

Bedfordshire Luton & Milton Keynes Portfolio Report

November 2024 Update

Welcome to the BLMK ICS Portfolio Report

If this is your first time reading the Portfolio Report, the Portfolio Report contains information on key strategic and transformational portfolios, programmes and projects across BLMK ICS

The first section of the report shows the hierarchy of portfolios, programmes and projects. Layer 1 and Layer 2 (programmes & projects grouped under Episodic Care & Prevention, Planned Care & Support, Complex Care and Enablers) and Layer 3 (additional layer of programmes & projects added following feedback on the last report)

The second section of the reports details the individual highlight reports for the portfolios, programmes and projects

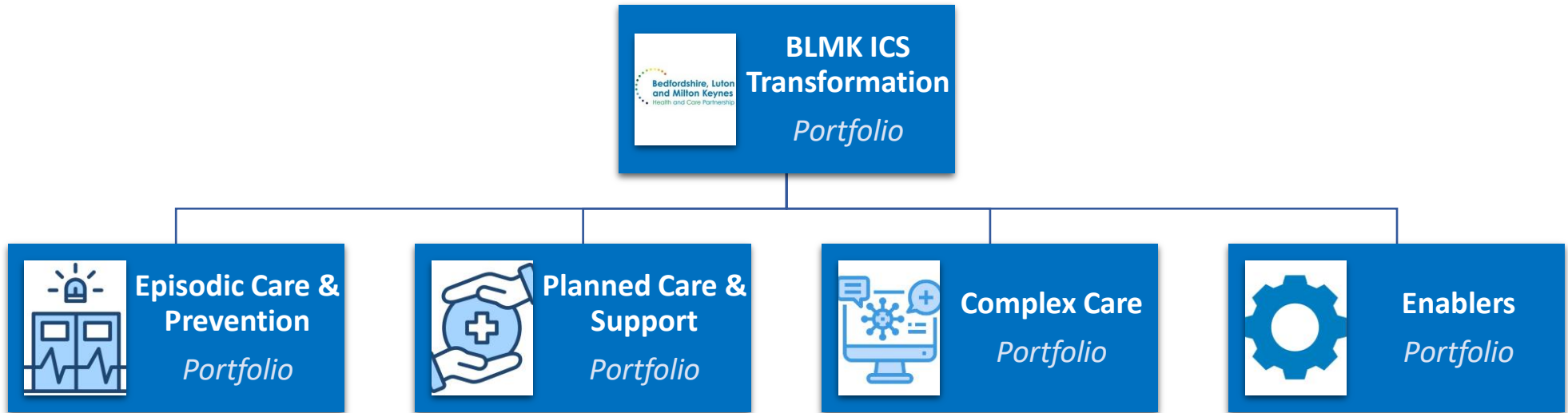
The highlight reports contain definitions, roles & responsibilities, governance, benefits, measures, geographic footprint, progress, risks and key milestones, and whether they are on-track (**green**), at risk (**amber**) or slipped (**red**)

Additional programmes & projects have been added to the November report to give a more granular picture of the work being undertaken in BLMK – these include additional programmes & projects in *UEC, Elective, Community Services, MHLDA, ICS System Efficiencies, Personalisation, Digital, Primary Care, Innovation, Workforce, Quality Improvement, CYP & LMNS, Estates & Environmental Sustainability & Growth*. Not all have Highlight Reports yet – those that do are shown in the contents page. Priority programmes, such as the ICB Priorities, are specified on the Highlight Reports where applicable.

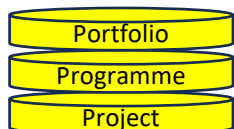
If you have any questions regarding the Portfolio Report, please contact the ICB PMO - blmkicb.pmo@nhs.net

171	Total number of programmes and projects
13	Total number of key milestones complete
87	Total number of key milestones on-track
21	Total number of key milestones at risk of slipping
5	Total number of key milestones that have slipped
109	Total number of key milestones not RAG Rated





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



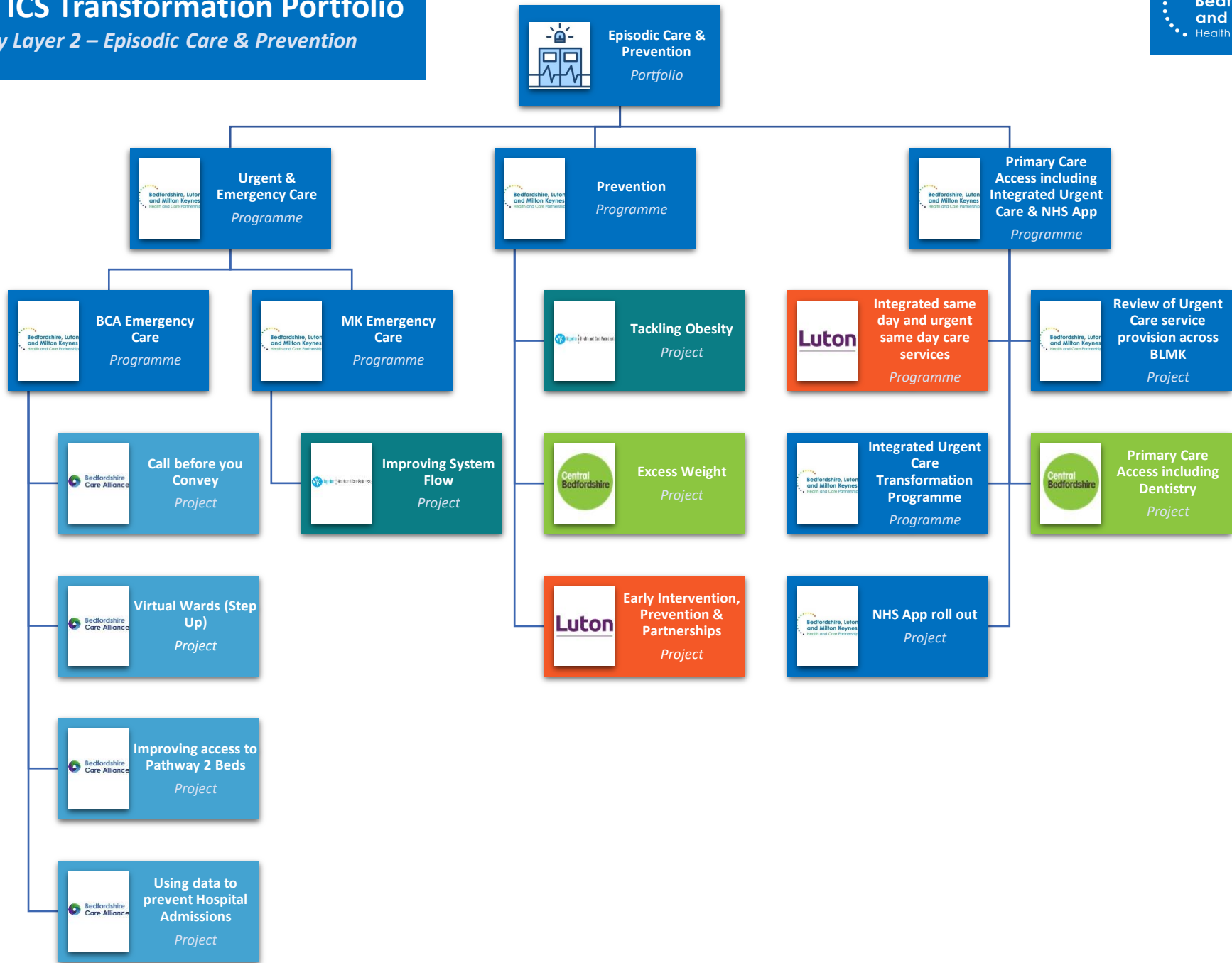
Strategic Grouping, Focus on maximising return on investment, Balanced mix of projects and programmes, Ongoing, Higher risk

Focus is on outcomes, Higher Complexity than projects, Longer Timescale, Higher Budget, Scope is less defined, Higher Risk

Focus is on outputs, Less Complex, Defined start and end dates, Agreed total budget, Defined Scope, Less Risk

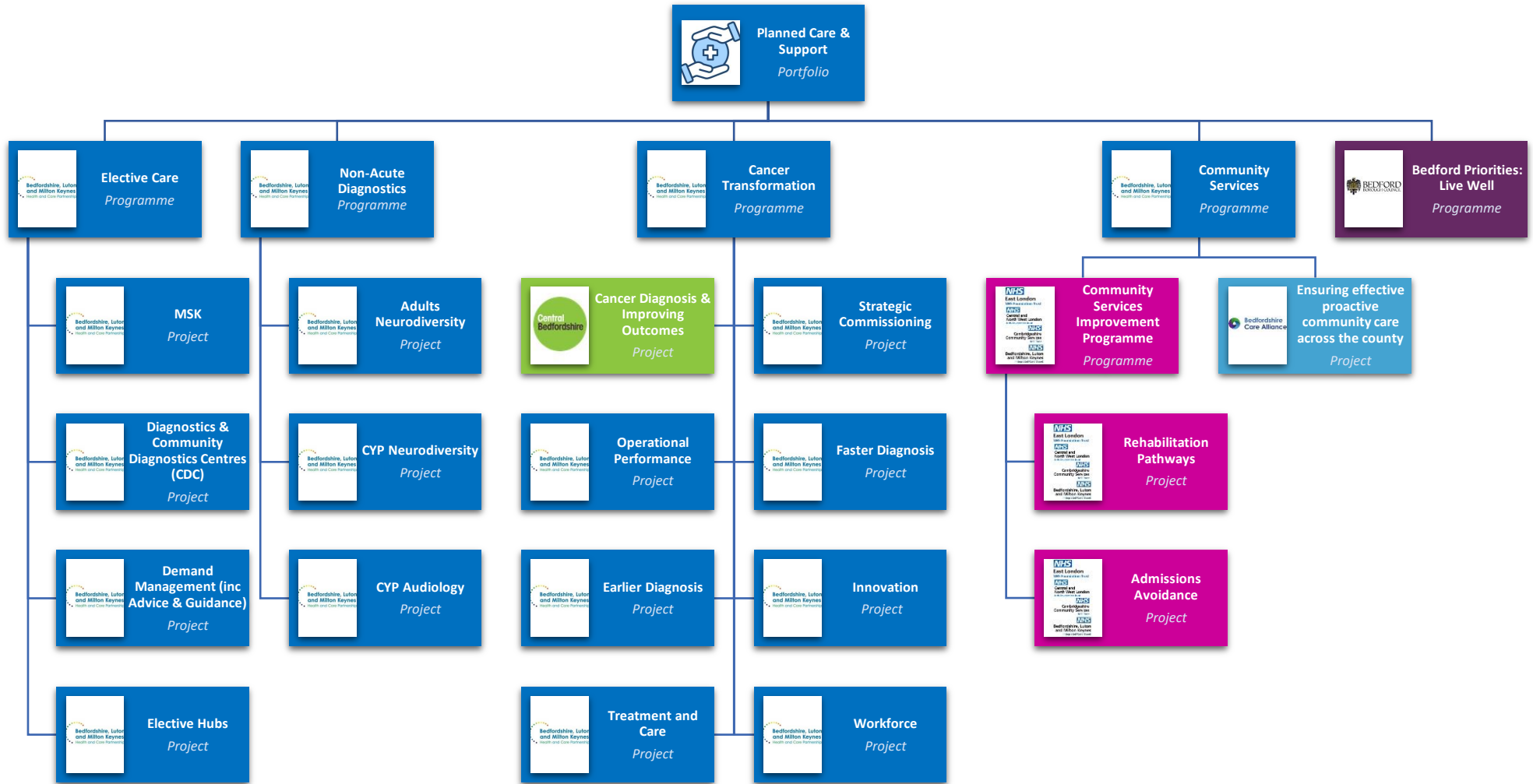
BLMK ICS Transformation Portfolio

Hierarchy Layer 2 – Episodic Care & Prevention



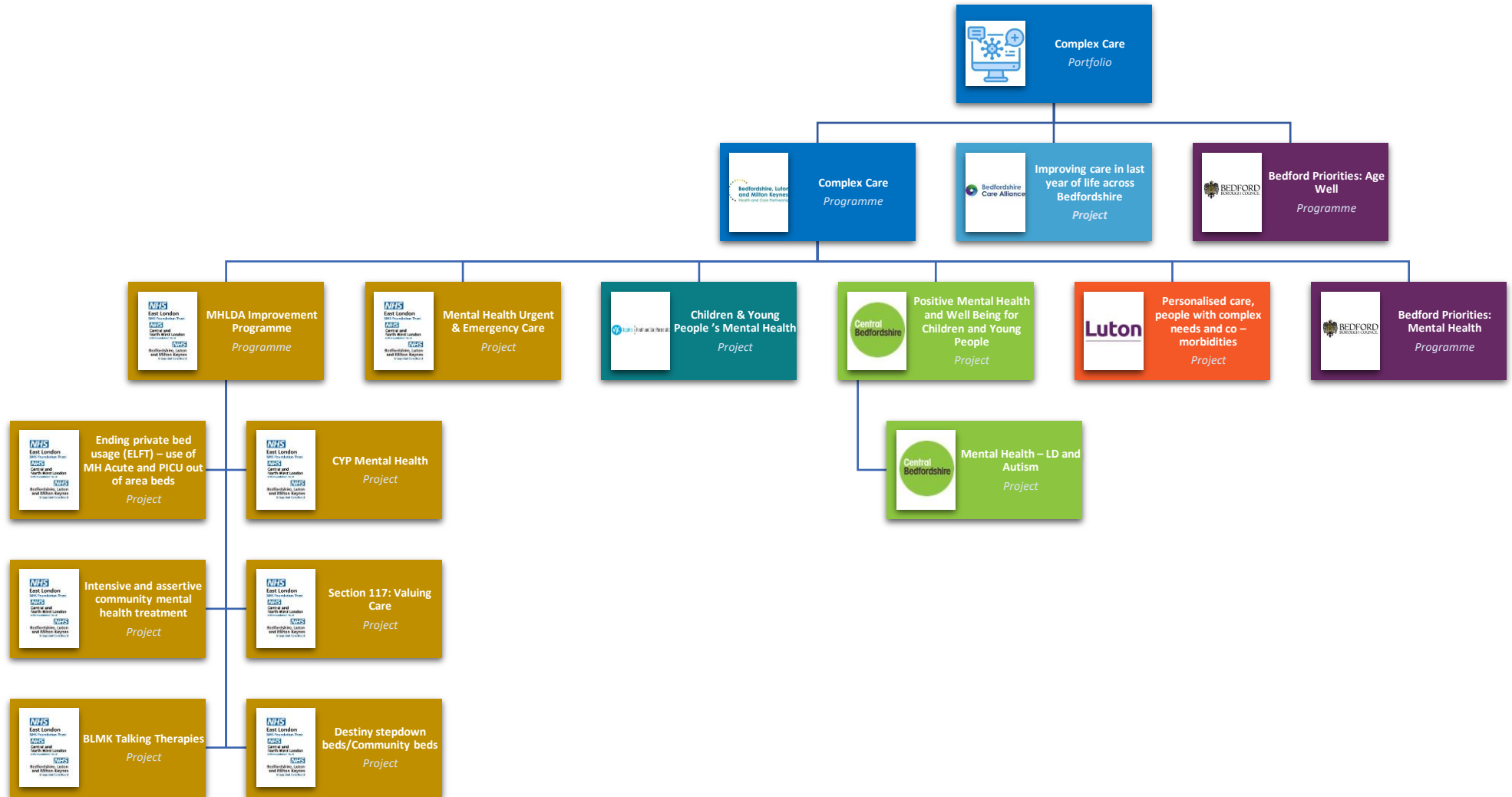
BLMK ICS Transformation Portfolio

Hierarchy Layer 2 – Planned Care & Support



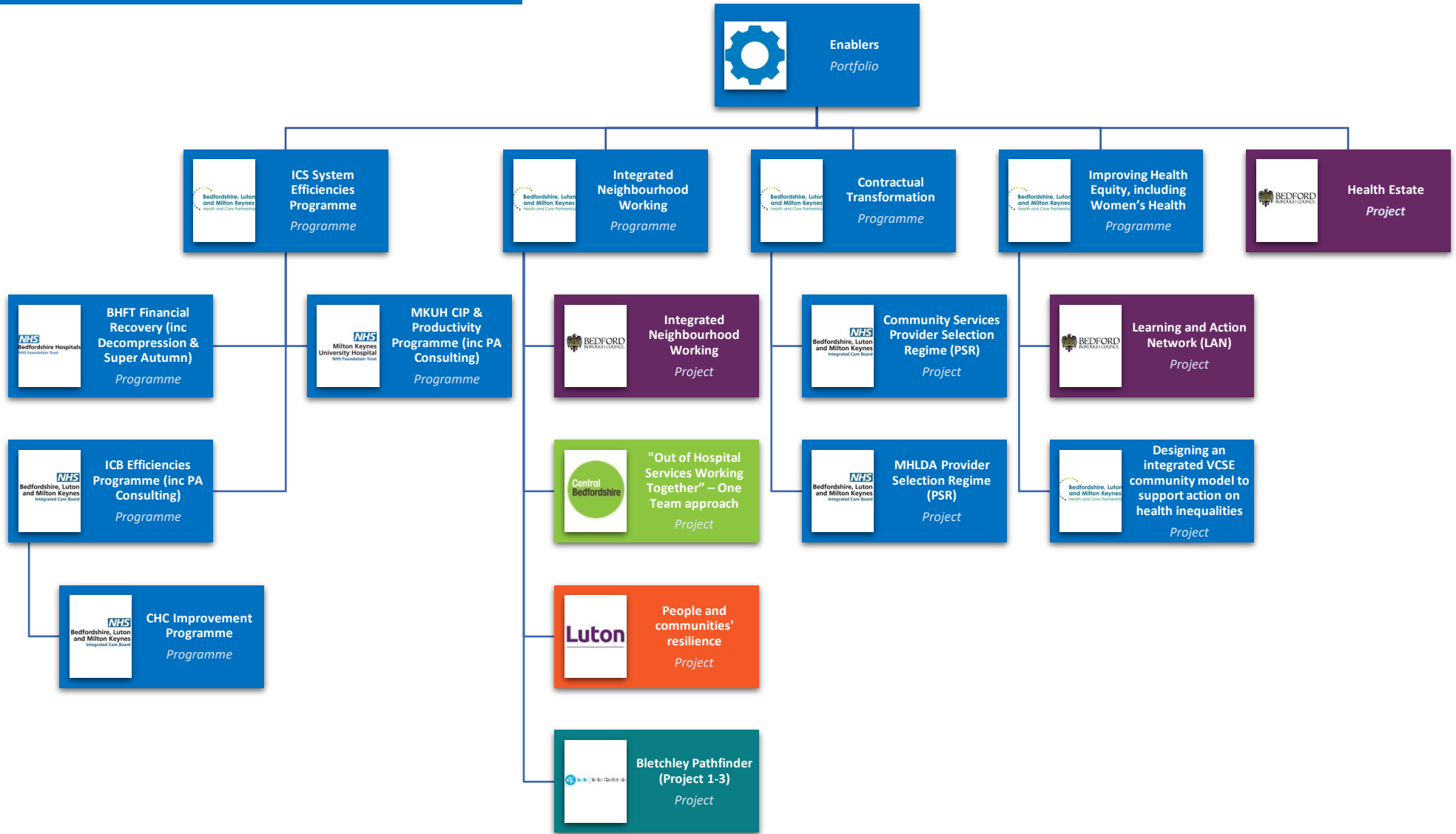
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Hierarchy Layer 2 – Complex Care



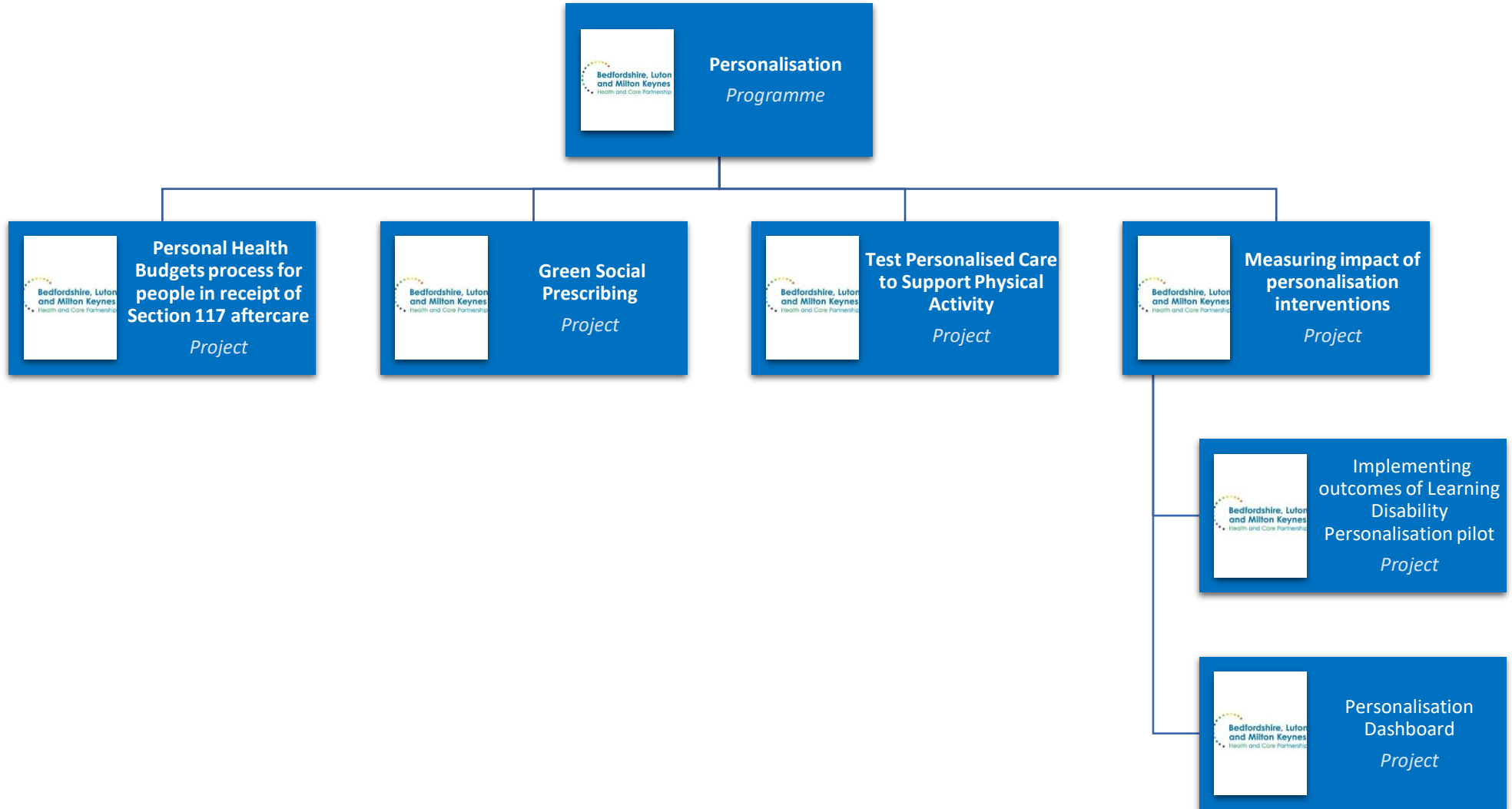
BLMK ICS Transformation Portfolio

Hierarchy Layer 2 - Enablers



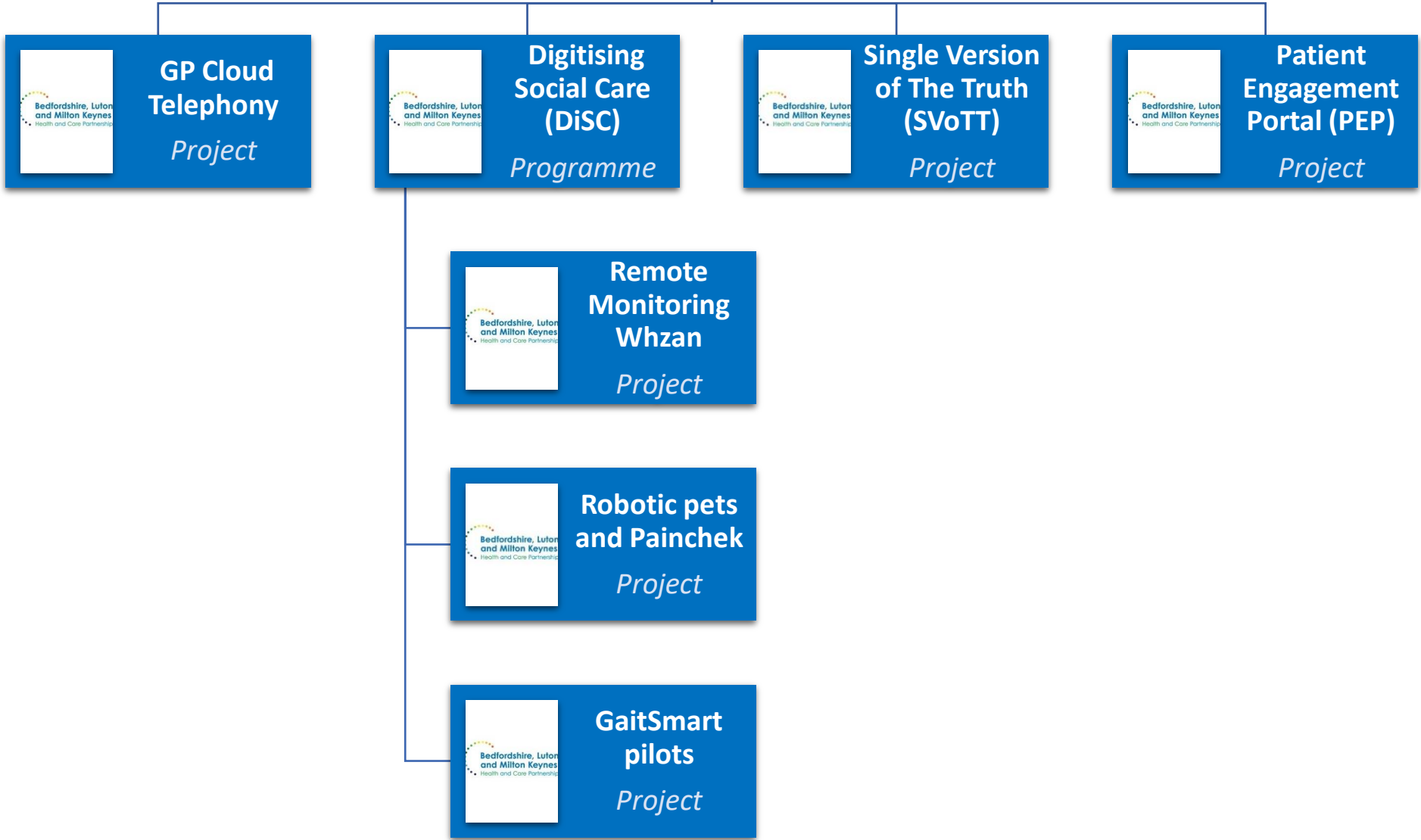
BLMK ICS Transformation Portfolio

Hierarchy Layer 3 – Additional Programmes & Projects



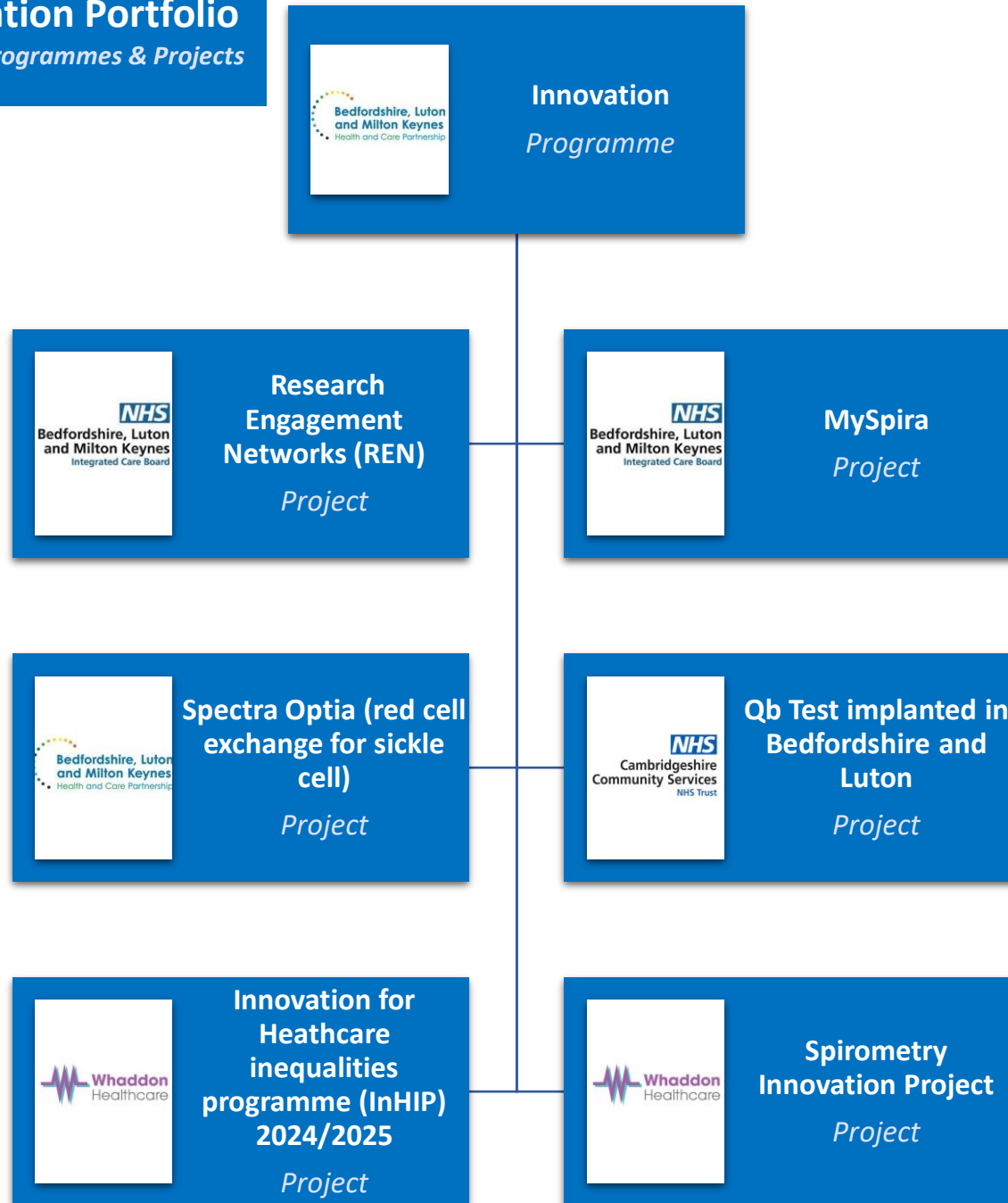
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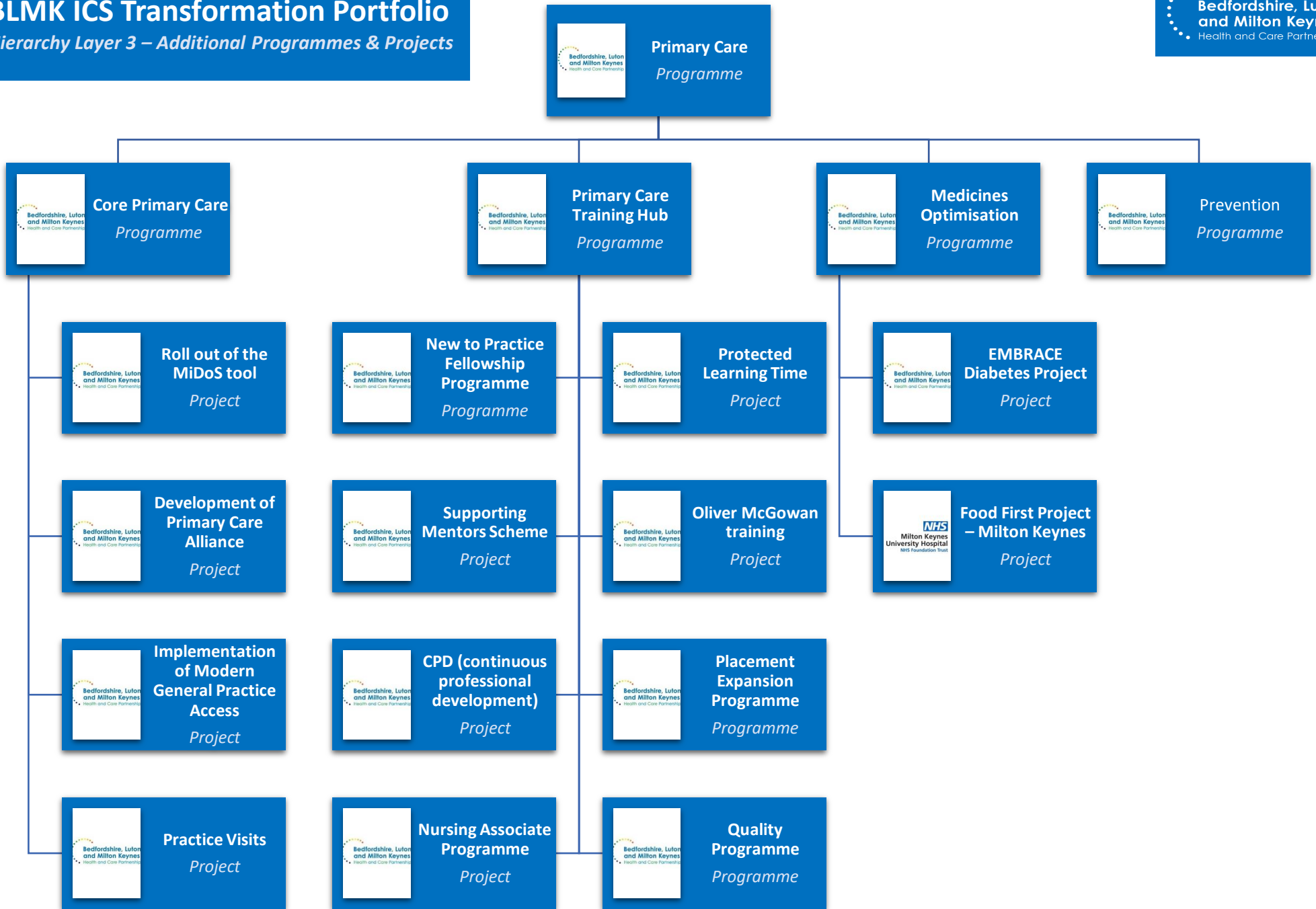
BLMK ICS Transformation Portfolio

Hierarchy Layer 3 – Additional Programmes & Projects



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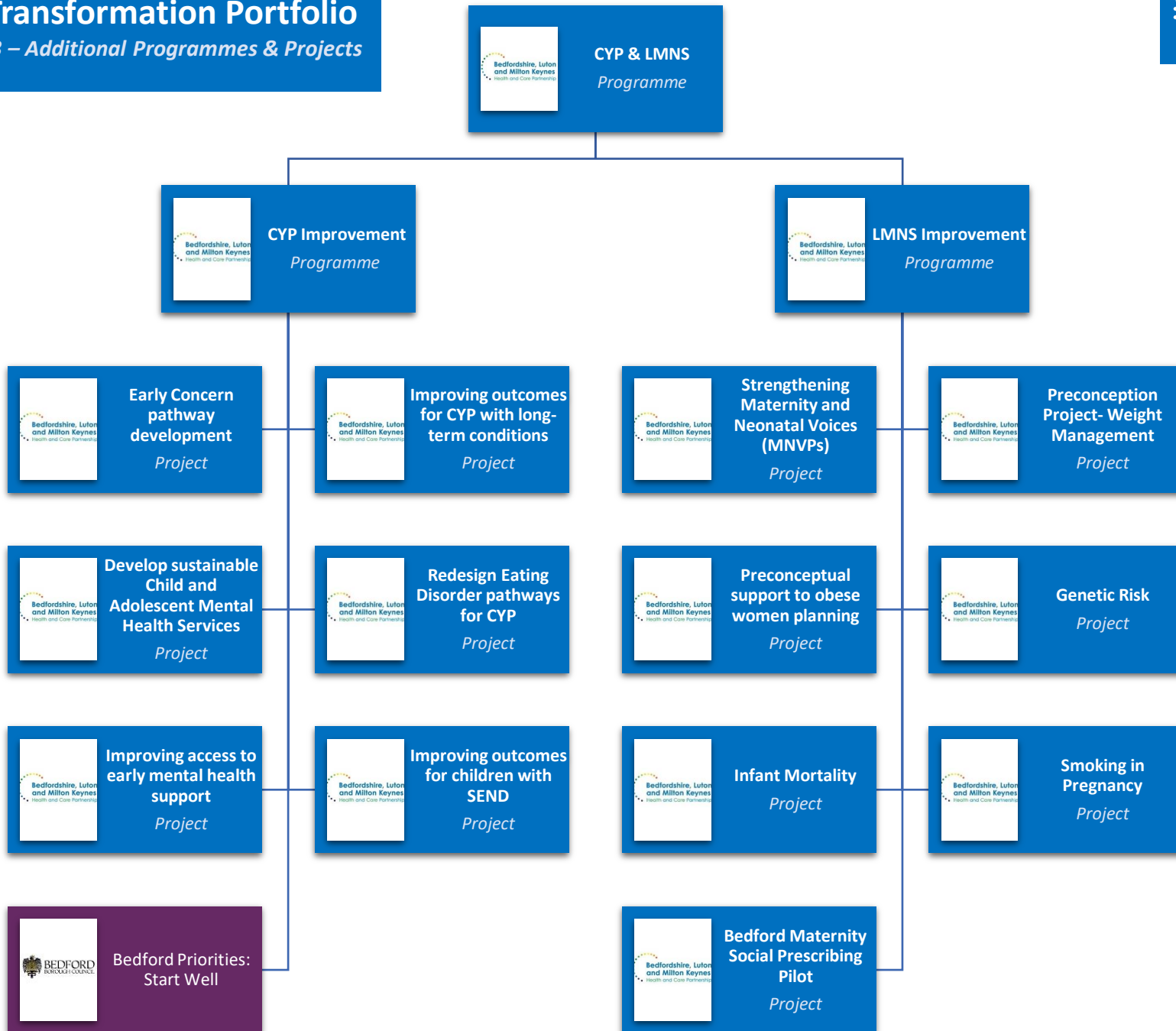
BLMK ICS Transformation Portfolio

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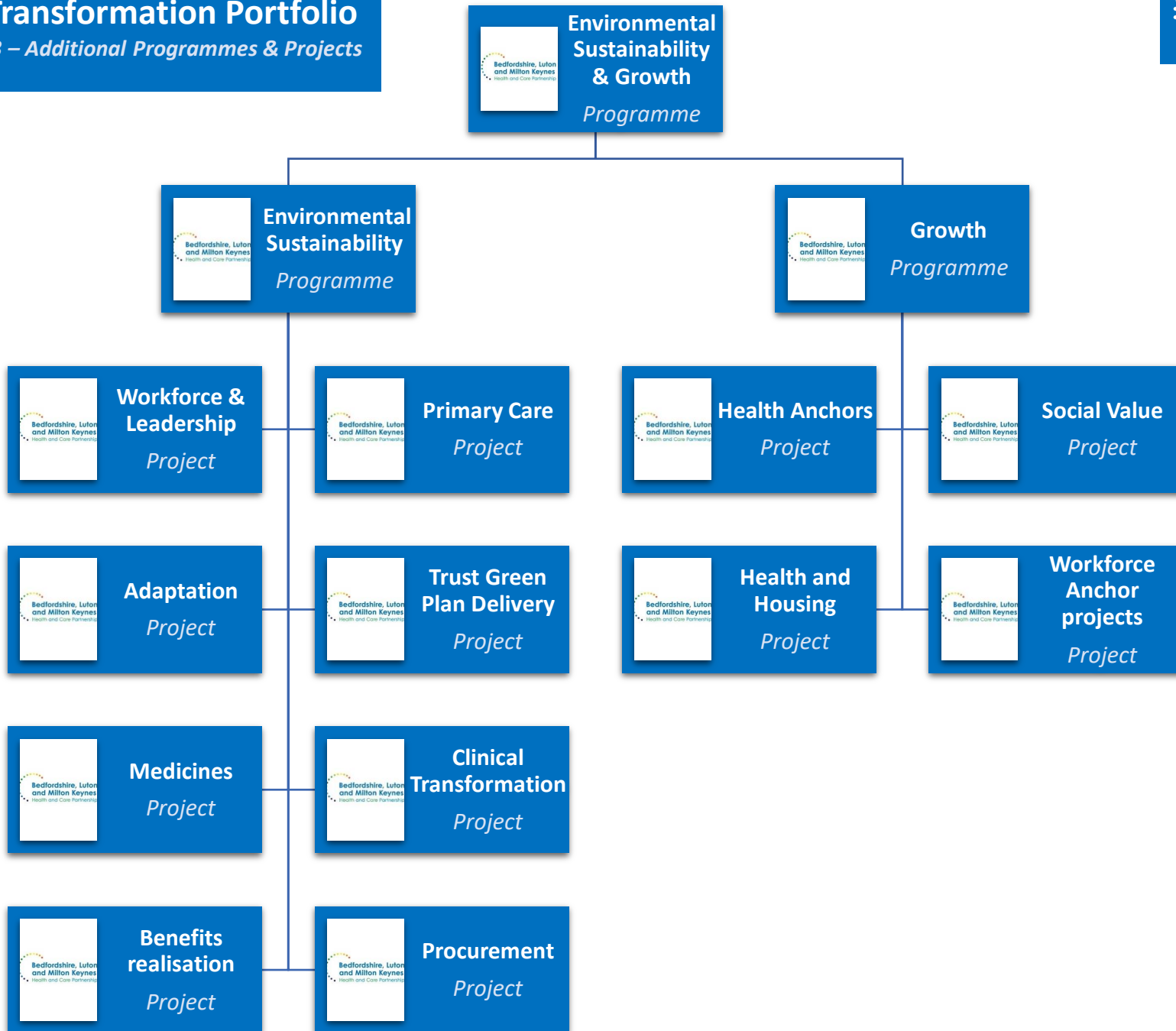
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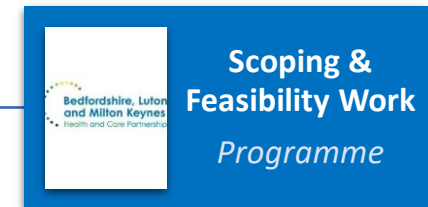
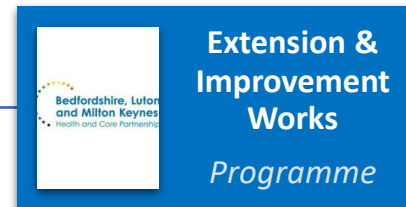
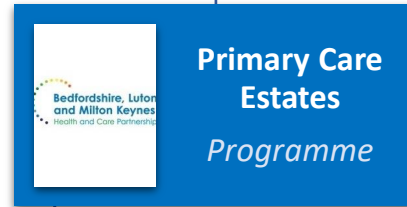
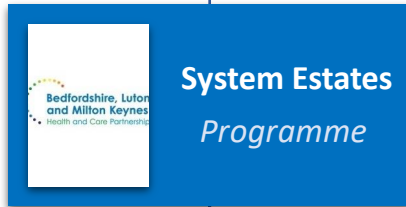
BLMK ICS Transformation Portfolio

Hierarchy Layer 3 – Additional Programmes & Projects



BLMK ICS Transformation Portfolio

Hierarchy Layer 3 – Additional Programmes & Projects



BLMK ICS Transformation Portfolio – *Highlight Reports*

Lead Team	Portfolio/Programme/Project	Slide No.	Lead Team	Portfolio/Programme/Project	Slide No.	Lead Team	Portfolio/Programme/Project	Slide No.
BCA	Call before you Convey	17	Luton	Integrated same day and urgent same day care services	37	MHLDA Collab	Mental Health Urgent & Emergency Care	58
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Central Bedfordshire	Primary Care Access including dentistry	30,31	BLMK ICS	BCA Emergency Care	50			
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Central Bedfordshire			BLMK ICS	ICS System Efficiencies Programme	56			
Central Bedfordshire			MHLDA Collab	MHLDA Improvement Programme	57			



Project Name	Call before you Convey
Project Team	Bedfordshire Care Alliance
Project SRO	Nicky Poulain
Project Lead	Faith Haslam
Geographical Footprint	Bedfordshire
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	PRE-PLANNING, All parts
Governance & Responsible Group	BCA Executive Group reporting to BCA Committee
Measures	<ul style="list-style-type: none"> - Proportion of ambulance attendances calling call before convey number prior conveyance - Aversion rate (% of calls where conveyance is averted) - Proportion of patients presenting in A&E who have been through call before convey - % of Care home residents ED arrivals assessed before conveyance to hospital - % of referrals and subsequent contact between VCS Crisis Cafés and crisis 24 hour phone lines

Project Description

The aim of this project is two-fold (i) to explore how a single number - call before you convey model could be implemented and (ii) further develop and consolidate the existing dispersed model of separate call before you convey options to give a more solid foundation for a single model and to not lose momentum and progress already achieved

Anticipated Benefits	Key Milestones	Progress made in Previous Period	Progress to be made in Next Period	Risks																		
<p>Map the existing services which exist as initial contact points for professionals prior to conveyance (e.g. Silver phone, rapid response team, GP liaison etc) Analyse the current usage and outcomes of these services</p> <p>Develop a proposed model for a single point of contact for urgent care (if considered appropriate and feasible) Consider how existing access routes can be developed. enhanced and communicated</p> <p>Agree how initial central funding (£125k) should be utilised</p> <p>Improve the take up of rapid responses services by other community services such as home care, GPs and District Nursing</p> <p>Greater integration of VCS Crisis cafes and Crisis Line and Home Treatment Teams</p>	<table border="1"> <thead> <tr> <th>No</th> <th>Milestone</th> <th>By When</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>BCA executive group to agree high level objective</td> <td>TBC</td> </tr> <tr> <td>2</td> <td>Conduct initial baseline scoping – produce a state of play summary</td> <td>TBC</td> </tr> <tr> <td>3</td> <td>Identify actions required to deliver objectives</td> <td>TBC</td> </tr> <tr> <td>4</td> <td>Agree required operating model and how this will be funded</td> <td>TBC</td> </tr> <tr> <td>5</td> <td>Agree and define appropriate outcome measures for project building on those in the PID</td> <td>TBC</td> </tr> </tbody> </table>	No	Milestone	By When	1	BCA executive group to agree high level objective	TBC	2	Conduct initial baseline scoping – produce a state of play summary	TBC	3	Identify actions required to deliver objectives	TBC	4	Agree required operating model and how this will be funded	TBC	5	Agree and define appropriate outcome measures for project building on those in the PID	TBC	<ul style="list-style-type: none"> • Discussed data, however it needs refining which is currently being completed – updates expected w/c 19/08/24. • Developed an understanding of D2A beds having an effect on numbers for the care homes they are in. Further data requested. • Luton PCN care home MDTs and ward rounds have been mapped and there maybe a link to higher conveyances where these are not face to face and not attended by anyone other than the GP and care home. • Readvertising the silver line in Luton Nursing Homes 	<ul style="list-style-type: none"> • Working with Pharmacy Care Home and Quality Care Home nurses in the ICB to replicate above across Bedfordshire to ensure appropriate calls are being made. Our place teams are well positioned to ensure that there is a bespoke approach to this in the three different locations, focusing on local needs. • Identify training gaps in care homes which are influencing admissions to hospital • Identify which care homes are calling before ambulance conveyance • Readvertising the 24 hour line Keech have available 	<p>Risks to be confirmed</p>
	No	Milestone	By When																			
	1	BCA executive group to agree high level objective	TBC																			
	2	Conduct initial baseline scoping – produce a state of play summary	TBC																			
	3	Identify actions required to deliver objectives	TBC																			
4	Agree required operating model and how this will be funded	TBC																				
5	Agree and define appropriate outcome measures for project building on those in the PID	TBC																				



Project Name	Virtual Wards (step up)
Project Team	Bedfordshire Care Alliance
Project SRO	Anita Pisani/Tammy Angel
Project Lead	Charlie Miller
Geographical Footprint	Bedfordshire
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	DELIVERY, All parts
Governance & Responsible Group	BCA Executive Group reporting to BCA Committee
Measures	Total patients on step up Virtual Ward; Average length of stay on virtual ward; Avoided hospital attendances; Total cost of virtual ward v assumed saving

Project Description

Every step-up patient we can manage via the virtual ward is one less physical bed taken up in the acute setting. 23% of patients seen in a virtual ward achieved a more independent social care outcome than they would have from an acute (in our experience to date this figure is higher). Patients are five times less likely to get an infection than if in hospital and eight times less likely to have functional decline

Anticipated Benefits

Increasing the Bedfordshire wide capacity of the step-up virtual ward by involving and aligning and providers
 Increasing the range of speciality virtual wards on offer
 Coordinating the procurement remote monitoring solutions
 Making Bedfordshire wide bids for funding
 Ensuring equality of access

Key Milestones

No	Milestone	By When
1	Point of Care Testing in place across CCS and ELFT	August 2024
2	Agree 24/25 recruitment priorities	August 2024
3	Ensure reporting aligns with new NHSE requirements	Sept 2024

KPI	April	May	June	July	August
Patients on ward *	185	205	219	202	233
% Occupancy	65%	72%	77%	71%	90% (capacity reset)
Readmission Rate					TBC

Progress made in Previous Period

- NHSE have confirmed funding for virtual wards will continue recurrently.
- ACP recruitment plans have been agreed.
- The South Team (ELFT and CCS) have now also had cannulation/IV training and are working under the MOU to build confidence in skills.
- Patient acuity levels are now starting to be recorded for the frailty pathway.
- All providers are working together to improve reporting and share system templates.
- POCT testing is in place at The Poynt (CCS) and IT requirements have almost been finalised for ELFT.
- The Doccla remote monitoring contract was renewed on 13th July until March 2025. Work is ongoing to improve utilisation.
- The paediatric ward activity is now included in the national reporting return.

Progress to be made in Next Period

Continue training and roll out of VW in BB and CBC

Additional ACP posts to advertised and existing staff upskilled to required level

Capture acuity data on all virtual ward instances and data systems

Risks

- 1, Data capture and completeness
- 2, Availability of workforce to increase provision
- 3 Clarity of clinical accountability
- 4, Geographical Variation in provision



Project Name	Improving access to Pathway 2 Beds	Project Description Reduce the time our residents spend waiting for a pathway two placement once optimised for discharge
Project Team	Bedfordshire Care Alliance	
Project SRO	Anne Brierley	
Project Lead	Kaysie Conroy	
Geographical Footprint	Bedfordshire	
Alignment to ICS Priorities	Live Well	
Maturity	Underway	
Governance & Responsible Group	BCA Executive Group reporting to BCA Committee	
Measures	Reduction in average time for discharge to a P2 bed from 10 to 5 days; Increase the occupancy of P2 commissioned beds; Reduce the LOS within P2 beds; Reduction in readmission rate from P2 beds; Evidence of positive rehab outcomes on discharge	

Anticipated Benefits Reduction in average time when medically optimised for discharge to a P2 bed from 10 to 5 days. Increase the occupancy of P2 commissioned beds and reduce spot purchase. Reduce the LOS within P2 beds and support onward flow. Reduction in readmission rate from P2 beds. Evidence of positive rehab outcomes on discharge.	Key Milestones			Progress made in Previous Period - Clinical audit finalised and presented at the P2 project group in Oct. - Fortnightly workstream meetings set up with key partners for a. Operational / process improvement & b. Strategic. - Clear aims and objectives defined for each workstream. - A review of the D2A beds was carried out by ELFT CHS in October 2023, recommendations have been shared with the P2 Intermediate Care Project Group. - Introduction of standard operating procedures for spot purchasing and 1:1 to ensure consistency and operational rigour.	Progress to be made in Next Period - Business case has been developed detailing the requirement to invest in the development of PHEW to gather data and intelligence that will support the delivery of this project around P2. - P2 project meeting in Nov, hosting Cambs & Peterborough FT to present on their model around investment in community therapy services. - ELFT D2A workforce review to be scoped and determine timescales. - Process improvements currently being developed, referral to CBC and BBC on day 2 for allocation of social worker (Luton already allocate on admission).	Risks 1, underutilised commissioned beds 2, failure to amend the process elements of delay 3, patient harm due to ineffective use of existing capacity 4, Patient harm due to insufficient commissioned therapy support 5, Misuse of existing capacity
	No	Milestone	By When			
	1	Complete a clinical audit and develop recommendations	Sept 2024			
	2	Establish 2 x workstreams (a. Operational / process improvement, b. Strategic) with clear aims and objectives developed and agreed.	Nov-24			
	3	Business case submitted to the ICB for consideration, investing in developing PHEW to provide the data and intelligence around P2.	Dec-24			
	4	Case for Change business – P2	Mar-25			
5	Variation of contract, reduction in Capwell Grange commissioned beds.	Jan-25				



Project Name	Ensuring effective proactive community care across the county
Project Team	Bedfordshire Care Alliance
Project SRO	Anita Pisani/Edwin Ndlovu
Project Lead	Pete Reeve/Robin Campbell
Geographical Footprint	Bedfordshire
Alignment to ICS Priorities	Age Well
Maturity	Underway
Governance & Responsible Group	BCA Executive Group reporting to BCA Committee
Measures	All places in Bedfordshire have the same level of access to community and mental health services; Agreed access targets for community services; Single cross county community services specification with single set of outcome measures; Improved life expectancy; The Bedfordshire health economy sees a lower than national average growth in demand for hospital services

Project Description

Through mapping our NHS trust's community and mental health services at a county level, develop a plan to provide proactive yet highly responsive community services across the county to allow people to manage their conditions at home. To do this in liaison with and where possible collaboration with neighbourhood teams

Anticipated Benefits

All community and mental health services provided by ELFT, CCS and HCRG
Any community services provided by BHT
Interaction with Place work on neighbourhood teams
Observing and identifying variation in county wide service provision by neighbourhood teams

Key Milestones		
No	Milestone	By When
1	Map existing community and mental services provided across the county by ELFT, CCS and HCRG	Oct 24
2	Open up discussions with HCRG in relation to their provision within the Luton locality	Sept 24
3	Commence discussions with Bedfordshire Hospitals in relation to activity that spans across into the community	Sept 24
4	Consider options for immediate change between CCS and ELFT provision, where it makes sense to do so	Oct 24

Progress made in Previous Period

Discussions between CCS and ELFT leads have taken place and mapping of the different service lines, within adult community services, has commenced.

Looking at comparing activity volume; staffing numbers; outcomes and comparing these against the local populations.

Progress to be made in Next Period

See milestones

- Risks**
- Consistency of data available is a risk.
 - HCRG may not be willing to share data/information in this context.
 - Potential procurement of community adult services may lead to parties being reticent to share information and/or work collaboratively.



Project Name	Improving care in last year of life across Bedfordshire	Project Description To improve the experience of residents and their relatives in the last year of life
Project Team	Bedfordshire Care Alliance	
Project SRO	Tammy Angel	
Project Lead	Joanna Morris	
Geographical Footprint	Bedfordshire	
Alignment to ICS Priorities	Operational & Clinical Excellence	
Maturity	Underway	
Governance & Responsible Group	BCA Executive Group reporting to BCA Committee	
Measures	Increase in the number of residents dying at the place of their choosing; Reduction in the number of readmissions for patients in the last 3 months of life; Improvement in feedback from relatives	

Anticipated Benefits Reviewing 'what matters most'-co-production and what models of care have been helpful in past To describe the core elements of a pan Beds EOL offer / service specification How information is shared across the system – shared list of patients on EOL pathway Developing transparent metrics showing activity and effectiveness of palliative care services Working to improve integration across provider pathways. Embed social care and VCS in the practice and pathways of end of life care.	Key Milestones			Progress made in Previous Period Reassessment of current provision against National Ambitions Framework. Review of data to understand number of people dying in the last year, whether they died in their usual place of residence or had 3 or more readmissions in last 90 days. Workshop held with all providers and people participant to describe current services and core elements or new operating model Draft proposal of new operating model is in discussion- with service specification that would be required	Progress to be made in Next Period BCA executive group to agree high level objective Review current EOL steering group TOR and membership Establish BCA project lead – macmillan lead appointed by ICB Review meeting Structure Conduct initial baseline scoping – produce a state of play summary Identify actions required to deliver objectives	Risks Risk that status quo suits all current providers and new model requires disruption and change. Risk that proposal is unaffordable without
	No	Milestone	By When			
	1	BLMK PeOLC review	October 24			
	2	Add financial aspects to the draft service model proposal	October 24			
	3	Bring a formal proposal to BCA execs for consideration	November 24			



Project Name	Using data to prevent hospital admission
Project Team	Bedfordshire Care Alliance
Project SRO	David Carter/Mark Thomas
Project Lead	John Fitzmaurice
Geographical Footprint	Bedfordshire
Alignment to ICS Priorities	Ways of Working
Maturity	PRE-PLANNING, all parts
Governance & Responsible Group	BCA Executive Group reporting into BCA Committee
Measures	Increased average life expectancy; Reduction in Hospital admissions; Patient satisfaction of those on proactive pathway

Project Description

To use the data available within health and social care to predict patients approaching a crisis, or a hospital admission within the next 6 months, and to allow a proactive intervention

Anticipated Benefits

- Scoping work underway across the ICB footprint involving integration of data and possible uses of AI in managing this data
- Using available data to predict those at risk of admission in the next 6 months.
- To consider further down stream uses of data to improve prevention work
- To propose investment and commissioning of projects to achieve the goals of this project
- To consider where this can be aligned with other pieces of work within the ICB to get best value for money and prevent duplication

Key Milestones

No	Milestone	By When
1	October ICB AI Workshop	Oct 24

Progress made in Previous Period

Agenda of meeting agreed with

Progress to be made in Next Period

Write up of workshop and proposed way forward.

Proposed statement agreeing remit of subsequent projects

Formation of Steering group

Risks

Risk of duplication across partners

Lack of delivery mechanism across organisations

No identified project resource



Project Name	Placed Based Plan Priorities – 1. Starting Well
Project Team	Bedford Borough Place Team
Project SRO	Laura Church / Sarah Stanley
Project Lead	Alex Wrack
Geographical Footprint	Bedford Borough
Alignment to ICS Priorities	Ways of Working
Maturity	Mapping and INITIATION, some parts
Governance & Responsible Group	Bedford Borough Executive Delivery Group
Measures	Outcome measured to be confirmed

Project Description

Bedford Place has 5 health areas of focus for transformation. These will be delivered through a number of teams e.g. Public Health and Adults Services and will be monitored through reporting to the Executive Delivery Group.

Anticipated Benefits

Bedford Borough has an updated Place Based Plan, with health and social care priorities based on population health data. The first set of priorities are focussed on children and young people. They include:

- Reduce childhood obesity
- Improve children's oral health
- Increase uptake of antenatal and childhood immunisations

The Place team are mapping current activity against these priorities with the relevant colleagues. Each areas of work with have measurable outcomes which will be reported to the EDG.

Key Milestones

No	Milestone	By When
1	Mapping of current activity and prioritisation of projects	December 2024
2	Working with colleagues across health and social care to agree measurable outcomes of improvement for each focus area	February 2025

Progress made in Previous Period

Established who is currently working on these initiatives and started mapping activities.

Progress to be made in Next Period

Complete scoping of existing activity and define reporting procedures.

Working with NHSE to look at immunisation data to explore opportunities for improvement.

Risks

Risks – challenge of showing change in the short term for childhood obesity and oral health as both long term aims.

Delivery of specific activity due to multiple competing priorities.



Project Name	Placed Based Plan Priorities – 2. Living Well
Project Team	Bedford Borough Place Team
Project SRO	Laura Church / Sarah Stanley
Project Lead	Alex Wrack
Geographical Footprint	Bedford Borough
Alignment to ICS Priorities	Ways of Working
Maturity	INITIATION, some parts
Governance & Responsible Group	Bedford Borough Executive Delivery Group
Measures	Outcome measured to be confirmed

Project Description
Bedford Place has 5 health areas of focus for transformation. These will be delivered through a number of teams e.g. Public Health and Adults Services and will be monitored through reporting to the Executive Delivery Group.

Anticipated Benefits
<p>Bedford Borough has an updated Place Based Plan, with health and social care priorities based on population health data. The second set of priorities are focussed on working aged adults. They include:</p> <ul style="list-style-type: none"> • Improve cardiovascular disease prevention and management • Increase the uptake of cervical and breast cancer screening programmes <p>The Place team are mapping current activity against these priorities with the relevant colleagues. Each areas of work with have measurable outcomes which will be reported to the EDG.</p> <p>The Place team have led setting up the LAN (more details in next slide).</p>

Key Milestones		
No	Milestone	By When
1	Recruiting to the Learning & Action Network (LAN)	November 2024
2	Mapping of current screening activity	December 2024
3	Integrating with the health inequalities CVD focussed work.	January 2025
4	Working with colleagues across health and social care to agree measurable outcomes of improvement for each focus area	February 2025

Progress made in Previous Period
Recruited team to LAN.

Progress to be made in Next Period
<p>Launch of the LAN.</p> <p>Collaborative work with Public Health and Primary Care colleagues on CVD.</p> <p>Part of a cervical screening pilot with CAJA at Linden Road, Ashburnham and Goldington Avenue practices.</p>

Risks
Risks – challenge of showing outcome changes related to CVD in short term.



Project Name	Placed Based Plan Priorities – 3. Aging Well
Project Team	Bedford Borough Place Team
Project SRO	TBC
Project Lead	TBC Sarah Pearson
Geographical Footprint	Bedford Borough
Alignment to ICS Priorities	Ways of Working
Maturity	Mapping
Governance & Responsible Group	Bedford Borough Executive Delivery Group
Measures	Outcome measured to be confirmed

Project Description

Bedford Place has 5 health areas of focus for transformation. These will be delivered through a number of teams e.g. Public Health and Adults Services and will be monitored through reporting to the Executive Delivery Group.

Anticipated Benefits

Bedford Borough has an updated Place Based Plan, with health and social care priorities based on population health data. The third set of priorities are focussed on older adults. They include:

- Reduce alcohol-related hospital admissions in the over 65s
- Support people with moderate frailty to live Independently
- Improve access to reablement

The Place team are mapping current activity against these priorities with the relevant colleagues. Each areas of work with have measurable outcomes which will be reported to the EDG.

Key Milestones

No	Milestone	By When
1	Write short paper on Age Care Technology/alternative options	December 2024
2	Conversations with potential SROs about work programmes and potential	February 2025
3	Make decision on whether to trail Age Care Technology	March 2025
4	Working with colleagues across health and social care to agree measurable outcomes of improvement for each focus area	March 2025

Progress made in Previous Period

Public Health set up working group to understand prevalence of alcohol-related hospital admissions in the over 65s.

Exploration of Age Care Technologies as possible mapping and prevention package for older people.

Worked with Adults Services to understand reablement issues – this is ongoing.

Progress to be made in Next Period

Agree work programmes for each element.

Agree SRO(s).

Make decision on Age Care Technology/use of other opportunities such as the Joy app.

Risks

Risks – not making a decision on activity as such a broad area to cover.



Project Name	Placed Based Plan Priorities – 4. Mental Health
Project Team	Bedford Borough Place Team
Project SRO	TBC
Project Lead	TBC
Geographical Footprint	Bedford Borough
Alignment to ICS Priorities	Ways of Working
Maturity	Mapping
Governance & Responsible Group	Bedford Borough Executive Delivery Group
Measures	Outcome measured to be confirmed

Project Description
Bedford Place has 5 health areas of focus for transformation. These will be delivered through a number of teams e.g. Public Health and Adults Services and will be monitored through reporting to the Executive Delivery Group.

Anticipated Benefits
<p>Bedford Borough has an updated Place Based Plan, with health and social care priorities based on population health data. The fourth set of priorities are focussed on mental health. They include:</p> <ul style="list-style-type: none"> • MHLDA workstreams (awaiting detail) • Reduce MH hospital admissions in under 18s • Prevent suicide in adults <p>This is a priority that will also touch more generally on the first 3 priority areas as a key factor.</p> <p>The Place team are mapping current activity against these priorities with the relevant colleagues. Each areas of work will have measurable outcomes which will be reported to the EDG.</p>

Key Milestones		
No	Milestone	By When
1	Work with ELFT colleagues to understand scope of under 18s in hospital for MH	January 2025
2	Work with PH colleagues to develop impact measurement of suicide prevention measures	February 2025
3	Once scope of problem better understood, work with ELFT colleagues to explore tackling under 18s in hospital for MH	March 2025

Progress made in Previous Period
<p>Scoping of suicide prevention, currently led by Public Health shared team.</p> <p>Presented at the Mental Health Alliance. Built relationships with key VCSE organisations.</p>

Progress to be made in Next Period
<p>Further understanding of the MHLDA workstream for Bedford Borough – new role may support our work at Place.</p> <p>Work with Public Health lead to understand how outcomes will be measured.</p> <p>Further exploration of under 18s in hospital with ELFT to determine the scope of the issue and actions being taken.</p>

Risks
<p>Risks – challenge of showing impact of suicide prevention outcomes in short term.</p> <p>Delay to progressing MHLDA workstreams due to change in staffing/MHLDA Board set up.</p>



Project Name	Placed Based Plan Priorities – 5. Health Estate
Project Team	Bedford Borough Place Team
Project SRO	Laura Church
Project Lead	Alex Wrack
Geographical Footprint	Bedford Borough
Alignment to ICS Priorities	Estates
Maturity	PRE-PLANNING, some parts; INITIATION, some parts
Governance & Responsible Group	Bedford Borough Executive Delivery Group
Measures	Success demonstrated by new/improved GP estate access across Bedford Borough / More efficient use of health care estates across the Borough

Project Description
Bedford Place has 5 health areas of focus for transformation. The aim of this project of work is to a) address patient access issues to primary care provision and ensure residents have adequate GP access b) provide strategic support and influencing to acute and community estate infrastructure.

Anticipated Benefits
<p>Bedford Borough has an updated Place Based Plan, with health and social care priorities based on population health data. The fifth set of priorities are focussed on Health Estate. They include:</p> <ul style="list-style-type: none"> Utilising & upgrading GP surgery provision Providing influencing and strategic support for acute and community health estate in Bedford Borough. <p>Health Estate has its own strategic board, chaired by Laura Church. The Bedford Borough Health Estate Board is focussed on delivering a number of GP Practice developments, including Biddenham, Great Barford, Kempston, Wixams and Wootton.</p>

Key Milestones		
No	Milestone	By When
1	Finalising a cost-effective feasibility study for Gt Barford practice in line with NHS requirements.	Nov 2024
2	Creation of a cost-effective feasibility study for Wootton practice, for future consideration.	Dec 2024
3	Potentially acquiring the Kempston Police Station site on Halsey Rd. Money not yet raised or agreed to use for health provision.	Jan 2025
4	Review of the previous Kempston SoC	Jan 2025
5	Ongoing negotiations with developers about Biddenham development and with CBC about Wixams development.	Spring 2025

Progress made in Previous Period
<p>Great Barford GP estate - early costings/feasibility reviewed several times for cost effectiveness. Final version, in line with NHS requirements, complete. Rent/revenue costs need to be worked out to make plan for potential funding gap.</p> <p>Wootton GP Estate - early costings/feasibility reviewed several times for cost effectiveness. Final version, in line with NHS requirements being completed.</p> <p>Kempston 'Hub' – consultants to be appointed imminently to carry out review of the 2019 strategic outline cost (SOC). Conversations started with Kempston Police Station about acquiring the Halsey Rd building. Initial costs received.</p>

Progress to be made in Next Period
<p>Kempston – work described is ongoing.</p> <p>Review of Gt Barford and Wootton to understand funding gaps and options.</p> <p>Wixams – continued conversations with CBC to consider who will drive the project forward.</p> <p>Closer working with BFHT to understand their estates challenges through Melanie Banks joining the Estates Board.</p>

Risks
Timeframes for work are liable to slip as there are so many factors affecting the progression e.g. stretch on staff time, cross-org working, procurement of external contractors, having to re-visit projects when costs etc are significantly different to those expected.



Project Name	Integrated Neighbourhood Working
Project Team	Bedford Borough Place Team
Project SRO	Laura Church / Sarah Stanley
Project Lead	Alex Wrack
Geographical Footprint	Bedford Borough
Alignment to ICS Priorities	Ways of Working
Maturity	INITIATION, some parts
Governance & Responsible Group	Bedford Borough Executive Delivery Group
Measures	Outcome measured to be confirmed

Project Description
The purpose of Integrated Neighbourhood Working (INW) is to centre care around people’s needs by integrating healthcare, social care, public services, community groups and voluntary agencies to work across neighbourhoods.
Bedford Borough has an INW Steering Group which will report to the Executive Delivery Group.

Anticipated Benefits
<p><u>Multidisciplinary teams</u>: The INW steering group will enable organisations to come together to map MDT working and make decisions about further staffing based on neighbourhood need.</p> <p><u>Prevention</u>: Organisations will come together to discuss prevention initiatives, how to replicate and implement learning across organisations and sectors.</p> <p><u>Personalised and proactive care</u>: providers will come together to refine and streamline pathways across different aspects of care and to create a holistic vision for resident care.</p> <p><u>Access</u>: Led by the ICB Primary Care Core team, this provides a platform for updates and insight to be fed to wider partners.</p> <p><u>Improving equity</u>: underpinning successful INW is a focus on improving inequity in health and social care. The INW steering group provides a place to challenge assumptions across providers and sectors.</p> <p><u>Innovation</u>: The INW have the opportunity to try more radical innovations and to learn from them using Health Inequalities/Place money.</p>

Key Milestones		
No	Milestone	By When
1	Initiation of the Integrated Neighbourhood Working steering group	November 2024
2	Discussion and creation of an INW short term plan and goals.	March 2025
3	Try, test and evaluate initial ideas.	June 2025

Progress made in Previous Period
Set up of INW Steering group and sign off from Board.

Progress to be made in Next Period
Developing steering group and short term (first 6 month) priorities.

Risks
<p>Risks – lack of buy-in or capacity from key organisations to develop and deliver the steering group priorities.</p> <p>Too many priorities – being pulled in lots of directions.</p>



Project Name	Learning and Action Network (LAN)
Project Team	Bedford Borough Place Team
Project SRO	Sarah Stanley
Project Lead	Usha Panchal
Geographical Footprint	Bedford Borough
Alignment to ICS Priorities	Ways of Working
Maturity	Pre-planning and INITIATION
Governance & Responsible Group	Bedford Borough Executive Delivery Group
Measures	Quality improvement designed in partnership with the IHI

Project Description

The Learning and Action Network (LAN) is part INW. It's a BLMK-wide QI programme aimed at improving hypertension management. In Bedford Borough Black African and Black Caribbean residents were identified as experiencing the highest levels of untreated hypertension, with the greatest prevalence in the Urban South neighbourhood. The LAN will be delivered in partnership with the Institute for Healthcare Improvement (IHI) quality improvement methodologies.

Anticipated Benefits

Improved Health Outcomes: Improved Hypertension Management, reducing the risks of complications. Early intervention enabling treatment and management at an earlier stage.

Increased Community Engagement: By involving residents, the LAN promotes greater understanding of hypertension and proactive health self-management behaviour; helps build trusted relationships with local leaders and residents, breaking down barriers to healthcare engagement.

Using Cultural Competency in delivery of care: Incorporate cultural insights and community feedback to create more effective and culturally sensitive health strategies to improve communication and relationships.

Stronger organisational Partnerships: Using an Integrated Neighbourhood Working approach to strengthen collaboration and relationships; enable resource sharing, learning from practices and promoting collective action.

Model for Future Health Initiatives: A model for addressing other health challenges across communities and improving organisational cultures through quality improvement methodologies.

Key Milestones

No	Milestone	By When
1	Core Team and Resident Selection	Mid-November
2	Establish baseline data using S1 searches	Mid-November
3	Kick off meeting with core team	Mid-November
4	Launch event with IHI and Core team and residents	Late-November

Progress made in Previous Period

Core clinical / professional team selected.

S1 searches created to identify residents at Cauldwell, London Road and King Street GP surgeries with hypertension not managed to target to use as baseline data.

Kick off meeting with Core Team planned for 15 Nov.

Launch event with IHI, Core team and residents planned for 22 Nov.

Progress to be made in Next Period

Resident selection finalised, 4 people maximum from across the 3 practices.

Establish terms of collaboration.

Agree on methods of communication: Teams, email and F2F.

Community engagement and awareness building.

Start to develop first PDSA improvement round.

Risks

Engaging the right residents (working age, right area). Lack of awareness around hypertension and health literacy in community.

Resource and funding constraints for interventions. Resistance from healthcare providers to change as suggested by residents.

Lack of sustained resident participation, Cultural Barriers. Difficulty in measuring impact.

Project Name	Primary Care Access including dentistry	Project Description Access to NHS dental services is a local and a national issue. The challenge is to increase NHS dental access to residents who have not seen a dentist over a 2 year period.
Project Team	Central Bedfordshire	
Project SRO	Amanda Flower	
Project Lead	Jason Ellis	
Geographical Footprint	Central Bedfordshire	
Alignment to ICS Priorities	Operational & Clinical Excellence	
Maturity	PRE-PLANNING, some parts; INITIATION, Some parts; IMPLEMENTATION, Some parts in implementation; DELIVERY, Some parts in delivery	
Governance & Responsible Group	Central Bedfordshire Place Board, Primary Care Delivery Group	
Measures	Measures to be confirmed	

Anticipated Benefits Reduce the number of patients seen requiring tooth extractions for dental decay. Lower the rate of tooth extractions delivered in a hospital setting Ensure residents have timely access to dental services Improve oral health inequalities for those resident groups experiencing poorer oral health	Key Milestones			Progress made in Previous Period Introduction of the new patient premium. This is an additional payment (up to a maximum of £50) to NHS dental contractors, to see new patients that have not been seen by a dentist in the previous two years. Dental Recruitment Incentive Scheme (a golden hello) to provide funding of £20,000 per new dentist recruited into the BLMK ICB footprint, payable over a 3-year commitment. The aim of the scheme is to increase dental capacity within our system.	Progress to be made in Next Period The ICB's dental access (Unscheduled Care) pilot review to be completed. The pilot's aim is to provide additional appointments during evenings, weekends and bank holidays using a finite budget. The key objectives of the pilot are: - patient appointments to be made available to treat and maintain dental health. - dental practices to accept all patient types (fee paying, fee exempt, adults and children) for treatment under this pilot. - the reduction of inequalities to vulnerable patient groups at elevated risk of dental diseases where access to dental care and oral health outcomes are poor . - early intervention to manage urgent problems in situations where there is a risk of deterioration in the patient's condition.	Risks Retention of existing dental clinical staff to deliver NHS services. The recruitment of new dental clinical staff into the BLMK footprint to deliver NHS services
	No	Milestone	By When			
	1	Develop strategic milestones and metrics that support delivery and gain maturity.	Apr 25			
	2	Agree a single integrated reporting mechanism and timescales,	Apr 25			
	3	Final sign off at Place Board.	Jul 25			

Project Name	Primary Care Access including dentistry, cont
Project Team	Central Bedfordshire
Project SRO	Amanda Flower
Project Lead	Beth Collins / Amanda Flower
Geographical Footprint	Central Bedfordshire
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	PRE-PLANNING, some parts; INITIATION, Some parts; IMPLEMENTATION, Some parts in implementation; DELIVERY, Some parts in delivery
Governance & Responsible Group	Central Bedfordshire Place Board, Primary Care Delivery Group
Measures	Measures to be confirmed

Project Description

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 support to work as part of integrated neighbourhoods.

Anticipated Benefits	Key Milestones			Progress made in Previous Period	Progress to be made in Next Period	Risks
	No	Milestone	By When			
<p>Ensure there are responsive and accessible primary care services, delivered by those best able to understand and meet the health and wellbeing needs of the local communities.</p> <p>Key Deliverables:</p> <ul style="list-style-type: none"> - Ensure delivery of services by General practice, Community pharmacy, Optometry, and Dental is maximised and accessible to residents - Integrated Neighbourhood Working across 4 neighbourhoods is developed - MiDOS fully available - Residents supported to manage their health and Well Being - Full 24/7 Primary Care Offer Defined, communicated and understood 	1	Develop strategic milestones and metrics that support delivery and gain maturity.	Apr 25	<p>Ongoing communication with patients and practices about how to use Pharmacy First.</p> <p>Continued work with practices to support the transition to Modern General Practice by 31st March 2025 with a number of practices in CB already delivering the new model.</p>	<p>Making certain that patient services providing primary care are joined up with other services to avoid gaps in care or duplication – using Integrated Neighbourhood Working to facilitate this.</p> <p>Supporting our practices to transition to a modern general practice access so our residents can contact their practice and know on the day how they will be supported – reduce the 8am rush and patients will not be asked to call back.</p>	<p>Risks to be confirmed</p>
	2	Agree a single integrated reporting mechanism and timescales,	Apr 25			
	3	Final sign off at Place Board.	Jul 25			

Project Name	Excess Weight
Project Team	Central Bedfordshire
Project SRO	Vicky Head
Project Lead	Vicky Head
Geographical Footprint	Central Bedfordshire
Alignment to ICS Priorities	Live Well
Maturity	PRE-PLANNING, some parts; INITIATION, Some parts; IMPLEMENTATION, Some parts; DELIVERY, Some parts
Governance & Responsible Group	Central Bedfordshire Place Board
Measures	Measures to be confirmed

Project Description
Too many people are living with Excess Weight. Excess Weight increases the risk of developing chronic diseases including cardiovascular disease, type 2 diabetes, cancer and osteoarthritis

Risks
Risks to be confirmed

Anticipated Benefits
<p>Multiple factors contribute to excess weight and its consequences for the health and wellbeing of our residents. A growing body of evidence suggests that excess weight cannot be tackled by a single agency. Alongside national interventions by Government, it requires a collaborative approach across organisational boundaries, making it everybody's business. Together, partner organisations and businesses in Central Bedfordshire play important roles in shaping our environment and keeping our population healthy. There is more we can do to prevent people developing excess weight and to support more people to lose weight. The ambitions below set out actions that the Council and partner organisations can take together to address the excess weight crisis and send a clear message to members, residents and service providers that this is a priority.</p> <p>Key Deliverables:</p> <ul style="list-style-type: none"> Fewer people living with excess weight Reduce rates of excess weight in children within areas of higher deprivation Lower prevalence of type 2 diabetes and cancers associated with excess weight Easier access to healthy food People being more physically active More people living with excess weight accessing services to support them More professionals feeling confident to talk to people about their weight in a supportive, non-stigmatising way

Key Milestones		
No	Milestone	By When
1	Develop strategic milestones and metrics that support delivery and gain maturity.	Oct 24
2	Agree a single integrated reporting mechanism and timescales,	Nov 24
3	Final sign off at Place Board.	Nov 24

Progress made in Previous Period
<p>Work has commenced on the refresh of the Local Plan which will provide more opportunities for building health & wellbeing e.g. encouraging active travel, into new developments.</p> <p>The Bus Shelter Advertising contract is up for renewal imminently. Discussions have been had with the Transport Manager to include a clause to the new contract which would restrict advertising of high fat/salt/sugar foods in favour of healthier options.</p> <p>The development of the Integrated Behaviour Change Service (IBCS) is progressing well. Pathways and the staffing structure have been agreed. Training and design for the healthy weight and motivational are being procured. The case management system has been commissioned.</p>

Progress to be made in Next Period
<p>The Food Fairness Grants (to increase access to healthy affordable food) will be launched in October 2024.</p> <p>Further development of the IBCS will continue including designing the website, marketing and communications plan, including access routes for those digitally excluded.</p> <p>Staff consultation and mobilisation of the new service with the anticipated start dates of April 2025</p>

Project Name	Cancer diagnosis and improving outcomes	Project Description Too many people are diagnosed with cancer at a late stage Too many people die from their cancer within 5 years of their diagnosis Too many people have cancers which are preventable. This programme aims to tackle these issues and improve Cancer outcomes for CBC residents.
Project Team	Central Bedfordshire	
Project SRO	Celia Shohet	
Project Lead	Kathy Nelson	
Geographical Footprint	Central Bedfordshire	
Alignment to ICS Priorities	Operational and Clinical Excellence	
Maturity	IMPLEMENTATION – All parts	
Governance & Responsible Group	Central Bedfordshire Place Board	
Measures	TBC	

Anticipated Benefits	Key Milestones			Progress made in Previous Period	Progress to be made in Next Period	Risks
	No	Milestone	By When			
- 75% of people with cancer will be diagnosed at an early stage by 2028 - >60% uptake of bowel cancer screening in each deprivation decile, in 2021/22 performance was 73.4% - >80% % uptake of breast cancer screening in each deprivation decile, in 2021/22 performance was 72.6% - >80 % uptake of cervical cancer screening in each deprivation decile, in 2021/22 performance was 75.5% in 25-49 year olds and 78.0% in 50-64 year olds.	1	Early detection – create opportunities to improve early detection through improved engagement with CORE20PLUS5 groups (younger women for cervical screening and black men and prostate cancer)	March 2025	Progressing early diagnosis programme of work including: - Improving screening uptake - Innovation - Primary care education - Lung Health Check programme BLMK patient forum continue to meet. Work on updating the patient handbook continues. Heartburn Health Check pilot completed at Priory Gardens. The project resulted in 4 referrals for urgent suspected cancer. Eclipse cervical screening patient engagement portal launched with 2 CBC practices participating.	Continue dashboard development Action plan agreed for Patient Forum working with group to expand membership Continuation of Eclipse patient engagement portal in 2 CBC practices. Recruit 1 CBC Practice to participate in behaviour change project	Risks to be confirmed
	2	Innovation- Complete Heartburn Healthcheck pilot at Priory Gardens (Capsule sponge test in primary care)	July 2024			
	3	Co-production – Continue to work with and support the Mid Beds Cancer Support Group and Ivel Valley PCN through the BLMK Patient Forum to provide information and support from the point of diagnosis	March 2025			
	4	Targeted Lung Health Checks programme expansion across CBC	March 2025			
	5	Understanding our population – Development of cancer dashboard to provide important cancer outcomes on key metrics by ethnicity, age, sex and deprivation	December 2024			
	6	Cervical Screening Behaviour Change project – resources using nudge techniques to improve uptake of cervical screening	March 2025			

Project Name	Positive Mental Health and Well Being for Children and Young People	Project Description Need for targeted spending and to focus on MH and emotional wellbeing for children.
Project Team	Central Bedfordshire	
Project SRO	Chantal Hampton	
Project Lead	Chantal Hampton	
Geographical Footprint	Central Bedfordshire	
Alignment to ICS Priorities	Start Well	
Maturity	PRE-PLANNING - Some parts; INITIATION - Some parts; IMPLEMENTATION - Some parts; DELIVERY - Some parts	
Governance & Responsible Group	Central Bedfordshire Place Board	Risks Risks to be confirmed
Measures	TBC	

Anticipated Benefits Increasing early intervention and prevention by strengthening community offer Increasing Mental Health Support for schools' teams Update and relaunch emotional/mental health wellbeing toolkit Accessible mental health support for children and young people with SEND Expanding support for young people with eating disorders Development of local leisure services to promote self-care Launch of emotional health and well-being online hub Co-production is embedded in everything we do	Key Milestones			Progress made in Previous Period As of January 2024, 311 CAMHS practitioners have been trained in SEND compliance. The SEND lead represents CAMHS at the CBC-led SEND Strategic and Operational Group and participates in working groups on mental health and emotional wellbeing. New Mental Health Support Team covering some schools in Flitwick and Biggleswade started in September 2023. Education Mental Health Practitioners are working to develop relationships with staff and young people within the schools, alongside completing their university courses The CAMHS Discovery College is holding workshops for young people aged 13-18 in various community locations, covering topics such as self-esteem, anxiety, and leadership. The college also collaborates with schools to offer workshops in schools with less support from MHST or Schools teams	Progress to be made in Next Period The Assistant Director of Capital Delivery, Children's Services in CB Council has confirmed that the directorate is going through and this priority will be discussed with the new incoming Director of services and a lead will be identified to take this work forward. The C&YP plan for 2025/28 has been co-produced and will be entering a period of consultation from December.
	No	Milestone	By When		
	1	Develop strategic milestones and metrics that support delivery and gain maturity.	Oct 24		
	2	Agree a single integrated reporting mechanism and timescales,	Nov 24		
	3	Final sign off at Place Board.	Nov 24		

Project Name	Mental Health – LD and Autism
Project Team	Central Bedfordshire
Project SRO	Michelle Bradley
Project Lead	Michelle Bradley
Geographical Footprint	Central Bedfordshire
Alignment to ICS Priorities	Live Well
Maturity	PRE-PLANNING - Some parts; INITIATION - Some parts; IMPLEMENTATION - Some parts; DELIVERY - Some parts
Governance & Responsible Group	Central Bedfordshire Place Board
Measures	TBC

Project Description

Working with the MH Collaborative and improving the secondary care interface for all ages. Improving health checks; developing a modernised response and improving outcomes for dementia

Risks

Risks to be confirmed

Anticipated Benefits	Key Milestones	Progress made in Previous Period	Progress to be made in Next Period																		
<ul style="list-style-type: none"> - Increase in the number of people accessing alternatives to A & E when in crisis, including Crisis Cafes, 111 option Mental Health - Reduction in the premature deaths of people with a learning disability & autistic people - Reduction in inequalities and breaking barriers for people to access services 	<table border="1"> <thead> <tr> <th>No</th> <th>Milestone</th> <th>By When</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>75% of the BLMK population who are on the LD registers to have received an LD Annual Health Check (AHC).</td> <td>Mar-25</td> </tr> <tr> <td>2</td> <td>60% of the BLMK population who are on the MH register to have received an SMI AHC.</td> <td>Mar-25</td> </tr> <tr> <td>3</td> <td>66.7% of the BLMK population to have received a dementia diagnosis.</td> <td>Mar-25</td> </tr> <tr> <td>4</td> <td>Launch of the Central Beds Learning Action Network improving the management of hypertension for people with MHLDA.</td> <td>Nov-24</td> </tr> <tr> <td>5</td> <td>Recommendations from the Max SAR being presented to the Adults Safeguarding Board, detailing the improvements that have been put in place to improve the outcomes for young people PfA.</td> <td>Nov-24</td> </tr> </tbody> </table>	No	Milestone	By When	1	75% of the BLMK population who are on the LD registers to have received an LD Annual Health Check (AHC).	Mar-25	2	60% of the BLMK population who are on the MH register to have received an SMI AHC.	Mar-25	3	66.7% of the BLMK population to have received a dementia diagnosis.	Mar-25	4	Launch of the Central Beds Learning Action Network improving the management of hypertension for people with MHLDA.	Nov-24	5	Recommendations from the Max SAR being presented to the Adults Safeguarding Board, detailing the improvements that have been put in place to improve the outcomes for young people PfA.	Nov-24	<p>- An update around the dementia diagnosis deep dive was presented at the Oct Joint Senior Leadership Group with the final report expected in Dec.</p> <p>- Community MH; Central Beds workforce are engaged in a QI project 'Alternative to CPA' testing with all disciplines taking on the role of 'key worker' and completing a dialogue scale with service users.</p> <p>- The Lighthouse has been working in partnership with the Recovery College in Leighton Buzzard who have now started offering courses and workshops with wellbeing with the aim of increasing knowledge and skills relating to mental health, wellbeing and recovery.</p>	<ul style="list-style-type: none"> - Presentation around the LD AHC performance in Dec with Clinical Directors, PCNs. - Physical Health, there is development of a physical health risk stratification tool to avoid readmissions to acute hospitals. This is being developed and co-produced with three service users and carers from CB and focus groups are being arranged. - Weight Management, ELFT SPLD services are to host a 2-year pilot weight management programme for people with LD & increased risk factors. - The crisis line service have bolstered up their response to the health care professional line (HCP) to improve access for professionals supporting patients experiencing mental health crisis in the community. ELFT are presenting to all GP leads around these new changes to promote the HCP line.
	No	Milestone	By When																		
	1	75% of the BLMK population who are on the LD registers to have received an LD Annual Health Check (AHC).	Mar-25																		
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Project Name	"Out of Hospital Services Working Together" – One Team approach
Project Team	Central Bedfordshire
Project SRO	Robin Campbell
Project Lead	Julia Mead / Helen Glyn-Davies
Geographical Footprint	Central Bedfordshire
Alignment to ICS Priorities	Ways of Working
Maturity	PRE-PLANNING, some parts; INITIATION, some parts; IMPLEMENTATION, some parts; DELIVERY, some parts
Governance & Responsible Group	Central Bedfordshire Joint Leadership Group
Measures	Measures to be confirmed

Project Description

Intermediate care, early intervention; Consistent approach to data collection and general need for improvement.

Risks

Risks to be confirmed

Anticipated Benefits

People are living longer with multiple, complex, long-term conditions but are struggling to access the primary care, social care and community-based services they need to manage these conditions. This means they may not receive treatment until their needs are more serious. Not only does this put increasing pressure on hospitals already struggling to be as productive as they were before the Covid-19 pandemic, but it can also be worse for people's health and more expensive for the taxpayer. Action is needed to enable more people to access care in their community so that they can stay healthier for longer. Key Deliverables:

- A workforce empowered to deliver health and social care at neighbourhood level
- Digital technologies are embedded to support residents and care delivery
- "One Team" approach to each neighbourhood
- People across all age groups have a seamless offer regarding health and social care
- People stay at home and live independently for longer
- Services co-produced with the populations they serve

Key Milestones

No	Milestone	By When
1	A case for change business case to be developed for P2 (BCA).	Mar-25
2	Review of the current MDT/Working Together groups across Central Bedfordshire aligned to PCNs.	Jan-25
3	Integration of IMC, CHS, & CBC.	Apr-25
4	Working Together expansion across West Mid Beds and Ivel Valley.	Apr-25
5	Falls service roll out across Central Beds.	Mar-25

Progress made in Previous Period

Implementation of VW in Dunstable. Link into EHICH to provide education and support to care homes. Workshop held with system partners to map out neighbourhood teams. Work ongoing with IMC pathway integration and bringing the CBC and CHS teams together at place to deliver unified care. At the business case writing stage. Teams are onboard and keen to progress with a new model. Update to the board re roll out of neighbourhood working – Oct. Separation of rapid response team. Pathway 2 D2A improvement work and pathway 1 review underway.

Progress to be made in Next Period

VW expansion to Mid Beds area time scale TBC. Business case to be presented to DASS and Director of CHS relating to integrated care model for reablement model delivered at place. Development of urgency care co-ordination hub. Establish route to expanding VW into mid beds. Fall service roll out. Intermediate care review (P1 and P2) Case for change for new models of commissioning and care. Delivery of P1 and P2 process improvements.

Luton

Project Name	Integrated same day and urgent same day care services	Project Description Develop a streamlined, integrated same day and urgent primary care service for the residents of Luton Ensure the offers are readily accessible for the population, with an appropriate and strengthened focus on priority cohorts to address inequalities
Project Team	Luton	
Project SRO	Nicky Poulain	
Project Lead	Faith Haslam	
Geographical Footprint	Luton	
Alignment to ICS Priorities	Ways of Working	
Maturity	IMPLEMENTATION, All parts	
Governance & Responsible Group	Luton Place Board	
Measures	See Anticipated Benefits / Outcomes	

Anticipated Benefits	Key Milestones	Progress made in Previous Period	Progress to be made in Next Period	Risks																		
Monitoring of the following KPIs: - GP appointments per 100,000 - UTC usage trajectory versus 22-23 - Urgent GP clinic usage – trajectory versus 22-23 - Arrival slot bookings- % of those that could have been booked an arrival slot	<table border="1"> <thead> <tr> <th>No</th> <th>Milestone</th> <th>By When</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Targeted and inclusive resident engagement events scheduled for 2024-25</td> <td>March 2025</td> </tr> <tr> <td>2</td> <td>All practices across Luton delivering Modern General Practice</td> <td>March 2025</td> </tr> <tr> <td>3</td> <td>Practices working collaboratively with IUC provider</td> <td>March 2025</td> </tr> <tr> <td>4</td> <td>All practices understand their residents use of NHS111 and GP OoH's service and are using that information to change behaviour</td> <td>March 2025</td> </tr> <tr> <td>5</td> <td>Integration plan in place</td> <td>March 2025</td> </tr> </tbody> </table>	No	Milestone	By When	1	Targeted and inclusive resident engagement events scheduled for 2024-25	March 2025	2	All practices across Luton delivering Modern General Practice	March 2025	3	Practices working collaboratively with IUC provider	March 2025	4	All practices understand their residents use of NHS111 and GP OoH's service and are using that information to change behaviour	March 2025	5	Integration plan in place	March 2025	<p>Luton Place are working with the Primary Care Core team to support practices and PCNs to ensure the consistent delivery of same day primary care.</p> <p>Work with NHS111 and GP OoH's provider and practices to reduce variation in use of the IUC offer</p> <p>Continue to develop and integrate IUC services with the urgent community offer</p>	<p>Continue resident & stakeholder engagement to explain the 24/7 primary care offer</p> <p>Work with Practices and PCNs to support consistent delivery of same day primary care</p> <p>Work with NHS111 and GP OoH's provider and practices to reduce variation in use of the IUC offer</p> <p>Continue to develop and integrate IUC services with the urgent community offer</p>	Risks to be confirmed
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Luton

Project Name	Early intervention, Prevention, and Partnerships	Project Description A programme of work containing Cancer Prevention & Early Detection, Learning disability and autism, Vaccinations, Mental Health and Technology and Digital Transformation via the BLMK DiSC Programme
Project Team	Luton	
Project SRO	Nicky Poulain	
Project Lead	Faith Haslam	
Geographical Footprint	Luton	
Alignment to ICS Priorities	Live Well	
Maturity	DELIVERY, All parts	
Governance & Responsible Group	Luton Place Board	
Measures	See Anticipated Benefits / Outcomes	

Anticipated Benefits	Key Milestones			Progress made in Previous Period	Progress to be made in Next Period	Risks
	No	Milestone	By When			
<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 <p>Mental Health</p> <ul style="list-style-type: none"> - Number of Luton residents accessing CMHT teams 	1	Children’s Flu programme to commence	September 2024	<p>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.</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>Flu Vaccinations</p> <p>Successful delivery of flu vaccination aimed at reducing morbidity and mortality in those most at risk, prevent ill-health and minimise winter pressures by helping to reduce demand for GP consultations and likelihood of hospitalisation.</p> <p>Covid-19 Vaccinations</p> <p>To focus on those at greatest risk of getting seriously ill, who will benefit the most from a further Covid-19 vaccine dose. Current vaccines provide good protection against severe disease, hospitalisation and can protect those most vulnerable from death.</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>Risks to be confirmed</p>
	2	Adult Flu programme to commence	October 2024			
	3	Covid-19 - To equal or exceed previous Spring 2023 uptake levels for each eligible cohort particularly those in clinical risks groups	June 2024			
	4	Improved early diagnosis of cancer in Luton through improved primary care interventions in targeted case finding	March 2025			
	5	Improved early diagnosis of cancer in Luton through improved primary care interventions in targeted case finding	March 2025			

Luton

Project Name	Personalised care, people with complex needs and co-morbidities	Project Description Long Term Conditions - early intervention and proactive care to prevent escalation of diagnosable conditions e.g. diabetes, CVD and respiratory diseases Personalised Care plans - ensuring people with complexity and LTC have prompt access to help manage exacerbations effectively
Project Team	Luton	
Project SRO	Nicky Poulain	
Project Lead	Faith Haslam	
Geographical Footprint	Luton	
Alignment to ICS Priorities	Live Well	
Maturity	IMPLEMENTATION – All parts	
Governance & Responsible Group	Luton Place Board	
Measures	See Anticipated Benefits	

Anticipated Benefits	Key Milestones	Progress made in Previous Period	Progress to be made in Next Period	Risks															
KPIs to support the workstream are: - Digital weight management Programme Refs & completion rates per 100,000 - Adults enrolled weight management support - National Diabetes prevention Programme Refs & completed rates per 100,000 - Smoking prevalence 18+ target	<table border="1"> <thead> <tr> <th>No</th> <th>Milestone</th> <th>By When</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Improving optimisation and management of Diabetes</td> <td>March 2025</td> </tr> <tr> <td>2</td> <td>Improving optimisation and management of CVD and Hypertension</td> <td>March 2025</td> </tr> <tr> <td>3</td> <td>Improving optimisation and management of Asthma</td> <td>March 2025</td> </tr> <tr> <td>4</td> <td>A co-designed model of care delivered for the population of Luton who are frail and/or have complex needs, ensuring that this aligned to the Luton priorities and strategies</td> <td>March 2025</td> </tr> </tbody> </table>	No	Milestone	By When	1	Improving optimisation and management of Diabetes	March 2025	2	Improving optimisation and management of CVD and Hypertension	March 2025	3	Improving optimisation and management of Asthma	March 2025	4	A co-designed model of care delivered for the population of Luton who are frail and/or have complex needs, ensuring that this aligned to the Luton priorities and strategies	March 2025	Luton Place is taking part in the Institute for Healthcare Improvement’s Learning Action Network (LAN), which will focus on improving outcomes for specific populations living with hypertension. This is an eighteen month quality improvement programme with clinical support from primary and secondary care teams. Luton continues to show great progress in smoking cessation, with an in house smoking cessation service available to all inpatients and maternity patients at Luton hospital. The National Diabetes Prevention Programme is ongoing.	Early intervention and proactive care to prevent escalation of diagnosable conditions e.g. diabetes, CVD and respiratory diseases Supporting people with long term conditions to take control of their own health and wellbeing (self-management) To co-design and deliver a model of care for the population of Luton who are frail and/or have complex needs, ensuring that this aligned to the Luton priorities and strategies	Risks to be confirmed
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Luton

Project Name	People and communities' resilience	Project Description Developing and supporting neighbourhood resilience to empower people and communities to build resilience and a sense of control to manage their own health and wellbeing
Project Team	Luton	
Project SRO	Nicky Poulain	
Project Lead	Faith Haslam	
Geographical Footprint	Luton	
Alignment to ICS Priorities	Operational & Clinical Excellence	
Maturity	DELIVERY, all parts	
Governance & Responsible Group	Luton Place Board	
Measures	See Anticipated Benefits / Outcomes	

Anticipated Benefits Supporting neighbourhood resilience through the following workstreams: - Identifying Neighbourhoods - Mapping MDTs & functions - Develop Neighbourhood Networks with MDTs as a starting point and integrating existing Communities in Practice - Development of an AI driven data source - Use the existing ICB led High Intensity User Scheme as a starting point to develop personalised care and associated MDT working practices within a pilot neighbourhood - Support people to help themselves, including parents, carers and wider family unit - Develop Community Hubs	Key Milestones			Progress made in Previous Period Supporting neighbourhood resilience through a Luton Integrated Neighbourhood Collaborative (LINC), aligned to the Fuller recommendations. This is now a well established group with system buy in, including primary care, adult social care and the VCSE. The Place Team are managing three cornerstone projects – -MDT Functions and approach -High intensity users (HIU) -Professional Networks	Progress to be made in Next Period Supporting neighbourhood resilience through a Luton Integrated Neighbourhood Collaborative, aligned to the Fuller recommendations The cornerstone projects are supported by our work with our social prescribing teams, and place based Personalised care project which focuses on reducing loneliness for vulnerable residents. Working in partnership with system colleagues including VSCE organisations to establish a holistic and preventative health and care approach for the agreed 5 neighbourhoods	Risks Risks to be confirmed
	No	Milestone	By When			
	1	A consistent approach to MDT's in place - Dec 2024	December 2024			
	2	A clear understanding of Luton MDTs, purpose, connectivity, source of access, gaps and issues arising - Dec 2024	December 2024			
	3	A standardised BLMK HIU service specification agreed - Jun 2025	June 2025			
	4	HIU service based on PHM findings to LINC agreed, neighbourhood has been piloted, with outcomes informing roll out across further neighbourhoods - Jun 2025	June 2025			
5	Integrated Neighbourhood Awareness Training including podcast - Sep 2024	September 2024				

Project Name	Improving System Flow	Project Description Transforming Urgent & Emergency Care services with MK providers working together to reshape demand, and the delivery of care
Project Team	Milton Keynes	
Project SRO	Vicky Alner/ Victoria Collins	
Project Lead	Mick Hancock (MKCC), Rebecca Green (IMK Place), Claire Brisland (MK Place)	
Geographical Footprint	Milton Keynes	
Alignment to ICS Priorities	Ways of Working	
Maturity	DELIVERY, All parts	
Governance & Responsible Group	System Flow Steering Group reporting into JLT	
Measures	Utilising Athena and SHREWD for monitoring activity – further work underway to refine metrics	

Anticipated Benefits	Key Milestones	Progress made in Previous Period	Progress to be made in Next Period	Risks																		
- Deliver better outcomes, with local people able to live healthier independent lives - Get people home as quickly as possible after a hospital or community bedded stay is completed, in order to maintain people's independence and minimise decompensation - Reduce average lengths of stay in hospital and other bedded care removing barriers to early discharge, and focusing on reablement from the point of admission - Better integrate discharge services to avoid duplication and maximising opportunities to resolve issues creating unnecessary admissions and attendances - Reduce reliance on long term care caused by delay and decompensation	<table border="1"> <thead> <tr> <th>N o</th> <th>Milestone</th> <th>By When</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Recruitment of VCSE Coordinator for the IDH.</td> <td>Q3 2024/25</td> </tr> <tr> <td>2</td> <td>Completion of DPIA for HFU project.</td> <td>Q3 2024/25</td> </tr> <tr> <td>3</td> <td>P1 Implementation.</td> <td>Q3 2024/25</td> </tr> <tr> <td>4</td> <td>Implementation of care home conveyances pilot.</td> <td>Q3 2024/25</td> </tr> <tr> <td>5</td> <td>ISF Metrics reported on through an Athena dashboard.</td> <td>Q3 2024/25</td> </tr> </tbody> </table>	N o	Milestone	By When	1	Recruitment of VCSE Coordinator for the IDH.	Q3 2024/25	2	Completion of DPIA for HFU project.	Q3 2024/25	3	P1 Implementation.	Q3 2024/25	4	Implementation of care home conveyances pilot.	Q3 2024/25	5	ISF Metrics reported on through an Athena dashboard.	Q3 2024/25	<ul style="list-style-type: none"> Recruitment continues of the VCSE coordinator role. Interviews are scheduled for the end of November 2024. - Continue Development a DPIA for the High Frequency Users of services in Milton Keynes project. Engagement with wider BLMK IG group. - Continue ISF metrics to an Athena dashboard mock up.- Completed MK Urgent and Emergency Care Programme Plan - ISF section focus - Metrics, KPIs all included. - Completed Falls Strategy sign off by the ISF Steering Group. - Completed Care Home Conveyances pilot to be implemented in 2 care homes (Water Hall & Willows) - Continue 	<ul style="list-style-type: none"> Sign off the ISF section of the MK UEC Programme Plan - ISF Steering Group. Continue to develop the DPIA for the High Frequency Users of services in Milton Keynes project. Feedback has been received from BLMK ICS IG Forum. Engagement with HIU commissioned service to discuss coordination of the High User project. Athena dashboard for ISF Metrics to be finalised and presented to the ISF core group and ISF steering group for sign off. Access to be sought for ISF members. Initial P1 performance meeting has been scheduled - to discuss success / outcome / performance measures Continue mobilisation of care home pilot. Implementing Consultant connect in UCR team as part of the pilot. Buy in from the linked GPs. ISF members to feed comments into the dying well report. Identify projects that ISF can lead on or contribute to. Falls Strategy implementation to commence through the working group. VCSE Role Interviews are scheduled for the end of November 2024. 	<ul style="list-style-type: none"> Schemes identified as winter priorities will not be implemented in time to impact winter pressures. Collaboration with all system partners to mitigate slippage.
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	1	Recruitment of VCSE Coordinator for the IDH.	Q3 2024/25																			
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Project Name	Tackling Obesity	Project Description 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.
Project Team	Milton Keynes	
Project SRO	Vicky Head / Omatayo Kufeji	
Project Lead	Megan Gingell (PH), Ollie Mytton (PH), Sandra Vanreyk (MK Place), Tom May (MK Place)	
Geographical Footprint	Milton Keynes	
Alignment to ICS Priorities	Live Well	
Maturity	PRE-PLANNING, CYP Tier 2+ service pilot; IMPLEMENTATION, healthy weight declaration; DELIVERY, activity wearables, streamlining referral services	
Governance & Responsible Group	Tackling Obesity Steering Group reporting into JLT	
Measures	Training uptake activity, referrals to WM (weight management services) patient outcomes measures (including reduction of velocity weight gain in the Tier 2 plus pilot)	

Anticipated Benefits	Key Milestones			Progress made in Previous Period	Progress to be made in Next Period													
	<ul style="list-style-type: none"> - 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. 	<table border="1"> <thead> <tr> <th>No</th> <th>Milestone</th> <th>By When</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Healthy weight declaration plan roll out.</td> <td>Q3 24/25</td> </tr> <tr> <td>2</td> <td>Gain expressions of interest from practices to lead/host Tier 2 plus CYP WMS</td> <td>Q3 24/25</td> </tr> <tr> <td>3</td> <td>Tier 2+ CYP WMS pilot soft launch</td> <td>Q1 25/26</td> </tr> <tr> <td>4</td> <td>Restart ACTIVATE Study with newly developed app</td> <td>Q3 25/26</td> </tr> </tbody> </table>	No			Milestone	By When	1	Healthy weight declaration plan roll out.	Q3 24/25	2	Gain expressions of interest from practices to lead/host Tier 2 plus CYP WMS	Q3 24/25	3	Tier 2+ CYP WMS pilot soft launch	Q1 25/26	4	Restart ACTIVATE Study with newly developed app
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	Risks																	
	<p>A dedicated psychological resource to work in an MDT setting for CYP Tier 2 Plus pilot could be limited given that there is a national shortage. Alternative opportunities will be explored as part of the service design model.</p>																	

Project Name	Children & Young People’s Mental Health
Project Team	Milton Keynes
Project SRO	Mark Maguire / Mac Heath
Project Lead	Liam Clarke (CNWL)/Rebecca Green (MK Place)
Geographical Footprint	Milton Keynes
Alignment to ICS Priorities	Start Well
Maturity	PRE-PLANNING – SPoA; DELIVERY - All other parts
Governance & Responsible Group	CYP MH Steering Group reporting into JLT
Measures	Qualitative and quantitative outcomes measures to be defined

Project Description
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 in care of complex and vulnerable young people

Anticipated Benefits
Improved outcomes in Prevention and early help through: <ul style="list-style-type: none"> - Business case to address gaps identified in having a systemwide provision of getting advice, support and early help - Secure new provision using the most appropriate framework which could include local grants, contract extensions and/or procurement Improved outcomes in Complex and vulnerable care through: <ul style="list-style-type: none"> - Immediate work to scope exactly which pathways the team will be responsible for and the interface with the workstream on managing complex needs. - Identify areas where outcomes and effectiveness can be improved for children and young people and get best use of system resources

Key Milestones		
No	Milestone	By When
1	SPA – Programme Leadership recruitment	Q2 24 / 25
2	SPA –Scoping and design phase	Q2 24 / 25
3	SPA – Engagement/mobilisation	Q4 24 / 25
4	SPA - Soft launch/trial	Q4 24 / 25
5	SPA Go Live	Q1 25/ 26

Progress made in Previous Period
An additional Clinical Psychologist (LAC post) in CAMHS has been appointed to Support social workers around trauma informed care, working with LAC team. A LAC fast track process operational
Wellbeing Service pilot launched with community-based counselling through two VCSE organisations .
Audit of current provisions of the iThrive conceptional model in MK area completed.
Crisis sanctuary commissioned and operational. Expanding HTT offer for CYP in crisis, MDT now in place.

Progress to be made in Next Period
Recruitment for programme leadership (SPA) underway
Develop service specification for Wellbeing Service to commission longer term offer for April.
Development of pathways/processes for SPA (single point of access) to create a more community-based offer and reduce referrals into CAHMS. Launch date April 2025.
Embed the principles of i-Thrive framework, e.g., Enhance and promote a single point of digital information on mental health & wellbeing

Risks
Programme leadership not yet in post. We are progressing actions in the interim through use of resource within the system

Project Name		Bletchley Pathfinder (Project 1-3)		Project Description To progress two of the Fuller recommendations in Bletchley (1) Proactive & Personalised Care, and (2) Prevention using a 2-staged approach to delivering the projects that will achieve the desired outcomes: Project 1 - Create 'Team Bletchley' Project 2 - Develop neighbourhood ways of working Project 3 - Implement a neighbourhood conferencing/problem solving model			
Project Team		Milton Keynes					
Project SRO		Michael Bracey					
Project Lead		Toni Fisher (Independent Chair), Sandra Vanreyk (MK Place), Zoe Durman (MK Place)					
Geographical Footprint		Milton Keynes					
Alignment to ICS Priorities		Ways of Working					
Maturity		IMPLEMENTATION, some parts; DELIVERY, some parts					
Governance & Responsible Group		Bletchley Pathfinder Delivery Board reporting into JLT					
Measures		Outcome measures to be defined once 'steady state' as been achieved					
Anticipated Benefits Transformation initiatives focused on tackling inequalities, prevention and early help to support those most in need: - Community Hubs for integrated health and wellbeing support with co-located professionals - A multi-disciplinary team problem-solving model to provide holistic co-ordinated support.	Key Milestones			Progress made in Previous Period		Progress to be made in Next Period	
	No	Milestone	By When	<ul style="list-style-type: none"> Continuous multi-organisational stakeholder engagement i.e. workshops, conferences & attendances at events. Ongoing. Screening tool/questionnaire for families with children and young people launched September, responses used to inform development of community support offers for complex families in community hubs. Completed 2 x Wellbeing Hubs successfully launched in October 2024. Completed Phase 1: Problem solving model coordinator in post. Completed A task and finish group formed to obtain additional subject matter expertise to help further shape the Problem-solving model. Triage and referral process finalised. Completed Launched multi-disciplinary team problem solving model with 2 x schools initially. In progress Early insights about learning from the Pathfinder obtained to feed into the full evaluation framework in Q2 25/25 Completed 		<p>Phase 1 Problem-solving model focusing on complex families will be fully operational for all schools in Bletchley by March 2025.</p> <p>Ongoing collaboration with system colleagues and VSCE organisations to enhance the wellbeing hub offers, embedding a holistic and preventative neighbourhood approach</p> <p>Team Bletchley employment, training, volunteering, and wellbeing event scheduled for January 2025, co-designed with Public Health and BLMK Workforce Development Academy.</p> <p>Phase 2 Problem solving model on substance misuse will commence with the design phase in January 2025 and will focus on specific cohorts of patients utilising a data driven approach.</p> <p>Evaluation of the problem-solving model for Phase 1 (complex families) February 2025</p>	
	1	Recruitment of care coordinator/trusted patient advocate.	September 2024				
	2	Confirm short/medium term community hub space allocation. - 2 sites identified and booked.	October 2024				
	3	Launch Wellbeing Hubs x2 including securing community groups/clubs and organisations to support facilitated by social prescribers and wellbeing coaches	October 2024				
	4	Pilot problem solving/MDT model – Phase 1 (PDSA model)	Q3 24/25				
	5	Pilot Phase 2 problem solving/MDT model	Q1 25/26				
6	Develop full evaluation framework (lessons learnt)	Q2 25/26					
Risks		A permanent location to host a dedicated community hub which has close links to other amenities including bus routes is required to maintain sustainability – opportunity is being considered through the Bletchley Regeneration Programme.					

Programme Name	Primary Care Access including Integrated Urgent Care & NHS App
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Nicky Poulain
Programme Lead	Amanda Flower (ICB)
Geographical Footprint	BLMK
Alignment to ICS Priorities	Ways of Working
Maturity	IMPLEMENTATION, some parts; DELIVERY, some parts
Governance & Responsible Group	Primary Care Delivery Group reporting to Primary Care Commissioning & Assurance Committee
Measures	Outcomes framework in development

Programme Description

Patients and carers experience a responsive and accessible primary care service, delivered by those best able to understand – and meet – the health and wellbeing needs of the local communities they are proud to serve.

Delivering the ambitions of the Fuller Stocktake (May 2022) and the Delivery Plan for Recovering Access to Primary Care (May 2023).

Anticipated Benefits

Improvement health outcomes for residents through:

- Episodic Care & Prevention
- Access
- Same day and urgent primary care
- Urgent & Emergency Care
- Increase BLMK residents use of NHS App
- Integration with UEC and other admission avoidance services.

Key Milestones

No	Milestone	By When
1	Briefing at ICB Board Seminar	19/07/24
2	Primary Care Assurance Committee approve SOC recommendation	16/08/24
3	ICB Board	27/09/24
4	Implementation of the Delivery Plan for Recovering Access to Primary Care	31/03/25

Progress made in Previous Period

- Strategic Outline Case for IUC submitted with a recommendation for approval the Primary Care Commissioning & Assurance Committee.
- MK Primary Care Alliance Launched
- Continue practice visit programme
- Practices launched modern general practice access models (total triage)
- Drive up use of NHS App
- Continued resident dialogue and facilitation of PPGs
- Development of future model for same day and urgent primary care
- Delivery of Integrated Urgent Care Efficiencies

Progress to be made in Next Period

Strategic Outline Case to be submitted to the ICB Board with the recommendation from Primary Care Commissioning & Assurance Committee.

Develop NHS App outcome measures

Risks

Agreement with strategic direction for IUC, controlled by robust governance

General practice workforce, estates and capacity

Lower than expected uptake of the NHS App in BLMK

Project Name	MSK	Project Description Re-procurement of community MSK services
Project Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board	
Project SRO	Anne Brierley	
Project Lead	Tara Dear	
Geographical Footprint	BLMK	
Alignment to ICS Priorities	Operational & Clinical Excellence	
Maturity	IMPLEMENTATION – All parts	
Governance & Responsible Group	MSK Programme Board	
Measures	See Anticipated Benefits / Outcomes	

<p>Anticipated Benefits</p> <p>Users report improvement in health-related quality of life There are no disparities in MSK health-related quality of life between population groups with protected characteristics Users report high levels of satisfaction with the MSK pathway Users feel supported to understand and manage their own MSK condition System partners report improved whole MSK pathway integration, effectiveness, and efficiency Reduction in the rates of unemployment or workplace sickness due to an MSK or Chronic Pain condition Reduction in directly controlled emissions contributing to the NHS 2040 Net Zero Target</p>	<p>Key Milestones</p> <table border="1"> <thead> <tr> <th>No</th> <th>Milestone</th> <th>By When</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Market Engagement Questionnaire phase complete.</td> <td>05/08/24</td> </tr> <tr> <td>2</td> <td>Decision to publish ITT to be made at Extended Finance and Investment Committee</td> <td>06/09/24</td> </tr> <tr> <td>3</td> <td>Publish ITT documents on tender portals</td> <td>27/09/24</td> </tr> <tr> <td>4</td> <td>Decision to award contract to be made at ICB Board</td> <td>28/02/25</td> </tr> <tr> <td>5</td> <td>Service go live</td> <td>01/10/25</td> </tr> </tbody> </table>		No	Milestone	By When	1	Market Engagement Questionnaire phase complete.	05/08/24	2	Decision to publish ITT to be made at Extended Finance and Investment Committee	06/09/24	3	Publish ITT documents on tender portals	27/09/24	4	Decision to award contract to be made at ICB Board	28/02/25	5	Service go live	01/10/25	<p>Progress made in Previous Period</p> <p>The ICB completed a successful Market Engagement Questionnaire (MEQ) process to assist the with testing assumptions and proposed service requirements.</p> <p>Attendance at BBC and CBC Health Overview and Scrutiny Committees in July.</p> <p>The ICB continued to work with BLMK residents to codesign questions for the next phase of procurement.</p> <p>Preparation for Finance and Investment Committee in September.</p>	<p>Progress to be made in Next Period</p> <p>Decision to publish ITT to be made at Finance and Investment Committee in September.</p> <p>Publication of ITT documentation on procurement portals.</p> <p>Continued engagement with residents about the evaluation phase of the procurement.</p> <p>Evaluation phase of the procurement to be completed.</p>	<p>Risks</p> <p>Risk of delay to the next phase of procurement – publication of the ITT which may impact on the go live date for the new service.</p>
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	2	Decision to publish ITT to be made at Extended Finance and Investment Committee	06/09/24																				
	3	Publish ITT documents on tender portals	27/09/24																				
	4	Decision to award contract to be made at ICB Board	28/02/25																				
5	Service go live	01/10/25																					

Programme Name	Diagnostics & Community Diagnostics Centres (CDC)
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	TBC
Programme Lead	Michael Ramsden/Matt Rogers
Geographical Footprint	BLMK
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	PRE-PLANNING - Luton CDC; Pre-implementation – Gilbert Hitchcock House. Implementation - Lloyds Court CDC and Whitehouse Park CDC; DELIVERY - All other projects
Governance & Responsible Group	Diagnostics Collaboratives/Sub-Modality Collaboratives report to the Elective Collaboration Board and various other committees as required i.e. FIG, CEOG, Elective Leadership Group etc
Measures	6ww Performance and Waiting times; Activity plan versus actual, including one-stop activity; Activity levels for each of the modalities are delivered in accordance with the agreed national minimum productivity rates; Patient satisfaction rates (surveys and Friends & Family Test); Staff satisfaction rates (quarterly survey during Y1 alongside NHS Staff Survey); Actual cost benchmarking against PBR rates; Capacity utilisation; DNA rates; Patient complaints; Sickness, vacancy and retention rates

Programme Description
Increased diagnostic productivity and capacity

Anticipated Benefits
Increasing diagnostic productivity and capacity through Community Diagnostic Centres whilst protecting services from emergency pressures. Development of improved clinical pathways with a specific focus on STT where applicable.

Key Milestones		
No	Milestone	By When
1	NOUS Service Review	End Nov
2	Pathology Efficiency Plan/Quantification of Opportunity	July 2024
3	Luton CDC Bid Prioritisation linked to Spending Review	March 2025
4	CDC Pathway Workshop Offer from NHSE Regional Team – Review for decision.	Dec 2025
5	BHFT – iRefer Implementation	Q1 2025
6	North Bedfordshire CDC	Sept 2025

Progress made in Previous Period
Work to quantify Pathology Efficiencies continues led by trusts. Lloyds Court is now live - October. Luton CDC being prioritised by NHSE bid for SR. MKUH have submitted a £1.4M bid to NHSE for Tier 1 diagnostic performance support which is likely to be approved; BHT have been encouraged to submit also. Diagnostics Programme transition is progressing. NOUS service reviews is in progress. CDC H2 Reprofitting complete and approved. Follow up questions from NHSE now in progress. Bid for programme funding to recruit new clinical SRO submitted but unsuccessful as considered as BAU and not transformation. Utilisation returns complete. Luton CDC mobile diagnostics bid not supported. However, BHFT delivering additional NOUS from Grove View.

Progress to be made in Next Period
Continuation of Diagnostics Programme transition. Complete NOUS Service Review and consider recommendations/next steps. Continued work of workforce particular focus on NOUS Sonographers Consider CDC Pathway proposal from NHSE and if agreed then to plan for early next year. Consider POCT Regional Network proposal

Risks
<ul style="list-style-type: none"> Absence of a clinical SRO for programme/CDCs. Update of the Luton CDC business case is at risk due to capacity and resource required to update the Business Case in readiness for submission should funding become available. System is currently considering the mitigation options so that opportunities to progress are not missed Diagnostics performance overall is slipping due to pressures from operational issues, UEC and elective – 85% target by March expected to be very challenging;

Programme Name	Non-Acute Diagnostics – Adults Neurodiversity, CYP Neurodiversity & CYP Audiology
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Martha Roberts
Programme Lead	Sarah Breton, Loraine Rosati, Matt Rogers, Mark Morton, Lucy Robertson
Geographical Footprint	BLMK
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	Adults Neurodiversity; Pre-Planning. CYP Neurodiversity; Pilot. CYP Audiology Pre-Planning
Governance & Responsible Group	Adults Neurodiversity; BLMK H&C Partnership Board, CYP Neurodiversity/Audiology - BLMK CYP Transformation Board.
Measures	The overarching measure of success will be achievement of the national diagnostic standard - 99% of patients should wait less than six weeks for a diagnostic test within 3 years. Adults Neurodiversity; National Diagnostic Standard/Prescribing costs/Financial - Psychiatry UK. CYP Neurodiversity; To be determined. CYP Audiology; National Diagnostic Standard/Others To be determined.

Programme Description
A programme of improvement and transformation that encompasses Adult & CYP Neurodiversity and CYP Audiology services. Adult Neurodiversity focusses on service offer improvement and model redesign. CYP Neurodiversity focusses on early intervention offers, pathway review and redesign to increase productivity. CYP Audiology focusses on standardising pathways and services including accreditation and mutual aid.

Anticipated Benefits
Adult & CYP Neurodiversity services, meet the needs of children & adults earlier to achieve a timely diagnostic intervention and support, ensuring access to services that deliver timely, safe and sustainable standardised pathways of care.
CYP Audiology; All babies, children and young people can access IQIPS accredited audiology services that ensure timely, safe and standardised pathways of care.

Key Milestones		
N	Milestone	By When
1	Driver Diagram for Adult Neurodiversity	End Nov 24
2	Adult Neuro Current Financial & Activity Status Paper	Nov-24
4	3 x Project Plans	Oct-24
5	CYP Neurodiversity NHSE Site Visits	Jan-24
6	Project specific measures to be defined and agreed – CYP Audiology	Oct-24
7	CYP Neurodiversity Early Concerns Pilot x 4 Places commence.	Luton: Feb24 MK: June24 BBC: Q2/24 CBC: Q3/24
8	CYP Audiology Improvement Proposal	End Nov

Progress made in Previous Period
Overall programme governance drafted and now in review as part of wider STT governance review. Verto updated with Service situation/landscape overview and measures for Adult and CYP Neurodiversity. Adults Neurodiversity: Driver Diagrams drafted and in review. Change ideas refreshed. Adult Neuro Current Financial & Activity Status Paper drafted. CYP Neurodiversity: Local early support pilots commenced and jointly resource with LA. CYP Audiology: NHS EoE Audiology Workforce Event took place on 7 th Nov System developing proposals to support improvement

Progress to be made in Next Period
Project plans to be developed. Project risk assessment review. Adults Neurodiversity: Agreement of priorities and capacity to progress delivery of plan CYP Neurodiversity: Delivery of pilots and outcome report of Luton pilot STT Exit Strategy as no requirement for support CYP Audiology: BLMK wide waiting list review of reporting – 28 th Nov Develop a workplan for CYP audiology – end Nov Develop measures – end Nov

Risks
Adult Neurodiversity: 1. Cost pressures associated with Learning disabilities S117 packages of care continue to increase. 2. Patients are not seen in the right place or are receiving the right care. CYP Neurodiversity 1. Increasing demand and backlog for these services 2. Recruitment and National shortage of Healthcare Scientists. CYP Audiology: 1. High waiting list and waiting times for first appointment in all services. 2. Quality of safety and risk of harm to patients following NHSE desktop review of all EoE services 3. Workforce

Programme Name	Cancer Transformation
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Ian Reckless
Programme Lead	Kathy Nelson
Geographical Footprint	BLMK
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	DELIVERY – Most Parts
Governance & Responsible Group	BLMK Cancer Board/Q&P/CEO Group
Measures	Measures agreed in 2022 – combination of KPIS, programme metrics and process measures

Programme Description
<p>Deliver Long Term Plan ambitions for cancer by creating more capacity to screen, case find and diagnose people earlier and faster; more people accessing stage one treatment earlier, with improved survival rates, patient experience and significantly reduced costs. Local collaboration with ICB partners to deliver the ICB and regional cancer strategy</p> <p>Reducing variation in access to treatments across BLMK by working with local and tertiary providers to localise or enhance treatment options</p> <p>Improving Performance: Ensuring efficient and effective cancer services to deliver post covid recovery actions for cancer</p> <p>Maintain system leadership role through the Cancer Board and supporting planning for cancer service provision across BLMK</p> <p>Address inequality in cancer outcomes using a whole pathway approach from access through to outcomes; maximising the opportunities to engage with people and local communities</p>

Anticipated Benefits
<p>To better outcomes and experience:</p> <ol style="list-style-type: none"> 1. Improved access to radiotherapy services 2. Reduced inequalities in cancer e.g. screening uptake and access to treatments 3. Increase in prevention and earlier and faster diagnosis (including increased workforce education and public awareness) 4. Reduced emergency presentations 5. Improved experience of living with and beyond cancer, and end of life care 6. Improved survival rates 7. Utilise innovative technology and diagnostic solutions

Key Milestones		
No	Milestone	By When
1	Delivery of cancer performance planning trajectories	30/12/24
2	Commence behaviour change project to support uptake in cervical screening and reducing DNAs	30/12/24
3	Await outcome of SBRI innovation bids to support Early Cancer Diagnosis – C-The Signs (primary care) and iPlayto (Lung Health Checks)	30/12/24
4	Launch revised Gynae urgent suspected cancer referral form and supporting primary care guidance	30/12/24
5	Health Services Strategy implementation of delivery group to support the priorities	30/12/24
6	Filming at MKUH and BHFT agreed to co-produce patient videos with an aim to walk newly diagnosed patients through cancer units	30/12/24

Risks
Delivery of the 62 day performance trajectory due to continued capacity issues with diagnostic pathways.

Progress made in Previous Period
<p>Early Diagnosis/ strategic planning – Work continues on the development of cancer population health dashboard in collaboration with AGEM.</p> <p>Innovation – Bids have been submitted to secure 3 new cancer innovations through the national SBRI programme in collaboration with the cancer alliance, outcomes are pending.</p> <p>Early Diagnosis - Cervical screening patient engagement (primary care support offer) with ECLIPSE has commenced.</p> <p>System Leadership - Cancer Board theme Colorectal Cancer Pathways and compliance with FIT testing.</p> <p>System leadership - BLMK breakout session for EoE Cancer Summit in June completed, the session focussed on the Prostate Cancer inequalities work and was well received.</p> <p>Faster Diagnosis – Scoping of the post-menopausal bleeding pathway has been completed. Referral guidance is being developed in collaboration with primary and secondary care colleagues to ensure this patient cohort is managed in primary care.</p> <p>Operational Performance – pathway analysers have been completed for pathways of concern identifying Trust level Actions.</p>

Progress to be made in Next Period
<p>Innovation – commence behaviour change project for gynaecology cervical screening and Urgent suspected cancer pathway compliance</p> <p>Innovation – establish next steps for SBRI innovations</p> <p>Faster Diagnosis – Launch new gynae referral form</p> <p>Treatment and Care – Progress patient forum videos to reduce anxiety when accessing care</p> <p>Earlier diagnosis – expand cytoprine primary care pathway into MKUH CDC.</p> <p>Operational performance / faster diagnosis – review NSS models to ensure continued sustainability</p> <p>Strategic planning – Refresh cancer board to incorporate requirements of health service strategy and increased trust executive representation.</p>



Programme Name	BCA Emergency Care
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board & Bedfordshire Care Alliance
Programme SRO	Anne Brierley
Programme Lead	Michael Ramsden, Chess Cummings
Geographical Footprint	BLMK
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	Delivery
Governance & Responsible Group	BCA Executive Group reporting to BCA Committee
Measures	Overall measure to reduce acute bed occupancy to <95% through admission prevention and reduce the number of Emergency Department (ED) presentations and conveyances. Creating triangulated reporting: 1. Expected demand on each part of the UEC pathway- i.e. ED attends, acute admissions, D2A run rate by Borough and so on 2. Expected increase in demand week on week through winter 3. Clarity from each partner on when their 'tipping point' is when winter pressures demand exceeds capacity.

Programme Description

A programme of work that focusses on Emergency Care transformation and three key priorities: 1. Virtual Wards. 2. Call Before Convey. 3. Pathway 2/Intermediate Care Beds

A separate workstream on Non-Emergency Patient Transport is also within scope of this priority.

Risks

- Discharge To Assess process is being increased across BLMK
- If additional UEC service pressure arises as a result of increased unplanned activity, particularly through the winter, this will threaten the stability of services/patient safety and outcomes. Escalating UEC pressure also risk the reduction of elective activity resulting in late cancellations of treatments impacting on quality and financial income.
- Challenging funding to deliver UCCH

Anticipated Benefits

To reduce acute bed occupancy to <95% through admission prevention and reduce the number of Emergency Department (ED) presentations and conveyances.

The overarching measure of success will be a reduction in Acute based bed occupancy levels.

Further indicators will include;

- Increased admission avoidance
- Increased early facilitated discharge
- Reduced Emergency Department attendances
- Reduced length of stay in the acute

Key Milestones		
No	Milestone	By When
1	Call Before Convey PID and Programme Plan	End Nov-24
2	Pathway 2 Project Plan	End Nov-24
3	Process Mapping - Pathway 2 - the patient flow from Acute to P2 bed	TBC
4	Review of Alternatives to ED Report	Oct-24
5	NEPTS – Horizon scan new transformation opportunities. Develop system eligibility criteria and ECJ process	Nov 24
6	SDEC Gap Analysis Report and Site Reports	TBC
7	Development of Early Warning Trigger System	TBC

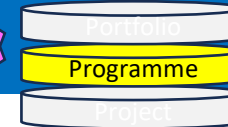
Progress made in Previous Period

- P2 IMC Project Group developing.
- NEPTS Transformation – Refreshed PID complete. Data Analysis complete.
- ICB STT/Core Leads meetings taking place.
- Development of a UEC Systemwide Programme Plan drafted and out for review/finalisation and prioritisation of key initiatives
- Bedfordshire UCCH/CB4C Programme Group established to end March-25.
- SDEC - L&D site visit and Gap Analysis complete
- P2 Clinical Audit completed Oct 24

Progress to be made in Next Period

Define & Agree STT support for

- (Alternatives to ED Awaiting the outcome report due end of w/c 26-08 now overdue) – Carry out review once available.
- Finalise the UEC Programme Plan and agree method for regular review/reporting.
- Progress development of Early Warning Trigger System
- Continue work on competencies of the care homes to minimise the calls into the SPOA/conveyance to ED
- Develop project plan for soft launch of UCCH
- SDEC - Bedford site visit to be arranged and progress individual site reports
- P2 Operational & Process Improvement Workstream meetings started 14/11/24
- P2 Strategic Workstream meetings to start 20/11/24
- P2 mapping interdependencies of work by end Nov 24



Programme Name	MK Emergency Care
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Maria Wogan
Programme Lead	Michael Ramsden, Chess Cummings
Geographical Footprint	BLMK
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	Implementation
Governance & Responsible Group	MK Operational Status Group (weekly) reporting to MK UEC Programme Board (monthly). Other committees incl. MK Improving System Flow Steering Group. ISF Core Group (weekly). MK Joint Leadership Team (3 weekly). BLMK UEC Planning and Assurance Group
Measures	Overall measure to reduce acute bed occupancy to <95% through admission prevention and reduce the number of Emergency Department (ED) presentations and conveyances.

Programme Description

A programme of work that focusses on Emergency Care transformation and three key priorities: 1. Virtual Wards. 2.Call Before Convey. 3. Pathway 2/Intermediate Care Beds

A separate workstream on Non-Emergency Patient Transport is also within scope of this priority.

Anticipated Benefits

To reduce acute bed occupancy to <95% through admission prevention and reduce the number of Emergency Department (ED) presentations and conveyances.

The overarching measure of success will be a reduction in Acute based bed occupancy levels.

Further indicators will include;

- Increased admission avoidance
- Increased early facilitated discharge
- Reduced Emergency Department attendances
- Reduced length of stay in the acute

Key Milestones		
No	Milestone	By When
1.	Review of Alternatives to ED Report	Oct-24
2.	NEPTS – Horizon scan new transformation opportunities. Develop system eligibility criteria and ECJ process	Nov - 24
3.	SHREWD – SCAS Trigger Data to Vital Hub	TBC
4.	SDEC – Hold discussions with Surgical Ops lead	TBC
5.	Development of Early Warning Trigger System	TBC

Progress made in Previous Period

- NEPTS Transformation – Refreshed PID complete. Data Analysis complete.
- ICB STT/Core Leads meetings taking place.
- Development of a UEC Systemwide Programme Plan drafted and out for review/finalisation and prioritisation of key initiatives
- Monthly MK UEC Transformation Meeting established.
- SHREWD; Good progress being made on Vital Hub
- SDEC – Site Reports Complete for Medical SDEC/Frailty (In draft)
- SDEC - HII - complete

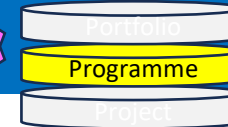
Progress to be made in Next Period

Define & Agree STT support for

- (Alternatives to ED Awaiting the outcome report due end of w/c 26-08 now overdue) – Carry out review once available.
- Finalise the UEC Programme Plan and agree method for regular review/reporting.
- Progress development of Early Warning Trigger System
- Continue work on competencies of the care homes to minimise the calls into the SPOA/conveyance to ED
- SHREWD – Obtain SCAS Trigger data for Vital Hub
- SDEC – Hold discussions with Surgical Ops lead following AL
- SDEC - continue working towards 7 days a week 10 hrs

Risks

- Discharge To Assess process is being increased across BLMK
- If additional UEC service pressure arises as a result of increased unplanned activity, particularly through the winter, this will threaten the stability of services/patient safety and outcomes. Escalating UEC pressure also risk the reduction of elective activity resulting in late cancellations of treatments impacting on quality and financial income.



Programme Name	Complex Care
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Anne Brierley
Programme Lead	Jan Wood
Geographical Footprint	BLMK System
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	Pre-planning
Governance & Responsible Group	Complex Care Plan Group
Measures	

Programme Description
To standardise and improve the processes systemwide for delivering Complex Care, whilst improving outcomes for service users accessing all forms of Complex Care and making the system more cost effective for the ICS

Anticipated Benefits
To standardise and improve the benefits systemwide for delivering Complex Care, whilst improving outcomes for service users accessing all forms of Complex Care and making the system more cost effective for the ICS
To reduce unnecessary spend on sub-optimal pathways
To increase co-production and personalisation in all pathways

Key Milestones		
No	Milestone	By When
1	Review current Health Consideration Policy – extend to all complex care cohorts (including children)	Nov 24 for Review of current Mar 25 for extensions
2	Agree standardised process for transition to adult services (to include fewer OOA placements)	Mar 25
3	BLMK Brokerage – maximise brokerage skills and opportunities to share where possible to reduce artificially inflating prices	Baselining 1 Oct 24 Sep 26
4	Map provision and gaps where universal services not being delivered and understand why.- Commission to fill gaps	Mar 26

Progress made in Previous Period
Presented the health considerations policy, explaining its purpose and the need to review and agree on a common approach with all local authorities. A timeline for the review was proposed with new policy enactment scheduled for April 2025
Reviewed financial position of the complex care program, highlighting significant cost pressures and differences between the budget and forecast for 2024-2025

Progress to be made in Next Period
Obtain and understand financial data by each borough to better understand the cost pressures and engage with local authorities
Cost Drivers Analysis: Estimate the root causes for increased costs in the current cohort, focusing on complexity of need, gaps in provision, market forces, and other factors. (All Participants)

Risks
Cost of care packages remain high due to in-area competition and lack of providers
Unmet needs will create cost pressures
Local authorities and other partners not engaged sufficiently in the programme with the result that the process remains fragmented


Project Name	Contractual Transformation / MHLDA and Community Services Provider Selection Regime (PSR)	Project Description We currently have varying levels of access and provision to CHS and MHLDA across BLMK with significant variation in services commissioned and cost. CHS and MHLDA contracts, due for renewal at the end of March 2025 and 2026 with aim to commission single model of service provision from April 2028
Project Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board	
Project SRO	Anne Brierley	
Project Lead	Kathryn Moody	
Geographical Footprint	BLMK	
Alignment to ICS Priorities	Operational & Clinical Excellence	
Maturity	PRE-PLANNING – All parts	
Governance & Responsible Group	Financial Improvement Group (FIG)	
Measures	Procurements achieved within 2-year planning	

Anticipated Benefits By undertaking a re-design of CHS and MHLDA services, the aim is to design and commission a single model of service provision across Bedfordshire, Luton and Milton Keynes from April 2028, resulting in: <ul style="list-style-type: none"> A smoother patient journey Greater clarity for referrers to the services Equity of service for patients across BLMK The right treatment, at the right time, in the right place 	Key Milestones			Progress made in Previous Period	Progress to be made in Next Period	Risks
	No	Milestone	By When	Having Board discussions on potential approach and requirements to shape the programme	Continue with baselining of existing provision	Order of consultations for CHS/MHLDA pre-PSR from a legal perspective
	1	Baseline of existing provision completed	Jan 2025	Work to baseline existing provision	Developing the engagement plan including engagement with incumbent providers	Some Community Health Services currently funded by BCF which Health & Wellbeing Boards have allocation oversight
	2	Key milestones define pre-procurement including engagement plan with incumbent providers	Jan 2025	Discussion with Board with future model scheduled	Define the key milestones pre procurement phase	
				Draft engagement plan scoped	Set up of formal Programme Board	

Programme Name	Improving Health Equity, including Women’s Health
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Sarah Stanley
Programme Lead	Natasha Young
Geographical Footprint	BLMK
Alignment to ICS Priorities	Reducing Inequalities
Maturity	PRE-PLANNING, some parts; INITIATION, some parts
Governance & Responsible Group	To be aligned with existing forums and report to BLMK Population Health Equity Board.
Measures	Resident feedback, health outcome measures

Programme Description

The Improving Health Equity programme is a three-year programme informed by population health analysis and key local reports such as The Denny Review and the Big Conversation. We want fair outcomes for all residents, with resources being distributed based on need.



Equality – everyone gets the same resources

Equity – everyone gets the same outcomes, with resources distributed according to need

Equal outcomes – through the removal of structural barriers

Figure 1: Equality, equity and removal of structural barriers sourced www.gov.uk

Anticipated Benefits	Key Milestones	Progress made in Previous Period	Progress to be made in Next Period	Risks												
<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) Reducing the gap in life expectancy Increasing the number of years people live in good health 	<table border="1"> <thead> <tr> <th>No</th> <th>Milestone</th> <th>By When</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Learning Action Network (LAN) launch workshops completed for each Place and cohorts to work with identified prior to launch date.</td> <td>22/11/24</td> </tr> <tr> <td>2</td> <td>Feedback received from initial observation visits reviewing existing translation and interpretation services and experiences from local workforce across the system.</td> <td>29/11/24</td> </tr> <tr> <td>3</td> <td>Luton Women’s Health Network go live delivering all 8 core elements of care (based on national set criteria).</td> <td>01/12/24</td> </tr> </tbody> </table>	No	Milestone	By When	1	Learning Action Network (LAN) launch workshops completed for each Place and cohorts to work with identified prior to launch date.	22/11/24	2	Feedback received from initial observation visits reviewing existing translation and interpretation services and experiences from local workforce across the system.	29/11/24	3	Luton Women’s Health Network go live delivering all 8 core elements of care (based on national set criteria).	01/12/24	<ul style="list-style-type: none"> All 4 place LAN workshops complete, and cohorts identified Observation visits scheduled and first visits undertaken across the system to review existing translation and interpretation services and experiences from local workforce. Improving Health Equity programme driver diagram socialised with key stakeholders and at ICB Board Seminar Spotlight on Denny events completed in all 4 places 	<ul style="list-style-type: none"> All four place based LAN groups launch on 22/11/24 Full report following translation and interpretation observational study visits and interviews completed by Healthwatch Luton Women’s Health Network launch 01/12/2024 	<p>In absence of tangible change being experienced by residents, there is a risk of reputational damage and resulting in ICB not meeting its duty towards addressing health inequalities.</p> <p>To mitigate, the programme has built in a three-year plan to ensure significant time is allocated and is realistic to apply. A feedback loop is critical to keep all stakeholders informed of progress.</p>
	No	Milestone	By When													
	1	Learning Action Network (LAN) launch workshops completed for each Place and cohorts to work with identified prior to launch date.	22/11/24													
2	Feedback received from initial observation visits reviewing existing translation and interpretation services and experiences from local workforce across the system.	29/11/24														
3	Luton Women’s Health Network go live delivering all 8 core elements of care (based on national set criteria).	01/12/24														

Programme Name	Integrated Neighbourhood Working
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Nicky Poulain
Programme Lead	Amanda Flower
Geographical Footprint	BLMK
Alignment to ICS Priorities	Ways of Working
Maturity	IMPLEMENTATION, some parts; DELIVERY, some parts
Governance & Responsible Group	Primary Care Delivery Group reporting to Primary Care Commissioning & Assurance Committee
Measures	Outcomes framework in development

Workstream Description

We will bring together teams from different organisations to wrap the right support around residents within their local neighbourhoods. This includes VCSE, blue light services, education, housing and social care. There are 19 neighbourhoods in development across BLMK.

Anticipated Benefits	Key Milestones	Progress made in Previous Period	Progress to be made in Next Period	Risks															
Improved health outcomes for residents through integrated working across teams from different organisations at a neighbourhood level.	<table border="1"> <thead> <tr> <th>No</th> <th>Milestone</th> <th>By When</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Developing resource area on website for all partners</td> <td>December 2024</td> </tr> <tr> <td>2</td> <td>Developing outcomes framework</td> <td>December 2024</td> </tr> <tr> <td>3</td> <td>Continue to support place projects / developments</td> <td>December 2024</td> </tr> <tr> <td>4</td> <td>Continue MiDOS roll out</td> <td>March 2025</td> </tr> </tbody> </table>	No	Milestone	By When	1	Developing resource area on website for all partners	December 2024	2	Developing outcomes framework	December 2024	3	Continue to support place projects / developments	December 2024	4	Continue MiDOS roll out	March 2025	<ul style="list-style-type: none"> 19 neighbourhood footprints agreed with LAs Neighbourhood profiles developed with mapped PCNs to neighbourhoods to show interconnectivity. INW programme group and collaborative stakeholder groups to share best practice between neighbourhoods and places Place based working groups / projects in development across all 4 places with CVSE engagement MiDOS development with each place comments FAQs for stakeholders development and a better understanding of Primary Cares contribution to effective neighbourhood working 	<ul style="list-style-type: none"> Review of programme governance and ToR of the INW Programme Board- this has been done Analysis of PHM data Developing resource area on website for all partners Work with place partners to develop an outcomes framework Continue to support place projects / developments Continue MiDOS roll out 	<p>LA capacity to drive the required transformation with competing priorities</p> <p>Sufficient community engagement due to competing priorities</p> <p>Lack of digital connectivity across health and care providers and patient held records</p>
No	Milestone	By When																	
1	Developing resource area on website for all partners	December 2024																	
2	Developing outcomes framework	December 2024																	
3	Continue to support place projects / developments	December 2024																	
4	Continue MiDOS roll out	March 2025																	

Programme Name	ICS System Efficiencies Programme	Programme Description The ICS System Efficiencies Programme is the programme that identifies, initiates, implements and delivers cash-releasing, reinvestment, cost avoidance, income generation and Cost-Improvement-Schemes (CIPs) across the ICB, BHFT and MKUH, together under one process and approach, to support balancing the ICSs overall financial position.
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board	
Programme SRO	Dean Westcott	
Programme Lead	Matt Hollex	
Geographical Footprint	BLMK	
Alignment to ICS Priorities	Finance	
Maturity	PRE-PLANNING - Efficiencies programme 2025/26; DELIVERY - Efficiencies programme 2024/25	
Governance & Responsible Group	Delivering our Operational & Financial Plan (DOFP)	
Measures	Monthly Reporting to DOFP on ICB, BHFT and MKUH efficiencies Plans vs Forecast vs Actual – all processed through a single system financial governance approach and system PMO Progress reporting on scheme delivery to DOFP	

Anticipated Benefits	Key Milestones	Progress made in Previous Period	Progress to be made in Next Period	Risks															
<p>Achieving financial balance in the financial year 2024/25</p> <p>Achieving financial balance in the financial year 2025/26</p> <p>Individual CIPs addressing key system drivers of excess cost, including CHC, prescribing, UEC/Escalation, MHLDA and workforce.</p> <p>Improvement across the three key areas, UEC, Elective and Productivity</p>	<table border="1"> <thead> <tr> <th>No</th> <th>Milestone</th> <th>By When</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Month 7 Efficiencies positions to be report to DOFP</td> <td>14/11/24</td> </tr> <tr> <td>2</td> <td>New Efficiencies/CIP Dashboard to be produced and presented to DOFP</td> <td>04/10/24</td> </tr> <tr> <td>3</td> <td>PA Consulting Diagnostics and Pipeline Efficiencies & CIPs to continue to be developed and progress reported to DOFP</td> <td>Nov 2024</td> </tr> <tr> <td>4</td> <td>Begin to build the efficiencies programme for 2025/26, starting with FYEs from 24/25 and meeting opportunity area leads</td> <td>Nov 2024</td> </tr> </tbody> </table>	No	Milestone	By When	1	Month 7 Efficiencies positions to be report to DOFP	14/11/24	2	New Efficiencies/CIP Dashboard to be produced and presented to DOFP	04/10/24	3	PA Consulting Diagnostics and Pipeline Efficiencies & CIPs to continue to be developed and progress reported to DOFP	Nov 2024	4	Begin to build the efficiencies programme for 2025/26, starting with FYEs from 24/25 and meeting opportunity area leads	Nov 2024	<p>M7 position reported to DOFP</p> <p>New Efficiencies/CIP Dashboard to be produced. CHC & prescribing drivers of excess cost. Year-end remains a balanced position. Both BHFT and MKUH presented to DOFP drivers of excess cost and plans to close the gap. MKUH and ICB being supported by PA Consulting. BHFT have adopted an 'in-house' approach to closing the gap – Financial Recovery Plan</p>	<p>Month 8 Efficiencies positions to be report to DOFP.</p> <p>PA Consulting Diagnostics and Pipeline Efficiencies & CIPs to continue to be developed and progress reported to DOFP.</p> <p>Continue building the efficiencies programme for 2025/26, starting with FYEs from 24/25 and meeting opportunity area leads .</p>	<p>Failure to achieve the ICS efficiencies target in 2024/25. Failure to identify a 2025/26 ICS efficiencies programme (of similar size to 2024/25). Failure to address key drivers of excess cost.</p>
	No	Milestone	By When																
	1	Month 7 Efficiencies positions to be report to DOFP	14/11/24																
	2	New Efficiencies/CIP Dashboard to be produced and presented to DOFP	04/10/24																
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4	Begin to build the efficiencies programme for 2025/26, starting with FYEs from 24/25 and meeting opportunity area leads	Nov 2024																	

Programme Name	MHLDA Improvement Programme
Programme Team	Mental Health, Learning Disabilities and Autism Collaborative
Programme SRO	Ross Graves / Richard Fradgley / Maria Wogan
Programme Lead	Loraine Rossati
Geographical Footprint	BLMK
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	INITIATION - 14 projects focused on financial recovery; IMPLEMENTATION - Existing recovery and red list schemes; DELIVERY - Existing recovery and red list schemes
Governance & Responsible Group	MHLDA Delivery Group & Finance Summit reporting into the MHLDA Exec + CFO meeting
Measures	See Anticipated Benefits / Outcomes

Programme Description
As of August 2024, there is a c£2.2m of risk in the BLMK MHLDA financial plan. This workstream is focused on fully mitigating this c£2.2m remaining risk in 2024/25 and supporting the development of the 2025/26 plan.

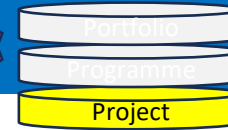
Anticipated Benefits
<p>Delivery of the 14 projects within the programme including:</p> <ul style="list-style-type: none"> • CYP Mental Health • Complex Care - S117 & MH&LDA Specialist Hospital Beds • S117 Valuing Care • Intensive and assertive community mental health treatment • Destiny Beds • Ending private bed usage (ELFT) – use of MH Acute and PICU out of area beds • Neurodiversity Pathways across BLMK • Mental health rehabilitation inpatient services (ceasing locked rehab) • Efficiency and Productivity Review of BLMK Talking Therapies

Key Milestones		
No	Milestone	By When
1	All PIDs to be completed and presented to Finance Summit	11/12/24
2	Further opportunities to be explored to close the c£2.2m gap	11/12/24

Risks
Failure to fully mitigate the c£2.2m of financial risk in MHLDA in 2024/25

Progress made in Previous Period
<p>5 of the 14 project PIDs were presented to MHLDA Exec + CFO meeting in August:</p> <ul style="list-style-type: none"> • CYP Mental Health • Complex Care - S117 & MH&LDA Specialist Hospital Beds • Ending private bed usage (ELFT) – use of MH Acute and PICU out of area beds • Neurodiversity Pathways across BLMK • Review of BLMK Talking Therapies

Progress to be made in Next Period
<p>All PIDs to be completed and presented to Finance Summit on 11/12/24. Further opportunities to be explored to close the c£2.2m gap. Review of MHLDA SDF projects to check status of progress made.</p>



Project Name	Mental Health Urgent & Emergency Care
Project Team	Mental Health, Learning Disabilities and Autism Collaborative
Project SRO	Sarah Stanley
Project Lead	Loraine Rossati
Geographical Footprint	BLMK
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	INITIATION – All parts
Governance & Responsible Group	MH Programme Board
Measures	The overarching measure of success will be a reduction to near-zero Out-Of-Area (OOA) acute inpatient beds (by December 2025), as per the NHSE Operating Plan target for 2024/25.

Project Description
<p>Patients on UEC Mental Health pathways are seen and treated in the right place, at the right time by:</p> <ol style="list-style-type: none"> 1) Removing all delays across community, acute, mental health care settings 2) Effective community-based admission avoidance and crisis prevention offer

Anticipated Benefits
<p>Aims to address the following:</p> <p>Significant delays (numbers and duration) of patients delayed in BHFT and community waiting for acute MH bed (c.10-16 at any given time) – plus same number who are not clinically ready for discharge waiting for supported discharge into community / tier 4 beds</p> <p>Exceeded by number of not clinically ready for discharge patients waiting supported discharge in ELFT acute MH beds</p> <p>Lengthy delays in ELFT beds (snap audit 060624 reported 33 patients who had collectively been delayed for 3,061 days)</p> <p>High use of OOA beds (significant breach of NHSE Ops Plan target) - £4.7m spend 2023/4, with FYE spend this year on track to exceed this</p> <p>High specialising costs to BHFT (use of agency RMNs), circa £50k / month</p> <p>Root causes – lack of general housing (especially LBC), lack of local supported independent living (SIL), delays in multi-agency discharge processes</p>

Key Milestones		
No	Milestone	By When
1	A reduction to near-zero of 12 hour ED delays for medically fit patients awaiting acute mental health beds	Dec 2025
2	A reduction to near-zero of Out-Of-Area (OOA) acute inpatient beds, as per the NHSE Operating Plan target for 2024/25	Dec 2025

Progress made in Previous Period
<p>Intensive work with ELFT and LBC has resulted in ELFT moving from OPEL4 to OPEL2 as at 27/08/24 (from 33 patients who have been delayed to 8-9 patients)</p> <p>Private bed use has reduced from a high of c.24 to 14 at 27/08/24</p> <p>Escalation of issues is more rapid however still more work to conduct</p>

Progress to be made in Next Period
<p>Planned decompression event to ensure that processes are robust and sustainable (Sept 2024)</p> <p>Establish clear escalation routes in LBC for housing and brokerage</p> <p>Complete review of community crisis resources</p> <p>Plan for further reduction in private bed use as community resources are stepped up</p>

Risks
<p>Lack of sustainable local post-acute recovery placements</p> <p>Significant clinical risk to patients delayed waiting for an acute MH bed (in BHFT and in community settings)</p> <p>Poor patient experience, and pressure to clinical staffing teams</p>



Programme Name	Community Services Programme, CHS Efficiencies (Revised Nov 24)
Programme Team	ICB Operations Team, ELFT, CNWL & CCS Community Services Teams
Programme SRO	Anne Brierley
Programme Lead	Jan Wood
Geographical Footprint	BLMK
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	PLANNING
Governance & Responsible Group	BLMK CFO Group
Measures	See Anticipated Benefits / Outcomes

Programme Description
A 2-year programme to improve Community Services for the residents of BLMK. Short to Medium aim to better understand and mitigate drivers of excess cost, increased demand and to make improvements to improve productivity/efficiencies/patient experience. Longer aim is the re-procurement of community services.

Anticipated Benefits
Existing work is <ul style="list-style-type: none"> Diabetes & Insulin Management Rehabilitation Pathways Admissions Avoidance <p>There are no intrinsic gains to each provider itself, but by working together to integrate services around the patient there are significant benefits to the system and many stakeholders. This work centres on admission avoidance and early transfer back to community (aka discharge from acute bed), so encompasses rehab and recovery, urgent same day care.</p>

Key Milestones		
No	Milestone	By When
1	Community Services Delivery Group established	Jul 2024
2	Schemes identified and agreed by BLMK CFOs – see slide pack	Nov 24
3	Detailed planning of benefits and deliverables etc	Dec 24
4	Investment required identified	Dec 24
5	Programme completion	Nov 25

Progress made in Previous Period
Providers agreed priority work, where benefits in terms of cost avoidance/savings will be achieved by the system, rather than the CHS provider.

Progress to be made in Next Period
CFO Group to agree approach.
More detailed planning
Data baselining to start

Risks
R1. That investment is unaffordable.
R2. That pathways cannot be agreed.

Programme Name	BLMK Elective Collaboration
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Anne Brierley
Programme Lead	Michael Ramsden
Geographical Footprint	BLMK
Alignment to ICS Priorities	Operational & Clinical Excellence
Maturity	TBC
Governance & Responsible Group	Elective Collaboration Board
Measures	TBC

Programme Description
Demand Management, Assurance and Elective Hubs

Anticipated Benefits
<ol style="list-style-type: none"> Elimination of Long Waits and sustainable reduction in wait list Improved outcomes

Key Milestones		
No	Milestone	By When
1	Develop a Strategic Outline case and support partners in a business case for Surgical Hubs	31/12/2024
2	Review opportunities to address unwarranted variation in advice and guidance and referrals across BLMK	31/12/2024
3	Explore opportunities to develop prime provider models in Milton Keynes, enabling streamlined pathways and income generation.	31/01/2024
4	Accreditation of new providers to support elective recovery (Dermatology and ENT)	31/03/2024

Progress made in Previous Period
<ol style="list-style-type: none"> Initial discussions with NHSE and BLMK Acute Trusts on Elective Hubs. ICB resources secured to support the development of business cases. Initial A+G and Referral data set developed. Discussions with Place teams on how to use this data to influence change Request made to ICB BI and Finance teams to analyse data and determine the potential financial impact of a prime provider model Service specification and contract requirements for Dermatology service shared with provider.

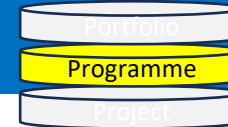
Progress to be made in Next Period
<ol style="list-style-type: none"> From Task and Finish group for Surgical Hubs, confirm stakeholders and commence drafting strategic outline case Discussion at Chiefs and Place leads meeting on next steps and for Place leads to progress Data to be shared with stakeholders prior to any next steps ENT service spec in development and awaiting approval before sharing with provider

Risks

BLMK ICS Transformation Portfolio – Highlight Reports

Programme Name		Digital Transformation		Programme Description		Programme Risks	
Programme Team		Bedfordshire, Luton and Milton Keynes Integrated Care Board		These projects are externally funded and delivered by ICS partner organisations. Detailed reporting is provided directly to NHSE, where they are the funding source, by the lead organisation – NHSE have responsibility for detailed assurance. The ICB Digital Team role is one of leadership, support, guidance and escalation in the event of issues for these projects.		SVoTT – procurement halted and external support released. Procurement closed in a controlled way to minimise risk however use cases were published which now have to be handled carefully so we do not breach procurement rules.	
Programme Lead		Mark Thomas & Helen Haumann					
Geographical Footprint		BLMK ICS					
Alignment to ICS Priorities		Digital					
Governance & Responsible Group		ICS Digital Transformation Board					
Project Name	Digitising Social Care (DiSC)	Frontline Digitisation	Patient Engagement Portal (PEP)	GP Cloud Telephony	Single Version of the Truth (SVoTT) - halted		
Project Delivery Lead	CBC as lead on behalf of all 4 LA's.	BHFT	BHFT	BLMK ICB Digital Team	BLMK ICB Digital Team		
Funding	Digitising Social Care Fund 24/25 NHSE Technology Fund 24/25 HTAAF Fund 23/24	£2.5m FY 24/25	£550k FY 24/25	£1.6m	N/A		
Governance and Reporting	NHS England – Assurance DiSC Programme Board ICS DTB BCA DTPB	NHS England - Assurance ICS DTB BCA DTPB BHFT ePR Programme Board BHFT Finance Investment Performance Committee (FIP)	NHS England - Assurance ICS DTB BCA DTPB BHFT Programme Board BHFT Finance Investment Performance Committee (FIP)	NHS England ICS DTB BCA DTPB	ICS DTB BCA DTPB Partner internal reporting ICB Operational & Exec Group		
Detail / Description/ Key Ongoing Projects	Implementation of digital services in CQC registered Care Homes, plus various remote monitoring and assistive technology in support of the frailty agenda including: GaitSmart, Acoustic Monitoring, RazierChair (home/domiciliary care), NHS Mail, Proxy Access Data Security Protection Toolkit (DSPT)	Supporting Bedfordshire Hospitals FT in accelerating their digital ambition to reach HIMMS Level 7. Modular and incremental approach based on best of suite and prioritised by the Trust agreed with ICB & NHSE	Funding provided for procurement process up to contract signature in relation to a Patient Engagement Portal which integrates with the NHS App - allowing residents to book/rebook Acute appointments as well as access letters and correspondence.	National programme to move from Analogue to Digital Cloud-based telephony platforms in GP Practices where not already. Upgrade of legacy CBT systems to enable latest capabilities. Helps practices adopt the Modern General Practice Access Model and supports PCARP by providing ability to manage access demand more effectively via queueing, call-back, call routing and workforce planning.	Market engagement to identify and engage a partner who can facilitate adding in data feeds that the ICS have but are not shared. Deliver 5 co-produced use cases to enable better informed service planning to make best use of scarce resources and enable more targeted services based upon local need.		
Measures / Milestones	*Reported directly to NHSE – latest DTB Summary provided*	Key 24/25 expectations: Emergency Department Clinical Documentation ePMA Order Comms (Read Only) Theatres Medical Device Integration	BHFT procurement of a PEP supplier by March 2025. Implementation to commence in FY 25/26.	In July 2023 the ICB was tasked to move all practices to a cloud-based telephony platform. As at November 2024 all BLMK practices except one are on CBT. The remaining practice is completing installation by December 2024. This programme is already releasing benefits including increase in staff moral and patient satisfaction, mostly from the call back function which is well received.	Market engagement not progressing as per decision at Chiefs 28th August 2024. Alternative options being investigated, however SVoTT Procurement and external support ceased. Individual Use Cases re bringing in additional data feeds on an ad hoc basis to be developed by requesting service.		
Risks	Delivery risk associated with Care Home provider's capacity to support delivery of initiatives. Continuation of programme reliant upon sustainable funding model post FY24/25.	24/25 Funding release is reliant upon achievement of milestones agreed with NHSE.	Tranche funding release dependent upon progress towards delivery milestone as agreed between BHFT and NHSE.	Delays in final practice delivery due to ongoing enabling networking installation.	Non-delivery of a single version of the truth (data) across the ICS partners		

BLMK ICS Transformation Portfolio – Highlight Reports



Programme Name	Research and Innovation: November 24	Programme SRO	Dr Sanhita Chakrabarti	Geographical Footprint
Programme Team	BLMK Integrated Care Board	Programme Lead	Emma Brown / Saddaf Shaheen	

Project	Summary, progress to date and next steps	Milestones	RAG	Risks
Access to Spectra-Optia (red cell exchange) for sickle cell	MedTech Funding mandate - NHS LTP commitment to give patients access to NICE approved, cost-efficient technologies more quickly. Hope to bring care closer to home by providing Spectra Optia in BLMK (MKUH and BHFT) <ul style="list-style-type: none"> Key stakeholders engaged Business case submitted for recurrent national funding MKUH and BHFT – await outcome 	Business cases submitted to National NHSE Specialist commissioning	Green	<ul style="list-style-type: none"> Delay in National NHSE Specialist Commissioning agreeing business case.
		Business cases agreed	Red	
GaitSmart Pilots in BLMK- Real world evaluation	Analysis of walking to produce tailored exercises – NHSE Funding for 4 BLMK pilot sites (Priory Gardens/West Street Surgery/Bedford Falls Team/Active Lifestyles CBC) <ul style="list-style-type: none"> Interim report presented to DiSC team and project presented at BCA AI event. Comms – BLMK ICB and HIE news Next steps: share interim report with stakeholders and identify any possible funding streams 	Interim report - Sep '24	Green	<ul style="list-style-type: none"> No funding after pilots. Project evaluation does not identify benefit – can't support bus. case for further investment.
		Final evaluation - Mar '25	Yellow	
QbTest to support diagnosis of ADHD: Bedford and Luton	Successful implementation of Qbtest in MK – inequality identified across ICS as no access to test in Bedford and Luton <ul style="list-style-type: none"> Yr 1 funding secured (NHSE EOE and ICS) to pilot, yr2 funding secured by CCS Key stakeholders connected and testing started in Bedford – June '24 Next steps: HIE project update meeting, and to share update with Transformation Team aligned to CYP/ADHD 	Secure funding for QbTest	Green	<ul style="list-style-type: none"> No recurrent funding at the end of the 2yrs. CCS evaluation does not show positive impact.
		Implementation Bedford/Luton June 24	Green	
		Collate provider feedback on impact - Mar '25	Yellow	
Innovation for Healthcare inequalities (InHIP) 2024/25	Heart failure patients with preserved ejection fraction (HFpEF), to optimise treatment using an SGLT2 inhibitor – design, implement and share workable local approaches in the 5 most deprived areas of MK. <ul style="list-style-type: none"> ICB CVD and HIE jointly identified opportunity for InHIP project, key stakeholders engaged and project outcomes shared Logic model workshop held by HIE Next steps: Whaddon HC and ICB to sign MOU, project delivery to start 	Project “go-live”	Yellow	<ul style="list-style-type: none"> Capacity at Whaddon HC delays project progress
		Final evaluation completed	Yellow	
Spirometry Innovation Project (Decreasing no. of people with asthma/COPD diagnoses)	Improving early, accurate diagnosis of respiratory conditions and scale up spirometry through: better use of ARTP registered staff, developing novel pathways (hub/outreach services), estimated 425 additional spirometry appts, trial of new case finding approach to identify residents in most deprived areas at risk of COPD, Collaboration with drug/alcohol/ smoking services to identify Emphysema and other respiratory conditions. <ul style="list-style-type: none"> Successfully bid for £79K regional NHSE funding Connected key stakeholders and shared project learning MOU from NHSE signed and returned by BLMK ICB Next steps: Funds to be transferred to project partners and project “go-live” Nov '24 	Project “go-live” - Nov '24	Yellow	<ul style="list-style-type: none"> Capacity at Whaddon HC possible delay to project progress
		Project update by Whaddon Healthcare to regional diagnostic network - Mar '25	Yellow	
		Final project report Q3/Q4 2025/26	Yellow	
Research Engagement Networks (REN)	NHSE and DHSC funding to establish “research ready communities”, working with regional collaborators to develop innovative approaches to inclusion and diversity in research. Projects engaging underserved communities in Luton and BLMK have highlighted the effectiveness of a community-led approach and secured over £200,000 in funding across all REN projects: <ul style="list-style-type: none"> Diabetes Research Champions (Luton) / Diabetes Research Community Events (BLMK) / CYP MH Champions (Luton & Beds) Next steps: To embed approaches to diverse engagement in research addressing health priorities across BLMK 	RAG Key		
			Green	Complete
		Yellow	On track	
		Red	Delayed	

Programme Name	Primary Care Workforce Programme (Training Hub)
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Martha Roberts
Programme Lead	Susi Clarke
Geographical Footprint	BLMK
Alignment to ICS Priorities	Workforce Transformation aligns to all 5 priorities
Maturity	Mature
Governance & Responsible Group	Primary Care Delivery Group Primary Care Commissioning & Assurance Committee
Measures	

Programme Description
New to Practice Fellowship Programme Supporting Mentors Scheme Personalised Care Workforce Development Practice Level Support – Culture & OD Transformation Programme Leadership, EDIB & Organisational Development Recruitment & Retention initiatives Improving digital access and skills for primary care staff Continued Professional Development Placement, Quality & Educator Expansion Programme Primary Care Workforce Integration supporting Integrated Neighbourhood Working (INW)

Anticipated Benefits	Key Milestones			Progress made in Previous Period	Progress to be made in Next Period	Risks
Workforce retention & growth Increased morale, reduced burnout Increased capacity and skill expansion Informed workforce and succession planning Positive and inclusive working environments Increased skill mix and talent development Diverse multi-disciplinary workforce improving access and providing high quality care Integrated neighbourhood working across professions and organisations	No	Milestone	By When	92% of ARRS funding utilised 44 GPs & GPNs supported on Fellowship Programme 6 th Personalised Care conference Nov 24 PLS transformation – showcased regionally, developing support offer Clinical Leadership development programme commenced Sept 24 Primary Care EDIB strategy in development Cultural Safety session for all Fellows – Oct 24 INW Podcast launched ABCD training for Place Teams Successful pilot of Yr3 nursing digital placement	Support to PCNs to embed GPs recruited via ARRS scheme Further Clinical Leadership share & learn sessions planned Support to Place with development of Professional Communities of practice Opportunities for further integration of Community Pharmacist PCN leads CPD programme completed Further podcast episodes completed Embed & induct Modern General Practice Clinical Lead Expansion of digital placements (Yr1 nursing & possible paramedic)	Training Hub capacity is restricted with loss of further resource from 1 st April 25 TH contract funding does not covers 25% of infrastructure costs NHS E continuing to devolve further workstreams without additional resource Practice & PCN ability to engage with programmes due to workload
	1	Maximise utilisation of ARRS funding	March 2025			
	2	Increase number of trainee placements, educators & learning environments	Ongoing			
	3	Maximise utilisation of CPD funding	March 2025			
	4	Maximise utilisation of Fellowship & Mentorship funding	March 2026			
	5	Embed workforce transformation to support Integrated Neighbourhood Working	March 2026			

Programme Name	CHC Improvement			Programme Description	
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board			CHC Invoice Validation Fast Track review back log Reduction of payment for people no longer eligible for CHC Reduction of payment for LA Dispute CHC/ICB Brokerage Service CHC Invoice Management My Care Bank data cleanse/development of Patient Level Data Set/Athena Report CHC Workforce All Age Continuing Care	
Programme SRO	Sarah Stanley				
Programme Lead	Diana Butterworth				
Geographical Footprint	BLMK				
Alignment to ICS Priorities					
Maturity					
Governance & Responsible Group					
Measures					
Anticipated Benefits	Key Milestones			Progress made in Previous Period	Risks
Governance & Assurance of financial CHC finances. Delivery to the CHC framework ensuring value for money. Effective financial forecasting. Development of data base and reporting to give real time access of budgetary pressures and anomalies. Effective recruitment and reduction to staff turnover, moving from agency staffing to bank to fulfil vacancies. Remodelling of AACC in line with NHSE expectations.	No	Milestone	By When	1) Awaiting update from Liaison Care. 2) On track to complete backlog by 31/12/24, significant improvement in position with 12 cases outstanding (August reported 60 cases) 3) To deliver in 2025/26 4) To deliver by 31/03/2026 further to contract extension with Xyla following 50% reduction of contract price from 01/01/2025. 5) Invoice group implemented, working through spreadsheet of issues. Finance/CHC workshop 14/11 to develop expectation of invoicing and review of invoice assistant role. 6) Data cleanse in progress, to be completed by 30/11/2024. Following completion further work to commence on ATHENA dashboard. 7) Remodelling pre TOM2 of non-recruited Assessors, pilot to recruit B5 Development Assessors/B4 Admin support in booking/non- clinical activity. Currently in sign off further to agreement from Exec, slow progress. Utilise x2 bank assessors, pilot pre 31/12/2024 to see if x1 agency assessor can be reduced. 8) Agreement to move to AACC, discussion around whether this would be within TOM2 or later in 2025 (from April) due to modelling of staffing requirement, change to JDs and roles.	1) Delay to invoice validation 2) Staff capacity 3) Revision of Operational Policy will be timely, this includes discussion with LAs 4) Work pressures and ability of working with 4 LAs 5) Staff capacity to develop invoice processes/governance and invoice assistants 6) Staff capacity, further work as PLDS V2 comes into effect in 2025 7) Staffing stability and slow sign off/recruitment process 8) Staffing consultation, trying to keep in timeline of TOM2.
	1	CHC Invoice Validation Liaison Care contract to review payments: Deceased patients Hospital Admissions Funding Allocation 1:1 Care Statements for CHC & Non CHC suppliers AP Review for CHC & Non CHC expenditure	TBC		
	2	Fast Track Review	31/01/25		
	3	Reduction of payment for people no longer eligible for CHC	2025/26		
	4	CHC/ICB Brokerage Service	2026		
	5	CHC Invoice Management	31/03/25		
	6	My Care Bank Data Cleanse/PLDS/ATHENA Report	31/01/25		
	7	CHC Workforce	31/03/25		
	8	AACC	25/26		

Programme Name	Personalisation Agenda
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Anne Brierley
Programme Lead	Mark Cox
Geographical Footprint	BLMK
Alignment to ICS Priorities	Live Well, Age Well
Maturity	Amber
Governance & Responsible Group	Personalisation Task and Finish Group (planned start Dec 2024) Primary Care Delivery Group
Measures	Individual metrics are applied to each project a appropriate Dashboard in development – to incl activity, capacity, demand, impact

Programme Description
<p>A suite of personalisation projects including:</p> <ul style="list-style-type: none"> • Personal Health Budgets process for people in receipt of Section 117 aftercare • Green Social Prescribing • Test Personalised Care to Support Physical Activity • Measuring impact of personalisation interventions • Personalisation Events • Implementing outcomes of Learning Disability Personalisation pilot • Personalisation Dashboard

Anticipated Benefits	Key Milestones			Progress made in Previous Period	Progress to be made in Next Period	Risks
<p>Improved health and well-being of citizens</p> <p>Empower citizens to manage their own health and well-being</p> <p>Reduce demand for NHS and care services</p> <p>System efficiencies including reduced duplication</p>	No	Milestone	By When	<p>Liaison with AGEM means that the Personalisation Dashboard will be wrapped into the programme of work including impact measurement (Rapid Evaluation Tool) and case finding</p> <p>Personalisation Event delivered</p> <p>Following liaison with LA colleagues, funding for green social prescribing has been identified.</p> <p>Programme Manager for S117 PHB's in place, (hosted by ELFT)</p> <p>Go live of Personalised Care to Support Physical Activity project</p>	<p>Set up Personalisation T&F to be administered/managed via VERTO</p> <p>Monitoring arrangements for Green Soc Px'ing to be agreed w LA colleagues</p> <p>PHB S117 Project Manager to present progress at S117 Board Review and evaluation of Engagement Event</p> <p>Final recommendations of LD Personalisation to be circulated</p> <p>Agree arrangements in light of Head of Personalisation leaving</p>	<p>The Head of Personalisation lead is leaving. Risks to be mitigated through analysis of and reallocation of tasks.</p>
	1	Final recommendations of LD Personalisation to be circulated	Dec 2024			
	2	First clients to join Personalised Care to Support Physical Activity Pilot	Nov/Dec 2024			
	3	Personalisation Engagement event	13 Nov 2024			
	4	First Personalisation T&F Group	Dec 2024			
	5	PHB S117 presentation to S117 Board	Dec 2024			

Programme Name	Children and Young People
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Sarah Stanley/Anne Brierley
Programme Lead	Sarah Breton & Beccy White
Geographical Footprint	BLMK
Alignment to ICS Priorities	BLMK Health Services Strategy
Maturity	
Governance & Responsible Group	BLMK Children’s Transformation Board
Measures	

Programme Description
Develop sustainable Child and Adolescent Mental Health Services
Local Transformation Plan is key to delivering sustainable mental health and emotional wellbeing services, this document is refreshed annually BLMK CYP Transformation Plan The progress of this plan is monitored through the CYP Mental Health Steering Group

Anticipated Benefits
Child and Adolescent Mental Health Services- improve access to mental health services across BLMK, continued delivery of high quality mental health services for children and young people

Key Milestones		
No	Milestone	By When
1	Continued implementation of the Local Transformation Plan	April 25
2	Implementation of the mental health access recovery plan	April 25
33	Commencement of project with NHSE and trusts in relation to efficiency and productivity	April 25
4		
5		

Progress made in Previous Period
Completed clinical review to test viability of all age eating disorder service Introduction of 2 new school Mental Health Support Teams BLMK wide access target workshop Formation of an access recovery task and finish group and access target recovery plan Formation of efficiency and productivity project group with input from NSHE

Progress to be made in Next Period
Commission early intervention services in Milton Keynes in partnership with MKCC Complete review of eating disorder services in Milton Keynes Progress efficiency and productivity project- webinars and site visits are scheduled. Planning to complete interim report by early January and review core CAMHS model by April 24 Continue to implement Access Target recovery plan

Risks
Loss of medium term funding has resulted in a reduction in some key services May be difficult to generate further savings whilst retaining clinically safe services Access target may be unobtainable if funding is further reduced.

Programme Name	Children and Young People
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Sarah Stanley/Anne Brierley
Programme Lead	Sarah Breton & Beccy White
Geographical Footprint	BLMK
Alignment to ICS Priorities	BLMK Health Services Strategy
Maturity	
Governance & Responsible Group	BLMK Children's Transformation Board
Measures	

Programme Description
<p>Improving outcomes for children and young people with long-term conditions:</p> <ul style="list-style-type: none"> • Asthma • Epilepsy • Diabetes <p>Review and improvement of CYP LTC pathways to improve outcomes for CYP.</p>

Anticipated Benefits	Key Milestones	Progress made in Previous Period	Progress to be made in Next Period	Risks																		
<ul style="list-style-type: none"> • Reduction in harm to CYP (injury or death from asthma exacerbation, diabetic ketoacidosis, etc) • Improved quality of life for CYP (e.g. being able to take part in everyday childhood activities despite LTC) • Improved potential for educational attainment (through reduced education or training time lost due to ill-health) 	<table border="1"> <thead> <tr> <th>No</th> <th>Milestone</th> <th>By When</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>First version of CYP Core20PLUS5 dashboard available</td> <td>End Dec 2024</td> </tr> <tr> <td>2</td> <td>GIRFT BLMK CYP Diabetes review</td> <td>3rd March 2025</td> </tr> <tr> <td>3</td> <td></td> <td></td> </tr> <tr> <td>4</td> <td></td> <td></td> </tr> <tr> <td>5</td> <td></td> <td></td> </tr> </tbody> </table>	No	Milestone	By When	1	First version of CYP Core20PLUS5 dashboard available	End Dec 2024	2	GIRFT BLMK CYP Diabetes review	3 rd March 2025	3			4			5			<p>Asthma:</p> <ul style="list-style-type: none"> • 2nd launch of Luton Asthma Friendly Schools pilot • Awareness raising at PC PLT event • Spirometry activity data review • Links made to LA housing initiatives <p>Epilepsy:</p> <ul style="list-style-type: none"> • Agreement for CYP Epilepsy Voice project <p>Diabetes:</p> <ul style="list-style-type: none"> • Hybrid Closed Loop roll-out planning (by ICB Medicines Management team) 	<p>Asthma:</p> <ul style="list-style-type: none"> • AFS: first analysis of L&D PAU patient school data <p>Epilepsy:</p> <ul style="list-style-type: none"> • Development of business case for continuation of Community Epilepsy Specialist Nurse pilot (led by CCS) <p>Diabetes:</p> <ul style="list-style-type: none"> • Planning for GIRFT CYP Diabetes BLMK review (3rd March 2025) <p>Inequalities:</p> <ul style="list-style-type: none"> • First version of CYP Core20PLUS5 dashboard available (includes asthma, epilepsy, and diabetes) 	<ul style="list-style-type: none"> • Gap in delivery of post-discharge asthma reviews in Bedfordshire • MK post-discharge asthma review service eroded by removal of funding • Currently no agreement for continuation of PKB, or ESN pilot
	No	Milestone	By When																			
	1	First version of CYP Core20PLUS5 dashboard available	End Dec 2024																			
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	3																					
4																						
5																						

Programme Name	LMNS
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Sarah Stanley
Programme Lead	Jayne Piggott
Geographical Footprint	BLMK
Alignment to ICS Priorities	Start Well, Live Well, Reducing Inequalities
Maturity	Defined
Governance & Responsible Group	BLMK Maternity & Neonatal Transformation Board
Measures	To reduce number of women smoking at time of birth

Programme Description
Stop Smoking
Reducing number of women who are smokers from time of pregnancy to delivery

Anticipated Benefits
Supporting women to reduce smoking during pregnancy
Reduction in risk factors to baby at time of birth

Key Milestones		
No	Milestone	By When
1	Funding agreed by NHSE	April-2024
2	Agree for project to be embedded as BAU	July-2024
3	Monthly review of smoking data as part of quality assurance meetings	BAU

Progress made in Previous Period
Project funding agreed to continue through Prevention SDF funding from 2024/25 financial year
Agreement to continue business as usual

Progress to be made in Next Period
Continue to collate monthly data and review at regular meetings as required

Risks
None currently identified

Programme Name	LMNS
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Sarah Stanley
Programme Lead	Komal Gorania
Geographical Footprint	BLMK
Alignment to ICS Priorities	Start Well, Reducing Inequalities
Maturity	Initial Phase
Governance & Responsible Group	BLMK Maternity & Neonatal Transformation Board
Measures	To identify number of women with health factors which may contribute to high risk of infant mortality To identify characteristics which may give a high outcome of infant mortality

Programme Description
<p>Infant Mortality</p> <p>To analyse the key reasons for infant mortality across BLMK and propose an action plan to reduce infant mortality based on outcomes</p>

Anticipated Benefits
<p>Supporting women with high risk factors leading to potential infant mortality</p> <p>Supporting babies to be born with a lower risk of infant mortality</p>

Key Milestones		
No	Milestone	By When
1	Set up infant mortality steering group (led by public health)	Sept-24
2	Agree methodology for data collection with key partners	Oct-24
3	Set up of questionnaire to gain insight into risk factors from health professionals	Nov-24
4	Review of data collection	Mar-25
5	Establish factors which may lead to high risk of infant mortality and produce action plan to support improvement	May-25

Progress made in Previous Period
<p>Weekly steering group set up for project</p> <p>Monthly review meetings with wider professionals to review data analysis and components of review</p> <p>Set up of questionnaire for more detail on clinical pathways</p> <p>Agreed methodology at LMNS Board</p>

Progress to be made in Next Period
<p>Collate feedback from questionnaires</p> <p>Share data analysis with LMNS Board</p>

Risks
<p>There is a risk that the data may not be accurate across all sources, due to the way data collection is managed by each Trust</p>

Programme Name	LMNS
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Sarah Stanley
Programme Lead	Jayne Piggott
Geographical Footprint	BLMK
Alignment to ICS Priorities	Start Well, Live Well, Reducing Inequalities
Maturity	Defined
Governance & Responsible Group	BLMK Maternity & Neonatal Transformation Board
Measures	To reduce number of women smoking at time of birth

Programme Description
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Progress made in Previous Period
Project funding agreed to continue through Prevention SDF funding from 2024/25 financial year
Agreement to continue business as usual

Progress to be made in Next Period
Continue to collate monthly data and review at regular meetings as required

Risks
None currently identified

Programme Name	LMNS
Programme Team	Bedfordshire, Luton and Milton Keynes Integrated Care Board
Programme SRO	Felitta Burney- Nicol
Programme Lead	Komal Gorania
Geographical Footprint	BLMK
Alignment to ICS Priorities	Start Well, Reducing Inequalities
Maturity	Defined
Governance & Responsible Group	BLMK Maternity & Neonatal Transformation Board
Measures	Number of women identified to have conceived through close marriage Number of referrals to close marriage midwife Number of referrals to genetic risk testing

Programme Description
Genetic Risk
To support families who may have conceived through close marriage who could therefore pose genetic risk offering genetic risk testing and the right information to make informed decisions

Anticipated Benefits Increase in awareness of genetic risk conditions and associated risks Increase in numbers of healthcare professionals trained to identify genetic risks	Key Milestones			Progress made in Previous Period Review of current data dashboard with Head and Direct of Midwifery to gain understanding of numbers and potential to increase Recruitment of Neonatal role to support repurpose of funding (initially agreed for literacy materials) Review of what is working well and what required support	Progress to be made in Next Period Book in further training sessions online Review of available literacy materials to support implementation Next steps from NHSE evaluation to be shared, and agree a plan for 2024/25 financial year	Risks There is a risk that healthcare professionals are not receiving this training due to conflicting pressures and time which will in turn give a low number of referrals to the service
	No	Milestone	By When			
	1	Funding agreement for a further financial year (2 year project)	April-2024			
	2	Agreement of funding for neonatal role	May-2024			
	3	Recruitment to Neonatal role for genetic risk	July-2024			
	4	Review of current dashboard and improvements to increase numbers for training with NHSE	Dec-2024			
5	Evaluation Phase	Apr-2025				