# HEALTH & CARE PARTNERSHIP

**FORMERLY THE HEALTH AND WELLBEING BOARD**

**When:** **Wednesday 20 September 2023 at 14:00**

**Where:** **Room 1.02, Civic, 1 Saxon Gate East, Milton Keynes, MK9 3EK This meeting will not be live streamed, but a recording of the meeting will be available on YouTube as soon as practical after the meeting.**

**Enquiries**

Please contact Andrew Clayton on 01908 252046 or andrew.clayton@milton-keynes.gov.uk

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We use our best efforts to either live stream meetings on YouTube, or upload recordings afterwards. From time to time there are technical problems which could mean we are unable to stream the meeting. When this happens, our meetings will continue, and we will do our best to upload a recording of the meeting after it takes place. Meeting minutes form the formal record and are published after every meeting.

For those registering or entitled to speak, facilities will be in place to do so in person or via video / audio conferencing, but this is not guaranteed. From time to time there are technical problems which mean we are unable to enable remote participation. When this happens our meetings will continue, although we will try to provide alternatives options, for example through a telephone call as opposed to a video call.

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**Agenda**

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## Agenda

**1. Welcome, Introductions and Apologies**

**2(a) Minutes (Pages 5 - 10)**

To approve, and the Chair to sign as a correct record, the Minutes of the meeting of the Partnership held on Tuesday 13 June 2023.

**2(b) Actions Arising (Pages 11 - 12)**

To consider the Health and Care Partnership Tracker 2022/23 and information regarding actions agreed at previous meetings.

**3. Disclosures of Interest**

Councillors to declare any disclosable pecuniary interests, other registerable interests, or non-registerable interests (including other pecuniary interests) they may have in the business to be transacted, and officers to declare any interests they may have in any contract to be considered.

**4. Integrated Care Board (ICB) Report (Pages 13 - 64)**

To consider:

BLMK ICB Report
Annex A: Target Operating Model consultation and organizational structure
Presentation: BLMK ICB Final Structure

**5. Bletchley Pathfinder (neighbourhood working) (Pages 65 - 76)**

To consider the Bletchley Pathfinder proposal

**6. Health Inequalities Funding (Pages 77 - 80)**

To consider, recommendations for the use of health inequalities funding

**7. A Spotlight on the Progress of the MK Deal (Pages 81 - 92)**

To consider, progress on active MK Deal priorities:

a. Improving System Flow
b. Reducing Obesity
c. Children and Young People's Mental Health

**8. The Better Care Fund (Pages 93 - 108)**

To consider, the Milton Keynes Better Care Fund Plan 2023 - 2025

**9. Date of the Next Meeting**

To note, the next meeting of the Health and Care Partnership is scheduled to take place on Wednesday 8 November at 2.00 p.m.

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Minutes of the meeting of the Health & Care Partnership held on Tuesday 13 June 2023 at 14:00

**Present**: Councillors Marland (Chair), R Bradburn, Darlington and D Hopkins, (Vice-Chair), M Bracey (Chief Executive, Milton Keynes City Council), V Collins (Director, Adult Services, Milton Keynes City Council), M Heath (Director of Children's Services, Milton Keynes City Council), V Head (Director of Public Health, Milton Keynes Council), J Hannon (Diggory Divisional Director of Operations, CNWL NHS Foundation Trust), J Blakesley (Deputy Chief Executive, Milton Keynes University Hospital NHS Foundation Trust), Dr T Nguyen (Representative of Primary Care Networks), J Thelwell (Bucks Fire & Rescue Service, Chief Executive), M Begley (South Central Ambulance Service, Head of Operations), M Taffetani (Chief Executive, Healthwatch Milton Keynes), Supt E Baillie (LPA Commander, Thames Valley Police) and P Wilkinson (VCSE Representative)

**Officers:** M Carr (Deputy Director Public Health, Milton Keynes City Council), and A Clayton (Overview and Scrutiny Officer, Milton Keynes City Council)

**Observers**: Councillor Long, R Green (Head of MK Improvement Action Team, BLMK ICB) and M Wogan (Chief of System Assurance and Corporate Services, BLMK ICB)

**Apologies**: Dr R Makarem (Chair of BLMK ICB), F Cox (Chief Executive, BLMK ICB), Dr N Alam (Representative of Primary Care Networks) (Dr T Nguyen deputising), J Held (Independent Scrutineer, MK Together) and J Harrison (Chief Executive, Milton Keynes University Hospital NHS Foundation Trust) (J Blakesley deputising)

**HCP1 Welcome, Introductions and Apologies**

The Chair welcomed members of the Partnership to the first meeting of the new Council Year. He explained for the benefit of new members that Milton Keynes Local Authority area was situated wholly within the geographical area of the Bedfordshire, Luton and Milton Keynes Integrated Care System (BLMK ICS). The role of the Partnership was to bring together key players involved in the planning and delivery health and care to residents of the city of Milton Keynes, to work collaboratively and collectively to add value to the services provided.

**HCP2 Minutes**

RESOLVED -

That the Minutes of the meeting of the Health and Care Partnership held on 22 February 2023 be approved and signed by the Chair as a correct record.

**HCP3 Decision Tracker**

The actions arising from the previous meeting held on 22 February 2023 were noted. All other actions were completed or in the process of being completed with a progress reported noted accordingly on the Decision Tracker.

**HCP4 Disclosures of Interest**

None.

**HCP5 Integrated Care Partnership (ICP) and Board (ICB) update**

The Partnership received a report from the Chief of System Assurance and Corporate Services, BLMK ICB. Key areas of the report were highlighted:

- The Report included the draft Joint Forward Plan (JFP) of the ICB at Annex A, which was required to be submitted to NHS England by 30 June 2023.
- The JFP was required to be a five year plan, but the ICB had elected to take a longer term strategic view to 2040. The intention was to create a "working" document that would be frequently revisited and revised in the light of changing priorities and new challenges. The JFP presented to members was the initial draft and a link to the latest version would be provided to members subsequent to the meeting for their further consideration and comment.
- Future health and care planning for the city was based on local needs using a population health approach. The ICB worked closely with local authority colleagues to analyse the data available and forecast future need, and had formed a "Population Health Intelligence Unit" with this specific remit.
- The system population was increasing at a fast rate, particularly in Milton Keynes, and it was important that this growth was properly forecast and understood in order to ensure that the supply of health services was able to meet resident demand. The work carried out in partnership with MKCC and others over the past year, particularly through the MK Deal, had provided valuable knowledge and experience and would greatly aid the development of the ICS into the future.
- Resident participation had been key in developing the JFP and this would continue. Over the summer and into the Autumn the ICB would be undertaking a "Big Conversation" with residents across BLMK, and would be a presence at many venues to discuss with residents their priorities and concerns, to ensure that this high level of participation continues.

- The findings of the "Big Conversation" would be combined with the further input of partners to produce a more detailed plan next Spring, with a target of March 2024. This would be presented to partners for further comment at that time.
- Further to the report to the last meeting, the Musculoskeletal (MSK) procurement had been extended to allow for further resident and partner engagement. The running costs exercise had also progressed, with staff consultation currently underway.

Members of the Partnership welcomed the JFP. However, concerns were expressed about the veracity of the population growth figures across the city. Population statistics could vary depending on their derivation and the metrics employed, e.g. whether based on voter numbers, housebuilding targets and so on, and so the creation of the Population Health Intelligence Unit would be vital to ensure accurate forecasting. It was agreed that partners would liaise outside of the meeting to ensure that the figures provided in the final submission were as accurate as possible.

**RESOLVED:**

**1. Having reviewed the Draft Joint Forward Plan the Partnership agreed that, subject to reflecting local projections on the level of population and housing growth, the Plan reflected MK's priorities**

**2. Noted, the content of the update report and its annexes**

**3. Noted, that the BLMK NHS Operational plan 2023/24 was submitted to NHS England at the end of March 2023 and finalised in May 2023**

**HCP6 MK Deal Update**

The Partnership received a report from the Chief Executive of Milton Keynes City Council. Key areas of the report were highlighted:

- Following consideration and discussion with partners the Joint Leadership Team recommended that Bletchley would be a suitable and sensible choice for the Neighbourhood Working pilot project. Bletchley possessed key criteria identified in the Fuller Report, for example the area was a clearly identified local area with substantial community involvements and an identified willingness to engage. There were identifiable and measurable health inequalities across the Bletchley community.
- The team were keen to take the pilot forward, and proposed that between now and September they devote time to discussing key issues with residents and partners in the community. One of the particular challenges was that partners, for example those in primary care, schools and in the VCSE sector, may need to vary their current working methods to fully engage with the integrated care methodology. Whilst the new systems promised significant opportunities, and parties had broadly welcomed the proposals thus far, change may be harder to achieve in practice. It was important that this was properly understood and agreed prior to the commencement of the pilot.
- In September, following the research phase, at the next meeting of the Health and Care Partnership it was proposed to bring the matter for decision to proceed with an 18 month pilot.

- This research phase would include a workforce audit in the area, identifying and mapping key health and care personnel in Bletchley. This would include primary care, community and mental health teams, local authorities (MKCC and town councils), Police, VCSE and schools amongst others. Case Management approaches and operating models would need to be developed to support specific groups of people. Consideration would need to be given to how the neighbourhood based approach would inter-relate to other relevant bodies, such as MK University Hospital. Finally, it was important that appropriate metrics of success were decided upon and agreed.
- Key operational developments would include growing the use of key assets, such as Bletchley Leisure Centre to support inactive residents, piloting the health and wellbeing coach role (taking a holistic view of an individual's health, to include smoking and weight management for example), developing the role of pharmacies and working with Primary Care Networks to expand initiatives that reduced health inequality.
- Consideration would also need to be given to high level co-ordination of this work, to include ongoing assessment of the pilot and the collation of evidence, to be used as neighbourhood working is rolled out more widely across the city.
- It was also important to note that the neighbourhood working pilot would need to co-ordinate with, and to complement, work that the ICB was carrying out city-wide to improve primary care services. This included, for example, improvements to GP practice websites and telephony systems, the increased use of remote consultations and better clinical signposting to the most appropriate health and care.

Members of the Partnership considered and discussed the proposal. The success of the project was dependent on a high level of integration of the many services that contributed to the health and wellbeing of the residents of Bletchley. It was recognised that this may involve change to existing working practices in some areas. The ICB emphasised their support for the pilot and recognised that changes would need to be made.

The Bletchley Town Councils also provided significant health and care, and community, support to their local residents. These were many and varied and included, for example, debt advice and support to families and children. It was important that the pilot team understood this and involved those town councils in the project, including using their expertise and local knowledge in the delivery of initiatives.

It was also the case that some of the health and care assets in Bletchley were considerably out of date, for example dentists and GPs located in older, residential properties. The Town Deal, for the regeneration of Bletchley, and the context of other initiatives such as the development of the East-West Railway, provided an opportunity and focus for capital investment in some of these assets to bring them up to date and to position the town better for the future.

Members heard that the pilot research team consisted of around 15 people covering a variety of roles. The Head of MK Improvement Action Team, BLMK ICB, (Rebecca Green) was supporting the development and readiness of the team. Members that wanted to discuss early involvement should contact Rebecca in the first instance. This was a very new project, with integrated care as a concept itself in relative infancy, so it would be the case that the team would be developing systems of working as it progressed.

It was recognised that the early priority was to engage with the workforce and assets that would provide the base to drive the pilot project, to ensure that they were onboard with its aims and methods of working. Once the infrastructure began to come together the next priority would be to engage with and gain the backing of the residents of Bletchley. The community was diverse, and it was important that all sections were listened to and their priorities understood.

The intelligent use of data, and the effective deployment of new technologies, was key to the successful integration of health and care in the city. Initiatives such as the "Smart City" and the "Dementia Friendly City" would rely on the use of, for example, remote monitoring of patients, remote consultation and the use of data to accurately understand and forecast the health and care needs of a city of more than 300,000 residents. This was an exciting and important development, and it was hoped that the pilot study would provide the insight and learning to enable a city-wide rollout in due course.

**RESOLVED:**

**1. Noted, the update report on the first six months of the MK Deal**

**2. Agreed, the recommendation of the Joint Leadership Team to select Bletchley as the area to pilot integrated neighbourhood working**

**3. Agreed, that the Joint Leadership Team undertake background work to prepare for a potential start of the Bletchley pilot in September 2023**

**HCP7 Date of the Next Meeting**

It was noted that the next meeting of the Health and Care Partnership would be held on Wednesday 20 September 2023 at 2.00 pm.

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# DECISION TRACKER 2022/23 - HEALTH AND CARE PARTNERSHIP

## OUTSTANDING ACTION POINTS

**COLOUR CODE**:

| | |
|---|---|
| (R) RED: | NO OR LIMITED PROGRESS |
| (A) AMBER: | PROGRESS PENDING FURTHER ACTION |
| (G) GREEN: | SIGNIFICANT PROGRESS MADE |
| (B) BLACK: | NO FURTHER ACTION |

Referrals to Council

Referrals to Cabinet

**Presented to Health and Care Partnership**: **20/09/2023**



Item 2(b)

## HEALTH AND CARE PARTNERSHIP

| Date of Meeting | Minute | Subject and Decision | Lead Officer | Action Since Last Review | Current Indicator |
|---|---|---|---|---|---|
| **13/06/2023** | **HCP05** | **THE MK DEAL**<br><br>**2. Agreed, the recommendation of the Joint Leadership Team to select Bletchley as the area to pilot integrated neighbourhood working**<br><br>**3. Agreed, that the Joint Leadership Team undertake background work to prepare for a potential start of the Bletchley pilot in September 2023** | Michael Bracey<br>Chief Executive | | **GREEN** |

MK Together | Health and Care Partnership

# Bedfordshire, Luton and Milton Keynes Integrated Care Board report

**Author:** Felicity Cox, Chief Executive, BLMK Integrated Care Board

**Date:** **20 September 2023**

**Purpose of Report:**

This report summarises key items of business from the BLMK Integrated Care Board and BLMK Health and Care Partnership (a Joint Committee between the local authorities and the ICB) that are relevant to Milton Keynes City Council.

## 1. Recommendation

The Health and Care Partnership is asked to **note** the report and to **agree** next steps in relation to the report and actions from the health and employment seminar which can be reported back to the ICB and ICP at their next meetings (ICB 29 September, ICP 31 October).

## 2. Introduction

2.1 The following summarises items of interest that have been considered by the BLMK Health and Care Partnership and the Board of the ICB since the last meeting of the MK Health and Care Partnership.

## 3. Board of the BLMK ICB Decisions

### 3.1. Specialised commissioning – ICB Board 28 July 2023

An extra-ordinary meeting of the ICB Private Board took place on 28 July to consider the delegation and hosting of 59 specialised commissioning services which will be delegated to ICBs from 1 April 2024. The specialised commissioning service are the more high-volume specialised services that affect a good proportion of the population (e.g. chemotherapy/radiotherapy, dialysis). NHSE is retaining the low volume and high complexity services and it is not known if it is planned to delegate the responsibility for these services in future.

BLMK does not have a tertiary acute provider in its area (although both MKUHFT and BHFT do provide some services under the specialised banner) and this affects access to the services and outcomes for our residents. The East of England is also the NHSE region with the lowest spend on specialised services, which may suggest that our population are not benefitting as much as they could be from these services. The delegation of services provides a real opportunity to bring services closer to home where clinically appropriate and increases the ability to influence decisions on service provision and financial investment.

The Board supported BLMK ICB hosting specialised commissioning in the East of England in a joint venture with other ICBs in the Region and NHSE, subject to certain conditions and assurances.

3.2 The Board of the ICB met on 30 June, the communications from the meeting are here. Key areas of note are as follows:

3.3 **Denny Review**

The Denny Review into Health Inequalities across Bedfordshire, Luton and Milton Keynes will be published in September 2023 and will be available on Bedfordshire Luton and Milton Keynes ICB website here. It is a landmark study that will guide work over the next five years and beyond, with its findings embedded in everything the Integrated Care Board, and wider Integrated Care System, does.

For the last three years, Reverend Lloyd Denny from Luton has been working with health and care partners and residents in all four places to undertake a root and branch review of health inequalities. The review sought to understand:

- Which communities in our area experience the greatest health inequalities;
- What the barriers are in this and other communities to accessing health and care services;
- What the lived experiences of health inequality are; and
- How we can remove barriers, improve experience and support good health.

Partners from local authorities, public health, Healthwatch, the VCSE, University of Bedfordshire and the NHS came together to agree the foundations for the study, anchor it into existing work programmes and, based on Revd Denny's fundings, support the development of the final report and its recommendations.

A Literature Review from the University of Sheffield analysed all published material about health inequalities in BLMK, and identified the populations most affected by health inequalities. These included Gypsy, Roma and Traveller communities, people who live in deprived neighbourhoods, people with learning and physical disabilities, people who experience homelessness, migrants, and LGBTQ people.

Based on these insights, population health data was used to map where the health inequalities were most prevalent in our four places, and our four Healthwatch organisations and VCSE partners led engagement with different communities to understand in-depth the lived experiences of these seldom-heard groups. In MK, this work was undertaken by Healthwatch MK, Community Action: MK and the YMCA the reports can be found here. (a joint summary report of the MK findings starts on page 204).

On publication of the Healthwatch and VCSE reports, a Quality Improvement approach was developed to analyse feedback and develop recommendations.

From the interviews and surveys undertaken with hundreds of residents, four main themes emerged:

- the accessibility of services;
- communication and language;
- culture/faith and the cultural competency of health and care organisations; and,
- unconscious bias, homophobia and racism.

Analysis established that the absence of a person-centred approach to health and care risks widening and entrenching health inequalities as people feel that services are “not for them”.

Reverend Lloyd Denny will publish his independent report in mid-September, setting out the recommendations based on the insights gathered. The ICB will then provide a formal response to outline how the recommendations will be taken forward.

The ICB looks forward to the publication of the report and to working with all Places and Partners, including Revd Denny, to progress the recommendations, and to making resources available to do this successfully.

Our ambition is clear: the findings of the Denny Review must be well understood across BLMK, and recommendations taken forward, with partners, to support people from all backgrounds to live longer lives in good health.

3.4 **Health Inequalities funding** – The Board of the ICB agreed a paper which included approval of the allocation of £500K to each of the four places in BLMK for the current year (2023/24) to ensure that funding is available to meet the greatest needs of the population locally, noting that this did not set a precedent for the delegation of other funds.

3.5 **BLMK Joint Forward Plan** – The Board formally approved the Joint Forward Plan for 2023-2040 following extensive engagement with partners. The report has been published onto the BLMK Health and Care Partnership website (here).

3.6 **Memorandum of Understanding with Healthwatch** – A Memorandum of Understanding between the ICB and Healthwatch was approved, recognising the important role that Healthwatch has as a strategic partner to the ICB. It also reflects the important role Healthwatch has in representing the resident voice, as well as their statutory function.

3.7 **Financial and operational reports** – members received formal updates from quality and performance, finance and governance, and approved Section 75 agreements with Luton Council and MK City Council.

4. **BLMK Health and Care Partnership and BLMK ICB Health and Employment Seminar - 21 July 2023**

The first joint seminar of the BLMK Integrated Care Board and Integrated Care Partnership took place on 21 July 2023 and around 80 people from local authorities, the NHS and other public services, including the Prison Service and the Department for Work and Pensions, were joined by representatives of the

voluntary, community and social enterprise sectors for a day of action planning on tackling poor health and employment outcomes. Councillor David Hopkins, Milton Keynes City Council, Ross Graves Chief Strategy and Digital Officer, CNWL, Vicky Head, Director of Public Health, Danielle Petch, Director of Workforce and Sue Milner from MKUH and Maria Wogan, Milton Keynes Place Link Director, BLMK ICB were amongst the MK representatives who attended the seminar.

Attendees also included residents with relevant lived experience, several of whom shared powerful stories of the positive health impact of finding employment.

A 2022 study by the Health Foundation found that unemployed people were more than five times as likely as those in employment to be in poor health, whilst NHS figures from 2021 indicate that people with a long-term condition have an employment rate of 64.5%, compared with 75% of the population as a whole, a gap of 10.5%. The employment gap is even wider in Luton (16.1%) and Central Bedfordshire (14.4%).

The event's keynote speaker, Professor Donna Hall CBE, is chair of the community-focused think tank New Local and an advisor on Integrated Care Boards to NHS England. She was formerly chief executive of Wigan Council.

Detailed planning sessions were held throughout the afternoon, with individual group discussions for Bedford Borough, Central Bedfordshire, Luton and Milton Keynes, to identify key priorities and agree actions to be taken forward by those working at Place, with support from the ICB. A summary of the discussion and action planning is here , with Milton Keynes Place group actions detailed on slides 33-39.

The next joint seminar is on 24 November 2023 and will focus on Children and Young People and the ICS Strategic Priority 'Start Well'.

5. **Integrated Care Partnership - governance**

The Council has reviewed its representatives on the BLMK Integrated Care Partnership (ICP) following the election and Milton Keynes City Council members are Cllrs Peter Marland, David Hopkins and Robin Bradburn. The Councils in BLMK can nominate the Chair of the ICP and it is proposed that Cllr Martin Towler, Bedford Borough Council and Cllr Khtija Malik, Luton Council, Co-Chair the ICP. This arrangement will be proposed at the next meeting of the ICP which is planned to take place on 31 October 2023.

6. **Update on Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative**

Since late last year, ELFT, CNWL and BLMK ICB have been working with system partners to progress the scoping and design of a MHLDA Collaborative for BLMK, with a particular focus on engaging with service users, carers, residents and health and care partners, whilst continuing to focus on the shared delivery of system priorities.

The goal of the Collaborative will be to support and enable the delivery of local Place priorities for MHLDA – including in Milton Keynes the priorities of the

Deal – whilst having a strong, shared vehicle to tackle system level challenges that require a joined-up response across multiple Places.

The team will be bringing an update to the September Integrated Care Board that summarises work to date and the emerging design of the Collaborative and proposes that the programme move into a six-month mobilisation phase including more formal oversight of the programme via a mobilisation group.

Key deliverables over this period of time will include the development of a MHLDA partnership agreement and strategic plan; rolling out of a new approach to the agreement of contracts and financial planning; and the development of collaborative functions and their supporting processes and resources.

Alongside this development work, the programme continues to oversee delivery against operational priorities including improving the all-age crisis pathway across BLMK, and delivering better outcomes for patients requiring complex mental health placements.

**7. ICB – new Target Operating Model (TOM)**

The ICB has completed its formal consultation with staff on its restructuring and has published its revised organisational structure (attached for information at Annex A). The ICB is grateful to the feedback received from MK partners as part of this process. The ICB's structure, once implemented will include a place team to support the implementation of the MK Deal priorities.

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List of Annexes
Annex A – TOM consultation feedback and organisational structure

List of Background Papers

None

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# ANNEX A - ICB Consultation Response – August 2023

On Thursday 24 August 2023, the ICB published its response to the staff consultation process aimed at supporting the ICB's transition to its new Target Operating Model and meeting a reduced running cost allowance. This paper shares key sections of the consultation document for MK Partners and is to be read in conjunction with the final structures which were published alongside.

This paper covers three sections – i) the feedback we received, ii) the ICB's response, and iii) a summary of the ICB's functions in our new Target Operating Model.

## Feedback Received

### Summary of Staff Feedback

The organisation received approximately 1500 pieces of feedback. These responses have been collated and reviewed and the key themes are outlined below.

### General Feedback

- Recognition of the need and requirement for change because of the mandate from NHSE for a 30% reduction in running costs
- Comments received regarding the potential for savings from the proposals within the consultation
- Feedback was provided and queries were raised around key stages of the management of change process and support for redeployment into Suitable Alternative Employment (SAE)
- Clarification requested that all roles would be open to flexible working including part-time hours
- Comments demonstrated that there would be an appetite for a Voluntary Redundancy Scheme should the ICB receive permission from NHSE to offer such a scheme
- Feedback received in regard to the ICB recruitment freeze and its criteria
- Feedback received regarding the timing of the consultation
- Positive feedback received about the tone and the improved timeline of this consultation
- Positive feedback received in respect to the Shared Transformation / Place engagement events

### Feedback on Organisational Change

- Comments were made in regard to the proportion of senior and junior roles within the structure and the impact this may have in respect to cost savings and career pathways for staff, especially the increased number of Band 9 roles
- Comments were made regarding the outlined structures and the potential impact on staff
- Concerns were raised about the reduction in structures and reduced resilience the proposed changes would create
- Comments voiced about the limited number of administrative roles and the impact for senior staff and the organisation
- Comments voiced concerning the requirement and remit for specific roles and the remit of directorates within the structure
- Alternative suggestions were provided for individual structures and roles to support and inform the achievement of financial efficiencies as well as the alignment of working practices needed for the ICB
- Comments were made with regard to career progression opportunities
- Concerns were voiced with regards to the level of resource and capacity within certain structures to complete the ICB's workload aligned to priorities and patient outcomes
- Comments received about the size of specific structures

- Feedback and queries about specific structures and how they might operate to meet requirements
- Clarification requested about how the various elements of the Target Operating Model would interface and work together
- Identification of some current functions perceived to be missing in the proposed structure
- Feedback was provided and queries and concerns raised around current and proposed new job descriptions including the consistency of roles and bandings
- Feedback was provided around the consistency and location within the structure of transformation roles
- Comments were received in regard to areas designated out of scope for this consultation
- Comments were voiced that the structure may lead to loss of relationships with partners, organisational memory and skills
- Comments were voiced concerning the level of consideration given to roles / functions interfacing with patients
- Comments were received in regard to ensuring the structures reflected the requirements of Primary Care and the Fuller report
- Comments were voiced about the appropriateness of the proposed location in the structure of the Shared Transformation Resource
- Feedback requesting confirmation about how the Shared Transformation Resource and Place teams will operate
- Comments were received about the suggestion for a Primary Care focus for some of the Place roles
- Comments were voiced about the size and capacity of Shared Transformation Resource / Place and whether it would contain the appropriate skills and experience; and
- Comments were shared regarding sustainable funding for a large number of fixed term contracts

**Summary of Trade Union Feedback**

The following feedback was raised as part of the consultation process by the trade unions.

- Consideration of a Voluntary Redundancy Scheme as part of a suite of mitigations against compulsory redundancies for staff
- Confirmation of measures relating to staff recently TUPEd into the ICB
- Clarification regarding Suitable Alternative Employment, employment rights and rights to redundancy
- Queries were raised about the use of interims and agency workers across functions within the ICB
- Trade Unions asked for support in ensuring that staff had access to TU representatives
- Confirmation as to the justifications for the continued recruitment to roles within the ICB
- Clarification regarding the difference in bandings between roles
- Confirmation of 1:1 consultation meetings and support to line managers
- Clarification and detail regarding the impact on staff because of the proposed structure changes
- Confirmation that consideration would be given to office accessibility, free parking and robust refreshment facilities when selecting alternative office locations

- Clarification regarding on-call arrangements and payments
- Detail in respect to the Slotting and Pooling process
- Detail in relation to the proposed Assessment process
- Confirmation that the consultation and its process was meaningful
- Concerns raised about the reduced structures and the resulting impact on staff and services
- Clarification regarding the support provided to staff during the consultation period to safeguard their wellbeing; and
- Request for updates regarding the non-pay review

**Summary of System Partner Feedback**

- Comments received that our partners are pleased to see the importance being connected to the VCSE but concerned to see the removal of other roles related to specific clinical conditions
- Clarification requested around how the ICB will meet national requirements for addressing its population needs with the potential removal of a dedicated PEoLC commissioner
- Recognition that a number of roles in the new structure will lean into Place but would appreciate further consideration about the size of the Place teams
- Consideration to be given to the scaling up of services e.g. back office functions
- Clarification requested as to where the ICB will focus its priorities in the future e.g. What will it stop doing?
- Comments supporting the improved clinical leadership for Allied Health Professionals
- Recognition of the benefits of the Target Operating model (TOM), greater collaborative working to mitigate risks of moving to the TOM
- Concern that close working relationships with ICS colleagues may be lost and clarification as to how the new Shared Transformation Resource team will work to mitigate this risk
- Comments regarding how the ICB will identify the work to be completed at scale versus at place; and
- Comments received that the ICB's focus on inequalities, prevention and the wider determinants of health is welcome but there are further opportunities to enhance this work with greater collaboration in these areas, making best collective use of our skills and resources, and serving our population more effectively and efficiently.

## BLMK ICB Consultation Response

The ICB understands that change of any type is challenging and difficult and appreciates the feedback and input that has helped the ICB to form a response to the consultation. During the consultation the ICB has been clear that year 1 is a transitional year and that we will be conducting further changes in year 2. Potential changes in year 2 are likely to include:

- Further discussions with system partners regarding provider collaborations
- Understanding opportunities to explore shared arrangements with other ICBs and local partners
- Clarifying the expectations and requirements of Specialised Commissioning and the need

to incorporate this function into our Target Operating Model
- Ensuring that the ICB instigates tight vacancy controls to mitigate potential redundancies. This will include reviewing all recruitment requests to ascertain whether the role could be delivered in a different way; and
- Continuing to review its estates to ascertain further opportunities for rationalisation

The impact of a 30% reduction in the ICB Running Cost Allowance after accounting for the expected impact of potential future unfunded pay awards to 2025/26, requires a reduction in Management Costs of £6.8m; this is composed of £5.5m reduction in Running Cost Allocation and expected the cost of expected future pay awards at £1.3m.

The impact of the final proposed structure is as follows:

- Without change and including the impact of expected future pay awards, the cost reduction requirement to manage from the ICBs current costs to the target allocation / budget is £6.8m
- NHSE has phased the savings requirement: 20% in 2024/25, with a further 10% in 2025/26.
- The final post-consultation structures and the review of non-pay shows a reduction in costs of £4.8m, delivering approximately two-thirds of the overall target.
- The remaining financial challenge will need to be delivered through further actions.

The ICB is conscious that staff questioned why the ICB is continuing to recruit to roles during the consultation period. As the ICB implements the Target Operating Model, we are being clear and honest about the major financial challenges the ICB faces as an organisation. The executive team has agreed a recruitment freeze will be in place between now until at least the end of the year. During this time, the ICB recognise that there may be some roles that are business critical or roles that have been identified due to additional funding streams. These exceptions will be agreed with the Executive Directors and offered as internal secondments in the first instance. The Executive team are retaining roles, where possible for re-deployment opportunities to support the mitigation of redundancies for existing staff.

As part of the ICB's mitigations against potential compulsory redundancies, the ICB is seeking approval from NHSE to offer a Voluntary Redundancy (VR) Scheme to staff. We have received an indication that our request has been approved but understand that approval will come with some caveats and restrictions. The ICB are awaiting further guidance from NHSE before sharing a VR scheme.

In line with good practice, the ICB reviewed our functions against director portfolios to ensure they were still correctly aligned and also to determine that directorates names reflected their remit. Following such a review, a few changes have been made.

- Chief Transformation Officer becomes Chief Operating Officer
- Chief of Corporate Services & System Assurance becomes Chief of Strategy and Assurance
- Oversight and Assurance of Population Health, and Business Intelligence moves to Strategy and Assurance, the Population Health Team will be seconded to the Population Health Intelligence Unit which is being hosted by Bedford Borough.
- Pharmacy and Medicines Optimisation will remain within Primary Care and the clinical leadership for Allied Health Professions and Pharmacy will be held in the Medical

Directorate.

Where alternative suggestions were made for the structures, these were reflected upon and implemented as appropriate. In particular, structure changes have occurred in Finance, Chief Operating Officer Directorate, Medical Directorate and Primary Care. Feedback has also been taken on board regarding sustainable funding for fixed term contracts reliant on external funding.

Feedback was provided regarding the need for roles within the Place team to have a focus on developing Primary Care. Following careful consideration, it was agreed that Place needed tailored support for Primary Care to become fully integrated at 'place' and to fully align primary care with community and council services to optimise integrated neighbourhood working and same day urgent care access in each Place. The final structure reflects this requirement with 4 x 8A roles now focused on Integrated Neighbourhood transformation and 4 x B7 roles supporting this work.

Comments received from feedback and the STR / Place engagement events demonstrated that the structure chart needed to reflect the integrated nature and flexibility of the work of the System Transformation Resource (STR) team. The chart has been amended to depict this. All staff members working within the STR team will have a named line manager but will work with a range of individuals as part of an integrated team.

The impact of the feedback and the resulting changes to the structure are listed below. At the start of the consultation period, we had indicated a potential impact of a loss of 84 roles within the organisation. Following consultation this has been amended to 71.

## Purpose of the ICB: Functions & Teams

### Chief of Staff

The Chief of staff team leads the corporate office functions of the ICB to enable, on a day-to-day basis, the effective and efficient operation of the CEO and Chair's activities. It ensures the effective conduct of business for the ICB and support to the ICS in undertaking its role ensuring that there are effective and robust risk management processes, mechanisms and management in place for the ICB.

The team is responsible for the effective management and response to Complaints, Freedom of Information (FOIs) requests and enquiries through the Enquiries and Experience team.

The Chief of Staff also provides the Accountable Emergency Officer role for the ICB, supported by the EPRR team who ensure the ICB is able to fulfil its statutory duties as a Category 1 responder under the Civil Contingencies Act. This includes, on call, emergency planning and preparedness, exercising and training, business continuity and incident response.

### Medical Directorate

The Medical Directorate has three key elements; clinical and professional leadership, research and innovation, and Digital.

The Clinical Senate and the Clinical and Professional Leadership groups support the voice of clinicians in the ICB and their development. Two key roles, Chief AHP and Chief Pharmacist create roles where local, senior clinical leaders in these areas can support the Chief Medical Director in

the transformation of clinical services. The medical directorate leads clinical professional oversight and provides professional leadership through the ICB registered workforce with the Chief Nursing Director and their team.

The research and innovation team support our ambition to be a research ICB. Working with our partners, University of Bedfordshire and others, the team will create and support opportunities to undertake and generate research.

The Digital team, work across the ICB to support and build the digital capacity and capability in all our providers in health and care. This exciting work draws the full potential of digital enablement into our system, developing us into a leading digital ICB.

**People & Development**

The People Directorate comprises three core teams and one hosted team. Their overall function is to deliver the ten key areas for workforce ascribed to ICBs and deliver a People service to the ICB as an employer. The system level work includes the workforces across social care and health. In relation to the NHS, the team deliver the NHS People Plan, the NHS People Promise and the NHS Long Term Workforce Plan and Social Care Workforce Plan.

People and Development provides the core operational People services to the ICB as an employer. They lead all the work that the ICB does to ensure good employment practice and retention, including equality, diversity, inclusion and belonging for the organisation. This team deliver the internal People Plan and Promise work for the ICB as an employer. In this team there is a temporary team to enable the current change process, reduction in running cost allowance and other delegated teams of staff to join us for their employment, they will be disbanded at the end of the change programmes.

The Workforce Development Academy (WDA) team provide a system focussed approach to delivering workforce planning, best practice in retention, recruitment, equality, diversity and inclusion and belonging and delivering the other People Plan and promise elements. They lead the system work on education and training, the Long-Term Workforce Plan and support the People Board sub- groups to operate. They are key relationship holders with social care and NHS providers on People issues, bringing research, best practice, and innovation into our system. The OD and EDIB team work across the system work and the ICB as an employer, sharing innovation, learning and best practice across the system and the ICB as an employer. The WDA team, with the Primary Care Training Hub, hold the relationship with NHS England Regional and National People Teams and Social Care Regional People teams.

The Primary Care Training Hub provides support to the primary care teams in our system. They bring in best practice, innovation, and development for the People elements in primary care. They develop the workforce supply and training capability of the primary care teams in our service and support primary care staff to start their careers, thrive and stay. They are key to the high performance of our primary care team and work alongside the Chief Primary Care Officer and the WDA team, spreading and sharing great People practice. The Hub supports two sub-groups of the People Board, Primary Care and Integrated Neighbourhoods. The Hub links into the Fuller programme implementation.

On behalf of East Region, the ICB hosts the regional team supporting regional and system cultural change.

**Finance & Estates**

**Finance**

The ICB Finance Team has the following statutory roles and functions.

- Cash management and supplier payments; in 2022/23 the ICB processed and paid over 40,000 supplier invoices. Payments must be made in line with national payment standards re: timeliness.
- Preparation of Annual Accounts carried out in line with statutory and regulatory requirements; these are audited by an external auditor.
- Co-ordination with HMRC re: tax, national insurance, and VAT.
- Stewardship of c£2bn of public money and assets. The Finance Team who has day-to-day responsibility in this area and who has a key role to play in demonstrating accountability to patients, the local public, NHSE, the Public Accounts Committee and other stakeholders. The internal financial control environment is managed by the Finance Team who ensure that effective controls are in place and working as they should and in line with prevailing legislation, rules and regulations; ensuring that there is an effective approach to financial risk assessment and mitigation.

Finance staff have a key role to play in modelling the right behaviours to ensure systems and places can benefit from working more closely together. The ICB Financial Management Team;

- Provides financial reporting, advice and guidance to budget holders and the wider organisation.
- Gather and interpret financial data required to make day-to-day and strategic management decisions. This information is used by budget holders, the Board and it's Committees and NHS England.
- The Finance Team support the development of organisational and system business cases for investment and support oversight to the delivery ICS transformation and efficiency schemes.

In addition, ICB Finance Teams have taken on several roles that CCGs did not have, for example,

- the ICB now undertakes an oversight, assurance and co-ordination process for system finance and financial reporting.
- Responsibility for system-based allocation policy, system annual and medium-term financial planning, including the co-ordination and prioritisation of the system capital programme.
- From April 2023, delegated responsibility for primary care commissioning, expanding beyond GP services to include ophthalmology, dentistry, and community pharmacy – this includes payments of contractors and a full financial management service.

**Estates**

The ICB Estates Team fulfils the following statutory / routine roles and functions:

- Management of the Primary Care Rent Review process to ensure primary care providers are reimbursed the correct amounts for their premises and that all primary care premises provide value for money
- Provides formal responses on behalf of the ICB as a statutory consultee for all housing

planning applications within BLMK, and oversees the funding secured by Local Authorities in relation to housing developments (S106 / Community Infrastructure Levy), prioritises how it is used to support primary care capacity, and coordinates the drawdown of funding for specific projects, including all necessary governance and legal arrangements
- Manages the Estates Programme Budget, including all charges for void and sessional spaces within the local estate held by NHS Property Services
- Supports Contracting activities where there is an Estates impact (e.g. providing estates input to contract procurements including supporting mobilisation of new leases etc, supporting the closure of contracts and exit/transfer plans for associated premises)
- Provides estates advice to primary care providers, including coordinating the formal approval of new leases / sale-and-leaseback arrangements
- Supports the decision-making around the allocation of the ICB BAU Capital budget, and manages the process for providing Premises Improvement Grants to primary care providers
- Coordinates the prioritisation of revenue investment for primary care premises
- Supports providers to work towards improving the energy efficiency of the buildings they operate from, to support delivery of the ICB Green Plan / Net Zero Carbon ambitions

Development of the Primary Care / Community Estate plays a key role in ensuring good access to services for patients, enabling transformation, and enabling more integrated approaches to care delivery. The ICB Estates Team supports this through:

- Leading on the development and delivery of local and system-level Estates Strategies, including carrying out/commissioning options appraisals, feasibility studies and business cases as required
- Supporting primary care providers to deliver premises improvement projects (including minor improvement works, extensions and practice relocations/new builds), including coordinating/assuring all necessary governance and legal arrangements
- Managing the delivery of specific estates projects, particularly larger multi-agency integrated schemes and partnership schemes (e.g. involving NHS Property Service and/or Local Authorities)

In addition, the ICB Estates Team provides a system coordination role in relation to Estates, including,

- Coordinating the development of the ICS Infrastructure Strategy, and supporting system decision making in relation to Estates and capital funding priorities
- Supporting all providers to identify and achieve Estates ambitions, including improving the utilisation of the local healthcare estate.

**Primary Care**

Primary care have accountability to transform and commission high quality and resilient primary medical, community pharmacy, dental and optometry services to meet the needs of the local population. Essential functions include the continuation of supportive partnership working to retain a resilient primary care offer to the population through workforce development, quality improvements, maximising digital innovations, estate developments and facilitating peak

performance with and across all primary care providers to enhance true collaboration.

As primary care providers (including primary medical practices, 111, urgent treatment centres, community pharmacists, dental practices, ophthalmology) are key partners in place-based working, the primary care team have a responsibility to assess, and plan bespoke organisational development in conjunction with the primary care training hub to enable them to be fully active with the work of the four Place Boards.

The Pharmacy and Medicines Optimisation function sits within the Primary Care Directorate and will drive pharmacy excellence, medicines optimisation and integrated working across the health and care system to ensure the safe and effective use of medicines and optimise medicines use to improve health outcomes and the quality of care.

Accountability for 'Prevention' in the ICB also rests in primary care and will be achieved by collaboration with Public Health and other partners in the ICS.

**Nursing and Quality**

The Chief Nurse has two deputy chief nurses to enable development and system shaping to four key statutory areas.

- Quality (assurance, planning and improvement),
- Inequality,
- Safeguarding and
- Vulnerabilities

These areas are supported by 35 members of staff the majority requiring a relevant clinical registration to be able to undertake their work.

**The quality and inequality portfolio covers:**

- Statutory national measures/contract measures e.g.CQC measures, NICE compliance, acute and system quality assurance metrics, CNST, Maternity & Neonatal actions plans x4, GIRFT, ECIST etc
- Quality improvement (NHS IMPACT as launched) to develop skills and a methodology across BLMK, linking with existing Qi providers so we marry expert knowledge from staff and residents alongside a scientific way to test and deliver changes/improvements.
- Deeper and professional support for Cancer, LNMS, Primary care and quality concerns about any services within BLMK.
- Lead BLMK to a new patient safety system for investigation and learning from harm through PSIRF - support and developed system wide - to include all providers, primary care, hospices and all registered CQC places.
- Oversee and lead the work in population health and inequalities for BLMK for inequality reduction and equity for all - including population health intelligence unit development and delivery and BLMK system wide programmes.
- Quality place support for 4 x LA/Providers - at least 50% of time spent in or with LA/Providers
- Professional leadership for ICB registered NMC Nurses

**The Safeguarding and vulnerabilities portfolio covers:**

- Statutory requirements for safeguarding escalation across BLMK in partnership with all LA's. Including SEND (special educational needs), Children in Care, Prevent, Mental Capacity, LEDER (learning disabilities) child deaths & serious violence duty, including Domestic Abuse
- Professional leadership as per board requirements for Safeguarding, MHLDA, CYP 0-25 years, Frailty & falls and end of life care.
- System leadership for all residents with vulnerabilities living and working anywhere in our system e.g., care homes, children's homes, eating disorders, learning disabilities, inpatient and community provision.
- Provide designated safeguarding across BLMK, educational functions, acute and community, Local Authority and Safeguarding Partnership Boards
- Safeguarding place support for 4 x LA/Providers - at least 50% of time spent in or with LA/providers.
- Research agenda with domestic abuse reduction and University of Bedfordshire overall vulnerabilities research.

**Chief Operating Officer: Team Functions**

**CYP&M**

- The Local Maternity and Neonatal Team fulfils the statutory responsibilities of the ICB in improving maternity outcomes for BLMK women.
- The Integration and Personalisation Team is child and family facing providing direct assessment and coordination for children with continuing care needs and those young people with learning disabilities and/or autism.
- The Commissioning and Transformation Team works through the pan-BLMK Children and Young People's Transformation Board has clear strategic objectives and there is good buy-in across stakeholders for the key deliverables identified in our Joint Forward Plan.
- Generates business cases for new investment associated with this portfolio & engagement with regional / national initiatives
- Has a very strong relationship with clinical and quality teams in the ICB

**Mental Health, Learning Disability and Autism (MHLDA)**

Currently this team carry out the following commissioning, transformation, and assurance functions:

- Commissioning and assurance for MH (all ages) & engagement with regional / national initiatives
- Commissioning and assurance for LD and ASD / ADHD (adults) & engagement with regional / national initiatives
- ICB resource for transformation on MH / LD / A pathways in BLMK
- Oversight of delivery of NHS Operating Plan objectives for this population
- Manages section 117 / OOA placements
- Convenes BLMK MH Transformation & Delivery Board.
- Generates business cases for new investment associated with this portfolio

As part of the ICB target operating model, this team together with our mental health providers (East London Foundation Trust and Central and North West London NHSFT) are working through the business case / assurance process to become a provider collaborative. As part of the due diligence of this, the 3 organisations will develop the collaborative leadership structure, with clarity on what needs to be retained by the ICB as commissioner. Any changes to this team will be fully consulted upon at the appropriate point in this process.

**NHS Delivery Team (UEC and Elective)**

This is a new team, bringing together planning and assurance of delivery for NHS UEC and elective delivery against the NHS Operating Plan. This senior team will have significant interfaces with the contracting, Place and STR teams to scope, support and assure delivery of key transformation programmes and embed clinical pathways development into provider contracts for urgent and emergency care and elective, across all provider settings commissioned by BLMK ICB. This includes independent sector and VCSE partners.

These senior roles have significant responsibility in building and maximising benefit from partnership with NHSE and special interest groups to deliver investment and benefit to BLMK residents.

This oversight and expertise relate to all aspects of elective and UEC delivery, including:

- Planning
- Delivery of NHS Operating Plan Objectives
- Transformation through Partnership (Place and Provider Collaboratives)
- Assurance of elective and UEC performance, with specific focus on impact of services in improving health outcomes and tackling inequalities
- Efficiencies – moving to sustainable top decile performance to make best use of resources, and support financial balance of the BLMK system

The BLMK ICB System Co-ordination Centre (SCC) will also be held in this team, with strong interfaces with the EPRR team. During September, provider collaboratives will work with the ICB to revise their individual and local-system escalation actions at OPEL 3 and 4 to ensure clear transparent action cards are in place with local co-ordination as appropriate. This preparation for winter will enable a seamless transition during the autumn to the new SCC specification and OPEL framework, which was released in mid-August by NHS England.

This team will also include the individual funding requests (IFR) and compliance audits team, which will have a professional oversight ‘dotted line’ of accountability to the nursing and quality directorate, as the majority of colleagues in this team are registered health professionals, in particular, nurses.

**Complex Care & Placements**

This team provides several key functions for residents in BLMK, including:

- Continuing health care
- Personalisation
- Community equipment service

- ABI / Stroke placements

These functions have been ‘out of scope’ in terms of any changes to the team’s structures whilst we work with NHS and Local Authority partners to develop the shared strategy and delivery plan. A summary of the rationale and approach for each of these functions is outlined below:

**Continuing Health Care** is a statutory responsibility for the ICB. However, inflationary costs for providers and the rising complexity of this patient cohort presents a challenge to us now and into the future in terms of sustainable and affordable service delivery.

As the ICB matures and our partnership working with our NHS and Local authority partners deepens, this is the time to pause and consider how we can adapt our delivery model to address these challenges.

How can the ICB work differently with providers to sustain the right clinical care (at home and placements)

The **community equipment team** works across all Places with a range of partners to deliver this service. It is central to the ICS’s commitment to enable our residents to thrive, providing equipment to support people to stay at home and to manage life as best as is possible with long term conditions and illness / disability.

This contract for the provision of community equipment, is due to move to a new Local Authority host in April 2024, moving from Milton Keynes to Central Bedfordshire. After this date, and with the new ICB TOMPlace Teams established, will be the time to review if any changes are needed in this team’s structures and ways of working to support delivery of our strategic ambitions. Therefore, this team were ‘out of scope’ in this staff consultation (except for changes to bases / on-call arrangements, where applicable).

**Personalisation** sits at the heart of our strategic objectives as an ICS to improve health outcomes, tackle inequalities, support local economic growth, and provide good value to the tax payer. It is applicable across the span of people’s lives, from maternity to frailty and older people’s care.

As the ICB moves from regionally-set NHSE targets for personalisation, the ICB need to work with residents and partners to develop our personalisation strategy and delivery programme for BLMK that underpins and enhances delivery of the High Impact Programmes in our Joint Forward Plan.

Personalisation is key in the ICB’s integrated neighbourhood working. Equally, it is a critical catalyst for change in how best the ICB meet the very complex needs of BLMK residents - children, young people and adults spanning physical health and mental health, learning disabilities and autism spectrum disorders.

**Shared Contracting Team -** A key development in the ICB’s target operating model is the move to a shared contracting team, bringing together the primary care contracting team (including the delegated community pharmacy, dental and optometry services) together with the contracting team for community, acute, mental health, learning disabilities and autism / ADHD, VCSE and independent sectors. This opens up strategic possibilities for the ICB to better align individual provider contracts with their partners at Place and Provider Collaborative to deliver our ICB objectives to improve health outcomes, tackle inequalities, offer value for money to taxpayers and support growth in our Boroughs.

The core functions of the contracting team will remain unchanged:

- Manages all NHS and independent sector contracts (procurement, contract management, annual contracting round)
- Engages across ICB to ensure ICB contracts are compliant and to a high standard across all areas of performance, quality, scope, productivity, compliance with legal standards (i.e. data governance, human trafficking) and finance
- Manages the account with the Commissioning Support Unit for all contracts & procurement services
- Leads as relationship manager with all partner providers
- Works with LA partners to manage the markets in mutual areas of contracting, e.g. care placements
- Lead for ICB on regional and out of area contracts (i.e. ambulance services)
- Manages engagement with regional / national colleagues on contracting and procurement

Professional oversight and accountability will be in place with the Chief Primary Care Officer and the Chief Operating Officer and associated teams. The contracting team will continue to have close working partnerships with quality, finance, performance and statutory functions in the ICB – as well as with all our contractual partners and providers.

**Strategy and Assurance (SA)**

The Strategy and Assurance Directorate has the following functions:

**Governance and Assurance -** managing the ICB's and ICP's governance and partnership arrangements including support for meetings and seminars, reporting including statutory reports (annual report, JFP) and performance reporting, maintaining statutory registers related to conflicts of interest, providing the board with assurance that its duties and plans are being delivered. Establishing and managing new governance arrangements in relation to delegation to Provider Collaboratives and place-based partnerships. The Chief of Strategy and Assurance is the SRO providing professional oversight risk management which is supported operationally by the Chief of Staff and their team.

**Working with People and Communities -** providing the ICB and partners with support to work with people and communities in delivering its business including communications, co-production, engagement, consultation and providing stakeholder management support in relation to all areas of its business. Providing communications, engagement and co-production support to proposed transformational change initiatives at system and place.

**Strategy, Planning, Performance, Business Intelligence and Population Health Management –** leading and co-ordinating data, population health and evidence-based ICP and ICB strategy development and NHS operational planning, including the production of corporate plans as required by NHSE. Working closely with the Population Health Intelligence Unit hosted by Bedford Borough Council to provide performance and data insights to shape transformation plans and priorities (i.e. work on single source of the truth.

**VCSE – Developing a Strategic Partnership –** working with the ICB and VCSE organisations to

develop a strategic partnership to support the delivery of the ICB's core purposes and deliver specific transformation schemes.

**Sustainability and Growth -** working with our ICS partners to deliver our green plan, grow our economy to improve the health and wellbeing of our population and develop a more sustainable health and care economy.

**Supporting System Transformation through the Shared Transformation Resource** - a new team in the ICB responsible for managing and delivering both system and place priorities to improve outcomes for residents. The team's work programme will be developed and agreed with the ICB Executive Team, ICB Board and system and place sponsors. It will deliver significant transformational activity to realise the ICB's Strategic Priorities, Place Priorities and the ambitions set out in the Joint Forward Plan.

Team members will have skills and experience in transformation, delivery, co-production, partnership working, programme/project management and quality improvement and plan do study act (PDSA) cycles. An embedded PMO will ensure appropriate programme and project structures, support and reporting mechanisms are in place to maximise the value of the team and transparently report to the Board and stakeholders on progress and impact.

The team will comprise flexible and agile transformation and improvement specialists, who will act as a catalyst for system and place collaboration to deliver value and improvements for residents and stakeholders, leading the development and delivery of complex transformational and other strategic improvements to benefit BLMK residents. These will be agreed and supported by Senior Responsible Owners (SROs), lead organisations and wider system and place partners.

The team will co-ordinate and deliver cross-system and place improvements in a way that allows the system and all partners across BLMK to:

- Understand where we are having an impact, identifying the delivery of benefits including social value.
- Reduce duplication and fill gaps in transformation work programmes.
- Support the system to have a clear understanding of where partners need to apply focus and prioritise
- Support delivery of national health and care policy; and
- Reduce health inequalities and deliver transformation, change and improvement.

**Place Teams**

The core responsibilities of each of the four Place teams are to;

- Facilitate delivery of Place set priorities including any adverse local variation.
- Support place inequality initiatives and support co-ordination within the ICS
- Deliver integrated neighbourhood working
- Working with local communities to utilise the universal primary care offer including same day access
- Drive and coordinate partnership working for delivery of care to specific vulnerable' groups
- Place co-ordination of UEC pathways and transformation and promoting proactive 'stay

well at home in the community'.

The teams will convene subject matter expertise in transformation in primary, community, acute and care services to deliver local transformation to improve the health outcomes of local residents and support all ICB partners in delivery of the Joint Forward Plan and NHS Operating Plan. This includes key strategic pieces of work such as integrated neighbourhood working, embedding prevention and early intervention at every opportunity and support local elective and UEC pathways.

The teams will have strong interfaces with all partner providers at Place, ICB core teams such as Quality, Primary Care, Contracting and Shared Transformation Resource and BLMK-wide SROs to translate national requirements and local / ICB priorities into integrated and sustainable pathways that benefit residents.

The team will evolve to become agile and innovative change and delivery agents, with strong skills in convening, co-production, and multi-agency transformation. They will require effective project management skills to help deliver tangible improvements to residents and communities. Teams will have proficiencies across the whole spectrum of NHS and partnership design, delivery and monitoring of multi-agency Place plans, and a strong grip on embedding change into standard operating procedures and aligned provider contract.

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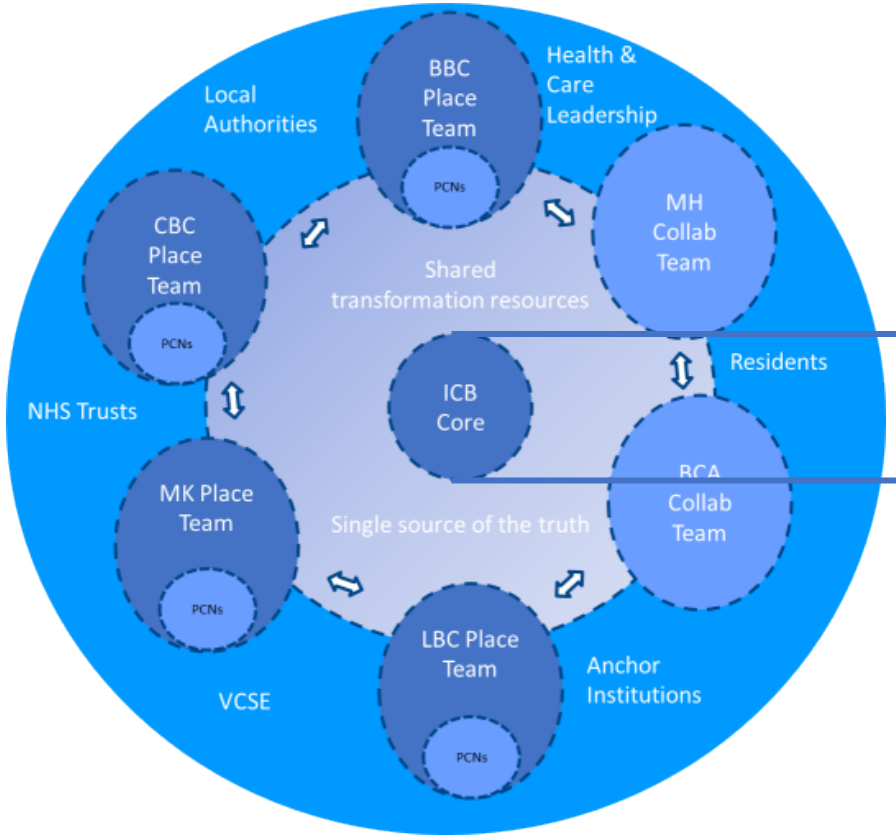
NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

# BLMK ICB Final Structures

24th August-23

# Contents

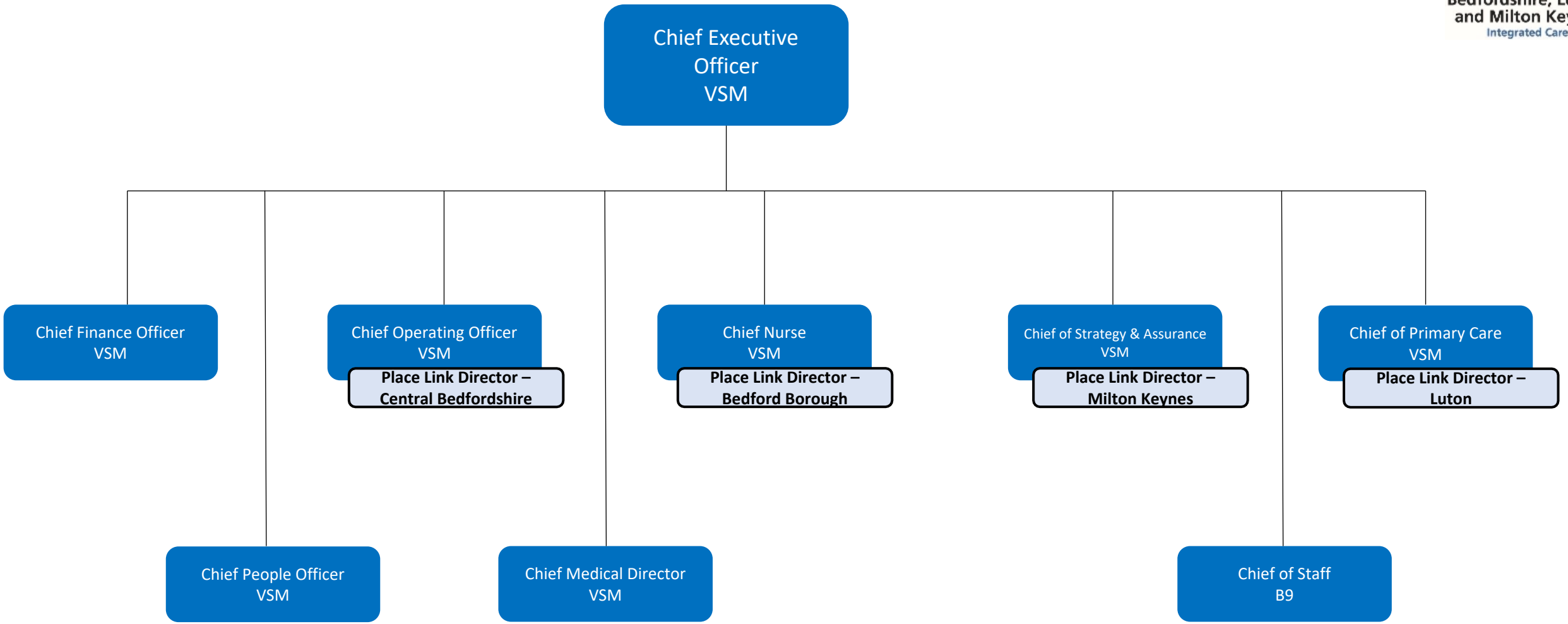



# Core ICB

KEY

- Core ICB Role
- Professional Supervision
- Role part of the Central Bedfordshire Place Network
- Role part of the Luton Place Network
- Key External Resource
- Externally funded role
- (FTC) Fixed Term Contract
- Role part of the Population Health Intelligence Unit
- Primary Care Training Hub Role
- Workforce Development Academy Role
- Role part of the Bedford Place Network
- Role part of the Milton Keynes Place Network
- Role part of the Shared Transformation Resource Network
- Temporary Resource for Change

# Executive Office




KEY (38)

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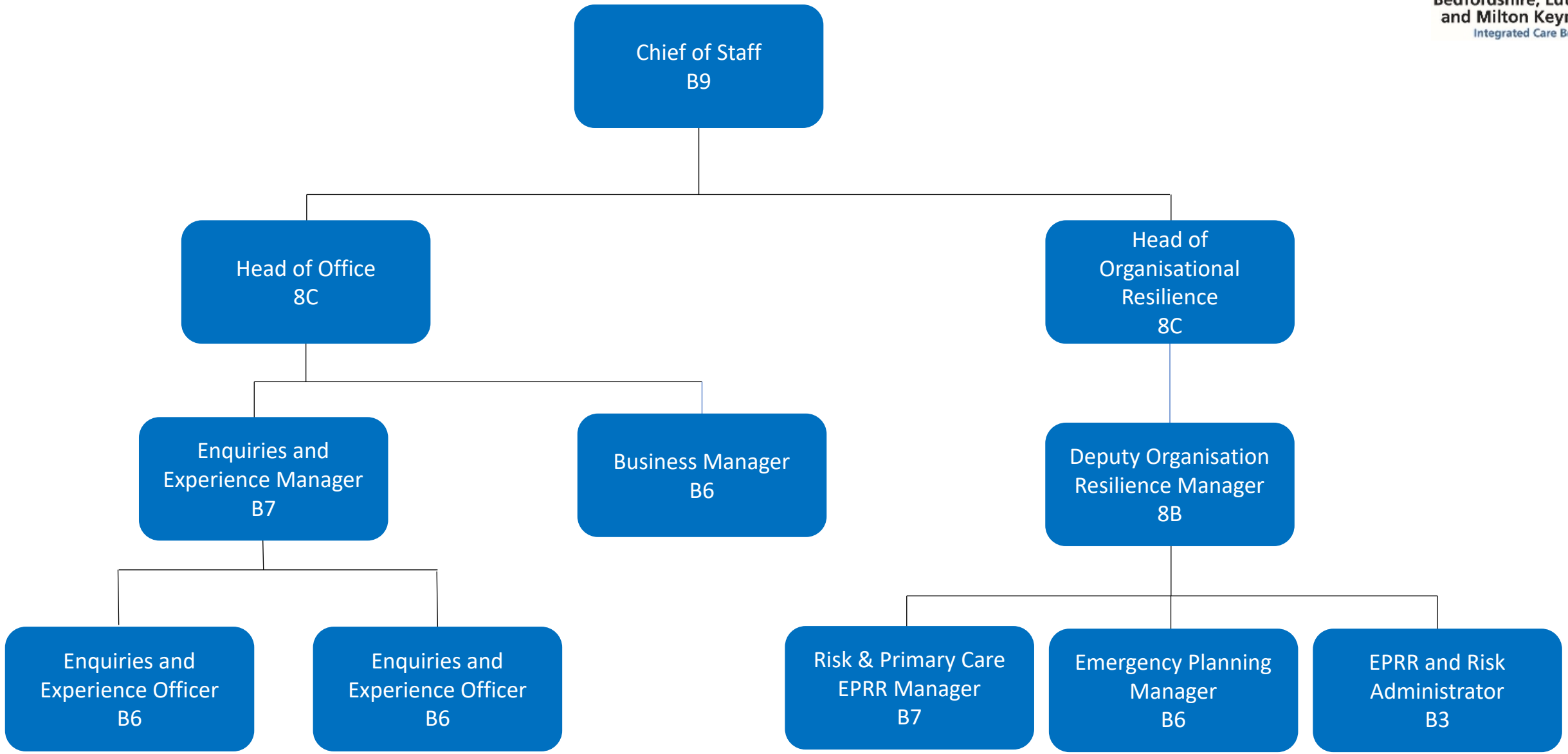
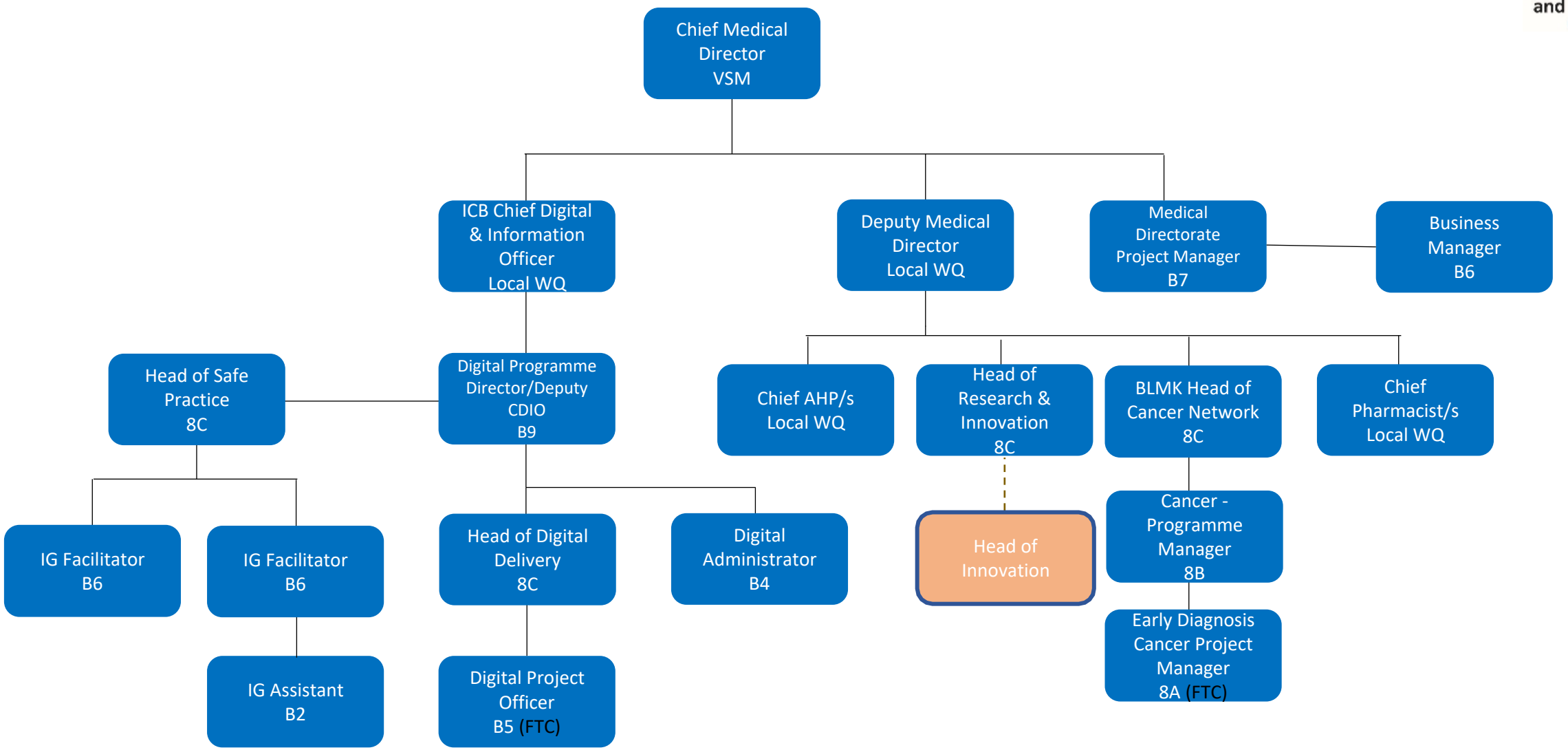
- Temporary Resource for Change

# Staff Directorate – Emergency Preparedness, Resilience and Response (EPRR), Corporate Office & Enquiries and Experience



# Medical Directorate – Digital, Information Governance (IG), Cancer, Research & Innovation, Leadership, Business Support and Clinical Strategy




KEY (40)

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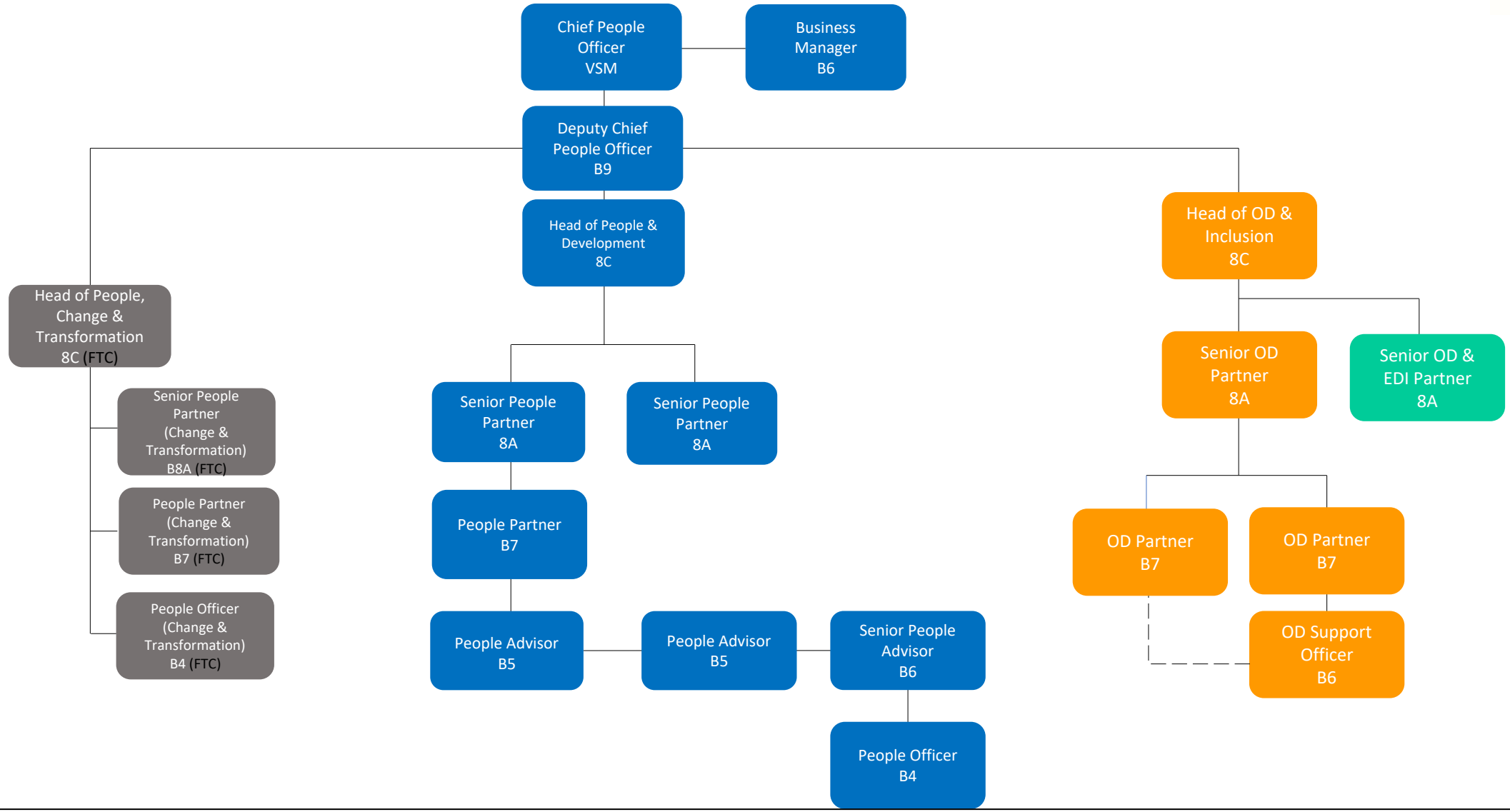
- Workforce Development Academy Role
- Role part of the Bedford Place Network
- Role part of the Milton Keynes Place Network
- Role part of the Shared Transformation Resource Network
- Temporary Resource for Change

# People Directorate – People & Development & Organisational Development (OD)




KEY (41)

- Core ICB Role
- Professional Supervision
- Role part of the Central Bedfordshire Place Network
- Role part of the Luton Place Network
- Key External Resource
- Externally funded role
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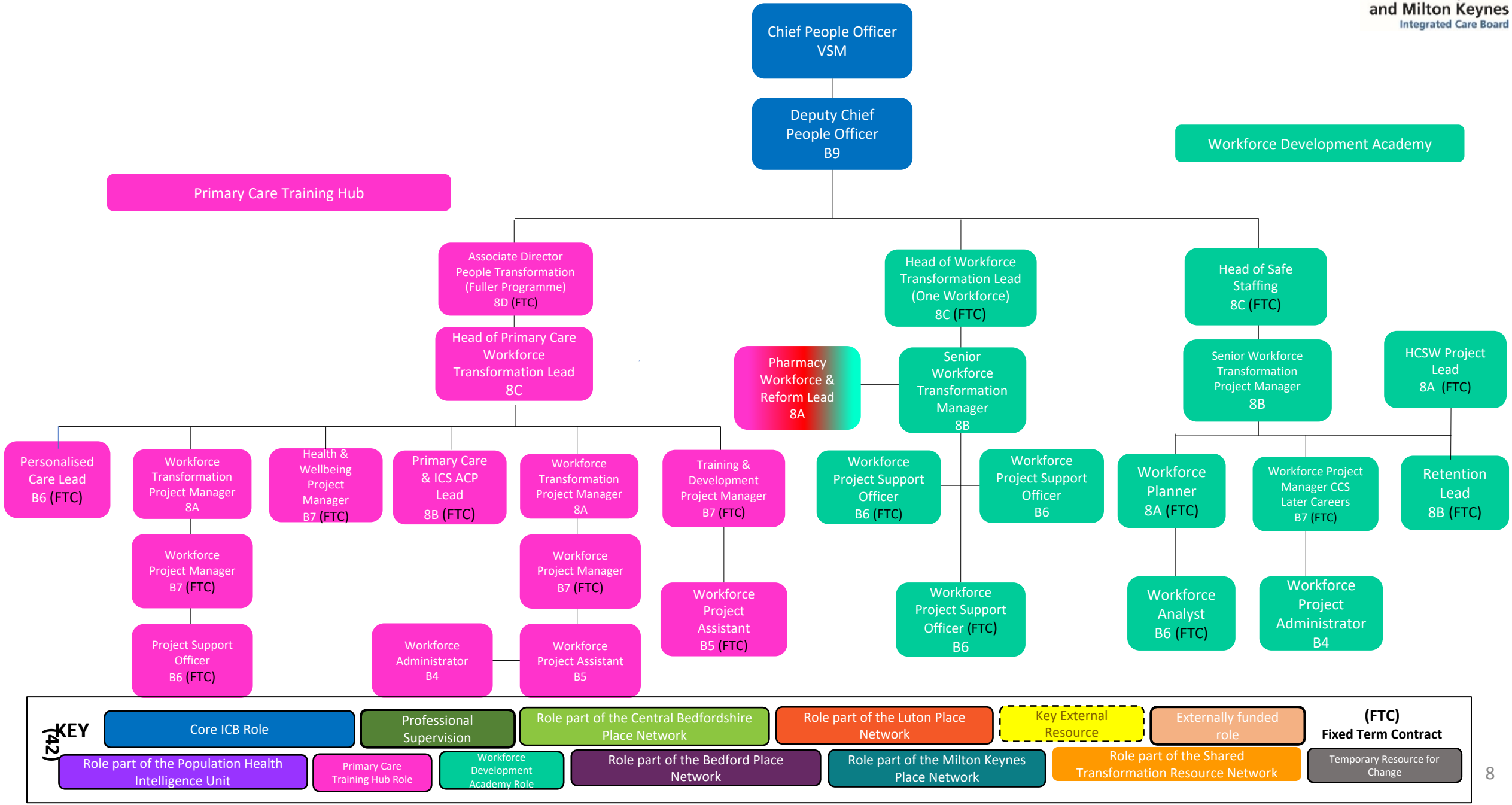
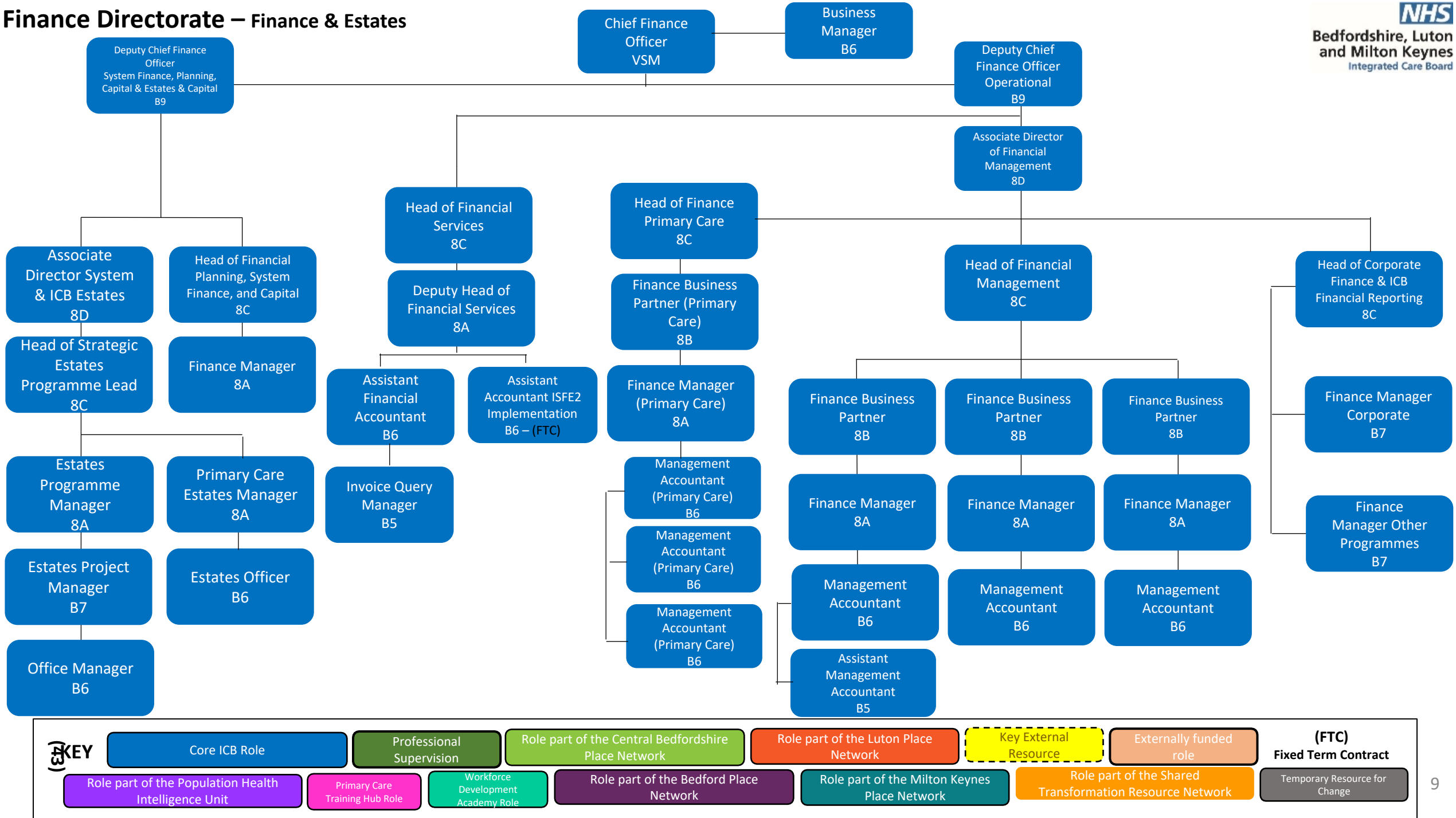
- Primary Care Training Hub Role
- Workforce Development Academy Role
- Role part of the Bedford Place Network
- Role part of the Milton Keynes Place Network
- Role part of the Shared Transformation Resource Network
- Temporary Resource for Change

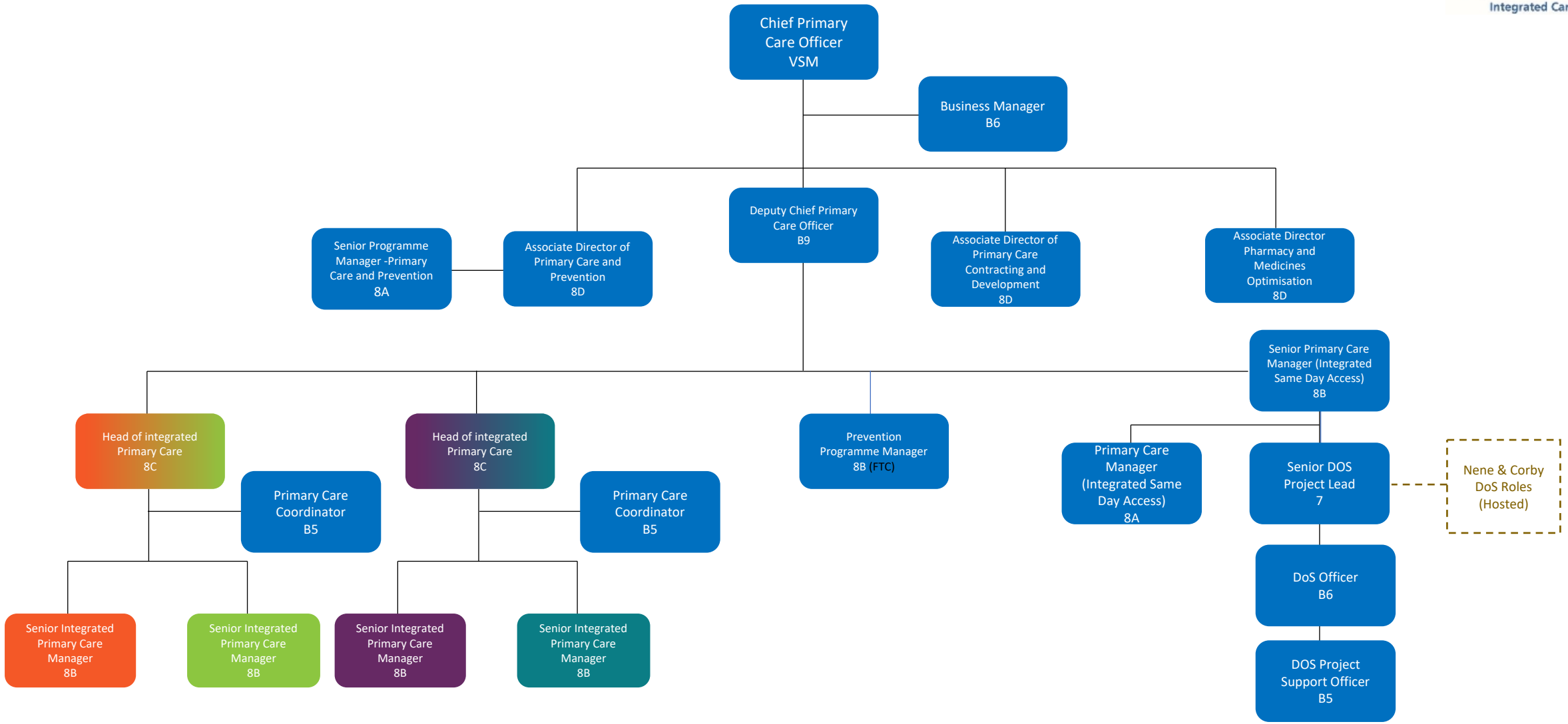
# People Directorate – Workforce Development Academy (WDA) and Primary Care Training Hub (PCTH)



# Finance Directorate – Finance & Estates



# Primary Care Directorate – Leadership, Integrated Primary Care, Integrated Same Day Access and Directory of Services (DoS)




KEY (44)

- Core ICB Role
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- Key External Resource
- Externally funded role
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- Primary Care Training Hub Role
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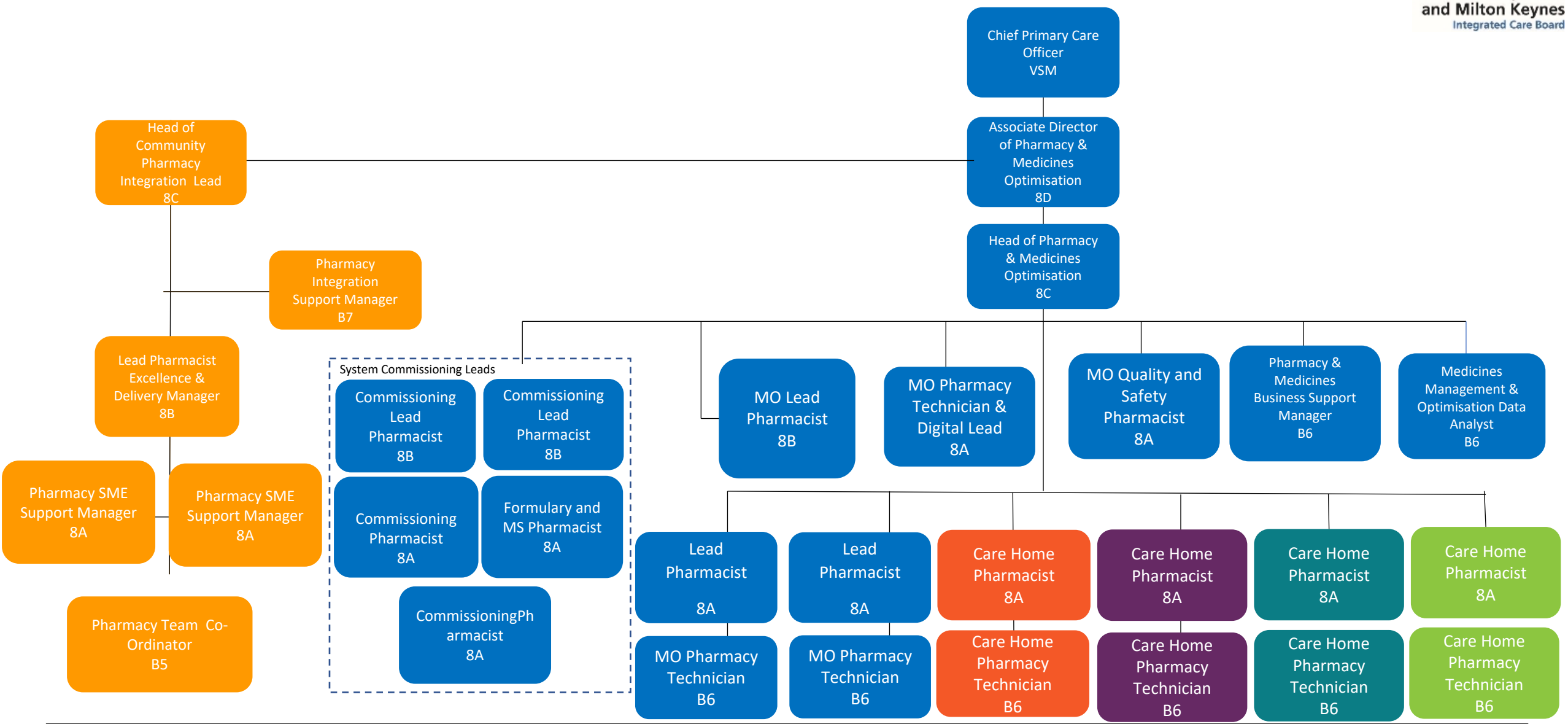
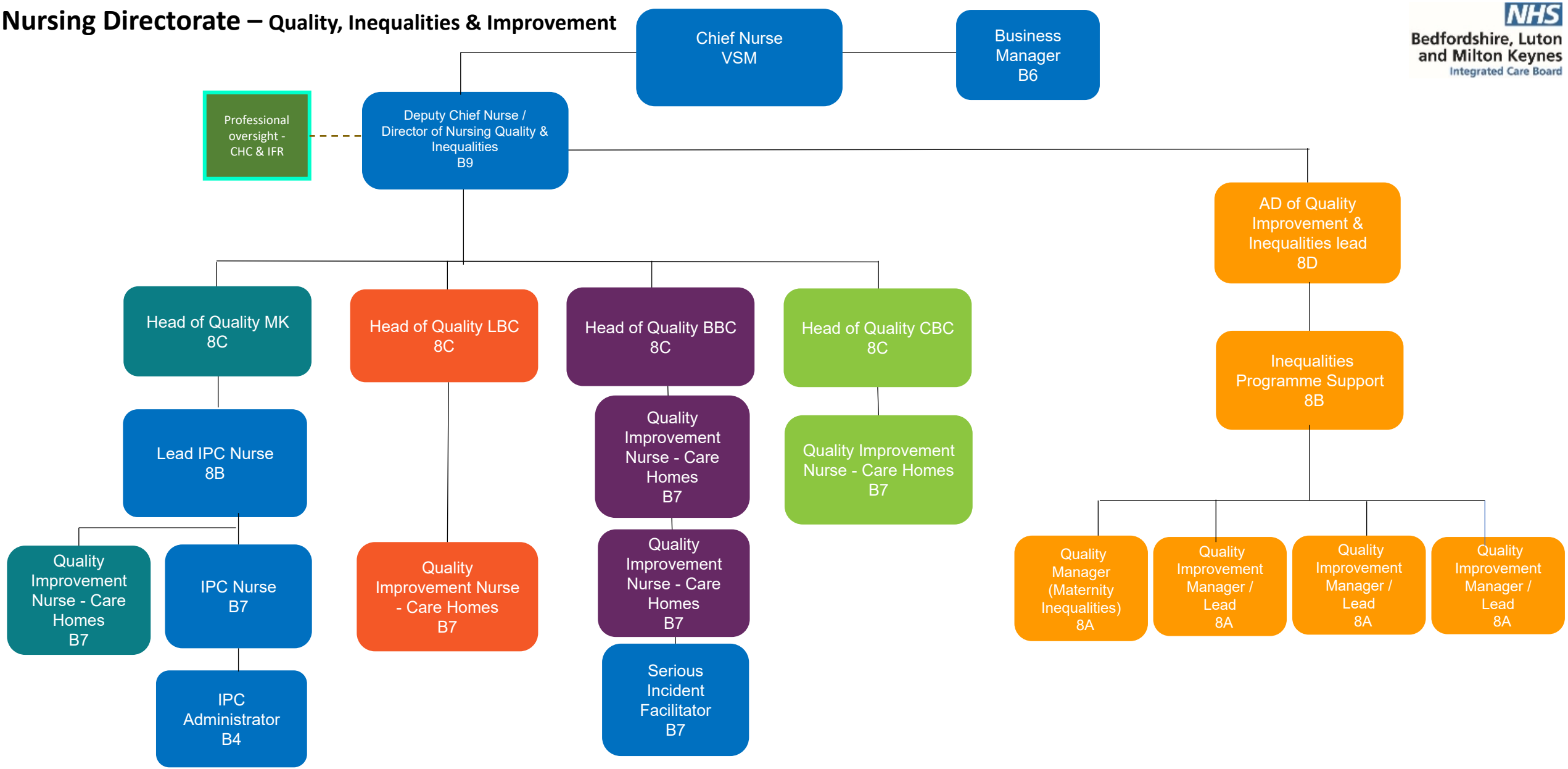
# Primary Care Directorate – Pharmacy



# Nursing Directorate – Quality, Inequalities & Improvement




KEY

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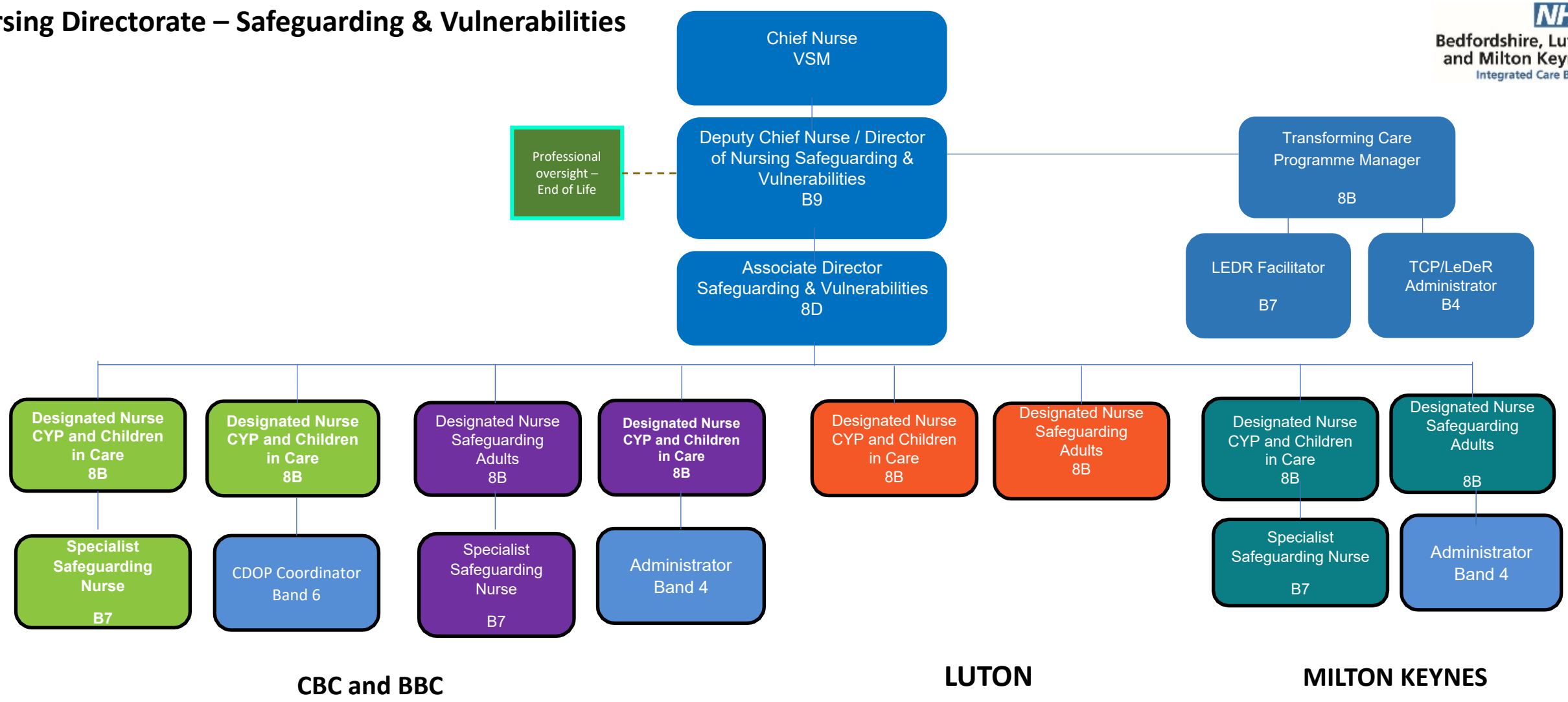
# Nursing Directorate – Safeguarding & Vulnerabilities




MCS/LPS Lead

**KEY** (47)

- Core ICB Role
- Professional Supervision
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- Role part of the Luton Place Network
- Key External Resource
- Externally funded role
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- Primary Care Training Hub Role
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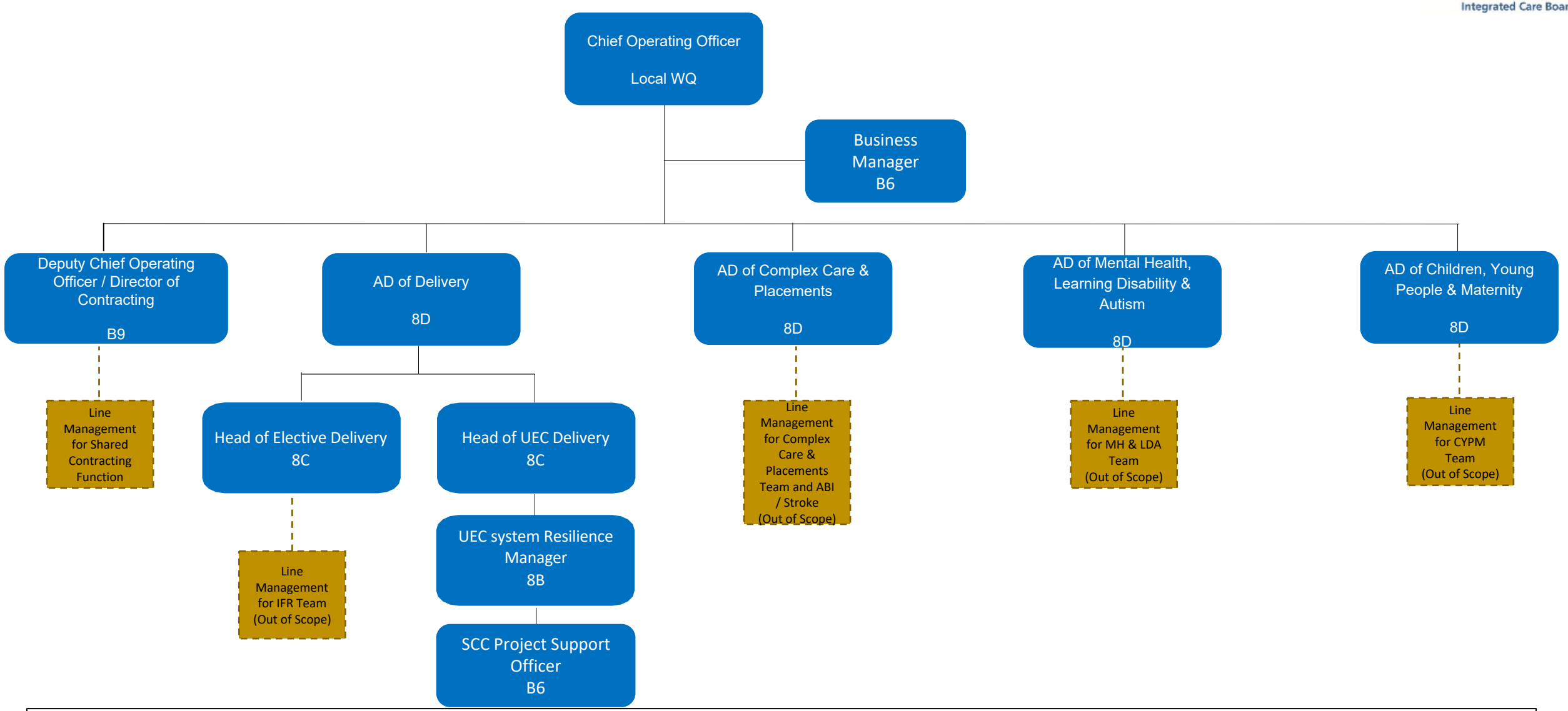
- Temporary Resource for Change

# Chief Operating Officer Directorate – Senior Structure




KEY (48)

- Core ICB Role
- Professional Supervision
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- Key External Resource
- Externally funded role
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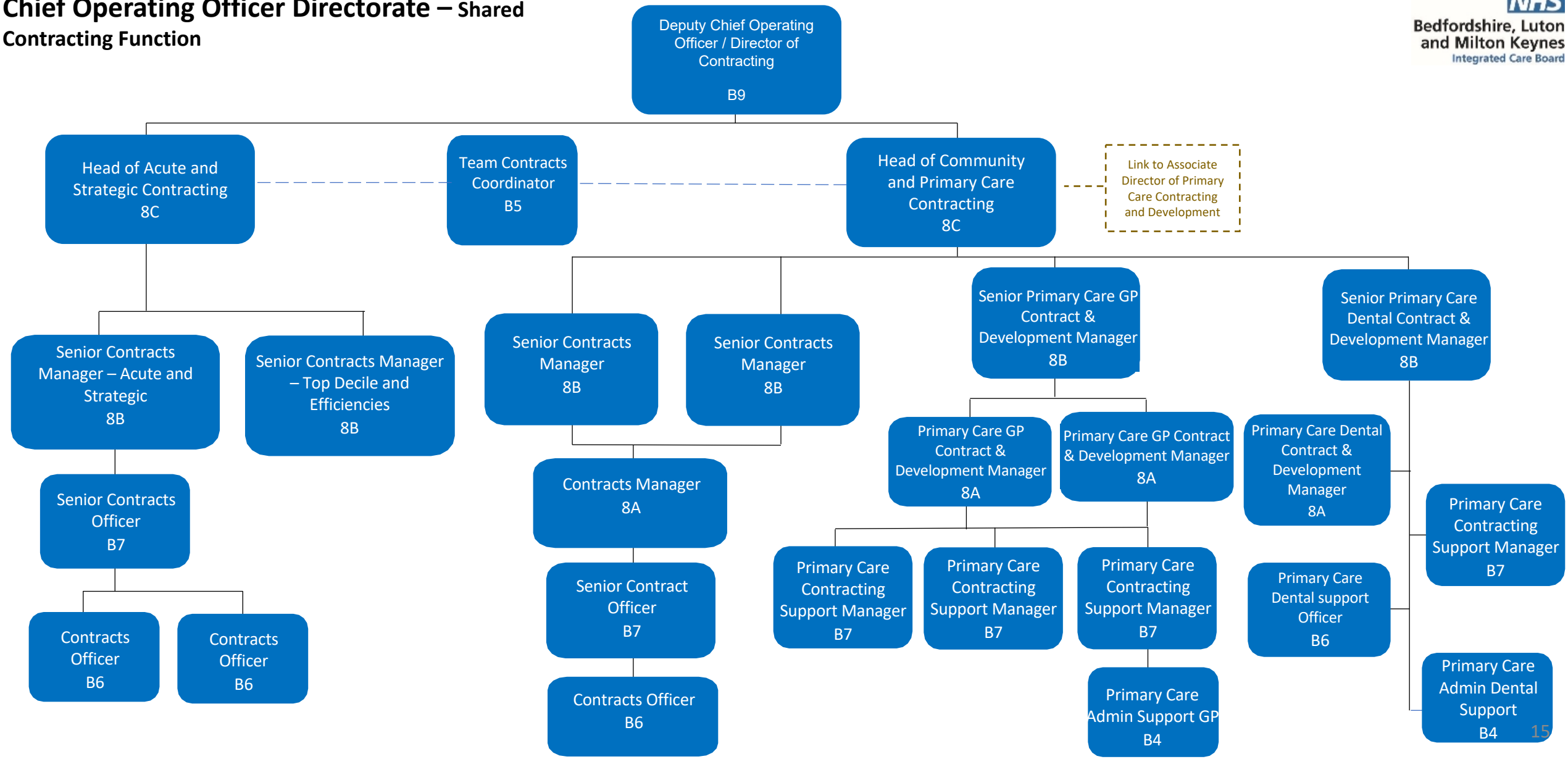
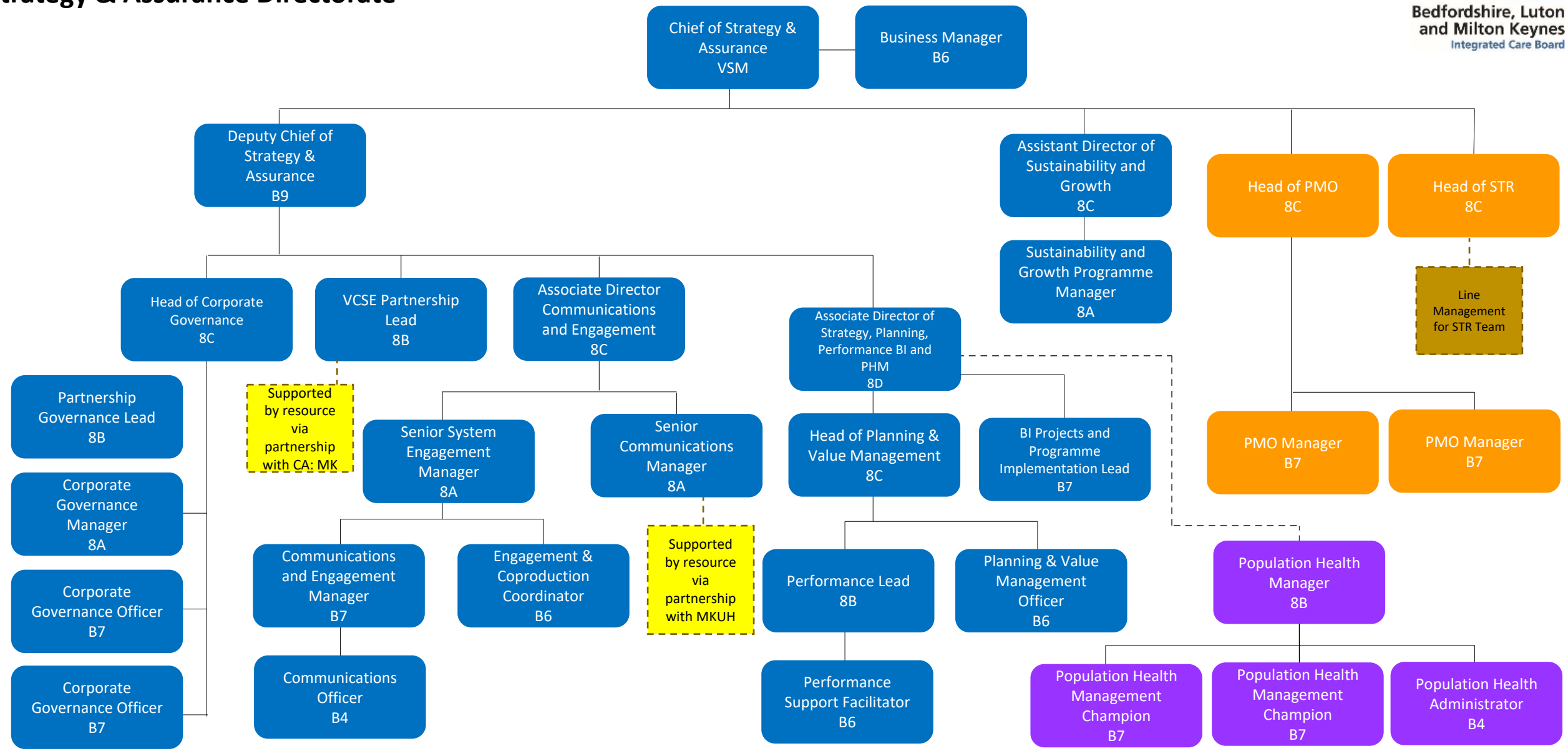
- Temporary Resource for Change

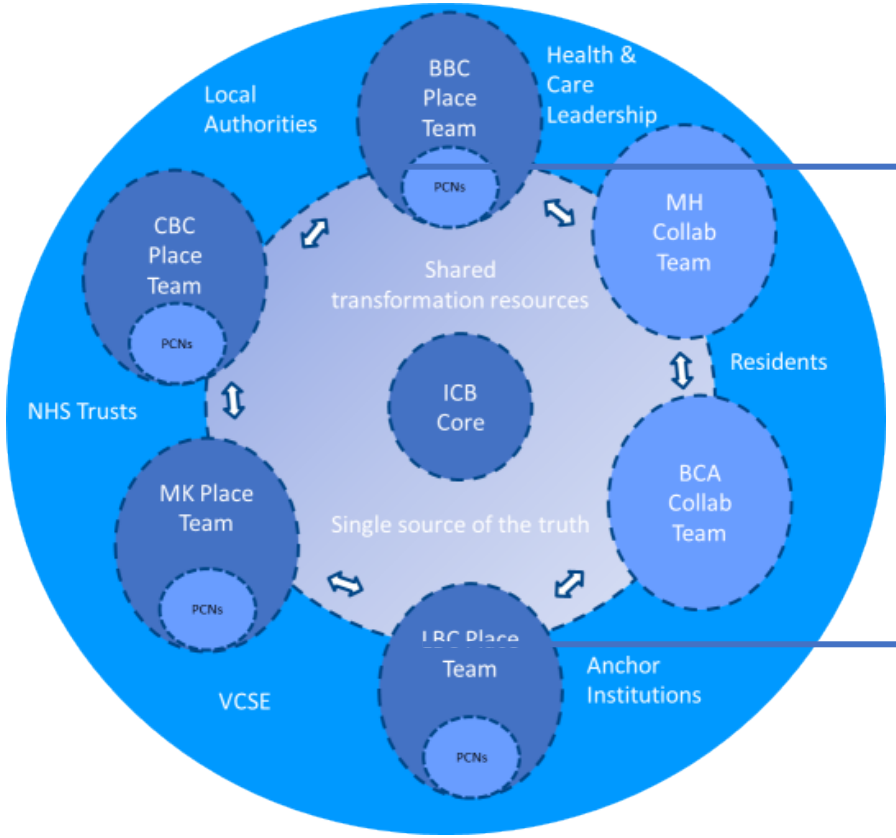
# Chief Operating Officer Directorate – Shared

## Contracting Function



# Strategy & Assurance Directorate






# Shared Transformation Resource Teams and the Wider Shared Transformation Network

KEY (51)

- Core ICB Role
- Professional Supervision
- Role part of the Central Bedfordshire Place Network
- Role part of the Luton Place Network
- Key External Resource
- Externally funded role
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- Role part of the Shared Transformation Resource Network
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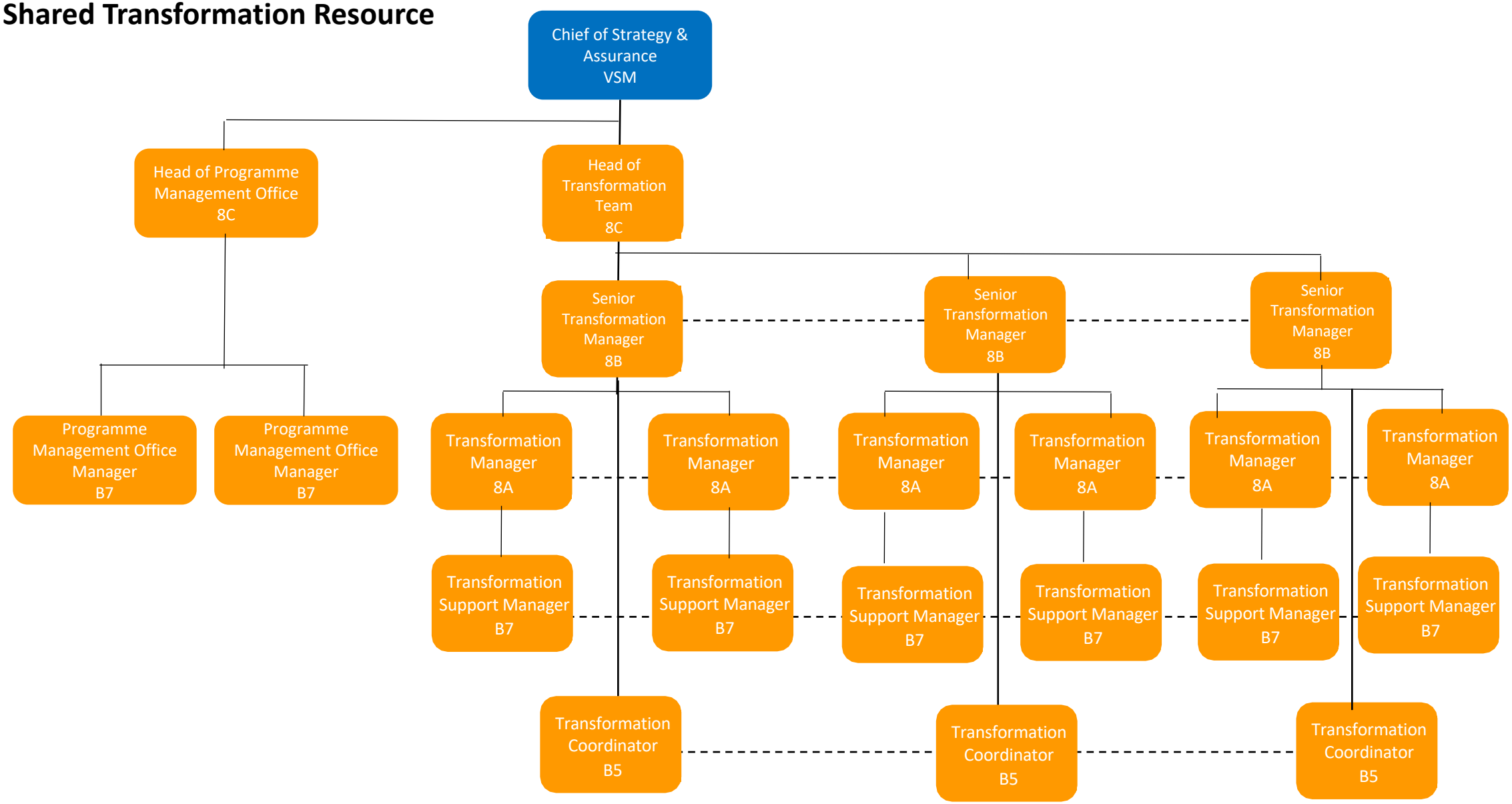
# Shared Transformation Resource




KEY (52)

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- Professional Supervision
- Role part of the Central Bedfordshire Place Network
- Role part of the Luton Place Network
- Key External Resource
- Externally funded role
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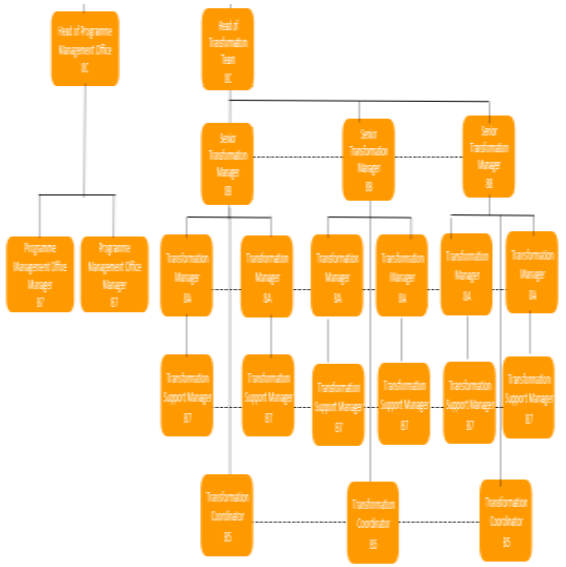
- Role part of the Milton Keynes Place Network
- Role part of the Shared Transformation Resource Network
- Temporary Resource for Change

# Shared Transformation Resource Team, supported by the Shared Transformation Network

Bedfordshire, Luton and Milton Keynes Integrated Care Board

## The Shared Transformation Network, supporting delivery of system & place priorities

**Shared Transformation Resource Team**



System & Place Priorities

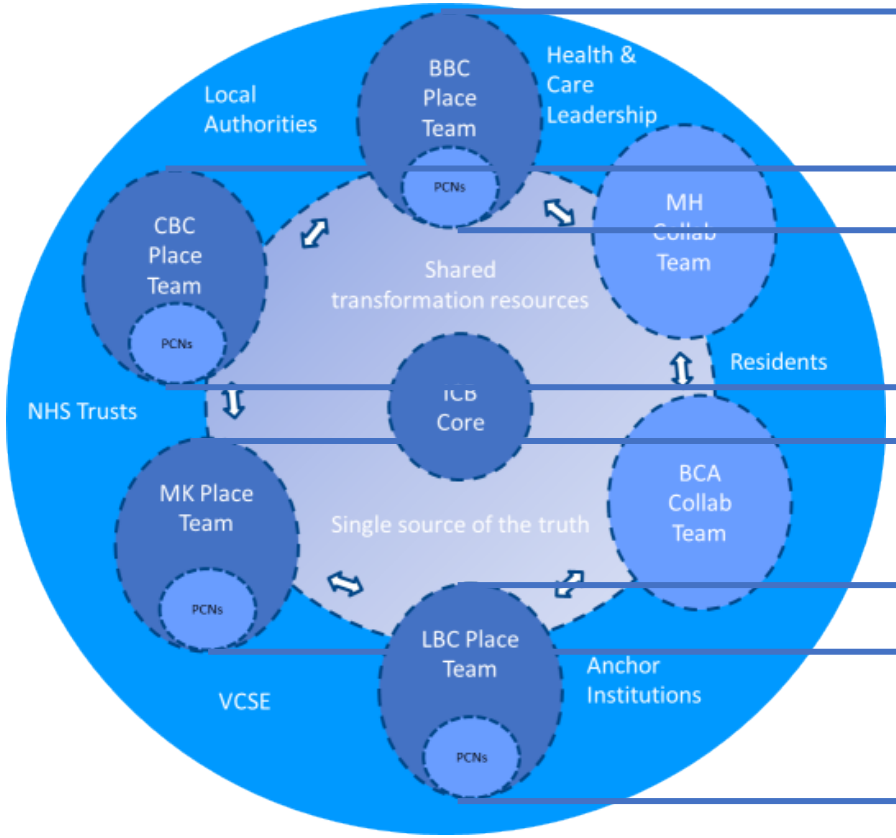
**ICB Transformation Aligned**

- **Pharmacy**
  - ICB Lead Pharmacist Excellence & Delivery Manager
  - Pharmacy SME Support Manager
  - Pharmacy & Medicines Optimisation Team Co-Ordinator
- **Organisational Development**
  - Head of OD & Inclusion
  - Senior OD Partner
  - OD Partner
  - OD Support Officer
- **Improvement**
  - AD of Quality Improvement & Inequalities lead
  - Inequalities Programme Support
  - Quality Manager
  - Quality Improvement Manager / Lead
- **PMO**
  - Head of PMO
  - PMO Manager

**Core ICB**

**System Partners**

(53)

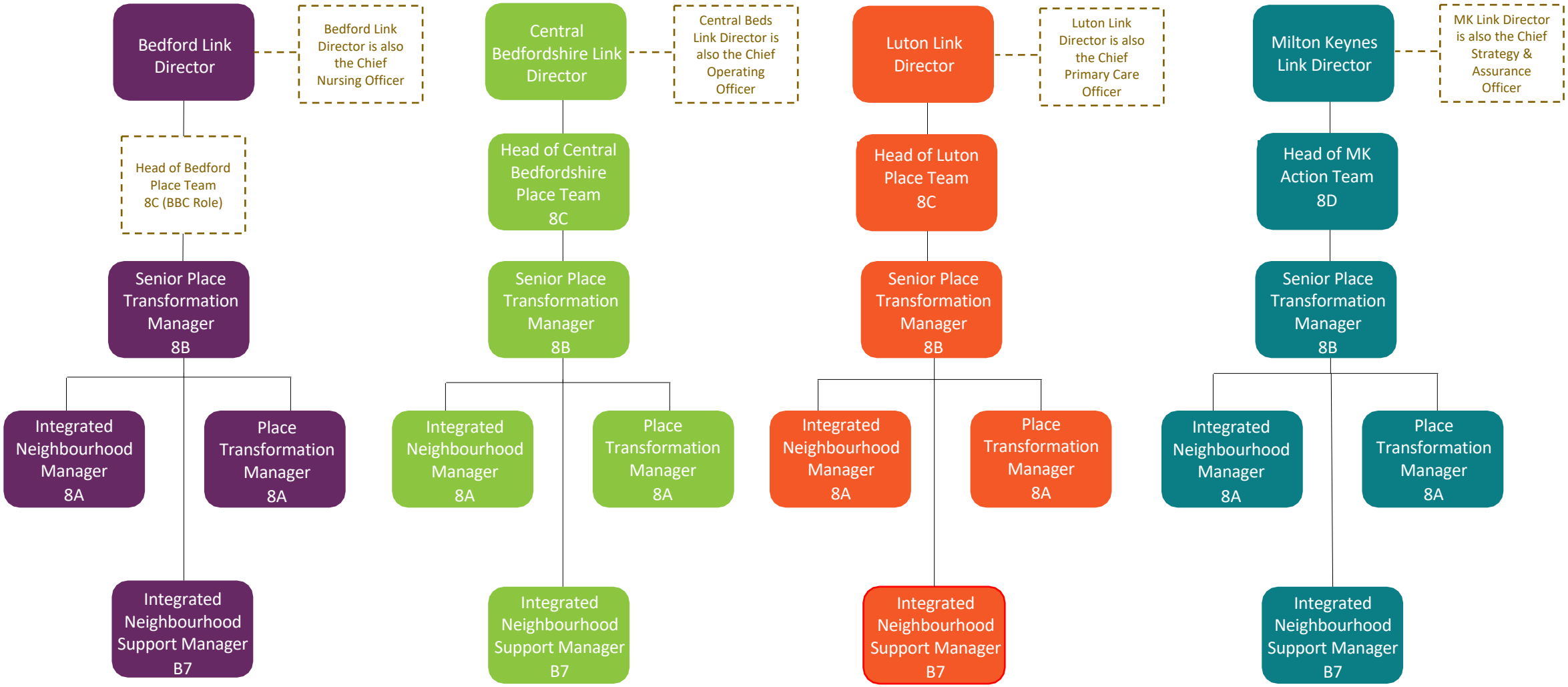



# Place Delivery Resource Teams and the Wider Place Network

KEY (54)

- Core ICB Role
- Professional Supervision
- Role part of the Central Bedfordshire Place Network
- Role part of the Luton Place Network
- Key External Resource
- Externally funded role
- (FTC) Fixed Term Contract
- Role part of the Population Health Intelligence Unit
- Primary Care Training Hub Role
- Workforce Development Academy Role
- Role part of the Bedford Place Network
- Role part of the Milton Keynes Place Network
- Role part of the Shared Transformation Resource Network
- Temporary Resource for Change

# Place Delivery Resource – Bedford, Central Bedfordshire, Luton and Milton Keynes (MK)




KEY

- Core ICB Role
- Professional Supervision
- Role part of the Central Bedfordshire Place Network
- Role part of the Luton Place Network
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- Externally funded role
- (FTC) Fixed Term Contract
- (5s)
- Role part of the Population Health Intelligence Unit
- Primary Care Training Hub Role
- Workforce Development Academy Role
- Role part of the Bedford Place Network
- Role part of the Milton Keynes Place Network
- Role part of the Shared Transformation Resource Network
- Temporary Resource for Change

# Bedford Borough Place Delivery Resource Team, supported by the Place Network 2024/25

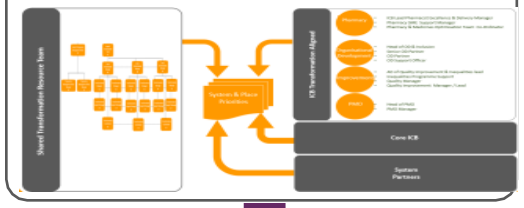
NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

## The Place Network, supporting delivery of place priorities

**Place Delivery Transformation Team**

- Bedford Link Director
- Head of Bedford Place Team 8C (BBC Role)
- Senior Place Transformation Manager 8B
  - Integrated Neighbourhood Manager 8A
  - Place Transformation Manager 8A
  - Integrated Neighbourhood Support Manager B7

**Shared Transformation Network**



**Place Priorities**

**ICB Place Aligned**

- **Pharmacy**
  - Care Home Pharmacist
  - Care Home Pharmacy Technician
- **Safeguarding & Care Home Nurses**
  - Designated Nurse Adults
  - Designated Nurse Children
  - Quality Improvement Care Home Nurses
- **Quality Lead**
  - Head of Quality
- **Primary Care**
  - Head of Primary Care Relationship Development & Transformation
  - Senior Primary Care Development & Transformation Manager
  - Primary Care Coordinator

**Core ICB**

**System Partners**

(56)

# Central Bedfordshire Place Delivery Resource Team, supported by the Place Network 2024/25

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

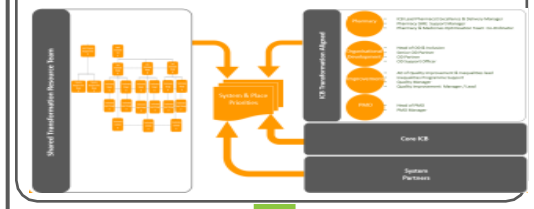
## The Place Network, supporting delivery of place priorities

**Place Delivery Transformation Team**

- Central Bedfordshire Link Director
- Head of Central Bedfordshire Place Team 8C
- Senior Place Transformation Manager 8B
  - Integrated Neighbourhood Manager 8A
  - Place Transformation Manager 8A
  - Integrated Neighbourhood Support Manager B7

(ST)

**Shared Transformation Network**



**Place Priorities**

**ICB Place Aligned**

- **Pharmacy**
  - Care Home Pharmacist
  - Care Home Pharmacy Technician
- **Safeguarding & Care Home Nurses**
  - Designated Nurse Adults
  - Designated Nurse Children
  - Quality Improvement Care Home Nurses
- **Quality Lead**
  - Head of Quality
- **Primary Care**
  - Head of Primary Care Relationship Development & Transformation
  - Senior Primary Care Development & Transformation Manager
  - Primary Care Coordinator

**Core ICB**

**System Partners**

# Luton Place Delivery Resource Team, supported by the Place Network 2024/25

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

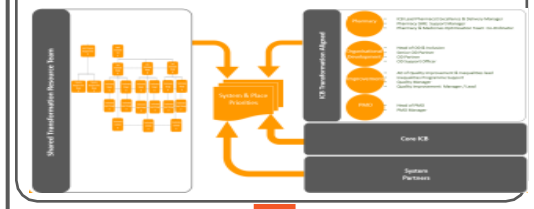
## The Place Network, supporting delivery of place priorities

**Place Delivery Transformation Team**

- Luton Link Director
- Head of Luton Place Team 8C
- Senior Place Transformation Manager 8B
  - Integrated Neighbourhood Manager 8A
  - Place Transformation Manager 8A
  - Integrated Neighbourhood Support Manager B7

(8E)

**Shared Transformation Network**



**Place Priorities**

**ICB Place Aligned**

- **Pharmacy**
  - Care Home Pharmacist
  - 1 x Care Home Pharmacy Technician
- **Safeguarding & Care Home Nurses**
  - Designated Nurse Adults
  - Designated Nurse Children
  - Quality Improvement Care Home Nurses
- **Quality Lead**
  - Head of Quality
- **Primary Care**
  - Head of Primary Care Relationship Development & Transformation
  - Senior Primary Care Development & Transformation Manager
  - Primary Care Coordinator

**Core ICB**

**System Partners**

# Milton Keynes Improvement Action Team, supported by the Place Network 2024/25

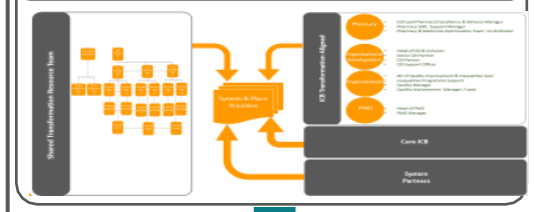
NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

## The Place Network, supporting delivery of place priorities

**Milton Keynes Improvement Action Team**

- Milton Keynes Link Director
- Head of MK Action Team 8D
- Senior Place Transformation Manager 8B
  - Integrated Neighbourhood Manager 8A
  - Place Transformation Manager 8A
  - Integrated Neighbourhood Support Manager B7

**Shared Transformation Network**



**Place Priorities**

**ICB Place Aligned**

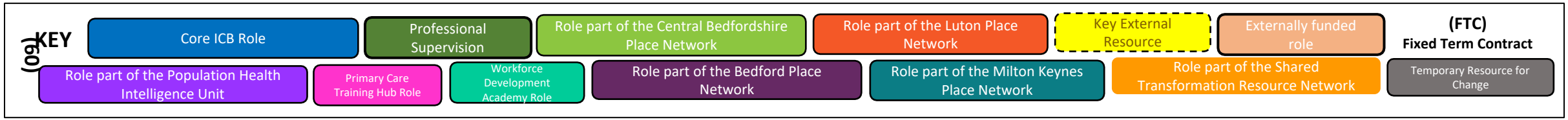
- **Pharmacy**
  - Care Home Pharmacist
  - Care Home Pharmacy Technician
- **Safeguarding & Care Home Nurses**
  - Designated Nurse Adults
  - Designated Nurse Children
  - Quality Improvement Care Home Nurses
- **Quality Lead**
  - Head of Quality
- **Primary Care**
  - Head of Primary Care Relationship Development & Transformation
  - Senior Primary Care Development & Transformation Manager
  - Primary Care Coordinator

**Core ICB**

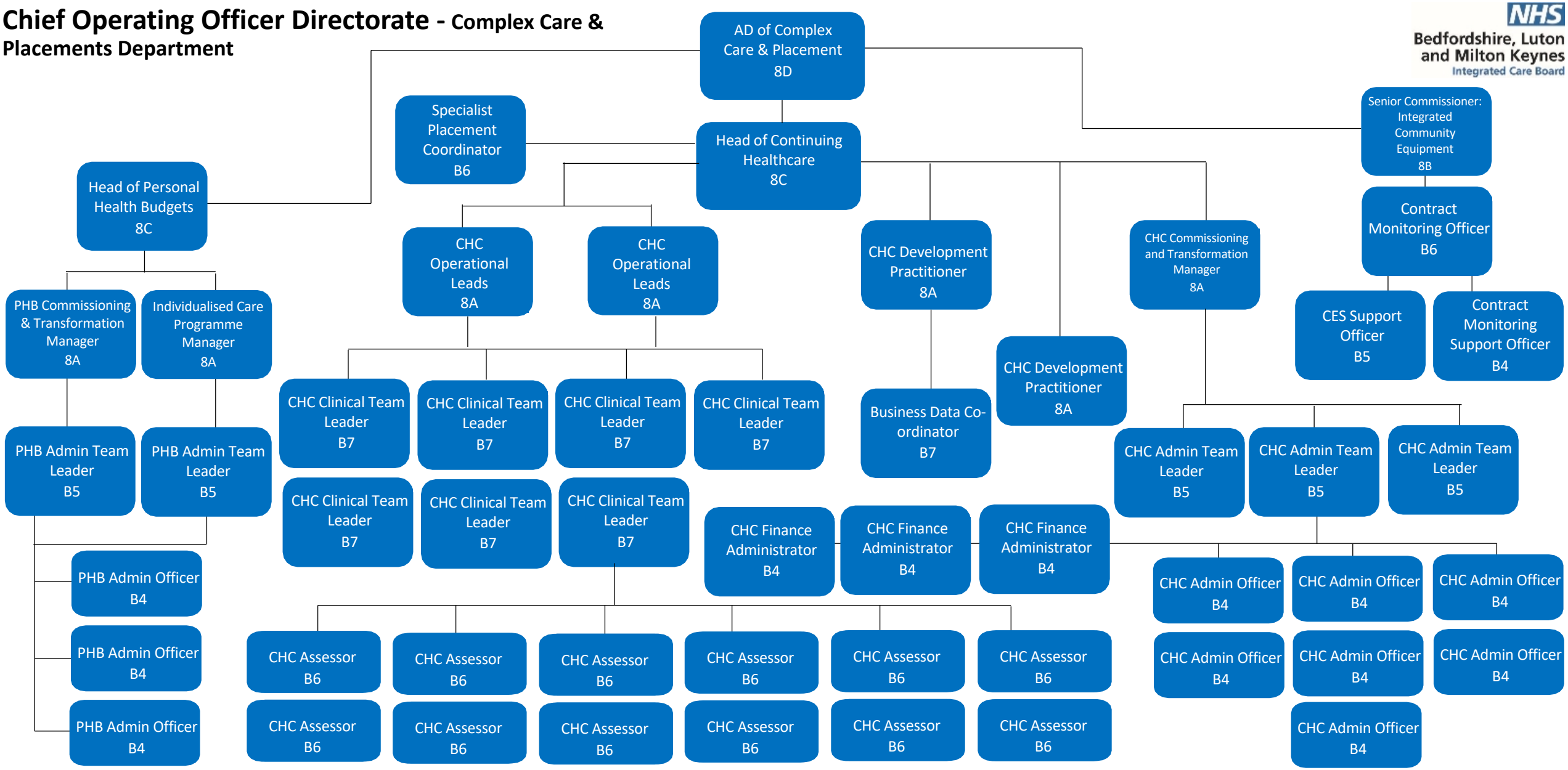
**System Partners**

(59)

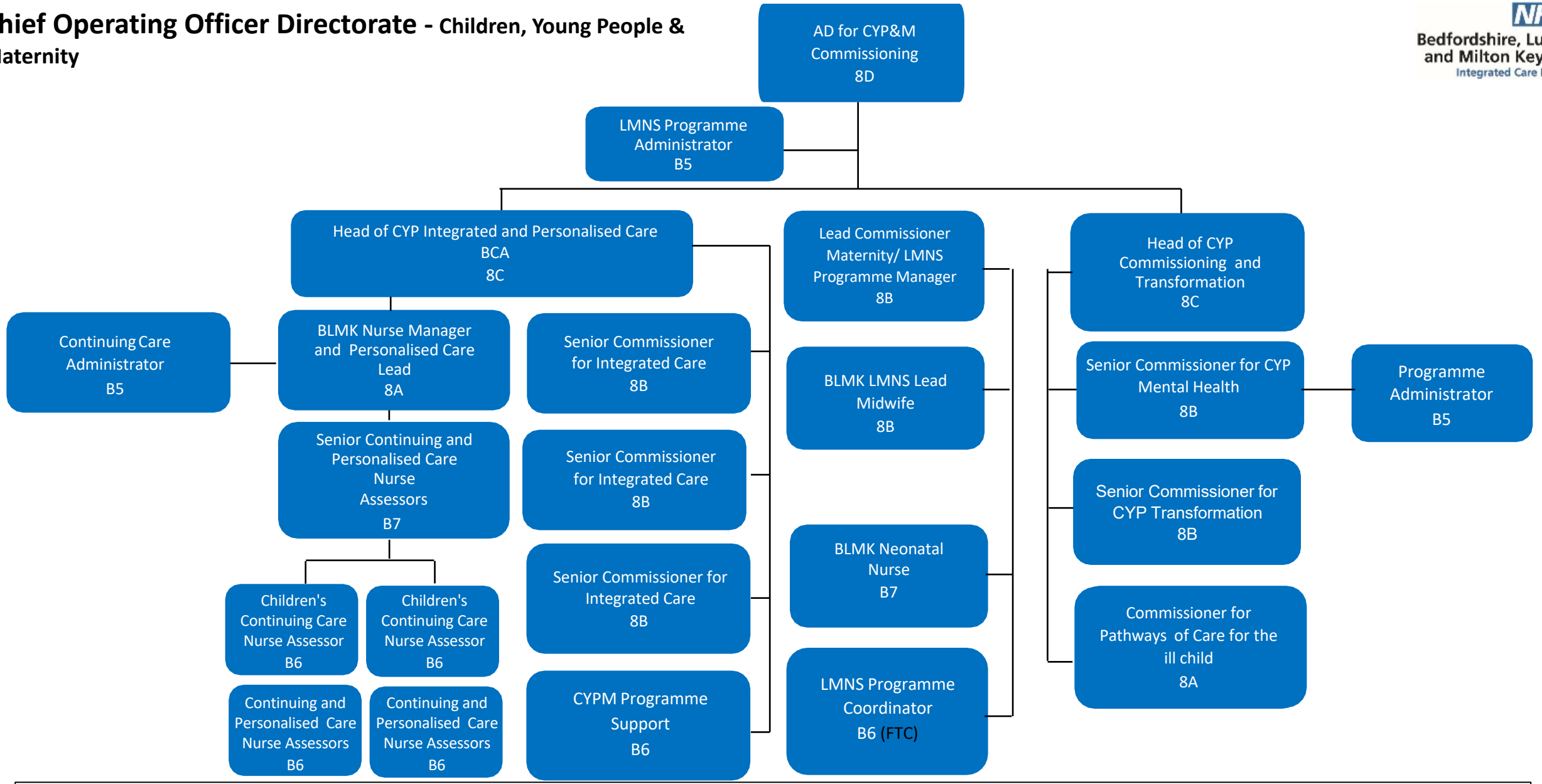
# Out of Scope of Year 1 Consultation



# Chief Operating Officer Directorate - Complex Care & Placements Department



# Chief Operating Officer Directorate - Children, Young People & Maternity




KEY

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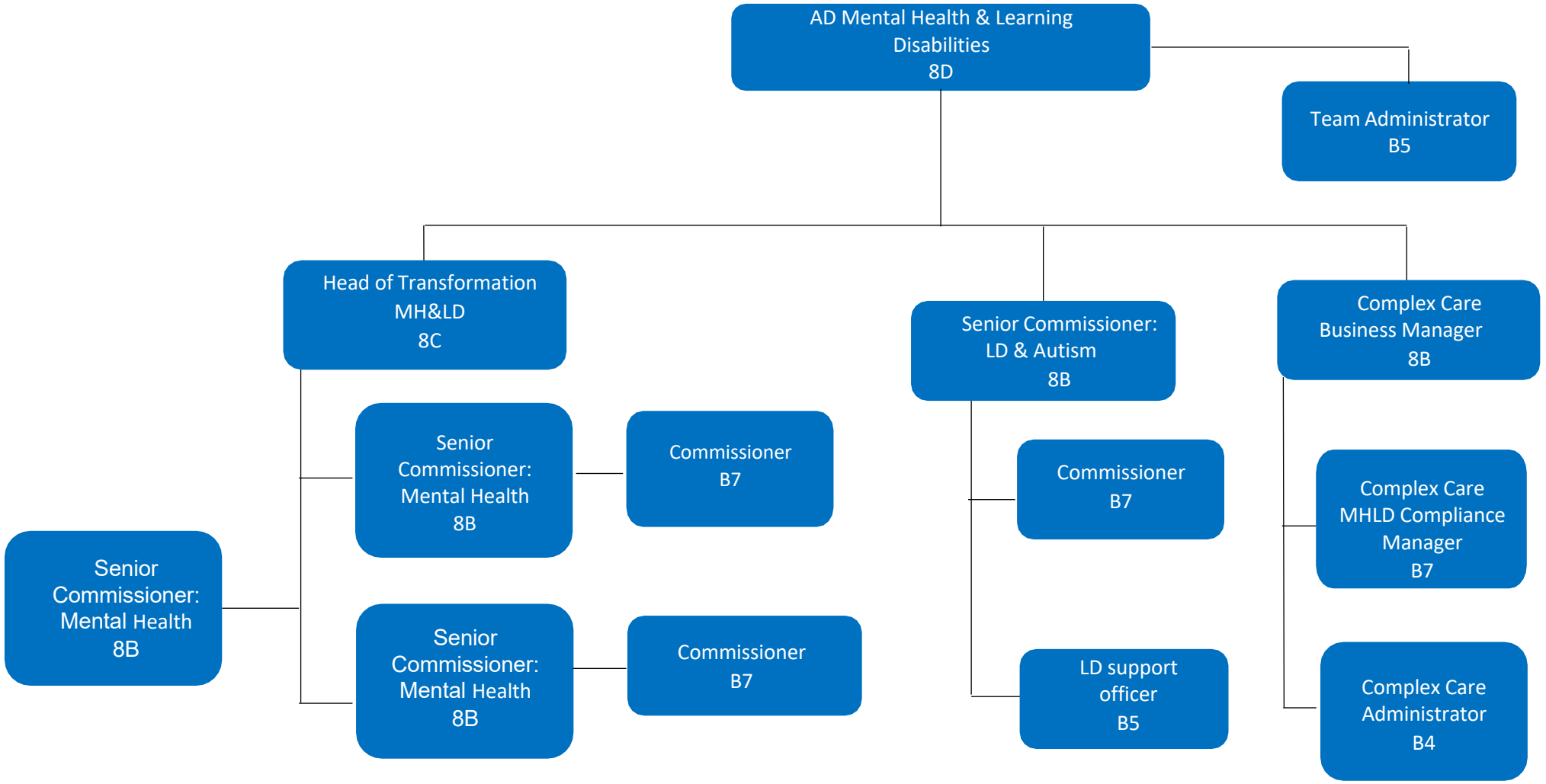
- Role part of the Shared Transformation Resource Network
- Temporary Resource for Change

(62)

# Chief Operating Officer Directorate - Mental Health, Learning Disabilities and Autism




(63) KEY

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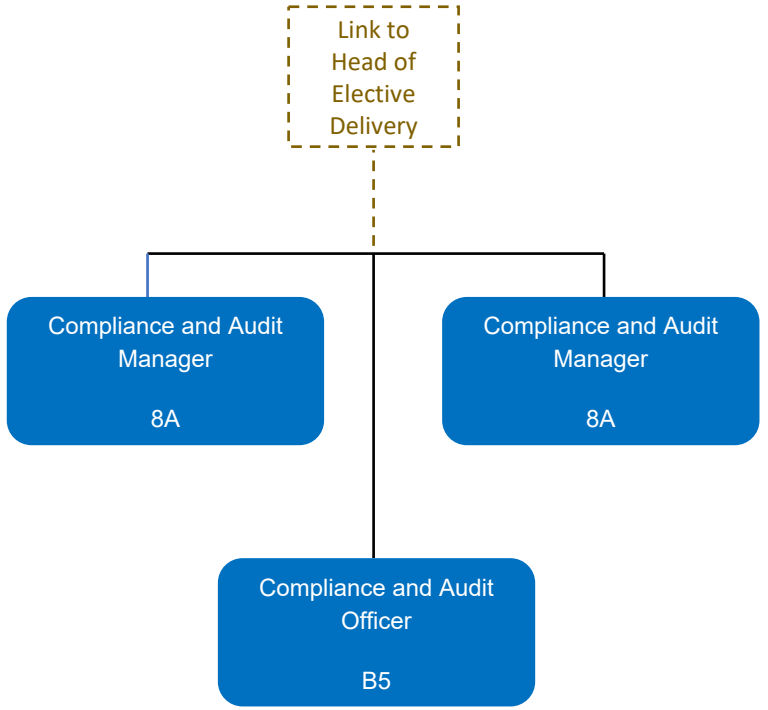
# Chief Operating Officer Directorate - Audit & Compliance (IFR)




KEY (64)

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- Primary Care Training Hub Role
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# Bletchley Pathfinder (Fuller)

Presentation to the Health and Care Partnership on 20 September 2023

## Recommendations

1. Agree to formally start the Bletchley Pathfinder (18 months)
2. Agree the six proposed areas of work
3. Ask the ICB to add ‘Bletchley Pathfinder’ to the MK Deal
4. Agree the proposed governance approach
5. Agree the indicative budget
6. Agree the broad approach to evaluation

Recap

# What is this work trying to achieve?

**To progress the Fuller recommendations**

Streamlining access to care and advice

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

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

**To address local partner priorities**

For example…

**Milton Keynes City Council**

Everyone in Milton Keynes deserves to have the same opportunities and chances in life, where people are valued, feel safe and are encouraged to participate in their community and lead healthier, fulfilled lives.

# Recap
# What have we done so far?

## 22 February

**The Health and Care Partnership…**

- Considered the Fuller report
- Agreed to pilot neighbourhood working in one or two areas of Milton Keynes
- Asked the Joint Leadership Team to develop a more detailed proposal for the pilot

**The Joint Leadership Team then…**

- Carried out initial research on the level of need and reached a view that Bletchley would be suitable as the pilot area
- Developed a better picture of how other areas are approaching the Fuller report and the recommendations

## 13 June

**The Health and Care Partnership…**

- Agreed to select Bletchley as the area to pilot neighbourhood working
- Asked the Joint Leadership Team to prepare for a potential start of the Bletchley Pathfinder in September 2023

**The Joint Leadership Team then…**

- Undertook initial engagement work, meeting Primary Care Network leads and sending introductory letters to Bletchley partners
- Commissioned 13 work packages to inform the design of the Bletchley Pathfinder

## 20 September

**The Health and Care Partnership…**

- Is asked to approve the start of the 18 month Bletchley Pathfinder in line with the design set out in this presentation

# Designing the Bletchley Pathfinder

## Informing our proposals

**13 work packages have informed the design, including…**

Carrying out a detailed local needs assessment

Gauging support from local NHS organisations

Talking with the local voluntary and community sector

Finding out the level of interest from schools

Looking at the role of community pharmacies

Getting feedback from the two Town Councils

Mapping the local public sector workforce

Background work on roles and ways of working

Asking local residents for their thoughts

Contact **Rebecca Green** to take a look at any of the work packages

# Designing the Bletchley Pathfinder

## The first three proposals

### What we found out…

Very broad support for working more closely together from the NHS family, police, schools, the city council, town councils and the voluntary sector

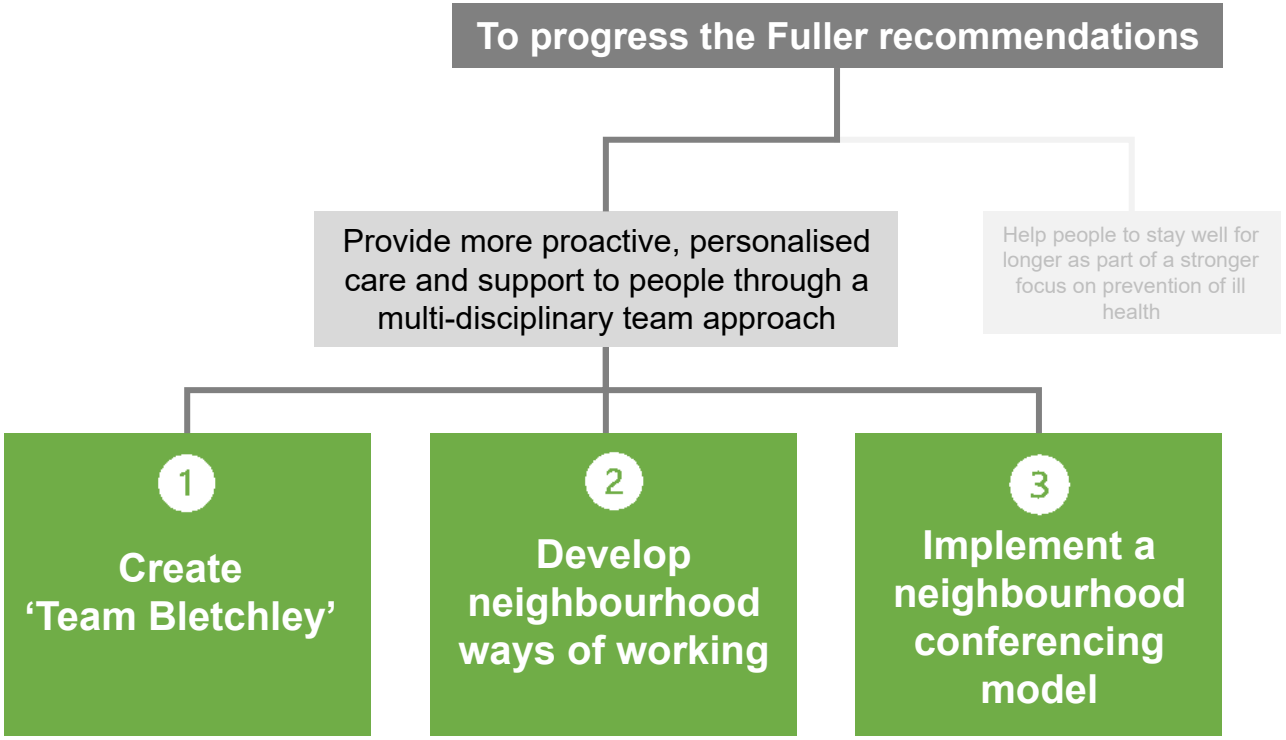
Lack of awareness of what different organisations do, how they operate and could interact better

There are some examples of multi-agency work taking place in the neighbourhood, but they are not consistent or could be developed further

Crime and the fear of crime a theme in resident feedback

Local people want to see better professional co-ordination

### What we are proposing initially…



# Designing the Bletchley Pathfinder

## The proposals

**1 Create 'Team Bletchley'**

- Focused on building relationships and trust between professionals
- Would create multiple opportunities for engagement and dialogue
- Some universal events, some targeted – for example older adults
- Products like an 'Induction to Bletchley' could be developed
- Inclusive - open to public and voluntary sector organisations to join

---

**2 Develop neighbourhood ways of working**

- All about agreeing the best ways of working together in Bletchley
- Could resemble detailed operational procedures or something looser
- Focus on how different sectors interact (for example schools and health)
- Will require a level of organisational sign up and commitment
- Some form of monitoring and management probably inevitable

---

**3 Implement a neighbourhood conferencing model**

- A way of addressing issues where multi-agency involvement is required
- Could be family-focused, or focused on a wider issue
- Standardised, well understood model
- Will need to be clear how it relates to other panel processes
- Will need active management and facilitation

# Designing the Bletchley Pathfinder

# The second three proposals

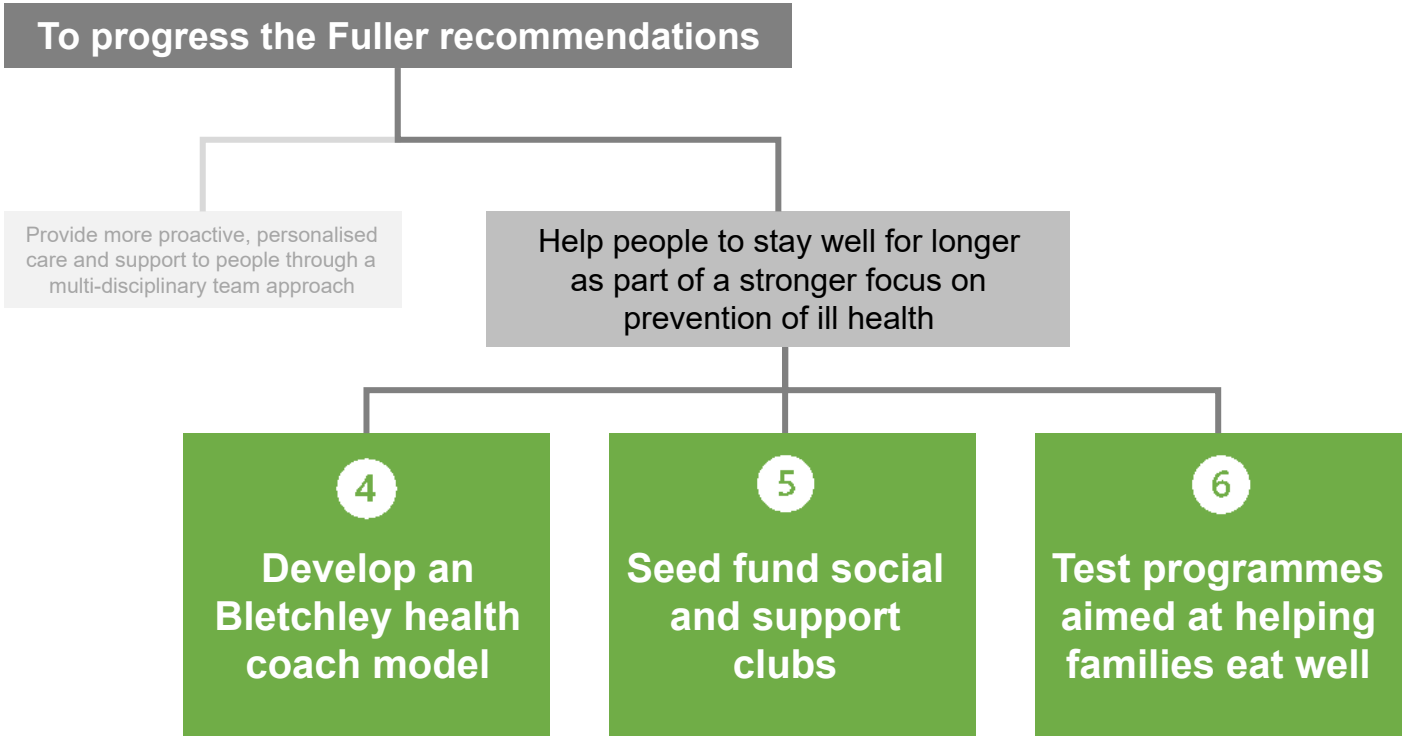
## What we found out…

Health inequalities are worse across the board, but obesity and smoking rates stand out as much worse than elsewhere

Too much use of emergency health care and issues with out patients/planned care engagement. High number of residents have long term conditions so helping people have more control over their health and care is an important issue

Local people liked the idea of a health coach, but also want to see more support services

## What we are proposing initially…



# Designing the Bletchley Pathfinder

## The proposals

**4 Develop an Bletchley health coach model**

- Based on health coaching model but with flexibility to innovate
- Focused on people with existing conditions
- Likely to be an ‘add-on’ to existing roles to achieve scale
- Some existing roles may be suitable for conversion to health coach
- Backed by training and support

---

**5 Seed fund social and support groups**

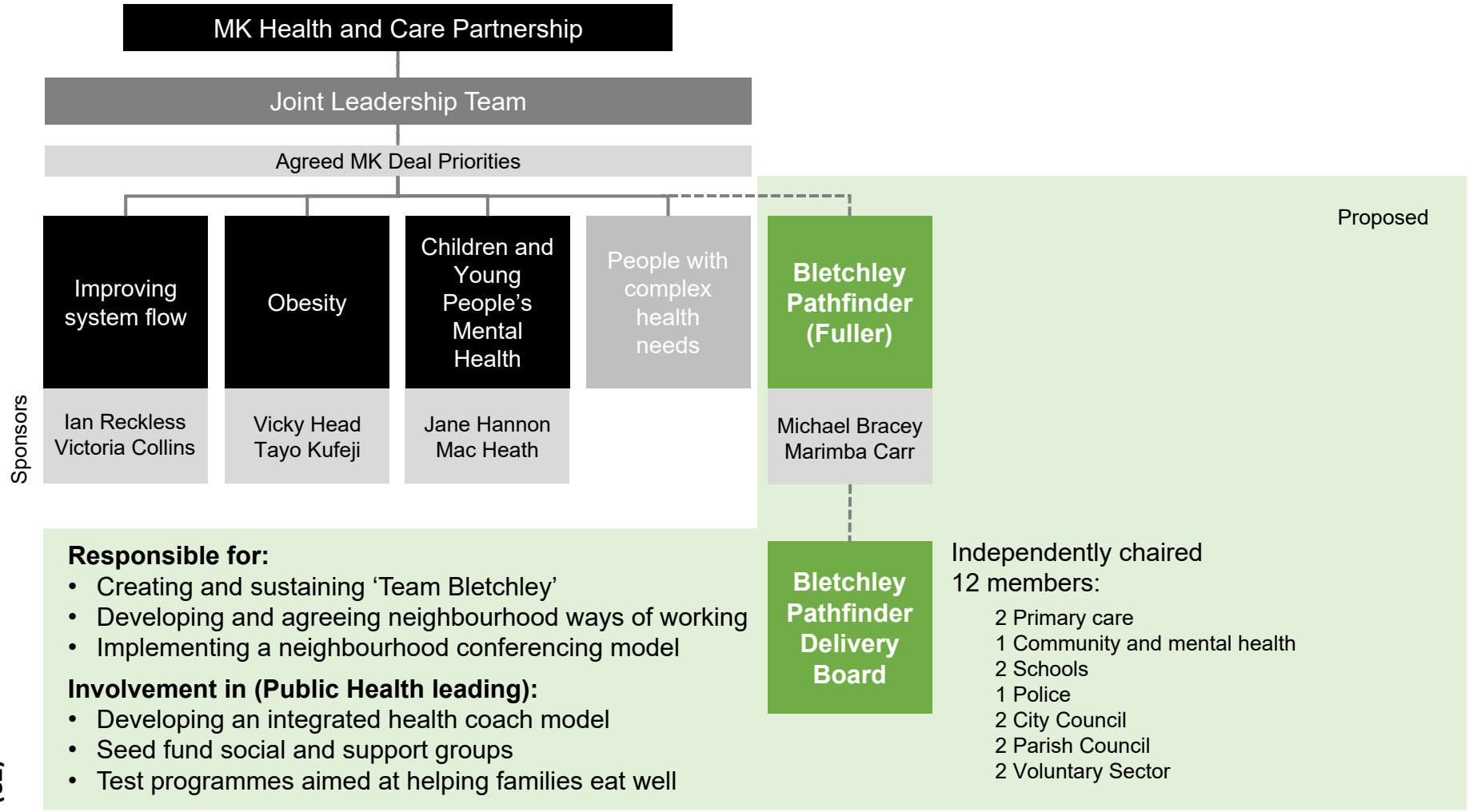
- Designed to fund both small social clubs and health support groups
- Focus on lower cost clubs and groups and supporting new activities
- Funding open to both residents and organisations
- Simple application and reporting processes
- Based on the successful ‘Lakes Clubs’ model

---

**6 Test programmes aimed at helping families eat well**

- Based on a ‘test and learn’ approach, co-produced with local people
- Targeted, focussing on families with young children
- Emphasis on improving food skills and access to heathier food
- Partnership approach including schools, children’s centres, primary care
- Close working with partners such as and SOFEA and MK Food Bank

# Designing the Bletchley Pathfinder
## Governance



# Designing the Bletchley Pathfinder

## Governance – Indicative budget

1. **Create 'Team Bletchley'**
2. **Develop neighbourhood ways of working**
3. **Implement a neighbourhood conferencing model**

**£100K**

Funding delegated to the Delivery Board

- Multi-agency training
- Practice workshops
- Networking events
- Communications budget
- Facilitation costs

4. **Develop an Bletchley health coach model**

**£200K**

- Training
- Recruitment
- Incentives
- Supervision

5. **Seed fund social and support groups**

**£150K**

- Grant funds
- Administration

6. **Test programmes aimed at helping families eat well**

**£100K**

- Supplies
- Services

Funding sources: £350K from the £500K 2023 Health Inequalities ICB funding and £200K from the £500K 2022 general ICB Place based co-ordination ('Population health management')

# Designing the Bletchley Pathfinder

## Evaluation proposals

| | |
|---|---|
| 1 **Create 'Team Bletchley'** | Sentiment tracking amongst professionals (regular engagement) |
| 2 **Develop neighbourhood ways of working** | Adherence with agreed ways of working (exception reporting) |
| 3 **Implement a neighbourhood conferencing model** | Attendance and participation in neighbourhood conferencing, tracking outcomes |
| 4 **Develop an Bletchley health coach model** | Record keeping by coaches demonstrating change, some record sampling |
| 5 **Seed fund social and support groups** | Numbers of groups and participants recorded. Qualitative report produced after twelve months. |
| 6 **Test programmes aimed at helping families eat well** | Project level evaluation will report on impact of interventions and focus on learning |

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MK Together | Health and Care Partnership

# Health Inequalities Funding in Milton Keynes

**Author:** Vicky Head, Director of Public Health

**Date:** **20 September 2023**

**Purpose of Report:**

To seek the Health and Care Partnerships approval of the recommendation for the use of £500K Health Inequalities funding.

## Recommendation

**The Partnership is asked to note and approve the recommendation detailed in the paper:**

1. **To approve the recommendation to deploy 70% of the available Health Inequalities funding on a large scale intervention as a part of the Bletchley Pathfinder work, with the remaining 30% to be used for community and primary care projects.**

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## Health Inequalities Funding in Milton Keynes

### Background

1. The BLMK Integrated Care Board has allocated some of its health inequalities funding for 2023/24 to place. £500K is being made available to each of the four places.

2. The use of the funding is not prescribed in detail other than to support measures which will help tackle inequalities that have an impact on health. The funding is likely to be transferred to the council under a Section 256 grant which means it does not all have to be spent by 31 March 2024, although clearly the funding is intended for use as soon as practicable.

3. There is separate funding (£300K across the Bedfordshire, Luton and Milton Keynes area) to support the implementation of the Denny review of health inequalities the ICB has commissioned. The funding will support the delivery

of the recommendations set out within the report, for instance using video, translations, accessible documents to communicate how we are implementing feedback from people and communities.

4. There was a discussion at the Joint Leadership Team (JLT) on 3 August which has informed the development of this short proposal.

**Recommendations**

5. We can use all of the £500K on one large scale intervention or break it down to fund several initiatives. Recent allocations of funding to tackle inequalities have been broken down and used on smaller initiatives. **On that basis the recommendation is to use around £350K (70%) of the funding for a larger intervention which will enable us to undertake further work at scale with around £150K (30%) set aside for community and primary care.**

6. Given the developing focus on Bletchley through the pathfinder work, the Joint Leadership Team had a strong view that the funding should be used to support this work over the next 12-18 months. The Bletchley work will be cross-cutting and so the use of the funding could, in practice, fund activities such as:

- Lower cost access to fitness activities
- School breakfast clubs
- Community cooking classes and access to healthy food
- Free bike loan scheme

7. It is likely whichever activities are funded, the design and delivery of them will be done in partnership with other organisations, in particular the voluntary and charitable sector. We know that interventions that work through established and respected community organisations are more likely to be effective.

8. If agreed, Vicky Head, Director of Public Health for Milton Keynes would advise on the use of the funding as part of the Bletchley Pathfinder to ensure we take an evidence based approach to selecting the activities to fund. The Health and Care Partnership would be updated on a regular basis on the use of this funding.

9. The Joint Leadership Team recommend setting aside around £150K (30%) of the funding for community and primary care. Although it was recognised that there is specific NHS funding for Primary Care Networks aimed at targeting inequalities (the Network Contract Direct Enhanced Service directs resource to participating PCNs to, among other things, tackle the unmet needs of a

population experiencing inequality in health provision or outcomes), there may be innovative and additional activities that community and primary care colleagues want to bring forward.

10. If agreed, Vicky Head, Director of Public Health for Milton Keynes would also advise on the prioritisation of funding for activities brought forward by community and primary care through the JLT. Activities funded are likely to be:

- Linked to the MK Deal agreed priorities
- In line with the NHS 'Core20PLUS5' framework for health inequalities
- Coordinated across Milton Keynes PCNs
- Bring clear additional benefit over standard primary care
- Respond to an evidenced inequality.

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MK Together | Health and Care Partnership

# MK Deal Priority 1 – System Flow

**SROs:** Dr Ian Reckless, Medical Director Milton Keynes University Hospital
Victoria Collins, Director Adult Services (DASS) Milton Keynes City Council

**Date:** **20 September 2023**

**Purpose of Report:**

To provide a progress update since the last reported period (June 2023) for the Partnership

## 1. Recommendations

1.1 That the update on achievements to date is noted.

1.2 That planned activities to further progress the above priority is noted.

## 2. Overall Objective

2.1 To develop a longer-term improvement plan to deliver functionally integrated services between MKUH, CNWL and MKCC, including:

- Simplification of existing pathways
- An integrated workforce
- Agreement of shared risk management and other clinical policies

Improved interface with Primary Care services and the Virtual Ward

2.2 Improving System Flow (ISF) focusses on urgent and emergency care services for older and/or frail and/or complex service users, in terms of facilitating safe hospital discharge and avoiding preventable admission in the first instance. The project will look at improving the current services in place - checking for gaps, duplications, IT system issues, and what works well and/or not so well, ultimately moving towards a more integrated approach.

Impacting factors include

- Transport – for patients and equipment
- End of life care
- Pharmacies
- Therapists
- IT systems
- Virtual Ward

- Out of area

2.3 This project went live on 1 December 2022 and is overseen by the Improving System Flow Steering Group (ISFSG) who provide strategic direction and assurance to the Joint Leadership Team (JLT). The ISFSG is chaired by Dr Ian Reckless, Medical Director, MKUH.

A core project team was established, to include representation from MKUH, CNWL, MKCC and the ICB.

A wider advisory group was also established, to include subject matter experts, stakeholders, and partners, to act as critical friends regarding what works well, current issues, and to provide input into proposed recommendations.

A finance sub-group has been established, with lead representatives from each organisation.

A communications sub-group has been established, with lead representatives from each organisation, to agree a process for socializing and implementing the Hub model.

An End of Life (EoL) focus group, led by CNWL, has recently set up and tasked with scoping admission avoidance/hospital discharge requirements, and identifying improvements.

A falls prevention focus group has been established to develop a system approach to falls prevention across MK. Members include South Central Ambulance Service, Public Health, Fire Service, and the voluntary sector.

A therapy task & finish group was set up to develop new integrated discharge pathways, and to develop a Care & Therapy Academy.

Two task and finish groups have been established focussing on reviewing and developing options regarding the Discharge to Assess (D2A) pathways.

## 3. Key Activities Achieved

3.1. **Service mapping** was completed for both hospital discharge and admission avoidance, to identify the current and contracted services in place, alongside the voluntary sector organisations working with MKCC. The end-to-end process for early discharge and admission avoidance was mapped and assessed. Out of Area, End of Life and Complex Care were also assessed.

3.2 Operational information and outcomes data have been reviewed and a set of **5 performance metrics identified** for monitoring by the ISFSG. A metrics dashboard

has been developed and will provide a comprehensive data set. This will be presented to the ISFSG meeting in September.

3.3 The **Virtual Ward business case** was agreed by JLT in June 2023 and a sub-group of the ISF steering group will drive delivery and provide regular reporting on progress. S256 funding will be released to Virtual Ward providers (CNWL, MKCC and MKUH) only when costs are actively being incurred in relation to a role within this business case. Where a staff member is seconded into a Virtual Ward role, funding will only be provided only if/when costs are being incurred through backfill of the vacated role.

3.4 A **discharge service model** was scoped and planned, alongside an assessment of the workforce. The recommended proposal, an integrated discharge hub, was agreed by both the ISFSG and JLT. Ongoing activity includes:

- Accurate costings for the Hub are being worked on with finance leads.
- A communications plan has been developed for approval by the ISFSSG in relation the Hub. - A proposal/consultation document, ratified by the ISFSG, will form the basis of future conversations with HR, Finance, and staff.
- A location for the Integrated Discharge Hub is currently being determined within the hospital.
- A workforce structure has been established, and role profiles are being developed and evaluated. Line Management arrangements and accountabilities are now being established.
- A Governance options paper is currently being prepared alongside a complaints process. Initial work has started on developing a service specification and operating procedures, while a Memorandum of Understanding, information-sharing agreements, and honorary contracts are being established.

3.5 The total spend on admission avoidance and hospital discharge has been verified and **current funding, reviewed**.

3.6 **Discharge to Assess (D2A) best practice** was identified and options for new D2A pathways were jointly formulated, ready for taking to the end-Aug ISF Steering Group. This is focussed on pathways 1 and 2.

3.7 The development of a **Care & Therapy Academy** was agreed by the ISF Steering Group, and £800k funding was agreed by JLT. Training needs have been mapped and a training programme is being developed, while venue options are being identified. From April'24 consideration will be given to introducing apprenticeship programmes for Therapy Assistants with a view to becoming registered therapists. Role profiles for the training Programme Co-ordinator and Health Care Assistants (HCA) have been developed and are currently under evaluation. CNWL is to be the employing body, and recruiting organisation, for the Programme Co-ordinator – the position will be fixed term for 12 months.

3.8 Assessment of the **Primary Care Interface** is underway and includes discussion with the Primary Care Network Alliance regarding issues in the sharing of patient

records. Discussions are underway with IT leads from each organisation to determine what equipment, software or applications may be required.

3.9 The Out of Area process in neighbouring Local Authorities has been determined. A **Trusted Assessment process** with Buckinghamshire County Council has been designed for trialling during Sept'23.

3.10The current focus is on admission avoidance - to identify gaps, and issues that need addressing. Existing models in other areas were explored and good practice identified. A **review of admission avoidance** data is underway. For example, work has commenced around identifying falls data and how the falls prevention pathways operate.

3.11 Ambulance transport was assessed, and issues identified in the current offer delivered by SCAS. Funding discussions following the SCAS review were delayed due to industrial action. A scoping exercise is now underway around the current CNWL **'man-and-a-van' offer** in order to design an improved transport service for patients and essential equipment.

3.12 **Healthwatch was commissioned** to provide insight into the patient journey. Their engagement proposal was signed-off by the ISFSG in April. A summary report of findings, with recommendations, will be ready for taking to the Sept ISFSG.

3.13 An **overarching winter plan was developed** in collaboration with the ICB, MKUH, CNWL and MKCC, and approved by the ISFSG. Design of a detailed ICB and MKCC winter resilience plan is in progress.

3.14 **A 2-year plan for Better Care Fund** (BCF) money was developed. This incorporated the new Hospital Discharge Fund (HDF). Examples of areas to be funded by the HDF include:

- recruitment of hospital HCA posts to support the Therapy Team. Advertising will commence during Aug'23.
- a new Bridging Care service to support speedier hospital discharge. This will be commissioned in the Autumn.
- a new 'Live In Care' service to support hospital discharge for those on the delirium pathway. This will be commissioned in the Autumn, additional funding for mental health step down beds.

## 4. Key Activities Planned: Sept 2023-March 2024

4.1 Establish the integrated discharge hub.

4.2 Launch the Care and Therapy Academy.

4.3 Identify relevant organisational information/data systems and formulate an IT plan to meet access requirements.

4.3 Determine a workforce structure around the D2A pathways once options agreed. Confirm recruitment and consultation requirements with relevant HR leads and start the consultation process. Enter contractual negotiations with commissioned services.

4.5 Review capacity and demand in step-down bed facilities.

# MK Deal Priority 2 – Tackling Obesity

**SROs:** Vicky Head, Director of Public Health
Dr Omotayo Kufeji, Clinical Director, The Bridge Primary Care Network

**Date:** **20 September 2023**

**Purpose of Report:**

To provide a progress update since the last reported period (June 2023) for the Partnership

## 1. Recommendations

1.1 That the update on achievements to date is noted.

1.2 That planned activities to further progress the above priority is noted.

## 2. Overall Objective

2.1 Tackling Obesity 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.

2.2 This priority went live on 1 December 2022 and is overseen by the Obesity Steering Group who provide strategic direction and assurance to the JLT. The Obesity Steering Group is chaired by Vicky Head.

2.3 The Tackling Obesity Priority has three key themes:

- Theme 1 focuses on increasing referrals, access to and engagement with weight management services.
- Theme 2 focuses on innovation and upscaling.
- Theme 3 focuses on shaping the environment.

## 3. Theme 1: Increasing referrals, access to and engagement with weight management services

3.1. This workstream is organised into five key Task and Finish Groups (TAF), focused on:

1. Simplifying the referral process into weight management services for healthcare professionals and residents.
2. Developing an education and training offer for clinical and non-clinical frontline professionals.

3. Population Health Management, maximising our use of data and using it to target priority groups.
4. Reviewing and scoping of Tier 2 plus/Tier 3 service for children, young people, and families.
5. Reviewing the Tier 3 weight management service provision for MK residents 18 years old and above and scoping the potential for a more local offer.

Membership of the task and finish groups include subject matter experts from Public Health, primary, community and secondary care. This membership will be expanded to include representation from VCSEs and the resident voice for specific TAF groups.

## 3.2 Key Activities Achieved

3.2.1 The **referral processes** from GP SystmOne and from the CNWL Mental Health modules have been simplified to allow referring into the weight management provider (MoreLife) a quicker process.

3.2.2 Designed a **training session** for primary care, focused on having conversations about excess weight and raising awareness of the local and national weight management services available across MK. This was co-produced with Primary Care GP registrars.

3.2.3 A successful **Obesity Training Event** was delivered on 20th July at a MK Primary Care Protected Learning Time session. Approximately 95 people attended, including GPs and other clinical staff from GP practices in MK. The event included speakers from Public Health (presenting the training session mentioned above) and LEAP, a paediatric dietician and consultant physician in Endocrinology, Diabetes and Metabolic Disease from Milton Keynes University Hospital.

3.2.4 Developed an **obesity dataset**, synthesising information about the prevalence of obesity within each GP practice, number of referrals to weight management services, number of people with a learning disability who have a BMI recorded and the National Childhood Measurement Programme (NCMP) data by ward. This database will be used to target interventions with practices and to evaluate the Theme 1 workstream.

## 3.3 Key Activities Planned: Sept 2023-March 2024

3.1. A 12-week programme for people with a Learning Disability and their carers, which is due to launch in September and two further programmes will be available in January.

3.2 Design and roll out a more targeted training package for specific GP practices (14 across MK).

3.3 Design a training package on having healthy weight/excess weight conversations with patients (using making every contact count principles), and raising awareness of the weight management services available across MK for wider clinical and non-clinical professionals (e.g., community pharmacy, CNWL, secondary care, carers, housing officers).

3.4 Review BMI data from the Severe Mental Illness register and work with CNWL and individual GP practices to increase the onward referrals to weight management services for this cohort.
3.5 Continue wider work with the Local Authority Public Health team to review the referral pathways for weight management services as part of the discussions around an integrated behaviour change service.
3.4 Develop a scoping paper for a Tier 2 plus/Tier 3 service for Children and Young People across MK and, as a separate paper, for a more local Tier 3 adults' service. To be presented to Joint Leadership Team (JLT) in November 2023.

## 4. Theme 2: Innovation and Upscaling

**4.1** Focuses on digital incentive scheme (digital wearables) to optimise movement in T2 diabetes. This is a collaborative research project between MK Council, MKUH, primary care and Loughborough University.

The research project will focus on a targeted cohort of participants (1,800) who will be provided with wearable technology (apple watch) and a physical activity plan and incentives for adherence to goals. These will be introduced through primary care annual reviews and followed up at 12 and 24 months with half of the participants received the full package at the start of the trial and half after 12 months. A robust evaluation conducted by Loughborough University will be undertaken to evaluate the impact on clinical outcomes and quality of life.

### 4.2 Key Activities Achieved

4.2.1 Procurement and **contract award completed** (this was led by Milton Keynes Council).
4.2.2 Outlined protocol for **randomised controlled trial developed** with evaluation partner (Loughborough University), colleagues in primary care and MKUH Diabetes service.
4.2.3 Local **patient engagement** (first round of PPI) completed.
4.3.3 Adoption **application submitted** to NHS ethics/National Institute for Health and Care Research.
4.3.4 Primary Care (GP) **engagement events** undertaken.
4.3.4 Application **approval received** from NHS ethics.
4.3.5 Healthcare practitioner **training commenced**.

### 4.3 Key Activities Planned (Sept 2023-April 2026)

4.3.1 Trail to commence & 1st patient recruitment (one practice initially – Whaddon Medical Centre).
4.3.2 Review trial with a view to expansion.
4.3.3 Last patient recruitment (trial to run for 2 years).
4.3.4 12 months of data collection completed (April 2025).
4.3.5 Report produced on first 12 months.
4.3.6 Trail completed (April 2026).
4.3.7 Report on trial 24 months data produced.

## 5. Theme 3: Shaping the Environment

Focuses on changing cultural, social, economic, and environmental factors that shape eating and physical activity habits and for MK partner organisations to agree what actions can be taken to change the underlying factors for obesity. This could include:

- Incentivising walking, cycling and public transport, either financially or through design. For the Council this could include transport planning or increases to car parking costs. For us all, as employers, it could include rewards or benefits for staff or patients/residents travelling to our sites (or while doing their work) by active modes.
- Reviewing food procurement, including on-site food and drink offers for staff and patients/residents such as cafes, restaurants, and vending machines, to include a focus on healthy food.
- Reviewing commercial agreements to sell food on our retail premises to specify requirements around the relative prominence/quantities of healthy and unhealthy foods. Both the NHS and the Council has estates that are used for retail.
- Developing sponsorship and partnership policies to restrict or limit the promotion of unhealthy food, particularly when targeted at children.

**5.1 Key Activity Achieved**

5.1.1 **Discussion paper** outlining the above examples submitted to JLT.

**5.2 Key Activity Planned**

5.2.1 Development of a 'call to action' proposal to JLT by December 2023 that would challenge partners to make specific commitments in a focused time scale.

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# MK Deal Priority 3 – Children and Young People Mental Health

**SROs:** Jane Hanlon, Managing Director, Diggory Division, CNWL
Mac Heath Director of Children's Services, MKCC

**Date:** **20 September 2023**

**Purpose of Report:**

To provide a progress update since the last reported period (June 2023) for the Partnership

## 1. Recommendations

1.1 That the update on achievements to date is noted.

1.2 That planned activities to further progress the above priority is noted.

## 2. Overall Objective

2.1 Lead Health & Care Partnership-based work plans to improve outcomes for children and young people's mental health.

2.2 Interface with the ICB Mental Health Transformation Programme to ensure join up for key deliverables and recovery plans.

2.3 Ensure that plans will address inequalities across MK.

2.4 Provide assurance as required to NHSE.

2.5 Provide information and training across system partners.

2.6 Identify and deciding the services necessary to meet the needs of the population including design of new pathways, services, working with finance, contracting, primary care and quality colleagues to ensure this is done to provide high quality care at best value.

The Children and Young People's (CYP) mental health has four key themes as outlined below:

## 3. Theme 1: Closer working together between system partners

This workstream focuses on:

- Closer working between system partners including sharing data

- Prioritisation and exploring co-location of teams

**3.1 Key Activities Achieved**

3.1.1 Improved **sharing of information.**

3.1.2 An additional **Clinical Psychologist post** been approved and funded.

3.1.3 **Agreed Joint Children & Adolescent Mental Health Service (CAMHS)/MKC actions** with an option for CAMHS to move to the MKC Building.

3.1.4 **Existing arrangements** and the links between CAMHS, Designated Safeguarding Leads, Special Education Needs Coordinators (SEN-Co's) and the ICB **reviewed.**

3.1.5 Potential **co-location option identified,** and access feasibility study initiated.

**3.2 Key Activities Planned: Sept 2023-March 2024**

3.2.1 Looked After Children (LAC) Clinical Psychologist in post and achieving agreed outcomes.

3.2.2. CYP are able to achieve their goals and an improvement in Scoring Strengths and Difficulties Questionnaire (SDQ) scores.

3.2.3 Increased confidence in foster carers and placement in supporting CYP with complex needs.

3.2.4 Increased confidence in social workers in supporting trauma and attachment informed support.

3.2.5 Reduction in the number of placement moves.

3.2.6 To reduce the declined referrals into CAMHS.

3.2.7 Review the impact of the agreed joint CAMHS/MKC Actions

3.2.8 Agree steps to address gaps/opportunities for improvements identified in the review of existing arrangements.

**4. Theme 2: Getting Help and Advice**

This workstream focuses on:

- Getting a greater understanding of existing provision.
- Building a more consistent, clear, and understandable MK-Wide offer with appropriate interventions for advice and early help that are accessible for groups at higher risk of poor mental health.
- Developing the mental health and wellbeing offer for 0-5s and their families, with a focus on prevention and early intervention.
- Expanding the indirect reach of the mental health support teams and improve system awareness of the offer.
- Increasing capacity in the voluntary sector to offer advice and help, including face-to face offers.
- Reframing the referral process away from 'referral to CAMHS' to 'referral for mental health support'

**4.1 Key Activities Achieved**

4.1.1 **Triangulation of mapping** template completed with results of Jane Held's Independent scrutiny review.

4.1.2 **Business case** (£35kpa over 3 years) finalised.
4.1.3 ICB and MKCC funding identified. Agreement in principle with MKYiS for support hubs. Wisdom Principle faith-based **community engagement sessions funded and scheduled**
4.1.3 **BeWell survey results** and feedback from CYP

### 4.2 Key Activities Planned: Sept 2023 – April 2024

4.2.1 Agree business case to be implemented with MKCC Children and Family Centres and voluntary sector partners (Knowledge Change Action).
4.2.2 Implement additional support for the agreed schools.
4.2.3 Roll out of Q Alliance support to schools to support the mental health and wellbeing of LGTBQ+ young people *(to be linked into the MKYiS support hubs).*
4.2.4 Bids from voluntary sector organisations assessments for short term commissioned services/grants up to 2 years.
4.2.5 Implementation of agreed expansion in voluntary section; monitoring of outcomes; review of CAMHS waiting times.
4.2.6 Establish foundations for continued work in FY24/25.

## 5. Theme 3: Joining Up training on neuro developmental pathways

This workstream is focused on:

- Joining up multi-professional training for Autism Spectrum Conditions (ASC)
- Evaluating the impact of the training to identify what further actions can be implemented and the proportion of referrals that are not appropriate.

### 5.2 Key Activities Achieved

5.2.1 **Questionnaire** sent to MK schools **completed** *(to identify current levels of training and future needs).*

### 5.3 Key Activities Planned: Sept 2023 – April 2024

5.3.1 Working group to draft a training plan.
5.3.2 Training plan to be communicated to SEN-CO's and trainers to be identified.
5.3.3 Delivery of training modules.
5.3.4 Evaluate impact of training to identify further actions requiring implementation and the proportion of inappropriate referrals.

## 6. Theme 4: A smoother crisis offer

This workstream is focused on:

- Improving our joint crisis response to C&YP.
- Implementing reporting to system partners on the use of Tier 4 (T4) CAMHS inpatient beds.

### 6.1 Key Activities Achieved

6.1.1 **Metrics identified** by task and finish (TAF) group and key data to be collected to support a revision of pathways.

### 6.2 Key Activities Planned: Sept 2023 – April 2024

6.2.1. Revise the pathways as defined by the TAF group.

6.2.2 Commence reporting to system partners on the use of T4 CAMHS inpatient beds.

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MK Together | Health and Care Partnership

# MILTON KEYNES BETTER CARE FUND PLAN 2023-2025

**Author:** Mick Hancock, Group Head of Commissioning MKCC

**Date:** **20 September 2023**

**Purpose of Report:**

To provide detail of the Milton Keynes Better Care Fund Plan for 2023 - 2025

## Recommendation

**The Partnership is asked to approve the Milton Keynes Better Care Fund Plan for 2023-2025**

### *1. Executive summary*

In Milton Keynes our Better Care Fund (BCF) plan has been agreed through a collaborative process. This approach is evident not only in the development of our plan but also in the governance, commissioning, monitoring and evaluation of our BCF schemes e.g. our joint approach to supporting carers, dementia, intermediate care services and community equipment. For 2023/24 whilst many of our schemes will continue and remain largely unchanged, we have seen a new and significant departure in our approach to the BCF. This is based upon our 'MK Deal', a ground breaking agreement brokered between the key health and social care partners in Milton Keynes and the Bedfordshire, Luton and Milton Keynes Integrated Care Board which delegates responsibility for improving four areas of health and care to Milton Keynes as a 'place'. The four areas are improving system flow, tackling obesity, children and young people's mental health and supporting people with complex needs.

We have sought to prioritise a number of areas, several of which are outlined below:

- Whilst we have had some success with our approach to hospital discharge, we are reviewing our Discharge to Assess pathways. We are now moving towards developing a fully integrated Home First service, with a single management structure. **This is a priority area for 2023/24**
- Similarly, we are looking to ensure that we have a co-ordinated, efficient and effective approach to bed-based support in care homes. It is currently fragmented and we expect to rationalise our use of care home beds, as we move towards supporting more people in their own home. **This is a priority area for 2023/24**

- We will also be introducing two new short term services to ensure speedier and safe discharge: a 'bridging care' service to provide immediate support at the point a patient is ready for hospital discharge; and live-in support in the persons own home, when they may be experiencing a deterioration in their cognitive abilities or suffering from delirium. **This is a priority area for 2023/24**

- We are continuing our investment in community equipment services as we rapidly move to integrate with three other local authorities and the ICB. **This is a priority area for 2023/24**

- In relation to our aim to improve system flow we will be reviewing our approach to falls, to see how we can further avoid admission to hospital. **This is a priority for 2023/24**

- Finally, we are developing further our commitment to support carers, especially in relation to maximising opportunities for carers breaks. **This is a priority area for 2023/24**

### *2. Overall Better Care Fund plan and approach to integration*

Milton Keynes' BCF plan has continued to be successfully implemented over a number of years. A significant number of our schemes are longstanding, several since the introduction of the BCF. For 2023/24 we will maintain our position in relation to many of our schemes, ensuring they continue to achieve excellent outcomes and are sustainable. This will allow us to evaluate and review our BCF plan for 2024/25 in light of the MK Deal.

Following the creation of the Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) there has been agreement across key partners to develop new arrangements for Milton Keynes to influence system improvements and jointly commission at a local level. To this end we have agreed the MK Deal with our key health and social care partners. A new collaborative approach between Milton Keynes City Council (MKCC), Milton Keynes University Hospital (MKUH), our community health services provider Central and Northwest London NHS Foundation Trust (CNWL), the ICB and our voluntary sector has resulted in a joined up approach over four key priority areas – improving system flow, tackling obesity, children and young people's mental health and manging complex needs. In terms of BCF the focus is on improving system flow.

We recognise the year round pressures on our health and social care system, and that our BCF schemes are very much focussed on ensuring timely and safe hospital discharge and admission avoidance. Our aim is to provide a functionally integrated approach in relation to improving system flow.

As in previous years we have seen the development of our BCF plan through a collaborative approach, which is now very much incorporated into the MK Deal and improving system flow. Our Improving System Flow Steering Group (IFSG) and project team has led the preparation of the plan. This group includes representation from all key partners – MKCC, MKUH, CNWL, ICB and the voluntary sector. As such we are now well positioned to jointly commission services that align to the priorities in our BCF plan. We see this approach as key to ensuring alignment of our priorities and reducing duplication of services. For example, our new Care and Therapy Academy is being jointly commissioned by MKCC, MKUH and CNWL (see Section 3). A further example of our joint commissioning is the work we are undertaking in relation to our integrated discharge hub (see below) and improving our Discharge to Assess pathways (see Section 3).

The BCF plan has been developed with regard to the uplift in the overall NHS minimum contribution. This has ensured that the expenditure on social care services has been maintained or increased. For example, in relation to intermediate care services once again there has been additional expenditure allocated to recuperation services. Similarly, with NHS commissioned out of hospital services, expenditure has been maintained or increased. For example, in relation to nursing assessors to improve hospital discharge, expenditure has been increased. Overall there is an increase of 5.6% in the BCF, which for 2023/24 totals £29.3m.

Our vision for integrated services is integral to our BCF plan - to support people to live independently in their own home, and within their local communities, wherever possible. To achieve this we will: simplify and improve pathways of care; renew our focus on getting people home; develop a more integrated workforce.

- We will continue to invest in our Home First approach that sees MKCC and CNWL provide therapeutic interventions, community nurse support, intermediate care beds and reablement to enable timely hospital discharge and admission avoidance. Our current approach is agreed by MKCC, ICB, MKUH and CNWL and builds upon the work undertaken as part of our 'Getting People Home Programme' that commenced in 2016. This programme developed our strategy for ensuring that, as a health and social care system, we were able to jointly commission suitable services to support hospital discharge. We successfully maintained our Seacole virtual community hospital, that can also accommodate higher acuity patients who need more intensive sub-acute care before going home or to a suitable placement. However, in line with our improving system flow project, we recognise that our Home First approach is not fully integrated. This can result in duplication and delays in providing necessary support to enable timely discharge from MKUH and community services. Following a review of the pathways, referral and assessment processes and community provision, we will be seeking to

fully integrate our provision (See Section 3 and 4 below). **This is a priority for 2023/24**

- The provision of community equipment services remains a vital component of our integrated approach. The Section 75 between the ICB and MKCC has ensured a joined up approach to developing appropriate support for promoting and improving independence. As a result investment in our community equipment services is ongoing and has made an impact in the management of hospital discharge delays, and also maintaining independence for people with more complex needs. We are now in the process of jointly commissioning a new integrated community equipment services across the wider Integrated Care System. This remains a priority for the ICB and four local authority areas: Milton Keynes, Luton, Central Bedfordshire and Bedford. **This is a priority for 2023/24**

- We will maintain dementia services for diagnosis, post diagnostic support and hospital discharge. These services continue to be at the forefront of our joined up approach. We have increased our investment in Admiral Nurses, who are key to supporting carers, ensuring that they have a valuable lifeline to continue their caring role. Over 160 referrals were received and 333 face to face contacts took place over a twelve month period. We will also continue to invest in our care home practitioner to aid diagnosis and support and train care staff. Our dementia step down beds continue to be very well utilised, and provide an opportunity for post-hospital discharge assessment. However, we recognise that demand often exceeds supply (see Section 3 below). Our investment in dementia support and awareness is seen as crucial to ensuring excellent outcomes and improving health and social care services.

- We also continue to invest in admission avoidance services. This includes our CNWL led Urgent Community Response team and funding for community based geriatricians. This service remains very responsive to meeting the needs of those individuals who may be at substantial risk of hospital admission or be high intensity users of health services. The team incorporates a swift response to those in the community as an alternative to referring to accident and emergency or calling an ambulance. The service has developed some key initiatives recently which has enabled taking patients directly from the local ambulance service and supporting our new Virtual Ward.

- Whilst we have successfully established a multi-disciplinary approach in the hospital's Accident and Emergency department, including a community nurse, social worker, Occupational Therapist and Physiotherapist, we recognise that a more integrated model is required from Accident and Emergency through to a ward admission and date of discharge. We are in the process of developing an integrated hospital discharge hub that focusses on the whole patient journey, to provide a co-ordinated multi-disciplinary team to facilitate timely

and appropriate discharge and where possible avoid admission.

**This is a priority for 2023/24**

Through the joint approach between the ICB and MKCC we have continued to support collaborative service delivery.

- The ICB and MKCC continue to work jointly in quality monitoring and safeguarding. This has enabled us to have a targeted and robust approach to compliance, safety and risk. Joint meetings between the ICB and MKCC take place monthly to oversee and plan monitoring activity, seek resolutions to quality issues and assess current intelligence. Information sharing, jointly agreed protocols and procedures and significantly less duplication are all well embedded in the Milton Keynes health and social care system.
- We have maintained our investment in CHC assessment and case management processes. The synergies between MKCC and the ICB are evident in managing complex care and support. This has resulted in improved quality oversight, reduced assessments/hand-offs, improved local intelligence and increased trust and confidence in assessment and review processes.

As a unitary authority MKCC is both the statutory lead authority for social care and housing. We have seen the success of the integration of adult social care and housing services in our Adult Services directorate. Services such as homelessness prevention, rough sleeper support, community support, housing allocations and the acquisition of temporary and long term accommodation are all embedded alongside more traditional social care services. This has been particularly beneficial in the management of complex care and homelessness.

### *3. Enabling people to stay well, safe and independent at home longer*

We have, over a number of years, made strategic decisions to ensure we are:

- enabling people to remain at home independently for longer
- able to support safe, timely and effective hospital discharge.

We have embedded our commitment to commissioning appropriate service provision in community and home settings, continuing to shift away from acute care to community care. Whilst we are seeing unprecedented demand for services we have continued to maintain the progress we have made in: managing the number of admissions to residential and nursing care; discharging people from MKUH to their normal place of residence; increasing the numbers of people still at home following reablement after 91 days. These achievements, through the use of BCF, have come through targeted schemes.

The High Impact Change Model (HICM) remains at the core of our processes. This tool encapsulates the actions we have taken in the use of BCF from early discharge

planning through to trusted assessment. It runs through the schemes we have developed and continue to employ. Again we have reviewed how we employ the HICM and consider that currently our processes continue to function well. However, we still consider that there is room for improvement. This is in the context of our improving system flow project.

Through the BCF we have invested in intermediate care and recuperation services for those people being discharged from hospital.

- In relation to Discharge to Assess pathway 1, we have focussed on our Home First Reablement and recuperation at home services to support and keep people in their own homes longer. Our reablement service has consistently achieved its target of keeping people at home 91 days after hospital discharge. Whilst our recuperation service, commissioned to provide up to 800 hours per week, has enabled people to recover at home to minimise hospital stays. We will continue to invest in these services during 2023/24. However, although we have seen many years of collaboration between MKCC's reablement service and the CNWL therapy led service, we recognise that they are not structurally integrated and are functionally separate from each other. Our capacity and demand work has also shown us that demand for reablement is often high, whilst our capacity is often stretched. To this end we will be looking to improve the efficiency and effectiveness of pathway 1 services through integration. We anticipate that during 2024 we will have developed one Home First Team to provide care, support and therapies, with a single management structure. **This is a priority for 2023/24**

- Our CNWL and MKCC therapy services provide very effective support to promote and maintain independence. However, we are consistently faced with recruitment difficulties in delivering therapeutic interventions. This impacts on our ability to meet demand, evidenced in our care capacity and demand work. As a result we are exploring how we can upskill our Reablement Assistants and Health Care Assistants to enable them to provide structured interventions to a therapy plan. This new approach, referred to as our Care and Therapy Academy, will require investment to educate and train these workers. We envisage that in 2024/25 we will be able to refocus a proportion of the BCF to support this initiative. This cannot be seen in isolation from our integrated approach to Discharge to Assess pathway 1. **This is a priority for 2023/24**

- Regarding Discharge to Assess pathway 2 both our care home bed-based services, Seacole and recuperation, have been crucial in ensuring that choice and independence are of the highest importance for individuals. Decisions about long term care needs are made outside of an acute setting and most importantly recuperation /recovery is maximised. This allows for the promotion of independence and self-care, whilst enabling choices to be made in a non-acute environment. At the same time de-compensation is reduced

and there is a more effective use of rehabilitation and reablement. We currently utilise the BCF through commissioned care homes for 19 recuperation beds, of which 3 are dedicated to dementia care, and 48 beds through Seacole, our therapy and nurse led service. Both bed-based services allow us to minimise hospital stays and provide support to enable people to maximise their independence. However, we have recognised, as part of our review process, that our approach is: not fully integrated; is provided across multiple sites; and at peak periods of the year demand exceeds supply (evidenced by our capacity and demand work). As a result we will be seeking to rationalise our bed-based support and integrate our support provision. The expectation is that we will begin to move the focus away from care home support to support in the person's own home. **This is a priority for 2023/24**

- The Trusted Assessor role, for those returning to a care home from hospital, has continued effective collaboration between the care home sector, acute hospital and social care. This has shown clear benefits in term of speedier discharges, improved information sharing and the development of professional relationships.

- Our integrated falls prevention service will continue to be funded through the through the BCF. This has been established to reduce hospital admission, provide speedier recovery post-admission and deliver a self-care approach through exercise programmes and physiotherapy. However, in view of our aim to improve system flow we will be reviewing our falls service, to see how we can further avoid admission to hospital. **This is a priority for 2023/24**

- Support services for people with direct payments and personal health budgets continue to be funded through the BCF. These services include: setting up Direct Payments; support to employ personal assistants; and administering a holding account service. They act as an ongoing essential aspect of promoting self-care, choice and independence.

- Primary care networks in Milton Keynes are now well embedded in 6 areas. Through our Integrated Community Support Teams we have maintained a joint approach with co-located social care, health and voluntary sector staff to provide interventions to reduce reliance upon GPs, admission to acute settings and promote preventative measures including social prescribing.

### *4. Providing the right care, in the right place, at the right time*

As highlighted above we are now seeking to develop a fully integrated approach to support people from the date of their hospital admission, through to our Discharge to Assess pathways. Working collaboratively our key partners recognise that a functionally integrated approach to supporting people to receive the right care, in the right place, at the right time is crucial. Our plans are ambitious and are largely based upon our MK Deal priority to improve system flow. For example, we are now exploring how we can functionally integrate our Home First Reablement and Home First Therapy services.

We are utilising our capacity and demand estimates to inform our work. We have concluded that whilst our Home First Reablement service currently offers 28 spaces a week, and supports 65 people at any one time, our demand often outweighs this capacity. We have also seen evidence of variations in demand throughout the year. Our ambition is to increase the capacity within our Home First Reablement service to over 80 people at any one time. As a result we are now offering additional funding to supplement our workforce through a 'Golden Hello' scheme to recruit and retain more reablement assistants. We will largely keep intact and grow our reablement service, whilst we develop our integrated approach. This also links with upskilling our Reablement Assistants through our new Care and Therapy Academy.

We will also enhance and support our discharge processes through utilising the Hospital Discharge Fund, the deployment of which has been agreed between the key partners in the MK Deal. We recognise that more traditional approaches to providing care and support, especially when demand is particularly high, may not always be the right solution. Our capacity and demand work has, for example, led us to identify that all too often people were discharged onto the wrong pathway. Whilst this has further evidenced the development of our integrated discharge hub, we are also seeking to ensure we can: arrange speedier discharge to the person's usual place of residence; strengthen our Discharge to Assess pathway; and reduce hospital acquired deconditioning. We will during 2023 provide two new schemes that will seek to discharge as many patients as possible from hospital at the point they meet 'no criteria to reside'.

- Firstly, we will invest in a 'bridging care' service, commissioned to provide immediate care and support (within four hours, 8 am – 8 pm, seven days a week). Primarily this will be for people with no ongoing support package yet in place. Any subsequent intervention, for example from our Home First Reablement service or a social work assessment, will be completed with the person in their own home. **This is a priority for 2023/24**

- Secondly, we will commission live in care options, to provide short term care for those who have had a deterioration in their cognitive abilities, or are suffering from delirium, to be discharged from hospital to their usual residence. Again this will aim to see subsequent interventions, such as a social work assessment, take place in the person's own home. Any ongoing support needs will be determined with the person, their family/carers in an environment that is familiar. **This is a priority for 2023/24**

Our approach to bed-based intermediate care has been a focus for a number of years. We have invested in both recuperation beds and Seacole, but our capacity and demand data is starting to show us that we are over reliant on such support. We have a strong domiciliary care market, which can be flexed to provide short term support where our reablement capacity is challenged during periods of high demand. As such we will continue to utilise our BCF innovatively. For example, to incentivise our domiciliary care providers over the winter months, when demand is high, to ensure continuity and sustainable out of hospital domiciliary care services. This has been a very successful approach, which has now led us to provide incentivises at other peak times during the year. There is still is no waiting list for domiciliary care services, which has been the case since 2019.

We have also utilised the BCF, and will continue to do so, to provide two flats in sheltered accommodation specifically for hospital discharge. These self-contained flats offer a more independent environment than a care home, and allow for ongoing support and assessments to take place there. As we shift away from the over reliance on care home bed-based support, we are now seeking to provide more self-contained accommodation during 2024/25. This is closely linked to the work we are undertaking in relation to improving system flow and our Discharge to Assess pathways.

We further recognise that having sufficient therapeutic interventions is equally important to supporting safe and timely discharge. Our improving system flow work is evaluating our therapy pathways and will report shortly. However, early indications show that there is insufficient capacity in our ward-based therapy teams to support our Discharge to Assess pathways and optimise system flow. As a result we will also utilise the Hospital Discharge Fund to:

- Provide additional hospital ward-based therapy staff. They will focus on improving outcomes through increased patient activity and promotion of independence on the ward. This will aim to reduce hospital acquired deconditioning, leading to a shorter length of stay and risk of re-admission. It is also anticipated that this will positively impact on the levels of ongoing care and support needs.

- Provide a sustainable Occupational Therapy triage service. We have successfully piloted triaging patients, which has allowed the Home First Therapy service to prioritise essential visits. We are now in a position where we can commission this on an ongoing basis.

We have continued to provide a fully staffed team of social workers based in the hospital through the use of the BCF. They work closely with the current Hospital Discharge Team, ensure attendance at multi-agency discharge events (MADE) and participate in daily teleconferences to review patients with no criteria to reside. Through our new integrated discharge hub we will enhance the effectiveness of this approach.

We will continue to fund MKCC's Access Team, the 'front door' of adult services. This is an integral element to ensuring that those people living in the community, that are seeking or requiring care and support, are referred or signposted to the appropriate resource. For example, it will ensure that if intermediate care is the required intervention, it will refer on to the Home first Reablement service. During 2022/23 it dealt with over 43,000 enquiries. This team deals not only with requests for care, but also triages community occupational therapy referrals. Not only is this important in ensuring that people are directed to the right care and support, it also allows for low level equipment provision to be resolved at the front door. The team will also ensure that where a major housing adaptation may be required, they are able to make a timely and appropriate referral to the Disabled Facilities Grant team (see Section 6).

The Milton Keynes Community Alarm service will continue to be funded by the BCF. This is a service for all ages, supporting people: who have been discharged from hospital; are at risk of falls; are disabled or frail; are at risk of domestic violence, harassment or distraction burglary. The standard equipment provided is an alarm unit and pendant. During 2022/23 we had 4842 users of the service, of which 533 were new. It has been successful in promoting and maintaining independence, hospital admission avoidance and timely discharge. For example, if a person falls our Community Alarm Service Responders will go to the person's home, provide assistance and where necessary seek medical support. If additional equipment is required, following a risk assessment, this is provided e.g. assistive technology, additional sensors. We are also undertaking a project to determine how we can embrace new technologies to further support admission avoidance and discharge from hospital. We see this as strategically important to ensure that there is appropriate and sufficient availability of assistive technology, to support and promote independence in the person's own home.

### *5. Supporting unpaid carers*

We will continue to prioritise support for unpaid carers, introducing more opportunities for carers to be resilient in their caring role. The BCF will continue to maintain the funding of the carers support service operated by Carers MK. However, as the contract for this commissioned service is reaching its end, we will review how we continue to support our carers. **This is a priority for 2023/24**

Carers MK have a physical presence in MKUH, referred to as the Carers Lounge. From this base they identify and support unpaid carers when either the cared for person, or indeed the carer themselves, is admitted to MKUH. They liaise closely with ward staff to ensure that they can provide valuable information, advice and emotional support, often when there has previously been no interaction with formal or informal support services. It has proved very beneficial in both providing and signposting to ongoing support services, and is an enabler for hospital discharge.

During 2023/24 we will be piloting a carers direct payment to enable timely hospital discharge. We will be offering carers, subject to assessment, the opportunity to be awarded a direct payment of up to £500 per week (for a maximum of two weeks) to provide the necessary care for the cared for person immediately following discharge. To enable safe and timely discharge the direct payment could cover loss of earnings, travel costs, childcare costs etc. We anticipate that this informal carer support will replace any formal/commissioned services that would otherwise be put in place.

As part of our improvements to carer support we have simplified the carers assessment process and brought in our Carer's Conversation. This has already seen the number of carers assessments increase. In April 2022 16 carers assessments were undertaken, whilst in March 2023 68 carers conversations took place. We have also introduced several new offers to carers:

- We have successfully introduced a new annual direct payment of £240 per carer, subject to assessment. This has seen the number of carers receiving a direct payment increase from 80 in 2021/22 to 259 in 2022/23. We will continue to use the BCF to fund direct payments.

- Following consultation with carers and carers groups, we have introduced innovative approaches to meaningful carers breaks. These include working with the voluntary sector to provide services, such as My Time and Carefree, which are focussed on ensuring carers are able to access leisure, cultural and educational activities. We will review these new carers break services during 2023.

- We have also commissioned a pilot of an online carers service called Mobilise. The range of online service provided by Mobilises includes: information, advice and guidance; peer support; and signposting to support services. We will review the efficacy of this during 2023.

### *6. Disabled Facilities Grant (DFG) and wider services*

In relation to the DFG our process remains multi-disciplinary in relation to adaptations.

- Following an assessment of need our social care and housing teams work closely to ensure that in relation to adaptations or community equipment, their statutory duties are carried out effectively.
- This includes: promoting and maintaining independence; supporting carers; finding cost effective solutions; ensuring equipment, adaptations are appropriately provided. We have found this leads to a sustainable approach to adaptations.

MKCC's Principal Occupational Therapist, the Lead Clinician and DFG Service Manager, has been involved in the process of agreeing our BCF plan. The DFG budget is devolved to them, and any expenditure associated with decisions agreed through our DFG process is monitored by them.

The use of our mandatory DFG has been key to delivering a key BCF priority, ensuring that people maintain their independence in their own home, preventing and delaying the need for care and support. During 2022/23 we supported 237 DFG applications.

We have successfully introduced Occupational Therapy Support Assistants into our Access Team, the 'front door' of adult social care. They are able to triage requests for services, and where major adaptations are required ensure this is actioned swiftly and with the appropriate team/service. During 2022/23 1950 occupational therapy related enquiries were triaged. Of these 471 were dealt with by the Access Team, preventing any referral to the Community Occupational Therapy team. This included signposting to other services, advice and guidance to purchase or acquire low level equipment etc.

### *7. Equality and health inequalities*

The Milton Keynes health and social care system are committed to ensuring that our BCF plan will not negatively impact groups with protected characteristics. The characteristics are in relation to: age, disability, gender, reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Once again an equality assessment identified that we have set out plans to ensure better outcomes for older and disabled people, especially in those areas we have prioritised. At the heart of our approach is a strong commitment to promote independence and for people to have a greater control over their own lives. Our plans for developing and further integrating our intermediate care services in a strengthened Home First service evidence our commitment. It is paramount that we are able to offer safe, timely care and support in a suitable environment.

Nonetheless we recognise that there are difficulties and preferences that need to be given more attention. Examples include those with mental health issues, cultural and religious differences and communication, especially speakers of other languages. Our BCF plan offers several means by which these preferences or difficulties can be addressed. These include:

- Our ongoing investment in dementia awareness and support (including our new live in care approach for the delirium pathway). The work to date has shown that there are much needed support networks in relation to community groups and appropriate cultural and faith groups, including better understanding of the effects of dementia to lessen stigmatisation.
- Ongoing efforts to improve our DFG processes to ensure full access to properties for disabled people.
- The use of BCF in relation to carer support (including carers for people with dementia), and support for those receiving a direct payment

In relation to reducing health inequalities we are focussed on improving and developing new solutions for people's care. Our BCF plan has a focus on reducing ill health and dependency, to significantly improve people's outcomes and lessen the need for more intensive care and support services. These include:

- Our work to jointly commission an integrated community equipment services
- The new bridging care service, which will provide a real option for people to be discharged at the optimum point in their recovery, allowing for more long term decisions to be made in their own home
- The ongoing funding of our falls reduction services, and importantly our plans to review and improve these services

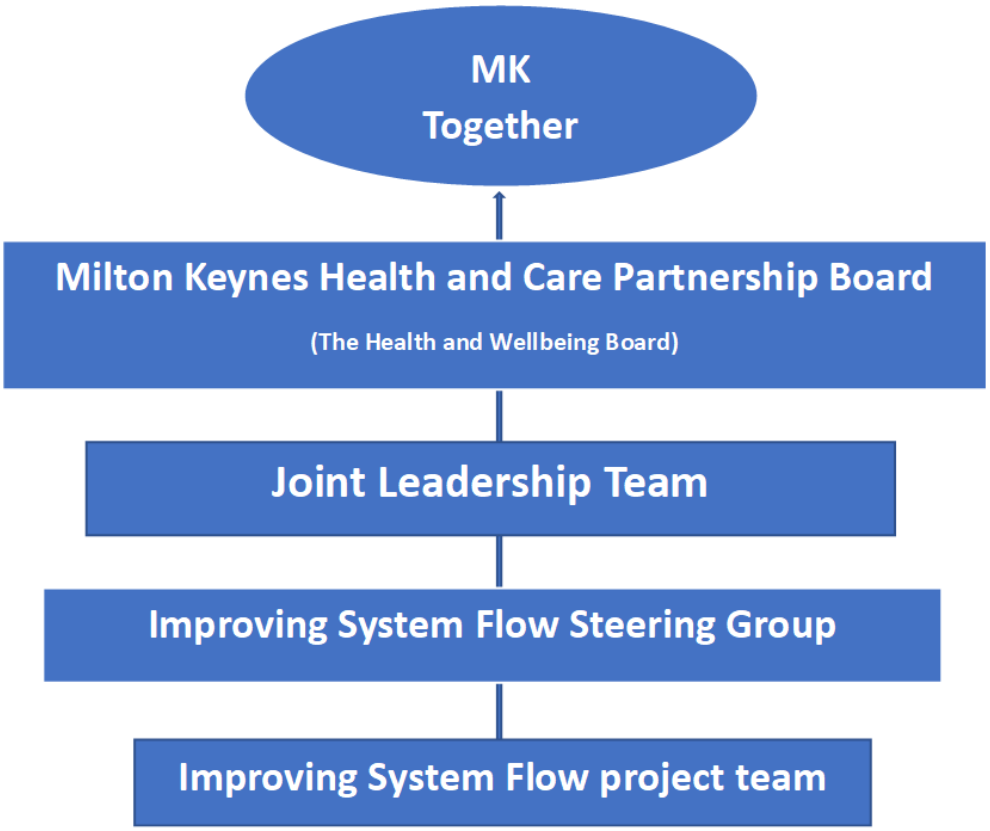
We will continue to assess and evaluate the evidence about what works to reduce inequalities. However, we believe that our BCF plan makes real advances in lessening health inequalities, and provides further opportunities to have due regard to various characteristics. Whilst the process of change is long term, this can only happen through sustained improvement in services and engagement with care users and communities.

### *8. Governance*

The overarching governance for the BCF (see below) is our MK Together Partnership arrangements, which includes our Health and Care Partnership Board (the Milton Keynes Health and Wellbeing Board). It is composed of senior managers from the ICB, MKCC, CNWL, MKUH, voluntary sector representatives and Healthwatch. This approach is now well embedded. As a system wide partnership it is helping us align our priorities across Milton Keynes. As a result, we have developed a forum to foster relationships and partnerships that support integration.

As part of our approach the Improving System Flow project team has collaboratively developed our plan. This group has representation from MKCC, MKUH, CNWL and the ICB. The plan has been reviewed by our Improving System Flow Steering Group (ISFSG), comprised of senior representatives from MKCC, CNWL, the ICB, MKUH and the voluntary sector. The ISFSG has in turn reported to our Joint Leadership Team, which oversees the MK Deal and reports to the Health and Care Partnership. Both the ISFSG and Joint Leadership Team have agreed our plan, including the allocation of the additional Hospital Discharge Fund.

The lead accountable officer for the BCF is the Group Head of Commissioning at MKCC.



# 9. Approval Summary

**Better Care Fund 2023-25 Template**

**2. Cover**

**Version 1.1.3**

*Please Note:*

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

| | | Complete: |
|---|---|---|
| **Health and Wellbeing Board:** | Milton Keynes | Yes |
| **Completed by:** | Mick Hancock | Yes |
| **E-mail:** | Mick.Hancock@milton-keynes.gov.uk | Yes |
| **Contact number:** | 01908 257967 | Yes |
| **Has this report been signed off by (or on behalf of) the HWB at the time of submission?** | No | Yes |
| **If no please indicate when the HWB is expected to sign off the plan:** | Wed 20/09/2023 << Please enter using the format, DD/MM/YYYY | Yes |

| | Role: | Professional Title (e.g. Dr, Cllr, Prof) | First-name: | Surname: | E-mail: | |
|---|---|---|---|---|---|---|
| ***Area Assurance Contact Details:** | Health and Wellbeing Board Chair | Cllr | Peter | Marland | peter.marland@milton-keynes.gov.uk | Yes |
| | Integrated Care Board Chief Executive or person to whom they have delegated sign-off | | Felicity | Cox | felicity.cox1@nhs.net | Yes |
| | Additional ICB(s) contacts if relevant | | Wendy | Rowlands | wendy.rowlands1@nhs.net | Yes |
| | Local Authority Chief Executive | | Michael | Bracey | michael.bracey@milton-keynes.gov.uk | Yes |
| | Local Authority Director of Adult Social Services (or equivalent) | | Victoria | Collins | victoria.collins@milton-keynes.gov.uk | Yes |
| | Better Care Fund Lead Official | | Isla | Rowland | i.rowland2@nhs.net | Yes |
| | LA Section 151 Officer | | Steve | Richardson | steve.richardson@milton-keynes.gov.uk | Yes |
| *Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process --> | | | | | | |
| | | | | | | |

# 10. Expenditure Summary

**Better Care Fund 2023-25 Template**

**5. Expenditure**

Selected Health and Wellbeing Board: Milton Keynes

<< Link to summary sheet

| | 2023-24 | | | 2024-25 | | |
|---|---|---|---|---|---|---|
| **Running Balances** | Income | Expenditure | Balance | Income | Expenditure | Balance |
| DFG | £1,267,783 | £1,267,783 | £0 | £1,267,783 | £1,267,783 | £0 |
| Minimum NHS Contribution | £19,640,705 | £19,640,705 | £0 | £20,752,368 | £20,752,369 | -£1 |
| iBCF | £6,176,149 | £6,176,149 | £0 | £6,176,149 | £6,176,149 | £0 |
| Additional LA Contribution | £0 | £0 | £0 | £0 | £0 | £0 |
| Additional NHS Contribution | £0 | £0 | £0 | £0 | £0 | £0 |
| Local Authority Discharge Funding | £865,887 | £865,887 | £0 | £1,446,031 | £865,887 | £580,144 |
| ICB Discharge Funding | £1,326,649 | £1,326,649 | | £2,273,248 | £1,344,972 | £928,276 |
| **Total** | **£29,277,173** | **£29,277,173** | **£0** | **£31,915,579** | **£30,407,160** | **£1,508,419** |

**Required Spend**

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

| | 2023-24 | | | 2024-25 | | |
|---|---|---|---|---|---|---|
| | Minimum Required Spend | Planned Spend | Under Spend | Minimum Required Spend | Planned Spend | Under Spend |
| NHS Commissioned Out of Hospital spend from the minimum ICB allocation | £5,578,254 | £11,767,360 | £0 | £5,893,983 | £12,433,529 | £0 |
| Adult Social Care services spend from the minimum ICB allocations | £6,518,285 | £7,394,426 | £0 | £6,887,220 | £7,812,680 | £0 |

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