Bedfordshire Luton & Milton Keynes

BLMK Portfolio Report

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Bedfordshire, Luton and Milton Keynes Health and Care Partnership

May 2025 Update

The BLMK 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 BLMK Portfolio Report is comprised of the (1) **Hierarchy Diagrams**, (2) **Governance Reports** and (3) **Measures**.

The BLMK Portfolio Report includes **Hierarchy Diagrams** for all 151 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 37 priority programmes and projects through **Governance Reports**, which offer progress updates against planned objectives. These 37 programmes and projects reflect key initiatives from Bedford Borough, Central Bedfordshire, Luton, Milton Keynes, Bedfordshire Care Alliance, and System Transformation.

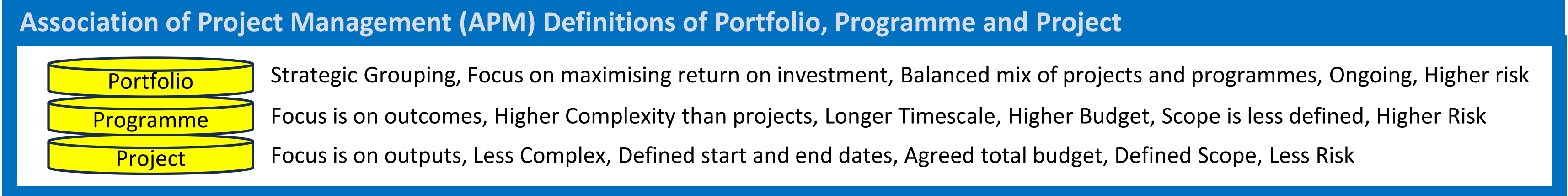
Lastly, the report includes **Measures** for these 37 priority programmes and projects, enabling the BLMK system to better understand how the changes being implemented are contributing to improvements for residents.

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

151	Total number of programmes and projects
37	Total number of governance reports
3	Total number programmes/ projects complete
98	Total number of programmes/ projects on-track
45	Total number of programmes/ projects at risk of slipping
1	Total number of programmes/ projects that have slipped
4	Total number of programmes/ projects no status declared
103	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 5 and 23. 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:



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 5 and 23. 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

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 5 and 23.

Overall Risk and Progress Sliders					
Risk Level			Overall Progress		
Low	Medium	High	Off Track	Slipping	On Track

BLMK ICS Portfolio Report

Bedfordshire & Milton Keynes Footprint, Place Priority & System Transformation Team (STT) Hierarchy

Lead Team	Page No.
BCA	5
Bedford Borough Place	6
Central Bedfordshire Place	7
Luton Place	8
MK Place	9

Organisational Programmes and Projects Hierarchy

Lead Team	Page No.
System Transformation Team (STT) and wider ICB	10
BLMK MHLDA Collaborative	11
System Transformation Priorities	12
System Efficiencies	13
Personalisation	14
Digital	15
Research & Innovation	16
Primary Care	17,18
Workforce Development Academy (WDA)	19
Quality Improvement (QI)	20
Children & Young People (CYP) & Local Maternity & Neonatal System (LMNS)	21
Environmental Sustainability & Growth	22
Estates	23

Governance Reports

Lead Team	Portfolio/Programme/Project	Page No.
BCA	Call before you Convey	24-27
BCA	Improving access to Pathway 2 Beds	28-31
Bedford Borough	BB - Integrated Neighbourhood Working	32-35
Bedford Borough	BB - Living Well - Learning & Action Network - Improve CVD Disease Prevention & Management	36-44
Bedford Borough	BB - Living Well - Increase uptake of breast cancer screening programme	45-48
Bedford Borough	BB - Living Well - Increase the uptake of cervical screening programme appointments	49-51
Bedford Borough	BB - Placed Based Plan Priorities – Health Estate	52-56
Bedford Borough	BB Placed Based Plan Priorities – Ageing Well	57-60
Bedford Borough	BB Placed Based Plan Priorities – Starting Well	61-65
Central Bedfordshire	CB - Dementia Diagnosis and Prevention	66-69
Central Bedfordshire	CB - Health Inclusion Practitioners	70-73
Central Bedfordshire	CB - Integrated Neighbourhood Working	74-79
Central Bedfordshire	CB - LAN 01 - Be Pressure Wise	80-83
Central Bedfordshire	CB - LAN 02 - Pressures on	84-88

BLMK ICS Portfolio Report

Governance Reports

Lead Team	Portfolio/Programme/Project	Page No.
Luton	Luton - Integrated Neighbourhood Working	89-96
Luton	Luton 1 - Hypertension Learning and Action Network (Black African population)	97-100
Luton	Luton 2 - Hypertension Learning and Action Network (Indian population)	101-104
Luton	Luton - Early intervention, Prevention, and Partnerships	105-108
Luton	Luton Health Ageing Programme (BCF)	109-115
MK	Improving System Flow	116-120
MK	Tackling Obesity	121-124
MK	Children & Young People's Mental Health	125-129
MK	INW - Bletchley Pathfinder (Project 1-3)	130-135
MK	MK - Hypertension Learning and Action Network (Black African population aged 40-64 years)	136-139
BLMK Wide	Primary Care Access including Integrated Urgent Care	140-143
BLMK Wide	Musculoskeletal (MSK)	144-1465
BLMK Wide	Cancer Transformation	147-150

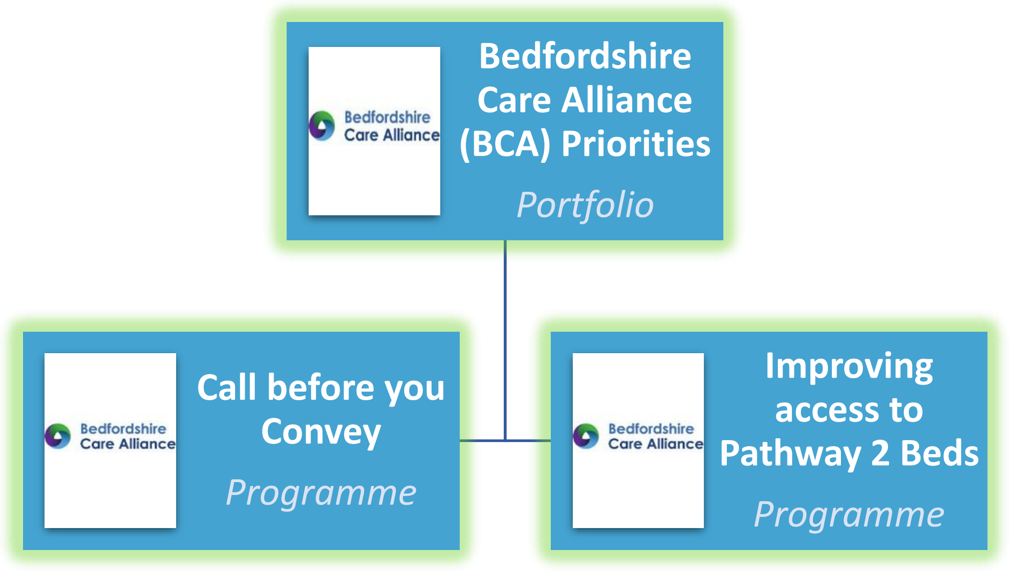
Governance Reports

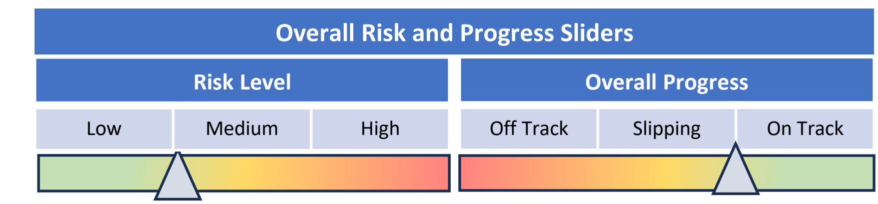
Lead Team	Portfolio/Programme/Project	Page No.
BLMK Wide	Community and Mental Health Services Transformation	151-154
BLMK Wide	Improving Health Equity	155-158
BLMK Wide	Women's Health	159-162
BLMK Wide	Transforming Admission and Discharge Pathways	163-166
BLMK Wide	Transforming Palliative End of Life Care	167-171
BLMK Wide	Transforming Complex Care	172-179
BLMK Wide	BLMK Children, Families, Women's and Maternity Board	180-183
BLMK Wide	BLMK Long Term Conditions Programme	184-187
BLMK Wide	BLMK Mental Health Transformation Programme	188-202
BLMK Wide	BLMK Fragile Services - Diagnostics	203-207

Measures

	Page No.
Programme and Project Measures	208-213

Bedfordshire, Luton and Milton Keynes
Health and Care Partnership


Bedfordshire Care Alliance (BCA) Priorities
Portfolio
Bedfordshire Care Alliance
Call before you Convey
Programme
Improving access to Pathway 2 Beds
Programme


Overall Risk and Progress Sliders
Risk Level
Low
Medium
High
Overall Progress
Off Track
Slipping
On Track

BLMK ICS Portfolio Report
Bedford Place Hierarchy

Bedfordshire & Milton Keynes Footprint, Place Priority & System Transformation Team (STT)

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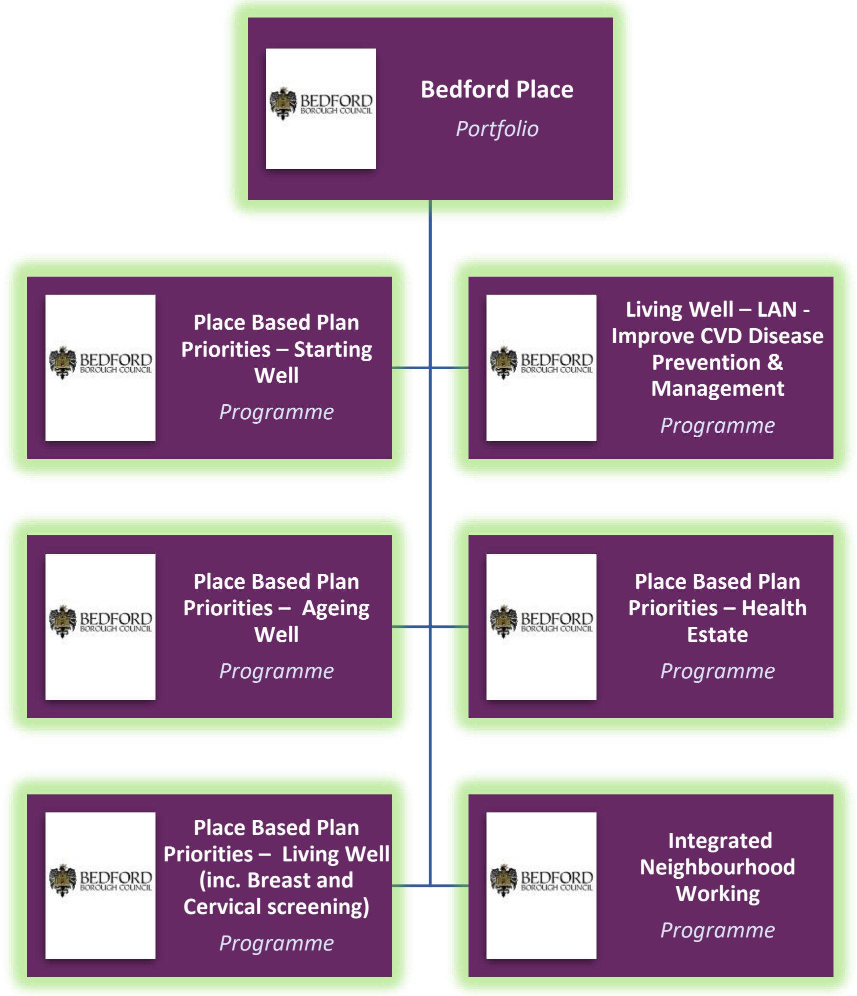
Bedfordshire, Luton and Milton Keynes
Health and Care Partnership



Overall Risk and Progress Sliders					
Risk Level			Overall Progress		
Low	Medium	High	Off Track	Slipping	On Track

For more information on any of the Portfolios, Programmes or Projects in this hierarchy please email the BLMK PMO Team (blmkicb.pmo@nhs.net) to request access via Verto 365 Verto – Login.

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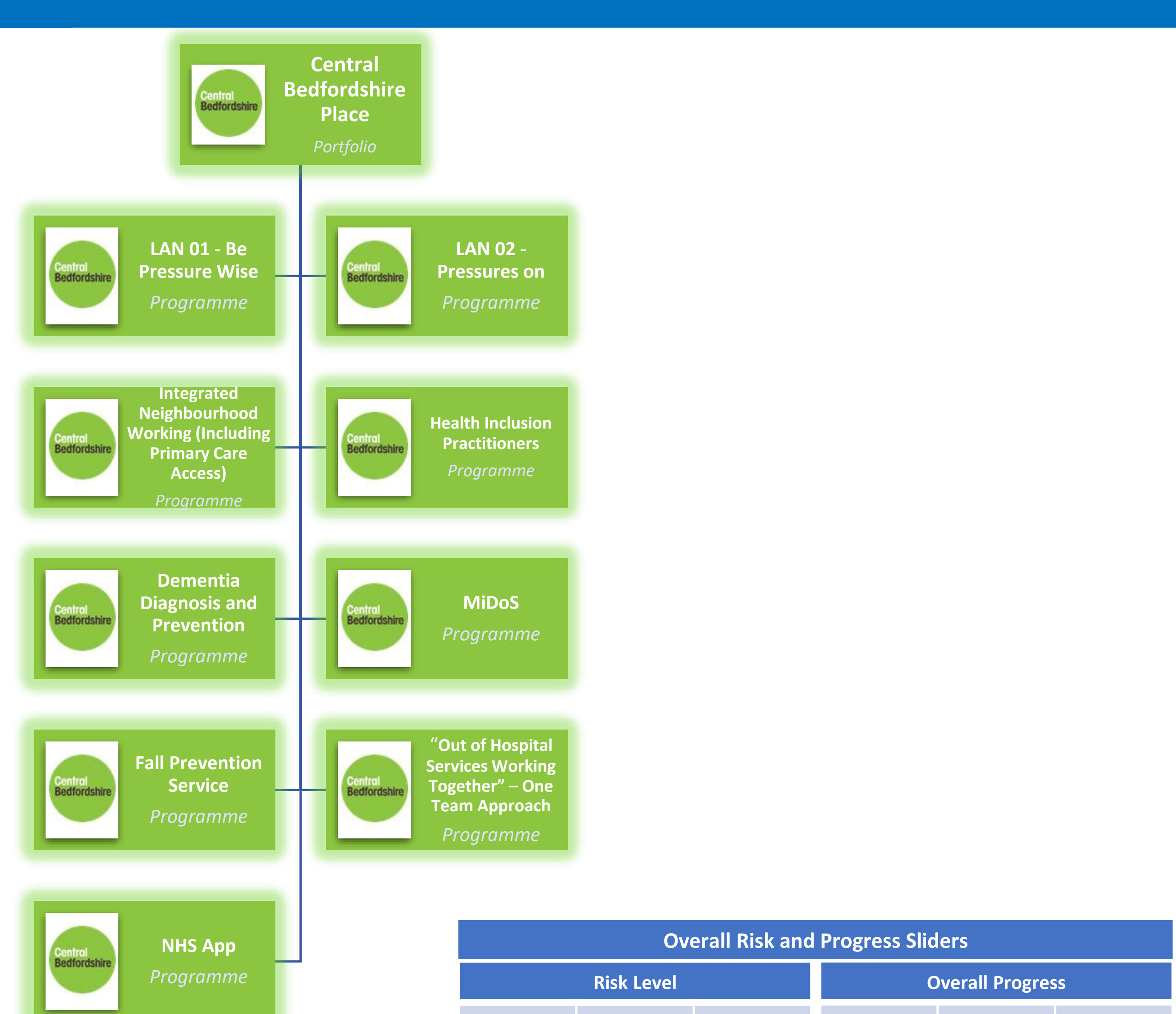
Central Bedfordshire Place Hierarchy

Bedfordshire & Milton Keynes Footprint, Place Priority & System Transformation Team (STT)

Bedfordshire, Luton and Milton Keynes Health and Care Partnership



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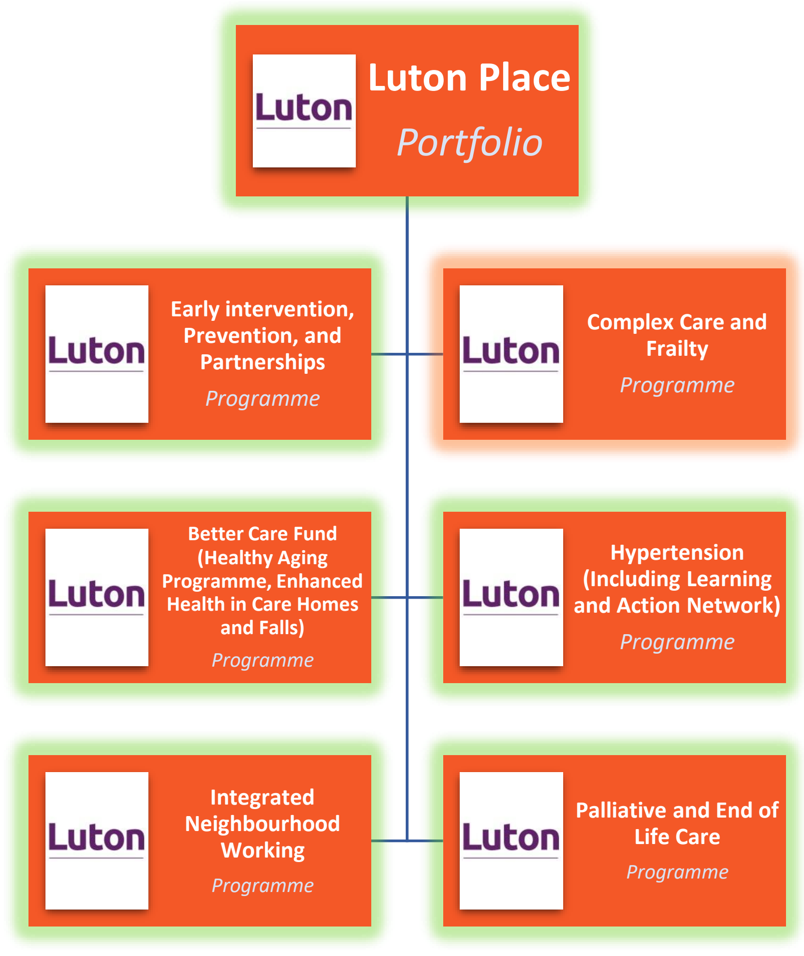
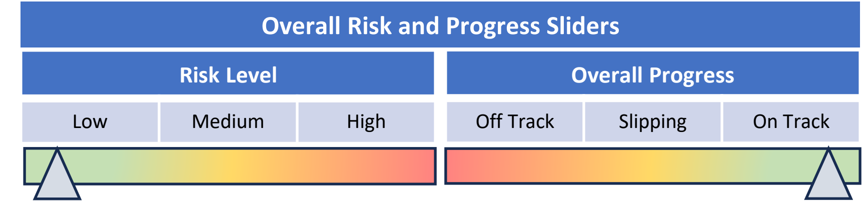
BLMK ICS Portfolio Report

Luton Place Hierarchy

Bedfordshire & Milton Keynes Footprint, Place Priority & System Transformation Team (STT)





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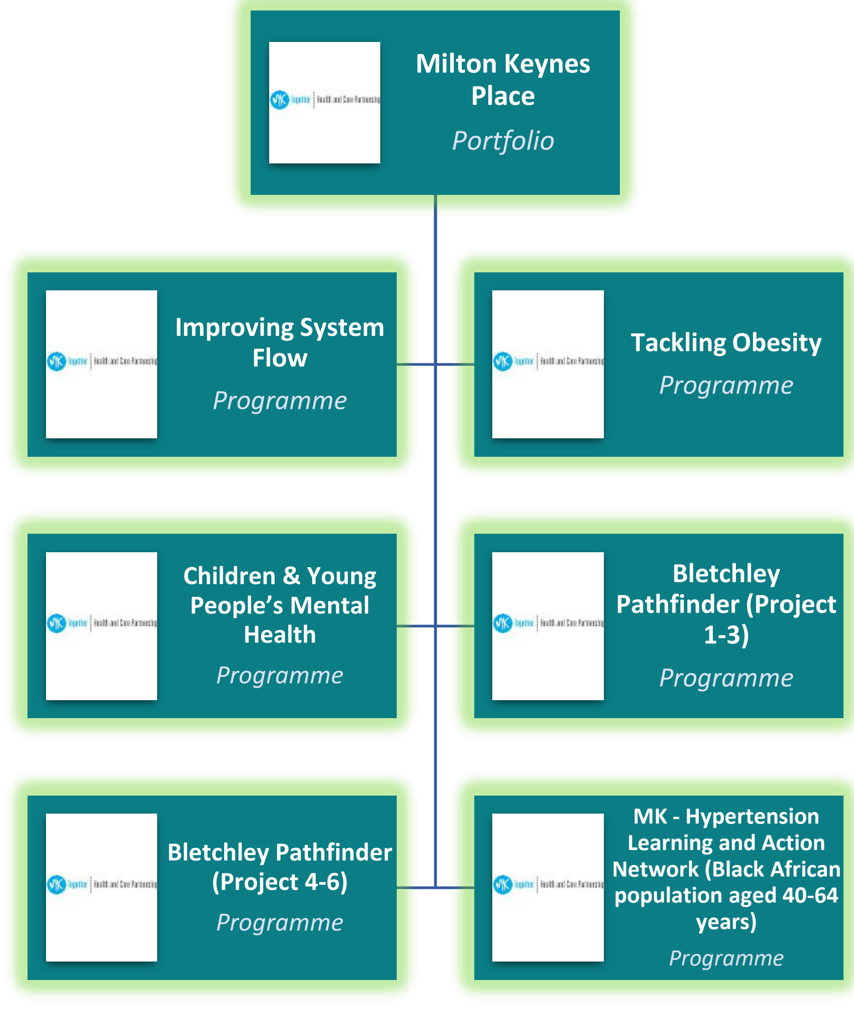
BLMK ICS Portfolio Report

Milton Keynes Place Hierarchy

Bedfordshire & Milton Keynes Footprint, Place Priority & System Transformation Team (STT)



Overall Risk and Progress Sliders

Risk Level			Overall Progress		
Low	Medium	High	Off Track	Slipping	On Track

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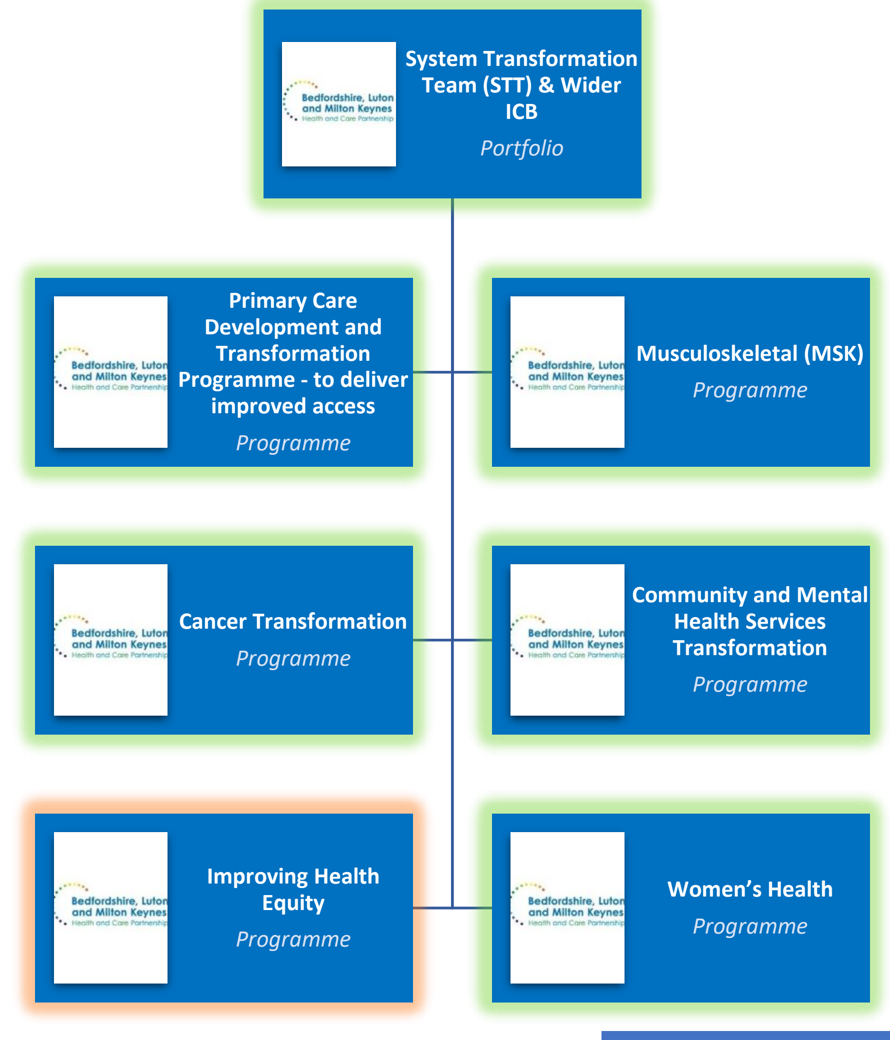
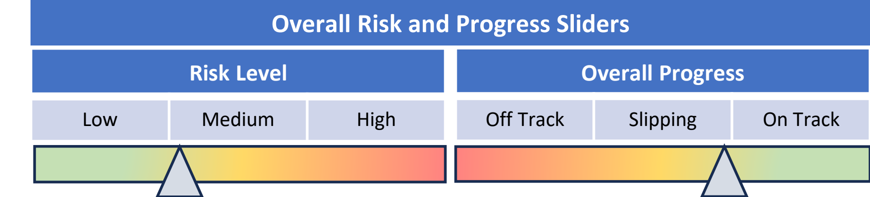
BLMK ICS Portfolio Report

System Transformation Team (STT) & Wider ICB Hierarchy

Bedfordshire & Milton Keynes Footprint, Place Priority & System Transformation Team (STT)





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BLMK ICS Portfolio Report

System Transformation Team (STT) & Wider ICB Hierarchy

Bedfordshire & Milton Keynes Footprint, Place Priority & System Transformation Team (STT)

BLMK Mental Health Programme
Portfolio

BLMK Perinatal Mental Health
Programme

BLMK Children and Young Peoples Mental Health
Programme

BLMK Community Mental Health Transformation for adults and older adults with severe mental illness
Programme

BLMK Integrating mental health care for students in HE and improving mental health care for young adults (18-25
Programme

BLMK Talking Therapies and Long-Term Conditions
Programme

BLMK Dementia Care
Programme

BLMK Improving physical health checks for people with severe mental illness
Programme

BLMK Mental Health Inpatient Care workstream (Including the MHLDA In-Patient Quality Transformation Programme)
Programme

BLMK Mental Health and Employment
Programme

BLMK Mental Health Equalities
Programme

BLMK Mental Health and Education
Programme

BLMK 10 Year Mental Health and Well-Being
Programme

BLMK Section 117
Programme

BLMK Suicide Prevention
Programme

Overall Risk and Progress Sliders

Risk Level			Overall Progress		
Low	Medium	High	Off Track	Slipping	On Track

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BLMK ICS Portfolio Report

System Transformation Priorities Hierarchy

Transformation Priorities, Enabling Programmes and the Health Services Strategy

BLMK ICS Strategic Priorities *Portfolio*

- **Transforming Admission and Discharge Pathways** *Programme*
- **Transforming Palliative & End of Life (EoL) Care** *Programme*
- **Transforming Complex Care** *Programme*

Health Services Strategy *Portfolio*

- **BLMK Mental Health Transformation** *Programme*
- **BLMK Children, Families, Women's and Maternity Board** *Programme*
- **BLMK Long Term Conditions** *Programme*
- **Improving UEC & Reducing Hospital Stays** *Programme*
- **BLMK Fragile Services – Diagnostics** *Programme*
- **BLMK Cancer Board** *Programme*

Enabling Programmes *Portfolio*

- **Integrated Neighbourhoods** *Programme*
- **Improving Health Equity** *Programme*
- **Digital Utilisation** *Programme*
- **Community and Mental Health Transformation** *Programme*

Overall Risk and Progress Sliders

Risk Level			Overall Progress		
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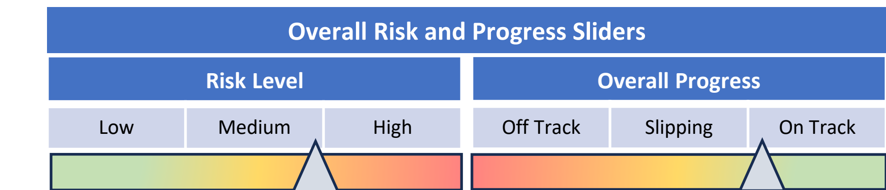
System Efficiencies Hierarchy

Efficiencies & Cost Improvement Plans (CIPs)

BLMK ICS System Efficiencies
Portfolio

- **BLMK ICB** *Programme*
  - **BLMK ICB Internal Efficiencies** *Programme*
    - **Service Change/ Difficult Decision Proposal** *Programme*
- **Bedfordshire Hospitals NHS Foundation Trust** *Programme*
  - **BHFT Internal Efficiencies** *Programme*
    - **Service Change/ Difficult Decision Proposal** *Programme*
- **Milton Keynes University Hospital (MKUH)** *Programme*
  - **MKUH Internal Efficiencies** *Programme*
    - **Service Change/ Difficult Decision Proposal** *Programme*
- **Cambridgeshire Community Services NHS Trust (CCS)** *Programme*
  - **CCS Internal Efficiencies** *Programme*
- **Central and North West London NHS Foundation Trust (CNWL)** *Programme*
  - **CNWL Internal Efficiencies** *Programme*
    - **Service Change/ Difficult Decision Proposal** *Programme*
- **East London NHS Foundation Trust (ELFT)** *Programme*
  - **ELFT Internal Efficiencies** *Programme*
    - **Service Change/ Difficult Decision Proposal** *Programme*



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BLMK ICS Portfolio Report

Personalisation Hierarchy

Organisational Programmes & Projects

Personalisation
Portfolio

Personal Health Budgets process for people in receipt of Section 117 aftercare
Project

Green Social Prescribing
Project

Test Personalised Care to Support Physical Activity
Project

Measuring impact of personalisation interventions
Project

Implementing outcomes of Learning Disability Personalisation pilot
Project

Personalisation Dashboard
Project

Overall Risk and Progress Sliders					
Risk Level			Overall Progress		
Low	Medium	High	Off Track	Slipping	On Track

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BLMK ICS Portfolio Report
Digital Hierarchy

Organisational Programmes & Projects

Digital
Portfolio

Digitising Social Care (DiSC)
Programme

Single Version of The Truth (SVoTT)
Project

Patient Engagement Portal (PEP)
Project

Remote Monitoring Whzan
Project

Robotic pets and Painchek
Project

GaitSmart pilots
Project

Overall Risk and Progress Sliders

Risk Level			Overall Progress		
Low	Medium	High	Off Track	Slipping	On Track

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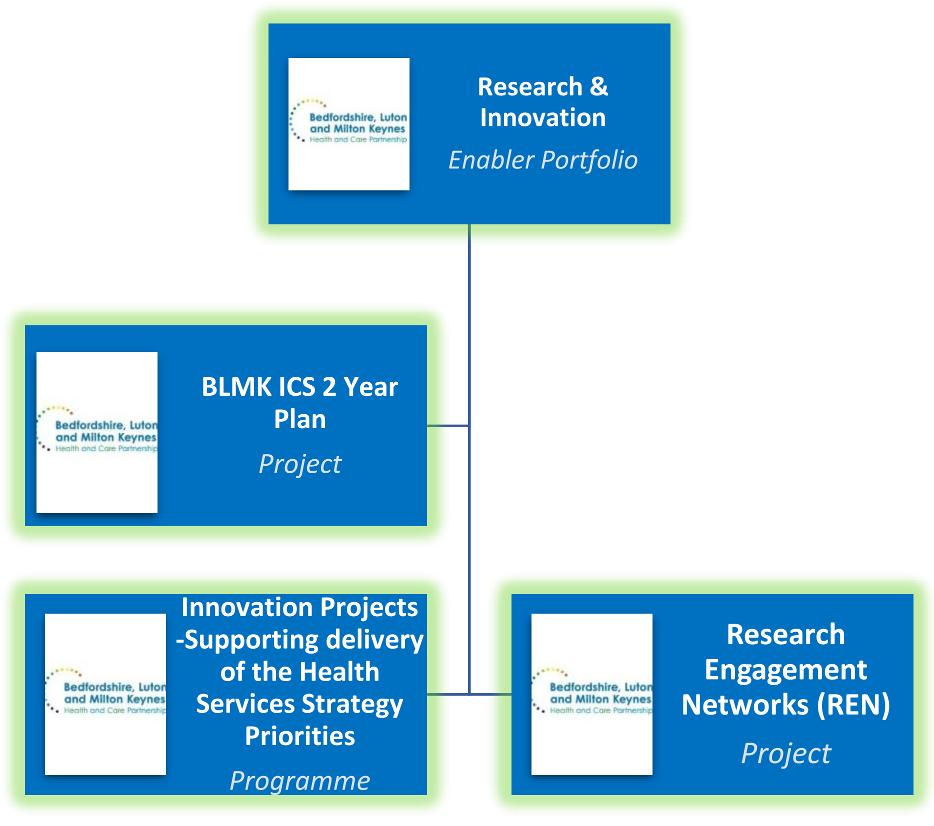
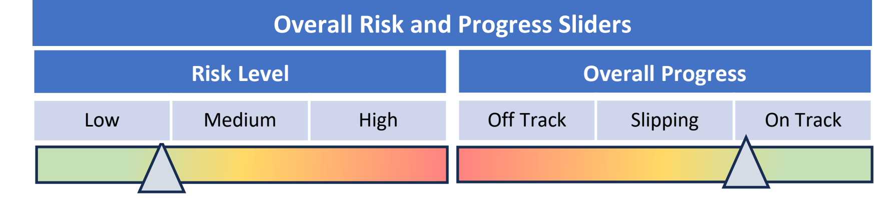
BLMK ICS Portfolio Report

Research & Innovation Hierarchy





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BLMK ICS Portfolio Report

Primary Care Hierarchy

Organisational Programmes & Projects

Primary Care Development and Transformation
Portfolio

- **Improving Care Navigation in Neighbourhoods (Including roll out of Midos and Self-Referral pathways)** — *Project*
  - **Improving outcomes for residents with Long Term Conditions including addressing variation** — *Project*
  - **Improving access to Dental services** — *Project*
  - **Development and Integration of Community Pharmacy Offer** — *Project*
- **Implementation of Modern General Practice Access** — *Project*
  - **Support and development programme to ensure resilient and sustainable general practice** — *Project*
  - **Improving productivity (Interface improvement and Red Tape Challenge)** — Project
  - **Streamlining access to same day and urgent primary care** — *Project*
- **Primary and Secondary Prevention** — *Programme*
  - **Prevention plan delivery** — *Project*
  - **Flu & Covid-19 Vaccination Programme** — *Programme*
  - **Section 7a Delegation (Screening, Immunisations and Vaccinations)** — *Programme*
- **Medicines Optimisation** — *Programme*
  - **EMBRACE Diabetes Project** — *Project*
  - **Food First Project – Milton Keynes** — *Project* (NHS Milton Keynes University Hospital NHS Foundation Trust)

Overall Risk and Progress Sliders

Risk Level			Overall Progress		
Low	Medium	High	Off Track	Slipping	On Track

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BLMK ICS Portfolio Report

Primary Care Hierarchy Continued

Organisational Programmes & Projects

Overall Risk and Progress Sliders

Risk Level			Overall Progress		
Low	Medium	High	Off Track	Slipping	On Track

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BLMK ICS Portfolio Report

Workforce Development Academy (WDA) Hierarchy

Organisational Programmes & Projects

Workforce Development Academy
Portfolio

- **Work and Health** — *Project*
- **Health & Care Academy** — *Project*
- **Supported Employment Pathways** — *Project*
- **Workforce Modelling and Supply** — *Project*
- **Apprenticeship Expansion Programme** — *Project*

Overall Risk and Progress Sliders					
Risk Level			Overall Progress		
Low	Medium	High	Off Track	Slipping	On Track

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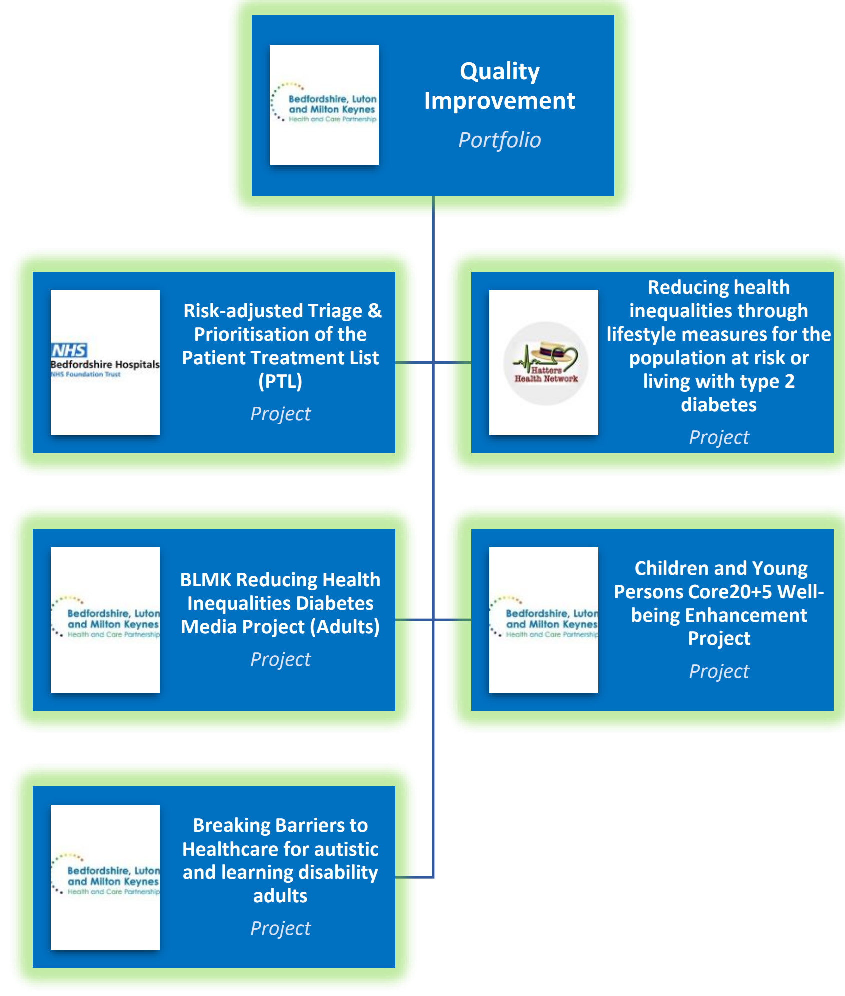
BLMK ICS Portfolio Report

Quality Improvement (QI) Hierarchy

Organisational Programmes & Projects



Overall Risk and Progress Sliders					
Risk Level			Overall Progress		
Low	Medium	High	Off Track	Slipping	On Track

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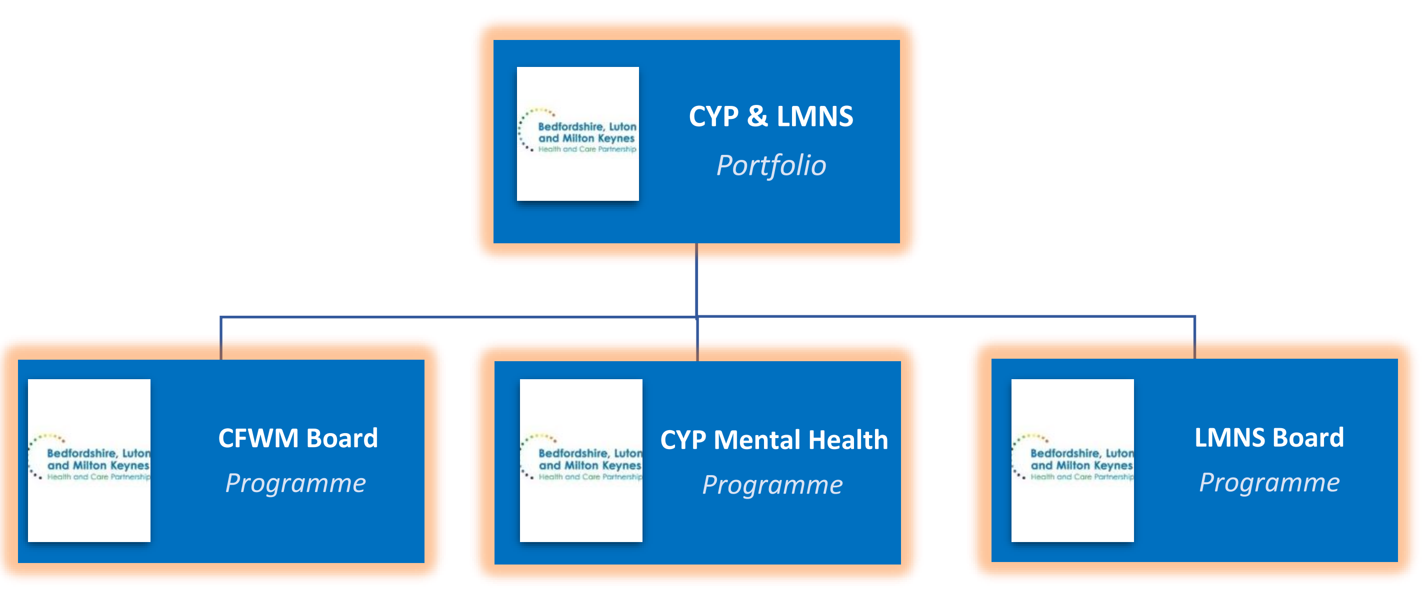
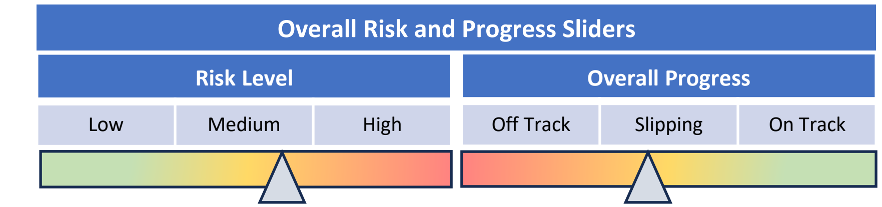
BLMK ICS Portfolio Report

Organisational Programmes & Projects





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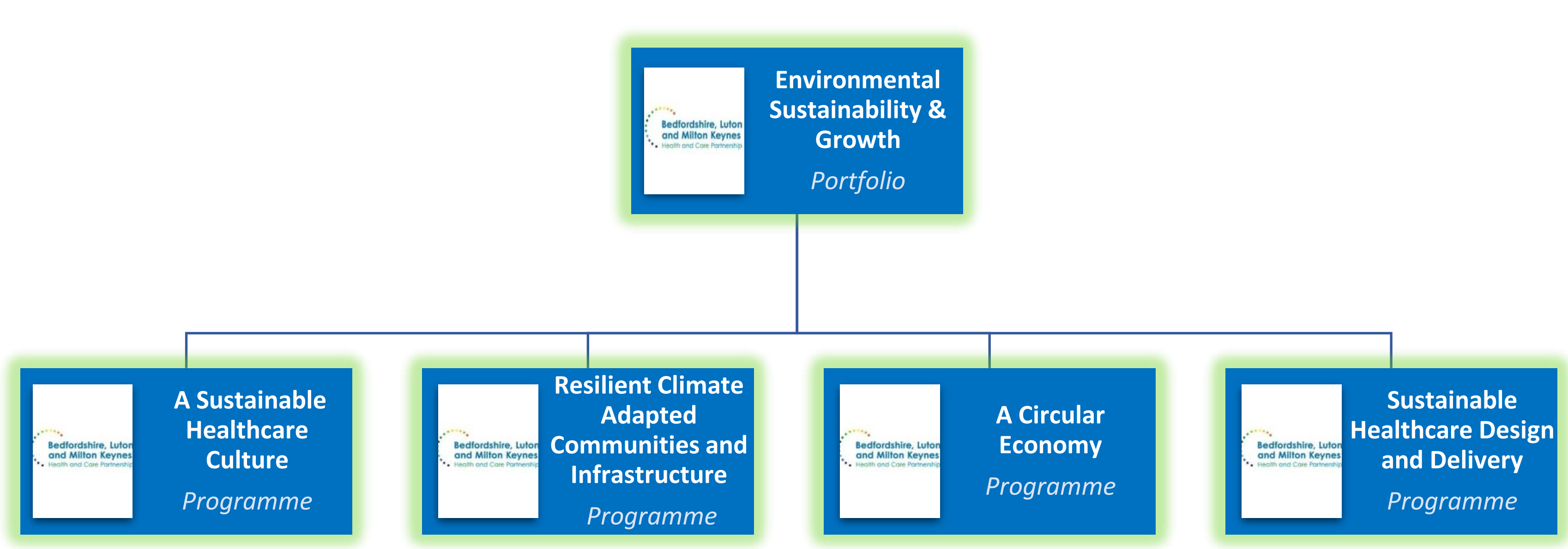
BLMK ICS Portfolio Report

Environmental Sustainability & Growth Hierarchy

Organisational Programmes & Projects



Note – The ICS Green Plan is currently going through governance and expected to be signed off by the end of the summer 2025, these target areas and timings are, therefore, subject to change

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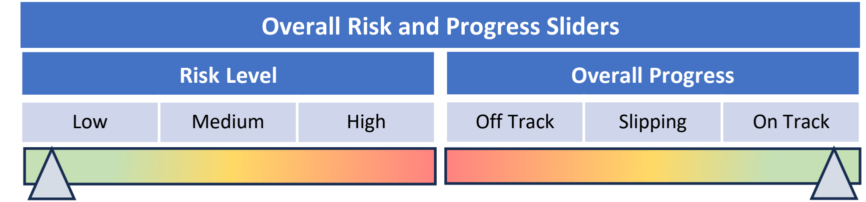

BLMK ICS Portfolio Report
Estates Hierarchy

Organisational Programmes & Projects

Estates Programme — *Portfolio*

- **System Estates** — *Programme*
  - **New Hospital Programme and Enabling Projects** — *Project*
  - **Oak House Ward** — *Project*
  - **L&D Redevelopment Programme** — *Programme*
  - **Community Diagnostic Centres** — *Project*
  - **Mental Health Inpatient Unit** — *Project*
- **Primary Care Estates** — *Programme*
  - **New Facilities** — *Programme*
  - **Extension & Improvement Works** — *Programme*
- **Void Estates** — *Programme*
  - **Utilisation Programme** — *Programme*
  - **Scoping & Feasibility Work** — *Programme*

Overall Risk and Progress Sliders

Risk Level			Overall Progress		
Low	Medium	High	Off Track	Slipping	On Track

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Portfolio Report Governance Report

Date of Highlight Report	12/05/2025
Project Code	PR000166
Project Name	BCA - Call Before you Convey
Project Team	BCA
Project Aim	**Call Before You Convey** Call before Convey ensures patients are seen by the right clinician, in the right place, at the right time – enabling shared clinical decision making and minimising avoidable conveyance to an emergency department (ED). The CB4C model has 3 key elements 1. Prevention - to identify and support patients earlier in their deterioration cycle so they don't reach ill health that requires A&E or ED conveyance 2. Maximising use of existing support services so patients receive appropriate support in a timely manner 3. Develop and improve UCCH to deliver SPOC for CB4C A single point of contact for clinicians to get advice on best place for ongoing assessment and treatment prior to conveyance to hospital. The first stage will be for ambulance crews and care home staff. This will utilise the the Bedfordshire unscheduled care hub which will be expanded to increase clinician expertise to ensure patients are appropriately referred to existing services to provide best level of care without the need for A&E attendance or ED admission if alternative support will provide better outcomes 1. i. to explore how a single number - call before you convey model could be implemented ii. further develop and consolidate the existing dispersed model of separate call before you convey options to give a more solid foundation for a single model and to not lose momentum and progress already achieved iii. Fully understand requirements of services from ambulance and care home staff
Governance & Responsible Group	BCA Executive Group reporting to BCA Committee
Geographical Footprint	Bedfordshire Care Alliance

Project Team Members

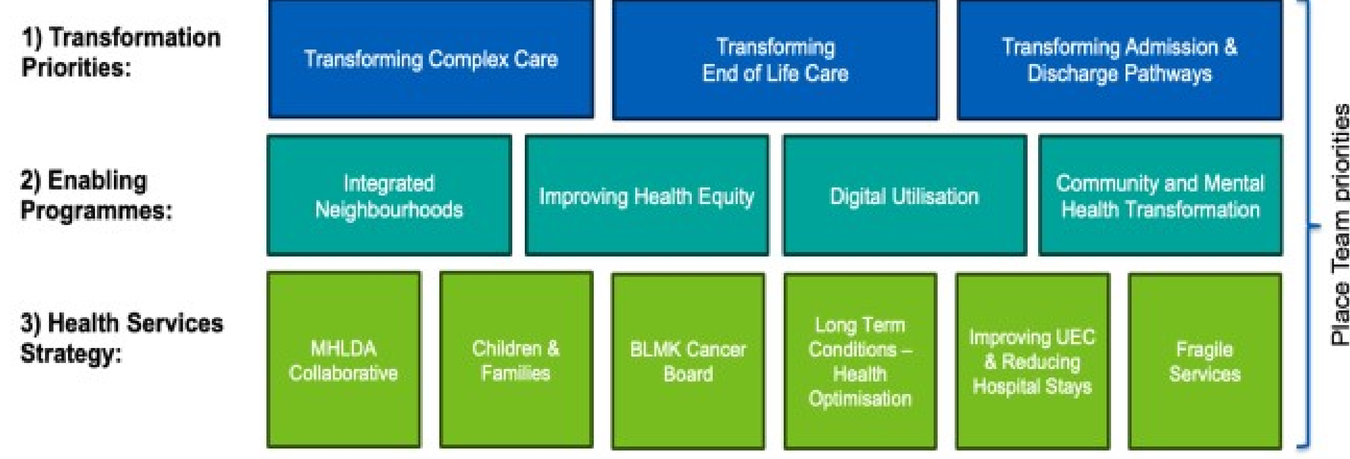
Name	Role
Kate Sutherland	Project Support
Faith Haslam	Project Support

Michael Ramsden	Senior Responsible Owner
Pete Reeve	Subject Matter Expert
Robin Campbell	Subject Matter Expert
John Fitzmaurice	Subject Matter Expert
Mark Morton	STT Team Member

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)	

Progress Update

Progress made in Previous Period	Good progress was made in 24/25 with the UCCH and Single Point of Access (SPOA) implemented in Q4. The SPOA connects Paramedics and Community Teams as per national guidance. The SPOA and Access to the Stack will support the avoidance of unnecessary conveyances to secondary care, helping to improve both Cat 2 and 4 hour performance. Paramedic referrals into the UCCH have increased to an all time high of 632 in January 24 with an acceptance rate of 77%. We will aim to continue this but will need to monitor community capacity to manage demand beyond this. •The Conveyance Avoidance Helpline (CAH) first phase went live 10th March. •Based at The Poynt (Dunstable) the first stage includes Frailty Team advice 7 days per week (8am-8pm) and Emergency or Acute Consultant advice 5 days per week (10am-6pm). •Telephony is in place with a single number 03000 134 134 – which will link the new consultant offer with the existing frailty line (initially remotely from the hospital) •A template has been developed in S1 to capture the required data for the hub •Consultant team and frailty ACPs have received training on the telephone system and S1 •The ambulance service (EEAST) is already in situ with access to the ambulance stack, working closely with Rapid Response and Virtual Ward Teams.
Progress to be made in Next Period	Work is underway to audit missed opportunities for patients currently being conveyed, ensure clarity on potential pathways and whether services will be able to meet any increase in demand. Q1 - Monitor the effectiveness of the SPOA ensuring there is confidence and reliability. Review the Directory of Services (DOS) to map other services that might be beneficial to route through the SPOA. Support pathway redesign so category 5 patients are held overnight by EEAST and transferred to the UCCH in the morning. Q2 - 4 Where beneficial and cost effective, move more services/pathways through the SPOA (i.e. EOL care). Continue to monitor the UCCH and community capacity; and measure impact to ensure the SPOA is supporting new models of care. Where necessary, develop a business case for additional funding in community services. We will continue to report to EoE UCCH activity data and support EEAST and Community partners to maintain referrals and acceptance/completion rates.

Tasks & Milestones

Overall Tasks & Milestones Status	**GREEN**
Reason for Overall Tasks & Milestones Status	On track Further Programme planning taking place 16 May 2025 - updated plan to be reflected thereafter

	Start Date	End Date	Apr 2025	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2026	Feb	Mar
Hub operational and fully staffed	30/06/25	30/06/25												
Comms developed and distributed to partner organisations	18/03/24	17/03/26												

Risks

Overall Risks Status	TBC
Reason for Overall Risk Status	All key risks and issues still need defining, although key challenages are: • Capacity concerns – ensuring community response and alternative pathways can manage additional demand. • Primary care support– what is the best approach to sharing information (eg tasks on S1), uncertainty over GP availability for urgent queries or visits. • Alternative pathway limitations – Need for clear referral processes to services beyond ED. • Impact on the existing Silver Phone line – Avoid disruption to frailty services while introducing the new CAH line.

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact

Issues

Overall Issues Status	TBC
Reason for Overall Issues Status	All key risks and issues still need defining

Issues

Issue Name	Key Issue?	Proximity & Impact

Portfolio Report Governance Report

Date of Highlight Report	07/05/2025
Project Code	PR000168
Project Name	BCA - Improving access to Pathway 2 Beds
Project Team	BCA
Project Aim	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. 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.
Governance & Responsible Group	Pathway 2 Project Group & BCA Committee Group
Geographical Footprint	Bedfordshire Care Alliance

Project Team Members

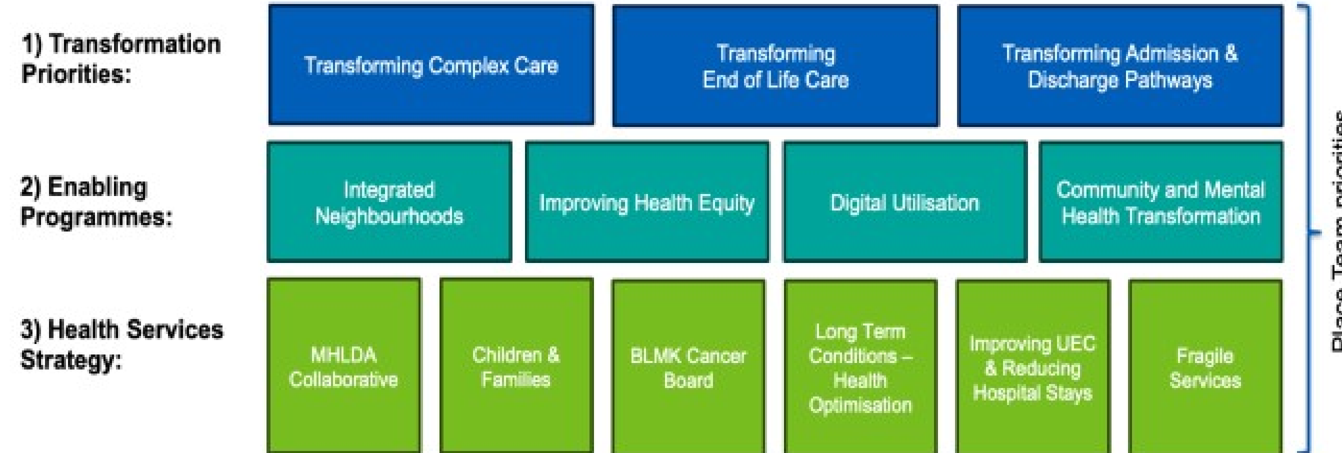
Name	**Role**
Kaysie Conroy	Programme Manager
Caron Morgan	Project Manager

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	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 BCA - 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	1. The P2 scope document has been refreshed and circulated to key stakeholders for review and comment. 2. P2 Operational and process improvement workstream, and Strategic workstream meetings continue to take place fortnightly, to drive this work forward. 3. The outline Business Case has been completed, and Kaysie Conroy presented it to the BCA System Leadership Group meeting on 29th April. 4. Bedford Hospital P2 discharges In Reach Pilot launched on 22nd April for 4 weeks, providing a multi-professional and multi-partner in reach discharge team in Bedford Hospital to provide real time decision making to support an effective discharge process. 5. A series of stakeholder meetings were established through the life of the pilot - weekly SITREP meetings, Project Mobilisation meeting, and System Leaders Group meetings. 6. Pilot project management documents - workplan, action log, highlight report, risk log - created to monitor activity through the Pilot. These will form evidence for reporting after the pilot ends.

Progress to be made in Next Period	1. Business Case to be finalised following presentation and comments at BCA System Leadership Group meeting on 29th April. 2. Development of the PHEW App request to be agreed by the ICB and data development to be taken forward to support this project. 3. Bedford Hospital P2 discharges in reach pilot ends on 22nd May. Reports will be created and shared of success/challenges of pilot. 4. Pilot next steps to be discussed, including running the same pilot at L&D Hospital. 5. P2 business case to be finalised and presented to ICB Chiefs

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	The milestones across each workstream and the overall project are currently on track for delivery. These will continue to be monitored and updated accordingly.

							2025					2026	
	Start Date	**End Date**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Development of the case for change business case		30/04/25	◆											
Bedford Hospital P2 discharges In reach Pilot	22/04/25	22/05/25	■	■										

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

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	07/05/2025
Project Code	PR000261
Project Name	BB - Integrated Neighborhood 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

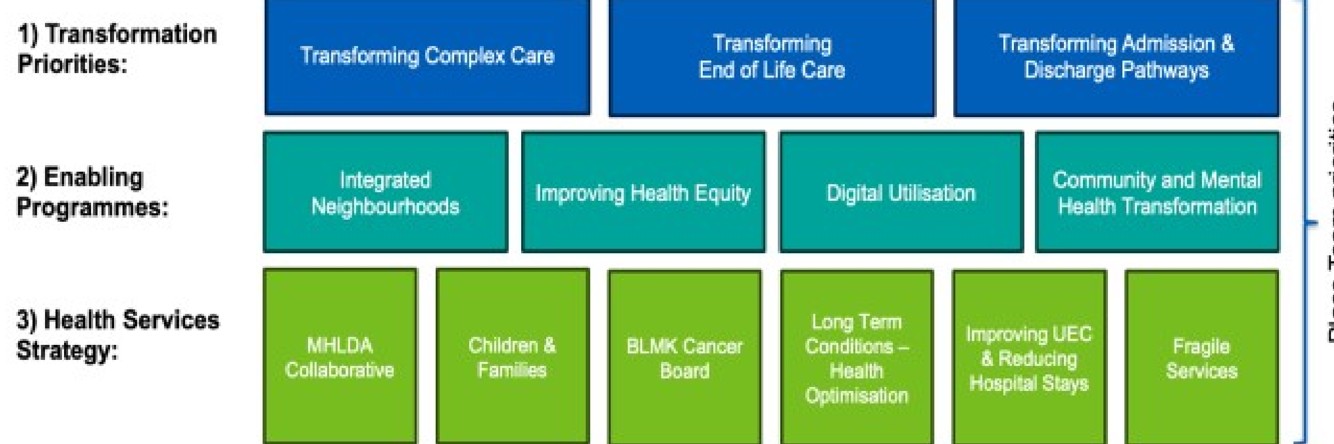
Project Team Members

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

Progress made in Previous Period	Set up of INW Steering group and built membership to circa 50 professionals, 20 organisations. Development of a Health on the High Street model - working with Public Health and other colleagues to develop the idea. Supporting ELFT colleagues with the set up of Working Together. Built understanding of Urban South neighbourhood through LAN work, working closely with clinicians and patients from 3 practices.

Progress to be made in Next Period	Continue to grow steering group (with people attending as needed). Launch first (official) Neighbourhood, hopefully aligned with the Working Together MDT. Develop learning of INW with wider cross-sector stakeholder group.

Tasks & Milestones

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

			2025									2026	
	Start Date	End Date	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			◆									
Set up working group(s) to focus on delivering 2025/26 goals.		13/06/25			◆									
BB INW Steering Group Meeting		25/06/25			◆									
Discussion and creation of 2025/26 goals.		27/06/25			◆									
BB INW Steering Group Meeting		23/07/25				◆								
BB INW Steering Group Meeting		27/08/25					◆							
BB INW Steering Group Meeting		24/09/25						◆						
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	07/05/2025
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	• 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. 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.
Governance & Responsible Group	Executive Delivery Group
Geographical Footprint	Bedford Borough

Project Team Members

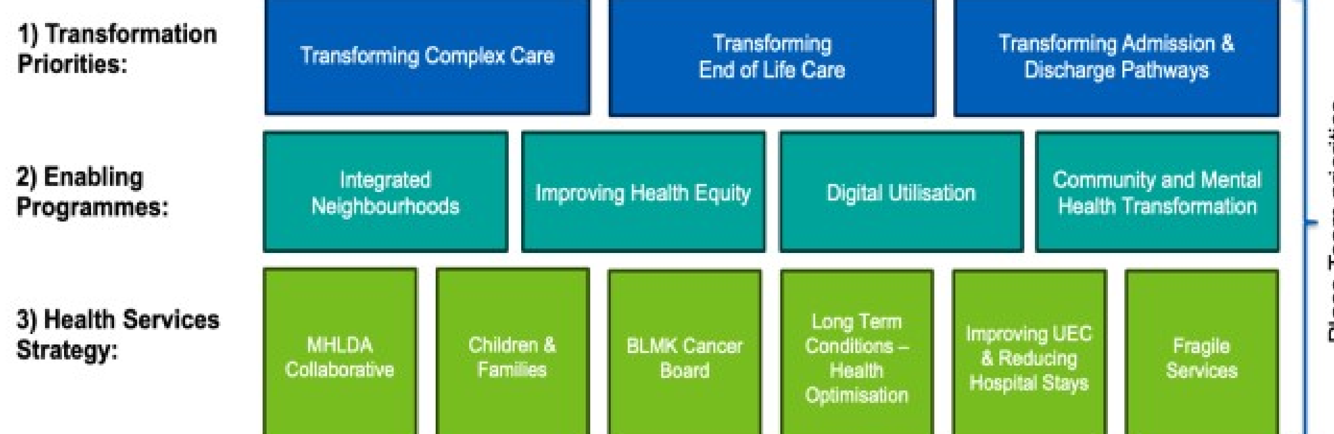
Name	Role
Brenda Carson	Improvement Manager
Angela Zambeaux	Improvement Manager
Lorraine Kavanagh	Project Manager
Usha Panchal	Project Manager
Adele Slaney	Project Manager

Sarah Pearson	Project Manager
Alex Wrack	Project Manager
Charlie Goodwin Smith	Senior Responsible Owner
Ellen Heaney	QI Coach
Chloe Stibbs	QI Coach
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

Project Status

Overall Project Status	**GREEN**
Reason for Overall Project Status	Project is on track as per update.
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. 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 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

	May Progress Report on 10 Change Ideas **1. Awareness Campaign & Faith Leaders Group** On **April 17th**, faith leaders from Black African and Black Caribbean communities in Bedford launched a **community-led**

Progress made in Previous Period	**hypertension awareness campaign** as part of the LAN initiative. The event:
	• Engaged **15+ faith leaders** in strategic health discussions.
	• Secured **cross-sector partnerships**, including local councils and Healthwatch.
	• Promoted the **NHS Hypertension Case-Finding Service** for residents aged 40+.
	• Established **four designated pharmacies** as screening hubs.
	• Introduced a **pilot booking system** for pharmacy appointments.
	
	Good news story: Kirstin Frost (PM and runs hypertension clinics) has reported that a patient in our cohort who hasn't been engaged with the practice for years made an appointment to see a clinician for a blood pressure review. His wife heard about our awareness campaign (which was only launched on 1st May) and encouraged him to make an appointment.
	
	2. Faith Leader Engagement Strategy
	• Faith leaders will act as health advocates, ensuring messaging reaches their communities by:
	  ◦ Tracking community referrals to pharmacies for BP checks.
	  ◦ Promoting the **May BP Measurement Campaign** in congregations.
	  ◦ Organizing **BP screening events** with local pharmacies.
	  ◦ Maintaining campaign momentum via **WhatsApp group collaboration**.
	
	2. Patient Engagement Strategy
	Leveraging **behavioral science** and resident input, residents decided on the structure and came up with messages and scripts for phone calls. We developed a **structured messaging system** for patient outreach:
	• **Week 1:** Monday text, Friday follow-up call.
	• **Week 2:** Second Monday text, Friday follow-up call.
	• **Week 3:** Third Monday text, Friday text.
	• **Week 4:** Physical letter sent.
	
	3. BLMK Hypertension Training
	Survey results showed **25% of clinicians** were unfamiliar or uncomfortable with the EofE hypertension protocol. To address this:
	• A **training session** was delivered by the meds optimisation team, with pre-/post-evaluations completed.
	• Each **surgery conducts audits** to ensure protocol adherence.
	• The **BLMK hypertension protocol** will be embedded into patient templates.
	
	4. Partnership with Holly Health App
	Holly Health has offered **free access** to their behavioral health app for our resident cohort. The collaboration will support:

- Development of **culturally relevant behavioral nudges**.
- Engagement-driven updates via resident-led **questionnaires**.
- Digital health **accessibility improvements**.

Next Steps: Finalise Information Governance (IG) requirements before implementation.

5.& 6 Standardised Resource Library & Template Development

- Residents helped currate a **suite of standardised resources**, including British Heart Foundation (BHF) booklets and videos.
- Resources will be embedded into the **Ardens Template** for universal access.
- Template enhancements include **tick-box questions** addressing patient preferences, social prescribing, and digital health referrals.

BP Monitors in Surgeries:

- King Street Surgery has acquired a BP monitor but has not initiated use.
- London Road Surgery was initially going to purchase a monitor using QOF funding, however, they have decided to train all their reception staff and admin staff to take blood pressure readings of patients in the waiting room whilst waiting for their appointments. They will use a separate room to enable patients to sit quietly for 5 minutes before their blood pressure is taken. If normal, then it will be recorded and read coded. If stage 1 or stage 2, the admin staff will book them in for an appointment.
- Cauldwell Surgery is already **actively using** its BP monitor.

7-10. Surgery-Specific Change Ideas

London Road:

- Collaborating with **community pharmacy** to integrate hypertension case-finding service and NMS referral, and provide a more holistic approach by referring to the social prescriber at London Road and offering the Holly Health App.

Cauldwell:

- Working with **ELC Group** to establish **group clinics** for hypertensive patients.
- Seeking funding for clinic implementation.
- Involvement of Social Prescribers in group clinics and the offer of the Holly Health App

King Street:

- Preparing to **launch hypertension clinics** in collaboration with the practice team. They are linked to BedsRCC, which has developed a cultural walking group route as part of their social care offer.

Next steps:

Progress to be made in Next Period	Set up measures for each change idea **Change Idea 1: Awareness Campaign & Faith Leaders Group** • Confirm date and venue for **June 2025** campaign meeting. • Sustain engagement with faith leaders via check-ins and phone calls. • Establish a **tracking system** for pharmacy referrals and BP checks. • Support faith leaders in organising **three community-led events** each allocated up to **£500 funding**. • Develop a **communication strategy** to reinforce hypertension messaging in congregations. **Change Idea 2: Patient Engagement Strategy** • Implement structured **text and call schedule** across surgeries • Test the approach with surgeries and **measure engagement rates**. • Adjust communication strategies based on **resident feedback**. **Change Idea 3: BLMK Hypertension Training** • Embed the BLMK Hypertension Protocol on a template. • Track **protocol adoption** with periodic medication audits. **Change Idea 4: Partnership with the Holly Health App** • Finalise **Information Governance (IG)** protocols for rollout. • Engage residents in **questionnaire-driven** app development to enhance cultural relevance. • Monitor **app uptake** and patient engagement trends and capture any learning. **Change Idea 5&6: Standardised Resource Library & Template Development** • Refine the **Ardens template prompts** to optimise usability. • Finalise the **selection of standard resources** with resident collaboration. • Provide **training on template integration** for clinicians. • Monitor **template utilisation rates** to measure impact. **Change Idea 7: BP Monitor Utilisation in Surgeries** • Support King Street surgery in **initiating BP monitor usage**. • Ensure the London Road surgery **maximises the QOF-funded BP monitor**. • Continue tracking **Cauldwell's utilisation of their BP monitor**.

Change Idea 7-10: Surgery-Specific Initiatives

London Road:

- Await the procurement of the **patient engagement portal** for streamlined referrals.
- Promote a **community pharmacy referral pathway** for hypertension management.

Cauldwell:

- Secure funding for **group clinic implementation** with ELC Group.

King Street:

- Work with the practice to **finalise the hypertension clinic setup**.

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	Project in progress

							2025						2026	
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Awareness Campaign Rollout		01/04/25												
Patient engagement messaging from practices / Text / Email / Phone / Letter	01/04/25	08/04/25												
First meeting with Faith Leaders		17/04/25												
Action webinar 4		28/04/25												
Hypertension training for clinicians		29/04/25												
Develop standard template for surgeries to complete - resources given, interventions, contacts preferences	10/04/25	09/05/25												
Action Webinar 5		19/05/25												
Develop suite of Hypertension resources available to patients	02/01/25	30/05/25												

	Start Date	End Date	Apr 2025	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2026	Feb	Mar
London Road - Enhanced Pharmacy Pathway	02/01/25	30/05/25												
May Measure Month - Blood Pressure reading awareness campaign	01/05/25	31/05/25												
Learning Session 3 (in-person)		20/06/25												
Offer Holly Health App to patient co-hort	08/04/25	27/06/25												
Action Webinar 6		28/07/25												
Action Webinar 7		18/08/25												
Learning Session 4 (virtual), link to be sent		16/09/25												
Action webinar 8		27/10/25												
Action Webinar 9		24/11/25												
Action Webinar 10		26/01/26												
Learning Session 5 (in-person)	23/02/26	23/02/26												
Holding the gains webinar		23/03/26												
Testing change ideas	12/12/24	19/05/26												
Engaging with Faith Leaders	11/03/25	22/05/26												
Cauldwell MC - Group Clinics	01/04/25	22/05/26												
King Street - Hypertension Clinics	01/04/25	22/05/26												
Blood Pressure Checking machine in practice waiting rooms: London Rd, Cauldwell MC, King Street	01/04/25	22/05/26												

Risks

Overall Risks Status	AMBER

Reason for Overall Risk Status	Generally the project is progressing well. The main risk currently is of losing a resident participant. To mitigate this there is a small group of other residents engaged.

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**

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	07/05/2025
Project Code	PR000296
Project Name	BB - Living Well - Increase uptake of breast cancer screening programme
Project Team	Bedford Borough Place Team
Project Aim	• Increase the uptake of breast cancer screening programmes
Governance & Responsible Group	Executive Delivery Group (EDG)
Geographical Footprint	Bedford Borough, BLMK System

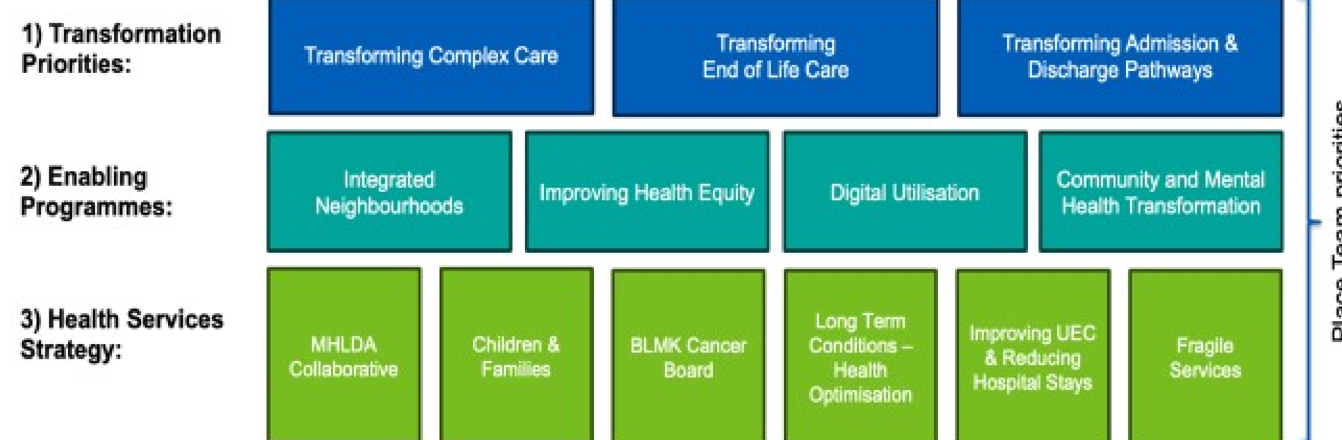
Project Team Members

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	Screening Projects are being scoped as expected. 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.
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	Creation of breast cancer screening promotional video: • Video created with GP of South Asian origin - completed end Feb 2025. Subtitles added. • Delay with adding BSL and awaiting final editing by Fujifilm for release w/c 21.04.25. • Video completed 02.05.25. • Video shared with King Street Surgery 06.05.25 • Video shared with Lila Begum, Senior Officer for Equality, Diversity & Inclusion at Bedford Borough Council 06.05.25

Progress to be made in Next Period	Release of finished video to social media platforms across BB. to include (not exhaustive list) • Community groups via WhatsApp • BBC Council social media • Faith Leaders • Cultural Groups • ICB Cancer Leads • ICB Women's Health Leads • Primary Care • Healthwatch for website • BLMK Comms for ICB social media • Beds RCC (Social Prescribing) • BLMK Screening Service via L&D • NHSE Breast Screening Service Lead Working with colleagues across health and social care to agree measurable outcomes of improvement for each focus area.

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

			2025									2026		
	Start Date	**End Date**	**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

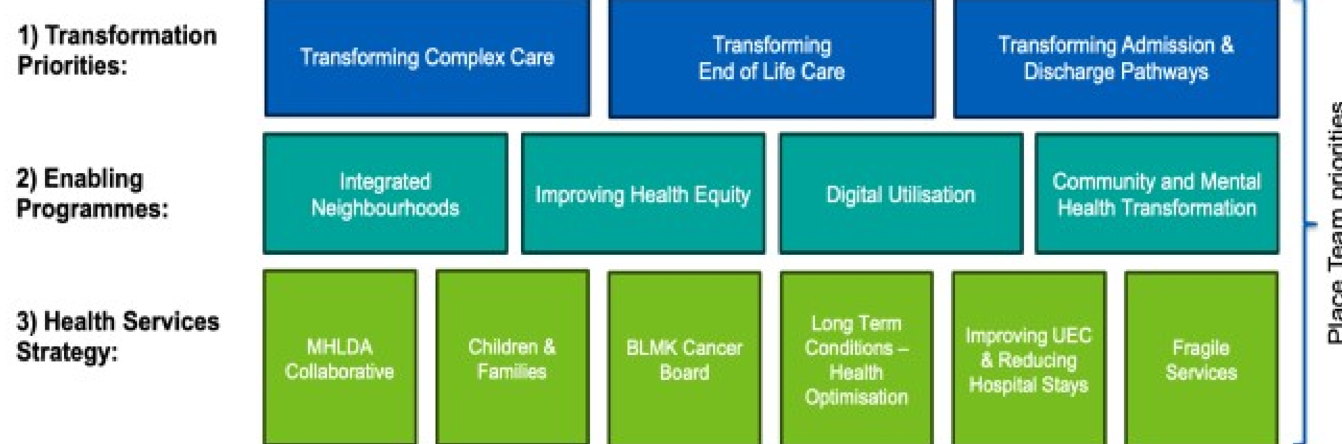
Date of Highlight Report	07/05/2025
Project Code	PR000295
Project Name	BB - Living Well - Increase the uptake of cervical screening programme appointments
Project Team	Bedford Borough Place Team
Project Aim	To increase uptake of cervical screening appointments in Bedford Borough. To reduce the number 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

Progress made in Previous Period	The initial pilot project with CAJA and a Bedford practice to encourage uptake of cervical screening, using behavioural change theories, in underserved communities is no longer taking place. The place team are scoping out other avenues to promote cervical screening and will be working closely with primary care partners who deliver the service.
Progress to be made in Next Period	Continue to work with colleagues across health and social care to agree measurable outcomes. Continue to scope how the place team could provide support or implement any new projects of work to increase screening uptake.

Tasks & Milestones

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

	Start Date	End Date	2025 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2026 Jan	Feb	Mar
Mapping current screening activity	03/04/23	01/12/25												

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	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. There are a number of priorities and the place team have not been able to focus on this one yet.

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

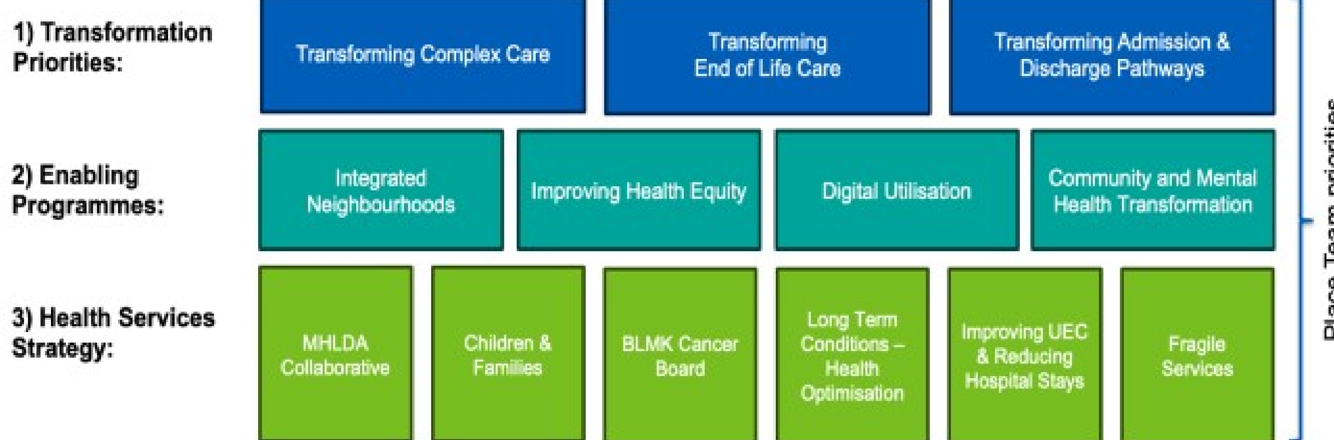
Date of Highlight Report	07/05/2025
Project Code	PR000260
Project Name	BB - Placed Based Plan Priorities – Health Estate
Project Team	BBC Estates / Place team / ICB Estates
Project Aim	A strategic approach to improving healthcare estate: • Utilising & upgrading GP surgery provision. • Providing influence and strategic support for acute and community health estate in Bedford Borough.
Governance & Responsible Group	Executive Delivery Group Health and Wellbeing Board
Geographical Footprint	Bedford Borough

Project Team Members

Name	Role
Alex Wrack	Programme Manager
Lorraine Kavanagh	Programme Manager

Project Status	
Overall Project Status	GREEN
Reason for Overall Project Status	Led through the Bedford Borough Strategic Estates Board, which meets bi-monthly, significant progress has been made on a number of projects. Further detail on each project is included throughout the report. It's important to note that these projects have a number of elements with competing priorities and require a large amount of investment to make them deliverable.
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)	Currently: Integrated Neighbourhoods, Improving Health Equity, Children & Families

Progress Update

Updates on the estates projects to April 2025:

Biddenham: The ICB remains in active discussions with the developer around progressing the Biddenham primary care new-build project. Concerns were raised by the developer about the financial viability for the scheme in 2023, and a series of extensive assessments have been carried out in partnership with the developer and the District Valuer since then to try and arrive at a proposal which is viable for the developer, acceptable to their investors, affordable to the ICB and which there is confidence will provide good value for money for the taxpayer. The most recent financial appraisal meeting took place on 5 February 2025, which resulted in further revisions to the agreement, and a further meeting took place to plan next steps with the two GP practices involved in the scheme on 26 February 2025. The ICB is now awaiting confirmation that this latest proposal is sufficient to achieve the necessary investment into the scheme. The ICB remains positive at this stage that the scheme will be able to go ahead and that construction will commence in 2025.

Great Barford: A detailed business case was presented at the Bedford Borough Council Executive meeting on 23 April 2025 and the following recommendations were agreed:

- That the Great Barford business case which identifies a total build cost of £3.43 million to build a new GP surgery on Silver Street, Great Barford be approved.
- That the allocation of up to £1.9 million (net) from the (Council's) approved Primary Care Estate capital scheme for the

	delivery of a new purpose-built GP practice in Great Barford be approved and to proceed with the project when the: ◦ sum of £1.017 million S106 developer contribution has been secured for the project, ◦ ICB formally commit to the project with a capital contribution of £525,000, and ◦ Agreement for lease is secured from the GP practice. • That it be agreed to release £470,000 of the £1.9 million (net) capital allocation to cover the costs of the planning permission application and demolition of the existing building on the proposed site and associated pre-demolition work. The project team are now working to bring forward the next stage of the project. **Kempston:** In November 2024, consultants Turner and Townsend were appointed to undertake a feasibility assessment of the project and the 2019 SOC findings, with a view to taking the project forward to Outline Business Case (OBC). The review, which was completed in March 2025 concludes that: • There remains a need for a new healthcare building in Kempston. • The police site on Halsey Road, as suggested in 2019, remains the preferred site. It ranks significantly above all other possible sites in terms of its suitability and deliverability. • The preferred estate would comprise of the retained Kempston Clinic (where the Cater Street surgery moved to) and a new primary care building on the police station site, replacing the Kings Street and St Johns surgeries. The current predicted cost for the project (including buying the police site) is circa £18.8 million. At the OBC stage the consultants will be looking at cost saving and (Improving the Health Care Estate Update/Executive Committee/23 April 2025) efficiencies based on the most viable options and location. This will provide an outline design and detailed assessment of the costs for delivering the preferred option. A sum of £2 million has been agreed in the Capital Programme and allocated to the acquisition of the Kempton Police Station site. However, there would only be a need to purchase the site if the healthcare building can be built. Ahead of this progressing, there needs to be a decision on whether to commit the finance or find external finance to build a new surgery on the police site for the King Street surgery to ensure the building does not become unused and expensive to run with no activity. At this stage there is no source of capital funding to deliver the facility, but developing the Outline Business Case will support future potential opportunities to apply for funding. **Wixams:** Urban & Civic have acquired the former developer and are in the process of reviewing and revising the plans for delivery of the town centre. A permanent healthcare facility remains within the plans. They have committed to providing an updated programme plan setting out an indicative timeline for submission of their planning application and for when construction work could commence, so that the impact on timescales for potentially delivering the health building can be understood – given that its delivery is dependent on the rest of the town centre coming forward (e.g. highway and utility infrastructure). (Improving the Health Care Estate Update/Executive Committee/23 April 2025) 7(6) Several potential funding options are being considered, taking into account likely availability of S106 funding. An update has been provided by Planning Officers in the Councils, and based on the latest housing development trajectories, it is expected that the following amounts will become available: • £0.56 million S106 funding for health is already available for the Wixams/Houghton Conquest area. • £2.2 million S106 funding is likely to be available by 2029. • There is potential for a further £0.85 million by around 2030. Once further detail is provided by Urban & Civic, the ICB intends to model the likely timeline for delivery of the facility against the likely costs and availability of S106 funding, to understand what the capital funding shortfall will be and options/affordability for
Progress made in Previous Period	

	addressing this. It is expected that the running (revenue) costs of the building will be covered by the primary care provider/s who will operate there, in the usual manner for GP practices. The ICB continues to consider and revise options for temporary provision with partners but are very mindful of the impact this could have on the overall funding levels and the risk that provision of a temporary facility could potentially delay delivery of the permanent facility. In the meantime, the ICB has taken action to improve primary care capacity in the surgeries on which Wixams residents currently rely. Residents of Wixams are able to register with practices in Bedford, Ampthill, Wootton and Great Denham, and a variety of projects have taken place recently to increase clinical capacity in the premises for some of these practices, for example London Road Surgery and for both practices based at Ampthill Health Centre. **Wootton:** A high-level feasibility study considers the options of a rebuild on the existing GP Practice site and a new build on Bedford Commercial Park. After consultation with the Wootton Ward Councillors and practice partners, the site at Bedford Commercial Park has been identified as a preferred option, subject to detailed financial feasibility appraisal/availability of funding. The estimated cost to build a new surgery is £4.865 million. The consultants have endeavoured to identify greater cost saving and efficiencies through the design process, however, little more can be done to reduce the latest building size requirement whilst incorporating the necessary facilities. A final draft has recently been produced to enable a pre-app to be submitted later this month. As it stands, the project would require significant revenue investment from the ICB which is not available at this time, due to financial constraints.
Progress to be made in Next Period	**Great Barford:** Officers are submitting a pre-app for this project. This will include the request to demolish the existing building on the site. **Kempston:** Turner and Townsend are moving onto the Outline Business Case (OBC) stage of the project. This will refine the design and plans for a new surgery. Currently there is not budget to build the new surgery or cover the revenue costs. The OBC is being carried out to put the project in a good position should finance become available. **Wootton:** Officers are carrying out a pre-app for this project. Although, a new health facility in Wootton was not considered affordable to progress at this time by the ICB in the 2023 prioritisation process. The pre-app and high level feasibility study will be used to provide estimate costings for the project and it is 'oven-ready' if the funding were to become available.

Tasks & Milestones

Overall Tasks & Milestones Status	**GREEN**
Reason for Overall Tasks & Milestones Status	Work is progressing at pace for a number of projects, challenges around funding will ultimately determine the outcomes.

								2025						2026	
	Start Date	**End Date**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Ongoing negotiations with developers regarding Biddenham development - this task is taking longer than hoped as the developers have a shortfall in funding.		30/04/25	◆											

	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
							2025						2026	
Ongoing negotiations with developers regarding Wixams development		30/04/25												
Potentially acquirting the Kempston Police Station site on Halsey Rd. Funding not yet raised or agreed for health provision. This action is reliant on having the funds to build the new surgery which currently are not available.		30/04/25												
Submit pre-app for Great Barford development.	01/04/25	01/08/25												
Submit pre-app for Wootton development.	25/04/25	01/08/25												

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	Timeframes for work are liable to slip as there are many factors affecting progression including: • Cross-organisation working • Stretch on resource/staff time • External developers • Budget constraint

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Securing revenue funding from the ICB to deliver the projects - varies across projects	Yes	16
Securing capital funding from the Council or other partners - varies across projects	Yes	9
Reputational risk if projects are not delivered.	Yes	12

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	07/05/2025
Project Code	PR000162
Project Name	BB - Placed Based Plan Priorities – Ageing Well
Project Team	Bedford Borough Place Team
Project Aim	Current aims: • Support older people to live independently and well for longer • Improve access to reablement The proposal is to revise the project aims to: • Support people over 65 to maintain independence • Keeping older people well during winter Pending EDG approval 12.05.25
Governance & Responsible Group	EDG
Geographical Footprint	Bedford Borough

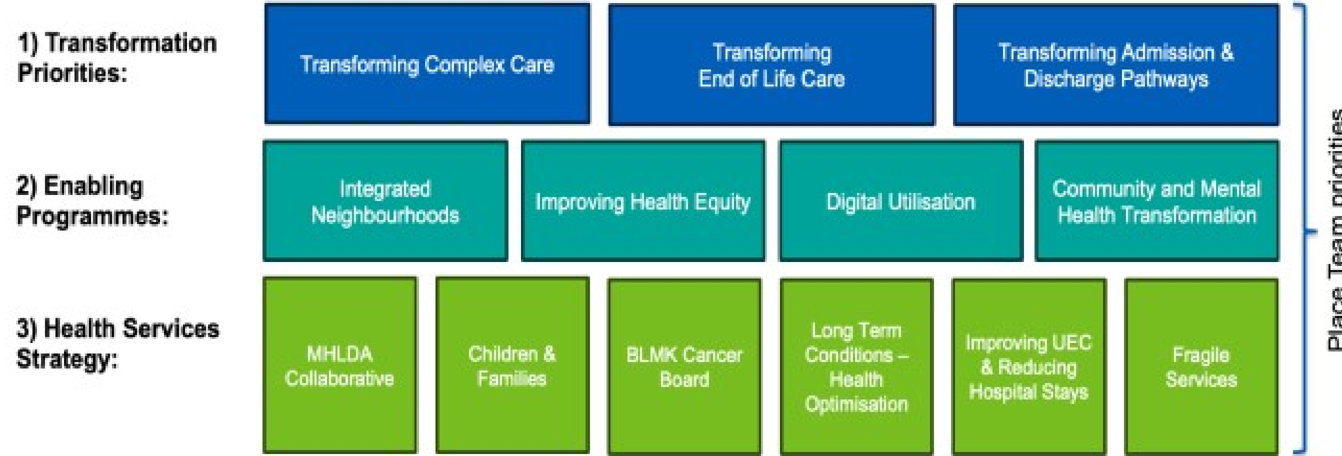
Project Team Members

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	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 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	**Support older people to live independently:** The Age Care Technologies 12 month pilot to work with 1,000 older people has been agreed by the Bedford Borough Executive Delivery Group on 10.03.25. This is a digital assessment tool that helps older people report their concerns, identify people at elevated risk and connect them to sources of support, resulting in improvements to their wellbeing, independence,social connection and health lifestyles. The project will be focused on residents living alone in areas of deprivation who are not currently receiving social care support. **Improve access to reablement:** This is a priority under Adults' Services and therefore the work programme sits with them. Following conversations with a range of colleagues the priorities have been changed to reflect the projects the place team are working on, such as Age Care Technology and the Enhanced Health in Care Homes, and the recognition of the pressure on services related to winter illness.
Progress to be made in Next Period	**Agree revised project aims with EDG.** Support people over 65 to maintain independence • Age Care Technology: planning for project initiation: data analysis to identify options for wards/practices to invite to participate. Agree project steering group and project group membership. PID to be produced. Planned start date 02.06.25. • Agree outcome measurements for other workstreams. Keeping older people well during winter • Agree outcome measurements for workstreams.

Tasks & Milestones

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

			2025									2026		
	Start Date	**End Date**	**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	01/05/25	30/05/25												
Agree role and membership for steering group and working group	01/05/25	31/05/25												

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	10
Take up of the ACT offer by residents	Yes	10

Issues

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

Issues

Issue Name	Key Issue?	Proximity & Impact

Portfolio Report Governance Report

Date of Highlight Report	07/05/2025
Project Code	PR000161
Project Name	BB - Placed Based Plan Priorities – Starting Well
Project Team	Bedford
Project Aim	• 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.
- Queens Park pre-diabetics project from Be Active – a family approach to tackling inactivity in the Queens Park area. Pre-diabetic South Asian women with children aged 5-12 project launched on 22nd April when texts were sent to the patient co-hort. The project has changed from previously being aimed at mothers and children, to just women, as BeActive were unable to secure venue bookings on evenings or weekends when children could attend with their mothers. BeActive will ensure there is an element of being a positive role model and modelling health enhancing behaviours for their children in the program. Due to this change updates on this project will be included in the 'Integrated Neighbourhood Working' programme in future reports. Confirmed start date for program Tue 13th May.
- Conversations are ongoing with Public Health if any support is required from the Bedford Borough place teams to improve outcomes for children with obesity.

Improving Children's Oral Health:

- Bedford Borough Council will receive additional government funding to fulfill their pledge to introduce supervised

Progress made in Previous Period	toothbrushing in early years settings for all 3-5 year olds living in the most deprived areas. Public Health are currently scoping how this would be delivered with an expected start date of September 2025. • Population Health Evidence & Intelligence data from February 2025 shows improvements have been made in oral health for children age 0-5 in the past 2 years. **Bedford Borough Children age 0-5** **2022** **2024** Mean number of decayed, missing or filled teeth 1.0 0.6 Percentage with one or more decayed, missing or filled teeth 22.5% 19.6% Mean number of decayed, missing or filled teeth in children with at least one decayed, missing or filled tooth 4.6 3.2 Percentage with incisor decay 7.8% 5.9% • Conversations are ongoing with Public Health, VCSE and ICB Contracting/Commissioning teams if any support is required from the Bedford Borough place teams to improve children's oral health. **Imms & Vaccs:** Analysing data, although Bedford Borough is doing reasonably well compared to the whole of BLMK, there are four practices that feature in the top 15 table for worst take up of childhood imms (21 patients not up to date as of 30/04): Queens Park Health Centre, London Road Surgery, Putnoe Medical Centre and Ashburnham Road Surgery. The place team attend the monthly NHSE meeting. Barbara Hamill from NHS England Screening and Immunisation team is booked to present at the 22nd July Bedford Borough Practice Managers meeting.

	Secured access to the Imms & Vaccs NHSE data portal. Funding for the Maternity Social Prescribing pilot accross 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	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. Continue to map current activity and prioritisation of projects for place team focus. 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. **Obesity:** Continue discussions with Public Health around the roll out of their new integrated behaviour change service. **Oral Health:** Continue discussions with Public Health to scope possibility of holding pop up clinics in Bedford Borough and link in with colleagues from Central Bedfordshire Place Team re joined up approach as shared public health service. Scope options to widen offer from voluntary sector. **Imms & Vaccs:** Continue with regular discussion and update with NHSE and Public Health around BI data sets and 'GP practices of concern'. Circulate information to practices following Barbara Hamill attending PM Forum on 22nd May. Continue to support strengthening antenatal vaccination uptake through continued community partnership, tapping into local assets such as the Family Hubs and maternity social prescriber.

Tasks & Milestones

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

			2025									2026		
	Start Date	**End Date**	**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	◆											

	Start Date	End Date	2025 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2026 Jan	Feb	Mar
Queens Park Project - Exercise and behavioural change sessions start		13/05/25		◆										
Dental Tasks & Milestones	02/04/24	31/12/25												
Childhood Obesity Tasks & Milestones	02/04/24	31/12/25												

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	07/05/2025
Project Code	PR000346
Project Name	CB - Dementia Diagnosis and Prevention
Project Team	Balraj Singh Rai
Project Aim	To contribute directly to the realisation of the national ambition for Dementia Diagnosis rate in Central Bedfordshire.
Governance & Responsible Group	• Central Bedfordshire Place Team • Central Bedfordshire Dementia Diagnosis Task & Finish Group • BLMK Dementia Strategy Group • DOG (Dementia Operational Group)
Geographical Footprint	Central Bedfordshire

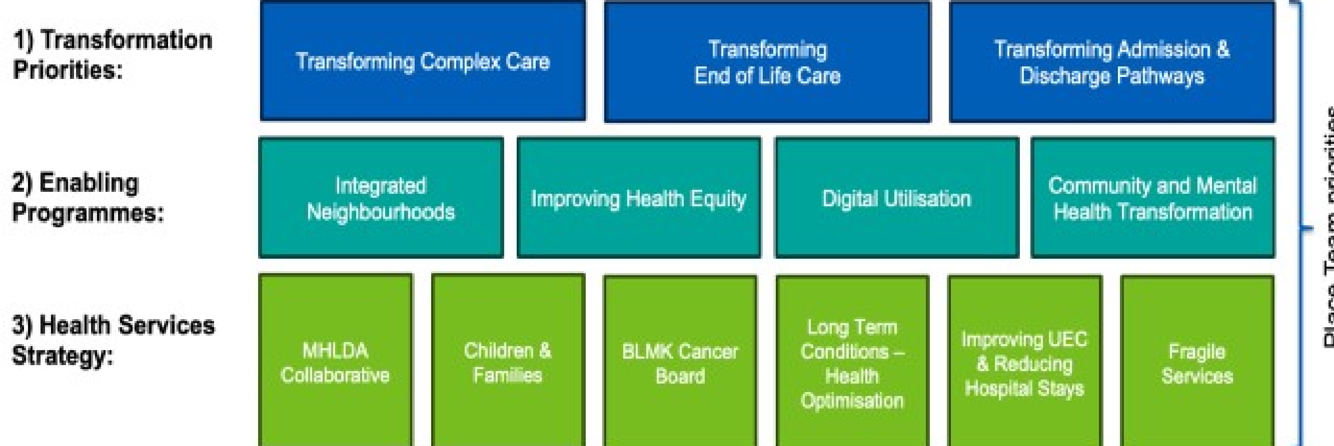
Project Team Members

Name	Role
Kaysie Conroy	Programme Manager
Danny Karystinos	Programme Manager
Balraj Singhrai	Project Manager

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	• 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

Progress to be made in Next Period	In the next reporting period: • Share the Health Needs Assessment widely across stakeholders in Central Bedfordshire (and beyond). • Develop, in collaboration with stakeholders in Central Bedfordshire, an action plan to incorporate three key elements - 1) testing a primary care based early dementia diagnosis tool, 2) communications & engagement, and 3) workforce development. • Endorse the dedicated Action Plan at the Dementia Operational Group (DOG) and Dementia Strategy Group • Continue to support the implementation of the pilot primary care early assessment tool, and strengthen links with ELFT MDT's • Engage with stakeholders in the creation of key tasks that fall under communications & engagement, and workforce development.

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

								2025						2026	
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Central Bedfordshire Dementia Diagnosis Action Plan	22/04/25	30/06/25												
Development of action plan for sign-off at the dedicated C Beds Dementia Diagnosis Task & Finish Group	01/05/25	30/06/25												
Sign-off CB DDR Action Plan at Task & Finish Group and two BLMK strategic Dementia Groups	01/07/25	31/07/25												
Dementia Diagnosis in Primary Care Assessment Tool pilot	01/08/25	30/11/25												
Workforce Development	01/08/25	30/11/25												

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

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	09/05/2025
Project Code	PR000349
Project Name	CB - Health Inclusion Practitioners
Project Team	Central Bedfordshire
Project Aim	To do targeted work with the most vulnerable families in Central Bedfordshire, 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 within GRT community. To scope the needs of families, do community profiling to include identification of gaps in services, working in collaboration with local services to support any identified needs. To support the work of the Gypsy, Roma, Traveller Learning & Action Network offering support education and awareness of hypertension within these communities.
Governance & Responsible Group	Central Bedfordshire Place Board
Geographical Footprint	Central Bedfordshire

Project Team Members

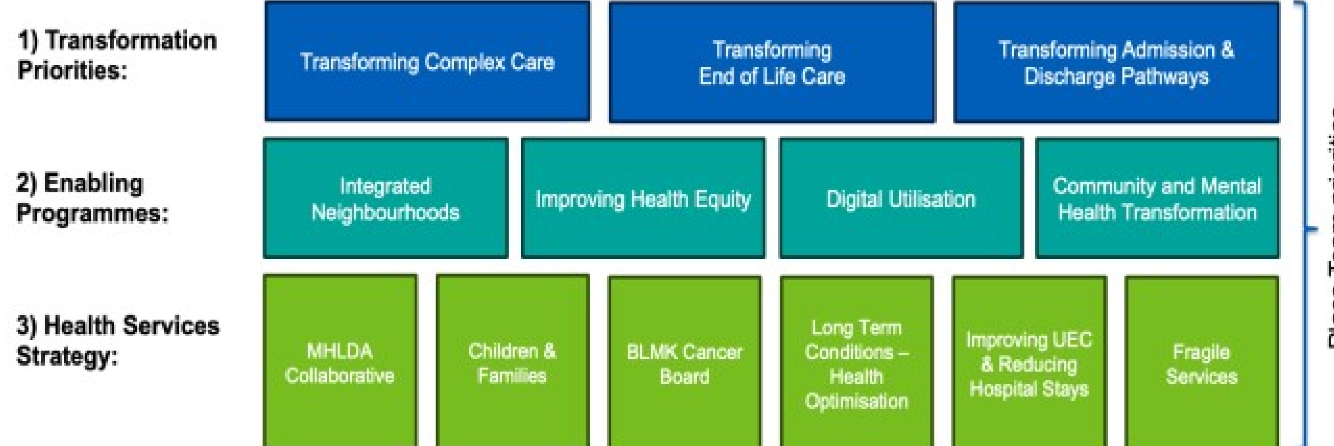
Name	**Role**
Danny Karystinos	Programme Manager
Kaysie Conroy	Programme Manager
Noeleen Mcloughlin	Project Manager

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 Programes, 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

Progress made in Previous Period	Project at its infancy. Project planning. Stakeholder management and identification of key metrics. Communication and engagement strategies.

Progress to be made in Next Period	Work in collaboration with CBC, to identify Traveller Sites to target work. Start visiting new sites to start building relationships and a source of trust Start to liaise with and identify system partners for onward signposting and support where applicable Develop pre and post interventions surveys that can be used in data capture & reporting Agree LAN outcome measures

Tasks & Milestones

Overall Tasks & Milestones Status	AMBER
Reason for Overall Tasks & Milestones Status	Undertaking scoping work regarding families on targeted sites to understand family needs and opportunities for interventions

			2025									2026		
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of Child Development Reviews completed	01/04/25	31/03/26												
Number of contacts	01/04/25	31/03/26												
Surveys completed	01/04/25	31/03/26												
Data collection - Qualitive & Quantitive		31/03/26												◆
Sites identified for internventions		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

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Engagement	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	06/05/2025
Project Code	PR000293
Project Name	CB - Integrated Neighbourhood Working
Project Team	Emma Moorbey, Noeleen McLoughlin, Balraj Singh Rai
Project Aim	To build neighbourhood teams to centre care around people's needs by integrating healthcare, social care, public services, community groups and voluntaty 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.
Governance & Responsible Group	Central Bedfordshire Assurance & Delivery Group
Geographical Footprint	Central Bedfordshire

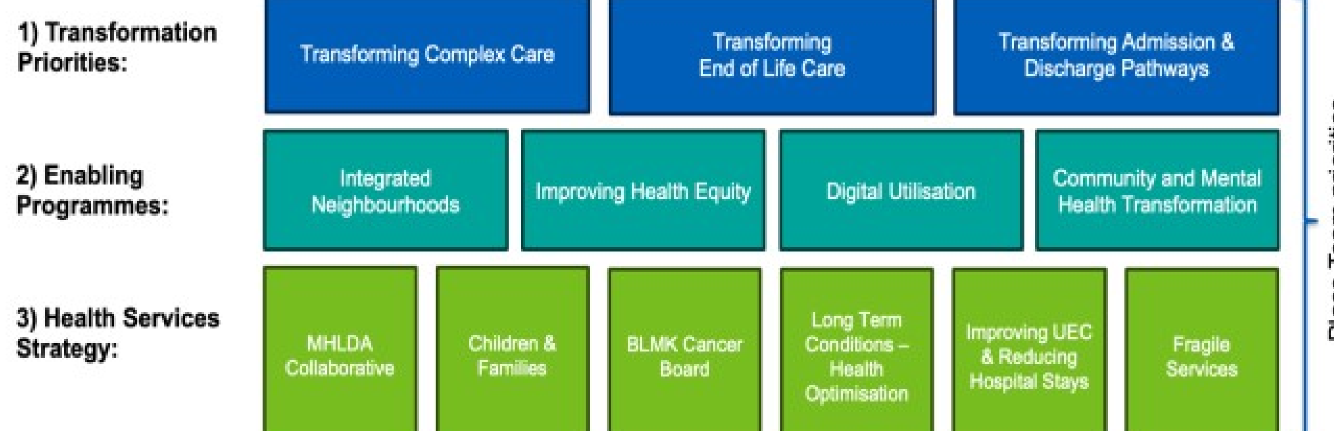
Project Team Members

Name	**Role**
Kaysie Conroy	Programme Manager
Emma Moorbey	Project Manager
Danny Karystinos	Project Manager
Balraj Singhrai	Project Manager
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:** • West Mid Beds Integrated Neighbourhood Working Group has been set up and membership defined and agreed. • Driver Diagram completed and agreed with INW Steering Group. • MUSIQ Score = 49.88 (17/03/25) **Primary Care Access:** • Ongoing communication with patients and practices about how to use Pharmacy First. Continued work with practices to support the transition to Modern General practice by 31st March 2026 with a number of practices in CB already delivering the new model. **Walking Buddies (HI Project):** • Job advert advertised, interviews taken place and post recruited to **Winter Warmth Community Agents (HI Project):** • Job advert advertised, interviews taken place and post recruited to

Progress to be made in Next Period	**Integrated Neighbourhood Working Groups:** • Co-create the Integrated Neighbourhood Working (INW) 'Plan on a Page' including measures/metrics for West Mid Beds (WMB). • Develop INW performance reporting/dashboard to show progress and report by exception for WMB. • Co-create the INW Communication & Engagement plan for INW. • MUSIQ score to be reviewed and agreed. • Data to be obtained from AGEM (Athena) and Public Health and reviewed by WMB INW group for areas of focus. **Primary Care Access:** • Develop metrics and measures for Pharmacy First across Central Bedfordshire and reporting to commence. **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 **INW - MDT** • Set up workshop for 21st May to explore opportunities for collaboration on Virtual MDTs. Workshop to include experts and senior leaders. Goal is to identify strenghts and challebges of the current model, understand areas of focus and explore change ideas.

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	The development of the West Mid Beds neighbourhood started Apr-25 and the key measures and metrics are yet to be developed. There are planned engagement events in May/June to work with system partners to co-design the plan for the WMB neighbourhood and review the current MDT and integrated care model. Further work is planned through integration with reablement and rehab services across social care and CHS. Currently, all tasks and milestones are on track.

	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
							2025						2026	
INW: Hold INW Virtual MDT Workshop	21/05/25	21/05/25												
INW: develop data pack for INW WMB Group	01/05/25	31/05/25												
Central Beds INW partnership event	10/06/25	10/06/25												
INW: Working group for West Mid Beds	01/04/25	30/06/25												
Pharmacy First: Develop reporting mechanism and timescales	01/04/25	30/06/25												
Review current MDT and integrated working in WMB neighbourhood		18/07/25												
Agreed key measures / metrics for the INW WMB neighbourhood		31/07/25												
Development of the Central Bedfordshire rehab/reablement business case between ELFT and CBC		31/07/25												
Final draft plan for WMB	31/07/25	31/07/25												
Establish assurance and delivery group to oversee implementation of the plan		29/08/25												
INW: Ivel Valley Neighbourhood Working Group	01/06/25	30/09/25												

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

Issues

Overall Issues Status	AMBER
Reason for Overall Issues Status	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.

Issues

Issue Name	**Key Issue?**	**Proximity & Impact**

Portfolio Report Governance Report

Date of Highlight Report	07/05/2025
Project Code	PR000287
Project Name	CB - LAN 01 - Be Pressure Wise
Project Team	Balraj Singh Rai/ Emma Moorbey
Project Aim	Drafted and being considered by the group for adoption
Governance & Responsible Group	BLMK IHI LAN Group Joint Leadership Group (C Beds)
Geographical Footprint	Central Bedfordshire

Project Team Members

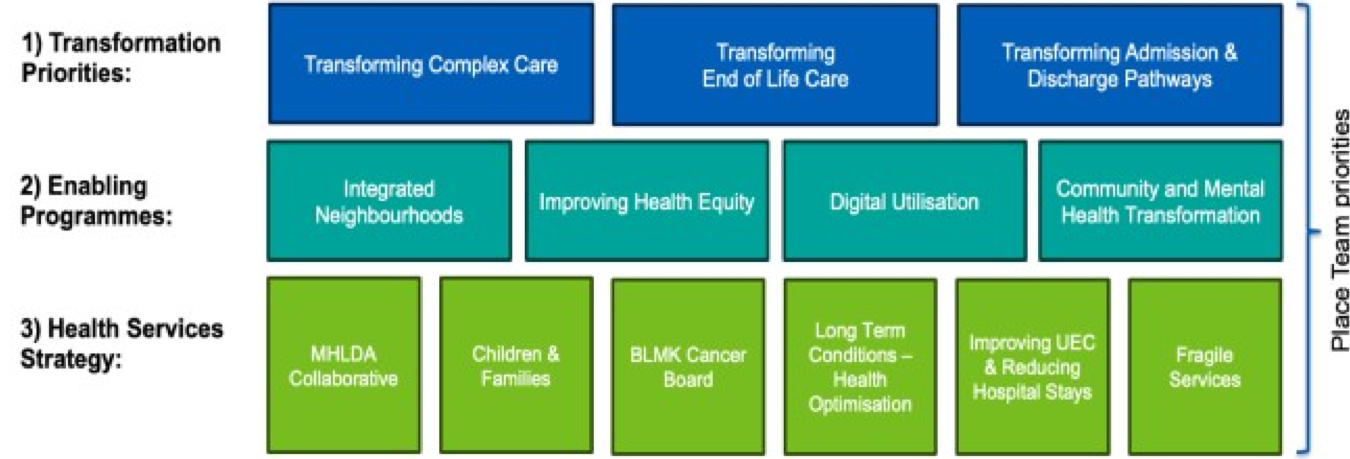
Name	**Role**
Noeleen Mcloughlin	Project Manager
Kaysie Conroy	Project Manager
Danny Karystinos	Project Manager
Emma Moorbey	Project Manager
Balraj Singhrai	Project Manager
Sonal Mehta	Project Manager
Chloe Stibbs	Project Manager
Charlie Goodwin Smith	QI Lead
Brenda Carson	QI Lead
Angela Zambeaux	QI Lead
Kamini Patel	QI Observer
Lorraine Kavanagh	QI Observer
Usha Panchal	QI Observer

Tom May	QI Observer

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	Project is on track and developing well
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)	• 2. Enabling Programmes: Improving Health Equity, Community • 3. Health Services Strategy: Long Term Conditions - Health Optimisation • Core20plus5

Progress Update

Progress made in Previous Period	• C Beds Core Team established • 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

Progress to be made in Next Period	To agree: • PDSA cycles that have been undertaken (potentially three) to be written up • Project Aim, fishbone graphic and Driver Diagram to be agreed/ signed-off by the group on 14/05/25 • Questionnaire survey to illicit 'the problem' around high blood pressure/ control amongst patients with Autism to be developed and implemented • Initial change ideas for the LD cohort to be defined, and actions agreed during May 2025 • Walk & Talk video being developed around 'Blood Pressure Management' with a focus on messages/ awareness for cohorts of LD and Autism

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	Many aspects are developing well, particularly those around project governance and foundation work A number of areas have been completed/ signed-off in the last reporting period, including • 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

			2025									2026		
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Project Aim, Fisbone and Driver Diagram to be signed off by Be Pressure-Wise Group	01/04/25	31/05/25												
PDSA Cycles to date to be logged/ written up	01/04/25	13/06/25												
Change ideas (initial) for LD cohort to be drafted and agreed on the pick-list format	01/05/25	13/06/25												
Questionnaire to illicut 'the problem' around blood pressure amongst patients with Autism to be designed and implemented	01/05/25	30/06/25												

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	The project is developing well 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

Risks

Risk Name	**Key Risk?**	**Residual Likelihood & Impact**
Input of service usr to group meetings	Yes	6

Issues

Overall Issues Status	GREEN
Reason for Overall Issues Status	No issues effecting the progress of the project have been identified

Issues

Issue Name	**Key Issue?**	**Proximity & Impact**

Portfolio Report Governance Report

Date of Highlight Report	08/05/2025
Project Code	PR000288
Project Name	CB - LAN 02 - Pressures on
Project Team	Noeleen McLoughlin
Project Aim	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.
Governance & Responsible Group	CB Place Team BLMK LAN Programme
Geographical Footprint	Central Bedfordshire

Project Team Members

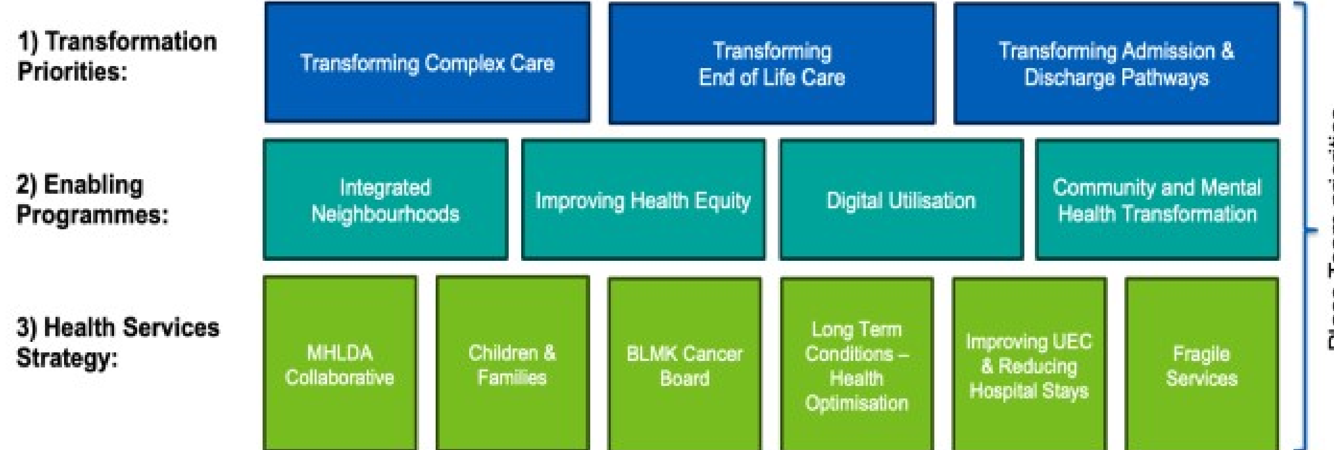
Name	**Role**
Noeleen Mcloughlin	Project Manager
Danny Karystinos	Project Manager
Balraj Singhrai	Project Manager
Kaysie Conroy	Project Manager
Emma Moorbey	Project Manager
Angela Zambeaux	Verto & QI Lead
Brenda Carson	Verto & QI Lead
Charlie Goodwin Smith	QI Lead
Kamini Patel	QI Observer
Tom May	QI Observer
Lorraine Kavanagh	QI Observer
Usha Panchal	QI Observer

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



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) 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 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

Progress made in Previous Period	• 01.05.2025 • Data sources continue to be explored with PCN, LA & Community Health Visitor Team working with GRT community • LAN group used whiteboard to discuss and get group involved in the impact / effort assessment tool to prioritise change ideas and agreed starting with videos • Draft script developed for videos with group • Place Team raising awareness of LAN work at GRT established working groups will use to network and share ideas - Luton Irish Forum - April • Discussion around purchase of BP machines took place which can be used for home monitoring and this was agreed as a good idea, also train the trainer on site was discussed but rejected due to clinical risk • Meds Op Team - completed Hypertension Training to 135+ Health Professionals across BLMK which included colleagues from CB
Progress to be made in Next Period	• IVS PCN to follow up any identified patients & re run their ethnicity data • Progress change idea for Bite Size videos - 1. Hypertension & 2.Ask Anything • Data sources - continue to explore • CCS Health Inclusion Team to provide update to group on how they can help with LAN work • Draft PDSA cycles • Work with QI Coaches & LAN Team to agreeing measures for change ideas

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	On Track

								2025						2026	
	Start Date	**End Date**	**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												

	Start Date	End Date	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
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												
Change idea - IVS PCN GRT Registered Patients		31/03/26												
Communication Barriers & Accessability		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	Generally the project is progressing well. 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.

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Losing resident participants	Yes	9
Financial incentive process - proving difficult for GRT residents	Yes	9

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	PR000223
Project Name	Luton - Integrated Neighbourhood Working
Project Team	Luton Place
Project Aim	**Integrated Neighbourhood Working** 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.' **Multi Disciplinary Teams for High Intensity Users** **Mapping of MDTs** 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. 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. **Expansion of MDTs** 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. 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. 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. **Mapping of HIU schemes across partnership organizations**

	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

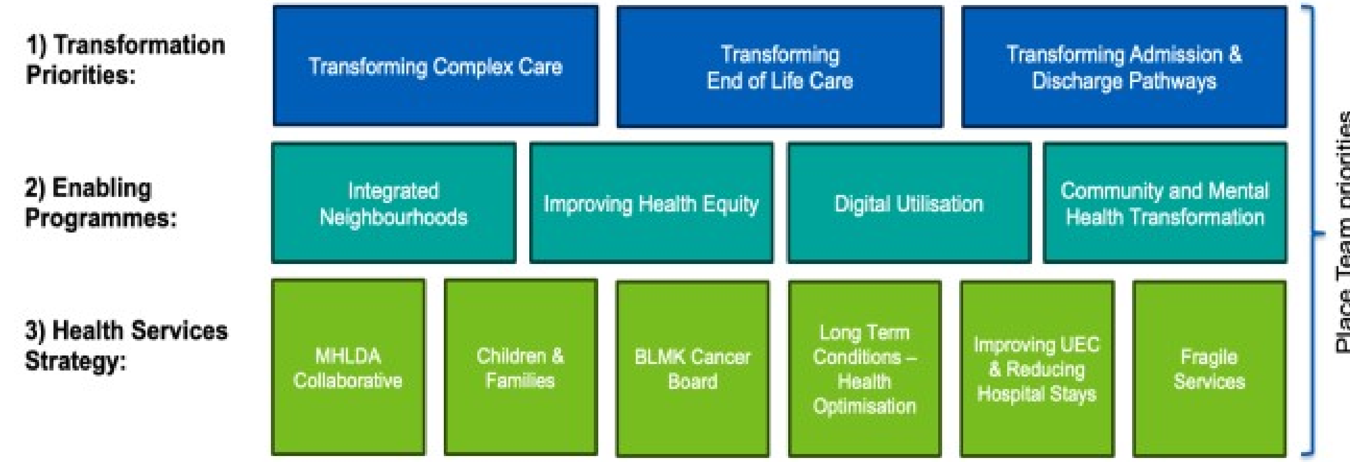
Name	**Role**
Kate Sutherland	Programme Manager
Diane Meddick	Programme Manager
Faith Haslam	Programme Manager
Rehan Tariq	Project Manager
Kamini Patel	Project Manager

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 identitied 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

Progress made in Previous Period	**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 to be made in Next Period	**Multi Disciplinary Teams for High Intensity Users** **Q1 - April 2025 onwards** • AGEM to finalise Athena report to support PCNs in patient cohort searches, over laid with HIU data across partner organisations. • System partners to feed in requested information around individual HIU schemes to inform Luton wide framework / guidance document. **Building Healthier Communities (stakeholder events)** **Q1 - May** • Confirmation of venues • Stakeholder invite list to be populated **Hypertension** Know Your Numbers Hypertension Campaign in West Central **Q1 2025-26** • Delivery of 'Easter Family and Fun Days during 7-10 April - complete **May 25 Project evaluation - complete** • Agree next steps in campaign with project team

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	Progress is being made in all areas

			2025									2026		
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Venue scoping	04/03/25	28/04/25												
Project evaluation	14/04/25	15/05/25												
Venues booked, confirmed, approved	28/04/25	15/05/25												
Data extraction and patient cohort identified	07/10/24	17/05/25												

	Start Date	End Date	2025 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2026 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												
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												
Multi disciplinary Teams for High Intensity Users	09/04/24	01/11/25												
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												

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	08/05/2025
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 African patients aged between 30 and 60 in eQuality PCN and Oasis PCN by 16th June 2025
Governance & Responsible Group	Other participants: Alisha GandhiBLMK MOTAustin ChinakidzwaCCS (community services)Chris ResidentLloyd DennyCommunity LeaderKwaku AdjeiCCS, co-production leadYakini JohnsonTotal Wellbeing LutonSimon PettyPCN managerCaroline BirchallPCNRehan Tariq
Geographical Footprint	Luton

Project Team Members

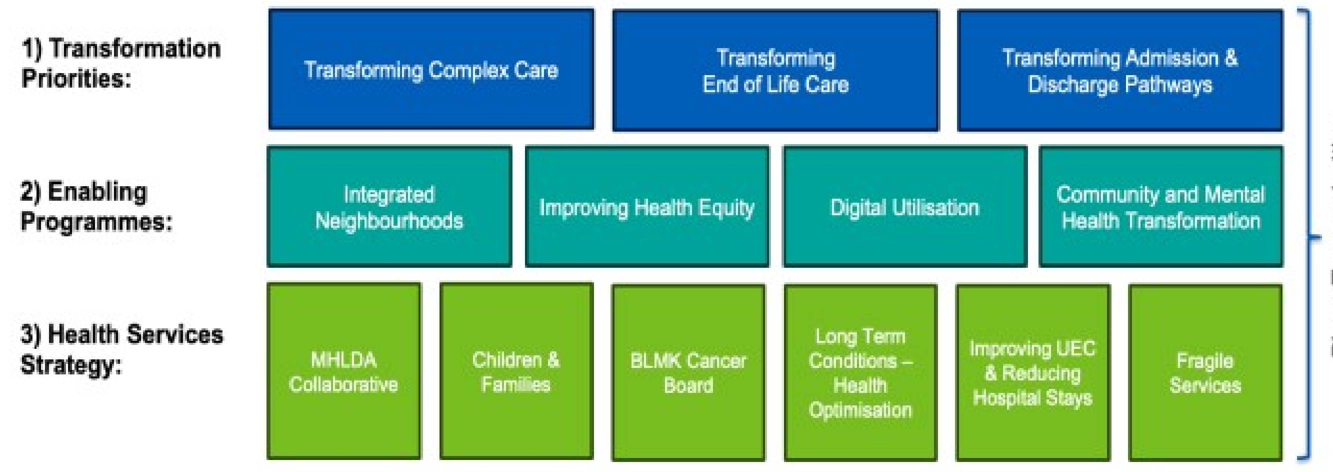
Name	**Role**
Kamini Patel	Project Manager
Rehan Tariq	Project Manager
Faith Haslam	Project Support
Cerys Gravener	Project Support
Dominic Woodward-Lebihan	Project Support
Yasmin Martin Leggitt	Project Support
Diane Meddick	Project Support
Andrew Rochford	Senior Responsible Owner
Angela Zambeaux	Verto & QI Lead
Brenda Carson	Verto & QI Lead
Charlie Goodwin Smith	QI Lead
Brenda Carson	QI Lead

Angela Zambeaux	QI Lead
Kirsty Thompson	QI Coach
Jayne Pigott	QI Coach
Matthew Kurima	QI Coach
Noeleen Mcloughlin	QI Observer
Balraj Singhrai	QI Observer
Lorraine Kavanagh	QI Observer
Tom May	QI Observer
Usha Panchal	QI Observer
Kate Sutherland	QI Observer
Joyce Baskerville	QI Sponsor
Chloe Stibbs	QI Sponsor

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

Progress made in Previous Period	The video has been completed and a link sent to patients. The measures for this change idea have been drafted. The video features a clinician and resident who recorded their messages separately and then the project lead put the two together with a slide (produced by a provider).
Progress to be made in Next Period	The video has been sent out at the end of April and therefore evaluating / studying the outcome of this and deciding on next idea will be discussed. eQuality PCN are holding an event around hypertension for Black African patients on 13th May and this will also be discussed and then any resulting actions agreed.

Tasks & Milestones

Overall Tasks & Milestones Status	**GREEN**
Reason for Overall Tasks & Milestones Status	The change idea is taking going through a number of changes based on feedback and now there are going to be 3 videos, but work still continues.

			2025									2026		
	Start Date	**End Date**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Hypertension event - eQuality	13/05/25	13/05/25												
Change Idea 1: Video to be sent to patients	06/01/25	09/06/25												
Change Idea 2:	23/06/25	01/09/25												
Events	06/05/25	31/12/25												

	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
							2025						2026	
Data Collection	06/05/25	31/03/26												

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	08/05/2025
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 by 16th June in Medics PCN
Governance & Responsible Group	Other members: Suliman Rafiq Public Health Alisha Gandhi BLMK MOT Austin Chinakidzwa CCS (community services) Dr Shahid Rahman GP Sadat Edroos Bedfordshire Hospitals Trust Kwaku Adjei CCS, co-production lead Yakini Johnson Total Wellbeing Luton
Geographical Footprint	Luton

Project Team Members

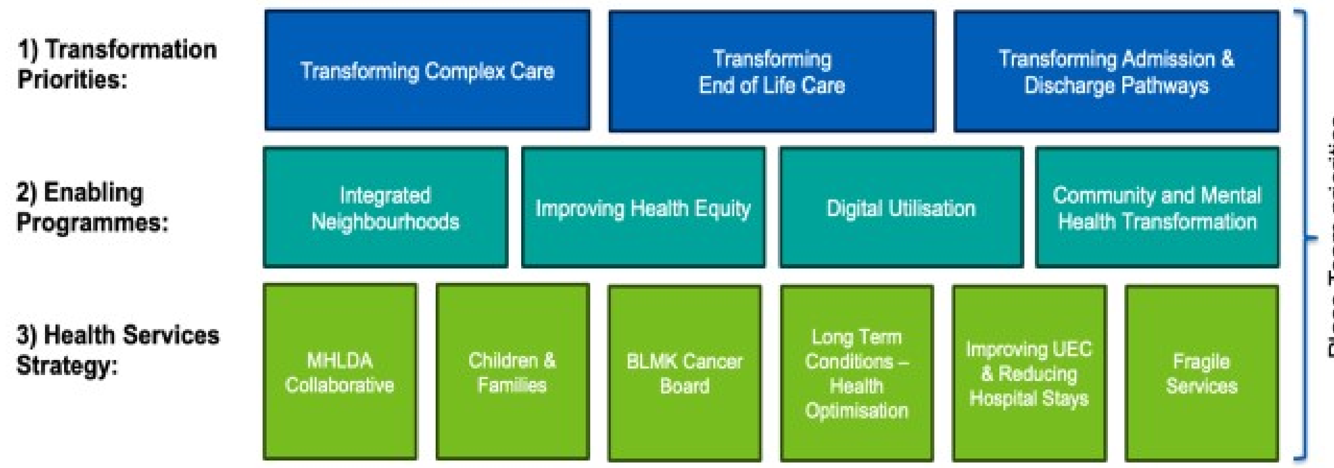
Name	**Role**
Kamini Patel	Project Manager
Faith Haslam	Project Support
Rehan Tariq	Project Support
Cerys Gravener	Project Support
Yasmin Martin Leggitt	Project Support
Diane Meddick	Project Support
Sarah Watts	Verto & QI Lead
Brenda Carson	Verto & QI Lead
Angela Zambeaux	Verto & QI Lead
Charlie Goodwin Smith	QI Lead
Kirsty Thompson	QI Coach

Jayne Pigott	QI Coach
Matthew Kurima	QI Coach
Lorraine Kavanagh	QI Observer
Tom May	QI Observer
Usha Panchal	QI Observer
Dominic Woodward-Lebihan	QI Observer
Kate Sutherland	QI Observer
Noeleen Mcloughlin	QI Observer
Balraj Singhrai	QI Observer
Joyce Baskerville	QI Sponsor
Chloe Stibbs	QI Sponsor

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



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

Progress made in Previous Period	There have been no further updates regarding the first change idea. Medics PCN are still collecting the data. Patient experience questionnaires went out to 164 and 28 people have responded within 5 days. The data from the questionnaires will be further investigated in April. The script has been drafted for a video which will be sent to the current non-responders to the text message. The process of how to send out the text message for the rest of the PCNs in Luton is still being drafted. The process map for inclusion in the pack has been drafted, but all PCNs will have different staff available to them and different relationships with community pharmacists and therefore individual conversations will have to be had with each PCN.
Progress to be made in Next Period	The patient experience questionnaire responses will be collected and learning extracted from them. The video will be drafted and ready to send to patients.

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	The project has started to progress, has reached half of it's aim and participants are very engaged

			2025									2026		
	Start Date	**End Date**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Patient Experience Questionnaire	17/02/25	01/04/25												
Change Idea 2: Video to send to patients	20/01/25	09/06/25												
Develop Social Media Campaign to send to patients before rolling out to wider community	12/05/25	01/09/25												
Change Idea 3	23/06/25	01/09/25												

	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
							2025						2026	
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	08/05/2025
Project Code	PR000172
Project Name	Luton - Early intervention, Prevention, and Partnerships
Project Team	Luton
Project Aim	Smoking cessation -Continuation of the NHS Long Term Plan Treating Tobacco Dependency programme within acute, maternity and mental health inpatient settings Weight management - Successful pilot of the NHS Digital Weight Management Programme within Luton GP practices Cancer - Increase in early diagnosis & 1 year survival rate Learning disability and autism - Decrease inpatient cohort against trajectory Vaccinations - Increased uptake in cohorts, especially within vulnerable groups. Mental Health - 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

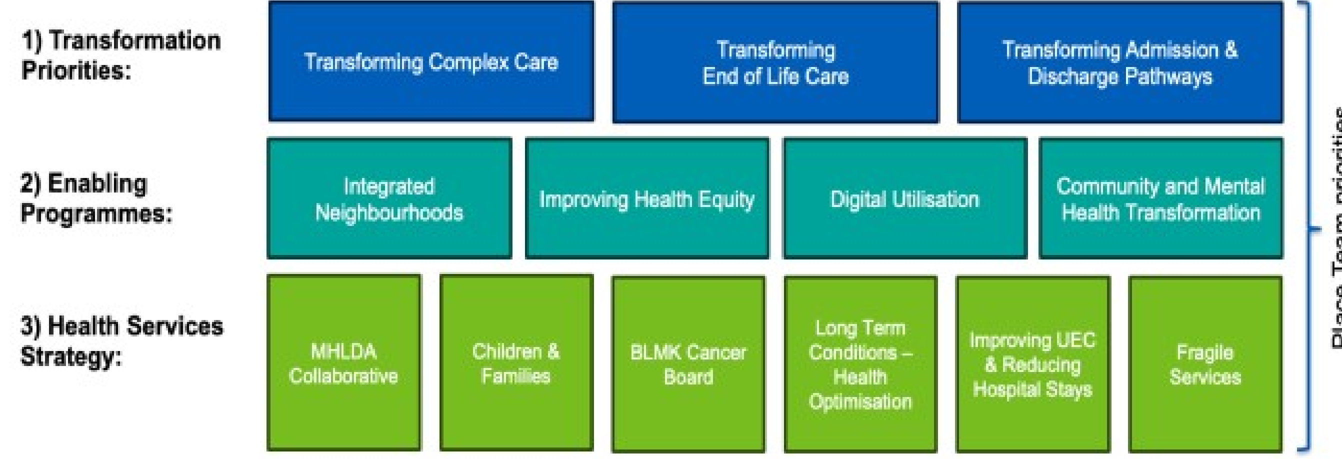
Project Team Members

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
Progress to be made in Next Period	• 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 embedded in the invite text messages. We hope to see a surge in referrals into the programme with this work. • Continue to work with NHSE & local practices to improve uptake of childhood vaccinations including MMR which has low rates within Luton. • 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 inequalities and survival rates • Continue the IHI LAN project which works to improve case finding and support of patients with hypertension.

Tasks & Milestones

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

	Start Date	End Date	Apr 2025	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2026	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

<table>
<tr><td>Date of Highlight Report</td><td>08/05/2025</td></tr>
<tr><td>Project Code</td><td>PR000248</td></tr>
<tr><td>Project Name</td><td>Luton - Health Ageing Programme (BCF)</td></tr>
<tr><td>Project Team</td><td>Diane Meddick</td></tr>
<tr><td>Project Aim</td><td>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 is 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.

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.

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;

• 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

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.</td></tr>
</table>

	• 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	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. Regular reports against Key performance Indicators and showing achievements against targets: KPI 1: Over 65's Falls Prevention Supporting BCF: Non-elective admissions, Delayed transfers of care, Patient/service user experience 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 KPI 2: Over 65's Falls Prevention Supporting BCF: Non-elective admissions, Delayed transfers of care, Patient/service user experience 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' 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.
Project Maturity	4.0 - Delivery

System Transformation

1) Transformation Priorities: Transforming Complex Care | Transforming End of Life Care | Transforming Admission & Discharge Pathways

2) Enabling Programmes: Integrated Neighbourhoods | Improving Health Equity | Digital Utilisation | Community and Mental Health Transformation

3) Health Services Strategy: MHLDA Collaborative | Children & Families | BLMK Cancer Board | Long Term Conditions – Health Optimisation | Improving UEC & Reducing Hospital Stays | Fragile Services

Place Team priorities

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 Optimisaton.

Progress Update

Progress made in Previous Period	Three Memorandum of Agreements are being updated for 2025?26 to reflect new activities available for this cohort of patiens 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 Stoplsey 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 or 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 progressPlace 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

			2025									2026		
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Dashboard	01/12/24	30/04/25												
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												
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

Portfolio Report Governance Report

Date of Highlight Report	08/05/2025
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 will continue to meet fortnightly during Phase 1 of the strategy implementation. Phase 1 of the Falls Strategy implementation is set to go live on 1st April 2025. - Complete. Service went live on 1st April 2025. - HIU Data collection to be identified. To demonstrate clear engagement with the identified cohort of patients through the Athena Dashboard. - Complete. Athena dashboard to be used to identify HIUs by the number of emergency admissions. - Memorandums of Understanding (MOUs) for S1 access have been circulated to Clinical Directors for their signatures. - Partially complete. Three MOUs have been received. Work to continue in to next period. - The High Intensity Users project will commence in March 2025. - Not complete. Further work to be carried out in the next period. - Feedback from the Improving system flow winter 2024/25 period is being collated to share with the BLMK ICB Urgent and Emergency Care Team. - ISF representation at the systemwide winter review workshop. - Complete - An initial review of the Care Home Conveyance Pilot is scheduled to take place - Apr / May. - Partially complete. - Options for extension of the care home conveyance pilot to be considered once the review has been completed. - Outstanding. - Next steps for the redesign of P2 will be identified. - Outstanding. - The BCF Review is ongoing, with sign-off from the Improving System Flow Steering Group once complete. - Complete. Submission has been signed off - Metrics to be identified for the BCF submission. - Completed.

Progress to be made in Next 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. - Attend the VCSE Falls workshop on the 7th May. -Engage with the PCNs that have not returned their Memorandums of Understanding (MOUs) for P3 to have access to the practice S1. - 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. - Attend the BLMK Transformation priority workshop on the 16th May. - Options for extension of the care home conveyance pilot to be considered once the review has been completed. - 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. - 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. - Work with performance and BI to ensure that BCF metrics are reported on as part of monthly metric reporting through Improving System Flow. - Neighbourhoods work to be incorporated in to ISF plan. - Continue to monitor plans for release from stack, engaging with CNWL and SCAS. - Completion of the BCF quarter 4 report. - Continue metrics reporting and data reviews as requested by the ISF core group.

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	There has been some slippage within projects that sit in the ISF programme of work. Slippage has been identified in the pathway 2 redesign project and the HIU service project. There are plans in place to mitigate further risk.

			2025									2026	
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Phase 1 of Milton Keynes Falls Strategy Implementation.		01/04/25	◆											
VCSE Falls Prevention Workshop		07/05/25		◆										

							2025						2026	
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Meet with LA colleagues top plan for BCF Q4 report submission.	08/05/25	09/05/25												
Meet with Arden and Gem to ensure all governance is completed prior to P3 having access to PID.	12/05/25	12/05/25												
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		31/05/25												

Risks

Overall Risks Status	GREEN
Reason for Overall Risk Status	Mitigations and controls in place

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Governance for Providers to access PID.	Yes	3
Pathway 2 Redesign Delay.	Yes	6

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	09/05/2025
Project Code	PR000175
Project Name	MK - Tackling Obesity
Project Team	MK Deal - SRO's: MK Public Health and Primary Care
Project Aim	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. Anticipated Benefits - 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

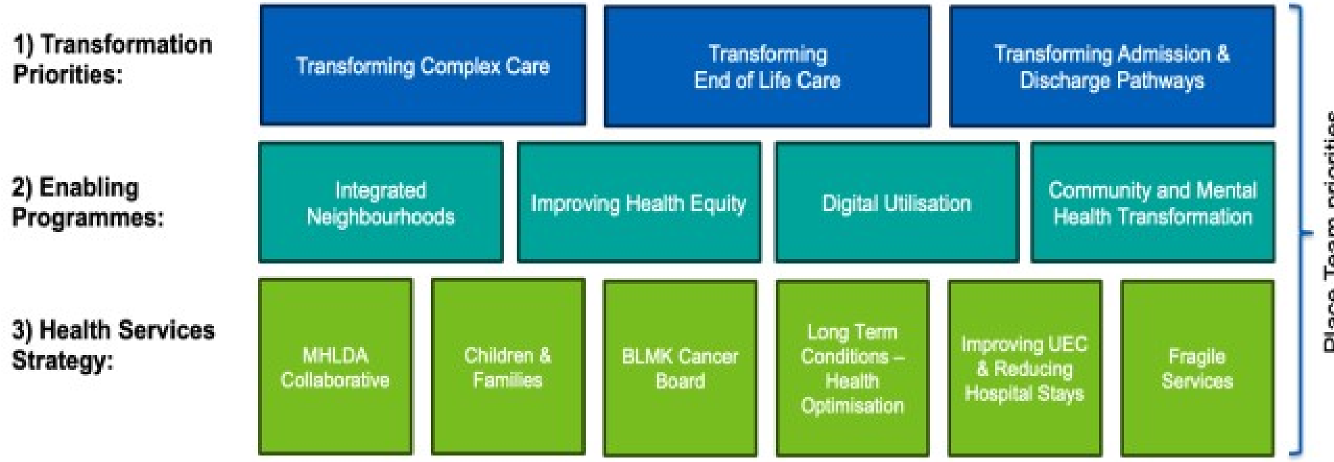
Name	**Role**
Sandra Vanreyk	Programme Manager
Zoe Durman	Project Manager

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 disproportionally 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 and intervention targeted and 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	Pilot of Tier 2 plus Weight Management service for CYP stakeholder group established and procurement of provider completed in Feb 2025. - 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	Key area of focus: 1.Mobilisation of Tier 2 Plus Children and Young People Pilot - 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	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
							2025						2026	
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	08/05/2025
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

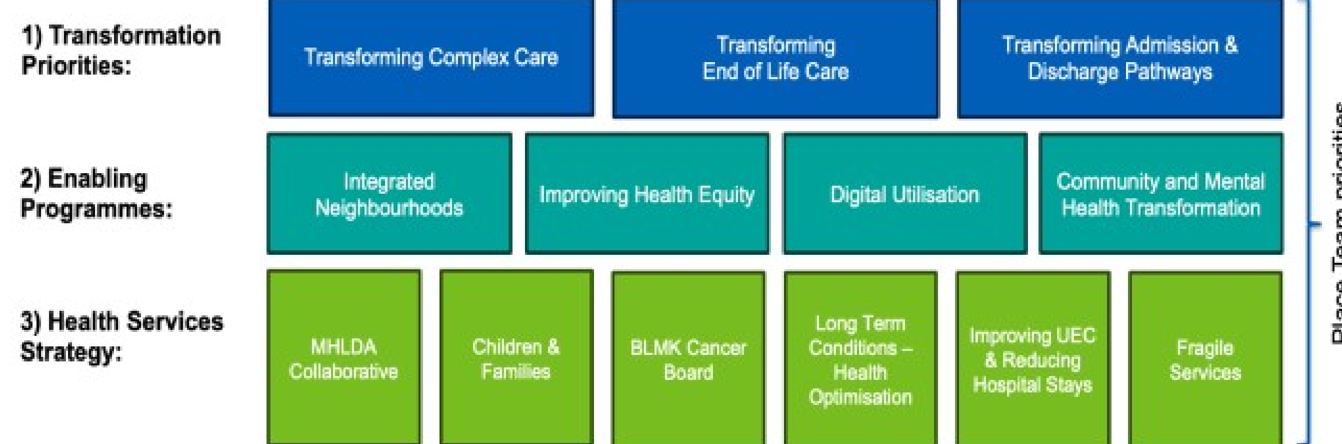
Project Team Members

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 with 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

Progress made in Previous Period	Partnership Lead for CYPMH commenced employment on 25/11/2024 and has successfully initiated a programme plan and brought clarity to the steering group around priorities.
	
	• Wellbeing Service
	  ◦ the tender for this service is currently in the moderation stage and whilst there has been hold up due to the robust due diligence of the process, contracting should be completed in June.
	  ◦ the Wellbeing Service pilot was extended for a period of three months, to provide support whilst the tendering process takes place.
	  ◦ planning is in place to consider a seamless transfer from the pilot organisations delivering The Wellbeing Service to the successful tender organisation.
	• Single point of Access (SPA)
	  ◦ VCSE organisations have been engaged with to consider their role within a Single Point of Access (SPA)
	  ◦ Scoping exercise of provision across seven other areas has been completed
	  ◦ SPA outline has been developed and presented to the steering group
	• Thrive framework
	  ◦ Presentation to group of VCSE reps has taken place
	
	A robust programme plan is now in place which aligns with the 2028 vision of the Health and Care Partnership Board.

Progress to be made in Next Period	• SPA
	  ◦ Continue to develop mapping exercise across MK to incorporate VCSE & MKCC Mental Health provision.
	  ◦ Confirm the model and resource needed
	  ◦ Develop Business case
	  ◦ Develop project plan
	• Wellbeing Service
	  ◦ Award three year contract
	  ◦ Mobilise new service
	  ◦ Develop robust monitoring mechanisms for oversight of the service
	• Thrive Framework
	  ◦ Engage VCSE's, Health, Care and Education to support understanding of the Thrive framework
	  ◦ Develop the system to embed the principles of the framework
	  ◦ Consider Thrive in developing SPA and Wellbeing service

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	Milestones on track for delivery

								2025					2026	
	Start Date	**End Date**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Wellbeing Service (Getting Help) contract awarded		30/05/25		◆										
Wellbeing Service (Getting Help) contract mobilisation		02/06/25			◆									
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	07/05/2025
Project Code	PR000200
Project Name	MK - INW - Bletchley Pathfinder (Project 1-3)
Project Team	MK Deal - SRO MKCC
Project Aim	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: Project 1 - Create 'Team Bletchley' Project 2 - Develop neighbourhood ways of working Project 3 - Implement a neighbourhood conferencing/problem solving model
Governance & Responsible Group	Bletchley Pathfinder Delivery Board reporting into JLT
Geographical Footprint	Milton Keynes

Project Team Members

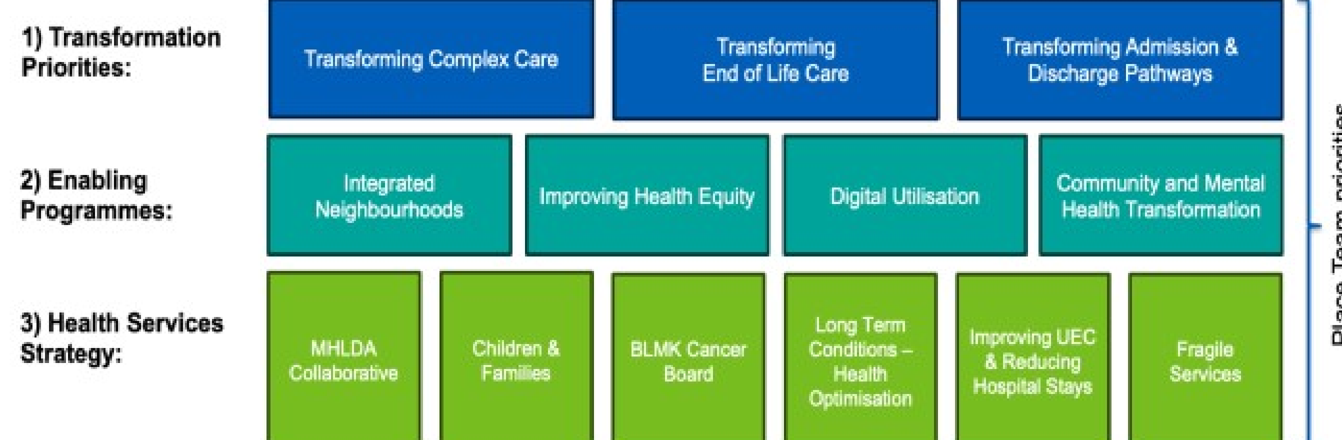
Name	Role
Sandra Vanreyk	Programme Manager
Rebecca Green	Programme Manager
Tom May	Project Manager
Zoe Durman	Project Manager

Project Status

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

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)	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 • Monthly multi agency forum launched for all Bletchley schools, supported by targeted communications. • Initial stakeholder feedback collected to inform ongoing development. • Future sessions actively promoted. **Initiatives Addressing Wider Determinants of Health** • Outcomes from the January Employment, Training, and Wellbeing event have been reviewed to guide the planning of similar events in other Milton Keynes neighbourhoods. **Community Engagement** • Ongoing partnerships with system colleagues and VCSE (Voluntary, Community and Social Enterprise) organisations are strengthening the delivery of wellbeing sessions at community hubs. 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). Events Held (March–April): 1. Arts for Health – Promoting creativity as a tool for mental and emotional wellbeing. 2. Ageing Well – Supporting healthy ageing through community-based resources. 3. Child Development – A community outreach event that provided information and advice about early years development from a range of clinicians.

Progress to be made in Next Period	**Multi-Agency Forum Phase 1** Connecting families more seamlessly with health and care services • Further promote and socialise the Multi-Agency Forum in the South Neighbourhood (Bletchley) • Secure mental health representation within the core panel to ensure a holistic support offer • Embed continuous improvement via regular stakeholder input and outcome reviews • Prepare a quarterly update report in July to capture progress and to inform next steps **Multi- Agency Forum Phase 2** • Initiate scoping and insight gathering - Working group to undertake initial scoping phase, data gathering and evidenced based insights to inform next steps. **Employment, volunteering, and wellbeing event** • Engage with multi-agency stakeholders to confirm participation from key partners • Define success metrics and begin development of outcome measures to evaluate event impact • Draft and initiate a communications plan to promote the event and ensure broad reach **Community Engagement** • **Targeted Outreach Delivery**: Continue implementing the community engagement program, guided by local population health data, to effectively engage priority groups. Events Planned May- July 1. Mental Health and Wellbeing - Raising awareness and promoting access to support services. 2. Cancer Awareness- Promoting participation in screening and providing information on local support services and groups 3. Volunteering - Highlighting opportunities for community involvement and strengthening local support networks.

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	Projects on track for delivery.

	Start Date	End Date	2025 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2026 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	06/06/25												

Risks

Overall Risks Status	GREEN
Reason for Overall Risk Status	Projects are on track for delivery with no significant risks 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	08/05/2025
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

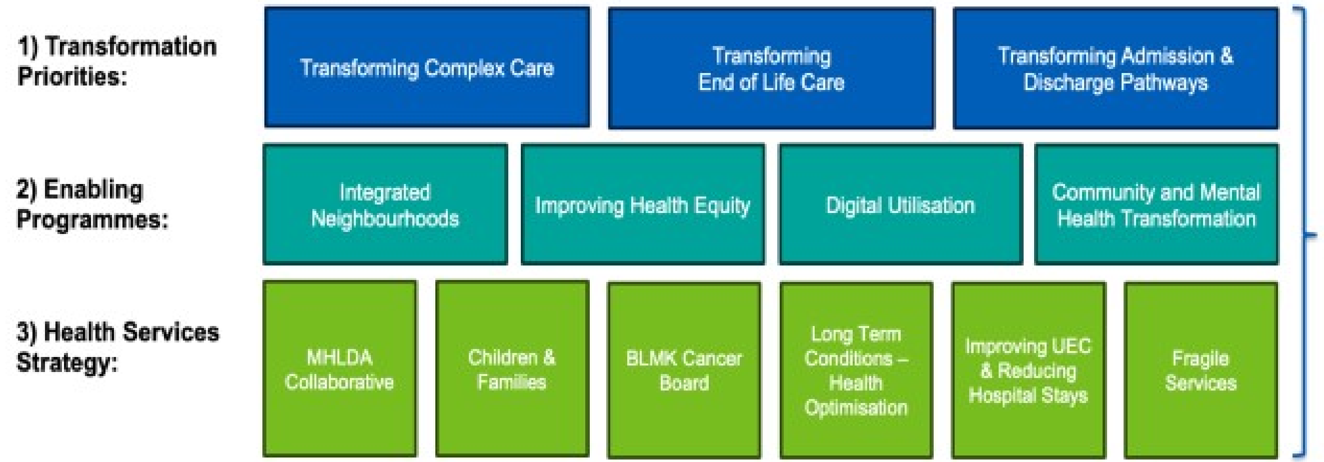
Name	**Role**
Tom May	Project Manager
Joyce Baskerville	Quality Lead
Tracy Keech	Subject Matter Expert
Sarah Watts	QI Lead
Charlie Goodwin Smith	QI Lead
Matthew Kurima	QI Observer
Kamini Patel	QI Observer
Lorraine Kavanagh	QI Observer
Usha Panchal	QI Observer
Alex Wrack	QI Observer
Danny Karystinos	QI 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

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	• Drivers diagram created • Change ideas developed • Data measures & definitions • Data source identified and reports further developed • Change ideas prioritised • Planning to run first PDSA cycles • MUSIQ score 137 - (120-168) = Project has a reasonable chance of success
Progress to be made in Next Period	• Start PDSA cycles for 2 change ideas • Change idea 1: Use hypertension prescribing incentive scheme to target Black African cohort first at CMK Medical centre • Change idea 2: Attendance at community events to engage with cohort, led by resident group members • Engage with the 3 remaining practices in the central neighbourhood • Finalise the data searches and reports to monitor project outcomes

Tasks & Milestones

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

			2025									2026		
	Start Date	**End Date**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Develop PDSA cycle for community engagement event (Jeans Festival)	02/05/25	06/05/25												
Develop a PDSA Cycle for Change Idea 2: Hypertension Prescribing Incentive Scheme	09/05/25	09/05/25												

	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
							2025						2026	
Attend Jeans Festival and engage with residents in the cohort	24/05/25	24/05/25												
Complete the first PDSA cycle related to the Jeans Festival engagement		27/06/25												

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
Hypertension Performance Data Collection	Yes	5

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	08/05/2025
Project Code	PR000150
Project Name	Primary Care Development and Transformation Programme - to deliver improved access
Project Team	Primary Care, STT
Project Aim	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. Delivering the ambitions of the Fuller Stocktake (May 2022) and the Delivery Plan for Recovering Access to Primary Care (May 2023).
Governance & Responsible Group	Primary Care Delivery Group reporting to Primary Care Commissioning & Assurance Committee See file "Governance" and "Collaboration and Connectivity" in the 'Governance' Folder.
Geographical Footprint	BLMK System

Project Team Members

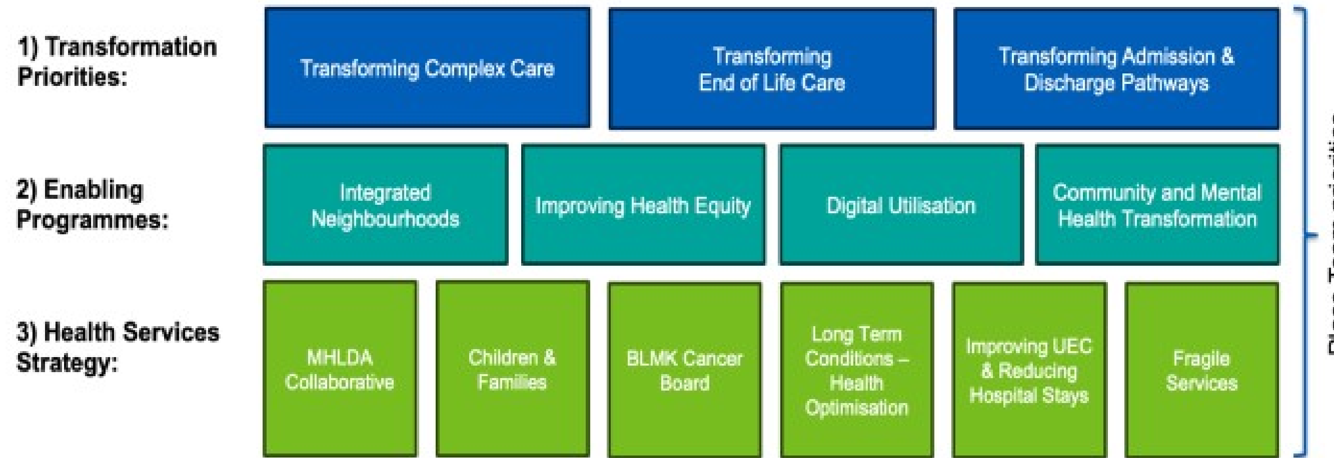
Name	**Role**
Gina Manning	Programme Manager
Amanda Flower	Senior Responsible Owner
Sara Burford	Transformation Manager
Lucy Robertson	Transformation Manager
Duncan McConville	STT Senior Lead
Janine Norman	STT Team Member
Layla Vardy	STT Team Member

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)	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

Progress made in Previous Period	Continued focus on driving up utilisation of the NHS App for primary care. Continued support to practices to to deliver a modern access model (residents know on the day they contact their practice how their request will be managed). Continued work on the practice transformation and support offer for 25/26. Arranged visits to all urgent primary care services (UTC, WiC and UGPC) to support service developments and transformation – and integration. Submitted operational plan response.
Progress to be made in Next Period	Ensure priority Primary Care visits to contractors are undertaken in Q1 and Q2, prioritising providers with those who have the most significant support needs Ensure practice support visits take a data led approach to identify and address variation Work with General Medical service providers to identify and engage take up with national General Practice improvement offer Ensure opportunities to integrate same day and urgent PC with Urgent and Emergency Care Developments are progressed as part of the admissions avoidance priority / transformation Programme Ensure the ICB has an implementation plan to deliver its share of urgent dental appointments Full Primary Care work plan to deliver the x5 core ambitions and all objectives to be reworked and enhanced. To be added to Verto and shared by late May 2025. The detailed Primary Care plan as part of the Operational Planning guidance is drafted and submitted by 30 June 2025

Tasks & Milestones

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

							2025						2026	
	Start Date	**End Date**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Briefing at ICB Board Seminar	19/07/25	19/07/25												
Primary Care Assurance Committee approve SOC recommendations for Integrated Urgent Care		16/08/25												

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	08/05/2025
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

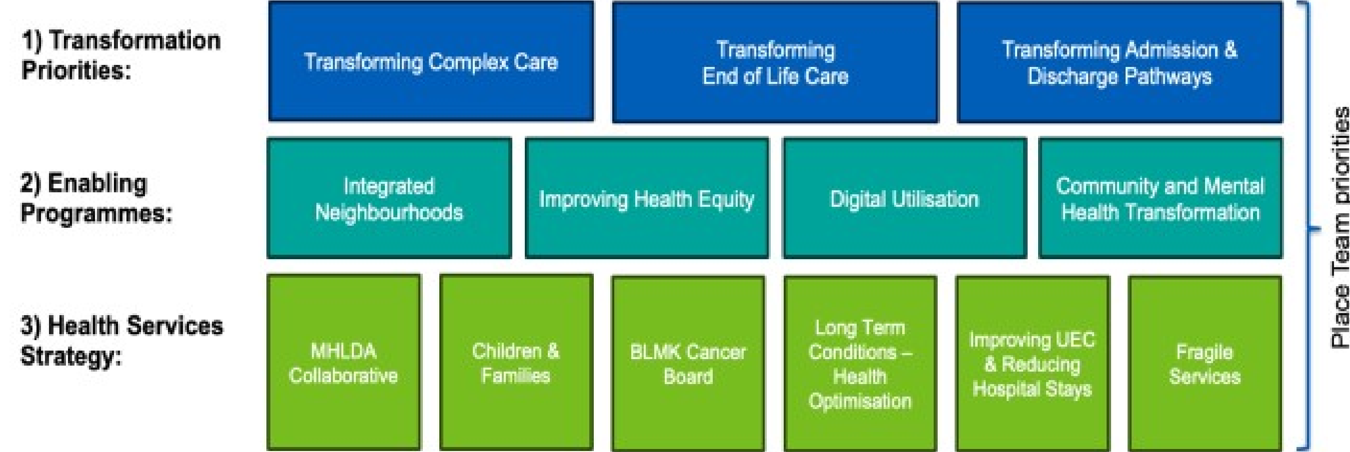
Name	**Role**
Linus Onah	Clinical Lead
Kathryn Moody	Contracting Lead
Tara Dear	Programme Manager
Sian Pither	Project Manager
Layla Vardy	Project Manager
Cat Lee	Project Manager
Maria Wogan	Senior Responsible Owner
Nikki Barnes	Subject Matter Expert
Vickie Place	Transformation Manager
Janine Norman	Transformation Support Manager
Denise Faehndrich	Transformation Coordinator
Ros Clarke	Procurement
Gamma Prasad	Procurement
Duncan McConville	STT Senior Lead

Samita Dass	STT Team Member
Angela Reynolds	STT Team Member
Michael Ramsden	Commissioning Lead

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)	Community MSK services are not in scope of the wider Community and Mental Health Services Transformation, however they are a significant part of the community health offer and a significant procurement for the ICB.

Progress Update

Progress made in Previous Period	Completion of the evaluation and moderation phase. Decision to award contract made at ICB Board on 2nd May 2025.
Progress to be made in Next Period	Completion of the standstill period and start of mobilisation phase.

Tasks & Milestones

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

	Start Date	End Date	Apr 2025	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2026	Feb	Mar
E. Procurement Phase	01/05/24	17/04/25												
Mobilisation period	13/03/25	31/10/25												
Service Commencement		01/11/25												

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	GREEN
Reason for Overall Issues Status	Issues are managed or fully mitigated

Issues

Issue Name	Key Issue?	Proximity & Impact

Portfolio Report Governance Report

Date of Highlight Report	09/05/2025
Project Code	PR000151
Project Name	Cancer Transformation
Project Team	BLMK ICB Cancer Team, STT
Project Aim	To support planning and delivery of the NHS Operating Plan, the NHS Long Term Plan ambitions for cancer and the Cancer Alliance delivery plan. BLMK ICS has established a local transformation programme to deliver the following priorities: Operational performance and faster diagnosis Innovation and early diagnosis Treatment and care Reducing inequalities and community engagement
Governance & Responsible Group	BLMK Cancer Board Dr Rory Harvey – Clinical Lead Dr Devy Raju – GP Clinical Lead Dr Uzma Sarwar – GP Clinical Lead Andrew Bland - Financial Lead
Geographical Footprint	BLMK System

Project Team Members

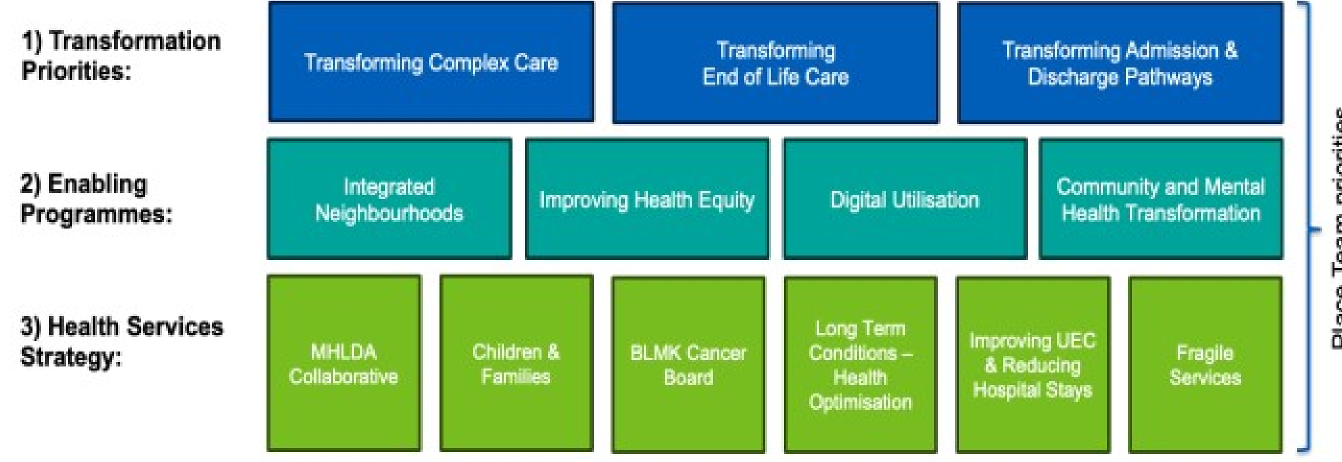
Name	**Role**
Neve Patel	Business Intelligence Lead
Cat Lee	Programme Manager
Beverley Husbands	Project Support
Gill Turrel	Quality Lead

Kathy Nelson	Subject Matter Expert
Naisha Henry	Subject Matter Expert
Helen Watt	Subject Matter Expert
Natasha Young	STT Senior Lead
Maria Browne	STT Team Member
Sara Burford	STT Team Member
Angela Reynolds	STT Team Member

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	In delivery with governance in place, supported by Cancer Board and funding to support delivery of transformation QI score given based on sustained improvement in key areas - Faster Diagnosis, backlog reduction and early stage ambition (BLMK is now 1st in the country for early stage diagnosis overall - recognising variation at place level)
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)	The Cancer Programme and Cancer Board are enablers for the Health Service Strategy. The health service strategy identified opportunities for enhancement to current services that would improve womens health and outcomes overall.

Progress Update

Progress made in Previous Period	Delivery of operational planning metrics for faster diagnosis and 62 day performance - Final figures for March performance are yet to be released. There was good progress in February with both providers compliant with the faster diagnosis standard. Delivery challenges remain in place for the 62 day performance standards. Evaluation and benefits realisation process complete - Closing projects are evaluated to determine the impacts that they have had on cancer pathways. We will continue to build this into processes as projects come to an end. Secondary care behaviour change project go live - the toolkit for secondary care has been developed and communicated through key stakeholder groups for sign off and approval. We are making the last changes to the toolkit in collaboration with the behavioural science company before agreeing a testing date. Refresh of pathway audits - has been completed. Identified actions are being incorporated into improvement action plans.
Progress to be made in Next Period	Finalise the delivery plan for 2025/26 with aligned workplan Communication of cancer transformation priorities through cancer board and providers, key actions details with sign off through the cancer board. Refresh cancer strategy. Cancer performance priorities and actions identified.

Tasks & Milestones

Overall Tasks & Milestones Status	**AMBER**
Reason for Overall Tasks & Milestones Status	The Programme plan for 2025/26 is awaiting sign off by the BLMK Cancer Board

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

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	Ongoing programme risks but under regular review at each Cancer Board meeting

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	08/05/2025
Project Code	PR000226
Project Name	Community and Mental Health Services Transformation
Project Team	System Transformation Team
Project Aim	We currently have varying levels of access and provision to Community and Mental Health Services across BLMK with significant variation in services commissioned and cost. Contracts are due to expire in March 2026 and alongside a decision regarding contract arrangements, there is a need to develop a case for change that sets our what our population need from these services over the next decade.
Governance & Responsible Group	BLMK ICB Financial Improvement Group (FIG)
Geographical Footprint	BLMK System

Project Team Members

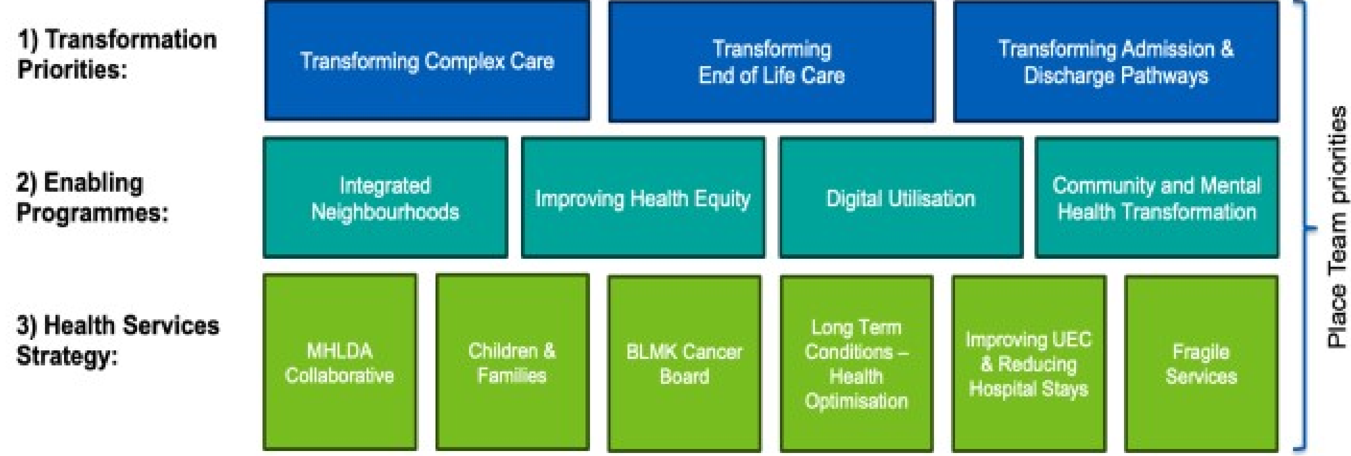
Name	**Role**
Jackie Bowry	Communications Lead
Kathryn Moody	Contracting Lead
Buz Dodd	Contracting Lead
Kathy Nelson	Executive Lead
Andrew Bland	Finance Lead
Tara Dear	Programme Manager
Jan Wood	Programme Manager
Loraine Rossati	Programme Manager
Duncan McConville	Programme Manager
Anne Brierley	Senior Responsible Owner
Ros Clarke	Subject Matter Expert

Matt Hollex	Verto & QI Lead
Denise Faehndrich	Transformation Coordinator

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	The March ICB Board agree the setup of this programme and the Programme Board met on 17th April to manage delivery of the programme.
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 four enabling programmes

Progress Update

Progress made in Previous Period	Paper to FIC in February and to ICB Board in March 2025 to agree the transformation delivery plan for the programme. Established Programme Board which met in April and sub groups. Systems Insight Network event held on 6th May, focused on feedback from stakeholder on Community and Mental Health Services. Strategic and commercial advisors onboarded.
Progress to be made in Next Period	Continued development of the Case for Change and transformation priorities. Continued setup of programme governance and processes. Health & Care Partnership Seminar planned for 23rdMay.

Tasks & Milestones

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

	Start Date	End Date	Apr 2025	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2026	Feb	Mar
Systems Insight Network		06/05/25												
Phase 1: Case for Change	27/01/25	30/06/25												
Phase 2: Business Case inc Options Appraisal (OBC)	30/06/25	12/12/25												
Phase 3c: Commercial Approach (FBC)	15/12/25	23/01/26												
Phase 4: Decision to Procure	15/12/25	06/02/26												
Phase 3b: Procurement Prep (FBC)	15/12/25	11/03/26												
Phase 3a: Service Specification (FBC)	15/12/25	24/04/26												
Phase 5: Procurement	15/12/25	23/10/26												

Risks

Overall Risks Status	AMBER

Reason for Overall Risk Status	Risks are being managed by the Programme Board.

Risks

Risk Name	**Key Risk?**	**Residual Likelihood & Impact**
Insufficient Resourcing	Yes	**5**
NHSE Business Case approval	Yes	**4**
Detailed planning yet to be completed	Yes	**12**
Key governance requirement (ICB and Local Authorities)	Yes	**5**

Issues

Overall Issues Status	**GREEN**
Reason for Overall Issues Status	Issues have been closed and mitigated

Issues

Issue Name	**Key Issue?**	**Proximity & Impact**

Portfolio Report Governance Report

Date of Highlight Report	07/05/2025
Project Code	PR000152
Project Name	Improving Health Equity
Project Team	Quality Improvement [QI] and System Transformation Team [STT]
Project Aim	"to listen and learn with our residents to improve health equity across BLMK over the next 3 years" The four primary drivers to achieve this programme are by ensuring: • 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	To report to Health Equity Programme Board via: - Weekly health equity delivery group, chaired by Sarah Watts - SRO: Sarah Stanley (ICB) - Board Champion - Lorraine Sunduza (ELFT)
Geographical Footprint	BLMK System

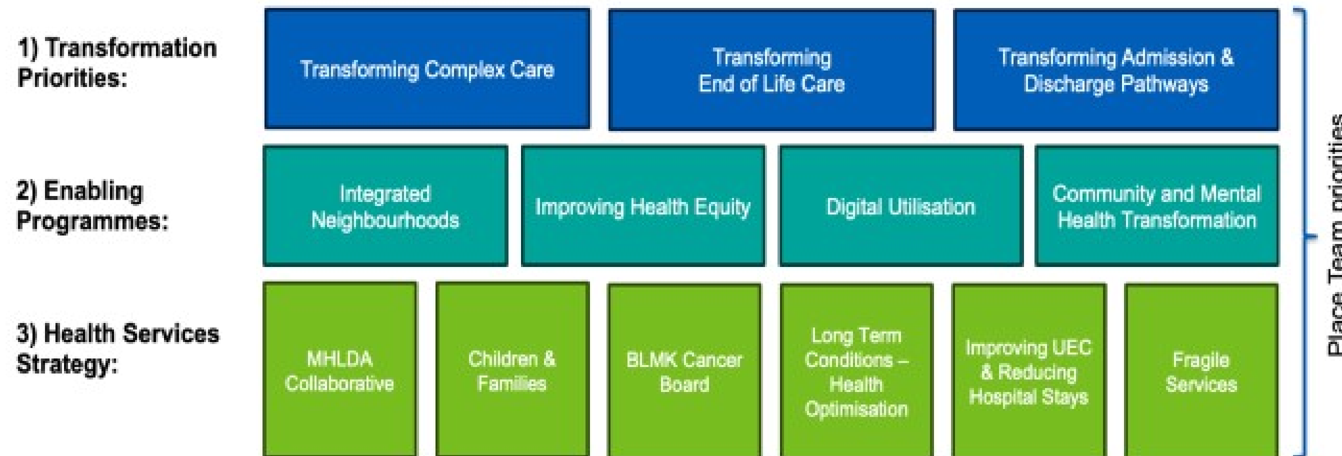
Project Team Members

Name	**Role**
Joyce Baskerville	Improvement Manager
Julia Robson	Programme Manager
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	Identified as one of the four enabling programmes across the ICB. Programme development to re-align opportunities with key stakeholders within the ICB.
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	• Healthwatch observational study into Translation and Interpretation (T&I) services completed and published. • Progress update of T&I review as part of Denny recommendations presented to Primary Care Delivery Group. • 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)
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 Commitee 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

Tasks & Milestones

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

			2025									2026		
	Start Date	End Date	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	07/05/2025
Project Code	PR000156
Project Name	Women's Health
Project Team	STT
Project Aim	**Local aims and objectives include:** 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] **The Women's Health Strategy for England lists 10 aims for women and girls:** 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

	Aims for the workforce: 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 **Aims for the health and care system:** 8. 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 9. 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 10. 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	Reporting is no longer aligned with Improving Health Equity Programme, and instead aligned with 'Children and families' Health Services Strategy chapter.
Geographical Footprint	BLMK System

Project Team Members

Name	**Role**
Sarah Stanley	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.
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.

Progress Update

Progress made in Previous Period	• BLMK Women's Health Summit held 27/03/25 attended by over 100 professionals, VCSE reps and industry reps to formally launch all initiatives and to gather insights in interactive workshops and 'speed dating' exercises. • Luton Women's Health Network with Lea Vale PCN gone live in January 2025 • 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. • Approval sought from execs to proceed with collaborative work with pharmaceutical industry to deliver training needs.
Progress to be made in Next Period	• Implementation plans in place for all pilots and reporting metrics and frequency agreed. • 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.

							2025						2026	
	Start Date	End Date	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		◆										

Risks

Overall Risks Status	CLOSED
Reason for Overall Risk Status	Funding allocations since issued, though slipped from planned timescales.

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
There is a risk that non-recurrent funds will not be utilised as planned if money cannot be moved within financial year, resulting in pilots not being able to be initiated.	Yes	6

Issues

Overall Issues Status	CLOSED
Reason for Overall Issues Status	Issues closed

Issues

Issue Name	Key Issue?	Proximity & Impact

Portfolio Report Governance Report

Date of Highlight Report	08/05/2025
Project Code	PR000297
Project Name	Transforming Admission and Discharge Pathways
Project Team	STT
Project Aim	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. Through the various projects and initiatives, the programme seeks to redesign discharge pathways to increase discharges to P0 and shift P3 placements to P2 or P1. 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 neighborhood'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 neighborhood care. Additionally, it aims to develop a system-level strategy to support neighborhood working, with a clear vision and high-level objectives for each local area.
Governance & Responsible Group	
Geographical Footprint	BLMK System, Bedfordshire Care Alliance, Milton Keynes

Project Team Members

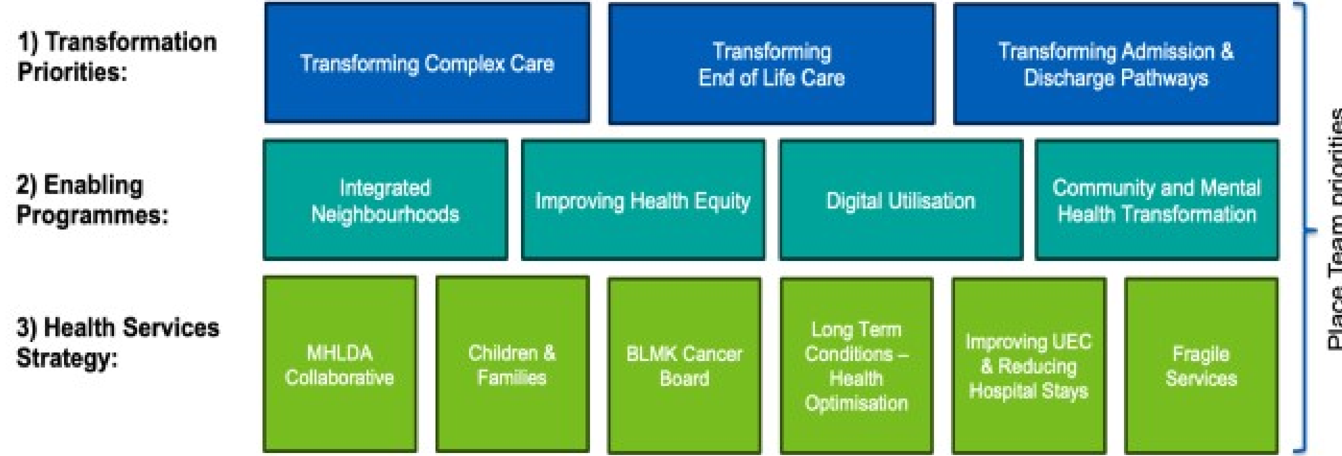
Name	**Role**
Cat Lee	Project Manager
Georgie Brown	Senior Responsible Owner
Michael Ramsden	Subject Matter Expert
Amanda Flower	Subject Matter Expert

Tara Dear	Head of STT
Mark Morton	Senior Transformation Manager
Matt Rogers	Senior Transformation Manager

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

Progress Update

Progress made in Previous Period	1. Admission and Discharge Plan completed 28/03 and presented to UEC Planning and Assurance Meeting 01/04 2. Chiefs workshop to identify themes and priorities 3. Matthew Wynne assigned as Programme Director 4. Georgie assigned as programme SRO 5. Verto populated 6. BCA P2 Business Case completed and presented to BCA Leadership Board for feedback
Progress to be made in Next Period	1. Charter to be developed following agreement of programme scope and priorities 2. Agreement of programme governance structure and initiation of the "Urgent and Emergency Health and Care Board" 3. Agree reporting metrics, developed into a scorecard that will give a high level view of areas of challenge for focus 4. Build in strategic commissioning actions 5. Agreement of focus groups to ensure priorities are being progressed 6. Workshop 16 May to engage system on the programme and identification of AA & Dx priorities 7. Agreement of additional support required including finance, contracts, business intelligence 8. P2 business case to be finalised and presented to ICB Chiefs 9. Production and delivery of all EUC updates and report will be reviewed in meeting on 16 May. Highlight reports will be presented to the Urgent and Emergency Health and Care Board which will be on 1st Monday of the month and once approved will be submitted to PMO for upward reporting 10. Transformation of Admission Avoidance and Discharge Programme will be reported to ICB Board in June

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	Programme Board in development with system wide reps agreed. Workshop on 16/05 will give greater clarity on priorities and timelines

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

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

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	08/05/2025
Project Code	PR000275
Project Name	Transforming Palliative End of Life Care
Project Team	STT
Project Aim	Programme aim statements are to be fully defined and agreed by Programme Board, though proposed as: • 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 [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	A new End of Life Programme Board is to be established with 3 supporting working groups [to be fully defined by the Programme Board]: 1. Clinical workstream; including data/digital 2. Finance workstream 3. Education workstream
Geographical Footprint	BLMK System

Project Team Members

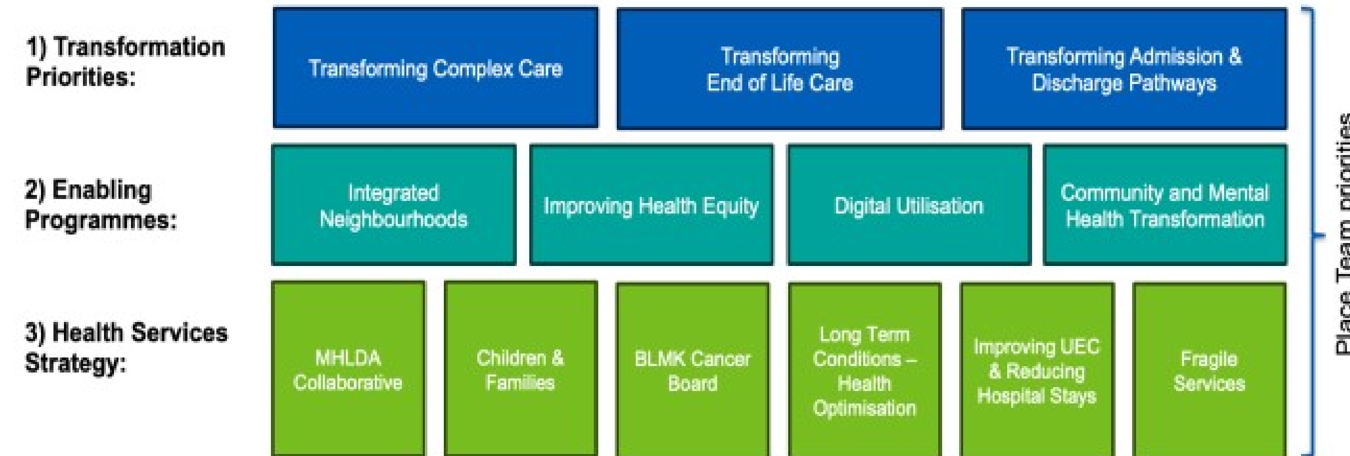
Name	**Role**
Sarah Stanley	Executive Lead
Samita Dass	Programme Manager
Jo Morris	Project Manager

Simon Hardcastle	Senior Responsible Owner
Angela Reynolds	Transformation Manager
Tara Dear	Senior Transformation Manager
Samita Dass	Senior Transformation Manager
Natasha Young	Senior 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 in 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.

Progress Update

Progress made in Previous Period	• Initial programme workshop held 24/01/25 • Finance and efficiency workshop held 12/02/25 to discuss operational planning opportunities [confirmed no £ in year]. • Planning meeting for Programme Board set up held 31/03/25 • Key membership for Programme Board identified and date set for first meeting 09/06/2025 [slipped from 31/03/25]. • System Charter document in development to clearly define problems, aims and measures to be agreed by Programme Board • Education working group established. • Finance working group in development with established chair. • Clinical Lead role was approved and published on Trac.

Progress to be made in Next Period	• Programme Board to be held 09/06/25 and charter document agreed by all stakeholders • All working groups to be established and key objective slide prepared for each group agreed • Dying Well week in May 2025; communications plan in delivery. • Quantify benefits based on revised aim statements [eg. more patients on register / reduction in palliative care bed days] • Recruiting to Clinical Lead role - advert closed 06.05.25.

Tasks & Milestones

Overall Tasks & Milestones Status	AMBER
Reason for Overall Tasks & Milestones Status	Reliant upon the Programme Board establishment to make key progress

			2025									2026		
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Business case developed for single co-ordination centre across Bedfordshire and Luton		30/05/25		◆										
Finance working group established		31/05/25		◆										
Recruitment to clinical lead role		31/05/25		◆										
Dying Well week in May - dedicated communications plan in place		31/05/25		◆										
Financial transparency shared across hospice providers.		09/06/25			◆									
Clinical working group established		13/06/25			◆									
Programme Board established		13/06/25			◆									

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	
Delayed mobilisation due to Programme Board date - to be scored	Yes	

Issues

Overall Issues Status	TBC
Reason for Overall Issues Status	All key issues still need defining

Issues

Issue Name	Key Issue?	Proximity & Impact

Portfolio Report Governance Report

Date of Highlight Report	08/05/2025
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)

Project Aim	**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 overarching aim of this element of the programme of work is 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 Continuing Health Care. As a result of of this it will help to: • Improve outcomes for children and young people and their Families who are in complex situations and have multiple needs e.g: Health, Social, Educational • Align processes and establish an understanding of responsibilities and specialities e.g.; Multi agency risk planning, Quality, Oversight and Senior decision making • Lead effective system wide multi professional solution focused approaches • Improve low volume high-cost provisions to improve efficiency for all agencies involved • Ensure a coordinated personalised care approach to provision **Adults with Unmet Health & Social Care Needs** The aim of this part of the programme is to address the unmet health and social care needs of individuals who fall between standard CHC and Section 117 aftercare eligibility. It will focus on managing complex cases, developing specialised care pathways, and ensuring integrated service delivery. The programme will work to fill service gaps through market shaping, develop frameworks for supported living and home care, and promote collaboration across health and social care sectors. Additionally, it will explore innovative technologies and AI solutions to improve care efficiency, alongside strategic planning to address rising costs and ensure financial sustainability. Key objectives include workforce development, data sharing, and the creation of flexible step-up and step-down care models to meet fluctuating needs and development of a unified approach that considers the financial and healthcare implications of unmet needs, ensuring individuals receive the necessary support.

Governance & Responsible Group	**Programme Governance Structure** 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. 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 and. 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). **Reporting Structure** The ICB Internal Steering Board will report into the following governance forums: • System Chief Executives (six-weekly reporting) • Finance and Investment Committee • Quality and Performance Committee • ICB Executive (monthly highlight report) **Programme Support and Coordination** 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. Overall coordination and management of the governance meetings will be led by the Transforming Complex Care Programme Management team, supported by the Children and Young People (CYP) and Continuing Healthcare commissioning teams.
Geographical Footprint	BLMK System, Milton Keynes, Bedford Borough, Central Bedfordshire, Luton

Project Team Members

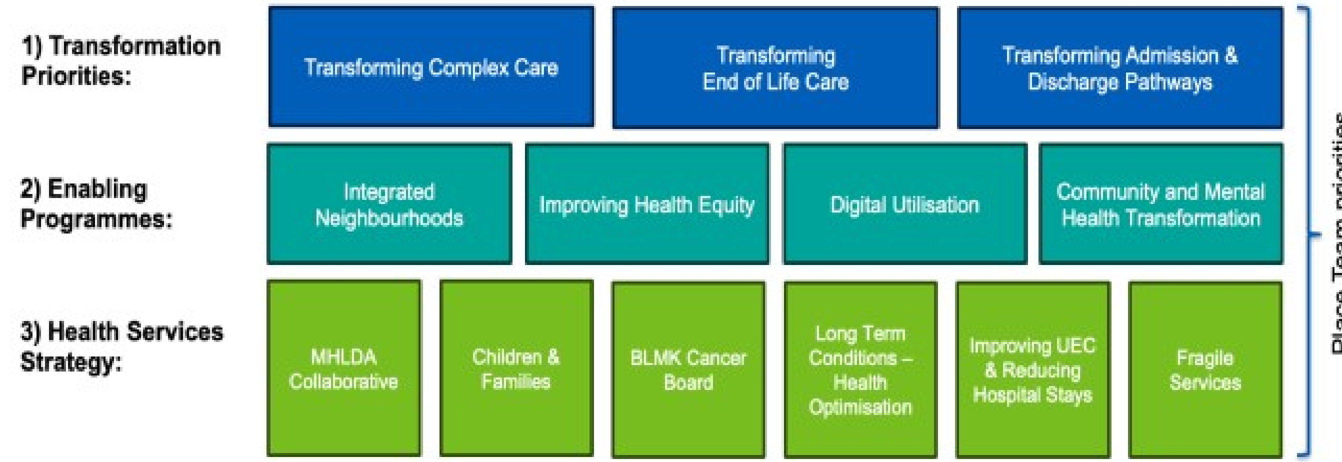
Name	**Role**
Rafael Barnett-Knights	Project Manager
Sarah Stanley	Senior Responsible Owner

Sarah Breton	Subject Matter Expert
Andrea Piggott	Subject Matter Expert
Diana Butterworth	Subject Matter Expert
Tara Dear	Head of STT
Matt Rogers	Senior Transformation Manager
Lucy Robertson	Transformation Support Manager
Layla Vardy	Transformation Coordinator

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	
Progress made in Previous Period	**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** Initial engagement meetings with ICB internal stakeholders have been successfully held. Michael Bracey has been identified as the System Champion. Programme kick-off meeting took place with four Directors of Children Services and ICB leads, where the proposed scope, purpose, and aims were defined. Draft governance structure was developed. Project Charter has been created, revised, and shared with the System lead. Verto has been populated, and a live project plan is in place with further work expected to refine/build upon it. Agreement to support the Healthcare Consumption modelling is in place, request submitted to AGEM, work is in progress however, there is an IG issue (outlined in Risks & Issues). Draft transformation measures have been proposed and further work to refine this is planned. Assessment and Decision making linking to Complex CYP workstream away day took place 06/05 **Adults with Unmet Health and Social Care Needs** Initial engagement meetings with ICB internal stakeholders have been completed. Review meetings were held with all four Local Authorities during end Jan-Mar. Laura Church has been identified as the System Champion for this initiative. **ICB Internal Programme** **Established internal Programme Steering Board, inaugural meeting took place 06/05** New dedicated Project Manager assigned to Children & Adults respectively Driver Diagrams drafted and presented to steering board on 06/05

Progress to be made in Next Period	**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** Pathway/Panel Mapping and Data Collection exercise will be conducted across all 4 Local Authorities to assess current pathways and panels. Service Landscape Mapping and Service Specification Baseline Mapping exercises will continue to progress, aiming to establish a clear understanding of service offerings and requirements. Programme Interdependency Mapping will be completed to identify key interdependencies and ensure alignment across the project. Outputs of the Assessment and Decision making linking to Complex CYP workstream away day to be progressed - key focus is on developing processes to ensure timely and appropriate interventions for children affected by trauma. ELFT/ICB to collaborate and engage with local authority stakeholders in the development of the Section 117 policy for children and young people, with the intention of ensuring joint agreement and effective implementation of the policy. **Adults with Unmet Health and Social Care Needs** Workshop with all 4 Local Authorities schedule for 16/05 to collaborate and gather insights. Following the workshop, a report will be presented to the ICB Board in June, summarising the findings and next steps to help shape the project. **ICB Internal Programme** Driver Diagrams for both children and adults, incorporating feedback and ensuring the diagrams accurately reflected the programmes objectives and priorities. ToR need refining Work Breakdown Structure and detailed Project Plans

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	Programme is being established and in planning phase

	Start Date	End Date	Apr 2025	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2026	Feb	Mar
Case Review Exercise	19/02/25	04/04/25												
Interdependency Mapping Exercise	19/02/25	11/04/25												
Single Decision-Making Process - Away Day	06/05/25	06/05/25												
Adults ICB/LA Workshop	16/05/25	17/05/25												
Healthcare Resource Consumption Exercise/Theograph Creation	19/02/25	30/05/25												
Childhood Trauma Steering Board Establishment	13/06/25	13/06/25												
Schedule Assessment and Decision-Making Working Group	27/06/25	27/06/25												
Schedule Finance Work Group	27/06/25	28/06/25												
Childhood Trauma	19/02/25	19/02/26												
Adults with Unmet Needs	19/02/25	19/02/26												

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	No current issues identified

Issues

Issue Name	Key Issue?	Proximity & Impact
Healthcare Resource Consumption Modelling	Yes	9

Portfolio Report Governance Report

Date of Highlight Report	08/05/2025
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	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 The CFWM reports to the BLMK Quality and Performance Committee which in turn reports to the Board of the ICB
Geographical Footprint	BLMK System

Project Team Members

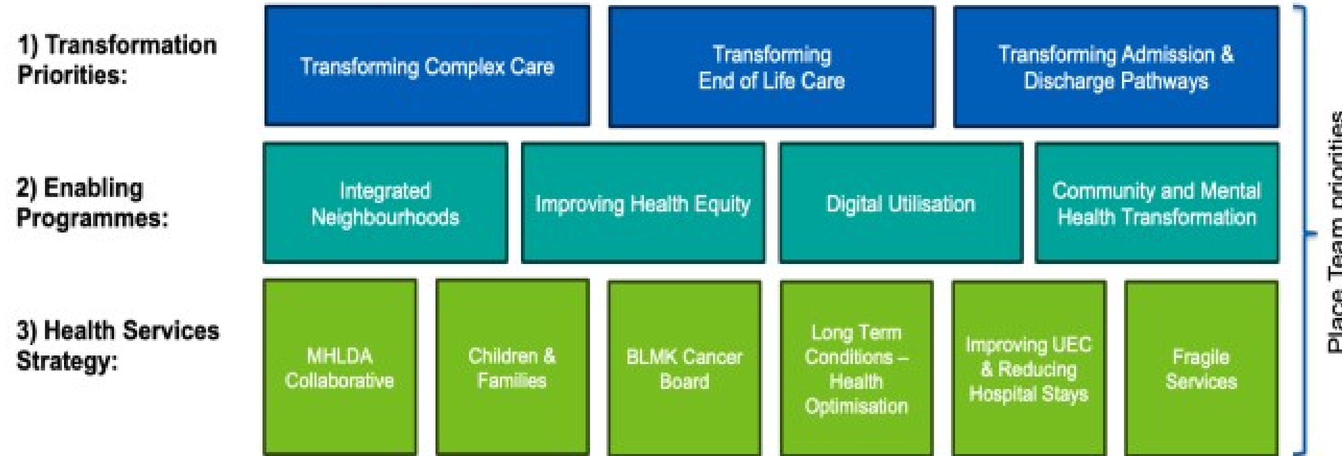
Name	**Role**
Cat Lee	Programme Manager
Sarah Breton	Programme Manager
Sanhita Chakrabarti	Programme Manager
Sarah Stanley	Senior Responsible Owner

Project Status

Overall Project Status	GREEN

Reason for Overall Project Status	On track with current tasks and milestones 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.
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)	One of the six priority delivery vehicles work programmes of the Health Services Strategy

Progress Update

	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. Priority Measures: **All babies are born healthy**

Progress made in Previous Period	1. Infant mortality Target: Sustained reduction in all four Places until 2030. 2. Low birthweight babies - Percentage of full term babies who had a birth weight under 2500 grams Target: BLMK reduction to England average by 2030 **Children are ready to learn/start school** 3. School readiness - Percentage of children achieving a good level of development at the end of Reception Target: BLMK rate to increase to England average by 2030 **Children remain healthy** 4. Oral Health - Proportion of children with experience of visually obvious dental decay Target: A year-on-year reduction in DMF % by 2030 5. Childhood obesity - Proportion of children in Year 6 (age 10-11) with obesity (including severe obesity) Target: To sustain the reduction in Year 6 children with obesity. 6. Asthma - Rate of hospital admissions for asthma (under 19 years), crude rate per 100,000 population Target: All areas except Luton have already reduced significantly so could set Place targets. **Young people are accessing education, employment or training** 7. Attainment 8 - Average Attainment 8 score for all pupils in state-funded schools, based on local authority of pupil residence Target: To increase Attainment 8 mean score to England average by 2030. 8. NEET - Percentage of people age 16 to 17 who are not in education, employment or training, or whose activity is not known Target: BLMK continues to see percentages below the England average **Children and young people's mental health and wellbeing** This outcome is a system priority for all partners, but we do not have a metric for children's mental health and wellbeing. Some places use school surveys but not all and are not comparable. Suggest the system works together during 2025/26 to develop the most appropriate metric. In the meantime, propose to adopt a proxy measure using the CYP mental health access performance target.

Progress to be made in Next Period	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

Tasks & Milestones

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

			2025									2026		
	Start Date	**End Date**	**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	■	■										
Work programme development - to deliver against agreed strategic outcome measures	25/04/25	31/07/25	■	■	■	■								

Risks

Overall Risks Status	TBC
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	08/05/2025
Project Code	PR000344
Project Name	BLMK Long Term Conditions Programme
Project Team	Medical Directorate, Primary Care
Project Aim	To refresh and energise the long term conditions programmes of work, providing better visibility to the Board of the ICB and the system as a whole, enabling outcome delivery for priority disease areas. The programe also aims to improve the primary/secondary care interface through closer clinical professional relationships, and collaborative approach to pathways and interventions The key principles of this programme are to: • Use data effectively to benchmark performance, monitor improvement and identify specific needs, including inequalities • Encourage proactive care, using population health management approaches to identify people with unmet need • Empower improvement through clear, practical actions and offers of support, with additional resourcing for priority areas
Governance & Responsible Group	Governance structure PROPOSED only - still to define/refresh the Elective Collaboration Board and its role in both LTC and Fragile Services oversight. It is proposed that the 4 condition-focused subgroups (CVD, Respiratory, Diabetes and MSK) will be supported by and report into the Elective Collaboration Board.
Geographical Footprint	BLMK System

Project Team Members

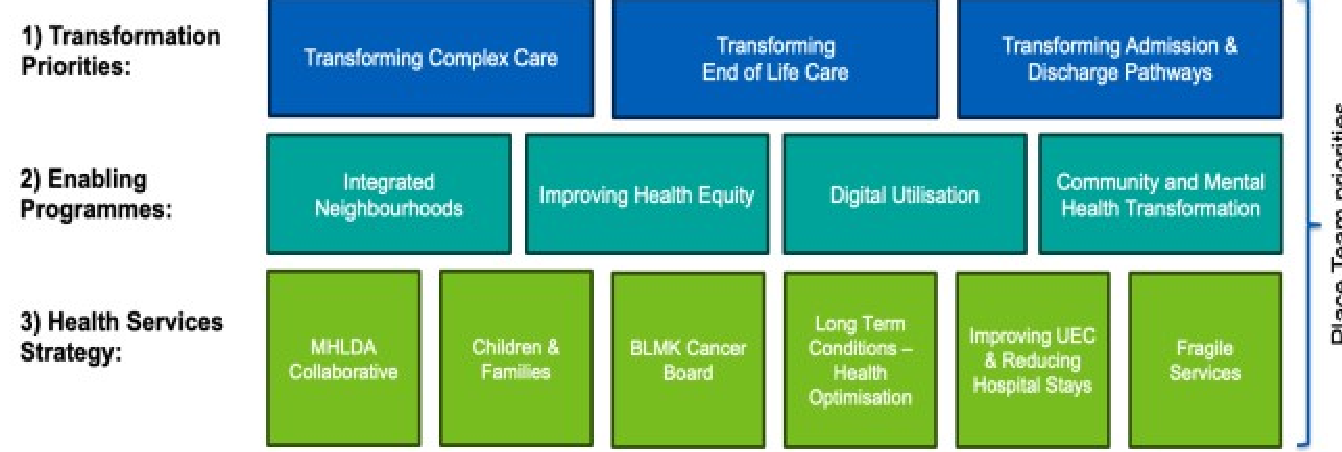
Name	**Role**
Cat Lee	Programme Manager
Amanda Flower	Programme Manager
Matthew Davies	Programme Manager

Andrew Rochford	Senior Responsible Owner

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	Detailed priorities and measures in place for the diabetes, CVD and Respiratory groups, however the groups themselves need re-energising and support with more specific action planning / accountability lines. MSK programme ongoing under STT leadership but needs to be brought together and linked in with overall LTC programme Still determining governance structure, but proposal being worked up with deadline to complete.
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)	One of the six priority delivery programmes of the Health Services Strategy. Also links to complex care and admissions avoidance since patients will long-term conditions can have increased complexity with other health problems, and good preventative and primary management of long term conditions will prevent unnecessary admission to secondary services.

Progress Update

Progress made in Previous Period	Four key priorities (areas of focus) identified, and objectives set: **1. Cardiovascular Disease & Prevention:** •Improving management of hypertension •Improving secondary prevention and optimisation in CVD •Improving identification and management of heart failure **2. Diabetes:** •Improving attainment of all 8 care processes and 3 treatment targets •Improving care and outcomes in Early Onset Type 2 Diabetes •Improving monitoring and support for women with previous GDM **3. Respiratory:** •Improving access to diagnostic tests for respiratory disease •Improving evidence-based management of asthma •Improving evidence-based management of COPD **4. MSK:** •Reducing the prevalence of musculoskeletal (MSK) conditions and improving timely management The first three are tracked via the LTC dashboard. MSK is currently a STT-led project - #PR000006 Musculoskeletal (MSK)
Progress to be made in Next Period	Finalise governance - confirm whether Elective Collaboration Board will be the right forum, update TOR and confirm chair Review TOR and membership of diabetes/CVD/respiratory subgroups - can they be effective in their current form? Work with subgroups to develop robust plans and provide clear guidance for reporting (once structure is defined) Board.

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	All open task are either on-track or completed at this time.

	Start Date	End Date	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Map Respiratory, CVD and Diabetes groups - membership and TOR/work programmes	21/03/25	30/05/25												
Finalise Governance and reporting structure	30/05/25	30/05/25												

Risks

Overall Risks Status	GREEN
Reason for Overall Risk Status	Risk identified has reasonable mitigation

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Delayed or slower progress due to lack of governance structure	Yes	4

Issues

Overall Issues Status	TBC
Reason for Overall Issues Status	Not identified at present

Issues

Issue Name	Key Issue?	Proximity & Impact

Portfolio Report Governance Report

Date of Highlight Report	08/05/2025
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.
	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: • 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. Since 2019 there has been significant progress made across BLMK with the above national ambitions 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: • 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. 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: • Deliver the 10 high impact actions for mental health discharges and ensure that system discharge plans include mental health

Project Aim	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 for BLMK which have been identified: **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 with a particular focus 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 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) Progressing the children and young peoples mental health recommendations from the NHS East of England Regional review 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 determinant 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 in Bedfordshire and Luton Progress the recommendations from the recent crisis care review of the Bedfordshire and Luton Crisis Care Pathway 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** Exploring opportunities to expand the use of the Shinymind app. 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, working with NHS East of England colleagues 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	Mental Health Delivery Group BLMK LDA Transformation Board BLMK MHLDA Programme Board BLMK ICS CEO Group BLMK MHLDA Collaborative Committee Board of the ICB
Geographical Footprint	BLMK System

Project Team Members

Name	**Role**
Michael Farrington	Programme Manager
Cat Lee	Programme Manager

Project Status	
Overall Project Status	**GREEN**

Reason for Overall Project Status	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 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: Increasing access to children and young peoples mental health services Meeting children and young peoples eating disorders waiting times standards Increasing access to Individual Placement and Support Services Increasing access to annual physical health checks for people with SMI Reducing average length of stay for adults in mental health in-patient services Eliminating inappropriate out of area placements
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)	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:

The Bedfordshire, Luton and Milton Keynes Suicide Prevention Hub

The Suicide Prevention Hub is a website that offers essential resources, information and tools to help save lives. Whether you’re a doctor, nurse, therapist, or part of a community organisation, the Hub is here to support your vital work. Suicide Prevention is everyone’s business.

Mental Health and Money Toolkit

There has been the promotion of the Mental Health and Money Toolkit which has been developed by Mental Health & Money Advice with support from the Money & Pensions Service and the National Academy for Social Prescribing. It has also been co-produced with people with lived experience. It is a toolkit that you can work through with your clients or on their own. It contains a range of CBT exercises to support avoidance and build self-esteem, plus some key money guidance information, including an income and expenditure sheet and how to access free debt advice.

Physical Health Navigator in Milton Keynes

A new physical health navigator role has commenced in Milton Keynes. They will help service users registered with a GP in Milton

Keynes who have a severe mental illness to improve both their mental and physical health. The benefits of being referred to the physical health navigator are as follows;

- Increase awareness about physical health
- Improve motivation, self-esteem and confidence
- Signposting (stop-smoking, healthy eating, diabetes management)
- Goal and feedback settings
- Improvement on quality of life

MIND BLMK's Service User Network (SUN) across Bedfordshire and Luton

The Service User Network is a new, open access, community-based, facilitated peer support service for adults experiencing difficulties with complex emotional needs often associated with a diagnosis of 'personality disorder'. The Service User Network offers regular facilitated peer support groups where members are encouraged to both give and receive support. Once you have registered as a member, you can attend as many or as few groups as is helpful. SUN groups are open to those with complex emotional needs, aged 18 years and over who are registered with a GP in Bedfordshire or Luton. SUN members do not need to have a formal diagnosis of 'personality disorder' to access the service.

Those accessing SUN groups may typically experience a range of longstanding challenges including:

- Difficulty managing intense emotions
- Uncertainty about who you are and/or your direction in life
- Lots of ups and downs in your relationships with others
- Frequent feelings of emptiness and loneliness
- Intense fear of abandonment
- Impulsivity and self-destructive behaviours (e.g. enduring suicidal thoughts, self-harm, addiction, gambling etc)

NHS 111 offering crisis mental health support for the first time

Millions of patients experiencing a mental health crisis can now benefit from support through 111, the NHS has announced**.**

The change means the NHS in England is one of the first countries in the world to offer access to a 24/7 full package of mental health crisis support through one single phone line.

People of all ages, including children, who are in crisis or concerned family and loved ones can now call 111, select the mental health option and speak to a trained mental health professional.

NHS staff can guide callers with next steps such as organising face-to-face community support or facilitating access to alternatives services, such as crisis cafés or safe havens which provide a place for people to stay as an alternative to A&E or a hospital admission.

Previously, local health systems had their own separate phone lines, which were fast-tracked during the pandemic and took around 200,000 calls per month.

For people who need support at A&E, if there is a risk to life, every emergency department in England now also has a liaison psychiatric team available to offer specialist care.

Progress made in Previous Period	NHS Talking Therapy Services are also available for people who need help with other mental conditions such as anxiety, depression, obsessive compulsive disorder and PTSD and anyone can refer themselves online via NHS.uk or by contacting their GP. The NHS continues to advise people to call 999 if there is a serious risk to life. **Review of intensive and assertive community treatment for people with severe mental health problems** Following the publication of guidance on intensive and assertive community mental health treatment, NHS England has written a letter to systems asking that reviews of intensive and assertive community care be completed. The letter states that reviews should be conducted in line with the national guidance around providing intensive support to people with a serious mental illness and should be presented and discussed at public ICB board meetings alongside an action plan for how the national guidance will be implemented. **MIND BLMK's Crisis Cafes and Recovery Lounges** Mind BLMK Recovery Lounges (formally known as Crisis Café) are open each evening in Bedfordshire and Luton. Anyone from Bedfordshire, Luton, and Milton Keynes are welcome at any location. The service operates from 5pm-11pm 365 days of the year and can support you to get well and stay well. For **Milton Keynes**, the crisis café is at the Queensway Clinic MK22TE – Open 365 days per year between 5pm and 11pm. For **Bedfordshire and Luton**, please use the timetable below: **MONDAY:** The Lighthouse, Whichellos Wharf, The Elms, Stoke Road, Leighton Buzzard LU72TD **TUESDAY:** The Lighthouse, Whichellos Wharf, The Elms, Stoke Road, Leighton Buzzard LU72TD **WEDNESDAY:** Luton Wellbeing Centre, Dumfries Street, Chapel Langley, Luton LU1 5BP **THURSDAY:** Bedford Wellbeing Centre, 3A Woburn Road, Bedford MK40 1EG **FRIDAY:** The Lawns Mental Health Resource Centre, The Baulk, Biggleswade SG18 0PT **SATURDAY:** Luton Wellbeing Centre, Dumfries Street, Chapel Langley, Luton LU1 5BP **SUNDAY:** Florence Ball House, Kimbolton Road, Bedford MK40 2PU Each site is open 5pm – 11pm on their dedicated day. **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. **Improving physical health checks for people with severe mental illness** There has been a particular focus on improving annual physical health checks for people with severe mental illness as follows: • Mental Health and Primary Care ICB colleagues are working together to resolve the issue that the outreach projects are having with accessing some of the GP Practices SystmOne's so that they can input the physical health check results. • Mental Health and Primary Care ICB colleagues are working together regarding circulating a letter to primary care colleagues regarding the importance of the annual physical health checks for people with severe mental illness. • There will continue to be the promotion of the outreach initiatives so as to maximise the support that they can provide • Mental Health ICB colleagues are continuing to work on the flow of the physical health checks results from ELFT into SystmOne and Mental Health ICB colleagues are going to request Q3 data from ELFT so that this can be provided to the Outreach initiatives. • ICB place colleagues in Central Bedfordshire will be promoting with GP Practices about the importance of the annual physical health checks and to invite colleagues to any meetings where they can highlight the importance of this. • Mental Health ICB colleagues will continue to work with CNWL colleagues about the flow of CNWL physical health check data into GP Practice Systmone systems. **Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs):** There are a number of change ideas that are being implemented relating to Bedfordshire and Luton patient flow to reduce active inappropriate adult acute mental health out of area placements which include the following: • Enhancing the Discharge Hub with increased Senior Social Worker capacity • Enhanced Senior Clinical oversight of OOA beds • Approaches to supporting admissions who are unknown to services • A review of Crisis Resolution and Home Treatment Teams and wider crisis alternatives • A focus on step down provision • A focus on improving purposeful admission and quality of inpatient care which has led to shorter length of stays and improved outcomes • A focus on addressing bottlenecks which prevent people being discharged from hospital when they are clinically well enough e.g. housing support/accommodation • Decompression Event and use of MADE events at high pressure times
	In the next period there will be a focus on the following: • 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. In addition, the following locally identified priorities are going to be progressed: **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 with a particular focus 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 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
Progress to be made in Next Period	

	outcomes, careplans, interventions (For both Children and Young People and Adults) and assessments (For adults) Progressing the children and young peoples mental health recommendations from the NHS East of England Regional review 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 determinant 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 in Bedfordshire and Luton Progress the recommendations from the recent crisis care review of the Bedfordshire and Luton Crisis Care Pathway 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**Exploring opportunities to expand the use of the Shinymind app. 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, working with NHS East of England colleagues 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

Tasks & Milestones

Overall Tasks & Milestones Status	**GREEN**
Reason for Overall Tasks & Milestones Status	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

	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
							2025						2026	
Perinatal Mental Health Transformation	01/04/25	31/03/26												
Children and Young Peoples Mental Health	01/04/25	31/03/26												
Adults and Older Adults Common Mental Health Problems	01/04/25	31/03/26												
Community mental health transformation for adults and older adults with severe mental illness	01/04/25	31/03/26												
Urgent and Emergency Care - Adult Crisis Care	01/04/25	31/03/26												
Adult Acute Mental Health Care	01/04/25	31/03/26												
Dementia Care	01/04/25	31/03/26												
Suicide Prevention and Bereavement Support	01/04/25	31/03/26												
BLMK Section 117 Programme	01/04/25	31/03/26												
BLMK improving physical health checks for people with severe mental illness	01/04/25	31/03/26												

Risks

Overall Risks Status	GREEN

Reason for Overall Risk Status	Although the current risk status is Green there are a number of risk areas which are as follows that need to be addressed throughout the course of the year: Children and young peoples mental health access Children and young peoples eating disorder waiting times standards Achieving the national ambition to expand the Mental Health Support Teams Due to system pressures in Bedfordshire and Luton there is a risk to delivering the national ambition of reducing average length of stay. There is a risk of meeting the national ambition of at least 60% of people with SMI having an annual physical health checks

Risks

Risk Name	**Key Risk?**	**Residual Likelihood & Impact**
Children and young peoples mental health access	Yes	**2**
Children and young peoples eating disorder waiting times standards	Yes	**4**
Achieving the national ambition to expand the Mental Health Support Teams	Yes	**4**
Due to system pressures in Bedfordshire and Luton there is a risk to delivering the national ambition of reducing average length of stay.	Yes	**4**
There is a risk of meeting the national ambition of at least 60% of people with SMI having an annual physical health checks ?	Yes	**4**

Issues

Overall Issues Status	**GREEN**

Reason for Overall Issues Status	Although the current risk status is Green there are a number of risk areas which are as follows that need to be addressed throughout the course of the year: Children and young peoples mental health access Children and young peoples eating disorder waiting times standards Achieving the national ambition to expand the Mental Health Support Teams Due to system pressures in Bedfordshire and Luton there is a risk to delivering the national ambition of reducing average length of stay. There is a risk of meeting the national ambition of at least 60% of people with SMI having an annual physical health checks

Issues

Issue Name	Key Issue?	Proximity & Impact
There is a risk of not achieving the children and young people mental health access ambition	Yes	4
There is a risk with not delivering the children and young peoples eating disorder standards	Yes	4
There is an issue about being able to expand the Mental Health Support Teams due to financial challenges	Yes	4
Due to current system challenges there is a risk about reducing average length of stay	Yes	4
There is a risk of meeting the national ambition of at least 60% of people with SMI having an annual physical health checks	Yes	4

Portfolio Report Governance Report

Date of Highlight Report	08/05/2025
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 Collaborative Board - System Chair, TBC Diagnostics Collaborative Endoscopy & Pathology Sub-Collaboratives
Geographical Footprint	BLMK System

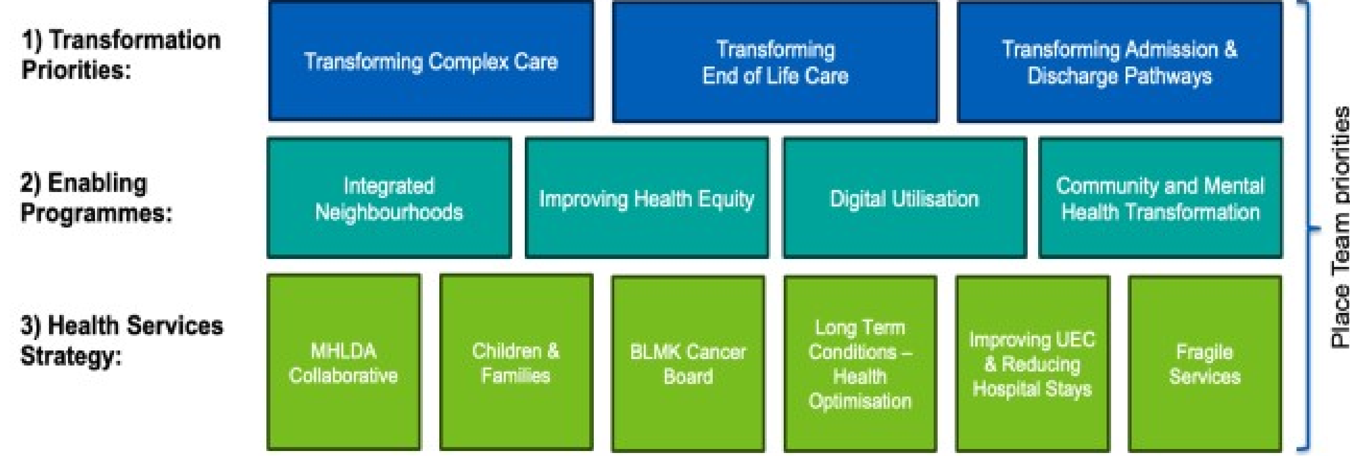
Project Team Members

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. However, the current phase of the programme under the Fragile Services programme of the Health Services strategy is still in early planning stages. The key risk to progress is project management resource.
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	•Milton Keynes Diagnostics Hubs (CDCs) already open – Oct 2024 •Bedfordshire CDC due to open – Sep 2025 •Business Case for Luton CDC under review with NHSE •Performance against the 6-week target, although inconsistent over the year, reached up to 70% in late 2024. •Clinical Lead appointed for Fragile Services and Diagnostics – April 2025 06/05/2025 - meeting with STT programme managers who have been involved in the diagnostic work to date. Identified initial actions and ambitions 07/05/2025 - discussion at Chiefs meeting to start work around Pathology and identify different workstreams across diagnostics to be aligned. These will be worked up into the programme plan in the next period.
Progress to be made in Next Period	• Mapping of diagnostic provision / gap analysis – review and update previous diagnostic work to date (incl driver diagrams and gap analysis) • BLMK Elective Collaborative Board – refresh and define purpose clearly to oversee this programme. Consider appropriate Chair and clinical leadership (part of objective setting for strategic clinical lead) • Demand and capacity exercise being undertaken by AGEM to quantify demand and capacity across the system – understand impact of CDCs. Expected completion – August 20255 • Support business case for iRefer at BHFT X-Ray: • Potential x-ray capability for MK UTC – map of current provision across BLMK (including any CDC) and understand demand (in particular ?fractures referred from UTC to A&E for x-ray) in order to support decision for ICB & MKUCS. Phlebotomy: • •Map of phlebotomy provision across primary care: List of practices, by place, delivery in/out of hours, delivery over the past year (2024/25) - how it is monitored and how payment works. • •Explore data from BHFT suggesting up to 40% of path results are not reviewed • •Further investigate potential and timelines for expansion through CDCs • •Meet with Trust financial teams to discuss internal funding of iRefer for Pathology

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN

Reason for Overall Tasks & Milestones Status	Still working up programme plan - further tasks and milestones to be defined or not yet started. the majority of those currently open are either on track or completed, though there is anxiety around ability to deliver due to resource - risk that this will push progress back to amber.

	Start Date	End Date	Apr 2025	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2026	Feb	Mar
Mapping of current diagnostic provision across BLMK (phlebotomy)	06/05/25	24/06/25												
Mapping of current diagnostic provision across BLMK (xray)	06/05/25	24/06/25												
Approval of Business Case for Luton CDC	21/01/25	31/07/25												
Demand and Capacity Review	01/05/25	31/07/25												
Mobilisation of North Bedfordshire CDC	01/09/25	30/09/25												
iRefer implementation - BHFT	01/06/25	31/12/25												
Mobilisation of Luton CDC		31/01/26												

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	Workforce risks identified have potential to delay programme progress. NHSE funding is unpredictable and could pose significant risk to the development of further CDC in Luton. At the moment, still amber as early stages of understanding the likelihood and ability to mitigate.

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	12
Limitation to Demand and Capacity Review Data	Yes	4

Issues

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

Issues

Issue Name	Key Issue?	Proximity & Impact

Project Name	Measure ID	Measure Name	Measure Type	Reporting Frequency
BB - Integrated Neighborhood Working	M000077	Launch Working Together pilot in first neighbourhood.	Indicator	Quarterly
BB - Integrated Neighborhood 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 – Health Estate	M000159	Delivery of a new GP practice building in Great Barford.	Indicator	Quarterly
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
BCA - Improving access to Pathway 2 Beds	M000085	Improving access to Pathway 2 Beds - Reduction in DRD days from 10 to 5 days	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 Long Term Conditions Programme	M000197	% of people treated to NICE-recommended BP targets	Measure	Monthly
BLMK Long Term Conditions Programme	M000198	% of people with CVD with modifiable risk factors treated to target	Measure	Monthly
BLMK Long Term Conditions Programme	M000199	% of people on evidence-based treatment for heart failure	Measure	Monthly
BLMK Long Term Conditions Programme	M000201	% of people with asthma with <6 inhalers in the previous 12 months	Measure	Monthly
BLMK Long Term Conditions Programme	M000202	% of people with COPD using LAMA/LABA (or triple therapy)	Measure	Monthly
BLMK Long Term Conditions Programme	M000203	% of adults with all 8 diabetes care processes recorded	Indicator	Monthly
BLMK Long Term Conditions Programme	M000204	% of adults with T2DM achieveing all 3 treatment targets	Indicator	Monthly
BLMK Long Term Conditions Programme	M000205	% women with recorded preconception advice	Measure	Monthly
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

Project Name	Measure ID	Measure Name	Measure Type	Reporting Frequency
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
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 - Health Inclusion Practitioners	M000252	CB - Health Inclusion Practitioners Example 01	Outcome	Quarterly
CB - Health Inclusion Practitioners	M000253	CB - Health Inclusion Practitioners Example 02	Outcome	Quarterly
CB - Health Inclusion Practitioners	M000254	CB - Health Inclusion Practitioners Example 03	Outcome	Quarterly
CB - Health Inclusion Practitioners	M000255	CB - Health Inclusion Practitioners Example 04	Outcome	Quarterly
CB - LAN 02 - Pressures on	M000267	CB - LAN 02 - Pressures on Example 01	Outcome	Quarterly
CB - LAN 02 - Pressures on	M000268	BLMK Hypertension Protocol Training for Health Professionals	Measure	TBC

Project Name	Measure ID	Measure Name	Measure Type	Reporting Frequency
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
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)	M000292	Change Idea 1: Number of appointments attended	Measure	Monthly
Luton 1 - Hypertension Learning and Action Network (Black African population)	M000293	Change Idea 1: No further action required	Measure	Monthly
Luton 1 - Hypertension Learning and Action Network (Black African population)	M000294	Change Idea 1: Number of follow-up appointments (to change meds)	Measure	Monthly
Luton 1 - Hypertension Learning and Action Network (Black African population)	M000295	Change Idea 1: Blood pressure now within limits	Measure	Monthly
Luton 1 - Hypertension Learning and Action Network (Black African population)	M000296	Change Idea 2: Did the video prompt you to attend the event	Measure	Annual

Project Name	Measure ID	Measure Name	Measure Type	Reporting Frequency
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
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	Bletchley Pathfinder (Project 1-3) - Example 01	Indicator	Monthly
MK - INW - Bletchley Pathfinder (Project 1-3)	M000026	Bletchley Pathfinder (Project 1-3) - Example 02	Indicator	Quarterly
MK - Tackling Obesity	M000169	Tackling Obesity - Service users starting service	Measure	Monthly

Project Name	Measure ID	Measure Name	Measure Type	Reporting Frequency
Primary Care Development and Transformation Programme - to deliver improved access	M000236	Number of appointments delivered by the practice teams	Measure	Monthly
Primary Care Development and Transformation Programme - to deliver improved access	M000237	Pharmacy First - activity delivered in BLMK by community pharmacist	Measure	Monthly
Primary Care Development and Transformation Programme - to deliver improved access	M000238	Delivery of contracted dental activity	Measure	Monthly
Primary Care Development and Transformation Programme - to deliver improved access	M000239	LTC Indicators for Diabetes, CVD, and Respiratory	Measure	Quarterly
Primary Care Development and Transformation Programme - to deliver improved access	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