

Bedfordshire Luton & Milton Keynes

ICS Portfolio Report

August 2025 Update

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ICS Portfolio Report



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The BLMK ICS Portfolio Report provides assurance on the delivery of key programmes and projects across Bedfordshire, Luton & Milton Keynes (BLMK) Integrated Care System (ICS). It is produced quarterly for the Integrated Care Board (ICB) Performance Executive, Chief Executive Officer (CEO) Group, Quality & Performance (Q&P) Committee, and ICB Board. A summary paper accompanies the BLMK Portfolio Report to the relevant forums, highlighting key observations, escalations, concerns, and any related remedial actions for Senior Responsible Owners (SROs) and programme leads.

In addition to the BLMK Portfolio Report being shared with key forums within BLMK ICS, it is available for anyone to read via the BLMK ICS Website - <https://blmkhealthandcarepartnership.org/publications/uncategorized/blmk-ics-portfolio-report/>

The BLMK Portfolio Report is generated by Verto 365. Verto 365 is a cloud-based project management and collaboration system used to manage our programmes and projects in real-time. If you have any questions on Verto 365 or would like access, please speak to the ICB PMO team (blmkicb.pmo@nhs.net).

The August 2025 BLMK Portfolio Report is comprised of the (1) **Hierarchy Diagrams**, (2) **Governance Reports**, (3) **Project Case Studies** and (4) **Project Measures**.

The BLMK Portfolio Report includes **Hierarchy Diagrams** for all 39 programmes and projects, offering a comprehensive overview of the work being carried out within the BLMK system. It highlights how these initiatives are interconnected, the scale of the work, and the status of each - whether on track, delayed, or behind schedule.

Additionally, the report provides detailed information on 39 priority programmes and projects through Project **Governance Reports**, which offer progress updates against planned objectives. These 39 programmes and projects reflect key initiatives from Bedford Borough, Central Bedfordshire, Luton, Milton Keynes, and the wider BLMK System Transformation.

In response to the ICB's Quality and Performance Committee's request for enhanced evidence of impact on our BLMK population, a new section to this report has been introduced showcasing case studies from previously delivered projects.

The August report now includes two **Improving Resident Experience & Population Health Case Studies**:

- Serious Mental Illness Health Checks
- Children & Young People CAMHS Access

Each case study outlines the original project objectives and includes Statistical Process Control (SPC) charts to demonstrate quantifiable improvements for BLMK residents.

Lastly, the report includes **Project Measures** for these 39 priority programmes and projects, enabling the BLMK system to better understand how the changes being implemented are contributing to improvements for residents.




If you have any questions regarding the Portfolio Report, please contact the ICB PMO - blmkicb.pmo@nhs.net

| | |
|-----|--|
| 39 | Total number of programmes/ projects |
| 29 | Total number of projects on-track |
| 5 | Total number of projects on track, however with some factors at risk of slipping |
| 4 | Total number of programmes/ projects that have some risks and delays |
| 1 | Total number of programmes/ projects off track |
| 111 | Total number of key measures identified |

Portfolios, Programmes and Projects

The BLMK Portfolio Report classifies all change initiatives into one of three categories: Portfolio, Programme, or Project. These categories are outlined in the hierarchy diagrams found between pages 6 and 10. Understanding this classification is crucial, as it determines how each change initiative will be managed and executed, as well as what can be expected in terms of inputs, outputs, and outcomes. The definitions for Portfolio, Programme, and Project are based on the Association of Project Management (APM) and are provided below:

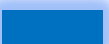
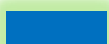


Association of Project Management (APM) Definitions of Portfolio, Programme and Project

| | |
|---|---|
|  | Strategic Grouping, Focus on maximising return on investment, Balanced mix of projects and programmes, Ongoing, Higher risk |
|  | Focus is on outcomes, Higher Complexity than projects, Longer Timescale, Higher Budget, Scope is less defined, Higher Risk |
|  | Focus is on outputs, Less Complex, Defined start and end dates, Agreed total budget, Defined Scope, Less Risk |

Complete, On-Track, Slipping or Slipped

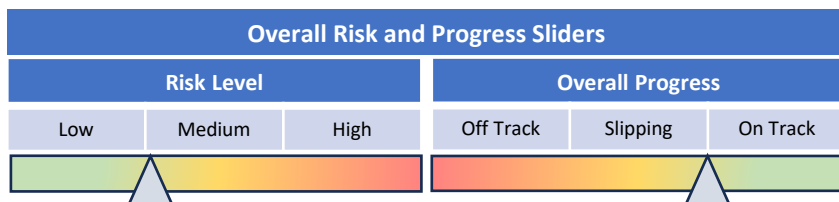
The BLMK Portfolio Report provides an update on the progress of each programme and project, indicating their status in relation to their plan. The progress can be classified as Complete, On-Track, Slipping, or Slipped (see the table below). This status is visually represented by a coloured glow around each programme and project on the hierarchy diagrams, which can be found between pages 6 and 10. The status is derived from the Overall Progress Status Box in Verto 365. Any remedial actions taken to address programmes or projects that are slipping or have slipped are detailed in governance reports and recorded on Verto 365

BRAG Glow – Status for the Programme or Project

| | | | | | | | |
|--|----------|---|----------|---|----------|---|---------|
|  | Complete |  | On-Track |  | Slipping |  | Slipped |
|--|----------|---|----------|---|----------|---|---------|

Overall Hierarchy Progress and Risk

Each hierarchy diagram in the BLMK Portfolio Report includes an overall progress and risk status. This assessment is based on the combined progress and risk evaluations of the individual programmes and projects within the hierarchy. The overall progress and risk status are displayed as coloured sliders at the bottom of each hierarchy diagram, which can be found between pages 6 and 10.



Hierarchy Diagrams

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| Bedford Borough Place | 6 |
| Central Bedfordshire Place | 7 |
| Luton Place | 8 |
| Milton Keynes Place | 9 |
| BLMK Wide | 10 |

Programme/ Project Governance Reports

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| Bedford Borough | BB - Integrated Neighbourhood Working | 11-15 |
| Bedford Borough | BB - Living Well - Increase the uptake of cervical screening programme appointments | 16-20 |
| Bedford Borough | BB - Living Well - Increase uptake of breast cancer screening programme | 21-24 |
| Bedford Borough | BB - Living Well - Increase uptake of breast cancer screening programme | 25-34 |
| Bedford Borough | BB Placed Based Plan Priorities – Ageing Well | 35-41 |
| Bedford Borough | BB Placed Based Plan Priorities – Starting Well | 42-46 |
| Central Bedfordshire | CB - Dementia Diagnosis and Prevention | 47-51 |
| Central Bedfordshire | CB – Falls Prevention Service (CBFPS) | 52-56 |

| Lead Team | Portfolio/Programme/Project | Page No. |
|----------------------|---|----------|
| Central Bedfordshire | CB - Health Inclusion Practitioners | 57-62 |
| Central Bedfordshire | CB – Hypertension Management in C Beds - SMI | 63-67 |
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| Luton | Luton 1 - Hypertension Learning and Action Network (Black African population) | 104-109 |
| Luton | Luton 2 - Hypertension Learning and Action Network (Indian population) | 110-115 |
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BLMK ICS Portfolio Report

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| BLMK Wide | BLMK - Fragile Services - Diagnostics | 144-149 |
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| BLMK Wide | BLMK – Hospital Opportunities Assessment | 155-158 |
| BLMK Wide | BLMK - Mental Health Transformation Programme | 159-172 |
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| BLMK Wide | Enhancing the Integration of IUC and Urgent Care with Primary Care and UEC | 179-184 |
| BLMK Wide | Improving Access to Pathway 2 Beds | 185-188 |
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| BLMK Wide | Musculoskeletal (MSK) | 194-196 |
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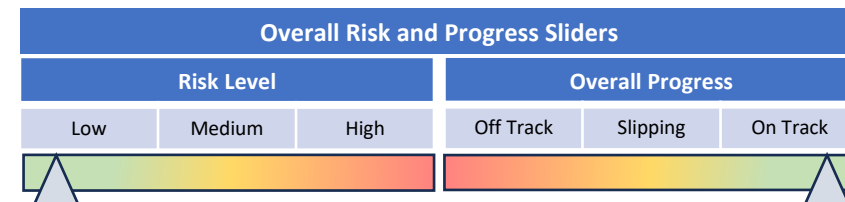
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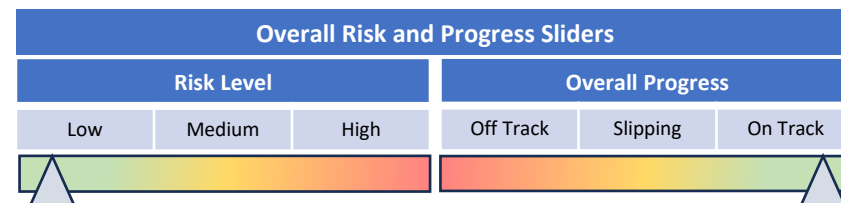
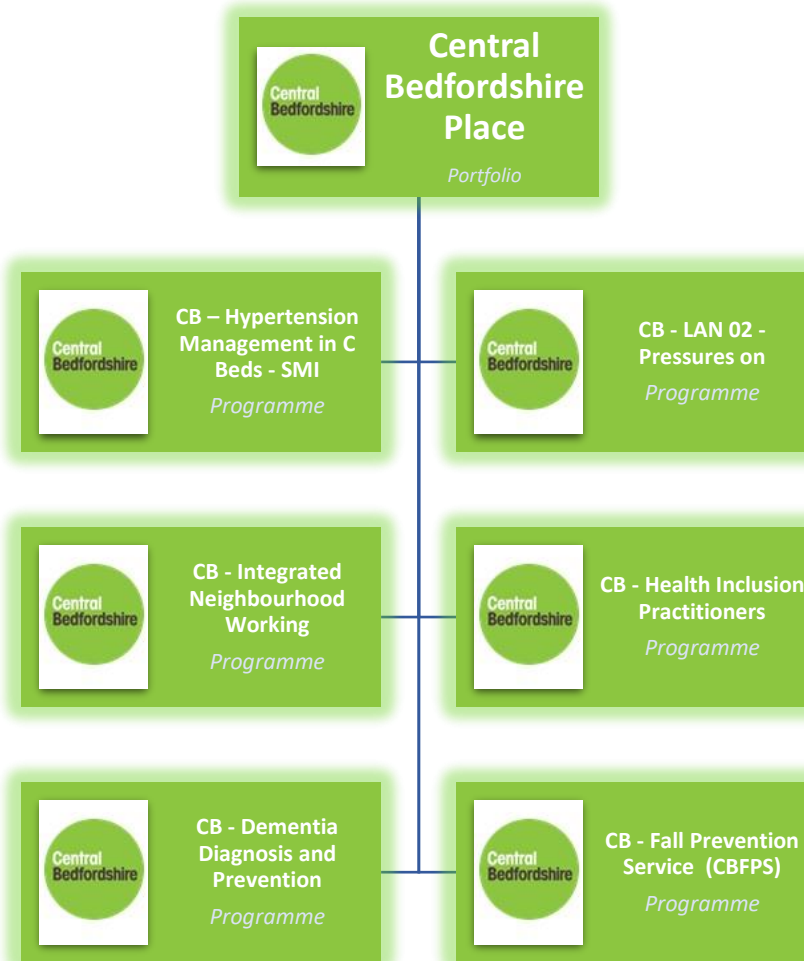
Improving Resident Experience & Population Health Case Studies

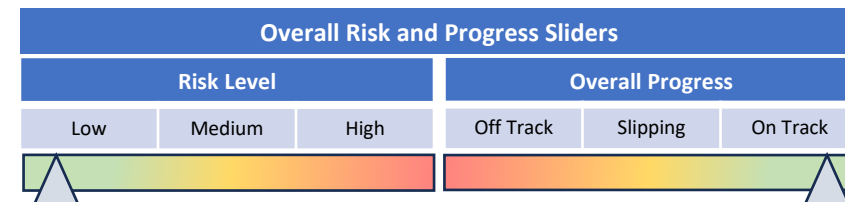
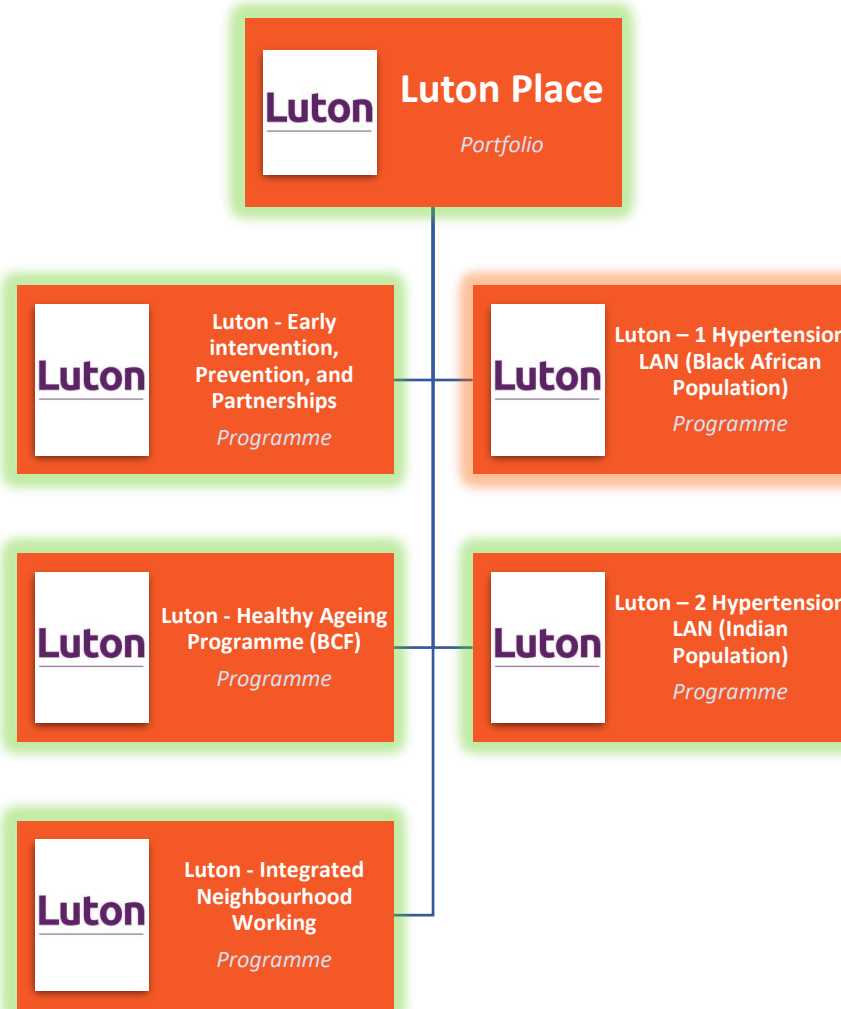
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| Serious Mental Illness Health Checks | 250 |
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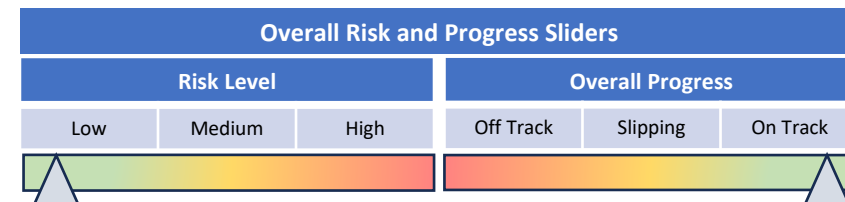
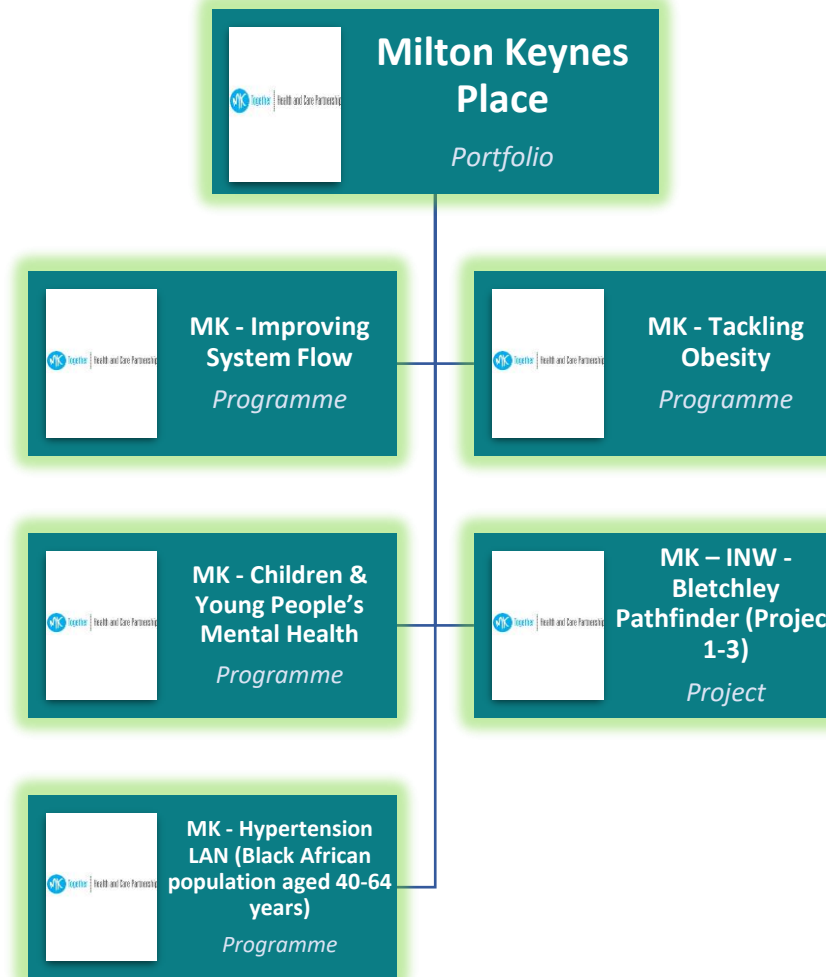
Programme and Project Measures

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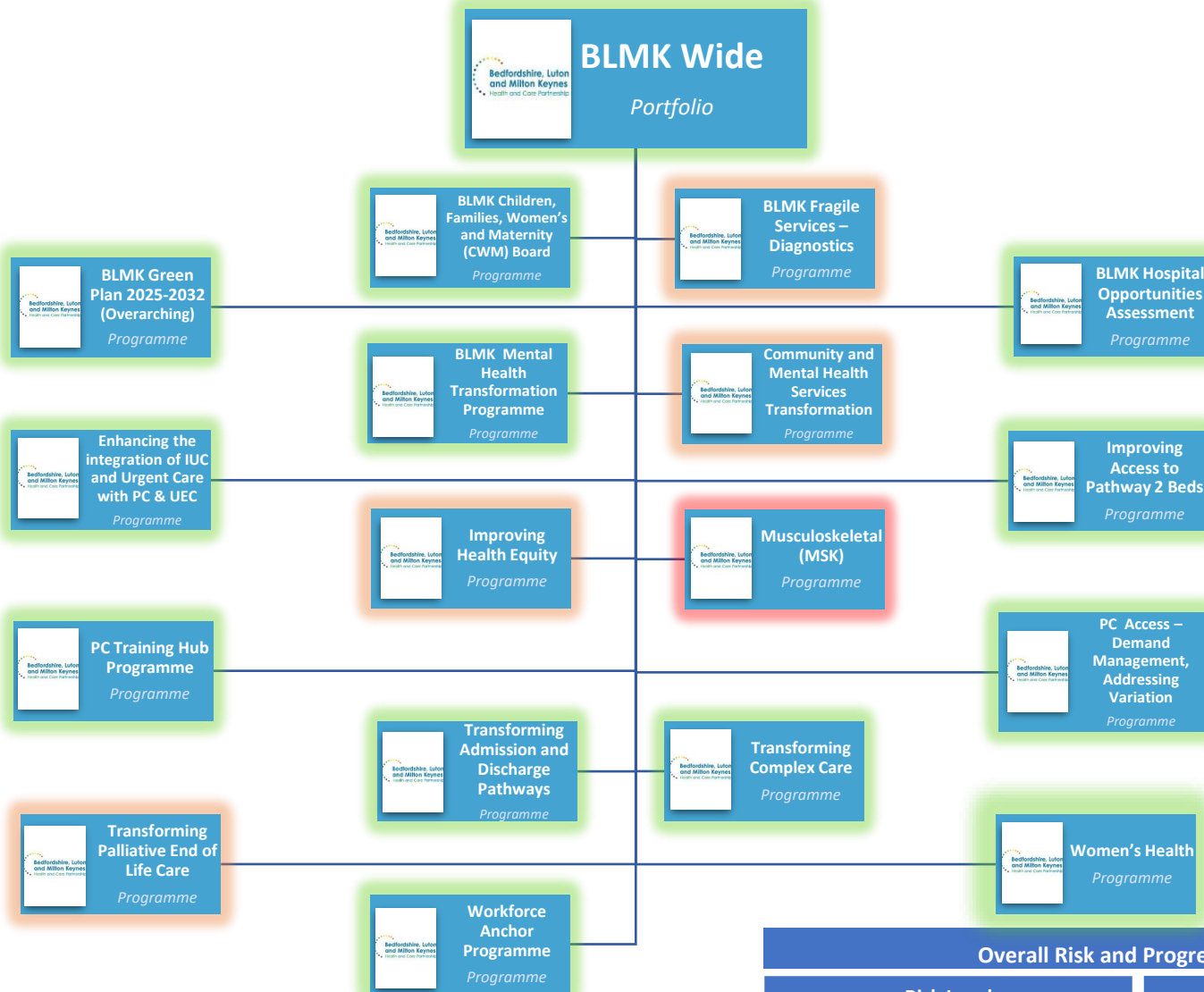






BLMK ICS Portfolio Report

BLMK Wide Hierarchy



Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000261 |
| Project Name | BB - Integrated Neighbourhood Working |
| Project Team | Bedford Borough Place Team |
| Project Aim | The purpose of Integrated Neighbourhood Working (INW) is to build Neighbourhood teams to centre care around people's needs by integrating healthcare, social care, public services, community groups and voluntary agencies to work across neighbourhoods. |
| Governance & Responsible Group | Bedford Borough has an INW Steering Group which reports to the Executive Delivery Group. |
| Geographical Footprint | Bedford Borough |

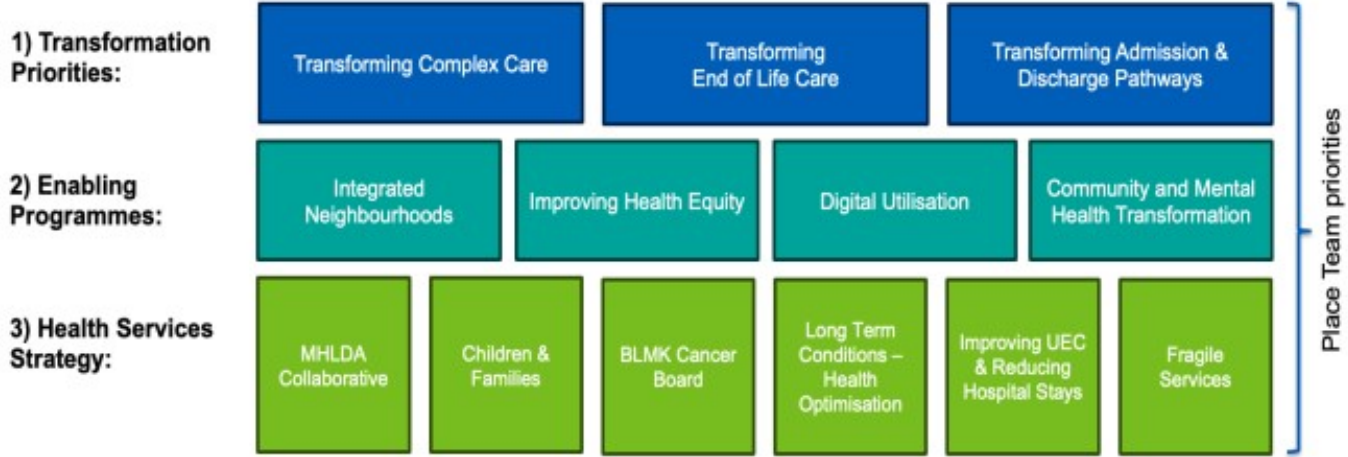
Project Team Members

| Name | Role |
|-------------------|-------------------|
| Alex Wrack | Programme Manager |
| Adele Slaney | Project Manager |
| Lorraine Kavanagh | Project Manager |
| Sarah Pearson | Project Manager |
| Duncan McConville | STT Senior Lead |
| Lucy Robertson | STT Team Member |

Project Status

| | |
|-----------------------------------|--|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | The work has started and is progressing as expected. |
| Project Maturity | 2.0 - Initiation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

Integrated Neighbourhoods: The Bedford Borough INW model currently includes a INW Steering group of professionals from across the Borough.

Community and Mental Health Transformation: We are working with ELFT who are setting up a pilot MDT called Working Together, based on the model they delivered in Central Bedfordshire.

More widely the place team are supporting a range of projects that will support elements of the system transformation priorities, such as the Better Care Find review.

Progress Update

| | |
|---|---|
| <p>Progress made in Previous Period</p> | <p>The INW Steering group membership continues to grow and invitations now go to circa 80 professionals, 20 organisations, attendance is steady at 25+ each meeting.</p> <p>The Health on the High Street model (now called Live Well Centre) - working with Public Health continues to progress with venues now being considered.</p> <p>Supporting ELFT colleagues with the set up of Working Together Group. Launch meetings scheduled for 12th, 19th 26th August to involve stakeholders and partner organisations.</p> <p>Updated neighbourhood health data shared in May 2025.</p> <p>Official launch of the first neighbourhood - Urban North East.</p> <p>The Bedford Hospital Acute Strategy for elderly care and frailty services was shared with the Steering Group and actions agreed for the next period.</p> <p>Continued to build on understanding of Urban South neighbourhood through LAN work, working closely with clinicians and patients from 3 practices.</p> <p>Fostering collaboration with VCSE organisations through the Age Care Technologies Pilot.</p> |
| <p>Progress to be made in Next Period</p> | <p>Continue to grow steering group (with people attending as needed).</p> <p>Start of Working Together Group (clinical MDTs) with DeParys Group practice on 1st September 2025.</p> <p>Develop learning from INW with wider cross-sector stakeholder group.</p> <p>Place team to explore how Comprehensive Geriatric Assessment (CGA) model work can be integrated into neighbourhood planning.</p> <p>Update from Bedford BC on establishment of a Cultural Compact with a Creative Health Working Group ready for launch of the Bedford Cultural Vision on 1 October 2025.</p> <p>Feedback to INW steering group on success of the Bedford Health Festival, targeting underrepresented communities with culturally sensitive activities.</p> <p>Place team to work with BeActive on 'ripple effect mapping' of Queens Park Pre-diabetes project.</p> <p>Feedback to INW steering group on success of the Queens Park Pre-diabetes pilot for Asian women.</p> |

| <h2>Tasks & Milestones</h2> | |
|--|---------------------|
| <p>Overall Tasks & Milestones Status</p> | <p>GREEN</p> |

Reason for Overall Tasks & Milestones Status All tasks and milestones have been met to date, we are still in the initiation stage.

| | Start Date | End Date | 2025 | | | | | | | | | | | | 2026 | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| BB INW Steering Group Meeting | | 28/05/25 | | ◆ | | | | | | | | | | | | | |
| Work with PHIU to get refreshed neighbourhood data. | 25/04/25 | 30/05/25 | ■ | | | | | | | | | | | | | | |
| Agree first neighbourhood to 'launch' with steering group. | | 12/06/25 | | | ◆ | | | | | | | | | | | | |
| BB INW Steering Group Meeting | | 25/06/25 | | | ◆ | | | | | | | | | | | | |
| BB INW Steering Group Meeting | | 23/07/25 | | | | ◆ | | | | | | | | | | | |
| BB INW Steering Group Meeting | | 27/08/25 | | | | | | ◆ | | | | | | | | | |
| BB INW Steering Group Meeting | | 24/09/25 | | | | | | | | ◆ | | | | | | | |
| Discussion and creation of 2025/26 goals. | | 01/10/25 | | | | | | | | | ◆ | | | | | | |
| Set up working group(s) to focus on delivering 2025/26 goals. | | 01/10/25 | | | | | | | | | ◆ | | | | | | |
| BB INW Steering Group Meeting | | 22/10/25 | | | | | | | | | ◆ | | | | | | |
| BB INW Steering Group Meeting | | 26/11/25 | | | | | | | | | | ◆ | | | | | |

Risks

| | |
|--------------------------------|--|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | Work is currently developing well with partners. Awareness that this is a complex programme of work with many competing priorities and areas of focus. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| Not having buy-in from all partners to develop neighbourhood working together (specific focus on first neighbourhood 'launch'). To mitigate this risk partners are part of deciding which neighbourhood to focus on at the steering group. | Yes | 5 |

Issues

| | |
|----------------------------------|---|
| Overall Issues Status | GREEN |
| Reason for Overall Issues Status | No significant issues to date and we are aiming to mitigate issues that may arise as the work progresses. |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|--|------------|--------------------|
| Capacity withing place team to launch neighbourhood and associated work. We will stagger the launch of each neighbourhood to manage the workload. | Yes | 9 |
| Effective measuring of impact of neighbourhood working. The place team will work with the STT to design measures as the work progresses. | Yes | 10 |
| The PCN and neighbourhood boundaries do not align. Mulitple practices will have to work with each other at neighbourhood level. The PCNs work well together - this will be opportunity for practices but they may need time/support. | Yes | 12 |

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000295 |
| Project Name | BB - Living Well - Increase the uptake of cervical screening programme appointments |
| Project Team | Bedford Borough Place Team |
| Project Aim | To increase uptake of cervical screening appointments in Bedford Borough. To reduce the number of women who develop invasive cervical cancer and reduce the number of people who die from it. |
| Governance & Responsible Group | Executive Delivery Group (EDG) |
| Geographical Footprint | Bedford Borough |

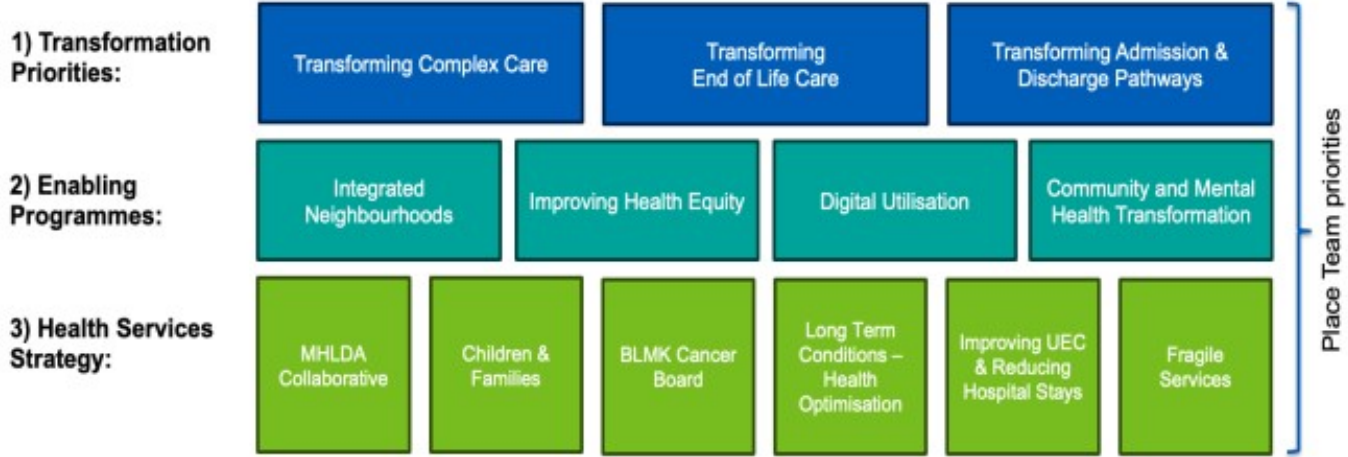
Project Team Members

| Name | Role |
|-------------------|-----------------|
| Adele Slaney | Project Manager |
| Alex Wrack | Project Manager |
| Lorraine Kavanagh | Project Manager |
| Sarah Pearson | Project Manager |
| Usha Panchal | Project Manager |
| Lucy Robertson | STT Team Member |

Project Status

| | |
|-----------------------------------|--------------------------------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Still in pre-planning/scoping stages |
| Project Maturity | 1.0 - Pre-Planning |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

This priority aligns to the 'Enabling Programmes' of Integrated Neighbourhoods & Improving Health Equity. It also aligns to the 'Health Services Strategy' BLMK Cancer Board.

Progress Update

Increase the uptake of cervical screening programmes has been confirmed and agreed for inclusion in the Bedford Borough Place Based Plan 2025 - 2030 by the EDG on 12th May 2025.

Bedford Borough PCNs were successful in their **BLMK Cancer Inequity System Clinical Bid Application**.

As a Place they will target Cancer Screening and Early Diagnosis Through Community Outreach and Case Finding in Bedford.

This project aims to address cancer inequalities through a three-pronged approach that targets under-screened and high-risk populations in Bedford. It aligns with the Core20PLUS5 framework and ICB strategies by focusing on populations with poor screening uptake and those facing access barriers.

Part of this project includes Community Outreach Cancer Screening Drop-ins

We will run pop-up cancer education and screening awareness sessions in trusted community venues, including:

- Queen's Park and Kempston Gurdwaras
- Christ the King Church (East Bedford monthly 'drop in')

These drop-ins will focus on raising awareness of bowel, cervical, and lung cancer screening. The sessions will be tailored for accessibility, culturally appropriate, and co-delivered with community partners to encourage participation from underserved groups.

CAJA:

The initial pilot project with CAJA to encourage uptake of cervical screening, using behavioural change theories, in underserved communities is now rolled out to all practices in BLMK. Information was provided to practices at the 22nd July Practice Managers Forum:

- **Cervical Screening Uptake Toolkit:** Naisha Henry and Andrew Dewis introduced a toolkit designed to improve cervical screening uptake using behaviour change techniques. They shared positive results from a trial in three GP practices and encouraged practices to attend upcoming webinars to learn more about the toolkit and its implementation.
 - **Toolkit Introduction:** The toolkit includes templated non-responder letters, text messages, conversational scripts, and social media posts to encourage screening participation.
 - **Trial Results:** The toolkit was trialled in three GP practices, resulting in an average 38% increase in cervical screening uptake over a 10-week period. This demonstrates the effectiveness of the toolkit in improving screening rates.

Webinar Invitation: Practices are encouraged to attend upcoming webinars to learn more about the toolkit and its implementation. The webinars will provide background information, detailed instructions, and support for integrating the toolkit into existing processes.

Progress made in Previous Period

| | |
|------------------------------------|--|
| Progress to be made in Next Period | <p>Continue to work with colleagues across health and social care to agree measurable outcomes.</p> <p>Continue to scope how the place team could provide support or implement any new projects of work to increase screening uptake.</p> <ul style="list-style-type: none"> •Work with community leaders, VCSE, and faith groups to raise awareness of the importance of screening in underrepresented populations. •Cancer Screening Services involved in creating local social media resources to promote cancer screening participation under the campaign ‘Screening Saves Lives’. •Increasing Cervical Screening Uptake using Behavioural Science toolkit to be implemented by GP Practices across BLMK. •Supporting/raising awareness of in-person screening events. •Deliver messages through social media and trusted community contacts on informal channels like WhatsApp. |
|------------------------------------|--|

Tasks & Milestones

| | |
|--|--------------------------|
| Overall Tasks & Milestones Status | GREEN |
| Reason for Overall Tasks & Milestones Status | Pre-planning and scoping |

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|--|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Resource pack to improve cervical screening uptake share with Practices | | 23/07/25 | | | | | ◆ | | | | | | | | | | |
| Mapping current screening activity | 03/04/23 | 01/12/25 | | | | | | | | | | | | | | | |

Risks

| | |
|--------------------------------|---|
| Overall Risks Status | AMBER |
| Reason for Overall Risk Status | <p>The initial pilot project secured by the place team did not continue with a Bedford practice and therefore learning has not been gathered locally - hopefully learning from other practices/areas can be transferred. July Update: The pilot concluded and will be rolled out to all practices in BLMK, learning can start to be gathered locally.</p> <p>There are a number of priorities and the place team have not been able to fully focus on this one yet.</p> |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| Showing progress in this area, particularly with underserved groups. | Yes | 12 |

Issues

| | |
|----------------------------------|---|
| Overall Issues Status | AMBER |
| Reason for Overall Issues Status | The main issue currently is staff capacity to dedicate time to this priority - we plan to focus on this area in the next quarter. |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000296 |
| Project Name | BB - Living Well - Increase uptake of breast cancer screening programme |
| Project Team | Bedford Borough Place Team |
| Project Aim | <ul style="list-style-type: none">Increase the uptake of breast cancer screening programmes |
| Governance & Responsible Group | Executive Delivery Group (EDG) |
| Geographical Footprint | Bedford Borough, BLMK System |

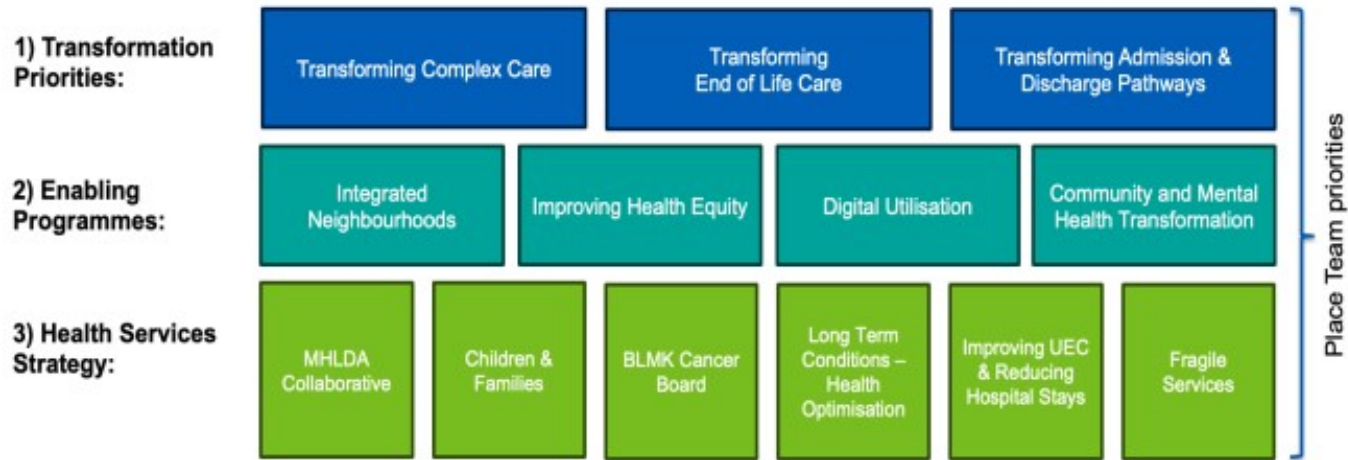
Project Team Members

| Name | Role |
|-------------------|-----------------|
| Adele Slaney | Project Manager |
| Usha Panchal | Project Manager |
| Alex Wrack | Project Manager |
| Lorraine Kavanagh | Project Manager |
| Sarah Pearson | Project Manager |
| Lucy Robertson | STT Team Member |

Project Status

| | |
|-----------------------------------|--|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | <p>Screening Projects are being scoped as expected.</p> <p>Led by the place team, an information video has been created in partnership with Fujifilm and Primary Care to promote breast cancer screening and is due to launch shortly.</p> |
| Project Maturity | 3.0 - Implementation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

The Increase uptake of Breast Screening project within the BB Living Well priority aligns to the 'Enabling Programmes' of Integrated Neighbourhoods and Improving Health Equity. It also aligns to the 'Health Services Strategy' BLMK Cancer Board.

The project seeks to transform uptake of screening provision to enable earlier diagnoses, prevention of extended medical need and prevention of death from breast cancer. It improves health equity as we seek to engage with underserved communities where uptake is poor and directly affects outcomes relating to the BLMK early cancer prevention programme of work.

Progress Update

Progress made in Previous Period

Breast Screening Uptake Campaign You Tube videos were shared with Practices and PCNs and INW Steering Group Members

- Video added to YouTube <https://youtu.be/CQJu2INfiYU> and <https://youtu.be/p1D6CjDHihM>
- Videos continue to be shared and re-shared.

| | |
|------------------------------------|---|
| Progress to be made in Next Period | <p>Working with colleagues across health and social care to agree measurable outcomes of improvement for each focus area.</p> <p>Work with community leaders, VCSE, and faith groups to raise awareness of the importance of screening in underrepresented populations.</p> <p>Cancer Screening Services involved in creating local social media resources to promote cancer screening participation under the campaign 'Screening Saves Lives'.</p> <p>Ensuring GPs and social prescribers are linked into local and national indicatives. Oversight of call and recall services.</p> <p>Supporting/raising awareness of in-person screening events.</p> <p>Deliver messages through social media and trusted community contacts on informal channels like WhatsApp.</p> <p>Monitoring uptake to identify low-coverage areas and targeting interventions with ICB, NHS England, and VCSE partners.</p> |
|------------------------------------|---|

Tasks & Milestones

| | |
|--|--|
| Overall Tasks & Milestones Status | AMBER |
| Reason for Overall Tasks & Milestones Status | The videos have been completed but unable to download due to size of file. Seeking advice from Comms and HBL |

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | |
| Source content, presenters and provider of filming | 03/02/25 | 30/05/25 | | | | | | | | | | | | | | |
| Share video with partners | | 30/05/25 | | ◆ | | | | | | | | | | | | |

Risks

| | |
|--------------------------------|--|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | There are currently no risks associated with this project. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-----------|-----------|------------------------------|
| | | |

Issues

| | |
|----------------------------------|---|
| Overall Issues Status | AMBER |
| Reason for Overall Issues Status | There is a potential issue with sharing the information video but this should be resolved asap. |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000159 |
| Project Name | BB - Living Well - Learning & Action Network - Improve CVD Disease Prevention & Management |
| Project Team | Usha Panchal, Lorraine Kavanagh, Ellen Heaney, Anita Powell, Kirstin Frost, Danielle Pulley, John Joseph, Kofi Acheampong, Shamaine King, Sylvia Genus-Turner, Racheal Ragoonan, Bola Dada, Garry Ayton, Ian Stewart, Kan Sivasoruban, Monica Ngoshi, Betty Nnadi, Gogo Abbey |
| Project Aim | <ul style="list-style-type: none"> • By the end of the Heart Health project in May 2026, 80% of the Black African population, aged 40-64, who have a diagnosis of hypertension alone, in the Urban South neighbourhood (Cauldwell, Kempston, and Kingsbrook wards) and are registered with one of the three practices serving this area (London Road Surgery, Cauldwell Medical Centre and King Street Surgery) will achieve a blood pressure reading of below 140/90 mmHg. • By the end of the Heart Health project in May 2026, 80% of the Black Caribbean population, aged 40-64, who have a diagnosis of hypertension alone, in the Urban South neighbourhood (Caudwell, Kempston, and Kingsbrook wards) and are registered with one of the three practices serving this area (London Road Surgery, Caudwell Medical Centre and King Street Surgery) will achieve a blood pressure reading of below 140/90 mmHg. <p>Potential to expand the scope of the project cohort to include patients with comorbidities (first in the Urban South neighbourhood), then scaling further to other neighborhoods (outside the Urban South), and then beyond to the general population.</p> |
| Governance & Responsible Group | Executive Delivery Group |
| Geographical Footprint | Bedford Borough |

Project Team Members

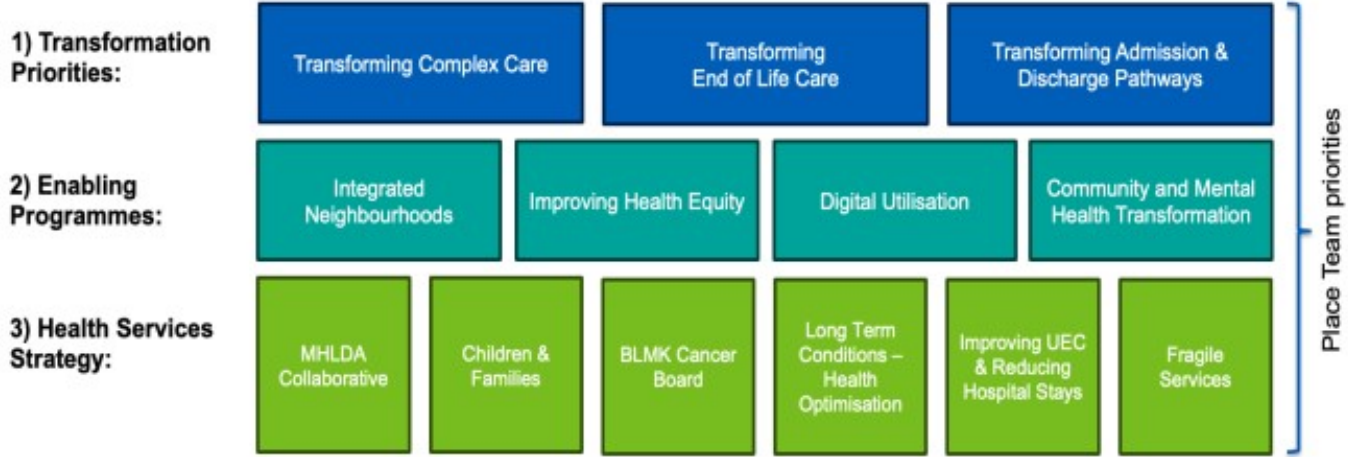
| Name | Role |
|-----------------|---------------------|
| Brenda Carson | Improvement Manager |
| Angela Zambeaux | Improvement Manager |
| Lourena Mendes | Improvement Manager |
| Shelby Reed | Improvement Manager |
| Lourena Mendes | Improvement Manager |

| | |
|-----------------------|--------------------------|
| Lorraine Kavanagh | Project Manager |
| Usha Panchal | Project Manager |
| Adele Slaney | Project Manager |
| Sarah Pearson | Project Manager |
| Alex Wrack | Project Manager |
| Ellen Heaney | QI Coach |
| Chloe Stibbs | QI Coach |
| Julia Robson | QI Observer |
| Tom May | QI Observer |
| Joyce Baskerville | QI Observer |
| Sarah Watts | QI Observer |
| Balraj Singhrai | QI Observer |
| Noeleen Mcloughlin | QI Observer |
| Rehan Tariq | QI Observer |
| Kamini Patel | QI Observer |
| Danny Karystinos | QI Observer |
| Sandra Vanreyk | QI Observer |
| Faith Haslam | QI Observer |
| Kaysie Conroy | QI Observer |
| Charlie Goodwin Smith | Senior Responsible Owner |

Project Status

| | |
|-----------------------------------|------------------------------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Project is on track as per update. |
| Project Maturity | 3.0 - Implementation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

1. Transformation Priorities:

Reducing Admissions and Readmissions: Early hypertension control prevents avoidable admissions of stroke, heart failure, kidney disease, and hypertensive emergencies.

2. Enabling programmes:

Integrated Neighbourhood working: Based in Urban South Neighbourhood, collaborating with practices, community pharmacy, social prescribers, residents, faith and community leaders.

Health Inequalities: Targeting a population with known health inequalities in hypertension outcomes.

Digital Enablement: Use of multi-modal messaging, self-booking links, Holly Health App, and patient engagement portal, e.g., Accurx for easier referral to Community Pharmacy for 24hr Ambulatory Blood pressure monitoring service and New Medicines Service.

3. Health Service Strategy:

Long-term Conditions: Hypertension is a major long-term condition identified by BLMK as poorly managed, and therefore, this project aims to close the gap and increase management of hypertension

Progress Update

Summary of August Activities & Outcomes

Results of engagement strategy. Please find our 'Template' for S1 (one of our change ideas) uploaded to the files.

London Road Hypertension Management Table (Surgery-reported outcomes)

Category Count % Notes Patients with Hypertension (Nov 24) 52 100% Initial cohort Managed to Target (Nov 24) 19 37% Pre-intervention Not Managed to Target (Nov 24) 33 63% Pre-intervention Engaged & Now at Target 19 — From the 33 not at the target Treatment Plan in Place 6 — Under active management Appointment Cancelled 1 — Yet to rebook Did Not Attend 5 — Follow-up needed No Engagement 5 — No contact Newly Identified Patients 3 — Added to the cohort Total Managed to Target (Aug 25) 52 73% Based on the Nov 24 cohort Managed to Target incl. New Patients (Aug 25) 55 69% Updated cohort

- Results of the seven modal engagement strategies were very positive: 28 of 33 people identified as having a high BP recorded in the system for more than 12 months have engaged with the surgery, 84% of those originally identified as not managed to target, which is a significant improvement in engagement rates of which 69% have continued to engage after the initial contact.
- London Road: Initial cohort of 52 patients with hypertension (Nov 2024). Post-intervention: 69% (55 patients incl. new ones) - 32% improvement.
- From the original cohort of 52 patients, a total of 38 patients were not managed to target: 73% - a 36% improvement.
- Only 5 patients remain unengaged: final letters pending approval. DNA and final letters are being revised to include opt-out options.
- 6 patients are being actively managed

King Street Hypertension Management Table (Surgery-reported outcomes)

Category Count % Total Patients Initially Identified 37 100% Initially Managed to Target (Nov 24) 10 27% Initially, Not Managed to Target 27 73% Appointments Booked via Engagement 16 Did Not Attend 3 Recontacted and booked 1 DNA Again 2 Served Under BEDOC 2 Not Engaged 9 Engaged 14 Engaged and Managed to Target (Aug 2025) 4 (newly managed to target) Engaged with Treatment Plan 10 Under active management Total Managed to Target (Pre + Post) Aug 2025 14 38%

- Results of the seven modal engagement strategies were very positive: 16 of 27 people identified as having a high BP recorded in the system for more than 12 months have engaged with the surgery, 59% of those originally identified as not managed to target, of which 52% have continued to engage with the surgery after the initial contact.
- King Street: Initial cohort of 37 patients. Post-intervention: 14 patients (37.84%) were now able to target—resulting in a 10.81% improvement.
- Patients remain unengaged; voicemail and non-engagement letters trialed.
- 10 patients are being actively managed

For both surgeries, most people responded to the second text by the second week. This method of engaging patients who had not previously been engaged is having a positive effect, with London Road doing remarkably well in initially engaging 84% of the cohort who had not been employed for over a year.

Data Reporting & Searches

AGEM is in the process of building searches to enable us to capture this information electronically to prepare run charts – hopefully, this will be available for the next report

Group Clinics – Cauldwell

We're introducing group consultations at Cauldwell, where patients with similar conditions will meet together with a clinician—either in person or via video. This model promotes more efficient care delivery, enhances patient engagement, and supports improved health outcomes.

The clinics will be led by Gogo and Sylvia, with support from Victoria (Practice Manager), who is helping secure buy-in from the surgery and coordinating logistics.

Key elements of the initiative include:

- **Person-centred care** and co-production with patients
- **Accredited training** and tailored implementation support provided by ELC
- **Training completed** before clinic launch
- **Dedicated Teams Channel** established to share learning materials and facilitate collaboration
- **Regular meetings** to be scheduled in diaries to maintain momentum and support

Progress made in Previous Period

Holly Health APP

We're partnering with Holly Health to tailor their behavioral change app for Black African and Black Caribbean residents with high blood pressure. By offering the app to both this cohort and a control group of non-Black residents with hypertension, and collecting feedback through questionnaires, we aim to help Holly Health make the app more culturally sensitive and effective for this cohort.

- Targeting Black African and Caribbean cohorts (~150 patients per practice).
- A control group from the general population for comparison.
- Aim: culturally sensitive behavioral change support.
- Links from King Street Surgery were sent out on 14th August 2025, London Road on 18th August & Cauldwell on 19th August.

Updated numbers are below.

Signup Link **Signed up Completed 'behavioural health check' and set up personalised habits (Onboarded)** 1 week feedback surveys completed

King Street

28 20 1

London Road

23 15 0

Cauldwell

0 0 0

Faith Leaders Meeting

- Agreed to broaden focus beyond hypertension to include PSA testing, sickle cell, maternal deaths, breast screening, racism, and digital inclusion.
- Public Health has contacted us to help connect them with faith leaders and community leaders to set up focus groups and listening forums, aiming to improve the uptake of flu vaccinations among 2-3-year-olds in Bedford Borough.
- Some residents may find the council's launch of the Ethnic Minorities Forum confusing, so it's essential to define clear and separate roles for each body.
- Concerns about the nightclub venue due to alcohol.
- Proposal to move to the council building (free Saturday parking).
- Cauldwell Health Centre offered as an alternative venue.

ACCURX Referral Service for ABPM

I have been working closely with Mark Peedle to secure the procurement of AccuRx for BLMK.

Once we have clarity, we will launch a pilot in collaboration with selected community pharmacies and GP practices to streamline referrals for Ambulatory Blood Pressure Monitoring (ABPM). Leveraging the free, web-based version of AccuRx for Community Pharmacists, GPs will be able to refer patients seamlessly. At the same time, pharmacists can input BP readings directly into patient records using read-coded entries. This approach not only improves data accuracy but also saves valuable GP time.

ABPM is widely recognised as the gold standard for blood pressure measurement. This initiative is designed to enhance patient choice and alleviate pressure on primary care services.

Pilot Overview:

- Launched with four community pharmacies and three GP practices
- Enables seamless referrals and direct BP data entry into patient records.

I'll be supporting Lorraine Kavanagh, who will lead the project when we begin.

Referrals protocol will be shared with other places when appropriate.

Community Events & Outreach

See the infographic **attached to the files**, which outlines all Community awareness and engagement and faith leaders' events.

Also uploaded a leaflet of NEW START - principles of living well, as suggested by one of our faith leaders at one of our faith leaders' meetings, and mentioned in the infographic.

Next Steps

Planned Actions for DNA & Non-Engaging Patients

- All letters have been **approved by the group**. The strategy now includes **site-specific trials**:
Letter/Action Target Group Location Purpose & Content Letter/Action Target Group Location Purpose & Content **DNA Letter** Patients who missed appointments Both sites Encourage rebooking, explain the importance of attendance, and the waste of an appointment that could be offered to another person. **Non-Engagement Letter Final letter** No response to outreach **London Road** Explain clinic benefits, offer contact options, and include an opt-out to clarify no further contact. **Voicemail Trial** Unanswered phone calls **King Street** Leave a clear message with callback info; document the attempt. **Sending a follow-up text** Unanswered phone calls **London Road** Leave a clear text message with info for booking **Occupier Letter** No contact after 3 months or FY end Both sites Confirm residency, help with surgery update records.

Group Clinics

- Hold logistics meeting with all stakeholders. Orientation of the platform and training meeting to be held on 19th August
- Plan **PCN-wide rollout** using remaining licenses in the new year, dependent on who the new provider for Cauldwell is.

Holly Health App

- Launch email outreach
- Monitor uptake and feedback via questionnaires.

Faith Leaders & Community Engagement

- Schedule next meeting with expanded health topics.
- Collaborate with the council's Ethnic Minorities Forum.
- Confirm new venue (council building or Cauldwell Health Centre).
- Ensure accessibility and neutrality.

ACCURX Referral Service for ABPM

- Prepare to launch once procurement is in place
- Plans to roll out to all other interested community pharmacies in Bedford that provide the service

Progress to be made in Next Period

| | | | | 2025 | | | | | 2026 | | | | | |
|------------------------------|------------|----------|-----|------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|
| | Start Date | End Date | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Cauldwell MC - Group Clinics | 01/07/25 | 31/12/26 | | | | | | | | | | | | |

| Risks | |
|--------------------------------|---|
| Overall Risks Status | AMBER |
| Reason for Overall Risk Status | Generally, the project is progressing well. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| Losing resident participant(s). | Yes | 9 |
| Securing Funding | Yes | 3 |
| Procurement of Patient Engagement Portal e.g. Accurx | Yes | 16 |
| Patient engagement | Yes | 16 |
| Engagement of wider staff at the surgeries | Yes | 9 |
| Building of searches in SystmOne by AGEM | Yes | |
| Holly Health App roll out | Yes | |
| Group Clinics | Yes | 16 |
| Faith Leaders Meetings | Yes | |

| Issues | |
|----------------------------------|--------------------------------|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | No issues currently identified |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000162 |
| Project Name | BB - Placed Based Plan Priorities – Ageing Well |
| Project Team | Bedford Borough Place Team |

| | |
|--------------------------------|---|
| Project Aim | <p>The project aims have been revised with EDG approval 12.05.25 to</p> <ul style="list-style-type: none"> Support people over 65 to maintain independence - pilot Age Care Technologies (ACT) <p>ACT project objectives:</p> <ol style="list-style-type: none"> To improve the health, wellbeing and independence of a targeted cohort of older people living in areas of deprivation using the Age Care Technology Assess and Connect model. To work in partnership with VCSE to design and deliver a local approach to implementing the Age Care Technology Assess and Connect model. To build a directory of services and support for older people with a focus on the VCSE sector To connect older residents to community resources, services and support to improve their health and wellbeing To measure the impact of the Age Care Technology Assess and Connect tool in the targeted cohort. To evaluate the impact of the Age Care Technology Assess and Connect model for wider adoption in BLMK. To quantify the demand for VSCE interventions to inform future commissioning decisions <ul style="list-style-type: none"> Keeping older people well during winter <ol style="list-style-type: none"> Increased referrals into the BHBH service and identifying eligible residents receiving the medium sized measure installs. Reduce isolation, increase awareness and use of Welcoming Spaces. Increase uptake of flu, covid and routine vaccinations in older people Raise awareness of the Falls Prevention Service and how people can reduce the risk of falls. |
| Governance & Responsible Group | EDG |
| Geographical Footprint | Bedford Borough |

Project Team Members

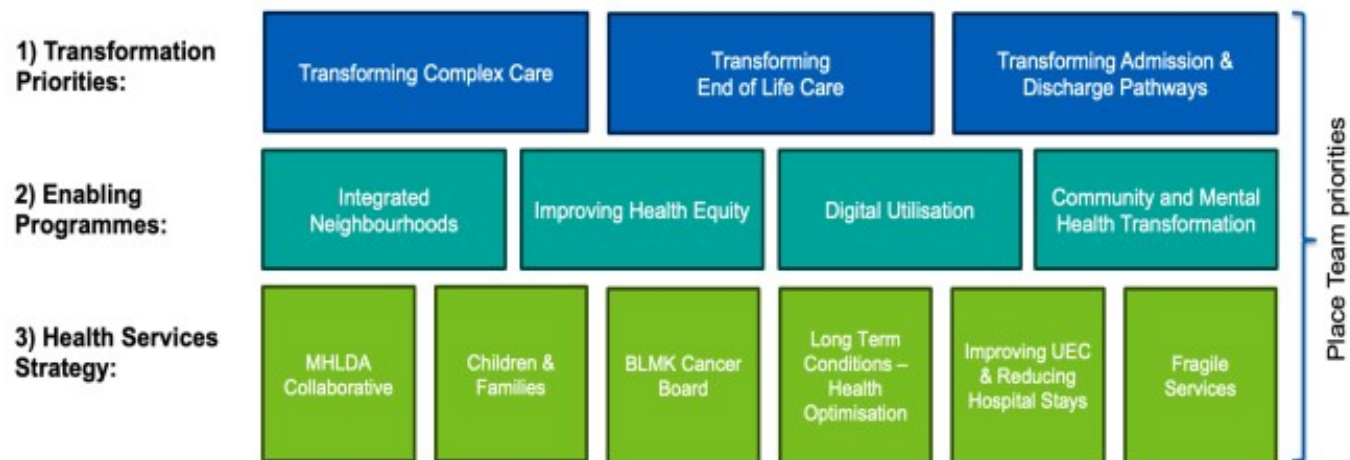
| Name | Role |
|-------------------|-----------------|
| Lorraine Kavanagh | Project Manager |
| Usha Panchal | Project Manager |

| | |
|----------------|--------------------------------|
| Alex Wrack | Project Manager |
| Sarah Pearson | Project Manager |
| Adele Slaney | Project Manager |
| Lucy Robertson | Transformation Support Manager |

Project Status

| | |
|-----------------------------------|---------------------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Each area is progressing. |
| Project Maturity | 2.0 - Initiation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

The BB-Ageing Well programmes of work align to the enabling programmes of Integrated Neighbourhoods, Improving Health Equity, Digital Utilisation.

Progress Update

Progress made in Previous Period

ACT project :

- 15/07 2nd Steering Group Meeting
- Confirmation of the 3 Demonstrator Sites: Putnoe Health Centre, Linden Road, Queens Park
- Agreement on Cohort identification criteria, assessment type and target numbers
- Draft DPIA reviewed by DPO
- Draft DoS shared with Project Team, Putnoe & Linden Road
- Draft Posters shared for review
- Follow-up meetings with Putnoe & Linden Road
- Escalation Pathways shared with Putnoe & Linden Road
- Follow-up meeting with VCSE regarding support for Queens Park

- Development of the Bedford platform

Keeping Older People well during winter

- New contract awarded to Better Housing Better Health (National Energy Foundation) in June 2025. The commissioned service offer includes Warm and Well Assessments plus grant funded medium-sized measures e.g. loft and cavity wall insulations, for low-income households and those in receipt of benefits who also have a health condition that is adversely affected by the cold/ households with a disability
- New joint local authority (Bedford Borough and Central Bedfordshire Councils) social prescribing service commissioned and started on 1 April 2025.
- Performance monitoring template agreed
- Welcoming Spaces continue to be promoted on the Bedford Borough Council website
- Public Health targeted flu campaign in under represented groups

Progress to be made in Next Period

Support people over 65 to maintain independence - ACT Project

- 19/08 3rd Steering Group Meeting
- Meeting with VCSE to confirm Trusted Partner to support Queens Park 11.09.25
- Update to DoS to enable upload to platform
- Update to DPIA to incorporate feedback from DPO
- Confirmation of Escalation Pathway focal points per site
- Update to the SystemOne Query to be run by each practice
- Confirmation on engagement offer text wording
- PPG for Putnoe Health Centre and Linden Road
- Practice Posters to be customised for Bedford
- Development of the Bedford platform

Keeping older people well during winter

- Continued delivery of Warm and Well Assessments to all Bedford Borough households
- Offer medium-sized measures to qualifying households
- Continued promotion of Better Housing Better Health offer, including to primary care
- Quarterly performance/ progress meetings
- Raising awareness of the Falls Service amongst high risk groups

Tasks & Milestones

| | |
|--|-----------------------------------|
| Overall Tasks & Milestones Status | GREEN |
| Reason for Overall Tasks & Milestones Status | Projects progressing as expected. |

| | Start Date | End Date | 2025 | | | | | | | | | | | | 2026 | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Working with colleagues across health and social care to agree measurable outcomes of improvement for each focus area | 01/04/25 | 30/04/25 | █ | | | | | | | | | | | | | | |
| Approval of pilot funding | | 15/05/25 | | ◆ | | | | | | | | | | | | | |
| Scoping work to identify options for target cohort | 30/05/25 | 30/05/25 | | █ | | | | | | | | | | | | | |
| Agree role and membership for steering group and working group | 01/05/25 | 31/05/25 | | █ | | | | | | | | | | | | | |
| Comms Plan | 18/08/25 | 12/09/25 | | | | | | █ | | | | | | | | | |
| Significant risk pathways developed | 01/08/25 | 12/09/25 | | | | | | █ | | | | | | | | | |
| Build local Directory of Services (DOS) | 04/08/25 | 30/09/25 | | | | | | █ | | | | | | | | | |
| VSCE collaboration | 04/08/25 | 30/09/25 | | | | | | █ | | | | | | | | | |

| Risks | |
|--------------------------------|-------------------------------------|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | No significant risks at this stage. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|---|-----------|------------------------------|
| To show value of Age Care Technology pilot | Yes | 8 |
| To secure primary care engagement and capacity | Yes | 8 |
| Take up of the ACT offer by residents | Yes | 10 |
| Production of SystMone Report for practices to identify target cohort | Yes | 8 |

| Issues | |
|----------------------------------|--------------------------------------|
| Overall Issues Status | GREEN |
| Reason for Overall Issues Status | No significant issues at this stage. |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|---|------------|--------------------|
| Langauge challenges may impact engagement | Yes | 8 |

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000161 |
| Project Name | BB - Placed Based Plan Priorities – Starting Well |
| Project Team | Bedford |
| Project Aim | <ul style="list-style-type: none">• Reduce childhood obesity and increase physical activity• Improve children’s oral health• Increase uptake of antenatal and childhood immunisations |
| Governance & Responsible Group | Executive Delivery Group (EDG) |
| Geographical Footprint | Bedford Borough |

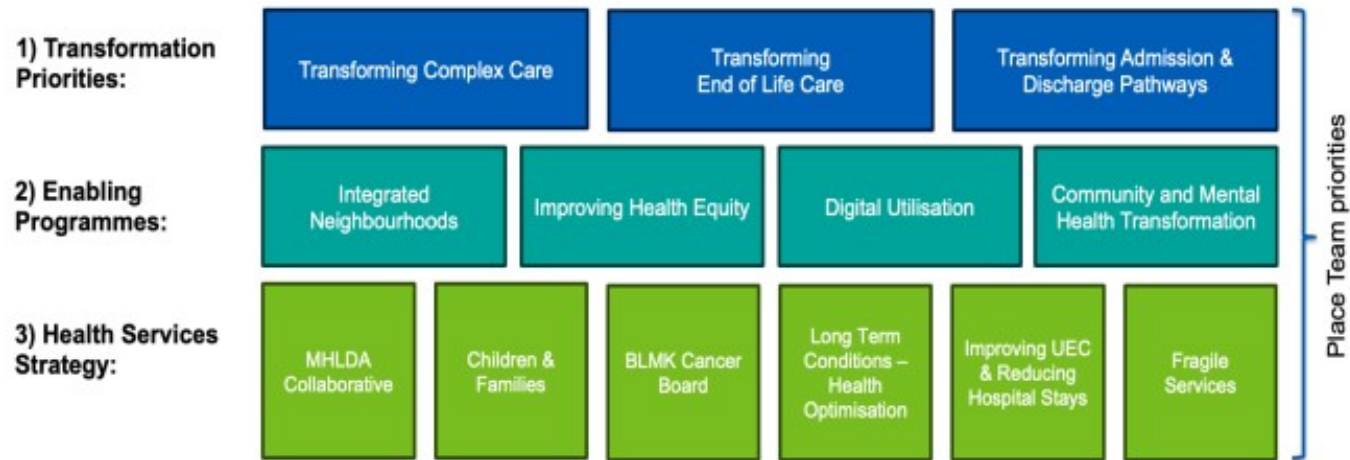
Project Team Members

| Name | Role |
|-------------------|-------------------|
| Alex Wrack | Programme Manager |
| Adele Slaney | Project Manager |
| Sarah Pearson | Project Manager |
| Usha Panchal | Project Manager |
| Lorraine Kavanagh | Project Manager |
| Lucy Robertson | QI Observer |

Project Status

| | |
|-----------------------------------|---|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Mapping work has progressed, conversations with partners ongoing. |
| Project Maturity | 1.0 - Pre-Planning |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

The programmes of work in the BB Starting Well priority align to the 'Enabling Programmes' of Integrated Neighbourhoods & Improving Health Equity. It also aligns to the 'Health Services Strategy' Children and Families.

The programmes are currently in a scoping/research phase as services are provided by teams/organisations outside of the BB Place Team.

Progress Update

Reducing childhood obesity & increasing activity:

- The new integrated behaviour change service 'Choose You' provided by Public Health was launched on 1st April. The programme includes a coaching component to support healthy weight focused on CYP and their families. The service is experiencing a high number of weight management referrals, which may result in a longer wait time before patients receive a follow-up call. They are working hard to resolve this issue as quickly as possible. Patients may experience a delay of up to 4 weeks before being contacted by the Choose You team.
- Conversations are ongoing with Public Health if any support is required from the Bedford Borough place teams to improve outcomes for children with obesity.
- Six schools in Bedford were accepted into the government's funded breakfast club programme but one has withdrawn.
- 2 to 2.5-year check by the 0–19 service has now returned to its mandated time frame, reaching 80% uptake by Q2.
- Eastern Region Partnerships held an Online Conference on 3 June focused on "The Power of Movement to Build Resilience in Children" aimed at community physical activity providers.

Improving Children's Oral Health:

Progress made in Previous Period

Dental Access in Bedford Borough

- Current Provision: Only one provider is delivering additional urgent dental care appointments in Bedford.
- Access Challenges: Bedford remains an area with limited provider coverage and higher unmet demand, particularly affecting vulnerable groups and those in deprived areas.
- BLMK wide pilot scheme service to be enhanced for 2025/26 to expand provider base expected launched 1st July 2025. The scheme if funded through non-recurrent clawback from the existing dental budget. Appointment slots per session increase from 7 to 9; appointment time reduce from 30 to 25 minutes. NHS 111 can now refer patients across BLMK without postcode restrictions.
- Oral health programmes: toothbrushes and toothpaste are now distributed to all Year R pupils. Additional targeted education support is being delivered in the 40% most deprived areas.
- New supervised toothbrushing funding (via Public Health Grant), limited to Early Years and Year R for one year; delivery expected Sept 2025 with voluntary participation, logistical challenges noted, and Bedford Borough in talks with oral health providers.

Imms & Vaccs:

NHS England Screening and Immunisation presented at the 22nd July Bedford Borough Practice Managers meeting:

- Barbara Hamill and Kayleigh Everett discussed the support available for immunisations, including the call and recall service for under-fives and MMR. They emphasised the importance of MMR uptake and the support mechanisms in place, such as clinic sizing tools and the EDSM training sessions.
- Kayleigh Everett presented the MMR dashboard, which provides monthly data on MMR uptake in the BLMK ICB area. She explained how the dashboard helps identify practices with low uptake and supports targeted interventions to improve immunisation rates.

Funding for the Maternity Social Prescribing pilot across East Beds and Caritas Medical PCNs secured for another 12 months. This pilot is now also extended to mums with young children and will therefore include checking imms & vaccs status of hard to reach patients.

| | |
|------------------------------------|--|
| Progress to be made in Next Period | <p>Evaluate current situation in each programme area, reviewing most up to date data set. Delving deeper into the data if it is available by Ward or Neighbourhood.</p> <p>Continue to map current activity and prioritisation of projects for place team focus.</p> <p>Working with colleagues across health and social care to understand how we can implement measurable outcomes of improvement for each focus area and realistic timeframes.</p> <p>Obesity: Continue discussions with Public Health around the roll out of their new integrated behaviour change service.</p> <p>Oral Health: Review updates when available from current service providers.</p> <p>Imms & Vaccs: Continue with regular discussion and update with NHSE and Public Health around BI data sets and 'GP practices of concern'.</p> <p>Continue to support strengthening antenatal vaccination uptake through continued community partnership, tapping into local assets such as the Family Hubs and maternity social prescriber.</p> |
|------------------------------------|--|

Tasks & Milestones

| | |
|--|---|
| Overall Tasks & Milestones Status | GREEN |
| Reason for Overall Tasks & Milestones Status | Progress is steadily being made against priorities - still in early stages. |

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|--|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Launch of new Public Health Integrated Behaviour Change Service "Choose You" | | 01/04/25 | ◆ | | | | | | | | | | | | | | |
| Receive updated data on 0-5yo dental decay/cavities etc. | | 07/04/25 | ◆ | | | | | | | | | | | | | | |
| Launch of Queens Park BeActive Project | | 22/04/25 | ◆ | | | | | | | | | | | | | | |
| Queens Park Project - Exercise and behavioural change sessions start | | 13/05/25 | | ◆ | | | | | | | | | | | | | |
| Barbara Hamill NHSE to attend PM Forum to raise awareness | 23/07/25 | 23/07/25 | | | | | | | | | | | | | | | |

Risks

| | |
|----------------------|-------|
| Overall Risks Status | AMBER |
|----------------------|-------|

| | |
|--------------------------------|---|
| Reason for Overall Risk Status | These priorities require a number of elements of input on large scale and focussed work in areas of higher need. Demonstrating significant change over a short period of time (less than 5 years) will be challenging. Need to focus on how the place team can most effectively make impact and support existing initiatives. |
|--------------------------------|---|

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|---|-----------|------------------------------|
| Challenge of showing change in the short term for childhood obesity as long term aim, to be advised by Public Health. | Yes | 12 |
| Challenge of showing change in the short term for childhood oral health. | Yes | 12 |
| Challenge of focusing on a range of vaccination and immunisation areas. May need to work through from antenatal to childhood. | Yes | 9 |

Issues

| | |
|----------------------------------|---|
| Overall Issues Status | AMBER |
| Reason for Overall Issues Status | These are big challenges and will need lots of different inputs as well as structural changes e.g. more dentists for all children to have access; poverty contributing to children's accessibility to fresh fruit and vegetables; and hesitation around vaccinations and immunisations. |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000346 |
| Project Name | CB - Dementia Diagnosis and Prevention |
| Project Team | Balraj Singh Rai - Central Bedfordshire Place Team |
| Project Aim | <p>Project Aim To contribute directly to achieving the national dementia diagnosis ambition rate of 66.7% in Central Bedfordshire by improving timely and accurate dementia diagnosis. The project focuses on supporting GPs with training and tools, strengthening pathways across health and social care, and reducing inequalities in access to assessment and support.</p> <p>Project Scope</p> <ul style="list-style-type: none"> • Develop a targeted programme of GP training to improve dementia assessment confidence and accuracy. • Conduct deep-dive analysis and utilise JSNA insights to identify key local gaps and priority groups. • Pilot innovative tools and interventions in primary care to streamline early identification and referral. • Embed outputs into Central Bedfordshire’s wider Integrated Neighbourhood Working (INW) model to ensure sustainability. |
| Governance & Responsible Group | <ul style="list-style-type: none"> • Central Bedfordshire Place Team • Central Bedfordshire Dementia Diagnosis Task & Finish Group • BLMK Dementia Strategy Group • DOG (Dementia Operational Group) |
| Geographical Footprint | Central Bedfordshire |

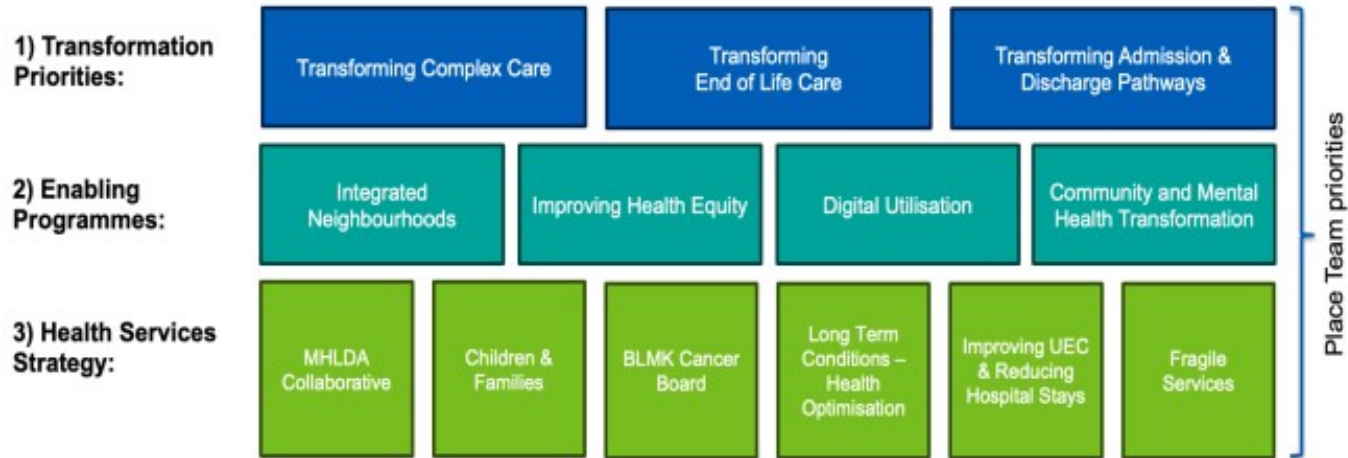
Project Team Members

| Name | Role |
|------------------|--------------------|
| Lianne Bowskill | Commissioning Lead |
| Kaysie Conroy | Programme Manager |
| Danny Karystinos | Programme Manager |
| Balraj Singhrai | Project Manager |

Project Status

| | |
|-----------------------------------|--|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | <ul style="list-style-type: none"> • One key element (deep-dive analysis) has been completed, reported and is influencing key areas of action • Other aspects are developing well and being implemented/ piloted, for example, in Primary Care settings • Two further elements (Comms & Engagement, and Workforce Development) are gaining momentum |
| Project Maturity | 3.0 - Implementation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

- 2. Enabling Programmes: Improving Health Equity, Community and Mental Health Transformation
- 3. Health Services Strategy: MHLDA Collaborative, Long Term Conditions - Health Optimisation
- Core20plus5

Progress Update

Progress made in Previous Period

- Deep-dive Dementia Diagnosis analysis was completed and findings reported back to CB Joint Leadership Group, Dementia Operational Group, Dementia Strategy Group, and PCN Clinical Director's
- A Health Needs Assessment chapter of the JSNA has been written and published, incorporating the findings of the deep dive analysis
- Key recommendations from the analysis are being developed/ implemented via the dedicated Dementia Task & Finish Group.
- The development of an Action Plan is under way, which is to include piloting a primary care-based early assessment tool, communications & engagement, and workforce development
- An exit strategy for the Task & Finish Group will be developed during 2025 to ensure that the areas of action that are developed and piloted become 'business as usual' in wider Dementia work in BMK

Update on May 25 to July 25 reporting period:

Action plan development and Exit Strategy:

- Comprehensive update to DOG (Dementia Operational Group). Agreed that the action plan is to be developed on VERTO platform (BSR to add LB to the project team). Also, the exit strategy should be developed alongside members of the BLMK DSG (Dementia Strategy Group)

Piloting an assessment tool in primary care settings) is developing well and being implemented. Tasks completed:

- A small sub-group to look at pilot has been established and meeting regularly
- Assessment tool to be utilised in the pilot has been adapted for primary care settings from the existing DiADeM resource
- Housebound patients from WMB and patients from C Hills PCN areas are being identified in the pilot, and being referred to the existing MAS MDT meeting run by ELFT, led by Dr Ismail and Dr White for their respective PCN areas

Comms & Engagement and Workforce Development) are gaining traction alongside key stakeholders, including VCSE organisations. Tasks completed:

- Printed and online learning resources shared with C Beds practitioners, including via PM's and CD's meeting.
- Discussion has commenced with Workforce Team around developing a focused learning session in a PLT session
- Appraisal of existing learning opportunities from VCSE organisations is underway.
- Shared the Health Needs Assessment widely across stakeholders in Central Bedfordshire (and beyond).
- Engagement with stakeholders in the creation of key tasks that fall under communications & engagement is underway.

Progress to be made in Next Period

In the next reporting period:

- Continue to support the implementation of the pilot assessment tool in primary care settings
- Continue dialogue for development of the Action Plan around Communications & Engagement and Workforce Development
- Work alongside existing strategic Dementia Governance structures in BLMK to develop exit plan
- Plan the expansion pilot of early assessment tool in Primary Care to wider PCNs/ GPs
- Data reporting to monitor progress against the national 66.7% target at neighbourhood and Place level

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

This status reflects that one major element (of four) has been completed, reported and its recommendations are being implemented.

One area (piloting an assessment tool in primary care settings) is developing well and being implemented. Tasks completed:

- small sub-group to look at pilot has been established and meeting
- Assessment tool to be utilised in the pilot has been adapted for primary care settings from the existing DiADeM resource
- Housebound patients from WMB and patients from C Hills PCN areas are being identified in the pilot, and referred to the existing MAS MDT meeting run by ELFT

Two areas (comms & engagement and workforce development) are gaining traction alongside key stakeholders, including a PPG and VCSE organisations. Tasks completed:

- Printed and online learning resources shared with C Beds practitioners, including via PM's and CD's meeting.
- Discussion has commenced with Workforce Team around developing a focused learning session in a PLT session
- Appraisal of existing learning opportunities from VCSE organisations is underway.

| | Start Date | End Date | 2025 | | | | | | 2026 | | | | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Publication of JSNA Health Needs Assessment chapter on Dementia | 01/04/25 | 31/05/25 | █ | | | | | | | | | | | |
| Project Update to Central Bedfordshire Clinical Director's | 29/05/25 | 12/06/25 | | █ | | | | | | | | | | |
| Sign-off CB DDR Action Plan at Task & Finish Group and two BLMK strategic Dementia Groups | 01/07/25 | 30/09/25 | | | | █ | | | | | | | | |
| Dementia Strategy Group - Agree action plan | 01/08/25 | 30/09/25 | | | | | █ | | | | | | | |
| Review and identify existing governance - for handover stage | 01/08/25 | 30/09/25 | | | | | █ | | | | | | | |

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|--|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Dementia Diagnosis in Primary Care Assessment Tool pilot | 01/08/25 | 30/11/25 | | | | | | | | | | | | | | | |
| Workforce Development | 01/08/25 | 30/11/25 | | | | | | | | | | | | | | | |
| CB Dementia Diagnosis | 02/01/25 | 31/03/26 | | | | | | | | | | | | | | | |
| Develop and refine the Central Bedfordshire Dementia Diagnosis Action Plan on Verto | 01/06/25 | 31/03/26 | | | | | | | | | | | | | | | |
| Exit Strategy - development to ensure work is assimilated into wider Governance Structures in BLMK | 01/08/25 | 31/03/26 | | | | | | | | | | | | | | | |

Risks

| | |
|--------------------------------|--|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | The project is developing well and no risks have been identified as yet. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|---|-----------|------------------------------|
| ICB restructure | Yes | 12 |
| Limited funding beyond pilot phase may impact sustainability. | Yes | 12 |

Issues

| | |
|----------------------------------|---|
| Overall Issues Status | GREEN |
| Reason for Overall Issues Status | All elements of the project are developing well, and no issues have been identified as yet. |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000345 |
| Project Name | CB - Falls Prevention Service (CBFPS) |
| Project Team | Central Bedfordshire Falls Prevention Service Project Group |
| Project Aim | <p>Project Aim To reduce falls incidence and related hospital admissions across Central Bedfordshire by developing an integrated Falls Prevention Service. The programme focuses on early identification, community-based interventions, and improved care pathways to enhance independence, safety, and wellbeing for residents at risk of falls.</p> <p>For individual service users, the objective of the service is to reduce the likelihood of them falling or re-falling, and if they do fall, reducing the likelihood of them seriously injuring themselves.</p> <p>Project Scope</p> <ul style="list-style-type: none"> • Establish a coordinated multi-agency Falls Prevention Service aligned with national best practice. • Deliver targeted community interventions, including strength and balance programmes, home hazard assessments, and medication reviews. • Strengthen referral pathways between primary care, community services, and acute trusts. • Build a robust monitoring and evaluation framework to demonstrate outcomes and system impact. |
| Governance & Responsible Group | <p>Falls Prevention Service Steering Group</p> <p>Central Bedfordshire Place Board</p> <p>ICB board</p> |
| Geographical Footprint | Central Bedfordshire |

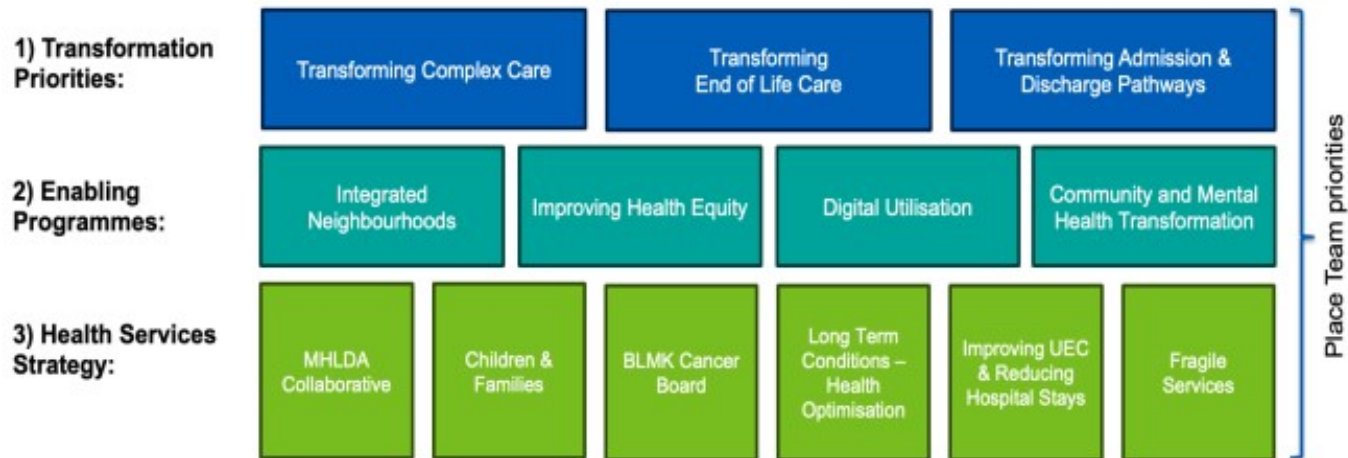
Project Team Members

| Name | Role |
|------------------|-------------------------------|
| Kaysie Conroy | Programme Manager |
| Danny Karystinos | Programme Manager |
| Balraj Singhrai | Project Manager |
| Sarah Pearson | Senior Transformation Manager |

Project Status

| | |
|-----------------------------------|---|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | <p>A number of key 'building blocks' for the intervention are agreed and signed-off. These include:</p> <ul style="list-style-type: none"> • BCF funding for a duration of one year • KPI's • Contract Variation documentation • a strong multi-disciplinary project group that meets monthly |
| Project Maturity | 3.0 - Implementation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

- NHS Outcomes Framework Domains & Indicators

Domain 1: Preventing people from dying prematurely v

Domain 2: Enhancing quality of life for people with long-term conditions v

Domain 3: Helping people to recover from episodes of ill-health or following injury v

Domain 4: Ensuring people have a positive experience of care v

Domain 5: Treating and caring for people in safe environment and protecting them from avoidable harm

Progress Update

Progress made in Previous Period

Agreed and signed-off:

- Service model agreed with stakeholders, with input from social care, VCSE, and community therapy teams.
- Engagement with PCNs and community providers secured to support onward referral and follow-up.
- BCF Funding for 1 year from "go-live" date
- Nominated project lead in provider organisation (ELFT)
- Recruitment process for designated clinical staff

Drafted for approval:

- KPI's, including service metrics
- Service Specification

Progress to be made in Next Period

- Introduce standardised referral pathway across all neighbourhoods.
- Publish evaluation framework and baseline measures.

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

| | | | | | | | | | | 2025 | | | 2026 | | |
|--------------------------|------------|----------|-----|-----|-----|-----|-----|-----|-----|------|-----|-----|------|-----|--|
| | Start Date | End Date | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | |
| Service Quarter 2 Review | | 13/03/26 | | | | | | | | | | | | ◆ | |

Risks

| | |
|--------------------------------|--|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | Risks are being managed and have controls and mitigations in place |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| Project timescale | Yes | 15 |
| Demand exceeds capacity if service is rapidly scaled without additional resources. | Yes | 9 |
| Engagement from primary care may vary, limiting referrals. | Yes | 9 |

Issues

| | |
|----------------------------------|--|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | No issues identified for this reporting period |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000349 |
| Project Name | CB - Health Inclusion Practitioners |
| Project Team | Central Bedfordshire |
| Project Aim | <p>To reduce health inequalities across Central Bedfordshire by targeting groups with the poorest access, experience, and outcomes. Current priority areas include hypertension management in Gypsy, Roma, Traveller communities— all aligned to Core20PLUS5 national priorities.</p> <p>Cambridgeshire Community Services (CCS) 0 - 19 Health Visitor and Health Care Assistant will work with our core20plus5 Gypsy, Roma, Traveller families to improve the physical and mental health of children and young people working across 20 GRT sites in Central Bedfordshire. The team will ensure that there is continuity of care and will promote equality in the health and wellbeing of their patients. They will scope the needs of families and children, do community profiling to include identification of gaps in services, working in collaboration with local services to support any identified needs. Do targeted work with the most vulnerable families, providing early advice and intervention and facilitating access to health and support services in the local area with a view to reducing DNA rates for Child Development reviews. Work involves antenatal assessments, newborn assessments, growth monitoring, general advise and other Health Visitor activities.</p> <p>In addition the team will support the promotion education and awareness of hypertension and is part of GRT Learning & Action Network (LAN) in Central Bedfordshire.</p> |
| Governance & Responsible Group | Central Bedfordshire Place Board |
| Geographical Footprint | Central Bedfordshire |

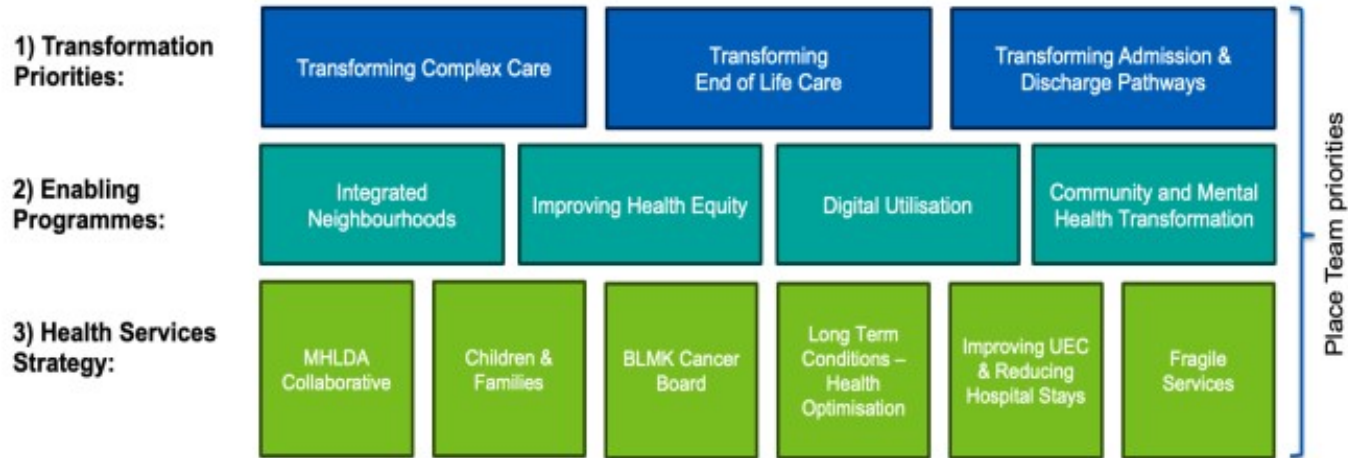
Project Team Members

| Name | Role |
|--------------------|-------------------|
| Danny Karystinos | Programme Manager |
| Kaysie Conroy | Programme Manager |
| Noeleen Mcloughlin | Project Manager |

Project Status

| | |
|-----------------------------------|----------------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | On track |
| Project Maturity | 3.0 - Implementation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

2. Enabling Programmes, Improving Health Equity, Integrated Neighbourhoods, Community & mental Health transformation.

Team working with the most vulnerable families in Central Bedfordshire to provide early advice and intervention and facilitating access to health and support services in the local area.

Team identifying and working with place partners that may be required to support this vulnerable population.

Progress Update

Initiated targeted projects addressing priority inequalities in Central Bedfordshire, including:

- Hypertension management in Gypsy, Roma, Traveller communities.
- Access to mental health support for residents with serious mental illness.
- Pilot initiatives supporting autistic residents and people with learning disabilities.

Worked in collaboration with CBC, to identify Traveller Sites to target work & to build trust on these sites, and identify families needing support,

Sites increased from 6 to 20,

Across all sites, 548 children registered on S1 as potential to target.

Q4 activity = 128 face to face Health assessments of families completed, 5 antenatal assessments, 16 new birth assessments (mother and baby), 6-8 week assessment = 10, 1 year dev review = 2, 2 year dev review = 5, other face to face contacts = 37

Engaging with adults to raise awareness and education of hypertension, and trialing a new clinical template within S1 to extract data going forward. - Q4 activity = 22 conversations taken place.

Progress made in Previous Period

Established partnerships with local VCSE organisations, primary care networks, and public health teams to co-produce solutions.

Engagement and Raising awareness of both LAN & Health Inclusion work across different networks

Liaising with and identifying system partners for onward signposting and support where applicable across new sites

Early data collection underway to baseline access, uptake, and outcomes, with insights feeding into the Integrated Neighbourhood Working model.

Review of pre and post interventions surveys that can be used in data capture & reporting for both LAN and Inclusion work

Supporting cultural awareness of the needs of the community across health care professionals, attendance at Practice Manager meeting to advertise then work with Place Team make connections.

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | |
|-----------------------------|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|---|---|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | |
| Q1 Performance Report | | 30/06/25 | | | ◆ | | | | | | | | | | | |
| Monthly Performance meeting | 02/07/25 | 02/07/25 | | | | ■ | | | | | | | | | | |
| Monthly Performance meeting | 03/09/25 | 03/09/25 | | | | | | ■ | | | | | | | | |
| Monthly Performance meeting | 01/10/25 | 01/10/25 | | | | | | | ■ | | | | | | | |
| Q2 Performance Report | | 31/10/25 | | | | | | | | ◆ | | | | | | |
| Monthly Performance Meeting | 26/11/25 | 26/11/25 | | | | | | | | | ■ | | | | | |
| Monthly Performance Meeting | 24/12/25 | 24/12/25 | | | | | | | | | | ■ | | | | |
| Q3 Performance Report | | 31/12/25 | | | | | | | | | | | ◆ | | | |
| Monthly Performance Meeting | 28/01/26 | 28/01/26 | | | | | | | | | | | | ■ | | |
| Monthly performance meeting | 28/02/26 | 28/02/26 | | | | | | | | | | | | | ■ | |
| Monthly Performance meeting | 04/03/26 | 04/03/26 | | | | | | | | | | | | | | ■ |
| Q4 Performance Report | | 31/03/26 | | | | | | | | | | | | | | ◆ |

| Risks | |
|--------------------------------|---|
| Overall Risks Status | AMBER |
| Reason for Overall Risk Status | Families not engaging - however to mitigate this, team building trust and awareness on sites and advising where they can help Families travel off sites between May - September - however to mitigate this new families come onto site and team make contact |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| Persistent barriers to engagement with seldom-heard groups risk limiting reach and impact. | Yes | 12 |

| | | |
|--|-----|----|
| Transition of families from sites between May - September | Yes | 9 |
| Sustainability concerns if national or local funding streams reduce. | Yes | 12 |

Issues

| | |
|----------------------------------|----------------------------------|
| Overall Issues Status | AMBER |
| Reason for Overall Issues Status | No reported issues at the moment |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000287 |
| Project Name | CB - Hypertension Management in C Beds - SMI |
| Project Team | Balraj Singh Rai/ Emma Moorbey |
| Project Aim | <p>Project Aim To improve detection, diagnosis, and management of hypertension in Central Bedfordshire, with a focus on tackling health inequalities and supporting targeted groups and residents with serious mental illness. The programme aims to reduce cardiovascular risk, prevent avoidable complications, and embed proactive community-based care.</p> <p>Project Scope</p> <ul style="list-style-type: none"> • Deliver targeted screening and case-finding interventions in patients with a SMI. • Improve primary care pathways for hypertension management in the priority group. • Develop culturally tailored approaches for SMI communities through VCSE partnerships. • Establish robust outcome monitoring to track improvements in diagnosis rates and management. |
| Governance & Responsible Group | <p>CB Hypertension Management Delivery Group</p> <p>Joint Leadership Group (C Beds)</p> |
| Geographical Footprint | Central Bedfordshire |

Project Team Members

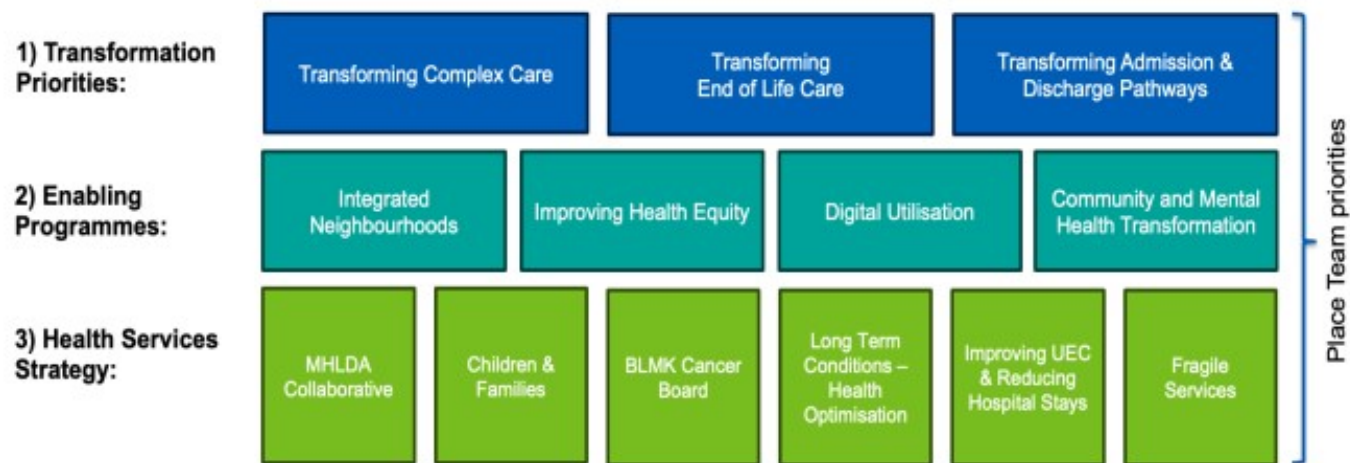
| Name | Role |
|--------------------|-----------------|
| Noeleen Mcloughlin | Project Manager |
| Kaysie Conroy | Project Manager |
| Danny Karystinos | Project Manager |
| Emma Moorbey | Project Manager |

| | |
|-----------------|-----------------|
| Balraj Singhrai | Project Manager |
| Sonal Mehta | Project Manager |
| Chloe Stibbs | Project Manager |

Project Status

| | |
|-----------------------------------|--|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Planning for the re-focused Project is on track and developing well, with good engagement across organisations under the theme 'SMI' |
| Project Maturity | 1.0 - Pre-Planning |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

- 2. Enabling Programmes: Improving Health Equity, Community
- 3. Health Services Strategy: Long Term Conditions - Health Optimisation
- Core20plus5

Progress Update

| | |
|---|---|
| <p>Progress made in Previous Period</p> | <ul style="list-style-type: none"> • C Beds Core Team redefined around focus and strategy: Initiated relationships of collaboration with PCNs to embed targeted hypertension reviews for people with serious mental illness. • Built partnership with Autism Bedfordshire and learning disability services to support inclusive approaches to blood pressure management. • Dedicated team for LD and Autism convened, and meeting regularly • Musiq score completed and agreed • Charter and Scoping agreed • Data conversation held, initial change idea focusing on 1 GP Practice agreed for testing • Developed Aim, Fishbone 'cause & effect' graphic and Driver Diagram <p>Progress in last reporting period (May to July 2025):</p> <ul style="list-style-type: none"> • Project has been reviewed to move away from LAN structure, which has been shared with IHI and QI colleagues • New colleagues have been engaged to form a network of support and action to hypertension management in patients with an SMI • Engagement with resident representative - from target group: Autistic people is developing well • Continuous engagement and collaboration with West Street Surgery, around Hypertnesion Management in LD |
| <p>Progress to be made in Next Period</p> | <p>To agree:</p> <ul style="list-style-type: none"> • Develop meeting/ governance structure for SMI focused work • Develop Aim, Driver Diagram and Fishbone illustration for SMI cohort • Collaboration with Autism Bedford and resident representative to review clinical pathways and recommend adjustments. • To plan scaling-up the West Street Practice model for hypertension management for people with LD, as appropriate • PDSA cycles that have been undertaken around learning from LD and Autism cohort to be drafted • Working alongside Autism Bedford and service users to finalise and implement survey to elicit 'the problem' around high blood pressure/ control amongst patients with Autism |

| <h2>Tasks & Milestones</h2> | |
|--|---------------------|
| <p>Overall Tasks & Milestones Status</p> | <p>GREEN</p> |

| | |
|--|---|
| Reason for Overall Tasks & Milestones Status | Many aspects are developing well, particularly those around project governance and foundation work for the SMI cohort |
|--|---|

| | Start Date | End Date | 2025 | | | | | 2026 | | | | | | |
|---|------------|----------|------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Project Aim, Fisbone and Driver Diagram to be developed and signed off for SMI cohort | 03/09/25 | 03/10/25 | | | | | | | | | | | | |
| Questionnaire to elicit 'the problem' around blood pressure amongst patients with Autism to be designed and implemented | 01/05/25 | 30/10/25 | | | | | | | | | | | | |
| PDSA Cycles to date (Autism and LD) to be logged/ written up | 01/06/25 | 31/10/25 | | | | | | | | | | | | |

Risks

| | |
|--------------------------------|--|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | <p>The project is developing well</p> <p>The main risk is that the service user on the group is not always able to attend meetings. A mitigating arrangement has been agreed and is working well</p> |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|---|-----------|------------------------------|
| Input of service user to group meetings | Yes | 6 |
| Primary care pressures delay uptake of enhanced reviews. | Yes | 12 |
| Funding constraints threaten sustainability beyond pilot phase. | Yes | 12 |

Issues

| | |
|-----------------------|--------------|
| Overall Issues Status | GREEN |
|-----------------------|--------------|

| | |
|----------------------------------|--|
| Reason for Overall Issues Status | <p>Considering the ICB restructure and deadline/ timeframe changes, the group and key stakeholders decided to progress as a standalone project, not falling into the IHI - LAN framework. The group will continue the work, focusing on SMI</p> <p>The learning from work with LD and Autism will be written-up to share with strategic groups for LD and Autism as well as primary care colleagues.</p> |
|----------------------------------|--|

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|---|------------|--------------------|
| Due to deadline changes and ICB restructure, the group and key stakeholders decided to progress as a standalone project, not falling into the IHI - LAN framework | Yes | 12 |

| | |
|--------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000293 |
| Project Name | CB - Integrated Neighbourhood Working |
| Project Team | Emma Moorbey, Noeleen McLoughlin, Balraj Singh Rai |

Executive Summary

To build neighbourhood teams to centre care around people's needs by integrating healthcare, social care, public services, community groups and voluntary agencies to work across neighbourhoods.

Improving resident experience of Primary Care in Central Bedfordshire. Primary Care is general practice, community pharmacy, dental, optometry and 111. Ensure that primary Care is supported to work as part of integrated neighbourhoods.

Access to NHS Dental services is a local and national issue. The challenge is to increase NHS Dental access to residents who have not seen a dentist over a two year period.

- **System:** Bedfordshire, Luton & Milton Keynes (BLMK) Integrated Care System (ICS) / ICB priorities: prevention, inequalities, person-centred care, productivity.
- **Place:** Central Bedfordshire Council locality model; Primary Care Networks (PCNs); Community Health, Mental Health, Adult Social Care, VCFSE partners.
- **Drivers:** Fuller Stocktake (Integrated Neighbourhood Teams), Core20PLUS5, hospital flow and discharge pressures, financial recovery, workforce constraints, digital interoperability gaps.

Vision: People in Central Bedfordshire receive joined-up, proactive, person- and community-centred care close to home, delivered by multidisciplinary neighbourhood teams that share goals, data and resources.

Project Aim

To embed Integrated Neighbourhood Working across Central Bedfordshire by aligning health, social care, and VCSE partners around population needs. The programme seeks to improve outcomes, reduce inequalities, and strengthen prevention by developing four neighbourhoods (West Mid Beds, Ivel Valley, Leighton Buzzard, and Chiltern Vale) into mature, multi-agency teams delivering joined-up, person-centred care.

High Level Objectives

1. **Improved access & experience**

2. **Reduced avoidable admissions**
3. **Flow & discharge**
4. **Inequalities narrowing**
5. **Staff experience**

Scope

- Establish four functioning INW neighbourhoods, each with clear governance, leadership, and delivery plans.
- Develop multi-agency Working Together Groups to co-produce priorities, oversee delivery, and drive community engagement.
- Align INW activity with BLMK system priorities, including prevention, health inequalities, and urgent/community care redesign.
- Build a shared data and intelligence approach to inform local decision-making.
- Support cultural and behavioural change across organisations to embed integrated ways of working.

Project Aim

Neighbourhood geography: Alignment to the PCNs

Population segments: Frailty, complex multimorbidity, frequent attenders, and Core20PLUS5 groups (e.g. severe mental illness)

Core components to design/implement:

- - Multidisciplinary Team (MDT) model & standard operating procedures.
 - Shared care planning and information sharing protocols.
 - Single front door/triage for professionals (and potentially citizens) – model options appraisal.
 - Community asset mapping & social prescribing integration.
 - Outcomes and measurement framework (including data dashboards).

- Governance & decision-making at neighbourhood level.
- Communication & engagement plan (citizens and workforce)

Workstreams

1. Communication and Engagement

Purpose:

To design and implement a robust communication and engagement infrastructure for Integrated Neighbourhood Working (INW) across Central Bedfordshire. This will ensure shared understanding, consistent messaging, community/stakeholder buy-in, and visibility of INW priorities.

Objectives:

- Develop Neighbourhoods **Packs** on Central Bedfordshire and its 4 Neighbourhoods
- Create a **bi-monthly Delivery Group** for communications planning and stakeholder engagement
- Design a **comms strategy** (internal & external) aligned with INW core components
- Map key **communication channels**, stakeholder groups, and engagement opportunities
- Co-produce localised comms with partners, residents, and VCSE

Deliverables:

- INW Neighbourhood Pack (including population, assets, living/working data, and neighbourhood profiles)
- Comms Strategy
- Stakeholder Map and matrix
- Engagement events
- Evaluation and feedback loops

Constraints:

Time-bound to 12 months. Dependent on availability of local data, stakeholder engagement, and resource capacity.

Governance & Responsible Group

Central Bedfordshire Assurance & Delivery Group

Geographical Footprint

Central Bedfordshire

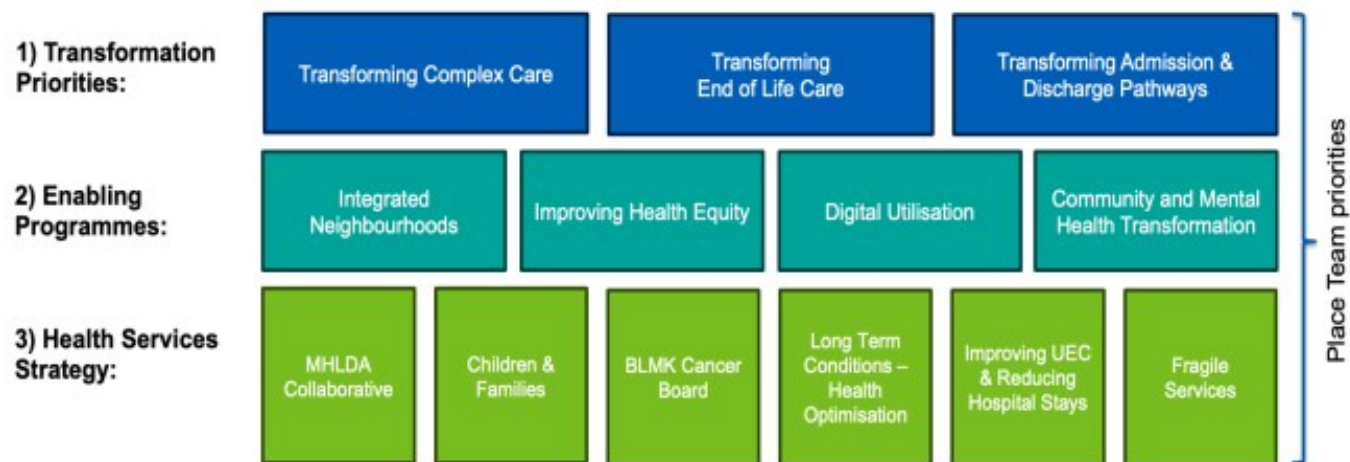
Project Team Members

| Name | Role |
|--------------------|-------------------|
| Kaysie Conroy | Programme Manager |
| Emma Moorbey | Project Manager |
| Danny Karystinos | Project Manager |
| Balraj Singhrai | Project Manager |
| Caron Morgan | Project Manager |
| Noeleen Mcloughlin | Project Support |

Project Status

| | |
|-----------------------------------|------------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | On track |
| Project Maturity | 2.0 - Initiation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

Enabling Programmes: Integrated Working. Bringing together teams from health, social care and the voluntary/community sector to improve community health and wellbeing. The main focus is on identifying the health and wellbeing needs of the neighbourhoods in Central Bedfordshire and addressing them through tailored interventions.

Progress Update

Progress made in Previous Period

Integrated Neighbourhood Working Groups:

- Integrated Neighbourhood Working (INW) 'Plan on a Page' created for West Mid Beds. Measures/metrics to be agreed.
- Area of focus agreed for West Mid Beds as falls prevention and target population identified via risk stratification.
- Working Group set up for Ivel Valley Neighbourhood. Initial areas agreed for discussion and activity packs to be produced for further discussion and agreement on area of focus.
- Physical assets mapped on Google My Maps for all neighbourhoods.

Integrated Neighbourhood Working - MDT:

- Workshop took place 21/05/25 to explore opportunities for collaboration on virtual MDTs.

Walking Buddies (HI Project):

- Walk Buddy Scheme Coordinator in post from April 2025; induction completed to include oversight of new project and how fits into the wider system
- Soft launch of Walk Buddy scheme in July 2025
- Coordinator has met with social prescribers to understand how these two offers work together
- Stakeholder engagements have taken place to present the offer, recruit volunteers and promote the service
- 11 volunteers have been recruited so far (5 in Amphill/Flitwick and 6 in Sandy/Biggleswade)
- Volunteer leaflet created and distributed to venues/organisations
- Professionals leaflet created and shared with GP practices, via Social Prescribers

Winter Warmth Community Agents (HI Project):

- Online referrals platform established via Your Wellbeing Bedfordshire website
- Promotional leaflet designed, printed and distributed
- Both Winter Warmth agents successfully undertook Level 2 City & Guilds Fuel Debt Advice in the Community
- 10 referrals received in Quarter 1 2025/26 from BRCC Social Prescribers, Biggleswade Community Agent and self-referrals from community outreach
- Onward referrals made to Better Housing Better Health, Dunstable Food Bank and Biggleswade Baptist Church Food Bank
- 20 visits to warm welcome spaces in Quarter 1 2025/26
- 8 Community groups visited
- Partnership working undertaken with 11 different organisations
- Stakeholder engagements have taken place to present the offer and promote the service

Progress to be made in Next Period

Communication and Engagement Workstream

- Launch a Central Beds INW Communications and Engagement Network to coordinate messaging and strengthen community partnerships.
- Develop INW packs and identify channels of distribution

Integrated Neighbourhood Working Groups:

- Measures/metrics to be agreed for the West Mid Beds 'plan on a page'
- Develop INW performance reporting/dashboard to show progress and report by exception for WMB
- Aim and driver diagram to be completed
- Activity pack to be produced for Ivel Valley for further discussion and agreement on area of focus. To include Mental Health, housebound, smoke free and obesity data. QI approach to be used.
- Task & Finish group to be set up for MDT working in West Mid Beds
- Working Group to be set up for Chiltern Vale in late September along with activity pack on Obesity

Walking Buddies (HI Project):

- Metrics to be agreed and reporting to commence

Winter Warmth Community Agents (HI Project):

- Metrics to be agreed and reporting to commence

Integrated Neighbourhood Working - MDT

- Task & Finish group to be set up to map existing MDT models across the four neighbourhoods, identify areas of best practice and understand how impact is measured

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

| | Start Date | End Date | 2025 | | | | | 2026 | | | | | | |
|--|------------|----------|------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Communication & Engagement | 16/07/25 | 31/03/26 | | | | | | | | | | | | |
| Review the Working Together MDT(s) across each neighbourhood | 31/07/25 | 31/03/26 | | | | | | | | | | | | |
| CBC / ELFT IMC Integration project | 21/07/25 | 31/03/26 | | | | | | | | | | | | |
| Chiltern Vale | 01/10/25 | 31/03/26 | | | | | | | | | | | | |
| Leighton Buzzard | 02/01/26 | 31/03/26 | | | | | | | | | | | | |
| Identify area of focus | | 31/03/26 | | | | | | | | | | | | ◆ |
| Complete stakeholder matrix | | 31/03/26 | | | | | | | | | | | | ◆ |
| Develop an Aim statement, supported by a driver diagram | | 31/03/26 | | | | | | | | | | | | ◆ |
| Agree key measures / metrics and complete 'Plan on a Page' | | 31/03/26 | | | | | | | | | | | | ◆ |
| Agree key measures / metrics and complete 'Plan of a Page' | | 31/03/26 | | | | | | | | | | | | ◆ |
| Develop an Aim statement, supported by a driver diagram | | 31/03/26 | | | | | | | | | | | | ◆ |
| Complete stakeholder matrix | | 31/03/26 | | | | | | | | | | | | ◆ |
| Identify area of focus | | 31/03/26 | | | | | | | | | | | | ◆ |

| Risks | |
|--------------------------------|---|
| Overall Risks Status | AMBER |
| Reason for Overall Risk Status | Neighbourhood work is progressing well with a good level of engagement from system partners across Central Bedfordshire. As the activity increases and spreads to other neighbourhoods, this will be reviewed to ensure we are maximising the resource in the best way to deliver neighbourhood working. Data and information is being collected and continues to build the local neighbourhood picture and is a key focus for the group. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|---|-----------|------------------------------|
| West Mid Beds Working Group partner capacity, limited resource | Yes | 9 |
| Limited accurate data broken down at neighbourhood level | Yes | 6 |
| Sustainability of project | Yes | 16 |
| Data sharing barriers | Yes | 8 |
| Lack of consistent engagement from some system partners may slow delivery. | Yes | 9 |
| Risk of programme fragmentation if INW not aligned with wider BLMK strategic initiatives. | Yes | 9 |

Issues

| | |
|----------------------------------|--|
| Overall Issues Status | AMBER |
| Reason for Overall Issues Status | <p>Central Bedfordshire political landscape is unsettled and this may present some issues when we engage with members from the wards and neighbourhoods. This will be monitored and support from council, Public Health and comms to ensure we are pitching the narrative in the most appropriate way that encourages a positive working relationship whilst managing expectations.</p> <p>No specific issue defined to date</p> |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000288 |
| Project Name | CB - LAN 02 - Pressures on |
| Project Team | Noeleen McLoughlin |
| Project Aim | <p>To improve hypertension detection, diagnosis, and management within Gypsy, Roma and Traveller (GRT) communities in Central Bedfordshire. The project seeks to address health inequalities by increasing awareness, access to screening, and early intervention, while embedding culturally sensitive approaches that build trust and improve long-term outcomes.</p> <p>To increase the percentage of GRT residents of all genders, 18+ with managed blood pressure (clinic BP below 140/90 mmHg) from Ivel Valley Neighbourhood and registered with one of three practices within IVS PCN which is serving this area by 20% by end of the LAN QI work March 2026.</p> |
| Governance & Responsible Group | CB Place Team BLMK LAN Programme |
| Geographical Footprint | Central Bedfordshire |

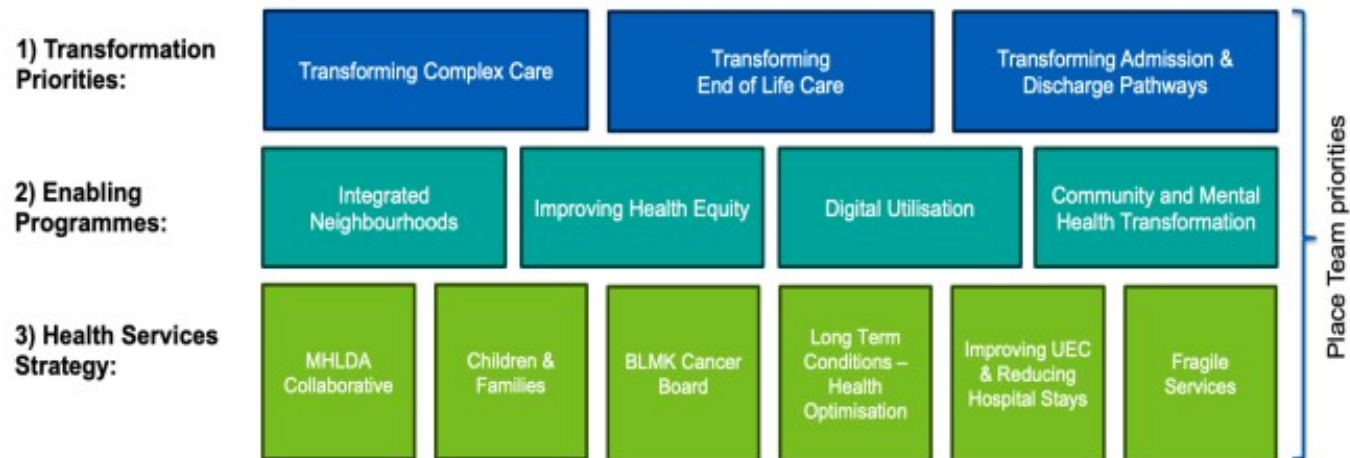
Project Team Members

| Name | Role |
|--------------------|-----------------|
| Noeleen Mcloughlin | Project Manager |
| Danny Karystinos | Project Manager |
| Balraj Singhrai | Project Manager |
| Kaysie Conroy | Project Manager |
| Emma Moorbey | Project Manager |
| Chloe Stibbs | QI Sponsor |
| Sonal Mehta | QI Sponsor |

Project Status

| | |
|-----------------------------------|---------------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Project is on track |
| Project Maturity | 2.0 - Initiation |

System Transformation



| | |
|--|--|
| <p>Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)</p> | <p>1) Transforming Admission and Discharge Pathways - managing hypertension reduces admissions for heart attacks and strokes</p> <p>2) Enabling Programmes - Improving Health Equity - the project starts with those who have worse outcomes from not managing hypertension and are hard to reach and who are within our Core20plus5 population</p> <p>3) Long Term Conditions and Health Optimisation - hypertension is a long term condition which has been identified by BLMK as poorly managed and therefore this project aims to close the gap and increase management of hypertension</p> |
|--|--|

Progress Update

Progress made in Previous Period

Delivered community-based hypertension screening events in partnership with local GRT representatives and VCSE partners.

- Worked with QI Coaches & IHI re data collection to assess if our interventions are making an improvement
- Presentation prepared re Data and Measures session with IHI - 5 PDSA's discussed during the data session. Presentation discussed at LAN Team meeting and place partners now reflecting on what data they have being collecting

Built strong links with primary care to ensure direct referral pathways and continuity of care for individuals with raised blood pressure.

CCS Health Inclusion Team tested new clinical system template and 22 conversations recorded so far, CCS continuing to build trust with families.

Developed educational resources, co-produced with the community, to improve awareness of cardiovascular risk factors.

Progress to be made in Next Period

Continue the robust engagement and Integrate blood pressure checks into wider community wellbeing events to reduce stigma and increase accessibility.

Planning taking place in preparation for "Know your numbers week in September" to see if we can expand the focus wider within than Arlesey into the other GRT sites across Ivel Valley neighborhood. CCS, IVS PCN & CBC agreed to collaborate and support - Know your numbers week across the remainder of GRT sites in Ivel Valley.

Discussions to take place with other Practices in Ivel Valley to see how they can support the work.

Expecting national comms to also support this. Linking in with our Pharmacist Lead to see how we can collaborate with our Pharmacies to support taking BPs that week.

IVS PCN to follow up on identified patients & re run their ethnicity data as linked to our teams aim statement, to see what improvement has been made.

IVS PCN - focusing on data for Clinic attendances, resident discussions & exploratory meeting being set up with Chloe/Noeleen re what other data could be collected.

Formatting to be completed and Share James video in August.

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

On Track

| | Start Date | End Date | 2025 | | | | | | | | | | | | 2026 | | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|---|---|---|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | | |
| Cause & effect | | 04/04/25 | ◆ | | | | | | | | | | | | | | | |
| EoE - PPIE - Innovation Grant Application | | 04/04/25 | ◆ | | | | | | | | | | | | | | | |
| PPIE - Application - submitted ahead of deadline 14.03.2025 | 07/03/25 | 04/04/25 | ■ | | | | | | | | | | | | | | | |
| Driver diagram | | 30/04/25 | ◆ | | | | | | | | | | | | | | | |
| Governance | | 30/04/25 | ◆ | | | | | | | | | | | | | | | |
| Impact & effect chart to prioritise change ideas | 25/05/25 | 25/05/25 | | ■ | | | | | | | | | | | | | | |
| Hypertension Awareness Training for Health Professionals | 29/05/25 | 29/05/25 | | ■ | | | | | | | | | | | | | | |
| Change idea - Ask Anything Q&A session | | 31/05/25 | | ◆ | | | | | | | | | | | | | | |
| Change idea - Hypertension Video | | 31/05/25 | | ◆ | | | | | | | | | | | | | | |
| Know your numbers week - 8 - 14 Sept - Campaign | 01/08/25 | 20/09/25 | | | | | | ■ | ■ | ■ | | | | | | | | |
| Data - for change ideas and aim | 01/08/25 | 31/03/26 | | | | | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Change idea - IVS PCN GRT Registered Patients | | 31/03/26 | | | | | | | | | | | | | | | | ◆ |
| Communication Barriers & Accessibility | | 31/03/26 | | | | | | | | | | | | | | | | ◆ |
| Culture & Lifestyle | | 31/03/26 | | | | | | | | | | | | | | | | ◆ |
| Data Identification barriers | | 31/03/26 | | | | | | | | | | | | | | | | ◆ |
| Education, Awareness & Medication | | 31/03/26 | | | | | | | | | | | | | | | | ◆ |

Risks

| | |
|--------------------------------|--|
| Overall Risks Status | AMBER |
| Reason for Overall Risk Status | <p>Generally the project is progressing well.</p> <p>The main risk currently is the loss of residents. To mitigate this Place Team is raising awareness of the work of the LAN to see where we may be able to get more residents involved and collaborate.</p> |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| Community disengagement leading to poor uptake of interventions. | Yes | 9 |
| Financial incentive process - proving difficult for GRT residents | Yes | 9 |
| Sustainability of programme dependent on ongoing funding and partner commitment. | Yes | 12 |

Issues

| | |
|----------------------------------|--------------------------------|
| Overall Issues Status | GREEN |
| Reason for Overall Issues Status | No issues currently identified |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 08/05/2025 |
| Project Code | PR000172 |
| Project Name | Luton - Early intervention, Prevention, and Partnerships |
| Project Team | Luton |
| Project Aim | <p>Smoking cessation</p> <ul style="list-style-type: none">-Continuation of the NHS Long Term Plan Treating Tobacco Dependency programme within acute, maternity and mental health inpatient settings <p>Weight management</p> <ul style="list-style-type: none">- Successful pilot of the NHS Digital Weight Management Programme within Luton GP practices <p>Cancer</p> <ul style="list-style-type: none">- Increase in early diagnosis & 1 year survival rate <p>Learning disability and autism</p> <ul style="list-style-type: none">- Decrease inpatient cohort against trajectory <p>Vaccinations</p> <ul style="list-style-type: none">- Increased uptake in cohorts, especially within vulnerable groups. <p>Mental Health</p> <ul style="list-style-type: none">- Increased engagement with ELFT, and an increased number of Luton residents accessing CMHT teams where appropriate. |
| Governance & Responsible Group | Prevention in Primary Care Connectivity Group |
| Geographical Footprint | Luton |

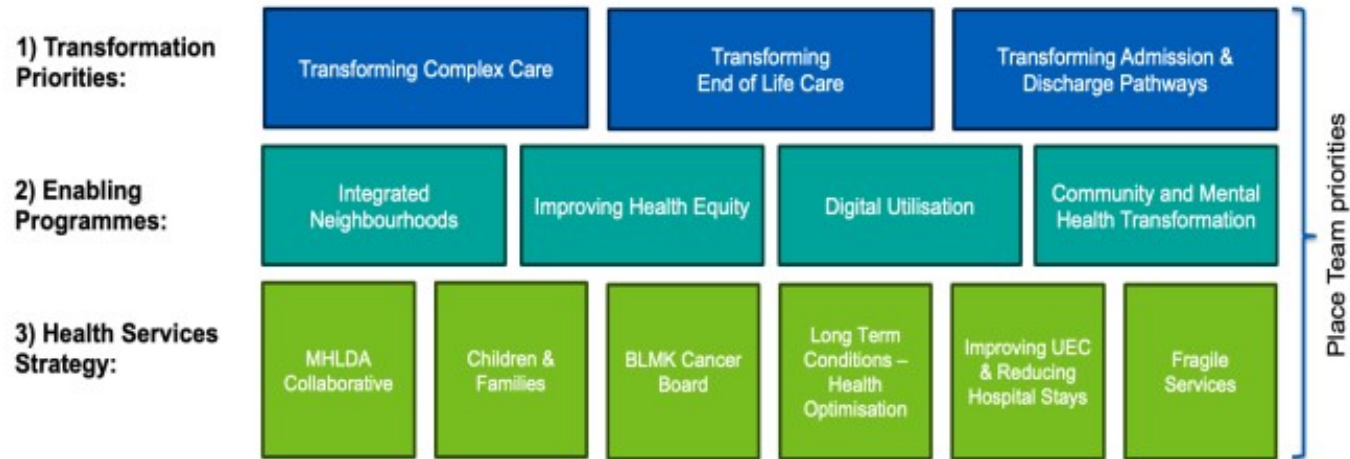
Project Team Members

| Name | Role |
|-----------------|--------------------------|
| Faith Haslam | Programme Manager |
| Rehan Tariq | Project Manager |
| Andrew Rochford | Senior Responsible Owner |

Project Status

| | |
|-----------------------------------|----------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | On track |
| Project Maturity | 4.0 - Delivery |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

1. Transformation Priorities:

Reducing Admissions and Readmissions: A strong focus on prevention and successful community partnerships promotes a community of healthier individuals, and prompts a reduction in avoidable hospital presentations and admissions.

2. Enabling programmes:

Both the prevention programme and Luton 2040 vision promote integrated neighbourhood working and improved health equity across Luton.

3. Health Service Strategy:

This programme is directly linked to the long term condition management/ health optimisation strand of the Health Service Strategy, with prevention a key element of the forward view for health.

Progress Update

Progress made in Previous Period

Luton Place is currently taking part in an improvement programme funded by the NHSE Access & Inequalities programme. This focuses on increasing uptake of vaccinations in hard to reach groups. We are working with the National Centre for Social Marketing to understand the barriers to accessing vaccinations for specific population groups, and working with Public Health to deliver a targeted programme.

Continued delivery of Improving Cancer Outcomes Project to address: 1) Cancer Prevention & Early Detection 2) Prevention and early detection 3) Addressing inequalities and survival rates

Continued delivery of Improving Cancer Outcomes Project to address: 1) Cancer Prevention & Early Detection 2) Prevention and early detection 3) Addressing

| | |
|---|---|
| <p>Progress to be made in Next Period</p> | <p>BLMK ICB have been selected to receive funding by NHSE to work with iPlato on the NHS Digital Weight Management Programme, a tier 2 online programme for patients with a suitable body mass index (BMI) & associated comorbidities. We have historically low uptake of this programme in BLMK & especially Luton, perhaps due to competing Tier 2 services causing some confusion amongst referring clinicians. iPlato will support practices to identify eligible patients to invite for referrals, and work with our community leaders to develop videos that can be embedded in the invite text messages. We hope to see a surge in referrals into the programme with this work.</p> <p>Continue to work with NHSE & local practices to improve uptake of childhood vaccinations including MMR which has low rates within Luton.</p> <p>Continued delivery of Improving Cancer Outcomes Project to address: 1) Cancer Prevention & Early Detection 2) Prevention and early detection 3) Addressing inequalities and survival rates</p> <p>Continued delivery of Improving Cancer Outcomes Project to address: 1) Cancer Prevention & Early Detection 2) Prevention and early detection 3) Addressing inequalities and survival rates</p> <p>Continue the IHI LAN project which works to improve case finding and support of patients with hypertension.</p> |
|---|---|

Tasks & Milestones

| | |
|--|--------------|
| Overall Tasks & Milestones Status | GREEN |
| Reason for Overall Tasks & Milestones Status | On track |

| | Start Date | End Date | 2025 | | | | | 2026 | | | | | | | |
|---|------------|----------|------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | |
| NHS Long Term Plan for Treating Tobacco Dependency - Luton provider plans | 01/04/25 | 31/03/26 | | | | | | | | | | | | | |
| Access & inequalities funding - childhood vaccinations | 02/04/24 | 31/03/26 | | | | | | | | | | | | | |
| Continuing oversight of Luton 2040 pledges | 07/05/25 | 31/03/26 | | | | | | | | | | | | | |
| Development and implementation of the Luton Digital Weight Management Programme pilot study | 07/05/25 | 31/03/26 | | | | | | | | | | | | | |

Risks

| | |
|--------------------------------|--------------------------------|
| Overall Risks Status | TBC |
| Reason for Overall Risk Status | Risks and issues to be defined |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|----------------------------------|-----------|------------------------------|
| Changes to ICB role & structure. | Yes | |

Issues

| | |
|----------------------------------|--------------------------------|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | Risks and issues to be defined |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000248 |
| Project Name | Luton - Health Ageing Programme (BCF) |
| Project Team | Diane Meddick - Luton Place Team |
| Project Aim | <p>The business case is requesting continuation of the £149,176 2023/24 BCF Funding (with the assumed 5.66% uplift) for a further 2 years to support this intervention which will help reduce the number of falls and the frailty status of this specific cohort of the population of Luton through encouraging them to participate in light physical activity to ensure better healthy lives and quality of lived years. By continuing the funding it allows further time to consider the future approach and sustainability of this intervention in relation to the fuller report and the development of neighbourhood teams and proactive personalised care for people with complex needs.</p> <p>The Healthy Ageing Programme focusses on offering a programme of physical activity free of charge for 12 weeks to encourage individuals to become more active in their day to day lives. The physical exercise provides an opportunity to improve strength, stability and mobility of those aged 65+ with a mild and moderate frailty score in Luton, and will support the Luton Sports and Physical Activity Strategy that is being developed by Luton Council in partnership with Be Active.</p> <p>The Luton Healthy Ageing Programme also supports the wider integrated falls pathway which has an emphasis on falls prevention and will support the delivery of the following objectives;</p> <ul style="list-style-type: none">• Ensure people getting older stay stable, strong and safe• Reduce the chances of a “first fall” being injurious• Ensure effective treatment of injurious falls, helping people return to maximum independence• Maximise the well-being of multi fallers• Reduce hospital admissions related to falls <p>People aged over 65, who score as ‘mildly frail’ via electronic frailty index, and some of the moderately frail patients identified within GP clinical systems, will be invited to attend an assessment which will be delivered face to face or virtually where they will undergo 3 simple tests to assess/confirm their level of frailty.</p> |

- Participants will be assessed for motivation to engage (PAM). Those with Level 1 PAM score will be referred to the social prescription navigator for targeted support. Those with a PAM score level 2-4 are offered a place on the course.
- Participants will then be offered the opportunity to receive a 12 week funded course of physical exercise, self-selected from a range of activities provided by community and voluntary organisations – with a key focus on increasing strength, stability, stamina and balance.
- Participants will also receive information about healthy living and falls prevention; a different topic for each of the 12 weeks, with homework to improve their self-engagement in other community/voluntary activities.

Participants in need of additional wellbeing support will also be able to access the Total Well-Being Luton offers including access to IAPT.

Governance & Responsible Group

The Joint Strategic Commissioning Group

Geographical Footprint

Luton

Project Team Members

| Name | Role |
|-----------------------|-------------------|
| Diane Meddick | Programme Manager |
| Cerys Gravener | Project Manager |
| Donna Holding | Project Support |
| Kamini Patel | Project Support |
| Kate Sutherland | Project Support |
| Yasmin Martin Leggitt | Project Support |
| Rehan Tariq | Project Support |

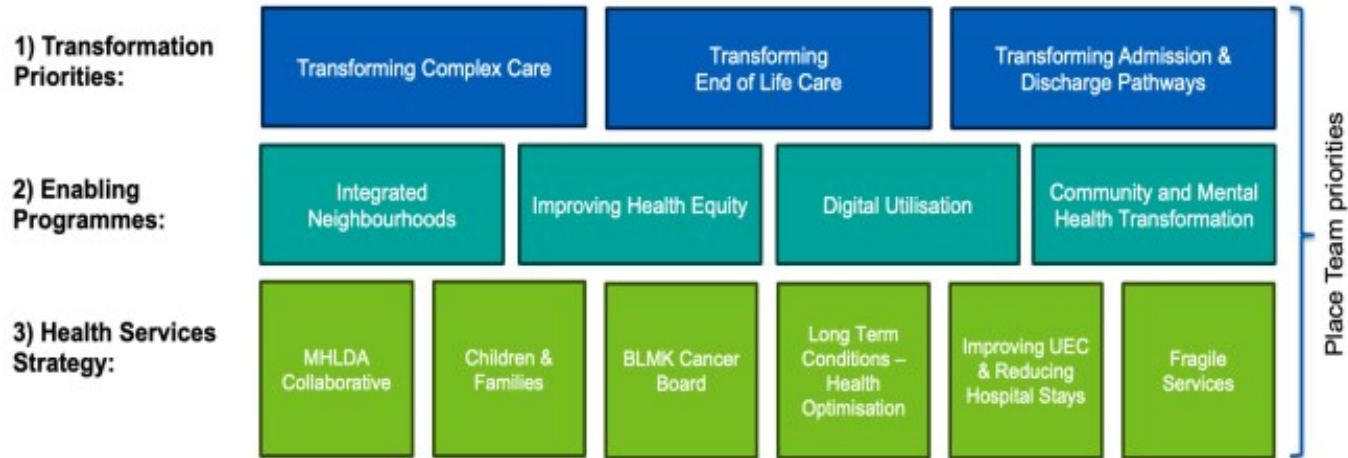
Project Status

Overall Project Status

GREEN

| | |
|-----------------------------------|--|
| Reason for Overall Project Status | <p>Positive movement sessions and delivered in various settings including within care home settings are proving successful and has helped develop a robust programme of support for residents that live in older age care homes for then next 12 months as a minimum. (Older age Care Homes primarily support residents aged 65 and over). The qualitative feedback of their experience has encouraged us to pursue this line of support as well as adding 2 additional venues to the Positive Movement portfolio across the town in community settings such as community centres and the central library which has been achieved by both local providers working collaboratively together to deliver more service offers to the residents in the community rather than a corporate Leisure facility as this does not always meet the needs of the cohort we are supporting.</p> <p>Regular reports against Key performance Indicators and showing achievements against targets:</p> <p>KPI 1: Over 65's Falls Prevention Supporting BCF: Non-elective admissions, Delayed transfers of care, Patient/service user experience</p> <p>KPI: Reduction on the 24/25 baseline data for the number of over 65's with a Mild/Moderate or Severe frailty score Data source: GP Clinical System – SystmOne – Gather baseline data for April 2025 and quarterly there after</p> <p>KPI 2: Over 65's Falls Prevention Supporting BCF: Non-elective admissions, Delayed transfers of care, Patient/service user experience</p> <p>KPI: Increase in the number of people participating in strength, stability and mobility services for the mildly frail population in Luton (excludes care homes) Data source: 'University of Bedfordshire Baseline Date followed by quarterly reporting'</p> <p>KPI 3: Ensuring residents living in care homes have access to this programme and can participate in in strength, stability, and mobility services in Luton Supporting BCF: Non-elective admissions, Delayed transfers of care, Patient/service user experience Provider organisation to provide details of homes supported, Residents engaged and ongoing support for the Positive Movement Sessions either directly with provider or via learning over the 12 weeks to be able to deliver some positive movement sessions inhouse directly.</p> |
| Project Maturity | 4.0 - Delivery |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

This programme aligns back to the following:

- 1) Transformation Priorities - Admission avoidance and discharges
- 2) Improving Health Equity
- 3) Long Term Conditions and Health Optimisation

The Healthy Ageing Programme focusses on offering a programme of physical activity free of charge for 12 weeks to encourage individuals to become more active in their day to day lives. The physical exercise provides an opportunity to improve strength, stability and mobility of those aged 65+ with a mild and moderate frailty score in Luton. The Healthy Ageing Programme aims to provide; improved quality of life for mild and moderately frail population, a reduction in the number of hospital admissions relating to falls and movement between the number of people with mild/moderate and severe frailty scores. Participants will notice the improvements in strength, stability, stamina and balance over the 12 weeks and will be encouraged to continue with a form of exercise on completion of the first 12 weeks. Following pre and post assessments participants will have an assessed/confirmed level of frailty that is maintained or reduced.

This aligns to Transforming Complex Care, Integrated Neighbourhood's and Improving Health Equity and Long Term Conditions Health Optimisation.

Progress made in Previous Period

Three Memorandum of Agreements are being updated for 2025/26 to reflect new activities available for this cohort of patients to be signed off by all partners.

The new healthy ageing team are in the process of meeting with Luton practices and primary care networks to re-iterate the service offer and how they can support the over 65 frailty cohorts.

This is a continued cycle of ongoing activity throughout the year as we embed the service with more practices/PCN's and support the UoB HAP Team to make connections with other stakeholder through Integrated Neighbourhood Working Forums

Annual report now received from the University of Bedfordshire summaries the participation, and outcomes for the year alongside recommendations to improve the service in 2025/26 following participant feedback. An annual report has been received from the team.

A dashboard is in development, it has taken longer than anticipated by University of Bedfordshire. The (UoB) Team have been testing this in Qtr. 3 and have provided assurance that it will be live for the commissioner to view high level data in Qtr. 4

Working with PCN's to explore additional pathways for referral in

Advertising the service on GP waiting room screens

University of Bedfordshire exploring other event links through programmes they are involved in

Raising awareness of the service with system partners as no referrals have been received from past discussions with several community teams. Email invites Phone calls

Collaborative approach with practices/primary care networks directly

University of Bedfordshire (UoB) team continue to meet with social prescribers from Hatters PCN and Medics PCN to explain the offer in person – referrals are starting to come through from these staff.

Team have also attended several community events as well as reaching out to several local Mosques and other places of worship across the town to spread the opportunities of this service. Including Care Homes and exploring supported living.

Business case for 2025/26 has been approved with some suggestions that the committee want to see implemented to support this to be more sustainable in 2025/26.

Discussion with the UoB to provide quarterly reports regarding activity and plans for the following quarter. Regular reports now received, and the 2024/25 Annual Report was received early April 2025.

This was put into place and reviews undertaken by the UoB Team looking at what sessions were receiving the most interest which formed the evidence basis for the 2025/26 planning discussions that took place in February 2025

Progress to be made in Next Period

University of Bedfordshire Team continue to engage with primary care networks, community engagement events and local places of worship to raise awareness of the programme, hand out flyers and encourage self-referral Plans to increase activity within the most popular venues during 25/26. Second Positive movement session to commence at Stoppley Baptist Church. The team will also continue to focus on working with care homes and explore opportunities with Primary Care Networks to support residents in supported living accommodation University of Bedfordshire will share access to the Dashboard that has been developed to allow ICB colleagues sight of real-time high-level data showing the engagement of stakeholder and the residents along with the activities that are proving most popular. Current project lead has met with the Luton Place lead, to support a smooth handover of the programme, ensuring all is in place ahead of April 2025. The Place Team now has full control and responsibility for this programme of work. The programme Lead will be meeting with the UoB to ensure robust reporting on progress Place team colleagues will use connectivity opportunities through the Luton LAN and other Integrated Neighbourhood working events to engage with wider providers and re-connect with services that also support this cohort of the population, including Adult Social Care services and Mental Health and Well-being The Luton place team will start to introduce the Luton Healthy Ageing Team into the place-based meetings to support connectivity and engagement to drive up referrals further as they are key partner in Luton Integrated Neighbourhoods Working.

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

Annual report and regular reports demonstrate meeting key milestones and tasks

| | Start Date | End Date | 2025 | | | | | | | | | | | | 2026 | | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|--|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | | |
| Evaluation | 01/12/24 | 30/05/25 | █ | | | | | | | | | | | | | | | |
| Prioritise co-production working to renew offers of activity for participants by collecting information on what is needed or why people decline the offer | | 30/06/25 | | | ◆ | | | | | | | | | | | | | |
| Dashboard | 01/12/24 | 31/07/25 | █ | | | | | | | | | | | | | | | |
| GP and PCN engagement | 02/04/24 | 31/07/25 | █ | | | | | | | | | | | | | | | |
| Mid Year Review | 30/06/25 | 30/10/25 | | | █ | | | | | | | | | | | | | |
| Review Frailty List | 30/06/25 | 31/12/25 | | | █ | | | | | | | | | | | | | |

Risks

Overall Risks Status

TBC

Reason for Overall Risk Status

No risks identified to impact delivery of project

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-----------|-----------|------------------------------|
|-----------|-----------|------------------------------|

Issues

| | |
|----------------------------------|--|
| Overall Issues Status | AMBER |
| Reason for Overall Issues Status | The dashboard is in development and being chased |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|----------------------------|------------|--------------------|
| Dashboard delivery delayed | Yes | 4 |

| | |
|--------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000223 |
| Project Name | Luton - Integrated Neighbourhood Working |
| Project Team | Luton Place |
| Project Aim | <p>Integrated Neighbourhood Working</p> <p>Citizens, communities, stakeholders and service providers working together to build resilience and confidence, through a holistic, organic and personalised neighbourhood approach, providing equal opportunities for individuals to improve their health and wellbeing outcomes and live more years in better health.'</p> <p>Multi Disciplinary Teams for High Intensity Users</p> <p>Mapping of MDTs</p> <p>The purpose of this project will be to map the current MDT's, including the purpose, interconnectivity, and accessibility. This understanding will provide a picture of the MDTs that take place across Luton and identify the variability in approach and any gaps. Bringing this information together will provide an opportunity to refresh existing models.</p> <p>The mapping will provide an understanding of the types of patient cohorts under an MDT approach currently, that will link with our Luton place priorities for example complex care and frailty patient cohort.</p> <p>Expansion of MDTs</p> <p>Following the review of existing MDTs, it will be crucial to lean into neighbourhood working to further support patient needs through community-based care, to identify what additionality can be included within MDTs to support the patient both clinically and holistically.</p> <p>We will use population health management data to identify patient needs and trends to adapt capacity and placement based on that need. MDTs was first introduced with a patient in mind who may have multiple co morbidities or complex needs and therefore may also require a health and wellbeing intervention as well clinical. To ensure we are covering both angles or determining which, we will expand upon our MDTs and tap into our personalised health model to support care in other ways such as social prescribing.</p> <p>The project aims to consider patient cases that are not progressing, where a 'diagnosis' is not necessarily required or appropriate but support in their lifestyle or wellbeing.</p> <p>Mapping of HIU schemes across partnership organizations</p> |

Working with existing HIU schemes to understand current position and link to commissioned services, to ensure a cohesive offer.

To also map and identify the resource that supports HIU's across the system, with a focus on Personalised Health roles; local authority funded roles, community navigators, community hub roles, mental health workers.

Identifying a cohort for MDT working.

Using Population Health Management tools we will review data to identify high user patients, within several health and social care settings. This information will provide an understanding of patient patterns and support the identification of a cohort with shared needs, where an MDT approach could be helpful. Once established we will pilot a collaborative approach to care with cohort of patients, working with PCNs and wider partners, via an MDT.

Structure and framework for MDTs

To underpin this work, we will develop in partnership an evidence based exemplary MDT approach and produce an MDT Framework for guidance for system partners.

Building Healthier Communities (stakeholder events)

5 neighbourhood based events to facilitate stakeholder engagement and connectivity.

Hypertension

Know Your Numbers Hypertension Campaign in West Central

This project was developed in collaboration with Luton Council (Public Health and Social Justice Unit) as a 'proof of concept' that a community-led, neighbourhood-based approach can be effective in delivering health promotion advice/interventions to residents.

The project is a 6 month time limited campaign in the West Central neighbourhood of Luton to raise awareness about the dangers of hypertension and encourage residents to monitor blood pressure.

Governance & Responsible Group

Luton Integrated Neighbourhood Collaborative (LINC)

Geographical Footprint

Luton

Project Team Members

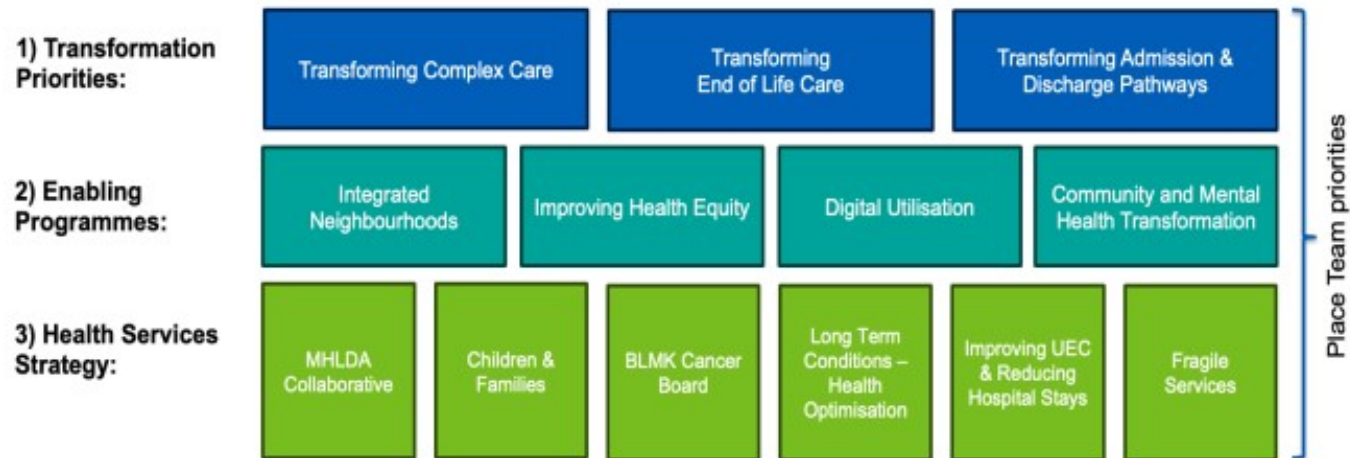
| Name | Role |
|-----------------|-------------------|
| Kate Sutherland | Programme Manager |
| Diane Meddick | Programme Manager |
| Faith Haslam | Programme Manager |
| Rehan Tariq | Project Manager |
| Kamini Patel | Project Manager |

| | |
|-----------------------|-----------------|
| Hayley Dixon | Project Support |
| Yasmin Martin Leggitt | Project Support |
| Cerys Gravener | Project Support |

Project Status

| | |
|-----------------------------------|--|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Various projects of integrated neighbourhood working have been identified and are on track |
| Project Maturity | 2.0 - Initiation |

System Transformation



Integrated Neighbourhood Working

1. Transforming admissions and discharge pathway

Introduction of neighbourhood working will ensure wrap around care for the patient population within the community, if health and wellbeing needs are addressed by partners as a collective, impact and demand on services could be reduced.

2. Integrated Neighbourhood Working

This programme of work will directly address this.

3. All

This programme of work will encompass all Health Services Strategies.

Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

Multi Disciplinary Teams for High Intensity Users

1. Transforming admissions and discharge pathway

The project will aim to address the needs of patients who present with multiple complex needs, across various system touch points, i.e. Primary Care, A&E, Mental Health or community services. With the intention for those partners to work jointly together in delivering more joined up care for the individual, via an MDT approach.

2. Integrated Neighbourhood Working

Whilst those examples of service providers will form a basis, this project will need to lean into neighbourhood working and utilise other agencies in supporting care needs, on a more localised level. This project will work with partners within the Luton collaborative to broaden relationships with local services, that can wrap around the patients needs in their geographical area.

3. LTC Health Optimisation/ Improving UEC

Based on population health needs across Luton the patient cohort identified will include those with at least one LTC or those at risk of an LTC. This will support PCNs in proactively reviewing patient lists and risk stratify emerging LTCs.

The patient cohort will include patients who are users of A&E and ambulance services, by addressing patient needs via an MDT and safety netting the individual, this project aims to see a reduction in those attendances.

Building Healthier Communities (stakeholder events)

1. Transforming admissions and discharge pathway

Connectivity across partner organisations to be facilitated via neighbourhood based events. To provide space for relationship building and to establish ways to work closely together, across health, social and VCSE services providers. In turn will streamline patient care and reduce impact on services.

2. Integrated Neighbourhood Working

The stakeholder events will look to bring partners together to see how they can work together further, share resource and maximise us of existing assets, leaning into the ABCD model.

3. All

Stakeholder events, will improve relationships with partner organisations across the ICS and facilitate the delivery of strategies.

Hypertension

Know Your Numbers Hypertension Campaign in West Central

1) Transformation Priorities - Transforming Complex Care - raising awareness of the risks of hypertension and finding hypertensives may potentially reduce the number of residents that need acute conditions as a result of unmanaged hypertension eg heart attacks

and strokes

2) Improving Health Equity - West Central has worse outcomes for hypertension than other neighborhoods - awareness and identification of hypertension will improve health equity in this neighbourhood.

Integrated Working - project is a proof of concept that neighbourhood working is effective and integrated working was demonstrated by stakeholders eg Total Wellbeing Luton, PCNs, Community Pharmacy and community assets.

3) Long Term Conditions and Health Optimisation - hypertension is a long term condition which has been identified by BLMK as poorly managed. This project aims to close the gap and increase management of hypertension

Progress Update

Multi Disciplinary Teams for High Intensity Users

Q4- End of March 2025

Hatters PCN have agreed to pilot the project and patient cohort identified

- Inclusion criteria
- 10+ GP appointments in the last year
- 26-65 years (working age)
- At least one LTC (diagnosed but not well managed)
- At least one risk factor
- At least one complexity
- Exclusion criteria
- Declined Social Prescription offer < last 6 months

Other PCNs to follow and join pilot, which will support test period of address patient needs via and MDT, to then inform full implementation.

Building Healthier Communities (stakeholder events)

- Initial planning meeting held with Luton Place team, Social Justice Unit to decide upon event format
- Venue scoping commenced
- Formal to include: networking event, potential stall holders,

Hypertension

Know Your Numbers Hypertension Campaign in West Central

Q3 2024-25

- Development of PID and planning for first stage of campaign 'Easter Family and Fun Days (7-10 April)

Progress made in Previous Period

Q1 2025-26

- Delivery of Easter Family and Fun Days (7-10 April):
 - Outcomes: 239 BP/health checks were completed, approximately half hadn't checked their BP in the last year. Several cases of high blood pressure were identified and follow up support was provided, including referrals to community pharmacy for 24-hour ambulatory blood pressure monitoring. Approximately 300 children engaged with creative and physical activities, enhancing family participation.
- Inspire Eid Festival 7th June 2025:
 - Outcomes: 40 residents were offered screening and advice to manage BP health. 6 out of 33 (with no known hypertension) will require further action and of the 7 patients who have hypertension 5 were found to have poorly controlled blood pressure. The team also provided advice on exercise, and lifestyle to support overall wellbeing.

Q2 2025-26

- Supported the delivery of Luton Health Fest (5 July):
 - Outcomes: 400 Blood pressure checks were completed by community pharmacy. 74 patients were identified with high blood pressure (18.5% potential hypertension detection rate). All patients with high readings were given healthy lifestyle advice and blood pressure education with either follow up appointments or signposting to the appropriate health service.

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|--|--|---|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Stakeholder mapping | 28/04/25 | 27/05/25 | █ | | | | | | | | | | | | | | |
| Approach UOB re art student attendance and mapping stakeholders upon arrival | 30/04/25 | 28/05/25 | █ | | | | | | | | | | | | | | |
| Stallholder mapping | 06/05/25 | 06/06/25 | | █ | | | | | | | | | | | | | |
| Produce flyer for event promotion | 06/06/25 | 20/06/25 | | | █ | | | | | | | | | | | | |
| Email invitation text to be drafted | 06/06/25 | 20/06/25 | | | █ | | | | | | | | | | | | |
| Communications & marketing of the events | 06/06/25 | 01/09/25 | | | █ | | | | | | | | | | | | |
| Building healthier communities | 25/02/25 | 30/09/25 | █ | | | | | | | | | | | | | | |
| Event planning group | 04/03/25 | 30/09/25 | █ | | | | | | | | | | | | | | |
| LINC Refresh | 12/05/25 | 30/09/25 | | █ | | | | | | | | | | | | | |
| Know Your Numbers Hypertension Campaign in West Central | 31/01/25 | 01/10/25 | █ | | | | | | | | | | | | | | |
| Pilot a systematic MDT approach that reflects equitability, ease of access and connectivity | 19/05/25 | 01/10/25 | | █ | | | | | | | | | | | | | |
| Review, reflect, assess MDT | 01/09/25 | 01/10/25 | | | | | | | █ | | | | | | | | |
| Draft MDT Operating Framework and obtain partners approval | 01/09/25 | 01/10/25 | | | | | | | █ | | | | | | | | |
| Event feedback summary | 30/09/25 | 07/10/25 | | | | | | | █ | | | | | | | | |
| Development & Adoption of agreed MDT for HIU framework | 01/10/25 | 01/11/25 | | | | | | | | █ | | | | | | | |
| Benefits realisation report to LINC | 01/10/25 | 01/11/25 | | | | | | | | █ | | | | | | | |
| Multi disciplinary Teams for High Intensity Users | 09/04/24 | 31/12/25 | █ | | | | | | | | | | | | | | |
| Luton Integrated Neighbourhood Collaborative Refresh | | 31/12/25 | | | | | | | | | | | | | | | ◆ |

Risks

Overall Risks Status

GREEN

| | |
|--------------------------------|--------------------------------------|
| Reason for Overall Risk Status | Risks managed with controls in place |
|--------------------------------|--------------------------------------|

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| MDT for HIU-Public engagement | Yes | 2 |
| MDT for HIU-Stakeholder and partnership working | Yes | 2 |
| MDT for HIU-Availability of community assets | Yes | 6 |
| MDT for HIUs-Increased demand on neighbourhood workforce | Yes | 2 |
| INW-Digital Operability across ICS partners | Yes | 9 |

| Issues | |
|----------------------------------|----------------------------|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | None identified at present |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000224 |
| Project Name | Luton 1 - Hypertension Learning and Action Network (Black African population) |
| Project Team | Kamini Patel |
| Project Aim | Reduce the number of people with unmanaged hypertension by 50% amongst Black patients aged between 30 and 60 in Luton by May 2026 |
| Governance & Responsible Group | Other participants: Chris Boakye, Luton Resident Caroline Birchall, PCN care co-ordinator Austin Chinakidzwa, CCS, Specialist Heart Failure Practitioner Kwaku Adjei, CCS, Co-production lead Yakini Johnson, Total Wellbeing Luton Rehan Tariq, Project Support Alisha Gandhi, BLMK Medicines Optimisation Team Kirsty Thompson, Quality Improvement Coach Matthew Toitei, Quality Improvement Coach |
| Geographical Footprint | Luton |

Project Team Members

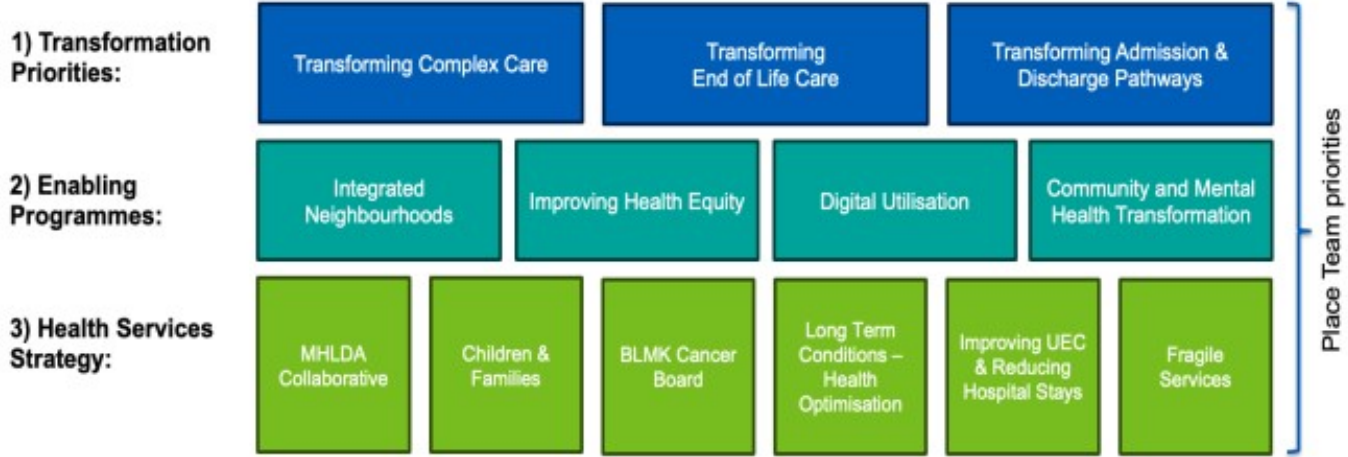
| Name | Role |
|--------------------------|-----------------|
| Kamini Patel | Project Manager |
| Rehan Tariq | Project Manager |
| Faith Haslam | Project Support |
| Cerys Gravener | Project Support |
| Dominic Woodward-Lebihan | Project Support |
| Yasmin Martin Leggitt | Project Support |
| Diane Meddick | Project Support |

| | |
|-----------------------|--------------------------|
| Jayne Pigott | QI Coach |
| Matthew Kurima | QI Coach |
| Kirsty Thompson | QI Coach |
| Charlie Goodwin Smith | QI Lead |
| Brenda Carson | QI Lead |
| Angela Zambeaux | QI Lead |
| Noeleen Mcloughlin | QI Observer |
| Balraj Singhrai | QI Observer |
| Lorraine Kavanagh | QI Observer |
| Tom May | QI Observer |
| Usha Panchal | QI Observer |
| Kate Sutherland | QI Observer |
| Chimene Egbutah | QI Observer |
| Julia Robson | QI Observer |
| Shelby Reed | QI Sponsor |
| Lourena Mendes | QI Sponsor |
| Joyce Baskerville | QI Sponsor |
| Chloe Stibbs | QI Sponsor |
| Andrew Rochford | Senior Responsible Owner |
| Angela Zambeaux | Verto & QI Lead |
| Brenda Carson | Verto & QI Lead |

Project Status

| | |
|-----------------------------------|----------------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Project has started |
| Project Maturity | 3.0 - Implementation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

- 1) Transforming Admission and Discharge Pathways - managing hypertension reduces admissions for heart attacks and strokes
- 2) Improving Health Equity - the project starts with those who have worse outcomes from not managing hypertension
- 3) Long Term Conditions and Health Optimisation - hypertension is a long term condition which has been identified by BLMK as poorly managed and therefore this project aims to close the gap and increase management of hypertension

Progress Update

| | Start Date | End Date | 2025 | | | | | | | | | | | | 2026 | | | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|--|--|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | | | |
| Develop Plan element of PDSA cycle | 07/07/25 | 18/07/25 | | | | | | | | | | | | | | | | | |
| Pull list of patients to consider calling (these need to be different from the ones for the pharmacy change idea) | 07/07/25 | 22/07/25 | | | | | | | | | | | | | | | | | |
| Develop a list of key messages | 02/06/25 | 25/07/25 | | | | | | | | | | | | | | | | | |
| Write up patient stories | 20/06/25 | 01/08/25 | | | | | | | | | | | | | | | | | |
| Change Idea 3: Making contact at the pharmacy on collection of data | 07/07/25 | 08/08/25 | | | | | | | | | | | | | | | | | |
| Develop Clinical education package | 07/07/25 | 15/08/25 | | | | | | | | | | | | | | | | | |
| Develop non clinical education package | 07/07/25 | 15/08/25 | | | | | | | | | | | | | | | | | |
| Mapping of Churches and other groups including their networks | 09/06/25 | 29/08/25 | | | | | | | | | | | | | | | | | |
| Develop posters, social media posts etc | 28/07/25 | 01/09/25 | | | | | | | | | | | | | | | | | |
| Change Idea 2: Calling a handful of patients to book an appointment | 16/06/25 | 12/09/25 | | | | | | | | | | | | | | | | | |
| Deliver Training | 18/08/25 | 12/09/25 | | | | | | | | | | | | | | | | | |
| Education of Health and Social Care Professionals | 07/07/25 | 30/09/25 | | | | | | | | | | | | | | | | | |
| Events (Balancing Measure) | 06/05/25 | 31/12/25 | | | | | | | | | | | | | | | | | |
| Work with Luton Town Football Club | 12/05/25 | 31/12/25 | | | | | | | | | | | | | | | | | |
| Data Collection | 06/05/25 | 31/03/26 | | | | | | | | | | | | | | | | | |
| Change idea: Events | 02/01/26 | 31/03/26 | | | | | | | | | | | | | | | | | |
| Media Campaign - Awareness and Education | 02/06/25 | 01/05/26 | | | | | | | | | | | | | | | | | |
| Drip feed of messages | 08/09/25 | 01/05/26 | | | | | | | | | | | | | | | | | |

Risks

Overall Risks Status

GREEN

| | |
|--------------------------------|--|
| Reason for Overall Risk Status | Risks are being managed with controls in place |
|--------------------------------|--|

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-------------------------------|-----------|------------------------------|
| Resident Engagement | Yes | 6 |
| Resident Renumeration Process | Yes | 8 |

Issues

| | |
|----------------------------------|-----------------|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | None identified |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000228 |
| Project Name | Luton 2 - Hypertension Learning and Action Network (Indian population) |
| Project Team | Kamini Patel |
| Project Aim | For 60% of Indians aged between 40-50 with a pre-existing medical condition (defined list) to have a recorded blood pressure in the last 12 months in Luton by May 2026 |
| Governance & Responsible Group | <p>Other members:</p> <p>Jarnail Sohal, Luton Resident Austin Chinakidzwa, CCS, Specialist Heart Failure Practitioner Sadat Edroos, Consultant, Bedfordshire Hospitals Trust Alisha Gandhi, BLMK Medicines Optimisation Team Irzam Malik, Public Health Dr Shahid Rahman, GP Medics PCN Kwaku Adjei, CCS, Co-production lead Yakini Johnson, Total Wellbeing Luton Rehan Tariq, Project Support Kamini Patel, Project Lead Kirsty Thompson, Quality Improvement Coach Matthew Toitei, Quality Improvement Coach</p> |
| Geographical Footprint | Luton |

Project Team Members

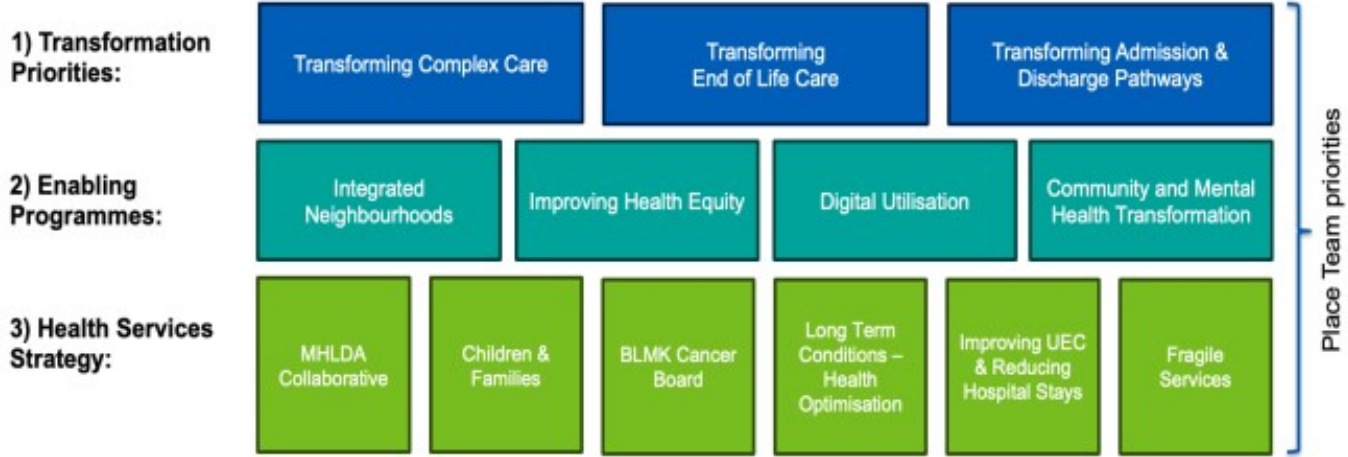
| Name | Role |
|-----------------------|-----------------|
| Kamini Patel | Project Manager |
| Faith Haslam | Project Support |
| Rehan Tariq | Project Support |
| Cerys Gravener | Project Support |
| Yasmin Martin Leggitt | Project Support |

| | |
|--------------------------|-----------------|
| Diane Meddick | Project Support |
| Matthew Kurima | QI Coach |
| Jayne Pigott | QI Coach |
| Kirsty Thompson | QI Coach |
| Charlie Goodwin Smith | QI Lead |
| Kate Sutherland | QI Observer |
| Noeleen Mcloughlin | QI Observer |
| Balraj Singhrai | QI Observer |
| Lorraine Kavanagh | QI Observer |
| Tom May | QI Observer |
| Usha Panchal | QI Observer |
| Dominic Woodward-Lebihan | QI Observer |
| Julia Robson | QI Observer |
| Shelby Reed | QI Sponsor |
| Lourena Mendes | QI Sponsor |
| Joyce Baskerville | QI Sponsor |
| Chloe Stibbs | QI Sponsor |
| Sarah Watts | Verto & QI Lead |
| Brenda Carson | Verto & QI Lead |
| Angela Zambeaux | Verto & QI Lead |

Project Status

| | |
|-----------------------------------|---|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | The project is continuing to progress and therefore remains green and at the implementation stage |
| Project Maturity | 3.0 - Implementation |

System Transformation



| | |
|--|--|
| <p>Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)</p> | <ul style="list-style-type: none"> 1) Transforming Admission and Discharge Pathways - managing hypertension reduces admissions for heart attacks and strokes 2) Improving Health Equity - the project starts with those who have worse outcomes from not managing hypertension 3) Long Term Conditions and Health Optimisation - hypertension is a long term condition which has been identified by BLMK as poorly managed and therefore this project aims to close the gap and increase management of hypertension |
|--|--|

Progress Update

| | | 2025 | | | | | | | 2026 | | | | | |
|-------------------------------|------------|----------|-----|-----|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|
| | Start Date | End Date | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Roll out to the rest of Luton | 05/03/25 | 26/05/26 | | | | | | | | | | | | |

| Risks | |
|--------------------------------|--|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | Risks are being managed with controls in place |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-------------------------------|-----------|------------------------------|
| Resident Renumeration Process | Yes | 8 |
| Resident Engagement | Yes | 6 |

| Issues | |
|----------------------------------|-----------------|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | None identified |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000184 |
| Project Name | MK - Children & Young People's Mental Health |
| Project Team | MK Deal - SRO's: CNWL and MKCC |
| Project Aim | Children and young people's mental health is a partnership responsibility and as such the MK Health and Care Partnership aim to improve prevention and early help and the care of complex and vulnerable young people. |
| Governance & Responsible Group | CYP MH Steering Group reporting into JLT |
| Geographical Footprint | Milton Keynes |

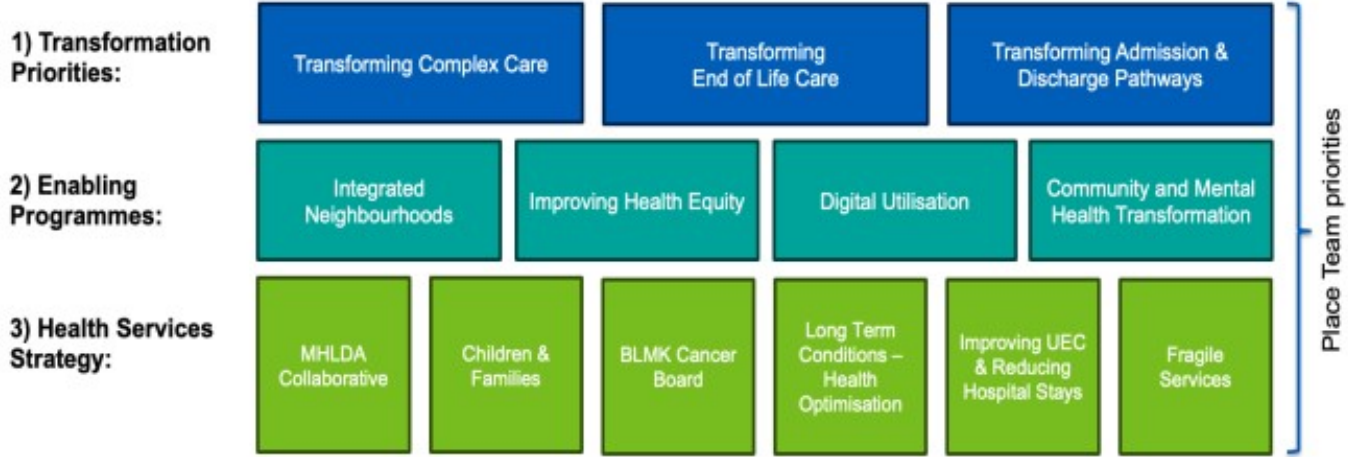
Project Team Members

| Name | Role |
|---------------|-------------------|
| Rebecca Green | Programme Manager |
| Tom May | Project Manager |
| Zoe Durman | Project Manager |
| Lisa Britton | Project Manager |

Project Status

| | |
|-----------------------------------|---|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | The programme plan has been re-developed to align with the 2028 vision statements as published by the Health and Care Partnership. Each Goal area has been assigned a lead who will oversee the development of the projects within their area. The group therefore is still at the initiation stage but further along with a more solid plan. |
| Project Maturity | 2.0 - Initiation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

The Children and Young People's Mental Health programme is one of the four MK Deal place priorities.

Progress Update

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|--|--|---|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Single Point of Access– Scoping and design. | | 30/06/25 | | | ◆ | | | | | | | | | | | | |
| Wellbeing Service (Getting Help) contract go live | | 01/07/25 | | | | ◆ | | | | | | | | | | | |
| Thrive Framework - Multi agency engagement | | 01/09/25 | | | | | | | ◆ | | | | | | | | |
| SPA – engagement and mobilisation | | 30/09/25 | | | | | | | ◆ | | | | | | | | |
| Thrive Framework - development and embedding across MK | | 01/12/25 | | | | | | | | | | ◆ | | | | | |
| SPA – Soft launch/trial | | 15/12/25 | | | | | | | | | | ◆ | | | | | |
| SPA - Go Live | | 27/02/26 | | | | | | | | | | | | | | | ◆ |

Risks

| | |
|--------------------------------|---|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | There are no significant risks to delivery. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-----------------------------|-----------|------------------------------|
| System capacity. | Yes | 4 |
| Lack of financial resource. | Yes | 12 |

Issues

| | |
|----------------------------------|-----------------------|
| Overall Issues Status | GREEN |
| Reason for Overall Issues Status | No issues identified. |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000263 |
| Project Name | MK - Hypertension Learning and Action Network (Black African population aged 40-64 years) |
| Project Team | Tom May |
| Project Aim | To increase the percentage of Black African residents of all genders, aged between 40-64 years with managed blood pressure (below 140/90 mmHg for a clinic reading and 135/85mmHg for a home reading) from the Central Milton Keynes Neighbourhood (covering 7 practices) by 10% through by end of the LAN QI work March 2026. |
| Governance & Responsible Group | MK Place Meeting BLMK LAN Programme |
| Geographical Footprint | Milton Keynes |

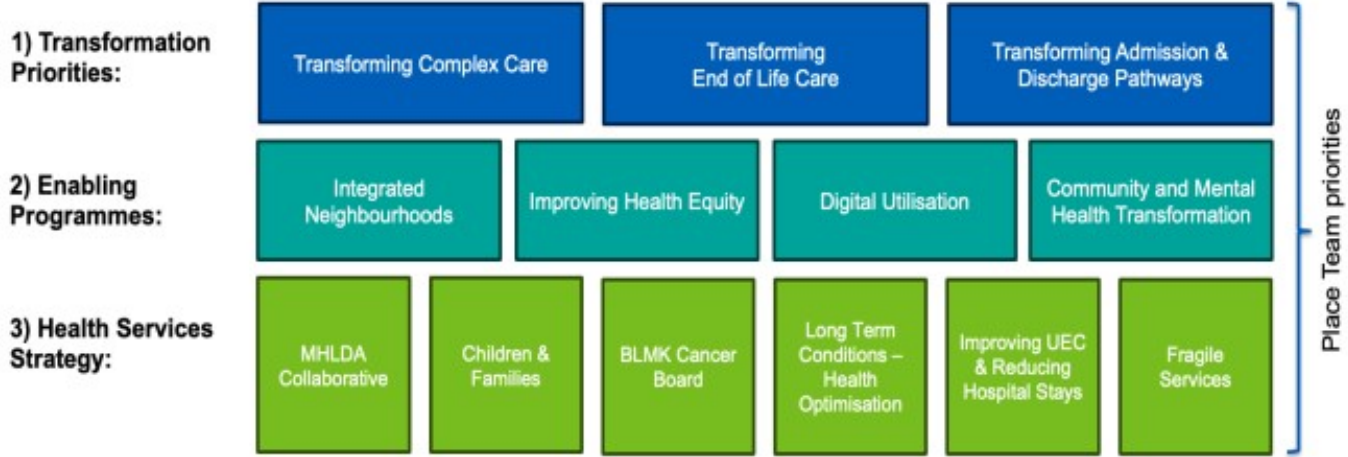
Project Team Members

| Name | Role |
|-----------------------|-----------------|
| Tom May | Project Manager |
| Sarah Watts | QI Lead |
| Charlie Goodwin Smith | QI Lead |
| Matthew Kurima | QI Observer |
| Shelby Reed | QI Observer |
| Lourena Mendes | QI Observer |
| Kamini Patel | QI Observer |
| Lorraine Kavanagh | QI Observer |
| Usha Panchal | QI Observer |
| Alex Wrack | QI Observer |
| Danny Karystinos | QI Observer |
| Balraj Singhrai | QI Observer |

| | |
|--------------------|-----------------------|
| Noeleen Mcloughlin | QI Observer |
| Rehan Tariq | QI Observer |
| Faith Haslam | QI Observer |
| Kaysie Conroy | QI Observer |
| Chloe Stibbs | QI Observer |
| Jayne Pigott | QI Observer |
| Sonal Mehta | QI Observer |
| Rebecca Green | QI Observer |
| Julia Robson | QI Observer |
| Brenda Carson | QI Observer |
| Angela Zambeaux | QI Observer |
| Joyce Baskerville | Quality Lead |
| Tracy Keech | Subject Matter Expert |

| Project Status | |
|-----------------------------------|---|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Project is going to plan with no major risks identified |
| Project Maturity | 2.0 - Initiation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

- 1) Transforming Admission and Discharge Pathways - managing hypertension reduces admissions for heart attacks and strokes
- 2) Improving Health Equity - the project starts with those who have worse outcomes from not managing hypertension
 - Integrated Neighbourhoods - working with a range of stakeholders to improve health outcomes for patients including Primary Care, VCSE and residents
- 3) Long Term Conditions and Health Optimisation - hypertension is a long term condition which has been identified by BLMK as poorly managed and therefore this project aims to close the gap and increase management of hypertension
 - Improving UEC & Reducing Hospital Stays - well managed hypertension in the community can lead to fewer heart attacks and strokes which require hospital stays

Progress Update

| | |
|------------------------------------|---|
| Progress made in Previous Period | <ul style="list-style-type: none"> • PDSA Cycle 1.1 Jeans Carnival run - 24/5/25 - added in files section in folder PDSA Cycles • PDSA Cycle 1.2 Melting pot coffee morning run - 16/6/25 - added in files section in folder PDSA Cycles • July SystmOne data searches run and analysed • Trend data Nov 24 - June 25 collated • Produce measures targets to achieve aim statement of increasing BP achievement by 10% • MUSIQ score 137 - (120-168) = Project has a reasonable chance of success • Analyse data to calculate MK LAN Targets to Achieve Aim Statement - added in files section in folder MK LAN Targets to Achieve Aim Statement • Produce overarching measures document - added in files section in Measures folder • Produce headline measure run charts - added in files section in Measures folder |
| Progress to be made in Next Period | <ul style="list-style-type: none"> • Develop PDSA cycle 2.1 - Posters to encourage residents to get their blood pressure checked • Develop PDSA cycle 3.1 - Use hypertension prescribing incentive scheme to target Black African cohort first at CMK Medical centre • Develop PDSA cycle 4.1 - Drop in session at Ashfield Medical Centre with Health and Wellbeing Coach • Engage with the 3 remaining practices in the central neighbourhood • Population Health Management Team to run monthly measures report to assess progress to achieving aim statement |

Tasks & Milestones

| | |
|--|---|
| Overall Tasks & Milestones Status | GREEN |
| Reason for Overall Tasks & Milestones Status | On track - Project plan to be developed further |

| | Start Date | End Date | 2025 | | | | | | 2026 | | | | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Develop posters to encourage residents to get BP checked | | 15/08/25 | | | | | | ◆ | | | | | | |
| Targetted text at CMK Medical Centre to invite cohort in for BP review | | 29/08/25 | | | | | | ◆ | | | | | | |
| Run drop in session with H&W coach for lifestyle advice at Ashfied MC | | 26/09/25 | | | | | | | ◆ | | | | | |

Risks

| | |
|--------------------------------|---|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | No major risks identified by the project steering group to date |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-----------|-----------|------------------------------|
|-----------|-----------|------------------------------|

Issues

| | |
|----------------------------------|----------------------|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | No issues identified |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000170 |
| Project Name | MK - Improving System Flow |
| Project Team | MK Deal Priority. MKUH/MKCC Lead |
| Project Aim | Transforming Urgent & Emergency Care services with MK providers working together to reshape demand, and the delivery of care. |
| Governance & Responsible Group | Improving System Flow Steering Group reporting into JLT |
| Geographical Footprint | Milton Keynes |

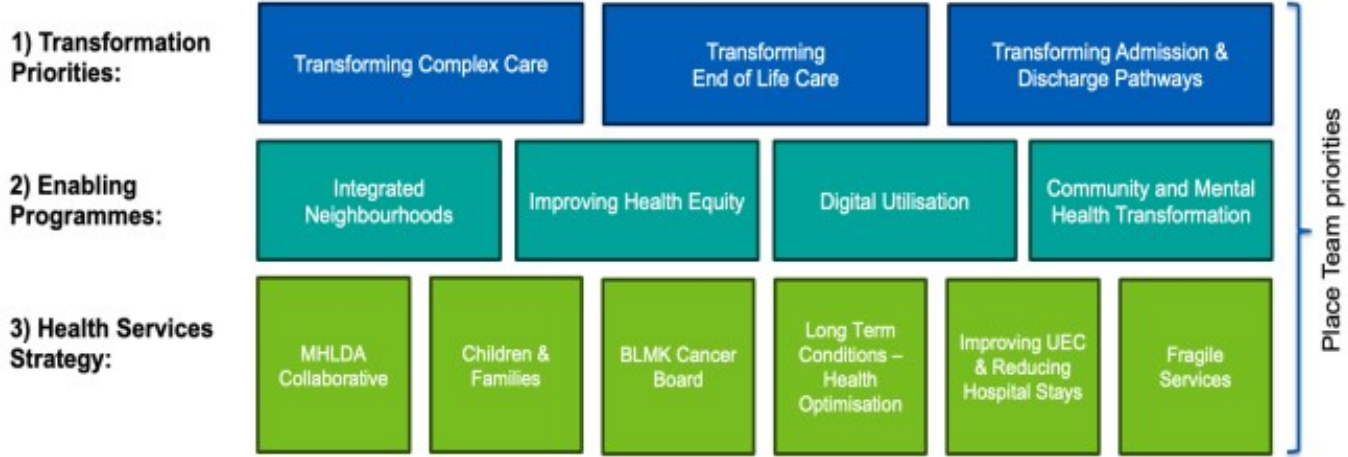
Project Team Members

| Name | Role |
|-----------------|-------------------|
| Claire Brisland | Programme Manager |
| Rebecca Green | Programme Manager |

Project Status

| | |
|-----------------------------------|--|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | The project is progressing, with all key aspects on track and controls in place to prevent risks from occurring. |
| Project Maturity | 4.0 - Delivery |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

This programme of work aligns with the Transforming Admissions and Discharge Pathways transformation priority and supports the Improving Urgent and Emergency Care (UEC) and Reducing Hospital Stays objectives within the health services strategy.

Progress Update

Progress made in Previous Period

- The Falls working group continues to meet to begin implementation of phase 2. Which involves looking at providing falls prevention through the VCSE sector. - Approval of a prevention digital tool, grants for VCSE groups across MK and prevention exercise classes through the VCSE. A paper went to ISF Steering group where it was agreed to spend the remaining BCF fund allocated to falls.
- Attend the VCSE Falls workshop on the 7th May. - Completed.
- Engage with the PCNs that have not returned their Memorandums of Understanding (MOUs) for P3 to have access to the practice S1. - Ongoing.
- Meet with Arden and Gem to ensure that all paperwork and governance is in place to go live with P3 having access to PID on the HIU dashboard. - Complete.
- Attend the BLMK Transformation priority workshop on the 16th May. - Complete.
- Options for extension of the care home conveyance pilot to be considered once the review has been completed. - Complete. Project being led by CNWL.
- Next steps for the redesign of P2 will be identified. - New model with associated costs to be reviewed by the ISF core group with recommendations to be made to the ISF steering group. - ongoing.
- Continue with the BCF review. Review of all Amber schemes that were identified in the review of the 2025/26 schemes. Identify a timeline for the review. Taking in to account of all governance that needs to take place also. - Ongoing
- Work with performance and BI to ensure that BCF metrics are reported on as part of monthly metric reporting through Improving System Flow. - Completed
- Neighborhoods work to be incorporated in to ISF plan. - Ongoing.
- Continue to monitor plans for release from stack, engaging with CNWL and SCAS. - Complete.
- Completion of the BCF quarter 4 report. - Complete
- Continue metrics reporting and data reviews as requested by the ISF core group. - Ongoing.

| | | | | 2025 | | | | | 2026 | | | | | |
|--|------------|----------|-----|------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|
| | Start Date | End Date | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| HIU Live with Crown as first PCN (Pilot Site) | | 23/05/25 | | ◆ | | | | | | | | | | |
| Completed PCN and P3 MOUs received by the ICB. | | 30/05/25 | | ◆ | | | | | | | | | | |
| High Intensity Users Go Live | | 30/05/25 | | ◆ | | | | | | | | | | |
| BCF 2024 / 25 Q4 Report | | 31/07/25 | | | | | ◆ | | | | | | | |

Risks

| | |
|--------------------------------|--------------------------------|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | No risks currently identified. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-----------|-----------|------------------------------|
|-----------|-----------|------------------------------|

Issues

| | |
|----------------------------------|---------------------------------|
| Overall Issues Status | GREEN |
| Reason for Overall Issues Status | No issues currently identified. |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000200 |
| Project Name | MK - INW - Bletchley Pathfinder (Project 1-3) |
| Project Team | MK Deal - SRO MKCC |
| Project Aim | <p>To progress two of the Fuller recommendations in Bletchley (1) Proactive & Personalised Care, and (2) Prevention using a 2-staged approach to delivering the projects that will achieve the desired outcomes:</p> <p>Project 1 - Create 'Team Bletchley'</p> <p>Project 2 - Develop neighbourhood ways of working</p> <p>Project 3 - Implement a neighbourhood conferencing/problem solving model</p> |
| Governance & Responsible Group | Bletchley Pathfinder Delivery Board reporting into JLT |
| Geographical Footprint | Milton Keynes |

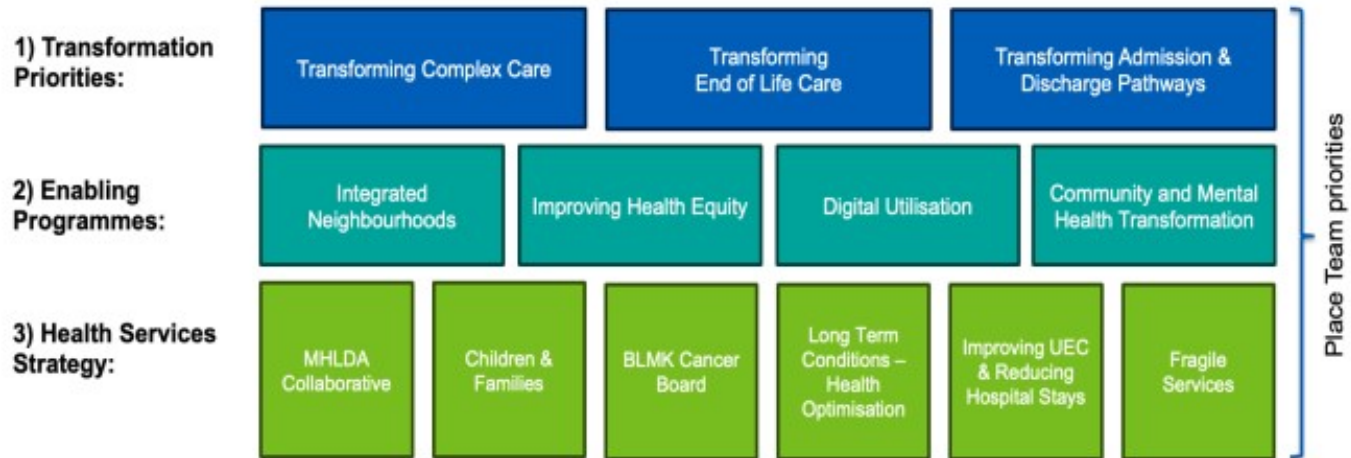
Project Team Members

| Name | Role |
|----------------|-------------------|
| Sandra Vanreyk | Programme Manager |
| Rebecca Green | Programme Manager |
| Tom May | Project Manager |
| Zoe Durman | Project Manager |

Project Status

| | |
|-----------------------------------|---|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Projects on track for delivery against timescales |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

Bletchley Pathfinder projects align with Enabling Programmes - Integrated Neighbourhood Working in the following key areas:

1. Provide more proactive, personalised care and support to people through a multi-disciplinary team approach

A new multi-disciplinary agency approach has been launched in Bletchley building stronger relationships with schools and health and care services. The programme has highlighted how vital early involvement in partnership with education providers is for prevention and early support and is creating a framework that helps avoid duplication and wasted effort, making support more efficient and impactful.

Improved communication and collaboration among professionals is paving the way for more effective approaches to population health management in the future roll out of the neighbourhood working programme across Milton Keynes.

Personalised approaches are embedded within neighbourhood working, utilising a community-focused approach to meet local needs.

2. Help people to stay well for longer as part of a stronger focus on prevention of ill health

Hundreds of residents have had a say in the support they need in Bletchley, monthly Community Hubs have been established where residents can access a range of information and support from diverse groups and health providers, and local clubs have been supported to start-up or expand activities that benefit their community.

Insights from population data have informed the design and delivery of tailored initiatives, ensuring alignment with identified health inequalities and community needs. Collaborative efforts with local partners are enhancing reach and impact, with continuous feedback loops in place to refine approaches and measure outcomes

Progress Update

Progress made in Previous Period

Multi- Agency Forum - (Phase 1) Connecting families more seamlessly with health and care services

- Further socialisation of the Multi-Agency Forum in the South Neighbourhood (Bletchley)
- Additional multi-agency representation within the core panel secured to ensure a holistic support offer.
- Continuous improvement embedded via regular stakeholder input and outcome reviews
- Quarterly update report from the youth mentoring initiative compiled to inform next steps

Initiatives Addressing Wider Determinants of Health

Outcomes from the January Employment, Training, and Wellbeing event have been reviewed and planning has commenced to hold a employment, training and volunteering event in October 2025 in collaboration with Milton Keynes City Council.

- Engagement commenced with multi-agency stakeholders to confirm participation from key partners
- Location secured
- Workshop planning in progress, 2 providers secured
- Communications plan to promote the event and ensure broad reach developed.

Community Engagement

Targeted Outreach Delivery: Continued implementation of the community engagement program, guided by local population health data, to effectively engage priority groups.

- Ongoing partnerships with system colleagues and VCSE (Voluntary, Community and Social Enterprise) organisations are strengthening the delivery of wellbeing sessions in the community. These efforts support a holistic, preventative empowering approach and fosters greater community involvement.
- Strategic Planning: Insights from a stakeholder workshop and population health data have shaped the design of six themed monthly wellbeing events in the South Neighbourhood (Bletchley) between April - July 2025.

Events held May- July 2025

- Mental Health and Wellbeing - Raising awareness and promoting access to support services.
- Cancer Awareness- Promoting participation in screening and providing information on local support services and groups
- Volunteering - Highlighting opportunities for community involvement and strengthening local support networks.

Progress to be made in Next Period

Multi-Agency Forum Phase 1 Connecting families more seamlessly with health and care services

- **Panel** be expanded to include mental health and VCSE representation
- Forum to be rebranded to **'Family Help Panel'** - Problem solving to produce positive outcomes to help families access the right support at the right time and to move forward
- Communications disseminated to schools about the expansion of the project in Q4 2025/26

Multi- Agency Forum Phase 2

- Scoping and data insight gathering - Working group to undertake initial scoping phase, data gathering and evidenced based insights to inform next steps.

Employment, volunteering, and wellbeing event

- Continue engagement with multi-agency stakeholders to confirm participation from key partners
- Define success metrics and begin development of outcome measures to evaluate event impact
- Initiate a communications plan to promote the event and ensure broad reach

Arts for health

Monthly Sessions to be launched in August, early outcomes to be evaluated.

Team Bletchley

Collaborative multi-agency networking event to be held in September in to celebrate Bletchley Pathfinder Projects and Bletchley neighborhood initiatives, share learning and to gain stakeholder feedback to help inform priorities going forward.

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

Existing projects are on track for delivery with no significant risks identified. Phase 2 of the conferencing model has been delayed to ensure neighbourhood priorities align with the 10 Year Health Plan.

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|--|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Roll out multi- agency approach offer to all schools in Bletchley (Phase 1) | | 25/04/25 | ◆ | | | | | | | | | | | | | | |
| Phase 2: Scoping - Data and Insights | 22/04/25 | 15/09/25 | █ | | | | | | | | | | | | | | |
| Conferencing Model (Phase 1) Explore longer term strategic funding options for mentoring provision | 01/09/25 | 15/12/25 | | | | | | | | █ | | | | | | | |

| | | | 2025 | | | | | | | 2026 | | | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|-----|------|-----|-----|-----|-----|
| | Start Date | End Date | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Conferencing Model (Phase 1) Roll out to an additional neighbourhood | 01/12/25 | 31/03/26 | | | | | | | | | | | | |

| Risks | |
|--------------------------------|--|
| Overall Risks Status | AMBER |
| Reason for Overall Risk Status | There has been some slippage within projects that sit in the programme of work. Slippage has been identified in project 2 and 3. There are plans in place to mitigate further risk |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| A permanent location to host a dedicated community hub | Yes | 4 |
| Youth Mentoring - Conferencing Model | Yes | 4 |

| Issues | |
|----------------------------------|--------------|
| Overall Issues Status | GREEN |
| Reason for Overall Issues Status | |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000175 |
| Project Name | MK - Tackling Obesity |
| Project Team | MK Deal - SRO's: MK Public Health and Primary Care |
| Project Aim | <p>The Tackling Obesity (MK deal) is focused on helping people lose weight and maintain a healthy weight through easily accessible weight management programmes, use of technology, pharmacological therapies, and education/prevention work.</p> <p>Anticipated Benefits</p> <ul style="list-style-type: none"> - Develop a Tier 2+ weight management pilot service to support obese CYP and their families - Increase awareness of the local and national weight management services available. - Increase confidence within front-line professionals about having a conversation about excess weight. - Increase referrals into local and national weight management services. - Increased access to healthy food across MK, including while using health services. - Improvements to the environment in MK to make it easier for people to maintain a healthy weight. - Over time, a reduction in the proportion of people aged over 18 with BMIs over 25. - Over time, a reduction in the proportion of Reception and Year 6 who are overweight or obese. |
| Governance & Responsible Group | Tackling Obesity Steering Group reporting into JLT |
| Geographical Footprint | Milton Keynes |

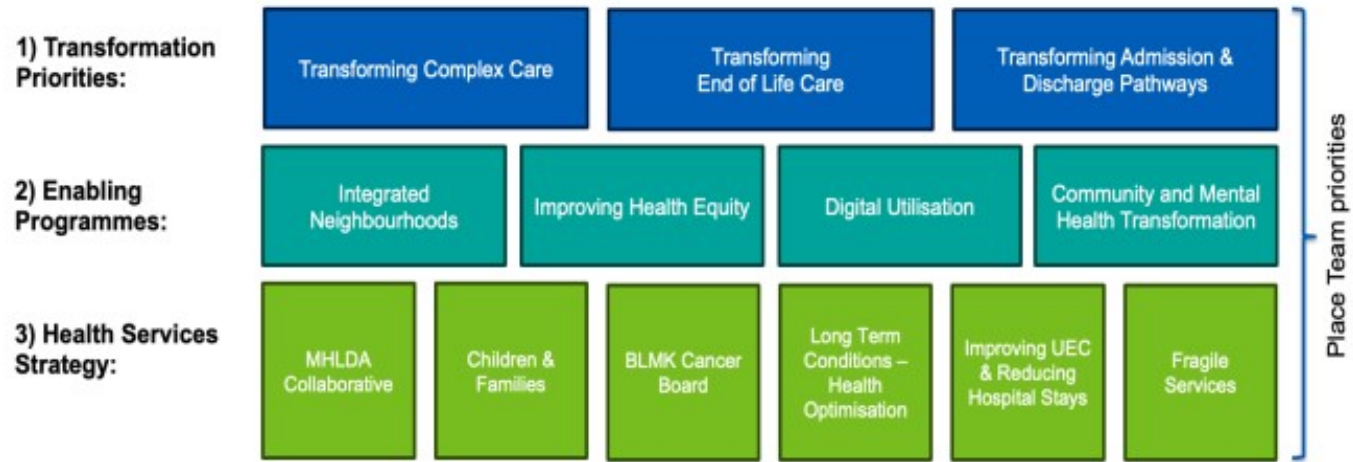
Project Team Members

| Name | Role |
|----------------|-------------------|
| Sandra Vanreyk | Programme Manager |
| Zoe Durman | Project Manager |

| | |
|---------|-----------------|
| Tom May | Project Manager |
|---------|-----------------|

| Project Status | |
|-----------------------------------|----------------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Milestones on track |
| Project Maturity | 3.0 - Implementation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

- 1) **Enabling Programmes**
- **Integrated Neighbourhoods** - The Tier 2+ obesity pilot service for CYP and their families will use a MDT approach with input from specialists in primary and secondary care as well as the community early years team. Links will be made with other key stakeholders such as family centres, education, food banks and VCSE organisations to support CYP living with obesity and their families.
 - **Improving Health Equity** - Obesity disproportionately affects those living in deprivation, also the pilot is located in CMK Medical Centre which serves a largely deprived population who face health inequalities
- 2) **Health Services Strategy**
- **Children and Families** - The Tier 2 + pilot is an intervention targeted at improving outcomes for CYP and their families as part of a whole family approach
 - **Long Term Conditions / Health Optimisation** - Tackling obesity is important as long term obesity can lead to numerous health conditions including type 2 diabetes, coronary heart disease, some cancers, stroke, depression, joint and respiratory problems

Progress Update

| | |
|------------------------------------|---|
| Progress made in Previous Period | <p>Pilot of Tier 2 plus Weight Management service for CYP stakeholder group established and procurement of provider completed in Feb 2025.</p> <ul style="list-style-type: none">- Contract in place with CMK Medical Centre to be the pilot service provider- Budget transferred to provider- Recruited the specialists for form the MDT- Engaged with all MDT members to help develop the pilot service evaluation framework- Scoping for potential CYP service users at CMK Medical Centre |
| Progress to be made in Next Period | <p>Key area of focus:</p> <p>1. Mobilisation of Tier 2 Plus Children and Young People Pilot</p> <ul style="list-style-type: none">- Identify and recruit eligible CYP and their families- Establish the MDT- Deliver education to MDT staff- Finalise service operating procedures- Agree pilot service evaluation framework- Pilot service go live by July 2025 |

Tasks & Milestones

| | |
|--|--------------|
| Overall Tasks & Milestones Status | GREEN |
| Reason for Overall Tasks & Milestones Status | All on track |

| | Start Date | End Date | 2025 | | | | | | | | | | | | 2026 | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|--|---|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Activate (digital wearables) Programme - Commence recruitment for focus group to input into the app design | | 30/05/25 | | ◆ | | | | | | | | | | | | | |
| Integrated behaviour change service - Develop comms plan for Primary Care | | 30/05/25 | | ◆ | | | | | | | | | | | | | |
| Children and Young People Tier 2 Plus Pilot - Mobilisation of service including training and onboarding | | 27/06/25 | | | ◆ | | | | | | | | | | | | |
| CYP Tier 2 plus service start | | 01/07/25 | | | | | ◆ | | | | | | | | | | |
| Healthier Weight Declaration - Progress update on phased implementation for best practice food outlets in MKUH | | 31/07/25 | | | | | ◆ | | | | | | | | | | |
| Year 1 MK2028 Review - Develop and implement a plan based on recommendations (phased approach) | | 30/01/26 | | | | | | | | | | | | | | | ◆ |

Risks

| | |
|--------------------------------|---------------------------|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | No major risks identified |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-----------|-----------|------------------------------|
|-----------|-----------|------------------------------|

Issues

| | |
|----------------------------------|--|
| Overall Issues Status | GREEN |
| Reason for Overall Issues Status | Mitigating actions in place to ensure that the timelines for Tier 2+ mobilisation are kept on track. |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000343 |
| Project Name | BLMK Children, Families, Women's and Maternity (CWM) Board |
| Project Team | Children, Families, Women's and Maternity Board Membership, LMNS |
| Project Aim | As well as delivering the BLMK Health Services Strategy BLMK Health Services Strategy . The Board will be responsible for responding to the government's new 10 Year NHS Plan once it is published this Spring. |
| Governance & Responsible Group | <p>The Children, Families, Women's and Maternity Board (meets quarterly) is established to drive the work. It will not replace existing place-based groups but will focus on where whole system change across the BLMK geography will make the most difference. In this iteration of the governance</p> <p>The CFWM reports to the BLMK Quality and Performance Committee which in turn reports to the Board of the ICB</p> |
| Geographical Footprint | BLMK System |

Project Team Members

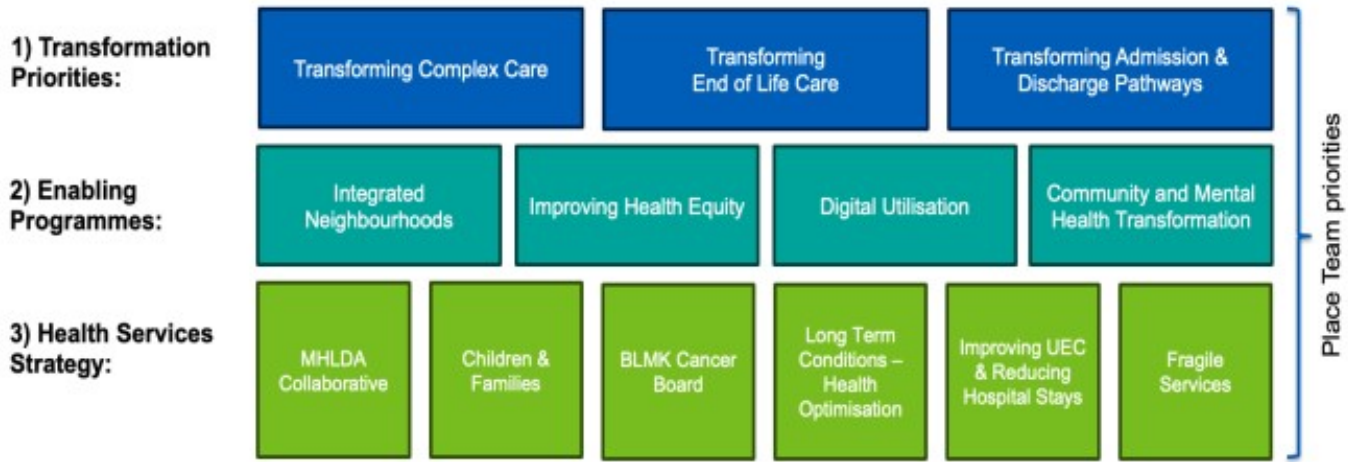
| Name | Role |
|---------------------|--------------------------|
| Cat Lee | Programme Manager |
| Sarah Breton | Programme Manager |
| Sanhita Chakrabarti | Programme Manager |
| Sarah Stanley | Senior Responsible Owner |

Project Status

Overall Project Status **GREEN**

| | |
|-----------------------------------|--|
| Reason for Overall Project Status | <p>On track with current tasks and milestones</p> <p>Initial meeting of the board has already taken place with a system Chair and the programme has outcome measures agreed which were agreed at that board.</p> |
| Project Maturity | 2.0 - Initiation |

System Transformation



| | |
|--|--|
| <p>Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)</p> | <p>One of the six priority delivery vehicles work programmes of the Health Services Strategy</p> |
|--|--|

Progress Update

| | |
|---|---|
| <p>Progress made in Previous Period</p> | <ul style="list-style-type: none"> • Strategic Outcome Measures - work to develop metrics and these have been co-produced with partners and will underpin the work programme of the new BLMK CFWM Board, setting out the difference the programme makes over the longer term (5-10 years). • These will be reviewed on an ongoing basis - outcome measures may need to change to reflect changing priorities and needs in the population. • Building a work programme plan around the 8 identified strategic outcome measures - working group to form around this • Work starting on developing a “wellbeing” measure • The BLMK Childhood Trauma Board will meet monthly through 2025/26 to deliver the workstreams on process and decision-making, assessment and de-escalation and new models of care |
|---|---|

| | |
|---|---|
| <p>Progress to be made in Next Period</p> | <p>Next CFWM Board to meet 01/09/2025</p> |
|---|---|

Tasks & Milestones

| | |
|---|---------------------|
| <p>Overall Tasks & Milestones Status</p> | <p>GREEN</p> |
| <p>Reason for Overall Tasks & Milestones Status</p> | <p>On track</p> |

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|--|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Inaugural Meeting of the Children, Families, Women's and Maternity Board (CFWM) | | 25/04/25 | ◆ | | | | | | | | | | | | | | |
| Terms of Reference | 25/04/25 | 30/05/25 | █ | | | | | | | | | | | | | | |
| CFWM Board | | 01/09/25 | | | | | | | ◆ | | | | | | | | |
| Work programme development - to deliver against agreed strategic outcome measures | 25/04/25 | 30/09/25 | █ | | | | | | | | | | | | | | |

Risks

| | |
|-----------------------------|-------------------|
| <p>Overall Risks Status</p> | <p>TBC</p> |
|-----------------------------|-------------------|

| | |
|--------------------------------|----------------------------------|
| Reason for Overall Risk Status | No risks identified at this time |
|--------------------------------|----------------------------------|

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-----------|-----------|------------------------------|
|-----------|-----------|------------------------------|

Issues

| | |
|----------------------------------|-----------------------------------|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | No issues identified at this time |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000157 |
| Project Name | BLMK Fragile Services - Diagnostics |
| Project Team | Medical Directorate, STT, Diagnostic Elective Collaborative, System Partner Organisations |
| Project Aim | To create the resilience within diagnostics provision to ensure residents are able to access diagnostic tests in the timeframes set by the constitution targets |
| Governance & Responsible Group | Elective and Fragile Service Collaborative - System Chair, Helen Beck (COO, MKUH) BLMK Diagnostics Collaborative Diagnostics Demand Management Oversight Group (BHFT) |
| Geographical Footprint | BLMK System |

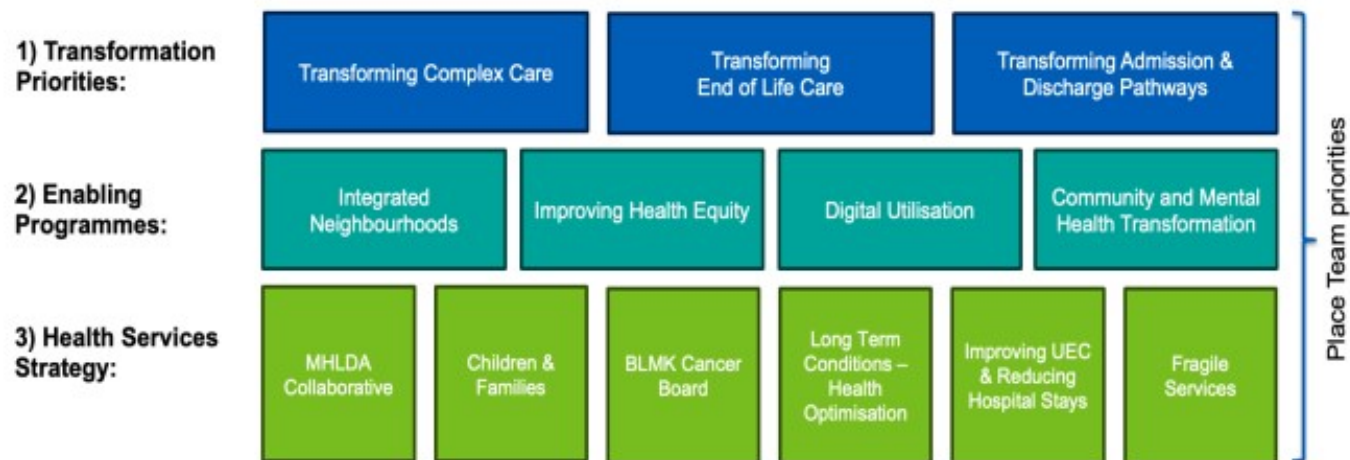
Project Team Members

| Name | Role |
|---------------------|--------------------------|
| Sanhita Chakrabarti | Executive Lead |
| Michael Ramsden | Programme Manager |
| Cat Lee | Programme Manager |
| Maureen Okolie | Project Support |
| Andrew Rochford | Senior Responsible Owner |
| Hema Sutton | Subject Matter Expert |

Project Status

| | |
|-----------------------------------|--|
| Overall Project Status | AMBER |
| Reason for Overall Project Status | The Diagnostics Programme lead by the STT has been in progress for several years and has established completed and in-progress workstreams. The current phase of the programme under the Fragile Services programme of the Health Services strategy is still building but it is expected to be Green by next period when system-wide governance structures and collaborative groups will be in place with more effective processes and clear aims. |
| Project Maturity | 2.0 - Initiation |

System Transformation



| | |
|---|--|
| Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above) | This programme is one of the six priorities identified as delivery vehicles for the Health Services Strategy |
|---|--|

Progress Update

Progress made in Previous Period

- **CDC Demand & Capacity Analysis:** Build completed by AGEM in collaboration/consultation with key project team - now live on Athena to support understanding of activity, demand and capacity across Milton Keynes acute and CDC sites.
- Date confirmed for first **BLMK Elective and Fragile Services Collaborative** – System Chair confirmed and TOR draft in progress
- **Clinical Biochemistry variation in practice QI Project:** Clinical team at BHFT, supported by BLMK Clinical Lead (Primary Care engagement) continue to focus on demand management for the tests below. Key engagement with MKUH established going forward.
 - calprotectin in >60's
 - allergy testing in adults
 - haematinics
 - HbA1c in children
 - auto-immunity testing
- **iRefer Pathology - ON HOLD**

There are a few different factors considered in decision to defer our application for any external source of funding for i-refer pathology (until 2026) for the following reasons:

1. Upgrade to ICE version 8 is on the critical path for this project to realise maximum benefits, and is not scheduled for delivery this FY.
2. Clinical focus currently on the five most significant demand management tests which are not dependent on i-refer
3. The PAH i-refer work focused on different tests to the ones we have identified in BLMK as having biggest impact. The test expected to have greatest savings in BLMK linked to i-refer based on the PAH learning is BNP at up to £22k, but we already have a local intervention in place on BNP so impact is not likely to be as great as seen at PAH
4. We understand that the funding allocated to the ME5 network has all been allocated.

BHFT will ensure that they are prepping a more robust version of the business case and benefits analysis for i-refer in the background, and will try and have this on the shelf for any future rounds of funding.

- **BLMK Diagnostics Collaborative:** on hold for July/Aug in order to refresh with clear, effective aims and robust accountability/escalation routes - meetings in place (August) to review and progress.
- **X-Ray provision at MK UTC:** ongoing work to understand potential benefit and whether feasible. Some data mapping complete but need to link in with MKUH for fuller understanding and to consider joint working and funding potential.

| | Start Date | End Date | 2025 | | | | | | | | | | | | 2026 | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|---|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Implementation of iRefer for Radiology - BHFT | | 01/08/25 | | | | | | ◆ | | | | | | | | | |
| CDC Dashboard | 01/05/25 | 07/08/25 | | █ | | | | | | | | | | | | | |
| Elective and Fragile Services Programme Board - First Meeting | | 10/09/25 | | | | | | | ◆ | | | | | | | | |
| Pilot of new pathways (East Bedford PCN) | 08/09/25 | 19/09/25 | | | | | | | █ | | | | | | | | |
| Mobilisation of North Bedfordshire CDC | 01/09/25 | 30/09/25 | | | | | | | █ | | | | | | | | |
| Launch Implementation of new pathways | | 03/11/25 | | | | | | | | | | ◆ | | | | | |
| Mobilisation of Luton CDC | | 31/01/26 | | | | | | | | | | | | | | ◆ | |

| Risks | |
|--------------------------------|---|
| Overall Risks Status | AMBER |
| Reason for Overall Risk Status | Risks identified but potential mitigations underway - hope to be green by next update |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| Reduction in revenue available (National "pot") for Luton Diagnostic Hub | Yes | 16 |
| Workforce resource to manage programme | Yes | 6 |
| Limitation to Demand and Capacity Review Data | Yes | 4 |
| BLMK ICB Organisational Changes | Yes | |
| PMO Support for Diagnostic Collaborative | Yes | 1 |

| Issues | |
|----------------------------------|---------------------------------|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | No issues identified at present |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

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|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000335 |
| Project Name | BLMK Green Plan 2025-2032 (overarching) |
| Project Team | BLMK ICB Sustainability and Growth |
| Project Aim | Improving health and wellbeing in harmony with the environment. |
| Governance & Responsible Group | BLMK Green Plan Leadership Group |
| Geographical Footprint | BLMK System |

Project Team Members

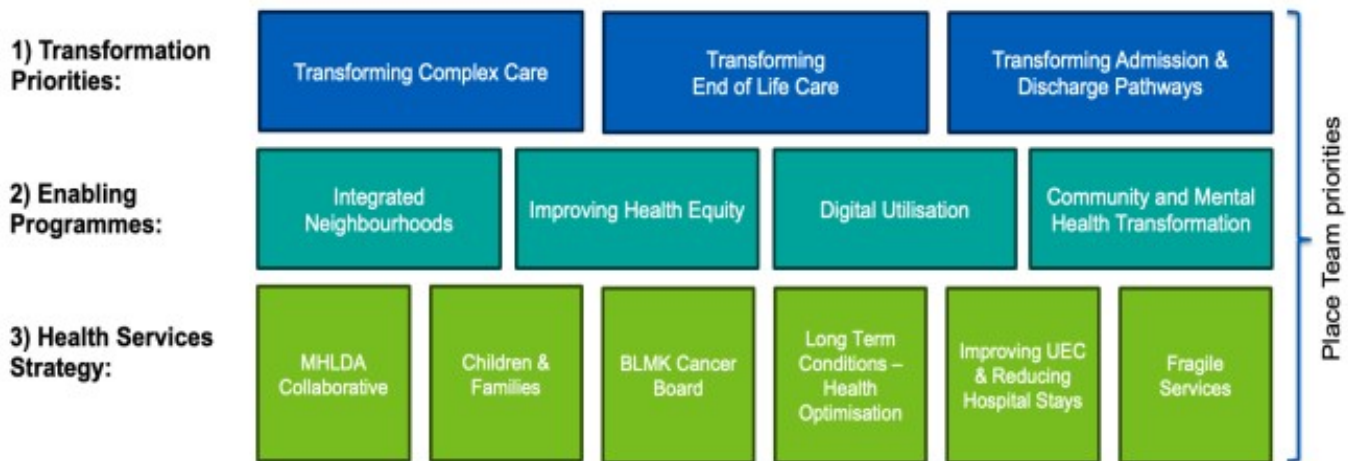
| Name | Role |
|---------------|--------------------------|
| Tim Simmance | Programme Manager |
| Fran Barnes | Programme Manager |
| Sian Pither | Project Manager |
| Dean Westcott | Senior Responsible Owner |

Project Status

| | |
|------------------------|--------------|
| Overall Project Status | GREEN |
|------------------------|--------------|

| | |
|-----------------------------------|--|
| Reason for Overall Project Status | <p>The programme to deliver the BLMK Green Plan 2025-2032 has only just commenced. However, the programme is highly ambitious and requires fundamental changes to the way healthcare services are designed and delivered.</p> <p>The two Board Assurance Framework risks, BAF0007 Health impacts from climate change and BAF0022 Achieving Net Zero, are rated as 16 and 12 respectively, highlighting the risk to achieving the outcomes which the Green Plan is addressing.</p> <p>Therefore the overall rating is Green, but key risks could result in the programme being delayed or failing to achieve its objectives, which will need oversight and management. These include:</p> <ol style="list-style-type: none"> 1. The person resource allocated to the programme is small, with progress to be made by weaving action throughout other ICB and Trust functions, adding to the breadth of outcomes each function is looking to achieve. This requires a cultural shift so that environmental outcomes are seen as an integral part of all functions, not additional. 2. There is no direct financial resource committed to delivery, and a lack of capital to decarbonise estate, with any investment requiring approval of individual business cases that may have a medium term return on investment. 3. There are many competing priorities that could result in deprioritising of the Green Plan actions, or create a conflict in achieving other goals (for example short-term financial balance, waiting list reduction). 4. A large proportion of overall healthcare emissions lie in the supply chain, reliant on other organisations to achieve their own carbon reduction objectives. Healthcare organisations can only influence suppliers, and financial imperatives may result in the cheapest rather than the greenest consumables and services being procured. 5. The reconfiguration of ICBs will likely result in responsibility for Green Plan and sustainability moving over time to providers. The implications for system-wide action are not yet known and may delay or inhibit progress. |
| Project Maturity | 3.0 - Implementation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

Environmental degradation and climate change pose significant risks to the health of the population, both in terms of acute events (for example extreme weather, service disruption) and chronically (for example, exposure to pollutants, new diseases, air quality).

Action to reduce the negative impacts on the environment can serve to improve the health of the population in general and reduce the demand for healthcare services. They are also required as a response to statutory requirements pertaining to environmental and climate change laws (reflected within the Health and Care Act 2022).

Environmentally sustainable service design not only applies low carbon alternatives, but is fundamentally preventative, encourages better self-care and self-directed recovery, and requires services to be efficient and effective. A system built on these principles should help improve care delivery across the Transformation Priorities, Enabling programmes, and Health Services Strategy areas, whilst simultaneously providing solutions to help address some of the challenges and objectives within those service areas.

Progress Update

Progress made in Previous Period

Delivery of the Green Plan 2022-2025 resulted in >10ktCO₂e emissions reductions (~20% of directly controllable emissions).

The new Green Plan for 2025-2032 was approved in June 2025 and has been published on the Health and Care Partnership website. Delivery of this has now commenced.

Progress to date (July and August 2025) includes:

- Refreshing the governance oversight group, putting in place a reporting rhythm and refreshing the membership of the Green Plan Leadership Group.
- Data and metrics - long list of metrics collated, reflecting all Green Plan 2025-2032 commitments and requirements from NHS England, identifying those which could act as Key Risk Indicators.
- Primary Care sustainability - a sustainability network for primary care (GP and POD) has been convened, and work has commenced on developing a Primary Care Green Plan (as agreed previously with the Primary Care Delivery Group).
- Adaptation - Trusts have been tasked with completing or refreshing Climate Change Risk Assessments, which will underpin new Adaptation plans (to be developed during 2025/26).
- Providing subject matter expertise to Community and Mental Health Service Transformation programme and to respond to two public consultations (Milton Keynes Sustainability Strategy and the Universal Destinations & Experiences Entertainment Resort Complex).

Progress to be made in Next Period

Expected activities in next period (Q3 2025/26):

- Culture:
 - Environmental skills: develop proposal for developing staff skills in healthcare carbon and environmental awareness (with level aligned to requirements of specified cohorts - e.g. board members, managers, general staff etc.)
 - Communications and engagement: refresh website with information and tools for staff and public
 - Primary Care: draft primary care Green Plan
 - Data and metrics: refine dataset for regular reporting, including first draft of internal carbon footprint calculation method.
 - Assess impact of ICB reconfiguration and make recommendations to embed sustainability in new structures
- Adaptation:
 - Adaptation: support drafting of Adaptation plans for Trusts, and draft system Climate Health Adaptation report.
 - Review outputs from analyses undertaken in 2024/25 by Greater South East Net Zero Energy Hub on opportunities to decarbonise estates
- Resource-consciousness:
 - Social Value (anchor workstream): define protocol and metric set for social value requirements in procurements, including process for reporting delivery of social value.
 - Create business case for system-wide office asset reuse platform
 - Support Trusts to embed and enhance walking aid reuse services.
 - Identify and initiate projects within Primary care to reduce consumable use.
- Environmentally sustainable services:
 - Review Trust progress against best practice and identify opportunities.

Tasks & Milestones

| | |
|--|--|
| Overall Tasks & Milestones Status | GREEN |
| Reason for Overall Tasks & Milestones Status | See rationale for overall project / programme status - programme has only just entered implementation. |

| | | 2025 | | | | | | | 2026 | | | | | |
|--|------------|----------|-----|-----|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|
| | Start Date | End Date | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| | | | | | | | | | | | | | | |

Risks

| | |
|----------------------|--------------|
| Overall Risks Status | AMBER |
|----------------------|--------------|

Reason for Overall Risk Status

Risks are currently managed separately from Verto. Aside from the two BAF risks relating to the Project, a summary of the main risks is provided below:

1. The person resource allocated to the programme is small, with progress to be made by weaving action throughout other ICB and Trust functions, adding to the breadth of outcomes each function is looking to achieve. This requires a cultural shift so that environmental outcomes are seen as an integral part of all functions, not additional. Likelihood 4 x Consequence 3 = Project Risk Rating 12
2. There is no direct financial resource committed to delivery, and a lack of capital to decarbonise estate, with any investment requiring approval of individual business cases that may have a medium term return on investment. Likelihood 3 x Consequence 4 = Project Risk Rating 12
3. There are many competing priorities that could result in deprioritising of the Green Plan actions, or create a conflict in achieving other goals (for example short-term financial balance, waiting list reduction). Likelihood 4 x Consequence 3 = Project Risk Rating 12
4. A large proportion of overall healthcare emissions lie in the supply chain, reliant on other organisations to achieve their own carbon reduction objectives. Healthcare organisations can only influence suppliers, and financial imperatives may result in the cheapest rather than the greenest consumables and services being procured. Likelihood 4 x Consequence 3 = Project Risk Rating 12
5. The reconfiguration of ICBs will likely result in responsibility for Green Plan and sustainability moving over time to providers. The implications for system-wide action are not yet known and may delay or inhibit progress. Likelihood 4 x Consequence 3 = Project Risk Rating 12

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-----------|-----------|------------------------------|
|-----------|-----------|------------------------------|

Issues

| | |
|----------------------------------|--------------------------|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | Issues yet to be defined |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000389 |
| Project Name | BLMK Hospital Opportunities Assessment |
| Project Team | System Transformation Team / PA Consulting |
| Project Aim | <ol style="list-style-type: none">1. Identify opportunities to deliver the best possible population health outcomes, rebalancing services to support proactive, preventative care closer to home.2. Identify opportunities to improve sustainability of our services and organisations across BLMK, reducing variation, improving performance and delivering positive clinical outcomes.3. Identify where transformation and investment can lay the foundation for a longer term clinical, workforce and capital strategy, aligned with system-wide priorities, and ensure acute providers are supported to adapt as part of a more sustainable care system.4. Inform the re-specification of community and mental health services to better meet the needs of the BLMK population |
| Governance & Responsible Group | BLMK ICB Board BLMK Executives |
| Geographical Footprint | BLMK System |

Project Team Members

| Name | Role |
|-----------------|-------------------------------|
| Tara Dear | Head of STT |
| Cat Lee | Project Manager |
| Maureen Okolie | Project Support |
| Andrew Rochford | Senior Responsible Owner |
| Matt Rogers | Senior Transformation Manager |

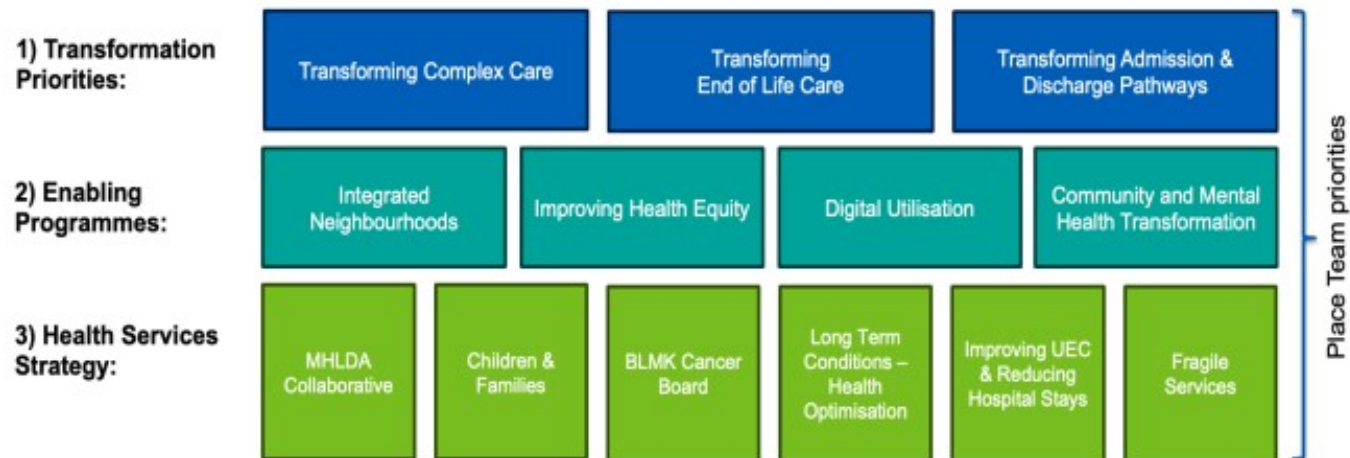
Project Status

Overall Project Status

GREEN

| | |
|-----------------------------------|--|
| Reason for Overall Project Status | Working at pace, significant progress already in phase 1. First HOA Programme Board to take place 21/08/25 |
| Project Maturity | 2.0 - Initiation |

System Transformation



| | |
|---|---|
| Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above) | Through wide-reaching stakeholder engagement and fundamental aims of the programme, it touches on all of the system priorities and enablers |
|---|---|

Progress Update

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|----------------------------------|---|
| Progress made in Previous Period | <p>Phase 1: Listening and Discovery</p> <ul style="list-style-type: none"> • Programme Governance agreed • Started stakeholder engagement • Draft TOR for Programme Board (for approval 21/08/25) • First draft of diagnostic report shared with Programme Board papers for comment |
|----------------------------------|---|

| | |
|------------------------------------|--|
| Progress to be made in Next Period | <p>Phase 1: Listening and Discovery</p> <ul style="list-style-type: none"> • First HOA Programme Board to meet 21/08/25 • CFO group to meet • Finalise diagnostic report • Continued stakeholder engagement 1:1s that have not yet happened <p>Phase 2: Testing and Refining</p> <ul style="list-style-type: none"> • First joint-board development session to take place - 26/09/25 • Start identifying 'left shift' intervention opportunities • Start identifying and exploring model of care options – clinical stakeholder groups to provide view on options |
|------------------------------------|--|

Tasks & Milestones

| | |
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| Overall Tasks & Milestones Status | GREEN |
| Reason for Overall Tasks & Milestones Status | Current logged tasks and milestones are on track. Where potential slippage has been identified, project team have adjusted timelines and processes to mitigate |

| | Start Date | End Date | 2025 | | | | | | 2026 | | | | | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | |
| First draft of Diagnostic Report | | 18/08/25 | | | | | ◆ | | | | | | | | |
| First HOA Programme Board | | 21/08/25 | | | | | ◆ | | | | | | | | |
| Stakeholder Engagement | 09/07/25 | 17/09/25 | | | | | | | | | | | | | |
| Phase 1: Listening and Discovery | 09/07/25 | 17/09/25 | | | | | | | | | | | | | |
| First Joint Development Board Session | | 26/09/25 | | | | | | ◆ | | | | | | | |
| Phase 2: Testing and Refining | 01/09/25 | 09/10/25 | | | | | | | | | | | | | |
| Second Joint Development Board Session | | 24/10/25 | | | | | | | | ◆ | | | | | |
| Phase 3: Validation and Recommendations | 10/10/25 | 28/11/25 | | | | | | | | | | | | | |

Risks

| | |
|----------------------|------------|
| Overall Risks Status | TBC |
|----------------------|------------|

| | |
|--------------------------------|--|
| Reason for Overall Risk Status | TBC - Update for November Portfolio Report |
|--------------------------------|--|

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-----------|-----------|------------------------------|
|-----------|-----------|------------------------------|

Issues

| | |
|----------------------------------|--|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | TBC - Update for November Portfolio Report |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

| | |
|--------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000341 |
| Project Name | BLMK Mental Health Transformation Programme |
| Project Team | The Mental Health Transformation Programme comprises of service users and carers and a range of organisations such as the ICB, the mental health trusts (ELFT and CNWL), VCSE organisations, primary care, Local Authority organisations and the acute trusts. |
| | <p>The vision of the BLMK 10 year mental health and well-being plan is centred around preventing our residents from becoming unwell, promoting good mental health and supporting people living with mental illness to recover and live well. We commit to doing this by:</p> <ul style="list-style-type: none"> • Supporting the general population to take action and look after their mental wellbeing. • Preventing the onset of mental health difficulties, by taking action to address the factors which play a crucial role in shaping mental health and wellbeing outcomes for adults and children. • Supporting services to continue to expand and transform to meet the needs of people who require specialist support. <p>Since 2019 there has been significant progress made across BLMK with mental health developments including increased access to mental health services (perinatal mental health services, children and young people’s mental health services, community mental health services and NHS Talking Therapies services) and in particular the mobilisation of new initiatives such as:</p> <ul style="list-style-type: none"> • Perinatal mental health services (Bedfordshire and Luton) and Maternal Mental Health Services (Across BLMK) • The creation of mental health support teams in schools • Dedicated rough sleeping provision in Luton and Milton Keynes • 24/7 mental health telephone line available through NHS 111 and crisis cafes/lounges provided by MIND BLMK as well as suicide prevention support through the suicide prevention pathway service • Increased access for children and young people and adults to eating disorder services • Increased access for people with mental health problems into employment through either the Individual Placement and Support Services or through the employment advisors working in the NHS Talking Therapies Services • Increased access for people with severe mental illness to having an annual physical health checks • Increased access to memory assessment services to support with dementia diagnosis and post-diagnosis support. <p>Although there has been significant progress as highlighted above, there is still an opportunity for further mental health improvements to be made across BLMK. The main national mental health priorities for 2025-26 as outlined in the priorities and operational planning guidance are to improve patient flow through mental health crisis and acute pathways and access to children and young people’s mental health services. To support the national mental health objectives for 2025/26, there is an expectation for ICBs to meet the Mental Health Investment Standard (MHIS) and work with providers to:</p> <ul style="list-style-type: none"> • Deliver the 10 high impact actions for mental health discharges and ensure that system discharge plans include mental health |

acute pathways to reduce average lengths of stay in the adult acute mental health pathway, improve local bed availability and reduce the need for inappropriate out of area placements

- Reduce waits longer than 12 hours in A&E through: maximising the use of crisis alternatives, including 111 mental health option, crisis resolution and home treatment teams, and community mental health services to keep people well at home
- Robust system oversight, implementation of the mental health OPEL framework and the use of the mental health UEC action cards
- Improve productivity by reducing unwarranted variation in the numbers of CYP accessing services and the number of contacts per whole time equivalent hours worked
- Reduce unwarranted variation in the numbers of CYP accessing services by improving productivity and increasing the number of direct and indirect contacts per whole time equivalent hours worked
- Reduce local inequalities in access to CYP mental health services, between disadvantaged groups and the wider CYP population
- Expand mental health support teams consistent with the government's aim of reaching 100% coverage by 2029/30
- Ring-fenced funding is available to support the delivery of effective courses of treatment within NHS Talking Therapies and reduce ill-health related inactivity, through access to individual placement support (IPS).
- To continue to reform and improve mental health services and improve value for money in the NHS, all mental health providers will be asked to submit, implement and report against a plan to improve productivity during 2025/26.
- In line with the proposed Mental Health Act reform, ICBs should work with local system colleagues to ensure that there is high quality and accessible community infrastructure in place for people with a learning disability and autistic people. They should also ensure that admissions to a mental health hospital are for assessment and treatment that can only be delivered in an inpatient setting.

Local Priorities for BLMK

The following are local priorities which have been identified for BLMK:

Prevention – (Preventing sickness not just treating it) Continue to implement the suicide prevention plan from 2024-28
Continuing to support the University of Bedfordshire with their work relating to the University Mental Health Charter
Continue to implement the BLMK 10 year mental health and wellbeing plan and suggestions from the 7 sessions run relating to the development of the national 10 Year Health Plan

Early Intervention – (Preventing sickness not just treating it) Continuing to develop the Mental Health Support Teams
Children and Young Peoples Mental Health developments - Bedfordshire and Luton's Children and Adolescent Mental Health Services are refreshing the local Getting Advice offer by developing a Children and Adolescent Mental Health Community Access Service (CAS).
Continue to develop the Early Intervention in Psychosis Services through the National Clinical Audit of Psychosis
On-going implementation of the Milton Keynes Wellbeing Service provided by VCSE providers and the VCSE provider, CHUMS, continuing to provide an early intervention hub supporting CYP across Bedfordshire and Luton.

Support – (Moving from hospital to community)
Continuing to implement co-production with people with lived experience and carers in all mental health developments/improvements
A focus on ensuring easy access to support, particularly focusing on children and young people's mental health access, perinatal mental health access and access to Individual Placement and Support Services. A focus on the NHS Talking Therapies metrics relating to completing treatment, reliable recovery and reliable improvement as well as continuing to track dementia diagnosis rates and

Project Aim

community mental health services access

A focus on reducing waiting times (Both non-urgent and urgent waiting times) which includes the 4 week wait ambition including outcomes, careplans, interventions (For both Children and Young People and Adults) and assessments (For adults)

Reducing local health inequalities including tracking annual physical health checks for people with severe mental illness and progressing with access to children and young people's mental health services for certain ethnic groups, age, gender and deprivation (Core20Plus5)

The mental health trusts continuing to implement the Patient and Carer Race Equality Framework

Addressing the wider determinants of health with a particular focus on mental health and employment – Continuing to provide the employment advisors in NHS Talking Therapies Services and expanding the Individual Placement and Support Services

Commence with being involved in the development of Neighbourhood Health Services – A particular focus in Milton Keynes on progressing with a 24/7 Mental Health Neighbourhood Centre

Continue with the work regarding ADHD and Autism developments

Continue with the S117 and Specialist placements work including housing

Continue with intensive and assertive community mental health care developments **Urgent and emergency mental health care – (Moving from hospital to community)** Reduce 12 hour waits in A&E through: maximising the use of crisis alternatives, including 111 mental health option, crisis resolution and home treatment teams, and community mental health services to keep people well at home

Progression of the crisis house development and an additional 9 acute in-patient mental health beds in Bedfordshire and Luton

Progression of the urgent and emergency mental health pathway across BLMK

Continue to focus on meeting the 4 core functions of a comprehensive crisis offer for children and young people under 18 as outlined in the urgent and emergency mental health care for children and young people: national implementation guidance

On-going work relating to Right Care Right Person and evaluating its impact **Making better use of technology**

Mobilisation of crisis text services across BLMK

Milton Keynes NHS Talking Therapies Service continuing to pilot Wysa and to evaluate its impact

Milton Keynes Children and Adolescent Mental Health Services continuing to pilot using digital technology such as using anathem, systemconnect and visualisation.

Quality

Improving admission avoidance, patient flow and discharge - Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Programme – Includes eliminating inappropriate out of area placements and reducing average length of stay and OPEL framework implementation

Undertake an Individual Placement and Support fidelity review in Milton Keynes and preparing for these in Bedfordshire and Luton
Rough Sleeping evaluation

Reviewing dementia pathways across BLMK

Community mental health services (Adults and older adults) review as well as mapping BLMK progress once the quality standards are published

Eating disorder developments – Reviewing children and young people's eating disorders provision once the national children and young people's eating disorders guidance has been published

| | |
|--------------------------------|--|
| | |
| Governance & Responsible Group | <p>Mental Health Delivery Group</p> <p>BLMK LDA Transformation Board</p> <p>BLMK MHLDA Programme Board</p> <p>BLMK ICS CEO Group</p> <p>BLMK MHLDA Collaborative Committee</p> <p>Board of the ICB</p> |
| Geographical Footprint | BLMK System |

Project Team Members

| Name | Role |
|--------------------|-------------------|
| Michael Farrington | Programme Manager |
| Cat Lee | Programme Manager |

Project Status

Overall Project Status

GREEN

There are a number of areas where performance is good which are as follows:

Perinatal mental health access

Early Intervention in Psychosis waiting times standard

Meeting the dementia diagnosis rate

Access to community mental health services

Supporting people to complete a course of treatment and there be reliable improvement and reliable recovery through NHS Talking Therapies Services

72 hr follow up following discharge from an adult mental health in-patient unit

Reason for Overall Project Status

6 and 18 week waiting times standards for NHS Talking Therapies Services

There are a number of areas that the programme are currently focusing on:

Children and Young Peoples Mental Health

Starting to mobilise 2 additional Mental Health Support Teams as well as starting to fully implement the recently mobilised 3 new Mental Health Support Teams

Increasing access to children and young peoples mental health services

Meeting children and young peoples eating disorders waiting times standards

Urgent and Emergency Mental Health Care

Starting to plan for the mobilisation of crisis text services.

Considering mental health crisis assessment centres

Starting to plan for a crisis house and an additional 9 acute mental health inpatient beds in Bedfordshire and Luton

Reducing average length of stay for adults in mental health in-patient services

Eliminating inappropriate out of area placements

Community mental health transformation (For adults and older adults)

Increasing access to Individual Placement and Support Services by expanding the workforce, improving productivity and data recording and data flow.

Progressing with intensive and assertive community mental health care

Increasing access to annual physical health checks for people with SMI

Considering 24/7 neighbourhood mental health centres

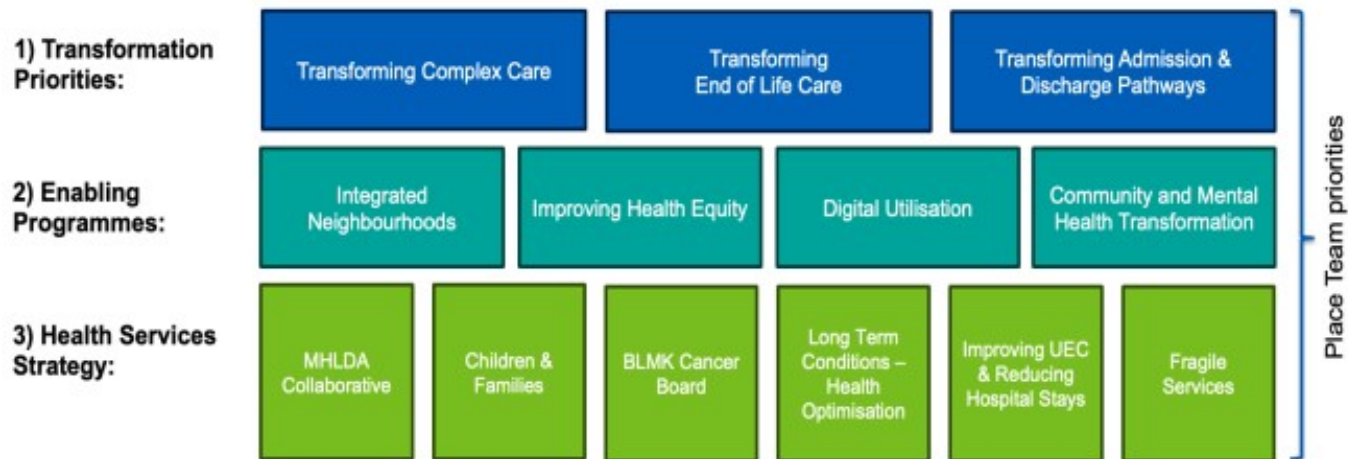
NHS Talking Therapies Services developments

Continuing to expand support for people with common mental health problems to NHS Talking Therapies Services.

Finances

There is also a focus on implementing a financial recovery programme to support with addressing the mental health financial challenge that BLMK is experiencing. The schemes that are going to be focused on are still being developed.

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

The Mental Health Transformation Programme (MHLDA Collaborative) is identified as one of the six priority programmes for delivery of the Health Services Strategy. The BLMK mental health programme board oversees the work of the Mental Health Transformation Programme as detailed in this project

Progress Update

In the previous period there has been a particular focus on the following developments:

Crisis Text Service development

There is currently the planning of how crisis text services can be implemented across BLMK.

Review of intensive and assertive community treatment for people with severe mental health problems

Work is on-going to continue to develop intensive and assertive community mental health care across BLMK.

Mental Health Support Team expansion for children and young people

There continues to be the mobilisation of the 3 Mental Health Support Teams and starting to mobilise 2 additional Mental Health Support Teams for children and young people

Individual Placement and Support Service expansion

Progress made in Previous Period

There continues to be the expansion of the Individual Placement and Support Services across BLMK so that more people with severe mental illness can be supported into employment.

Increasing the number of people completing treatment and improving peoples recovery who receive support through NHS Talking Therapies Services

There continues to be a focus on increasing the number of people completing treatment and improving peoples recovery who receive support through NHS Talking Therapies Services.

24/7 Neighbourhood Mental Health Centres

Six new Neighbourhood Mental Health Centres have been launched and are offering 24/7 community support for individuals with serious mental illness. Building on the success of the community transformation programme, these centres integrate crisis intervention, community support, and open access beds to facilitate extra support - tailored to local needs.

Rooted in local neighbourhoods, individuals can visit without a referral and receive help from a range of professionals including psychiatrists, social workers, and peer support workers, and support such as psychological therapies, medication support, and assistance with related issues such as housing or employment. Each centre, led by an NHS provider, will work in partnership with people with lived experience, as well as voluntary, charity, faith and social enterprise organisations. With a strong focus on open access, continuity of care and fostering trusted therapeutic relationships, the centres will provide support closer to home, reducing the need for out-of-area hospital inpatient treatment, and ensuring people can maintain a sense of citizenship and belonging in their community while accessing the service. The six centres are located in Whitehaven, York, Birmingham East Central, Tower Hamlets, Lewisham, and Sheffield. Milton Keynes is an associate site to start taking this work forward. Work is commencing to explore the opportunities to develop this further across BLMK.

Crisis Mental Health Assessment Centres

Work is commencing to explore the possibility of mobilising crisis mental health assessment centres across BLMK.

Urgent and Emergency Mental Health Care

Work is progressing to improve the urgent and emergency mental health care pathway across BLMK. In Bedfordshire and Luton there is a focus on setting up a crisis house and opening an additional 9 acute mental health in-patient beds.

In the next period there will be a focus on the following:

Crisis Text Service development

There will continue to be planning of how crisis text services can be implemented across BLMK.

Review of intensive and assertive community treatment for people with severe mental health problems

Work is on-going to continue to develop intensive and assertive community mental health care across BLMK.

Increasing access to mental health services for children and young people

There will continue to be a focus on increasing access to mental health services for children and young people.

Mental Health Support Team expansion for children and young people

There continues to be the mobilisation of the 3 Mental Health Support Teams and starting to mobilise 2 additional Mental Health Support Teams for children and young people

Individual Placement and Support Service expansion

There continues to be the expansion of the Individual Placement and Support Services across BLMK so that more people with severe mental illness can be supported into employment.

Increasing the number of people completing treatment and improving peoples recovery who receive support through NHS Talking Therapies Services

There continues to be a focus on increasing the number of people completing treatment and improving peoples recovery who receive support through NHS Talking Therapies Services.

24/7 Neighbourhood Mental Health Centres

Six new Neighbourhood Mental Health Centres have been launched and are offering 24/7 community support for individuals with serious mental illness. Building on the success of the community transformation programme, these centres integrate crisis intervention, community support, and open access beds to facilitate extra support - tailored to local needs.

Rooted in local neighbourhoods, individuals can visit without a referral and receive help from a range of professionals including psychiatrists, social workers, and peer support workers, and support such as psychological therapies, medication support, and assistance with related issues such as housing or employment. Each centre, led by an NHS provider, will work in partnership with people with lived experience, as well as voluntary, charity, faith and social enterprise organisations. With a strong focus on open access, continuity of care and fostering trusted therapeutic relationships, the centres will provide support closer to home, reducing the need for out-of-area hospital inpatient treatment, and ensuring people can maintain a sense of citizenship and belonging in their community while accessing the service. The six centres are located in Whitehaven, York, Birmingham East Central, Tower Hamlets, Lewisham, and Sheffield. Milton Keynes is an associate site to start taking this work forward. Work is commencing to explore the opportunities to develop this further across BLMK.

Crisis Mental Health Assessment Centres

Work is commencing to explore the possibility of mobilising crisis mental health assessment centres across BLMK.

Urgent and Emergency Mental Health Care

Work is progressing to improve the urgent and emergency mental health care pathway across BLMK as well as focusing on the mental health crisis care waiting times ambitions. In Bedfordshire and Luton there is a focus on setting up a crisis house and opening an additional 9 acute mental health in-patient beds.

Patient and Carer Race Equality Framework

Progress to be made in Next Period

The mental health trusts continue to implement the Patient and Carer Race Equality Framework

Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Programme

There is a focus on improving the quality of mental health in-patient care which includes eliminating inappropriate out of area placements, reducing the use of restrictive practice and reducing the average length of stay.

Implementing the mental health operational priorities across BLMK

There is an on-going focus on delivering the following mental health operational priorities across BLMK:

- Deliver the 10 high impact actions for mental health discharges and ensure that system discharge plans include mental health acute pathways to reduce average lengths of stay in the adult acute mental health pathway, improve local bed availability and reduce the need for inappropriate out of area placements
- Reduce waits longer than 12 hours in A&E through: maximising the use of crisis alternatives, including 111 mental health option, crisis resolution and home treatment teams, and community mental health services to keep people well at home
- Robust system oversight, implementation of the mental health OPEL framework and the use of the mental health UEC action cards
- Improve productivity by reducing unwarranted variation in the numbers of CYP accessing services and the number of contacts per whole time equivalent hours worked
- Reduce unwarranted variation in the numbers of CYP accessing services by improving productivity and increasing the number of direct and indirect contacts per whole time equivalent hours worked
- Reduce local inequalities in access to CYP mental health services, between disadvantaged groups and the wider CYP population
- Expand mental health support teams consistent with the government's aim of reaching 100% coverage by 2029/30
- Ring-fenced funding is available to support the delivery of effective courses of treatment within NHS Talking Therapies and reduce ill-health related inactivity, through access to individual placement support (IPS).
- To continue to reform and improve mental health services and improve value for money in the NHS, all mental health providers will be asked to submit, implement and report against a plan to improve productivity during 2025/26.
- In line with the proposed Mental Health Act reform, ICBs should work with local system colleagues to ensure that there is high quality and accessible community infrastructure in place for people with a learning disability and autistic people. They should also ensure that admissions to a mental health hospital are for assessment and treatment that can only be delivered in an inpatient setting.

Tasks & Milestones

Overall Tasks & Milestones Status

AMBER

There are a number of tasks that the BLMK mental health transformation programme are delivering which fall under the following areas of focus:

- Perinatal mental health
- Children and young people's mental health
- Adults and older adults common mental health problems (NHS Talking Therapies Services)
- Community mental health transformation for adults and older adults with severe mental illness
- Crisis care support (urgent and emergency mental health care)
- Acute mental health care
- Dementia care
- Suicide prevention

There are a range of groups that support with the delivery of the programme which are as follows:

BLMK Perinatal Mental Health Group

BLMK Childrens and Young Peoples Mental Health Group

BLMK Urgent and Emergency Mental Health Care Group

BLMK Community Mental Health Transformation Group

BLMK Talking Therapies and LTC Meeting

BLMK MHLDA In-Patient Quality Transformation Programme

BLMK Section 117 Meeting

BLMK Dementia Group

BLMK Improving physical health checks for people with SMI group

BLMK Mental Health and Employment Meeting

BLMK Suicide Prevention Group

BLMK Mental Health Equalities Group

BLMK Mental Health and Education Group

BLMK Integrating mental health care for students in higher education and improving mental health care for young adults (18-25 year olds)

BLMK Mental Health Workforce Group

BLMK Mental Health Finance Group

BLMK Working Together Group

BLMK 10 Year Mental Health and Well-Being Group

Reason for Overall Tasks & Milestones Status

| | |
|--|--|
| | |
|--|--|

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | |
|--|------------|----------|--------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Continue to maintain access to perinatal mental health services across BLMK | 01/04/25 | 31/03/26 | Green | | | | | | | | | | | |
| Improving access to mental health services for children and young people as well as improving outcomes | 01/04/25 | 31/03/26 | Red | | | | | | | | | | | |
| Continue to focus on increasing the number of people completing treatment and improving peoples recovery who receive support through NHS Talking Therapies Services. | 01/04/25 | 31/03/26 | Green | | | | | | | | | | | |
| Continuing to transform community mental health services for adults and older adults with severe mental illness including considering 24/7 mental health neighbourhood centres | 01/04/25 | 31/03/26 | Green | | | | | | | | | | | |
| Continue to improve urgent and emergency care pathways across BLMK | 01/04/25 | 31/03/26 | Orange | | | | | | | | | | | |
| Improving acute mental health in-patient care including pathways such as clinically ready for discharge, eliminating inappropriate out of area placements and reducing the use of restrictive practice | 01/04/25 | 31/03/26 | Orange | | | | | | | | | | | |
| Continuing to meet the dementia diagnosis rate and improving dementia support services | 01/04/25 | 31/03/26 | Green | | | | | | | | | | | |
| Continue to focus on suicide prevention and suicide bereavement support | 01/04/25 | 31/03/26 | Green | | | | | | | | | | | |
| Developing the Section 117 and complex care placements workstream | 01/04/25 | 31/03/26 | Orange | | | | | | | | | | | |
| Improving physical health checks for people with severe mental illness across BLMK | 01/04/25 | 31/03/26 | Green | | | | | | | | | | | |
| Mental health and employment workstream | 01/04/25 | 31/03/26 | Green | | | | | | | | | | | |
| BLMK Mental health equalities workstream | 01/04/25 | 31/03/26 | Green | | | | | | | | | | | |
| BLMK Integrating mental health care for students in higher education and improving mental health care for younger adults workstream | 01/04/25 | 31/03/26 | Green | | | | | | | | | | | |
| BLMK 10 year mental health and well-being plan workstream | 01/04/25 | 31/03/26 | Green | | | | | | | | | | | |
| BLMK Mental health and education workstream | 01/04/25 | 31/03/26 | Green | | | | | | | | | | | |

| | Start Date | End Date | 2025 | | | | | 2026 | | | | | | |
|---|------------|----------|------------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Continue to expand Individual Placement and Support Services across BLMK so that more people with severe mental illness can be supported into employment. | 01/04/25 | 31/03/26 | Orange bar | | | | | | | | | | | |
| Continue to focus on addressing mental health inequalities across BLMK including implementing the Patient and Carer Race Equality Framework | 01/04/25 | 31/03/26 | Green bar | | | | | | | | | | | |
| Continue to mobilize 3 Mental Health Support Teams and start to mobilize 2 additional Mental Health Support Teams for children and young people | 01/04/25 | 31/03/26 | Green bar | | | | | | | | | | | |
| Improving intensive and assertive community mental health care across BLMK | 01/04/25 | 31/03/26 | Green bar | | | | | | | | | | | |
| Reducing waiting times to community children and young people's mental health services and community adult and older adult mental health services | 01/04/25 | 31/03/26 | Orange bar | | | | | | | | | | | |
| There will continue to be planning of how crisis text services can be implemented across BLMK. | 01/04/25 | 31/03/26 | Green bar | | | | | | | | | | | |
| Throughout 2025-26 achieve mental health financial balance | 01/04/25 | 31/03/26 | Red bar | | | | | | | | | | | |

| Risks | |
|--------------------------------|---|
| Overall Risks Status | AMBER |
| Reason for Overall Risk Status | <p>There are a number of risk areas which are as follows that need to be addressed throughout the course of the year:</p> <ul style="list-style-type: none"> Increasing access to mental health services for children and young people Improving children and young peoples eating disorder waiting times standards Improving mental health outcomes for children and young people Increasing access to Individual Placement and Support Services Reducing community waiting times for children and young people and adults and older adults Improving the urgent and emergency mental health care pathways which includes eliminating inappropriate out of area placements and reducing average length of stay. There is a risk in relation to achieving financial balance for the mental health programme and so a financial recovery programme is commencing to take this workstream forward. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|---|-----------|------------------------------|
| Achieving the children and young peoples mental health access ambition | Yes | 15 |
| Achieving the children and young peoples eating disorder waiting times standards | Yes | 9 |
| Reducing community waiting times for children and young people and adults and older adults | Yes | 6 |
| There is a risk with the urgent and emergency mental health care pathway due to patient flow pressures which presents a risk with eliminating inappropriate out of area placements and reducing average length of stay. | Yes | 8 |
| There is a risk to achieving financial balance for the mental health programme | Yes | 16 |
| Achieving the national access ambition for Individual Placement and Support Services | Yes | 9 |

Issues

| Overall Issues Status | AMBER |
|----------------------------------|---|
| Reason for Overall Issues Status | <p>Although there is positive progress overall for the mental health programme, there are the following risk areas that make the overall status amber which are as follows that need to be addressed throughout the course of the year:</p> <ul style="list-style-type: none"> Increasing access to mental health services for children and young people Improving children and young peoples eating disorder waiting times standards Improving mental health outcomes for children and young people Increasing access to Individual Placement and Support Services Reducing community waiting times for children and young people and adults and older adults Improving the urgent and emergency mental health care pathways which includes eliminating inappropriate out of area placements and reducing average length of stay. There is a risk in relation to achieving financial balance for the mental health programme and so a financial recovery programme is commencing to take this workstream forward. |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|---|------------|--------------------|
| There is a risk of not achieving the children and young people mental health access ambition | Yes | 15 |
| There is a risk with not delivering the children and young peoples eating disorder standards | Yes | 9 |
| Reducing community waiting times for children and young people and adults and older adults | Yes | 6 |
| There is a risk with the urgent and emergency mental health care pathway due to patient flow pressures which presents a risk with eliminating inappropriate out of area placements and reducing average length of stay. | Yes | 8 |
| There is a risk in relation to achieving financial balance for the mental health programme and so a financial recovery programme is commencing to take this workstream forward. ? | Yes | 16 |
| There is an issue of not delivering the Individual Placement and Support access ambition | Yes | 9 |

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000226 |
| Project Name | Community and Mental Health Services Transformation |
| Project Team | System Transformation Team |
| Project Aim | <p>Recognising the increasing demand on community and mental health services there is a need to rethink how we commission these services for the next 10 years to address current unwanted variation in how these services have historically been commissioned.</p> <p>The transformation programme will describe the case for change, agree our priorities for transformation and approach to provider selection within the next two years.</p> <p>This programme has been established to deliver the ICB Board's Strategic Delivery Plan and is a 'must do' for the system.</p> |
| Governance & Responsible Group | CMHST Programme Board |
| Geographical Footprint | BLMK System |

Project Team Members

| Name | Role |
|-------------------|--------------------|
| Beccy White | Commissioning Lead |
| Michael Ramsden | Commissioning Lead |
| Tim Simmance | Commissioning Lead |
| Mark Peedle | Commissioning Lead |
| Kamini Patel | Commissioning Lead |
| Sian Pither | Commissioning Lead |
| Catherine Jackson | Commissioning Lead |

| | |
|-------------------|--|
| Amanda Flower | Commissioning Lead |
| Michelle Summers | Communications Lead |
| Jackie Bowry | Communications Lead |
| Kathryn Moody | Contracting Lead |
| Jonathan Tweed | Contracting Lead |
| Kathy Nelson | Executive Lead |
| Andrew Bland | Finance Lead |
| Dion Davies | Finance Lead |
| Stephen Makin | Finance Lead |
| Tara Dear | Head of STT |
| Vicki Peacey | Population Health Intelligence Unit (PHIU) |
| Buz Dodd | Population Health Management Lead |
| Angela mortley | Procurement |
| Duncan McConville | Programme Manager |
| Sarah Florey | Quality Lead |
| Ros Clarke | Subject Matter Expert |
| Penny Harris | Subject Matter Expert |
| Nikki Barnes | Subject Matter Expert |
| Ellen Keegan | Transformation Coordinator |
| Denise Faehndrich | Transformation Coordinator |
| Eunice Sudlow | Transformation Manager |
| Janine Norman | Transformation Support Manager |
| Matt Hollex | Verto & QI Lead |

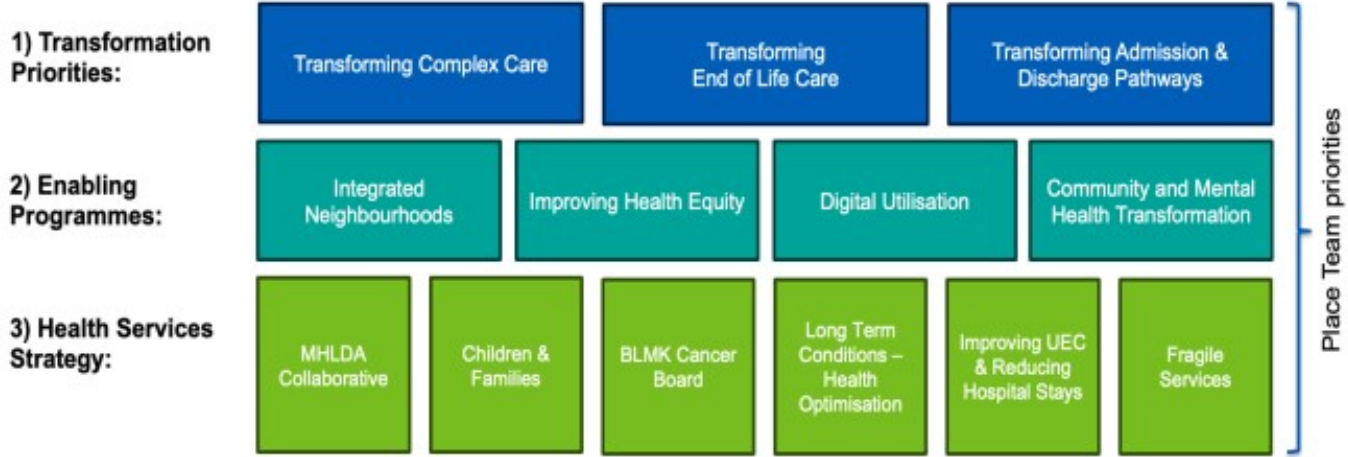
Project Status

Overall Project Status

AMBER

| | |
|-----------------------------------|---|
| Reason for Overall Project Status | <p>The CMHST programme is very large and complex. This is the largest commissioning exercise that BLMK ICB has taken through the relatively new Provider Selection Regime, and is doing so working with Local Authorities commissioners. The programme is being implemented during significant changes to the ICB.</p> <p>Risks are monitored at the Programme Board and we have identified a number of risks that could impact the timeline. This includes risks related to the proposed changes to ICBs. The programme plan has been reviewed to run activities concurrently to mitigate these risks, however there remains a risk of slippage.</p> |
| Project Maturity | 3.0 - Implementation |

System Transformation



| | |
|---|---|
| Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above) | This programme is one of the four enabling programmes |
|---|---|

Progress Update

Progress made in Previous Period

- First draft of the Case for Change produced and feedback received from system partners with final version due to go to ICB Board in September 2025.
- Case for change shaped by learning from previous engagement with residents, workforce and system partners, and recent engagement such as the System Insights Network event on 6th May.
- Agreed resourcing plan for the programme.
- Two early market engagement events held in July to gather views from providers.
- Developed the Commissioning Principles with BLMK local authorities.
- Developed Transformation Priorities shaped by engagement with residents, workforce and system partners.
- Defined scope of services with local authority commissioners.
- Research into best practice models of care and outcomes frameworks.
- Work started on the developing the business case.
- Working towards a Collaborative Commissioning Agreement between the ICB and BLMK local authorities.

Progress to be made in Next Period

- Case for change to go to ICB Board in September 2025.
- Develop the business case, due to go to ICB Board in December 2025.
- Agree approach and develop service specification/s.
- Finalise the scope of services.
- Finalise the commissioning principles.
- Finalise the transformation priorities.
- Develop the outcomes framework.
- Develop performance and local reporting requirements.
- Develop impact assessments.
- Develop the commercial strategy.

Tasks & Milestones

| | |
|--|---|
| Overall Tasks & Milestones Status | AMBER |
| Reason for Overall Tasks & Milestones Status | Risks are monitored at the Programme Board and we have identified a number of risks that could impact the timeline. This includes risks related to the proposed changes to ICBs. The programme plan has been reviewed to run activities concurrently to mitigate these risks, however there remains a risk of slippage. |

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | |
| Phase 0: Initiation | 02/12/24 | 17/04/25 | █ | | | | | | | | | | | | |
| Phase 1: Case for Change | 03/02/25 | 26/09/25 | █ | | | | | | | | | | | | |
| Phase 2: Business Case | 02/06/25 | 12/12/25 | | | | █ | | | | | | | | | |
| Phase 4: ICB Governance | 15/12/25 | 19/01/26 | | | | | | | | | | | | | |
| Phase 3: Specification and Provider Selection Preparation | 15/12/25 | 05/05/26 | | | | | | | | | | | | | |
| Direct Award Workstream | 13/02/25 | 30/07/26 | █ | | | | | | | | | | | | |
| Phase 5: Provider Selection | 15/12/25 | 19/10/26 | | | | | | | | | | | | | |

Risks

| | |
|--------------------------------|--|
| Overall Risks Status | AMBER |
| Reason for Overall Risk Status | Risks are monitored at the Programme Board and we have identified a number of risks that could impact the timeline. This includes risks related to the proposed changes to ICBs. The programme plan has been reviewed to run activities concurrently to help mitigate these risks, however there remains a risk of slippage. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| Insufficient Resourcing | Yes | 10 |
| NHSE Business Case approval | Yes | 15 |
| Lack of subject matter expertise in planning | Yes | 12 |
| Key governance requirement (ICB and Local Authorities) | Yes | 15 |
| Reduction in ICB running costs | Yes | 16 |

Potential changes to the organisational structure of the ICB

Yes

16

Issues

Overall Issues Status

AMBER

Reason for Overall Issues Status

Issues are being managed by the Programme Board and sub-groups.

Issues

Issue Name

Key Issue?

Proximity & Impact

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000402 |
| Project Name | Enhancing the Integration of IUC and Urgent Care with Primary Care and UEC |
| Project Team | Primary Care |
| Project Aim | <ol style="list-style-type: none">1. Maximise all opportunities for integration of IUC with urgent and emergency services including Unscheduled Care Co-ordination Hubs2. Review of demand, capacity and capabilities of urgent 'same day' primary care models of UTC, WiC and UGPC3. Optimise the integrated urgent care process so that people receive the right care at the right time and from the right service. |
| Governance & Responsible Group | <p>Primary Care Delivery Group reporting to Primary Care Commissioning & Assurance Committee</p> <p>See file "Governance" and "Collaboration and Connectivity" in the 'Governance' Folder.</p> |
| Geographical Footprint | BLMK System |

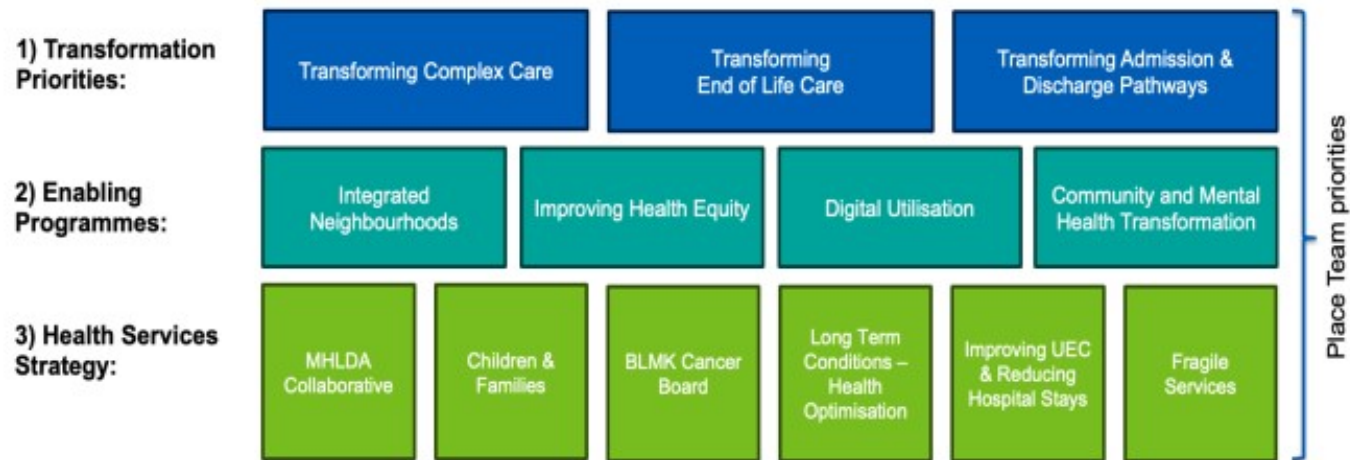
Project Team Members

| Name | Role |
|------------------|------------------------|
| Steve Gutteridge | Programme Manager |
| Jade Vandyke | Programme Manager |
| Ali Hussain | Project Manager |
| Oliver Malczyk | Project Support |
| Dee Bricknell | Project Support |
| Jay Willet | Transformation Manager |

Project Status

| | |
|-----------------------------------|----------------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | On track |
| Project Maturity | 3.0 - Implementation |

System Transformation



| | |
|--|---|
| <p>Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)</p> | <p>1) Transformation priorities;</p> <p>Admission avoidance transformation priority</p> <p>2) Enabling Programmes;</p> <p>Improving health equity, digital utilisation, community and mental health transformation</p> <p>3) Health services strategy;</p> <p>Improving UEC and reducing hospital stays</p> |
|--|---|

Progress Update

| | |
|--|--|
| | <p>Optimise the integrated urgent care process so that people receive the right care at the right time and from the right service; Benefits; By improving the assessment of urgent and same day need that has presented via NHS111, patients will be signposted/referred to the appropriate service. By increasing the proportion of calls that require referral to direct bookings with a service (as opposed to signposting), there will be greater compliance with the NHS111 triage, and more patients will receive the right</p> |
|--|--|

care, in the right place, first time. This will lead to less ambulances being despatched and reduce attendances at A&E

1. *Minimise the number of 111 calls that result in an ambulance or ED outcome (March 2026) - exploring the opportunity to carry out a category 2 validation pilot within HUC (b&l) - currently in discussions with HUCs ICB commissioners in the region.*

2. *Optimising DoS profiles and ranking of alternative services- this is BAU*

3. *MiDoS programme - develop the content within MiDoS and roll out MiDoS access to all BLMK health, social care and voluntary sector professionals and BLMK residents (October 2025) as at the 31st July 2025 all PCNs and Practices have been given the opportunity to access MiDoS. Work has commenced to develop the public midos page ahead of the roll out to BLMK residents in October 2025.*

4. *Optimise 111 direct booking into services across the system (March 2026) - ICB are working closely with 111 providers across BLMK (HUC and DHU) to increase the percentage of direct bookings made into GP practices and have resolved a number of issues relating to IT configurations which were preventing 111 being able to book into the appointments practices were making available.*

5. *Patient tagging and flagging (B&L / HUC only) - awaiting timescales from provider (HUC)*

6. *EOL/Palliative line to be accessible via 111 so patients calling 111 can be redirected via the local IVR, B&L only (October 2025) - a palliative care advice line which will be jointly delivered by Sue Ryder and Keech hospices, is expected to be accessible via 111 as an IVR option during October 2025. HUC, Sue Ryder and Keech are working closely to get this implemented ahead of winter. The activity numbers are expected to be low however this will be a much better patient journey and experience.*

7. *ICE portal integration (B&L/ HUC only) - allowing 111 clinicians access to blood result to enable better patient management (provider to confirm timescales) - HUC are currently awaiting an update from Advanced who are the owners of HUCs clinical system (Adastra) who need to release a product to enable the integration to take place.*

Review of demand, capacity and capabilities of urgent 'same day' primary care models of UTC, WiC and UGPC

Benefits; By ensuring urgent same day primary care services have the optimal capabilities and capacity to meet appropriate demand. this will lead to less attendances at A&E and potentially less admissions.

1. *Review of Urgent Same Day Primary Care services (September 2025) - UTC dashboard live on Athena (April 2025). it is expected the IUC (111, gp ooh & Clinical Assessment Service) dashboard will be on Athena by end of Sept 2025*

Maximise all opportunities for integration of IUC with urgent and emergency services including UCCHs

Benefits; By integrating IUC with the whole system, patient experience will be improved, duplication will be reduced, productivity will increase and patients access to the right service will improve, leading to less attendances at A&E and potentially less admissions

1. *Optimise the integration with Unscheduled Care Coordination Hubs (March 2026) - 111 (HUC) have begun initial discussions with UCCH project team*

2. *111 booking 'arrival slots' in ED to support A&E departments manage their capacity (provider to confirm) - BHFT; its likely this will*

Progress made in Previous Period

not be in place until summer 2026 due to the ED clinical system needing to be Booking and Referral Standards (BARS) compliant to enable the arrival slot booking functionality. BHFT are moving to Nerve Centre early spring 2026 and works will commence once the new clinical system is in place

3. *Self-triage at the front doors of ED using a form of NHS 111 Pathways triage to stream patients to alternative services and away from ED where appropriate (provider to confirm) BHFT*; its likely this will not be in place until summer 2026 due to the ED clinical system needing to be Booking and Referral Standards (BARS) compliant to enable the arrival slot booking functionality. BHFT are moving to Nerve Centre early spring 2026 and works will commence once the new clinical system is in place

4. *ED to GP OOH - using spare GP OOH capacity to divert A&E attendances (B&L only) - (September 2025)* - HUC have offered mutual aid support to BHFT for ED to stream patients to HUCs GP Out Of Hours bases. BHFT are reviewing their streaming processes as currently the streamers are restricted on time and do not have the capacity to make a phone call in order to refer a patient to GP OOH. ED clinicians are also concerned re patient risk as there is currently no mechanism to robustly record streaming decisions. Once the new clinical system is in place there may be the functionality for ED staff to directly book patients into GP OOH which may alleviate some concerns from ED clinicians but currently BHFT are unlikely to begin streaming patients in the short term

Progress to be made in Next Period

MiDoS programme;

- Community Pharmacies - pilot giving midos access to a few pharmacies across Beds Borough and Central Beds during September 2025
- Public to be given access to MiDoS in October 2025

Review of Urgent Same Day Primary Care services;

- IUC dashboard to be live on Athena (Sept 2025)
- Gap Analysis against the National UTC Standards and Principles to be completed (Sept 2025)

Optimise the integration with Unscheduled Care Coordination Hubs (B&L/HUC only)

- 111 (HUC) to become more involved in UCCH stocktake meetings and discuss future integration and potential models

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

Delivery on track

| | Start Date | End Date | 2025 | | | | | | | 2026 | | | | | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|------|-----|-----|-----|-----|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | |
| Review of Urgent Same Day Primary Care services | 01/04/25 | 30/09/25 | █ | | | | | | | | | | | | | |
| Optimising DoS profiles and ranking of alternative services | 01/04/25 | 31/10/25 | █ | | | | | | | | | | | | | |

| | Start Date | End Date | 2025 | | | | | | | | | | | | 2026 | | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|--|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | | |
| Palliative Care advice line accessible via 111 (Bedfordshire & Luton) | 02/06/25 | 31/10/25 | | | | | | | | | | | | | | | | |
| Roll out MiDoS access to BLMK residents | | 31/10/25 | | | | | | | | | | | | | | | | |
| Review of demand, capacity and capabilities of urgent 'same day' primary care models of UTC, WiC and UGPC | 01/04/25 | 31/03/26 | | | | | | | | | | | | | | | | |
| Optimise the integrated urgent care process so that people receive the right care at the right time and from the right service. | 02/04/24 | 31/03/26 | | | | | | | | | | | | | | | | |
| MiDoS programme | 01/09/24 | 31/03/26 | | | | | | | | | | | | | | | | |
| Optimise 111 direct booking into services across the system | 01/04/25 | 31/03/26 | | | | | | | | | | | | | | | | |
| Maximise all opportunities for integration of IUC with urgent and emergency services including Unscheduled Care Co-ordination Hubs | 01/04/25 | 31/03/26 | | | | | | | | | | | | | | | | |
| Self-triage at the front doors of ED | 01/04/25 | 31/03/26 | | | | | | | | | | | | | | | | |
| ICE portal integration (B&L/ HUC only) | 02/06/25 | 31/03/26 | | | | | | | | | | | | | | | | |
| Patient tagging and flagging (B&L / HUC only) | 01/08/25 | 31/03/26 | | | | | | | | | | | | | | | | |
| Optimise the integration with Unscheduled Care Coordination Hubs | 01/08/25 | 31/03/26 | | | | | | | | | | | | | | | | |
| 111 booking 'arrival slots' in ED to support A&E departments manage their capacity | 01/04/25 | 30/09/26 | | | | | | | | | | | | | | | | |

Risks

| | |
|--------------------------------|---------------------|
| Overall Risks Status | TBC |
| Reason for Overall Risk Status | None yet identified |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-----------|-----------|------------------------------|
|-----------|-----------|------------------------------|

Issues

| | |
|----------------------------------|---------------------|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | None yet identified |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000168 |
| Project Name | Improving access to Pathway 2 Beds |
| Project Team | Kaysie Conroy, Robin Campbell, Helen Glyn-Davies, Emma Stoneman, Mark Morton, Caron Morgan |
| Project Aim | <p>Reduce the bed occupancy rate in BHT (Beds Hospital and L&D) by reducing the time our residents spend waiting for a Pathway 2 (P2) placement once medically optimised for discharge and review the community care service model to ensure we are delivering an efficient therapeutic offer for local people that focuses on prevention across Bedfordshire and Luton.</p> <p>The step-down element of the programme remains the key to achieving the aim and it is expected to improve outcomes, experiences and independence of people discharged, reduce avoidable readmissions, and reduce avoidable/premature long term care provision. Additional expected benefits include improved flow and discharge from acute hospitals. For clarity the pathways to identify appropriate patients falls outside of the scope of the P2 bed project, the provision of the beds and supporting care is within scope.</p> |
| Governance & Responsible Group | Pathway 2 Steering Group Project Group & BCA Committee Group |
| Geographical Footprint | Bedfordshire Care Alliance |

Project Team Members

| Name | Role |
|---------------|-------------------------------|
| Kaysie Conroy | Programme Manager |
| Caron Morgan | Project Manager |
| Mark Morton | Senior Transformation Manager |

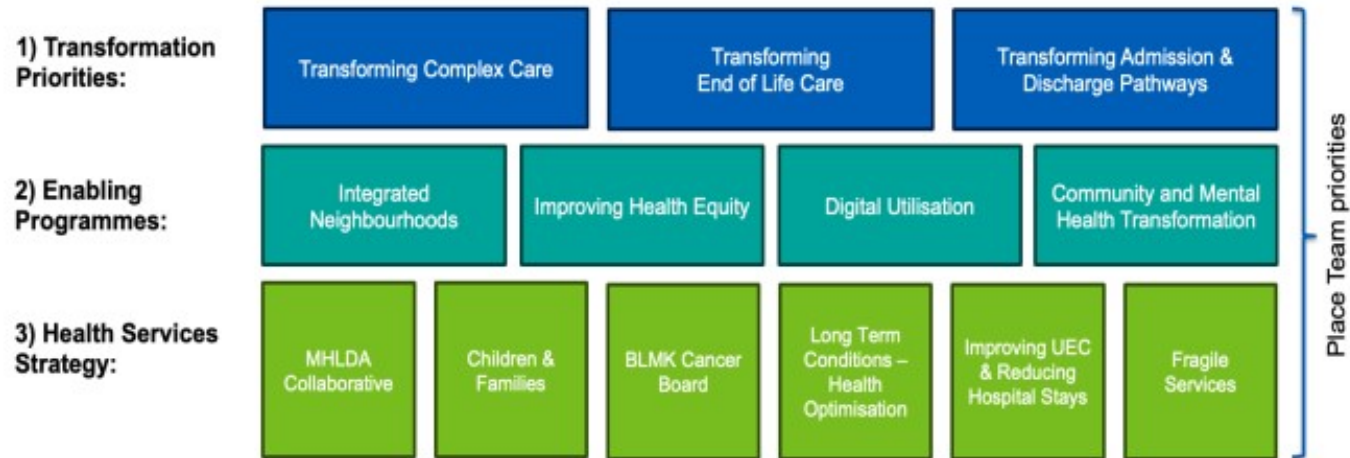
Project Status

Overall Project Status

GREEN

| | |
|-----------------------------------|--|
| Reason for Overall Project Status | The project has been divided into two areas (Operational and process improvement & Strategic). Both areas are supported by workstream groups that report into the P2 Steering Group Project Group. The Strategic group is focused on developing the 'case for change' and business case that is long term. The Operational and process improvement group is focusing on short term opportunities to improve the quality and efficiency of the process supporting P2. |
| Project Maturity | 3.0 - Implementation |

System Transformation



| | |
|---|---|
| Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above) | The Improving Access to Pathway 2 Beds programme sits within the 1) Transformation Priority 'Transforming Admission and Discharge Pathways' Mark Morton, Senior Transformation Manager is taking the lead on this transformation priority within the ICB System Transformation Team (STT). |
|---|---|

Progress Update

| | |
|----------------------------------|--|
| Progress made in Previous Period | <ol style="list-style-type: none"> 1. The P2 scope document has been refreshed and circulated to key stakeholders for review and comment. Awaiting feedback comments. 2. In July it was agreed to end the series of P2 Operational and process improvement workstream, and Strategic workstream meetings. This work will now sit under the UEC Programme for admission avoidance and discharge. 3. P2 Business Case was presented by Kaysie Conroy at the Operational group on 23rd June, where it was approved in principle. 4. P2 Business Case was presented by Kaysie Conroy to Open Space Chiefs meeting on 2nd July. 5. QEIA completed and presented by Kaysie Conroy to Clinical Advisory Group (CAG) on 11th July, where it was supported and approved. |
|----------------------------------|--|

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|--|--|---|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| BCF Luton sign off | 29/08/25 | 29/08/25 | | | | | | | | | | | | | | | |
| Pilot to inform plan to run pilot at L&D Hospital in October 2025 | 29/09/25 | 28/11/25 | | | | | | | | | | | | | | | |
| Bed Occupancy workstream | | 19/12/25 | | | | | | | | | | | | | | | ◆ |

Risks

Overall Risks Status

AMBER

Reason for Overall Risk Status

Overall risk to the delivery of this project is amber due to the increasing pressure across BHT and the risk of scope creep as system partners want this project to respond to other areas outside of P2 pathways and bed capacity.

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|---|-----------|------------------------------|
| Scope creep | Yes | 12 |
| ICB transition - there is a risk that there will not be an ICB resource in place long term to help deliver the P2 programme | Yes | 12 |
| Governance sign off at Place - for the BCF initiatives, there is a risk that all 3 Places won't agree sign off. | Yes | 6 |
| Substantive funding into 26/27 - pressure in Bedford Borough Place and £800k financial gap in their BCF | Yes | 9 |
| L&D Discharge Pilot - risk of inequity for Bedfordshire and Luton residents as a result of not being able to scale up the Pilot model due to engagement, capacity and resource issues at L&D | Yes | 9 |
| Bedford Hospital Discharge Pilot next steps paused - risk of loss of learning and opportunities to embed long term change. Mitigation to agree system wide learning through life of project to inform strategic learning. | Yes | 6 |

Issues

Overall Issues Status

AMBER

Reason for Overall Issues Status

Next steps following Pilot - work has been paused, including recruitment of Band 7 Therapist.

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|--|------------|--------------------|
| Bedford Hospital Discharge Pilot - need for Therapist role to be recruited to, to enable progress on findings and opportunities from Pilot. New Health and Care Board which started on 2nd June, is an opportunity to raise concerns and get support to progress | Yes | 9 |

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000152 |
| Project Name | Improving Health Equity |
| Project Team | Quality Improvement [QI] and System Transformation Team [STT] |
| Project Aim | <p>"to listen and learn with our residents to improve health equity across BLMK over the next 3 years"</p> <p>The four primary drivers to achieve this programme are by ensuring:</p> <ul style="list-style-type: none"> Residents feel services are for them Residents feel they can access services they need Residents are involved in making improvements Women feel seen and heard (linking to the Women's Health Programme) |
| Governance & Responsible Group | <p>To report to Health Equity Programme Board via:</p> <ul style="list-style-type: none"> - Weekly health equity delivery group, chaired by Sarah Watts - SRO: Sarah Stanley (ICB) - Board Champion - Lorraine Sunduza (ELFT) |
| Geographical Footprint | BLMK System |

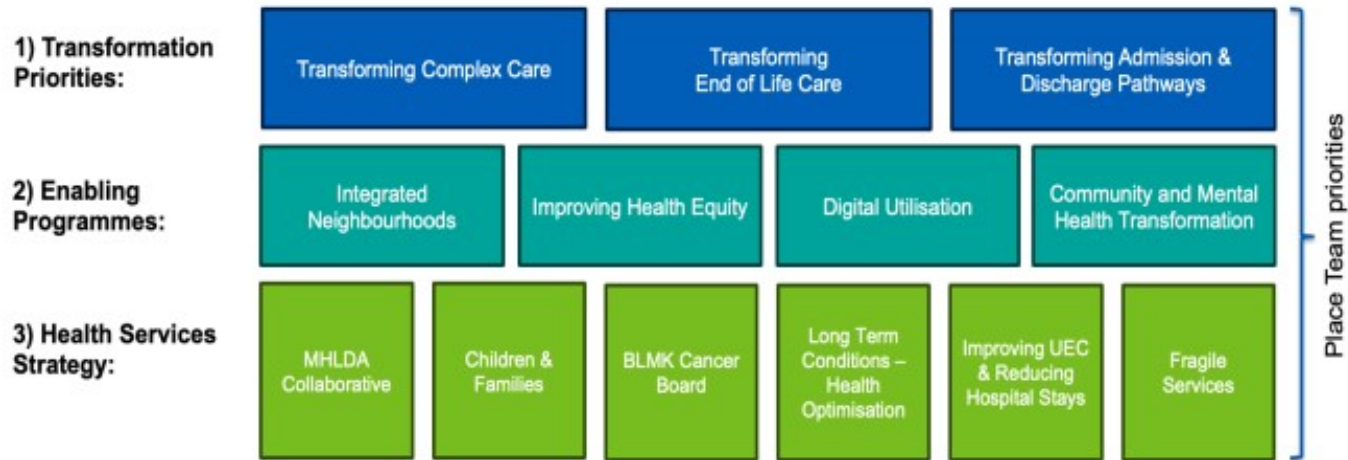
Project Team Members

| Name | Role |
|-------------------|--------------------------|
| Joyce Baskerville | Improvement Manager |
| Julia Robson | Programme Manager |
| Beverley Husbands | Project Support |
| Sarah Stanley | Senior Responsible Owner |
| Natasha Young | STT Senior Lead |
| Omos Olunloyo | STT Team Member |
| Samita Dass | STT Team Member |

Project Status

| | |
|-----------------------------------|---|
| Overall Project Status | AMBER |
| Reason for Overall Project Status | <p>Identified as one of the four enabling programmes across the ICB.</p> <p>Programme development to re-align opportunities with key stakeholders within the ICB.</p> |
| Project Maturity | 2.0 - Initiation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

Improving Health Equity is agreed as one of the four enabling programmes, as agreed by Execs and Board.

There are disproportionate health outcomes across BLMK dependent upon who you are, where you live, your background and exposures.

The Improving Health Equity programme is informed by population health analysis and key local reports such as The Denny Review and the Big Conversation.

The Denny Review published in September 2023 included some short and long term recommendations for action to address health inequalities under four themes: 1) access, 2) communication, 3) representation and 4) cultural competency. A service review of translation and interpretation services has been identified as a particular priority in response to the recommendations.

Progress Update

Progress made in Previous Period

- Learning Action Networks (LANs) live across each place with focus on hypertension - see individual place based reports for progress updates.
- Health Equity workshop held 12/02/2025 to develop over-arching programme driver diagram, re-aligning opportunities with key stakeholders within the ICB. Four Drivers are now in place with a lead for each area.
- AgeCare Technologies identified as opportunity to progress a focused 'What Matters To You' type initiative and agreed to be delivered in Bedford place in collaboration with the VCSE strategy group. See Bedford Borough Ageing Well report for progress updates.
- LGBTQIA+ webinars / shared learning events held during Feb 2025 awareness week.
- New TOR developed for weekly health equity delivery group and quarterly health equity programme Board (first one taking place in August)

08/08/25

- **Translation and Interpretation (T&I) Services Review** – Progress update presented to the Primary Care Commissioning and Assurance Committee as part of the Denny recommendations. Strategic opportunities been scoped and shared with the Improving Health Equity Faculty. Horizon scanning, supported by the Head of Innovation with the East of England Innovation hub, has been undertaken to identify emerging opportunities for service enhancement. Gap analysis of recently published national T&I framework has also been completed, supporting the scoped opportunities.
- LAN workshops took place on 19th and 20th June 2025 at the Forest Centre, Marston Moretaine. Workshops were attended by IHI representatives, BLMK LAN project teams and residents. Covered teaching on the PDSA cycle and measurements and included residents' stories. Monthly webinars continue to take place hosted by IHI.
- Health Equity Board, due to take place August 2025, has been postponed to November 2025. Lorraine Sunduza, ELFT CEO, and Champion for Health Inequalities across BLMK will chair. This Board will have oversight of the Health Equity Programme (which includes progression of the Denny review recommendations) and aims to be a collaborative board to help tackle inequalities.
- The QI team is fully established with one of the improvement advisors supporting the System Transition Team.
- The QI team, through the lens of health equity, aims to provide Quality Improvement support to the Health Equity Programme and ongoing transformation programmes.
- The QI team introduced Quality Improvement / Health Equity training to the ICB from July 2025 to continue on a monthly basis. This work aligns with programme's aim of increasing capabilities in QI to solve complex problems.

Progress to be made in Next Period

- Revise governance structure and Health Equity programme board to be established.
- Alignment of all health inequalities and equity work to improve programme management and visibility of work on Verto.
- T&I progress update to be presented by May Primary Care Commissioning & Assurance Committee 09/05/25.
- T&I options appraisal to be socialised in committees prior to submission to June 2025 Board. Based on outcome at Board, STT to take forward recommendations.
- As part of T&I opportunities, undertake deep dive within maternity services.
- LAN face to face workshop taking place on 19th and 20th June with the IHI and all project teams

08/08/25

- **Translation and Interpretation (T&I) Services** - Progress update and scope of opportunities will be presented to the next Health Equity Programme Board with the STT team leading on the implementation of recommendations. The original driver diagram will be revisited to identify and agree on quality improvement (QI) opportunities, alongside establishing clear timelines for delivery. Coordination with clustering ICBs is underway to understand their strategic direction and explore opportunities for alignment.
- A lead for one of the drivers, Michelle Summers is leaving – some of the associated work has been paused. To help mitigate, the Quality Improvement Team has set up a new excel document which will aid discussions with the leads for each driver to understand what work is already in place and needs to be strengthened as well as what could be paused until the face-to-face meeting takes place (A face-to-face meeting is planned to review oversight of the programme and to re-establish leads for the drivers)

Tasks & Milestones

| | |
|--|--------------|
| Overall Tasks & Milestones Status | GREEN |
| Reason for Overall Tasks & Milestones Status | On track |

| | Start Date | End Date | 2025 | | | | | | 2026 | | | | | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|---|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | |
| Translation and Interpretation Services reviewed and options appraisal presented | | 13/06/25 | | | ◆ | | | | | | | | | | |
| Improving adherence to AIS data standards through contract monitoring | | 31/03/26 | | | | | | | | | | | | | ◆ |
| Offer of cultural competency webinars / shared learning across the system | | 31/03/26 | | | | | | | | | | | | | ◆ |

Risks

| | |
|--------------------------------|---|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | The scope of the programme is in development, and risk status to be reviewed following agreement with key stakeholders. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-----------|-----------|------------------------------|
|-----------|-----------|------------------------------|

Issues

| | | |
|----------------------------------|---|--|
| Overall Issues Status | CLOSED | |
| Reason for Overall Issues Status | Healthwatch brief has been amended and agreed with the ICB, with clear direction and support controls in place. | |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000006 |
| Project Name | Musculoskeletal (MSK) |
| Project Team | STT |
| Project Aim | BLMK has a top performing integrated Community MSK and chronic pain service, which equitably supports the 'whole person' to get early support, self-management advice and care they need to live well |
| Governance & Responsible Group | MSK Programme Board (with Exec Lead & Exec SRO), and 3 sub-groups: 1. Technical Sub-Group 2. Clinical & Quality Sub-Group 3. Population Needs Sub-Group |
| Geographical Footprint | BLMK System |

Project Team Members

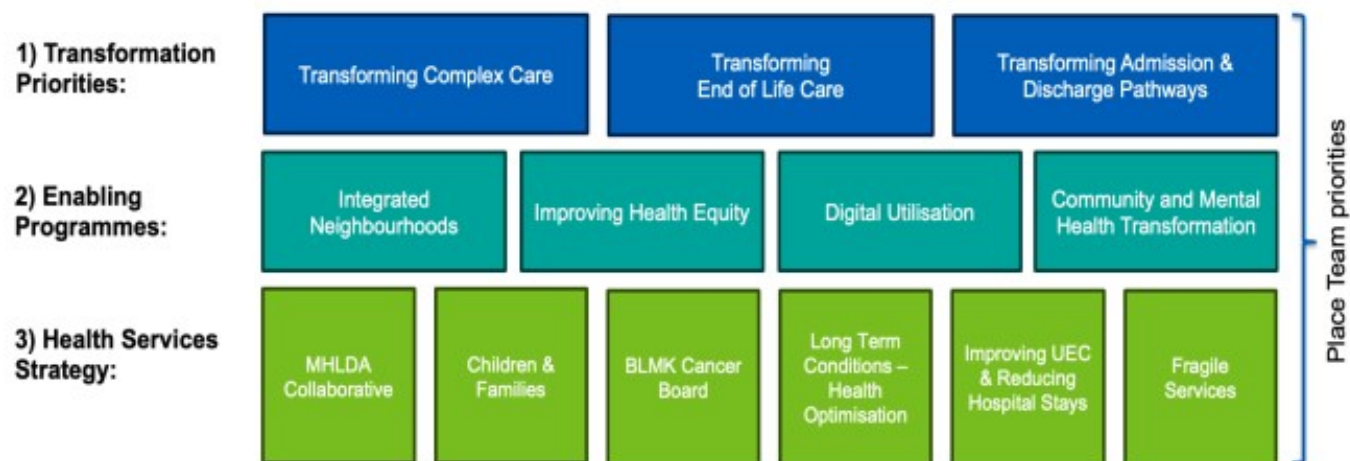
| Name | Role |
|-------------------|-------------------------------|
| Linus Onah | Clinical Lead |
| Michael Ramsden | Commissioning Lead |
| Kathryn Moody | Contracting Lead |
| Tara Dear | Head of STT |
| Ros Clarke | Procurement |
| Gamma Prasad | Procurement |
| Sian Pither | Project Manager |
| Cat Lee | Project Manager |
| Maria Wogan | Senior Responsible Owner |
| Duncan McConville | Senior Transformation Manager |
| Samita Dass | Senior Transformation Manager |
| Nikki Barnes | Subject Matter Expert |
| Denise Faehndrich | Transformation Coordinator |
| Omos Olunloyo | Transformation Manager |

| | |
|-----------------|--------------------------------|
| Vickie Place | Transformation Manager |
| Angela Reynolds | Transformation Manager |
| Janine Norman | Transformation Support Manager |

Project Status

| | |
|-----------------------------------|--|
| Overall Project Status | RED |
| Reason for Overall Project Status | The procurement continues to be in standstill which has caused a delay to the go live date by at least three months. |
| Project Maturity | 3.0 - Implementation |

System Transformation



| | |
|---|--|
| Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above) | Community MSK aligns to 3) Health Services Strategy - Long Term Conditions and presents a live opportunity to support all three left shifts and deliver financial efficiencies and improved outcomes for our population. |
|---|--|

Progress Update

| | |
|------------------------------------|--|
| Progress made in Previous Period | The procurement continues to be in standstill which has caused a delay to the go live date by at least three months. |
| Progress to be made in Next Period | Completion of the standstill period and start of mobilisation phase. |

Tasks & Milestones

| | |
|--|--|
| Overall Tasks & Milestones Status | RED |
| Reason for Overall Tasks & Milestones Status | The procurement continues to be in standstill which has caused a delay to the go live date by at least three months. |

| | Start Date | End Date | 2025 | | | | | | | | | | | | 2026 | | | |
|----------------------|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|--|--|---|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | | |
| E. Procurement Phase | 01/05/24 | 27/06/25 | █ | | | | | | | | | | | | | | | |
| Mobilisation period | 30/06/25 | 02/02/26 | | | █ | | | | | | | | | | | | | |
| Service Commencement | | 02/02/26 | | | | | | | | | | | | | | | | ◆ |

| Risks | |
|--------------------------------|---|
| Overall Risks Status | AMBER |
| Reason for Overall Risk Status | Risk of delay to the contract award or mobilisation due to representation which may impact on the go live date for the new service. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|-----------|-----------|------------------------------|
|-----------|-----------|------------------------------|

| Issues | |
|----------------------------------|--|
| Overall Issues Status | RED |
| Reason for Overall Issues Status | The procurement continues to be in standstill which has caused a delay to the go live date by at least three months. |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

| | |
|--------------------------|---------------------------|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000406 |
| Project Name | PC Training Hub Programme |
| Project Team | Susi Clarke |

CPD Programme

Advanced Practitioners

We support practices, PCNs, and staff in understanding the clinical standards and competencies outlined in the multi-professional framework and Centre for Advancing Practice, assisting with appropriate recruitment and connecting to necessary educational programmes. Additionally, we manage the demand for training opportunities and oversee the allocation of funding for educational programmes.

Apprenticeships

Supporting staff and practices to access apprenticeships and consider apprenticeships within workforce planning and retention activities.

CPD Programme

An annual CPD Programme delivered for relevant clinicians within BLMK Primary Care to upskill, develop competence, refresher training (e.g. Immunisations updates), and provide courses to facilitate career development.

First Contact Practitioners

Supporting practices, PCNs and staff to understand the clinical standards and competencies in the Roadmap to Practice for FCPs, appropriate recruitment and linking to required educational programmes.

GP Symposiums

Clinical educational sessions for GPs from Bedfordshire and Luton taking place 10 times per year.

Nurse Degree Apprenticeships (accelerated route)

A twenty-month degree apprenticeship (accelerated route, must have foundation degree) undertaken at a HEI while still employed in general practice. Work continues with individuals, practices and PCNs to advertise this style of study and the benefits, enrol onto cohorts and continue regular support throughout the apprenticeship. Can then support onto the GPN fundamentals to gain treatment room skills.

Nursing Associate Apprenticeships

A two-year foundation degree apprenticeship undertaken at a HEI while still employed in general practice. Work continues with individuals, practices and PCNs to advertise this style of study and the benefits, enrol onto cohorts and continue regular support throughout the apprenticeship. Next steps can be to remain a Nursing Associate and join the GPN fundamentals to gain further skills or continue to study for the nurse degree.

Oliver McGowan Training

Specialist Commissioned HEI Courses

Annual programme of post-graduate courses to support career development and upskilling of staff in practice.

Leadership Development Programme

Primary Care Leadership Programme

A 6-month programme for staff in their mid-career across General Practice, Community Pharmacy, Dentistry & Optometry who are interested in expanding their leadership skills in the context of Integrated Neighbourhood Working.

New to Practice Fellowship Programme

New to Practice Fellowship Programme

Two-year programme of support for GPs and GPNs who are within their first year of qualifying or joining general practice.

Supporting Mentors Scheme

Mentoring and coaching for GPs on the New to Practice Fellowship Programme and a portfolio career opportunity for mid to late career GPs who are trained to become coaches and mentors.

OD & Transformation

Digital and Transformation Leads

Supporting the PCN Digital & Transformation Leads through a network, sharing information and facilitating sessions. Led by our

Modern General Practice (MGP) Ambassador to support transformation at practice & PCN level.

Equity, diversity and inclusion

Delivery of EDI-focused interventions to raise awareness, reduce inequalities, and promote inclusive workplace cultures in primary care.

Health and wellbeing

Supporting the health and wellbeing of staff throughout BLMK in practice through wellbeing events & resources. Includes establishing and coordinating a network of wellbeing champions across BLMK to support peer-led wellbeing activities in primary care.

Knowledge and Library Services

Support to access knowledge and library resources, literature searches and evidence summaries, training, research support.

Practice Level Support Programme

A programme of support for practices across BLMK to improve patient access, reduce variation, embed modern general practice and support the development of practice culture.

PC Workforce Integration

Hypertension Conference

Conference for primary care professionals involved in the detection and treatment of hypertension.

Pharmacy Workforce Strategy Group

Supporting the ICB Chief Pharmacist to deliver the pharmacy workforce strategy for the BLMK system.

Work and health

Supporting transformation of fit note processes and improving interface between primary care and wider work & health systems to encourage supported return to work. Connecting with wider national strategy of Connect to work.

Personalised Care Workforce Development

Personalised Care - Peer support forums

Safe, structured spaces held regularly for Health and Wellbeing Coaches, Social Prescribers, and Care Coordinators across BLMK, offering connection, shared learning, supervision, and system updates. Sessions are role-specific and cross-role, and often feature

guest speakers from the VCSE sector, local services, or ICB projects. Forums are co-designed with staff to reflect, inspire, and inform workforce development.

Personalised Care Conferences

Personalised Care Programme Overall

A strategic workforce development initiative designed to embed, support, and grow the ARRS personalised care roles (Health and Wellbeing Coaches, Social Prescribers, and Care Coordinators) across BLMK. Focuses on peer support, supervision, digital innovation, leadership development, integration with clinical teams, and a whole-system approach to preventative, personalised care. Aims to enhance role experience, improve retention, and build a sustainable, person-centred primary care workforce.

Personalised Care- Athena Casefinding Tool

The Athena Casefinding Tool, developed with the Ardens team, uses AI within SystemOne to help staff proactively identify patients who may benefit from personalised care interventions such as social prescribing, health coaching, or care coordination. Focuses on prevention and early support for individuals with unmet psychosocial needs, long-term conditions, or complex circumstances, linking them into non-clinical support pathways.

Personalised Care- Reporting on Personalised Care Roles (Ardens)

A project with Ardens to develop a standardised reporting dashboard for ARRS roles, fully integrated into SystemOne. Enables practices and PCNs to more accurately report on activity, outcomes, and population reach of Health and Wellbeing Coaches, Social Prescribers, and Care Coordinators. Supports operational monitoring and strategic workforce planning to ensure the value of these roles is visible and measurable across BLMK.

Placement Expansion

GP Educator + 12 Training Programme

12 monthly support sessions with a mix of educational topics and open forum discussion to help new educators transition into their roles. Sessions are open to experienced educators who want to refresh particular skills.

Multi-professional Digital Placement

A 2-week digital style placement originally for nursing but suitable for all roles. 2 days per week online and 3 days in practice. Advertises general practice as a career destination and gives GP experience. Main focus on communication and basic observation skills.

Paramedic Digital Placement Model

A 2-week digital placement specifically for paramedics, first cohort due to start May 2026. 2 days per week online and 3 days in practice. Advertises general practice as a career destination and gives GP experience.

Placement Capacity Expansion - Digital Nurse Placements

A 4–6 week digital style placement for nursing students. 2 days per week online and 3 days in practice for 2nd year students, changing for other years. Advertises general practice as a career destination and gives GP experience. Main focus on all GPN tasks and skills. Available now to year groups 1, 2 and 3.

Placement Capacity Expansion - GP Educators

Annual GP Educator Programme to equip GPs to become GP Educators (Tier 2b or Tier 3) or to upskill from Tier 2b to Tier 3.

SSSA Training

All SSSA training moved online for accessibility and team capacity. A flyer was created to explain the training and give access links. Justine keeps a spreadsheet of all completions and their update due dates. COP meetings and a FAQ sheet are available and advertised for hosting students.

Student Pharmacist Summer Placement Programme

A 6-week summer placement for 2nd and 3rd year pharmacy students. 8 student pharmacists have been placed in practices across BLMK. The placement provides practical experience for the students as well as administrative and clinical support for the practices hosting.

Quality Programme

ARCP Panels

Backfill support for educators to attend ARCP panels for ongoing requirements and trainee progression through training.

Quality programme

Quality of education in general practice including training and approval of educators, approval of new sites, and ongoing quality monitoring of the education provided to learners.

Recruitment

GPN Pipeline Support Programme

Project to support newly qualified nurses into general practice vacancies. Aims to fill GPN vacancies, provide newly qualified GPNs with roles, and support PCNs to utilise ARRS funding through the GPN recruitment route.

International GP Recruitment

Signposting and supporting practices to become sponsors and supporting those requiring a sponsor to connect with practices.

Recruitment Support

Advice and coaching support to practices for recruitment activities as well as keeping the website up to date with recruitment information.

Workforce Planning Session

A face-to-face learning session for practice and PCN managers to help plan workforce strategies: utilise ARRS funding, improve access, and reduce inequalities.

Retention

Pharmacy alumni network

Creation of a community of past and current pharmacy professionals, focusing on peer support, mentorship, and developing a pipeline into Practice.

Physician Assistants

Preceptorship Programme

12-month support programme for newly qualified colleagues and those transitioning from other areas of the NHS.

Governance & Responsible Group

People Board and Primary Care Commissioning and Assurance Committee

Geographical Footprint

BLMK System

Project Team Members

| Name | Role |
|-------------------------|-------------------|
| Helen Worthington-Smith | Programme Manager |
| Lydia Jacks | Programme Manager |
| Susi Clarke | Programme Manager |
| Hannah Baker | Programme Manager |

Project Status

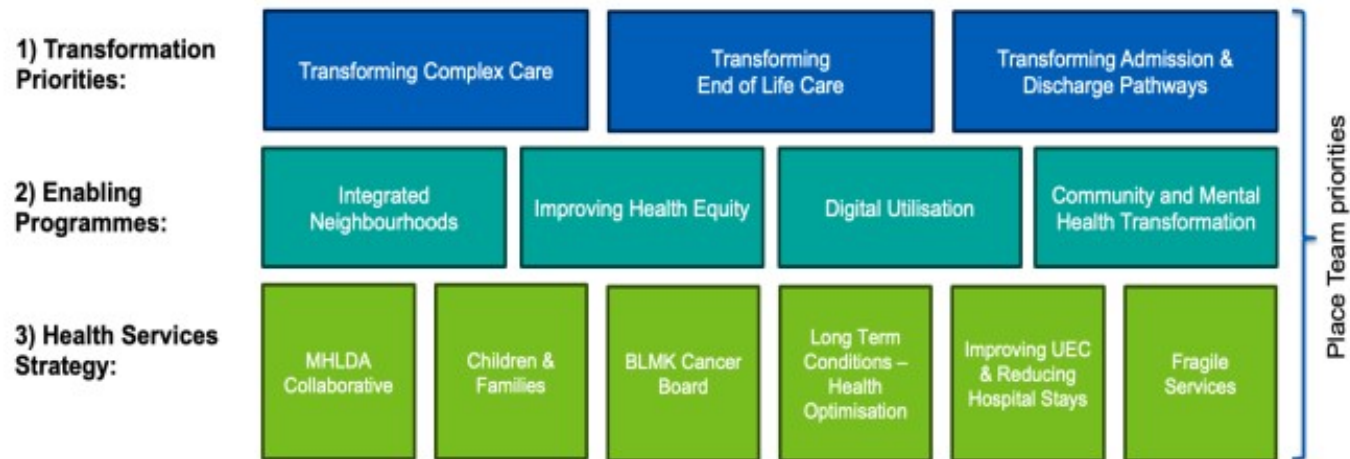
Overall Project Status

GREEN

Reason for Overall Project Status

Showing green due to 32 projects are on track, 3 projects currently behind schedule due to external delays.

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

Workforce education and development is an enabler to achieve all transformation priorities, enabling programme and health services strategies

Progress Update

CPD Programme

Advanced Practitioners

- Joint interviews continued, final reminder for September starts sent for last apprenticeship intake.
- Decision taken to pause forum due to limited engagement. Ongoing engagement through Whatsapp and MS Teams continues well.

Apprenticeships

CPD Programme

- CPD 2025/26 Programme planning underway.

First Contact Practitioners

- N/A

GP Symposiums

- Feedback form completed by approximately 50% of attendees, demonstrating the impact of symposiums.
- Symposiums advertised in the TH newsletter.

Nurse Degree Apprenticeships (accelerated route)

- 2 more Apprentices are almost ready to apply, with conversations with 3 more ongoing.

Nursing Associate Apprenticeships

- 2 new apprentices ready to join in September.

Oliver McGowan Training

Specialist Commissioned HEI Courses

- Funding confirmed from NHSE.

Leadership Development Programme

Primary Leadership Programme

- Applications closed at the end of July (51 received in total).

New to Practice Fellowship Programme

New to Practice Fellowship Programme

- Supported two GPs to organise their own Away Day scheduled for 1st July 2025. QI Programme launched for a group of GPs on the programme.

Supporting Mentors Scheme

- Ongoing checking of GP invoices and regular contract management meetings with AKESO.

OD & Transformation

Digital and Transformation Leads

- A poll completed to determine interest in a F2F session; planning for this session has commenced, with the D&T Leads wanting to discuss AI tools.

Equity, diversity and inclusion

Health and wellbeing

- Engagement with wellbeing champions, promoting the most recent resources and support.

Knowledge and Library Services

- Delivered Medical Terminology Training, added bespoke content for the NHS Knowledge and Library Hub upgrade, and communicated with users.

Practice Level Support Programme

- Practices have been sent information about the Support Level Framework and Practice Level Support offers and have started signing up. Work has commenced with practices to support them to implement total triage and discuss CQC outcomes.

PC Workforce Integration

Hypertension Conference

- Conference organised and all tickets booked. Delivered on 2nd April 2025.

Pharmacy Workforce Strategy Group

- First meeting of the Pharmacy Workforce Strategy Group held; three priority areas identified.

Work and health

- Advancement of fit notes transformation working group. Strategy confirmed. Increased focus on Primary Care.

Personalised Care Workforce Development

Personalised Care - Peer support forums

- Report from peer support forums to highlight challenges, wins, and areas for improvement.

Personalised Care Conferences

Progress made in Previous Period

Personalised Care Programme Overall

Personalised Care- Athena Casefinding Tool

Personalised Care- Reporting on Personalised Care Roles (Ardens)

Placement Expansion

GP Educator + 12 Training Programme

- Sessions continuing.

Multi-professional Digital Placement

- Timetable written and meeting booked for June to discuss and identify student groups to attend.

Paramedic Digital Placement Model

- Programme timetable planned; awaiting UoB to identify students and confirm dates for two placements in May 2026.

Placement Capacity Expansion - Digital Nurse Placements

- Next cohort in June organised and ready to go. June cohort had to be cancelled due to students changing trusts; only 4 students so not financially or time efficient to run. July placement started (2 weeks, first year placement).

Placement Capacity Expansion - GP Educators

- GPs are open, currently advertising and receiving applications.

SSSA Training

Student Pharmacist Summer Placement Programme

- 8 students successfully interviewed and recruited.

Quality Programme

ARCP Panels

- Communicated funding available to VTS schemes and first panels being reimbursed.

Quality programme

- Agreement to move forward with a pilot MK PCN approval to test newly developed cross-deanery processes. Positive progress

with quality concerns.

Recruitment

GPN Pipeline Support Programme

- TaFG has met and priorities identified. A survey sent out to practices to identify GPN vacancies. Document produced for GPNs to help them understand support and roles available. Scoping around modular delivery for the GPN fundamentals course.

International GP Recruitment

- N/A

Recruitment Support

- No specific progress, this project is BAU.

Workforce Planning Session

- Sign-up form sent out; 36 people signed up. Session was delivered and a version of the session was recorded for managers who were unable to make the face to face session.

Retention

Pharmacy alumni network

- Potential alumni identified.

Physician Assistants

- N/A

Preceptorship Programme

CPD Programme

Advanced Practitioners

- Submit final applicant report to NHSE for September starts.
- Request invoices for Q1 training grants.
- Check EC schedule to verify correct payments.

Apprenticeships

CPD Programme

- Start analysing data for the end of year 2024/25 CPD report and slide deck.

First Contact Practitioners

GP Symposiums

- Ongoing advertising of symposiums.

Nurse Degree Apprenticeships (accelerated route)

Nursing Associate Apprenticeships

Oliver McGowan Training

Specialist Commissioned HEI Courses

- Advertising, reviewing applications, and seeking clarity on prescribing funding.

Leadership Development Programme

Primary Leadership Programme

- Applications will close on the 31st July 2025 and successful candidates will be informed in August 2025. Programme to commence in September 2025

New to Practice Fellowship Programme

New to Practice Fellowship Programme

- Away Day to take place in October 2025
- Process invoices for Q2 funding.

Supporting Mentors Scheme

- Ongoing meetings with AKESO to manage contract.

OD & Transformation

Digital and Transformation Leads

- Continue planning for the F2F session scheduled for September 2025.

Equity, diversity and inclusion

- Continued promotion of EDI resources and activities.

Health and wellbeing

- Continued linking in with ICB and national NHS wellbeing campaigns.

Knowledge and Library Services

- Complete translation and interpreting literature search. Dementia diagnosis literature search, schedule introductory sessions to the Knowledge & Library Hub upgrade.

Practice Level Support Programme

- Commence SLF visits with RCPG to learn how to do the SLF diagnostic assessment.

PC Workforce Integration

Hypertension Conference

- None, project complete.

Pharmacy Workforce Strategy Group

- Set up the three TaFGs to commence work on the priority areas.

Work and health

- Continued work with fit note transformation.
- Exploration of the Money Guiders training to be promoted across Primary Care staff.

Personalised Care Workforce Development

Personalised Care - Peer support forums

Personalised Care Conferences

Progress to be made in Next Period

Personalised Care Programme Overall

Personalised Care- Athena Casefinding Tool

Personalised Care- Reporting on Personalised Care Roles (Ardens)

Placement Expansion

GP Educator + 12 Training Programme

- Continue monthly delivery and potentially add another session for trainees in difficulty.

Multi-professional Digital Placement

Paramedic Digital Placement Model

- No meetings in the next month, but confirmations from practices to host students are being sought.

Placement Capacity Expansion - Digital Nurse Placements

- Continuing to work with SNEE and C&P to build a new learning platform.

Placement Capacity Expansion - GP Educators

- Closing funding offer and reviewing applications.

SSSA Training

Student Pharmacist Summer Placement Programme

- Onboard advisors and students through eQuality.

Quality Programme

ARCP Panels

- Two-way communication with VTS schemes on panels.

Quality programme

- Plan for pilot MK PCN, plan for site visits, and resolve a couple of quality concerns.

| | | | 2025 | | | | | | 2026 | | | | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|
| | Start Date | End Date | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| GP Educator Training incentive funding offer open | | 27/06/25 | | | ◆ | | | | | | | | | |
| GP Educator Training incentive funding offer close | | 27/07/25 | | | | ◆ | | | | | | | | |
| Digital Nursing Cohort - UoB 1st Years | 01/07/25 | 30/07/25 | | | | ■ | | | | | | | | |
| Digital Paramedic Model scoping period | 01/04/25 | 01/08/25 | ■ | ■ | ■ | ■ | ■ | | | | | | | |
| CPD scoping / TNA / Planning | 01/04/25 | 22/08/25 | ■ | ■ | ■ | ■ | ■ | | | | | | | |
| Student Pharmacy Summer Placement | 14/07/25 | 22/08/25 | | | | ■ | ■ | ■ | | | | | | |
| Student Pharmacy Placement Programme | | 22/08/25 | | | | | ◆ | | | | | | | |
| Submit CPD Plan to NHSE | | 22/08/25 | | | | | ◆ | | | | | | | |
| Advanced Practice - confirm final funding utilisation for Autumn cohorts | | 29/08/25 | | | | | ◆ | | | | | | | |
| Digital Paramedic Model Implementation period | 01/08/25 | 30/09/25 | | | | | ■ | ■ | ■ | | | | | |
| Specialised Commissioning demand scoping period | 01/09/25 | 30/09/25 | | | | | | ■ | | | | | | |
| Digital Paramedic Model 1st Cohort delivery | 01/10/25 | 15/10/25 | | | | | | | ■ | | | | | |
| Oliver McGowan - start planning future sessions | 01/10/25 | 31/10/25 | | | | | | | ■ | | | | | |
| Digital Nursing Cohort - UoB 3rd Years | 01/10/25 | 31/10/25 | | | | | | | ■ | | | | | |
| GP Educator Training Programme Cohort | 10/09/25 | 05/11/25 | | | | | | ■ | ■ | ■ | | | | |
| Prepare and submit new educator approvals to NHSE | 05/11/25 | 01/12/25 | | | | | | | | ■ | ■ | | | |
| Specialised commissioning – finalise GPN Fundamentals spring cohort | 12/11/25 | 17/12/25 | | | | | | | | ■ | ■ | | | |
| Implement Wave 1 of CPD Courses | 01/10/25 | 31/12/25 | | | | | | | ■ | ■ | ■ | | | |
| Apprenticeships - L7 current model funding ends | | 31/12/25 | | | | | | | | | ◆ | | | |
| New Educator Development 12 month programme - 2026/27 | 01/09/25 | 30/01/26 | | | | | | ■ | ■ | ■ | ■ | ■ | | |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000150 |
| Project Name | Primary Care Access - Demand Management, Addressing Variation |
| Project Team | Primary Care |
| Project Aim | <p>Patients and carers experience a responsive and accessible primary care service, delivered by those best able to understand – and meet – the health and wellbeing needs of the local communities they are proud to serve.</p> <p>We will work with all PC Providers to identify and address variation to support them with level and trans and will increase contract oversight where applicable.</p> |
| Governance & Responsible Group | <p>Primary Care Delivery Group reporting to Primary Care Commissioning & Assurance Committee</p> <p>See file "Governance" and "Collaboration and Connectivity" in the 'Governance' Folder.</p> |
| Geographical Footprint | BLMK System |

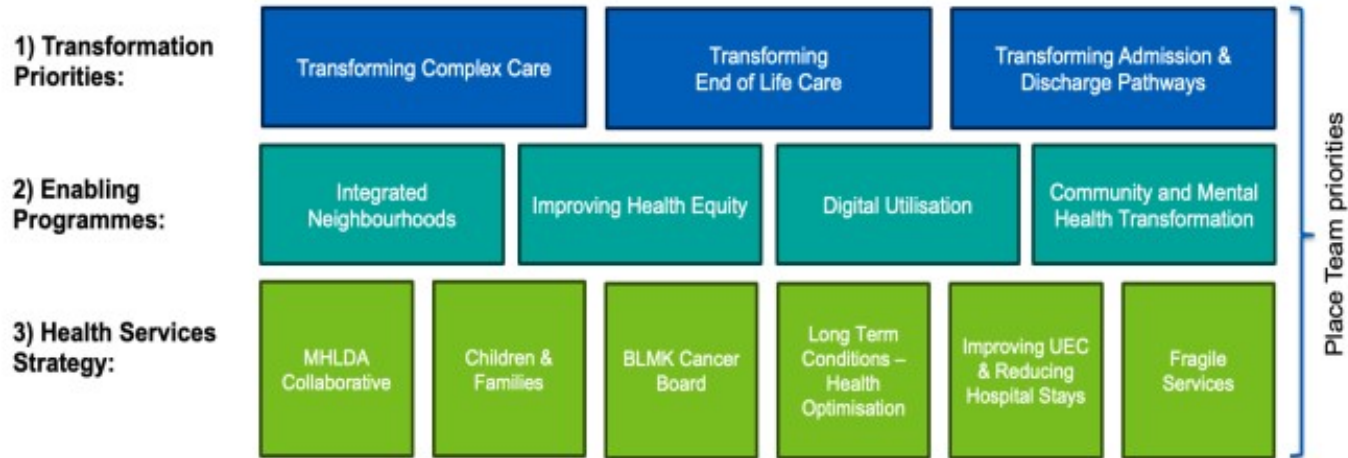
Project Team Members

| Name | Role |
|-------------------|--------------------------|
| Jade Vandyke | Programme Manager |
| Steve Gutteridge | Programme Manager |
| Amanda Flower | Senior Responsible Owner |
| Duncan McConville | STT Senior Lead |
| Janine Norman | STT Team Member |
| Layla Vardy | STT Team Member |
| Sara Burford | Transformation Manager |
| Lucy Robertson | Transformation Manager |

Project Status

| | |
|-----------------------------------|----------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | On track |
| Project Maturity | 4.0 - Delivery |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

Primary Care (and particularly General Med services who hold the registered list), are fundamental to delivery of **all System Transformation Priority programmes as per the diagram**

Improved access to, and integration of, Primary Care will support resident management in the place they call home and should therefore support **admission avoidance** schemes.

Digital Utilisation With NHS App development

LTC and Health Optimisation

Progress Update

| | |
|---|--|
| <p>Progress made in Previous Period</p> | <p>Continued focus on driving up utilisation of the NHS App for primary care.</p> <p>Continued support to practices (more than 80% of practices in BLMK are delivering total triage) to deliver a modern access model (residents know on the day they contact their practice how their request will be managed).</p> <p>Completed PC Visits in Q2 with relevant reporting to PC Delivery Group through HLR reporting mechanism</p> <p>Continued to engage practices with training and support offer</p> <p>Arranged visits to all urgent primary care services (UTC, WIC and UGPC) to support service developments and transformation – and integration.</p> <p>Submitted GP Action plan by 30 June, as part of Op Plan req.</p> <p>Provided bespoke support to practices identified with most sig access challenge</p> |
| <p>Progress to be made in Next Period</p> | <p>Ensure priority Primary Care visits to contractors are undertaken inline with the stratified plan</p> <p>Ensure practice support visits take a data led approach to identify and address variation</p> <p>Work with General Medical service providers to ensure take up of the support level framework and GP improvement offer.</p> <p>Continue to deliver the ICB share of additional Dental Appointments (6041)</p> <p>Ensure clinical leadership is utilised and embedded as part pf practice support approach to deliver priorities.</p> <p>Continue to build on success of pharmacy first implementation, utilising community pharmacy engagement leads to support relationship development and integration between all PC Providers</p> <p>Use protected learning time sessions to provide support to PC Providers</p> <p>Continue to support the development of Primary, Secondary and Community interface forums, to improve joint working and increase productivity</p> <p>Continue to support PC Networks to deliver the req of the DES by 30/09, which incudes. Continued expansion of online consultation and embedding of risk stratification</p> |

Tasks & Milestones

| | |
|--|--------------|
| Overall Tasks & Milestones Status | GREEN |
| Reason for Overall Tasks & Milestones Status | On track |

| | Start Date | End Date | 2025 | | | | | | | | | | | | 2026 | | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|--|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | | |
| Briefing at ICB Board Seminar | 19/07/25 | 19/07/25 | | | | | | | | | | | | | | | | |
| Ensure all PCNs deliver the requirement to have online consultation for all core hours - by 1/10/25 | 01/04/25 | 30/09/25 | | | | | | | | | | | | | | | | |
| Ensure all PCNs are utilising the Risk Strat tool as specified in the PCN DES | 01/04/25 | 30/09/25 | | | | | | | | | | | | | | | | |
| Complete visits to all 84 Practices | 01/04/25 | 31/03/26 | | | | | | | | | | | | | | | | |

| Risks | |
|--------------------------------|---|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | Risks to be reviewed following controls and mitigations |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|---|-----------|------------------------------|
| General practice workforce, estates and capacity to meet growing demand | Yes | 4 |
| Lower than expected uptake of the NHS App in BLMK | Yes | 4 |

| Issues | |
|----------------------------------|----------------------|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | No issues identified |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000297 |
| Project Name | Transforming Admission and Discharge Pathways |
| Project Team | STT |
| Project Aim | <p>The overarching aim of the Transforming Admissions and Discharge Flow programme, is to reduce acute bed occupancy to below 95% by improving system flow in hospital settings, preventing admissions, and reducing Emergency Department presentations and conveyances.</p> <p>Through the various projects and initiatives, the programme seeks to address the low numbers of patients being discharged on the P0 pathway and high numbers on P1 and P2. Discharge pathways require a redesign to increase discharges to P0 and left-shift placements from P3 to P2, P2 to P1 and P1 to P0.</p> <p>It seeks to right-size P2 and P3 bedded capacity, as well as redesign Reablement and Intermediate Care pathways to better align with local needs. The programme focuses on reducing discharge delays by integrating and streamlining fragmented pathways, and promoting proactive, personalised care to manage variations in length of stay in P2 rehab beds, while also utilising commissioned P2 bed capacity to avoid the temporary use of P3 placements as well as reducing the use of SPOT purchase beds. It aims to enhance admission avoidance initiatives, particularly for falls, through integrated working and risk stratification, targeting high users of resources. Strengthening multidisciplinary teams in neighbourhood's is a key priority to reduce length of stay in Milton Keynes, maintain low lengths of stay in Bedfordshire Hospital, and prevent unnecessary hospital admissions. The programme also emphasises the importance of robust multidisciplinary teams in preparing discharges, fostering a Home First culture, and ensuring all decisions are made through multi-agency collaboration focused on neighbourhood care. Additionally, it aims to develop a system-level strategy to support neighbourhood working, with a clear vision and high-level objectives for each local area.</p> |
| Governance & Responsible Group | |
| Geographical Footprint | BLMK System, Bedfordshire Care Alliance, Milton Keynes |

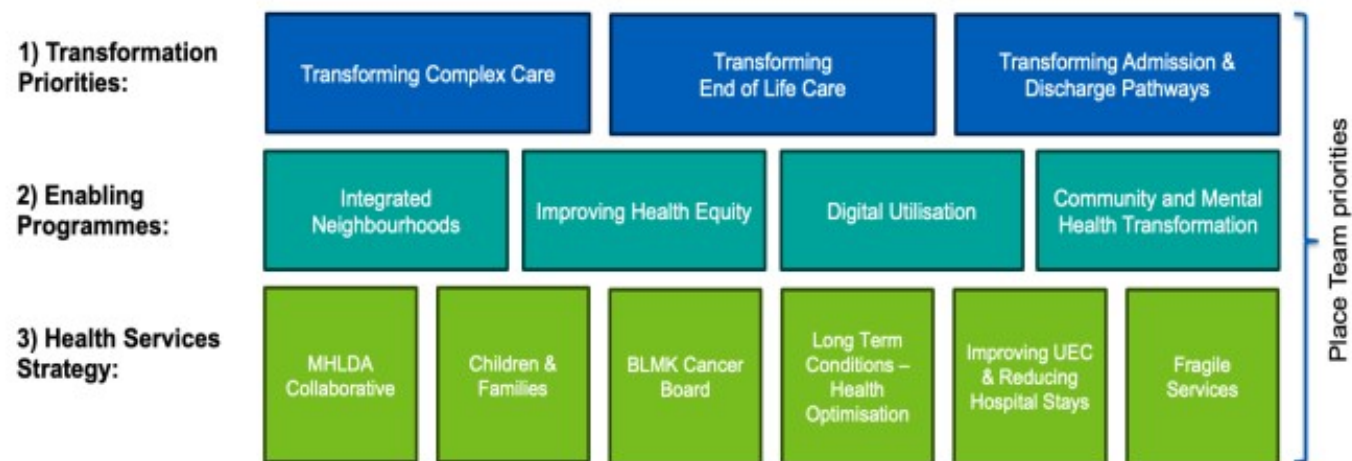
Project Team Members

| Name | Role |
|-----------|-----------------|
| Tara Dear | Head of STT |
| Cat Lee | Project Manager |

| | |
|-----------------|-------------------------------|
| Georgie Brown | Senior Responsible Owner |
| Mark Morton | Senior Transformation Manager |
| Matt Rogers | Senior Transformation Manager |
| Michael Ramsden | Subject Matter Expert |
| Amanda Flower | Subject Matter Expert |
| Caron Morgan | Transformation Manager |
| Vickie Place | Transformation Manager |

| Project Status | |
|-----------------------------------|----------------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | On track |
| Project Maturity | 3.0 - Implementation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

Transforming Admissions and Discharge Pathways is one of the 3 key transformation priorities for the ICB in 2025/26. There are links and interdependencies with the other key priorities and enabling programmes.

Progress Update

| | |
|------------------------------------|---|
| Progress made in Previous Period | <ol style="list-style-type: none"> 1. Workshop with system partners (16 May) to identify priority areas and identify options for projects to stop or that have been delivered and move towards business as usual 2. 3 meetings of "Urgent and Emergency Health and Care Board" with membership agreed. 3. Draft TOR developed and shared with board members. 4. Scorecard developed and agreed by Board 5. System Charter drafted with input from Board members including priority areas including challenges, aims and success measures 6. P2 Business Case discussed and approved at system Leaders Group (SLG). Agreement that a Commission 10 IMC P2 dementia beds by direct award, for people across Bedfordshire and Luton is the preferred option. Proposal discussed at IVOG 7. Priority projects developed at MK Place and Bedfordshire level |
| Progress to be made in Next Period | <ol style="list-style-type: none"> 1. Develop delivery model of priority linking activity across BCA and MK ISF 2. Develop metrics to track improvements in the post acute phase of the patient pathway including in social care 3. Agree thresholds/targets at a local level for the scorecard metrics 4. Agree governance and accountability in terms of decision making for funding sources and responsibilities to be included in TOR 5. Agree key priority areas for admission avoidance and discharge at MK and Bedfordshire place level and identify areas of commonality that would benefit from a BLMK level development 6. Agree Task and Finish Groups for priority projects 7. Move into design and implementation phase of the 10 dementia beds for P2 pathway |

Tasks & Milestones

| | |
|--|--|
| Overall Tasks & Milestones Status | GREEN |
| Reason for Overall Tasks & Milestones Status | Programme Board in development with system wide reps agreed. |

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | |
| Develop MK ISF Priority Projects | 03/06/25 | 15/08/25 | | | | | | | | | | | | | |
| Agree Funding of P2 Dementia beds at IVOG | | 27/08/25 | | | | | ◆ | | | | | | | | |
| Develop Bedfordshire Priority Project List | 03/06/25 | 01/09/25 | | | | | | | | | | | | | |
| Agree Scorecard for Programme Monitoring | | 01/09/25 | | | | | | | ◆ | | | | | | |
| BLMK UEC Priorities Agreed | | 01/09/25 | | | | | | | ◆ | | | | | | |

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | | |
|---|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|--|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Agree Task and Finish Groups for priority projects | 18/08/25 | 30/09/25 | | | | | | | | | | | | | | | |
| Market Engagement for Delivery of P2 Dementia Beds | 20/08/25 | 30/09/25 | | | | | | | | | | | | | | | |
| Implementation of P2 Dementia Beds Service | 01/10/25 | 21/11/25 | | | | | | | | | | | | | | | |
| Develop Phase 2 (Community Workforce and Bed Restructure) of P2 Programme | 22/09/25 | 31/12/25 | | | | | | | | | | | | | | | |
| Delivery of P2 Dementia Service through winter 25/26 | 01/11/25 | 31/03/26 | | | | | | | | | | | | | | | |

Risks

| | |
|--------------------------------|---|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | Risk identified at this stage is how to reduce the number of projects in progress down to a manageable number |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|---------------------|-----------|------------------------------|
| Collaboration | Yes | 2 |
| Long Term Structure | Yes | |

Issues

| | |
|----------------------------------|------------------------------------|
| Overall Issues Status | GREEN |
| Reason for Overall Issues Status | No issues identified at this stage |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000285 |
| Project Name | Transforming Complex Care |
| Project Team | Children's Services (LA), Children and Maternity (ICB), Adult Services (LA), Continuing Healthcare (ICB), STT (ICB) |

The aims, outcomes, benefits and enablers highlighted below fall within an agile and adaptive programme of work. They will be reviewed and refined throughout the programme's lifecycle. Version History can be reviewed in Verto365 through clicking on 'Aim' on the left-hand side of the 'Project Stage – Overview' page.

3.1 – Aim - "Children's":

Aim: To develop a new approach to supporting children most impacted by childhood trauma resulting in health and social care needs not being met through the Mental Health Act 1983 or meet the criteria for Children's Continuing Health Care.

High-Level Outcomes, Benefits & Enablers:

- Improve the lives of children and young people facing complex challenges in health, social care, and education, along with support for their families.
- Ensure all services and agencies work together smoothly, with clear roles and shared understanding. This includes planning for risks, maintaining high quality, and having strong leadership in decision-making.
- Lead a joined-up approach where professionals from across the system collaborate to find the best solutions.
- Use resources more effectively by improving the provision of expensive, specialist care.
- Provide coordinated, personalised care that places each child's individual needs at the centre of planning and support.

3.2 - Aim - "Adults":

Aim: To address the unmet health and social care needs of individuals who fall between the standard CHC and S117 aftercare eligibility. Focus will be on managing complex cases, developing specialised care pathways, and ensuring integrated service delivery. Additionally, the project aims to develop a unified approach that considers the financial and healthcare implications of unmet needs, to ensure individuals receive the necessary support.

High-Level Outcomes, Benefits & Enablers

- Simplify joint funding processes, making them easier to understand and use for staff working on the ground.
- Ensure the BLMK system adheres to national rules for funding care (the CHC Framework), so people receive the appropriate financial support. If someone doesn't qualify for standard funding, they will still receive a comprehensive care plan covering both their health and social care needs.
- Identify gaps in current community and mental health services to determine where improvements or new services are needed in the future.
- Establish a specialist health team to assist people whose health needs are not being met. This team will provide expert advice and work closely with local councils to ensure people receive the care they need.

Project Aim

| | |
|---|--|
| <p>Governance & Responsible Group</p> | <p>10.1 - Programme Governance Structure</p> <p>The programme will be governed by the ICB Internal Steering Board, which is responsible for providing assurance on the actions being undertaken across BLMK in relation to the programme. The Board takes a systemic approach to delivery, fosters continuous learning, evaluates financial impacts on plans, and oversees dynamic risk assessment and mitigation strategies.</p> <p>In addition, the programme is supported by BLMK Systemwide External Steering Boards, which are responsible for driving and implementing transformational change across both Children’s and Adults’ services. These Boards leverage the collective expertise of system partners to lead change.</p> <p>A number of task and finish groups are also being established to support the delivery of key workstreams. These groups will be accountable for implementation and will report into the Children’s Transformation Steering Board (CTSB) or the Adults’ Steering Board (with the relevant reporting line to be confirmed).</p> <p>10.2 - Reporting Structure</p> <p>The ICB Internal Steering Board will report into the following governance forums:</p> <ul style="list-style-type: none"> • System Chief Executives (six-weekly reporting) • Finance and Investment Committee • Quality and Performance Committee • ICB Executive (monthly highlight report) <p>10.3 - Programme Support and Coordination</p> <p>The Transforming Complex Care Programme Manager will play a key role in reviewing key themes, data, and learning arising from these meetings throughout the year.</p> <p>Overall coordination and management of the governance meetings will be led by the Transforming Complex Care Programme Management team (sits within the System Transformation Team), supported by the Children and Young People (CYP) and Continuing Healthcare commissioning teams.</p> |
| <p>Geographical Footprint</p> | <p>BLMK System, Milton Keynes, Bedford Borough, Central Bedfordshire, Luton</p> |

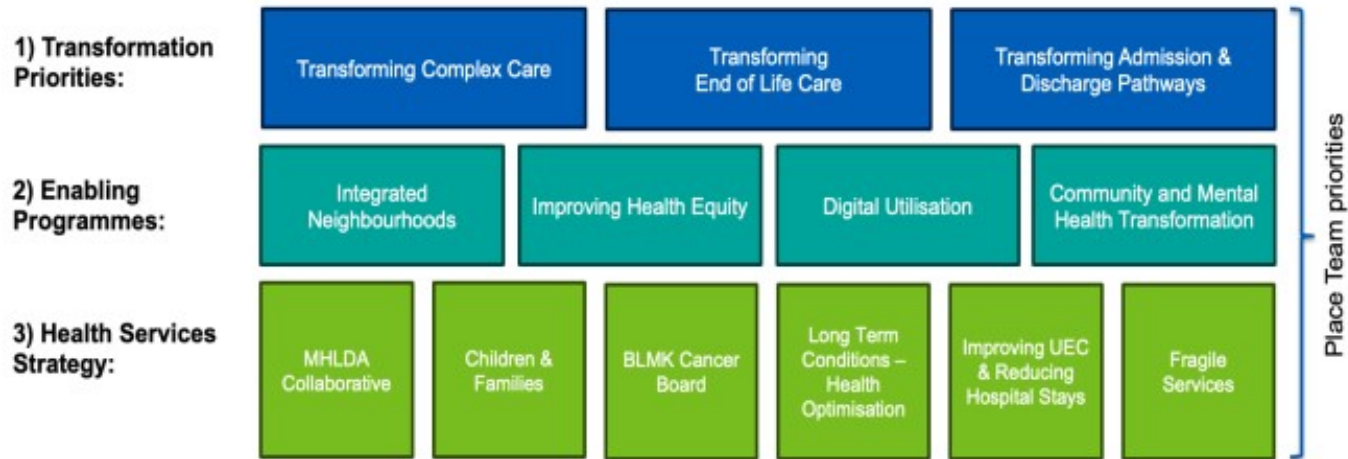
Project Team Members

| Name | Role |
|------------------------|--------------------------------|
| Tara Dear | Head of STT |
| Rafael Barnett-Knights | Project Manager |
| Vickie Place | Project Manager |
| Matthew Kurima | QI Lead |
| Cat Lee | QI Observer |
| Sarah Stanley | Senior Responsible Owner |
| Matt Rogers | Senior Transformation Manager |
| Sarah Breton | Subject Matter Expert |
| Andrea Piggott | Subject Matter Expert |
| Diana Butterworth | Subject Matter Expert |
| Layla Vardy | Transformation Coordinator |
| Lucy Robertson | Transformation Support Manager |

Project Status

| | |
|-----------------------------------|------------------------------------|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Project is in the initiation phase |
| Project Maturity | 2.0 - Initiation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

The programme aligns with 1) Transforming Priorities

Progress Update

Children who have experienced Childhood Trauma resulting in health and social care needs not being met through the Mental Health Act 1983 or meet the criteria for Continuing Health Care

The thematic work has progressed well, with a structured multi-agency panel process established in Milton Keynes, Luton and Central Beds to support the top 10 children with complex needs. This process includes ongoing meetings for close monitoring and adjustment.

- Panels comprise professionals from social care, health, and education to ensure coordinated planning. New cases are being added over time to maintain responsiveness.
- Financial reviews are underway to identify funding gaps, with feedback being used to refine the approach.
- Strong collaboration and communication were recognized as central to effective care and future planning.
- Initial findings highlighted three key priority areas agreed by the Board:
 - i. Transitions for Children Moving Out of Area: Variability in CAMHS involvement during transitions has led to gaps in care and increased costs; a review of system protocols is needed.
 - ii. Deprivation of Liberty Safeguards (DoLS): Lack of CAMHS or clinical involvement in DoLS decisions raises concerns about decisions made without clinical input.
 - iii. CAMHS Formulation in Placement Decisions: Stronger clinical input from CAMHS is needed to support social care in placement decisions and to challenge costly therapeutic offers from providers.

Progress made in Previous Period

- Discussions identified additional issues related to education provision for children not in school or not of statutory school age, highlighting the need for meaningful daily activities.
- Dates for case review meetings with two Local Authorities took place at the end of July, with efforts to confirm a date with one remaining authority which is now planned for 15/08.
- The ISTAC (Intensive Systemic Therapy Around the Child) model was presented, demonstrating effective community-based therapeutic intervention with positive outcomes and cost-effectiveness. The pilot in the South of England and national evaluation were noted.
- The importance of bespoke health literacy training for social workers was emphasized to improve understanding and communication of health information.
- The Segmentation tool has been developed which shows Looked After Children in the BLMK area interactions with Acute, Mental Health, Community, and Primary Care services during the 2024/25 period. The purpose of this data is to understand the service use and associated costs for these children to inform system improvements and resource planning. This will be presented at the next internal steering board.
- Internal/External steering board meeting continue as planned, albeit internal board meetings have been cancel due to key stakeholder availability

Adults with Unmet Health and Social Care Needs

- Captured a shared understanding of the challenges and issues being faced by the BLMK system, in relation to Adults with Unmet Health and Social Care needs.
- Developed a comprehensive CHC (Continuing Healthcare) Funding Flow Chart to clarify funding processes.
- Established the Adult's Transformation Pre-Meeting to prepare and align stakeholders ahead of formal discussions.
- Set up the Adult's Transformation joint meeting involving the Integrated Care Board (ICB) and Local Authority to foster collaboration.
- Completed agenda and document planning in preparation for the upcoming Adult's Transformation meeting.

Children who have experienced Childhood Trauma resulting in health and social care needs not being met through the Mental Health Act 1983 or meet the criteria for Continuing Health Care

- Hold the outstanding case review meeting date with the remaining Local Authority, scheduled for 15/08.
- Commence and develop improvement plans focused on the top three priority initiatives - plan to start in September:
- Enhance CAMHS transition support for children moving out of area.
 - Improve oversight of court-directed clinical assessments to inform DoLS decisions and support stepping down DoLS from CAMHS.
 - Ensure up-to-date clinical formulations to guide placement searches and appropriate support.
- Continue to develop a Therapeutic Interventions Costing Sheet to support and clarify funding principles – complete by end of August
- Investigate current initiatives and coordination efforts across Hertfordshire and Cambridge & Peterborough ICBs regarding placements and residential development – complete by mid Aug
- Conduct a mapping exercise of existing and planned residential provision, including clinical and therapeutic services - complete by end of Aug.
- Explore and scope out commissioning opportunities for the ISTAC model
- Implement targeted training offers to enhance social workers' health literacy regarding therapeutic assessments and health-related decision-making.
- Continue developing a set of internal Funding Principles, to be reviewed in collaboration with Finance colleagues for alignment and approval – end of August
- Maintain a detailed record of outputs from case review meetings and transfer onto the dedicated monitoring tool to ensure accurate tracking of changes and progress – Beginning Sept.
- Produce a report summarising the initial and key findings from ongoing case reviews to inform stakeholders – mid Sept.
- Complete and submit a short report on “Mentoring” and Unaccompanied Asylum-Seeking Children – complete by 14/08

Adults with Unmet Health and Social Care Needs

- Pre-meet with Laura Church scheduled for 22nd August
- Adult Social Care Transformation Review Meeting with all 4 Local Authorities schedule for 13th October (earliest dates LA availability). To confirm whether Local Authorities still consider this a priority project or if it can be managed by operational teams following adoption of the CHC joint funded policy.

Progress to be made in Next Period

Tasks & Milestones















Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

This programme and its two projects have been established. Children's is in the delivery phase. Adults is still in planning phase.

Please note: The start and end dates assigned to each task (Start: [Today's Date], End: 31/12/2025) are indicative placeholders only. Due to the adaptive and agile nature of this project, actual timelines are subject to change based on evolving priorities, stakeholder input, and system readiness. These dates are used solely to enable tracking and reporting within the project management system and do not reflect fixed delivery deadlines.

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | | |
|---|------------|----------|---|---|---|-----|---|-----|---|---|-----|-----|---|-----|--|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Set up ICB Internal Children's and Adults Steering Board | 06/05/25 | 06/05/25 | |  | | | | | | | | | | | | | |
| Present initial findings at ICB Board | | 27/06/25 | | |  | | | | | | | | | | | | |
| Identify Priority Cohorts - 10 children per Local Authority | 04/04/25 | 15/08/25 |  | | | | | | | | | | | | | | |
| Initial Case Meetings - ICB and Local Authorities | 04/04/25 | 15/08/25 |  | | | | | | | | | | | | | | |
| Project Establishment | 23/06/25 | 15/08/25 | | |  | | | | | | | | | | | | |
| Hold review meeting and capture outputs | | 15/08/25 | | | | |  | | | | | | | | | | |
| Establish anonymised Outcomes Tracker for priority cohorts | 15/08/25 | 29/08/25 | | | | |  | | | | | | | | | | |
| Establish a BLMK Adults Transformation Steering Board | 15/08/25 | 01/09/25 | | | | | | | | | | | | | | | |
| Agree statutory and mandatory responsibilities and the definition of 'unmet needs' (INTERNAL ICB) | 20/06/25 | 02/09/25 | | |  | | | | | | | | | | | | |
| Establish 'New Ways of Working' groups with Local Authorities | 03/09/25 | 03/09/25 | | | | | | |  | | | | | | | | |
| Establish an unmet needs protocol | 18/08/25 | 26/09/25 | | | | | | | | | | | | | | | |
| Produce diagnostic report - key findings from Initial Case Meetings and recommended next steps | 05/09/25 | 26/09/25 | | | | | | |  | | | | | | | | |
| Finalise improvement measures | 29/09/25 | 03/10/25 | | | | | | |  | | | | | | | | |
| Develop funding principles | 09/06/25 | 24/10/25 | | |  | | | | | | | | | | | | |
| Produce concept dashboard | 06/10/25 | 20/11/25 | | | | | | | |  | | | | | | | |
| Produce working dashboard | 01/12/25 | 31/12/25 | | | | | | | | | | |  | | | | |

Risks

| | |
|--------------------------------|--------------------|
| Overall Risks Status | GREEN |
| Reason for Overall Risk Status | Programme on track |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|---|-----------|------------------------------|
| High Cost Placements and ICB contribution | Yes | 9 |
| Programme Scale | Yes | 4 |
| Model ICB Blueprint | Yes | 4 |

Issues

| | |
|----------------------------------|---------------------|
| Overall Issues Status | GREEN |
| Reason for Overall Issues Status | Issue being managed |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|---|------------|--------------------|
| Healthcare Resource Consumption Modelling | Yes | 9 |

Portfolio Report Governance Report

| | |
|--------------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000275 |
| Project Name | Transforming Palliative End of Life Care |
| Project Team | STT |
| Project Aim | <ul style="list-style-type: none"> To have a maximum of 2 coordination centres across Bedfordshire, Luton and Milton Keynes delivering standardised care with a single point of access. To reduce the number unplanned palliative care bed days in hospital in the last 3 months of life by 50% by end of year 2, following development of the co-ordination centres. To increase recognition of people in their last year of life and evidence an improving trend of palliative care registrations with ambition to have 80% expected registered by year 3 [~8000 patients]. Hospital staff within identified clinics [tbc: eg heart failure, respiratory, oncology] feel more confident to facilitate meaningful conversations about end-of-life choices and signpost to the co-ordination centres accordingly. 100% of co-ordination centre contacts offer an advanced care plan [ACP]. To raise the profile and talk more about death and dying across communities |
| Governance & Responsible Group | <p>A new Palliative and End of Life Programme Board has been established with 2 supporting steering groups:</p> <ol style="list-style-type: none"> Clinical ; including data/digital, and education and communication Finance |
| Geographical Footprint | BLMK System |

Project Team Members

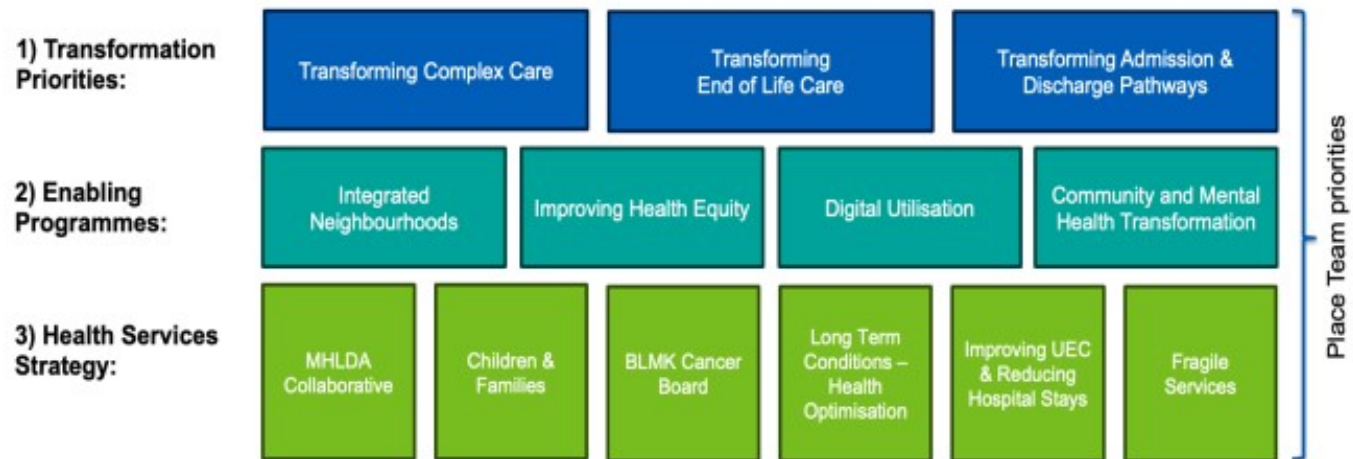
| Name | Role |
|------------------|-------------------------------|
| Sarah Stanley | Executive Lead |
| Tara Dear | Head of STT |
| Jo Morris | Project Manager |
| Simon Hardcastle | Senior Responsible Owner |
| Natasha Young | Senior Transformation Manager |
| Samita Dass | Senior Transformation Manager |

| | |
|-------------------|----------------------------|
| Denise Faehndrich | Transformation Coordinator |
| Angela Reynolds | Transformation Manager |

Project Status

| | |
|-----------------------------------|--|
| Overall Project Status | AMBER |
| Reason for Overall Project Status | Project in pre-planning stage awaiting initial Programme Board 09/06/2025, though is identified as 1 of 3 key ICB transformation priorities. |
| Project Maturity | 1.0 - Pre-Planning |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

Transforming End of Life Care aligns with 1) Transformation priorities

End of life care has been identified as one of the three transformation priority programmes for ICB. Problem statements include:

1. **Co-ordination Centres [Palliative Care Hubs]** – there is a fragmented offer across the existing three hubs, with disparities in funding and specialist nursing services. Signposting to services across the Bedfordshire geography is further complicated for users across Central Bedfordshire, Bedford Borough and Luton where there are currently two hubs in situ.

Improved coordination of care pathways could enhance patient experiences while reducing unnecessary hospital admissions and readmissions. For example, in 2023, BLMK recorded 64,851 unplanned palliative care bed days and 5,982 palliative care emergency admissions, where enhanced pathway coordination could alleviate these pressures and see more patients cared for in the right place, by the right clinician, at the right time.

1. **Identification** - the palliative care register is underutilized, with only ~3000 patients recorded out of an expected 10,000 [based on assumption at any one time 1% of population can have an anticipated death], presenting missed opportunities for meaningful and personalised care plans to be used, and resulting in preferred places of death not being known or realised.

In 2023-24, only 5% of 2,603 individuals living with frailty and multiple life-limiting illnesses were identified as palliative. This group accounted for 19% of emergency admissions, with 40% ultimately dying in hospital, illustrating gaps in access to palliative support.

1. **Communication** – there are societal barriers for us all, but the reluctance to talk about death and dying could contribute to delays in initiating palliative care discussions.

These delays could lead to inappropriate treatment decisions being made and personalised care plans not being initiated or used.

1. **Projected growth** - population growth in BLMK has been approximately twice the national rate, and the area's age profile will continue shifting, with the population over age 50 set to grow significantly, and the population over 79 projected to double within the next two decades.

Any future service needs to be equipped for an increase in demand over time and enabled to maximise the resources available.

| | Start Date | End Date | 2025 | | | | | | | | | | | | 2026 | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|--|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Education and comms plan agreed and signed off by programme board for implementation | | 28/08/25 | | | | | | ◆ | | | | | | | | | |
| Financial transparency shared across hospice providers. | | 29/08/25 | | | | | | ◆ | | | | | | | | | |
| Business case for MK PEoLC model developed and signed off through programme governance processes | | 31/10/25 | | | | | | | | | ◆ | | | | | | |
| Business case for single PEoLC hub across Bedfordshire Partnership developed and signed off through programme governance processes | | 31/10/25 | | | | | | | | | ◆ | | | | | | |
| Dashboard and scorecard in place to monitor measures | | 31/10/25 | | | | | | | | | ◆ | | | | | | |

Risks

| | |
|--------------------------------|--|
| Overall Risks Status | TBC |
| Reason for Overall Risk Status | All key risks still need defining and are to be scored |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| Fragmented offer across existing co-ordination centres - to be scored | Yes | |
| Financial investment required in a constraint environment - to be scored | Yes | |
| To implement changes to the coordination centre offer, there may be financial investment required which presents a cost pressure to the organisation Cost pressure of invest to save modelling in financially constraint environment | Yes | |

Issues

| | |
|----------------------------------|------------------------------------|
| Overall Issues Status | TBC |
| Reason for Overall Issues Status | All key issues still need defining |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

| | |
|--------------------------|--|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000156 |
| Project Name | Women's Health |
| Project Team | Medical Directorate |
| Project Aim | <p>Local aims and objectives include:</p> <ul style="list-style-type: none"> a. Develop and mobilise Women's Health Network in Luton - acting as a proof of concept site to deliver 7/7 core elements for women and girls, and those who may not identify as women though still require services. b. Develop and mobilise Women's Health pilots across Bedford, Central Bedfordshire and Milton Keynes [phase 2] c. Undertake training needs analysis across primary care and identify opportunities to upskill local workforce in women's health d. Establish a local Women's Health Stakeholder Forum to share best practice and identify opportunities to improve experiences across BLMK e. Identify clinical pathways that have opportunity to improve efficiency and reduce system waste and develop new local guidance, for example post menopausal bleed on HRT (interdependency with cancer faster diagnosis), and long acting reversible contraception (LARC) fitting for gynae purposes. f. Addressing the gynaecology backlog in secondary care, ensuring all women are seen in the right place, at the right time and by the right clinician based on their needs. g. Delivery of wider Women's Health strategy aims to address gender inequalities [interdependency with Improving Health Equity programme] <p>The Women's Health Strategy for England lists 10 aims for women and girls:</p> <ul style="list-style-type: none"> 1. better access to services, including preventative healthcare and early intervention, and reduced unmet need for healthcare 2. improved patient experience, with care being delivered in one appointment where possible 3. improved health outcomes and reduced health inequalities 4. improved access to health information, in a range of formats, and supported patient self-management where appropriate |

| | |
|--------------------------------|--|
| | <p>Aims for the workforce:</p> <ol style="list-style-type: none"> 5. optimising the skills of multi-disciplinary teams (MDTs) through joint working and training opportunities 6. improved workforce experience and retention 7. improved communication and partnership working between primary, community and secondary care 8. at least one accredited and competent clinician trained in and delivering menopause care and contraception at PCN level, ideally at practice level, by September 2026, to better meet the needs of our women and girls. <p>Aims for the health and care system:</p> <ol style="list-style-type: none"> 9. greater efficiency, through care delivered at the right time, in the right place, and by the right person; fewer unnecessary secondary care referrals; and collaborative commissioning to make best use of resources 10. more integration and partnership working between health system partners – NHS, local authorities, the voluntary and community sector, and patients – so that services better meet the needs of women and girls 11. better collection and use of data by commissioners and providers to understand women’s health needs and improve service provision and outcomes |
| Governance & Responsible Group | <p>Reporting is no longer aligned with Improving Health Equity Programme, and instead aligned with 'Children and families' Health Services Strategy chapter.</p> <p>Key programme meetings:</p> <ul style="list-style-type: none"> • BLMK Women's Health Stakeholder Forum (monthly) - chaired by Sanhita Chakrabarti • BLMK Women's Health Networks Business and Clinical Pathways Meeting (monthly) - rotating chair between 3 WH Networks |
| Geographical Footprint | BLMK System |

Project Team Members

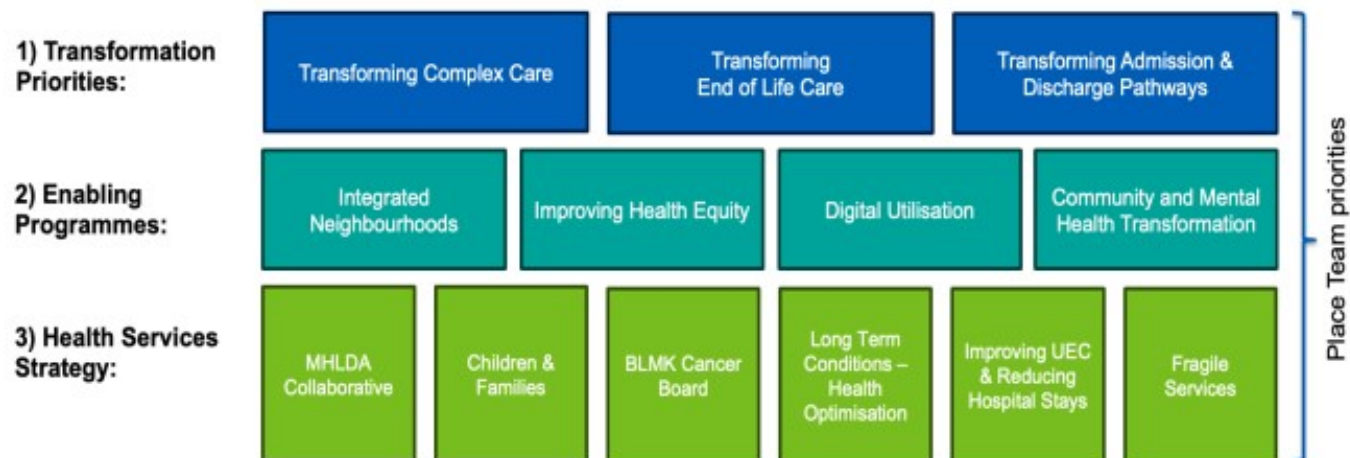
| Name | Role |
|----------------|-----------------|
| Cat Lee | Project Manager |
| Maureen Okolie | Project Support |

| | |
|---------------------|--------------------------|
| Julia Robson | QI Lead |
| Sarah Stanley | Senior Responsible Owner |
| Sanhita Chakrabarti | Senior Responsible Owner |
| Natasha Young | STT Senior Lead |
| Vickie Place | STT Team Member |
| Layla Vardy | STT Team Member |

Project Status

| | |
|-----------------------------------|---|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Implementation of Luton Women's Health Network and supporting pilots across other places now all live Primary care training programme in progress - first session to take place 05/09/25 |
| Project Maturity | 3.0 - Implementation |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

The programme is now aligned to the Children & Families Health Services Strategy chapter.

It has strong links with improving health equity in its aims to improve care access and quality for women in harder to reach communities.

Progress Update

Progress made in Previous Period

- **Governance and Programme Strategy**
 - Project management transferred from STT to Medical Directorate
 - AGEM supporting development of women's health dashboard - baseline and trajectory mapping of aim for 20% gynae referral reduction (OP wait to first outpatient for gynae)
- **Primary Care Training Programme**
 - Mapping of women's health provision and expertise across BLMK collated - will be used to help direct training resource and summarised as part of baseline for overall programme evaluation
 - Primary Care Women's Health training provider ([PCWHS](#)) identified and first full-day session "Menopause Foundation" to take place 5th September 2025 - fully booked for 40 participants.
 - Funding confirmed for the total cost of the above through Pharmaceutical industry partner sponsorship (managed under ABPI guidelines)
- **Women's Health Networks**
 - Luton Women's Health Network with Lea Vale PCN (went live in January 2025) has reported a reduction in gynae hospital referrals
 - Reporting process to share progress and updates with colleagues - established through PCDG and CFWM Board.
- **Clinical Pathways**
 - Pathway mapping at neighbourhood level for high volume areas - initial priorities identified for workshops in early 2026:
 - menopause (unscheduled bleeding on HRT)
 - heavy menstrual bleeding
- **Pilot Projects**
 - Bedfordshire based pilot launched with ELFT focused on menopause and mental health in March 2025
 - Bedfordshire based pilot launched with BEDOC in March 2025 to enhance the offering of women's health services to all PCNs with a dedicated focus on women from inclusion health groups
 - Milton Keynes based pilot launched with Whaddon in March 2025 to focus on group consultations within high volume low complexity pathways [such as menopause].
 - Milton Keynes based pilot launched with Pelvic Health Physiotherapist in March 2025 to support women waiting for urogynae procedures using a digital app.

Progress to be made in Next Period

- **Governance and Programme Strategy**
 - Continue to work with AGEM on dashboard, linking with BHFT to understand complex diagnosis data
 - Transition of responsibility for collaboration and meeting chair to network leads for sustainability moving forwards
- **Primary Care Training Programme**
 - Begin evaluation (resource provided by public health registrar starting Aug 2025) incorporating mapping work to understand baseline
 - Training sessions planned:
 - PCWHS Menopause Foundation Training (05/09/2025) full day
 - PCWHS Menopause Update Training (19/09/2025) half day
 - PCWHS Women's Health Foundation Training (28/11/2025) full day
 - 1 further training session (Jan-Mar 2026) TBC
- **Women's Health Networks**
 - Support 3 women's health networks to build business case for continuation of funding April 2026
 - Reporting process to share progress and updates with colleagues - established through PCDG and CFWM Board.
- **Clinical Pathways**
 - Establish introductory meetings between BHFT and Lea Vale / Bedoc to build collaborative space for pathway discussions and workshops
 - Confirm dates for industry partner facilitated pathway mapping workshops:
 - First session proposed: Menopause pathway mapping (am) / Heart health for women (pm) - Theramex
 - Second session proposed: Heavy menstrual bleeding pathway mapping (am) / Endometriosis and pain (pm) - Gedeon Richter
- **Pilot Projects**
 - All pilots - review reporting metrics and frequency agreed to ensure in track to deliver and identify any support or changes needed
 - ELFT menopause and mental health (Beds)
 - BEDOC enhancing women's health service offer to all PCNs, with dedicated focus on women from inclusion health groups (Beds)
 - Whaddon group consultations within high volume low complexity pathways (MK)
 - Pelvic Health Physiotherapy to support women waiting for urogynae procedures using a digital app (MK)
- From last period - still to complete - Driver diagram session to be held with maternity, childrens and quality improvement colleagues to align future programme deliverables.

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

Initiatives live.

| | Start Date | End Date | 2025 | | | | | | | | | | 2026 | | | | |
|--|------------|----------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|-----|---|---|--|
| | | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| Evaluation process agreed for all initiatives | | 30/05/25 | | ◆ | | | | | | | | | | | | | |
| Reporting metrics agreed and captured for all initiatives | | 30/05/25 | | ◆ | | | | | | | | | | | | | |
| Pelvic health Physiotherapy - Train the Trainer Training F2F | 10/06/25 | 10/06/25 | | | ■ | | | | | | | | | | | | |
| Evaluation support from HIE Networks | 18/06/25 | 31/07/25 | | | ■ | ■ | | | | | | | | | | | |
| Development of Squeezy App | 01/07/25 | 30/09/25 | | | | ■ | ■ | ■ | | | | | | | | | |
| Patient Enrollment | 01/07/25 | 30/09/25 | | | | ■ | ■ | ■ | | | | | | | | | |
| Data | 19/09/24 | 31/10/25 | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | | |
| Coordinate 2x pathway mapping sessions | 04/08/25 | 31/12/25 | | | | | ■ | ■ | ■ | ■ | ■ | | | | | | |
| Primary Care Rolling Training Programme | | 31/12/25 | | | | | | | | | | | | | | ◆ | |
| Pilot Evaluation | 03/11/25 | 02/01/26 | | | | | | | | | | | ■ | ■ | ■ | | |

| Risks | |
|--------------------------------|---|
| Overall Risks Status | AMBER |
| Reason for Overall Risk Status | Funding concerns post March 2026 for WH Networks is biggest risk and not confident it is well mitigated against yet - ongoing work to support Network Managers and Clinical Leads to prepare for this with a sustainable model. |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| Women's Health Networks not currently funded past March 2026 | Yes | 6 |

| Issues | |
|----------------------------------|---------------------|
| Overall Issues Status | GREEN |
| Reason for Overall Issues Status | None currently open |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Portfolio Report Governance Report

| | |
|--------------------------------|---|
| Date of Highlight Report | 20/08/2025 |
| Project Code | PR000405 |
| Project Name | Workforce Anchor Programme |
| Project Team | Workforce Development Academy |
| Project Aim | <p>The aim of the portfolio is to present a comprehensive overview of quarterly performance for the Executive team, with a particular focus on the Anchor Workforce Programme.</p> <p>This programme highlights key initiatives that are considered core to ICB business. The Supported Employment Pathways and Widening Access project aims to support underrepresented groups, including care leavers and individuals with lived experience of the care system, by creating inclusive employment opportunities and support.</p> <p>The Work and Health agenda focuses on improving access to employment for people with health conditions, supporting their wellbeing and economic participation.</p> <p>The Apprenticeships initiative is aligned with long-term workforce planning, aiming to build sustainable career pathways and meet national targets for workforce development.</p> <p>The Health and Care Academy aims to build and strengthen the local health and care workforce by offering high-quality training, development opportunities, and robust performance monitoring. A key focus of the Academy is to inspire future talent by actively showcasing both clinical and non-clinical roles to schools, helping young people understand the breadth of career opportunities available within the sector.</p> |
| Governance & Responsible Group | BLMK People Board |
| Geographical Footprint | BLMK System |

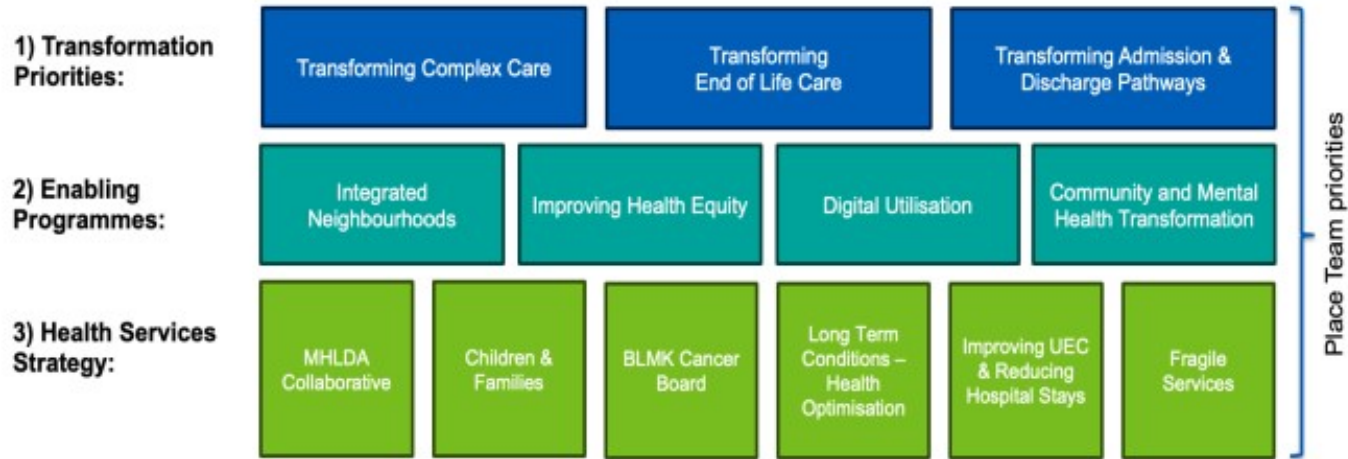
Project Team Members

| Name | Role |
|-------------------|-------------------|
| Alexandra Farkas | Programme Manager |
| Catherine Jackson | Programme Manager |
| Bethan Billington | Programme Manager |
| Jane Hall | Project Manager |

Project Status

| | |
|-----------------------------------|---|
| Overall Project Status | GREEN |
| Reason for Overall Project Status | Despite a few Amber-rated tasks across the projects, the majority of milestones are progressing well, with no Red flags. The Amber items are either in planning stages or have mitigation strategies in place. Therefore, the programme is on track overall, with manageable risks. |
| Project Maturity | 4.0 - Delivery |

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)

Alignment with Transformation Priorities

- Transforming Complex Care & Admission/Discharge Pathways: The Supported Employment Pathways and Widening Access project contributes by helping individuals with complex needs transition into employment, reducing dependency on health and care services and supporting smoother discharge planning.
- End of Life Care: While not directly linked, workforce development through apprenticeships and the Health and Care Academy ensures a skilled workforce capable of delivering compassionate and effective end-of-life care.

Alignment with Enabling Programmes

- Integrated Neighbourhoods: These programmes support place-based workforce models, enabling local recruitment and development through apprenticeships and academy outreach.
- Improving Health Equity: The Supported Employment Pathways and Widening Access initiative directly targets underrepresented groups, care leavers, and those with lived experience of the care system, promoting equity in employment and career progression.
- Digital Utilisation: The use of platforms like Verto to track and report progress reflects a commitment to digital tools for workforce planning and performance monitoring.
- Community and Mental Health Transformation: By building a diverse and skilled workforce, these programmes underpin efforts to transform community and mental health services with staff who reflect and understand the populations they serve.

Alignment with Health Services Strategy

- Children & Families: Outreach to schools through the Health and Care Academy helps raise awareness of clinical and non-clinical roles, inspiring future generations to consider careers in health and care.
- Long Term Conditions – Health Optimisation: Apprenticeships and academy training equip staff with the skills needed to support patients with long-term conditions more effectively.
- Improving UEC & Reducing Hospital Stays: A well-trained and locally rooted workforce contributes to more efficient urgent and emergency care, helping reduce unnecessary hospital admissions and stays.
- Fragile Services: Workforce development helps stabilise services at risk by ensuring a pipeline of skilled professionals ready to fill critical roles.

Progress Update

Period June/July 2025

Work & Health - EOI for co-Chair for Work & Health Stewardship Group – meeting planned for Sept 25 taking a programme oversight approach to deliverables within Primary Care and Local Authority Connect to Work initiatives.

Second stage in EA in MSK bid within Primary Care – awaiting final outcome

Submitting second bid to DWP & DHSC for support with MSK in the community - £100k for pilot sites

Widening access/supported employment pathways

National Universal Family audit was completed. NHSE KPI's exceeded. Self-assessment tool is now established. We offer regular drop-in sessions for CEYP, and continue to support them into training, work experience, job applications and employment. We have 6 CEYP who are on pathways 'volunteer to career' and 9 have gained employment.

The WDA have co-designed and co-produced an employment pathway locally, and have taken full account of the perspectives, needs and ambitions of those that it is intended to benefit. The pathway was built around input from our stakeholders (including the DWP) and care experienced service users and young people in Bedfordshire.

Passport into NHS Careers : 5th Cohort starting in September. We also do workshops with Shaw Trust, Jobs 22 and DWP across BLMK.

The BLMK Health and Care Academy Advance programme is dedicated to supporting 18-30-year-olds by fostering a shared vision to nurture the next generation of healthcare talent. Our goal is to develop a workforce that meets demand in both clinical and non-clinical roles and reflects the local demographic. We strive to reduce economic marginalisation, overcome systematic obstacles, and increase employment opportunities within the healthcare sector. 2nd Cohort planned for October 25.

Co-location partnership with the Kings Trust (April 25), jointly awarded with BHFT as the most economically advantages tender. Collaborative working to develop employability programmes for young people and enable them to start their careers in Health and Care. The programme has a specific focus group:16-30, Luton IMD1-3 postcode, young people from areas of multiple deprivation and those who have faced disadvantage and adversity. Since the start of the programme in April we employed 30 young people into entry level roles in BHFT far exceeding our planned KPI's.

Successful bid with DHSC for widening access to employment in health and care for working class population of Luton. Ministerial announcement Friday 18th advising of BLMK ICB successful bid. Implementation July 25.

Health and Care Academy:

Increased engagement and stronger partnerships with local FEs:

BLMK Health and Care Academy hosted a graduation ceremony to recognise the BTEC L3, T level and supported internship students who have worked so hard on placement during the last academic year.

Bid to Department of Education for an Industry Placement Coordinator role to support the further expansion of T Levels was unsuccessful, with the successful ICB in the EoE being SNEE. There may be some further funding available in October.

Apprenticeship Expansion:

Confirmation received that L7 apprenticeships will no longer be funded via the Levy from Jan 2026 onwards, except for those aged 21 and under or under 25 for care leavers and those with an EHCP. In anticipation of this, providers have already been starting staff on L7 courses, particularly linked to leadership.

Awaiting new growth targets for apprenticeship in the soon to be published 10 year workforce plan.

Progress made in Previous Period

Progress to be made in Next Period

August/September planned activities:

Work and Health:

Review TOR for Work & Health Stewardship Group

Widening Access/Supported Employment Pathways:

Work with region to review the feedback of self-assessment on National Universal Family audit

Review and report on uptake of workshops and outcomes relating to employment pathways work and continue to expand across system partners.

Commence 5th Cohort of Passport to NHS Careers in September

2nd Cohort of Kings Trust Employability Programme in October 2025

Widening Access Demonstrator (WAD) Programme underway July 25 strict KPIs and deadlines, outcome deliverables measured monthly.

Health and Care Academy:

Increased engagement and stronger partnerships with local FEs:

Evaluation data from the Careers Carousel (which showed that 54% of those completing evaluation forms felt that they knew a lot more about careers in health and social care as a result of attending), will be used to shape future events. At present, the feasibility of a Careers Expo in Spring 2026 is being explored. Academy Plus face to face programme running in August 2025 as a one week programme for the first time. 15 young people (mainly aged 17) attending this interactive programme showcasing health and care careers.

Apprenticeship expansion:

Collection of next quarter of DAS information to track growth in apprenticeship numbers.

Apprenticeship Expansion Board meetings paused until the Autumn and the awaited new growth targets for apprenticeship in the soon to be published 10 year workforce plan. .

Tasks & Milestones

| | | | | | | | | | | | | | | | |
|--|---|------------|----------|-----|-----|-----|-----|------|-----|-----|-----|------|-----|-----|-----|
| Overall Tasks & Milestones Status | GREEN | | | | | | | | | | | | | | |
| Reason for Overall Tasks & Milestones Status | Programme of work well on track and not reporting and substantial delays of concern | | | | | | | | | | | | | | |
| | | | | | | | | 2025 | | | | 2026 | | | |
| | | Start Date | End Date | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |

Risks

| | | | | | | | | | | | | | |
|--------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Overall Risks Status | GREEN | | | | | | | | | | | | |
| Reason for Overall Risk Status | <p>No major risks to delivery this financial year. Key risks relate to lack of sustainable funding for much of this activity.</p> <p>Mix of March 2026 and March 2027 end dates for current funding; uncertainty re eventual 'home' of some workforce activity due to ICB transition means that mitigation activities can't always be identified at present.</p> | | | | | | | | | | | | |

Risks

| Risk Name | Key Risk? | Residual Likelihood & Impact |
|--|-----------|------------------------------|
| Work and Health: place in ICB future (blueprint) | Yes | 12 |
| Future of Health & Care Academy | Yes | 9 |
| Apprenticeship Expansion Funding | Yes | |

Issues

| | | | | | | | | | | | | | |
|----------------------------------|---|--|--|--|--|--|--|--|--|--|--|--|--|
| Overall Issues Status | GREEN | | | | | | | | | | | | |
| Reason for Overall Issues Status | No issues identified at present for this financial year's activity. | | | | | | | | | | | | |

Issues

| Issue Name | Key Issue? | Proximity & Impact |
|------------|------------|--------------------|
|------------|------------|--------------------|

Serious Mental Illness Health Checks

Project Leads: MHLDA Team, Community Providers: ELFT / CNWL, Outreach providers and Primary Care

Results

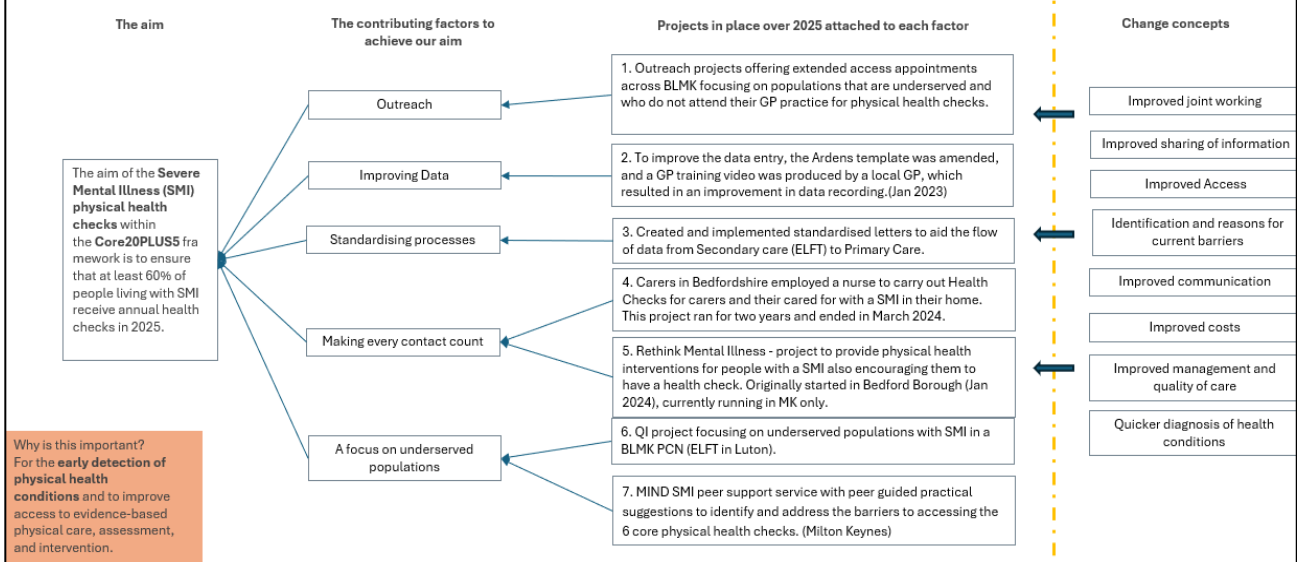
Introduction / Background

1. Addressing Health Inequalities: People with SMI face reduced life expectancy between 15-20 yrs due to preventable physical health issues. The NHS's Five Year Forward View and LT plan for MH aims to reduce this disparity through integrated, preventative care.

AIM / Objectives

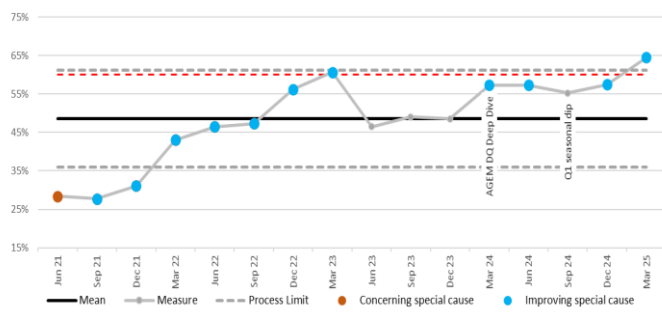
- To improve SMI health check uptake and performance – Ensuring annual health checks for 60% of those living with SMI
- To improve uptake of *all 6* health checks and better address health risks
- Catch issues early and improve health outcomes / mortality of those with SMI
- Ensure follow-up delivery or referral to NICE recommended interventions and personalised care planning.

SMI theory of change explained through a driver diagram

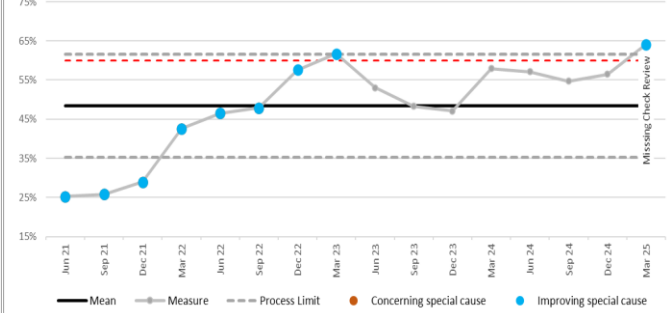


Data / Performance

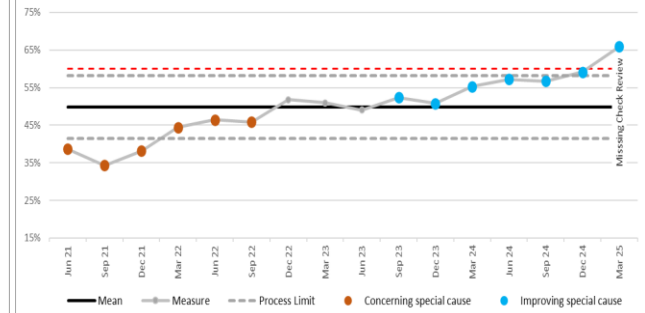
Percentage of people with SMI to receive the complete list of physical health checks in the preceding 12 months - BLMK



Percentage of people with SMI to receive the complete list of physical health checks in the preceding 12 months - Bedfordshire



Percentage of people with SMI to receive the complete list of physical health checks in the preceding 12 months - Milton Keynes



Children & Young People CAMHS Access

Project Leads: CYP and MH Team, Community Providers: ELFT / CNWL and Outreach providers / VCSE Providers

Work Program

Introduction / Background

1. Improving access to CAMHS services is one of the 4 key national priorities in the NHS 2025/2026 Operating Plan and is also a key priority for the ICB system.
2. The CAMHS target ambition for 25/26 is that at least 17,614 will have at least 1 contact from NHS funded MH services in a year across BLMK. The BLMK operating plan reduces the target to 15,982 contacts. M1 performance indicates was 13,500 contacts, (23.4% below the LTP ambition target and 16.9% short of the operating plan).
3. Data note: The system saw a dramatic reduction in performance between April 22 and March 23 when our community services in Beds and Luton ceased submitting data for neurodevelopmental assessments.

CNWL

- **Maximise Productivity** – Clinicians to take minimum no. of calls / increased emphasis on clinician assessments and targets / Promote self-referrals
- **Digital Streamlining** – Utilise Systmone capability for assessment letters, invites and GP comms / streamlining pathways using AI
- **Data Quality** – DQ checks and pro-active DNA work

ELFT

- **Maximise Capacity** – Development of CAMHS access pathway (CAS) and modernise the SPOE. This will support Outreach team referrals, improve direct access, streamline clinical offer and reduce duplication.
- **CAS AIMS** – Workforce flexibility and improved capacity/ reduce unwarranted variation/ improve triage
- **iThrive Model** - Utilisation of national framework of support, which in turn will support demand, risk and resource management

AIM / Objectives

1. To improve CAMHS Access and performance – ensuring we meet the reduced target of 15,982 over 25/26.
2. To improve uptake, referrals, productivity and efficiency including unwarranted variation across our footprint.
3. To explore digital solutions and develop a standardised approach and develop a sustainable workforce.
4. **ICB Target set** - ELFT 10,343 contacts (including MHSTS) / CNWL 4,452 contacts (including MHSTS) / VCSE organisations 1,187 contacts / Total 15, 982 contacts.

VCSE

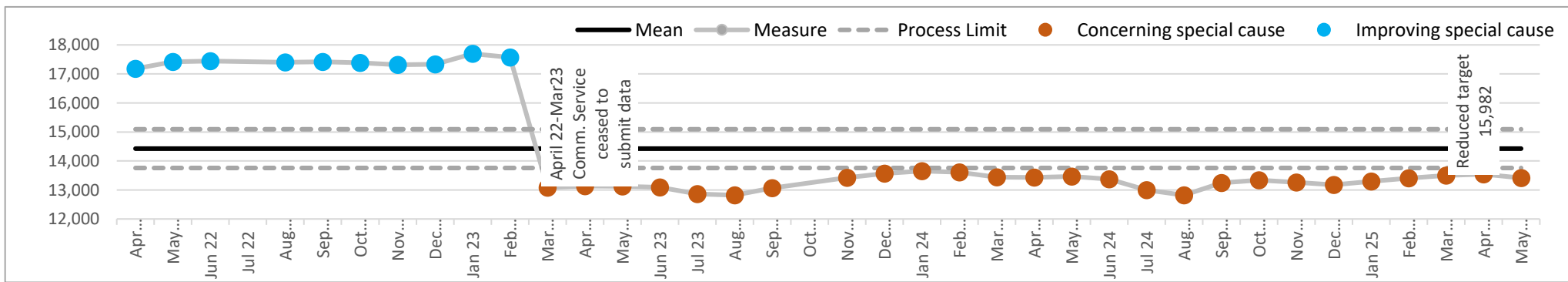
- **CHUMS** – to provide emotional support with an annual target of 650 contacts
- **TOKKO** – to provide counselling in Luton with an annual total of 200 - VCSE total – 850 contacts.
- **Extend VCSE Capacity** – expansion planned with provider for a further 400-600 contacts. Improving total VCSE capacity to 1250-1450 contacts a year.

RISK

- **CNWL** have committed to 4,452 contacts
- **ELFT** have committed to 9,480 (863 short of ICB set target (10,343))
- **VCSE** with expansion will provide between 1,250 -1,450
- **TOTAL** between 15,189-15,389 (**793-593 short of 15,982 target**)

Data / Performance

Number of CYP supported through NHS funded mental health with at least one contact - 12 month rolling - BLMK



| Project Name | Measure ID | Measure Name | Measure Type | Reporting Frequency |
|--|------------|--|--------------|---------------------|
| BB - Integrated Neighbourhood Working | M000077 | Launch Working Together pilot in first neighbourhood. | Indicator | Quarterly |
| BB - Integrated Neighbourhood Working | M00009 | Neighbourhood event to engage key stakeholders. | Indicator | Quarterly |
| BB - Living Well - Increase the uptake of cervical screening programme appointments | M000210 | National screening programme coverage statistics | Measure | Quarterly |
| BB - Living Well - Increase uptake of breast cancer screening programme | M000216 | Number of views of video. | Measure | Monthly |
| BB - Living Well - Increase uptake of breast cancer screening programme | M000217 | Number of distributors video is shared to and their reach. | Measure | Monthly |
| BB - Living Well - Learning & Action Network - Improve CVD Disease Prevention & Management | M000020 | Multi-Modal Patient Engagement Tracking | Measure | Weekly |
| BB - Living Well - Learning & Action Network - Improve CVD Disease Prevention & Management | M000021 | Awareness campaign to engage faith leaders in promoting blood pressure (BP) screenings, with 4 pharmacy hubs | Measure | TBC |
| BB - Living Well - Learning & Action Network - Improve CVD Disease Prevention & Management | M000022 | Faithleaders Meetings | Measure | TBC |
| BB - Living Well - Learning & Action Network - Improve CVD Disease Prevention & Management | M000023 | BLMK Hypertension Protocol Training | Measure | TBC |
| BB - Placed Based Plan Priorities – Starting Well | M000006 | Starting Well - Oral Health Decay | Measure | Bi-Annual |
| BB - Placed Based Plan Priorities – Starting Well | M000140 | Starting Well - Oral Health Decay % | Measure | Bi-Annual |
| BB - Placed Based Plan Priorities – Starting Well | M000141 | Starting Well - Oral Health Mean No. of decayed teeth | Measure | Bi-Annual |
| BB - Placed Based Plan Priorities – Starting Well | M000142 | Starting Well - Oral Health Incisor decay | Measure | Bi-Annual |
| CB - Dementia Diagnosis and Prevention | M000242 | Where the Provider provides Services for children and young people with an eating disorder, the percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week. | Measure | Quarterly |
| CB - Dementia Diagnosis and Prevention | M000243 | CB - Dementia Diagnosis and Prevention Clinicians Experience Improve GP confidence and capability in dementia assessment, measured through evaluations and listening events. | Outcome | Annual |
| CB - Dementia Diagnosis and Prevention | M000244 | CB - Dementia Diagnosis and Prevention System Integration. Enhanced system integration by embedding dementia work into INW priorities and governance. | Outcome | Annual |
| CB - Dementia Diagnosis and Prevention | M000245 | CB - Dementia Diagnosis and Prevention Identification rates Earlier identification of dementia leading to timelier access to support and interventions for residents and carers. | Measure | Annual |
| CB - Falls Prevention Service (CBFPS) | M000247 | CB - Fall Prevention Service Reduction of falls. Reduction in falls-related hospital admissions by 10% within 12 months of service launch. | Outcome | Quarterly |
| CB - Falls Prevention Service (CBFPS) | M000248 | CB - Fall Prevention Service Patients/ Residents experience. Improved patient-reported outcomes: mobility, confidence, and independence, qualitative data via survey | Outcome | Annual |

| Project Name | Measure ID | Measure Name | Measure Type | Reporting Frequency |
|--|------------|--|--------------|---------------------|
| CB - Falls Prevention Service (CBFPS) | M000249 | CB - Fall Prevention Service Integration. Greater integration across health, social care, and VCSE services supporting at-risk residents, qualitative data via survey. | Outcome | Quarterly |
| CB - Health Inclusion Practitioners | M000252 | CB - Health Inclusion Practitioners: number of Screenings and Reviews. Health assessments of families completed, including mental health screening and developmental reviews. | Outcome | Quarterly |
| CB - Health Inclusion Practitioners | M000253 | CB - Health Inclusion Practitioners: number of health interventions. Culturally specific family health interventions identified and developed | Outcome | Quarterly |
| CB - Health Inclusion Practitioners | M000254 | CB - Health Inclusion Practitioners: qualitative measure of resident's experience/feedback. Families report increased confidence in where/how they can access a range of health services and local support services. | Outcome | Quarterly |
| CB - Health Inclusion Practitioners | M000255 | CB - Health Inclusion Practitioners: awareness and education impact. LAN - education and awareness of hypertension | Outcome | Quarterly |
| CB - Hypertension Management in C Beds - SMI | M000262 | CB - Be Pressure Wise: Hypertension Diagnosis. Increase hypertension diagnosis rate in target communities by 10% within 12 months | Outcome | Annual |
| CB - Hypertension Management in C Beds - SMI | M000263 | CB - Be Pressure Wise Improve Control rate. Improve blood pressure control rates among residents with SMI and learning disabilities and AS, by 20% within 18 months. | Outcome | Quarterly |
| CB - Hypertension Management in C Beds - SMI | M000264 | CB Be Pressure Wise residents/ patients' satisfaction. To measure patients' satisfaction on clinical services and pathways, re Hypertension Management, via survey | Outcome | Annual |
| CB - Hypertension Management in C Beds - SMI | M000265 | CB - Be Pressure Wise Clinicians experience. To measure Clinicians engagement and satisfaction re Hypertension Management, via survey | Outcome | Annual |
| CB - Integrated Neighbourhood Working | M000257 | CB - Integrated Neighbourhood Working Residents Experience | Outcome | Quarterly |
| CB - Integrated Neighbourhood Working | M000258 | CB - Integrated Neighbourhood Working Streamline Process | Process | Quarterly |
| CB - Integrated Neighbourhood Working | M000259 | CB - Integrated Neighbourhood Working Health Outcomes and Equality | Outcome | Annual |
| CB - Integrated Neighbourhood Working | M000260 | CB - Integrated Neighbourhood Working Resources/ Capacity Assessment and Measurement | Measure | Annual |
| CB - Integrated Neighbourhood Working | M000261 | CB - Integrated Neighbourhood Working Staff Satisfaction | Outcome | Annual |
| CB - LAN 02 - Pressures on | M000267 | CB - LAN 02 - Pressures on: increase of percentage of managed hypertension | Outcome | Quarterly |
| CB - LAN 02 - Pressures on | M000268 | BLMK Hypertension Protocol Training for Health Professionals: increase of interventions and training uptake | Measure | TBC |
| CB - LAN 02 - Pressures on | M000269 | CB - LAN 02 - Pressures on - Know your numbers campaign: increase of engagement numbers and residents' visits during Know Your Numbers week | Measure | Monthly |

| Project Name | Measure ID | Measure Name | Measure Type | Reporting Frequency |
|---|------------|--|--------------|---------------------|
| CB - LAN 02 - Pressures on | M000270 | CB - LAN 02 - Pressures on: social media engagement data- Resident's video | Measure | Monthly |
| CB - LAN 02 - Pressures on | M000271 | CB - LAN 02 - Pressures on: Visits to sites | Measure | Monthly |
| Luton - Health Ageing Programme (BCF) | M000287 | Patient and resident feedback | Indicator | Quarterly |
| Luton - Health Ageing Programme (BCF) | M000288 | Reduction in hospital conveyance, emergency admissions or attendances | Indicator | Quarterly |
| Luton - Health Ageing Programme (BCF) | M000289 | Improved strength and mobility | Measure | Quarterly |
| Luton - Health Ageing Programme (BCF) | M000290 | Improved Frailty Status | Indicator | Quarterly |
| Luton - Health Ageing Programme (BCF) | M000291 | Reduction in Home Adaptations | Indicator | Annual |
| Luton - Integrated Neighbourhood Working | M000272 | L - Luton - Integrated Neighbourhood Working - Reduction in A&E activity, GP appointments and 111 services (improved capacity) | Measure | Quarterly |
| Luton - Integrated Neighbourhood Working | M000273 | L - Luton - Integrated Neighbourhood Working - Increased interconnectivity between statutory and VSCFE services | Measure | Quarterly |
| Luton - Integrated Neighbourhood Working | M000274 | L - Luton - Integrated Neighbourhood Working - Improved job satisfaction for workforce and relationships | Measure | Quarterly |
| Luton - Integrated Neighbourhood Working | M000275 | L - Luton - Integrated Neighbourhood Working - Resident benefits of INW | Measure | Quarterly |
| Luton 1 - Hypertension Learning and Action Network (Black African population) | M000277 | Change Idea 1: Number of people text | Measure | Weekly |
| Luton 1 - Hypertension Learning and Action Network (Black African population) | M000278 | Change Idea 1: Number of hits on video | Measure | Weekly |
| Luton 1 - Hypertension Learning and Action Network (Black African population) | M000279 | Change Idea 1: Number of responses to the text message | Measure | Weekly |
| Luton 1 - Hypertension Learning and Action Network (Black African population) | M000280 | Change Idea 1: How many patients the care co-ordinator was not able to get hold of following them responding yes to the text message | Measure | Weekly |
| Luton 1 - Hypertension Learning and Action Network (Black African population) | M000281 | Change Idea 1: Number of 1st appointments made (blood pressure checks) | Measure | Weekly |
| Luton 1 - Hypertension Learning and Action Network (Black African population) | M000295 | Change Idea 1: Blood pressure now within limits | Outcome | Monthly |
| Luton 2 - Hypertension Learning and Action Network (Indian population) | M000282 | Change Idea 1: Number of text messages sent | Process | Monthly |
| Luton 2 - Hypertension Learning and Action Network (Indian population) | M000283 | Change Idea 1: Number of people received texts | Process | Monthly |
| Luton 2 - Hypertension Learning and Action Network (Indian population) | M000284 | Change Idea 1: Number of people who have booked an appointment with the PCN pharmacist | Process | Monthly |
| Luton 2 - Hypertension Learning and Action Network (Indian population) | M000285 | Change Idea 1: Number of patients referred for a 24 ABPM | Process | Monthly |
| Luton 2 - Hypertension Learning and Action Network (Indian population) | M000286 | Change Idea 1: Number of patients with no further action following an appointment | Outcome | Monthly |

| Project Name | Measure ID | Measure Name | Measure Type | Reporting Frequency |
|---|------------|--|--------------|---------------------|
| Luton 2 - Hypertension Learning and Action Network (Indian population) | M000299 | Change Idea 1: Of those blood pressures taken how many have hypertension | Outcome | Monthly |
| Luton 2 - Hypertension Learning and Action Network (Indian population) | M000300 | Change Idea 1: Other conditions identified (diabetes, cholesterol, obesity etc) | Outcome | Monthly |
| Luton 2 - Hypertension Learning and Action Network (Indian population) | M000301 | Change Idea 1: Second text sent | Process | Monthly |
| Luton 2 - Hypertension Learning and Action Network (Indian population) | M000302 | Change Idea 1 Evaluation: Number of questionnaires sent | Process | Monthly |
| Luton 2 - Hypertension Learning and Action Network (Indian population) | M000303 | Change Idea 1 Evaluation: Number of responses from questionnaire (split via those who have previously responded and those who have not) | Outcome | Monthly |
| MK - Hypertension Learning and Action Network (Black African population aged 40-64 years) | M000313 | Outcomes from Healthwatch Community Engagement at the Jeans Festival | Outcome | Annual |
| MK - Improving System Flow | M000010 | Proportion of acute adult beds occupied by patients no longer meeting Criteria to Reside (LoS 7+ Days) | Indicator | Monthly |
| MK - Improving System Flow | M000101 | Patients discharged on the appropriate pathway to be in line with the government targets of the percentage of people to be discharged on each pathway. Pathway 0 – 50% Pathway 1 – 45% Pathway 2 – 4% Pathway 3 – 1% | Indicator | Monthly |
| MK - Improving System Flow | M000102 | Reduction in people residing in hospital who do not have the criteria to reside and are delayed. | Indicator | Monthly |
| MK - Improving System Flow | M000103 | Reduction in unnecessary hospital admissions | Indicator | Monthly |
| MK - Improving System Flow | M000104 | Discharge to Normal Place of Residence | Indicator | Monthly |
| MK - INW - Bletchley Pathfinder (Project 1-3) | M000025 | Community Wellbeing Sessions | Indicator | Monthly |
| MK - INW - Bletchley Pathfinder (Project 1-3) | M000026 | Phase 1 - Conferencing Model Forum | Indicator | Quarterly |
| MK - INW - Bletchley Pathfinder (Project 1-3) | M000027 | Attendance trajectory improvement | Measure | Bi-annual |
| MK - Tackling Obesity | M000169 | Tackling Obesity - Service users starting service | Measure | Monthly |
| BLMK Children, Families, Women's and Maternity (CWM) Board | M000189 | All Babies are Born Healthy: Infant mortality | Measure | Quarterly |
| BLMK Children, Families, Women's and Maternity (CWM) Board | M000190 | All Babies are Born Healthy: Low Birthweight Babies | Measure | Quarterly |
| BLMK Children, Families, Women's and Maternity (CWM) Board | M000191 | Children are ready to learn/start school: School Readiness | Measure | Quarterly |
| BLMK Children, Families, Women's and Maternity (CWM) Board | M000192 | Children Remain Healthy: Oral Health | Measure | Quarterly |
| BLMK Children, Families, Women's and Maternity (CWM) Board | M000193 | Children Remain Healthy: Childhood Obesity | Measure | Quarterly |
| BLMK Children, Families, Women's and Maternity (CWM) Board | M000194 | Children Remain Healthy: Asthma | Measure | Quarterly |
| BLMK Children, Families, Women's and Maternity (CWM) Board | M000195 | Young People are Accessing Education, Employment or Training: Attainment 8 | Measure | Quarterly |
| BLMK Children, Families, Women's and Maternity (CWM) Board | M000196 | Young People are Accessing Education, Employment or Training: NEET | Measure | Quarterly |

| Project Name | Measure ID | Measure Name | Measure Type | Reporting Frequency |
|---|------------|---|--------------|---------------------|
| BLMK Fragile Services - Diagnostics | M000209 | % of patients meeting the 6-week diagnostic target | Measure | Quarterly |
| BLMK Mental Health Transformation Programme | M000221 | NHS Talking Therapies performance metric | Measure | Monthly |
| BLMK Mental Health Transformation Programme | M000223 | Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) | Measure | Monthly |
| BLMK Mental Health Transformation Programme | M000224 | Women Accessing Specialist Community Perinatal Mental Health Services | Measure | Monthly |
| BLMK Mental Health Transformation Programme | M000225 | Access to Children and Young People's Mental Health Services (Key Metric) | Measure | Monthly |
| BLMK Mental Health Transformation Programme | M000226 | Number of people accessing Individual Placement and Support | Measure | Monthly |
| BLMK Mental Health Transformation Programme | M000227 | Average length of stay for Adult Acute Beds (Key Metric) | Measure | Monthly |
| BLMK Mental Health Transformation Programme | M000228 | Early Intervention in Psychosis NCAP | Measure | Annual |
| BLMK Mental Health Transformation Programme | M000229 | Patient and Carer Race Equality Framework | Measure | Annual |
| BLMK Mental Health Transformation Programme | M000230 | The percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care | Measure | Quarterly |
| BLMK Mental Health Transformation Programme | M000231 | Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care | Measure | Quarterly |
| BLMK Mental Health Transformation Programme | M000232 | NHS Talking Therapies for Anxiety and Depression programmes: the percentage of service users who wait six weeks or less from referral to accessing NHS Talking Therapies and who finish a course of treatment | Measure | Monthly |
| BLMK Mental Health Transformation Programme | M000233 | Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) | Measure | Monthly |
| BLMK Mental Health Transformation Programme | M000234 | Where the Provider provides Services for children and young people with an eating disorder, the percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks. | Measure | Quarterly |
| BLMK Mental Health Transformation Programme | M000235 | Where the Provider provides Services for children and young people with an eating disorder, the percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week. | Measure | Quarterly |
| Improving access to Pathway 2 Beds | M000085 | Improving access to Pathway 2 Beds - Reduction in DRD days from 10 to 5 days | Measure | Monthly |
| Improving access to Pathway 2 Beds | M000086 | Improving access to Pathway 2 Beds - Reduce average Medically Fit For Discharge Days (MFFD) | Measure | Monthly |
| Improving Health Equity | M000096 | Improving Health Equity - Increase the number of years spent in good health | Indicator | Quarterly |
| Improving Health Equity | M000097 | Improving Health Equity - Reduce the gap between the healthiest and least healthy in our community | Indicator | Quarterly |

| Project Name | Measure ID | Measure Name | Measure Type | Reporting Frequency |
|---|------------|---|--------------|---------------------|
| PC Training Hub Programme | M000328 | PCTH - Growth of workforce by staff group e.g. GPs, GPNs, Direct Patient Care & Admin | Outcome | Quarterly |
| PC Training Hub Programme | M000329 | PCTH - Reduction in vacancies at practice level | Outcome | Bi-Annual |
| PC Training Hub Programme | M000330 | PCTH -Even spread of training & development | Process | Annual |
| PC Training Hub Programme | M000331 | PCTH - Maximising utilisation of ARRS funding | Outcome | Monthly |
| Primary Care Access - Demand Management, Addressing Variation | M000236 | Number of appointments delivered by the practice teams | Measure | Monthly |
| Primary Care Access - Demand Management, Addressing Variation | M000237 | Pharmacy First - activity delivered in BLMK by community pharmacist | Measure | Monthly |
| Primary Care Access - Demand Management, Addressing Variation | M000238 | Delivery of contracted dental activity | Measure | Monthly |
| Primary Care Access - Demand Management, Addressing Variation | M000239 | LTC Indicators for Diabetes, CVD, and Respiratory | Measure | Quarterly |
| Primary Care Access - Demand Management, Addressing Variation | M000240 | Vaccination take up and delivery | Measure | Monthly |
| Transforming Palliative End of Life Care | M000070 | Number of live coordination centres across Bedfordshire, Luton and Milton Keynes | Measure | Annual |
| Transforming Palliative End of Life Care | M000071 | Reduce number of unplanned palliative care bed days in the last 3 months of life | Measure | Quarterly |
| Transforming Palliative End of Life Care | M000072 | Increase of Palliative care registrations | Measure | Quarterly |
| Women's Health | M000184 | Women's Health - Activity from each initiative [tbc] | Outcome | Monthly |
| Women's Health | M000185 | Women's Health - Case study examples | Outcome | Quarterly |
| Women's Health | M000186 | Gynaecology Referrals Outcome | Outcome | Quarterly |