Partnership Board for
Bedfordshire, Luton and Milton Keynes

15 September 2020
2pm to 5pm
Via Microsoft Teams

Item	Lead	Timings
Welcome	**Chair**	
1. **Apologies for absence** To receive any apologies for absence.	**Chair**	**2pm**
2. **Declarations of Interest** To receive any declarations of interest.	**Chair**	
3. **Partnership Board 5 August 2020 meeting notes** a. To approve the meeting notes of the Partnership Board on 5 August 2020 - attached b. Action log - attached	**Chair**	**2.05pm**
4. **Public Questions** To receive any questions by members of the public	**Chair**	**2.15pm**
5. **Cancer Services** a. A patient's perspective **b. Cancer services rec**overy and transformation – presentation	**Jaff Newton & Linda Wilson** **James Ramsay, SRO BLMK Cancer**	**2.25pm**
6. **Population Health Management wave 2 - attached**	**Clare Steward Programme Director**	**3.15pm**
7. **People Plan - presentation**	**Anita Pisani SRO BLMK Workforce**	**3.30pm**
8. **Recovery Plan update - attached**	**Daphne Thomas Acting Programme Director**	**3.50pm**
9. **BLMK Clinical Commissioning Group Case for Change - attached**	**Patricia Davies/ Maria Wogan**	**4pm**
10. **Update Reports** a. Chair / SRO update b. ICPs' reports:	**Chair / SRO**	**4.30pm**

Bedfordshire Care Alliance Milton Keynes ICP	**David Carter** **Ian Reckless**	
11. **AOB** a. Partnership Board work plan - attached		

Documents for information:

1 – Performance data pack
2 – Finance update
3 – ICS workstreams' report – to follow

Partnership Board meeting notes
Meeting held on 5 August 2020
Time: 14.00
Microsoft Teams

Members	
Dr Rima Makarem (BLMK ICS Chair)	RM
Michael Bracey (MK Council)	MB
Paul Calaminus (East London FT - ELFT)	PC
Richard Carr (Central Bedfordshire Council)	RC
Patricia Davies (Commissioning Collaborative - CCG)	PD
Tom Davis (East Anglia Ambulance)	TD
Ross Graves (Central and North West London Trust - CNWL)	RG
Dorothy Griffiths (CNWL)	DG
Joe Harrison (MK Hospital)	JH
Simon Linnett (Bedfordshire Hospitals)	SL
Cllr Peter Marland (MK Council)	PM
Cllr Christine McHugh (Bedford Borough Council)	CM
Mandy Nagra (BLMK ICS Executive)	MN
Robin Porter (Luton Borough Council)	RP
Cllr Simmons (Luton Borough Council)	HS
Dr Nicola Smith (Commissioning Collaborative -CCG)	NS
Cllr Tracey Stock (Central Bedfordshire Council)	TS
Daphne Thomas (BLMK ICS)	DT
Mark Thomas (BLMK ICS)	MT
Matthew Winn (CCS)	MW
Apologies	
David Carter (Bedfordshire Hospitals)	
Mary Elford (Cambridge Community Services - CCS)	
Mayor Dave Hodgson (Bedford Borough Council)	
Cllr Jamieson (Central Bedfordshire Council)	
Mark Lam (ELFT)	
Simon Lloyd (MK Hospital)	
Claire Murdoch (CNWL)	
Phil Simpkins (Bedford Borough Council)	
Attendees	
Sanhita Chakrabarti (BLMK CCG Children & Young People lead)	SC
Michelle Evans-Riches (BLMK ICS)	ME-R
Amit Goyal (GP Luton CCG)	AG
Christopher Longstaff (GP Bedfordshire CCG)	CL
Prabu Rajendran (Bedfordshire Hospitals – Consultant Paediatrician)	PR
Kirti Singh (GP MK CCG)	KS
Clare Steward (BLMK CCG – Programme Director)	CS
Maria Wogan (BLMK CCG – Programme Director)	MWo

Item No.	Discussion	Action/Decision Risk/Issues
1.	**Apologies for absence**	
	As detailed above.	
2.	**Partnership Board meeting notes**	
a.	**Meeting notes** The meeting notes of the Partnership Board which took place on 3 July 2020 were confirmed as a true record.	
b.	**Actions** **Action 5 Health & Wellbeing Strategies** The date for the review of Health and Wellbeing strategies to identify commonalities would be changed to November 2020. **Action 8 Health & Wellbeing Strategies** There will be regular reports from the ICPs to the Partnership Board and it was agreed that this item was now closing. **Action 10 Independent Chair reflections & reset of ICS** Defining roles and responsibilities for the ICS, ICPs and CCG is continuing. The CCG merger item is on the agenda and the matrix working for the ICS. **Action 12 System Recovery Plan** The recovery plan is being developed with all partner organisations and updates will come to each Partnership Board. It was agreed that this item is now closing.	
3	**CCG Clinical Case for Change**	
	The Partnership Board was informed that the NHSE Long Term Plan had specified that typically there should be one CCG for each ICS, ideally across the system footprint. There were three CCGs in BLMK, Bedfordshire, Luton and Milton Keynes and there is an opportunity to reset the purpose of the CCGs to be one organisation to act as a strategic commissioner to bring about real change for the population. The CCGs believed this would assist in achieving the goals of the ICS to enable people living and working in BLMK to live longer healthier lives. Three GPs gave examples of how an amalgamated CCG would assist sharing of learning, standardise care and practices e.g. in mental health, attract trainee GPs with more diverse training opportunities, improve patient pathways for example in stroke, use population health information to inform decisions on system, place and local health and care provision and undertake research. It was stressed that the benefits were expected to grow as the CCG became one legal entity and the focus on local health services would be retained and	

	improved. Milton Keynes Council had scrutinised the proposals and unanimously raised concerns regarding the merger as there is no detail as to what would be commissioned at scale, local authority level and local/parish level. The benefits of working at scale and locally need to be articulated. The role of the ICS and CCG requires definition and in particular what is meant by strategic commissioning. There is a need to have appropriate resource to enable Place to work effectively to meet the health needs of local people and the CCGs collectively have a large infrastructure. The CCG must ensure that it engages with all local partners in decisions it takes regarding Place for example the Chief Operating Officer appointments. PD stated that strategic commissioning will be developed in collaboration with partners in BLMK. As the ICPs develop, the CCG is open to discharging its commissioning functions to the ICPs and with it resources. This is an opportunity to reset representative arrangements so that multi-disciplinary professionals including social care were engaged in commissioning. The proposal currently seems transactional and needs to articulate what will be different culturally and how the CCG will operate. It needs to be clear what will be done at the different levels and how the CCG will support the ICPs in delivering services. Bedford Borough Council Executive is opposed to the proposed merger as it is believed the restructure is at the expense of health outcomes. Bedfordshire CCG had not engaged fully with the local authority and elected members and it is believed this would not improve with the proposed merger. Central Bedfordshire Council accepted that this is a national ask to have one CCG but believed the proposals required more consultation, defining what strategic commissioning meant and being clear the improvement to outcomes for local people. It was confirmed that the proposals would have 3 GP representatives from Bedfordshire, at least one from each of Bedford Borough and Central Bedfordshire Borough. SW stated that the strategic commissioner role had to be co-developed and stressed the importance of PCNs, integrated neighbourhood teams and local delivery. BLMK partners had worked with Carnall Farrar last year to develop an understanding of strategic commissioning and this would be re-visited. **Agreed:** **That a report be made to the next Partnership Board to include:** **a. What is meant by strategic commissioning with examples of services that could be commissioned at scale, local authority and local levels?** **b. How will the single CCG body be culturally different and how will it operate, in particular to reduce process?** **c. How will it work in partnership with local partners and at**	

	a system level? d. **How will the size and infrastructure of the CCG change to support local delivery?**	
4	**Questions from the Public**	
	Two questions were submitted by a member of the public: 1. In terms of the agenda for the meeting of the BLMK Partnership Board on the 5th August, perhaps the Board might be encouraged to consider adding 'Patient Representation' to the Board's membership. Whilst the structure of ICSs is clearly determined by CCGs, Trusts and other health care providers, that structure will undoubtedly influence the local provision of services in which patients have a vested interest. **Response: The work plan for the Partnership Board will have over time reports from specific workstreams with patients invited to attend the meeting. There are also elected representatives from the four local authorities in BLMK who represent patient and public views. Decisions on services will be made with engagement and involvement of the public and the CCG has a duty to consult patients and the public regarding services it commissions.** **2.** Does the ICS intend to commission the Digital Transformation Board to produce a robust plan for the delivery of an ICS-level population health database to provide the Board with analytics to support the analysis of health services including outcomes and health inequalities? **Response: Across BLMK the ICS is supporting two health economy approaches, the Bedfordshire Care Alliance which is co-terminus with the three Local Government Councils of Bedford, Central Bedfordshire and Luton; and the Milton Keynes integrated care partnership. [Both economies have different technical architectures within the Foundation Trusts that will have the capability for persisting data to support population health management.- don't understand this sentence? Do we need it?]** **Following the recovery from BLMK's response to the global pandemic, the ICS is reviewing and refreshing the over-arching digital strategy which will develop, with all the System partners, the logical databases to support the requirements for all BLMK health and care management.** **At this stage it is not intended to purchase a new stand-alone population health management database because through semantic interoperability and the implementation of national data sharing standards, it will be possible to access data as if it**	

	were a single database.	
5	**System Recovery Plan**	
	A nominated lead for each partner has been appointed and there are weekly meetings to progress the recovery plan. Infrastructure capital of £5.4m has been approved for BLMK and there is further funding expected for A&E developments to enable social distancing and infection prevention to be maintained. The main aims of the recovery plan are to: • Restore cancer services, • Recover the elective activity close to pre-pandemic levels with challenging targets of 90% of electives and 100% diagnostics by October 2020. There will be a penalty imposed if these targets are not met. • Restore primary and community care • Expand and improve mental health • Prepare for winter. Innovation to support the workforce and improve health inequalities has been encouraged. Covid restrictions meant that patients had to be dealt with differently and the system was examining ways of using capacity where there were blockages in another part of the system and outside BLMK, especially if clinical outcomes were better elsewhere. The impact on local authority services and community care is being taken into account, for example any increase in re-ablement would require resourcing and would potentially impact other services. It was stressed that the scale of the challenge was not to be underestimated, local authorities were still in response mode. However, every effort was being made to restore services and these were being prioritised as to the impact on the public. It was proven that best practice was to discharge a patient home with appropriate support and only the patients with the most complex needs should be discharged to nursing homes. This provided the best outcome for the patient and improved hospital flow. There was an opportunity to use the independent sector to undertake elective operations and the acute trusts were working collaboratively to address the waiting lists, although it was stressed that community and social care must be involved. However, it was acknowledged that there was little capacity in both the private sector and NHS. Clinicians were being encouraged to examine radical ways in order to increase capacity and improve patient flows and pathways. There was the opportunity to examine what was working well in other STP/ICS.	

	Flu Campaign An extensive flu campaign was being developed with Health & Wellbeing Boards, primary and community care and acutes. Innovative ways to deliver vaccinations e.g. the use of mobile units, are being looked at. High risk patients have been identified by primary care and how and where to vaccinate those patients was being explored for example in the patients home, clinic setting etc. Another ICS had used an automated booking system for Covid testing and this is also being used for flu vaccination and SW would share the contact details. **Noted**	**ACTION 15 SW**
6	**Update Reports**	
	SRO Report There are regular discussions between ICS system leaders and the regional NHSE/I team. The following objectives for BLMK ICS for 2020/21 have been agreed: • **Winter planning**: to cope with 'normal' winter pressures, flu and a possible second wave of Covid. • **Recovery plan**: resumption of NHS services suspended to respond to Covid, including through a shared waiting list and building on innovation • **A plan for the ICS's continued development,**including to arrive at a shared understanding of the strategic commissioning and the interplay with the ICPs. Drawing on the maturity matrix to work through how we leverage the value of the system for local people • **BLMK Long Term Plan** actions. Flowing from the above, what steps do we need to take to deliver the ambitions we set out in the plan There is an emphasis on using data to drive actions and the importance of the interplay with local authority social care. The regional NHSE/I team are seeking to prepare ICSs for taking on additional responsibilities and an operating model is being developed to support the ICS working. Expressions of interest had been invited for a NHSE/I Executive Director for each ICS and Simon Wood would maintain the Executive lead Drector role for the system. It would be helpful to articulate the dynamic between the ICS, ICP and the region, expecially in light of the CCG merger. There was an opportunity for each ICS to gain earned autonomy, but it is unclear at present what this would include. **Noted.**	
b	**ICPs report**	
	Milton Keynes	

	The ICP was looking at how its plans tie in with the Long Term Plan, recovery and Winter plans as well as deliver transformational change. It was also examining how it interacts with the Bedfordshire Care Alliance, CEO group and Partnership Board. The partners were developing mechanisms for measuring the impact and outcomes of the implementation of local plans.	
	Bedfordshire Care Alliance (BCA) A programme Director has been appointed and the BCA was meeting on a monthly basis. There is a clear statement of collaboration between partners. . As previously stated the three areas of focus are frailty, digital and primary care network development. The outcomes that are expected were being mapped out. **Noted**	
c	**Finance and Performance**	
	BLMK has access to vast amounts of data and a reporting dashboard for the Partnership Board was being developed and would be reported to the next meeting for comment.	**ACTION 16 ICS Core team**
7	**Matrix working**	
	There are a number of groups across the system and the Partnership Board will be receiving regular reports to provide oversight of what is being delivered and the outcomes at system, Place and locality level.	
8	**AOB**	
	The next Partnership Board will have reports from the Cancer Board, population health, business intelligence and analystics. It was therefore proposed that the meeting be extended to three hours.	

The meeting ended at 16.05
6 August 2020
Michelle Evans-Riches

BLMK Partnership Board Action log

Ref	Date	Item	Action	Responsible	Deadline	Status	Comments
5	04-Mar-20	Health & Wellbeing Strategies	That the Chairs of the Health and Wellbeing Boards would collectively review the strategies to identify commonalities e.g. growth and child poverty that might merit taking forward across more than one place.	Tracey Stock	Nov-20	Open	
7	04-Mar-20	Health & Wellbeing Strategies	That the information on local people living with multiple issues, that is held by partner organisations be collated and reported to the Partnership Board.	Geraint Thomas	Aug-20	Open	Proposed for closure as it will be looked at as part of the performance data dashboard
9	04-Mar-20	Health & Wellbeing Strategies	That a detailed report be made to the next meeting on Wave 5 Capital funding and the health and care hub strategy.	Daphne Thomas	Dec-20	Open	July 20 - Wave 5 Capital bids delayed due to Covid 19 **The estates strategy will be refreshed post-CV19 and in line with the reset of the LTP**
10	03-Jul-20	Independent Chair reflections & reset of ICS	Roles and responsibilities of the ICS, ICPs and CCG will clarified and circulated.	Daphne Thomas	Aug-20	Open	Proposed for closure – this is an ongoing piece of work as part of the ICS reset. Is ongoing, supported by Carnall Farrar
15	04-Aug-20	System Recovery Plan	Another ICS used an automted booking system for COVID testing. This is also being used for flu vaccination	Simon Wood	Aug-20	Open	Simon to share contact details
16	04-Aug-20	Finance & Performance	Repoitng dashboard is being developed and be reported to the next meeting for comment.	ICS Core Team	Sep-20	Open	To be shared for comment outside the meeting

BLMK
Population Health Management
- Wave 2 update
Supporting COVID Recovery

Mike Thompson, Director of Strategy, Planning and Population Health Management, BLMK CCGs
Ian Brown, Chief Officer for Public Health, BLMK PHM Programme Board (Chair)
Clare Steward, Programme Director
Kane Woodley, Optum

Context

- The Population Health Management Development Programme (PHMDP) due begin on 3rd April 2020 was paused due to COVID 19.
- The programme has since been refocussed in light of COVID.
- The programme will commence with the first System Action Learning Set on Wednesday 30 September 2020 (invites should have been received).
- The programme will run for 22 weeks
- The core programme Action Learning sets are as follows:
  - ***System (bringing together system leaders for BLMK as a whole)***
  - ***Segmentation and Priority setting workshop***
  - ***ICP / (known as 'Place' on the programme)***
  - ***PCN (Four PCNs, one from each local authority borough, have been selected)***
  - ***Integrated Care Finance & Contracting***
  - ***Data & Analytics***
- As part of our commitment to optimise the learning across BLMK an additional actuarial model has been commissioned to ensure that the work is undertaken across both BLMK ICPs
- In addition, the BLMK system has been selected to be one of four systems participating in the Enhanced Finance and Contracting workstream

System Engagement

- BLMK PHM Programme Board re-established at End August.
  This will meet monthly with ICS, ICP, PCN, MH, Community services, Local Authority, Third sector, Public Health and NHSE/I representation
- Strong ICS partner engagement both at Programme Board and throughout the Action Learning sets
- Close working with ICS Directors of Finance in relation to the additional Enhanced Finance and Contracting module
- Dedicated resource/focus to ensure PCNs are supported
- Working closely with Public Health colleagues given the current capacity challenges

System Objectives

The programme will support Phase 3 COVID recovery and integrated working across our system by helping to:

- Restore local services inclusively, so that they are used by those with greatest need
- Accelerate preventative programmes which proactively engage those at greatest risk
- Develop a collective understanding of health inequalities through the use of shared and linked data
- Collaborate locally in planning and delivering action to address health inequalities
- Develop an unmitigated projection of demand for health and care services and assess potential impact of new interventions (through the actuarial workstream)

System Benefits

- Support BLMK in developing system infrastructure:
  - Test and learn - building system wide linked data set
  - Influencing future system-wide BI strategy
  - Early adoption and shaping of future finance and contracting mechanisms
- Support BLMK analysts in producing insight to support 'on the ground' health and care professionals
- Supporting Phase 3 recovery at all levels of the system
- Accelerating changes to care delivery through design and delivery of proactive care models for specific cohorts
- Development of a roadmap to further embed PHM after the life of the programme

Previous waves of the programme led to real changes to care

Data analysis

Care model

Impact

Barbara from Blackpool

Partners across the ICS (PCNs, council and NHS analytical teams and third sector) linked NHS and council held data to find **people who had seen a GP five times or more a year in the last three years, who lived in multi-occupancy housing and also had depression.**

New care model of **proactive and holistic health assessments by health coaches in the PCN. Follow up assessment of social situation** by health and wellbeing workers in the council.

Barbara lived in poor quality housing, suffered from depression, was unemployed and recently experienced a bereavement. She was in rent arrears and turned to alcohol to help her relax. The PCN health and wellbeing worker identified severe risks in the quality of Barbara's building and was concerned for her welfare and safety. The worker supported Barbara to call her letting agent and strengthen the locks on the door to help her feel safer. Barbara was referred to a local charity to support her with her bereavement. Other support around her housing was provided, and she found **support for finding employment and building her skills and confidence**. **Barbara's patient activation rose from a level 2 to a level 4 during this time.**

Paula from Pudsey

System analytical and PCN teams identified **80 people, aged 60 - 74yrs within moderate frailty segment, multiple Long Term Conditions (LTCs), balance and nutrition issues, not connected to the neighbourhood** teams.

PCNs Designed **proactive outreach service with telephone based triage,** including using PAM to assess ability to self manage. **Patients triaged to either 'live well' group consultation, individual medical consult in clinic, home visit led by an OT**.

Paula' is a 63 year old woman with moderate frailty. She has multiple medical conditions as well as challenges associated with falls, memory and nutrition. Following telephone triage, Paula was visited at home by an OT. The at-home visit gave a holistic view of Paula's needs, with a focus on preventing falls, enabling better nutrition and improving Paula's ability to self-care. Paula and the OT had a discussion about her needs and her own personal goals. The OT identified specific opportunities to enable a healthier lifestyle for Paula at home – for example by enabling easier use of kitchen tools to help her prepare food.

Bob from BOB

Wokingham PCN with CCG and provider analytical teams linked local primary and secondary care data and **identified a cohort of people aged 45-65 with diabetes who have attended A&E 2-3 times last year**.

PCN designed **new care model to provide multi-disciplinary evening clinics (some via group consultations and some with co-morbidities 30 min consultations) with a lead diabetes GP, diabetes specialist nurse, health and lifestyle coach, with input from psychologists with the aim of developing personalised action plans.**

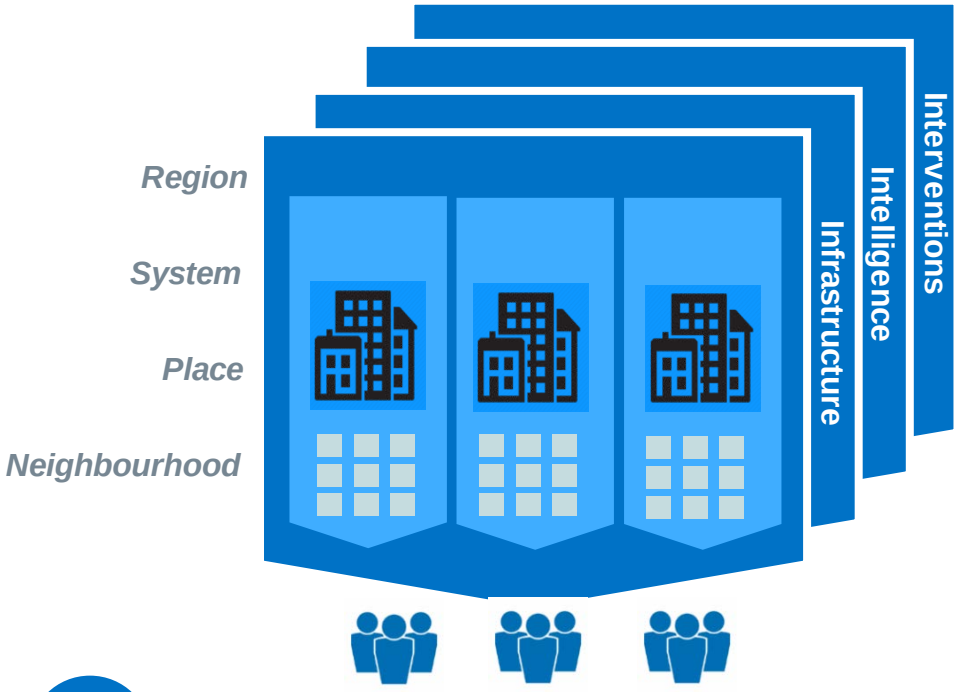
Bob is 56 years old and works as a management consultant. He has an extremely busy life, often travelling for work. He has had diabetes for 6 years and is overweight and has suffered from anxiety and depression. He struggles to attend his nurse-led diabetes appointments and he has high levels of HbA1c. After just one visit so far, focusing on a whole-person approach with a lifestyle medicine practitioner, Bob and his wife have made daily lifestyle changes and Bob's **HbA1c and weight both continue to decline weeks after the intervention.**

Integrated Care System Population Health Management Development Programme

COVID-19 Recovery Programme Focus

NHS England and NHS Improvement

The PHM Development Programme has two core objectives



2

Advance the System's infrastructure and build sustainable capability across all tiers which supports a focus on proactive population health management and tackling unwarranted risk.

Ensuring the lessons learnt throughout the programme enable system and provider participants to accelerate PHM infrastructure across the rest of the ICS, with clear roadmaps for making PHM 'business as usual' and clarity on critical support functions and enablers (including analytics, finance, contracting, care coordination, local assets to support personalised care interventions including VCSE partners)

1

Accelerate changes to care delivery at Neighbourhood and Place through PCNs and their public health, local authority, community, mental health, acute sector and VCSE partners, to start to achieve demonstrably better outcomes and experience for selected population cohorts and secure the skills to spread the approach to other cohorts.

PCNs and wider System partners designing and implementing proactive care models for specific population cohorts, identified through advanced analytics measuring the net impact using local intelligence tools

The programme has been refocused in light of COVID-19

1. **Strategic context:** The COVID-19 response has brought in changes at national, regional and system level that will continue to evolve. The programme has been refocused with these in mind and will align wtih phase 3 and 4 planning guidance letters are published

2. **Completely virtual programme:** All sessions will now be delivered via MS Teams or webinar with no face-to-face element

3. **New segmentation model:** A model has been developed using the latest evidence and clinical advice. The model considers both those at risk of COVID-19 complications, but also the indirect impact of COVID-19 on health and care

4. **Place/ICP workstream:** to support collaboration between acute providers, Local Government and Primary Care, to think about their PHM leadership role at Place. This module is comprised of three Action Learning Sets and will support phase 3 recovery thinking around how to bolster capacity for winter and deliver new care models that address health inequalities

5. **Integrated Care finance and contracting workstream:** Four Systems will receive an enhanced package that supports them to design a shadow pricing and contracting model for one of their Places. *For those not included, learning will be shared back during System Action Learning Sets*

6. **In programme spread and sustain:** Previously the PHM roadmap was developed towards the end of programme, we will now start this process much earlier in the programme

7. **Partnership working with regional / PHE colleagues throughout programme**

Changes to PHM Development Programme Approach

The Population Health Management Development Programme is changing to enable systems to focus on the response to, and recovery from the COVID-19 pandemic:

1. **Method of Delivery:** The programme will move from face-to-face to virtual delivery, using MS Teams or Webex as the virtual learning and connectivity platform. If it becomes possible to carry out face-to-face activities during the 20 week programme, then we may look to reinstate these where appropriate to do so.

2. **Scope & Scale:** To support systems to be able to 'scale' up PHM capabilities, planned roadmap and sustainability of PHM activities will take place earlier in the programme. These discussions with PHM Steering committees and ICS executive leaders will form part of refresh planning.

3. **Cohort Selection**: The programme provides greater structure to identifying key population groups based on latest evidence from PHE and work within NHSE/I on care models and personalised care.

4. **Action Learning across all workstreams:** We will apply action learning/ 'learning by doing' methods across all workstreams in the programme, to ensure that teams have the opportunity to apply their learning with the support of programme PHM SME's.

5. **Enhanced Integrated Care Finance and Contracting workstream:** Designed to support systems to explore how to move forward with the system finance and contracting agenda, exploring simulated new population based payment models and alliance agreements.

6. **Timetable**: It will be possible to review the timing of key components of the programme delivery, in order to be flexible in responding to system needs.

How will the PHM programme support system recovery?

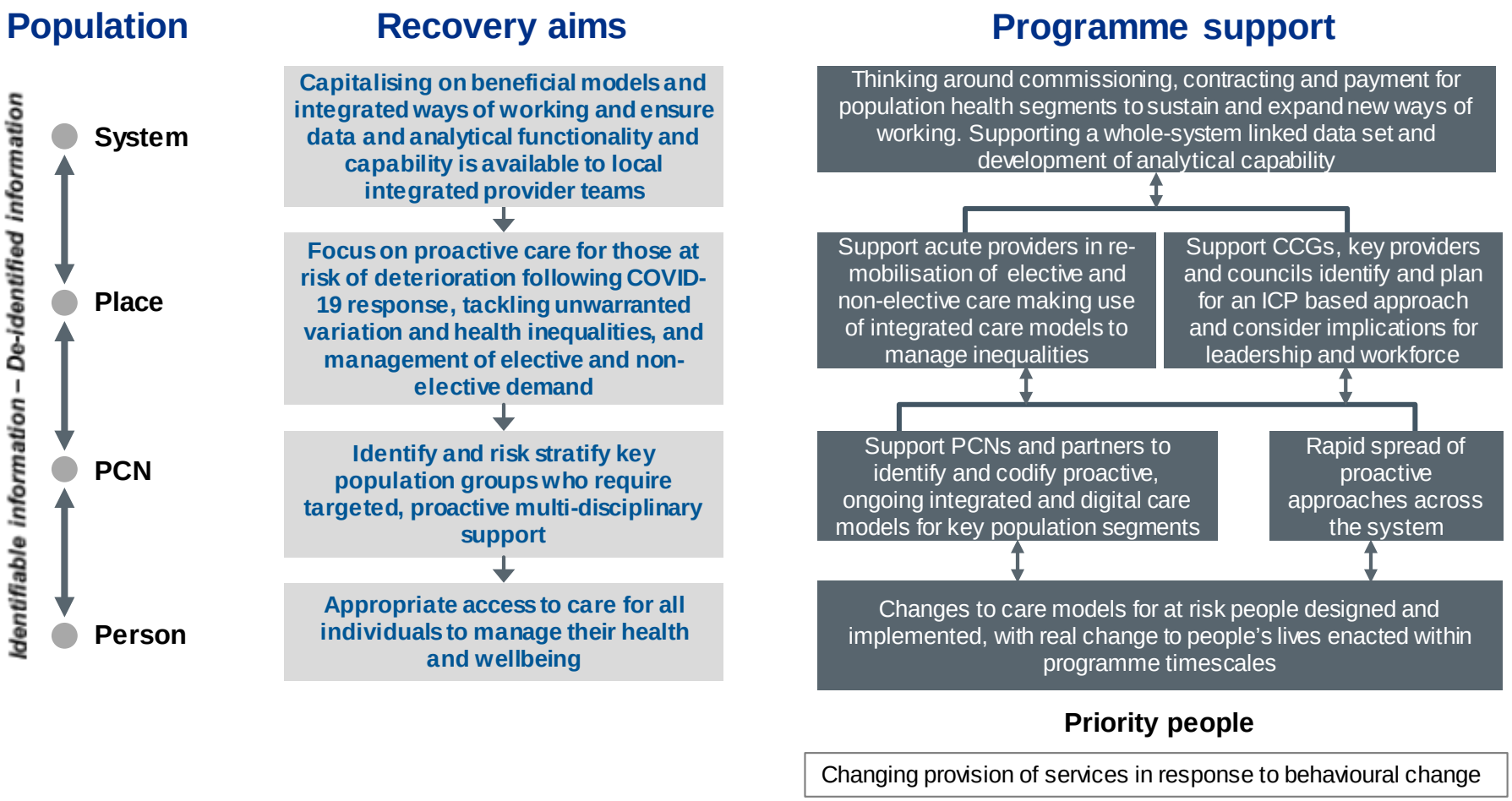
Phase 3 planning guidance has been released (August 2020), and the programme has been aligned to support achievement of national requirements in the context of each System's individual needs

The programme will support the response to and recovery from COVID-19, at **all tiers** of the system by:

- Positioning the programme as a **key component of system recovery**, sitting within recovery workstreams and planning.
- Supporting **CCGs, key providers and councils** in their key priorities for immediate focus for the next phase of recovery, such as targeting of specific population at risk of factors such as social vulnerability, long term conditions and those at risk of deterioration of mental health.
- Supporting **acute providers** to re-mobilise elective and non-elective activity by making better use of wider primary, community and third sector partners through consideration of alternative out of hospital and virtual integrated models of care.
- Supporting **PCNs and their acute, mental health and community partners** to identify and codify proactive and ongoing integrated and digital care models for key population groups and think through future practical enablers such as shared workforce models and operating procedures.
- Supporting **systems** in their thinking around commissioning, contracting and payment for population health to sustain and expand new ways of working.
- Supporting the **linkage of local data sets** across system partners and the provision of local integrated provider teams with risk stratification and analytical functionality and the local analytical and clinical transformation capacity they need to enable them to use these tools.
- Supporting rapid spread of these proactive approaches across the system and the ongoing effort to spread behavioural change in the **population's** use of services**.**

What is the offer for different parts of the system

The programme will support the response to and recovery from COVID-19, at <u>all tiers</u> of the system:

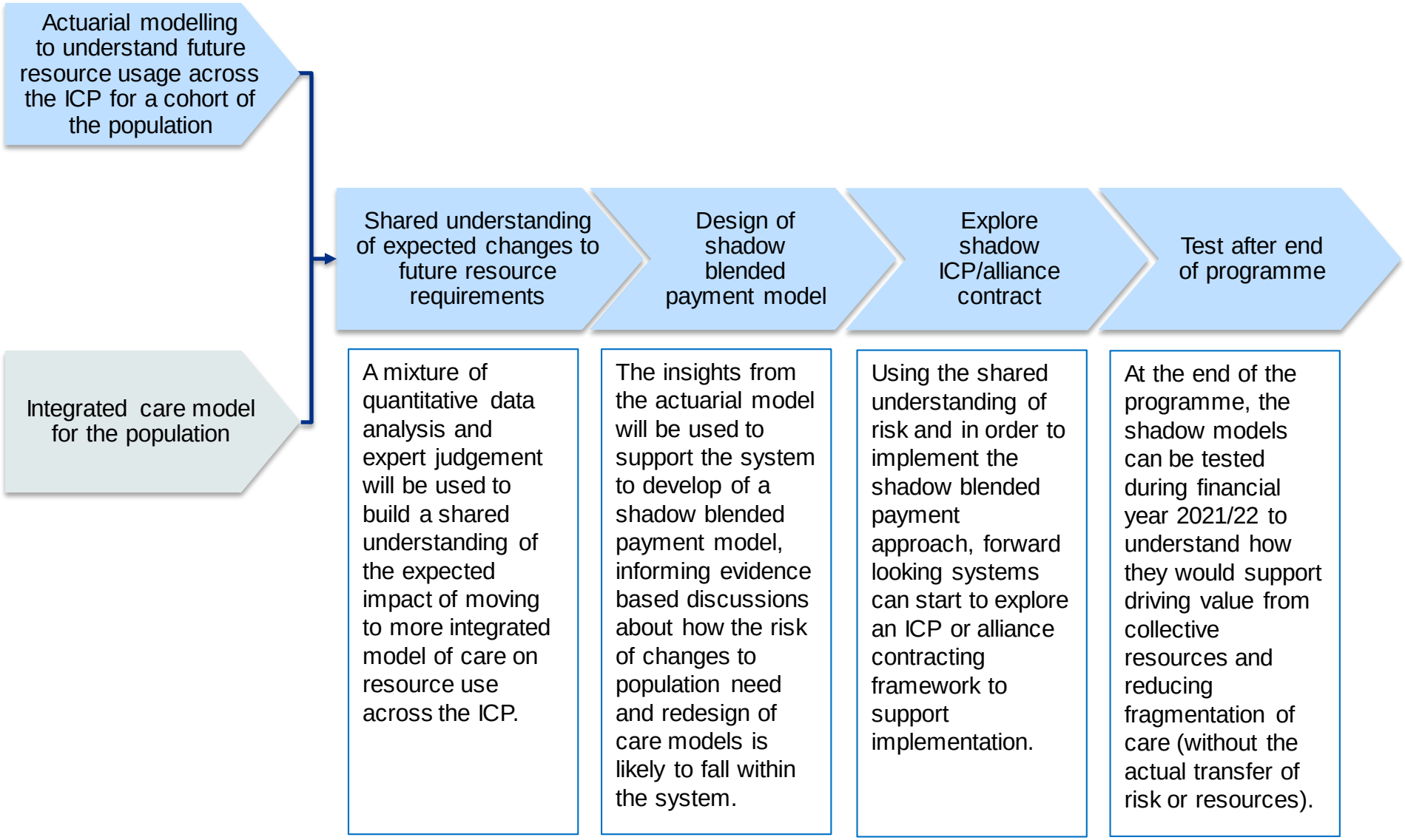


Additional Enhanced Integrated Care Finance and Contracting Action Learning Sets

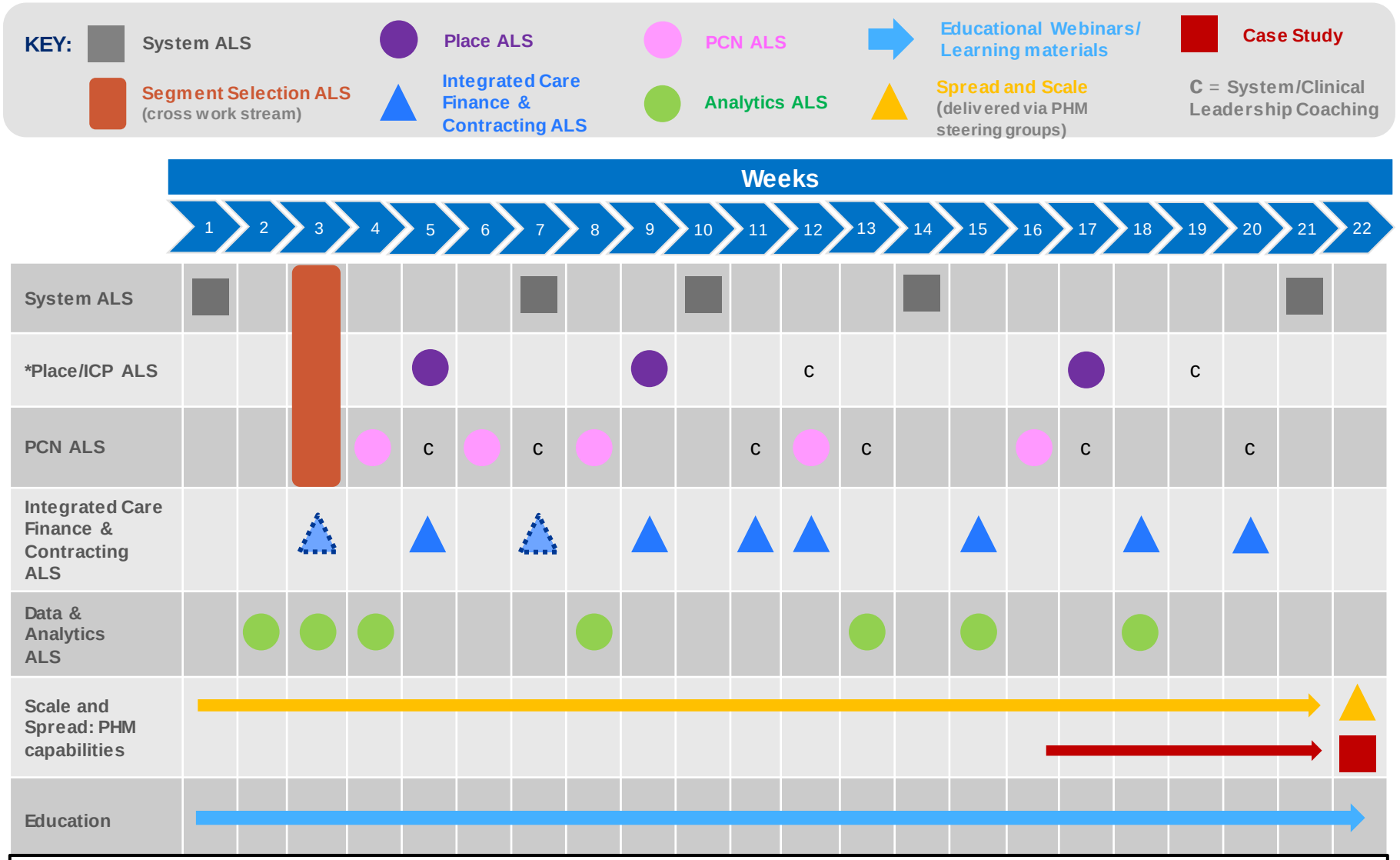
The Enhanced Integrated Care Finance and Contracting work stream has been offered to four systems participating in the PHM Development Programme.

- The work stream offers forward looking systems the opportunity to take the learning from the programme a step further, and use the insights gained through the actuarial modelling **to explore innovative approaches to payment and contracting** to enable the system to drive value from collective resources and ultimately reduce fragmentation of care.
- **Systems will develop projections of ICS-level and place-level (for one place within the ICS) demand for health and care services** using activity volumes within service lines and the financial spend on these services (cost from the perspective of commissioners and providers).
- The early Action Learning Sets (ALS) focuses on the **development of an "unmitigated projection"** should the current operating model stay the same.
- The work stream then moves on to **topics and techniques for building a "mitigated scenario projection".** This is a view of future demand for health and care activity and spend on the basis that new interventions and new models of care are implemented.
- For the enhanced work stream, the later ALS (5/6/7) focus on **contracting and payment models**, and the development of a shadow blended payment model for a cohort of the population.
- Systems will take part in three additional sessions compared to the standard work stream, with an additional focus on action learning to achieve outcomes.

The workstream will build a shared understanding of financial risk in the system and use this to develop a shadow payment and contracting framework



Illustrative timetable and sequencing of activity



***To note:** Ideally Place/ICP ALS1 is held during week 5, however discussion needed with individual systems as to the feasibility of obtaining data and attendance required to conduct Place level analytics for week 5 start.

Next Steps

- Programme Board oversight will continue throughout the duration of the Wave 2 programme and beyond
- Maintain links to the ICS Delivery programme already in place
- Ensure the alignment of this work and the wider System recovery planning work as part of ongoing dialogue and programme adaptation as required
- Understand if there are any further requirements of the Partnership Board in relation to Population Health Management

Meeting title	**Partnership Board**	**Date: 15 September 2020**
Report title:	**BLMK ICS Recovery Plan Update**	**Agenda item: 8**
SRO: **Report Author:**	**Name: Richard Carr** **Name: Daphne Thomas**	**Title: SRO BLMK ICS** **Title: Interim Programme Director, BLMK ICS**

Document summary	The purpose of this document is to provide the Partnership with assurance and an overview of the recovery plans developed with NHS and social care system partners across Bedfordshire, Luton and Milton Keynes (BLMK).			
Ask of the CEO Group	To note the contents of the update and raise any concerns with progress to date and discuss any issues.			
Potential Risks and Issues				
Purpose *(tick one box only)*	**Information** ☐	**Approval** ☐	**To note** x	**Decision** ☐
Recommendation				
Document history	None			
Appendices	None			

1. Summary

In March 2020, the government declared a pandemic which resulted in a level four national incident being declared and a national lockdown followed. As the country gradually returns back to the 'new' normal way of life, the NHS and partner organisations are setting out Recovery Plans that will enable the restoration of routine and planned services whilst allowing the system to be able to manage any further Covid-19 outbreaks or surge as well as meet the impact of the winter period (this report can also be considered alongside the report on winter planning).

2. Purpose

The purpose of this document is to provide the CEO Group with assurance and an overview of the recovery plans developed with NHS and social care system partners across Bedfordshire, Luton and Milton Keynes (BLMK).

3. Background and Scope

The recovery plans for BLMK respond to the requirements of the guidance set out in the "Implementing phase 3 of the NHS response to the Covid-19 pandemic" issued 7 August 2020. The detailed guidance followed the letter of 31 July from Simon Stevens setting out the national priority actions for the 3rd phase of the NHS response to Covid-19.
A draft plan was submitted to NHS England/Improvement (NHSE/I) on 1 September (previous submissions, including activity and data, were made in June and July) to be followed by a final submission on 21 September 2020. The content of this report is the overview of the narrative as submitted.

The objectives of the recovery plan can be summarised as follows:

1. Restore full operation of all cancer services;
2. Recover the maximum elective (planned) capacity possible between now and winter with specific targets of reaching 90% of prior year activity levels by October 2020 for overnight electives and day cases, 100% of outpatients activity and 100% diagnostics activity (MRI/CT and endoscopy);
3. Expand and improve mental health services and services for people with learning disabilities and /or autism;
4. Restore service delivery in primary care and community services;
5. Prepare for winter alongside possible Covid-19 resurgence;
6. Develop a local People Plan to address systemic inequality, grow our workforce, offer flexible working and keep staff safe, healthy and well; and
7. Reduce health inequalities.

4. Plan of action/Summary of Progress

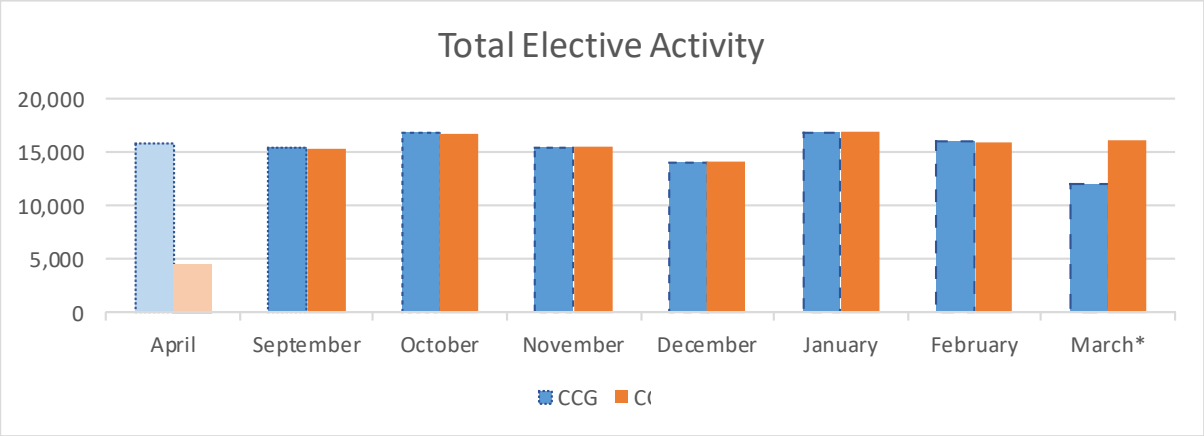
Projected Performance against Phase 3 Targets

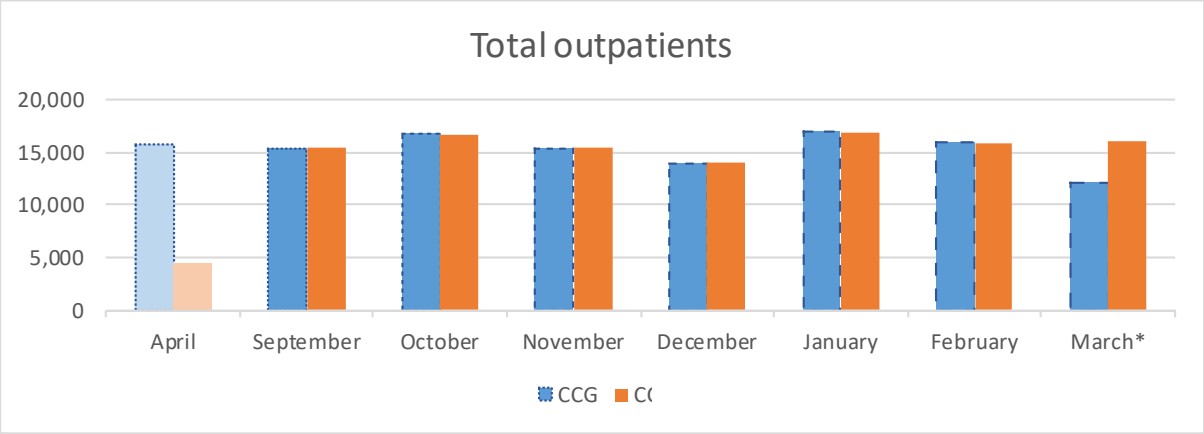
The projected performance against the ambitions set out the in Phase 3 letter (Simon Stevens 31 July 2020) is summarised below:

Area	Summary performance	Achievement
Cancer	Full restoration of services	Fully achieved
Electives	90% activity to be delivered in October 20 vs prior year	Fully achieved
Outpatients	100% activity to be delivered in October 20 vs prior year	Fully achieved
Diagnostics	95% activity to be delivered in October 20 vs prior year	Partial for draft
Mental Health	All metrics to be achieved except for annual health check targets and IAPT in some areas	Partial for draft

Cancer services have been a priority during all phases of the Covid-19 pandemic response and as we enter Phase 3, urgent cancer referrals are being restored to pre-Covid-19 levels, services are being restored to respond to this increased demand and long waits are being actively managed - whilst we continue to work on reducing the number of patients waiting over 62 days we will also continue prioritise the most clinically urgent.

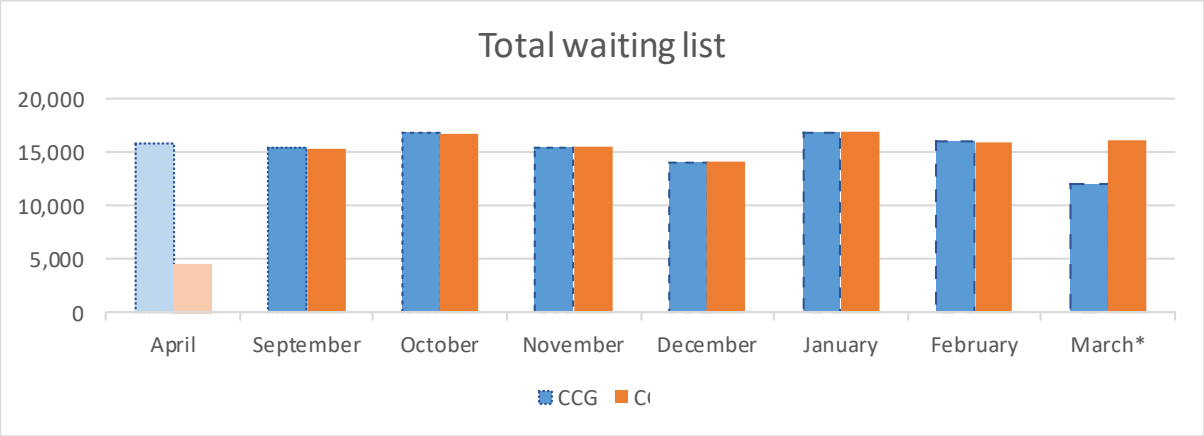
Elective and **Outpatient** services are projected to be restored to 90% and 100% respectively of prior year activity levels by October 2020. This will be achieved through provision of additional clinics and theatre sessions and implementing the new IPC (Infection Prevention and Control) guidance as well as continuing to upgrade our facilities to increase productivity in particular air ventilation and filtration. These measures are designed to mitigate the impacts of the need for enhanced IPC and social distancing to control the spread of infection. The following graphs show the monthly projected recovery of Outpatients and Electives activity against the April position and compared to the same period last year.





Diagnostics activity is expected to be recovered to 100% of prior year activity levels in all areas by October 2020 with the exception of endoscopy which remains our most challenged area. Work continues in this area and the recently announced capital allocations in this area should enable us to make further progress – the impact of this will be included in the final submission to NHSE/I on the 21st of September 2020.

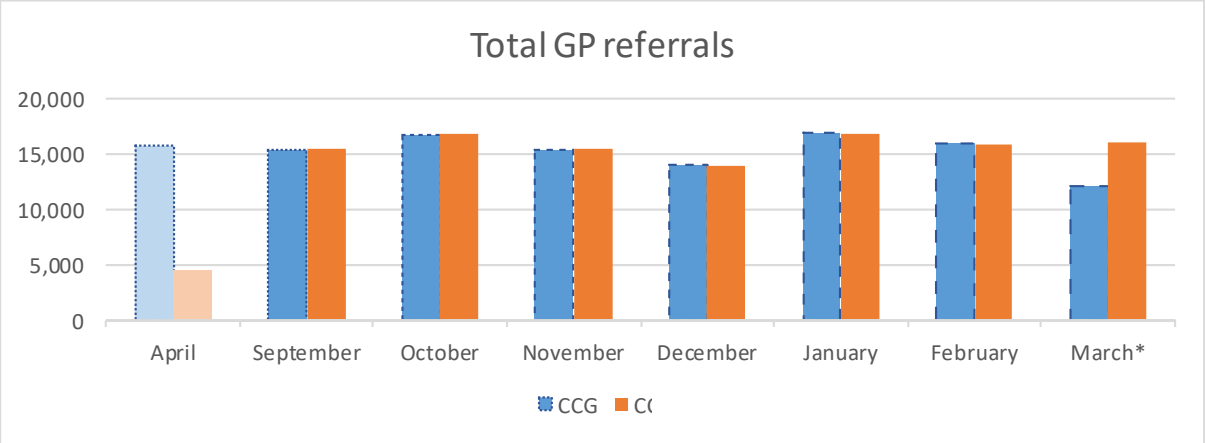
The restoration of elective, outpatient and diagnostic services will mitigate the rise in the size of our waiting lists and delays in treatment of patients as GP and other referrals are restored to pre-Covid levels. Current projections show that the **waiting list** level will peak in September 2020 (estimated at circa 12% above prior year levels) before steadily reducing over the next six months to below the prior year level in March 2021. The graph below shows the projected size of the waiting list against the position at April and against the position last year by month.



Patients will continue to be prioritised on clinical urgency with the next priority given to those waiting longest. We have projected that the number of patients waiting over 52 weeks will be also peak in September 2020 and then reducing steadily to March 2021. Communication are in place to engage with patients on the waiting lists to ensure current low and improved DNA (Did Not Attend) rates are maintained (these are around 3.5% which compares to the pre-COVID levels of 9.5%).

There are actions in place for **Urgent and Emergency** services to maintain services, moderate rising demand and be prepared for future outbreaks of Covid-19. Expansion of the 111 service, support to care homes, the flu campaign, maintaining effective hospital discharges and all out of hospital services working together across the system will be crucial in preparing us for the winter ahead.

Detailed plans for **Primary Care** have been submitted directly to NHSE/I (recognising the national oversight and contracting requirements differ from acute and community services). Primary Care service plans have a focus on being able to maintain some of the transformative changes seen during Covid-19, for example the use of video and technology to meet needs, whilst recognising the need to provide face to face capacity for those who need it. Primary care is of course integral to the response described above for urgent and emergency care. Primary care actions will also be instrumental in restoring the levels of referrals to secondary care and the graph below sets out the monthly projected recovery of referrals activity against the April position and compared to the same period last year.



As noted above, at this stage all **mental health** targets are projected to be achieved with the exception of annual health checks and non-recovery of all IAPT provision in certain areas which continues to be an area of focus. Specific and detailed plans for Mental Health have been worked up across BLMK and have to date been assessed as exemplary.

Addressing **inequalities** in healthcare provision and outcomes is an important and developing area of our recovery planning and we will measure our actions and performance against the eight national priority area set out in the guidance. The 8 NHS priorities are;

1. Protect the most vulnerable from COVID 19
2. Restore NHS services inclusively
3. Digital Inclusion
4. Proactive engagement on prevention
5. Mental ill-health
6. Strengthen leadership and accountability
7. Complete and timely datasets
8. Collaborative local planning and delivery

Each priority area contains specific actions. Given the inherent priority for Local Authorities in addressing inequalities this will entail close collaborative working across the system to ensure the NHSE/I priority actions are addressed but also support, complement and respect the structures and priorities existing within 'place' for inequalities.

5. Wider System Response

The recovery plan submissions to NHSE/I have predominantly focussed on health services, in response to the requirements, with a particular focus on cancer, acute and mental health services. The role of the **wider system** has been crucial in responding to the pandemic thus far and this will continue and develop further through this next stage as we seek to maintain elective services through winter and any future infection spikes. GP's, community providers, local authorities, hospitals and the voluntary sector will need to work as one team across localities, places and the ICS to deliver the best possible outcomes for the population of BLMK. The role of community, primary and social care services highlights increasing demand and scopes the potential cost implications of the requirement to expand these services. The valuable contribution of the voluntary sector to the system is acknowledged and we need to ensure this is preserved and expanded – the easing of lockdown will likely have an impact the availability of volunteers but may give rise to opportunities too. We plan to utilise the expected receipt of NHS Charities Together funding to sustain the well-being of our workforce and explore how patients can be supported to enable them to stay or remain out of hospital and, if they do need hospital treatment, return to home safely and more quickly.

6. Proposed Next Steps

Our overall plan is challenging and ambitious and will be further developed ahead of the final submission on the 21st of September, 2020. Feedback from NHSE/I on the submission of 1 September is expected in the week commencing 7 September which will inform next steps. Meanwhile we are working to understand the financial implications of the activity levels projected within this plan in the context of BLMK's allocated financial envelope. This is still work-in-progress at this point and will be more fully reported on following the submission of our financial projections on the 3rd of September, 2020. A separate financial update is being provided to CEO Group.

The work on the plans is coordinated through the following groups; the Recovery and Ongoing Covid Management Cell and the Health and Social Care Cells (Milton Keynes and Bedfordshire), the Cancer Board, BLMK Mental Health Group, A&E Delivery Boards and the People Board. These groups include senior representatives of health and local authorities who provide the senior management leadership in the development of plans.

All elements of the Phase 3 recovery plan will be monitored through a programme management office (PMO) approach with detailed metrics and measurable indicators. In addition a self-assessment framework with Executive leads nominated for each of the 7 areas of recovery: Inequalities, Mental Health, Elective, Cancer, Primary Care, Community Services & Social Care, Workforce, and Winter Planning and reported upwards to the CEO Group.

7. Conclusion

The development of the BLMK recovery plans has been an iterative process that has brought together health and social care organisations to better plan for the next phase of recovery. This will continue, in the finalisation of the plans by 21 September, but also in the ongoing response to Covid-19 and potential future winter pressures. The CEO Group is asked to note the report.

Meeting title	**ICS Partnership Board**	**Date: 15 September 2020**
Report title:	**BLMK CCG Merger - Update**	**Agenda 9**
SRO:	**Name: Patricia Davies**	**Title: Accountable Officer, Bedfordshire, Luton and MK CCGs**
Report Author:	**Name: Maria Wogan**	**Title: Programme Director, Bedfordshire, Luton and MK CCGs**

Document summary	This document provides an update on the proposed merger of the CCGs in Bedfordshire, Luton and Milton Keynes. Specifically it responds to the points raised at the last Partnership Board meeting and gives feedback on the themes from the meetings with partnership board members which took place during August. It also proposes next steps for this work including work with all partners up to the end of October to co-design the Target Operating Model for the Strategic Commissioner.			
Ask of the PB	To receive the update and support the next steps with this work.			
Potential Risks and Issues				
Purpose *(tick one box only)*	**Information** ☐	**Approval** x	**To note** ☐	**Decision** ☐
Recommendation	To receive the update and support the next steps with this work.			
Document history	Report made to previous Partnership Board meeting			
Appendices	None			

BLMK CCG Merger - Update

ICS Partnership Board 15 September 2020

Patricia Davies, Accountable Officer and Maria Wogan Programme Director

Bedfordshire, Luton and Milton Keynes CCGs

Summary of Key Themes & Actions from ICS Partner Engagement

BLMK Integrated Care System

You said:	Our response:
Establish a collaborative, partnership and delivery-orientated culture which maintains a strong local focus	• We will involve ICS partners in shaping our new organisational values and will use our OD programme to develop a collaborative culture • We will continue to take a co-design approach to the development of the new CCG and will involve ICS partners in the ongoing development of the BLMK CCG's strategies and plans, including GB appointments (more detail on slides 3-6)
Focus on reducing inequalities & working with Councils on the wider determinants of health	• Taking a Population Health Management approach is integral to the vision and strategic priorities of the BLMK CCG. We are investing making this a reality and are leading the Wave 2 PHM programme on behalf of the BLMK system • Our work in this area will be shaped by local Health and Wellbeing Plans and other local strategies to address inequalities such as Luton 2040
Importance of a strong & 'fair share' of local focus	• We will follow up on the individual requests made by Councils about representation at local meetings and focus on local priority projects - the CCG's Lead Executive Director will be accountable for delivery • We will give sufficient and equal focus to all four local authorities on our footprint (more detail on slide 7)
Define the roles & relationships between the strategic commissioner, ICS & ICPs	• Carnall Farrar will work with the CCGs and ICS partners to develop the Target Operating Model for the strategic commissioner. This co-designed piece of work will describe roles, relationships, governance between the CCG and the ICPs and identify the potential transfer to CCG resources to ICPs. Work commences 14 September. (more detail on slides 8-11)
Provide greater transparency on the merger savings & what resources will be available to ICPs & LAs	•We are aiming to save a minimum of £2.4M through the CCG merger to meet the required 20% reduction in CCG running costs. •We will work with partners and Carnall Farrar to identify the CCG resources which could transfer to providers in ICPs and which will be dedicated to 'place' (more detail on slide 12)

Enhanced Healthcare in Care Homes - an example of how the BLMK CCG will improve outcomes for people in BLMK – Joan's story

BLMK Integrated Care System

Joan is 83 and has lived in Aspley Guise, Bedfordshire all her life and has just moved into a **care home** in Newport Pagnell, Milton Keynes. She has **diabetes, COPD, high blood pressure** and is being discharged from hospital after having had a fall at home and fractured her hip. Within the first week of her arrival at the care home, the GP and care home arranged **a meeting to agree a care plan** with Joan and her family. Her case was then discussed at the regular **multidisciplinary team meeting (MDT),** where it was shared with all partners who would be involved in Joan's care. The meeting took place over video conference and was **chaired by a GP from the local PCN** and attended by the **care home manager**, the **community nursing team**, **a physiotherapist**, the **geriatrician** from the hospital and the **local authority**.

The MDT agreed to **review the care plan every month** and organised for a **pharmacist from the local PCN** to visit the Care Home and perform a **review of Joan's medication**. The MDT also arranged for an **Occupational therapist** to undertake a **falls assessment** of Joan to make sure the risks of Joan falling again are minimised.

The **local community nursing team** (CNWL) have arranged to visit Joan regularly to **check on her diabetes, COPD and blood pressure**. Joan told the team that she was feeling anxious about being in strange surroundings so the MDT organised for another resident to act as Joan's buddy to help her to settle in. A copy of Joan's care plan has been shared with Joan, the family, the care home and all of the health and care agencies involved in Joan's care. Joan's family said that they felt reassured to know that their Mum would receive such good care and regular reviews.

Joan's family had been worried that moving Joan into a care home in Milton Keynes might be difficult because Joan had lived in Central Bedfordshire but the care home had explained that **all of the care homes in BLMK do care planning in the same way** and this means it is easier for people who move between boroughs to have **consistent care**.

The MDT met a week later over video conference to review how Joan was settling in and she was reported to have other needs with her swallowing and also feeling quite **lonely and isolated**. This prompted further **referrals to the Speech and Language team** and Joan was also invited to join in with the **social activities** at the Care Home. She now seems to be settling in quite well and she and her family are very pleased.

Benefits of single BLMK CCG

BLMK Integrated Care System

Better healthcare and healthcare outcomes for people in BLMK	Stronger local voice & broader clinical expertise in decision making	Reducing inequalities & unwarranted clinical variation
Improved collaborative working re-directing capacity to local delivery	Increased staff satisfaction due to integration with providers & LAs	Providing increased capacity & capability enabling ICS/ICPs to flourish
BLMK more attractive place to work for GPs	Long term financial sustainability	Improved cost mgt & use of resources via economies of scale

How will the single CCG body be culturally different and how will it operate, in particular to reduce process?

Our OD programme is designed to start work developing the BLMK CCG values in September/October

We will co-design our values with our membership, staff and ICS Partners Sept 2020-March 2021

BLMK CCG Commissioning for Outcomes & Reducing 'Process'

Our Ambition
BLMK CCG will develop, **with ICS partners** a commissioning approach that has the patient at its heart, and which focuses on the specification and delivery of outcomes.

Ultimately, as a strategic commissioner within the system, the CCG will articulate the outcomes required **having co-produced them by working with providers, the public and Local Authorities**.

The CCG will rely on the **ICPs to manage** their own supply chain and delivery through **the tactical commissioning** and contracting of multiple providers.

The focus of **strategic commissioning** will therefore be much more about the development of the **'why' and the 'how'**, with the **ICP prime provider/s** establishing the '**what' and the 'whom**'. This will reduce transactional contracting and processes in the system. **Next steps on this work will be progressed with support from Carnall Farrar Sept-Oct 2020.**

How will BLMK CCG work in partnership with local partners and at a system level?

Supporting BLMK ICS

Contributing as an ICS partner to:

- system strategy, planning, performance & finance
- population health management
- clinical leadership
- reducing inequalities & variation
- transformation & recovery planning PMO support
- leveraging national transformation funding
- system-wide quality & safeguarding support
- communications and engagement support

Working with Local Authorities

Contributing as a local partner to:

- Section 75 agreements & integrated commissioning
- Joint Strategic Needs Assessments
- Delivering Heath & Wellbeing Strategies
- Population Health Management to reduce inequalities
- Attending key local meetings
- Regular informal meetings with CEOs and Leaders/Mayor
- Joint posts/teams/services
- Locally based teams
- Local Executive Leadership
- Locally agreed priorities & plans
- Service changes agreed via local OSCs

Supporting ICPs & PCNs

Contributing as a partner to:

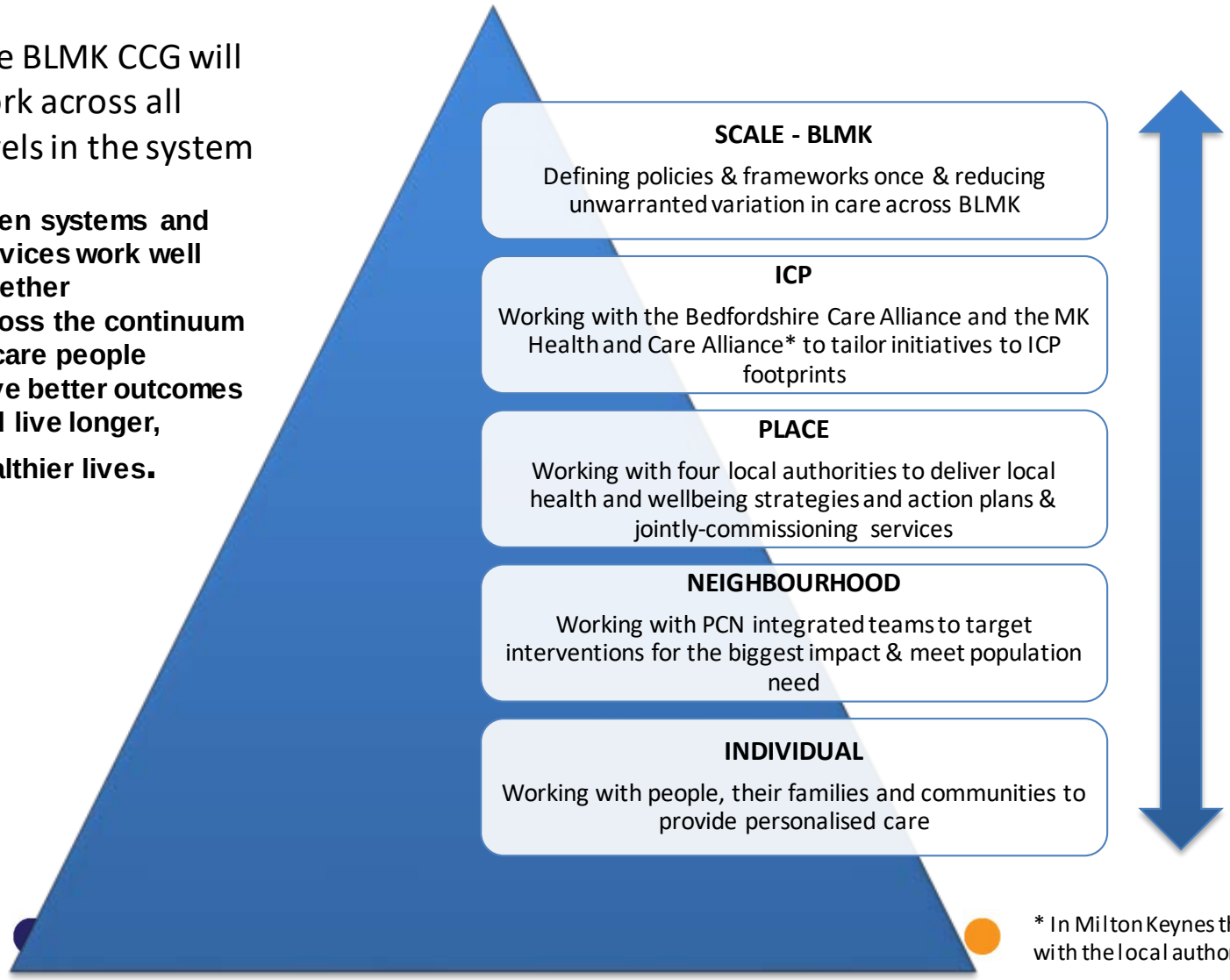
- Outcomes-based longer-term contracts
- Opportunities for lead provider arrangements & transfer of tactical commissioning and associated resource
- Streamlined commissioning - one commissioning voice for providers
- Business intelligence to support population health management
- Transformational support - people, £ and time
- Partnership approach - ending commissioner/provider split

We will work in partnership at all levels and co-design the new strategic commissioning operating model with ICS partners via Carnall Farrar work

What is meant by strategic commissioning with examples of services that could be commissioned at scale, local authority and local levels?

The BLMK CCG will work across all levels in the system

When systems and services work well together across the continuum of care people have better outcomes and live longer, healthier lives.



BLMK CCG will work across the continuum of scale, ICP, place, neighbourhoods and individuals

CCG activities will operate at all of these levels – as appropriate to the work that needs to be done, the local partnerships in place and the local context.

For example the enhanced health care in care homes has being developed and implemented by working at scale, place, neighbourhood and with individuals.

* In Milton Keynes the ICP is co-terminous with the local authority footprint

Strategic Commissioning Activities

Source: Carnall Farrar

	Core Activity	Activity Breakdown
1	Population needs assessment	Population health management, public and patient engagement (FOI/complaints included), provider engagement and JSNA
2	Statutory responsibility review and adherence	Governance, finance, annual reporting, safeguarding and cooperation, public consultations, Health and Wellbeing strategy, reducing inequalities, emergency readiness, adherence with procurement law [and *JSNA]*
3	Service and resource evaluation and gap analysis	[Linked to activity 1, 2 and 9]
4	Commissioning strategy development and alignment with legislation and guidance	Priority setting, compliance with national/constitutional standards, outcome statements and integrating care
5	Annual commissioning plan development	Setting commissioning policy and frameworks, capitated resource allocation, strategic capital planning, financial planning and cost improvement schemes
6	Service design / transformation	Capitated resource allocation, drive system wide transformation, foster innovation and quality improvement,
7	Provider capacity development (stimulate the market)	Market shaping, risk/gain share mechanisms, enhancing patient choice and system resilience and demand management
8	Relationship and performance management	Financial incentives, agreeing and monitoring services, quality assurance, contract compliance monitoring, penalties and remedial actions
9	Strategic performance and outcomes review	System wide accountability, ICP performance assessment and monitoring criteria

Initial CCG suggestions of activities the BLMK CCG could do at scale – *for onward co-design & development as part of the Carnall Farrar work*.

BLMK Integrated Care System

Some of this work could be done at scale but all will need to be delivered across the continuum of care as described on slide 8

Commissioning Activity	Current Examples
Reducing variation in standards of care & sharing best practice	Long-term conditions – development of protocols and clinical guidance, health checks for people with SMI & LD, discharge protocols for Covid-19 patients, development of joint formulary
Securing transformation funding	Such as for eating disorders, key worker pilot for C&YP with LD, perinatal mental health, low calorie weight loss & diabetes prevention programme
Improving training and development for the primary care workforce	Working across CCG boundaries on GP training, training & development hub, expansion of nurse apprenticeship and nurse associated routes, support expansion and placement for NHS Graduate Management Scheme, build on development of advanced care practitioner roles across partner organisations, place based pilots for Health & Social care rotational apprenticeships for support worker roles
Commissioning of more 'specialist' services	Such as the special patient allocation scheme and commissioning stroke and cancer care as part of wider regional/sub-regional networks. Liaison with mental health New Care Models at regional level.
Taking on delegated commissioning functions from NHSEI	Delegated primary care commissioning allows more local engagement in commissioning & procurement decisions local governance arrangements, the CCG may receive additional delegated primary care commissioning functions from NHSEI such optometry and dental
Implementing national/regional programmes	Flu campaign, Local Maternity System, Transforming Care, Cancer screening programmes, e.g., FIT, Lung Health Checks, exemplar site for Personalised Care Programme
Responding to Covid-19	PPE stock management, swab-testing for key workers and care homes, IPC training, red & green sites, risk assessments for staff
Work with PCNs @ BLMK level	Care home work, training hub, digital transformation, access, frailty pathway, occupational health for practice staff, enhanced care models utilising new roles
Others	Social prescribing Link Workers (PCN level), digital access in care homes across BLMK, Wave 2 PHM development programme, Data sharing/Preparation of System Information Dashboards

Our system's journey towards strategic commissioning

BLMK Integrated Care System

Initial Strategic Commissioner & ICP design work

October-December 2019

Carnall Farrar supported ICS partners to review commissioning and define strategic commissioning activities and the role of ICPs

Principles for the Bedfordshire Care Alliance and the Milton Keynes Health and Care Alliance were agreed

Programme to Establish BLMK CCG

April 2020-September 2020

CCG Merger application submitted 30/09/20

Subject to approval in principle Oct 20

Co-design strategic commissioner TOM

September-October 2020

ICS partners supported by Carnall Farrar - co-design Strategic Commissioner Target Operating Model – the design will be informed by the vision for the 2 ICPs and will **define 'tactical commissioning' activities** that can transition to ICP providers

Agree strategic commissioner Target Operating Model and vision for 2 ICPs

Prepare to implement BLMK CCG TOM

October 2020– March 2021

CCG staff dedicated to working on the transition process and supporting ICP development

Initiate work for transfer of 'tactical commissioning' activities and resources from CCG to ICPs

Work with local authorities to enhance local joint commissioning arrangements if appropriate

BLMK CCG Established

April 2021 onwards

BLMK CCG established

Begin implementation of strategic commissioner TOM

CCG 'tactical commissioning' activities and resources transition to providers in ICPs following assurance processes and timeline agreed by all parties

Draft BLMK CCG Financial Strategy

Financial Priorities

- Investment in primary and community services growing faster than our allocation
- Investment in mental health services growing faster than the overall CCG allocation & addressing the historic shortfall in MK & Bedfordshire
- Making funding available to increase the number of planned operations & cut long waits
- Realising financial benefits from the merger and making more efficient and effective use of our collective resources. Primary care funding ring-fenced for 2 years
- Working with ICS partners to ensure a sustainable health and care system

Financial Principles

- Sustainable
- Efficient
- Effective
- Transformational/realistic
- Compassionate

How will the size and infrastructure of the CCG change to support local delivery?

As part of the NHS LTP requirements, the CCGs are required to reduce their running costs by 20% from a 2017 baseline. The 2019/20 running costs of the 3 CCGs were £20.8M and the required reduction in these costs for 2020/21 equates to £2.4M which is the **minimum** saving the merger programme needs to achieve in 2021/22 to enable the BLMK CCG to balance its budget. The table below describes the areas where savings have been identified. These savings are currently estimates as the detailed plans to realise these savings are being developed and are dependent on the merger application being approved in principle by NHSEI in October. We have identified additional savings opportunities which would not impact local delivery and are developing plans to realise these. Our intention would be to re-invest any additional savings achieved in front-line services.

Our staffing plans in the merged CCG structure are designed to protect locally facing staff resources for example local primary care teams. **As part of the Carnall Farrar work starting on 14 September we will work with ICS partners to identify commissioning activities and the associated resources that could transfer to partner organisations in the ICPs (tactical commissioning) as we implement strategic commissioning in due course**. It is expected therefore that the BLMK CCG will reduce in size over time as we implement the co-designed Target Operating Model for the strategic commissioner.

Pay	Estimated Total	Non-Pay	Estimated Total
Reductions in pay costs e.g. expected reduction in Governing Body roles; reduction in roles in central back office areas due to economies of scale & removal of duplication. Details of the new structure are in development & will be subject to formal staff consultation for 45 days Oct-Nov 2020.	£1.53M	Rationalise financial services provision	£0.23M
		Reduced travel & venue hire	£0.10M
		Reducing from 3 to 1 internal & external audit	£0.16M
		Rationalisation of estate (more significant reductions expected medium / longer term)	£0.10M
		Reduced IT expenditure due to reduced headcount	£0.05M
		Rationalisation of communications activity	£0.08M
		Rationalisation of BI provision	£0.15M
		TOTAL	£0.87M
			GRAND TOTAL £2.4M

There are also some costs of change associated with the merger programme such as programme team costs, costs related to the establishment of the new CCG's infrastructure and potential redundancy costs. These costs will impact in the current year and the first year of the new CCG.

Next Steps & Actions

- Carnall Farrar will support the CCGs and ICS Partners to co-design the Target Operating Model for strategic commissioning informed by the ICPs' visions, including which CCG activities could transition to ICP providers as 'tactical commissioning'. Timescale: 6 weeks mid-Sept-end Oct. Outcome will be reported to the ICS Partnership Board.

- The CCG will update its Case for Change and merger application documents in the light of feedback from ICS Partners prior to submitting its merger application on 30 September 2020

- The CCG will deliver on actions agreed in one-to-one meetings with partners and will continue to involve ICS Partners in the co-design of the BLMK CCG including:

    - the development of the CCG's values
    - appointments to the new Governing Body
    - development of the commissioning strategy and approach to outcomes based commissioning
    - progress with the identification of benefits from the merger programme

Partnership Board Forward Plan

			Forward Plan		
	5 August 2020	**15 September 2020**	**14 October 2020**	**November Date TBC**	
Strategy					
1	Recovery plan update	Cancer services	BLMK Workforce workstream	Estates	
2	Governance work update	Recovery Plan update	Digital		
3	BLMK Clinical Commissioning Group Case for Change	Population Health Management Wve 2	Clinical Leadership Group		
4		BLMK Clinical Commissioning Group	Flu update		
5		Clinical Leadership Group			
		People Plan			
Update reports					
	Update from Chair/Executive Lead	Update from Chair/Executive Lead	Update from Chair/Executive Lead	Update from Chair/Executive Lead	
	Update from ICPs	Update from ICPs	Update from ICPs	Update from ICPs	
	Performance and Finance report	Performance and Finance report	Performance and Finance report	Performance and Finance report	
	Update from workstreams	Update from workstreams	Update from workstreams	Update from workstreams	

Workstreams:
Cancer
Workforce
Estates

Digital
Population Health