, groups or subject matter experts for specific items on the agenda for the meeting.

3.0 Joint Committee Chair

3.1 The Joint Committee Chair will be nominated by the Councils in BLMK and will be appointed by the ICP at its first meeting and serve for a two-year period.

3.2 The Councils in BLMK will nominate a deputy Chair who will be appointed by the Joint Committee at its first meeting and will Chair the Joint Committee meeting in the absence of the Joint Committee Chair. This appointment will also be for a two-year period.

4.0 Quorum

4.1 At least half of the members of the Joint Committee must be present for a quorum to be established including at least one member from the ICB and one member from two of the local authorities.

4.2 No formal business shall be transacted where a quorum is not reached.

5.0 Frequency of meetings and attendance

5.1 A minimum of two scheduled meetings shall be held per year and if the meetings are face to face will be held in each of the four Places in rotation and will be scheduled at different times and days of the week.

5.2 Members of the Joint Committee should make every effort to attend all meetings of the Committee and it is expected that core members attend at least 75% of Joint Committee meetings. The Secretary to the Joint Committee will monitor attendance and will report on this annually. Attendance figures will be published in the Annual Report.

6.0 Meetings to be held in public

6.1 The meetings of the Joint Committee will be held in public in accordance with the Public Bodies Admission to Meetings Act 1960. The Joint Committee may resolve to hold part of its meeting in private if it would be prejudicial to the public interest to meet in public.

6.2 The Joint Committee may hold regular workshops which will not be formal meetings of the Joint Committee, will not be taking decisions and will not be held in public. These workshops will be open to a wider group of participants than Joint Committee members and participants and will be forums for discussion to develop proposals for later consideration by the Joint Committee at a formal meeting.

7.0 Agenda setting

7.1 The agenda for Joint Committee meetings and workshops will be set by the Joint Committee's agenda setting group comprising of:

- Joint Committee Chair.
- ICB Chair.
- Health and Wellbeing Board Chairs (or nominated deputies) of Bedford Borough Council, Buckinghamshire Council, Central Bedfordshire Council, Luton Council and Milton Keynes Council.

7.2 A forward plan of items for consideration will be included in the agenda papers for each Joint Committee meeting.

8.0 Duties

8.1 It is the duty of the Joint Committee to develop, agree and monitor the implementation of the Integrated Population Health Strategy for Bedfordshire, Luton and Milton Keynes based on the Joint Strategic Needs Assessments, Health and Wellbeing strategies, Place plans, and the voice of people with lived experience.

8.2 In fulfilling its statutory duty, the Joint Committee's role is to:

- Facilitate joint action to improve health and care outcomes and experiences.
- Influence the wider determinants of health, including creating healthier environments and inclusive and sustainable economies.
- Create a dedicated forum to enhance relationships between the leaders across the health and social care system.
- Build a culture of partnership and broad collaborations to promote and support holistic care.
- Highlight where coordination is needed on health and care issues and challenges partners to deliver the actions required.

9.0 Emergency powers

9.1 Where an urgent decision needs to be made in between scheduled meetings, members of the Joint Committee can convene an extra-ordinary meeting to discuss a particular issue. Quorum rules in paragraph 4 still apply.

9.2 If it is not practicable to meet in person, matters can be dealt with through telephone or the exchange of emails. The exercise of such powers shall be reported, and a minute taken at the next Joint Committee meeting.

10.0 Reporting arrangements to the Board

10.1 The Joint Committee will report to the ICB and the Health and Wellbeing Boards of Bedford Borough Council, Buckinghamshire Council, Central Bedfordshire Council, Luton Borough Council and Milton Keynes Council on a quarterly basis.

11.0 Reporting arrangements of other Committees and Groups

11.1 The Joint Committee has authority to establish committees and groups (below) which will report into the ICP and provide minutes of their meetings:

12.0 Annual review of the Committee

12.1 The Joint Committee will undertake a self-assessment within six months of operating and annually thereafter to:

- Review that these Terms of Reference have been complied with and whether they remain fit for purpose.
- Determine whether its planned activities and responsibilities for the previous year have been sufficiently discharged; and,
- Recommend any changes and / or actions it considers necessary, in respect of the above.
- Provide the ICB, and Health and Wellbeing Boards of Bedford Borough Council, Buckinghamshire Council, Central Bedfordshire Council, Luton Council and Milton Keynes Council with an annual report, which details the outcome of the annual review.

13.0 Committee servicing

13.1 The Joint Committee shall be supported administratively by the Integrated Care Board's Governance team (or other nominated representative), who's duties in this respect will include:

- Agreement of the agenda with the Joint Committee's agenda setting group and collation of papers in-line with the Committee's Annual Cycle of Business.
- Providing written notice of meetings to Joint Committee's members, and the papers, not less than five working days before the meeting.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Producing a single document to track the Joint Committee's agreed actions and report progress to the Joint Committee.
- Producing draft minutes for approval within five working days of the meeting.

Appendix B

Health and Care Partnership Members, 2023/24

Organisation	Role	Name
NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board	Chair	Rima Makarem
	Chief Executive Officer	Felicity Cox
Bedford Borough Council	Health and Wellbeing Board Chair	Cllr Martin Towler
	One or two further people appointed by the Council	Kate Walker One vacancy
Buckinghamshire Council	One person as nominated by the Council	Cllr Angela MacPherson
Central Bedfordshire Council	Health and Wellbeing Board Chair	Cllr Rebecca Hares
	One or two further people appointed by the Council	Andy Sharpe One vacancy
Luton Borough Council	Health and Wellbeing Board Chair	Cllr Hazel Simmons
	One or two further people appointed by the Council	Cllr Khtija Malik Cllr Fatima Begum
Milton Keynes Council	Health and Wellbeing Board Chair	Cllr Peter Marland
	One or two further people appointed by the Council	Cllr David Hopkins Cllr Robin Bradburn
Directors of Public Health	Bedford Borough, Central Bedfordshire and Milton Keynes Councils	Vicky Head
	Luton Borough Council	Sally Cartwright
Bedfordshire Hospitals NHS Foundation Trust	Chair	Richard Sumray
Milton Keynes University Hospital NHS Foundation Trust	Chair	Alison Davis
Cambridgeshire Community Services NHS Trust	Chair	Mary Elford
East London NHS Foundation Trust	Chair	Eileen Taylor
Central and North West London Foundation Trust	Chair	Tom Kimbasi
South Central Ambulance Service NHS Foundation Trust	Chair or nominated deputy	Mike Murphy
East of England Ambulance Service NHS Trust	Chair or nominated deputy	Emma De-Carteret
Primary Care Networks	Bedford	Dr Jane Kocen
	Luton	Dr Manraj Barhey
	Central Bedfordshire	Vacancy
	Milton Keynes	Dr Navaneetha Rammohan
Healthwatch	Bedford	Emma Freda
	Luton	Lucy Nicholson
	Central Bedfordshire	Diana Blackmun
	Milton Keynes	Tracy Keech
NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board's Health and Care Senate	One representative	Vacancy
Voluntary, Community and Social Enterprise	BLMK nominated representative	Sonal Mehta

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 31 October 2023

Partners: Rima Makarem, ICB Chair
Cllr Martin Towler, Chair of Bedford Borough Health and Wellbeing Board
Cllr Rebecca Hares, Chair of Central Bedfordshire Health and Wellbeing Board
Cllr Hazel Simmons, Chair of Luton Health and Wellbeing Board
Cllr Peter Marland, Chair of Milton Keynes Health and Care Partnership

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

Report Author: Michelle Evans-Riches, Acting Head of Corporate Governance

Report to the: Health and Care Partnership

Item: 8 - Delivering our Strategy at System and Place – Reports from the Health and Wellbeing Boards and ICB

1.0 Executive Summary

1.1 The report provides a brief report from the recent meetings of the Health and Wellbeing Boards and the ICB as relevant to the delivery of the strategic and place priorities.

2.0 Recommendations

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

3.0 Reports from the Health and Wellbeing Boards

3.1 Bedford Borough Health and Wellbeing Board

The Borough's Health and Wellbeing Board met on 20 September and a summary of the items and discussion is given below:

Joint Local Health and Wellbeing Strategy
The Board considered the draft Joint Local Health and Wellbeing Strategy for 2024-2027. The Board heard that health inequalities were a particular issue in Bedford Borough, where the life expectancy of an adult male was 15 years less in the most deprived ward compared to the least deprived ward; and for adult females the difference was 11 years. The draft Strategy focuses on improving the health and wellbeing of residents and reducing health inequalities by strengthening the five 'building blocks of health': inclusive employment; healthy communities; healthy homes; early years and a sustainable built and natural environment. The next step will be to consult and engage widely on the draft Strategy before it is signed-off by the Board at a future meeting.

Winter Planning, Influenza and COVID-19 Immunisation
The Board received an update from the ICB on winter planning, including the progress of the influenza and COVID-19 vaccination programmes. The Board was advised of the steps that were being taken locally to manage the expected winter pressures and were told that

seasonal influenza and COVID-19 vaccination programmes had been brought forward in a precautionary response to the emerging BA.2.86 variant. Vaccination started in Bedford Borough care homes on 11 September 2023, and other eligible cohorts had commenced on 18 September 2023.

Joint Strategic Needs Assessment
The Board received a demonstration of the new Joint Strategic Needs Assessment web platform https://www.bedford.gov.uk/social-care-and-health/bedford-borough-jsna-0. The new platform provides a suite of public health intelligence products in one place, and interactive dashboards enable users to interrogate local data on health and wellbeing, in some cases down to a ward or 'medium super output area' level.

Better Care Fund – 2022-23 outturn and 2023-25 Plan
The Board noted the final submission of the Plan for 2023-25.

The Bedford Borough Place Executive Delivery Group (EDG) also reported to the Board on its work to support the delivery of the Place Based Plan, including:

- **Primary care estates**
  A Primary Care Estates Board has been constituted and held its first meeting. An update report will be presented to the Council's Executive meeting on 18 October 2023.
- **Place Lead**
  A new post had been created and filled for a Bedford Borough Place Lead, to facilitate closer working between the Council and the ICB.
- **Employment and health**
  The EDG received an update on the Health and Care Seminar held on 21 July 2023 on employment and health. The EDG agreed that the new Place Lead would take forward any local actions emerging from seminar.

3.2 Central Bedfordshire Health and Wellbeing Board 4 October 2023

- The Board received a report on the background and context for refreshing the Joint Health and Wellbeing Strategy (JHWS) for 2024– 2029 and the proposed approach to developing the strategy. The Board discussed potential focus areas and agreed the Kings Fund (2018) model should be used.
- The Board received a report on what Be Active, the Active Partnership's for Bedfordshire, are doing to achieve their strategy 'Moving Forwards Together', how their work aligns with other strategic plans and how they are utilising physical activity to tackle health inequalities. Although the report had been mainly focussed on Young people, older people were a key priority and the organisation had funded opportunities within care homes and this work was to be developed further. Recently, funding was given to instructors to upskill to be able to deliver evidence-based strength and balance provision as part of the fall's prevention agenda.
- The Board received a report on the Integrated Care Board (ICB) and Integrated Care Partnership (ICP). Key points highlighted to the Board were the delegation of 59 Specialised Commissioning Services that were due to be delegated to ICBs in April. Out of six ICBs in the East of England, BLMK ICB had been asked to act as host. Good progress was being made at the Mental Health, Learning Disability and Autism Collaborative and it was suggested that this should be an item brought to a future Health and Wellbeing meeting. Currently, the ICB were in the process of

delivering the staff constitutional change in order to meet the national requirement to reduce running costs by 30%. The consultation was expected to complete at the end of December.

- The Board received a verbal update and the notes from the previous four meetings of the Central Bedfordshire Place Board. Key topics that had been discussed at the Place Board were Vaccination/Immunisation and Covid Boosters for the winter and in particular reaching vulnerable groups, Digitising Social Care and the various schemes being implemented, and the approach on how to develop the neighbourhood teams.
- The Board were advised that the Better Care Fund Plan had been submitted and an approval letter had been received from NHS England.

3.3 Luton Health and Wellbeing Board

- **Better Care Fund (BCF) Narrative Plan 2023-2025** - the BCF 2022-2023 End of Year Template was retrospectively formally approved, following approval by the Chair and Vice Chair outside the meeting.
- **Better Care Fund Quarter 2 Report –** the BCF Quarter 2 template was reviewed by the Board and approved for submission to the BCF Board and the Department of Health and Social Care
- **Bedfordshire, Luton and Milton Keynes Health and Care Partnership and Integrated Care Board (ICB) update –** The Board considered and noted the ICB update report, agreeing the next steps in relation to the actions from the health and employment seminar to be reported back to the ICB and the ICP at their next meetings on 31 October 2023.

  Some specific Issues raised included:
  - In relation to the Denny Review, the Board was keen to understand the difference that the recommendations would make for health inequalities in Luton and called for a specific separate report for its next meeting on 12 December 2023. The Board also requested that Rev Lloyd Denny be invited to attend the meeting.
  - The Board also requested that the results of consultation on the BLMK Clinical Strategy be included in the next ICB update report to the Board.

- **Fuller Stocktake update for Luton –** The Board received and discussed an update in respect of the activity to develop neighbourhood working as part of the Fuller Stocktake in Luton. Comments were made into the direction of travel across the range of work linking to the recommendations of the Fuller report published in May 2022, identifying the contribution from Primary Care Services (including primary medical, community pharmacy, primary dental and optometry.

  Some specific Issues raised included:
  - Problems accessing GP and dental appointments in Luton
  - Patients being referred back to Primary Care following referral to Secondary Care and Mental Health Services due to lack of capacity in these services, putting additional pressure on Primary Care
  - Education to raise awareness about available services
  - Promotion of the NHS App to assist people access health information.

- **Adult Mental Health Strategy and BLMK Mental Health Provider Collaborative** - The Board received an update on and agreed with the approach and direction of travel for the Luton Adult Mental Health Strategy and the BLMK mental health provider collaborative.

  Some of the specific issues raised included:
  - How would people know if the strategy and the work of the provider collaborative was making a difference, i.e. What key performance measures would be used.
  - Patients in distress needing services being referred to CAMHS by Primary Care, being referred back to Primary Care, due to lack of capacity in CAMHS. It was recognised that this was a challenge but should not be happening. ELFT would look at the data on back referrals and report back.
  - The crisis café in Luton was mentioned where service users could go and seek support.
  - The Board requested an update on the outcome of the implementation of the strategy at an appropriate time (6 or 12 months), showing the priorities and the measures put in place to monitor changes.

- **Luton Family Hubs Update –** The Board received an update on the progress of the Family Hub programme and development of network of Family Hubs and Start for Life services. The Board supported the continued direction of travel for Luton Family Hub programme and the progress and approach to the development of Luton's Family Hub network. The Board was thankful to the officers for a first class piece of work.

  Some key points raised included:
  - The importance of partnership working and community involvement
  - Link to the mental health strategy, looking if it was making a difference
  - Use of the outcome framework to measure outcomes

- **Healthwatch Luton (HWL) Update - Report on Informatics –** The Board considered the report explaining the HWL online informatics system, which supported people giving independent feedback on Luton services.

  HWL sought the advice of the Board on whether that element of the system was still wanted, needed or fit for purpose and on certain aspects of its operations.

  Following discussions, the Board resolved that HWL should keep the current approach, with some moderating of the publishing element to make providers feel more comfortable with feedback provided and agreed that providers be informed of the role of HWL, when services were commissioned.

3.4 Milton Keynes Health and Wellbeing Board

The Milton Keynes Joint Leadership Team's key areas of focus have been:

- Commissioning an external review of the place based strategy and partnership approach in Milton Keynes. This review will conclude in October and it is proposed that the final report is presented to the ICB board in December after its consideration by the MK Health and Care Partnership in November.

- The implementation of the business case for the expansion of the virtual ward and the development of a single point of access to improve system flow and care for more residents in the community.
- Integrated working between the Council and Central and North West London NHS Foundation Trust with an initial focus on working better together to support looked after children.
- Preparing for the launch of the Digital Wearables project in October as part of the Tackling Obesity priority.

The MK Health and Care Partnership met on 20 September and:

- Considered the Denny Review into Health Inequalities with a particular focus on the MK findings.
- Discussed the BLMK Health and Employment Seminar which had been well received and considered the actions agreed on the day by the Milton Keynes Place representatives.
- Reviewed progress on the delivery of the active MK Deal priorities (improving system flow, tackling obesity and children and young people's mental health) detailed reports are available on the Mk Health and Care Partnership webpage https://milton-keynes.moderngov.co.uk/ieListDocuments.aspx?MId=6893&x=1
- Formally accepted the proposed Bletchley Pathfinder model of locality/neighbourhood working (slides available in above link) and agreed that the Bletchley Pathfinder should be included in the MK Deal.

4.3 ICB Board

The ICB Board met on 29 September and summary of the meeting is below:

Resident's story – members watched a video from Catherine, a resident from Bedford who is deaf. She shared her powerful story using British Sign Languages (BSL). She explained the challenges that people who are deaf face when accessing health and care, including being able to make or change an appointment and engage with health and care professionals. The Board reflected on the need to think about and change how we communicate to ensure easy and fair access for everyone – a key part of the Denny Review of Health Inequalities.

Health and Employment Outline Strategy – The Board heard how Places are taking forward the action plans arising from the ICB's Health and Employment Seminar in July. These include efforts to maximise the support from 'anchor'; institutions, make full use of the Apprenticeship Levy and broaden volunteering opportunities. The Chief People Officer for the ICB outlined what the ICB will be working on to support residents in applying for work in the health and care system. The Chief People Officer also shared examples of recent work, such as a campaign to support residents without easy access to the internet to hear about job opportunities. It was confirmed that VCSE organisations would be central to supporting the development and implementation of new Health and Employment Strategy for BLMK, an outline of which will come to the BLMK Integrated Care Partnership meeting on 31 October.

Mental Health, disabilities and autism – The Board supported work to develop a new Mental Health, Disabilities and Autism Collaborative Committee in BLMK that would encourage more joined up working across the system, with focused work at place to deliver care closer to those who need it. The Board heard how a model for new ways of working was in development and asked for more information on how Primary Care

Networks (PCNs) and GP surgeries would fit into the model. The Board asked for more detailed work to be undertaken around the governance and membership as the collaborative emerges.

Equality, Diversity and Inclusion – the Chief People Officer for BLMK took the Board through six areas where focus is needed to help us retain our health and care workforce. Providing a living wage for staff and creating the right culture was the focus of the discussion, including ensuring that all people are empowered to 'speak up'. Partner organisations were invited to reflect on the culture of their organisations and endorse the action areas to support their people in thriving at work.

Financial and operational reports – members received formal updates from quality and performance, finance and governance, as well as an update on Section 75 agreements from local authority chief executives, which were agreed by the Board. The Chief Transformation Officer provided assurance on urgent and emergency care and the Board approved the plan, in line with NHSE requirements and thanked partners for their efforts in working together to maintain system flow. Clinical members asked that officers continue to work to a prevention agenda to support people in keeping well and encouraged neighbourhoods to lead the way on this work. The roll out of virtual wards was commended as among the best performing in the England. The Board added a strategic risk to its register to respond to the challenge of health literacy in our population as highlighted by the Denny Review.

5.0 Next Steps

5.1 Regular updates from the health and wellbeing boards and the Board of the ICB will be reported to the Health and Care Partnership to support the Partnership in monitoring implementation of the Health and Care Strategy which includes the Place priorities. A more detailed progress report will be prepared for the March meeting to inform the strategy review/refresh.

List of appendices

None

Background reading

None

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 31 October 2023

ICS Partner: Reverend Lloyd Denny, the Author of the Denny Review

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

Report Author: Michelle Summers, Associate Director of Communications

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

Item: **9 The Denny Review of Health Inequalities**

1.0 Executive Summary

1.1 The independent Denny Review of Health Inequalities across Bedfordshire, Luton and Milton Keynes was published on 12 September 2023. The Review, commissioned by Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (BLMKCCG), is a landmark study that will inform the ICS' work over the next three years, with its findings embedded across health, care, and beyond in BLMK.

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

1.5 Using population health data, analysis and insights from residents who have lived experience of health inequalities, the independent Review presents short-term (for delivery within the first one to two years) and medium-long-term recommendations (delivered within three to five years) that have been developed following engagement with residents and partners.

1.7 In June 2023, the ICB's Board took a detailed item on the draft findings of the Review. Following procedural approval by the ICB's Working with People and Communities Committee, attached at **Annex A** is the full Denny Review of Health Inequalities to which it is proposed the ICB, working with ICP partners, issues a full and formal response.

2.0 Recommendations

2.1 The ICP is asked to:

1. **Note** the content of the Denny Review of Health Inequalities, including the recommendations made to support tackling inequalities in BLMK; and,

2. **Discuss** the areas which the ICP would prioritise in the Board's response to the Review's recommendations in December.

3.0 Key Implications

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

3.1 Resourcing – A diverse Team will need to be established to take forward the findings of the Report, working closely with partners oversee the implementation of the ICB's response.

3.2 Health Inequalities - This paper is focused on achieving health equality in BLMK

3.3 Engagement - Extensive engagement has been undertaken over three years. Insights from this engagement have been incorporated into the Joint Forward Plan for 2023/24.

3.4 Green Plan Commitments – Engagement will seldom-heard communities undertaken as part of the Denny Review should be continually built upon in the delivery of the Green Plan

4.0 Report

4.1 The Denny Review was commissioned by the Bedfordshire, Luton and Milton Keynes CCG in 2020. Over the last three years, Reverend Lloyd Denny, a former Patient Participation Lay Member from Luton CCG, has been working with health and care partners from across the system to:

- Understand who is affected by health inequalities.
- What this means in practice and what the barriers are to good health
- How we can tackle these head on to create equality of access to everyone, regardless of their background.

4.2 A literature review and assessment of population health data was undertaken in the first instance to provide a robust evidence base to the study. The data highlighted that the people most affected by health inequalities were:

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

4.3 With an evidence base in place, extensive engagement was undertaken with those most affected by health inequalities and trusted advocates including the four local Healthwatch organisations and grassroots VCSE organisations were recruited to lead conversations locally. Overall, the review heard the lived experiences of more than 2,000 people from seldom heard communities.

4.4 The review heard that there are four areas that need to be addressed to tackle health inequality. These include:

- Access
- Communication
- Representation
- Cultural competency

4.5 The review made a series of short-term recommendations, which Reverend Lloyd Denny and the Steering Group believe could be delivered within the first and second year after the publication of the review, to build trust with local communities and act as a lightening rod for a period of reflection, followed by recommendations which could be delivered in years three, four and five to deliver longer term generational change.

Short-term change

INSIGHT AREA	RECOMMENDATION
Access	Contracts for new products and services should rigorously apply the Equality Delivery System so that they meet the needs of all residents and staff members, for example when purchasing personal protective equipment (PPE). This includes ensuring that residents are asked about or offered information in a format or language that they can understand.
	An urgent review of all health and care premises should be undertaken to ensure disability access is always available.
	Hearing loops should be installed across all healthcare establishments and staff should be provided with training to ensure they are always functional.
	Hospital trusts and primary care should undertake a review of the interpreter services to determine the quality and availability of translation services to ensure patient needs are being met.
	GP practices should review their procedures so that residents are not being unfairly stopped from registering, potentially denying them access to essential health services. Practices must ensure they meet Primary Medical Care Policy and Guidance, and that national policy is not applied selectively.
Communications	Residents and partners to come together to co-develop a communications campaign to support people to explain how the health and care system works, and how to navigate it, with a particular focus on supporting minority groups. This campaign should include regular updates on the implementation of the Denny Review , and, where relevant, have a gender focus too for specific men's/women's issues highlighted.
	Urgent review of all communications and marketing materials to ensure that imagery and language is culturally appropriate and reflects the different communities in BLMK.

INSIGHT AREA	RECOMMENDATION
	Undertake an urgent review of all translation services provided in BLMK's health and care sector to check whether it complies with Accessible Information Standards. This should ensure interpreters are always available, that there is consistency across primary and secondary care services, and that British Sign Language (BSL) interpreters are included in the list of different languages available.
Representation	Investment is made in Patient Participation Groups to review representation and actively encourage wider involvement of residents to bring the voice of health inequality into the mainstream.
	BLMK Integrated Care System should set out how its future engagement work is shared, to avoid duplication of effort and maximise impact.
	Training for members of Healthwatch, VCSE organisations or those in community connector roles in Quality Improvement (QI), a way of tackling difficult issues in a more person-centred way, so that people's needs are at the heart of any solution.
	Ensure satisfactory personal protective equipment (PPE) is available for all NHS staff.
	Senior leadership mentoring scheme introduced within NHS organisations for people from ethnic minority backgrounds. Encourage greater diversity within management, and greater diversity on interview panels.
Cultural competency	Training rolled out to all health and care settings to support with language, and understanding the needs of residents, including different ethnicities, those with physical and learning disabilities, and LGBT+ people. This will help to address perceptions of cultural bias / racism which was a consistent theme within community engagement and can build on current patient participation.
	Greater investment in services that are working well, including the Luton Sexual Health Service/iCASH.

Long-term change

INSIGHT AREA	RECOMMENDATION
Access	Consider extending the service hours available in primary care to evenings and weekends for those unable to attend day-time appointments. Also include access to female-only clinics to support people from different faiths and cultures, and victims of male violence.
	Ensure that residents who would prefer to access some healthcare services anonymously are able to do so. This could

INSIGHT AREA	RECOMMENDATION
	be done, for example, through more services, or a greater proportion of them, being provided digitally.
	Work with the VCSE to fund Access Champions to support people who are unsure how to navigate health and care services or have additional needs to access appointments, or other services to support their health and wellbeing.
	Establish an end-to-end service for long COVID.
Communication	Based on the findings of the review of interpretation services, ensure that there is a consistent service across health and care and that translated materials are available in line with legal duties.
Representation	Improve integration of housing, hospitals and mental health support in homeless shelters
	1 in 4 black men will get prostate cancer in their lifetime. Black men are more likely to get prostate cancer than other men, who have a 1 in 8 chance of getting prostate cancer, according to Prostate Cancer UK. The ICB should work with researchers to better understand the extent of this issue in BLMK and the reasons behind it. Furthermore, that the ICB develop a programme of engagement with men in general regarding their personal health and co-produce with residents communications activity focused on specific support available for male health.
Cultural competency	Develop an Asset Based Community Development (ABCD) approach to engaging with local communities to drive grassroots change and represent their views in service development. ABCD is a way of local people taking the lead, and developing solutions for themselves, supported by statutory organisations, such as local councils. This would be achieved by ring-fenced investment being provided to VCSE and Healthwatch organisations to continue to build on the dialogue and trusted relationships developed in this review and lead to continuous improvements. Funding these organisations would enable them to proactively co-produce solutions with residents.
	Co-produce solutions with people from different backgrounds, including people with learning disabilities, young people affected by mental ill health and autism, and refugees, to adjust health services and the spaces in which they are delivered to make them more appropriate and inclusive.
	Co-produce services and training resources with transgender people, people from different ethnic minorities and cultures or faiths to increase awareness of individual needs, so that health and care professionals feel confident and empowered

INSIGHT AREA	RECOMMENDATION
	to better support patients. This will better support people when receiving diagnoses or delivering care for their specific needs.
	Develop an education programme for refugees to develop skills and independence to support them in understanding the health system and navigating it. This should also educate refugees on rights available to them, such as taking time off work to support family members and access to health and care.
	Undertake further research to understand the barriers that ethnic minorities including Gypsy, Roma, Travellers, face. Work with residents as part of an Asset Based Community Development approach to develop solutions for greater equality.
	Develop more service offers that involve going into communities, where people are most comfortable, such as pop-up centres, building on the successful approaches adopted through the COVID vaccination programme.
	Encourage health and care professionals to add a 'listening to patients' section to every training event to ensure lived experiences of local people are shared and professionals are given the opportunity to identify solutions to improve the quality of services / experiences.
	Develop an advice, guidance and signposting platform so that residents know which services are available and how to access them.

What has happened since the review was published?

4.6 On 30 June 2023, The Board agreed that £300,000 funding from the inequalities budget should be ring fenced to support the delivery of recommendations from the Denny Review, which includes support for continued engagement by Healthwatch and the VCSE. However, it is recognised that additional funding (at place and scale) will be required to deliver the level of change required.

4.7 BLMK's four local Healthwatch and VCSE partners are developing proposals to determine how allocated funds could be applied to delivering recommendations locally. The Inequalities Steering Group will consider these proposals on 24 November 2023.

4.8 In addition, the Chair and Chief Executive of the ICB have written to all system partners to share the findings from the Denny Review and ask them to join a movement locally to achieve the level of change outlined in the review. The letter to partners asks for three things:

1. To review the Denny Review report and recommendations in the context of their organisations, to identify any gaps and opportunities for improvement.
2. To agree in principle to participating in a system-wide improvement programme that we will co-design and agree the scope of together, to enable us to deliver a radical response to the Denny Review report findings.

3. To commit to an annual update on their continued quality improvement and progress made against the Denny recommendations.

4.9 Partners have been asked to respond by 17 November, to enable a draft of the radical response to the Denny Review to be shared with the Board on 8 December for their consideration.

4.10 The ICP is asked to note these recommendations, including the ask of the ICB to report annually against their implementation and to present a clear rationale for any that are not pursued.

4.11 The ICP is asked to consider in detail the content of Reverend Denny's Review, the insights that it shares about residents' experiences and the recommendations made and share their views on what should be prioritised in the ICB's response to the Review in December.

4.12 On 22 September, the Working with People and Communities Committee discussed the findings of the Denny Review to consider their feedback on how the recommendations could be taken forward to deliver a radical response to the report.

4.13 In keeping with the commitment to keep residents informed in the most accessible ways, learning lessons from the Review, national and local media, social media, internal communications and stakeholder communications will be used to promote the publication of the ICB's response, once agreed.

4.14 A series of place based meetings will also be held, with partners to share the findings of the review and response in the most accessible ways possible, in keeping with the findings from the Review.

Risks and issues

4.15 The Denny Review raises wide ranging and complex issues about how and for whom we are delivering health and care across our system. We intend to reflect lessons learned from Denny in reviewing all system risks, as appropriate. There are several existing risks of relevance, include those relating to widening inequalities and our response to the rising cost of living. The Board agreed in September to make updates to these risks part of the proposed system-wide response, alongside any new risks required to address the issues Denny raises in relation to barriers to access. In the short term we have also added a new risk on Health Literacy (the degree to which individuals can find, understand, and use information and services to inform health-related decisions), inspired by the Denny Review and the associated patient story heard at the last Board meeting.

5.0 Next Steps

5.1 A formal response from the Board is in development and will be presented to the Working with People and Communities Committee on 1 December, and the Board on 8 December, for further discussion and approval.

List of appendices

Denny Review of Health Inequalities (2023)

Background reading

Denny review - Bedfordshire, Luton and Milton Keynes Integrated Care System (blmkhealthandcarepartnership.org)

The Denny Review

A review of health inequalities in Bedfordshire, Luton and Milton Keynes

September 2023

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Commissioned by

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Now is the time for change

Foreword by Reverend Lloyd Denny DL

As a local pastor working in the heart of Luton, I listen to people's stories each day.

Often people tell me about their health problems. These stem from a range of issues, such as poverty, poor housing and unhealthy lifestyle choices.

When some residents try to get help from our local health and care system, they tell me about the barriers they face. The system, plainly, is not designed for them. I hear very clearly that this experience can be frustrating and often demeaning.

The truth is that some people do much better out of the health and care system than others. And it has hugely significant real-life consequences.

Life expectancy across Bedfordshire, Luton and Milton Keynes varies widely. A typical woman living in a deprived area of Luton, such as Bury Park where I am a Minister, has a life expectancy around six years lower than a woman living in a more affluent part of town. For men, the difference is an even more shocking nine years.

These issues have long been with us. This year marks both 75 years since the NHS was founded, and 75 years since the Empire Windrush brought men and women from the Caribbean to help get Britain back on its feet after the Second World War. It is still people from migrant backgrounds who often face the greatest health inequalities.

I have seen diseases like diabetes become a fact of life for too many people, particularly from our Caribbean and south Asian communities, for lack of education and support about healthy lifestyles. I have seen people not getting the care they need because they don't understand how the health system works. I have seen people die before their time because they cannot afford to travel out of our area to access treatment.

Experiences like this will be familiar to many. Health inequalities are common not just for people from migrant backgrounds, but also people experiencing homelessness, the LGBT+ community, the Gypsy, Roma and Traveller communities, people living in deprived neighbourhoods, and people with learning and physical disabilities. But these experiences, while common, are rarely heard.

This three-year study was triggered by the COVID-19 pandemic, when the data told us that people from ethnic minorities were much more likely to be infected and die from the disease. These people were often on the frontline, supporting us all through the crisis. That is an injustice we cannot let slide.

I was not the only one observing this. A group called the Legacy of Windrush Descendants (LOWD), based in Bedford, called on the NHS in Bedfordshire, Luton and Milton Keynes and their partners to do something about the inequalities people face.

This prompted the study which I was asked to lead, to get to the root cause of health inequalities in our area, and to work with those most affected to tackle the issues head-on.

This report is the culmination of that work. I have no doubt that it will take time to rebuild residents' trust, as will responding to this report in full in a way that delivers the radical change required. However, I am confident that if the recommendations in this report are acted upon, we will be much closer to getting the fair and equal health and care system we all need.

Executive Summary

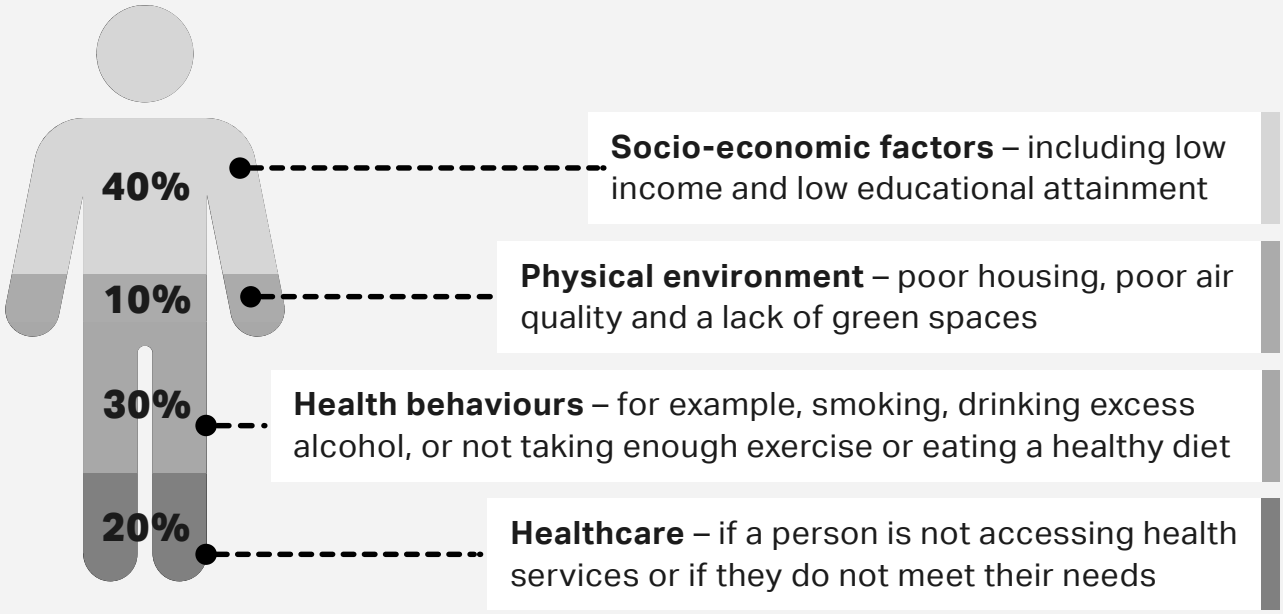
The Denny Review investigated health-related inequalities in Bedfordshire, Luton and Milton Keynes (BLMK). We have sought to understand where health inequalities are greatest and what can be done to improve the situation for those affected.

A review of the published evidence both in the local area and nationally was commissioned from the University of Sheffield to establish what is known about health inequalities. Local voluntary, community and social enterprises (VCSE), including the four local Healthwatch organisations, engaged directly with local residents, particularly those from under-represented groups.

Our recommendations reflect the evidence gathered, particularly residents' experience.

The factors driving health inequalities

The published evidence explains why some people face much worse health outcomes than others. These are:



These factors often combine to mean that a person facing health inequality is more likely to be in poor health. The following groups are more likely to be affected by health inequalities:

- People living in deprived neighbourhoods
- People from ethnic minorities
- LGBT+ people
- Gypsy, Roma and Traveller people
- People with physical or learning disabilities
- People who have experienced homelessness.

A better, more personalised service needed

Following in-depth engagement work with residents from these groups and beyond, four themes emerged:

1. Cultural competency
2. Communication
3. Access
4. Representation.

Cultural competency

The majority of residents we spoke with felt an understanding of their cultural background was often lacking in healthcare staff.

Examples include:

- Migrant women feeling that their condition was not being taken seriously
- An LGBT+ person being spoken to with the wrong pronouns, even after repeatedly explaining what the correct ones were
- A member of the Gypsy, Roma and Traveller community being treated differently as soon as they said what their background was
- A person with autism being expected to wear a face mask even though the healthcare staff member was told it would make them distressed.

Communication

Linked to cultural competency, many issues with communication were raised by residents.

Issues raised include:

- A lack of interpreters to help migrants access healthcare services
- Communication materials with images and text perceived to exclude LGBT+ people
- The body language of a GP receptionist making a resident feel unwelcome
- Hearing loops not being made available to a deaf person
- A person experiencing homelessness being sent letters which they cannot receive.

Access

Access to services plays a big role in someone either feeling that a service is for them, or if they are excluded from it.

Issues around access include:

- Having services in a location that a person cannot afford to get to
- Having GP appointments at times when a resident cannot attend
- Long waiting times for referrals to specialists
- Not having female-only clinics, which would make it easier for some women, such as victims of male violence, to openly discuss their health.

Representation

The need for residents to feel represented in the services they use is a critical part of those services truly serving all residents.

We know that working with patient participation groups from the beginning of a healthcare project increases its chance of success by 20%. Therefore, we need to make sure that the ability for residents to give their views is clearly available and can be fed into decisions made about services where they live.

Evidence-based recommendations

The evidence we present strongly indicates that large-scale change is needed in how health and care is delivered in Bedfordshire, Luton and Milton Keynes to help rebuild trust with residents that healthcare services are truly for them.

The Denny Review Steering Group has worked together to design a series of recommendations based on the published evidence and the views of residents. These are presented in full from page 38.

Recommendations are broken into:

- **Short-term solutions** that can be implemented quickly, which will help to make an immediate difference to the experience of residents over the next one to two years.
- **Larger changes** to how healthcare is delivered, which residents will see the effect of over the next three to five years.

These recommendations are for the Bedfordshire, Luton and Milton Keynes Health and Care Board, working with the Integrated Care Partnership and local residents, to take forward. Regular updates should be shared on the Partnership's website and social media. A comprehensive update will be published each year so that residents can see that change is happening.

Why the Denny Review is different

The Denny Review comes from the people of Bedfordshire, Luton and Milton Keynes. It is the result of intense engagement with residents, much of which has taken place inside communities that feel forgotten, underrepresented, and left behind. The true test in assessing the success of the response to the Report will be whether those individuals to whom we listened begin, over time, to feel like health and care services are for them, and that the barriers to access are tackled with pace and determination. The Report calls for a bold and radical response from system leaders with a real focus on action, not words.

The Denny Review provides a timely focus to help drive positive change. The introduction of the Integrated Care Board (ICB) sees a fundamental shift to a community-led approach to responding to residents' healthcare needs and a greater focus on stopping health problems from appearing in the first place, rather than just treating them when they do.

In addition, the BLMK ICB has used inequalities funding to invest in VCSE organisations. It has recruited community connectors to work with the communities highlighted in the Denny Review and develop equal partnerships with them. Since the pandemic, discrete programmes to tackle health inequalities have been established in all four unitary authority areas of BLMK.

The Denny Review plays a vital role in holding up a mirror to health and care organisations, showing leaders the reality for many minority groups, and acting as a lightning rod for change.

By bringing all insights and recommendations together and learning from existing best practice, we have the opportunity to ensure that insights from residents reach all areas of health and care. This should lead to more residents consistently experiencing improved care.

Introduction

The Bedfordshire, Luton and Milton Keynes Health Inequalities Review, also known as the Denny Review, was commissioned during the early part of the COVID-19 pandemic.

During 2020, evidence showed that while the effects of the virus were felt by all, people from ethnic minorities were disproportionately affected.

The Government ordered a rapid review to look at the facts, determine causes and make recommendations. That **review**, called Disparities in the Risk and Outcomes of COVID-19, was conducted by Public Health England and published in August 2020.

The purpose of this review is not to go over what already is known nor to look solely at the impact of COVID-19 on different communities. Instead it investigates health inequalities in Bedfordshire, Luton and Milton Keynes (BLMK) in their wider sense.

Wider determinants of health, such as housing, poverty and education, have a considerable and measurable impact on health, and are considered as part of this review.

In partnership with the four local Healthwatch organisations which cover the BLMK area, and a range of other organisations, we listened in depth to communities often described as 'seldom heard'. These include people from ethnic minorities, people with physical and learning disabilities, LGBT+ people, and those living in areas of deprivation.

The BLMK Integrated Care System (BLMK ICS) has developed five strategic priorities to improve the health of the local population. Reducing inequalities is one of these priorities, described as: **In everything we do, we promote equalities in the health and wellbeing of our population**. Reducing health inequalities is also woven through the other four priorities.

But what is clear from the evidence in the pages that follow is that health inequalities are real, and exist due to multiple factors, each of which needs to be tackled. Areas of deprivation tend to have poor housing, fewer green spaces, and poorer levels of education, all of which have an impact on health outcomes.

With the advent of the new Integrated Care System (ICS), there is an opportunity to work together in a more collaborative, integrated and impactful way. And, in doing so, to truly deal with longstanding and deeply entrenched issues.

This Review brings together what is known, and gathers new evidence from people directly experiencing health inequalities.

This allows us to make clear, actionable, time-specific recommendations, which can both start to make changes in the short-term, but also make the longer term, more systemic changes which will make a lasting difference.

The recommendations form part of the ways in which the NHS in Bedfordshire, Luton and Milton Keynes can meet its obligations to the Equality Delivery System (EDS) 2022. The main purpose of the EDS is to help local NHS systems and organisations, in discussion with local partners and residents, review and improve their performance for people with protected characteristics.

This means that a person is legally protected from discrimination due to characteristics such as disability, sex, or race.

Those changes will only happen by working together as a health and care system. That includes NHS organisations, local authorities, VCSE organisations, the faith sector and, of course, residents.

About Bedfordshire, Luton and Milton Keynes residents and their health

Bedfordshire, Luton and Milton Keynes (BLMK) is home to about 1 million people. Its population is projected to grow strongly over the coming years.

There are four Places, each covered by local councils:

- Bedford Borough
- Central Bedfordshire
- Luton
- Milton Keynes

Health in the area is covered by the BLMK Integrated Care System, an Integrated Care Board, and an Integrated Care Partnership.

Integrated Care System (ICS)
– a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in the area. In BLMK this is called the BLMK Health and Care Partnership, and it has a website which you can find **here**.

Integrated Care Partnership (ICP)
- A statutory committee jointly formed between the NHS integrated care board and local authorities. It brings together partners, including voluntary, charity and social enterprises (VCSE) concerned with improving the care, health and wellbeing of the population.

Integrated Care Board (ICB)
– A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services.

Where are the most deprived areas in BLMK?

There are 64 small areas, highlighted on the map below, within Bedfordshire, Luton and Milton Keynes which are among the 20% most deprived in England. These areas have populations of between 1,000 and 3,000.

Of these areas there are:

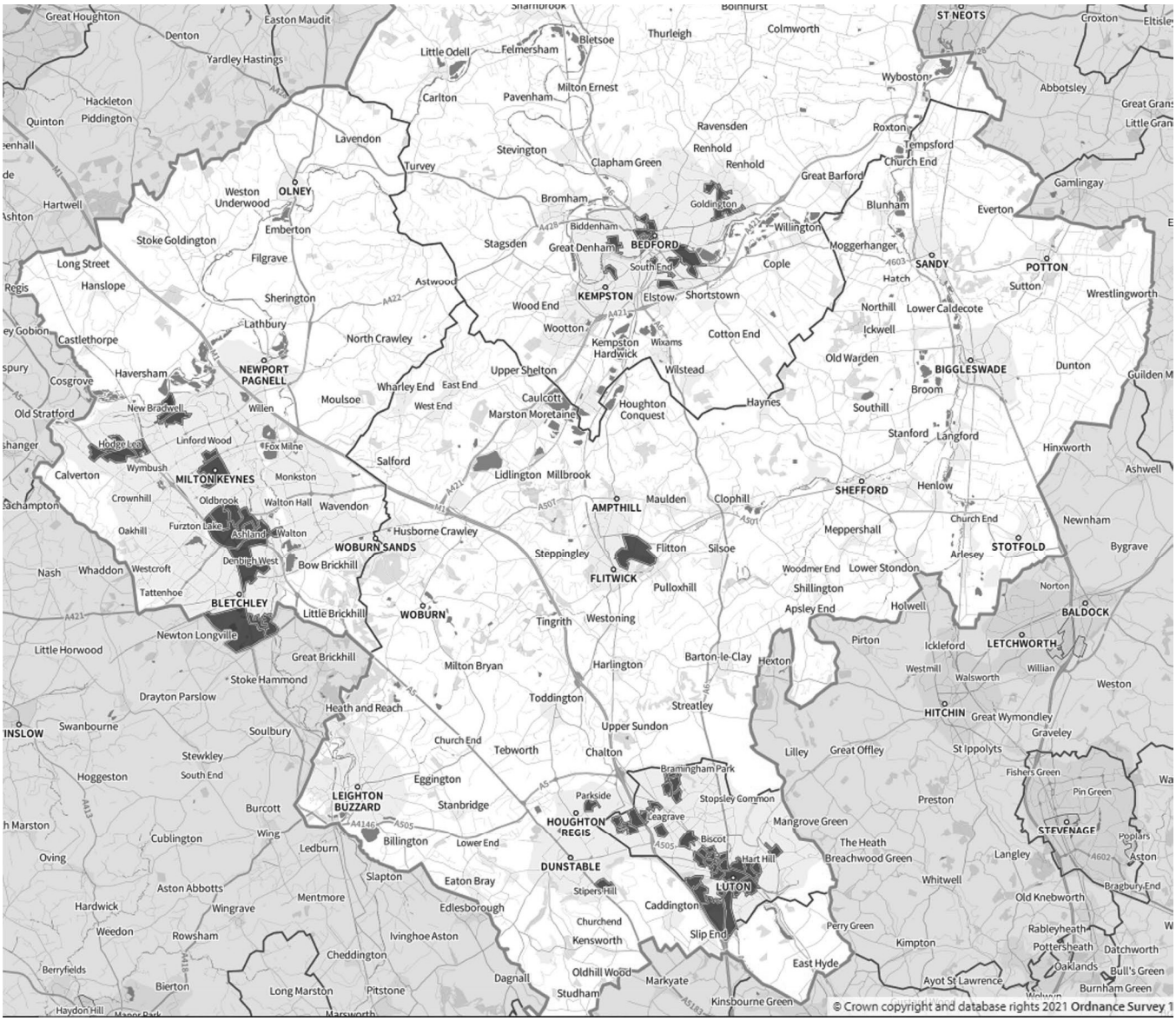
14 in Bedford

3 in Central Bedfordshire

29 in Luton

18 in Milton Keynes

Health inequalities can be found throughout BLMK, but these areas are where residents are most likely to be disadvantaged by the health and care system as it is at present.



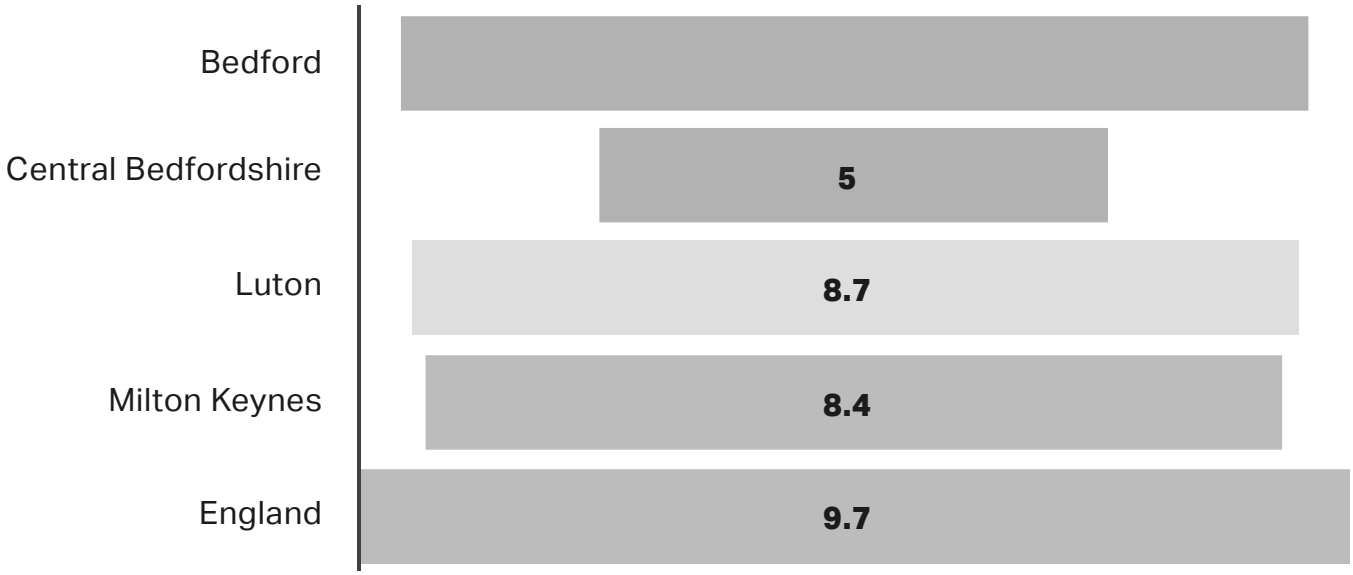
Differences in life expectancy

There are significant differences in life expectancy between people living in the most and least deprived areas of BLMK.

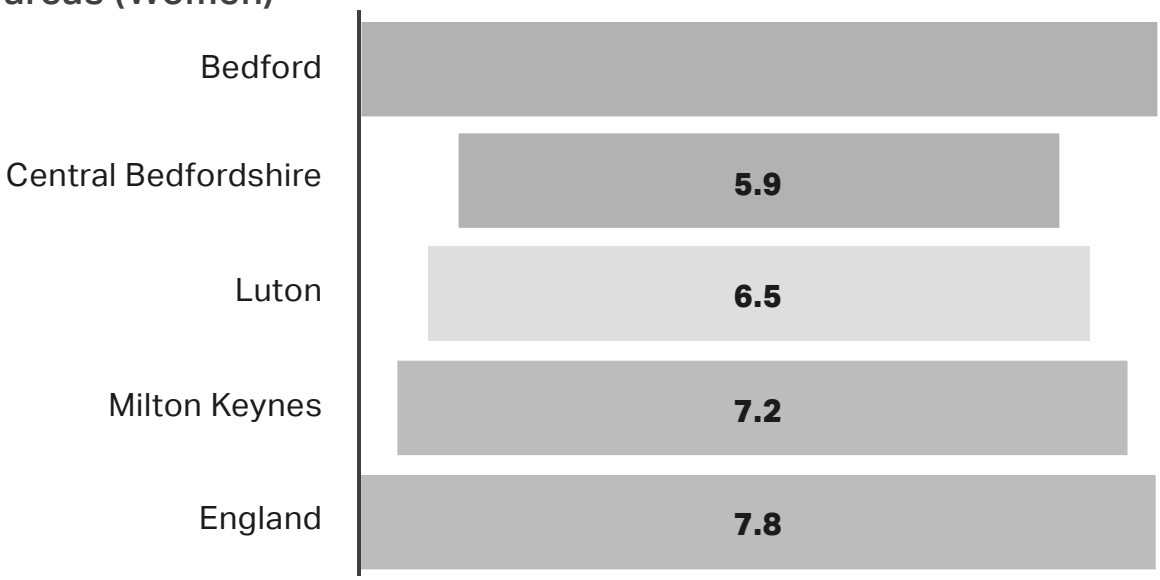
As the chart below shows, a woman living in an affluent part of Central Bedfordshire can expect to live around six years longer than a woman in a deprived area. This difference rises to almost eight years in Bedford.

For men, the difference is even greater. There is a difference of more than eight years between the life expectancy of the least and most deprived areas of Bedford, Luton and Milton Keynes. The differences are, on average, slightly less than the national average, but nevertheless unacceptable.

Difference in life expectancy 2018-20 between most and least deprived areas (Men)



Difference in life expectancy 2018-20 between most and least deprived areas (Women)



Context and terms of reference

In June 2020, the Legacy of Windrush Descendants wrote to the BLMK Clinical Commissioning Group asking that health inequalities be addressed urgently. The charity was responding to emerging evidence that people from black Caribbean and African backgrounds were more adversely affected by the COVID pandemic because of existing inequalities. The Reverend Lloyd Denny was invited to lead a review the following year, when the relaxing of regulations allowed for access to the communities most affected.

A Steering Group was established in the winter of 2020 to agree the methodology for the review and first met in September 2021.

Governance

The Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (from July 2022 the BLMK ICS) leadership commissioned this review to ensure that all inequalities work across the system is informed by an up-to-date evidence base.

This review was led by a dedicated Steering Group. It reported through the BLMK ICS inequalities group, and through that to the ICS Partnership Board.

Remit

The review was led by Reverend Lloyd Denny, former lay board member for patient and public involvement at Luton Clinical Commissioning Group and a respected member of the community.

The review posed the following questions as a starting point to help identify recommendations for the BLMK healthcare system to address:

1. **How were members of different communities affected by COVID-19? What impacts has the pandemic had on health, housing, poverty and education for different groups in BLMK?**
2. **Has the system in the BLMK area done anything to mitigate these inequalities? What are the highest priorities for the system to address based on the evidence?**
3. **What should BLMK ICS do to help address these inequalities, with the maximum impact for residents? What should be done at neighbourhood, place, Care Alliance and system levels?**

This review was based on lived experience and sought evidence from a wide section of our population, paying particular attention to the often-overlooked sections of our population.

Furthermore, the review endeavoured to be transparent and accountable. It was focused on enabling the right actions to be taken to reduce inequalities.

A **virtual library** has been set up to help manage the multiple documents and enable the review to clearly reference the evidence base.

What we heard

A summary of the evidence gathered in the literature review commissioned from the University of Sheffield.

Health inequalities is not a new concept. In commissioning this review, it was important to first review the literature on the health inequalities from different social groups and communities in Bedfordshire, Luton, and Milton Keynes, to ensure that the review had a solid evidence base and took account of the population health data from public health. The review, conducted by the University of Sheffield, also looked at national data on health inequalities, as well as studies of specific groups in different parts of England.

The review set out to address the following research questions:

What information is available on health inequalities in BLMK?

What good practices are there to reduce health inequalities, and what can be learnt from them?

What are the connections between what we know about health inequalities in our area, what are the key themes, and what gaps in our knowledge?

What work does the ICS need to do in collaboration with the communities to improve understanding of people's experiences of inequalities and how to reduce them?

Case study: Mr and Mrs W – experience of accessing care for son with complex needs

Mr and Mrs W live in a deprived part of Central Bedfordshire with their son, who has mental health issues, obsessive compulsive disorder (OCD), autism and severe learning disabilities.

The couple feel that they have been "badly let down" by the Community Mental Health Team, who have not provided consistent support for their son. Mrs W said: "No one takes responsibility, you are just shoved from one person to another."

Their son was prescribed medication but only after he was admitted to a psychiatric ward. Mr W said: "There's no follow-up, no monitoring, no checking on whether the patient is taking the medication, or whether the medication is working."

Mr and Mrs W both feel that healthcare professionals need to find a better way of communicating with him because their son lacks social skills and is very difficult to interact with.

Both parents would like to see a change in the way emergency situations are dealt with. Also, they feel healthcare professionals should be trained to identify people who are under enormous stress, and are not getting the support they need, so they can get help.

More recently, having finally achieved support from the Community Mental Health Team, a support worker visits their son once a week to try to identify their son's needs and how they can help him. Mr W said their son can be responsive to people he feels are 'nice' or who are trying to help him, and he appears to be responding to the weekly visits.

Mr and Mrs W do not feel involved in decisions regarding their son. When they have complained about a service, they either feel that their complaint is 'dismissed' or they are told changes will be made but nothing ever happens. Mrs W said: "In the end I just get fed up because the system doesn't work."

The evidence base

The literature review looked at local evidence identified by the Bedfordshire, Luton and Milton Keynes ICS, including searches of data from the four Healthwatch organisations within the area. Data was also gathered from a range of sources, including health research databases and data from across the NHS, the King's Fund, and the Department of Health and Social Care. For the full list of data sources, go to the literature review document **here**.

Eighty-eight relevant reports were identified, including 71 academic studies or other reports. Seventeen documents were from local health data sources, mostly small studies engaging with specific groups of residents. Nine studies looked at research about the COVID-19 pandemic, and eight papers presented good practice examples.

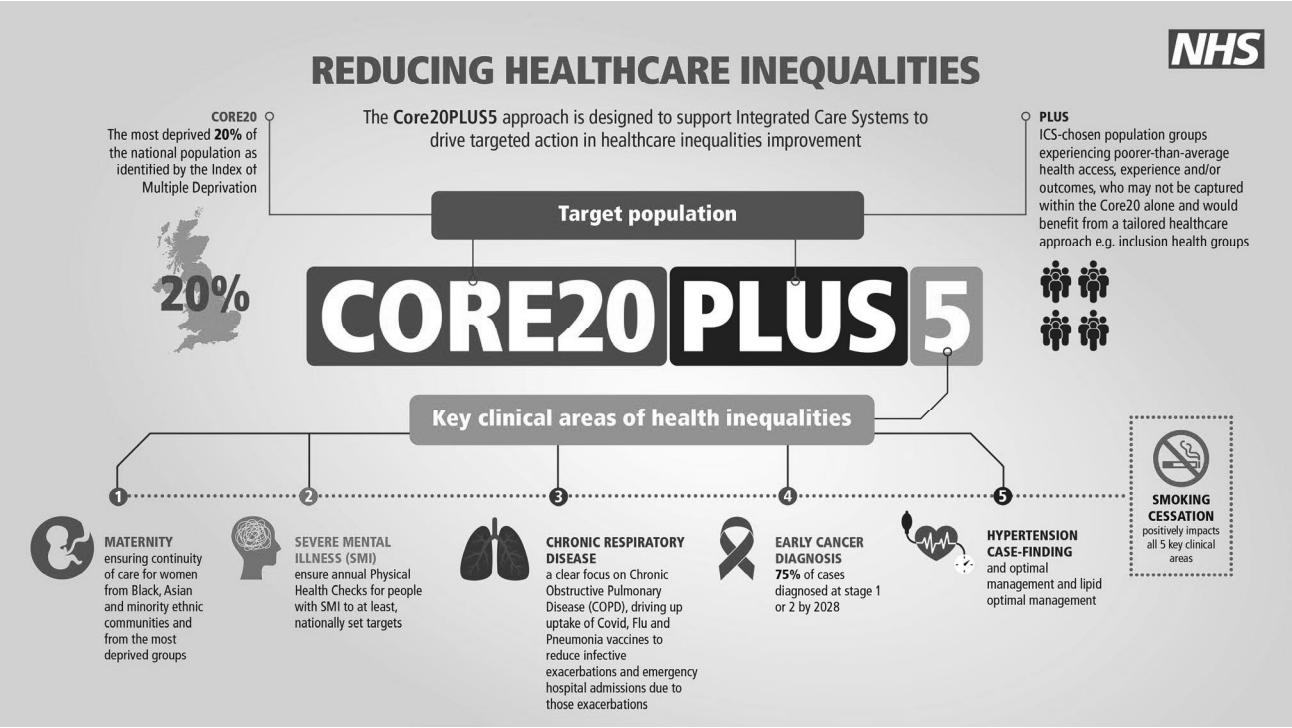
The review looked at evidence across a person's whole life. These include protective factors, which aid good health, such as a good diet, exercise, good housing, and clean air.

Risk factors, which have a negative effect on a person's health outcomes, include smoking, poor diet, physical inactivity, and harmful alcohol use can lead to preventable diseases and premature deaths.

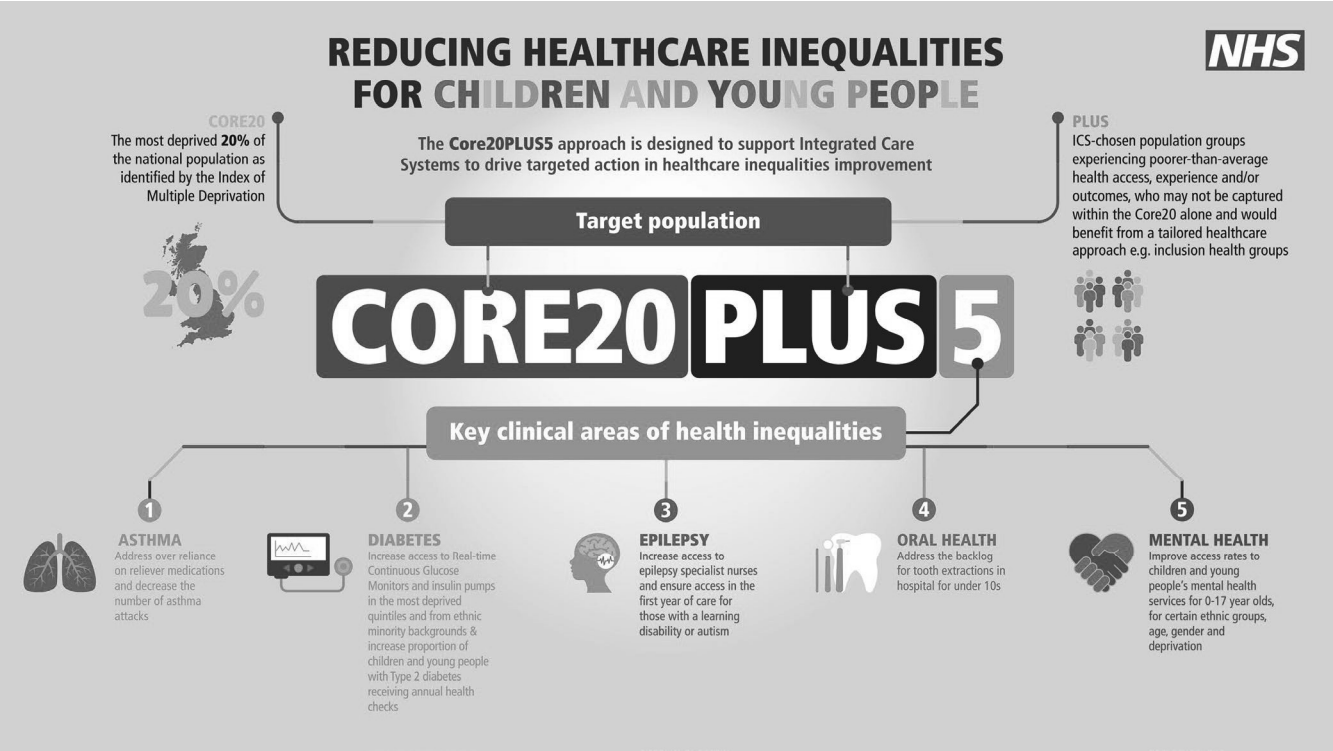
Looking at these wider determinants of health will help draw out specific ways to improve the conditions into which people are born, live and work.

The literature review paid attention to NHS England and NHS Improvement's approach, Core20PLUS5, to reduce health inequalities (see tables below). It focuses on the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD) and five priority areas. It targets the most vulnerable groups and communities identified through population data for addressing health inequalities (NHS England, 2021).

Core 20 + 5 for adults



Core 20 + 5 for children and young people



What the evidence showed

The findings from our commissioned review of health inequalities research were clear.

A person's health behaviours, their physical environment, and socioeconomic factors, affect their health and wellbeing throughout their life. These factors – such as poor housing, pollution, poor diet, smoking, and lack of exercise –can combine to have a bigger effect on an individual, family, social group, or community. They lead to higher rates of a range of health conditions and, ultimately, lower life expectancy. Below we explore the various themes which help to explain health inequalities.

Ethnic minority groups have generally poorer health

Ethnic minority groups generally live in the most deprived areas of the UK. This is also true of people living with two or more health conditions, people with a disability, those experiencing homelessness, and those with drug or alcohol dependence.

Research by the Centre for Ageing Better shows that people reporting that they have poor health has been higher for ethnic minority groups than the white British population. For example, black Caribbean people and those from Pakistan and Bangladesh report poor health between 1.5 times and double the rate of white British people.

Cultural factors can influence health outcomes

The literature review looked at several studies focusing on how cultural factors can have an impact on an individual's health outcomes.

On the positive side, cultural factors, such as family support, sense of community, and religion, were shown to have a positive effect on the mental wellbeing of people from ethnic minority backgrounds.

However, cultural factors for ethnic minority groups can have an impact on health outcomes or be a barrier to accessing health and social care. Cultural or religious beliefs can lead to the misplaced use of traditional remedies. Differences in the presentation of symptoms can lead to misunderstandings, misdiagnosis, or incorrect referrals. Cultural differences may lead to a person not wanting to seek help if they have symptoms of cancer or a sexually transmitted infection[1].

In addition, a limited understanding of the English language may mean people do not understand health promotion materials and how to access the related services if translations or interpreters are not provided.

The role of the environment in a person's health

Environmental factors play an important role in a person's health outcomes.

A report[2] showed that Luton lacks green space – and the most deprived wards have less access to green spaces than wealthier parts of town.

A Friends of the Earth study on England's green spaces found a strong link between ethnicity and green space deprivation. It suggested that people from ethnic minorities are twice as likely as white people to live within areas with few green spaces.

In Milton Keynes, it has been identified[3] that 5.8% of deaths in adults over 30 are estimated to be due to poor air quality.

People who struggle to afford heating bills – those said to be in fuel poverty – are lower than the regional and national numbers in Milton Keynes but are increasing. This can make health conditions worse in the winter for people living in cold homes. People living in poverty may also be less likely to access the care they need or access it only when their condition has worsened.

1 Goff et al. 2020; Ehiwe et al. 2012
2 Joint Strategic Needs Assessment, Luton (2015)
3 Health Impact Assessment, Milton Keynes (2021)

Living and working conditions

Poor living and working conditions have a significant impact on a person's health outcomes. They are recognised as a critical problem within BLMK health reports.

The pandemic highlighted poor working conditions leading to health inequalities. The Race and Health Observatory 2022 review suggested ethnic minority healthcare workers had less access to personal protective equipment (PPE), with the pandemic having a more negative effect on their mental health.

Housing can play a very important role in widening inequalities. Many low-income families live in poor quality or overcrowded housing – some in temporary accommodation, disrupting children's well-being.

Children who live in poor housing[4] are more likely to suffer from poor health, have a longstanding illness or disability, dislike the area they live in, run away from home, be excluded from school, and leave school with no GCSEs. Poor housing leads to health risks such as respiratory illnesses, poor nutrition, depression, and anxiety.

Homelessness is a key driver of severe health inequalities. According to estimated data from Shelter, one in 66 people in Luton are classed as homeless, the worst figure for the entire UK outside of London. Milton Keynes was also ranked in the top 10 list of local highest rates areas for homelessness and rough sleeping.

There is a direct link between homelessness and access to health and social care services and management of long-term conditions. The Government's figure on the prevention and relief of homelessness in England shows that people from ethnic minority backgrounds are disproportionately affected by homelessness.

Health behaviours

Health behaviours, including physical activity, healthy food and social connections, can make a big difference to a person's overall health.

We know that access to affordable food is strongly influenced by income, so people living in poverty are estimated to need to use 45% of their available resources to afford healthy food, clearly not an option when there are so many competing demands. Whilst some physical activity opportunities are free to access there are barriers, such as transport and equipment, so inequalities exist here too.

A study[5] with Pakistani, Bangladeshi and white British mothers in Luton revealed that very few women consumed folic acid before conception, nor understood its benefits in preventing health problems from birth.

A different report found that African and South Asian women were more likely to endorse "using traditional remedies" for cancer and were more likely to report that they "pray about a symptom" than white British women. This may lead to accessing the NHS when their condition was at a later, harder to treat, stage.

4 Finney, & Harries (2013). Understanding ethnic inequalities in housing
5 Garcia (2018). Understanding the consumption of folic acid during preconception in Luton

A study[6] showed that COVID-19 had a significant impact on the health behaviours of ethnic minority groups especially during the lockdowns as they reported changes to behaviour such as low levels of physical activities. Hence, it is important to promote health awareness among ethnic minority groups to encourage healthy living.

Access to and uptake of health services

People affected by health inequalities had many barriers to accessing health services.

The biggest barrier for migrants to general practice registration is the inability to provide paperwork, with two out of five (39%) of registration refusals due to lack of ID.

Evidence shows that ethnic minority groups, including Gypsy, Roma and Traveller communities, and LGBT+ people face prejudice from GP surgery staff, including refusal to book an appointment. Several local studies also highlighted that patients were not always clear how to access urgent care services.

Inequalities in access to healthcare were experienced by the deaf community. According to Healthwatch Bedford Borough and Healthwatch Central Bedfordshire's 2021 Seen and Heard report, most study participants representing the deaf community found it challenging to access a GP appointment.

Social networks

Family and community networks were shown to be positive forces for ethnic minority groups. One study from the north of England showed participants preferred to live in neighbourhoods with people of the same ethnicity, even if it was a deprived area.

Another study showed that participants' spiritual and religious beliefs directly influenced their behaviour to maintain health and wellbeing.

A study[7] exploring relationships and faith argued that faith-based affiliations were significantly relevant for ethnic minority groups to pursue health and wellbeing.

6 Randhawa (2023) The impact of COVID-19 on the changes in health behaviours among Black, Asian and Minority Ethnic (BAME) communities in the United Kingdom (UK)

7 Ochieng, B. (2010).Spirituality as a mediating factor in black families' beliefs and experiences of health and wellbeing.

The pandemic and health inequalities

The COVID-19 pandemic disproportionally affected people from ethnic minority backgrounds.

Several studies showed that people from these groups have been at a much greater risk of contracting, being hospitalised, and dying from COVID-19.

Two studies, one for Bedford Borough and Central Bedfordshire[8], and another for Luton[9], revealed that participants acknowledged that inequalities experienced by different communities contributed to a more severe impact of COVID-19. Participants discussed how poor living conditions and overcrowded homes contributed to the transmission of the virus.

They said there was a great deal of community suspicion surrounding how ethnic minority groups were treated, compounded by a lack of confidence to complain.

A recent paper on vaccine hesitancy[10] among Luton's ethnic minority groups found a significant association between educational attainment and vaccine hesitancy. The most common reasons for low vaccine uptake among ethnic minority groups included lack of trust in the Government and vaccines, and concerns about vaccine side-effects. Public Health England statistics from 2021 showed that Luton had the third-lowest uptake of COVID-19 vaccine outside London in the UK.

8 Community Engagement & COVID-19 (2023), National Centre for Social Research
9 Ali, N., et al, (2021). Talk, Listen, Change (TLC) COVID-19.
10 Cook, et al (2022). Vaccination against COVID-19.

Listening to residents

The Denny Review commissioned studies by Healthwatch Bedford Borough, Healthwatch Central Bedfordshire, Healthwatch Luton and Healthwatch Milton Keynes, working in partnership with grassroots VCSE organisations where trusted relationships were held.

The lived experiences part of the review ensured that the voices of more than 2,000 local people who experienced health inequalities were heard through a range of surveys, case studies and detailed discovery interviews.

Gypsy, Roma and Traveller community

Despite growing evidence that Gypsies and Travellers are particularly disadvantaged in access to health care, there are very few studies to explore the reasons for this. Healthwatch Bedford Borough investigated the nature of the social disadvantage that the group experience. Nineteen members of this community were interviewed to explore both attitudes and structural reasons behind this health inequality.

People from the Gypsy, Roma and Traveller community told us:

- Almost all described **literacy as a barrier** to meaningful communication about their health or social care. About half said it was the most important barrier. One person described their feeling of shame in not being able to read or write.
- Only two or three people out of 19 interviewed felt literacy was not a barrier for them. The majority said they can't read text messages. Consequently, they often take these to the Gypsy and Traveller Liaison Officer for help.
- For some, the challenges regarding health literacy are so overwhelming that they feel lost in the system. Gypsies and Travellers say that they have described their issues to the NHS, and yet see nothing changing to address or improve these. One said: "All of those forms, stupid asking."
- The move to online services has resulted in more isolation and, as a result, the elderly and sick were unable to get help.
- The need for **videos and voice messages** was mentioned as a way of overcoming communication barriers. However, the lack of secure Wi-Fi on either of Bedford's local authority-run sites was an issue.
- The need to be understood was mentioned by people in the Gypsy and Traveller communities when asked that they wanted from the NHS.
- **Cultural understanding** was also mentioned by the majority of the Gypsies and Travellers who talked about communication barriers. They felt people were "clueless" at best and "scared of them" at worst.

Voices of Gypsy, Roma and Traveller people

One woman said:

> "Female doctors for pregnancy, smear tests. It's against Traveller ways for men to be involved."

When asked about the impact of being a Gypsy or Traveller on the treatment they receive, all but two felt that their cultural identity had a negative impact.

One said:

> "Every time they think I'm a Traveller I get treated real bad."

Another said:

> "They don't understand what I'm on about, I hate talking to them."

Women from migrant backgrounds

Women from migrant backgrounds have been found to be particularly at risk of health inequalities due to a combination of different factors, such as language skills and cultural differences. Healthwatch Bedford Borough spoke with women from West Africa, Bangladesh and Bulgaria.

Women from West Africa

A consistent theme was women's experiences of negative interactions, stereotyping, disrespect and cultural insensitivity. Interviews also explored the issue of female genital mutilation (FGM), a traditional cultural practice undertaken in some countries in West Africa. This is the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons. Interviewers spoke with 15 black women from West Africa and women who have undergone FGM.

Women from West Africa said:

- There is a concern that the **stereotype** of the strong black woman may lead health professionals to discount expressions of pain, anxiety and vulnerability.
- Migrant women from Africa asked for **greater sensitivity** by healthcare providers. Half of this group said that being a black African woman had a negative impact on their care. They said they wanted to be spoken to nicely by healthcare professionals.
- FGM is a significant issue for this community. Women who had undergone FGM spoke of being subjected to hurtful comments, being asked questions such as "how did you get pregnant?" or "did your husband do this to you?"
- Negative experiences have meant that some women have avoided going to see their GPs, putting these women's health at further risk.
- **Language issues** and accent can become a barrier.

Voices of West African women

One woman said:

> "I hate how non-inclusive some services are. They will tell you what works for the average white female without even taking into consideration who you are [African]."

In contrast, one participant described a positive GP relationship:

> "My doctor and I have the same native language and it is great. It makes me feel heard and respected since we have the same cultural background."

Bangladeshi women

The Bangladeshi population in Bedford is a complex network of people who are the first, second and third generation of migrant families. Language skills, attitudes towards health, and attitudes about how to 'fit in' to mainstream society vary widely. Nine out of 10 Bangladeshi women could not read or write in either English or Bengali.

People from a Bangladeshi background are most likely not to speak English well, with Bangladeshi women five times more likely to speak no English at all.

Bangladeshi women said:

- They had a **high level of frustration**, because they are seen as being time-wasters with trivial reasons for approaching healthcare.
- All felt that they would get better treatment if they were white. They felt it was easy for them to be overlooked and not listened to.
- They were concerned about having to jump through hoops and described being talked down to by staff which, they say, results in unfair treatment.
- Some said they relied on a relative to help them access health services.
- All said they needed support from an interpreter.

Voices of Bangladeshi women

"Give us an appointment when needed not when about to die."

"The receptionist was very rude - she didn't listen and talked down to me."

"Sometimes it doesn't make sense. I have waited over 12 months to see someone. I had to do a blood test before the appointment. I had to book online and the next slot available was two weeks later. Waiting time in waiting room for completing blood tests is quick at the hospital. What was the point of me doing a blood test 12 months before I see someone at the hospital?"

Bulgarian women

Bulgarian people were part of a more recent pattern of migration following entry into the European Union in 2014. Bulgarians have high levels of cardiovascular disease, but cancer is below the European average. Mental health is generally not discussed in Bulgaria. Excess alcohol consumption and smoking are higher than the UK national average. Only one Bulgarian woman we spoke with could speak, read or write in English.

Bulgarian women said:

- Their health priorities included advice on stopping smoking, reducing alcohol intake, healthy eating and where to go to participate in activities.
- They were keen not to criticise, but they found **accessing care difficult.**
- All needed help from an interpreter. Seven out of the eight Bulgarian women were unaware of NHS messages, attributing this to the language barrier.
- Several Bulgarian women described **negative experiences** due to language difficulties. One spoke of a GP who refused to book an interpreter. Another had the phone put down on her.
- Three women mentioned poor communication, feeling stuck between departments and organisations that were not communicating with one another.
- Misunderstandings can arise from **cultural differences**. The women try to anticipate what would get a negative reaction from healthcare professionals.
- They thought that an understanding of the different culture and background of clients or patients should be a requirement for healthcare professionals.
- They were concerned about **understanding English etiquette** and would like to have group classes so that they can blend in.

Voices of Bulgarian women

"It can be interpreted wrongly, and you can have your child taken away. It is a difference in culture."

"Would not know where to go if there was an emergency."

LGBT+ people

Healthwatch Luton listened to 52 LGBT+ people, through survey, interview, email or phone call. LGBT stands for lesbian, gay, bisexual or transgender, and the plus sign stands for a range of other descriptions people may choose to use, such as queer or questioning, intersex or asexual.

LGBT+ people told us:

- Over half of respondents said staff and **staffing attitudes** were **more favourable** than in the past. They said staff were, caring, respectful, empathetic and responsive.
- The use of inclusive language was praised. This had the effect of a more honest dialogue between health and care clinicians and patients, with trusting relationships developed for ongoing care.
- Luton Sexual Health services/ iCaSH was praised as having **knowledgeable staff** and providing relevant information. Hospital support was 'great' according to a few respondents.
- General health prevention messages were clear but could be advertised more in more appropriate places, such as on digital forums and apps.
- Digital access to clinicians where available – worked best for a lot of responders, to support anonymity, when important, and allowed more flexible appointment times.
- For under-18s, information on gender identity was lacking, and waiting times for gender identity psychoanalysis were raised as concerns.
- Many felt they did **not have enough time with GPs**, particularly face-to-face, to discuss issues. Not seeing the same GP made it harder to have an open conversation. They felt there was a lack of support in referrals and hospital discharges.
- Residents said there was a lack of follow-ups or referrals from Children and Adult Mental Health Services (CAMHS), which resulted in increased hospital admissions.
- Some said health and care **staff continually got their gender wrong**, despite being corrected by the resident on more than one occasion. Residents said there was a lack of culturally or age appropriate LGBT+ groups.
- Some respondents had completely **stopped engaging** with health and care services, due to previous, distressing experiences. Sexual health information could be more widely available, for people of different age groups and cultures.
- A lack of cultural competency – both in terms of race and gender – was felt by some respondents, along with a lack of standardised sexual orientation and gender identity data collection.

Voices of LGBT+ people

"Being from the culture I am, being how I am is viewed so differently to how British people view it. But if you want to really understand how it makes us feel, then change how you present the world to us. My mental health has not ever been in crisis state, but I could have appreciated some more **culturally relevant support**.

"Telling my doctor from a different culture to mine, who has his own views on what I am and what I do – just makes for a very un-honest approach. I would never go to him for health advice and would only use online."

Male, Black Caribbean, bisexual

"I have had **many positive experiences** of health and care over the years and have to say I have felt limited stigmatisation in general health settings. Most I have encountered have accepted and not perceptibly judged or changed their level of care, from what I can tell.

"It is hard to discuss openly with my GP – so I tend to revert to the sexual health clinic for all manner of support, as I trust them. Training on **sensitivities of language** would be good – if you get the language right or try, you're half-way there. Some people just show disrespect with not even attempting to find the right words."

Male, white British, gay

"If you grow up seeing white women who don't reflect yourself, in every textbook or media image, **you learn to disengage very early on**...More culturally appropriate images have been seen on health messages more recently, but I wouldn't say it's the norm.

"We are constantly told Luton has more Asian people than other towns, and yet everything I still encounter is white – white, hetero-normative messaging – nothing that ever speaks to me as a young, questioning Pakistani."

Young Pakistani female, who identifies as queer / questioning

"There is more information than before – and that is great – but it's like it is all **written by people who don't really understand** what it is like to be LGBTQIA+. There is a lot even in the NHS guidelines that refer to all questioning or queer young people as 'transient' as though it's not for all of us something sustainable, or real.

"The support for young people with their mental wellbeing is so old-school and face-to-face – we need the online anonymous digital support to really support us... through what we are feeling."

Female, Catholic teenager, identifies as questioning

People who have experienced homelessness

YMCA Milton Keynes spoke with 47 young adults who live at its accommodation in the city centre. All the young people interviewed felt comfortable to share their information and views with a trusted professional in a familiar setting. YMCA staff clearly explained why they were collecting the information, and how the information would be used.

The residents interviewed were aged 18-35. 47% identified as female, 47% as male, while6% identified as 'other' including three transgender men.

The most common ethnicity was white British. Other ethnicities included black African, black British and Asian British. One in three interviewees (34%) identified as LGBT+ while two out of three did not.

Nearly half of respondents (49%) identified as having a disability, including mental health conditions. 13% declined to answer the question.

People who have experienced homelessness said:

- They had **difficulties getting GP appointments**, and some found receptionists to be rude in GP practices. Others said that GP appointments were often not long enough to deal with their issues.
- There was a varied experience of A&E services at hospital. Some said it was positive, while others said they had to wait a long time whilst experiencing significant pain.
- Mental health services are insufficient with long wait times experienced. One respondent said **services were inaccessible** due to their location. Others said they did not feel like they were being treated seriously.
- Those with mental health concerns said that the NHS often takes a 'medication-first' approach, rather than addressing the root cause.
- Those accessing social services said they felt social workers were sometimes not listening to them properly, or had acted against their interests or those of their family.

Voices of people who have experienced homelessness

"It's been eighteen months since I've been involved with my kids. I was deemed unfit because of my mental health. The social worker asked my partner questions about my mental health, but they never asked me. I feel I was written off because of it and I've been completely pushed out the picture. No effort to speak to me or to try and help me with my kids so I can have a relationship with them."

Male aged 31

"I've experienced a lot of racism [accessing the NHS]. One time, I said I had food poisoning and the paramedic said, "have you eaten chicken curry?" I think to myself, why is that? Is it because I'm Asian? He then asked me if I eat ham and I thought why are you [the paramedic] asking me this?"

British Asian female, aged 25

"You wait for ages, and then at the end of the wait, they say there's nothing they can do. It's the same across all the services. They make referrals to seem like they're doing something and it never goes anywhere."

Male, aged 19

People with a physical or learning disability, living in deprived areas

A survey was created and widely distributed by Healthwatch Central Bedfordshire which generated 1298 responses in October and November 2022. The questions sought to understand what specific services work well for individuals and which ones do not, and how those services could be improved.

People were asked what was most important to them in the way they are treated by healthcare professionals, and what the barriers are to accessing healthcare services. They were also asked how communications could be improved to access services more easily, and if they knew which preventative services were available to them.

People with a physical or learning disability said:

- The most common services which did not work well were GP services (29%), Children and Adolescent Mental Health Service (CAMHS) on 21%, and hospital on 18%.
- When asked what could be improved, residents particularly highlighted **easier access to appointments** and staff to be more helpful. The same improvements were desired for hospital services.
- A need for interpreters in hospitals was highlighted by 26% of respondents. A similar proportion said more appointments with a Disability Champion would be beneficial. This suggests **disability awareness is an issue** within hospital services.
- The way residents with disabilities are listened to was highlighted as a key issue. Three out of 10 respondents said they wanted to be listened to, and a quarter wanted to be involved in decision-making. Being **treated equally** was highlighted by one in every five survey respondents.
- Respondents viewed the biggest barriers to accessing services as the difficulty in getting appointments, waiting lists, staff shortages, **no disabled access** and a lack of interpreters.
- **Communication** was a key area for improvement. A majority wanted hearing loops installed, longer appointments and interpreter services. They also wanted their individual needs to be understood.
- Many survey respondents were positive about participating in activities to **prevent health problems**. Exercise and active lifestyle choices were desired by people with disabilities, as well as screening services.

Voices of residents experiencing physical or learning disabilities

"My GP seems to rely on 111 to screen patients and arrange appointments. Also, I am deaf and they don't seem to understand that a phone appointment is useless, I need face to face but cannot get this."

"My husband and I have repeatedly been let down by social services. Hospital communication needs significant improvement for those with dementia. There needs to be closer communication between professionals, for people who live in Central Beds but whose GP is in Buckinghamshire and whose nearest hospital is Luton & Dunstable, or other cross-county issues."

Case study: A mother's experience of accessing healthcare with her autistic son

Mrs C, from Luton, is a care-giver to her teenage son who has autism and learning disabilities.

Mrs C told us that getting appointments with a GP for her son was usually difficult. She often found that they had to wait for a long time in the surgery for an appointment to begin, which her son, who is sensitive to loud noises, beeping sounds or unexpected movement, finds stressful. She also said that healthcare workers were often not well-informed about her son's medical history, and might be unfamiliar with the variety of behaviour autistic people can display.

For example, when Mrs C visited a doctor's surgery with her son, the receptionist insisted he wore a mask, even when she explained this was difficult for her son. She then put it on her son, only for him to rip it off.

She said: "For this reason I do not go to appointments alone with my son, I go with one of his brothers or anyone I can find. He is such a body builder and things can go horribly wrong."

Mrs C and her son have had positive experiences, such as when a healthcare worker took time with her son, going at his pace when taking measurements. She also praised the annual health checks to which her son is entitled.

Mrs C cited a major challenge as the lack of joined-up care, where her son is passed between different people, rather than a more consistent co-ordinated approach being taken.

In addition, she said that simple changes can make a big difference. Providing photos of the healthcare setting her son will attend can help him to prepare and result in him being more calm and comfortable.

Mrs C was dissatisfied with information from healthcare providers about the guidelines for her son's health needs. She thinks information could be more tailored, such as for non-verbal individuals. She emphasised the importance of training for parents, who can play a critical role in supporting their child's health needs – with people sharing their lived experience of providing care particularly beneficial.

Insights and themes

In the many conversations and responses from residents, common insights and themes were raised. Here we summarise the key areas which were consistently brought up by residents. Some of the insights are linked, or can combine, to create a greater, negative impact for those who experience health inequalities.

Accessing services

Gaining access to services – whether that is with a GP, a hospital, or a different healthcare setting – was consistently raised as an issue by residents, such as in Healthwatch Milton Keynes' inequalities survey and interviews.

For GP services, simply getting an appointment was found to be difficult by many. When residents managed to get an appointment, this was sometimes not face-to-face when that was a clear, and sometimes necessary, preference. In addition, the length of appointments was felt to be too short by many to get to the heart of the matter.

At each stage, residents spoke of difficulties convincing someone that they needed help, or that their need was sufficiently serious. For example, people spoke of having to convince a receptionist they needed to see a GP, or convincing a GP that they needed a referral.

"I can't get an appointment, when I do get through on the phone, they say you have to access the online portal. When I say I can't, they hang up on me."

Some residents said that appointment times were not available at the times when they could attend, creating a barrier to health services.

People with physical disabilities found that having to attend A&E or urgent care was particularly difficult because the long wait times could be physically impossible for them. This was also noted as an issue for people with mental ill health or neurodiverse conditions.

Some felt doubly penalised because they tended to avoid contacting the GP due to worries about staff attitudes towards their particular characteristic, and so their needs were more acute by the time they were seen.

"I always feel rushed which makes me nervous and forget what I want to say...long waits and impatient staff over the years also increase my nervousness and inability to approach health and care services in a relaxed manner."

Digital methods of accessing services caused barriers for a range of different people. This includes those with low levels of literacy, people who aren't fluent in English, and people who can't afford an internet connection, or don't have a smartphone.

Finally, while there are many VCSE groups offering support, there is no single place to find this information, or it is inaccessible. This means there is often a disconnect between those offering support and people who need it most.

Literacy and interpreters

Literacy was raised as an issue for some people, both from migrant backgrounds, and members of the Gypsy, Roma and Traveller community, for whom literacy is not a traditional part of their culture.

Migrant women are more likely to be illiterate than their male counterparts. They therefore find it difficult to access health information and successfully navigate the health and care system. This language and literacy barrier is a significant driver of health inequality.

Residents spoke of the need to access services to reduce the barriers they face. There is a need for resident to know about what is available to help them.

The need for **interpreters** was a consistent theme from people from migrant backgrounds. Most migrant women we spoke with could not speak English, which presented a barrier to them getting the help they needed. Some said they asked friends or family to help them, but again they tried not to do this too often because they did not want to be a burden. This in turn could lead to a delay in getting help, and their condition getting worse.

Those who needed an interpreter struggled to find one. And if they did, this greatly reduced the appointments they could attend with an interpreter, due to their availability. However, even with interpreters some said they didn't understand what was being explained to them – suggesting that a visual approach using photos, diagrams or pictures could help.

For members of the Gypsy, Roma and Traveller community, audio messages would be welcome.

> "If English isn't your first language, you may have a male family member take you to the appointment but how can you feel comfortable if the appointment was to talk about a female thing, a personal female issue?"

Cultural understanding and personalisation

The residents we spoke with often felt that there was a simple lack of understanding of their culture, background or characteristics. While this might be unintentional, it can make a person feel that a service is not for them – and that racism, sexism or homophobia might be the root cause. This can lead to them being much more reluctant to access health and care services.

This can play out in a range of different ways. It could mean that a person is judged by stereotypes, rather than who they are as an individual, or their symptoms downplayed or disregarded. It could mean that the way in which a person speaks is misinterpreted, due to cultural difference. Or it could be that parts of a person's religious or cultural backgrounds which are a vital part of their understanding and approach to health matters are not taken into account.

For LGBT+ people, a common issue was referring to them by the wrong name, gender, or pronouns, which leads to a sense that they are not being treated fairly or equally.

This lack of understanding can have a damaging impact for the people affected – but if an understanding is demonstrated, or a willing to adjust, this is welcomed.

Seeing the whole person

The need to be seen as an individual was regularly cited by residents as something they wanted to see from healthcare professionals. People felt that services were not linked together, so that they had to repeat the same facts again and again.

In addition, residents felt that services were not 'person-centred'. In essence, this comes down to services being delivered in a way that makes sense to organisations, but not to the individual. This often meant that services feel inflexible, and could send a person down a path which was not right for them.

People from ethnic minority groups said they often felt health professionals didn't see them as a whole person. They also had a strong sense that they weren't being cared for because appointments were so rushed.

Those with strong religious beliefs said they felt there was no place for their faith to be part of discussions around care and treatment. Whether discussions were around lifestyle or around medication, they felt that their particular belief system was seen as separate to themselves, their illness or their recovery. They felt their beliefs should be integrated into the conversation to support more appropriate clinical care.

People with mental ill health felt that a lot of the care or treatment they received was done to them, not with them, and that they were not involved in discussions about the benefits, or side effects, of available treatments. They shared that they often felt 'fobbed off' with pills on the first attempt to talk about their mental health. Those who had an existing diagnosis said they were worried that if they talked about what they were experiencing, they would be sectioned.

Appropriate communication

Issues with communication were many and varied – and almost all respondents had some sense that they were not being communicated with properly.

For example, one deaf person said they were spoken to by a healthcare professional wearing a mask, which made it impossible for them to understand what was being said. More generally, it was often felt that front-line staff made presumptions about a person based on their individual characteristics, such as skin colour, accent, or how they dressed.

Communication by healthcare professionals was often too technical or full or jargon to be understood. This could leave a patient feeling overwhelmed with information, and unable to make informed choices.

Information produced by NHS organisations was often off-putting for people from some groups, such as LGBT+ people. The information might be written in a way that suggested the author did not understand their perspective, or the images were not inclusive.

Sometimes the type of communication was not right, with a reliance on more traditional forms of communication, like letters, when text messages, audio messages, or better use of video might open up access to people from a range of different backgrounds.

Case study:
Ms F – a generally positive experience

Ms F (using pronouns they/them) has, in general, had a positive experience of using healthcare services. They did not say what their specific needs were, but said healthcare professionals adapted to suit those needs.

Ms F said, however, that there is a lack of flexibility in scheduling appointment times. They said the "ability to reschedule is very difficult and rigid" and the next appointment "can be weeks away."

Furthermore, they sometimes need additional support to access the venue of the service they are using, which isn't always offered.

However, within the service, adjustments are usually made in an appropriate way, and staff are mostly friendly and helpful.

Ms F welcomed text messages with information about appointments but said this was inconsistent across different services. In addition, they said that their patient records were shared across the GP and hospital, but this was not the case for other, smaller services.

Overall, Ms F was happy with the services, but felt that the health service could be more joined up, with better customer service, and improved flexibility on appointment times.

Recommendations

Our recommendations fit within four groups. These are access, communication, representation and cultural competency. They are grouped in two time-frames. The first is short-term changes which can be actioned over the next one to two years.

These changes will allow residents to see that things are changing for the better. The second category of recommendations are longer-term and will change how the health and care system operates in a deeper and more fundamental way. It's important to note that some work has already taken place in some of the areas outlined in the recommendations – but greater focus and momentum is essential.

How we developed the recommendations

Overall it is the clear ambition of this report to make recommendations which, when taken together, spur system leaders to respond radically in designing and delivering their approach to health inequalities.

The recommendations have been developed by the Denny Review Steering Group based on the published evidence and the views of residents.

Further work is required with community pharmacists, dentists, optometrists, NHS Trusts and local authorities and the VCSE sector to determine how the recommendations can be implemented and performance monitored, and to define the crucial role provider collaboratives can play. These organisations will need to come together to determine whether the recommendations are delivering the impact called for by residents and healthcare professionals.

Short-term change

Recommendations that can be implemented in the shorter term, which will help to make an immediate difference to the experience of residents over the next one to two years.

Insight area	Recommendation
Access	Contracts for new products and services should rigorously apply the Accessible Information Standards and the Equality Act so that they meet the needs of all residents and staff members, for example when purchasing personal protective equipment (PPE). This includes ensuring that residents are asked about or offered information in a format or language that they can understand. Consideration should be made to help prevent residents being excluded from services due to barriers which include a lack of access to digital technology.
	An urgent review of all health and care premises should be undertaken to ensure disability access is always available.
	Hearing loops should be installed across all healthcare establishments and staff should be provided with training to ensure they are always functional.
	Hospital trusts and primary care should undertake a review of what, if any, interpreter and translation services are available and accessible to ensure patient needs are being met.
	GP practices should review their procedures to stop residents being wrongly stopped from registering, potentially denying them access to essential health services. Practices must ensure they meet Primary Medical Care Policy and Guidance, and that national policy is uniformly and rigorously applied.

Insight area	Recommendation
Communications	Residents and partners to come together to co-develop a communications campaign to support people to explain how the health and care system works, and how to navigate it, with a particular focus on supporting minority groups. This campaign should include regular updates on the implementation of the Denny Review, and, where relevant, have a gender focus too for specific men's/women's issues highlighted.
	Urgent review of all communications and marketing materials to ensure that imagery and language is culturally appropriate and reflects the different communities in BLMK.
	Collaborate to implement a universal translation service for BLMK that provides consistency across all NHS provider organisations. This should be achieved by undertaking an urgent review of all translation services provided in BLMK's health and care sector to ensure it complies with Accessible Information Standards. This should mean that interpreters are always available, that there is consistency across primary and secondary care services, and that British Sign Language (BSL) interpreters are included in the list of available languages.

Insight area	Recommendation
Representation	Support GP practices to ensure that Patient Participation Groups, as required within contracts, are in place and receive sufficient investment.
	BLMK Integrated Care System should set out how its future engagement work is shared, to avoid duplication of effort and maximise impact.
	Training for health and care professionals and those people involved in community connector roles in Quality Improvement (QI) and co-production. This will help to embed a more person-centred approach, so that residents' needs are at the heart of any solution.
	Support the healthcare system to be more resilient for future pandemics. Consider the impact they can have on the workforce, specifically people from ethnic minority backgrounds. Within this, look at how PPE is distributed to meet the needs of a diverse health and care workforce.
	Senior leadership mentoring scheme introduced within NHS organisations for people from ethnic minority backgrounds to help improve diversity management across the ICS. Encourage greater diversity within management, and greater diversity on interview panels.
Cultural competency	Training rolled out to all health and care settings to support with language, and understanding the needs of residents, including different ethnicities, those with physical and learning disabilities, and LGBT+ people. This will help to address perceptions of cultural bias / racism which was a consistent theme within community engagement and can build on current patient participation.
	Greater investment in services that are working well, such as local sexual health services.

Long-term change

Recommendations which make larger, more fundamental changes to how healthcare is delivered, which residents will see the effect of over the next three to five years.

Insight area	Recommendation
Access	Consider extending the service hours available in primary care to evenings and weekends for those unable to attend day-time appointments. Also include access to female-only clinics to support people from different faiths and cultures, and victims of male violence.
	Ensure that residents who would prefer to access some healthcare services anonymously are able to do so. This could be done, for example, through more services, or a greater proportion of them, being provided digitally.
	Work with the VCSE to fund Access Champions to support people who are unsure how to navigate health and care services or have additional needs to access appointments, or other services to support their health and wellbeing.
	Establish an end-to-end service for long COVID.
Communication	Based on the findings of the review of interpretation services, ensure that there is a consistent service across health and care and that translated materials are available in line with legal duties.
Representation	Improve integration of housing, hospitals and mental health support in homeless shelters.
	1 in 4 black men will get **prostate cancer** in their lifetime. Black men are more likely to get prostate cancer than other men, who have a 1 in 8 chance of getting prostate cancer, according to Prostate Cancer UK. The ICB should work with **researchers** to better understand the extent of this issue in BLMK and the reasons behind it. Furthermore, that the ICB develop a programme of engagement with men in general regarding their personal health and co-produce with residents communications activity focused on specific support available for male health.

Insight area	Recommendation
Cultural competency	Develop an Asset Based Community Development (ABCD) approach to engaging with local communities to drive grassroots change and represent their views in service development. ABCD is a way of local people taking the lead, and developing solutions for themselves, supported by statutory organisations, such as local councils. This would be achieved by ring-fenced investment being provided to VCSE and Healthwatch organisations to continue to build on the dialogue and trusted relationships developed in this review and lead to continuous improvements. Funding these organisations would enable them to proactively co-produce solutions with residents.
	Co-produce solutions with people from different backgrounds, including people with learning disabilities, young people affected by mental ill health and autism, and refugees, to adjust health services and the spaces in which they are delivered to make them more appropriate and inclusive.
	Co-produce services and training resources with transgender people, people from different ethnic minorities and cultures or faiths to increase awareness of individual needs, so that health and care professionals feel confident and empowered to better support patients. This will better support people when receiving diagnoses or delivering care for their specific needs.
	Develop an education programme for refugees to develop skills and independence to support them in understanding the health system and navigating it. This should also educate refugees on rights available to them, such as taking time off work to support family members and access to health and care.
	Undertake further research to understand the barriers that ethnic minorities including Gypsy, Roma, Travellers, face. Work with residents as part of an Asset Based Community Development approach to develop solutions for greater equality.
	Develop more service offers that involve going into communities, where people are most comfortable, such as pop-up centres, building on the successful approaches adopted through the COVID vaccination programme.
	Encourage health and care professionals to add a 'listening to patients' section to every training event to ensure lived experiences of local people are shared and professionals are given the opportunity to identify solutions to improve the quality of services / experiences.
	Review what is currently in place to provide healthcare advice, guidance and signposting information to residents. Develop a consistent approach so that people can get access to information about the services they need.

Embedding the recommendations through Quality Improvement

Our recommendations aim to tackle deep, longstanding issues, which are often complex.

To succeed, this requires a Quality Improvement (QI) approach, which involves staff and service users to explore the issues, unpick them, and develop services in a more person-centred way.

This means giving residents a much stronger voice, and thinking about what the ultimate goal is, rather than how organisations are currently run. Ultimately, residents need to feel that services have taken into account what they want, how they feel, and what is logical for them. It necessarily means being more flexible, and not rushing to judgement about what a person does or does not need.

By focusing on what residents and staff who work within services areas think, this should help to make inclusion something that is inherent within health and care services, part of their DNA.

Equality Delivery System (2022)

While much of the focus of our review has been on residents, we cannot forget staff members, who often live in the communities they serve.

The Equality Delivery System (EDS) helps NHS systems and organisations improve the services they provide while supporting better working environments, free of discrimination.

The main purpose of the EDS is to help the NHS, in discussion with local partners and local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010, such as sex, disability or race.

Therefore, part of the way we can reduce health inequalities is through ensuring the EDS is rigorously applied and appropriately scrutinised. There is an opportunity to apply the EDS when health and care providers procure new products and services, to create a more fair and equal health service for all, including NHS staff.

Accessible Information Standard

A big theme from residents was around accessibility. One of the ways better accessibility can be delivered is through the Accessible Information Standard. All organisations that provide NHS care or publicly-funded adult social care are legally required to follow the Standard. It sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Financial investment

This review has not put a price tag on its findings and recommendations. However, to deliver the generational change required to level the playing field, significant investment will be required to support the delivery of the above recommendations.

While it is recognised that considerable investment is needed across BLMK in its entirety, the Denny Review recommends that funding be prioritised in areas where there is a greater prevalence of known health inequalities.

Prioritisation of funding would support the Integrated Care System's prevention agenda. This is because data shows that areas with large populations of black and south Asian residents have greater numbers of people who contract diseases including type 2 diabetes, sickle cell anaemia, thalassaemia, long COVID, heart disease, cancer, as well as higher levels of infant and maternal mortality.

The quality of services is unequal in terms of availability and delivery. Therefore, spending needs to be prioritised to address historical inequalities so the past is not carried into the future. For example, more needs to be spent on preventing type 2 diabetes because this preventable disease significantly disproportionately affects Black and Asian people.

Conclusion

by Reverend Lloyd Denny

COVID-19 as a global emergency is now over. However, the long-term effects of the pandemic cast an uncertain shadow into the future. The inequalities identified in this report in terms of the disease and death and take-up of the COVID-19 vaccine were exacerbated due to a lack of trust in officialdom and in "the system".

To build trust, the challenge is to demystify decision-making processes, so they can be better understood. Furthermore, we need to make sure that there is cultural competency and diversity at senior levels of organisations. This is particularly important in the public sector.

Building trust will take time. Bedfordshire, Luton and Milton Keynes ICB, and all its system partners, need to acknowledge this and find ways to ensure that health inequalities for people from different communities or with different personal characteristics are mitigated against. Reducing health inequalities needs to become part of everyday business.

Leadership is the key to change. This review was commissioned to draw out recommendations and support system leaders to make evidence-based decisions. I have participated in NHS-wide events, discussions and meetings in connection with this review and have been assured that the review has national interest.

This report has focused on the experiences of the public as recipients of NHS services and care. The evidence shows there is clear disparity in the quality of care received and outcome.

I have seen for myself the benefits of good health and social care. The relief, joy and gratitude patients and their families have when a baby is successfully delivered at a hospital. The tears of joy when a life-saving medical procedure goes well. Sadly, good outcomes are not universal across the system. Sometimes this disparity is only a postcode away.

I hope that those in leadership positions in the health and social care system will recognise the scale of the change needed, rise to the challenge for the public wants it, and work with communities to bring about equality for all in the most basic of human need. A failure of leadership created some of the health inequalities faced by the Windrush generation. Therefore, we need to show, 75 years on, that we have learned.

These recommendations must be acted upon to help improve the healthcare system and to build residents' trust in it. If implementation of specific recommendations doesn't happen, the reasons why need to be clearly communicated.

Conclusion *continued*

Health inequality and inequity

There are many kinds of health inequality and several ways in which the term is used. Various definitions exist[11] but broadly speaking, health inequalities can be defined as:

- The avoidable and unfair differences in health across different groups of people
- Differences and biases in the access, quality and experiences of care
- The wider determinants of health, such as housing and income.

A further definition of health inequality by Lord Victor Adebowale, Chair, NHS Confederation: "Inequality is the way of the world; inequity is what we do with the way of the world."

Also from Lord Adebowale: "The NHS was not designed for inequality or inequity; it was designed to eradicate it. It should shame us that we are heading in the wrong direction. We have to make this core business. There isn't a plan B for the NHS."

We must heed these words, and those of residents and NHS staff, to make the changes we need, and demonstrate that serious action is being taken.

11 King's Fund (2020): What are health inequalities?

Steering Group Members

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Helen Terry
Chief Executive, Healthwatch Bedford Borough (until December 2022) – Elizabeth Learoyd and Emma Freda have represented Healthwatch Bedford Borough since the beginning of 2023.

Thank you

We would like to thank all of the residents from across Bedfordshire, Luton and Milton Keynes people who gave their views to the Denny Review.

We also want to thank all of the organisations who have contributed to the Denny Review:

Healthwatch Bedford Borough

Healthwatch Central Bedfordshire

Healthwatch Luton

Healthwatch Milton Keynes

YMCA Milton Keynes

Community Action: MK

Disability Resource Centre

ACCM (UK)

Queen's Park Community Organisation (QPCO)

Bedford Borough Council's Gypsy and Traveller Liaison Officer, Sharon Wilson

Community Dental Services

Penrose Synergy Ambassadors

Pride in Luton

All others who participated and contributed.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 27 October 2023

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

Report Author: Bethan Billington, Deputy Chief People Officer, and Tim Simmance, Associate Director of Sustainability and Growth

Report to the: Integrated Care Partnership

Item: 10. Health and Employment outline strategy framework

1.0 Executive Summary

1.1 This paper outlines recent ICB progress relating to employment and skills, and anchor development in support of the ICS's Growth priority and Joint Forward Plan.

1.2 A joint Integrated Care Board (ICB) and Integrated Care Partnership (ICP) seminar was held on 21 July 2023. The seminar provided the opportunity for members of the ICB, ICP, wider system partners, and residents to identify the opportunities and challenges in obtaining and retaining employment for those with health conditions. Place-based ideas and action plans were developed to increase employability and recruitment and reduce economic inactivity, sickness absence and barriers to employment. These action plans are currently under review by Place Boards to be adopted as part of the wider work programmes of each place.

1.3 The ICB also collated a set of system-level activities, which have informed development of an ICB outline strategy framework (the "framework") to support improving employment for those with health conditions. This will enable the ICS to fulfil its responsibilities to support local social and economic development, improve health and reduce inequalities.

2.0 Recommendations

2.1 The members are asked to **note** the outputs of the Health and Employment seminar and the next steps through the Place Boards.

2.2 The members are asked to **approve** the proposed ICB Health and Employment outline strategy framework and governance for system-wide work on employment and skills, which will support an improvement in employment and economic inactivity rates for local residents, through using the assets of the Health and Social Care system. This outline framework received approval at the ICB Board meeting on 29 September 2023:

3.0 Key Implications

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

3.1 **Risks:**

a) **ICB resource (people and finances) –** there is no additional resource yet associated with the proposed work at Place-level, nor for the proposed outline framework. This may limit pace of progress.
Mitigation:
   i. The framework directly and indirectly supports key elements of the ICS's overarching strategy and Joint Forward Plan, and align with existing work at the ICB – the framework represents a shift in emphasis and activities, rather than setting new outcomes.
   ii. Aligning the programme with existing strands of work means progress towards the Health and Employment framework outcomes can be made alongside other goals (for example, focusing initially on employment within the Housing Anchors workstream of the Growth strategic priority will deliver benefits to health, employment and reducing inequalities for social housing residents, as well as support work on supporting Housing Associations as anchors).
   iii. Roles within the new ICB structure will have some time (up to 0.6wte) allocated to support ICB work on sustainability and growth, though this time will not be available for several months.
   iv. Constant review of work within the Workforce and Sustainability and Growth portfolios will ensure this strategy is prioritised.

b) **Place priorities and resource (people and finances)** may also mean that it is difficult to progress the proposed activities.
Mitigation:
   i. Stakeholders from place geographies, from a wide range of partners organisations, were involved in the July seminar
   ii. Review of the seminar outputs via Place Board is occurring in September and October to ensure alignment to existing priority outcomes and work programmes

c) **Access to employment opportunities** within our Partner organisations
Mitigation: Engagement through the People Board, Workforce Planning and Supply group, and directly with HR Directors and their deputies.

3.2 **Resourcing:** There are no direct additional resourcing implications of this report. The strategy represents a shift in emphasis and activities, rather than setting new outcomes. Any additional resource requirements as a result of individual projects or activities supporting work on Health and Employment would be subject to future requests and business cases as appropriate. Please note the related risk noted above on resourcing and the potential impact on pace and progress.

3.3 **Inequalities**: The Health and Employment strategy aims to address some of the wider determinants of health. Employment and income gaps are highest for those with health conditions and in areas of higher deprivation. Many of the ideas developed at the Health and Employment seminar specifically target groups that have worse health and employment outcomes. There are employment rate gaps for those with health conditions (e.g. mental health, learning disabilities) and in certain social situations (e.g. ex-offenders, carers). Addressing barriers to good employment for these groups, be they related to health, social situation or organisational systems, should have mutually beneficial effects, reducing health need, unemployment, and, therefore, inequalities.

3.4 **Engagement:** The content relating to the Health and Employment seminar was co-produced by the approximately 80 participants. This content is in the process of being reviewed through the four place boards, and an update is included in the below paper. The proposed Health and Employment strategy was shared with the ICS Recruitment and Retention group in April 2023 and People Board in May 2023; suggestions were incorporated, alongside further ideas linked to the aforementioned seminar.

3.5 **Green Plan contribution:** One of the ways to reduce emissions from healthcare is to reduce demand for services. Employment is a key factor in an individual's and a population's health and wellbeing. Unemployed people are five times more likely to be in poor health and thus higher employment rates should significantly reduce the need for healthcare services, and associated emissions (e.g. direct emissions from service delivery, and indirect emissions such as supply chain and patient travel). Ill health in a workforce reduces productivity, which introduces additional inefficiencies. Although not easily calculable, the assumption is that inefficient organisations will undertake more unnecessary work and thus use more resources, with an increase in associated emissions.

4.0 Report

4.1 Context

4.1.1 The fourth pillar of an ICS[1] is to help the NHS support social and economic development. The ICS has many anchor institutions which have a significant influence on the health and wellbeing of communities. To maximise the value of these organisations, the ICB is supporting development and collaboration work across several areas, including environmental sustainability, employment and skills, estates, procurement, and VCSEs.

4.1.2 A report for BLMK by the Centre for Local Economic Studies (see Annex B) recommended the ICS to "Target skills development and employment opportunities towards people and communities who need them the most".

4.1.3 The aim of the work on employment and skills is to use the influence of our partner anchor institutions to re-invest in our local communities, by ensuring that we proactively provide local employment opportunities in health and social care to populations furthest from employment.

4.1.4 Employment is one of the key factors supporting an individual's health. For every £1 spent on the NHS, £4 is returned to the economy, due to better resident health, and employment opportunities within health and care, among other reasons. (In some sectors of healthcare this "Gross Value Add" is as much as £14[2].). Reducing rates of economic inactivity and increasing rates of good employment, particularly for those with health conditions, will thus contribute to better population health, improved local economic growth, and reduced inequalities.

4.1.5 The health and care system presents many different direct employment opportunities for residents, as well as supporting better health to support residents to gain and maintaining employment in other sectors.

4.1.6 By maximising the impact of healthcare and other anchor institutions, we can improve employment rates for residents that are furthest from employment due to their health conditions or social situation, supporting improvements in health, wellbeing, inequalities and the local economy.

4.2 Health and Employment Seminar July 2023

4.2.1 The first joint seminar of the BLMK Integrated Care Board and Integrated Care Partnership took place on 21 July 2023 and approximately 80 people from local authorities (officers and councillors), the NHS and other public services, including the Prison Service and the

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[2] https://www.nhsconfed.org/system/files/2023-08/Creating-better-health-value.pdf

Department for Work and Pensions, were joined by representatives of the voluntary, community and social enterprise sectors for a day of action planning on tackling poor health and employment outcomes.

4.2.2 Attendees also included residents with relevant lived experience, several of whom shared powerful stories of the positive health impact of finding employment.

4.2.3 A 2022 study by the Health Foundation[3] found that unemployed people were more than five times as likely as those in employment to be in poor health, whilst NHS figures from 2021 indicate that people with a long-term condition have an employment rate of 64.5%, compared with 75% of the population as a whole, a gap of 10.5%. The employment gap is even wider in Luton (16.1%) and Central Bedfordshire (14.4%).

4.2.4 The event's keynote speaker, Professor Donna Hall CBE, is chair of the community-focused think tank New Local and an advisor on Integrated Care Boards to NHS England. She was formerly chief executive at Wigan Council.

4.2.5 Detailed planning sessions were held throughout the afternoon, with individual group discussions for Bedford Borough, Central Bedfordshire, Luton and Milton Keynes, to identify key priorities and agree actions that will be taken forward by those working at Place, with support from the ICB.

4.3 Seminar outputs and recent Place progress for noting

4.3.1 Full details of the seminar are captured in Annex A.

4.3.2 The morning session considered what was important to our residents and partners – this included resident videos, a resident and VCSE panel discussion, the keynote speech, and table discussions across 10 different cohorts, based on their health, social or demographic situation.

4.3.3 Common themes from the morning included the need to eliminate stigma, to raise awareness of existing support, to join up services across sectors, to address health conditions earlier, for flexibility from employers, and for reducing barriers to achieving educational outcomes, training, and stable employment.

4.3.4 The afternoon session was dedicated to place-based action planning, to develop and implement ideas addressing some of the challenges identified in the morning. Each set of ideas and action plans are in Annex A.

4.3.5 Themes running through the action plans include: closer working with employers to increase the number of workplaces which support people into jobs after a period outside employment, enhancing the level and relevance of young people's skills for the modern workplace, better use of the apprenticeship levy, better in-work support, and investigating whether people can be directed more efficiently to volunteering opportunities when they receive treatment for their mental health or substance misuse.

4.3.6 Place boards are in the process of receiving and reviewing the action plans, with a view to integrating them within their existing priorities and resource. Recent progress is provided below.

[3] https://www.health.org.uk/evidence-hub/work/employment-and-unemployment/how-employment-status-affects-our-health

4.3.7 **Bedford Borough:**

- CEO for Bedford Borough, Laura Church, and ICB Link Director, Sarah Stanley, presented the seminar outputs to the Bedford Borough Executive Delivery Group met in September. Key points raised at the meeting were:
    - There is a strong cross over with the Bedford Borough Health & Wellbeing Strategy in supporting people into getting back into work.
    - The Delivery Group highlighted the need to work with employers to provide supporting initiatives to their employees.
    - There is a highly beneficial and affordable mental aid first aid training course, which can be completed virtually
    - There is already a lot of work progressing in Bedford Borough with the Harpur Trust, such as the Bedford Giving initiative.
    - The Group acknowledged that there is more work to be done around the supported intern programme.
- Actions from the Health and Care Seminar are being taken forward by the Bedford Borough ICB Place Lead, Alex Wrack.
- Initial activities include:
    - mapping the current status, opportunities and gaps around awareness in workplaces to help people gain and retain good employment for all adults with mental health difficulties.
    - map the seminar outputs against current work in Bedford Borough
- An update will be presented to the next Bedford Borough Executive Delivery Group on 15th November 2023, to discuss next steps and a focus for the programme.

4.3.8 **Central Bedfordshire:**

- reviewed the proposed ideas and actions at Place Board on the 28th September
- agreed to focus on children and young people (CYP) and what can be done together with partners to support more young people into employment.
- Approved immediate actions as:
    1. Work with CBC local authority to agree a consistent outreach programme to local schools and academies to engage with careers opportunities in NHS and council.
    2. Link with the Director for Social Care for Children to explore opportunities for NHS colleagues to mentor or sponsor looked-after young people in CBC as they age out of care and into working-age.
    3. Develop a deeper understanding of the support currently provided to neurodiverse people in employment (all partners) and opportunities to do more. Proposed actions will be presented to the next CBC Place Board.

4.3.9 **Luton Borough**

- The outputs from the seminar were shared with the Luton place board on 8 August and are undergoing review against existing local priorities and strategies, including the Luton 2040 vision to eliminate poverty.
- Luton have recently convened an Inclusive Economy Board (IEB), including representation from the ICB. The first meeting was held on 25 September 2023. The Terms of Reference for the IEB include "strategic alignment of partners collective strategies" and agreeing "shared priorities which support an inclusive economy in the town.

4.3.10 **Milton Keynes**

- The feedback from the seminar was reported to the MK Health and Care Partnership on 20 September and the action plan for MK place is being discussed by MK's Joint Leadership Team on 16 November.

4.4 The ICP is asked to note the outputs from the seminar and the recent progress at Place Boards.

4.5 ICS Health and Employment Outline Strategy Framework

4.5.1 The aim of the proposed ICS Health and Employment outline strategy framework is to improve employment rates for residents that are furthest from employment due to their health conditions or social situation, by maximising the impact of healthcare and other anchor institutions.

4.5.2 Objectives:
i) improve employment rates for those furthest from employment;

ii) increase the proportion of health and care workforce from local populations, where possible;

iii) maximise support from anchors as employers (including volunteering opportunities, apprentices, occupation health, awareness);

4.5.3 It is proposed that delivery of the Health and Employment framework would be overseen via the ICB People Board, with work being undertaken through the Workforce Planning and Supply subgroup. An earlier version of this framework was shared with the People Board in May 2023, and further updates will continue to be presented to that group.

4.5.4 Key strands of the outline framework are proposed to be:
a) A shared understanding of resident cohorts that are furthest from employment, and current barriers to obtaining and maintaining good employment;

b) A targeted approach to improve employment rates in local population, addressing health barriers to employment, and using the health system as an opportunity for good employment;

c) Work with place boards and partner organisations (including VCSE) to prioritise projects that are making a difference to employment rates in disadvantaged groups;

d) Support anchor institutions to align to wider economic growth programmes (for example Real Living Wage) and common commitments (e.g. use of apprenticeship levy).

4.5.5 A set of high-level ideas for cross-system activity led by the ICB and recent project progress is in the Health and Employment Outline Strategy Framework and Programme Outline (Appendix A)

4.6 The ICP is asked to approve the outline framework for a strategy for the ICB to use to progress the work, and the proposal to use the ICB People Board as the governing group. The next update will be taken to People Board in Q3 2023/24.

5.0 Next Steps

5.1 Place Boards to complete review of seminar outputs and agree action plans aligned with existing work and priorities during Q3 2023/24.

5.2 Updated progress to be presented to People Board in Q3 2023/24, with ongoing oversight of progress managed through the Workforce Planning and Supply sub-group.

5.3 Updated progress to be presented to ICB Board in December 2023.

List of appendices

Appendix A – Proposed ICB Health and Employment Outline Strategy Framework and Programme Outline

Background reading

Annex A – Outputs from BLMK Health and Employment seminar 21 July, particularly ideas and actions (slides 22-42). Link: https://blmkhealthandcarepartnership.org/wp-content/uploads/2023/08/The-BLMK-Health-and-Employment-seminar-July-2023-full-write-up.pptx

Annex B – "Health institutions as anchors: maximising potential through integrated care systems. An action plan for BLMK ICS", Centre for Local Economic Studies, 2023 (in particular section 3, pp 17-19). Link: https://blmkhealthandcarepartnership.org/wp-content/uploads/2023/10/20230313-BLMK-Anchor-action-plan-CLES-vF.pdf

BLMK
Integrated Care System

Right Care Right Person

BLMK Integrated Care Partnership

31 October 2023

Humberside, 2019…

BLMK
Integrated Care System

Background

NHS
Humber Teaching
NHS Foundation Trust

- In November 2018 Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) produced the report 'Policing and Mental Health: Picking Up the Pieces' Policing and mental health: picking up the pieces (justiceinspectorates.gov.uk).
- The report highlighted the need for greater joined up working and for the police to be a last resort rather than a first option when responding to people with mental health difficulties.
- This was to achieve a better patient experience and to ensure effective use of all resources to make sure people experiencing mental health crisis will receive the right help, at the right time, and by the most appropriate service.
- The Right Care, Right Person initiative was commenced by Humberside Police in 2019 and is a **phased** programme of partnership working and withdrawal of the police from certain types of demand, aiming to achieve that vulnerable people are given the right care and support when they are in crisis.
- Meaning that where there is immediate risk to life or a risk of serious harm, police will still attend. However, when agencies call police about issues which don't meet the threshold for police intervention, they will signpost them to the most appropriate service. THERE IS STILL A ROLE FOR POLICE, this should not impact on general public contacts.

National Partnership Agreement, July 2023

BLMK Integrated Care System

"When people are in mental health crisis, they need timely access to support that is compassionate and meets their needs. While there will always be cases where the police need to be involved in responding to someone in mental health crisis (for example, where there is a real and immediate risk to life or serious harm, or where a crime or potential crime is involved), police are increasingly involved when they are not the most appropriate agency to respond, and they are not able to handover care to a more appropriate professional in a timely manner. This impacts on the ability of the police to carry out their other duties effectively, and importantly, can result in people with mental health needs experiencing greater distress and having poorer experiences of the mental health care pathway."

"It is crucial that at the heart of planning and implementing RCRP for people with mental health needs, there is a focus on ensuring patient safety is maintained and people in mental health crisis are not left without support. This means the approach to RCRP implementation for people with mental health needs should be planned and developed jointly through cross-agency partnerships before changes to responses are introduced."

Home Office | Department of Health & Social Care | NPCC | NHS England | Association of Police and Crime Commissioners | College of Policing

https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement-right-care-right-person-rcrp

RCRP areas of focus

Systems to work towards ending police involvement in the following situations:

1. *Initial response to people experiencing mental health crisis*; Ensuring that people in crisis are seen by the most appropriately skilled professional

2. *Concern for welfare*: Ensuring that people with mental health needs are seen by the most appropriate service, where the person is already in contact with a mental health service or other service commissioned to provide mental health support

3. *Walk out of a healthcare facility*: ED's at acute hospitals, informal patients on MH wards and other facilities, no longer call the police where patients with mental health needs leave unexpectedly, unless they are deemed to be an immediate threat to themselves or others

4. *AWOL:* Patients under section who have gone AWOL are no longer reported to police as a matter of routine with partners accepting their legal duty to locate and return these individuals

5. *Reducing HBPOS handover time & reducing conveyance in police vehicles*: police and health working together to quickly and efficiently identify the best place to take a person detained under section 136 of the MHA

Implementation requirements

1. Focus on ensuring patient safety is maintained and people in mental health crisis are not left without support. Implementation should be planned and developed jointly through cross-agency partnerships before changes to responses are introduced.

2. Due regard to the Public Sector Equality Duty.

3. Embedding multiagency ways of working that can support effective decision-making about which service or services are the most appropriate to respond to an incident reported to the emergency services e.g. health-led, integrated multi-agency triage of 999 calls that enables shared decision-making

4. To establish effective mechanisms to support data collection and sharing across agencies, to inform the development and implementation of RCRP

5. Multi-agency training needs analysis and implement multi-agency training to support decision-making and understanding of roles and responsibilities in relation to RCRP, as well as the MHA

6. Multi-agency review of relevant policies and procedures related to RCRP

7. Business case development as required.

NOTE recent national survey on implementation plans, issues and risks, and request to NHS for indicative costings.

Milton Keynes/Thames Valley

BLMK
Integrated Care System

In Milton Keynes, Thames Valley Police were one of three early adopter forces in the UK . RCRP commenced in Milton Keynes in May 2023. There was a rapid implementation of RCRP following training to call centre operatives. The focus to date has been on three areas:

- Concern for safety (welfare checks)
- AWOL from psychiatric hospitals
- Walk-outs from other healthcare settings (predominately acute care)

RCRP elements that have not yet been implemented are: s.136, transportation/conveyance, application of RCRP to voluntary patients, not applicable to children and young people.

Extensive engagement (within context of rapid implementation) was undertaken across system partners.

Formal guidance was developed in partnership and rolled out in July 2023. No significant incidents have been raised at this stage however evaluation of the impact of RCRP in this first phase will be undertaken via RCRP steering group.

Multi-agency governance arrangements in place to oversee next phase.

Learning from early adopter:

- Formal TVP guidance received in July, albeit a delay from May implementation, was extremely useful.
- Until TVP guidance, internal escalation process was in place in the event that police refused to attend.
- Apart from incidents across the first two weekends. No further incidents were reported or escalated.
- Staff are now clear when police will and will not attend
- When police are required, staff know how to request assistance, having exhausted their own enquiries and knowing how to be clear about the level of risk or harm is.

Bedfordshire & Luton

BLMK
Integrated Care System

- In Bedfordshire, we are building on a strong history of joint working across mental health services and Bedfordshire Police, e.g. the nationally recognised & celebrated Street Triage team
- Multi-agency governance arrangements are in place to take forward the programme of work
- Partners are working towards January 2024 for implementation of concern for welfare (welfare checks), with walkout of a healthcare facility, absent without leave and s.136 changes intended to follow by March 2024
- Key to next steps is understanding potential activity in scope. A data group is working across the NHS and Police to do so, with the aim of holding a partnership event to review the data & its implications for change on 16/11/23
- Delivery dates for each RCRP element are subject to fully understanding the activity in scope, and any required changes in processes, practice or resource allocation as a consequence.

Summary of elements of project plan for concern for welfare:

1. Set up Police & multi-agency data group (in place)
2. Agreement of scope
3. Data reporting on activity from Police and partner systems (target 16/11/23)
4. Understanding activity transfer - demand and capacity analysis - stakeholder impact analysis
5. Develop model for activity transfer – including resource requirements, changes to care pathways and practice, understand any legal implications
6. Develop and deliver training for staff on key elements (multi-agency training needs analysis)
7. Develop business case (as required)
8. Review/update Team Operational policies - New policy/protocol on welfare checks including escalation procedure
9. Post-implementation evaluation.
10. Other areas of RCRP to follow similar process.

BLMK RCRP Governance

Across Bedfordshire Luton and Milton Keynes (BLMK) ICB footprint there is an Urgent and Emergency Care Programme Steering Group for mental health, learning disabilities and autism (MHLDA). This steering group has oversight for delivery of RCRP across BLMK and reports into the BLMK MH Programme Board for the ICS. The steering group is multi-agency and consists of the following members:

Bedfordshire and Luton
East London NHS Foundation Trust / Bedfordshire Police / Bedfordshire Hospitals NHS Trust / East of England Ambulance / Bedford Borough Council / Central Bedfordshire Council / Luton Borough Council / MIND BLMK

Milton Keynes
The police force, Thames Valley Police (TVP) and ambulance, South Central Ambulance Service (SCAS) only covers the MK geographical area of the ICB. Milton Keynes is a small geographical area of the TVP and SCAS footprints.

Central North West London NHS Foundation Trust / Thames Valley Police / South Central Ambulance Service / Milton Keynes University Hospital / Milton Keynes Council

Across BLMK

BLMK ICB / BLMK MIND / Primary Care Mental Health Lead

Because of the differing system partners each area (1) Bedfordshire and Luton and (2) Milton Keynes also has individual multi-agency Right Care Right Person (RCRP) steering groups with membership as per above.

BLMK RCRP Governance

BLMK Integrated Care Board

Other B&L Governance

Bedfordshire Police RCRP Programme Board
Chair: Jaki Whittred

Place Boards, Safeguarding Boards, Overview and Scrutiny Committee

BLMK MHLDA Collaborative

BLMK MH Programme Board
Chair: Richard Fradgley

MHLDA UEC Steering Group
Chair: Michelle Bradley

Beds and Luton

B&L RCRP Steering Group
Chair: Maxine Obeng / Elena Baker-Glenn / Jaki Whittred

B&L RCRP Multi Agency Workstreams / Subgroups
1) Communications 2) Workforce and Training 3) Policy and Legal 4) Data group 5) Transport

Milton Keynes

MK RCRP Steering Groups and Workstreams
Phase 1 for welfare checks, AWOL and walk outs has been implemented. Phase 2 workstreams to be set up for S136 handover and conveyancing

Other MK Governance

RCRP Strategic Management Board
Chair: NHS England and TVP

Thames Valley Police Mental Health Strategic Partnership
Chair: TVP

Place Boards, Safeguarding Boards, Overview and Scrutiny Committee

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

NHS Operational Planning 2024-5

An Overview of our Proposed Approach
October 2023

Integrated Care Board – Bedfordshire Luton and Milton Keynes

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

The **four core aims** of Integrated Care Systems are to:

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

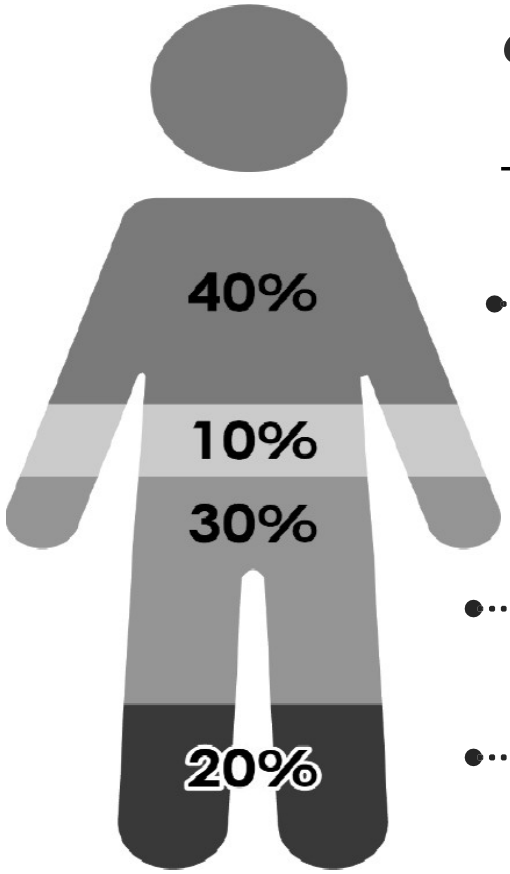
The Health & Care Partnership has a role in assuring that our operational delivery is focused on achieving our overarching strategy.

Our over-arching strategy for BLMK is:

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

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

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



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

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

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

BLMK Joint Forward Plan

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

- Extends to 2040 to enable delivery our strategic change to deliver our ICB objectives and our Health & Care Partnership strategy
- Focused on those most complex & stubborn challenges that we can only resolve through working in partnership
- Delivery centred on local communities' needs (population health) not limited by existing ways of delivering health & care services

Our High Impact Programmes are:

- **Advancing Equity**
- **Improving Effectiveness & Efficiency**
- **Enabling our Children & Young People to Thrive**
- **Improved Access & Treatment**
- **Integrated Neighbourhood Working**
- **Thriving & Prosperous Communities**
- **Improving Outcomes for People with Mental Health, Learning Disabilities and Autism Spectrum Disorder**
- **Intelligence-led Performance, Outcomes, Quality & Inequalities Improvement**
- **ICB Target Operating Model**

The health & care landscape 2024-5

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

Our Medium-Term Financial Plan indicates an **unmitigated £130 million cost pressure in NHS services for 2024-5**

This is against annual spend of £1.8 billion on NHS services in BLMK

This is expected & has informed how we have developed our High Impact Programmes and our planning & contracting round for next year

Our cost pressures driven by

- Post-pandemic population health needs - urgent & emergency care (increased complexity of need)
- Recovery of routine elective services (reducing waiting times)
- Inflationary pressures (capital & revenue)
- Increases in the cost of prescribing (global pressure)
- Costs increasing for complex placements (council and NHS)

NHS Planning for 2024-5

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

In BLMK we have already started the NHS Planning round for 2024-5

Our approach is to develop our Operational Plans in partnership, based on local communities' need

This partnership approach is to address historic 'silo-d' planning so that we improve overall benefit to residents and maximise value for money (NHS and Councils)

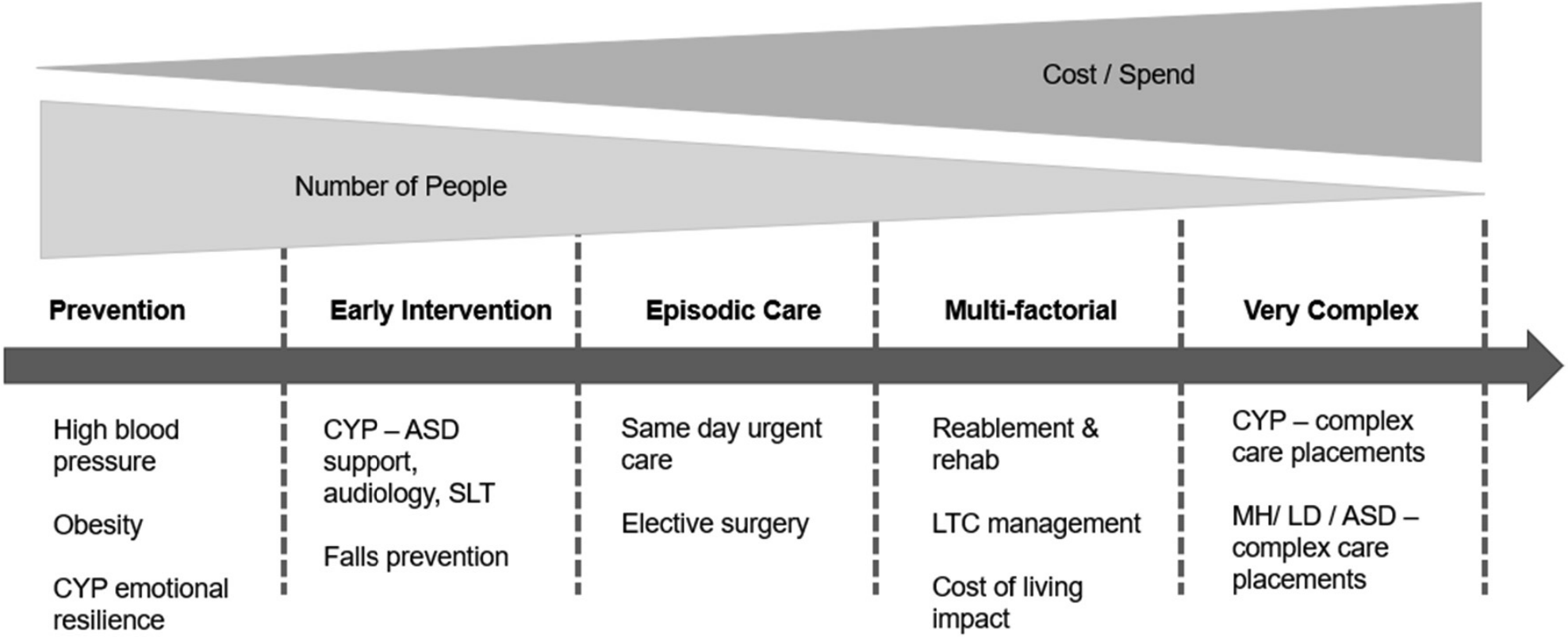
For residents, we aim to improve patient experience by continuing to integrate services

Our Operational Plans for 2024-5 will be developed between partners at Place / Collaborative*

Our population-focused planning will:

- Triangulate between local population need, NHS England targets, and available resource to agree how best to meet population needs
- With Residents' and VCSE input, challenge ourselves to simplify pathways & improve access
- Get 'up-stream' to maximise outcomes (prevention & earlier intervention)
- Confirm our system-level efficiency programmes
- Make sure we understand the impact on all partners for any changes we make along a pathway of care
- Develop consensus for difficult choices that need to be made about how we use our resources to best benefit our residents

** Historically, NHS Operational Planning has been 1:1 negotiations between the NHS Commissioning Organisation & individual NHS Provider organisations*

Focusing our collaborative operational plans where they will have optimum impact

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