Developing the Sustainability and Transformation Plan for Bedfordshire, Luton & Milton Keynes Footprint

9th June – Approach and Emerging Priorities in BLMK STP
Our approach to creating the right environment for transformation in BLMK

What are we starting with?

Stocktake BLMK As-Is position across:

• Public engagement
• Service user involvement
• Social capital
• Quality of intelligence about population’s health
• Quality of commissioning
• Workforce
• Care records
• Fit for purpose services (out-of-hospital, secondary & social care)
• Spending well beyond our means with worse to come

Who are we changing with?

BLMK is a new footprint so...

• Is everyone on board?
• Do we even know each other?
• Do we work well together?
• Do we respect each other?
• Can we change together?
Our approach to creating the right environment for transformation in BLMK

How will we plan and deliver that change?

By:
• Engaged leadership across H&SC
• Commonly developing and collectively-owning a clear vision
• Developing change plans by staff working together in place-based teams
• Engaging with key stakeholders
• Engaging with service users
• Making targeted use of 3rd party support and only for “rifle-shot” technical assistance

What are we transforming to?

• Engaged and informed public
• High quality local social capital
• Active service users and carers
• Engaged self-confident workforce, eager to empower service users
• Shared and accessible care records, “owned” by service users not clinicians
• Fit for purpose services (out-of-hospital, secondary & social care)
• Living within our financial means
What’s the STP process telling us so far…(1)?

- **Triple aim** - all three present challenges in BLMK, some have been around for some time and are hard-to-shift (e.g. life expectancy), some developed in last couple of years but now pressing (e.g. finance gap) and some emerging and likely to worsen if no change (quality gap)

- **As-Is** - case for change is compelling in almost all areas of STP interest
  - Not very engaged public
  - Low levels of service user involvement or self management of care
  - Flimsy social capital platform
  - Poor quality of intelligence about population’s health
  - Quality of commissioning is patchy and lots of leadership change in recent years
  - Overly stretched workforce, very difficult to recruit in primary and social care, lack of resilience of medical workforce across 3 hospital sites, paternalistic in approach
  - Fragmented working across primary care, absence of strong self-starting GP federations
  - Low levels of digitisation and absence of inter-operability preventing easy access to care records
  - Poor quality estate in primary and community care
  - Lack of sustainability of secondary care services across 3 hospital campuses
  - Over-spending
What’s the STP process telling us so far…(2)?

• **Coalition of the willing?** - BLMK is new footprint and there are a number of new leaders (esp. in CCGs) so relationships are not all well developed (crucial to transformation); but STP has worked hard on “atmospherics”:
  - To make sure CCGs continue to significantly influence the process
  - To ensure Councils are central players in plotting and delivering the transformation journey
  - To persuade secondary care leaders that their interests must align and their futures converge

• **Localised STP planning activity:**
  - 9 primary workstreams plus HCR, each with an STP Steering Group sponsor and a subject matter Workstream Lead (typically executive director level from STP Partner. Workstream Groups populated from across STP Partners
  - Optum is undertaking bottom-up population health analysis across BLMK having secured access to all 16 STP partners pseudonymised data (via formal ISAs), plus some from GP practices
  - Optum is also connected into each of the 9 Workstreams ensuring that insights and observations from Optum’s work informs planning activities of each work stream
  - STP is running periodic “congresses” where Optum update on findings to an audience from across the footprint
What are the 3-5 big themes emerging across BLMK…?

The Health Care Review

- Endorse cross STP support for outcome re HCR preferred option for clinical and financial sustainability, expedite further planning and consultation activities under programme management by STP.

- Implement preferred HCR solution via a Single STP Secondary Care Provider Transformation Board, supported by integrated clinical leadership across the three hospital via a uni-institutional, tri-hospital campus model, with detailed service configurations harmonised with STP plans to strengthen out-of-hospital care.
Out-of-Hospital Services

✓ Systematically invest to strengthen health and social care “outside of hospital” across BLMK (short term underpinning and long term sector development)

✓ Prioritise recurrent and non-recurrent investment in:
  ➢ Adding to, up-skilling and building the self-confidence of the out-of-hospital (health and social care) workforce
  ➢ Maximising the contribution from BLMK’s “virtual” workforce (the contribution of family and informal carers personal and corporate volunteers)
  ➢ Bring about a step-increase in the contribution from self-managed care (empowerment of service users and family carers through promotion, education and training, through development of health coaching skills amongst the BLMK workforce, supported by accessible shared care records)

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Commissioning

 ✓ Recognise the need to make a step-change in the way in which the system commissions health and social care:
   ➢ At a technical level (by improving, inter alia, population health intelligence and skills required to specify, calibrate and source outcome-based and/or capitation risk based relationships across the BLMK system)
   ➢ In terms of scale (both by pooling scarce commissioning skills across CCGs and across CCGs and Councils and seeking to commission health and social services in an integrated way)
   ➢ In terms of scope (by shifting the emphasis to strategic commissioning, and reformulating the traditional commissioner-supplier relationship by introducing accountable-care type approaches)
**Key Enablers**

- **Workforce development including:**
  - Cultural change (shift to enabling self-managed care and maximising care as an increasingly “self-service” phenomena)
  - Empowering the front-line (training but also by removing factors driving risk-averse practice)
  - Investing in BLMK social capital (our “virtual workforce”)

- **Faster and broader digitisation to enable:**
  - Co-ordinated care planning
  - Reduced need for face-to-face contacts in H&SC
  - Greater self-management of care

- **NMOCs** - building on work being done at a national level, to:
  - Size and shape the organisational capacity, capabilities and structure of a strategic commissioning BLMK contracting Authority
  - Define, test and codify the mechanisms of exchange (e.g. contract terms, payment mechanism etc.) between such an Authority and an accountable care-type delivery vehicle(s)
  - Size and shape the organisational and financial capacity, capabilities, structure, ownership and governance of that accountable care-type delivery vehicle(s)
BLMK STP themes and workstreams

Population-facing initiatives
- BLMK Prevention Plan

Service user-facing initiatives
- Primary, community and social care
- Urgent & emergency care

Enabling initiatives
- Workforce
  - Shared care record, digitisation and assistive technology
  - NMOC

Reducing system overheads
- Clinical support services
- Back-office services
- Estates

Bedfordshire & Milton Keynes Health Care Review (HCR)