



Bedfordshire, Luton
and Milton Keynes
Integrated Care Board



Cambridgeshire &
Peterborough
Integrated Care Board



Hertfordshire and
West Essex
Integrated Care Board

Bedfordshire Luton & Milton Keynes

ICS Portfolio Report

November 2025 Update

Bedfordshire Luton & Milton Keynes ICS Portfolio Report

November 2025 Update

The BLMK ICS Portfolio Report provides assurance on the delivery of key programmes and projects across Bedfordshire, Luton & Milton Keynes (BLMK) Integrated Care System (ICS).

The report has been produced quarterly for over two years; previously it was presented to BLMK Integrated Care Board (ICB) Performance Executive, Chief Executive Officer (CEO) Group, Quality & Performance (Q&P) Committee, and ICB Board. In November 2025, the report is presented at the Central East ICB Utilisation Management & Quality Improvement Committee (UMQIC).


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 ICS 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 ICS 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 November 2025 BLMK Portfolio Report is comprised of the (1) **Governance Reports**, and the (2) **Project Case Studies**

The Portfolio Report also flags those projects that align to the Central East Priorities (Mental Health, Advanced Illness, CVD, Respiratory and Cancer) these are shown with a  symbol on the content pages

Additionally, the report provides detailed information on 46 priority programmes and projects through Project **Governance Reports**, which offer progress updates against planned objectives. These 46 programmes and projects reflect key initiatives from Bedford Borough, Central Bedfordshire, Luton, Milton Keynes, and the wider BLMK System Transformation.

Each edition of the BLMK Portfolio Report includes a case study highlighting improvements to resident experience and population health based on a previously mobilised project. The **Improving Resident Experience & Population Health Case Study** outlines the original project objectives and includes Statistical Process Control (SPC) charts to demonstrate quantifiable improvements for BLMK residents. The November report Improving Resident Experience & Population Health Case Study is Medicines Optimisation – Inhalers.


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



46	Total number of programmes/ projects
23	Total number of projects on-track
18	Total number of projects on track, however with some factors at risk of slipping
4	Total number of programmes/ projects that have some risks and delays
1	Total number of programmes/ projects off track
130	Total number of key measures identified in the 46 programmes and projects

BLMK ICS Portfolio Report






Contents

Projects that align to the Central East ICB Priorities (*Mental Health, Advanced Illness, CVD, Respiratory and Cancer*) are shown with a  symbol.

Programme/ Project Governance Reports

Lead Team	Portfolio/Programme/Project	Page No.
Bedford Borough	BB - Age Care Technology 	5-9
Bedford Borough	BB - Integrated Neighbourhood Working	10-14
Bedford Borough	BB - Living Well - Increase the uptake of cervical screening programme appointments 	15-19
Bedford Borough	BB - Living Well - Increase uptake of breast cancer screening programme 	20-22
Bedford Borough	BB - Living Well - Learning & Action Network - Improve CVD Disease Prevention & Management 	23-31
Bedford Borough	BB Placed Based Plan Priorities – Ageing Well 	32-36
Bedford Borough	BB - Placed Based Plan Priorities – Health Estate	37-41
Bedford Borough	BB Placed Based Plan Priorities – Starting Well	42-46
Central Bedfordshire	CB - Dementia Diagnosis and Prevention	47-51
Central Bedfordshire	CB – Falls Prevention Service (CBFPS) 	52-57



Lead Team	Portfolio/Programme/Project	Page No.
Central Bedfordshire	CB - Health Inclusion Practitioners	58-63
Central Bedfordshire	CB – Hypertension Management in C Beds - SMI	64-68
Central Bedfordshire	CB - Integrated Neighbourhood Working	69-79
Central Bedfordshire	CB - LAN 02 - Pressures on 	80-85
Luton	Luton - Early intervention, Prevention, and Partnerships	86-90
Luton	Luton Health Ageing Programme (BCF) 	91-97
Luton	Luton - Integrated Neighbourhood Working	98-107
Luton	Luton 1 - Hypertension Learning and Action Network (Black African population) 	108-113
Luton	Luton 2 - Hypertension Learning and Action Network (Indian population) 	114-118
MK	MK - Children & Young People’s Mental Health	119-122
MK	MK - Hypertension Learning and Action Network (Black African population aged 40-64 years) 	123-126
MK	MK - Improving System Flow	127-132
MK	MK - INW - Bletchley Pathfinder (Project 1-3)	133-138
MK	MK - Tackling Obesity	139-144

BLMK ICS Portfolio Report

Contents



Lead Team	Portfolio/Programme/Project	Page No.
BLMK Wide	Transforming Admission and Discharge Pathways	145-148
BLMK Wide	Transforming Palliative End of Life Care ★	149-155
BLMK Wide	Transforming Complex Care	156-163
BLMK Wide	Cancer - Early Diagnosis and Health Inequalities ★	164-168
BLMK Wide	Cancer Project - Living with and beyond cancer ★	169-172
BLMK Wide	Cancer - Operational Performance and Faster Diagnosis ★	173-177
BLMK Wide	Cancer - Treatment and Care ★	178-181
BLMK Wide	Improving Health Equity	182-185
BLMK Wide	Enhancing the Integration of IUC and Urgent Care with Primary Care and UEC	186-190
BLMK Wide	BLMK – Long Term Conditions (CVD, Respiratory & Diabetes) ★	191-194
BLMK Wide	BLMK - Fragile Services - Diagnostics	195-199
BLMK Wide	BLMK - Children, Families, Women's and Maternity (CWM) Board	200-203
BLMK Wide	BLMK – Hospital Opportunities Assessment	204-207
BLMK Wide	BLMK - Mental Health Transformation Programme ★	208-221

Lead Team	Portfolio/Programme/Project	Page No.
BLMK Wide	Community and Mental Health Services Transformation ★	222-227
BLMK Wide	Improving Access to Pathway 2 Beds	228-232
BLMK Wide	Musculoskeletal (MSK)	233-235
BLMK Wide	PC Training Hub Programme	236-252
BLMK Wide	Primary Care Access – Demand Management, Addressing Variation	253-256
BLMK Wide	BLMK – Green Plan 2025-2032 (Overarching)	257-263
BLMK Wide	Women's Health	264-270
BLMK Wide	Workforce Anchor Programme	271-276

Improving Resident Experience & Population Health Case Studies

Case Study	Page No.
Medicines Optimisation - Inhalers	277-278

Portfolio Report Governance Report

Date of Highlight Report	21/10/2025
Project Code	PR000164
Project Name	BB - Age Care Technology
Project Team	Bedford Borough Place Team
Project Aim	<p>To support older people to live independently for longer.</p> <p>The specific objectives of the improvement project are:</p> <ol style="list-style-type: none"> 1. To improve the health, wellbeing and independence of a targeted cohort of older people living in areas of deprivation using the Age Care Technology Assess and Connect model. 2. To work in partnership with VCSE to design and deliver a local approach to implementing the Age Care Technology Assess and Connect model. 3. To build a directory of services and support for older people with a focus on the VCSE sector. 4. To connect older residents to community resources, services and support to improve their health and wellbeing 5. To measure the impact of the Age Care Technology Assess and Connect tool in the targeted cohort. 6. To evaluate the impact of the Age Care Technology Assess and Connect model for wider adoption in BLMK. 7. To quantify the demand for VSCE interventions to inform future commissioning decisions.
Governance & Responsible Group	Executive Delivery Group (BB Place Board)
Geographical Footprint	Bedford Borough

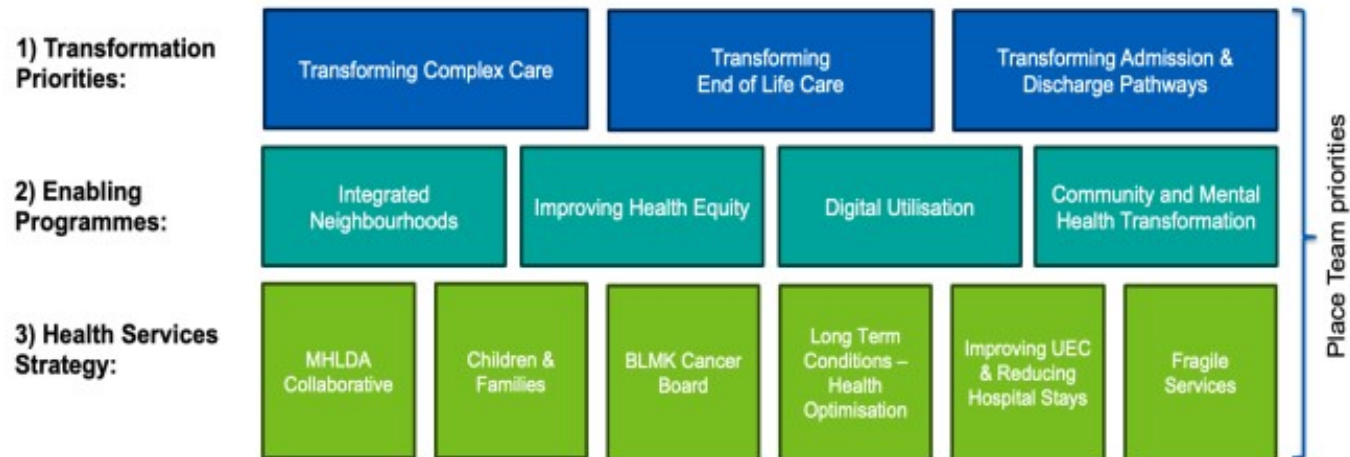
Project Team Members

Name	Role
Lorraine Kavanagh	Project Manager
Usha Panchal	Project Manager
Sarah Pearson	Project Manager
Alex Wrack	Project Manager
Adele Slaney	Project Manager

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	Project progressing along planned timeline
Project Maturity	3.0 - Implementation

System Transformation



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

1) Transformation Priorities: Transforming End of Life Care. 2) Enabling Programmes: Integrated Neighbourhoods, Improving Health Equity, Digital Utilisation.

The use of the ACT Assess and Connect tool aligns with the ICB strategic priority of “Supporting people to Age Well, with proactive interventions to stay healthy, independent and active as long as possible.”

Progress Update

<p>Progress made in Previous Period</p>	<p>July:</p> <ul style="list-style-type: none"> • 15th Stakeholder Steering Group meeting • Confirmation of 3 sites: Putnoe Health Centre, Linden Road Surgery & Queens Park Surgery • Draft Data Protection Impact Assessment (DPIA) reviewed by Data Protection Officer (DPO) • Draft posters shared for review <p>August:</p> <ul style="list-style-type: none"> • 28th Project team meeting • 19th Stakeholder Steering Group meeting • Reviewed Directory of Services (DoS) - updating and amending with further review by stakeholders • Confirmation of escalation pathways for Putnoe HC and Linden Road Surgery • Update the SystmOne Query to be run by each practice. <p>September:</p> <ul style="list-style-type: none"> • 29th first batches of patient invite texts sent out • 16th Stakeholder Steering Group meeting • ACT team development of the Bedford IT platform & testing • 11th meeting with VCSE re trusted partner to support Queens Park Surgery • 11th Project team meeting • 9th attended Linden Road Patient Participation Group (PPG) meeting • Confirmation of text offer to patient wording • 4th Project team meeting <p>October:</p> <ul style="list-style-type: none"> • 13th contact information of consenting individuals to be sent to ACT for upload to platform • Practice Staff awareness session • 2nd Assessor training
<p>Progress to be made in Next Period</p>	<ul style="list-style-type: none"> • Next Steps to be confirmed for engaging VCSE Trusted Partner to support Queens Park Surgery • Updates to DoS to enable upload to platform • Testing of the Bedford platform <p>Delivery Team:</p> <ul style="list-style-type: none"> • Next groups of invites to be issues • First reminders to be issued • Continue to contact information of consenting individuals to be provided for upload into the platform • ACT to confirm VCSE partner • VCSE Assessor training

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

Meeting targets and identified pilot practices, contacting patients with offer.

	Start Date	End Date	2025										2026					
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar				
Initiate project governance arrangements including establishing the Project Group		30/04/25	◆															
1st Steering Group Meeting		17/06/25			◆													
Review population health data, agree target cohort and sites,	01/05/25	15/07/25		■														
Agree project approach, Information governance processes, outcome measures		15/07/25				◆												
Agree scope of VCSE and payment process for VSCE participation		19/08/25						◆										
Build Local Directory of Services (DOS)	01/08/25	13/09/25					■											
Commence Invitations to target cohort		29/09/25								◆								
Undertake assessments, generate reports and provide links to local services/support		30/09/25								◆								
Significant risk pathways developed		01/10/25									◆							
Assessment training on ACT tool	02/10/25	02/10/25									■							
First patient assessment complete		27/10/25											◆					
Contact patients by text with offer, send reminders	29/09/25	31/10/25							■									
VCSE Assessor Training		31/10/25											◆					
Assess & Connect follow up with patients at 3 months		31/12/25															◆	
Assess & Connect follow up with patients at 6 months		31/03/26																◆

Risks

Overall Risks Status

GREEN

Reason for Overall Risk Status	Emerging risks identified & mitigation being developed / put in place to manage those risks
--------------------------------	---

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Language challenges	Yes	12

Issues

Overall Issues Status	GREEN
Reason for Overall Issues Status	Issue arose regarding text messaging costs. Now resolved with agreement from Public Health to fund costs from Inequalities Budget.

Issues

Issue Name	Key Issue?	Proximity & Impact
Cost impact of SMS text message length	Yes	4

Portfolio Report Governance Report

Date of Highlight Report	20/10/2025
Project Code	PR000261
Project Name	BB - Integrated Neighbourhood Working
Project Team	Bedford Borough Place Team
Project Aim	The purpose of Integrated Neighbourhood Working (INW) is to build Neighbourhood teams to centre care around people's needs by integrating healthcare, social care, public services, community groups and voluntary agencies to work across neighbourhoods.
Governance & Responsible Group	Bedford Borough has an INW Steering Group which reports to the Executive Delivery Group.
Geographical Footprint	Bedford Borough

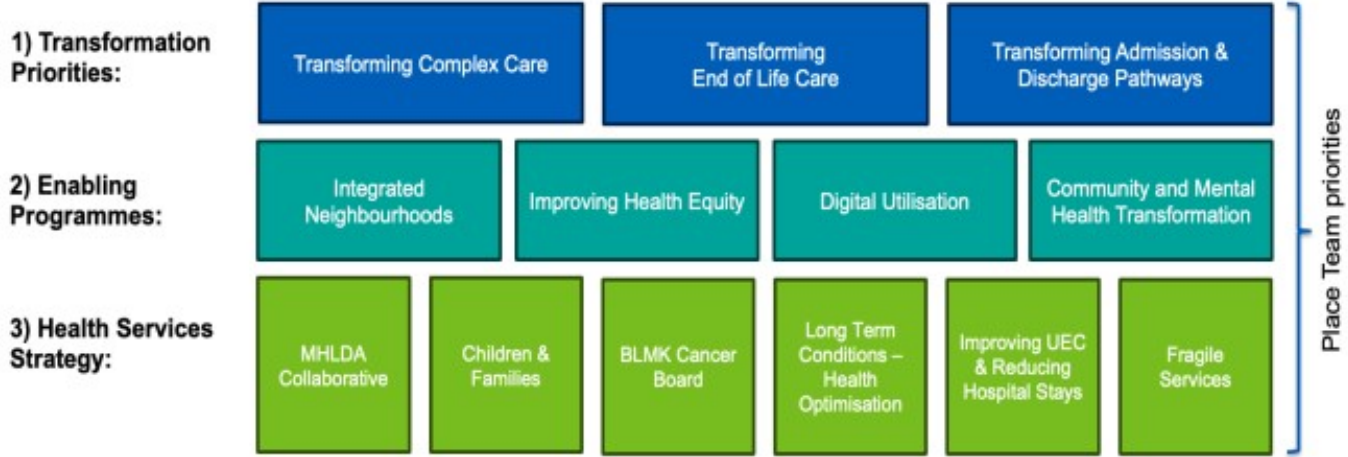
Project Team Members

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

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	The work has started and is progressing as expected.
Project Maturity	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)

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

Community and Mental Health Transformation: The Bedford Borough place team has provided project management support to the set up of the ELFT Working Together MDT pilot.

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 and quarterly national reporting.

Progress Update

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
BB INW Steering Group Meeting		25/06/25			◆												
BB INW Steering Group Meeting		23/07/25				◆											
BB INW Steering Group Meeting		27/08/25						◆									
BB INW Steering Group Meeting		24/09/25								◆							
Set up working group(s) to focus on delivering 2025/26 goals.		01/10/25									◆						
BB INW Steering Group Meeting		22/10/25									◆						
BB INW Steering Group Meeting		26/11/25											◆				

Risks

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

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Not having buy-in from all partners to develop neighbourhood working together (specific focus on first neighbourhood 'launch'). To mitigate this risk partners are part of deciding which neighbourhood to focus on at the steering group.	Yes	5
Losing focus on needs and specificities of Bedford Borough as ICB goes through changes and emphasis on places develops.	Yes	12

Issues

Overall Issues Status	GREEN
Reason for Overall Issues Status	Although there are some challenges there are 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 within 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. Multiple practices will have to work with each other at neighbourhood level. The PCNs work well together - this will be opportunity for practices but they may need time/support.	Yes	12

Portfolio Report Governance Report

Date of Highlight Report	20/10/2025
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

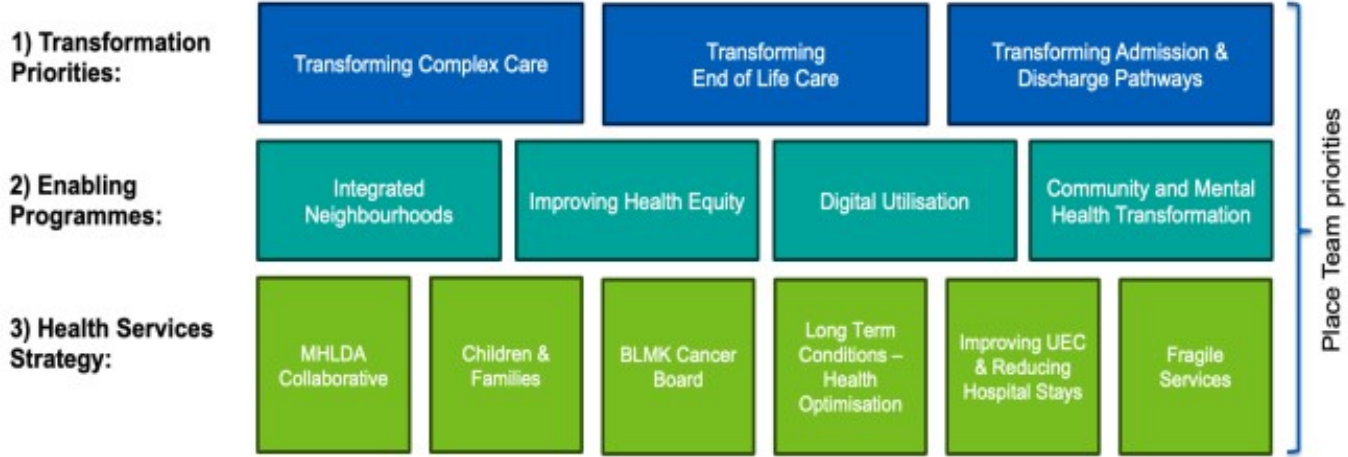
Project Team Members

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	Work being led by clinicians at place.
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 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

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

As a collective of practices they will target Cancer Screening and Early Diagnosis through Community Outreach and Case Finding in Bedford. This project aims to address cancer inequalities through a three-pronged approach that targets under-screened and high-risk populations in Bedford. It aligns with the Core20PLUS5 framework and ICB strategies by focusing on populations with poor screening uptake and those facing access barriers.

Part of this project includes Community Outreach Cancer Screening Drop-ins. The PCNs will run pop-up cancer education and screening awareness sessions in trusted community venues, including:

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

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

2. CAJA:

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

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

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

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

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
-----------------------------------	--------------

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

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

Risks

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

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

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Showing progress in this area, particularly with underserved groups.	Yes	12
Not having capacity within the team to deliver this work. Reduced capacity within the place team, including lead for this work.	Yes	8

Issues

Overall Issues Status	AMBER
Reason for Overall Issues Status	The main issue currently is staff capacity to dedicate time to this priority.

Issues

Issue Name	Key Issue?	Proximity & Impact
Reduced capacity within the place team, including a lead for this work. Mitigated to some extent by the work the ICB cancer team and GP Practices are doing.	Yes	8

Portfolio Report Governance Report

Date of Highlight Report	20/10/2025
Project Code	PR000296
Project Name	BB - Living Well - Increase uptake of breast cancer screening programme
Project Team	Bedford Borough Place Team, GPs, Clinical Leads
Project Aim	Increase the uptake of breast cancer screening programmes
Governance & Responsible Group	Executive Delivery Group (EDG)
Geographical Footprint	Bedford Borough, BLMK System

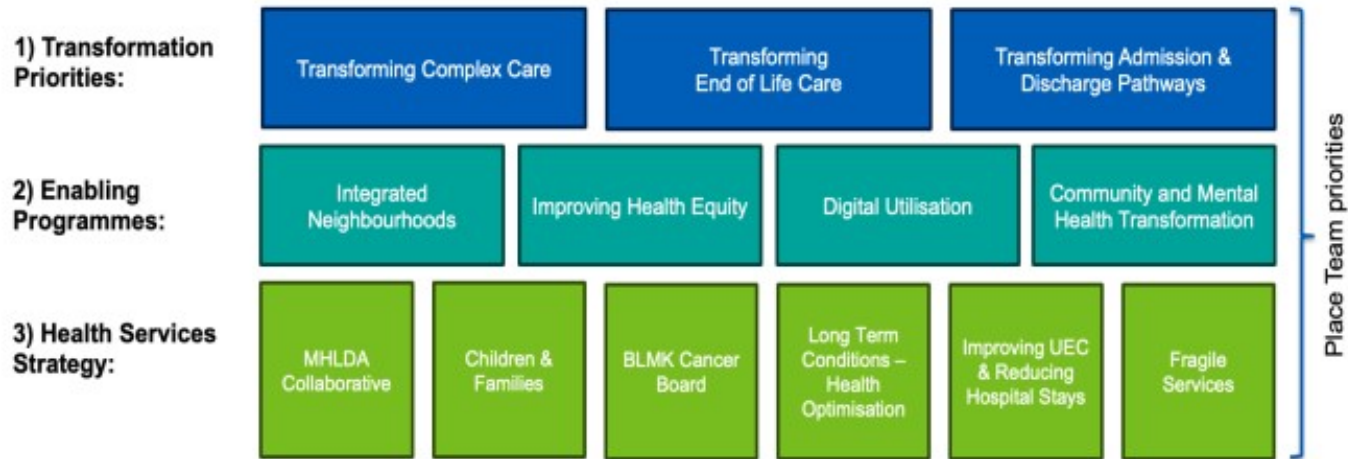
Project Team Members

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 has been shared with a range of community groups and on social media.
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

The Breast Screening Uptake Campaign video was shared on YouTube (link below). It was also shared on social media and with a range of community groups. The video was shared on WhatsApp with a range of grassroots groups in the local target population, with approximately 1000 people in the groups.

You Tube videos were shared with Practices and PCNs and INW Steering Group Members

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

Progress to be made in Next Period

This project is currently on hold due to reduced capacity in the place team. A plan to progress the work is being discussed with the local clinical leads.

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	The videos have been completed and shared.

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

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	Some issues around capacity to deliver any more work in this area at the moment. As a mitigation, the place team will be seeking support from the clinical leads.

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Risk of no further work being completed due to reduced capacity within the place team.	Yes	8

Issues

Overall Issues Status	AMBER
Reason for Overall Issues Status	Issues with capacity to develop this work as mentioned above. Mitigation as above.

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	20/10/2025
Project Code	PR000159
Project Name	BB - Living Well - Learning & Action Network - Improve CVD Disease Prevention & Management
Project Team	Place team, QI lead, community and faith leaders, and residents
Project Aim	<ul style="list-style-type: none"> • By the end of the Heart Health project in May 2026, 80% of the Black African population, aged 40-64, who have a diagnosis of hypertension alone, in the Urban South neighbourhood (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. • By the end of the Heart Health project in May 2026, 80% of the Black Caribbean population, aged 40-64, who have a diagnosis of hypertension alone, in the Urban South neighbourhood (Caudwell, Kempston, and Kingsbrook wards) and are registered with one of the three practices serving this area (London Road Surgery, Caudwell Medical Centre and King Street Surgery) will achieve a blood pressure reading of below 140/90 mmHg. <p>Potential to expand the scope of the project cohort to include patients with comorbidities (first in the Urban South neighbourhood), then scaling further to other neighborhoods (outside the Urban South), and then beyond to the general population.</p>
Governance & Responsible Group	Executive Delivery Group (EDG)
Geographical Footprint	Bedford Borough

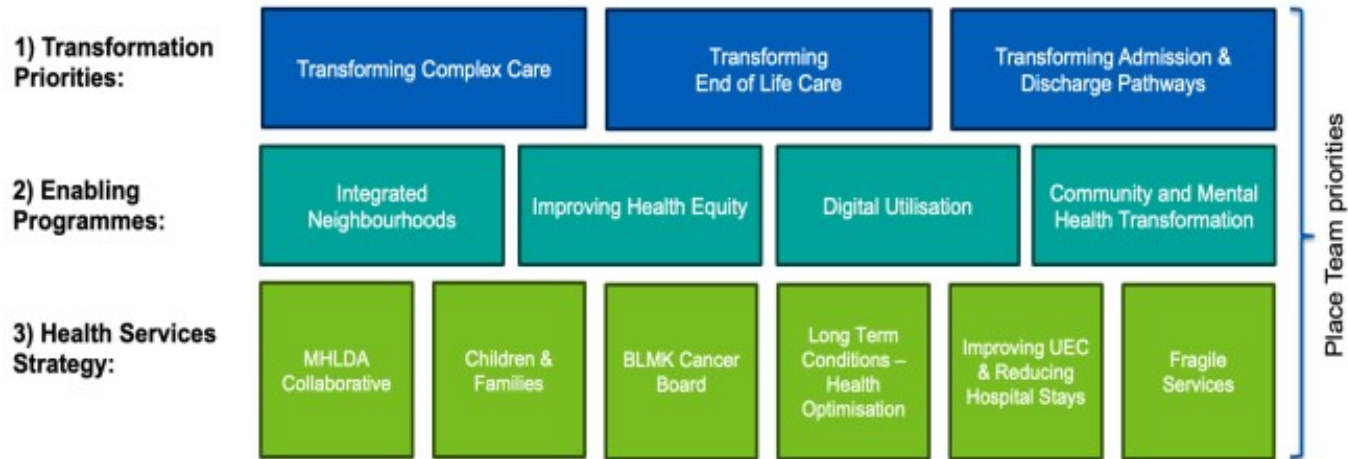
Project Team Members

Name	Role
Brenda Carson	Improvement Manager
Angela Zambeaux	Improvement Manager
Lourena Mendes	Improvement Manager
Shelby Reed	Improvement Manager
Lourena Mendes	Improvement Manager
Lorraine Kavanagh	Project Manager

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

Project Status	
Overall Project Status	GREEN
Reason for Overall Project Status	Project is on track as per update.
Project Maturity	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: Early hypertension control prevents avoidable admissions of stroke, heart failure, kidney disease, and hypertensive emergencies.

2. Enabling programmes:

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

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

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

3. Health Service Strategy:

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

Progress Update

1. Dashboard Progress Update

I have been collaborating closely with HBICT and AGEM to develop a comprehensive dashboard that pulls data directly from the clinical system using pseudonymised patient information. The dashboard tracks key metrics:

- Percentage of hypertensive patients meeting the QoF treatment targets
- Number and percentage of patients with a recorded blood pressure in the past three months
- Number of patients contacted who subsequently attended a check-up
- Number of patients contacted who went on to receive a treatment plan

This initiative was designed to streamline data collection for clinicians and improve visibility of patient outcomes. The dashboard has now been successfully built and implemented across all surgeries in Bedford. The data will be ready to present at the next briefing.

2. Engagement & Template Strategy Update

The strategy has been revised to improve efficiency and better reflect recent changes to the template. The updated engagement sequence is as follows:

- Week 1: Text message
- Week 2: Text message
- Week 3: Phone call
- Week 4: Letter

This amendment aligns with the recommendations from the latest PDSA cycle.

We are also updating our template and added links to training and resources, and other questions.

3. Community Pharmacy Ambulatory Blood Pressure Monitoring (ABPM) Referrals via GP Connect – Update & Next Steps

Background:

As of 1st October, we will be using GP Connect instead of ACCURX as the referral method for ABPM from community pharmacies to GP practices. This is intended to streamline communication and improve integration across primary care.

Current challenges identified by clinicians who have had referrals from Community Pharmacy are:

- Referrals for patients already diagnosed with hypertension
- Incomplete referral information, such as:
 - Only one BP reading provided
 - No rationale for referral
- Referrals from pharmacies without ABPM capability

These issues are contributing to unnecessary workload for GP surgeries and risk undermining the benefits of the new system.

Actions to help understand the problems:

- A 4-week audit is being conducted by clinicians to understand the scope and nature of inappropriate referrals.
- Collaboration is ongoing with Community Pharmacy Leads to:
 - Identify training needs
 - Clarify referral criteria
 - Ensure only ABPM-capable pharmacies are listed

4. Group Clinics Implementation

Update:

- Training has now been completed
- Website: Built
- DPIA: Awaiting approval

- Key Dates:
 - Co-design with ELC: 21st October
 - Dry run with residents: 28th October
 - Go live: 10th November

5. Faith Leader Meeting update:

- Exploring the expansion of the group's scope and viability at the meeting on 23rd October.

6. Holly Health App intervention – Patient questionnaires, presentation from Holly Health App – Tackling Health Inequalities, Obesity Innovation Pathway Programme & Holly Health App Funding Opportunity added to files.

Phase 1 Overview:

- Timeline: Summer 2025
- Target Group: 300 patients (aged 40–64) across 3 Bedfordshire GP practices, including Black African & Black Caribbean communities

Key Findings:

Engagement

- Signup Rate: 10% (above Holly Health's average of 3–5%)
- Onboarding Completion: 60% of signups
- Survey Completion: 22% of onboarded users

User Feedback

- Satisfaction: 70% satisfied or very satisfied
- Ease of Use: 80% found it easy or very easy
- Cultural Relevance: 70% felt content was culturally relevant
- Perceived Impact: 90% believed it would positively affect BP/heart health
- Popular Features: Habit reminders, BP/mood/stress tracking
- Suggestions: Add BP logging (now implemented), chronic pain content, and meal prep ideas

Email Engagement

- Survey Email Open Rate: 29% (vs 47% general population)
- Implication: SMS and community-based channels (e.g., places of worship, local centres) are more effective for engagement

Key Learnings

- SMS invitations outperform email for this population
- Community outreach boosts uptake and feedback
- Behavioural barriers include cravings, chronic pain, and motivation
- Holly Health's tone and reminders are well received.

6. Website: Heart Health Bedford Hypertension page is now available on the Health & Care Partnership website.

Next Steps

1. Dashboard Progress: Develop further to capture data for the general hypertensive population and group clinics at Cauldwell Medical Centre.

2. Engagement & Template Strategy Update

- Implement revised sequence across the updated template in East Beds PCN and De Parys PCN
- Provide training on using the template and monitor results through the dashboard

3. Community Pharmacy ABPM Referrals via GP Connect – Update & Next Steps

Address Identified Issues:

- Develop and deliver targeted training for community pharmacies
- Create a referral checklist/template to ensure completeness and appropriateness
- Explore the new feature in System One (BARS) to enable an easier referral process for GPs.

Raise Awareness Among GP Practices

- Promote referral pathway
- Share audit findings and improvements made

Develop a Local Protocol for Shared Care

Once a patient is diagnosed and stabilised at the GP practice, community pharmacies will:

- Conduct 3-monthly BP checks for the first year
- Support patient engagement and adherence, and refer to the New Medicines Service if change in medication.
- Refer to social prescribers
- Feed back to GPs ahead of the annual review

Goal:

To create a sustainable, collaborative model where community pharmacies play a proactive role in hypertension management, reducing GP workload while enhancing patient support and outcomes, which was the change idea for London Road.

4. Group Clinics Implementation

Implementation learning has been completed by Usha Panchal, and clinical pharmacist and facilitator at Cauldwell Medical Centre.

- Conduct a dry run and refine logistics; Residents are attending to role play and feedback on their experience.
- Launch clinics on 10th November

5. Faith Leader Meeting

- Facilitate discussion on broader health topics
- Capture community feedback

Progress to be made in Next Period

	Start Date	End Date	2025							2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Confirm proposal and processes		16/09/25							◆					
Learning Session 4 (virtual), link to be sent		30/09/25							◆					
Chase Accurx contact sign off confirmation	15/09/25	30/09/25												
Faith Leaders Meeting		23/10/25									◆			
Action webinar 8		27/10/25									◆			
Offer Holly Health App to patient cohort	08/04/25	31/10/25												
London Road - Enhanced Pharmacy Pathway	02/01/25	31/10/25												
Action Webinar 9		24/11/25									◆			
Action Webinar 10		26/01/26											◆	
Learning Session 5 (in-person)	12/02/26	13/02/26												
Holding the gains webinar		19/03/26												◆
Celebration Event		27/03/26												◆
Patient engagement messaging from practices / Text / Email / Phone / Letter	01/04/25	31/03/26												
Testing change ideas	12/12/24	19/05/26												
Engaging with Faith Leaders	11/03/25	22/05/26												
King Street - Hypertension Clinics	01/04/25	22/05/26												
Reception staff taking ad-hoc BP measurements @ London Road	01/04/25	01/09/26												
Cauldwell MC - Group Clinics	01/07/25	31/12/26												

Risks

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

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Losing resident participant(s).	Yes	9
Accessing Funding	Yes	16
Patient engagement	Yes	16
Group Clinics	Yes	16
The presence of statutory organisations at sensitive community faith leader meetings may inhibit open dialogue, reduce community trust, or discourage participation due to concerns around confidentiality etc	Yes	16

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	21/10/2025
Project Code	PR000162
Project Name	BB - Placed Based Plan Priorities – Ageing Well
Project Team	Bedford Borough Place Team
Project Aim	<p>Support people over 65 to maintain independence</p> <ol style="list-style-type: none"> 1. Pilot Age Care Technologies (ACT) Assess and Connect Tool - the ACT project is now being reported as a separate project. 2. Establish a subgroup of the BB Older Person's Partnership Board and agree a priority issue and project from the priorities for older people identified within the Place Plan. <p>Keeping older people well during winter</p> <ol style="list-style-type: none"> 1. Increased referrals into the BHBH service and identifying eligible residents receiving the medium sized measure installs. 2. Reduce isolation, increase awareness and use of Welcoming Spaces. 3. Increase uptake of flu, covid and routine vaccinations in older people 4. Raise awareness of the Falls Prevention Service and how people can reduce the risk of falls.
Governance & Responsible Group	Executive Delivery Group (EDG)
Geographical Footprint	Bedford Borough

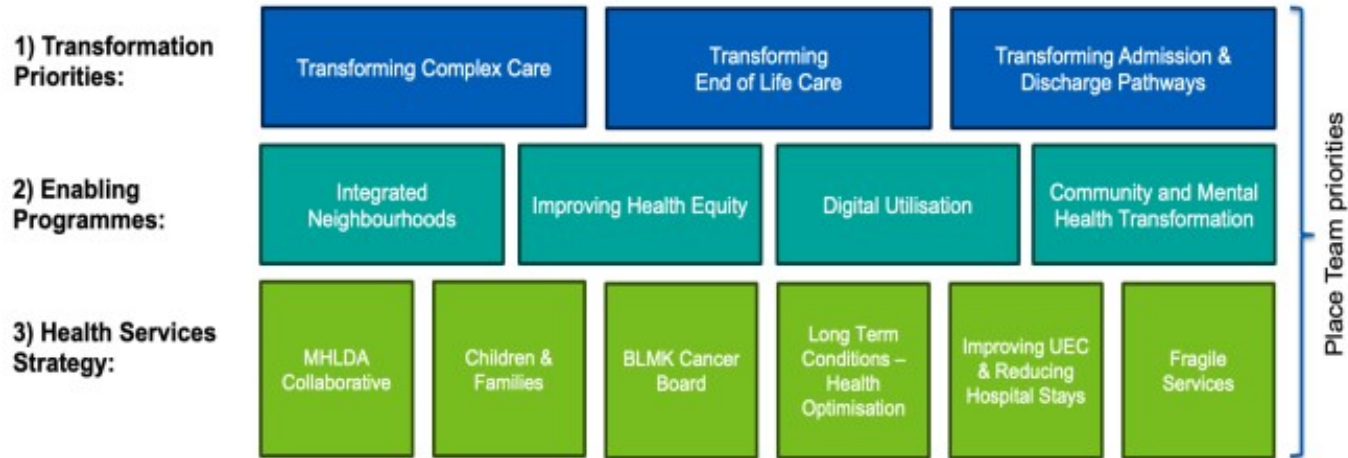
Project Team Members

Name	Role
Lorraine Kavanagh	Project Manager
Usha Panchal	Project Manager
Alex Wrack	Project Manager
Sarah Pearson	Project Manager
Adele Slaney	Project Manager
Lucy Robertson	Transformation Support Manager

Project Status

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

System Transformation



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

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

Progress Update

Progress made in Previous Period

Support people over 65 to maintain independence

- First meeting of subgroup of the Older Person's Partnership Board
- Participated in the BB Ageing Well Exhibition 08.10.25
 - Place priorities for older people shared at the event and feedback received
 - Engaged with 50 residents on NHS app and internet usage, what is working well for residents, resident priorities
 - Provided information on flu and covid vaccinations, 111, Pharmacy First, ACT project

Keeping Older People well during winter

- New contract awarded to Better Housing Better Health (National Energy Foundation) in June 2025. The commissioned service offer includes Warm and Well Assessments plus grant funded medium-sized measures e.g. loft and cavity wall insulations, for low-income households and those in receipt of benefits who also have a health condition that is adversely affected by the cold/ households with a disability.

Outcome of work between 1 April and 30 September 2025

- 73 warm and well assessments completed – summer months are consistently quieter, but calls are now increasing.
- 29 home visits booked and 16 completed.
- 0 medium sized installations delivered to date however 4 residents were referred to installers under the ECO 4 scheme for heating and insulation upgrades and Better Housing Better Health (BHBH) provided 3 small measures grants from their UKPN funding worth £75 to residents during Q2. These were for items such as heated throws and cold monitors.
- BHBH spoke to over 100 people in Q2 at various events including the Community Network event: Poverty in Bedford Borough, FACES pop up information service events, at foodbank and at the Bedford Health Fair.
- New joint local authority (Bedford Borough and Central Bedfordshire Councils) social prescribing service commissioned and started on 1 April 2025.
- Performance monitoring template agreed
 - The service received 991 referrals between 1 April and 30 September 2025.
 - Social prescribers regularly attend a wide range of drop in and engagement events.

- Welcoming Spaces continue to be promoted on the Bedford Borough Council website
 - A small grant of up to £500 launched in October to support organisations with the costs associated with offering a welcoming space.

Public Health targeted flu campaign in underrepresented groups:

- Focus groups with residents to understand vaccine hesitancy

		2025							2026					
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
VSCE collaboration	04/08/25	18/10/25												
Working with colleagues across health and social care to agree measurable outcomes of improvement for each focus area	01/04/25	30/11/25												

Risks

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

Risks

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

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	20/10/2025
Project Code	PR000260
Project Name	BB - Placed Based Plan Priorities – Health Estate
Project Team	BBC Estates / Place team / ICB Estates
Project Aim	<p>A strategic approach to improving healthcare estate:</p> <ul style="list-style-type: none"> Utilising & upgrading GP surgery provision. Providing influence and strategic support for acute and community health estate in Bedford Borough.
Governance & Responsible Group	<p>Strategic Health Estates Board</p> <p>Executive Delivery Group (EDG)</p> <p>Health and Wellbeing Board (H&WB)</p>
Geographical Footprint	Bedford Borough

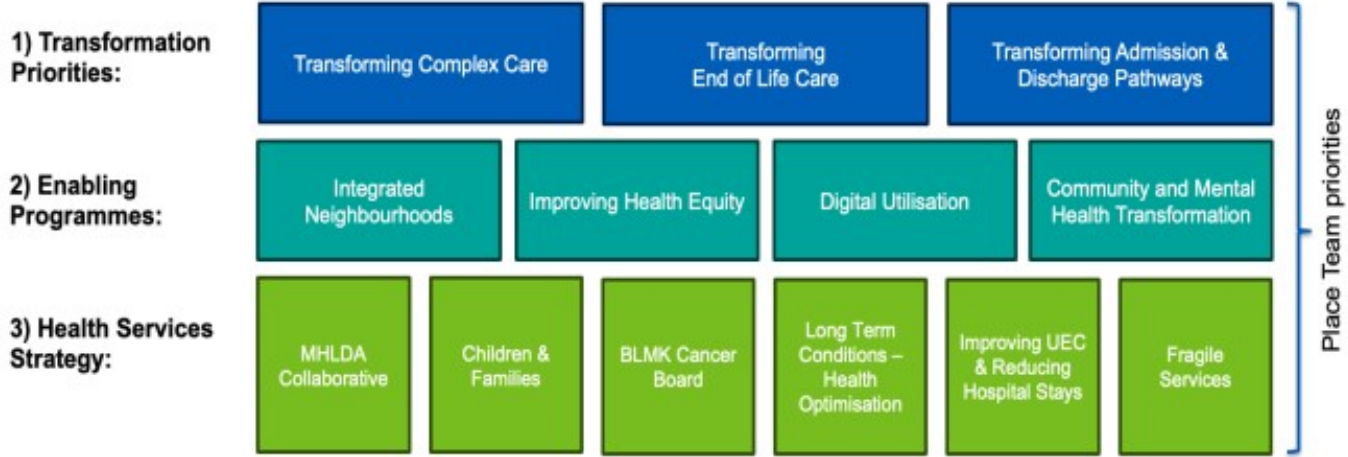
Project Team Members

Name	Role
Alex Wrack	Programme Manager
Lorraine Kavanagh	Programme Manager

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	<p>Led through the Bedford Borough Strategic Health Estate 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.</p> <p>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.</p>
Project Maturity	3.0 - Implementation

System Transformation



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

Currently: Integrated Neighbourhoods, Improving Health Equity, Children & Families

Progress Update

<p>Progress made in Previous Period</p>	<p>Updates on the estates projects to October 2025:</p> <p>Biddenham: The ICB and Bedford Borough Council have had further meetings with the developer around progressing the Biddenham primary care new-build project. Despite challenges with the financial viability of the project, officers are working in partnership to support the developer to try to find a viable option.</p> <p>Great Barford: Work towards a new Great Barford GP Surgery is continuing, with officers preparing to submit a full planning application, rather than the initial pre-app as previously planned. This is in order to save time in the process.</p> <p>Kempston: The consultants Turner and Townsend have made considerable progress through the Outline Business Case (OBC) and are working with architects to find the most cost effective option that would fit the local environment and provide the space needed for the surgery. While different price options are being explored, this project is still expected to be at least £18 million and therefore significant capital funding would need to be found to deliver the project.</p> <p>Wixams: There have been a series of discussions between Bedford Borough Council (BBC), Central Bedfordshire Council (CBC) and the ICB regarding options for accelerating delivery of a healthcare facility in Wixams. CBC have secured in principle significant sums of S106 funding for the Wixams South developments which will help to deliver a facility, but this funding is unlikely to be available for a number of years. The ICB has limited access to capital funding; therefore, any acceleration of the project will require a partnership approach. Delivering a facility in Wixams remains a stated ambition for the ICB, with strong support from both Councils. The Councils, ICB and the developer are continuing to work together to find a suitable solution. Options being discussed include exploring any alternative funding sources, and the potential for one of the partners to “forward-fund” the S106 funding for several years, which could enable faster delivery of the permanent healthcare facility.</p> <p>Wootton: A replacement health facility in Wootton was not considered affordable by the ICB in their Primary Care Estate – Prioritisation of Revenue Consequences process in 2023. The Council has continued to pressure the ICB to improve facilities at Wootton and commissioned a high-level feasibility study to identify potential costs ahead of any potential funding becoming available. A pre-app has been carried out for this project to understand limitations and possibilities. As it stands, the project would require significant revenue investment from the ICB which is not available at this time, due to financial constraints.</p>
<p>Progress to be made in Next Period</p>	<p>Great Barford: Officers are submitting a full planning application for this project. Key local stakeholders from the GP Surgery and the local Parish Council will have the planning information shared with them.</p> <p>Kempston: Turner and Townsend will complete 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.</p> <p>Wootton: The Council Executive will consider a business case for Wootton to decide if the project is viable without additional revenue funding from the ICB.</p>

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.

	Start Date	End Date	2025										2026				
			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	◆														
Ongoing negotiations with developers regarding Wixams development		30/04/25	◆														
Potentially acquiring the Kempston Police Station site on Halsey Rd. 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 Wootton development.	25/04/25	01/08/25	■														
Submit full planning application for Great Barford development (was previously planned to be a pre-app and therefore pushed back as additional work needed).	20/10/25	09/01/26									■						

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	<p>Timeframes for work are liable to slip as there are many factors affecting progression including:</p> <ul style="list-style-type: none"> • 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	20/10/2025
Project Code	PR000161
Project Name	BB - Placed Based Plan Priorities – Starting Well
Project Team	Bedford
Project Aim	<ul style="list-style-type: none">• Reduce childhood obesity and increase physical activity• Improve children’s oral health• Increase uptake of antenatal and childhood immunisations
Governance & Responsible Group	Executive Delivery Group (EDG)
Geographical Footprint	Bedford Borough

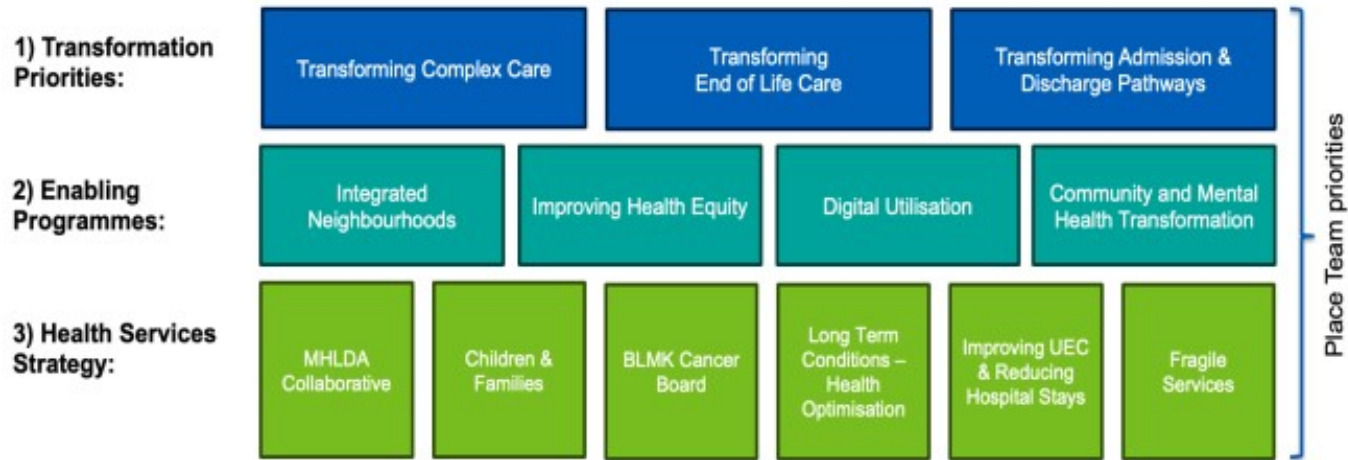
Project Team Members

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

Project Status

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

System Transformation



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

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

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

Progress Update

Reducing childhood obesity & increasing activity:

- Choose You provided by Public Health was launched on 1st April. Choose You delivers the HENRY programme to children and families on a one-to-one basis to support healthy weight. They also deliver an adult weight management, postnatal, and antenatal programmes. The service is experiencing a high number of weight management referrals, which may result in a longer wait time before patients receive a follow-up call. They are working hard to resolve this issue as quickly as possible by streamlining internal processes, recruiting to fulfil vacant roles, and redistributing resource to better meet service demand. The Choose You website provides access to self-support resources for those who are waiting to book onto the programmes or for those who would prefer going down a self-support route. You can access Choose You here: <https://chooseyou.co.uk/healthy-weight/children-and-families/>

Improving Children's Oral Health:

Dental Access in Bedford Borough

- Current Provision: Provision has increase to four providers. Three Dental practices delivering the NHS additional urgent dental care appointments scheme plus Community Dental Services provider operating from its Bedford site.

Progress made in Previous Period

- Access Challenges: Bedford place base has (twenty-three dental practices delivering NHS dental care which is the second most within BLMK place bases. As in other place bases there exists an ongoing unmet need which we continue to encounter.
- Urgent dental care: The additional urgent dental care appointment scheme has been expanded with four dental providers operating within Bedford place base. Both of our NHS 111 providers can direct residents to our selected providers with the aim of maximising the utilisation of the available additional urgent dental care appointments.
- General: There are three dental practices within Bedford Borough that have been issued with more NHS dental activity in 2025/2026, 9,105 additional units of dental activity to support providing more general dental (routine) care to our residents in Bedford.
- Our dental practices continue to have recruitment and retention challenges, two dentists have left the Bedford patch in the last six weeks and we are supporting dental practices via the dental recruitment incentive scheme.

Oral Health

- The Integrated Health and Education Review at 2-2.5 years reached 85% of children in Q1 2025-26. Quality Improvement in relation to uptake of the review is taking place to better understand the barriers to attendance.
- The National Childhood Measurement Programme (NCMP) is delivered to children in Year R and Year 6. Over 99% of children in Bedford Borough schools were screened within the academic year 2024-25.
- The 0-19 team distribute toothbrushes, toothpaste to all Year R pupils. Additional targeted education support is being delivered in the most deprived areas. The Bedfordshire Oral Health Improvement Service continue to offer support to targeted settings through the Let's Brush and My Smile toothbrushing schemes.
- DHSC Supervised Toothbrushing Scheme: September 2025 – 16 new settings have been identified in the most deprived areas of Bedford Borough. They have received free toothbrushing kits/resources and have been invited to sign up for a supervised toothbrushing scheme for 3,4,5 year olds.

Imms & Vaccs

The Bedford Borough Place team continue to support the NHS England Screening and Immunisation team to contact practices that are highlighted as having low vaccine uptake.

The place team attend the NHSE BLMK ICB practice data meetings to receive updates on:

- Data: flu 2- & 3-year-old (if relevant); MMR; 8-week imms; 1-year imms; pertussis in pregnancy; RSV in pregnancy (snapshot)
- Practices being actively engaged by CHIS / NHSE (includes waiting list work and others, i.e. RSV low uptake older adults)
- Any immunisation-related incidents or complaints of note

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

Tasks & Milestones

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

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

Risks

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

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

Risks

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

Issues

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

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	22/10/2025
Project Code	PR000346
Project Name	CB - Dementia Diagnosis and Prevention
Project Team	Balraj Singh Rai - Central Bedfordshire Place Team
Project Aim	<p>Project Aim To contribute directly to achieving the national dementia diagnosis ambition rate of 66.7% in Central Bedfordshire by improving timely and accurate dementia diagnosis. The project focuses on supporting GPs with training and tools, strengthening pathways across health and social care, and reducing inequalities in access to assessment and support.</p> <p>Project Scope</p> <ul style="list-style-type: none"> • Develop a targeted programme of GP training to improve dementia assessment confidence and accuracy. • Conduct deep-dive analysis and utilise JSNA insights to identify key local gaps and priority groups. • Pilot innovative tools and interventions in primary care to streamline early identification and referral. • Embed outputs into Central Bedfordshire’s wider Integrated Neighbourhood Working (INW) model to ensure sustainability.
Governance & Responsible Group	<ul style="list-style-type: none"> • Central Bedfordshire Place Team • Central Bedfordshire Dementia Diagnosis Task & Finish Group • BLMK Dementia Strategy Group • DOG (Dementia Operational Group)
Geographical Footprint	Central Bedfordshire

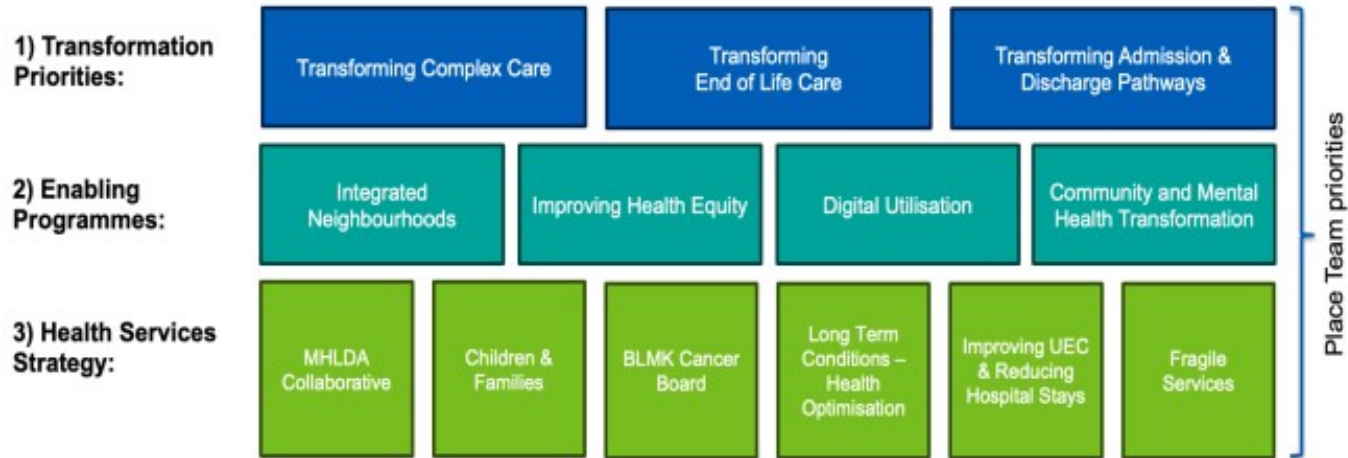
Project Team Members

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

Project Status

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

System Transformation



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

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

Progress Update

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

developed and piloted become 'business as usual' in wider Dementia work in BMK

Update on May 25 to July 25 reporting period:

Action plan development and Exit Strategy:

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

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

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

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

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

Update on August 25 to October 25:

- Meetings of the Dementia Strategy Group and Dementia Operational Group have not taken place/ were not attended in this period
- Focused work around piloting an assessment tool in primary care settings continues to develop well with two practices in two separate PCN areas - please see below for ambition on this
- Liaison with key stakeholders eg. Tibbs Dementia Foundation , to secure patient involvement in different aspects the project's three elements

Progress made in Previous Period

Progress to be made in Next Period

In the next reporting period (October to December 2025):

- Continue to support the implementation of the pilot assessment tool in primary care settings via development of a "baseline" ,e,ory assessment proforma/ survey for implementation in the pilot practices
- Continue dialogue with C Beds MH Lead at Shefford HC to secure their active involvement in the pilot phase
- Continue dialogue for development of the approach around Communications & Engagement and Workforce Development with key stakeholders
- Work alongside existing strategic Dementia Governance structures in BLMK to develop exit plan
- Plan the expansion pilot of early assessment tool in Primary Care to wider PCNs/ GPs (from January 2026)
- Data reporting to monitor progress against the national 66.7% target at neighbourhood and Place level

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

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

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

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

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

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

	Start Date	End Date	2025							2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Publication of JSNA Health Needs Assessment chapter on Dementia	01/04/25	31/05/25	█											
Project Update to Central Bedfordshire Clinical Director's	29/05/25	12/06/25		█										
Draft of Workforce Development plan	01/08/25	30/11/25					█							

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Review and identify existing governance - for handover stage	01/08/25	30/11/25															
Sign-off CB DDR Action Plan at Task & Finish Group and two BLMK strategic Dementia Groups	01/07/25	31/12/25															
Dementia Strategic Group - Agree action plan	01/08/25	31/12/25															
Dementia Diagnosis in Primary Care Assessment Tool pilot	01/08/25	28/02/26															
CB Dementia Diagnosis	02/01/25	31/03/26															
Develop and refine the Central Bedfordshire Dementia Diagnosis approach on Verto	01/06/25	31/03/26															
Exit Strategy - development to ensure work is assimilated into wider Governance Structures in BLMK	01/08/25	31/03/26															

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	status reflects a cautionary position where the project is progressing but with notable concerns that need active monitoring and resolution.

Risks

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

Issues

Overall Issues Status	TBC
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

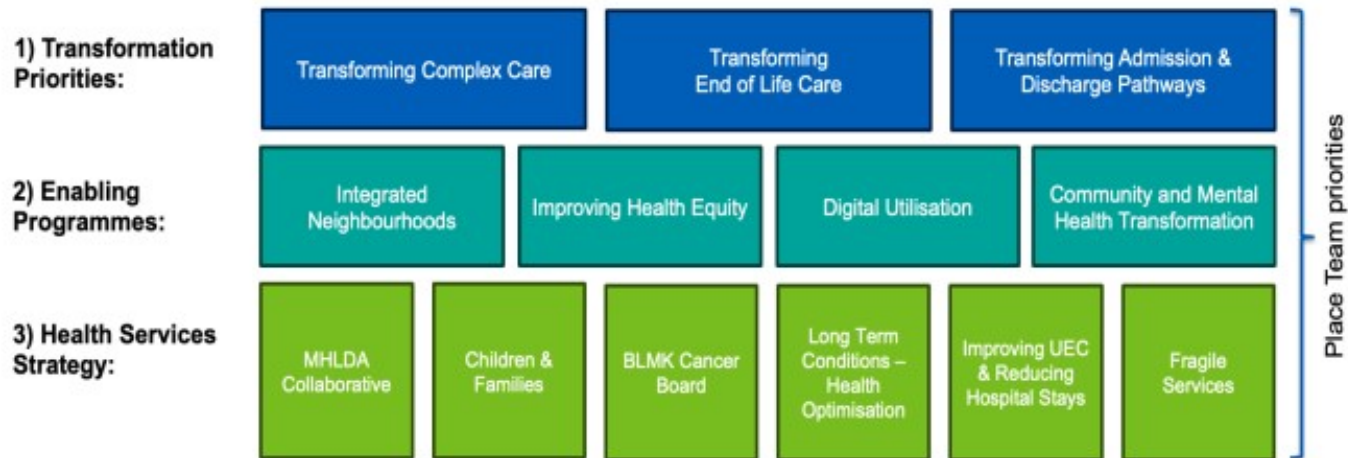
Date of Highlight Report	22/10/2025
Project Code	PR000345
Project Name	CB - Falls Prevention Service (CBFPS)
Project Team	Central Bedfordshire Falls Prevention Service Project Group
Project Aim	<p>Project Aim To reduce falls incidence and related hospital admissions across Central Bedfordshire by developing an integrated Falls Prevention Service. The programme focuses on early identification, community-based interventions, and improved care pathways to enhance independence, safety, and wellbeing for residents at risk of falls.</p> <p>For individual service users, the objective of the service is to reduce the likelihood of them falling or re-falling, and if they do fall, reducing the likelihood of them seriously injuring themselves.</p> <p>Project Scope</p> <ul style="list-style-type: none">• Establish a coordinated multi-agency Falls Prevention Service aligned with national best practice.• Deliver targeted community interventions, including strength and balance programmes, home hazard assessments, and medication reviews.• Strengthen referral pathways between primary care, community services, and acute trusts.• Build a robust monitoring and evaluation framework to demonstrate outcomes and system impact.
Governance & Responsible Group	Falls Prevention Service Steering Group Central Bedfordshire Place Board ICB board
Geographical Footprint	Central Bedfordshire

Project Team Members

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

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

System Transformation



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

- NHS Outcomes Framework Domains & Indicators

Domain 1: Preventing people from dying prematurely v

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

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

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

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

Progress Update

Progress made in Previous Period

Agreed and signed-off:

Service model agreed with stakeholders, with input from social care, VCSE, and community therapy teams.

- Engagement with PCNs and community providers secured to support onward referral and follow-up.
- BCF Funding for 1 year from "go-live" date
- Nominated project lead in provider organisation (ELFT)
- Recruitment process for designated clinical staff

Drafted for approval:

- KPI's, including service metrics
- Service Specification

Progress update August 25 to October 25 reporting period:

- Service started on 8 September 2025
- Work underway around monitoring, evaluation, and defining metrics

Progress to be made in Next Period	<p>October 25 to December 25:</p> <ul style="list-style-type: none"> • Standardised referral pathway developed and being implemented/ monitored • Monitor uptake and troubleshoot any emergent issues • Consider a new round of publicity for the service, if appropriate • Make Care Homes aware of the Falls training that is available to all staff, via EHiCH group and direct communication • Hold first evaluation session (early December)
------------------------------------	---

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
-----------------------------------	--------------

Reason for Overall Tasks & Milestones Status	<p>Several key tasks are completed (detailed below) to allow implementation of the project:</p> <ul style="list-style-type: none"> • Better Care Fund Funding for one year (from the "go live" date has been secured and agreed • Contract Variation has been agreed • KPI's for ELFT are agreed <p>Other aspects are in-train and developing, namely:</p> <ul style="list-style-type: none"> • Communications piece for the new service has been drafted • KPIs for the strength and balance classes the CBC Active Lifestyle team provide are drafted • KPIs for the level 1 Falls prevention service the CBC team provide are drafted • Support ELFT in staff recruitment process • Consultant Clinic and MDT support • S1 development and data sharing • Implementation/ integration with other services • Performance metrics • Strength & Balance L1 • Website development • Falls Pathway training in CHS • Patient Information
--	---

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Better Care Fund Funding	02/01/25	30/04/25	█														
Contract Variation	02/01/25	30/04/25	█														
KPIs with ELFT (Community Services Provider)	02/01/25	30/04/25	█														
Communications Briefing - First Distribution	30/04/25	31/07/25	█	█	█	█	█										
Communications via attendance at C Beds PM's meeting on 03/09/25	28/07/25	04/09/25				█	█	█	█								
Communications Briefing - Second Distribution	26/08/25	05/09/25					█	█	█								
Communications via attendance at CB CD's meeting ON 11/09/25	28/07/25	12/09/25				█	█	█	█								
Agree KPIs for Strenfth & Balance classes from CBC Active Lifestyles Team	01/04/25	30/11/25	█	█	█	█	█	█	█	█	█						
Agree overall KPIs and measures for the new CBC Falls Prevention Service	01/04/25	30/11/25	█	█	█	█	█	█	█	█	█						
IG considerations across stakeholder organisations	01/07/25	30/11/25				█	█	█	█	█	█						
Active Lifestyles Programme KPI's and Funding	21/07/25	30/11/25				█	█	█	█	█	█						
Service Quarter 1 Review		12/12/25											◆				
Service Quarter 2 Review		13/03/26															◆

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

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Project timescale	Yes	15
Demand exceeds capacity if service is rapidly scaled without additional resources.	Yes	9

Engagement from primary care may vary, limiting referrals.

Yes

9

Issues

Overall Issues Status

TBC

Reason for Overall Issues Status

No issues identified for this reporting period

Issues

Issue Name

Key Issue?

Proximity & Impact

Portfolio Report Governance Report

Date of Highlight Report	22/10/2025
Project Code	PR000349
Project Name	CB - Health Inclusion Practitioners
Project Team	Central Bedfordshire
Project Aim	<p>To reduce health inequalities across Central Bedfordshire by targeting groups with the poorest access, experience, and outcomes. Current priority areas include child development reviews & vaccinations and in adults education and awareness of hypertension management in Gypsy, Roma, Traveller communities— all aligned to Core20PLUS5 national priorities.</p> <p>Cambridgeshire Community Services (CCS) 0 - 19 Health Visitor and Health Care Assistant will work with our core20plus5 Gypsy, Roma, Traveller families to improve the physical and mental health of children and young people working across 23 GRT sites in Central Bedfordshire. The team will ensure that there is continuity of care and will promote equality in the health and wellbeing of their patients. They will scope the needs of families and children, do community profiling to include identification of gaps in services, working in collaboration with local services to support any identified needs. Do targeted work with the most vulnerable families, providing early advice and intervention and facilitating access to health and support services in the local area with a view to reducing DNA rates for Child Development reviews. Work involves antenatal assessments, newborn assessments, growth monitoring, general advise and other Health Visitor activities.</p> <p>In addition the team will support the promotion education and awareness of hypertension and is part of GRT Learning & Action Network (LAN) in Central Bedfordshire.</p>
Governance & Responsible Group	Central Bedfordshire Place Board
Geographical Footprint	Central Bedfordshire

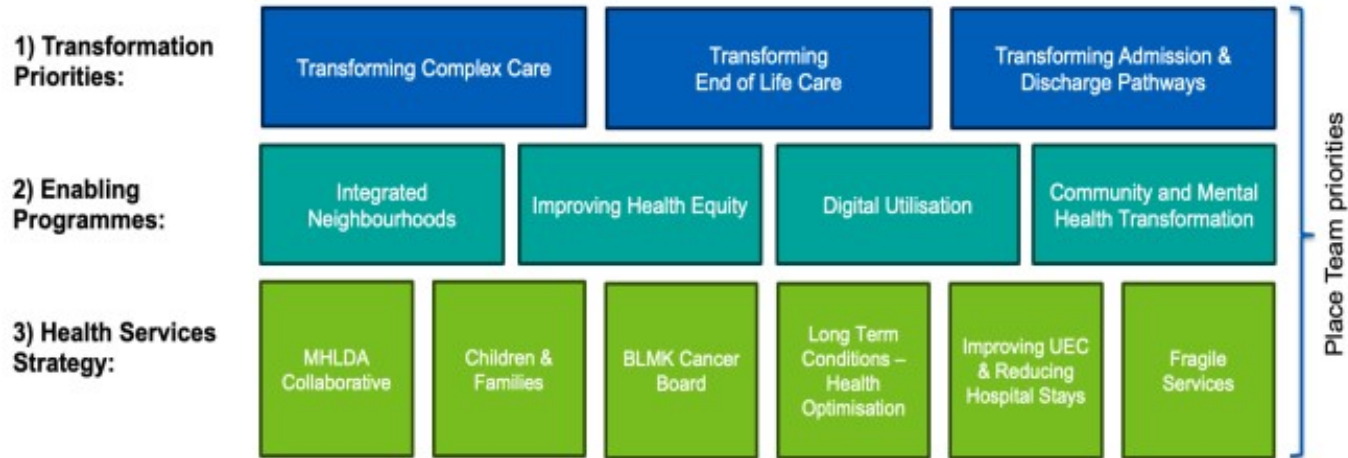
Project Team Members

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

Project Status

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

System Transformation



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

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

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

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

Progress Update

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

- * Education & awareness of hypertension management in Gypsy, Roma, Traveller communities.
- *To improve access to healthcare to those in inclusion health groups
- *To improve service user experience of healthcare

Progress:

Progress made in Previous Period

Targeted Sites increased from 20 to 23,

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

NB: Summer period - families on site go travelling so although a bit quiet, other families move and new children transfer in

August Update face to face Health assessments of families completed 25 antenatal assessments 1 new birth assessments (mother and baby) 46-8 growth monitoring week assessment 2 other face to face contacts, general advice 2

CCS have developed a Health Inclusion Page on their website where they are developing videos as a method of communicating with the community due to literacy issues, a QR code has been developed and is now used during visits and families scan this and parents are taken to the website where they can get access to vaccination and hypertension information.

August activity = Immunisation video views = 2 Hypertension conversations = 7, hypertension video will be used going forward

Know your numbers week - 8 - 14, had a focus on hypertension across Leighton Buzzard sites, shared hypertension video during interventions

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

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

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

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


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

Supporting cultural awareness of the needs of the community across health care professionals. Working with CB Place Team to support this work, attended monthly Practice Manager meeting to promote and now meeting with individual GP Practices during PLT or internal practice meetings.

<p>Progress to be made in Next Period</p>	<p>Launch community-based awareness campaigns</p> <p>Continue to build relationships across sites and with partners.</p> <p>LAN - Hypertension video to be used more to raise awareness.</p> <p>Progress deep-dive analysis into barriers to access and co-design interventions with communities and framework to evidence impact, ensuring alignment with Core20PLUS5 national priorities.</p> <p>CCS will continue with Health Visitor interventions & HTN discussions</p> <p>Engaging with community to gain service user feedback following interventions & following the creation of any video resources</p>
---	---

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, role dependent on engagement with the team and building trust which takes time. Work expanding from 6 sites to 20 and word spreading around site regarding the teams work.

	Start Date	End Date	2025										2026		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Monthly Performance catch up meeting	15/05/25	15/05/25													

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

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

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Persistent barriers to engagement with seldom-heard groups risk limiting reach and impact.	Yes	12
Transition of families from sites between May - September	Yes	9

Sustainability concerns if national or local funding streams reduce.

Yes

12

Issues

Overall Issues Status

AMBER

Reason for Overall Issues Status

No reported issues at the moment

Issues

Issue Name

Key Issue?

Proximity & Impact

Portfolio Report Governance Report

Date of Highlight Report	22/10/2025
Project Code	PR000287
Project Name	CB - Hypertension Management in C Beds - SMI
Project Team	Balraj Singh Rai/ Emma Moorbey
Project Aim	<p>Project Aim To improve detection, diagnosis, and management of hypertension in Central Bedfordshire, with a focus on tackling health inequalities and supporting targeted groups and residents with serious mental illness. The programme aims to reduce cardiovascular risk, prevent avoidable complications, and embed proactive community-based care.</p> <p>Project Scope</p> <ul style="list-style-type: none"> • Deliver targeted screening and case-finding interventions in patients with a SMI. • Improve primary care pathways for hypertension management in the priority group. • Develop culturally tailored approaches for SMI communities through VCSE partnerships. • Establish robust outcome monitoring to track improvements in diagnosis rates and management.
Governance & Responsible Group	<p>CB Hypertension Management Delivery Group</p> <p>Joint Leadership Group (C Beds)</p>
Geographical Footprint	Central Bedfordshire

Project Team Members

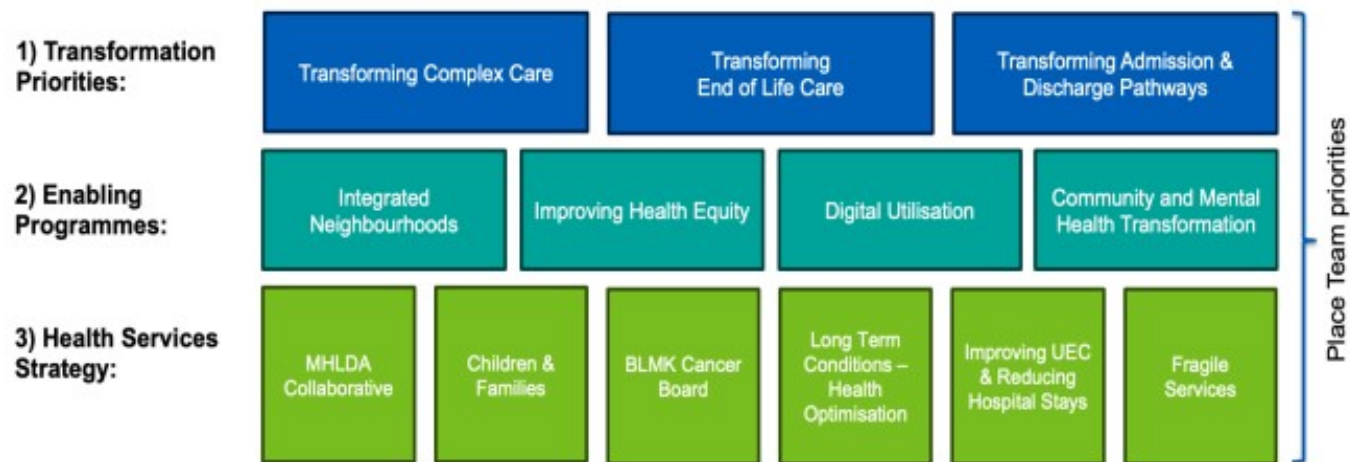
Name	Role
Noeleen Mcloughlin	Project Manager
Kaysie Conroy	Project Manager
Danny Karystinos	Project Manager
Emma Moorbey	Project Manager

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

Project Status

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

System Transformation



Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)	<ul style="list-style-type: none"> • 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 redefined around focus and strategy: Initiated relationships of collaboration with PCNs to embed targeted hypertension reviews for people with serious mental illness.
- Built partnership with Autism Bedfordshire and learning disability services to support inclusive approaches to blood pressure management.
- Dedicated team for LD and Autism convened, and meeting regularly
- Musiq score completed and agreed
- Charter and Scoping agreed
- Data conversation held, initial change idea focusing on 1 GP Practice agreed for testing
- Developed Aim, Fishbone 'cause & effect' graphic and Driver Diagram

Progress in last reporting period (May to July 2025):

- Project has been reviewed to move away from LAN structure, which has been shared with IHI and QI colleagues
- New colleagues have been engaged to form a network of support and action to hypertension management in patients with an SMI
- Engagement with resident representative - from target group: Autistic people is developing well
- Continuous engagement and collaboration with West Street Surgery, around Hypertension Management in LD

Progress in August to October 2025 period:

- Collaboration with Autism Bedford and resident representative to review clinical pathways and recommend adjustments is progressing.
- Collaboration to capture good practice at West Street Surgery (for hypertension management for people with LD) is underway
- PDSA cycles that have been undertaken around learning from LD and Autism cohort are being drafted alongside input/ guidance from IHI colleagues.
- Working alongside Autism Bedford and service users to finalise and implement survey to elicit 'the challenge/ problem' around high blood pressure/ control amongst patients with Autism

Progress to be made in Next Period

From October to December 2025:

- Develop meeting/ governance structure for SMI focused work and hold workshop to develop Aim, Driver Diagram and Fishbone illustration for SMI cohort
- Engage with key stakeholders to secure input of service users to the SMI project
- Collaboration with Autism Bedford and resident representative to review clinical pathways and recommend adjustments.
- Learning journey/ PDSA cycles that have been undertaken around learning from LD and Autism cohort to be drafted in collaboration with IHI colleagues
- Working alongside Autism Bedford and service users to finalise and implement survey to elicit 'the problem' around high blood pressure/ control amongst patients with Autism

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 for the SMI cohort

	Start Date	End Date	2025							2026					
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Questionnaire to elicit 'the problem' around blood pressure amongst patients with Autism to be designed and implemented	01/05/25	30/11/25		█											
PDSA Cycles to date (Autism and LD) to be logged/ written up	01/06/25	30/11/25		█											
Project Aim, Fishbone and Driver Diagram to be developed and signed off for SMI cohort	03/09/25	30/11/25							█						
Hold face to face QI introductory workshop	01/10/25	30/11/25							█						

Risks

Overall Risks Status

GREEN

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

Risks

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

Issues

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

Issues

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

Date of Highlight Report	22/10/2025
Project Code	PR000293
Project Name	CB - Integrated Neighbourhood Working
Project Team	Emma Moorbey, Noeleen McLoughlin, Balraj Singh Rai
	<p>Executive Summary</p> <p>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.</p> <p>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.</p> <p>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.</p> <ul style="list-style-type: none"> • System: Bedfordshire, Luton & Milton Keynes (BLMK) Integrated Care System (ICS) / ICB priorities: prevention, inequalities, person-centred care, productivity. • Place: Central Bedfordshire Council locality model; Primary Care Networks (PCNs); Community Health, Mental Health, Adult Social Care, VCFSE partners. • Drivers: Fuller Stocktake (Integrated Neighbourhood Teams), Core20PLUS5, hospital flow and discharge pressures, financial recovery, workforce constraints, digital interoperability gaps. <p>Vision: People in Central Bedfordshire receive joined-up, proactive, person- and community-centred care close to home, delivered by multidisciplinary neighbourhood teams that share goals, data and resources.</p> <p>Project Aim</p> <p>To embed Integrated Neighbourhood Working across Central Bedfordshire by aligning health, social care, and VCSE partners around population needs. The programme seeks to improve outcomes, reduce inequalities, and strengthen prevention by developing four neighbourhoods (West Mid Beds, Ivel Valley, Leighton Buzzard, and Chiltern Vale) into mature, multi-agency teams delivering joined-up, person-centred care.</p> <p>High Level Objectives</p>

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

Scope

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

Neighbourhood geography: Alignment to the PCNs

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

Core components to design/implement:

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

Workstreams

Project Aim

1. Communication and Engagement

Purpose:

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

Objectives:

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

Deliverables:

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

Constraints:

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

2. MDT Working

Purpose:

Evaluate the Working Together model and implement across Central Bedfordshire

Objectives:

- Standardise the Working Together process across Central Bedfordshire

Deliverables:

- Create a Working Together review group

- Standardise referral pathways, SPOA, outcomes and KPIs
- Develop a SOP or service specification
- Strengthen the feedback loop and engagement with residents, families, carers and partners
- Agreement to support the evaluation and governance reporting into the Delivery and Implementation Group

Constraints:

Dependent on availability of local data, stakeholder engagement, and resource capacity.

Governance & Responsible Group	Central Bedfordshire Assurance & Delivery Group
--------------------------------	---

Geographical Footprint	Central Bedfordshire
------------------------	----------------------

Project Team Members

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

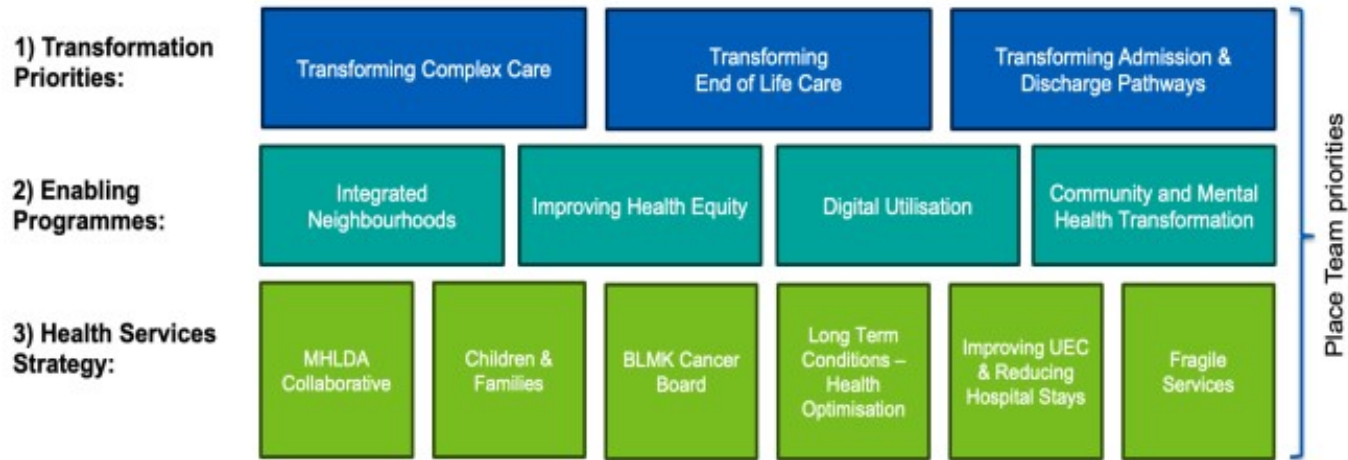
Project Status

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

Communication and Engagement Workstream:

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

Integrated Neighbourhood Working Groups:

- Aim and driver diagram completed for West Mid Beds
- Activity pack produced for Ivel Valley including Mental Health, housebound, smoke free and obesity data
- Working Together review group set up to review MDT working across Central Bedfordshire (replaced West Mid Beds Task & Finish group)
- Working Group and activity pack set up for Chiltern Vale and area of focus agreed as childhood obesity
- Asset map for physical assets in Central Bedfordshire set up on Google My Maps

Walking Buddies (HI Project):

- Metrics to be agreed and reporting to commence

Progress made in Previous Period

Winter Warmth Community Agents (HI Project):

- Outcome metrics agreed and reporting commenced in Quarter 2 2025/26:
 - Number of clients with an improvement across all areas of the Outcome Star scores at discharge and by dimension - 9
 - Number of clients reporting that they feel happier post intervention - 9
 - Number of clients reporting they have joined a social group - unknown
 - Number of clients reporting they are more active - unknown
- Agents undertook an Introduction to Domestic Engrery course run by NEA and a winter wise webinar run by independent Age
- 15 referrals received in Quarter 2 2045/26 from Client self referrals, BRCC community agents, BRCC CWC and Working Together Dunstable
- Increase of 5 referrals in Quarter 2 2025/26. (Q1 = 10, Q2 = 15)
- Onward referrals made to Better Housing Better Health, Beds Fire Brigade Warm & Well Team, Biggleswade Baptist Church Food Boost, Biggleswade Good Neighbours scheme, MDT and CBC HSF vouchers
- 9 visits to warm welcome spaces in Quarter 2 2025/26
- 7 Community groups visited
- Partnership working undertaken with 14 different organisations
- Stakeholder engagements have taken place to present the offer and promote the service
- Patients reported an improvement in the 7 key areas of their life. Areas most improved are 'Looking after yourself better' and 'Feeling positive'
- 94 year old client helped to switch to a new tariff, saving money per month and avoiding a price hike in October
- Donation of items received from a partner organisation to be given to clients in need (gilets, heated blankets and hot water bottles)
- provided joint support with BRCC agent to a vulnerable client in Biggleswade
- Supported running of slow cooker courses in Dunstable and Sandy. Slow cookers were donated and given to participants

Working Together (MDT) Review Group:

- Working Together review group set up
- Begin to review action plan and Clarity Consulting evaluation

Progress to be made in Next Period

Communication and Engagement Workstream:

- Produce a comms piece for key stakeholders (GPs, PCNs, etc) on Working Together MDT
- Continue to develop INW pack and identify channels of distribution

Integrated Neighbourhood Working Groups:

- Identify SRO for West Mid Beds
- Plan on a Page, metrics and measure to be completed for West Mid Beds
- Flowchart for Frailty referrals to be completed for West Mid Beds
- DPIA assessment for referrals to be completed for West Mid Beds
- Identify SRO for Ivel Valley
- Aim and driver diagram to be completed for Ivel Valley
- Cause & Effect diagram to be completed for Ivel Valley
- Identify SRO for Chiltern Vale
- Determine if Beds Fire & Rescue Service is part of BLMK sharing agreement and process to be added if not
- Asset map to be embedded on the ICS website along with INW information

Walking Buddies (HI Project):

- To continue monitoring service performance

Winter Warmth Community Agents (HI Project):

- To continue monitoring service performance

Working Together (MDT) Review Group:

- Review action plan and Clarity Consulting evaluation with ELFT
- Update action plan with comments, proposed leads and work happened to date
- Identify gaps in the plan for further discussion

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

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

Risks

Overall Risks Status **AMBER**

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

Risks

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

Issues

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

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	15/10/2025
Project Code	PR000288
Project Name	CB - LAN 02 - Pressures on
Project Team	Noeleen McLoughlin
Project Aim	<p>To improve hypertension detection, diagnosis, and management within Gypsy, Roma and Traveller (GRT) communities in Central Bedfordshire. The project seeks to address health inequalities by increasing awareness, access to screening, and early intervention, while embedding culturally sensitive approaches that build trust and improve long-term outcomes.</p> <p>To increase the percentage of GRT residents of all genders, 18+ with managed blood pressure (clinic BP below 140/90 mmHg) from Ivel Valley Neighbourhood and registered with one of three practices within IVS PCN which is serving this area by 20% by end of the LAN QI work March 2026.</p>
Governance & Responsible Group	<p>CB Place Team</p> <p>BLMK LAN Programme</p>
Geographical Footprint	Central Bedfordshire

Project Team Members

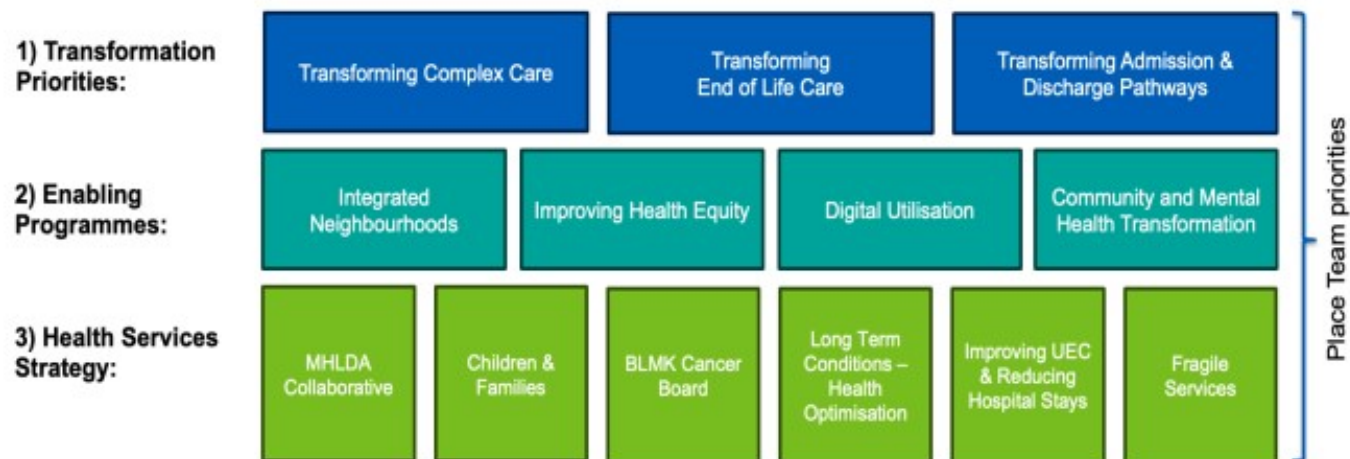
Name	Role
Noeleen Mcloughlin	Project Manager
Danny Karystinos	Project Manager
Balraj Singhrai	Project Manager
Kaysie Conroy	Project Manager
Emma Moorbey	Project Manager
Angela Zambeaux	QI Observer
Lourena Mendes	QI Observer
Brenda Carson	QI Observer
Shelby Reed	QI Observer

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



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

Progress Update

	<p>15.10.2025</p> <p>Delivered community-based hypertension screening event in partnership with local GRT representatives and partners.</p>
--	--

"Know your numbers week in (8-14) September"

Robust engagement and promotion event delivering blood pressure checks, education and awareness to the whole of Ivel Valley neighborhood GRT sites took place. The event helped to reduce stigma and increase accessibility to this community. Collaboration during the event was with LA, local PCNs & Practices, CCS and Community Pharmacy. PCN and Council colleagues advertised the event during their regular visits prior to the event with 12 additional sites targeted during the event were.

*124 education & awareness individual conversations took place

*65 BPs taken

*In addition, collaboration with Community Pharmacies who supported signposting & referrals and offered BPs to the wider community during this week with 147 BPs completed.

Ambition is in building strong links with primary care to ensure direct referral pathways and continuity of care for individuals with raised blood pressure.

*A communication plan was drawn up and other Practices and community pharmacies in Ivel Valley and we kept them informed about the initiative and invited to support the work if required. National communications helped in promoting awareness. Links strengthened with Pharmacist Lead who helped when needed and collaborated with other Pharmacies to support taking BPs across Ivel Valley that week.

* Online GRT Cultural Awareness session - taking place during Protected Learning Time (PLT) across Bedfordshire and Luton to all General Practice Staff - 15.10.2025

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

* Hypertension video completed formatting and a communications plan developed to share as a resource across system, regional and national partners. This resource was used during the know your numbers campaign and well received and will be used during interventions across sites.

*CBC - using resource to support education and awareness during site visits, feedback has been positive

*CCS sharing hypertension video to support education and awareness with families during site interventions, and gaining feedback regarding the resource. Resource added to CCS Health Inclusion webpage and families directed to the resource via a QR code which is scanned during visits.

* GRT Forums - sent hypertension video for sharing with professionals working with our communities, positive feedback been received.

Progress made in Previous Period

IVS PCN clinicians followed up on identified patients data linked to our teams aim statement, to see what improvement has been made. Discussions continuing with IVS PCN to see what data could be measured going forward

Lessons learnt update presented to IHI session during September two day event

Continue with robust engagement and integration of blood pressure checks, education and awareness into wider community wellbeing events and family visits to reduce stigma and increase accessibility.

Data and outcome measures & lessons learnt

Communication plan for hypertension video being rolled out via LAN Team

Progress to be made in Next Period

LAN Team continuing to focus on data collection for up and running change ideas, making modifications to PDSAs then reviewing, considering what can be measured that demonstrates our impact on the work we are doing. Building on the success of know your numbers week a second event is being considered by partners for in the new year.

Linking with LAN team to promote other ideas on how to continue to promote blood pressure checks for the community

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

On Track

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

Risks

Overall Risks Status

AMBER

Reason for Overall Risk Status	<p>Generally the project is progressing well.</p> <p>The main risk currently is the loss of residents. To mitigate this Place Team is raising awareness of the work of the LAN to see where we may be able to get more residents involved and collaborate. CCS & CBC linking in with families to ask about collaboration in the future.</p> <p>Loss of LAN Team members, due to contract end dates that are not being renewed , transition, and changes in partner organisations. To mitigate these we have got lots of change ideas up and running. We are networking with system groups that can help promote and support our work .</p>
--------------------------------	--

Risks

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

Issues

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

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	20/10/2025
Project Code	PR000172
Project Name	Luton - Early intervention, Prevention, and Partnerships
Project Team	Luton
Project Aim	<p>Smoking cessation</p> <ul style="list-style-type: none">-Continuation of the NHS Long Term Plan Treating Tobacco Dependency programme within acute, maternity and mental health inpatient settings <p>Weight management</p> <ul style="list-style-type: none">- Successful pilot of the NHS Digital Weight Management Programme within Luton GP practices <p>Cancer</p> <ul style="list-style-type: none">- Increase in early diagnosis & 1 year survival rate <p>Learning disability and autism</p> <ul style="list-style-type: none">- Decrease inpatient cohort against trajectory <p>Vaccinations</p> <ul style="list-style-type: none">- Increased uptake in cohorts, especially within vulnerable groups. <p>Mental Health</p> <ul style="list-style-type: none">- Increased engagement with ELFT, and an increased number of Luton residents accessing CMHT teams where appropriate.
Governance & Responsible Group	Prevention in Primary Care Connectivity Group
Geographical Footprint	Luton

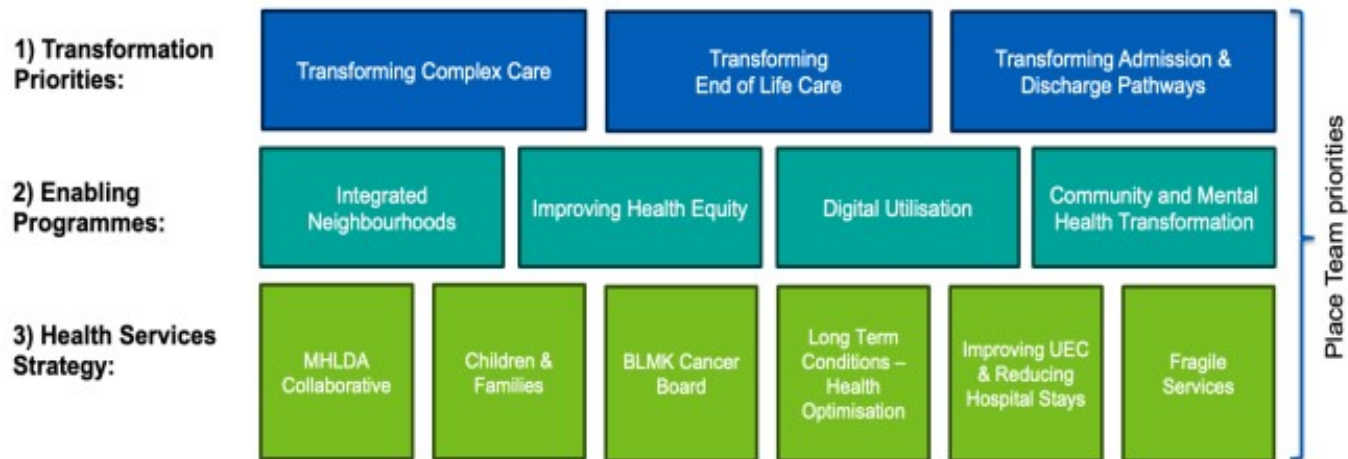
Project Team Members

Name	Role
Faith Haslam	Programme Manager
Kamini Patel	Programme Manager
Rehan Tariq	Project Manager
Kamini Patel	Project Manager
Andrew Rochford	Senior Responsible Owner

Project Status

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

System Transformation



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

1. Transformation Priorities:

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

2. Enabling programmes:

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

3. Health Service Strategy:

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

Progress Update

Progress made in Previous Period

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

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

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

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

Tasks & Milestones

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

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

Risks

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

Risks

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

Issues

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

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	20/10/2025
Project Code	PR000248
Project Name	Luton - Health Ageing Programme (BCF)
Project Team	Diane Meddick - Luton Place Team
Project Aim	<p>The business case was successful in requesting continuation of the £149,176 2023/24 BCF Funding (with the assumed 5.66% uplift) for a further 2 years to support this intervention which will help reduce the number of falls and the frailty status of this specific cohort of the population of Luton through encouraging them to participate in light physical activity to ensure better healthy lives and quality of lived years. By continuing the funding it allows further time to consider the future approach and sustainability of this intervention in relation to the fuller report and the development of neighbourhood teams and proactive personalised care for people with complex needs.</p> <p>The funding comes to an end at the end of April 2026 so a new business case to continue this programme will be produced in November / December 2025</p> <p>Summary: Quarter 2 has demonstrated strong growth, particularly in community reach and programme diversity. With a mix of new classes, innovative activities, and operational developments, the Healthy Ageing Programme is on track to deliver inclusive, sustainable opportunities that promote active ageing.</p> <p>The Healthy Ageing Programme focusses on offering a programme of physical activity free of charge for 12 weeks to encourage individuals to become more active in their day to day lives. The physical exercise provides an opportunity to improve strength, stability and mobility of those aged 65+ with a mild and moderate frailty score in Luton, and will support the Luton Sports and Physical Activity Strategy that is being developed by Luton Council in partnership with Be Active.</p> <p>The Luton Healthy Ageing Programme also supports the wider integrated falls pathway which has an emphasis on falls prevention and will support the delivery of the following objectives;</p> <p>Ensure people getting older stay stable, strong and safe</p> <ul style="list-style-type: none"> • Reduce the chances of a “first fall” being injurious • Ensure effective treatment of injurious falls, helping people return to maximum independence • Maximise the well-being of multi fallers • Reduce hospital admissions related to falls <p>People aged over 65, who score as ‘mildly frail’ via electronic frailty index, and some of the moderately frail patients identified within</p>

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.

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

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

Governance & Responsible Group

The Joint Strategic Commissioning Group

Geographical Footprint

Luton

Project Team Members

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

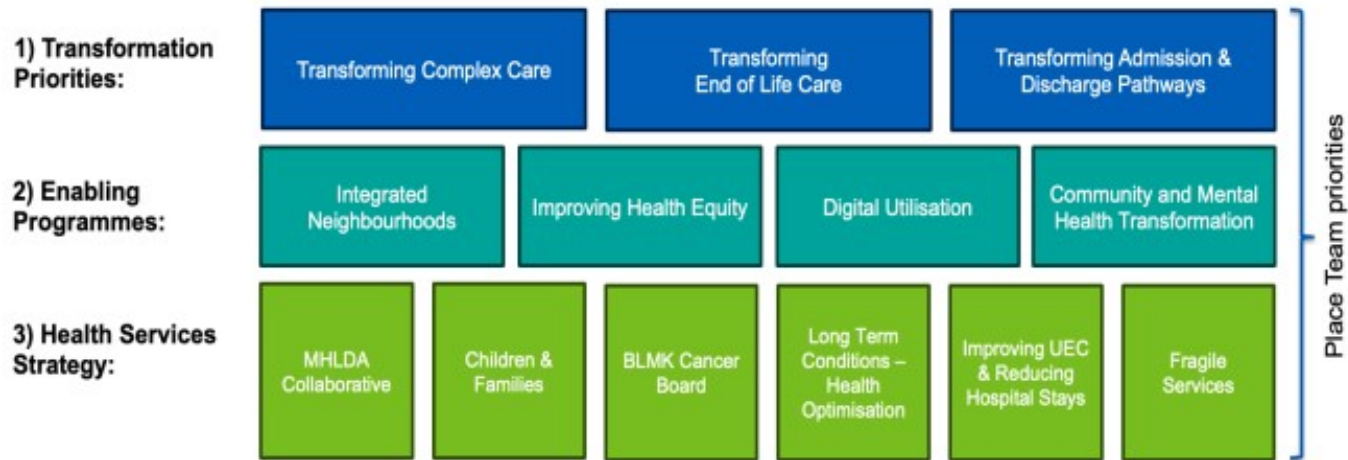
Project Status

Overall Project Status

GREEN

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

System Transformation



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

This programme aligns back to the following:

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

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

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

Progress made in Previous Period

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

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

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

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

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

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

Advertising the service on GP waiting room screens

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

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

Collaborative approach with practices/primary care networks directly

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

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

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

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

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

Progress to be made in Next Period

University of Bedfordshire Team continue to engage with primary care networks, community engagement events and local places of worship to raise awareness of the programme, hand out flyers and encourage self-referral Plans to increase activity within the most popular venues during 25/26. Second Positive movement session to commence at 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 of the programme, ensuring all is in place ahead of April 2025. The Place Team now has full control and responsibility for this programme of work. The programme Lead will be meeting with the UoB to ensure robust reporting on progress Place team colleagues will use connectivity opportunities through the Luton LAN and other Integrated Neighbourhood working events to engage with wider providers and re-connect with services that also support this cohort of the population, including Adult Social Care services and Mental Health and Well-being The Luton place team will start to introduce the Luton Healthy Ageing Team into the place-based meetings to support connectivity and engagement to drive up referrals further as they are key partner in Luton Integrated Neighbourhoods Working.

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

Annual report and regular reports demonstrate meeting key milestones and tasks

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Evaluation	01/12/24	30/05/25	█														
Dashboard	01/12/24	31/07/25	█														
GP and PCN engagement	02/04/24	31/07/25	█														
Mid Year Review	30/06/25	30/10/25			█												
Review Frailty List	30/06/25	31/12/25			█												
Developing a usiness Case for funding for 2026/ 2028		31/12/25															◆
Prioritise co-production working to renew offers of activity for participants by collecting information on what is needed or why people decline the offer		31/01/26															◆

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 Both issues are pivotal and unresolved, warranting attention.

Issues

Issue Name	Key Issue?	Proximity & Impact
Dashboard delivery delayed	Yes	4
Business Case for future funding from 31 03 2026	Yes	5

Date of Highlight Report	20/10/2025
Project Code	PR000223
Project Name	Luton - Integrated Neighbourhood Working
Project Team	Luton Place
Project Aim	<p>Integrated Neighbourhood Working</p> <p>Citizens, communities, stakeholders and service providers working together to build resilience and confidence, through a holistic, organic and personalised neighbourhood approach, providing equal opportunities for individuals to improve their health and wellbeing outcomes and live more years in better health.'</p> <p>Multi Disciplinary Teams for High Intensity Users</p> <p>Mapping of MDTs</p> <p>The purpose of this project will be to map the current MDT's, including the purpose, interconnectivity, and accessibility. This understanding will provide a picture of the MDTs that take place across Luton and identify the variability in approach and any gaps. Bringing this information together will provide an opportunity to refresh existing models.</p> <p>The mapping will provide an understanding of the types of patient cohorts under an MDT approach currently, that will link with our Luton place priorities for example complex care and frailty patient cohort.</p> <p>Expansion of MDTs</p> <p>Following the review of existing MDTs, it will be crucial to lean into neighbourhood working to further support patient needs through community-based care, to identify what additionality can be included within MDTs to support the patient both clinically and holistically.</p> <p>We will use population health management data to identify patient needs and trends to adapt capacity and placement based on that need. MDTs was first introduced with a patient in mind who may have multiple co morbidities or complex needs and therefore may also require a health and wellbeing intervention as well clinical. To ensure we are covering both angles or determining which, we will expand upon our MDTs and tap into our personalised health model to support care in other ways such as social prescribing.</p> <p>The project aims to consider patient cases that are not progressing, where a 'diagnosis' is not necessarily required or appropriate but support in their lifestyle or wellbeing.</p> <p>Mapping of HIU schemes across partnership organizations</p>

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

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

Identifying a cohort for MDT working.

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

Structure and framework for MDTs

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

Building Healthier Communities (stakeholder events)

5 neighbourhood based events to facilitate stakeholder engagement and connectivity.

Hypertension

Know Your Numbers Hypertension Campaign in West Central

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

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

Governance & Responsible Group

Luton Integrated Neighbourhood Collaborative (LINC)

Geographical Footprint

Luton

Project Team Members

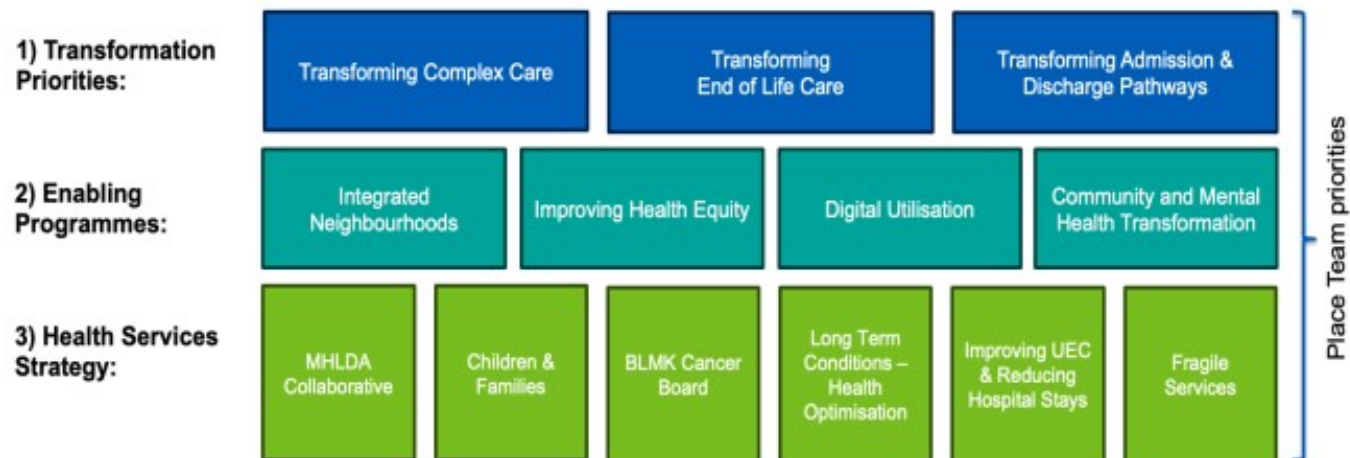
Name	Role
Faith Haslam	Programme Manager
Kate Sutherland	Programme Manager
Diane Meddick	Programme Manager
Kamini Patel	Project Manager
Rehan Tariq	Project Manager

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

Project Status

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

System Transformation



Integrated Neighbourhood Working

1. Transforming admissions and discharge pathway

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

2. Integrated Neighbourhood Working

This programme of work will directly address this.

3. All

This programme of work will encompass all Health Services Strategies.

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

Multi Disciplinary Teams for High Intensity Users

1. Transforming admissions and discharge pathway

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

2. Integrated Neighbourhood Working

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

3. LTC Health Optimisation/ Improving UEC

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

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

Building Healthier Communities (stakeholder events)

1. Transforming admissions and discharge pathway

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

2. Integrated Neighbourhood Working

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

3. All

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

Hypertension

Know Your Numbers Hypertension Campaign in West Central

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

and strokes

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

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

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

Progress Update

Multi Disciplinary Teams for High Intensity Users

Q4- End of March 2025

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

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

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

Building Healthier Communities (stakeholder events)

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

Hypertension

Q3 2024-25

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

Q1 2025-26

Progress made in Previous Period

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

Q2 2025-26

- Supported the delivery of Luton Health Fest (5 July):
 - Outcomes: 400 Blood pressure checks were completed by community pharmacy. 74 patients were identified with high blood pressure (18.5% potential hypertension detection rate). All patients with high readings were given healthy lifestyle advice and blood pressure education with either follow up appointments or signposting to the appropriate health service.
- During the month of September Luton Place Team, Public Health, colleagues in the LAN Programme group supported and organised several events to increase hypertension awareness and management, screening and hypertension case finding in the community. These were timed to coincide with the annual 'Know your Numbers' week. Events included the Luton Baako Festival, Ujala Indian Luncheon Club, Over 50 Black Men Group, Unity Fest and a Blood Pressure awareness and screening session at Luton Point on Sunday 14th September. This has resulted in over 350+ BP and health checks with a high number of residents with potential stage 1 hypertension. Results were shared with the GP practices and residents given advice on lifestyle and blood pressure management, if appropriate. A number of residents with high blood pressure were referred on including referral to community pharmacy for 24 hour ambulatory blood pressure monitoring.

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 - project on hold and continuing hypertension work under LAN and community event

Q2 2025-26

- Delivery of Luton Health Fest (5 July):
 - Outcomes: 400 Blood pressure checks were completed by community pharmacy. 74 patients were identified with high blood pressure (18.5% potential hypertension detection rate). All patients with high readings were given healthy lifestyle advice and blood pressure education with either follow up appointments or signposting to the appropriate health service.
- September 2025: Delivery of several events to increase hypertension awareness and management, screening and hypertension case finding in the community. eg Luton Baako Festival, Ujala Indian Luncheon Club, Over 50 Black Men Group, Unity Fest and a Blood Pressure awareness and screening session at Luton Point on Sunday 14th September.

Q3 2025-26

On October 22nd Luton Place team in partnership with the Council are hosting an Employment, Education, Training, and Health and Wellbeing Fair at Luton Point. The event aims to encourage attendance residents who are economically inactive or on long-term sick leave, helping connect them with local opportunities and support.

Support the delivery of:

- 25.10.25 - CVD/Hypertension awareness and screening event community for the Black Community at Lewsey Community Centre
- 28.10.25 - Support the Amenia Centre to deliver a community event focusing on heart disease, high blood pressure in the African and Caribbean Community.

Progress to be made in Next Period

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

Progress is being made in all areas

	Start Date	End Date	2025										2026				
			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	█	█													
Stakeholder mapping	28/04/25	27/05/25	█	█													
Approach UOB re art student attendance and mapping stakeholders upon arrival	30/04/25	28/05/25	█	█													
Stallholder mapping	06/05/25	06/06/25		█	█												
Produce flyer for event promotion	06/06/25	20/06/25			█												
Email invitation text to be drafted	06/06/25	20/06/25			█												
Communications & marketing of the events	06/06/25	01/09/25			█	█	█	█	█								
Building healthier communities	25/02/25	30/09/25	█	█	█	█	█	█	█								
Event planning group	04/03/25	30/09/25	█	█	█	█	█	█	█								
LINC Refresh	12/05/25	30/09/25		█	█	█	█	█	█								
Know Your Numbers Hypertension Campaign in West Central	31/01/25	01/10/25	█	█	█	█	█	█	█	█							
Pilot a systematic MDT approach that reflects equitability, ease of access and connectivity	19/05/25	01/10/25		█	█	█	█	█	█	█							
Review, reflect, assess MDT	01/09/25	01/10/25							█	█							

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Draft MDT Operating Framework and obtain partners approval	01/09/25	01/10/25															
Event feedback summary	30/09/25	07/10/25															
Development & Adoption of agreed MDT for HIU framework	01/10/25	01/11/25															
Benefits realisation report to LINC	01/10/25	01/11/25															
Multi disciplinary Teams for High Intensity Users	09/04/24	31/12/25															
Luton Integrated Neighbourhood Collaborative Refresh		31/12/25															◆

Risks

Overall Risks Status

GREEN

Reason for Overall Risk Status

Risks managed with controls in place

Risks

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

Issues

Overall Issues Status

TBC

Reason for Overall Issues Status

None identified at present

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	15/10/2025
Project Code	PR000224
Project Name	Luton 1 - Hypertension Learning and Action Network (Black African population)
Project Team	Kamini Patel
Project Aim	Increase the number of Black African patients aged between 30 and 60 with managed hypertension (to QoF target) to 50% in Luton by 31st March 2026
Governance & Responsible Group	Other participants: Chris Boakye, Luton Resident Caroline Birchall, PCN care co-ordinator Austin Chinakidzwa, CCS, Specialist Heart Failure Practitioner Kwaku Adjei, CCS, Co-production lead Yakini Johnson, Total Wellbeing Luton Rehan Tariq, Project Support Alisha Gandhi, BLMK Medicines Optimisation Team Kirsty Thompson, Quality Improvement Coach Matthew Toitei, Quality Improvement Coach
Geographical Footprint	Luton

Project Team Members

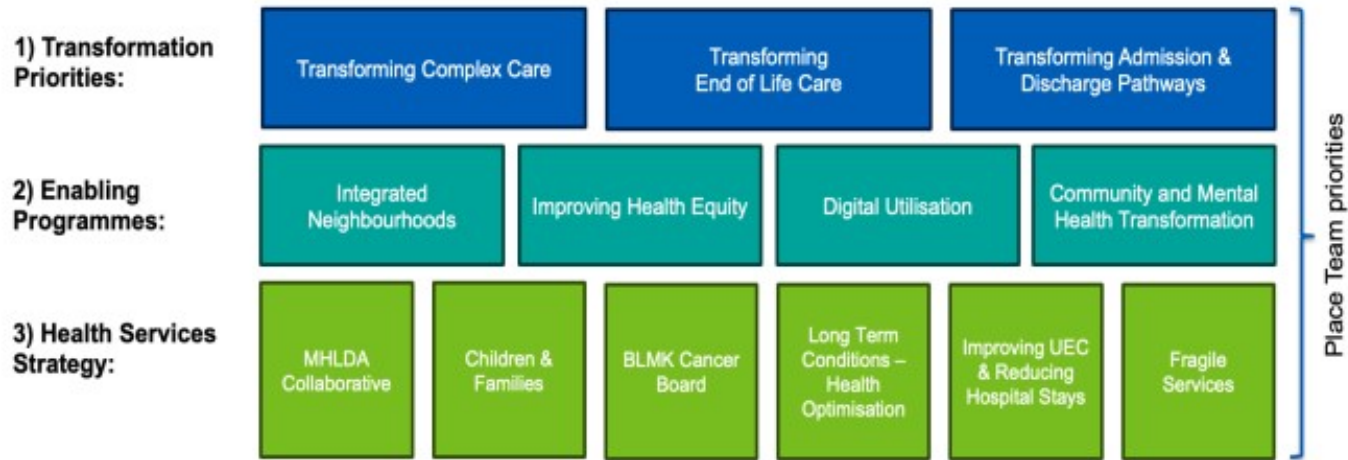
Name	Role
Kamini Patel	Project Manager
Rehan Tariq	Project Manager
Faith Haslam	Project Support
Cerys Gravener	Project Support
Dominic Woodward-Lebihan	Project Support
Yasmin Martin Leggitt	Project Support
Diane Meddick	Project Support

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

Project Status

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

System Transformation



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

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

Progress Update

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

Risks	
Overall Risks Status	GREEN
Reason for Overall Risk Status	Risks are being managed with controls in place - it requires active monitoring and intervention to ensure these risks are managed effectively.

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	15/10/2025
Project Code	PR000228
Project Name	Luton 2 - Hypertension Learning and Action Network (Indian population)
Project Team	Kamini Patel
Project Aim	For 60% of Indians aged between 40-50 with a pre-existing medical condition (defined list) to have a recorded blood pressure in the last 12 months in Luton by May 2026
Governance & Responsible Group	<p>Other members:</p> <p>Jarnail Sohal, Luton Resident Austin Chinakidzwa, CCS, Specialist Heart Failure Practitioner Sadat Edroos, Consultant, Bedfordshire Hospitals Trust Alisha Gandhi, BLMK Medicines Optimisation Team Irzam Malik, Public Health Dr Shahid Rahman, GP Medics PCN Kwaku Adjei, CCS, Co-production lead Yakini Johnson, Total Wellbeing Luton Rehan Tariq, Project Support Kamini Patel, Project Lead Kirsty Thompson, Quality Improvement Coach Matthew Toitei, Quality Improvement Coach</p>
Geographical Footprint	Luton

Project Team Members

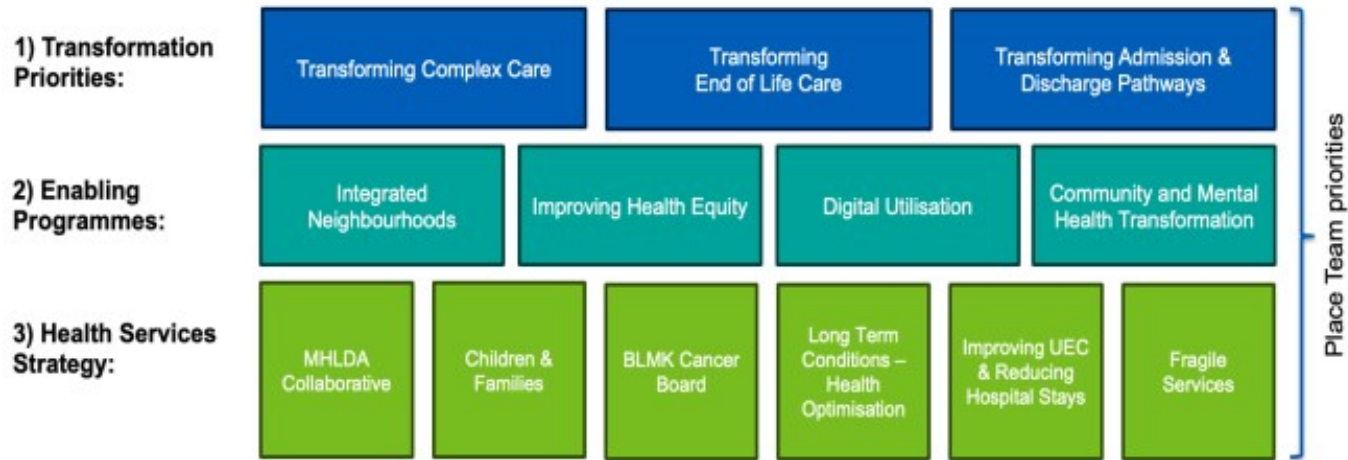
Name	Role
Kamini Patel	Project Manager
Faith Haslam	Project Support
Rehan Tariq	Project Support
Cerys Gravener	Project Support
Yasmin Martin Leggitt	Project Support

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

Project Status

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

System Transformation



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

Progress Update

<p>Progress made in Previous Period</p>	<p>The hypertension awareness campaign has continued</p> <p>It was decided that Navrathri celebrations would not be a good time to take blood pressures but enquiries about a children’s session were made</p> <p>The Diwali poster has been redrafted to sound less threatening and is also being translated and printed to send out next week.</p>
<p>Progress to be made in Next Period</p>	<p>Finalise the Diwali posters in English, Gujarati and Punjabi</p> <p>Print the posters</p> <p>Distribute the posters</p> <p>Revisit the Driver diagram at the next working group meeting on 27th October</p>

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

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Develop a video to send to patients	20/01/25	27/05/25	█														
Analyse patient experience data	14/04/25	13/06/25	█														
Complete Story Board for face to face IHI sessions in June	19/05/25	19/06/25		█													
Meeting with football club	24/06/25	24/06/25			█												
Change Idea 2: Video to send to patients	20/01/25	30/06/25	█														
Check the over 40s health check numbers for GP practices	14/04/25	04/07/25	█														
Create a list of places where people can get their blood pressure checked	14/04/25	11/07/25	█														
Act: Add poster to beginning of the videos to send out to link to the video	23/06/25	14/07/25			█												
Develop a list of key messages to be developed into social media posts	14/04/25	28/07/25	█														
Check to see if there is any patient information already available	14/04/25	28/07/25	█														
Balancing measure: comparing Indians with no pre-existing condition	04/08/25	26/08/25					█										
Develop videos for social media	18/07/25	29/08/25				█											
Change Idea 3: send text asking for blood pressure reading	21/07/25	01/09/25				█											
Develop posters, social media content etc	01/08/25	01/09/25					█										
Schedule events to attend	01/08/25	01/09/25					█										
Agree standalone events to be held	01/08/25	01/09/25					█										
Agree measures for events	15/08/25	01/09/25					█										

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Test messages with the community	01/09/25	30/09/25															
Work with Luton Town Football Club	12/05/25	31/12/25															
Events where blood pressures can be checked	01/08/25	30/01/26															
Develop Media Campaign to send to patients before rolling out to wider community	12/05/25	01/05/26															
Drip feed messages	08/09/25	01/05/26															
Roll out to the rest of Luton	05/03/25	26/05/26															

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

Risks

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

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

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	20/10/2025
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

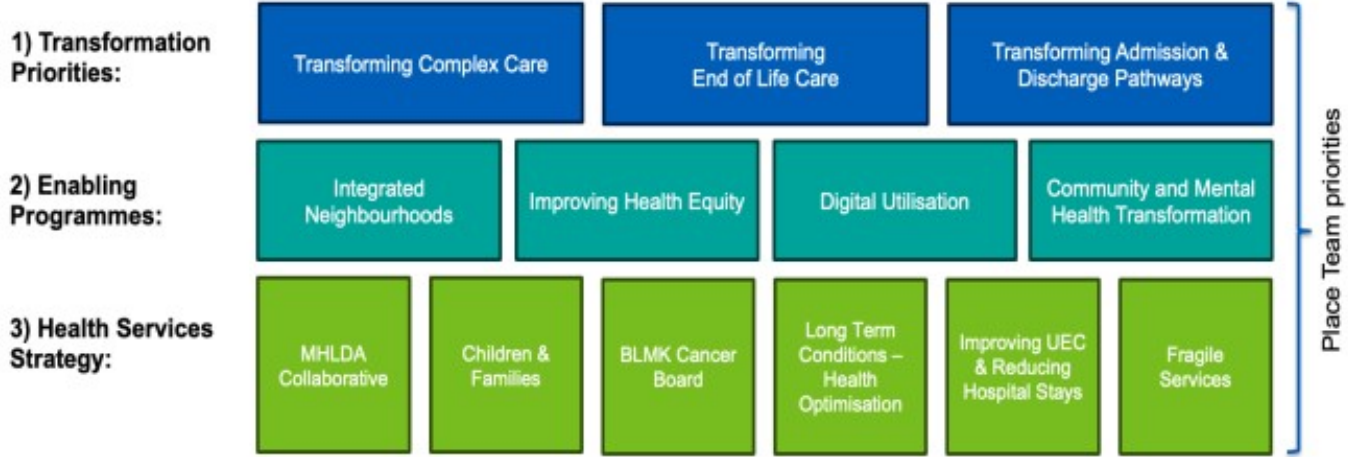
Project Team Members

Name	Role
Rebecca Green	Programme Manager
Tom May	Project Manager
Zoe Durman	Project Manager
Lisa Britton	Project Manager
Claire Brisland	Project Manager

Project Status

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

System Transformation



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

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

Progress Update

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

Risks

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

Risks

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

Issues

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

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	22/10/2025
Project Code	PR000263
Project Name	MK - Hypertension Learning and Action Network (Black African population aged 40-64 years)
Project Team	Tom May
Project Aim	To increase the percentage of Black African residents of all genders, aged between 40-64 years with managed blood pressure (below 140/90 mmHg for a clinic reading and 135/85mmHg for a home reading) from the Central Milton Keynes Neighbourhood (covering 7 practices) by 10% through by end of the LAN QI work March 2026.
Governance & Responsible Group	MK Place Meeting BLMK LAN Programme
Geographical Footprint	Milton Keynes

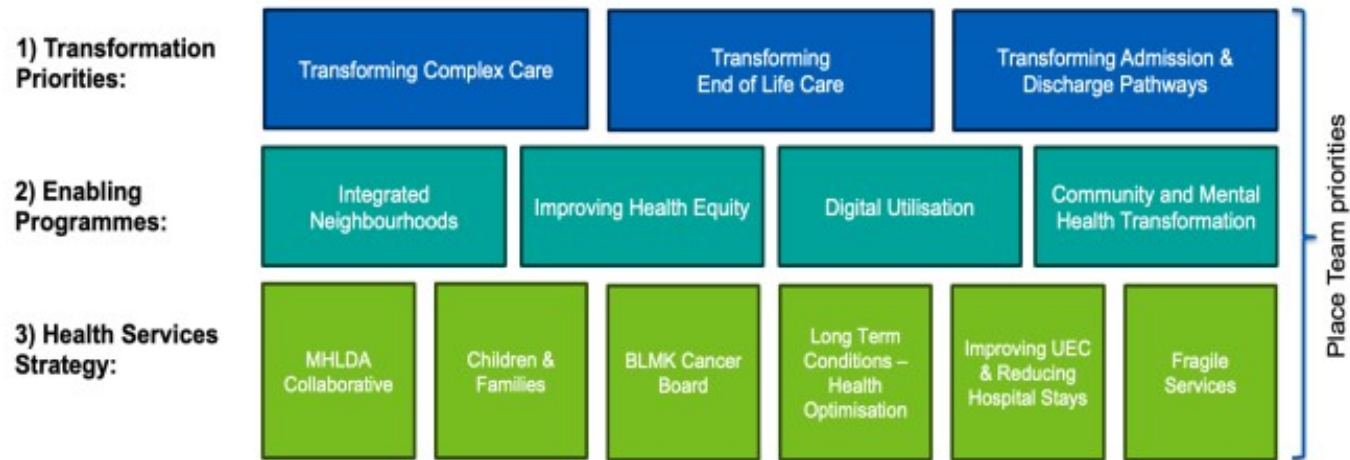
Project Team Members

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

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

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

System Transformation



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

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

Progress Update

Progress made in Previous Period

- Plan Melting pot community event at the Trinity Centre, planned date 30/10/25 - PDSA uploaded to files section
- Present MK update at LAN Virtual Learning Session on 30/09/25 - presentation uploaded to files section
- Develop trend data run charts Nov 24 - Oct 25 - added in files section in Measures folder
- Run chart data updated for aim and balancing measure
- Produce overarching measures document - added in files section in Measures folder
- Deliver drop in BP clinics across target practices, events delivered at Ashfield MC and CMK MC led by HWB coach
- Start PDSA cycle 3.1 - Text messages under prescribing incentive scheme at CMK MC - PDSA uploaded to files section

Progress to be made in Next Period	<ul style="list-style-type: none"> Continue to run PDSA cycle 3.1 - Use hypertension prescribing incentive scheme to target Black African cohort first at CMK Medical centre Continue run PDSA cycle 4.1 - Drop in BP sessions at PCN practices with Health and Wellbeing Coach. Delivery at different times to establish which gets the best uptake Engage with the 3 remaining practices in the central neighborhood Population Health Management Team to run monthly measures report to assess progress to achieving aim statement
------------------------------------	---

Tasks & Milestones

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

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

Risks

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

Risks

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

Issues

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

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	21/10/2025
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

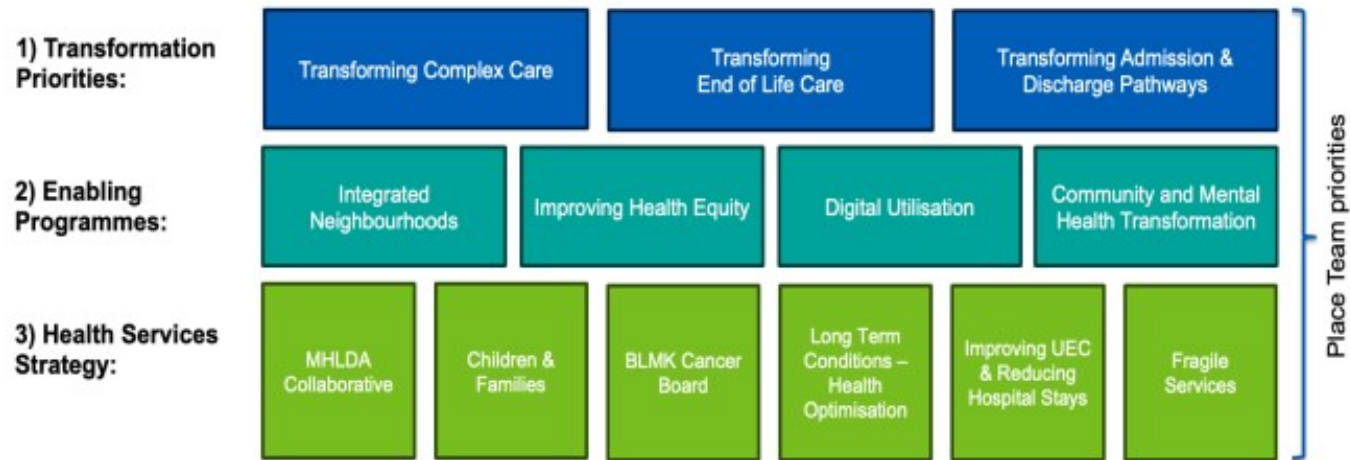
Project Team Members

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

Monthly metrics reporting and data reviews as requested by the ISF core group.

August metrics pack produced and presented to the ISF steering group.

BCF Q1 report submitted to NHSE.

BCF Metrics dashboard produced and presented to the BCF review group. This is a standing agenda item to be presented monthly.

BCF modelling carried out to address the challenges from NHSE review of the Q1 reporting, and this will continue to form part of the monthly reporting to the BCF review group.

Facilitated a dedicated session within the Improving System Flow (ISF) programme, focusing on metrics and performance reporting. The session aims to enhance data transparency, and support evidence-based decision-making across system flow initiatives.

- ISF focus sessions completed for this period:

Respiratory pathways - Suggested focus areas are the AIRS clinic and streamlining the pulmonary rehab pathways. It was also thought that as part of winter planning we should consider what else can be done for the winter period.

Progress made in Previous Period

Unscheduled care Hub - Agreed principles and that a paper should be drafted for the ISF steering group outlining the plan to move forward.

Intermediate care Metrics - This session was part of a national initiative led by ADASS and NHS England to assess how local systems are applying intermediate care guiding principles and to co-develop metrics that reflect outcomes, not just activity. Milton Keynes (MK) was selected as one of two deep-dive areas due to its promising integrated care model.

Winter Planning

Coordination of the system wide winter plan for 2025 completed.

Trajectories agreed and baseline data completed.

Individual organisations' are now putting in place the reporting mechanisms to ensure winter reporting is completed.

Winter stress test exercise attended by system representatives.

Falls

Staying steady has secured a venue for Otago classes.

S1 development has been agreed and request for change has been submitted. Development work is underway to collect the new dataset. The aim is to go live with the new reporting from the 1/4/26 to prevent mid-year change to reporting.

Steady on your feet website - service spec has been sent to BLMK ICB to enable start of work on tender process.

Care and Response (MKCC) are now supplying service users with calling cards that hold staying steady contact details on it. This will be monitored if there is an effect on referral numbers.

Community Action MK is reviewing the criteria and proposal for the community grants.

HIU

A meeting was successfully organised for Milton Keynes (MK) colleagues to engage with the High Intensity Users service currently operating in Bedfordshire and Luton, enabling the sharing of best practices around patient identification through data.

Athena data report is now live for Whaddon, with the staff from P3 being able to access it now they have received training.

S1 access has now been granted for the relevant staff within P3.

Pathway 1 and 2

There is an increased use of bridging care for hospital discharge, though underutilisation remains. A business case is being developed to expand usage and improve discharge processes.

NHS 10-year plan

Continue aligning the NHS 10-Year Plan themes with the Improving System Flow (ISF) priorities. An initial discussion paper is was presented at the ISF Steering Group on 14th August, with further scoping and development to follow based on feedback and strategic direction.

Progress to be made in Next Period

Continue active participation in the ISF Core Group to lead and support the transformation of the P2 pathway in Milton Keynes, ensuring alignment with system-wide priorities and improved patient flow outcomes.

Respiratory pathways - engage with the MK respiratory action group to streamline pathways based on hospital clinical audits, readmissions in to hospital and access to pulmonary rehab.

Conduct a national scoping exercise to investigate existing delirium care pathways. This includes identifying available models, evaluating their effectiveness, and gathering insights into best practice approaches to inform future service development.

Collaborate with the CSU to identify and understand the available data sources supporting the respiratory pathways. This includes assessing data quality, coverage, and relevance to inform pathway redesign and performance monitoring.

Continue the initial scoping work from the ADDAS intermediate care workshop to understand if a dashboard can be implemented within this reporting year.

Go live with the community grants for falls prevention within the identified pilot site. Identification of this will be done via Population Health data.

Steady on your feet website procurement process to be initiated.

Initiate the go live of the HIU service working on behalf of Whaddon practice to begin focused work identifying HIU from that practice and actively engaging with them to work towards better outcomes and reduced usage of emergency services.

Agree a HIU go live date following meeting between P3, Whaddon and Redhouse.

Increase VCSE engagement within the Integrated Discharge Hub. Outreach to discharge officers has been initiated. Further focus on how the VCSE coordinator can help with admission avoidance on discharge to be communicated with the IDH leads.

Winter comms plan has been drafted with co-branding and messaging agreed across the MK system. Press releases are currently in development.

Continue with the good neighbor's scheme. A pilot has been proposed to core group and will need to be presented to the steering group.

Monthly Metrics to be updated for the BCF and the ISF Steering 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.

	Start Date	End Date	2025										2026				
			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		◆													
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		■													
Completed PCN and P3 MOUs received by the ICB.		30/05/25		◆													
High Intensity Users Go Live		30/05/25		◆													
BCF 2024 / 25 Q4 Report		31/07/25					◆										
Complete data request for respiratory pathway redesign.	22/10/25	24/10/25									■						
Compile a Spec for ADAS Dashboard.	20/10/25	24/10/25									■						
BCF Metrics Updated		28/10/25									◆						
Respiratory Kick off meeting	29/10/25	29/10/25									■						
HIU Live with Crown as first PCN (Pilot Site)		31/10/25									◆						
BI Meeting to discuss how the ADAS dashboard can be pulled together and viewed by LA and Health.	27/10/25	31/10/25									■						
Monthly metrics update - September		31/10/25									◆						
Data Review for Respiratory Pathway design		14/11/25										◆					
ISF Metrics Update - October		30/11/25										◆					
ISF Core Group	03/12/25	03/12/25											■				

			2025							2026				
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Falls Community Grants Pilot Programme Launched.		31/12/25									◆			
ADAS Intermediate Care Dashboard		31/01/26										◆		

Risks

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

Risks

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

Issues

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

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	10/10/2025
Project Code	PR000200
Project Name	MK - INW - Bletchley Pathfinder (Project 1-3)
Project Team	MK Deal - SRO MKCC
Project Aim	<p>To progress two of the Fuller recommendations in Bletchley (1) Proactive & Personalised Care, and (2) Prevention using a 2-staged approach to delivering the projects that will achieve the desired outcomes:</p> <p>Project 1 - Create 'Team Bletchley'</p> <p>Project 2 - Develop neighbourhood ways of working</p> <p>Project 3 - Implement a neighbourhood conferencing/problem solving model</p>
Governance & Responsible Group	Bletchley Pathfinder Delivery Board reporting into JLT
Geographical Footprint	Milton Keynes

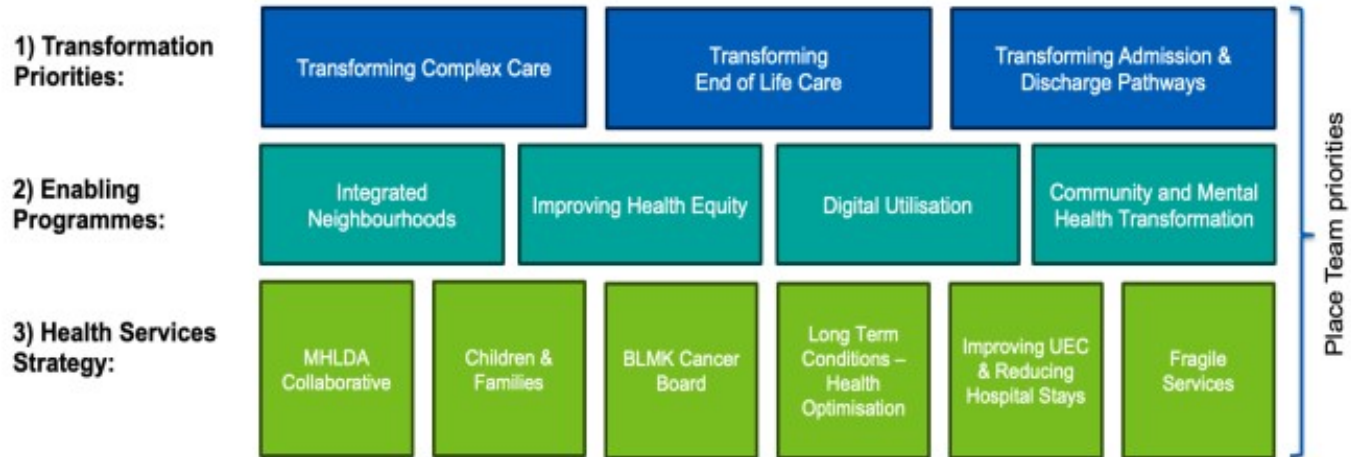
Project Team Members

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

Project Status

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

System Transformation



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

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

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

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

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

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

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

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

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

Progress Update

Progress made in Previous Period

Multi- Agency Forum Phase 1

Youth Mentoring and schools coordinator roles extended to July 2026.

- Contract completed
- Grant agreement approved

Employment, volunteering, and wellbeing event held October 2025

In partnership with MKCC held the “Back to Work, Back to You” event which brought together over 30 organisations to support Milton Keynes residents with job applications, volunteering, training opportunities, and health and wellbeing services. The event was open to all MK residents and designed to be inclusive, accessible, and informative.

Two free employability workshops were hosted by Citizens Advice Milton Keynes to provide advice about CV and Interview preparation. Additionally, stallholders were invited to attend a Disability Confident employer training, including a masterclass on reasonable adjustments.

Arts for Wellbeing

Monthly Art for Wellbeing sessions, facilitated by Arts for Health, were successfully launched in August. To date, three sessions have been held, each attracting an average of 18 participants.

Team Bletchley

To celebrate Phase 1 of the Bletchley Pathfinder programme of work we held a collaborative multi-agency networking event in September. This event was an opportunity for system partners to share learning.

The occasion brought together over 140 partners including Thames Valley police, Community Health Services, Primary care, MK College, schools, Family Centres, Milton Keynes University Hospital, VCSFE organisations and clubs funded via Bletchley Pathfinder, for an afternoon of performances, networking, and celebration of local initiatives and projects.

Progress to be made in Next Period	<p>Multi-Agency Forum Phase 1 Connecting families more seamlessly with health and care services</p> <ul style="list-style-type: none"> • Panel be expanded to include mental health and VCSE representation • A new cohort of 10 children to take part in the youth mentoring pilot • Forum to be rebranded to 'Family Help Panel' - to produce positive outcomes to help families access the right support at the right time aligning with the national programme known as the Family First Approach in 2026/27. <p>Multi-Agency Working Phase 2 - Cohort - Based Interventions:</p> <p>We are continuing to gather data and evidence based insights for the the development of two new targeted cohort-based interventions which will be implemented across Bletchley, focusing on residents with specific health and care needs.</p> <p>These interventions will leverage a data-driven approach to improve pathways and service delivery. The aim is to enhance personalised care through multi-agency collaboration, informed by insights from population health data.</p>
------------------------------------	--

Tasks & Milestones

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

	Start Date	End Date	2025										2026					
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar				
Roll out multi- agency approach offer to all schools in Bletchley (Phase 1)		25/04/25	◆															
Conferencing Model (Phase 1) Explore longer term strategic options for mentoring provision	01/09/25	15/12/25																
Pathway 1- Initiation Phase - (Phase 2)	19/01/26	13/07/26																
Pathway 2 - Initiation Phase - (Phase 2)	02/03/26	13/07/26																
Conferencing Model (Phase 1) Integration with Family First Approach	02/03/26	20/07/26																

Risks

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

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
A permanent location to host a dedicated community hub	Yes	8
Youth Mentoring - Conferencing Model	Yes	2

Issues

Overall Issues Status	GREEN
Reason for Overall Issues Status	No current issues have been identified that could affect the overall progress of the projects.

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	22/10/2025
Project Code	PR000175
Project Name	MK - Tackling Obesity
Project Team	MK Deal - SRO's: MK Public Health and Primary Care
Project Aim	<p>The Tackling Obesity (MK deal) is focused on helping people lose weight and maintain a healthy weight through easily accessible weight management programmes, use of technology, pharmacological therapies, and education/prevention work.</p> <p>Anticipated Benefits</p> <ul style="list-style-type: none"> - Develop a Tier 2+ weight management pilot service to support obese CYP and their families - Develop a digital wearables pilot to establish if this approach can be a tool to achieve weight loss (Activate Trial) - Increase awareness of the local and national weight management services available. - Increase confidence within front-line professionals about having a conversation about excess weight. - Increase referrals into local and national weight management services. - Increased access to healthy food across MK, including while using health services. - Improvements to the environment in MK to make it easier for people to maintain a healthy weight. - Over time, a reduction in the proportion of people aged over 18 with BMIs over 25. - Over time, a reduction in the proportion of Reception and Year 6 who are overweight or obese.
Governance & Responsible Group	Tackling Obesity Steering Group reporting into JLT
Geographical Footprint	Milton Keynes

Project Team Members

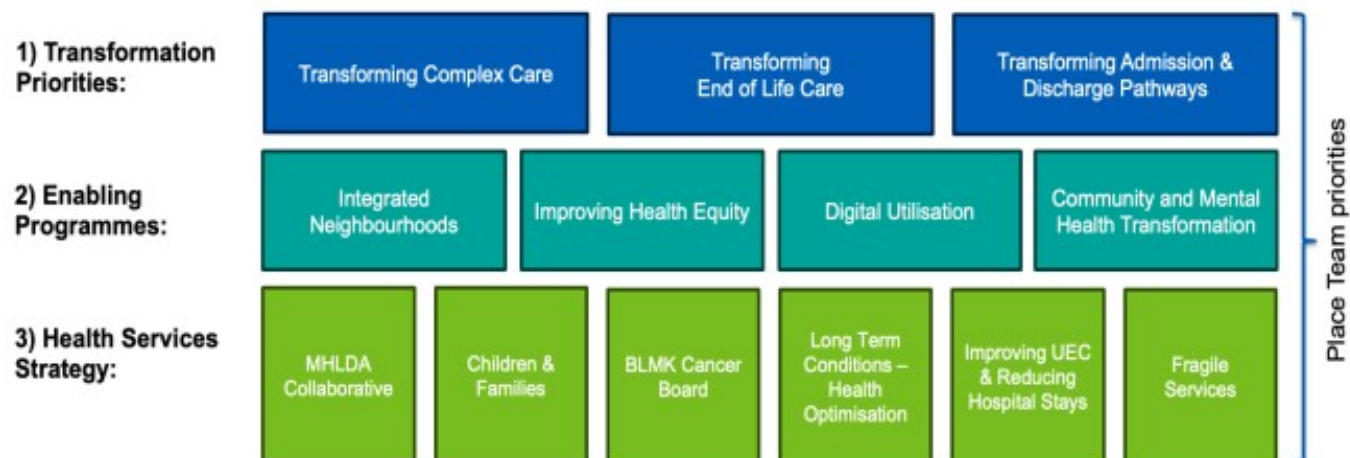
Name	Role
Sandra Vanreyk	Programme Manager

Zoe Durman	Project Manager
Tom May	Project Manager

Project Status

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

System Transformation



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

1) Enabling Programmes

- **Integrated Neighbourhoods** - The Tier 2+ obesity pilot service for CYP and their families will use a MDT approach with input from specialists in primary and secondary care as well as the community early years team. Links will be made with other key stakeholders such as family centres, education, food banks and VCSE organisations to support CYP living with obesity and their families.
- **Improving Health Equity** - Obesity disproportionately affects those living in deprivation, also the pilot is located in CMK Medical Centre which serves a largely deprived population who face health inequalities

2) Health Services Strategy

- **Children and Families** - The Tier 2 + pilot is an intervention targeted at improving outcomes for CYP and their families as part of a whole family approach
- **Long Term Conditions / Health Optimisation** - Tackling obesity is important as long term obesity can lead to numerous health conditions including type 2 diabetes, coronary heart disease, some cancers, stroke, depression, joint and respiratory problems

Progress Update

Progress made in Previous Period

Tier 2 + Pilot

- Shortlist and invite CYP and their families to to the programme
- Clinic go live date planned for 19th September
- Test the S1 clinic template and make any amendments based on MDT members feedback prior to going live
- MDT met prior to going live
- Confirm memorandum of understanding has been signed off between CMK and MKUH prior to go live date
- The service launched in September 2025. The programme is currently full, comprising of 20 families. The patients range in age from 5 to 15 years old. Initial engagement has been strong, with only two families withdrawing. Both families were quickly replaced.
- Developed a robust evaluation monitoring and evaluation framework.

Activate Trial (digital wearables)

- A new contract with Loughborough University for this next phase of work was signed in summer 2025. An app developer, Cuttlefish, have subsequently been appointed by Loughborough and begun work to develop the app.
- MKCC led a procurement exercise, using a framework, over the summer. Despite initial interest, no device producers or suppliers put forward a tender. A second tender went out to open market on the 3 October 2025 and will close on 24 October 2025. To ensure as many residents as possible can participate, we are seeking a single device that is compatible across both Apple and Android platforms.

Progress to be made in Next Period

Tier 2 + Pilot

- Continue to on board CYP and their families onto the programme
- Refine evaluation framework
- Outcome evaluation measures:
- Clinical measures (weight, blood markers including blood sugar and kidney function).
- Mental wellbeing scores via quality-of-life questionnaires.
- Social care involvement.

Process evaluation

- The evaluation will include an estimation of professional contact time with each child or young person (CYP) and their family. While indicative contact time has been built into the service planning, flexibility is maintained to allow for tailored support based on individual needs. As a result, the configuration and duration of interactions between CYP and members of the multidisciplinary team (MDT) may vary.

Additional process elements to be monitored include:

- Patient flow: the sequence of appointments, including initial contact points (e.g. family worker welcome and orientation).
- Communication methods: how families are contacted and engaged, including strategies used to encourage questionnaire completion and follow-up.
- Management of non-attendance and drop -out: frequency of non-attendance, approaches to follow-up, and any adaptations made to improve attendance and engagement, challenges tin engagement.

Activate Trial (digital wearables)

- In October 2025 starting to work with Cuttlefish and our resident group to develop the app. We plan to have the app ready for field testing in early January 2026.
- We will reopen ACTIVATE to recruitment on 1 April 2026 and aim to recruit 760 participants over 18 months. If recruitment exceeds expectations, we will increase this to just under 1000 participants.
- Despite the changes to recruitment, it remains possible that possible that we do not achieve our recruitment goals. At this stage, in autumn 2026, there would be two options to increase participation: a) expand to other areas in BLMK; and b) expand to patients with other conditions in MK, most likely people with pre-diabetes.

Tasks & Milestones

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

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

Risks

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

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Clinical Psychologist Provision Availability	Yes	9

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

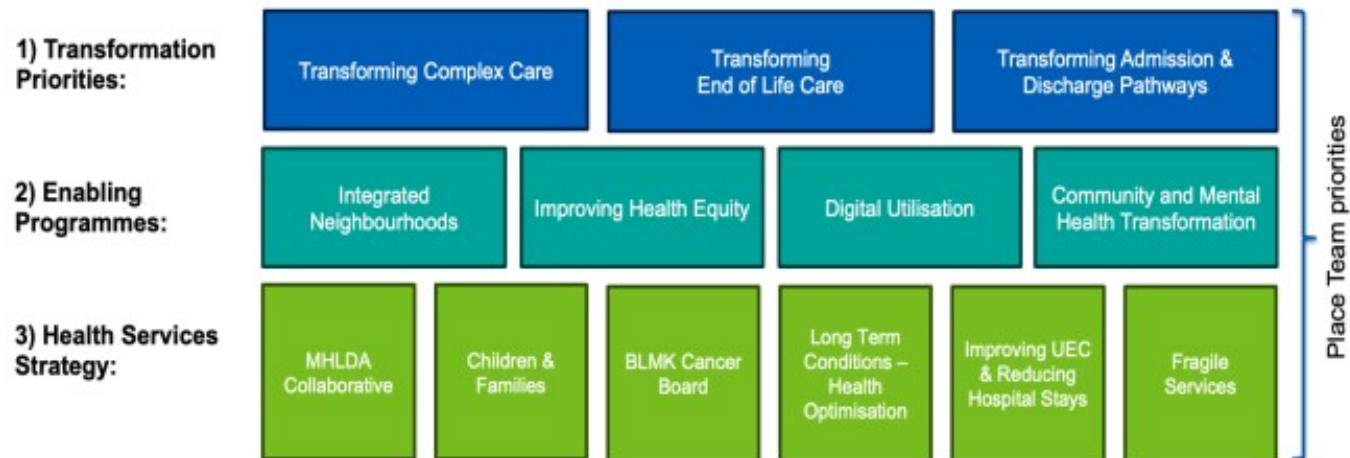
Date of Highlight Report	22/10/2025
Project Code	PR000297
Project Name	Transforming Admission and Discharge Pathways
Project Team	STT
Project Aim	<p>The overarching aim of the Transforming Admissions and Discharge Flow programme, is to</p> <ul style="list-style-type: none"> • Reduce the average days MFFD (by 1 day / 8% across all pathways) with no widening of inequalities and addressing variation • Improving the 'left shift' of discharge intervention, by increasing the proportion of patients discharged through lower pathways (To increase the proportions of P0s that used to be P1s and a shift in P2s to P1s) <p>Discharge pathways require a redesign to develop a home first discharge model, increasing discharges to P0 and left-shift placements from P3 to P2, P2 to P1 and P1 to P0.</p> <p>It seeks to right-size P2 and P3 bedded capacity, as well as redesign Reablement and Intermediate Care pathways to better align with local needs. The programme focuses on reducing discharge delays by integrating and streamlining fragmented pathways, and promoting proactive, personalised care to manage variations in length of stay in P2 rehab beds, while also utilising commissioned P2 bed capacity to avoid the temporary use of P3 placements as well as reducing the use of SPOT purchase beds. It aims to enhance admission avoidance initiatives, particularly for falls, through integrated working and risk stratification, targeting high users of resources. Strengthening multidisciplinary teams in neighbourhood's is a key priority to reduce length of stay in Hospital Trusts, reducing the delays in DRD and actual date of discharge, and prevent unnecessary hospital admissions. The programme also emphasises the importance of robust multidisciplinary teams in preparing discharges, fostering a Home First culture, and ensuring all decisions are made through multi-agency collaboration focused on neighbourhood care. Additionally, it aims to develop a system-level strategy to support neighbourhood working, with a clear vision and high-level objectives for each local area.</p>
Governance & Responsible Group	Proposed Governance Structure for Discharge Transformation across Bedfordshire and Luton
Geographical Footprint	BLMK System, Bedfordshire Care Alliance, Milton Keynes

Project Team Members

Name	Role
Tara Dear	Head of STT
Cat Lee	Project Manager
Georgie Brown	Senior Responsible Owner
Mark Morton	Senior Transformation Manager
Matt Rogers	Senior Transformation Manager
Michael Ramsden	Subject Matter Expert
Amanda Flower	Subject Matter Expert
Caron Morgan	Transformation Manager
Vickie Place	Transformation Manager

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

System Transformation



	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Develop Bedfordshire Priority Project List	03/06/25	01/09/25			█												
Agree Scorecard for Programme Monitoring		01/09/25								◆							
BLMK UEC Priorities Agreed		01/09/25								◆							
Agree Task and Finish Groups for priority projects	18/08/25	30/09/25						█									
Market Engagement for Delivery of P2 Dementia Beds	20/08/25	30/09/25						█									
Implementation of P2 Dementia Beds Service	01/10/25	03/11/25									█						
Develop Phase 2 (Community Workforce and Bed Restructure) of P2 Programme	22/09/25	31/12/25								█							
Delivery of P2 Dementia Service through winter 25/26	01/11/25	31/03/26										█					

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

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Collaboration	Yes	2
Long Term Structure	Yes	15

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	21/10/2025
Project Code	PR000275
Project Name	Transforming Palliative End of Life Care
Project Team	STT
Project Aim	<ul style="list-style-type: none"> To have a maximum of 2 coordination centres across Bedfordshire, Luton and Milton Keynes delivering standardised care with a single point of access. To reduce the number unplanned palliative care bed days in hospital in the last 3 months of life by 50% by end of year 2, following development of the co-ordination centres. To increase recognition of people in their last year of life and evidence an improving trend of palliative care registrations with ambition to have 80% expected registered by year 3 [~8000 patients]. Hospital staff within identified clinics [tbc: eg heart failure, respiratory, oncology] feel more confident to facilitate meaningful conversations about end-of-life choices and signpost to the co-ordination centres accordingly. 100% of co-ordination centre contacts offer an advanced care plan [ACP]. To raise the profile and talk more about death and dying across communities
Governance & Responsible Group	<p>A new Palliative and End of Life Programme Board has been established with 2 supporting steering groups:</p> <ol style="list-style-type: none"> Clinical ; including data/digital, and education and communication Finance
Geographical Footprint	BLMK System

Project Team Members

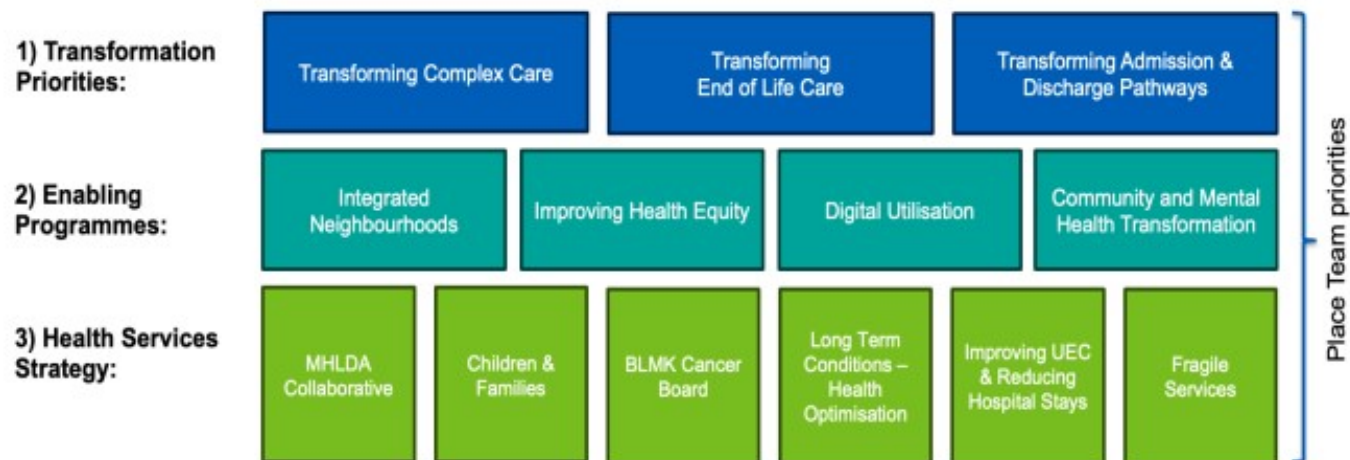
Name	Role
Sarah Stanley	Executive Lead
Tara Dear	Head of STT
Jo Morris	Project Manager
Matthew Kurima	QI Lead
Simon Hardcastle	Senior Responsible Owner
Natasha Young	Senior Transformation Manager

Samita Dass	Senior Transformation Manager
Denise Faehndrich	Transformation Coordinator
Angela Reynolds	Transformation Manager

Project Status

Overall Project Status	AMBER
Reason for Overall Project Status	Project in pre-planning stage awaiting initial Programme Board 09/06/2025, though is identified as 1 of 3 key ICB transformation priorities.
Project Maturity	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 End of Life Care aligns with 1) Transformation priorities

End of life care has been identified as one of the three transformation priority programmes for ICB. Problem statements include:

1. **Co-ordination Centres [Palliative Care Hubs]** – there is a fragmented offer across the existing three hubs, with disparities in funding and specialist nursing services. Signposting to services across the Bedfordshire geography is further complicated for users across Central Bedfordshire, Bedford Borough and Luton where there are currently two hubs in situ.

Improved coordination of care pathways could enhance patient experiences while reducing unnecessary hospital admissions and readmissions. For example, in 2023, BLMK recorded 64,851 unplanned palliative care bed days and 5,982 palliative care emergency admissions, where enhanced pathway coordination could alleviate these pressures and see more patients cared for in the right place, by the right clinician, at the right time.

1. **Identification** - the palliative care register is underutilized, with only ~3000 patients recorded out of an expected 10,000 [based on assumption at any one time 1% of population can have an anticipated death], presenting missed opportunities for meaningful and personalised care plans to be used, and resulting in preferred places of death not being known or realised.

In 2023-24, only 5% of 2,603 individuals living with frailty and multiple life-limiting illnesses were identified as palliative. This group accounted for 19% of emergency admissions, with 40% ultimately dying in hospital, illustrating gaps in access to palliative support.

1. **Communication** – there are societal barriers for us all, but the reluctance to talk about death and dying could contribute to delays in initiating palliative care discussions.

These delays could lead to inappropriate treatment decisions being made and personalised care plans not being initiated or used.

1. **Projected growth** - population growth in BLMK has been approximately twice the national rate, and the area's age profile will continue shifting, with the population over age 50 set to grow significantly, and the population over 79 projected to double within the next two decades.

Any future service needs to be equipped for an increase in demand over time and enabled to maximise the resources available.

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Clinical steering group established		23/06/25			◆												
Governance	06/01/25	30/06/25	■														
Finance steering group established		31/07/25				◆											
Education and comms plan agreed and signed off by programme board for implementation		28/08/25						◆									
Patient Forum established		19/09/25								◆							
Model shared with programme board and wider stakeholders	01/04/25	30/09/25	■														
Business case for MK PEOLC model developed and signed off through programme governance processes		30/11/25									◆						
Business case for single PEOLC hub across Bedfordshire Partnership developed and signed off through programme governance processes		30/11/25									◆						
Merging of 2 Palliative Care co-ordination service centres		01/12/25											◆				
Contracting requirement in place		01/12/25											◆				
IG Requirements in place		01/12/25											◆				
Build financial transparency across system partners		16/12/25											◆				
Bedfordshire model development		16/12/25											◆				
Phasing of model agreed		16/12/25											◆				
Phasing of model agreed	16/12/25	16/12/25											■				
Developed impact of clinical model		16/12/25											◆				
Financial modelling based on clinical model	16/12/25	16/12/25											■				
Developed impact of clinical model		31/12/25											◆				
Final report shared with ICB	17/10/25	06/02/26															■
Core programme group established	01/04/25	31/03/26	■														

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	22/10/2025
Project Code	PR000285
Project Name	Transforming Complex Care
Project Team	Children's Services (LA), Children and Maternity (ICB), Adult Services (LA), Continuing Healthcare (ICB), STT (ICB)

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

3.1 – Aim - "Children's":

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

High-Level Outcomes, Benefits & Enablers:

- Improve the lives of children and young people facing complex challenges in health, social care, and education, along with support for their families.
- Ensure all services and agencies work together smoothly, with clear roles and shared understanding. This includes planning for risks, maintaining high quality, and having strong leadership in decision-making.
- Lead a joined-up approach where professionals from across the system collaborate to find the best solutions.
- Use resources more effectively by improving the provision of expensive, specialist care.
- Provide coordinated, personalised care that places each child's individual needs at the centre of planning and support.

3.2 - Aim - "Adults":

Aim: Further to the ICB serving notice to the LBC S75 arrangement, the aim is to move this element of the S75 under the BLMK CHC Joint Funding Policy. This will be for adults over the age of 18 years and supports a consistent approach and process.

High-Level Outcomes, Benefits & Enablers

- Simplify joint funding processes, making them easier to understand and use for staff working on the ground.
- Ensure the BLMK system adheres to national rules for funding care (the CHC Framework), so people receive the appropriate financial support. If someone doesn't qualify for standard funding, they will still receive a comprehensive care plan covering both their health and social care needs.
- Identify gaps in current community and mental health services to determine where improvements or new services are needed in the future.
- Establish a specialist health team to assist people whose health needs are not being met. This team will provide expert advice and work closely with local councils to ensure people receive the care they need.

Project Aim

Governance & Responsible Group	<p>10.1 - Programme Governance Structure</p> <p>The programme will be governed by the weekly ICB Internal Programme Meeting, which is responsible for providing assurance on the actions being undertaken across BLMK in relation to the programme. This meeting takes a systemic approach to delivery, fosters continuous learning, evaluates financial impacts on plans, and oversees dynamic risk assessment and mitigation strategies.</p> <p>In addition, the programme is supported by the Childhood Trauma Steering Board, which is chaired by the system champion and which is responsible for driving and implementing transformational change across both Children’s services through the focus 40 initiative.</p> <p>10.2 - Reporting Structure</p> <p>The CTSB and internal Programme Meeting will report into the following governance forums:</p> <ul style="list-style-type: none"> • System Chief Executives (six-weekly reporting) • Finance and Investment Committee • Quality and Performance Committee • ICB Executive (monthly highlight report) <p>10.3 - Programme Support and Coordination</p> <p>The Transforming Complex Care Programme Manager will play a key role in reviewing key themes, data, and learning arising from these meetings throughout the year.</p> <p>Overall coordination and management of the governance meetings will be led by the Transforming Complex Care Programme Management team (sits within the System Transformation Team), supported by the Children and Young People (CYP) and Continuing Healthcare commissioning teams.</p>
Geographical Footprint	BLMK System, Milton Keynes, Bedford Borough, Central Bedfordshire, Luton

Project Team Members

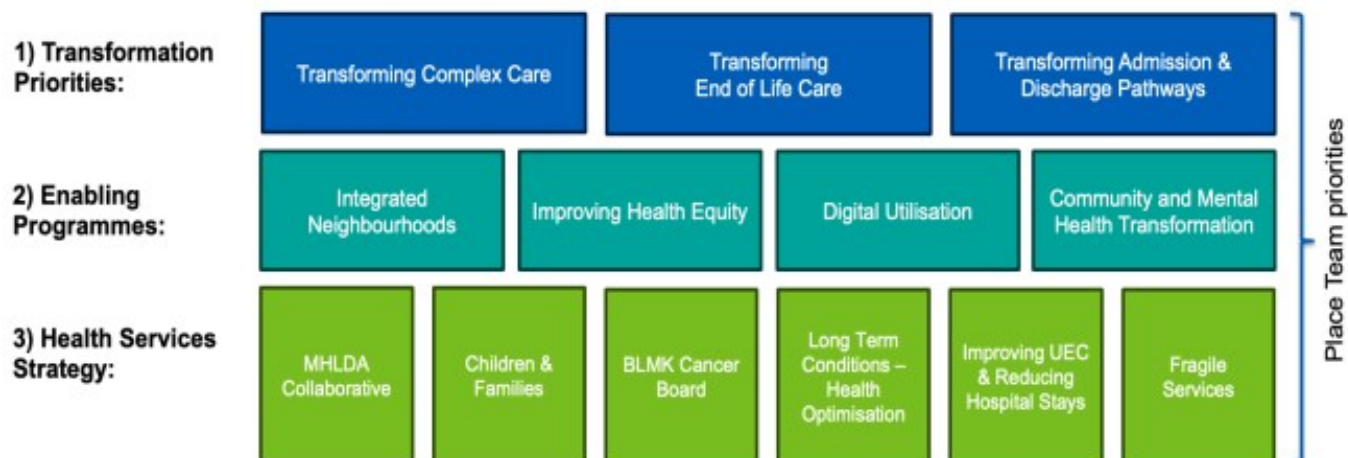
Name	Role
Tara Dear	Head of STT
Matt Hollex	PMO Lead

Hayley Dixon	PMO Lead
Rafael Barnett-Knights	Project Manager
Vickie Place	Project Manager
Matthew Kurima	QI Lead
Cat Lee	QI Observer
Sarah Stanley	Senior Responsible Owner
Matt Rogers	Senior Transformation Manager
Sarah Breton	Subject Matter Expert
Andrea Piggott	Subject Matter Expert
Diana Butterworth	Subject Matter Expert
Layla Vardy	Transformation Coordinator
Lucy Robertson	Transformation Support Manager

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	Project is in the initiation phase
Project Maturity	2.0 - Initiation

System Transformation



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

The programme aligns with 1) Transforming Priorities

Progress Update

Progress made in Previous Period

Programme

- The Complex Care programme has been restructured. Internal governance has been revised, with the previous six-weekly steering board replaced by a new weekly programme meeting.
- There has been no changes made to the Childhood Trauma Steering Board, which remains.
- The programme scope has been expanded to include Adults Section 75 and joint funding arrangements and programme membership now includes leads from the associated workstreams.

Children's

- All Local Authorities have completed initial panel meetings to support focus 40 initiative and have established ToRs in place.
- Focused 40 initiative Trauma informed multi agency panel operating effectively in Milton Keynes. Evolving in Bedford Borough and Central Beds. Off track in Luton.
- Milton Keynes Council - Trauma informed multi agency Panel (Focus 10) took place 28th Aug & 25th Sept - Progress review meeting planned 30th Oct
- Bedford Borough Council - Trauma informed multi agency Panel (Focus 10) took place on 15th Aug & 9th Oct
- Central Beds - Trauma informed multi agency Panel (Focus 10) - took place on 22nd Oct
- Luton - Trauma informed multi agency Panel (Focus 10) - took place on 29th July
- Local improvement themes and system challenges are being identified.
- Focused 40 work identified a critical gap in therapeutic services for young people with complex trauma. As such system is piloting new Trauma therapeutic model/offers based on an enhanced multisystemic therapy model and Childhood Trauma Steering Board approved development of a business case for a joint-commissioned model.
- An action tracker has been implemented to support the Trauma-Informed Multi-Agency Panel meetings. Additionally, an outcomes tracker has been developed to distil key actions into measurable metrics for monitoring improvements. The Quality Improvement (QI) team is supporting this work.
- Outcome improvements are being realised – MK Summary:
Notable progress has been made across multiple areas. The number of children in residential placements has reduced from 7 to 5, with three returning home and none remaining in unregulated or secure settings. Clinical formulations have been developed for 7 children (previously 0), and those under CAMHS responsibility have increased from 5 to 8. Significant reductions have been observed in children reported missing (9 to 1), with community access restrictions (6 to 2), and those subject to DoLS (6 to 2). Two children have stepped down from Tier 4 admissions. Involvement with the Criminal Justice System decreased from 8 children in April to 3 in October. There have also been marked improvements in engagement:
 - Education: 7 children (up from 1)

- Community access: 8 (up from 3)
- Peer interaction: 9 (up from 2)
- Participation in hobbies/activities: 10 (up from 4)
- Average weekly residential placement costs have reduced by 39%.

Adults

- The programme scope has been expanded to include Adults Section 75 and joint funding arrangements and programme membership now includes leads from the associated workstreams.
- BLMK ICB has a recently updated CHC Joint Funded policy, further to a workshop with all BLMK LAs, this is in the process of Exec sign off. This policy has been in place with BBC, CBC and MK LAs since becoming BLMK CCG. Currently there is a Joint Funded Protocol in place which was originally between LCB and LCCG, this is a historic arrangement which is inequitable across BLMK.
- Further to the ICB serving notice to the LBC S75 arrangement, the aim is to move this element of the S75 under the BLMK CHC Joint Funding Policy

Progress to be made in Next Period

Children's

- Development of a business case to create a "Health Team" to support the transition of the Trauma Informed Trauma Panel meetings into a Business-as-Usual model.
- Local Authority consideration being given to the establishment of new working groups to identify gaps and opportunities in trauma-informed residential provision, particular efforts focus on the decision to progress a shared residential provision model and coordinating services.
- Business case for a jointly commissioned multisystemic therapy model, outlining financial contribution arrangements and incorporating case studies to support invest-to-save proposals.
- Multi-Agency Trauma Informed Panels continue as planned
- Establish the systemwide finance working group
- Scoping services that support/treat children and young people demonstrating Harmful Sexual Behaviours

Adult's

- Work is being undertaken a project level to formalise plans to move an element of the S75 under the BLMK CHC Joint Funding Policy

Tasks & Milestones















Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

This programme and its two projects have been established. Children's is in the delivery phase. Adults is still in planning phase.

Please note: The start and end dates assigned to each task (Start: [Today's Date], End: 31/12/2025) are indicative placeholders only. Due to the adaptive and agile nature of this project, actual timelines are subject to change based on evolving priorities, stakeholder input, and system readiness. These dates are used solely to enable tracking and reporting within the project management system and do not reflect fixed delivery deadlines.

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Set up ICB Internal Children's and Adults Steering Board	06/05/25	06/05/25															
Present initial findings at ICB Board		27/06/25															
Identify Priority Cohorts - 10 children per Local Authority	04/04/25	15/08/25															
Initial Case Meetings - ICB and Local Authorities	04/04/25	15/08/25															
Project Establishment	23/06/25	15/08/25															
Hold review meeting and capture outputs		15/08/25															
Establish anonymised Outcomes Tracker for priority cohorts	15/08/25	29/08/25															
Establish a BLMK Adults Transformation Steering Board	15/08/25	01/09/25															
Agree statutory and mandatory responsibilities and the definition of 'unmet needs' (INTERNAL ICB)	20/06/25	02/09/25															
Establish 'New Ways of Working' groups with Local Authorities	03/09/25	03/09/25															
Establish an unmet needs protocol	18/08/25	26/09/25															
Produce diagnostic report - key findings from Initial Case Meetings and recommended next steps	05/09/25	26/09/25															
Finalise improvement measures	29/09/25	03/10/25															
Develop funding principles	09/06/25	24/10/25															
Produce concept dashboard	06/10/25	20/11/25															
Produce working dashboard	01/12/25	31/12/25															

Risks

Overall Risks Status	GREEN
Reason for Overall Risk Status	Programme on track

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
High Cost Placements and ICB contribution	Yes	9
Programme Scale	Yes	4
Model ICB Blueprint	Yes	4

Issues

Overall Issues Status	GREEN
Reason for Overall Issues Status	Issue being managed

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	14/10/2025
Project Code	PR000397
Project Name	Cancer - Early Diagnosis and Health Inequalities
Project Team	BLMK Cancer Team
Project Aim	<ul style="list-style-type: none">• Ensure a greater focus on cancer prevention through smoking cessation, obesity reduction, alcohol moderation, and HPV vaccination.• Reduce preventable cancers through lifestyle interventions and targeted public health messaging.• By 2028, 75% of cancers will be diagnosed at stage 1 or 2.• Comprehensive use of the Faecal Immunochemical Test (FIT) in patients with symptoms of bowel cancer.• Improve uptake of screening programmes and reduce variation.• Support earlier and faster diagnosis through community-based approaches and digital tools.
Governance & Responsible Group	BLMK Cancer Board
Geographical Footprint	BLMK System

Project Team Members

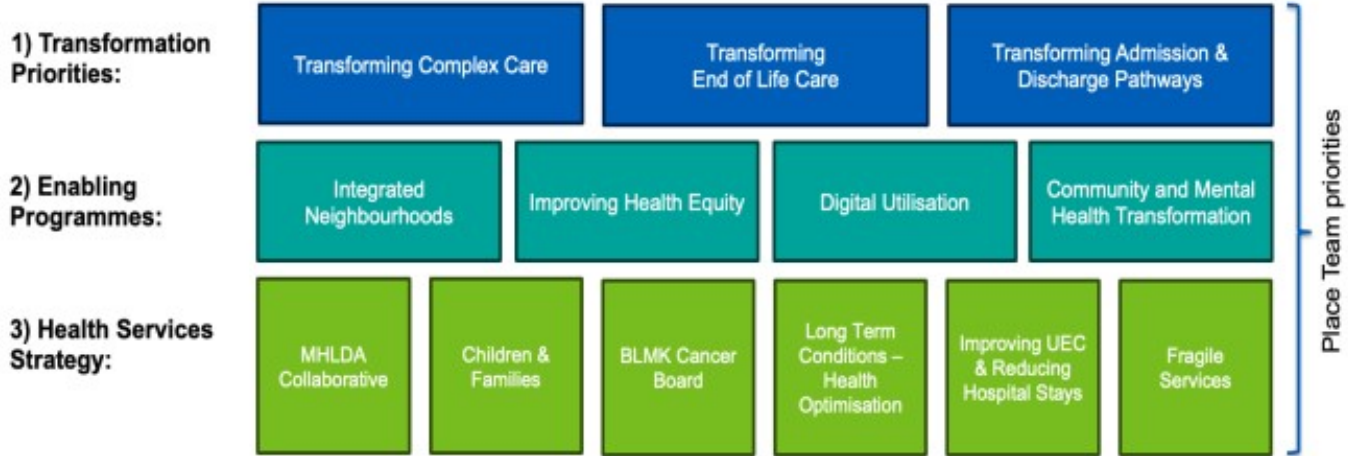
Name	Role
Helen Watt	Programme Manager
Naisha Henry	Project Manager

Project Status

Overall Project Status **GREEN**

Reason for Overall Project Status	<p>Lung cancer screening roll out - we continue to reach out to remaining Central Bedfordshire Practices to submit patient lists while making preparations for the roll out into Bedford borough.</p> <p>The Behaviour change pilot to develop resources to improve cervical screening uptake is now complete and the report is being finalised. A webinar was held with Practice staff to socialise the resources and the Primary Care team will be hosting the resources on the shared workspace.</p> <p>Five PCN projects have been supported with funding, these projects are intended to improve cancer outcomes and reduce inequalities in early diagnosis. Reports on the first months activities have been received.</p> <p>Scoping continues on a project to improve HPV vaccination. Stakeholders include School Immunisation team, NHS England and the University of Bedfordshire.</p> <p>Scoping also continues on a project to better understand barriers to cervical screening in the Traveller Community</p>
Project Maturity	4.0 - Delivery

System Transformation



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

BLMK Cancer Board is the responsible governance board for this work which is also embedded within the Health Services Strategy.

Progress Update

Progress made in Previous Period

Early Detection of Pancreatic Cancer in Primary Care Using SystmOneContact made with Pancreatic Cancer Action Charity (03/09); meeting arranged

Referral pathway update shared (04/09)

QI meeting (04/09) agreed measurement points:

- o Compare referrals and outcomes over previous 6–12 months vs. 6-month pilot
- o Track the number of referrals and outcomes of diagnoses

Ardens pilot reports produced; Amanda Townsend assigned as clinical lead (05/09)

Clinical meeting held (12/09) ? clinicians informed about Ardens pilot template

Protocol and key symptom codes added to SystmOne

Resources downloaded from Pancreatic Cancer UK

Meeting with Pancreatic Cancer Action Charity (12/09): support confirmed with banners, leaflets, GP packs, and possible CPD speaker

Rooms booked at Grove HUB for November event (15/09) Pancreatic Cancer case finding Project1. Clinical lead identified

2. Project plan developed
3. Care-coordination support recruited
4. Initial searches completed
5. Records reviewed to identify weight loss
6. Communication plan developed
7. Telephone call crib sheet drafted

8. Met with BLMK QI lead Targeted Cancer Screening and Early Diagnosis Through Community Outreach and Case Finding in Bedford

Completed a sample audit of Barretts Oesophagus patients at London Rd and Putnoe. AIM: 1) Identify whether follow-up oesophagogastroduodenoscopies (OGDs) are occurring in patients with Barrett's oesophagus according to current recommendations.

2) Assess the quality of proton-pump inhibitor (PPI) prescribing in these patients.

Held Cancer Engagement Event on 02 October 2025

Met with the lung cancer screening team to discuss possible areas for mobile unit siteing . Have agreed to promote Lung screening in bedford.

Improving Early Diagnosis of Cancer by identifying High Risk Patients

Deployment of CtheSigns has been initiated. The IT team have confirmed installation and referral forms are in the process of being uploaded

Identification of good practice when diagnosing/referring suspected cancer patients

Continuing with breast screening promotion following an influx of breast cancer diagnoses.

Noted that there are occasions where cancer diagnosis has been missed from discharge paperwork. The issue is being investigated.

Currently investigating patient with numerous consultations prior to 2WW referral

Have purchased models to support LD patients to attend screening

Using a behaviour change approach to improve cervical screening uptake

Project complete. Webinar to lauch resources held on 17 Sept.

Progress to be made in Next Period

- PCNs to continue working on projects related to inequalities bids
- Behaviour change resources to be hosted on sharepoint
- Continued scoping of HPV vaccination proposal
- Continued scoping of cervical screening self-sampling pilot in GRT communities
- SBRI ApptHealth cervical screening project launched by NHS England. To confirm which BLMK Practices are participating
- Cancer focussed BLMK Womens Stakeholder Forum to be held in November
- The team will support the MK Macmillan Community Action event on 20 November
- Support also to be offered at the Luton Health Fest event on 25 October

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status

All projects on track and in progression

	Start Date	End Date	2025							2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Behaviour Change approach to improving Cervical Screening Uptake		31/10/25								◆				
Roll out of Lung Cancer Screening Programme across BLMK		31/03/26												◆

Risks

Overall Risks Status

GREEN

Reason for Overall Risk Status

Currently in early stages of community projects. To date all clinicians are reported to be engaged and supportive of the work.

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Community Outreach - Low engagement at outreach events	Yes	4
CtheSigns implementation	Yes	4
Pancreatic Cancer case-finding	Yes	12
Pancreatic cancer case-finding (2)	Yes	9

Issues

Overall Issues Status

AMBER

Reason for Overall Issues Status

Project to proceed recognising that less patients than previously thought will be identified.

Issues

Issue Name	Key Issue?	Proximity & Impact
Pancreatic cancer case-finding project identifying low numbers of patients for investigative CT scan. Hosptial unwilling to accept referrals for patients below the criteria age of 60	Yes	12

Portfolio Report Governance Report

Date of Highlight Report	22/10/2025
Project Code	PR000400
Project Name	Cancer - Living with and beyond cancer
Project Team	BLMK Cancer Team
Project Aim	<ul style="list-style-type: none">• Use, and encourage Trusts/System partners to use, insight and feedback (including CPES/U16CPES) to understand how people are experiencing cancer services to inform improvements to services.• Maintain a comprehensive approach to community and public engagement, ensuring that the diverse voices of local communities are heard and integrated into all work programmes
Governance & Responsible Group	BLMK Cancer Board
Geographical Footprint	BLMK System

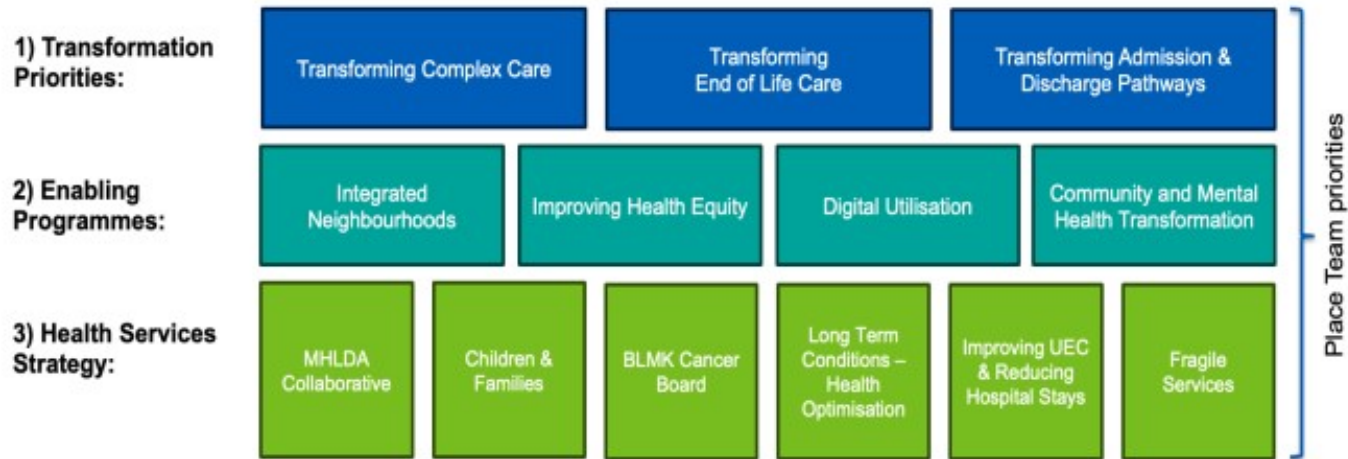
Project Team Members

Name	Role
Helen Watt	Programme Manager
Sara Burford	Project Manager
Naisha Henry	Project Support

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	Project momentum has slowed, as stakeholders remain cautious about fully engaging due to the broader ICB context.
Project Maturity	4.0 - Delivery

System Transformation



<p>Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)</p>	<p>The project has cross-overs with transforming end of life care as some cancer patients will need PEoLC.</p> <p>The project aligns with improving health equity and digital utilisation.</p> <p>The project feeds into the Cancer board</p>
--	---

Progress Update

<p>Progress made in Previous Period</p>	<ul style="list-style-type: none"> • Discussions around MK Community Psychology continues to be reviewed pending funding/contracting confirmation. • Walk through videos of the Cancer centres have been signed off by the hospitals for sharing and are now live on the Health and Care Partnership website for wider sharing. • Discussions are ongoing around a BLMK Cancer prehab/rehab video, to support the service. • A Bedford Borough Cancer marketplace event was successfully held with a range of professionals who support patients across BB on hand to talk to patients, carers and family members about what support is available, locally. • An MK Cancer marketplace event had to be cancelled due to lack of engagement from professionals and patients. There is a Macmillan event in November so once details are known, these will be shared.
<p>Progress to be made in Next Period</p>	<ul style="list-style-type: none"> • Completion of a Luton Cancer Marketplace event (scheduled mid-Dec) • Planning for a possible Central Bedfordshire Cancer Marketplace event, pending interest • Completion of planning and possible completion of filming of a BLMK Cancer prehab/rehab video, to promote the service • The NCPES has been completed. Once the trust action plans have been completed, these will be shared with the BLMK Cancer Patient forum, for feedback and review. • Wide sharing of the BLMK Cancer walk through videos

Tasks & Milestones

Issues

Issue Name	Key Issue?	Proximity & Impact
Lack of engagement	Yes	4

Portfolio Report Governance Report

Date of Highlight Report	16/10/2025
Project Code	PR000398
Project Name	Cancer - Operational Performance and Faster Diagnosis
Project Team	BLMK Cancer Team
Project Aim	<p>Develop and deliver an operational performance improvement plan which will contribute to an improvement in cancer waiting times performance across the three standards: Faster diagnosis, 31 day decision to treat to treatment and 62 day referral to treatment standards.</p> <p>Actions and improvement areas should be pathway wide including staging and treatment element of the pathways and detail:</p> <ul style="list-style-type: none"> • Separate plans for tumour sites where performance is in the bottom quartile • Actions to address where more than 25% of patients are waiting over 31 days for treatment • Lung 62 day performance • Overcoming seasonality to support a consistent performance improvement across the year • Reducing variation
Governance & Responsible Group	BLMK Cancer Board
Geographical Footprint	BLMK System

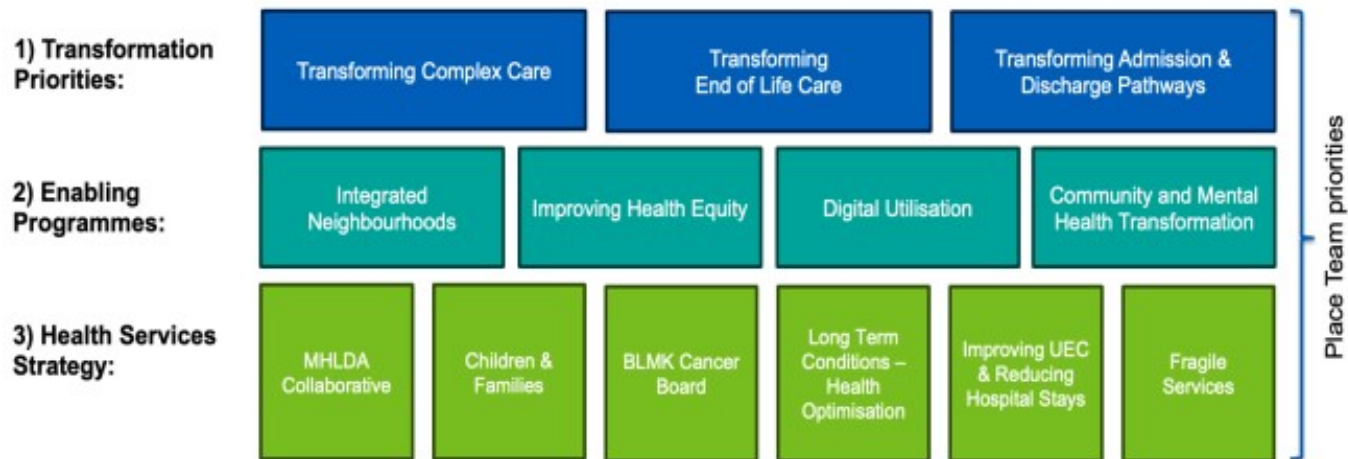
Project Team Members

Name	Role
Naisha Henry	Programme Manager
Helen Watt	Programme Manager

Project Status

Overall Project Status	AMBER
Reason for Overall Project Status	While all providers are tracking above the performance trajectory submitted at planning for the 28D targets. Significant challenges remain in relation to the 31D and 62D targets. Both providers continue to run performance improvement projects across all tumour sites with increased executive input where required.

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 BLMK Cancer Board had overall responsibility for this programme. The programme also aligns closely with the BLMK Health Services Strategy and the BLMK Cancer Strategy (2025-2030)

Progress Update

Progress made in Previous Period

The cancer board continues to oversee operational performance and delivery of the cancer metrics; we have developed a tumour site level performance improvement plan which is updated monthly with the provider cancer management team and reported into our delivery group. This is then taken to the cancer board on a quarterly basis with a summary of the actions, improvements, and any escalations. Both providers are running performance improvement projects with across all tumour sites with increased executive input where required. Outputs of their projects are also being fed into the improvement plan with monitoring of the benefits.

We are supporting additional projects in Lung and Gynaecology which are pathways of concern for the ICB across all targets.

- 28D FDS

We continued to see improved performance for the Faster Diagnosis Target in August across both providers and for the ICB. All are tracking above the performance trajectory submitted at planning. We have been working with challenged pathways (Gynaecology, Haematology, LGI, Lung, UGI and Urology) to ensure that restorative actions are taking place.

- 31D Waits

Bedfordshire Hospitals delivered the 31 day target in August, Milton Keynes and BLMK ICB were below the compliance metric and planning trajectory submitted. Challenges at MKUH were in relation to Breast, LGI and UGI tumour sites. All of which have been impacted by theatre refurbishment work which completed in September. The ICB performance was impacted by delays for specialist treatments at tertiary centres.

- 62D Waits

62 day performance continues to be a challenge across all providers and the ICB. Our August cancer board focussed on the delivery of treatments, mapping of treatment provision and discussion of key issues that impact on the delivery of the target such as capacity and demand across treatment modalities, the increased use of immunotherapy and chemotherapy as well as the complexity of patients, their comorbidities and complexity of pathways.

Progress to be made in Next Period

Focus areas for the next period include

- Supporting delivery of the planning trajectories for the 3 compliance metrics (Faster diagnosis, 31 day treatments and 62 day pathways)
- Deep dive into Lung pathway and development of the separate improvement plan
- Go live for the secondary care gynaecology behaviour change project
- Develop monitoring methodology for breach and harm reviews supporting quality assessment and trend analysis

Tasks & Milestones

Overall Tasks & Milestones Status	AMBER
Reason for Overall Tasks & Milestones Status	<p>while there is significant progress and improvement, some critical elements have not yet reached their targets, warranting continued attention and action.</p> <p>October update - 62 day performance is trending upwards across BLMK despite not delivering the performance trajectories. We have updated our system action plan and reported into monthly delivery groups; with overview assurance into the cancer board. There has been progress against actions at provider level (such as recruitment into roles, utilisation of waiting list initiative funds, in depth pathway reviews completed) supported by restore and recovery processes at provider level. We will continue to monitor against the trajectories to ensure performance continues to improve.</p>

		2025							2026					
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
62 Day performance		31/03/26												◆

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	Industrial action has been confirmed. Trusts have also confirmed that cancer will be prioritised. MKUH submitted derogation requests for urgent suspected cancer referrals for the duration of the Industrial action as per NHS England guidance explicitly stating that such services should be included under patient safety derogations

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Junior Doctor's Industrial Action	Yes	9

Issues

Overall Issues Status	AMBER
Reason for Overall Issues Status	Performance against the 62-day Standard remains significantly off plan nationally, meaning a step change in performance will be needed over the coming months in order to achieve the year-end ambition of 75%.

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	17/10/2025
Project Code	PR000399
Project Name	Cancer - Treatment and Care
Project Team	BLMK Cancer Team
Project Aim	Implement national priority recommendations from clinical audit/GIRFT reposts to reduce variation in treatment in trust not meeting the NHS-wide target.
Governance & Responsible Group	BLMK Cancer Board
Geographical Footprint	BLMK System

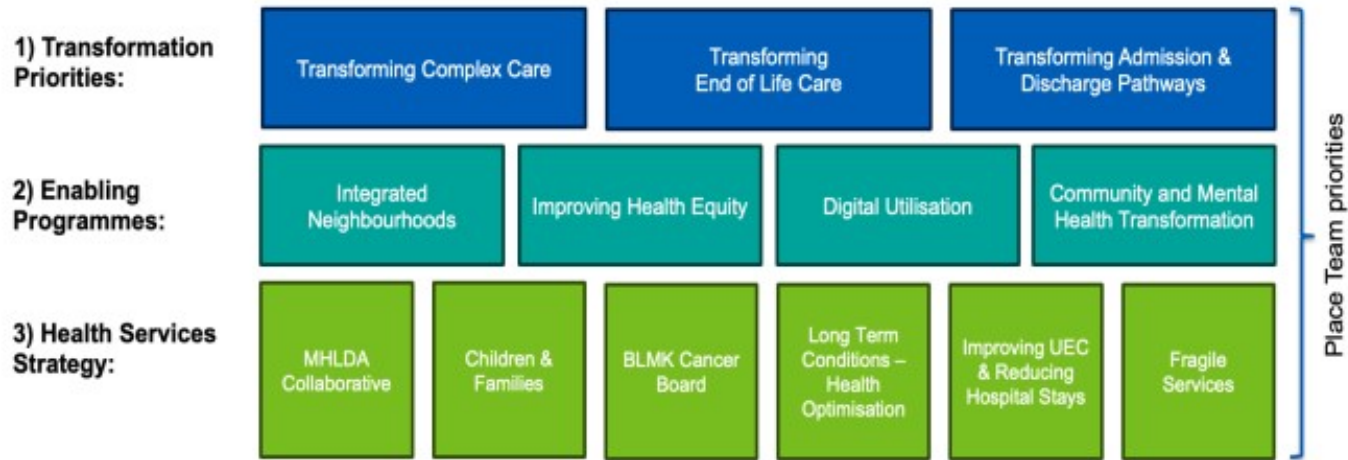
Project Team Members

Name	Role
Naisha Henry	Programme Manager
Helen Watt	Programme Manager

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	<ul style="list-style-type: none">Work on lower performing pathways have been initiated through the Rapid Cancer Action Team (RCAT) work led by the Cancer Alliance. A steering group has been established, leads have been identified and the data packs are in the process of being completed and shared.
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 Cancer strategy sets out the direction of travel and key priorities for BLMK cancer services over the next five years. In the development of this we have considered and aligned to the ICB priorities; the Health Service Strategy; the EoE cancer delivery plan and in recognition of the challenges facing the health care system.

Progress Update

Progress made in Previous Period

The September cancer board was focussed on treatment delivery; the main report into the board included information on the complexity of treatment pathways, the requirements of the treatment element of cancer pathways and mapping of where patients from each BLMK place could go for specific treatment modalities. The discussion in the group identified a list of actions that will be woven into the action plan and project.

We have been working with our providers to understand the operational challenges within chemotherapy units as all our units are reporting increasing capacity challenges. This has included potential capacity and demand methodology, as well as scoping how we can support increased delivery of chemotherapy at home. One of our providers has requested some increased support as they have a particular area of challenge.

Progress to be made in Next Period

Set up a meeting with most challenged provider to support capacity and demand management

Work with providers to develop a task and finish group focussed on chemotherapy delivery

Obtain access to COSD reporting for Milton Keynes.

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
Reason for Overall Tasks & Milestones Status	BHT and MKUH are actively working with the Cancer Alliance on Rapid Cancer Action Team (RCAT) work. This is a pathway-led group of subject matter experts within our region. Pathways of focus have been identified. Gynae and Lung for BHT and Gynae, Luton and Breast for MKUH.

	Start Date	End Date	2025							2026					
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Recruit additional CNS to support patient treatment pathways at challenged tumour sites	01/04/25	01/07/25	█												

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	The project 'Cancer - Treatment and Care' is currently facing notable risks, particularly related to workforce, demand, and capacity challenges impacting critical areas such as histopathology and gynaecology cancer pathways. These risks are significant due to their potential impact on meeting reporting turnaround times and maintaining key diagnostic pathways. However, the risks are not immediately described as critical or unavoidable, which would necessitate a 'RED' status. Given these circumstances, an 'AMBER' status is appropriate as it reflects a situation that requires attention and management but is not yet at a crisis level. This indicates that while there are challenges, they are being actively managed with the expectation of mitigation strategies being implemented.

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Histopathology Delays	Yes	9
Gynaecology Cancer Pathway	Yes	9

Issues

Overall Issues Status	TBC
Reason for Overall Issues Status	<p>Given that no specific information about progress, challenges, deadlines, or completion status is available, it is appropriate to select 'TBC' (To Be Confirmed). This choice reflects the need for further clarification and additional data to accurately assess the project's current standing.</p> <p>Once more detailed information becomes available regarding any ongoing issues, milestones reached, or potential delays, a more informed decision can be made regarding the status. For now, 'TBC' indicates that the status is yet to be determined.</p>

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	22/10/2025
Project Code	PR000152
Project Name	Improving Health Equity
Project Team	Quality Improvement [QI] and System Transformation Team [STT]
Project Aim	<p>"to listen and learn with our residents to improve health equity across BLMK over the next 3 years"</p> <p>The four primary drivers to achieve this programme are by ensuring:</p> <ul style="list-style-type: none"> • Residents feel services are for them • Residents feel they can access services they need • Residents are involved in making improvements • Women feel seen and heard (linking to the Women's Health Programme)
Governance & Responsible Group	<p>To report to Health Equity Programme Board via:</p> <ul style="list-style-type: none"> - Weekly health equity delivery group, chaired by Sarah Watts - SRO: Sarah Stanley (ICB) - Board Champion - Lorraine Sunduza (ELFT)
Geographical Footprint	BLMK System

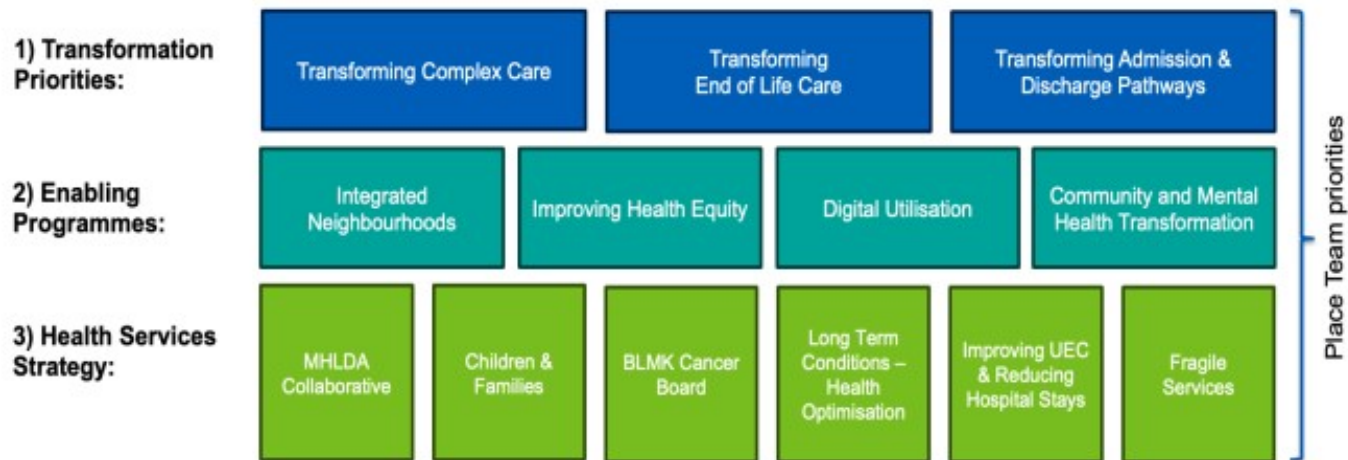
Project Team Members

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

Project Status

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

System Transformation



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

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

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

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

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

Progress Update

<p>Progress made in Previous Period</p>	<p>04/11/25</p> <ul style="list-style-type: none"> • Board Assurance Framework risk "Widening Inequalities" was updated and redefined, further consideration is needed in light of ongoing transition arrangements to new Central East ICB • Several workstreams are being reviewed as part of alignment with to the new Central East ICB footprint • Introduction to the Institute for Healthcare Improvement, current work within BLMK and adjacent areas, and future ambitions for the wider Central East ICB footprint took place 21st October • QI improvement advisors have continued to deliver Introductory Quality Improvement / Health Equity training to the ICB on a monthly basis. This work aligns with programme's aim of increasing capabilities in QI to solve complex problems. • Concluding LAN Event planned and is to take place February 13th and 14th 2026
<p>Progress to be made in Next Period</p>	<p>04/11/25</p> <p>We are undergoing a transition which will encompass a much larger footprint, governance and priorities are being re-evaluated for Health Equity & Quality Improvement across the new Central East Integrated Care Board.</p> <ul style="list-style-type: none"> • Several workstreams are being reviewed as part of alignment to new Central East structures, and where appropriate re-established, e.g. Denny Review metrics - identifying any relevant metrics that can be included in the Health Equity data report and ensuring diverse representation from the employment pathways in patient participation groups. • Translation & Interpretation Services - testing with maternity services still to be undertaken, contact has been made with the MNVP lead to progress. • Health Equity Programme Board governance arrangements to be reconsidered and governance pathways clarified. • Arrangements for EDS Domain 1 to be reviewed and agreed prior to submission to the Board • Recommendations and outcomes from the Denny Review and workstreams to be reviewed and updated by the group with clear alignment to Central East ICB priorities • Alignment of all health inequalities and equity work to improve programme management and visibility of work on Verto. • Translation and Interpretation (T&I) Services - The original driver diagram is to be revisited to identify and agree on quality improvement (QI) opportunities, alongside establishing clear timelines for delivery. Coordination with clustering ICBs is underway to understand their strategic direction and explore opportunities for alignment. • Quality Improvement Team have reviewed and developed workplans with leads for each driver to understand what work is already in place and needs to be strengthened as well as what could be paused until the face-to-face meeting takes place (A face-to-face meeting is planned to review oversight of the programme and to re-establish leads for the drivers)

Tasks & Milestones

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

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
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	TBC
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	22/10/2025
Project Code	PR000402
Project Name	Enhancing the Integration of IUC and Urgent Care with Primary Care and UEC
Project Team	Primary Care
Project Aim	<ol style="list-style-type: none">1. Maximise all opportunities for integration of IUC with urgent and emergency services including Unscheduled Care Co-ordination Hubs2. Review of demand, capacity and capabilities of urgent 'same day' primary care models of UTC, WiC and UGPC3. Optimise the integrated urgent care process so that people receive the right care at the right time and from the right service.
Governance & Responsible Group	<p>Primary Care Delivery Group reporting to Primary Care Commissioning & Assurance Committee</p> <p>See file "Governance" and "Collaboration and Connectivity" in the 'Governance' Folder.</p>
Geographical Footprint	BLMK System

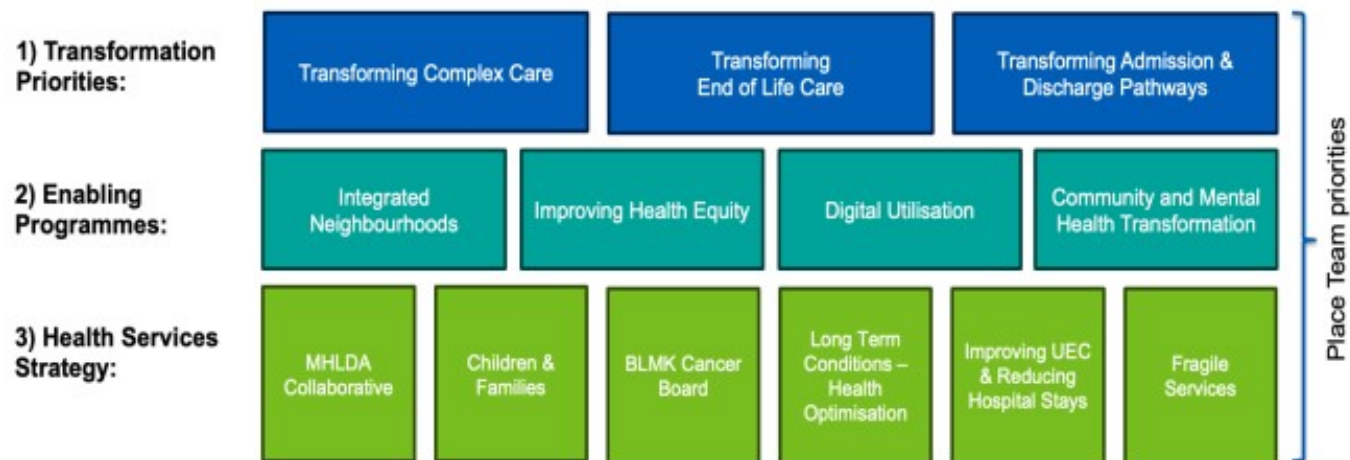
Project Team Members

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

Project Status

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

System Transformation



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

Progress Update

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

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

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

*MiDoS programme - develop the content within MiDoS and roll out MiDoS access to all BLMK health, social care and voluntary sector professionals and BLMK residents **(October 2025)** The public MiDoS page was made available via the ICB website for BLMK residents on Thurs 30th October. This will be a soft launch initially but will move to a more targeted approach over the coming weeks. All community pharmacies were given access to MiDoS in September.*

*Optimise 111 direct booking into services across the system **(March 2026)** - ICB continue to work closely with 111 providers across BLMK (HUC and DHU) to increase the percentage of direct bookings made into GP practices.*

*EOL/Palliative line to be accessible via 111 so patients calling 111 can be redirected via the local IVR, B&L only **(October 2025)** - The keech and sue ryder palliative advice teams have been having joint daily capacity and demand huddles since 8th Sept, positive results seen so far with hospice avoidances. The two teams are due to merge in November 2025 and are in the process of agreeing processes, governance etc. The joint advice line is now expected to be available via a 111 IVR option in December 2025.*

Progress made in Previous Period

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

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

*1. Review of Urgent Same Day Primary Care services **(September 2025)** - IUC dashboard (111, GP OOH & CAS) development; issues were identified with data quality which have been worked through and it is now expected to be live on Athena w/c 3rd November 2025.*

Develop an ED leaflet for patients to support with signposting to alternatives services, this will include information on pharmacy, GP practices dental, 111 and MiDoS - leaflet has been drafted and sent to BHFT for review

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

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

*1. Optimise the integration with Unscheduled Care Coordination Hubs **(March 2026)** - 111 are now included as attendees in the UCCH stocktake meetings with the last meeting held in October.*

Progress to be made in Next Period	<p>MiDoS programme;</p> <ul style="list-style-type: none"> • Confirm next steps for the public comms plan/approach for the public roll out • Further expand the social prescribing content on MiDoS <p>Review of Urgent Same Day Primary Care services;</p> <ul style="list-style-type: none"> • IUC dashboard to be live on Athena w/c 3rd November • Finalise ED leaflet for patients by 30th Nov
------------------------------------	---

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
-----------------------------------	--------------

Reason for Overall Tasks & Milestones Status	Delivery on track
--	-------------------

	Start Date	End Date	2025							2026							
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Review of Urgent Same Day Primary Care services	01/04/25	30/09/25															
Optimising DoS profiles and ranking of alternative services	01/04/25	31/10/25															
Roll out MiDoS access to BLMK residents		31/10/25								◆							
Deliver an IUC Dashboard	01/04/25	30/11/25															
Palliative Care advice line accessible via 111 (Bedfordshire & Luton)	02/06/25	31/12/25															
Review of demand, capacity and capabilities of urgent 'same day' primary care models of UTC, WiC and UGPC	01/04/25	31/03/26															
Optimise the integrated urgent care process so that people receive the right care at the right time and from the right service.	02/04/24	31/03/26															
MiDoS programme	01/09/24	31/03/26															
Optimise 111 direct booking into services across the system	01/04/25	31/03/26															
Maximise all opportunities for integration of IUC with urgent and emergency services including Unscheduled Care Co-ordination Hubs	01/04/25	31/03/26															
Self-triage at the front doors of ED	01/04/25	31/03/26															
ICE portal integration (B&L/ HUC only)	02/06/25	31/03/26															

			2025							2026				
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Patient tagging and flagging (B&L / HUC only)	01/08/25	31/03/26												
Optimise the integration with Unscheduled Care Coordination Hubs	01/08/25	31/03/26												
111 booking 'arrival slots' in ED to support A&E departments manage their capacity	01/04/25	30/09/26												

Risks

Overall Risks Status	GREEN
Reason for Overall Risk Status	Projects remain on track overall

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
111 Direct Booking into GP Practices	Yes	9

Issues

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

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	20/10/2025
Project Code	PR000344
Project Name	BLMK Long Term Conditions Programme
Project Team	Medical Directorate, Primary Care
Project Aim	<p>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 programme also aims to improve the primary/secondary care interface through closer clinical professional relationships, and collaborative approach to pathways and interventions</p> <p>The key principles of this programme are to:</p> <ul style="list-style-type: none">• 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	<p>Governance structure PROPOSED only - still to define/refresh the Elective Collaboration Board and its role in both LTC and Fragile Services oversight.</p> <p>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.</p>
Geographical Footprint	BLMK System

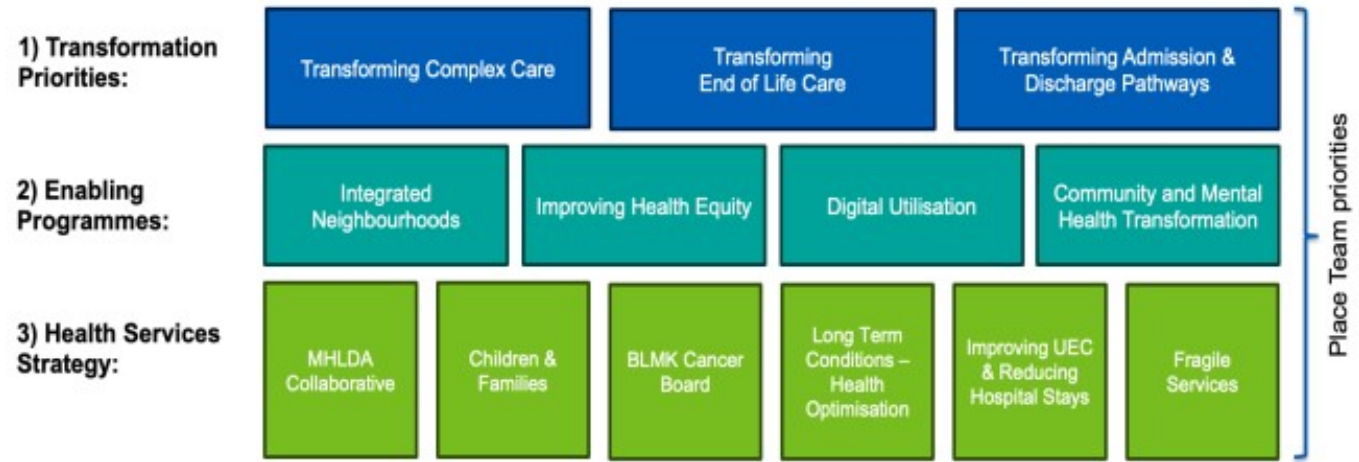
Project Team Members

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

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	<p>Detailed priorities and measures in place for the diabetes, CVD and Respiratory groups, however the groups themselves need re-engaging and support with more specific action planning / accountability lines.</p> <p>MSK programme ongoing under STT leadership but needs to be brought together and linked in with overall LTC programme</p> <p>Still determining governance structure, but proposal being worked up with deadline to complete.</p>
Project Maturity	2.0 - Initiation

System Transformation



<p>Please explain how your programme/ project aligns back to the 1) Transformation Priorities, 2) Enabling Programmes and 3) Health Services Strategy (as per the diagram above)</p>	<p>One of the six priority delivery programmes of the Health Services Strategy. Also links to complex care and admissions avoidance since patients with 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.</p>
--	---

Progress Update

<p>Progress made in Previous Period</p>	<p>Four key priorities (areas of focus) identified, and objectives set:</p> <p>1. Cardiovascular Disease & Prevention:</p> <ul style="list-style-type: none"> •Improving management of hypertension •Improving secondary prevention and optimisation in CVD •Improving identification and management of heart failure <p>2. Diabetes:</p> <ul style="list-style-type: none"> •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 <p>3. Respiratory:</p> <ul style="list-style-type: none"> •Improving access to diagnostic tests for respiratory disease •Improving evidence-based management of asthma •Improving evidence-based management of COPD <p>4. MSK:</p> <ul style="list-style-type: none"> •Reducing the prevalence of musculoskeletal (MSK) conditions and improving timely management <p>The first three are tracked via the LTC dashboard.</p> <p>MSK is currently a STT-led project - #PR000006 Musculoskeletal (MSK)</p>
<p>Progress to be made in Next Period</p>	<p>Finalise governance - confirm whether Elective Collaboration Board will be the right forum, update TOR and confirm chair</p> <p>Review TOR and membership of diabetes/CVD/respiratory subgroups - can they be effective in their current form?</p> <p>Work with subgroups to develop robust plans and provide clear guidance for reporting (once structure is defined) Board.</p>

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	2025							2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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	03/10/2025
Project Code	PR000157
Project Name	BLMK Fragile Services - Diagnostics
Project Team	Medical Directorate, STT, Diagnostic Elective Collaborative, System Partner Organisations
Project Aim	To create the resilience within diagnostics provision to ensure residents are able to access diagnostic tests in the timeframes set by the constitution targets
Governance & Responsible Group	Elective and Fragile Service Collaborative - System Chair, Helen Beck (COO, MKUH) BLMK Diagnostics Collaborative Diagnostics Demand Management Oversight Group (BHFT)
Geographical Footprint	BLMK System

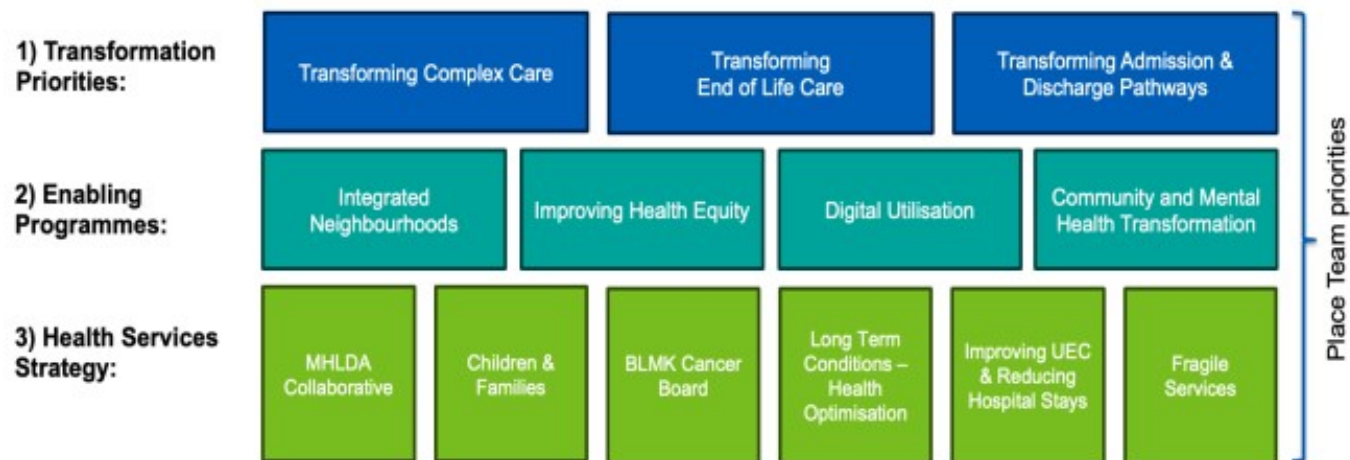
Project Team Members

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

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	Diagnostic Collaborative has been refreshed and TOR near approval. Multiple specific priority pieces of work actively progressing and engagement building across both trusts
Project Maturity	3.0 - Implementation

System Transformation



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

This programme is one of the six priorities identified as delivery vehicles for the Health Services Strategy

Progress Update

Progress made in Previous Period

- **CDC Demand & Capacity Analysis:** Dashboard build completed by AGEM in collaboration/consultation with key project team - now live on Athena to support understanding of activity, demand and capacity across Milton Keynes acute and CDC sites.
- updates on data reported to Diagnostic Collab
- **Pathology Transformation QI Project:** Clinical team at BHFT, supported by BLMK Clinical Lead (Primary Care engagement) continue to focus on demand management for the tests below. Key engagement with MKUH established going forward.
 - calprotectin in >60's
 - allergy testing in adults
 - haematinics
 - HbA1c in children
 - auto-immunity testing

Education sessions held with primary care x2. FAQ developed and circulated with information slides as well as info via PCN Bulletin Launch due 21/10/2025

Regular agenda item for interface forum going forward to update and continue with further tests

- **BLMK Diagnostics Collaborative:**
 - Refreshed TOR and agenda from October
 - Good engagement from across the system
- **X-Ray provision at MK UTC:** ongoing work to understand potential benefit and whether feasible. Some data mapping complete but need to link in with MKUH for fuller understanding and to consider joint working and funding potential.
- **iRefer Pathology - ON HOLD**

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

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

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

Progress to be made in Next Period

- **Pathology Transformation QI Project:**
Feedback on phase 1 of the changes implemented for first 4 tests - review at clinical interface forum Jan 2026
Phase 2: identification of next cohort (up to 5) of tests, information sharing / Q&A, then go-live date to be sat early 2026
- **Programme Management:**
Streamlining and focusing of various informal meetings across diagnostics to ensure correct attendance and effectiveness

Tasks & Milestones

Overall Tasks & Milestones Status

AMBER

Reason for Overall Tasks & Milestones Status

Progress being made across sub-projects and collaborative governance now being refreshed. CDC Analysis milestone completed and North Beds CDC set to open late Oct. Connections made between acute trusts and primary care through ICB support which offers more confidence in delivery.

	Start Date	End Date	2025							2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	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	■	■	■	■	■							
Implementation of iRefer for Radiology - BHFT		01/08/25					◆							
CDC Dashboard	01/05/25	07/08/25		■	■	■	■	■						
Elective and Fragile Services Programme Board - First Meeting		10/09/25								◆				
BLMK Clinical Advisory Group (CAG) Meeting		16/09/25								◆				
Mobilisation of North Bedfordshire CDC	01/09/25	30/09/25							■					
Launch Implementation of new pathways		21/10/25									◆			

		2025											2026	
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mobilisation of Luton CDC		31/01/26										◆		

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	<p>Risks identified but potential mitigations underway - hope to be green by next update</p> <p>This status reflects the high level of uncertainty and the critical nature of the unresolved risks affecting the project's viability and progress.</p>

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Reduction in revenue available (National "pot") for Luton Diagnostic Hub	Yes	16
Workforce resource to manage programme	Yes	6
Limitation to Demand and Capacity Review Data	Yes	4
BLMK ICB Organisational Changes	Yes	12
PMO Support for Diagnostic Collaborative	Yes	1

Issues

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

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	03/10/2025
Project Code	PR000343
Project Name	BLMK Children, Families, Women's and Maternity (CWM) Board
Project Team	Children, Families, Women's and Maternity Board Membership, LMNS
Project Aim	As well as delivering the BLMK Health Services Strategy BLMK Health Services Strategy . The Board will be responsible for responding to the government's new 10 Year NHS Plan once it is published this Spring.
Governance & Responsible Group	<p>The Children, Families, Women's and Maternity Board (meets quarterly) is established to drive the work. It will not replace existing place-based groups but will focus on where whole system change across the BLMK geography will make the most difference. In this iteration of the governance</p> <p>The CFWM reports to the BLMK Quality and Performance Committee which in turn reports to the Board of the ICB</p>
Geographical Footprint	BLMK System

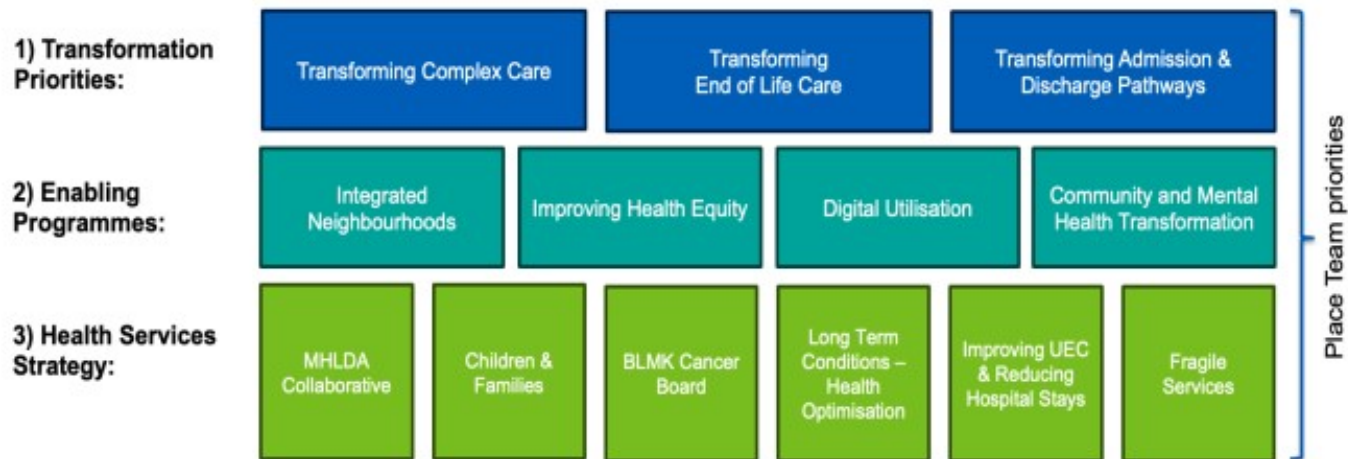
Project Team Members

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

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	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.

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

Progress made in Previous Period

- The CFWM Board met on 1st September 2025, chaired by Kate Howard and with a focus on the Women's Health Programme.
- 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).
- Building a work programme plan around the 8 identified strategic outcome measures - working group to form around this
- Work ongoing to develop a “wellbeing” measure
- The BLMK Childhood Trauma Board continues to meet monthly through 2025/26 to deliver the workstreams on process and decision-making, assessment and de-escalation and new models of care

Progress to be made in Next Period	<p>Proposed Forward Plan</p> <ul style="list-style-type: none"> • Alignment to NHS 10-year Plan and BLMK Health Services Strategy • Integrated neighbourhood working – what does this look like for children, young people and families • Business case for community gynae – shift of services out of hospital to the community • Next CFWM Board to meet 17/12/2025 <p>Discussion at next CFWM about 10year plan and how we want to work in alignment with this across BLMK (particular focus on neighbourhood working)</p>
------------------------------------	--

Tasks & Milestones

Overall Tasks & Milestones Status	GREEN
-----------------------------------	--------------

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

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Inaugural Meeting of the Children, Families, Women's and Maternity Board (CFWM)		25/04/25	◆														
Terms of Reference	25/04/25	30/05/25	[Bar]														
CFWM Board		01/09/25								◆							
Strategic Work Programme Development	25/04/25	17/12/25	[Bar]														
CFWM Board		17/12/25											◆				

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	03/11/2025
Project Code	PR000389
Project Name	BLMK Hospital Opportunities Assessment
Project Team	System Transformation Team / PA Consulting
Project Aim	<ol style="list-style-type: none">1. Identify opportunities to deliver the best possible population health outcomes, rebalancing services to support proactive, preventative care closer to home.2. Identify opportunities to improve sustainability of our services and organisations across BLMK, reducing variation, improving performance and delivering positive clinical outcomes.3. Identify where transformation and investment can lay the foundation for a longer term clinical, workforce and capital strategy, aligned with system-wide priorities, and ensure acute providers are supported to adapt as part of a more sustainable care system.4. Inform the re-specification of community and mental health services to better meet the needs of the BLMK population
Governance & Responsible Group	BLMK ICB Board BLMK Executives
Geographical Footprint	BLMK System

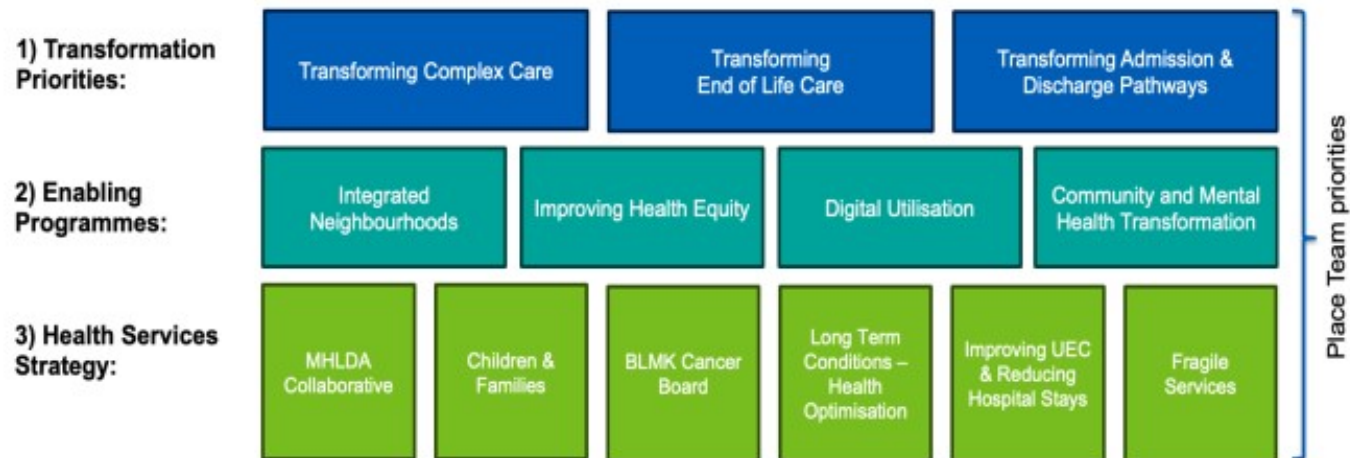
Project Team Members

Name	Role
Andrew Rochford	Clinical Lead
Tara Dear	Head of STT
Cat Lee	Project Manager
Maureen Okolie	Project Support
Maria Wogan	Senior Responsible Owner
Matt Rogers	Senior Transformation Manager

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	Project progressing at pace and on track accounting for recent adjustments to timeline.
Project Maturity	2.0 - Initiation

System Transformation



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

Progress Update

Progress made in Previous Period	<ul style="list-style-type: none"> • Programme Board established and has met on 5 occasions since 21/08/25 • Joint Board session (BLMK ICB, BHFT and MKUH) held on 26/09/25 to review headlines and agree principles for improvement • Diagnostic Report agreed by Programme Board setting out case for change based on population forecast, Demand & Capacity, Workforce assessment, Financial model, and Do nothing projections • Extensive stakeholder engagement with strategic and clinical leaders across BLMK including: x40 1:1s sessions, x10 Modelling Groups, x5 CFOs group, x15 Clinical Working Groups - the output has informed the diagnostic report, the modelling assumptions, the left shift interventions, the hospital opportunities, the risk log and will inform the final report and implementation plan • Clinically-led Left Shift Interventions developed and quantified, interventions to be taken forward by the Community and Mental Health Services Transformation Programme (where applicable to scope) • Critical Success Factors drafted • Programme governance (including Programme Board) being reviewed following new Central East ICB Leadership, Programme Boards currently on hold, but work progressing
Progress to be made in Next Period	Following change of leadership in Central East, the programme approach and next steps is currently being reviewed. Updates will be provided in the next report.

Tasks & Milestones

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

	2025							2026						
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Agreement on next steps and approach to the remaining phases of the programme		28/11/25								◆				

Risks

Overall Risks Status	TBC
Reason for Overall Risk Status	Risks to be reviewed as per next phase of the programme and updated in next report.

Risks

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

Issues

Overall Issues Status	GREEN
Reason for Overall Issues Status	Issues managed in line with programme governance - none to report at this time and programme on track

Issues

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

Date of Highlight Report	22/10/2025
Project Code	PR000341
Project Name	BLMK Mental Health Transformation Programme
Project Team	The Mental Health Transformation Programme comprises of service users and carers and a range of organisations such as the ICB, the mental health trusts (ELFT and CNWL), VCSE organisations, primary care, Local Authority organisations and the acute trusts.
	<p>The vision of the BLMK mental health and well-being programme is centred around preventing our residents from becoming unwell, promoting good mental health and supporting people living with mental illness to recover and live well. We commit to doing this by:</p> <ul style="list-style-type: none"> • Supporting the general population to take action and look after their mental wellbeing. • Preventing the onset of mental health difficulties, by taking action to address the factors which play a crucial role in shaping mental health and wellbeing outcomes for adults and children. • Supporting services to continue to expand and transform to meet the needs of people who require specialist support. <p>Since 2019 there has been significant progress made across BLMK with mental health developments including increased access to mental health services (perinatal mental health services, children and young people’s mental health services, community mental health services and NHS Talking Therapies services) and in particular the mobilisation of new initiatives such as:</p> <ul style="list-style-type: none"> • Perinatal mental health services (Bedfordshire and Luton) and Maternal Mental Health Services (Across BLMK) • The creation of mental health support teams in schools • Dedicated rough sleeping provision in Luton and Milton Keynes • 24/7 mental health telephone line available through NHS 111 and crisis cafes/lounges provided by MIND BLMK as well as suicide prevention support through the suicide prevention pathway service • Increased access for children and young people and adults to eating disorder services • Increased access for people with mental health problems into employment through either the Individual Placement and Support Services or through the employment advisors working in the NHS Talking Therapies Services • Increased access for people with severe mental illness to having an annual physical health check • Increased access to memory assessment services to support with dementia diagnosis and post-diagnosis support. <p>Although there has been significant progress as highlighted above, there is still an opportunity for further mental health improvements to be made across BLMK. The main national mental health priorities for 2025-26 as outlined in the priorities and operational planning guidance are to improve patient flow through mental health crisis and acute pathways and access to children and young people’s mental health services. To support the national mental health objectives for 2025/26, there is an expectation for ICBs to meet the Mental Health Investment Standard (MHIS) and work with providers to:</p> <ul style="list-style-type: none"> • Deliver the 10 high impact actions for mental health discharges and ensure that system discharge plans include mental health

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 which have been identified for BLMK:

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

Early Intervention – (Preventing sickness not just treating it) Continuing to develop the Mental Health Support Teams
Children and Young Peoples Mental Health developments - Bedfordshire and Luton's Children and Adolescent Mental Health Services are refreshing the local Getting Advice offer by developing a Children and Adolescent Mental Health Community Access Service (CAS).

Continue to develop the Early Intervention in Psychosis Services through the National Clinical Audit of Psychosis
On-going implementation of the Milton Keynes Wellbeing Service provided by VCSE providers and the VCSE provider, CHUMS, continuing to provide an early intervention hub supporting CYP across Bedfordshire and Luton.

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

community mental health services access

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

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

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

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

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

Continue with the work regarding ADHD and Autism developments

Continue with the S117 and Specialist placements work including housing

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

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

Progression of the urgent and emergency mental health pathway across BLMK

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

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

Mobilisation of crisis text services across BLMK

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

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

Quality

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

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

Reviewing dementia pathways across BLMK

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

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

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

Project Team Members

Name	Role
Michael Farrington	Programme Manager
Cat Lee	Programme Manager

Project Status

Overall Project Status

GREEN

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

Early Intervention in Psychosis waiting times standard - Currently at 100% (In July 2025) which is the highest in the East of England Region

Meeting the dementia diagnosis rate - Currently at 69.6% (In July 2025) which is the highest in the East of England Region

Access to community mental health services - Currently at 14,805 (In July 2025) which is the second highest in the East of England Region

Meeting the ambitions of supporting people to complete a course of treatment and there being reliable improvement through NHS Talking Therapies Services

72 hr follow up following discharge from an adult mental health in-patient unit - Currently at 86% (In July 2025) which is the highest in the East of England Region

6 and 18 week waiting times standards for NHS Talking Therapies Services which are currently at 93% and 99%

Very urgent referrals to crisis care services (Seen within 4 hours) - Currently at 89% (In July 2025) which is the highest in the East of England Region

Urgent referrals to crisis care services (Seen within 24 hrs) - Currently at 84% (In July 2025) which is the highest in the East of England Region

Increasing access to annual physical health checks for people with SMI - Currently meeting the national minimum ambition of 60%

For non-urgent children and young peoples mental health waits (Over 104 weeks), BLMK have the 2nd lowest number of children and young people waiting as an ICB in England. This makes BLMK the 2nd 'best' performing ICB in England.

For non-urgent adults and older adults mental health waits (Over 104 weeks), BLMK have the 2nd lowest number of adults and older adults waiting as an ICB in England. This makes BLMK the 2nd 'best' performing ICB in England.

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

Children and Young Peoples Mental Health

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

Increasing access to children and young peoples mental health services

Meeting children and young peoples eating disorders waiting times standards

Urgent and Emergency Mental Health Care

Starting to plan for the mobilisation of crisis text services.

Considering mental health crisis assessment centres

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

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

Eliminating inappropriate out of area placements

Community mental health transformation (For adults and older adults)

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

Progressing with intensive and assertive community mental health care

Reason for Overall Project Status

Considering 24/7 neighbourhood mental health centres

NHS Talking Therapies Services developments

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

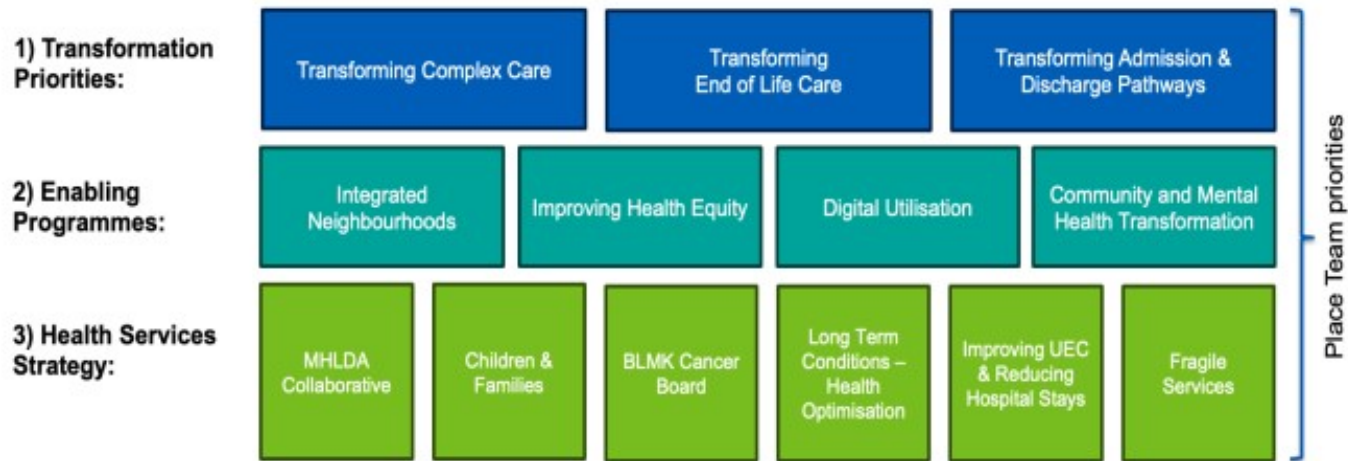
Finances

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

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 progress on the following:

Crisis Text Service development

BLMK is part of a NHS East of England Regional approach to mobilising crisis text services with an ambition for the service to be 'live' in 2026.

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

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

Mental Health Support Team expansion for children and young people

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

Individual Placement and Support Service expansion

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

Employment Advisors in NHS Talking Therapies Services

There continues to be the development of employment advisors in NHS Talking Therapies Services across BLMK.

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

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

24/7 Neighbourhood Mental Health Centres

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

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

Urgent and Emergency Mental Health Care

Work is progressing to improve the urgent and emergency mental health care pathway across BLMK. In Bedfordshire and Luton

Progress made in Previous Period

there is a focus on setting up a crisis house and opening an additional 9 acute mental health in-patient beds.

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

Crisis Text Service development

BLMK will continue to work with NHS East of England colleagues to progress with developing a crisis text service.

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

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

Increasing access to mental health services for children and young people

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

Mental Health Support Team expansion for children and young people

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

Individual Placement and Support Service expansion

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

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

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

24/7 Neighbourhood Mental Health Centres

Work is commencing to explore the opportunities to develop 24/7 Neighbourhood Mental Health Centres in BLMK.

Community Forensic Service development

Work is progressing to develop a community forensic service in Bedfordshire and Luton.

Urgent and Emergency Mental Health Care

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

Patient and Carer Race Equality Framework

Progress to be made in Next Period

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

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

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

Tasks & Milestones

Overall Tasks & Milestones Status

AMBER

Reason for Overall Tasks & Milestones Status

There are a number of priority areas 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 including expanding Mental Health Support Teams in Schools.
- Adults and older adults common mental health problems including expanding NHS Talking Therapies Services
- Community mental health transformation for adults and older adults with severe mental illness including expanding Individual Placement and Support Services and Intensive and Assertive Community Treatment
- Crisis care support (urgent and emergency mental health care)
- Acute mental health care including the mental health in-patient quality transformation programme.
- Dementia care
- Suicide prevention

In addition, there is a financial recovery programme being implemented to support with achieving financial balance.

Many of the above areas are 'on track' but there are the following areas where there is a particular area of focus to have these 'on track' which are as follows:

Improving access to children and young peoples mental health services

Improving the urgent and emergency mental health care pathway with a particular in Bedfordshire and Luton with eliminating inappropriate out of area placement and reducing length of stay

Improving access to Individual Placement and Support Services

Focusing on achieving financial balance across BLMK

Improving children and young peoples eating disorder waiting times standards

	Start Date	End Date	2025							2026			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Continue to maintain access to perinatal mental health services across BLMK	01/04/25	31/03/26											

	Start Date	End Date	2025							2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Improving access to mental health services for children and young people as well as improving outcomes	01/04/25	31/03/26	[Red bar]											
Continue to focus on increasing the number of people completing treatment and improving peoples recovery who receive support through NHS Talking Therapies Services.	01/04/25	31/03/26	[Green bar]											
Continuing to transform community mental health services for adults and older adults with severe mental illness including considering 24/7 mental health neighbourhood centres	01/04/25	31/03/26	[Green bar]											
Continue to improve urgent and emergency care pathways across BLMK	01/04/25	31/03/26	[Orange bar]											
Improving acute mental health in-patient care including pathways such as clinically ready for discharge, eliminating inappropriate out of area placements and reducing the use of restrictive practice	01/04/25	31/03/26	[Orange bar]											
Continuing to meet the dementia diagnosis rate and improving dementia support services	01/04/25	31/03/26	[Green bar]											
Continue to focus on suicide prevention and suicide bereavement support	01/04/25	31/03/26	[Green bar]											
Developing the Section 117 and complex care placements workstream	01/04/25	31/03/26	[Orange bar]											
Improving physical health checks for people with severe mental illness across BLMK	01/04/25	31/03/26	[Green bar]											
Mental health and employment workstream	01/04/25	31/03/26	[Green bar]											
BLMK Mental health equalities workstream	01/04/25	31/03/26	[Green bar]											
BLMK Integrating mental health care for students in higher education and improving mental health care for younger adults workstream	01/04/25	31/03/26	[Green bar]											
BLMK 10 year mental health and well-being plan workstream	01/04/25	31/03/26	[Green bar]											
BLMK Mental health and education workstream	01/04/25	31/03/26	[Green bar]											
Continue to expand Individual Placement and Support Services across BLMK so that more people with severe mental illness can be supported into employment.	01/04/25	31/03/26	[Orange bar]											
Continue to focus on addressing mental health inequalities across BLMK including implementing the Patient and Carer Race Equality Framework	01/04/25	31/03/26	[Green bar]											
Continue to mobilize 3 Mental Health Support Teams and start to mobilize 2 additional Mental Health Support Teams for children and young people	01/04/25	31/03/26	[Green bar]											
Improving intensive and assertive community mental health care across BLMK	01/04/25	31/03/26	[Green bar]											

			2025							2026				
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Reducing waiting times to community children and young people's mental health services and community adult and older adult mental health services	01/04/25	31/03/26	[Orange bar]											
There will continue to be planning of how crisis text services can be implemented across BLMK.	01/04/25	31/03/26	[Green bar]											
Throughout 2025-26 achieve mental health financial balance	01/04/25	31/03/26	[Red bar]											

Risks

Overall Risks Status

AMBER

Reason for Overall Risk Status

There are a number of risk areas which are as follows that need to be addressed throughout the course of the year:

Increasing access to mental health services for children and young people

Improving children and young peoples eating disorder waiting times standards

Improving mental health outcomes for children and young people

Increasing access to Individual Placement and Support Services

Reducing community waiting times for children and young people and adults and older adults

Improving the urgent and emergency mental health care pathways which includes eliminating inappropriate out of area placements and reducing average length of stay.

There is a risk in relation to achieving financial balance for the mental health programme and so a financial recovery programme is commencing to take this workstream forward.

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Achieving the children and young peoples mental health access ambition	Yes	15
Achieving the children and young peoples eating disorder waiting times standards	Yes	9

Reducing community waiting times for children and young people and adults and older adults	Yes	4
There is a risk with the urgent and emergency mental health care pathway due to patient flow pressures which presents a risk with eliminating inappropriate out of area placements and reducing average length of stay.	Yes	8
There is a risk to achieving financial balance for the mental health programme	Yes	16
Achieving the national access ambition for Individual Placement and Support Services	Yes	9

Issues

Overall Issues Status	AMBER
Reason for Overall Issues Status	<p>Although there is positive progress overall for the mental health programme, there are the following risk areas that make the overall status amber which are as follows that need to be addressed throughout the course of the year:</p> <p>Increasing access to mental health services for children and young people</p> <p>Improving children and young peoples eating disorder waiting times standards</p> <p>Improving mental health outcomes for children and young people</p> <p>Increasing access to Individual Placement and Support Services</p> <p>Reducing community waiting times for children and young people and adults and older adults</p> <p>Improving the urgent and emergency mental health care pathways which includes eliminating inappropriate out of area placements and reducing average length of stay.</p> <p>There is a risk in relation to achieving financial balance for the mental health programme and so a financial recovery programme is commencing to take this workstream forward.</p>

Issues

Issue Name	Key Issue?	Proximity & Impact
There is a risk of not achieving the children and young people mental health access ambition	Yes	15
There is a risk with not delivering the children and young peoples eating disorder standards	Yes	9
Reducing community waiting times for children and young people and adults and older adults	Yes	4
There is a risk with the urgent and emergency mental health care pathway due to patient flow pressures which presents a risk with eliminating inappropriate out of area placements and reducing average length of stay.	Yes	8

There is a risk in relation to achieving financial balance for the mental health programme and so a financial recovery programme is commencing to take this workstream forward. ?	Yes	16
There is an issue of not delivering the Individual Placement and Support access ambition	Yes	9

Portfolio Report Governance Report

Date of Highlight Report	22/10/2025
Project Code	PR000226
Project Name	Community and Mental Health Services Transformation
Project Team	System Transformation Team
Project Aim	<p>Recognising the increasing demand on community and mental health services there is a need to rethink how we commission these services for the next 10 years to address current unwanted variation in how these services have historically been commissioned.</p> <p>The transformation programme will describe the case for change, agree our priorities for transformation and approach to provider selection within the next two years.</p> <p>This programme has been established to deliver the ICB Board's Strategic Delivery Plan and is a 'must do' for the system.</p>
Governance & Responsible Group	CMHST Programme Board
Geographical Footprint	BLMK System

Project Team Members

Name	Role
Jill Janes	Business Intelligence Lead
Koyrun Nessa	Business Intelligence Lead
Catherine Chapman	Business Intelligence Lead
Amanda Flower	Commissioning Lead
Samantha Ryan	Commissioning Lead
Michael Ramsden	Commissioning Lead
Tim Simmance	Commissioning Lead

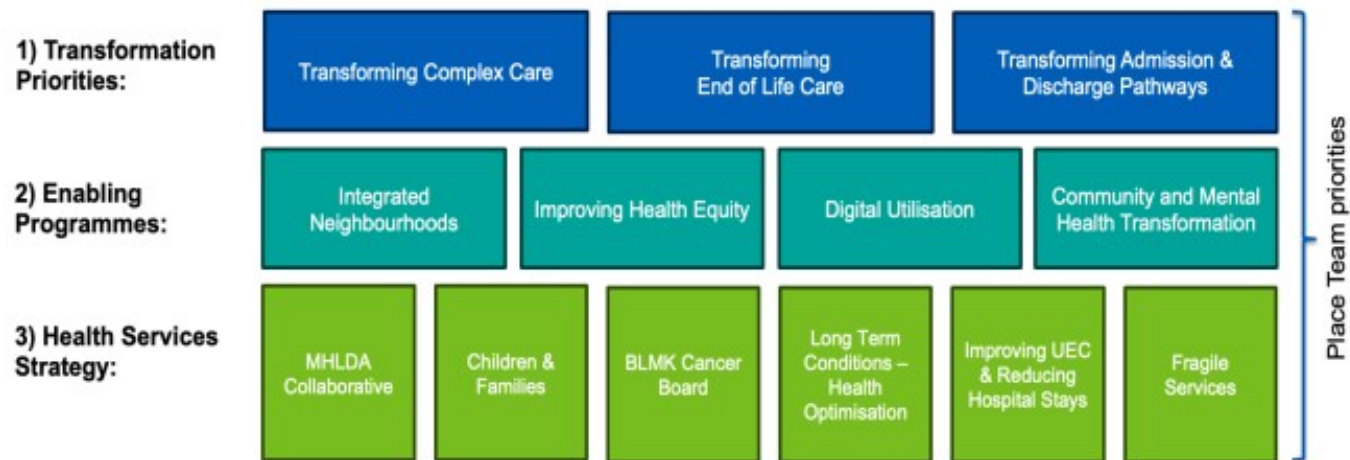
Mark Peedle	Commissioning Lead
Kamini Patel	Commissioning Lead
Sian Pither	Commissioning Lead
Catherine Jackson	Commissioning Lead
Beccy White	Commissioning Lead
Carrie Walker	Commissioning Lead
Jackie Bowry	Communications Lead
Kathryn Moody	Contracting Lead
Anna-Marie Knapp	Contracting Lead
Jonathan Tweed	Contracting Lead
Kathy Nelson	Executive Lead
Andrew Bland	Finance Lead
Dion Davies	Finance Lead
Stephen Makin	Finance Lead
Suzanne Tracey	Finance Lead
Tara Dear	Head of STT
Vicki Peacey	Population Health Intelligence Unit (PHIU)
Buz Dodd	Population Health Management Lead
Roz Samuel	Procurement
Angela mortley	Procurement
Duncan McConville	Programme Manager
Rafael Barnett-Knights	Project Manager
Sarah Florey	Quality Lead
Matt Rogers	Senior Transformation Manager
Ros Clarke	Subject Matter Expert
Penny Harris	Subject Matter Expert
Nikki Barnes	Subject Matter Expert
Ellen Keegan	Transformation Coordinator

Denise Faehndrich	Transformation Coordinator
Layla Vardy	Transformation Coordinator
Eunice Sudlow	Transformation Manager
Janine Norman	Transformation Support Manager
Matt Hollex	Verto & QI Lead

Project Status

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

System Transformation



			2025							2026				
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Phase 3: Specification and Provider Selection Preparation	15/12/25	05/05/26												
Direct Award Workstream	13/02/25	30/07/26												
Phase 5: Provider Selection	15/12/25	19/10/26												

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

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Insufficient Resourcing	Yes	10
NHSE Business Case approval	Yes	15
Lack of subject matter expertise in planning	Yes	12
Key governance requirement (ICB and Local Authorities)	Yes	20
Reduction in ICB running costs	Yes	16
Potential changes to the organisational structure of the ICB as a result of ICB clustering	Yes	16
Lack of Subject Matter Expertise to Produce and Validate the Service Specs	Yes	12
Lack of Opportunity in the Programme Plan to Co-Produce and Validate Service Specs and Outcomes Framework	Yes	12

Issues	
Overall Issues Status	AMBER
Reason for Overall Issues Status	Issues are being managed by the Programme Board and sub-groups.

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	21/10/2025
Project Code	PR000168
Project Name	Improving access to Pathway 2 Beds
Project Team	Kaysie Conroy, Robin Campbell, Helen Glyn-Davies, Emma Stoneman, Mark Morton, Caron Morgan
Project Aim	<p>Reduce the bed occupancy rate in BHT (Beds Hospital and L&D) by reducing the time our residents spend waiting for a Pathway 2 (P2) placement once medically optimised for discharge and review the community care service model to ensure we are delivering an efficient therapeutic offer for local people that focuses on prevention across Bedfordshire and Luton.</p> <p>The step-down element of the programme remains the key to achieving the aim and it is expected to improve outcomes, experiences and independence of people discharged, reduce avoidable readmissions, and reduce avoidable/premature long term care provision. Additional expected benefits include improved flow and discharge from acute hospitals. For clarity the pathways to identify appropriate patients falls outside of the scope of the P2 bed project, the provision of the beds and supporting care is within scope.</p>
Governance & Responsible Group	Pathway 2 Steering Group Project Group & BCA Committee Group (BCA Committee Group is no longer in place)
Geographical Footprint	Bedfordshire Care Alliance

Project Team Members

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

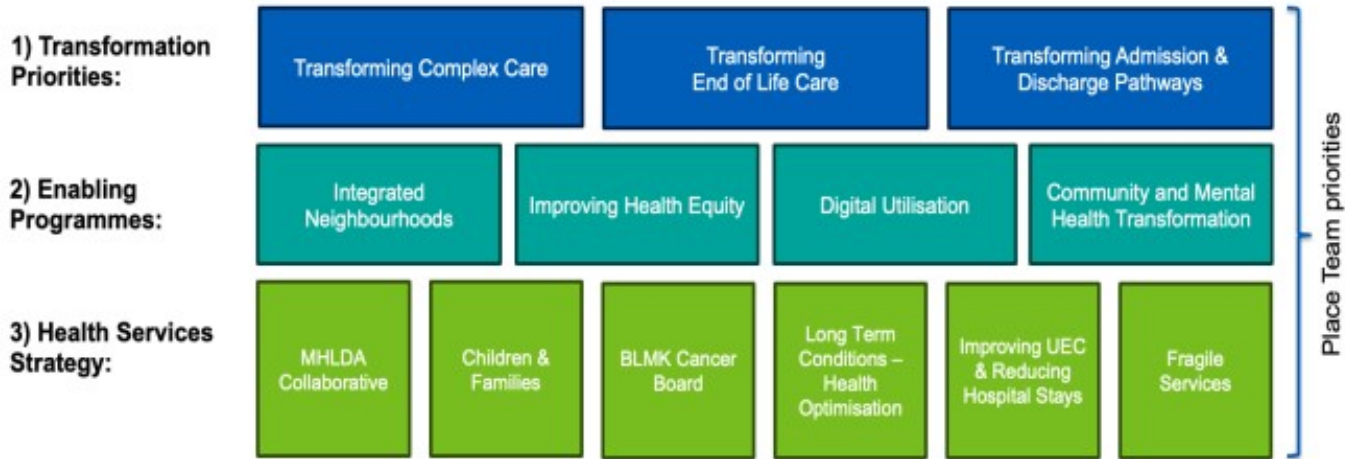
Project Status

Overall Project Status

GREEN

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

System Transformation



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

Progress Update

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
P2 Business Case presented by Kaysie Conroy at Operational Group on 23/06	23/06/25	23/06/25			■												
BCF Bedford Borough sign off	30/06/25	30/06/25			■												
June 25 Pilot Report taken to Board	22/05/25	01/07/25		■	■	■	■										
P2 Business Case presented by Kaysie Conroy at Open Space Chiefs meeting 02/07	02/07/25	02/07/25				■											
Operational and Process Improvement Workstream meetings		10/07/25				◆											
P2 QEIA written and presented by Kaysie Conroy at Clinical Advisory Group 11/07 - approved in principle	11/07/25	11/07/25				■											
BCF CBC sign off	31/07/25	31/07/25			■												
Strategic Workstream - Business Case		01/08/25						◆									
BCF Luton sign off	29/08/25	29/08/25					■										
Finalise service specification	03/10/25	10/10/25															
Issue Contract Award Notice		24/10/25									◆						
Dementia Beds Mobilisation	01/10/25	31/10/25															
Go Live		03/11/25										◆					
Pilot to inform plan to run pilot at L&D Hospital in October 2025	29/09/25	28/11/25								■	■	■					
Bed Occupancy workstream		19/12/25											◆				

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

Risks

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

Issues

Overall Issues Status	AMBER
Reason for Overall Issues Status	Next steps following Pilot - work has been paused, including recruitment of Band 7 Therapist.

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	20/10/2025
Project Code	PR000006
Project Name	Musculoskeletal (MSK)
Project Team	STT
Project Aim	BLMK has a top performing integrated Community MSK and chronic pain service, which equitably supports the 'whole person' to get early support, self-management advice and care they need to live well
Governance & Responsible Group	MSK Programme Board (with Exec Lead & Exec SRO), and 3 sub-groups: 1. Technical Sub-Group 2. Clinical & Quality Sub-Group 3. Population Needs Sub-Group
Geographical Footprint	BLMK System

Project Team Members

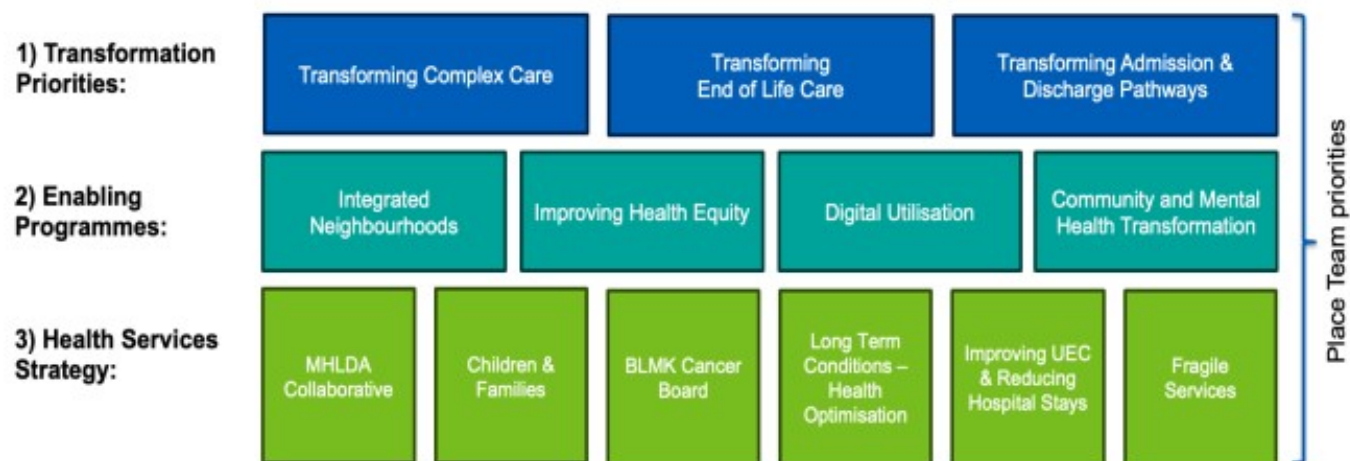
Name	Role
Linus Onah	Clinical Lead
Michael Ramsden	Commissioning Lead
Kathryn Moody	Contracting Lead
Tara Dear	Head of STT
Ros Clarke	Procurement
Gamma Prasad	Procurement
Sian Pither	Project Manager
Cat Lee	Project Manager
Maria Wogan	Senior Responsible Owner
Duncan McConville	Senior Transformation Manager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

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

Project Status

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

System Transformation



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

Progress Update

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

Tasks & Milestones

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

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

Risks

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

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact

Issues

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

Issues

Issue Name	Key Issue?	Proximity & Impact

Date of Highlight Report	20/10/2025
Project Code	PR000406
Project Name	PC Training Hub Programme
Project Team	Susi Clarke

CPD Programme

Advanced Practitioners

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

Apprenticeships

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

CPD Programme

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

First Contact Practitioners

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

GP Symposiums

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

Nurse Degree Apprenticeships (accelerated route)

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

Nursing Associate Apprenticeships

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

Oliver McGowan Training

Specialist Commissioned HEI Courses

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

Leadership Development Programme

Primary Care Leadership Programme

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

New to Practice Fellowship Programme

New to Practice Fellowship Programme

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

Supporting Mentors Scheme

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

OD & Transformation

Digital and Transformation Leads

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

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

Equity, diversity and inclusion

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

Health and wellbeing

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

Knowledge and Library Services

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

Practice Level Support Programme

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

PC Workforce Integration

Hypertension Conference

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

Pharmacy Workforce Strategy Group

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

Work and health

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

Personalised Care Workforce Development

Personalised Care - Peer support forums

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

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

Personalised Care Conferences

Personalised Care Programme Overall

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

Personalised Care- Athena Casefinding Tool

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

Personalised Care- Reporting on Personalised Care Roles (Ardens)

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

Placement Expansion

GP Educator + 12 Training Programme

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

Multi-professional Digital Placement

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

Paramedic Digital Placement Model

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

Placement Capacity Expansion - Digital Nurse Placements

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

Placement Capacity Expansion - GP Educators

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

SSSA Training

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

Student Pharmacist Summer Placement Programme

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

Quality Programme

ARCP Panels

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

Quality programme

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

Recruitment

GPN Pipeline Support Programme

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

International GP Recruitment

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

Recruitment Support

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

Workforce Planning Session

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

Retention

Pharmacy alumni network

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

Physician Assistants

Preceptorship Programme

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

Governance & Responsible Group

People Board and Primary Care Commissioning and Assurance Committee

Geographical Footprint

BLMK System

Project Team Members

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

Project Status

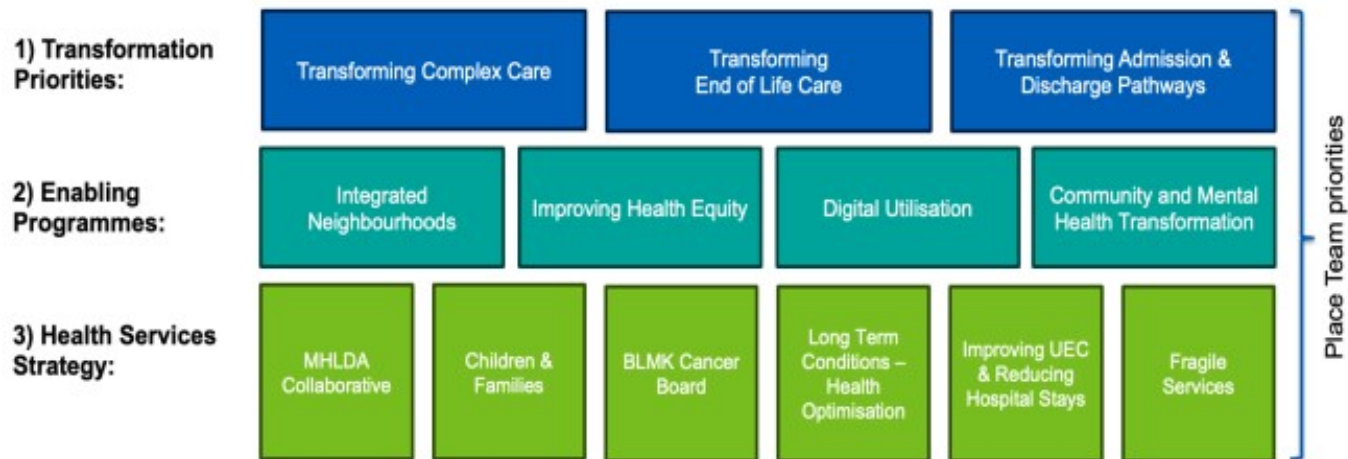
Overall Project Status

GREEN

Reason for Overall Project Status

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

System Transformation



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

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

Progress Update

CPD Programme

Advanced Practitioners

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

Apprenticeships

CPD Programme

- CPD 2025/26 Programme planning underway.

First Contact Practitioners

- N/A

GP Symposiums

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

Nurse Degree Apprenticeships (accelerated route)

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

Nursing Associate Apprenticeships

- 2 new apprentices ready to join in September.

Oliver McGowan Training

Specialist Commissioned HEI Courses

- Funding confirmed from NHSE.

Leadership Development Programme

Primary Leadership Programme

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

New to Practice Fellowship Programme

New to Practice Fellowship Programme

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

Supporting Mentors Scheme

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

OD & Transformation

Digital and Transformation Leads

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

Equity, diversity and inclusion

Health and wellbeing

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

Knowledge and Library Services

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

Practice Level Support Programme

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

PC Workforce Integration

Hypertension Conference

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

Pharmacy Workforce Strategy Group

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

Work and health

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

Personalised Care Workforce Development

Personalised Care - Peer support forums

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

Personalised Care Conferences

Progress made in Previous Period

Personalised Care Programme Overall

Personalised Care- Athena Casefinding Tool

Personalised Care- Reporting on Personalised Care Roles (Ardens)

Placement Expansion

GP Educator + 12 Training Programme

- Sessions continuing.

Multi-professional Digital Placement

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

Paramedic Digital Placement Model

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

Placement Capacity Expansion - Digital Nurse Placements

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

Placement Capacity Expansion - GP Educators

- GPs are open, currently advertising and receiving applications.

SSSA Training

Student Pharmacist Summer Placement Programme

- 8 students successfully interviewed and recruited.

Quality Programme

ARCP Panels

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

Quality programme

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

with quality concerns.

Recruitment

GPN Pipeline Support Programme

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

International GP Recruitment

- N/A

Recruitment Support

- No specific progress, this project is BAU.

Workforce Planning Session

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

Retention

Pharmacy alumni network

- Potential alumni identified.

Physician Assistants

- N/A

Preceptorship Programme

CPD Programme

Advanced Practitioners

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

Apprenticeships

CPD Programme

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

First Contact Practitioners

GP Symposiums

- Ongoing advertising of symposiums.

Nurse Degree Apprenticeships (accelerated route)

Nursing Associate Apprenticeships

Oliver McGowan Training

Specialist Commissioned HEI Courses

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

Leadership Development Programme

Primary Leadership Programme

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

New to Practice Fellowship Programme

New to Practice Fellowship Programme

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

Supporting Mentors Scheme

- Ongoing meetings with AKESO to manage contract.

OD & Transformation

Digital and Transformation Leads

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

Equity, diversity and inclusion

- Continued promotion of EDI resources and activities.

Health and wellbeing

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

Knowledge and Library Services

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

Practice Level Support Programme

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

PC Workforce Integration

Hypertension Conference

- None, project complete.

Pharmacy Workforce Strategy Group

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

Work and health

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

Personalised Care Workforce Development

Personalised Care - Peer support forums

Personalised Care Conferences

Progress to be made in Next Period

Personalised Care Programme Overall

Personalised Care- Athena Casefinding Tool

Personalised Care- Reporting on Personalised Care Roles (Ardens)

Placement Expansion

GP Educator + 12 Training Programme

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

Multi-professional Digital Placement

Paramedic Digital Placement Model

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

Placement Capacity Expansion - Digital Nurse Placements

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

Placement Capacity Expansion - GP Educators

- Closing funding offer and reviewing applications.

SSSA Training

Student Pharmacist Summer Placement Programme

- Onboard advisors and students through eQuality.

Quality Programme

ARCP Panels

- Two-way communication with VTS schemes on panels.

Quality programme

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

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

	Start Date	End Date	2025							2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Primary Leadership Programme		28/02/26												◆
CPD Programme	01/04/25	31/03/26	█											
Placement Expansion	01/04/25	31/03/26	█											
New GP Educator Development 12 month Programme - monthly sessions	01/04/25	31/03/26	█											
Quality Programme	01/04/25	31/03/26	█											
Implement Waves 2 + of CPD courses	02/01/26	31/03/26												█
x2 Teaching sessions to UoB year 1 Nursing Students - dates TBC	02/02/26	31/03/26												█
Advanced Practice demand scoping period	02/03/26	31/03/26												█

Risks

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

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Training Hub Capacity and sustainability of work streams	Yes	16
Meeting the placement demand of the Long Term Workforce Plan	Yes	6

Issues

Overall Issues Status	AMBER
Reason for Overall Issues Status	Newly qualified nurses & GPs unable to gain employment (national issue).

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	20/10/2025
Project Code	PR000150
Project Name	Primary Care Access - Demand Management, Addressing Variation
Project Team	Primary Care
Project Aim	<p>Patients and carers experience a responsive and accessible primary care service, delivered by those best able to understand – and meet – the health and wellbeing needs of the local communities they are proud to serve.</p> <p>We will work with all PC Providers to identify and address variation to support them with level and trans and will increase contract oversight where applicable.</p>
Governance & Responsible Group	<p>Primary Care Delivery Group reporting to Primary Care Commissioning & Assurance Committee</p> <p>See file "Governance" and "Collaboration and Connectivity" in the 'Governance' Folder.</p>
Geographical Footprint	BLMK System

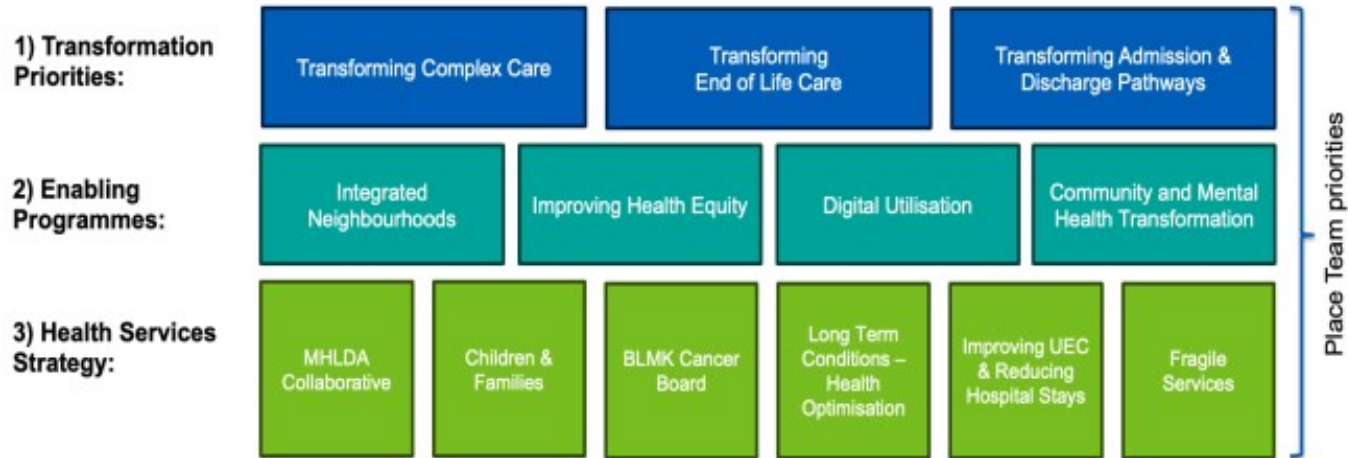
Project Team Members

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

Project Status

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

System Transformation



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

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

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

Digital Utilisation With NHS App development

LTC and Health Optimisation

Progress Update

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

Tasks & Milestones

Overall Tasks & Milestones Status	AMBER
Reason for Overall Tasks & Milestones Status	Task development and further planning to take place. Full review of programme plan to ensure reflects accurate position of all passed target dates, with additions built in the plan post Q3 25/26

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

Risks

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

Risks

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

Issues

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

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	09/10/2025
Project Code	PR000335
Project Name	BLMK Green Plan 2025-2032 (overarching)
Project Team	BLMK ICB Sustainability and Growth
Project Aim	People, Places, Planet: BLMK CARES. Improving health and wellbeing in harmony with the environment.
Governance & Responsible Group	BLMK Green Plan Leadership Group
Geographical Footprint	BLMK System

Project Team Members

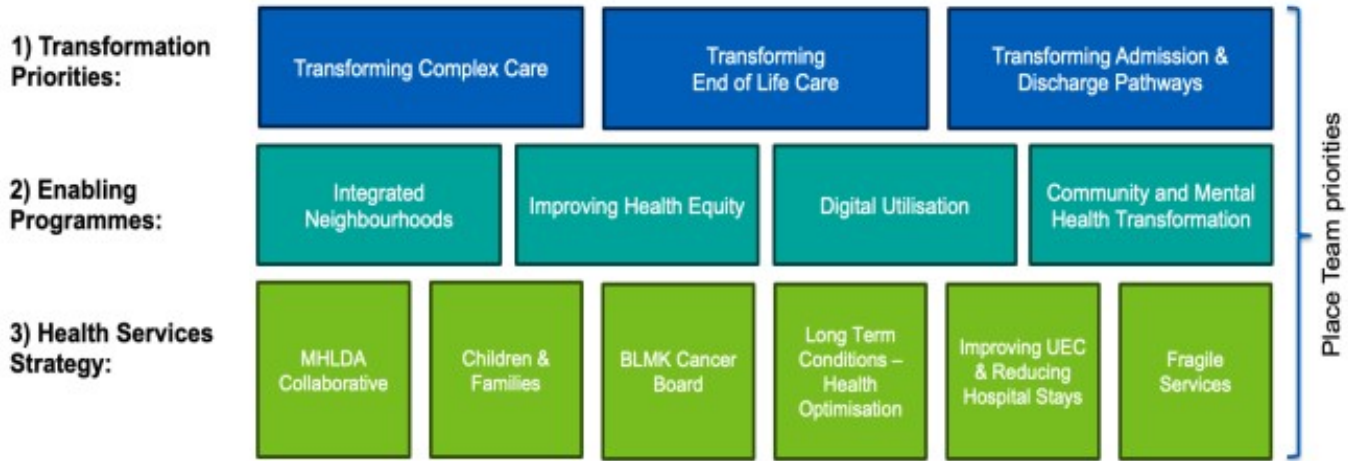
Name	Role
Tim Simmance	Programme Manager
Fran Barnes	Programme Manager
Sian Pither	Project Manager
Dean Westcott	Senior Responsible Owner

Project Status

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

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

System Transformation



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

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

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

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

Progress Update

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

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

Progress to date (September 2025) includes:

- Culture:
 - Data and metrics - dashboard created, which calculates carbon footprints on a more-timely basis
 - Primary Care sustainability - work ongoing on developing a Primary Care Green Plan, including two practice visits
 - Environmentally Sustainable Healthcare Skills: no progress tactically; two new sessions planned for November.
- Adaptation:
 - Previous climate projections and risk assessment reviewed and being refreshed for system, alongside Climate Adaptation Maturity assessment.
 - Trusts progressing Climate Change Risk Assessments.
- Resource-consciousness:
 - Procurement Participation Group identifying priorities for system work, including Social Value approach for health system.
- Environmentally sustainable services:
 - Best practice: collating best practice in reusables and resource efficiency related to sustainable healthcare that translate into both carbon and financial savings.
 - Ongoing subject matter expertise to Community and Mental Health Service Transformation programme, including completing Environmental and Social Impact Assessment (EaSIA).
- Project Governance:
 - Governance: Meeting of the refreshed Green Plan Leadership Group held. Non-Exec Champion and BLMK Green Plan SRO both stepping down during transition to new ICB - increases risk of delay to delivery
 - Verto populated with some high-level and key milestones and tasks for reporting purposes - full management of programme to continue outside of Verto pending further understanding of impact on the programme of ICB reconfiguration.

Progress made in Previous Period

	Start Date	End Date	2025							2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
System Health Climate Adaptation Plan	27/06/25	31/03/26												
Green Plan metrics and dashboard	27/06/25	31/03/26												
Primary Care Green Plan	27/06/25	31/03/26												

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	<p>Risks are currently managed separately from Verto. Aside from the two BAF risks relating to the Project, a summary of the main risks is provided below:</p> <ol style="list-style-type: none"> 1. The person resource allocated to the programme is small, with progress to be made by weaving action throughout other ICB and Trust functions, adding to the breadth of outcomes each function is looking to achieve. This requires a cultural shift so that environmental outcomes are seen as an integral part of all functions, not additional. Likelihood 4 x Consequence 3 = Project Risk Rating 12 2. There is no direct financial resource committed to delivery, and a lack of capital to decarbonise estate, with any investment requiring approval of individual business cases that may have a medium term return on investment. Likelihood 3 x Consequence 4 = Project Risk Rating 12 3. There are many competing priorities that could result in deprioritising of the Green Plan actions, or create a conflict in achieving other goals (for example short-term financial balance, waiting list reduction). Likelihood 4 x Consequence 3 = Project Risk Rating 12 4. A large proportion of overall healthcare emissions lie in the supply chain, reliant on other organisations to achieve their own carbon reduction objectives. Healthcare organisations can only influence suppliers, and financial imperatives may result in the cheapest rather than the greenest consumables and services being procured. Likelihood 4 x Consequence 3 = Project Risk Rating 12 5. The reconfiguration of ICBs will likely result in responsibility for Green Plan and sustainability moving over time to providers. The implications for system-wide action are not yet known and may delay or inhibit progress. This is already materialising as the NED champion and Green Plan Executive SRO are stepping down as a result of the transition; likelihood remaining at 4 as there is still potential to avoid impact on delivery. Likelihood 4 x Consequence 3 = Project Risk Rating 12

Risks

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

Issues

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

Issues

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

Date of Highlight Report	17/10/2025
Project Code	PR000156
Project Name	Women's Health
Project Team	Medical Directorate
Project Aim	<p>Local aims and objectives include:</p> <ul style="list-style-type: none"> a. Develop and mobilise Women's Health Network in Luton - acting as a proof of concept site to deliver 7/7 core elements for women and girls, and those who may not identify as women though still require services. b. Develop and mobilise Women's Health pilots across Bedford, Central Bedfordshire and Milton Keynes [phase 2] c. Undertake training needs analysis across primary care and identify opportunities to upskill local workforce in women's health d. Establish a local Women's Health Stakeholder Forum to share best practice and identify opportunities to improve experiences across BLMK e. Identify clinical pathways that have opportunity to improve efficiency and reduce system waste and develop new local guidance, for example post menopausal bleed on HRT (interdependency with cancer faster diagnosis), and long acting reversible contraception (LARC) fitting for gynae purposes. f. Addressing the gynaecology backlog in secondary care, ensuring all women are seen in the right place, at the right time and by the right clinician based on their needs. g. Delivery of wider Women's Health strategy aims to address gender inequalities [interdependency with Improving Health Equity programme] <p>The Women's Health Strategy for England lists 10 aims for women and girls:</p> <ul style="list-style-type: none"> 1. better access to services, including preventative healthcare and early intervention, and reduced unmet need for healthcare 2. improved patient experience, with care being delivered in one appointment where possible 3. improved health outcomes and reduced health inequalities 4. improved access to health information, in a range of formats, and supported patient self-management where appropriate

	<p>Aims for the workforce:</p> <ol style="list-style-type: none"> 5. optimising the skills of multi-disciplinary teams (MDTs) through joint working and training opportunities 6. improved workforce experience and retention 7. improved communication and partnership working between primary, community and secondary care 8. at least one accredited and competent clinician trained in and delivering menopause care and contraception at PCN level, ideally at practice level, by September 2026, to better meet the needs of our women and girls. <p>Aims for the health and care system:</p> <ol style="list-style-type: none"> 9. greater efficiency, through care delivered at the right time, in the right place, and by the right person; fewer unnecessary secondary care referrals; and collaborative commissioning to make best use of resources 10. more integration and partnership working between health system partners – NHS, local authorities, the voluntary and community sector, and patients – so that services better meet the needs of women and girls 11. better collection and use of data by commissioners and providers to understand women’s health needs and improve service provision and outcomes
Governance & Responsible Group	<p>Reporting is no longer aligned with Improving Health Equity Programme, and instead aligned with 'Children and families' Health Services Strategy chapter.</p> <p>Key programme meetings:</p> <ul style="list-style-type: none"> • BLMK Women's Health Stakeholder Forum (monthly) - chaired by Sanhita Chakrabarti • BLMK Women's Health Networks Business and Clinical Pathways Meeting (monthly) - rotating chair between 3 WH Networks
Geographical Footprint	BLMK System

Project Team Members

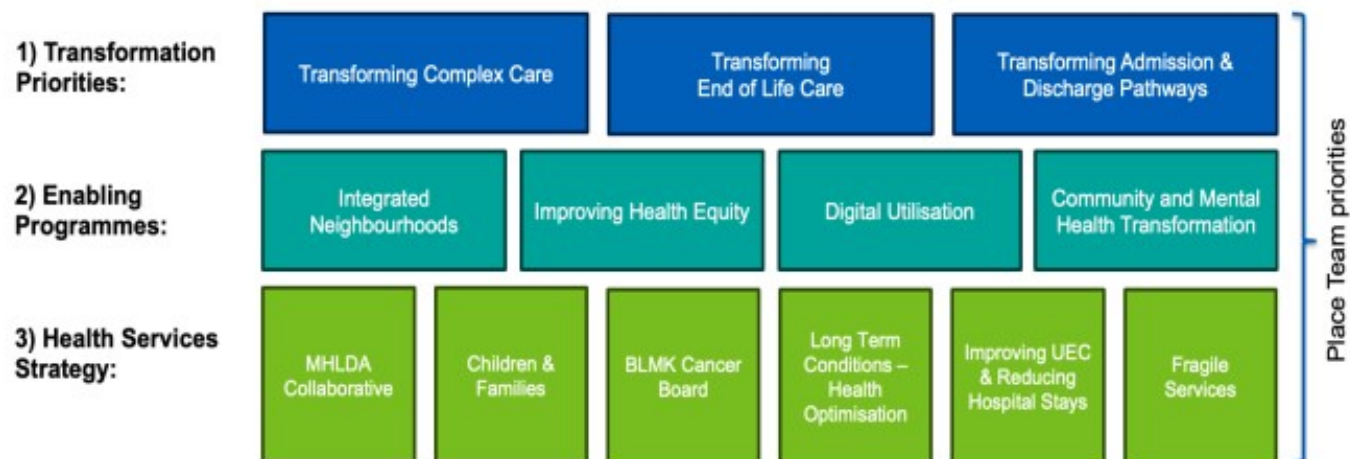
Name	Role
Cat Lee	Project Manager
Maureen Okolie	Project Support

Julia Robson	QI Lead
Sarah Stanley	Senior Responsible Owner
Sanhita Chakrabarti	Senior Responsible Owner
Natasha Young	STT Senior Lead
Vickie Place	STT Team Member
Layla Vardy	STT Team Member
Amira Nazzal	Subject Matter Expert

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	Implementation of Luton Women's Health Network and supporting pilots across other places now all live Primary care training programme in progress
Project Maturity	3.0 - Implementation

System Transformation



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

The programme is now aligned to the Children & Families Health Services Strategy chapter.

It has strong links with improving health equity in its aims to improve care access and quality for women in harder to reach communities.

Progress Update

Progress made in Previous Period

- **Data and Evaluation**
 - Continue to work with AGEM on dashboard, linking with BHFT to understand complex diagnosis data
 - Working with Public Health Registrar, and supported by HIE to build programme evaluation
- **Primary Care Training Programme**
 - Training sessions delivered in collaboration with Primary Care Women's Health Society and sponsored (non-promotional, ABPI compliant):
 - - PCWHS Menopause Foundation Training (05/09/2025) full day
 - PCWHS Menopause Update Training (19/09/2025) half day
 - PCWHS Women's Health Foundation Training (28/11/2025) full day
 - 1 further training session (Jan-Mar 2026) TBC
 - Feedback questionnaire circulated to support evaluation with qualitative feedback
- **Women's Health Networks**
 - Luton Women's Health Network with Lea Vale PCN (went live in January 2025) has reported a reduction in gynae hospital referrals
 - Support 3 women's health networks to build business case for continuation of funding April 2026
 - Reporting process to share progress and updates with colleagues - established through PCDG and CFWM Board.
- **Clinical Pathways**
 - Pathway mapping at neighbourhood level for high volume areas - initial priorities identified for workshops in early 2026:
 - menopause (unscheduled bleeding on HRT)
 - heavy menstrual bleeding
 - Establish introductory meetings between BHFT and Lea Vale / Bedoc to build collaborative space for pathway discussions and workshops
 - Confirm dates for industry partner facilitated pathway mapping workshops:
 - First session proposed: Menopause pathway mapping (am) / Heart health for women (pm) - Theramex
 - Second session proposed: Heavy menstrual bleeding pathway mapping (am) / Endometriosis and pain (pm) - Gedeon Richter
- **Pilot Projects**
 - Bedfordshire based pilot launched with ELFT focused on menopause and mental health in March 2025
 - Milton Keynes based pilot launched with Pelvic Health Physiotherapist in March 2025 to support women waiting for urogynae procedures using a digital app.
 - All pilots - review reporting metrics and frequency agreed to ensure in track to deliver and identify any support or changes needed
 - ELFT menopause and mental health (Beds)
 - Pelvic Health Physiotherapy to support women waiting for urogynae procedures using a digital app (MK)

	Start Date	End Date	2025										2026				
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
Evaluation support from HIE Networks	18/06/25	31/07/25															
Development of Squeezy App	01/07/25	30/09/25															
Patient Enrollment	01/07/25	30/09/25															
Primary Care Rolling Training Programme		31/12/25															
Pilot Evaluation	03/11/25	02/01/26															
Case for Change Development	01/09/25	31/01/26															

Risks

Overall Risks Status	AMBER
Reason for Overall Risk Status	Funding concerns post March 2026 for WH Networks is biggest risk and not confident it is well mitigated against yet - ongoing work to support Network Managers and Clinical Leads to prepare for this with a sustainable model.

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Women's Health Networks not currently funded past March 2026	Yes	6

Issues

Overall Issues Status	GREEN
Reason for Overall Issues Status	None currently open

Issues

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

Portfolio Report Governance Report

Date of Highlight Report	15/10/2025
Project Code	PR000405
Project Name	Workforce Anchor Programme
Project Team	Workforce Development Academy
Project Aim	<p>The aim of the portfolio is to present a comprehensive overview of quarterly performance for the Executive team, with a particular focus on the Anchor Workforce Programme.</p> <p>This programme highlights key initiatives that are considered core to ICB business. The Supported Employment Pathways and Widening Access project aims to support underrepresented groups, including care leavers and individuals with lived experience of the care system, by creating inclusive employment opportunities and support.</p> <p>The Work and Health agenda focuses on improving access to employment for people with health conditions, supporting their wellbeing and economic participation.</p> <p>The Apprenticeships initiative is aligned with long-term workforce planning, aiming to build sustainable career pathways and meet national targets for workforce development.</p> <p>The Health and Care Academy aims to build and strengthen the local health and care workforce by offering high-quality training, development opportunities, and robust performance monitoring. A key focus of the Academy is to inspire future talent by actively showcasing both clinical and non-clinical roles to schools, helping young people understand the breadth of career opportunities available within the sector.</p>
Governance & Responsible Group	BLMK People Board
Geographical Footprint	BLMK System

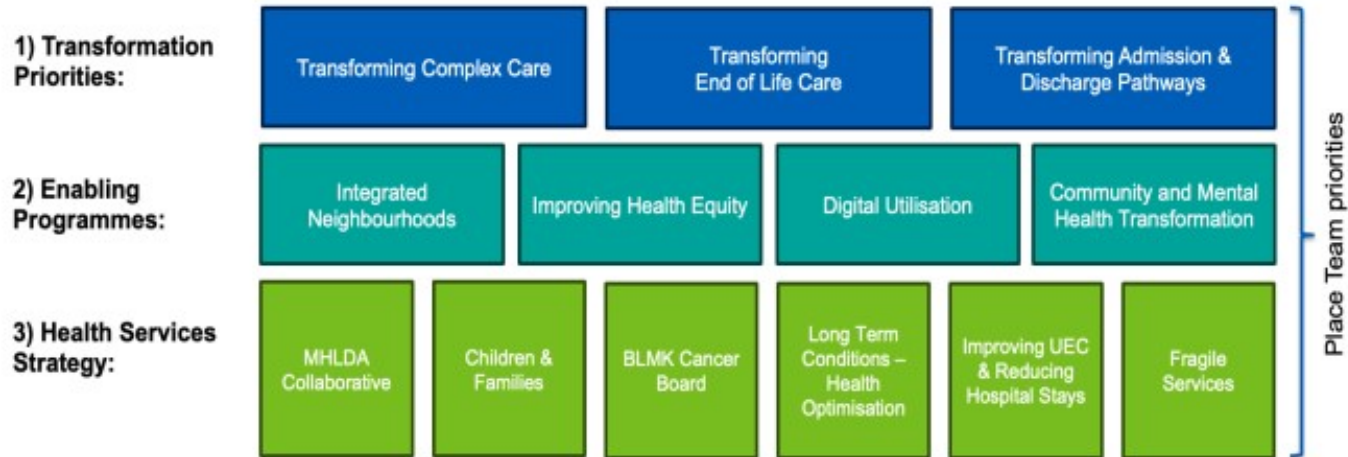
Project Team Members

Name	Role
Alexandra Farkas	Programme Manager
Catherine Jackson	Programme Manager
Bethan Billington	Programme Manager
Jane Hall	Project Manager

Project Status

Overall Project Status	GREEN
Reason for Overall Project Status	Despite a few Amber-rated tasks across the projects, the majority of milestones are progressing well, with no Red flags. The Amber items are either in planning stages or have mitigation strategies in place. Therefore, the programme is on track overall, with manageable risks.
Project Maturity	4.0 - Delivery

System Transformation



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

Alignment with Transformation Priorities

- Transforming Complex Care & Admission/Discharge Pathways: The Supported Employment Pathways and Widening Access project contributes by helping individuals with complex needs transition into employment, reducing dependency on health and care services and supporting smoother discharge planning.
- End of Life Care: While not directly linked, workforce development through apprenticeships and the Health and Care Academy ensures a skilled workforce capable of delivering compassionate and effective end-of-life care.

Alignment with Enabling Programmes

- Integrated Neighbourhoods: These programmes support place-based workforce models, enabling local recruitment and development through apprenticeships and academy outreach.
- Improving Health Equity: The Supported Employment Pathways and Widening Access initiative directly targets underrepresented groups, care leavers, and those with lived experience of the care system, promoting equity in employment and career progression.
- Digital Utilisation: The use of platforms like Verto to track and report progress reflects a commitment to digital tools for workforce planning and performance monitoring.
- Community and Mental Health Transformation: By building a diverse and skilled workforce, these programmes underpin efforts to transform community and mental health services with staff who reflect and understand the populations they serve.

Alignment with Health Services Strategy

- Children & Families: Outreach to schools through the Health and Care Academy helps raise awareness of clinical and non-clinical roles, inspiring future generations to consider careers in health and care.
- Long Term Conditions – Health Optimisation: Apprenticeships and academy training equip staff with the skills needed to support patients with long-term conditions more effectively.
- Improving UEC & Reducing Hospital Stays: A well-trained and locally rooted workforce contributes to more efficient urgent and emergency care, helping reduce unnecessary hospital admissions and stays.
- Fragile Services: Workforce development helps stabilise services at risk by ensuring a pipeline of skilled professionals ready to fill critical roles.

Period August/September - reported to BLMK People Board 1/10/25

Work & Health: Bid to host employment advisors with MSK practitioners in Primary Care at two PCNs was successful; proceeding to IVOG for approval to progress

National Universal Family: audit was completed. NHSE KPI's exceeded. Self-assessment tool is now established. We offer regular drop-in sessions for CEYP, and continue to support them into training, work experience, job applications and employment.

Passport into NHS Careers : 7th Cohort will take place in November. To date the programme, via its various workshops and offers, has reached over 200 young people, 79 of whom has secured employment. From January 2026, DWP in Bedford and Milton Keynes will start running this as a Sector Based Work Academy Programme (SWAP)

Health & Care Academy + programme ran during the Summer for those aged 17-19 with aspirations to pursue a role in health and social care; the course was attended by 11 young people. Due to run again in March/ April 2026 during the Easter break.

Widening Access: BLMK WDA had a successful bid with DHSC for widening access to employment in health and care for working class population of Luton (WAD). Implementation from July 25. Programme will over-deliver on the KPIs as already 10 young people successful into employment. KPI was 12 in 9 months. Data so far from start of the programme in July of range of participants.

Meeting on 14th October hosted by Lord Patel of Bradford at the Houses of Parliament to review progress and share learning from the WAD programme.

Apprenticeship Expansion: From April 2026, alternative funding for the following Level 7 apprenticeships will be available: Advanced clinical practitioner; Specialist community public health nurse (SCPHN); District nurse (Community Specialist Practice Qualification); Clinical associate in psychology (CAP) and Population health intelligence specialist (PHIS)

Still awaiting new growth targets for apprenticeship in the soon to be published 10 year workforce plan, currently expected December

Progress made in Previous Period

October/November planned activities - reported to BLMK People Board 1/10/25:

Work and Health:

Review TOR for Work & Health Stewardship Group

Commence MSK EA POC

Roll out of Money Saving Guide training across system

Widening Access/Supported Employment Pathways:

Work with region to review the feedback of self-assessment

Review and report on uptake of workshops and outcomes.

Continue to expand across system partners.

Health and Care Academy:

Second cohort of Health and Care Academy Advance to commence in November

Preparation to take the Health and Care Academy van on the road, as a mobile careers offer to local schools and colleges.

Apprenticeship expansion:

Collection of next quarter of DAS information to track growth in apprenticeship numbers.

Apprenticeship Expansion Board meetings paused until the Autumn and the awaited new growth targets for apprenticeship in the soon to be published 10 year workforce plan.

Finalise scope of evaluation report of rotational apprenticeship pilot

Progress to be made in Next Period

Tasks & Milestones

Overall Tasks & Milestones Status

GREEN

Reason for Overall Tasks & Milestones Status	Programme of work well on track and not reporting and substantial delays of concern																
												2025			2026		
	Start Date	End Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			

Risks

Overall Risks Status	GREEN
Reason for Overall Risk Status	<p>No major risks to delivery this financial year. Key risks relate to lack of sustainable funding for much of this activity.</p> <p>Mix of March 2026 and March 2027 end dates for current funding; uncertainty re eventual 'home' of some workforce activity due to ICB transition means that mitigation activities can't always be identified at present.</p>

Risks

Risk Name	Key Risk?	Residual Likelihood & Impact
Work and Health: place in ICB future (blueprint)	Yes	12
Future of Health & Care Academy: no source of sustainable funding at present	Yes	12
Apprenticeship Expansion Funding: funding of 20% off the job training challenges providers	Yes	9

Issues

Overall Issues Status	GREEN
Reason for Overall Issues Status	No issues identified at present for this financial year's activity.

Issues

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

Improving Resident Experience & Population Health Case Study

Medicines Optimisation – Inhalers



Introduction / Background

(see 1-4 References on next slide).

1. Asthma affects 7.2M people in the UK with an annual cost of approx. £3B.
2. The 2023 published GINA Report detailed guidelines and national recommendations for evidence-based asthma management (anti-inflammatory reliever (AIR) or combined maintenance and reliever therapy (MART)).

Method

1. Designed a suite of clinically led educational resources including: updating asthma guidelines / asthma management sessions / protected learning events and direct GP communications.
2. Each practice identified a respiratory champion
3. A Community of practice was developed, facilitating shared learning
4. Objective clinical searches were built to ID SABA overuse and underuse of inhaled corticosteroids.
5. Initial pump-prime funding was available for early adopter PCNs for training and reviews, followed by the Prescribing Incentive Scheme payments for reducing SABA overuse.
6. Quarterly data was given to practices for benchmarking purposes.

AIM / Objectives

(see 3-6 References on next slide).

1. This project aims to improve patient outcomes through a multi-faceted approach – this will include enhancing competency and confidence in management, offering practical approaches to ID, stratify and optimise care and resourcing and rewarding best practice across BLMK.
2. To move away from reliance on short-acting beta agonist (SABA) reliever inhalers towards approaches using AIR or MART, expected to reduce asthma exacerbations, prevent hospital admissions, and decrease premature mortality
3. Patient education and clinician support will be used to modify long-standing asthma management behaviours.

Results

(see 7-10 References on next slide).

1. Over 2024/25, out of the 4.5K patients coded as being offered the new AIR / MART therapy, over 2/3 of clinically suitable patients changed treatment.
2. This resulted in a 30% reduction in SABA overuse from 8,500 to 6,000.
3. BLMK ICB progressed from being in line with the national medium for SABA inhaler prescribing, to the 5th best performing ICB nationally on this metric (≥ 6 SABA inhalers in 12 months) and secure within the best performing quintile – see charts 1 and 2 on slide 3
4. Whilst the prescribing incentive scheme has retired due to successful completion, the separate incentive for avoiding SABA overuse has continued into 2025/26 with data continuing to show on-going improvement.
5. In addition to clinical benefits, BLMK has seen marked environmental improvements: with a 25% drop in salbutamol inhalers issued quarterly over this timeframe (~93000 to ~70000), an estimated carbon footprint of nearly 1,500,000kg CO₂e has been averted over 2 years, representing the equivalent of nearly 7 million petrol car miles.

Next Steps:

1. Understanding the deeper impact of changes to management and prescribing behaviour, this will include looking at admissions and additional outcomes;
2. Encouraging other systems to consider adopting a multifaceted approach to improving asthma management, with support for enhancing competency and confidence with updated guidelines, provision of practical tools for improvement, and appropriate resource and encouragement for best practice care.
3. Collaborative working project developed to provide 2000 additional asthma reviews for young individuals (age 12–25 years), as identified as less likely to receive AIR/MART

Improving Resident Experience & Population Health Case Study

Medicines Optimisation – Inhalers

Chart 1 Proportion of patients receiving ≥ 6 SABA inhalers, split by ICB

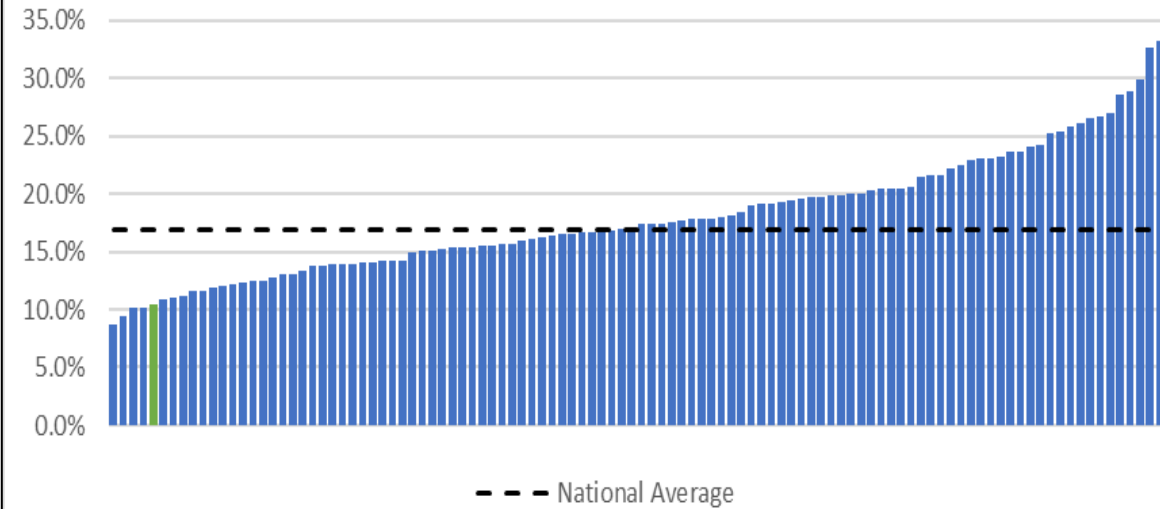
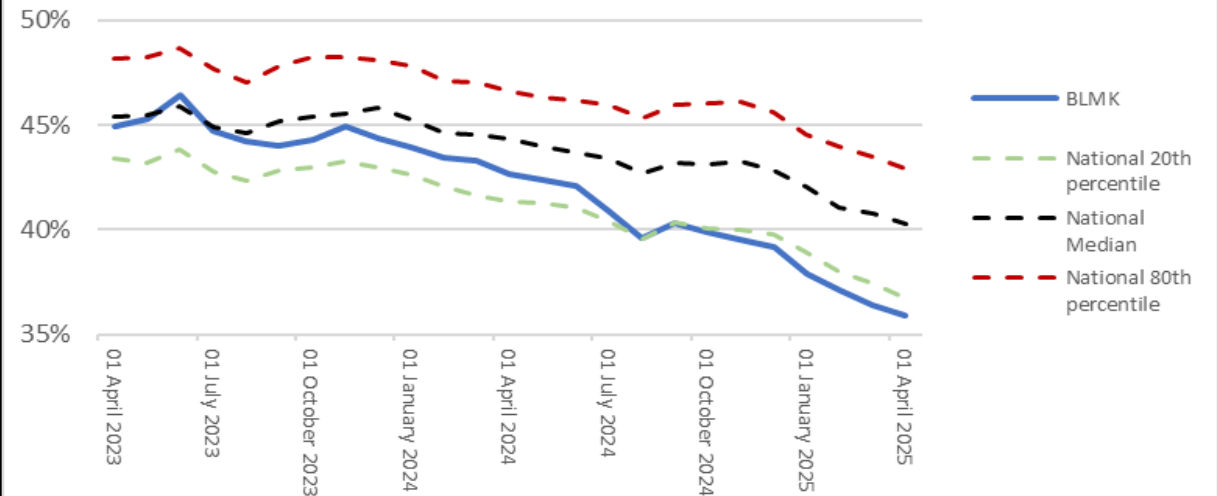


Chart 2 Number of SABA inhalers compared with number of all ICS and SABA inhalers (Open Prescribing, April 2025)



References

- (1) Asthma + Lung UK. What is asthma? (2024).
- (2) Asthma + Lung UK. Estimating the economic burden of respiratory illness in the UK.; (2017).
- (3) Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention. (2023).
- (4) NICE. Asthma: diagnosis, monitoring and chronic asthma management (BTS, NICE, SIGN). NG245. (2024).
- (5) MHRA. Drug Safety Update. Volume 18, Issue 9: April 2025
- (6) BLMK Respiratory Group. Asthma Guidelines for Adults (2024).
- (7) ePACT2 Respiratory Dashboard (accessed 10th September 2025).
- (8) OpenPrescribing. Short acting beta agonist inhalers in BLMK ICB. (accessed 10th September 2025). <https://openprescribing.net/sicbl/M1J4Y/measures/?tags=respiratory>
- (9) OpenPrescribing. Environmental impact of inhalers in BLMK ICB. (accessed 10th September 2025). https://openprescribing.net/measure/carbon_salbutamol/sicbl/M1J4Y/
- (10) OpenCO2net. CO2 converter. (accessed 10th September 2025). <https://www.openco2.net/en/co2-converter>