BEDFORD BOROUGH COUNCIL

Committee: **Joint Health Overview and Scrutiny Committee - Sustainability Transformation Partnership**

Date of Meeting: **Monday, 16 July 2018**

Time: **4.00 pm**

Venue: **Committee Room 1, Borough Hall, Cauldwell Street, Bedford MK41 9AP - Borough Hall**

A pre-meeting briefing for Members will be held at 3pm in Committee Room 1, Bedford Borough Council, Borough Hall, Cauldwell Street, Bedford, MK42 9AP

AGENDA **Introduced by**

1. Election of Chair ACE(L&CG)

To elect a Chair for the meeting.

2. Questions Chair

To consider any questions from members of the public and Members of the Councils.

3. To receive any apologies for absence Chair

4. Minutes Chair

To agree the minutes of the meeting of the Joint Health Overview and Scrutiny Committee – Sustainability Transformation Partnership held on 26 March 2018 (copy previously circulated).

5. Disclosure of Local and/or Disclosable Pecuniary Interests Chair

Members are reminded that where they have a local and/or disclosable pecuniary interest in any business of the Council to be considered at this meeting they must disclose the existence and nature of that interest at the commencement of that consideration, or when the interest becomes apparent, in accordance with the Council's Code of Conduct

6. BLMK STP Single System Operating Plan 2018/2019 — Representative of BLMK STP

To receive an update regarding the BLK STP Single System Operating Plan 2018/2019 (copy enclosed).

7. Primary Care Development regarding access to GP Services — Representative of BLMK STP

To receive a presentation from BLMK STP to provide further information on the Primary Care developments under access to GP Services.

8. Work Programme for the JHOSC STP — Chair

To consider suggestions for the Work Programme for 2018/2019 (copy enclosed).

9. Dates of future meetings — Chair

To confirm the dates of future meetings of the JHOSC for 2018/2019.

P J SIMPKINS
Chief Executive

To: Each Member of the **JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - SUSTAINABILITY TRANSFORMATION PARTNERSHIP**

Democratic Services Contact Officer: Lynn McKenna
Tel: (01234) 228193
email: lynn.mckenna@bedford.gov.uk

Date of Issue: 6 July 2018

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The direction to Bedford College Media Department is that video recording of the public at meetings should be avoided. Audio and video recordings may be stored on computer servers outside of the European Union."

26 March 2018

Agenda Item 4

For publication

AT MEETING

of the

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

held in the Council, Chamber, Luton Borough Council, Town Hall, Luton
on the 26th day of March 2018 at 4.00pm

PRESENT:

Representing Bedford Borough Council (BBC):

Councillors Mingay, Rider and Uko

Representing Central Bedfordshire Council (CBC):

Councillors Downing and Hollick

Representing Luton Borough Council:

Councillors Lewis and Pederson

Representing Milton Keynes Council:

No councillors in attendance

Representing Bedford, Luton and Milton Keynes Sustainability and Transformation Partnership

Mark England, Chief of Staff, Sustainability and Transformation Partnership (STP)
Dr Nina Pearson, GP Lead BLMK

Mike Thompson, Priority 2 Enhances Primary Care Director, BLMK
Richard Fradgley, Director of Integrated Care, East London Foundation Trust (ELFT), mental health services in BBC, CBC and Luton
Paul Rix, Associate Director ELFT,
Patrick Gillespie, Service Director Central and North West London NHS Foundation Trust, mental health services for MK

Also Present:

5 Members of the public.

Apologies for absence were received from Councillors Bradburn, Coventry, Duckett and Jenkins.

1. ELECTION OF CHAIR

RESOLVED:

That Councillor Agbley be elected Chair for the meeting.

2. QUESTIONS

Andi Assan raised a question in relation to GP access. Dr Pearson responded that there was an item on the agenda which would respond to GP access queries.

Richard Hillier, a member of the public from Milton Keynes was concerned at the lack of public awareness of what was happening with the health service. There was an appreciation of the availability of the STP newsletter but would be interested to know on developments. He had rung the number quoted on the website but there had been no response. Mr Hillier had signed up for newsletter but only received one newsletter to date.

Mark England apologised and agreed to take Mr Hillier's comments back. He confirmed the importance of communication to relevant bodies and partners. It was explained that there was a communication lead and a communication collaborative to discuss priorities and how to ensure these messages are cascaded appropriately.

Alan Hancock – Healthwatch Milton Keynes was concerned that the Joint Health Overview & Scrutiny Committee meeting was poorly publicised and it should be advertised on the STP website. It was felt that the STP website was poorly updated and maintained. Mark England agreed to feedback comments and ensure this was rectified. The Chair added that the meeting should be publicised as widely as possible due to the importance of the meeting to work together to ensure partners understand what the public concerns.

3. MINUTES

RESOLVED:

That the Minutes of the meeting of the Informal Joint Health Overview & Scrutiny Committee held on 28 January 2018 be received.

4. DISCLOSURE OF LOCAL AND/OR DISCLOSABLE PECUNIARY INTERESTS

There were no disclosures of interest.

5. ACCESS TO GP SERVICES

Dr Pearson (GP in Luton, Chair of CCG and Bedford lead on Integrated care system) and Mike Thompson introduced themselves to the Committee.

Dr Pearson presented the report which outlined developments in primary care and to provide an overview of further work. It was explained that there were new models of Primary Care and interlinked programmes in local places to establish what worked across the footprint. NHS England explained that a forward plan was in place and how this fitted in with overall programme of work. There had been a lot of positive engagement and progress was ongoing.

Dr Pearson advised that primary care had been enhanced and the transformational offer of health care which covered wider areas as listed in the report. The 5 year forward view formed GP practices into networks to work together based on a population of 30,000 – 50,000. This concept used across the UK came from an evidence base. This enabled the sharing of skills and workforce and provided access outside of normal hours. This was a larger scale offer of health care which could not be delivered in smaller areas. Specialist care was based around 30,000 – 50,000 population and helped with recruitment and improvement in staff

satisfaction. Work was ongoing in relation to the delivery of services and care that met needs and the difference in need; and how to use resources and capital effectively. Key elements of primary care networks and working with other teams at a national level was in relation to solution based approach rather than identifying problems.

Mike Thompson outlined the table in the report which demonstrated how initiatives benefitted from being done at scale or at place particularly focussing on information systems, population health and ongoing projects. The whole programme of what each area needs, access to national monies was bureaucratic so there was benefit in economies of scale. Clearly without the workforce services cannot be delivered effectively. Work was being undertaken on new model which was not always in relation to additional staff but freeing up individuals and changing roles to increase efficiency. There was an opportunity to work with national association of primary care through the STP wide and funding programmes. This also included community mental social health. The GP forward view was driven at a local level which included a resilience programme and agreed with NHS England areas at risk and there was investment in NHS England for this. Extended access was included in five year programme with a pilot being undertaken in Milton Keynes with an aim for extended access to be implemented in Luton and Bedford by 1 October 2018.

Dr Pearson reported that through working differently, understanding the population and having a wider team for general practice access to care would look different and evidence from practices showed that by working in this way it demonstrated that not everyone needs to see a GP and therefore the delivery of services would look different by ensuring that the right care was available for varying needs. Continual work was being undertaken on recruitment but this did not underestimate the level of workforce required to deliver services.

Cllr Rider, Bedford Borough Council was encouraged by the information provided and agreed to the need to change but requested clarification on the reality of the situation and the progress that had been made.

Dr Pearson was unable to provide a clear answer at the moment as this was a major challenge but there was significant engagement with GPs and practice managers which provided better opportunities for positive change in delivery.

Cllr Rider, Bedford Borough Council sought clarification on the implementation of hubs; while Cllr Hollick, Central Beds Council sought clarification on the development of the hubs.

Dr Pearson advised that the report presented was a summary of information to meet the timescale of the meeting but more detailed information could be provided if required. The needs of the population varied and there was a need to tailor to place.

Mike Thompson reported that there was a need to work with NHS England to unblock national processes and to develop the hub programme incorporating a combination of short term and long term processes.

Dr Pearson explained that communication was being increased to promote via twitter and relevant websites were becoming more interactive and also using social media more effectively.

Mike Thompson reported on the development of IT information sharing and £2million national investment in the system to build capabilities and building infrastructure to move forward.

In response to a question from Councillor Uko, Bedford Borough Council, Dr Pearson explained that GP access cannot fail and keeping services running and create models that are different to meet needs was a priority. It was advised that strong practices were only as strong as neighbouring practices. Dr Pearson was not able to provide figures on costs and savings at this stage but could demonstrate the development programme and the national funding. It was reportedly difficult to quantify savings and any reduction in admissions and A&E attendance. Councillor Uko asked whether the funding was enough to cover services.

Councillor Pederson left the meeting at 17.04

Dr Pearson advised that there was not enough funding in the health service. It was reported that significant spend was being made in hospitals and on emergency admissions and the changes in approach was based on models used in Frimley, Nottingham and South Somerset which had been introduced and savings were being achieved.

Councillor Rider left the meeting at 17.07

Councillor Uko requested increased level of detail in the report on budgets and expected savings, this was supported by the views of the Committee.

Mike Thompson reported that all areas were struggling with resilience in the next financial year, and Dr Pearson added that there was a need to establish where the transformation money was being spent

Councillor Lewis requested an update on progress with primary care networks.

Mike Thompson explained that there was increased collaborative working between 18 clusters / networks and NHS England was issuing a new definition document

Councillor Lewis queried how the 30,000 – 50,000 population threshold was determined.

Dr Pearson explained that this was a formula adopted across the areas but it did have a degree of flexibility; for example in Luton the figure was 43,000 – 70,000 population. Mike Thompson added that GPs were being actively recruited. Opportunities for recruitment were being developed including a focus on career opportunities. It was noted that the impact of Brexit may result in international recruitment becoming more difficult.

Councillor Downing, Central Beds Council was encouraged by progress and sought clarification on progress with blue light collaboration regarding emergency services increasing partnership working.

Dr Pearson advised that there were opportunities being developed with the fire service and with the ambulance service. There was a need to improve partnership working with the police.

RESOLVED:

i) That further details be provided to the Committee on primary care developments.

ii) That the NAPC programme from December 2017 be reported back to a meeting of the Committee in October/November 2018.

iii) That a progress report be provided to the next meeting of the Committee on blue light services collaboration.

6. MENTAL HEALTH SERVICES

Richard Fradgley presented the report which outlined that within the STP there were high levels of poor mental health which were particularly high in Bedford and Luton and depression had high levels in Bedford.

The key factors for this were serious mental illness, people who most needed mental health services, health outcomes versus life expectancy figures and the conclusion that serious mental health often linked to poor general health. It was reported that mental

health patients used less planned care but there was more focus on mental health and the 5 year forward view for mental health and implementing this including the investment plan was a priority.

BLMK's integrated care system was one of the first in the country to adopt a new way of working which provided a mental health programme to bring together relevant providers to deliver five year forward review. The focus of the STP was where value can be added and clarifying responsibilities for delivery focus.

The STP partnership was responding to potential opportunity to improve pro natal service, which in Milton Keynes did not meet required need and there was no service in Luton and Bedford. The STP had submitted a bid and were hoping to receive a positive outcome in April to meet the need with national requirements.

Adult mental health improvements were in relation to delivery of access, home treatment teams outside of hospital, health checks, and help into employment. There was more work required in this area to help people to prepare for and find a job. There was national funding available for various waves and the bid for funding in wave one focussed on the Bedfordshire team expanding service into Luton and a future wave was to include Milton Keynes. Physical health checks was a new service to be commissioned which linked to crisis pathway and suicide prevention. Adequate workforce for mental health was a real issue. There were 19,000 more than 2015/16 baseline but to deliver services efficiently there was a need for 300 more. There was a requirement to develop an investment strategy and funding sources that articulated in the national plan. There was a need for an invest uplift annually to meet investment standard to improve efficiencies from acute services. The main areas of focus were to develop crisis pathway and to establish how mental health fits in and how we can better deliver services.

In response to a query from Councillor Mingay, Bedford Borough Council, the Committee were advised that children and young people with serious mental health issues could be sent anywhere in the country and it was noted that London have tier 4 services available. There was an opportunity to bid for funding for this locally.

In response to a question from the Chair in respect of the impact of changes to Universal Credit, it was explained that public health was a local authority function and organisations were working together to seek improvements to this national issue. Physical and mental health was bound together quite closely and the biggest factor was poverty.

Councillor Uko questioned that issues locally were greater than national averages. The Committee were advised that local research was not available but there was a growth in serious mental illness and development of the primary care model to minimise the impact of this growth was a focus on the neighbourhood. It was reported that Local needs assessments were undertaken by local

authorities to help inform health bodies. There was currently significant interest in mental health and the need to understand each neighbourhood to improve the delivery of services. It was noted that loneliness was a contributing factor to depression and social prescribing was a tool to be used in health service provision which looked beyond the delivery of care. The Committee were advised that a new service was being rolled out through joint working with Luton council to have a blended service social prescription to help patients to have healthy lifestyle. It was reported that 12% of the budget was allocated for mental health services and 25% of the population needed mental health services. Mark England agreed to provide place based comparison figures to a future meeting.

RESOLVED:

i) That the Committee receive a report at a future meeting on the progress of funding bids.

ii) That the Committee receive an update on the development of a mental health enforcement plan.

7. FUTURE WORK PROGRAMME FOR THE JHOSC STP

The following items were requested to be included on the Committee's Work Programme:

- Item from pharmacy in respect of the local representative and engagement of STP to assist with reducing use of GP services and how can funds can be saved;
- Suggested update on NAPC programme in October/November 2018;
- A further report on funding and finance to ensure services can be delivered; and
- Standard template on what we need to gain from these reports.

The meeting ended at 6.27pm.

Bedfordshire, Luton and Milton Keynes (BLMK) Single System Operating Plan 2018/2019

Narrative

30th April 2018

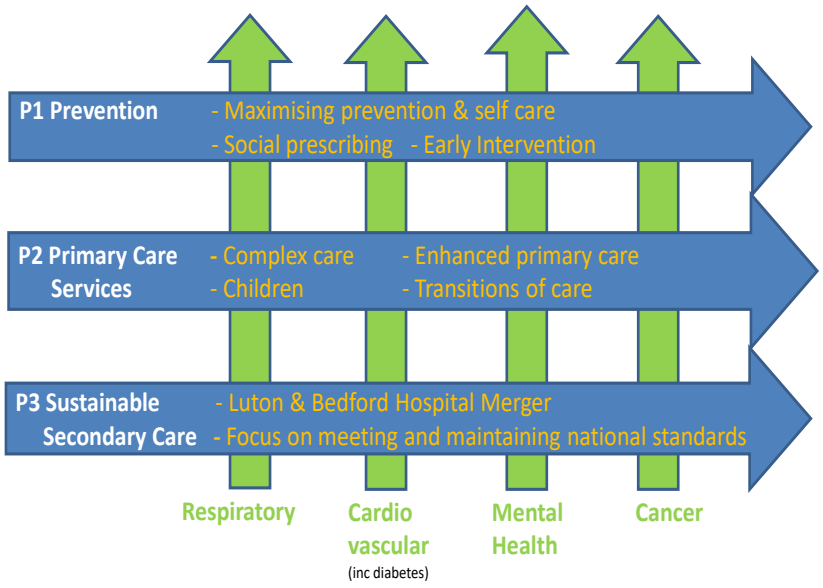
Version Control	V0.23 FINAL DRAFT		
Publication Date	30th April 2018		
Description	This document has been produced in response to the NHSE planning guidance published in February 2018. Shadow ICSs are required to prepare a single system operating plan narrative. It captures our shared transformation programme across our 15 organisations and General Practice partners, outlining the BLMK system priorities and approach. It describes our system aligned assumptions on income, expenditure, activity and workforce across commissioners and providers.		
Distribution Summary	Draft v.01	6th March	STP Team – initial outline & content
	Draft v.05	7th March	STP Team – following v. 01 comments and with additional content added.
	Draft v.06	7th March	BLMK CEO Group
	Draft v.06 RFC	8th March	Version submitted to NHS England
	Draft v.09	6th April	STP Team – following addition of draft 'place based' summary plans & amendments to 18/19 GPFV priorities; inclusion of Glossary & QiPP slides
	Draft v10	10 April	Amendments from BCCG re place based plans. Version for CBC TB
	Draft v11	11 April	Additions from BGH & MKUHFT re secondary care and ICS & BCCG on references to Bedfordshire. Version submitted to CIC & STP CEO Group
	Draft v12	17th April	Amendments (as marked in red) from Luton CCG following Luton Board meeting on 10th April. Version submitted to CIC
	Draft v13	24th April	Addition of Welcome; Executive Summary; Financial information; Engagement; amendments to Strategic Priorities slide; Editorial review; Version submitted to STP CEO Group.
	Draft v17	28th April	Updates received from CEO group; Place-based boards; system summary. This has not been reported to Health and Wellbeing Boards due to timescales.
	Draft v23	30th April	Final version for submission to NHS England

Executive Summary

As a wave one 'shadow' Integrated Care System, BLMK has produced a Single System Operating Plan for 2018/19. This plan describes how the BLMK ICS aim:

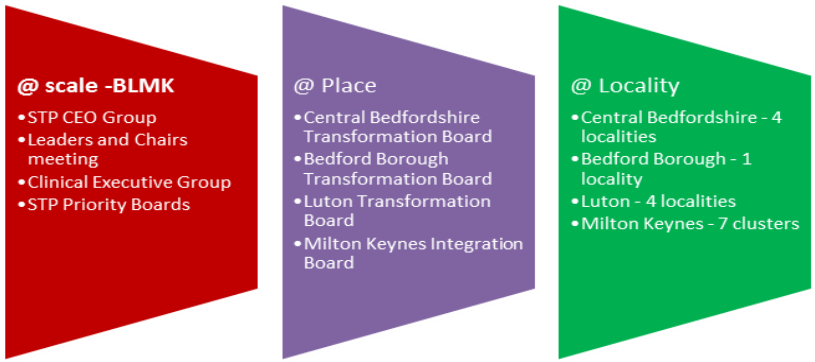
- To improve the health and wellbeing of our residents during 2018/19 and beyond by integrating health and social care at point of service delivery meet
- In so doing we aim to deliver;
  - the NHS Triple aim;
  - the NHS Five Year Forward View;
  - The agreed BLMK financial system control plan

This plan provides a strategic framework for our work together as a partnership during 2018/19. During 2017/18, we developed our ICS 'triple tier model' of scale; place and locality and our relationships strengthened as we have come to understand each other better. However, we are still very much on our journey towards becoming a 'live' Integrated Care System. Our Single System Operating Plan 2018/19 should support us to direct our collective efforts as a partnership on our agreed key focus areas of:



The plan also describes other enabling workstreams that will help us to deliver on these key areas of focus such as: FYFV workstreams on mental health; cancer; urgent care; maternity; transforming care; digitalisation (P4); system re-design (P5); workforce and organisational development; communications; finance and estates.

Delivery of our 2018/19 Plan will be overseen by our partnership governance arrangements:



The impact of our work will be monitored using the STP and Collaborative Investment and Savings Programme (CISP) dashboards. These key metrics will be the measures of our collective success in 2018/19.

Organisations within the system have individually been tasked with delivering financial control totals which sum collectively, at BLMK STP level, to a £9.7m surplus, reflecting £14.8m of prior year debt repayment in the CCG sector. This would necessitate £80.5m of financial efficiencies to be delivered within 2018/19. Whilst the STP has genuine concerns regards the deliverability of such a level of financial improvement in a single year, it nonetheless awaits refreshed national planning guidance before determining any next steps on formally agreeing a system planning control total and how this may impact upon future ICS status level. The STP is of course focused to ensure the maximum possible level of efficiency improvement is achieved, to ensure sustainable financial balance is delivered recurrently.

As a partnership, our most important asset is our workforce. Our staff have told us that working together in partnership we can achieve much more for our residents than is possible as single organisational entities. Our Single System Operating Plan for 2018/19 provides health and social care staff in BLMK with clarity on our strategic direction and our key areas of focus in the year ahead.

Foreword by Richard Carr (Senior Responsible Officer)

Councils and Health Partners in Bedfordshire, Luton and Milton Keynes are determined to improve the health and wellbeing of our residents. For us, it has become what we call *'our noble cause,'* working beyond our individual organisational interests to focus on achieving the best outcomes for our population.

Historically health and social care organisations have developed their strategic plans in relative isolation of each of other. However, this year within our system we have worked together to create a single system plan, in collaboration with our general practitioner colleagues and wider stakeholders. Is it perfect? No. Is it all encompassing? No. But it is exciting; it is a new way of working that we will continue to build on.

The Single System Operating Plan (SSOP) for 2018/19 will support the improved provision of care to our residents and patients within a more affordable framework. It is based upon the principles of prevention; integration of services at the point of access; and is entirely dependent upon partnership working. The time invested in relationship building to generate one SSOP for all of our residents' health and social care needs for now and for the future should not be underestimated, nor should the complexity of such an endeavour. The development of this single plan for our system for 2018/19, for all its imperfections, is a significant milestone. We have invested in our noble cause. In 2017/18 we became one of eight first wave Integrated Care Systems, with our ambition to mature from our current shadow status into a 'live' Integrated Care System during 2019/20.

Fortnightly meetings of partner Chief Executives, enriched by a Lead General Practitioner to reflect the critical perspective of clinicians have helped shape the work of our Integrated Care System during 2017/18. As a result, we have:

- Enabled the formation of partnerships and relationships which were not in existence before;

- Enabled healthy challenge of cross-sector thinking and direction;

Most importantly, it has resulted in our focus on some specific areas of work for 2018/19, captured within our five STP Priorities. The positive differences we are aiming to make for our residents are always and very deliberately at the forefront of our thinking. Our priorities for 18/19 and the way we intend to deliver them have been derived from Clinical Conversation events, workshops, system days, and public engagement and partner events. Our residents, staff and senior leaders have engaged proactively and with such energy that our system plan for 18/19 is based on their reality and their experience of delivering change successfully in BLMK. Further to this we have taken account of actuarial analysis of the system, evidence and lessons learnt from innovation in health and social care both nationally and internationally. The Chief Officers are confident that implementation of our 18/19 focus areas will support and enable the service improvements laid out in the NHS Five Year Forward View and most importantly will deliver real improvements for the residents of Bedfordshire, Luton and Milton Keynes.

The programme operates at *Scale* and *place.*

At scale the Priority Boards and Subject Matter Expert Groups, chaired by one of our CEOs and attended by representatives from our partners, have been critical to understanding each other's priorities, risks and issues. Further to this the creation of the BLMK Clinical Commissioning Groups' Committees in Common and the emergent collaboration between the hospitals in Bedford and Luton and Dunstable. These fora have been the work engines of design, thought and collaboration, and though, at times rightly challenging, have concluded and recommended areas of focus. During 2017/18, we have also developed ways of working in partnership at *Place*, with the creation of four place-based Transformation Boards, which are co-terminus with our local authority areas,

One of the key lessons we have learned as a partnership during 2017/18, is that the changes we want to make have greatest chance of success if they are delivered 'at place' in BLMK.. 'Place' for us, is the local authority footprint and that is why, now we have agreed our Single System Operating Plan as an overarching framework, we are looking to our four place-based Transformation Boards to develop detailed implementation plans for their communities. The four boards of Central Bedfordshire, Bedford Borough, Luton and Milton Keynes will be responsible for delivery and providing assurance against key milestones and their realisation of service changes for their residents. BLMK's local council colleagues have not had sufficient time to fully engage with their colleagues and councillors either informally or formally and, in particular, councillors have not been able to meaningfully contribute to, comment on or scrutinise this document. Neither have NHS partners necessarily taken the completed document through their own governing processes. At the Chief Officer level it has been supported and represents the next evolution of our agreed Sustainability and Transformation Plan. Importantly, all partners are actively developing and shaping strategies within place-based Health and Well-being Boards where this SSOP will be further developed with a wider group of partners and local democratic legitimacy.

The ask for our partnership in 2018/19 is significant, with the system carrying material financial pressures, against the context of rising demand, particularly for emergency reactive services, and inequality of health and quality outcomes. These pressures are increasing and there is a requirement to future proof our services in the context of significant population growth, reinforced by the National Infrastructure Commission's proposals for the Oxford-Cambridge Corridor, to which BLMK is central.

Our single system operating plan for 18/19 describes our collective response to this 'ask' and I would like to record my sincere thanks to all the health and council partners in BLMK for their commitment and support for our 'noble cause'. I look forward to the next year on our journey as an Integrated Care System and to us working together to deliver tangible improvements to the health and wellbeing of local people.

1. Introduction

Welcome to our first BLMK Single System Operating Plan. Our Sustainability and Transformation Partnership (STP) has been one of the eight first wave Integrated Care Systems (ICSs) and our plan reflects this and brings together our individual organisational plans to support our work as one system. We have grown and developed as a system in the last year, building on our track record of delivery and collaborative working.

The plan describes the ambitions of the transformation programmes we are undertaking across Bedfordshire, Luton & Milton Keynes (BLMK). It sets out the high level work programmes for how we will work together to:

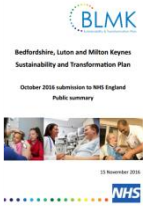
- deliver our vision as set out in our original STP plan;
- deliver the national priorities;
- improve health and wellbeing across each of our places;
- improve quality of care;
- improve efficiency and productivity.

The plan acts as an umbrella for the plans developed and owned by each of our four place-based Transformation Boards and the operational plans for each of BLMK's partner organisations. It is underpinned by detailed activity and financial trajectories and supported by workforce and digital plans. A high level snapshot of each 'place based plan' is shown in summary within this narrative. Under the auspices of the 4 Transformation Boards these will be developed further and finalised by June 2018.

It has been developed in the context of national policy and local needs, illustrated below

National

NHS Mandate
Five Year Forward View
Must do's for 18/19
ACS Memorandum of Understanding



BLMK Footprint

BLMK Sustainability and Transformation Plan

Place

Central Bedfordshire Health & Wellbeing Strategy

Bedford Borough Health & Wellbeing Strategy

Luton Health & Wellbeing Strategy

Milton Keynes Health & Wellbeing Strategy

Bedfordshire, Luton & Milton Keynes

BLMK Sustainability & Transformation Plan

- Almost one million people live in Bedfordshire, Luton and Milton Keynes (BLMK). These are three very different places that are also diverse within themselves. These differences affect what local people need from their health and social care services.

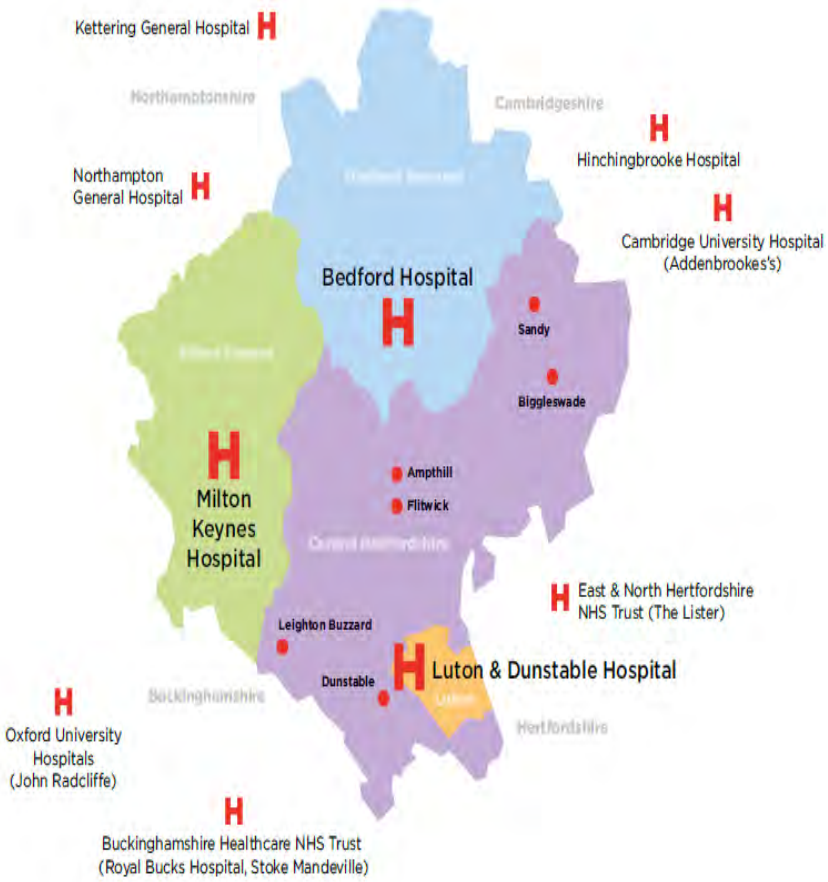
- BLMK has a combined population of nearly 930,000 which is projected to grow to 1,127,000 by 2035. The number of people aged 85 and over is projected to double by 2035 and there will be higher than average growth the number of adults aged 65 and over and the number of children and young people aged 10-19 years old.

- Luton is the most urban, most deprived and most ethnically diverse of the four local authority areas; Bedford Borough and Milton Keynes are urban with significant ethnic minority communities with some rural areas; Central Bedfordshire is the most rural, least deprived and least diverse of the four areas. It does however have pockets of deprivation and around 30% of its residents use acute hospitals outside of the BLMK footprint.

- BLMK is included within the Oxford – Milton Keynes – Cambridge Arc (1 million new homes by 2050). BLMK partners are working together to ensure appropriate health and social care infrastructure is in place to meet the challenges of this significant growth in BLMK population.

- There are also significant differences in demographics, ethnic diversity and deprivation within the footprint which our plans need to be alive to. Across the BLMK geography we have some significant variances in health and wellbeing outcomes and quality and care gaps. For example, healthy life expectancy, an estimate of the average number of years lived in good health, varies from 59.3 years for men in Luton to 67.2 years for women in Bedford Borough.

- There are 109 GP practices within the BLMK footprint, employing 411 GPs. At 2,349, the average list size per GP compares unfavourably with England as a whole (with Luton a particular outlier at 2,804 patients per GP).



2. Context & Purpose

- In 2018/19 NHS England expects that STPs will take an increasingly prominent role in planning and managing system wide efforts to improve services, including:-

  - » ensuring a system-wide approach to operating plans that aligns key assumptions between providers and commissioners;
  - » working with local clinical leaders to implement service improvements that require a system-wide effort;
  - » identifying system-wide efficiency opportunities;
  - » undertaking a strategic, system-wide review of estates, developing a plan that supports investment in integrated care models, maximises the sharing of assets, and the disposal of unused or underutilised estate; and
  - » taking further steps to enhance the capability of the system including stronger governance and aligned decision-making, and greater engagement with communities and other partners.

- BLMK is still determining its ultimate status as an Integrated Care System (ICS) in 2018-19 but has together prepared this single system operating plan.

- This document sets out that single narrative and aligns with the key assumptions for income, expenditure, activity and workforce across BLMK as outlined in separate financial and activity plans

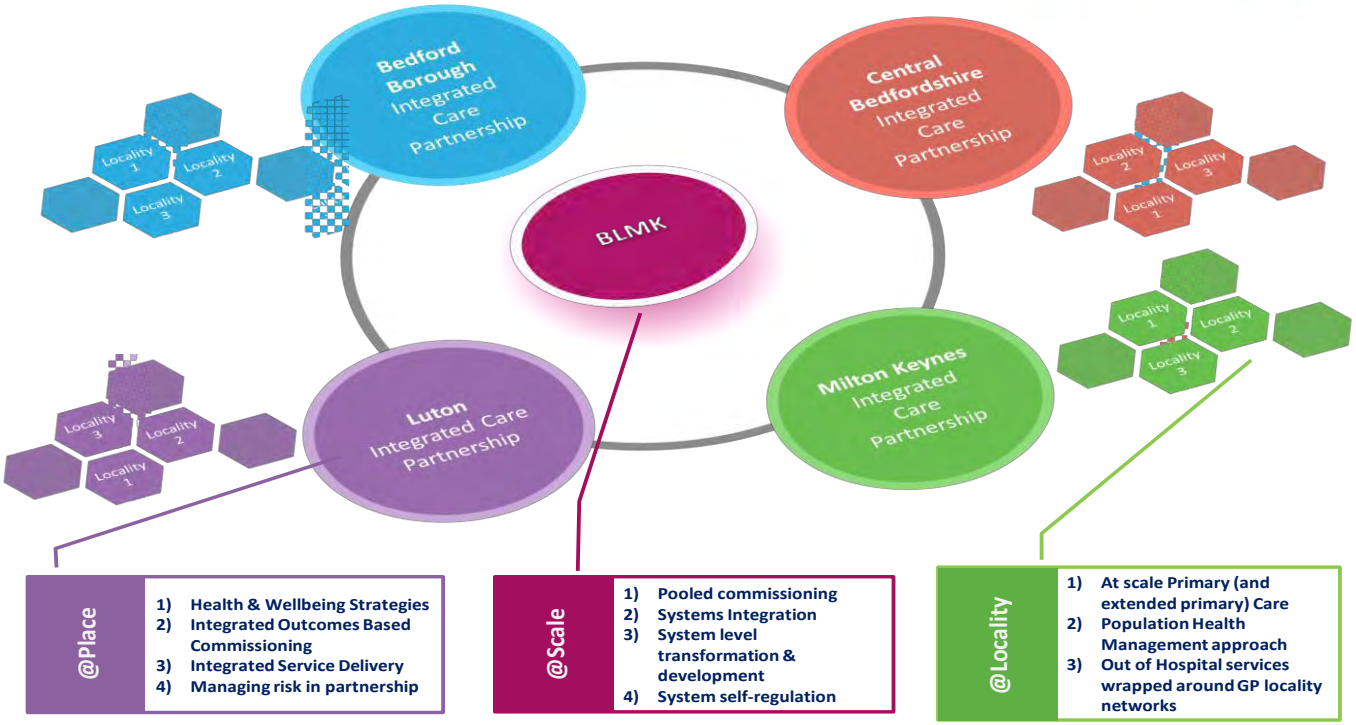
- It builds on the BLMK STP Plan, published in October 2016, which describes the route map for how the system will implement the NHS Five Year Forward View. This plan provides an overview of the progress that has been made in delivering the five priorities of the STP and the key next steps for 2018/19.

- It provides a summary of the delivery priorities for 2018/2019 to drive better care delivery and health outcomes for our local population, whilst at the same time making significant progress in ensuring a sustainable financial position going forward.

New Integrated Care Systems

BLMK is one of eight 'lead' Integrated Care Systems in England and will be moving into 2018-19 after a year of further integration in 2017/18. The 15 partners within BLMK are working to deliver a transformed system. The strategy of the NHS – *"The Next Steps of the Five Year Forward View"* sets out plans for the transition of the NHS to population-based integrated health systems, and moving beyond the NHS to break down the barriers between the Health and Care system to serve our population's needs in the best possible manner. In order to navigate the complexity of the different geographical footprints within which our population lives, and in which services and interventions are delivered BLMK has agreed a Triple Tier Model as shown below.

Triple Tier Model



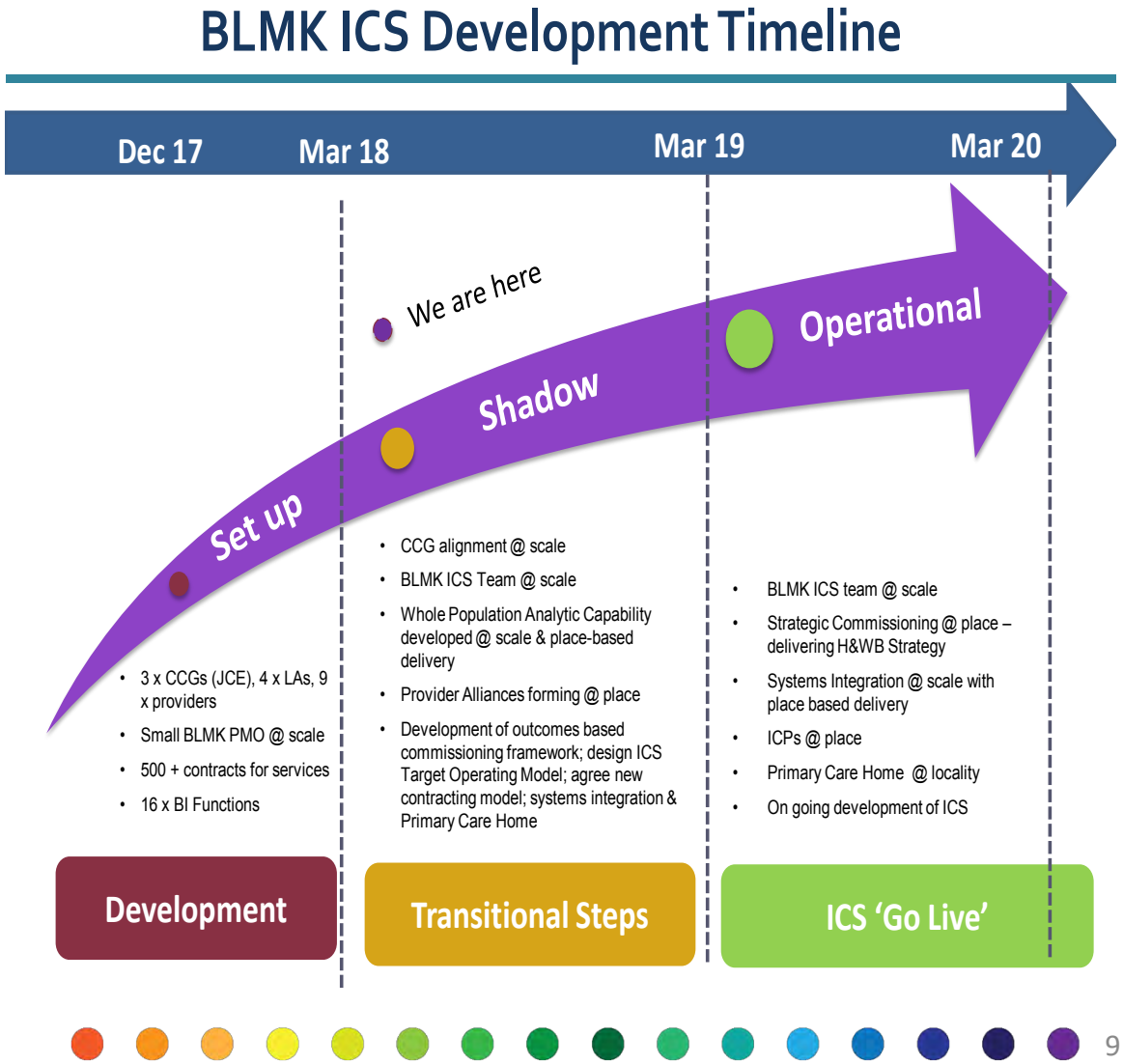
Progress in 2017/2018

Our ambition

An integrated health and care system that delivers resilient services based around a person needs and that improve outcomes for our residents.

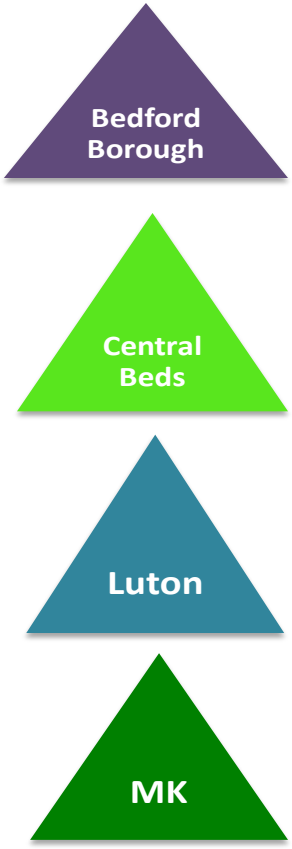
In 2017/18 we have achieved:

- Wave one Integrated Care System
- Established CCGs' Committees in Common to agree common issues together for BLMK
- Full Business Case and Plan developed for the Luton & Dunstable University Hospital and Bedford Hospital merger
- Agreed a Triple Tier ICS Model, which will deliver:
- Care wrapped around networks of GP practices covering a 30-70,000 population – our locality model based on Primary Care Home, the National Association of Primary Care's enhanced primary care model.
- Place (Borough) based strategic commissioning and Integrated Care Partnerships and Provider Alliances.
- Collaboration at scale to support place-based delivery
- Establishment of place based transformation / integration boards



Geography & Scale

Integrated Care System Provision Map from 1/4/18



Acute	Mental Health	Community Services	Social Care	Primary Care
Bedford Hospital	East London Foundation Trust	East London Foundation Trust & Cambridgeshire Community Services	Bedford Borough Council	1 Locality
Luton & Dunstable Hospital			Central Bedfordshire Council	4 Localities
			Luton Borough Council	4 Localities
Luton Provider Alliance				
MK Hospital	CNWL		Milton Keynes Council	7 Clusters 1 GP Federation

3. Vision

Strategic Narrative

Why we are doing what we're doing

Vision Statement: Bedfordshire, Luton and Milton Keynes health and care partnership

We are working together to improve the health and wellbeing of the people living in Bedfordshire, Luton and Milton Keynes, and are responsible for making sure people get the information, support and access to services they need to live healthy lives for as long as possible. We are working together to make sure local people know how stay healthy. And when people are ill or need social, mental health or community support, that those services are delivered in a way that meets their needs and are delivered in the best place – whether that's in someone's home, the local community, a GP surgery, an integrated health and care hub or a hospital.

We want to put an end to a health and care system that starts and stops because the organisations involved don't work together. We want to put our residents at the heart of our health and care system and make sure services are delivered around their needs.

We want to support the thousands of doctors, nurses and other health and care staff working in our organisations to deliver the best care and services they can now and for future generations.

We have a responsibility to work together to respond to the challenges our health and social care system faces today to make sure local people have the best possible health and care services in the years ahead.

What does our System Look Like Now

- There are 15 statutory organisations responsible for delivering or organising the delivery of health and care services in Bedfordshire, Luton and Milton Keynes. These include local councils (for social care not necessarily limited to social care – eg Public Health and other related universal services and public health), hospitals, clinical commissioning groups (led by GPs and responsible for the planning and buying of NHS healthcare), and organisations providing community and mental health services. There are also many, many charities, voluntary carers and community groups providing help, care and support to residents.

- Currently, many organisations work independently and provide the care and services that is within the scope of their contract. This means that people who need those services from multiple organisations have to work out how and where to get them. Sometimes that's simple – most of us know who our GP is, or how to call 111, how to get emergency care at A&E or by calling 999. But sometimes it's very complicated – many of us wouldn't know who to contact if our elderly relative was about to be discharged from hospital and needed transport, community care support and care from a district nurse.

- When getting care and support is difficult, we tend to use those services that are familiar – our GP, A&E and the ambulance service. That may mean we don't get the right care and support at the right time, in the right place. It also means that there is a greater pressure on these services.

- Organisations working separately means that patients and residents are not at the centre of services – institutions are. Care starts and stops at the door of the organisations responsible for providing it. This means people – often at their most vulnerable – have the challenging task of navigating a complex health and care system.

- We think we can do better.

What do we want the future to look like?

- That every person in Bedfordshire, Luton and Milton Keynes can live healthy lives for as long as possible. People will have the knowledge and support to live healthy lives and to manage their long-term conditions and are able to participate in their communities. We will tackle the lifestyle behaviours that have a negative impact on health (smoking, alcohol, poor diet and physical inactivity) and promote mental wellbeing.

- That every resident has access to community, mental health, primary and social care that is personalised and organised around the individual. Integrated Health and Care Hubs, Primary care hubs, where GPs work hand-in-hand with specialists across community, mental health and social care, pharmacy and therapies are established for every community.

- That there is parity of esteem for mental health and learning disability services, with services built around the needs of residents.

- That the three acute hospitals provide services for their populations, with every resident having access to world-class specialist care as close to home as possible. Reduce variations in quality of care received by those who use services outside of the BLMK footprint.

- That care records are shared so there is real continuity of care, and data is used to predict and plan health care interventions and proactively meet the demand for services.

- For Bedford, Central Bedfordshire, Luton and Milton Keynes to develop as an Integrated Care System with shared goals and targets focussed on improving health outcomes and services for local people with local democratic legitimacy and the support of statutory boards.

4. What should our focus be?

- We think we can do better than the fragmented health and care system we have at the moment. Working together means putting our residents at the heart of the services we provide, rather than focusing on which institution is providing them.

- And there are other reasons that mean we need to work differently to make sure we have the best health and care services available for local people now and in the future.

  - Our population is growing. Almost a million people live in Bedfordshire, Luton and Milton Keynes and the population of every local authority areas is growing. By 2032 around 150,000 more people will be living in our region, and there are ambitious potential plans to accommodate even more homes as the arc between Oxford and Cambridge is focussed for more growth.
  - We still have significant health inequalities in Bedfordshire, Luton and Milton Keynes. In some parts of BLMK there is an 11 year difference in life expectancy between the least and most deprived areas.
  - Demand for our health services is increasing at a faster rate than ever before – around 10% more people every year come to our A&E departments, and more than people than ever are being admitted to hospital.
  - We need to do more to recruit and retain doctors, nurses and other health and care professionals. Around 25% of the GPs in Bedfordshire, Luton and Milton Keynes are eligible for retirement in the next five years. Recruiting specialist consultants is becoming increasingly challenging. Changes in how nurse training is funded, and the uncertainty created by Brexit, means fewer nurses are coming into the profession.
  - We need to focus on the challenges within the Care Market. Market sustainability, as well as recruiting and retaining a skilled and capable workforce is key to delivering our priorities for promoting independence and keeping people at home, in their communities with care for much longer, when it is appropriate to do so.
  - We focus much of our resource on treating rather than preventing ill health.
  - The money is challenging with increasing numbers of people living longer with more complex health needs, and increasing demand for health and care services, there will be a financial shortfall of £335 million in Bedfordshire, Luton and Milton Keynes to meet the needs of our residents by 2020, unless we fundamentally change our model of hospital focussed care.

- These are compelling reasons to change, and the 15 organisations that make up the health and care system in Bedfordshire, Luton and Milton Keynes are committed to working together to ensure those changes deliver the best possible health and care services for residents now and in the years to come.

5. Health & Care Focus

Life expectancy and health inequalities

- Life expectancy across BLMK has been rising for decades but in the last couple of years this rise has slowed or halted. Male life expectancy at birth ranges from 78.4 years in Luton to 81.5 years in Central Bedfordshire, and for females it ranges from 82.2 years in Luton to 84.0 years in Central Bedfordshire.
- There are significant gradients of life expectancy within each local authority area. For men the life expectancy gap between the least and most deprived areas is largest in Luton (10.4 years); for women it is largest in Milton Keynes (8.3 years).

Wider determinants of health

- Wider determinants of health including social, economic and environmental factors contribute to an estimated 50% of health outcomes.
- 27,749 households across BLMK experience fuel poverty.
- Less than half of adult social care users in BLMK report that they have as much social contact as they would like.

Health behaviours and risk factors

- In 2016/17 53% of pregnant women did not receive a seasonal flu vaccination.
- Coverage of childhood immunisations generally good, but the proportion of children receiving two doses of the measles mumps and rubella vaccine fell short of the 95% national target.
- 1 in 5 children aged 5 to 6 are overweight or obese, rising to 1 in 3 by age 10 to 11.
- In line with the national trend, hospital admissions for self-harm are rising across BLMK.
- Four unhealthy behaviours are responsible for the majority of preventable ill health and mortality: smoking, poor diet, lack of physical activity and excessive alcohol consumption.
- More than a third of adults in Bedford Borough consume more than 14 units of alcohol a week and in Central Bedfordshire alcohol related admissions continue to rise.
- The proportion of adults who are overweight or obese ranges from 56.7% in Bedford Borough, to 65.1% in Luton .

Morbidity and Mortality

- Across BLMK the leading causes of preventable mortality are cancer and cardiovascular disease, followed by respiratory disease and liver disease.
- 1 year survival for breast cancer is worse than expected for Bedfordshire and Milton Keynes CCGs; 1 year survival for lung cancer is poor for Bedfordshire and Luton CCGs; and 1 year survival for colorectal cancer is poor for Luton CCG.
- The Incidence of alcohol-related cancers is higher than expected across BLMK.
- Cervical screening coverage is falling across BLMK, in line with the national trend.
- There are an estimated 89,000 adults across BLMK with undiagnosed high blood pressure and 27,100 who are not treated to target. There are an estimated 7,200 adults with undiagnosed atrial fibrillation (AF), which is a major risk factor for stroke, and 2,400 adults with high risk AF who are not optimally treated.
- The rate of premature deaths from heart attacks is higher than expected across BLMK.
- The prevalence of diabetes is rising for Milton Keynes and Luton CCGs and the proportion of diabetes patients who achieve treatment targets for blood sugar, blood pressure and cholesterol is lower than expected across BLMK.
- Emergency admissions for asthma are higher than expected for Bedfordshire and Milton Keynes CCGs. Emergency admissions for children with lower respiratory tract infections are rising for Bedfordshire and Luton CCGs.
- Across BLMK there are between 1,270 and 1,895 women with mild-to moderate perinatal depression or anxiety.
- The proportion of adults in BLMK with anxiety or depression entering Improving Access to Psychological Therapies (talking therapies) is lower than the England average, and the rates of planned and emergency admissions for mental health are higher than expected for Bedfordshire and Luton CCGs.
- Emergency admissions due to falls in adults over 65 are rising in Bedford Borough, Central Bedfordshire and Luton and the rate of hip fractures is rising in Milton Keynes.
- There are 5,551 people in BLMK with a diagnosis of dementia but a further 3,308 are thought to be undiagnosed. Bedfordshire CCG has not achieved the target for 66.7% of dementia cases to be diagnosed.
- By the age of 65 most adults have two or more long term conditions (what's known as multimorbidity). Multimorbidity is more common in more deprived neighbourhoods and while older people tend to have more long term conditions there are more people under 65 with multimorbidity than over 65.

6. Communications & Engagement with our residents

BLMK Sustainability & Transformation Plan

What we have done so far

- Conducted a series of public/staff/other stakeholder engagement events in 2016 to discuss initial ideas and plans
- Established Public Voice Partnership meetings with HealthWatch colleagues, Staff Voice (more recently)
- Held clinical conversations to engage clinical staff in the key clinical challenges for BLMK and share best practice from other systems
- Development of a single vision for BLMK
- Developed patient stories to inform and inspire change across BLMK
- Established communications and engagement collaborative with all 15 partners
- Established central communications team to support each new 'place' communications group/network – Luton, Bedford, Bedfordshire, Milton KeynesCreated collateral to support the programme – website, monthly brief, summary documents, reports
- Briefing meetings with political stakeholders
- Managed all media enquiries including organising press briefings and managing high-news value items
- Facilitated visits to BLMK of national news outlets and senior NHSE figures
- Presentations to scrutiny panels, JOHSC, elected members, Leaders and Chairs

Tactical Management and Development/Actions

- Beginning new work with priority leads and HealthWatch colleagues to pull together communications plans, campaigns and narratives across both place and priority. So our residents and staff can visualise our ambitions
- Focussed work on increasing the public (including staff and stakeholder) understanding of the **breadth and depth** of work across health and care sectors under the auspices of the STP
- Continue to develop engagement plans for all stakeholders, including increased twitter presence and link to BLMK active website. We want our partners and stakeholders to see in real time changes in our health and social care provision and be part of them.
- Continue to manage **high news value narrative** (e.g. acute sector) which dominates in the public sphere discretely (but not in isolation)
- Refreshing all collateral – website, newsletters, core briefing material to reflect narrative context
- Produce annual review
- Continue to develop patient and staff experiences stories to inform and inspire change across BLMK, for each priority board and CEO group, supporting all service developments to be driven from the perspective of our residents.
- Continue and develop our Clinical Conversations to ensure our programmes are developed by our front line staff and wider stakeholder groups

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6. C&E with our Statutory Partners

BLMK Sustainability & Transformation Plan

What we have done so far

- Across the system
  - Fortnightly CEO group – innovation in partnership working, setting strategic direction, holding transformation programme to account on delivery and unlocking complex issues
  - Fortnightly DoF group – one view of our demand, income, expenditure, savings plan
  - Priority Boards, Subject Matter Expert Groups and tactical collaboration groups in place – drivers of innovation, sharing of best practice internally, nationally and across system, escalating concern on delivery against plans
  - Establishment of four place based boards – responsible for design and implementation and local assurance of transformation plan

- Across and Within Organisations at Place
  - Partners fully represented at Priority Boards and SME Groups
  - Tactical collaboration groups formed of front line staff
  - CEOs responsible for engagement within their organisation
  - Monthly news letter distributed across organisations through Coms Collaborative

- With our NHS Regulator
  - Fortnightly development meetings with our regulator
  - Development meetings and support from National 1st Wave Integrated Care System support work streams
  - Established links and some appointments for FYFV clinical networks, Mental Health, Diabetes in place
  - Quarterly joint assurance meetings with regulators and CCGs

Next steps

- Across the system
  - Step change our relationship and collaborative design with the Third Sector; voluntary, housing
  - Further develop our relationship and form a joint strategic approach with all our Health and Wellbeing Boards
  - Ensure we understand our Return On Investment across our system
  - Develop our partnership with our residents and communities

- Across and Within Organisations at Place
  - Detailed development and delivery of placed-based plans
  - Develop the nature and depth of consensus behind the SSOP through more formal engagement with partners, including elected members and non-executive directors.

- With our NHS Regulator
  - Joint oversight of system assurance
  - Development and establishment of simplified assurance processes and returns with our regulators
  - Resolve our historic funding gap and deficit repayment structure

7. Partner Workstreams

PREVENTION AND HEALTH PROMOTION (P1)
Preventing ill health and promoting good health by giving people the knowledge and ability, individually and through local communities, to manage their own health effectively.

PRIMARY, COMMUNITY AND SOCIAL CARE (P2)
Delivering high quality and resilient primary, community and social care services across Bedfordshire, Luton and Milton Keynes.

SUSTAINABLE SECONDARY CARE (P3)
Delivering high quality and sustainable secondary (hospital) care services across Bedfordshire, Luton and Milton Keynes.

DIGITAL PROGRAMME (P4)
Working together to design and deliver a digital programme, maximising the use of information technology to support the delivery of care and services in the community and in primary and secondary care.

SYSTEM RE-DESIGN (P5)
Working together to make sure the right services are available in the right place, at the right time for everyone using health and social care in Bedfordshire, Luton and Milton Keynes.

8. Building on 2017/2018

BLMK Sustainability & Transformation Plan

P1 **Prevention:** 4 Prevention Champion workshops on the role of community pharmacy, seasonal flu, CVD prevention and workplace health have resulted robust plans to deliver interventions at scale including; Pan-BLMK social prescribing offer; Screening for Hypertension & Atrial Fibrillation; Whole-system response to seasonal flu vaccinations & actions to improve prevention, early detection and optimise treatment of CVD

P2 **Primary, Community & Social Care**: Building high quality, resilient, integrated primary, community and social care services across BLMK including; Primary Care Home champions & early adopters identified; enhanced primary care opportunities; Place based programmes of work to deliver Enhanced Health in Care Homes

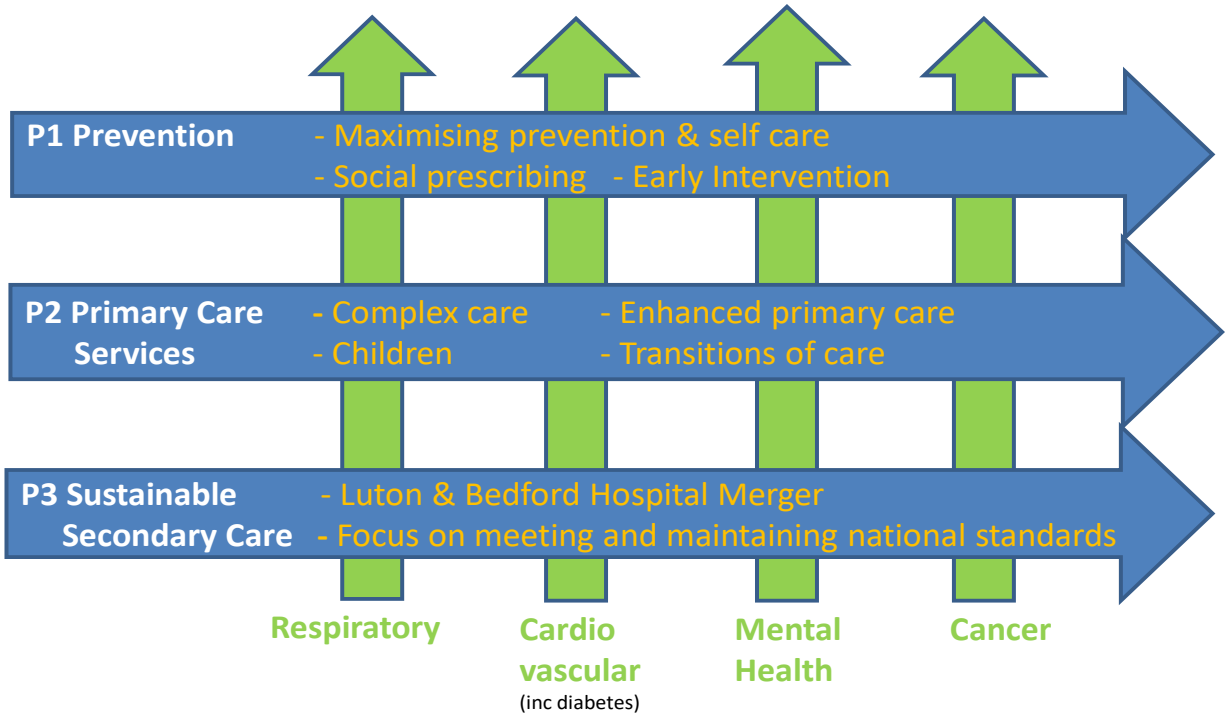
P3 **Sustainable Secondary Care**: Delivering high quality and sustainable secondary (hospital) care services across the ICS; full business case developed for proposed merger between Luton & Dunstable and Bedford Hospitals; joint board established; clinical collaboration meetings; ongoing work to develop integration & streamlining patient care. A focus on meeting national standards and cost reduction including working with other secondary care and tertiary providers

P4 **Digitalisation:** Transformation of digital platforms to ensure better coordinated care including; predictive data analysis & intelligence; supporting new ways of working; shared infrastructure & interoperability; provider digital maturity & records assessment & plans.

P5 **Re-Engineering:** Ongoing work to develop a Integrated Care System (ICS) in BLMK including: Wave 1 ICS application approved; Functional Review of Commissioning conducted; MKICS pilot approved with Whole Population Health Analytic work commissioned; learning & liaison from Luton system work & national programmes to support ICS

9. Areas of Focus 18/19

Across BLMK there is significant resident and patient growth; demand continues to outstrip current services and funding. Too many people are presenting at hospitals and GPs are also under pressure. Service resilience needs to be strengthened and capacity enhanced in prevention services; primary care, community, mental health and social care; and secondary care. There are also some significant health and wellbeing outcomes/care and quality gaps that need to be addressed. **Our learning from 17/18 told us that as a system we will have the best impact if we target our efforts on a small number of key focus areas**. The focus for our transformation is shown in the diagram below.



Underpinning our key areas of focus are enabling workstreams such as:-

- Digital (P4)
- System Redesign (P5)
- Workforce
- Engagement & Communications
- Estates
- Finance and Information

10. Priorities for 2018/2019

Focus	Elements and their Impact	Delivery and Ambition
Prevention	Social Prescribing offer will release capacity in primary care and support residents to find sustainable solutions to practical, social and emotional issues.	Addressing social, emotional and practical determinants of ill health by rolling out social prescribing across the geography. Business case written, localised pathways developed in each place, with full roll out in one place. Proposals to implement locally in BLMK currently being assessed jointly between NHS and LA and national partners.
	Cardio-vascular prevention - Across BLMK an estimated 89,900 people have undiagnosed hypertension (high blood pressure) and 7,200 have undiagnosed atrial fibrillation (AF). Hypertension management accounts for approximately 1 in 10 GP visits. Circa £2m of costs to BLMK of stroke management, plus additional capacity released.	Evaluation of hypertension detection pilot due in June. Ask of NHSE to enable continuation of programme in commissioning specification of Pharmacy and technical solution (PharmaOutcomes) for e-referral management to GPs (currently funded part year to support flu only by NHSE). Establishing a BLMK-wide cardiovascular prevention community of practice. (Including potential to work with private businesses to raise awareness and early identification.)
	Flu Campaign – ensuring maximisation of prevention thus minimise impact on individuals, health demand and wider socio-economic implications	Pan system wide communication and engagement approach in 2018/19, building on success of 17/18 with increased work with private and tertiary care sector. Ensuring frontline workforce and 'at risk' groups are able to access vaccination in convenient places at convenient times.
Enhanced Primary Care	Support and accelerate the development of primary care networks / primary care home for our local communities with a focus on population health management. Ambition is to proactively support complex care patients; prevent rising health care risks, improve primary care access for patients, and reduce inappropriate preventable crisis demand on the acute sector. Development of partnerships, across General Practice, and with multi-disciplinary teams supported by local care navigation patients will enable residents to access the right clinician / support at the right time to support their needs. The implementation of the programme will enable staff to work at top of license, with expected result in improved recruitment and retention as a result of a better work environment.	Rollout our Primary Care Home Programme to our 21 clusters; 4-5 clusters with accelerated support to demonstrate PCH benefits earlier. Implement the ICS wide Primary Care Workforce Development Plan aligned to development of CEPN, NAPC programme and in support of place based initiatives GPFV Develop and Implement 18/19 primary care incentive scheme, building on success of 17/18. Align local investment opportunities, GPFV, Locality and overarching programme. Target use of additional NHSE primary care resource to maximise service developments within clusters; Continue to implement technical capabilities and solutions to support PCH and GPFV (Priority 4 - Information Sharing Project); Implement the Workforce and new models local website, supporting easy access to transformation solutions; Triangulation of NAPC/PCH programme with Complex Proactive Care work required; Support development of Estates Hub programme, specifically articulating the strategic case to support business cases & implementation of PCH within improved estate Ensure alignment of GPFV delivery (x 3) within overall primary care programme & place based out of hospital strategies; Work with place based systems to develop local innovative primary care solutions e.g. MK GP Fed, Provider Alliance

Focus	Elements and their Impact	Delivery and Ambition
Complex Care (20% of our population)	Care Homes (2%) Resident Improved Care and Experience, including the delivery of proactive care management within homes which is sophisticated and supported by the system so residents crisis escalation in care needs which is preventable is minimised.	Rollout of programme in each place (supported by AHSN), key elements include Medication Review, Advanced Care Planning, Crisis support for residents, carers and staff. Adopting zero tolerance for residents being transferred 'unnecessarily' to A&Es. Support monitoring of implementation and impact. Align National and Regional, and local KPIs
	Place-based solutions to enable and improve the resilience and capacity of health and social services providing proactive management of complex care patients with rising needs outside of hospital within a redesigned financial incentive framework.	Development work underway to agree the initial population cohorts which will be managed under this proposal in each place, across acute, general practice, community, mental health and at some social care partners. Places developing workforce and service models to improve the support to these patients in their place of residence. Place and system designing training packages, and communications and engagement strategies to support the full deployment of service models and the sustained usage of them. Places developing a phased model of deployment of ambition, to ensure significant improved service provision to residents in 2018/19, with these initial focused solutions being positioned to enable the full ambition and potential across health and social care going forward. System support ongoing to resolve information governance challenges to enable robust and secure data sharing to support proactive care and contract management. System supporting places with access to a tactical solution for the provision of shared care records ahead of strategic solution. Places developing radically different means of contracting and payment associated with these patients, supported by the system and 1st Wave ICS NHS England teams. The system collectively believes this model of working is crucial to delivery of long-term STP redesign objectives, both financial and clinical.
Mental Health	Develop investment plan to secure full FYFMH delivery through to 2021 Ensure 2018/19 FYFV goals are delivered Develop consensus model for mental health in primary care home	The ICS partners are committed to ensuring the delivery of the FYFV for Mental Health, and to going further in realising the potential for mental health to support population health and system effectiveness through more integrated physical and mental health care and prevention.

Focus	Elements and their Impact	Delivery and Ambition
Transitions of Care	Building on 111 procurement and partial deployment on Social Prescribing, 18/19 Single Point of Access / Assessment International and complex companies demonstrate and evidence the benefit of integration functionality to improve 'customer' experience and reduction of significant cost risk.	Complex plethora of historic access routes and digital procurements in place. 18/19 to create a system owned five year vision and make tactical changes Requires sponsored subject matter expert review of baseline explore ETTF with UEC programme support from the region
	17/18 and beyond to reduce Delayed Transfers of Care (DTOCs) Further ambition to reduce unnecessary beds for all medically fit, improving patient experience and reduced health capacity and cost pressures	Solution is dependant upon the integration of the functions of teams across providers and commissioners and must be enabled through true partnership working. Each organisation must therefore be held locally, regionally and nationally to account to the same end with a dovetailing of performance indicators (BLMK part of NHSE ICS performance dashboard development); UEC programme support from region needed
Children and Young People	Phase 1: Improved service provision and management of bronchiolitis pathways. Full implementation will resolve one of our outlying areas of patient management and reduce demand on acute Trusts. (45 %, £1.2m of additional spend across the STP for 0-4yr olds respiratory conditions against our peer average.)	Full role out of system programme at place started in 17/18 with associated committed funding. Programme includes, provision of paediatric o2 saturation monitors to 130 GP practices 100% of GPs to have access to and to be trained on bronchiolitis management pathway Deploy funding and specification in place for increased Rapid Response community nursing in North and South Bedfordshire and to pilot clinic based model in Luton. Ensure NHSE Region and local Primary Care Programme aligned to ambition with regard to GP contracts and programme plan. Ensure alignment with NHSE Region paediatric network
	Phase 2: Review current complex service commissioning and provision, with recommendations of focus areas of next step of children's programme for 18/19	Initial assessment of priority areas derived from the Clinical Conversation event in Jan 2018 on Children and Young People across all partners (including third sector providers) are: - Continuation of work to reduce emergency admissions of 0-4 year olds - Scope the potential for delivering community paediatric pathways at scale, develop a prioritised action plan and commence delivery - Scope the potential for achieving economies of scale and improving specialist mental health pathways through provision across the STP footprint, develop a prioritised action plan and commence delivery -

Focus	Elements and their Impact	Delivery and Ambition
Sustainable Secondary Care	Luton and Dunstable University Hospital and Bedford Hospitals merge to create a single NHS Foundation Trust	Fundamental to the BLMK STP, financially, culturally, and an enabler for service transformation with enhanced primary care. By bringing together teams and services from both hospitals, the new Trust will play a pivotal role in offering a more coordinated approach to healthcare provision across the whole system. Requires NHSE Regional and national support to unlock in year financial revenue benefits and significant capital investment to ensure 'fit for purpose' facilities to support future service provision. Merger business case development continues (Q2/3) Significant investment - estates programme business case development (Q2/3) Clinical workstream and pathway development to continue throughout 2018 Merger expected to progress (Q1 19/20)
	Economies of scale leading to more efficient and effective healthcare provision	**At place level** Working closely with other programmes in respect of Transitions of Care and Complex Care. Supporting development of High Intensity User programmes at scale (Q3) – currently in pilot **At service level** Developing pathways with other local providers including tertiary providers in order to meet and maintain national standards (Q2/3/4) Establishing economies of scale across both systems through acute support services provision, e.g. Pathology services through the national pathology networks (Luton / Bedford and Milton Keynes / Oxford) (Q2/3/4)
Cancer	Improve cancer outcomes across our systems, through system support, place implementation of cancer alliance developed plans	Deploy implementation plan focusing on transformation plans that secured significant funding for our system, supporting ; Prevention; Improved waiting times; New care models supporting earlier diagnosis Ensure 2018/18 FYFV goals are delivered
Digital	Patient and staff facing digital solutions, to enable care and self-care across the continuum of a residents needs, irrespective of provider supporting the individual.	Delivery in tactical information sharing to support PCH and Complex Care service design changes for 18/19. Enable tactical strategic business solutions for complex care programme and whole population health analytics Enable data sharing agreement between practices, including public communication for both direct care and secondary use. Continue technology enablement of improved care building on deployment of SMS messaging across practices in system; wifi and system one access and digitalisation of care homes.

Focus	Elements and their Impact	Delivery and Ambition
System Re-engineering	Single System Operating Plan (SOP) – ongoing development and deployment of a transformation plan across our provider and commissioner partners to improve the services we provide to our residents. Improving our outcomes, enabling residents to be supported in the most effective and efficient manner to support services which are sustainable from workforce, clinical and financial perspectives.	Submission of SOP to NHS Regulator in April 2018 Delivery, assurance and communication through system and place delivery plans and mechanisms in 18/19, to ensure realisation of ambitions and change of service provision and access to our residents. Operationalise 'co-ordinated oversight' NHS regulator assurance approach ready for joint oversight by 19/20 Proof of concept of whole population health analytics enabling a step change in strategic commission capability. Utilising learning from transformation supporting partnership governance and implementation of plans develop extended transformation focus for 19/20 and thus next years SOP.
	Aligning ICS infrastructure and design work – to enable plans to be more effectively supported by lean, capable and efficient leadership functions	Alignment of commissioning at scale by creation of Joint Executive Team for 3 CCGs Enabling delivery of some commissioning activities at scale Q1-4 as follows: Q1 – aligned planning, NHSE assurance, primary care contracting and governance via Committee in Common Q2 – 4 – back office review, alignment of other contracting functions including acute contracting. Supporting the definition and calibration of what activities are deliver at scale or at place. Recruitment to Chief Finance Officer, Chief Information Officer and Director System Re-engineering roles established in ICS programme in 17/18 Production of: outcomes based commissioning framework, contracting mechanism and framework and supply side resourcing strategy; provider alliance framework; refresh ICS, commissioning and provider governance frameworks and ICS Target Operating Model for strategic commissioning, systems integration and integrated care partnerships at place.
	Place-based partnerships will enable innovations in service delivery that have historically been inhibited by silo working driven from organisational boundaries	Development of Integrated Care Partnerships, Provider Alliances and Place Transformation Boards Accelerate health and social care integration at place by creation of 'COO' role at place Test gain / risk share models via complex care initiatives at place Demonstrate implementation of transformation programme

What will be different?

Improved

- resident patient and carer experience of our services
- outcomes for our patients, focusing in 18/19 on high priority areas of variation to national outcomes, Cancer, Mental Health, Respiratory, Cardio Vascular Disease (Including Diabetes)
- Focus on early intervention and promotion of independence
- self management and prevention of health and social care service need
- access to primary care services
- staff satisfaction, retention of workforce.
- service collaboration, resilience and service sustainability with capacity and capability to provide high quality services for our growing and increasing complex and rising comorbidities of our residents
- Robust Care Market and a multidisciplinary workforce

Reduced

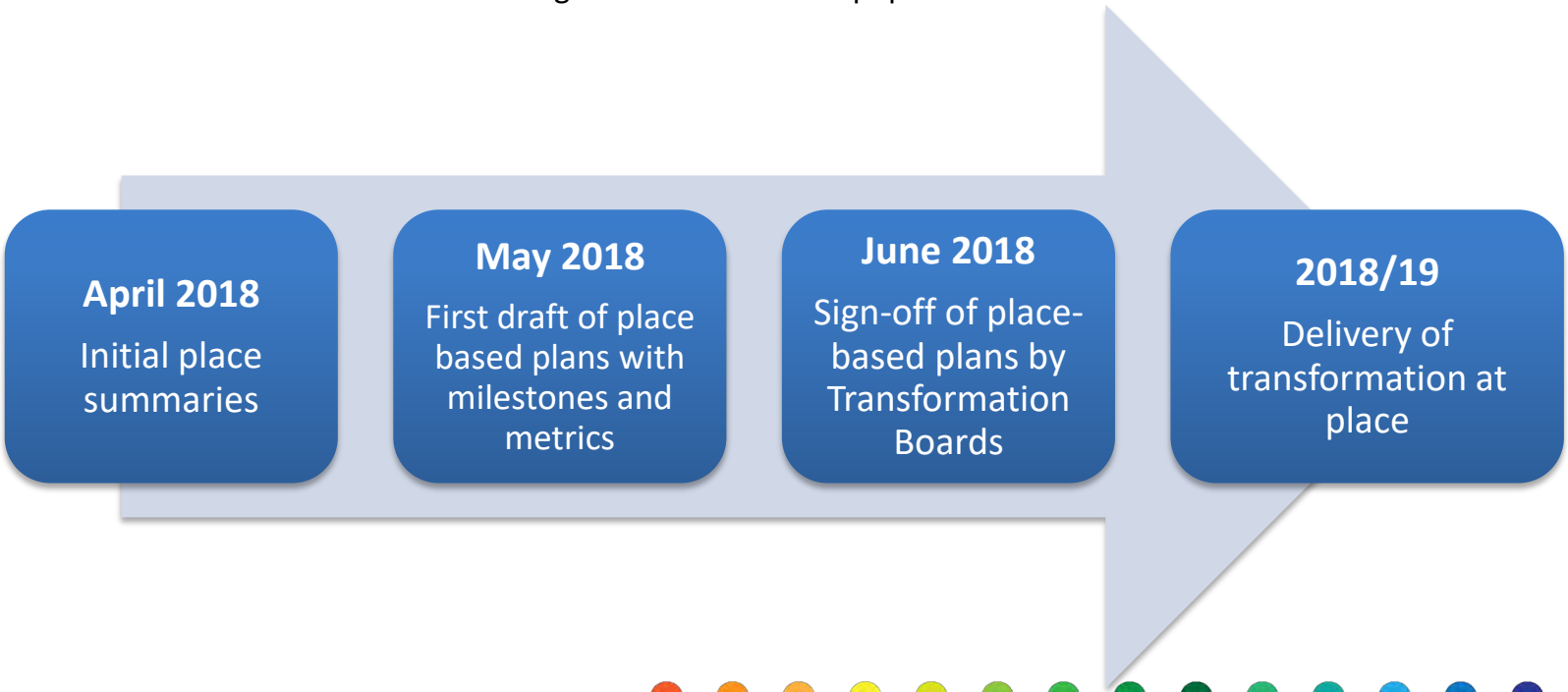
- ambulance conveyancing where historic crisis support has necessitated this
- high end service utilisation by mental health needs
- demand on urgent services and acute inpatient services
- non-medical demand on Primary Care
- non-medical use of acute provider beds resulting from delayed transfers of care to appropriate alternative environments

Changes will

- create financial sustainability of our system, creating circa an additional £15 – 30m savings through collaboration and partnership resolving complex service issues at the point where our organisational boundaries have historically inhibited shared innovation.

‘Place Based’ Delivery 2018/2019

- There are four ‘places’ in BLMK: Bedford Borough, Central Bedfordshire, Luton and Milton Keynes
- Work is underway to develop detailed ‘place based’ delivery plans overseen by the Transformation Boards in each of the four places.
- These will support the implementation of the BLMK Operational Plan and will be finalised and agreed by end of June 2018.
- It is expected that these will be co-produced and signed-off by Transformation Boards and will be monitored and delivered at place.
- The three CCGs are supporting the co-ordination of these place-based plans
- Initial summaries of how the STP priorities are being delivered in local systems are shown in the following slides.
- These will be used as a starting point for Transformation Boards to develop their local plans which address STP priorities in the context of the health and wellbeing needs of their local populations.



Priority 1 – Prevention

BLMK approach

Reducing non-medical demand on Primary Care – Each of the place-based systems are developing Social Prescribing to improve support to the 18+ population, improving wellbeing and increasing people's resilience and ability to self-care. This includes social support, health coaching and navigation.

Early identification and proactive management of residents with rising risk health needs – Each of the place-based systems are putting in place proactive management of residents with Long Term Conditions that are at risk of exacerbation. There is also a focus on unidentified need and improving timely diagnosis, as well as the need to ensure opportunities for vaccination and screening are maximised.

Bedford Borough | **Central Bedfordshire**

Bedfordshire Out of Hospital Strategies for Bedford Borough and Central Bedfordshire, have a strong focus on prevention, early intervention and supporting people in the community to maintain their health and wellbeing.

Working with Primary Care home Model proactively manage patients and offer more preventative services closer to home with access to a wider range of support to prevent ill-health, with increased emphasis on early intervention supported by voluntary , community and long term condition services, enabling people to stay healthier for longer

Luton

- The Joint Luton CCG and Luton Borough Council draft Prevention and Wellness Plan sets out the local priorities. and the actions to deliver them. These are:
  1. Giving every child the best start
  2. Target high risk groups to prevent disease or complications
  3. Improving four lifestyle behaviours and our environment
  4. Promoting mental wellbeing
  5. Inclusive growth and economic wellbeing
  6. Enhance identification of illness and empower self-care
- Self-care and supported self-management through access to health coaches, support to carers, personal health plans and the integrated wellness and wellbeing service

Milton Keynes

- High intensity service user support provided by MDT and P3, and in partnership with Police. A&E and ambulance data being used to identify individuals and put in place bespoke care and support packages
- Cardiovascular disease is a priority in Milton Keynes. A practice level incentive scheme is being developed to proactively search for undiagnosed hypertensive and AF patients. Optimising treatment increasing the level of known AF patients that are offered and started on appropriate treatment from 83% to 89% over three years.
- Flu vaccination uptake will be improved building on previous successful campaigns. Action to reduce variation between GP practices, bringing them all in line with the best performing. Outpatient flu clinics will expand to cater for at risk groups.

Priority 2 – Delivering high quality and resilient primary, community and social care services

BLMK approach

Enhanced Primary Care: Primary Care Home (PCH) to be rolled out across system including development of multi-disciplinary teams (MDTs)
Complex Proactive Care: Residents with complex needs and those at high risk of deterioration
Children and Young People: Improved service provision and management of bronchiolitis pathways
Transitions of Care: Building on 111 procurement and partial deployment on Social Prescribing, 18/19 Single Point of Access / Assessment
Mental Health: Delivery of FYFV across system
Diabetes and Respiratory: Delivery of FYFV across system
Learning Disabilities: Delivery of the NHS Transforming Care programme

Bedford Borough

4 PCH clusters

Primary Care Home underpins the Out of Hospital Strategies and will, through a multidisciplinary approach,;
NAPC Primary Care Home.

- EOIs from all clusters for GP Incentive scheme inc Information Sharing agreements
- Clusters have developed transformation project and development plan to work collaboratively to deliver services out of hospital and extended access to primary care.
- PMS scheme for 18/19 to support cluster practices to work together with other health and social care teams to develop and expand MDT working.
- Capital Funding has been applied for to develop Healthcare Hubs in localities to provide a range of primary care and out of hospital services – closer to home.

Central Bedfordshire

6 PCH Clusters

Luton

Primary Care Home collaboration
Four clusters have been established for some time as commissioning clusters, and these are now moving forward as provider clusters to underpin Primary Care Home. Two of the clusters have been identified to accelerate implementation, focussing resource (CCG and external) to establish the methodologies for population segmentation and new models of delivery.

- Population health (right size to care 30 – 50k)
- New service models: prevention, ongoing care, self-care and treatment
- Enhanced access and care navigation
- Workforce skill mix / capacity to meet demand

Milton Keynes

GP Collaboration - 7 clusters working towards PHC health population based model with support provided by MK's GP Federation and NAPC utilising best practice models from vanguard sites. 2018/19 will focus on delivery of each clusters' short, medium and long term development plans.

All practices have agreed to share data with MK partners to produce whole population health management data packs for each cluster to support the development and targeting of PCH work and interventions with a focus on High Intensity Users of acute services to encourage and enable care in the most appropriate settings.

Priority 2 – Delivering high quality and resilient primary, community and social care services

BLMK approach

Complex Proactive Care: Residents with complex needs and those at high risk of deterioration. BLMK Care Home Dashboard in development.

Bedford Borough / Central Bedfordshire

Care Home Residents

- Trusted Assessor model in place at BHT and L&D
- Red bag scheme go live in April
- Annual medicines management reviews undertaken by BCCG care home pharmacists, additional pharmacist and technician capacity is planned through the pharmacy integration fund to increase support to care homes and multidisciplinary teams
- Hydration training delivered to all care homes in as part of NEL task force work, Jan-Mar 2018
- Falls champions and prevention training being delivered in care homes Mar-Jul 2018
- GP alignment and enhanced offer from Primary Care to care homes
- Complex care management in care homes
- All care homes to achieve a minimum of silver digitisation status in 18/19. A small pilot using the Whzan technology to identify patients requiring clinical intervention will go live in May 2018.
- Implementation of local solution to telemedicine offer to care homes in line with the 'Airdale' model
- Pilot urgent care service using *6 in Care Homes

Luton

Frailty and Complex Care Programme

- Frailty framework – Frailty identified and managed as a long term condition
- Falls prevention and coordination
- Proactive multi-provider / multi-disciplinary care to a defined cohort / list of complex patients
- Intermediate care and rehabilitation
- Enhanced (coordinated) health in care homes
- Coordinated end of life care
- Roll out telephony based support to Care Homes through the Integrated Urgent Care Service using*6 navigation
- Full review of Ambulatory Care Services in and outside of the Acute Trust and agree pathway across the system.

This links to Primary Care Home, as this will form the basis of one of the prioritised population segments, with a view to rolling out across the other three clusters once the delivery model has been established.

Milton Keynes

Residents with complex needs (Care Homes)

- red bag and patient passport roll out across all care homes. The system wide approach will continue to focus on the following themes:

- Care planning to support advanced care planning and DNACPR for residents
- Medicines Optimisation by additional recruitment of pharmacy technician to increase support into care homes
- Rollout of the Independent Assessor programme and the hydration scheme
- Digitalisation - to enable care homes to have remote access to clinical systems and trialling of telehealth functionality
- Primary Care & MDT support model implementation plan

Priority 2 – Delivering high quality and resilient primary, community and social care services

BLMK approach

Complex Proactive Care: Residents with complex needs and those at high risk of deterioration. BLMK Care Home Dashboard in development.

Bedford Borough | **Central Bedfordshire**

Complex Care - All residents

- Community Provider Incentive Scheme to develop named cohort of patients within agreed criteria to be proactively managed by community provider supported by GPs, social care, and voluntary sector to avoid A&E attendances and hospital admissions.
- Community provider is also developing a more streamlined SPA to include a rag rating for urgent referrals.
- BCCG and IBCF funded beds to support discharge of medically fit patients. BCCG has also commissioned 15 winter beds until 31st May 18 to support discharge of medically fit patients. D2A is embedded in both L&D and BHT.
- Proactive MDT approaches to determine best care for individual
- Dementia – implement advance care planning for people with dementia in all care settings.

End of Life

- Advanced Care Plans rolled out to Bedfordshire residents. Training undertaken across health and social care professionals. The number of ACP discussions have increased. Compassionate Communities initiative rolled out to support.

Luton

Personalised Care Closer to Home

- Patient activation measure including the development of an MOU with NHSE and BLMK setting out the targets for implementation
- Person-centred care plans for top 20% most complex patients where not already in place
- Personal Health Budgets across all service areas and improve levels of take up in CHC as a priority area
- The development of a joint strategy for Continuing Healthcare (all ages) to bring the delivery in to Primary Care Home
- Learning disabilities community support including development of personalised plans for the top 10 intensive users of services
- Acquired brain injury / traumatic brain injury community support to enable better care in the community

Milton Keynes

Residents with complex needs in Primary Care

Implementation of a placed based system wide 'care connection' solution integrated into daily working practices within GP surgeries providing patient centric holistic assessment and 1:1 focused personalised care and navigation

Priority 2 – Delivering high quality and resilient primary, community and social care services

BLMK approach

Transitions of Care: Building on 111 procurement and partial deployment on Social Prescribing, 18/19 Single Point of Access / Assessment

Bedford Borough / Central Bedfordshire

Transitions of Care

- BCCG and LCCG jointly procured Integrated Urgent Care (IUC) service in March 2017 provided by Herts Urgent Care (HUC). BCCG and LCCG completed a contracted specification gap analysis, against revised mandated NHSE spec for IUCs to be in place by March 2019. Working with HUC to mobilise by March 2019 including: NHS111 Digital Online, 24/7 Clinical Advisory Service, Directly bookable In Hours appointments from 111, Direct Access to a clinician for Care Homes.
- Urgent Treatment Centre (12/7) will be in place for Bedfordshire CCG residents and transient patients from 1st October 2018 located in Cauldwell Medical Centre, on BHT site. Proposals are to be tested to provide a satellite service for walk in appointments at Gilbert Hitchcock House on the north wing of Bedford Hospital from 1 October 2018.
- STP programme reviewing points of access
- Deployment of social prescribing utilising health and wellbeing champions aligned to Primary care/Village care/Good Neighbour schemes. Plus new models of care in GP practices including signposting and care navigation.
- Joint assessment and care planning through MDTs.

Luton

Transitions of Care: Integrated Urgent Primary Care Transformation

- Development of Urgent Treatment Centre at the Town Centre Practice
- Directly bookable appointments in Primary Care - Expand directly bookable referrals into UTC, Fully roll out directly bookable appointments in hours.
- Coordinate the requirement for same day access in to Primary Care through NHS 111 as a single point of access
- Urgent GP Centre and Urgent Treatment Centre - Review, develop and implement new models of care for the Urgent GP Clinic

Milton Keynes

Transitions of Care

CISP Workstream - in place & developing.

- Points of Access - Integrated Urgent Care Service currently being procured (along with Urgent Treatment Centre). To be integrated with NHS 111 and Out-of-Hours Primary Care. Direct appointment booking (Primary Care) by NHS 111 being trialled. Additional Directory of Services (DoS) management capacity secured in order to develop and improve the local DoS.
- Record sharing (not necessarily single care record) in place. Summary Care Record access in place.

Priority 2 – Delivering high quality and resilient primary, community and social care services

BLMK approach

Children and Young People: Improved service provision and management of bronchiolitis pathways

Bedford Borough

Children and Young People

- Collaborative Investment Savings priorities for 0-4s being implemented.
- Saturation monitors purchased utilising STP funding to be distributed at locality boards meetings during May / June 2018.
- CAKES training for assessing children with acute short term illness and train the trainer sessions to be provided to both BB & CB Practice Nurses. Joint initiative with NSHI delivering paediatric asthma management guidelines targeting high referring GP practices rolling into Yr2 delivery.
- 2018 / 19 initiatives focus on improving service provision (by reducing NEL activity and providing care closer to home) under development including: Roll out of further 6 high volume pathways across primary care; Formalisation of urgent A&G; Front door triage; Community Nursing for children with acute short term illness.
- CAMHS –Implementation of Local Transformation Plan including further development of Specialist Eating disorders community service (across STP); 7 day crisis service; Early intervention and schools support; Roll out of CYP IAPT; Development of seamless pathways for inpatient admission with specialist commissioning

Central Bedfordshire

Luton

Children and Young People

- Information and signposting for parents and professionals (GPs specifically)
- Reducing unnecessary emergency / non-elective admissions to PAU
- Review and re-development of Paediatric Rapid Response Service
- Review Urgent Care Pathways including 0-6 months pathway
- Review GP Referrals to PAU
- Management and monitoring of children with complex needs (Paediatric Passports)
- Proactive management of Long Term Conditions linked to Primary Care Home
- Improving Primary Care Access for children linked to Integrated Urgent Care

Children's mental health (CAMHS)

- Implementation of Bedfordshire and Luton plan including further development of Specialist Eating disorders community service (across STP); 7 day crisis service; Early intervention and schools support; Roll out of CYP IAPT; Development of seamless pathways for inpatient admission with specialist commissioning

Milton Keynes

Children and Young People

- CISP Workstream - in place & developing.
- Saturation Monitors – distributed and training to be complete at GP PLT in July 2018.
- Same Day Appointments for Urgent Care - all children followed up by CPCT 48hrs after going home following admission for asthma/ wheeze.
- Condition-specific pathways (traffic light) developed and in use.

Children's mental health

- Implementation of MK CAMHS Transformation Plan

Priority 2 – Delivering high quality and resilient primary, community and social care services

BLMK approach

Mental Health: Delivery of FYFV across system as detailed in Slide 47.

Bedford Borough

- BCCG is working across ICS to develop costed STP growth model to support FYFV planning (activity, workforce and finance) to inform opportunities, risks and investment plan to deliver 2021 trajectories. Working with HEE to develop ICS workforce plan. For 2018/19, working through 2018/19 contract variation process to support delivery of FYFVMH 2018/19 trajectories.
- Working with ELFT to embed mental health MDT working and with Housing Officers to support people with mental health needs
- Working with SW CSU on nationally commissioned project to develop a demand and capacity model for CYP, with focus on FYFV access requirements through to 2021. Submitted bid as part of national Wave 2 perinatal process to secure NICE guidance compliant perinatal service across ICS. Currently provide Liaison Mental Health Core 24 compliant services in L&D and MKUH. BHT will be Core 24 in 2018-19. Bedfordshire remains under target for dementia diagnosis. STP Improvement Manager to provide support to Bedfordshire system.

Central Bedfordshire

Luton

- Consultant-led team in Primary Care – development of a business case and co-production of a service model that would see better integration and services closer to home. This includes Early Intervention in Psychosis
- Build on the current model of Primary Care Link Workers that are supporting practices in better managing patients with mental health conditions to improve identification of those with need and ensure seamless care between physical and mental health
- Support for people being discharged from Secondary Care through the Consultant-led Primary Care Team
- Crisis support - Develop multi-organisational support for people in mental health crisis based on person-centred approach
- Older adults mental health support - Develop business case with ELFT for expanding support to older adults in the community using parity of esteem funding
- Review and strengthening of eating disorder support
- Total wellbeing service (including IAPT)

Milton Keynes

2018/19 local areas of focus will be on:

- Healthy Aging Pathway focusing on elderly both as home treatment and care home liaison service
- Out of Area Placements utilising placement efficiency programme expertise to repatriate service users to more local care where appropriate
- Primary Care Plus involving mental health specialists in primary care to undertake medication reviews and support with a roll out across all 7 clusters
- Dementia Pathway scoping diagnostic pathway combined with post diagnosis support

Priority 2 – Delivering high quality and resilient primary, community and social care services

BLMK approach

Diabetes: BLMK Diabetes Network overseeing implementation of NHE Transformation Funding and opportunities for shared services.

Bedford Borough | **Central Bedfordshire**

To improve health outcomes and reduce unplanned episodes of care:

- Two-year NHS Diabetes Prevention Programme providing education and support for people at risk of diabetes to help prevent or delay onset
- Patient participation in care planning as part of annual review including jointly agreed care plan
- Improved access to services including health and well-being services and structured education, provided by Integrated Diabetes Service
- Early identification of foot problems and referral to specialist MDFT services, to reduce hospital admissions for people with diabetes, reduced length of stay and reduction in foot amputations
- Investment within the Integrated Community Diabetes Service to support patients who are struggling to optimise control of their diabetes and tailored support to practices where indicated by current outcomes and performance

Luton

- Multidisciplinary community-based integrated service delivery / pathways
- Reduction in unwarranted variation
- Maximise structured education for patients (DESMOND and Pulmonary Rehabilitation)
- Two-year NHS Diabetes Prevention Programme providing education and support for people at risk of diabetes to help prevent or delay onset
- Patient participation in care planning as part of annual review including jointly agreed care plan
- Improved access to services including health and well-being services and structured education, provided by Integrated Diabetes Service
- Early identification of foot problems and referral to specialist MDFT services, to reduce hospital admissions for people with diabetes, reduced length of stay and reduction in foot amputations
- Investment within the Integrated Community Diabetes Service to support patients who are struggling to optimise control of their diabetes and tailored support to practices where indicated by current outcomes and performance

Milton Keynes

2018/19 will continue to maintain resource allocation to focus on:-

- Increasing attendance rates for residents at risk of developing Type 2 Diabetes
- Increase compliance on treatment care targets with enhanced care planning in primary care
- Expansion of patient facing structured education programmes to tackle 'hard to reach' communities and peer to peer support for self care
- Maintain service delivery for high risk/active foot care services to continue reductions in amputation rates
- Utilise digital apps to improve patient education and avoid risk of future complications
- Scope an integrated hypoglycaemia care pathway(s) for implementation in 2019/20

Priority 2 – Delivering high quality and resilient primary, community and social care services

BLMK approach

Respiratory: Using Rightcare analysis to target place-based interventions to reduce unwarranted variation and to help people stay well at home

Bedford Borough | **Central Bedfordshire**

- Aim: Improving health outcomes and reducing variation, particularly emergency admissions:
- Children:
- Ensuring all practices have access to paediatric oxygen saturation monitor with the necessary equipment and training
- Mobilisation of the local bronchiolitis management pathway
- Provision of Paediatric Community Nursing support to Bedfordshire, in line with what is already available in Luton and MK
- Adults:
- Structured preventative care in primary care avoiding emergency presentations during exacerbations
- Improve diagnosis and management of COPD in primary care by proactive recall of patients at risk of COPD for spirometry
- Enhance delivery of community based services to support patients to better understand their condition and improve self-management.
- Providing access to timely treatment and support will significantly impact on patients quality of life, psychological issues associated with chronic conditions and co-morbidities such as obesity, social isolation and mortality, which create pressures on other areas of the system

Luton

- Address clinical variation in primary care
- Development of integrated care pathways
- Development of a service model and business case for integrated community respiratory care with consultants in the community
- Review of cohort of patients 65 years plus with pneumonia as primary reason for unscheduled admission over Winter 2017/18 to establish alternative pathways of care, and links to P1 around vaccinations for both influenza and pneumonia

Milton Keynes

2018/19 priorities will continue to:-

- Address clinical variation in primary care with upskilling HCPs in respiratory care management & optimisation of therapies
- Implement an integrated diagnostic community respiratory/cardiology service for patients with unexplained breathlessness for early diagnosis and self management care plans
- Enhance community oxygen service to support patients with increased mobility and reduce social isolation
- Streamline points of access for patients requiring referrals to rehabilitation programmes
- Develop an integrated community based Breathe Easy support groups based on BLF best practice model

Priority 3 – Sustainable Secondary Care

BLMK approach

Transformation of Services - ICSs involve all organisations in a local area working together and in partnership to improve population health and local services. Through delivery of the NHS Five Year Forward View ambitions, BLMK will transform the way that care is delivered within priority areas including Cancer & Maternity. All CCGs will work with providers to achieve eight Cancer Waiting Time standards and new national waiting time initiatives. In February 2016 Better Births set out the Five Year Forward View for NHS maternity services in England. The BLMK LMS Transformation plan was submitted on 31/10/17.

Bedfordshire and Luton system

Cancer

BCCG is lead CCG for Cancer across the STP and as such will continue to work with the Cancer Alliance to develop the EoE Cancer ambitions across the STP In 18/19 the CCG will focus on performance, improving 1 year survival, implementing national best practice pathways for Breast, Lung, Colorectal and Urology services and developing a strategy for Cancer as a long term condition.. The STP Cancer Delivery Plan and NHSE Cancer Transformation Funding will support delivery against the plans, which cover Early Diagnosis and Living with and Beyond Cancer

Maternity

Delivery of Local Maternity Services Plan. In line with 'Better Births' the LMS is the basis on which future BLMK maternity services will be taken forward as shown in detail on slide 31. In summary priorities include *Improve the safety of maternity services; Create a joined-up approach to workforce planning; Develop and implement standardised pathways; Improve choice and personalisation of maternity services.* Place based workstreams are focussed on effective service user co-production and the establishment of independent, formal, multidisciplinary "Maternity Voice Partnerships" to influence and share decision making. Service quality in order to show that by 2020/21 BLMK maternity services have made significant progress towards the "halve it" ambition to reduce still births and neonatal deaths, maternal death and brain injuries during birth by 50% by 2030. A newly developed Maternity dashboard to monitor progress against Better Births Standards has been added to BHT contract this year . Alignment of Local Maternity Services in Integrated Health and Care Hubs.

Milton Keynes system

Cancer

a) Early Diagnosis

- FIT Testing Project: Primary care diagnostic tool for patients at low risk of GI cancer (national evidence of reduction of colonoscopies up to 40%)
- Vague Symptoms Project - Rapid route for diagnostics for patients who fall outside 2ww referral criteria. BLMK cancer stakeholder work stream set up (linked with EoE Cancer Alliance)
- Lung Cancer Co-Commissioning – streamlining primary care referral processes for lung cancer pathways. Scoping begin in March 2018

b) Recovery Package

Cancer Care Reviews – patient centric psychosocial & rehabilitation model to reduce elective and non-elective spend to improve the patient discharge from hospital care back to the primary care setting

c)Risk Stratification

Community Cancer Care – Community nursing support to deliver assessments, interventions and patient educational/emotional support

Maternity

Delivery of Local Maternity Services Plan. In line with 'Better Births' the LMS is the basis on which future BLMK maternity services will be taken forward as shown in detail on slide x31. In summary priorities include *Improve the safety of maternity services; Create a joined-up approach to workforce planning; Develop and implement standardised pathways; Improve choice and personalisation of maternity services*

Priority 3 – Sustainable Secondary Care

BLMK approach

Secondary Care resilience & sustainability – BLMK is working with its 3 acute trusts to ensure they can deliver excellent care into the future in a sustainable way. This includes the proposed merger of Luton & Dunstable Hospital and Bedford Hospital. The Trusts have concluded that the sustainability requirements ahead are so significant that they can only be addressed by the change in organisational form, in order to continue to deliver high quality and effective hospital services and support a move to 7 day service provision. Central to the merger proposal is taking the "best of both" hospitals – service delivery models, people, information technology – to improve patient care and patient experience.

Bedfordshire and Luton system

Working together as a bigger, stronger organisation, the two hospitals will be able to expand the range of services while meeting the extra demands of an ageing and growing population.

The new Trust will be committed to maintaining emergency (A&E), maternity and paediatric services at both sites. Work has started to identify how best to integrate these key services. Two additional service priorities are Frailty (including Complex Care) and Emergency Surgery.

Through the integration of clinical services and teams, it is anticipated the merged Trust will deliver high standards of inpatient care that is safe, timely, effective, efficient and patient focused, and can be used to drive a system-wide approach to the delivery of streamlined integrated care.

Opportunity	Impact On Patient	Impact on Sustainability
Create single specialist services across the two hospitals e.g. gastro, elective orthopaedics and gynaecology	Improved specialisation improving clinical outcomes Better access to seven day specialist input	More resilient specialist services Making the most of the hospital estate Potential for one on-call support service for both sites Reduced on-call costs from operating as a large single team
Bring services back into Bedfordshire currently delivered elsewhere e.g. plastic surgery, specialist cardiac imaging	Prevents need for travel out of county Supports improved quality of local services	Best use of existing facilities and staff expertise Helps with recruitment and retention of specialist staff
One team providing planned care and diagnostics	Single booking process for patients supports choice of location of care	Reduces waiting times Helps manage peaks in activity and demand Best use of resource across both sites
Change in service model to ensure emergency cases are seen as quickly as possible	For critically unwell patients, Ambulance team liaises with the Emergency team at the closest site Patients go directly to the hospital with the most appropriate capacity at that time	Reduces risk of either site being overwhelmed Will help the hospitals manage patient flows most effectively Best use of clinical staff
Integration with community services	Care jointly delivered between hospital and community teams avoids 'handovers' and ensures best outcomes for patients Reduces unnecessary admissions	Manages rapid growth in ageing population without the need for more hospital beds Allows staff to develop their skills to better support patients with complex needs

Milton Keynes system

Delivering services at scale

Following the NHS initiatives around Right Care and GIRFT there is a focus on service provision at sufficient scale to ensure consistency to meet national standards (including 7 day working). In some instances, this involves activity taking place within tertiary centres where levels of activity are able to meet national standards for safe rotas and for adequate training purposes.

Another key opportunity area for financial sustainability highlighted by the Lord Carter Review is within clinical support services such as imaging and pathology. Work carried out with clinicians as part of the STP identified opportunities such as:

Further opportunities are being explored in the management of the acute hospital as part of a more integrated MK Place leveraging the organisation of care across the City.

Priority 3 – Sustainable Secondary Care

Bedfordshire and Luton system

Resilience & Sustainability
BCCG is working with Bedford Hospital to meet and maintain performance and system resilience across Planned and Unplanned Care Services, taking actions where appropriate to improve delivery.
An Acute Transformation Board has been established to drive CIP/QIPP priorities providing senior focus on key deliverables and outcomes that provide system benefits.

Integration
Bedford Borough and Central Bedfordshire Transformation Boards are supporting integrated delivery plans. Integrated teams are co-located in both L&D and BHT. MDTs are being rolled out across all localities.

Radiology Services
Undertaking review of Diagnostic services provided to Bedford Borough and Central Bedfordshire by both Any Qualified Providers and Acute Providers to determine local needs, particularly linked to the developing hub models. Local findings will be fed into ICS level discussions regarding Radiology sustainability across BLMK.

Stroke
Stroke Pathway Redesign across Bedford Borough and Central Bedfordshire, with establishment of Stroke Community Rehabilitation Service supporting optimal Stroke Pathway for Bedfordshire patients. This will enable appropriate discharge from L&D Stroke HASU into adequate community stroke rehab, resulting in a reduction of spot purchase placements.

Milton Keynes system

Resilience & Sustainability
MKUHFT is exploring opportunities for closer working with L&D and BHT within BLMK as well as discussing opportunities with Buckinghamshire Healthcare Hospitals and Oxford University Hospitals, which are key to MK patient flow and tertiary pathways.

Integration
MKUHFT is a member of the MK Integration Board and is an active partner in work to develop and Integrated Care Partnership in MK. During 2018/19 will benefit from whole population health management information about the MK population and will use this data to target system-wide interventions to improve health and wellbeing outcomes. MKUHFT will be a key partner in this work.

Radiology Services
Undertaking a review of cross sectional imaging to ensure that all patients have access to appropriate imaging techniques . Reporting links for PACS across the local health economies will continue to be rolled out so that patient care can be managed at the most appropriate location.

Stroke
An evaluation of the MKUHFT part-time HASU will be undertaken to inform future commissioning arrangements for the stroke pathway across MK and BLMK.

Priority 4 – Digitalisation

BLMK approach

Shared Care Record: Continued N3 replacement across STP; Continued Wi-Fi roll out in Practices and Care Homes; Data sharing agreements and IG agreements between Practices and with STP Providers supporting development of shared care records across clusters and place.

Technology: SMS messaging in practices rolled out across STP; Development and procurements for online consultations; Telehealth monitoring pilots begin in Care Homes.

Whole population health analytics: Tactical Business Intelligence solutions being explored.

Information Governance: BLMK information sharing agreements reconfirmation in Q1; Data-sharing model to continue to be developed; Assurance of compliance with GDPR across STP.

Bedford Borough

Shared Care Record

- EHR Core mobilisation at BHT (Q1), rollout of S1 to ELFT PC link workers, Clinical System Reviews and template alignment for BCCG member practices
- Care Home undertaking IG Toolkit readiness and assessment to expand the LGA funded pilot

Whole population health analytics

- Continue to commission Civica SLAM
- Community Provider Incentive Scheme to test out having named cohorts of patients supported with tailored multi disciplinary care management

Central Bedfordshire

Luton

Shared Care Record

- Local Digital Road Map supported by GP IT group, complete practice clinical system switch over

Whole population health analytics

- Predictive data analytics and operational intelligence with system wide planning assumptions
- Data-driven interventions

Milton Keynes

EPR

- MK implementing a full EPR with healthcare record sharing across health sectors

Shared Care Record

- Care homes also undertaking IG toolkit assessment in move to establish access to patient records
- HER Core roll out to ambulance in Q2/3
- Extension of Summary Care Record to CHC Q1

Whole population health analytics

- Development of a whole population analytics ‘snapshot’ linking datasets from providers at place-level.

Priority 5 – System Redesign

BLMK approach

BLMK is still determining its ultimate status as an Integrated Care System (ICS) in 2018-19 and is awaiting confirmation of the national guidance in this area. During 2018/19 BLMK will continue the detailed design work required to establish an operational Integrated Care System in 2019/20 including development of the Target Operating Model which will define which activities will operate at scale, place (Borough) and locality and which will define the key functions of strategic commissioning, system integration and Integrated Care Provision. This builds on a review of BLMK commissioning functions undertaken in 17/18. The ICS outcomes based commissioning and contracting framework will be developed, in line with national guidance and the ICS will support the development of provider alliances/networks. The ICS will also continue to mature its governance and assurance framework in line with the developing ICS. During 2018/19, BLMK ICS will also implement some key transitional steps to progress the journey towards an ICS including:

- the implementation of new CCG Leadership arrangements that support greater integration of commissioning at scale and at place
- Building the ICS infrastructure
- Supporting the development of provider alliances/partnerships and networks at place to progress greater integration between health and social care. This will support the Primary Care Home development work being undertaken across BLMK.
- Maturing collective financial management arrangements across BLMK, including managing and delivering the BLMK system control totals
- Implementing whole population health management capability as a key enabler to the ICS becoming operational

Bedford Borough

Transformation Board established

Central Bedfordshire

Transformation Board established

From 1 April 2018, East London Foundation Trust has take over responsibility for delivering **community health services in Bedfordshire against an outcomes based contract.**

A potential **risk/gain share mechanism** related to the management of non-elective activity in the Bedfordshire system in is development.

Luton

Transformation Board established in Luton.

The **Concordat between Luton CCG and Luton Borough Council** will continue to be implemented with co-location of CCG and LBC teams happening in August 2018 and increased joint commissioning of services via Section 75 agreements.

The Luton Provider Alliance will continue to mature and is developing a **risk/gain share mechanism** to support the management of non-elective demand in the Luton system.

Milton Keynes

Integration (Transformation) Board established in MK.

MK is acting as a BLMK 'test site' for whole population health analytics. In 18/19 a snapshot report of linked data from acute, community, mental health, primary care and social care will inform the strategy for BLMK and will give deeper insight into how best to meet the needs of the MK population.

MK system is developing a systems saving initiative to manage non-elective demand from complex patients based on a risk/gain share model.

9. Finance - Headlines

- The BLMK system has an extremely challenging financial outlook at present, following a 2017/18 year which saw material financial difficulties emerge at Bedfordshire CCG, resulting in an in-year system deficit of £6m.
- Nonetheless the system has managed to deliver £69.1m of efficiency savings in this same period (well over 3% of budget).
- As financial recovery becomes embedded into the system, stretching control totals have been set for member organisations, which require not only cumulative balance to be achieved but also significant historic debt repayment (£14.8m in CCG sector)
- AT STP aggregate level, a surplus control total of £9.7m is required in order to meet regulatory expectations. This represents a £15.7m actual year on year improvement, and would necessitate in-year efficiency savings of at least £80.5m.
- As part of bridging this efficiency gap however, Luton & Dunstable Foundation Trust (L&D) have formally requested £9m of national financial support, in recognition of concerns regards their control total calculation. This has been acknowledged by regulatory bodies in prior years and funded at these levels. The L&D submitted plan (and hence the STP's) assumes these funds will be forthcoming.
- On the basis of the above, all six organisations within the STP control total are individually therefore submitting financial plans which are aligned with their required control totals.
- However there is very material concern regards the deliverability of these organisational plans, particularly with regards to achievability of Commissioner QIPP plans, which sum to £45.3m
- At this point in the planning process the STP believe that the system is likely to see an actual 2018/19 financial deficit of £13.4m, based on identified QIPP shortfalls, known risks and the relative immaturity of efficiency programmes.
- It should be noted that without the historic debt repayment requirement, the system would be projecting a balanced in-year financial plan.
- Significant work underway to seek to bridge this figure closer to the required control total but there is material risk this will not be achievable.

9. Finance – ICS Status

- BLMK is still determining its ultimate status as an Integrated Care System (ICS) in 2018-19, and is awaiting finalised guidance to inform its decision.

- However the financial consequences of becoming a full or partial ICS are potentially significant, with the explicit linking of Provider Sustainability Funds to delivery of the overall STP control total. These funds equate to £29.5m in 2018/19, of which (under current published planning guidance) all would be tied to system financial delivery in a full ICS and £8.8m if BLMK adopted interim status.

- Whilst the financial binding of system partners is seen as a positive policy direction, the scale of the financial exposure for Acute Providers, at a time of unprecedented financial challenge in the Commissioning sector, means it would be challenging to adopt full ICS status

- In order to ensure Provider (and hence STP) ability to accept Partial ICS status, a number of proposals are currently under discussion with national bodies:
  - ✓ A tapering of the linkage between control total delivery and PSF payment
  - ✓ A limitation to the proportion of PSF resource that is actually tied to system control total delivery.
  - ✓ An agreement of a System Control Plan financial target which is less onerous than that set as the sum of aggregated individual organisation control totals. This target would be the threshold against which PSF payment would be set.

- At the point of this plan submission there is no conclusion to these discussions and, as such, the STP is not in a position to confirm or otherwise its agreement to any control total requirement (and hence its proposed ICS status).

9. Finance – next steps

- The STP recognises the requirement to ensure the system lives recurrently within its means and also to ensure payback of any accumulated historical debts. Whilst we do not believe the pace of debt repayment can be as rapid as control totals currently require, without impacting on frontline care, we do believe a multi-year plan to deliver this payback is critical.

- The system recognises that it needs to operate in a different, more coherent manner going forward. From a financial perspective this means we have commenced a process of review of how all discretionary funds such as MRET/Readmissions rebates, national Transformation resource and Better Care Funds are utilised in 2018/19.

- This is in parallel to ongoing discussions regards developing payment models that ensure risk and incentives are better aligned with those able to influence outcomes. In the first instance this will see innovative new models of contracting and payment put in place with community providers, focused around high-intensity patient cohorts.

- It is intended that as a result of these processes, the STP will collectively commit material additional resource to empowering non-Acute Providers to deliver scaled services aimed at reducing emergency service demands in the Acute setting.

- In exchange Providers in receipt of these funds will bear financial risk should demand not be contained.

Activity & Finance Planning

- CCG's have fully reflected the national planning guidance regards prescribed levels of activity growth. It is felt this provides a more solid starting point for the new financial year than in previous periods.
- The system has a good level of formal alignment between CCG and Provider plans regards levels of activity. However there remains real risk that activity volumes, particularly non-elective, exceed planned levels, and hence contingency capacity continuing to be required.
- The system developed activity plans prior to the conclusion of 2017/18. Work is to be undertaken to ensure that any deviation in final activity volumes, which in turn informs 18/19 planning, is fully understood and implications on recurrent activity into 18/19 clearly defined.
- System efficiency plans are clearly anchored against the planned levels of activity, in order to ensure that the financial delivery opportunity is necessarily aligned with formal organisational planned spend.

Capital Planning & Estates

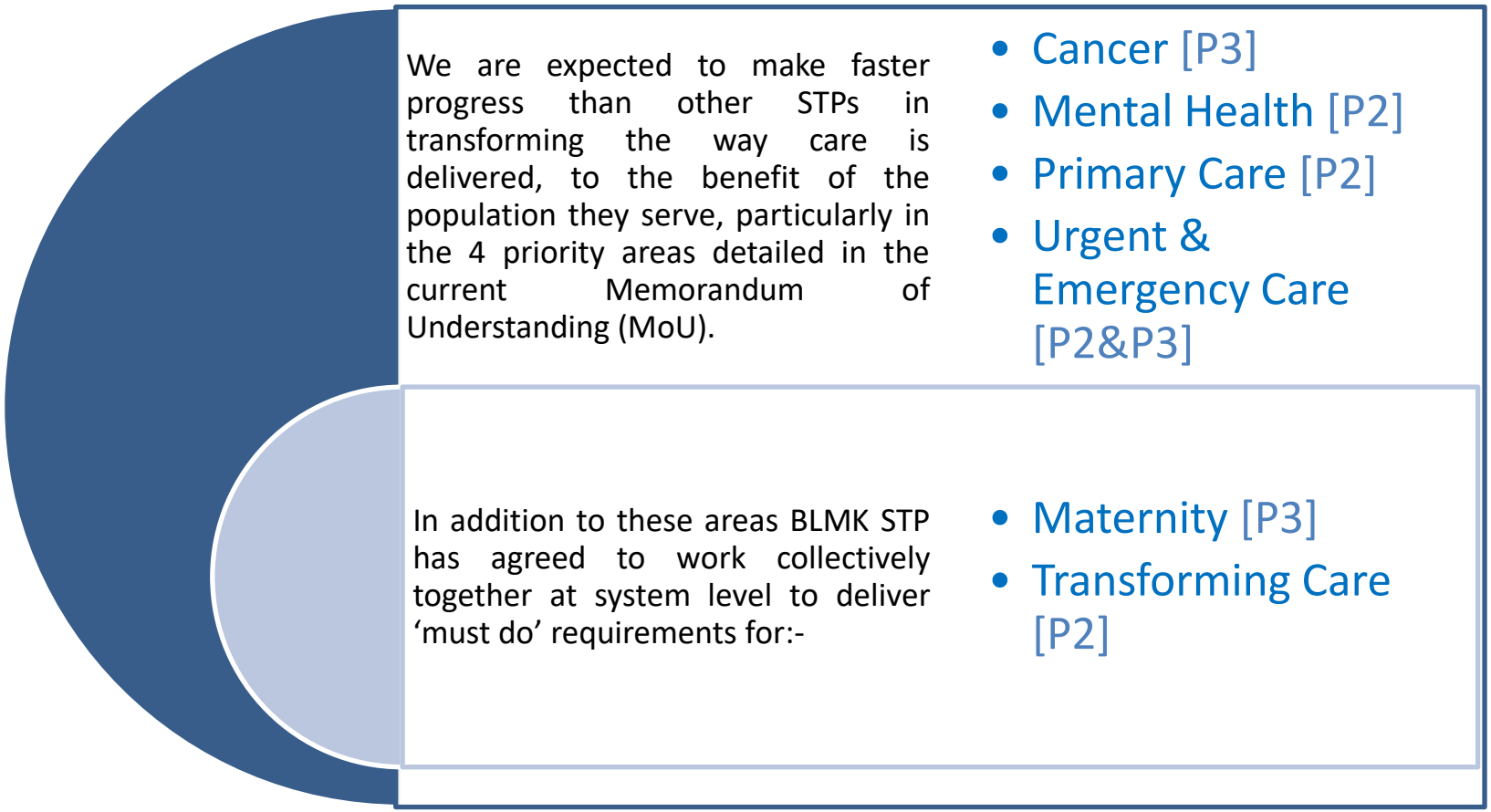
- Organisations within the BLMK system have submitted Capital plans that reflect those developments they have assurance over funding upon.
- For clarity no schemes that are subject to additional national approvals have been included, notably the £106m Luton and Dunstable Hospital hot services block and Bedford Hospital redevelopment costs of £38m. Both these cases are integrally linked to the proposed acute merger.
- The STP also has a number of national capital bids in process that relate largely to development of primary care hubs. These are again excluded from the plans at this stage pending national approvals.
- With regard to the submitted plan, this equates to £67.7m in 18/19
- This comprises notably of £17.5m of new build costs, £27.1m plant and machinery costs , £9.2m of backlog maintenance charges and £12.5m of IT expenditure.
- This will be funded by £42.8m of internally generated resources, £11.3m from loans and £13.6m of PDC.
- Headlines schemes in the programme relate to the building of the cancer centre at MKFT (£8.6m), and Luton and Dunstable developing a Helipad (£4m)
- The capital programme for the system over the next five years equates to £230.2m, plus any schemes which ultimately are approved from national monies.
- The STP will be submitting its capital and estates workbook, setting out national funding requirements for the next period, in July 2018 – in line with national process timetable.

INFORMATION TECHNOLOGY

- ETTF Schemes e.g. shared care records, GDE, Global digital exemplar, Care Home and GP practice connectivity with System 1 (starting to achieve bronze level)

12. 5YFV Must Do's

As laid out in *Next Steps*, ICSs involve all NHS organisations in a local area working together and in partnership with local authorities to take collective responsibility for resources and population health. BLMK developed an STP Five Year Forward View milestone plan back in June 2017 which it is continuing to implement.



Urgent & Emergency Care

To support planning & delivery of the FYFV in this area, BLMK has established 4 transformational Collaborative Investment and Savings Projects (CISP) work streams that are focussed on collaborative working to deliver system wide solutions. The focus of work is summarised below:-

Complex Care
Care Homes: Providers and commissioners believe by working closer together that there is real opportunity for improvements in care provision for care home residents. Improvement programmes focus on providing more proactive, responsive care and this in turn will lead to a reduction in avoidable hospital admissions. Each place based area has their own programmes of work that focus's on key priority areas identified within the Enhanced Health in Care Homes Framework.

Transitions of Care
Review of DTOC pathways
Development of integrated complex discharge teams
Development of Single Point of Access / Assessment solutions for our system and across our continuity of services

Paediatrics
Work to reduce emergency admissions in 0-4 year olds
Scope the potential for delivering community paediatric pathways at scale
Scope the potential for achieving economies of scale and improving specialist mental health pathways through provision across the STP footprint.

Primary Care Home
(see later Primary Care slides)

2018/2019 DELIVERABLES	
Q1	1. Review and refinement of single assessment process 2. Re-commissioning Community Bed Stock in line with Discharge to Assess principles, providing Step-Down Assessment Beds 3. Transformational funding successful for further funding to support core 24 mental health services in all acutes 4. Continue to develop and deliver key components of the Enhanced Health in Care Homes Framework 5. BLMK care homes dashboard to be operational and used to drive improvement
Q2	1. Core 24 service in place in all BLMK providers 2. Recommissioning of urgent care in MK

Cancer

To support planning & delivery of the FYFV ambitions for Cancer, BLMK STP has established local governance across all commissioners, providers, patient representatives and charities. Governance with NHSE Regions has also been agreed. The focus of work centres on:-

Prevention & Screening

- Increased public awareness of key risk factors and signs & symptoms of cancer
- Equity of Access and increased uptake of cancer screening and timely contact with primary care
- Case finding for patients at high risk of Lung Cancer
- Use of FIT for Bowel cancer Screening June 2018

Waiting Times

- Meet and maintain all 8 cancer waiting time (CWT) including 62 day operating standards across the STP
- Implement best practice timed pathways across all settings for: lung, prostate, upper GI and lower GI
- Improve one year survival rates

Implementing New Models of Care

- Cancer diagnosis confirmed or ruled out within 28 days
- Key Early diagnosis projects – FIT, Prostate Cancer and Lung Cancer
- Increase people diagnosed at stage 1 or 2 aim for 62%
- Implementation of Radiotherapy Networks

2018/2019 DELIVERABLES	
Q1	• Early diagnosis project set up for Lung, Prostate and FIT testing in primary care. • Review and improve rapid access for lung, prostate and colorectal cancers
Q2	• Implementation of improved pathways for Lung Cancer • Initiation of FIT testing in primary care for symptomatic patients • Uplift to current Recovery package for Living with and Beyond Cancer with particular focus on Stratified follow up for breast pts
Q3	• Implementation of improved pathway for Prostate Cancer Patients • Initial roll out in Luton of Transforming Cancer Care in the Community
Q4	Further Implementation of Transforming Cancer Care in the Community across the rest of BLMK
Ongoing from 17/18	• Meet target s for cancer wait times and use new system for CWT • Improve screening uptake for Bowel, Breast and Cervical screening programmes • Implementation of Best Practice Pathways with focus on lung, prostate and colorectal

Mental Health

During 2017/18 BLMK STP has developed an ambitious STP mental health plan and established a mental health workstream, which includes senior representatives from each of the key commissioning and provider partners, the East of England Clinical Network, and the national NHSE FYFVMH Team. A central focus of the mental health workstream is driving rapid and tangible progress in improving mental health outcomes for the citizens of BLMK, in particular in implementing FYFV for Mental Health and GP FYFV.

Steps to implement MH 5 Year Forward View

To continue to implement the FYFV which includes:
Increase access to mental health support for children and young people,
Improve access to psychological therapies for people with common mental health problems
Increase the number of people being diagnosed with dementia and receiving post-diagnostic care
Improving physical health care for people with severe mental illness (SMI)
To continue to increase access to perinatal mental health support.

Making Parity of Esteem a reality

Each of the BLMK CCGs is expected to meet the minimum investment standard. We are currently working as commissioners and providers to work through the 2018/19 contract variation to support delivery of the 2018/19 access requirement

Implementing New Models of Care

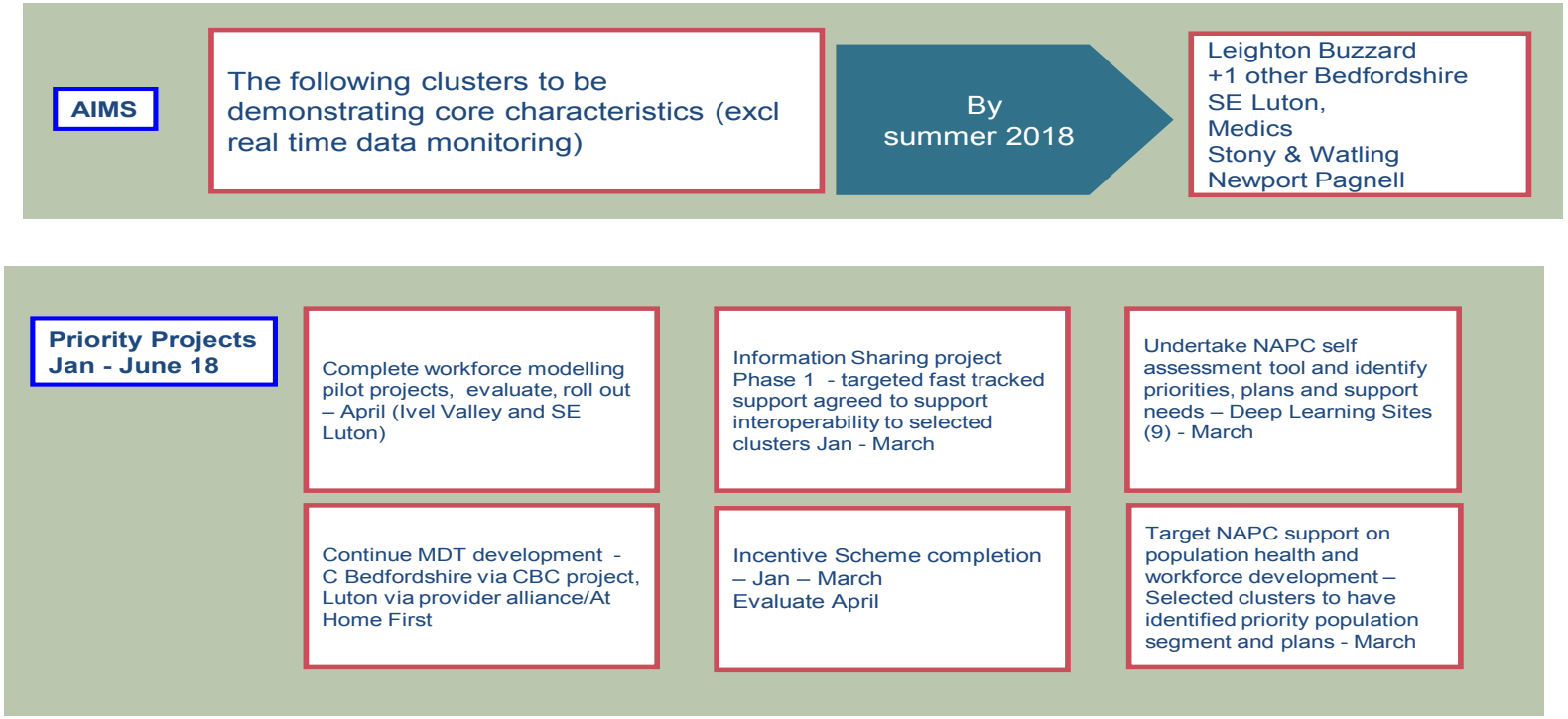
A key focus of the STP going into 2018/19 is the development and roll out of the primary care home model, with the support of the National Association of Primary Care. In 2018/19, the mental health workstream will be working with the Kings Fund to develop a model for mental health in primary care home. This is a major strand of work timetabled for 2018/19, which will be supported by the BLMK Mental Health Programme Manager .

2018/2019 DELIVERABLES	
Q1	1. Develop consensus perinatal pathway encompassing psychiatric support and enhancing local community based offer including primary care and third sector 2. Implement extended IPS service in Bedfordshire and Luton 3. Develop ICS mental health investment plan identifying costs of full FYFV delivery through to 2021 and including investment requirement , return on investment through integrated care, & innovation
Q2	1. Develop consensus model for mental health in primary care home. including range of preventative and treatment modalities for people with common mental health problems , serious mental illness & dementia 2. Review urgent care/crisis care pathways for people with mental health problems, developing case for change 3. Develop & refine mental health workforce plan (against investment plan)
Q3	1. Develop BLMK ACS consensus model CYPMH pathways to support place based integrated children's services

Primary Care

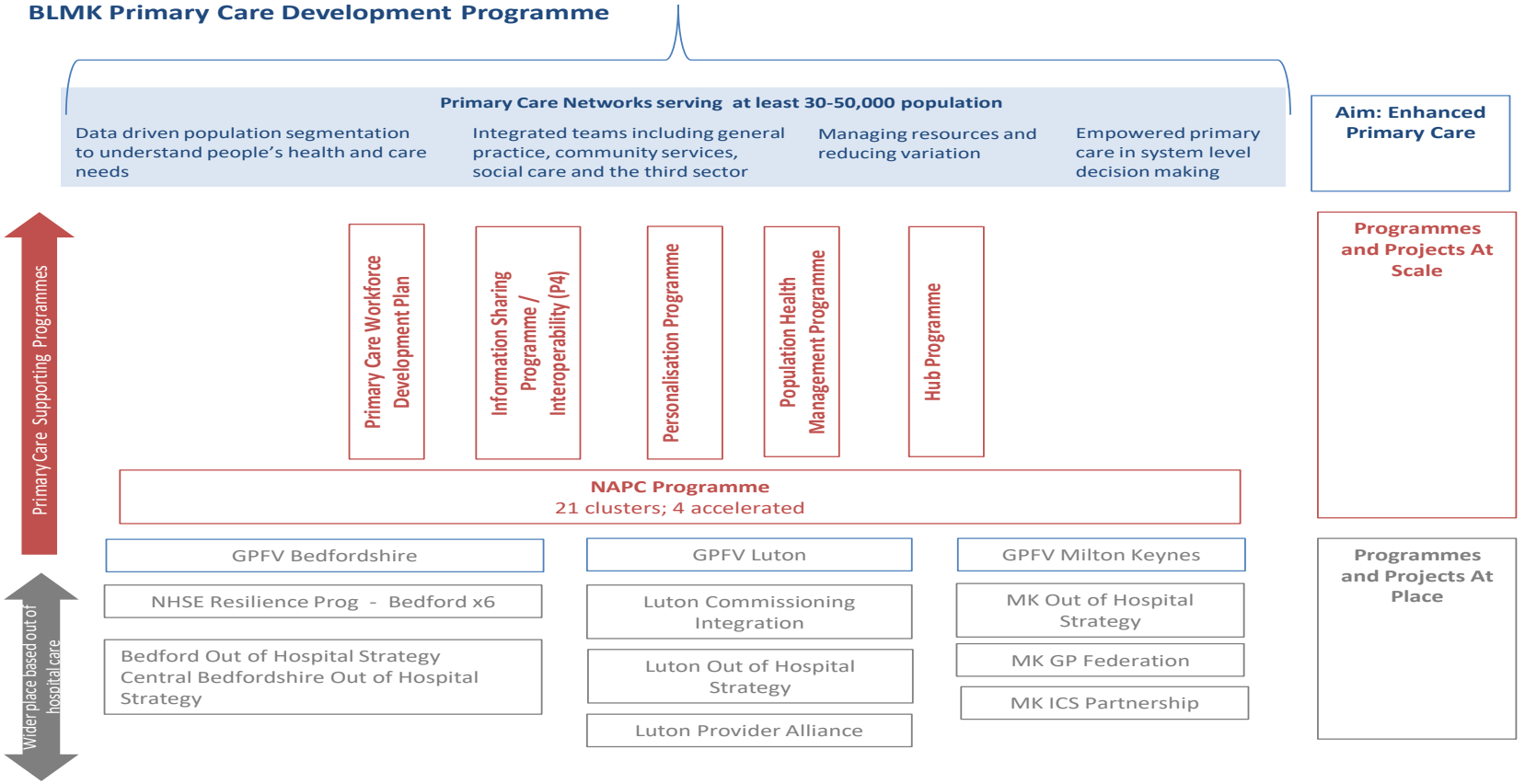
Local delivery plans set out how we will implement specific GPFV requirements during 2017-19 and beyond, ensuring sustainability of general practice. These plans underpin broader BLMK STP goals, with local partners commissioning and providing more care in community and home settings, along streamlined care pathways, by making better use of the available resources. Responsive, proactive and accessible primary care needs to be led and orchestrated by general practice. It must be delivered by a wide range of professionals. In BLMK, we see this being achieved through an enhanced delivery model which draws inspiration from the Primary Care Home (PCH) model.

NAPC BLMK Programme Overview



Primary Care

The PCH solution will, of course, manifest itself in different ways in different parts of the footprint, but areas of commonality will exist at ICS system level. E.g general practices will be supported to create coherent and cohesive collaboratives to manage the health and well-being, and deliver "out of hospital" care, to their localities numbering between 30-70,000 people. We have put in place an effective blend of STP-wide and locally sensitive plans to deliver the transformation as shown in the programme diagram below.



Primary Care

2018/2019 DELIVERABLES	
Q1	1. NAPC roll-out - continued development of enhanced delivery model which draws inspiration from the Primary Care Home (PCH) model. 2. Wave 3 - STP submissions for Clinical Pharmacists in General Practice Programme & roll-out as successful 3. Develop BLMK ACS consensus model for primary care mental health services including range of preventative and treatment modalities for people with common mental health problems and SMI to support place-based delivery model development 4. Deliver Local Digital Roadmap supported by GP IT Group 5. Review estates development progress through PCJCC Sub-groups and STP Governance 6. Delivery of GP Workforce Plan milestones
Q2	1. Deliver Local Digital Roadmap supported by GP IT Group 2. Review estates development progress through PCJCC Sub-groups and STP Governance 3. Delivery of GP Workforce Plan milestones
Q3	1. Deliver Local Digital Roadmap supported by GP IT Group 2. Development of OBC and FBC for two further integrated health & care hubs subject to approval processes and funding 3. Review estates development progress through PCJCC Sub-groups and STP Governance 4. Delivery of GP Workforce Plan milestones
Q4	1. 100% coverage of extended access, as per NHS England specification 2. Deliver Local Digital Roadmap supported by GP IT Group 3. Development of OBC and FBC for two further integrated health & care hubs subject to approval processes and funding 4. Review estates development progress through PCJCC Sub-groups and STP Governance 5. Delivery of GP Workforce Plan milestones

Maternity

The most recent iteration of the BLMK LMS Transformation plan was submitted to NHSE in February 2018. This plan sets out an ambitious, but realistic and sustainable plan for delivering maternity services differently in the future. In line with *Better Births* the LMS has described a set of principles on which future BLMK maternity services are to be based and outlined below.

Improve the safety of maternity services, ensuring that:

- Standardised care is delivered in line with a fully implemented Saving Babies Lives Care Bundle; is compliant with recommendations in Each Baby Counts, Action on Neonatal Mortality, the Neonatal Critical Care Review (NCCR) and is in accordance with NICE guidelines
- Rates of still birth, neonatal death, maternal death and brain injury during birth are halved by 2025
- There is transparency of reporting for serious incidents and external review of incidents as appropriate

Create a joined-up approach to workforce planning that will ensure services:

- Are delivered by staff who are focussed on the principles set out in better births – personalisation and safety
- Involve their staff in joined up training and education and share good practice
- Are adequately staffed to deliver safe and high quality neonatal care

Develop and implement standardised pathways to:

- Increase women's choice and access to midwifery led care and births and ensure continuity of carer
- More effectively target groups of high risk women, especially in the areas of hypertension, obesity, diabetes, mental health and those with complex needs
- Support provision of high quality neonatal care as close to home as possible, in the nearest appropriate centre

Improve choice and personalisation of maternity services so that by 2020/21:

- All women have a personalised care plan
- All women report that they have choice & have experienced personalised care

2018/2019 DELIVERABLES

Co-production, Communication and Engagement

- Co-production, communication and engagement events across the LMS footprint
- Co-production training for key stakeholders
- Local maternity offer

Improving service quality and data

- LMS wide reporting framework and quality metrics dashboard – to include monitoring related to reducing still births, neonatal deaths and brain injury during birth, continuity of carer, personalised care and choice of place of birth.

Finance & Digital

- Costed model for maternity services across the LMS
- Digital Maturity Assessment completed and local digital plan and roadmap formulated

Community Hubs (including post-natal)

- Hub pilots evaluated and plans developed accordingly in relation to future roll out

Safe and Effective Care

- Single LMS wide Safety Action Plan supported by LMS wide learning events
- Standardised LMS wide maternity guidelines

Continuity of Carer

- Birth-rate plus outcomes reviewed and plans developed
- Pilot teams established to test out models of caseloading

Prevention

- Prevention in Maternity Services Self-assessment toolkit completed and priorities accordingly
- Baby friendly Initiative accreditation achieved for all services

Transforming Care

The most recent iteration of the BLMK TCP Transforming Care plan was submitted to NHSE in June 2017. This plan updated the plan originally set out by the BLMK TCP in April 2016 "Transforming Care for people with learning disabilities and/or autism who display challenging behaviour".

TCP Transforming Care Plan

The focus of the BLMK TCP plan is on delivering a significant reduction in out of area inpatient placements (these are spot purchased); reducing in-area inpatient admissions to acute settings; and improving repatriation into local community settings with 149 patients (as of 31/01/2016) placed outside of BLMK area within a community setting. In order to deliver against these planning assumptions local areas need to build capacity in communities and redesign pathways in order to support people better at home. For BLMK this means providing existing community LD teams with enhanced capacity: skill to manage forensic patients; intensive support for those who are near/in crisis.

Forensic Service

The BLMK partnership have been, and continue to be, engaged with service providers, the police & youth offending teams with the purpose of developing a "pre-forensic" service. Multiple service delivery options are being both developed and piloted with the aim of agreeing a service model.

Inpatient Trajectories

The number of CCG inpatients is planned to reduce from 15 to 11 at the end 2018/19. With the number of inpatients with stays of over five years reducing from 5 to 1 by end 2018/19

Housing

The BLMK partnership is working through the system wide issue of securing appropriate housing for individuals as part of the community support offer. A TCP wide housing plan for Transforming Care is to be delivered to support the delivery of housing to meet the needs of people with LD and/or autism and behaviour that challenges.

2018/2019 DELIVERABLES	
Q1	• Initial tranche of Independent Case Reviews completed for the most complex cases.
Q2	• TCP wide Housing Plan in place • Final plans for anticipated loss of provider capacity due to falling inpatient numbers
Q3	• Evaluation of programme pilots including forensic support services and intensive/crisis support – action plan for final stages of programme and post-programme
Q4	• CCG inpatient numbers to reach the level of 11 inpatients including 1 long stay • Transfer of outstanding plans to business as usual.
Ongoing from 17/18	• Piloting of forensic support service • CYP complex and long stay case reviews • Focus on long stay inpatients discharge plans

13. Workforce

Our health and social care staff are our greatest asset. Workforce is a critical enabler to delivery of our plans for service transformation and new models of care.

New ways of working across organisational boundaries and professional silos, new roles, multi-disciplinary team working around local communities and an ethos of helping each other to do the best we can for our local place and people is core to developing our integrated care system (ICS).

Our local knowledge of BLMK health and social care workforce profiles and challenges is evolving. Through our Local Workforce Action Board (LWAB) we have instigated quarterly workforce returns, however, further refinement of the quality of this data will enable us to better describe our key workforce headlines.

BLMK Workforce Headlines

Health

12,079 WTE
Staff in Post

11.7% Vacancy

3,600 WTE
In Direct Care

Key messages:

- Midlands and East STPs' Bank and Agency usage is 11% however BMKL is higher at 14-16% (Midlands and East STP data packs 2016)
- 26% GPs over 54 which is 2nd highest in EoE and 4% above national average, significant GP workforce gap
- High vacancy rate in Mental Health & Community OT (56.6%), MH Nursing (21.5%) & Adult Nursing (19.9%)
- High % of staff over 54 in support to clinical staff
- Over 24% consultants over the age of 54
- Agency usage equivalent to 4-5% of SIP, Bank usage equivalent to 6% in MH & community and 2% in acute services.

Social Care

18,900 WTE
Staff in Post

11.9% Vacancy

14,000 WTE
In Direct Care

Key messages:

- Over 50% of the Health workforce have professional qualification compared to 6% in Social Care
- Vacancy ratio for Health and Social Care similar however numbers significantly higher in Social Care.
- % Social Care pay bill spent on agency is half that of Health however Social Care usage of agency is more than Health.
- Recruitment challenges to Social Worker and Domiciliary Carer roles
- There is no significant difference between the age profiles of the Social Care and Health workforce

What we have achieved so far

- Established our BLMK LWAB with representation from our 15 organisations, Health Education England, union representatives, education institutes and Skills for Care
- Established and met regularly with our Partnership Forum. A group which includes representation from all local union groups e.g. RCN, Unison, BMA, LMC etc. to engage with local plans and development. This best practice approach has been recognised by NHS employers and will feature as a case study within the social partnership forum.
- Developed and commenced implementation of a BLMK leadership and OD plan.
- Initiated a collaborative approach to apprenticeship opportunities and the apprenticeship levy.
- Started testing workforce modelling approaches for developing multi-disciplinary teams within the Primary Care Home model.
- Developed a robust GP Workforce Plan and Development Programme, supporting the requirements of the GP Five Year Forward View deliverables. Initiated a centralised single Community Education Provider Network (CEPN) to oversee delivery.
- Commenced the development of a Mental Health workforce strategy, supporting the Mental Health Five Year Forward View deliverables.
- Commenced the development of BLMK Health and Social Care Workforce Strategy.

2018/19 Priorities

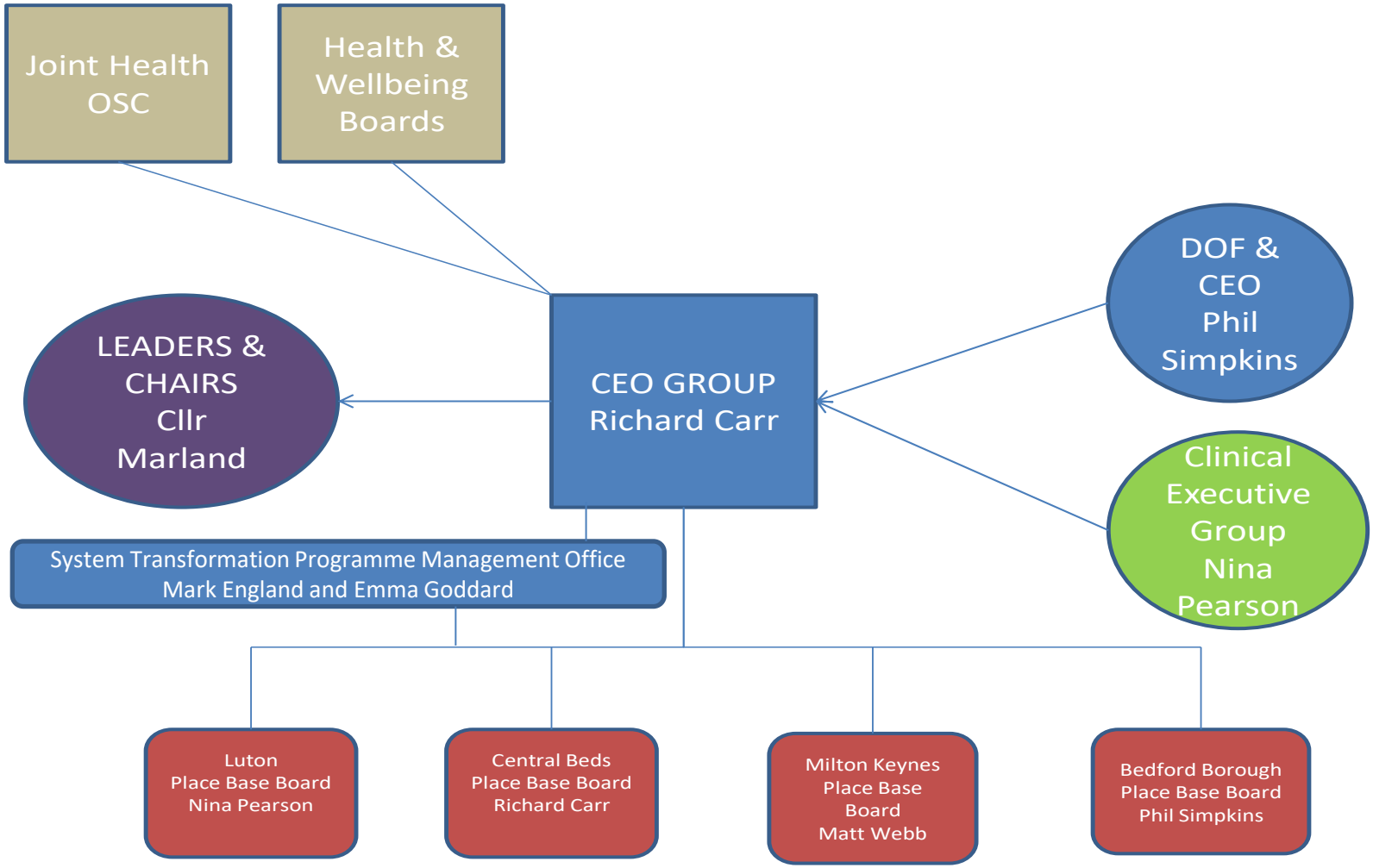
Grow our own	
Beacon of Excellence In Education and Training	✓ Accredited Apprenticeship Academy & Training provider ✓ Shared education and training portal ✓ Pooled CPD programmes & resources
Centralised Community Education Network	✓ Delivery of GP workforce and development plan ✓ Education infrastructure Hub; tutors, supervisors, assessors ✓ Pastoral support, preceptorship, mentorship roles
Development Framework for carers & volunteers	✓ Identify core skills and competencies ✓ Development framework and training portfolio ✓ Delivery of development framework
Securing future supply through collaborative commissioning	✓ Central commissioning hub ✓ Review existing programmes and curriculum ✓ Model future demand and supply forecasts

BLMK: a great place to work and learn	
BLMK Attraction Strategy	✓ Placed-based and ACS level ✓ Standard approach for 'Get Into Employment' & 'Talent for Care' ✓ Consistent 'employment guarantee' schemes
Developing a BLMK Employer's Brand	✓ Spread best practice employment Practices ✓ PR recruitment campaigns ✓ Recognition & Reward Schemes
Harmonising Collaborative Working Practices	✓ Non-competitive recruitment & retention premiums ✓ BLMK Streamlining Programme ✓ Shared back office functions

Adaptable Skills; Flexible Approach	
Health & Care Apprenticeships at all levels	✓ Joint Health & Care apprenticeships ✓ National Apprenticeship targets achieved
Designing teams to work across Health & Care sectors	✓ Enhance workforce design and modelling approaches ✓ Rotational / portfolio Development Posts
New Roles and Ways of Working	✓ Expansion of Support worker roles ✓ Expansion of Advanced Roles ✓ Top of licence skills development ✓ Shared training & development for prevention
Filling difficult gaps	✓ Working alongside HEI to target supply into workforce gaps ✓ Collaborate to reduce agency staff spend

Developing leaders and organisations	
Building for Success	✓ BLMK wide talent mapping and pipelines ✓ BLMK Staff Health & Wellbeing Programme ✓ BLMK ACS development masterclasses
System Change	✓ Quality Improvement and Change skills development ✓ IT and Digitally fluent workforce ✓ Staff across health & care co-design change
Leadership: Compassionate & Collective	✓ Living our Leadership Charter ✓ Collaborative systems leadership development ✓ BLMK Leadership Network
Culture and Collaboration	✓ High quality care culture ✓ Multi-professional pre and post registration training ✓ 'Stepping into My Shoes' Interchange Offer

14. BLMK ICS Governance



System Transformation Programme Overview

BLMK Sustainability & Transformation Plan

PRIORITIES

- **P1** Prevention Ian Brown SRO: Carole Mills
- **P2** Primary, community & social SRO: Nicky Poulain
- **P3** Secondary Vacant SRO: Joe Harrison
- **P4** Digital Pam Garraway SRO: Stephen Conroy
- **P5** System re-design SRO: Matt Webb

Collaborative Investment Saving Projects

- **Transitions of Care** Emily King
- **Paediatrics** Linda Willis
- **Complex Care** Emily King
- **Primary Care Home** Mike Thompson

Subject Matter Experts

- **Workforce** Alison Lathwell SRO Matthew Winn
- **Finance** Sophia Aldridge SRO Phil Simpkins
- Communications Kate Jarman SRO Navina Evans
- **Estates** TBC SRO Trevor Holden
- **Governance & Legal** Vacant

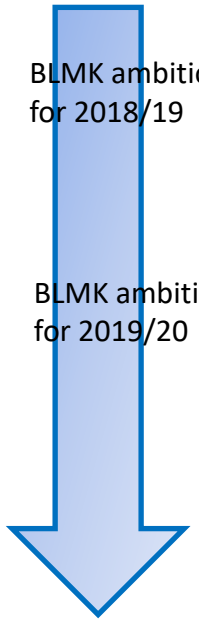
Transformation Boards

- **Luton** Place Based Board Nina Pearson
- **Milton Keynes** Place Based Board Matt Webb
- **Central Beds** Place Based Board Richard Carr
- **Bedford Borough** Place Based Board Phil Simpkins

BLMK's maturity against the National NHS ICS progression model

- NHSE has developed an ICS progression model which indicates how the ICS role in oversight can change as it develops.
- BLMK starts 2018/19 intent of securing Level 1 in the progression model and is committed to working towards Level 2 during 2019/20 in readiness for 'go live' later that year.

	Stage of progression	Overview	Explanation
1	**'Coordinated oversight'**	ICS system leads in the room during national bodies oversight decision-making	• This is the model of oversight that we are working towards first • We expect that this level is the minimum for each ICS • Oversight between national regulators more closely aligned with single point of contact for ICS and a single performance framework
2	**'Joint oversight'**	Co-oversight with decisions made together, with a 'double lock', where appropriate	• Decisions on oversight taken jointly • Examples such as Greater Manchester and the proposed Surrey Heartlands deal are models to build on
3	**'ICS led oversight'**	Decision making process for oversight led by ICSs	• ICSs to take the lead on oversight for the majority of oversight functions/responsibilities (within existing statutory framework) to instruct/draw down on regulators powers • ICSs to take over, as far as possible, significant staff resource



BLMK will mature as an ICS during 2018/19.

BLMK Sustainability & Transformation Plan

We will use this maturity tool to assess progress on our journey at regular intervals.

Maturity →

	Beginning	Developed
Accountability as a system	• Strong but part-time leadership. • Collective decision-making but governance is fragile. • Regulators act alongside system leaders. • System is building the capacity to execute. • Subsidiarity/who does what still being worked out.	• Full time leadership with the capacity to execute. • Decisions are taken on each other's behalf. • Collective performance goals managed by systems. with delegated regulatory functions. • Systems get things done; clarity in division of labour.
Resilient & integrated primary care	• Practices are coming together and beginning to share assets and to deliver extended access. • Data on variation between practices in routine use. • Integrated teams work to reduce hospital admissions. • Investment in primary care: capital, revenue, time.	• Networks serving 30-50k operating across the system. • Fully interoperable systems in place, including shared care record, highly integrated workforce and estate. • Population data used to prevent acute illness. • Practices sharing in hospital utilisation gains/risks.
Interlinked hospitals	• Hospitals are active participants in system leadership. • Providers collaborate, sharing some shortage staff. and assets to improve resilience. • They work together to achieve efficiencies. • Mental health trusts are involved on par with acutes.	• Standardised care 'protocols' that reduce variation. • Highly coordinated acute & support services with economies of scale & little unnecessary duplication. • Shared workforce, teams and rotas. • Hospital groups/chains to formalise collaboration .
Population health management	• Integrated services being formed between primary, acute, mental health and social care. • Data shared between services to improve population intelligence. • Care models redesigned to serve 'at risk' groups.	• Population needs are analysed and segmented using validated analytical approaches. • Clinical and other interventions designed to prevent illness and/or acute deterioration. • Highly integrated teams between services.
Reformed payments and collective financial mgt	• System control total that permits offsets. • System operating plans determine organisations'. • Move away from PbR to block contract + collective. management of activity and financial risk. • Organisations collaborate in resource allocation.	• Capitated population budget, with risks and gains shared through agreed mechanism. • 'Open book', whole system accounts. • Resource allocation decisions follow system plans and are made through system governance.

15. BLMK 'Place' Assurance

All our partners are working in so many dimensions to improve our services and the health and well-being our population. In our 2016 plan the actuarial analysis helped us to focus on four key areas for a Collaborative Savings and investment Programme (CISP). These are areas in which we already have considerable focus, and in 2018-19 we will aim to deliver substantial improvement in these key areas. They all contribute to mitigating non-elective activity, which is causing considerable operational and financial pressure in the system. The dashboard below has been co-produced through the P2 Programme Board and will be used to track progress at place and scale in BLMK.

CISP Full Performance Dashboard	
Measure Descripotion	**Rate per 100,000 population**
Paedeatirc Non-Elective Activity	
Paediatric Emergency Department attendance rate, 0-4 for respiratory conditions	Number and YTD Rate per 1,000
Paediatric NE admission rate, 0-4 for respiratory conditions	Number and YTD Rate per 1,000
Transitions Of Care	
A&E attendance	Rate per 1,000
Non Elective Admissions (General & Acute)	Rate per 1,000
Non Elective Admissions (General & Acute)	Rate per 100K population
Non Elective Admissions (G&A)	Actual Number of admisisons
30 day Non Elective Re-admissions	Rate per 1,000
Delayed Transfers of Care	Days / Trust % / Rate per 1,000
Care Homes	
Call Outs	Monthly Average and Range
Conveyance	Monthly Average and Range
Primary Care Home	
% registered population covered by network (cluster/neighbourhood)	
Networks with MOU or formal agreement to collaborate	
Networks actively demonstrating sharing between practices eg. Back office - premises, IT solutions	
% of practices that have recruited to new roles: Physicians Associate, Clinical pharmacist, Emergency Care Practitioner, Physiotherapist	
Networks with Information Sharing Agreement in place	
No of networks that have completed self-assessment and have developed an iterative PCH plan	
Networks with GP led MDT in operation	
Networks signed up to BLMK incentive scheme	

STP Progress Dashboard

BLMK Sustainability & Transformation Plan

Grey = Last published IAF data July 2017				Performance is for September 2017 (unless otherwise stated)		
Measure	**Frequency of reporting**	**Target**	**STP Overall progress July 2017**	**STP Average Sept 17 Data**	**RAG**	**Comments**
% of patients admitted, transferred or discharged from A&E within 4 hours	Monthly	95.00%	95.10%	94.14%	↑	Monthly reported figure which will vary
Patients waiting 18 weeks or less from referral to hospital treatment	Monthly	92.00%	92.60%	91.80%	↓	Monthly reported figure which will vary
NHS Providers in special measures within STP boundaries	Annual	None	None	None	—	Annual change only
Cases of MRSA per 100,000 acute trust bed days (for September)	Monthly	Zero	0.6	1 STP Ave. p/6 m	—	This is a YTD (6 month) figure rather than per 100,000 bed days
Cases of c-difficile per 100,000 acute trust bed days (for September)	Monthly	17/18 STP threshold Total = 182	5.5	6 STP Ave. p/6 m	—	This is a YTD (6 month) figure rather than per 100,000 bed days 17/18 CCG thresholds Beds = 73 / Luton = 28 / MK = 81 / Total = 182
% of GP's meeting minimum access requirements	Annual	100% by end of 2018/19	13.00%	17.30%	↑	STP data is an average across 3 CCGs based on only MK CCG performance Grey = Last IAF published data - this is an annual measure so no change MK CCG is the only CCG to receive funding from the GP Access Fund, however, this measure was a part of the NHSE 17/18 CCG Monthly Activity and other Requirements, so all CCG's will be expected to deliver this measure over 2017/18 and 2018/19.
No. of respondents satisfied with their GP opening times	Annual	NA	74.5%	74.5%	—	Annual change only (July 2018)
% of IAPT patients recovering following at least two treatment contacts	Monthly	50.00%	50.5% rolling ave. for Q4 16/17	49.08% STP for Aug 17	↓	This measure is reported monthly but assessed at the end of the year (YTD target). CCG figures are for August 2017 (Rolling Quarter Recovery Rate), this is the latest published set of figures.
People with first episode of psychosis starting treatment with a NICE recommended package of care treated within 2 weeks of referral	Monthly	50.00%	78.40%	91.06%	↑	STP data is an average across 3 CCGs (MK had small numbers in Sept) - Monthly figure which will vary
% of cancer diagnosed at an early stage	Annual	60% by end of 2018/19	55.20%	54.70%	↓	This is a National Quality Premium Measure with a target of either 60% or a 4% improvement on the previous year - locally defined. This is to be achieved by the end of 2017/18. Grey = Last IAF published data July 2017
People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Monthly	85.00%	83.20%	82.91%	↓	This measure is reported monthly but assessed every quarter. Monthly figures will vary due to period of validation required before final publications.
Average cancer patient experience, case-mix adjusted	Annual	NA	8.70	8.70	—	Grey = Last IAF published data July 2017
Total emergency spells per 10,000 population age-sex standardised	Monthly	NA	* 1,040	1,102	↑	Data taken from 2016/17 SUS The measure states per 10,000 population but the figures for July 2017 show per 1,000 population. We have supplied for both 1,000 and 10,000. * figures have been input by MK CCG as a proxy for comparison
Emergency bed days per 10,000 population, age-sex standardised	Monthly	NA	* 5,340	6,042	↑	
Total emergency spells per 1,000 population age-sex standardised	Monthly	NA	104	110	—	
Emergency bed days per 1,000 population, age-sex standardised	Monthly	NA	534	604	↑	
Delayed transfers of care (delayed days) for all reasons per 100,000 population	Monthly	Varies by CCG	3,636	IAF Ave = 8.97% Trust Sept Ave = 893 (quarterly figure = 3,572)	—	Grey = Last IAF published data July 2017 Trust figures are for the whole Trust (will include non CCG patients) and for September only - rolling quarterly figures are not available but are being sourced.
System Leadership status	Annual	NA	Advanced			National assessment of STP leadership
CCG/Trust combined surplus or deficit vs. total resource avoidable (control total) (In year financial performance - IAF reported)	Annual	NA	0.6%		↓	

Glossary

STP	Sustainability and Transformation Plan/Programme:	Sustainability and Transformation Plan/Programme: how local health and care services will evolve and become sustainable over the next five years, ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.
ICS	Integrated Care System:	Integrated Care System: Where commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations.
BLMK	Bedfordshire, Luton and Milton Keynes.	Bedfordshire, Luton and Milton Keynes.
Footprint		The term used to describe Bedfordshire, Luton and Milton Keynes
CCG		Clinical Commissioning Group.
A&E		Accident and emergency
Place		Local authority area
PCH	Primary Care Home	Primary care home is an innovative approach to strengthening and redesigning primary care. Developed by the NAPC, the model brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for their local community.
MDT	Multidisciplinary Care Team	A group of professionals from different professional backgrounds who together are caring for a patient.
Estate		Within BLMK this is considered to include all property and land owned by all partners of the ICS.
Secondary Care		Secondary care refers to services provided by health professionals who generally do not have the first contact with a patient, for instance a neurologist or a rehabilitation consultant. Secondary care services are usually based in a hospital or clinic, though some services may be community based.
Social Care		Social care in England is defined as the provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.

DTOC	Delayed Transfer of Care	A 'delayed transfer of care' occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.
Enhanced Primary Care		Enhanced primary care is an increased level of clinical and social support provided in the local community through 'neighbourhood care teams'. It sees nurses, care coordinators, therapists, wellbeing support workers and others working alongside local GPs to empower patients to self-care by learning more about their condition and how they can stay well for longer.
NHSI		NHS Improvement
Social Care		Social care in England is defined as the provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.
Community Care		Community care services are intended to help people who need care and support to live with dignity and independence in the community and to avoid social isolation. The services are aimed at the elderly and those who have mental illness, learning disability and physical disability.
Single point of access		On way to access a service (for example dialling 111 for urgent care).
NICE		The National Institute for Health and Care Excellence.
Acute Trusts		A hospital trust, also known as an acute trust is an NHS trust that provides secondary health services within the English National Health Service and, until they were abolished, in NHS Wales. Hospital trusts are commissioned to provide these services by clinical commissioning groups.
Inpatient services		Inpatient care refers to medical treatment that is provided in a hospital or other facility and requires at least one overnight stay. For example, hospitalists are physicians who practice only inpatient care, and no office-based or outpatient care.
Financial sustainability		Financial sustainability is where an NHS provider is able to successfully manage activity, quality and financial pressures within the income they receive.
SIP		Service Improvement Programme.

Glossary

Quarterly workforce returns		Data/information templates that describe current numbers of staff by profession and role.
Bank		Provision of staff to provide cover for planned and unplanned shortfalls in staffing, covering vacancies and staff absences as well as bringing specific required skills for short periods of time.
Domiciliary care		Domiciliary care is provided to people who still live in their own homes but who require additional support with household tasks, personal care or any other activity that allows them to maintain their independence and quality of life. This includes services, such as meals-on-wheels, health visiting, and home help.
RCN		Royal College of Nursing
HEE	Health Education England	Health Education England (HEE) is a national leadership organisation for education, training and workforce development in the health sector. HEE is an executive non-departmental public body, sponsored by the Department of Health and Social Care.
Skills for care		An organisation that provides tools and resources to supports workforce planning and development within social care and the independent care sector e.g. home-care agencies.
Unison		UNISON is one of the UK's largest trade unions, serving more than 1.3 million members. It represents full-time and part-time staff who provide public services.
BMA		British Medical Association
LMC	Local Medical Committee	LMCs are local representative committees of NHS GPs and represent their interests in their localities to the NHS health authorities. They interact and work with – and through – the General Practitioners Committee as well as other branch of practice committees and local specialist medical committees in various ways, including conferences.
GP workforce plan		An STP wide General Practice plan focusing on recruitment, retention and development for the GP and wider General Practice Workforce.
Mental Health Five Year Forward Plan		The Mental Health Five Year Forward View (MH FYFV) sets out our plans for improving and expanding care.

PVP	Public Voice Partnership	In BLMK this means the collaboration between the ICS and HealthWatch. BLMK is supported by four HealthWatch groups – Luton, Central Bedfordshire, Bedford and Milton Keynes.
PMO		Programme Management Office
SRO	Senior Responsible Officer	The visible owner of the overall business change, accountable for successful delivery and recognised as the key leadership figure in driving the change forward.
ACO/ACS		Accountable Care Organisation: An Accountable Care System or Organisation brings together a number of NHS organisations and other providers, to take responsibility for the cost and quality of care for a defined population within an agreed budget. They can take many different forms ranging from fully integrated systems to looser alliances and networks of hospitals, medical groups and other providers
DOFs		Directors of Finance Group
CISG		Collaborative Investment and Savings Group.
ACSAB		Accountable Care Activation Board.
Adaptable skills		Health and social care staff developing enhanced skills to better support the needs of local people.
GLC		Governance, legal and consulting.
CEPN	Community Education Provider Network	Community Education Provider Networks: are a model of planning and providing education and training for the health and care workforce.

JHOSC
BLMK Single Operating Plan Summary

This document is a summary of the full BLMK Single Operating Plan which can be found on the BLMK website, http://www.blmkstp.co.uk.

The intention is to:

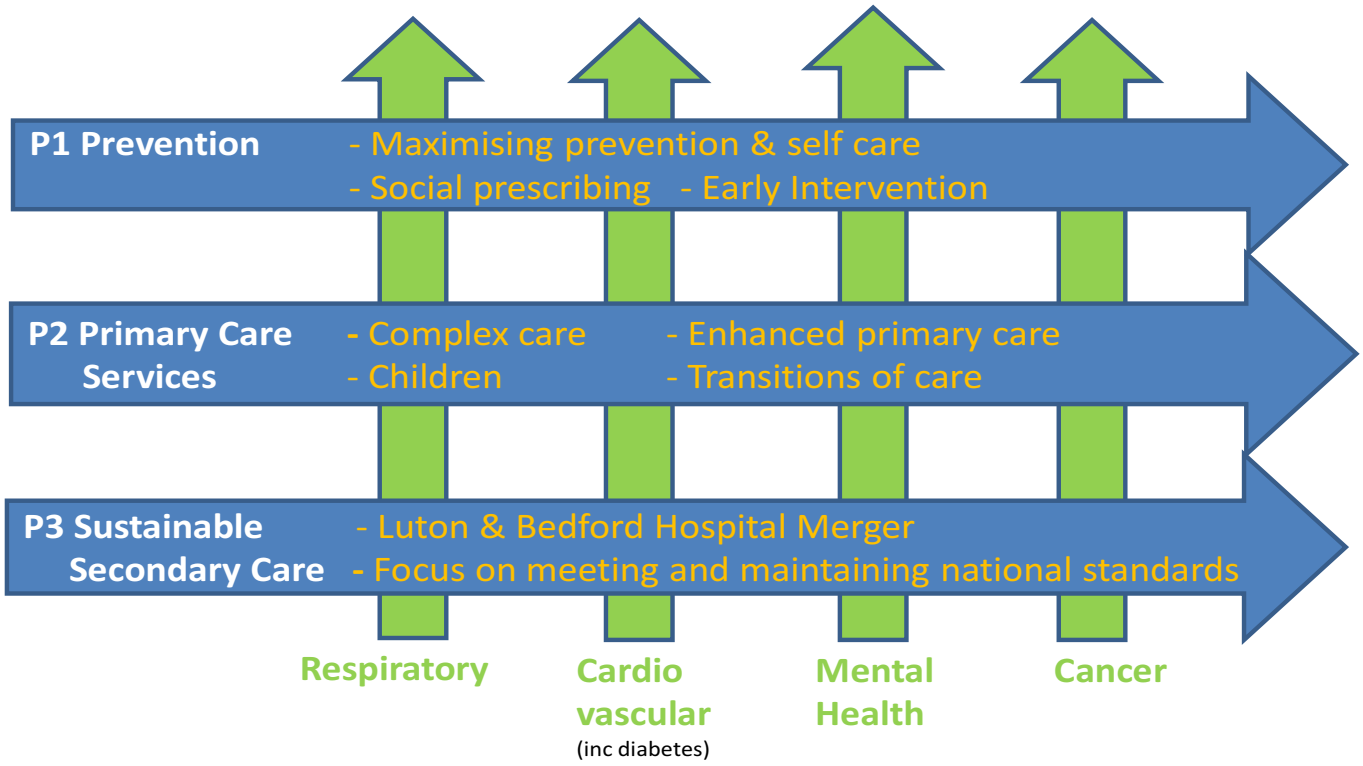
1. Provide the Leaders and Chairs with four system wide, Agreed Areas of Focus for service transformation. For each Area of Focus the key elements of the of the planned programme is described, as well as what will be delivered and how. See Slides 3 – 7 (Please note that these are high level summaries of more detailed programme and project plans.)
2. Describe where our residents will experience a positive difference in service access and experience in 18/19, Slide 8.
3. Clearly articulate the expectation of delivery at Place, (Slide 9). In the full document the Places have provided a summary of their Place plans, reflecting the Agreed Areas of Focus.
4. Give an example of enablers we are using across the system to proactively support collaboration and learning between the four Places. The example given here is a description of a dashboard developed by Priority 2, Primary, Community, Mental and Social Care which enables Places to track impacts of project implementation against carefully considered metrics. Success stories can therefore be evidenced and shared across Place, alongside those with less impact so that we can constantly and positively learn across the system. (Slide 10).

Included for reference are slides which demonstrate aspects of our systems relationship with NHS England and NHS Improvement. Here we see the key national expectation of improved delivery for 18/19 (Slide 11). These national areas of focus are congruent with those we have defined locally and have been imbedded into the system programme governance structure .

The final two slides articulate how our relationship with NHS England and Improvement is expected to change over time. It is important to note that this development and opportunity is only available to us as a 1st wave Integrated Care System.

Areas of Focus 18/19

Across BLMK there is significant resident and patient growth; demand continues to outstrip current services and funding. Too many people are presenting at hospitals and GPs are also under pressure. Service resilience needs to be strengthened and capacity enhanced in prevention services; primary care, community, mental health and social care; and secondary care. There are also some significant health and wellbeing outcomes/care and quality gaps that need to be addressed. **Our learning from 17/18 told us that as a system we will have the best impact if we target our efforts on a small number of key focus areas**. The focus for our transformation is shown in the diagram below.



Priorities for 2018/2019

Focus	Elements and their Impact	Delivery and Ambition
Prevention	Social Prescribing offer will release capacity in primary care and support residents to find sustainable solutions to practical, social and emotional issues.	Addressing social, emotional and practical determinants of ill health by rolling out social prescribing across the geography. Business case written, localised pathways developed in each place, with full roll out in one place. Proposals to implement locally in BLMK currently being assessed jointly between NHS and LA and national partners.
	Cardio-vascular prevention - Across BLMK an estimated 89,900 people have undiagnosed hypertension (high blood pressure) and 7,200 have undiagnosed atrial fibrillation (AF). Hypertension management accounts for approximately 1 in 10 GP visits. Circa £2m of costs to BLMK of stroke management, plus additional capacity released.	Evaluation of hypertension detection pilot due in June. Ask of NHSE to enable continuation of programme in commissioning specification of Pharmacy and technical solution (PharmaOutcomes) for e-referral management to GPs (currently funded part year to support flu only by NHSE). Establishing a BLMK-wide cardiovascular prevention community of practice. (Including potential to work with private businesses to raise awareness and early identification.)
	Flu Campaign – ensuring maximisation of prevention thus minimise impact on individuals, health demand and wider socio-economic implications	Pan system wide communication and engagement approach in 2018/19, building on success of 17/18 with increased work with private and tertiary care sector. Ensuring frontline workforce and 'at risk' groups are able to access vaccination in convenient places at convenient times.
Enhanced Primary Care	Support and accelerate the development of primary care networks / primary care home for our local communities with a focus on population health management. Ambition is to proactively support complex care patients; prevent rising health care risks, improve primary care access for patients, and reduce inappropriate preventable crisis demand on the acute sector. Development of partnerships, across General Practice, and with multi-disciplinary teams supported by local care navigation will enable residents to access the right clinician / support at the right time to support their needs. The implementation of the programme will enable staff to work at top of license, with expected result in improved recruitment and retention as a result of a better work environment.	Rollout our Primary Care Home Programme to our 21 clusters; 4-5 clusters with accelerated support to demonstrate PCH benefits earlier. Implement the ICS wide Primary Care Workforce Development Plan aligned to national workforce programmes, and local clinical models. Develop and Implement 18/19 primary care incentive scheme, building on success of 17/18. Align local investment opportunities, GPFV, Locality and overarching programme. Target use of additional NHSE primary care resource to maximise service developments within clusters; Continue to implement technical capabilities and solutions to support PCH and GPFV (Priority 4 - Information Sharing Project); Implement the Workforce and new models local website, supporting easy access to transformation solutions; Enable the improved proactive management of complex care patients through a combined approach with the established Primary Care Home Programme Support development of Estates Hub programme. Specifically articulating the strategic case of the Primary Care Home model, relationship to estate requirements to facilitate improved access to professional and services locally at point of resident need. Ensure alignment of GPFV delivery (x 3) within overall primary care programme & place based out of hospital strategies; Work with place based systems to develop local innovative primary care solutions e.g. MK GP Fed, Provider Alliance

Focus	Elements and their Impact	Delivery and Ambition
Proactive Complex Care Management (20% of our population)	Care Homes (2%) Resident Improved Care and Experience, including the delivery of proactive care management within homes which is sophisticated and supported by the system so residents crisis escalation in care needs which is preventable is minimised.	Rollout of programme in each place (supported by Academic Health Science Network), key elements include Medication Review, Advanced Care Planning, Crisis support for residents, carers and staff. Adopting zero tolerance for residents being transferred 'unnecessarily' to A&Es. Support monitoring of implementation and impact. Align National and Regional, and local KPIs
	Place-based solutions to enable and improve the resilience and capacity of health and social services providing proactive management of complex care patients with rising needs outside of hospital within a redesigned financial incentive framework.	Development work underway to agree the initial population cohorts which will be managed under this proposal in each place, across acute, general practice, community, mental health and at some social care partners. Places developing workforce and service models to improve the support to these patients in their place of residence. Place and system designing training packages, and communications and engagement strategies to support the full deployment of service models and the sustained usage of them. Places developing a phased model of deployment of ambition, to ensure significant improved service provision to residents in 2018/19, with these initial focused solutions being positioned to enable the full ambition and potential across health and social care going forward. System support ongoing to resolve information governance challenges to enable robust and secure data sharing to support proactive care and contract management. System supporting places with access to a tactical solution for the provision of shared care records ahead of strategic solution. Places developing radically different means of contracting and payment associated with these patients, supported by the system and 1st Wave ICS NHS England teams. The system collectively believes this model of working is crucial to delivery of long-term STP redesign objectives, both financial and clinical.
Mental Health	Develop investment plan to secure full FYFMH delivery through to 2021 Ensure 2018/19 FYFV goals are delivered Develop consensus model for mental health in primary care home	The ICS partners are committed to ensuring the delivery of the detailed Five Year Forward View asks for Mental Health. We are committed going further by realising the potential for improved prevention through further integration across the system, from work with private and voluntary sector, through to the police, local authority and health services.

Focus	Elements and their Impact	Delivery and Ambition
Transitions of Care	Rationalisation of access points to our myriad of services. Enabling residents to navigate our services more easily by calling 'one' number, where they will talk to a 'care navigator' who will directed them to the right support service for their needs.	Complex plethora of historic access routes and digital procurements in place. 18/19 to create a system owned five year vision and make tactical changes Requires sponsored subject matter expert review of baseline explore Estates and Technology Funds with Urgent and Emergency Care programme support from the region
	17/18 and beyond to reduce Delayed Transfers of Care (DTOCs) Further ambition to reduce unnecessary beds for all medically fit, improving patient experience and reduced health capacity and cost presssures.	Solution is dependant upon the integration of the functions of teams across providers and commissioners and must be enabled through true partnership working. Each organisation must therefore be held locally, regionally and nationally to account to the same end with a dovetailing of performance indicators (BLMK part of NHSE ICS performance dashboard development); Urgent and Emergency Care programme support from region needed
Children and Young People	Phase 1: Improved service provision and management of bronchiolitis pathways. Full implementation will resolve one of our outlying areas of patient management and reduce demand on acute Trusts. (45 %, £1.2m of additional spend across the STP for 0-4yr olds respiratory conditions against our peer average.)	Full role out of system programme at place started in 17/18 with associated committed funding. Programme includes, provision of paediatric o2 saturation monitors to 130 GP practices 100% of GPs to have access to and to be trained on bronchiolitis management pathway Deploy funding and specification in place for increased Rapid Response community nursing in North and South Bedfordshire and to pilot clinic based model in Luton. Ensure NHSE Region and local Primary Care Programme aligned to ambition with regard to GP contracts and programme plan. Ensure alignment with NHSE Region paediatric network
	Phase 2: Review current complex service commissioning and provision, with recommendations of focus areas of next step of children's programme for 18/19	Initial assessment of priority areas derived from the Clinical Conversation event in Jan 2018 on Children and Young People across all partners (including third sector providers) are: - Continuation of work to reduce emergency admissions of 0-4 year olds - Scope the potential for delivering community paediatric pathways at scale, develop a prioritised action plan and commence delivery - Scope the potential for achieving economies of scale and improving specialist mental health pathways through provision across the STP footprint, develop a prioritised action plan and commence delivery -

Focus	Elements and their Impact	Delivery and Ambition
Sustainable Secondary Care	Luton and Dunstable University Hospital and Bedford Hospitals merge to create a single NHS Foundation Trust	Fundamental to the BLMK STP, financially, culturally, and an enabler for service transformation with enhanced primary care. By bringing together teams and services from both hospitals, the new Trust will play a pivotal role in offering a more coordinated approach to healthcare provision across the whole system. Requires NHSE Regional and national support to unlock in year financial revenue benefits and significant capital investment to ensure 'fit for purpose' facilities to support future service provision. Merger business case development continues (Q2/3) Significant investment - estates programme business case development (Q2/3) Clinical workstream and pathway development to continue throughout 2018 Merger expected to progress (Q1 19/20)
	Economies of scale leading to more efficient and effective healthcare provision	**At place level** Working closely with other programmes in respect of Transitions of Care and Complex Care. Supporting development of High Intensity User programmes at scale (Q3) – currently in pilot **At service level** Developing pathways with other local providers including tertiary providers in order to meet and maintain national standards (Q2/3/4) Establishing economies of scale across both systems through acute support services provision, e.g. Pathology services through the national pathology networks (Luton / Bedford and Milton Keynes / Oxford) (Q2/3/4)
Cancer	Improve cancer outcomes across our systems, through system support, place implementation of cancer alliance developed plans	Deploy implementation plan focusing on transformation plans that secured significant funding for our system, supporting ; Prevention; Improved waiting times; New care models supporting earlier diagnosis Ensure 2018/18 FYFV goals are delivered
Digital	Patient and staff facing digital solutions, to enable care and self-care across the continuum of a residents needs, irrespective of provider supporting the individual.	Support professionals to manage patient care more effectively by enabling a holistic view of individual patient needs, by access to 'a' care record for each. In year tactical solution to be deployed to specifically support the patient groups supported in the Primary Care Home and Complex Care change programmes of 18/19. Develop a strategic business solution that will support improved care delivery for complex care patients over future years and enable improved whole population health analytics that will support and enable integrated service redesign across organisations from a long term design, contracting and payment perspective. Enable data sharing agreement between practices, through public discussion on need for both direct care and secondary use of their records. Continue technology enablement of improved care; deployment of SMS appointment reminder messaging across primary care practices; deployment of wifi and access to patient records in system one in all care homes.

These programs will become the foundations of our service changes for the forthcoming years. Over time, scaled and fully deployed they will support:

Improved

- resident patient and carer experience of our services; experiencing ‘a’ service for their needs from their perspective; improved access to the right service at the right time for their needs; greater support in self management and prevention of health and social care needs; staying healthy for longer; improved experience of end of life care of their choosing.
- outcomes for our patients, focusing in 18/19 on high priority areas of variation to national outcomes, Cancer, Mental Health, Respiratory, Cardio Vascular Disease (Including Diabetes)
- Focus on early intervention and promotion of independence
- access to primary care services
- staff satisfaction, retention of workforce.
- service collaboration, resilience and service sustainability with capacity and capability to provide high quality services for our growing and increasing complex and rising comorbidities of our residents
- Robust Care Market and a multidisciplinary workforce

Reduced

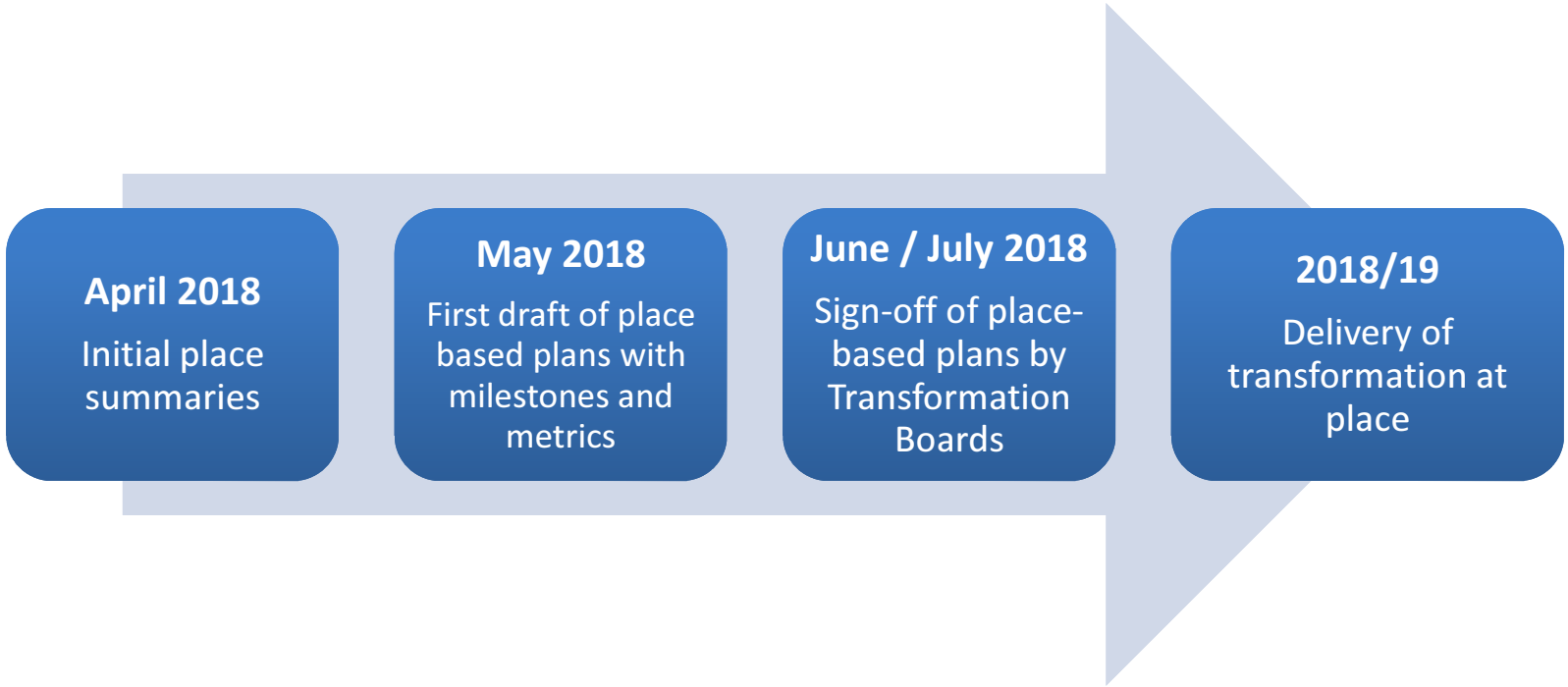
- ambulance conveyancing where historic crisis support has necessitated this
- high end service utilisation by mental health needs
- demand on urgent services and acute inpatient services
- non-medical demand on Primary Care
- non-medical use of acute provider beds resulting from delayed transfers of care to appropriate alternative environments

Changes will

- help create financial sustainability of our system, creating circa an additional £15 – 30m savings through collaboration and partnership resolving complex service issues at the point where our organisational boundaries have historically inhibited shared innovation.

‘Place Based’ Delivery 2018/2019

- There are four ‘places’ in BLMK: Bedford Borough, Central Bedfordshire, Luton and Milton Keynes
- Work is underway to develop detailed ‘place based’ delivery plans overseen by the Transformation Boards (or their equivalents) in each of the four places.
- Initial summaries of how the STP priorities are being delivered in local systems are shown in the full BLMK Single Operating Plan document.



An example of BLMK 'Place' Learning as Part of the System

Priority 2 are supporting shared learning between places by understanding the impact of the implementation of service changes within projects of our agreed focused areas. In this way they are able to share positive and negative experiences of projects, creating greater opportunity for the positive pace delivery at place to our local residents.

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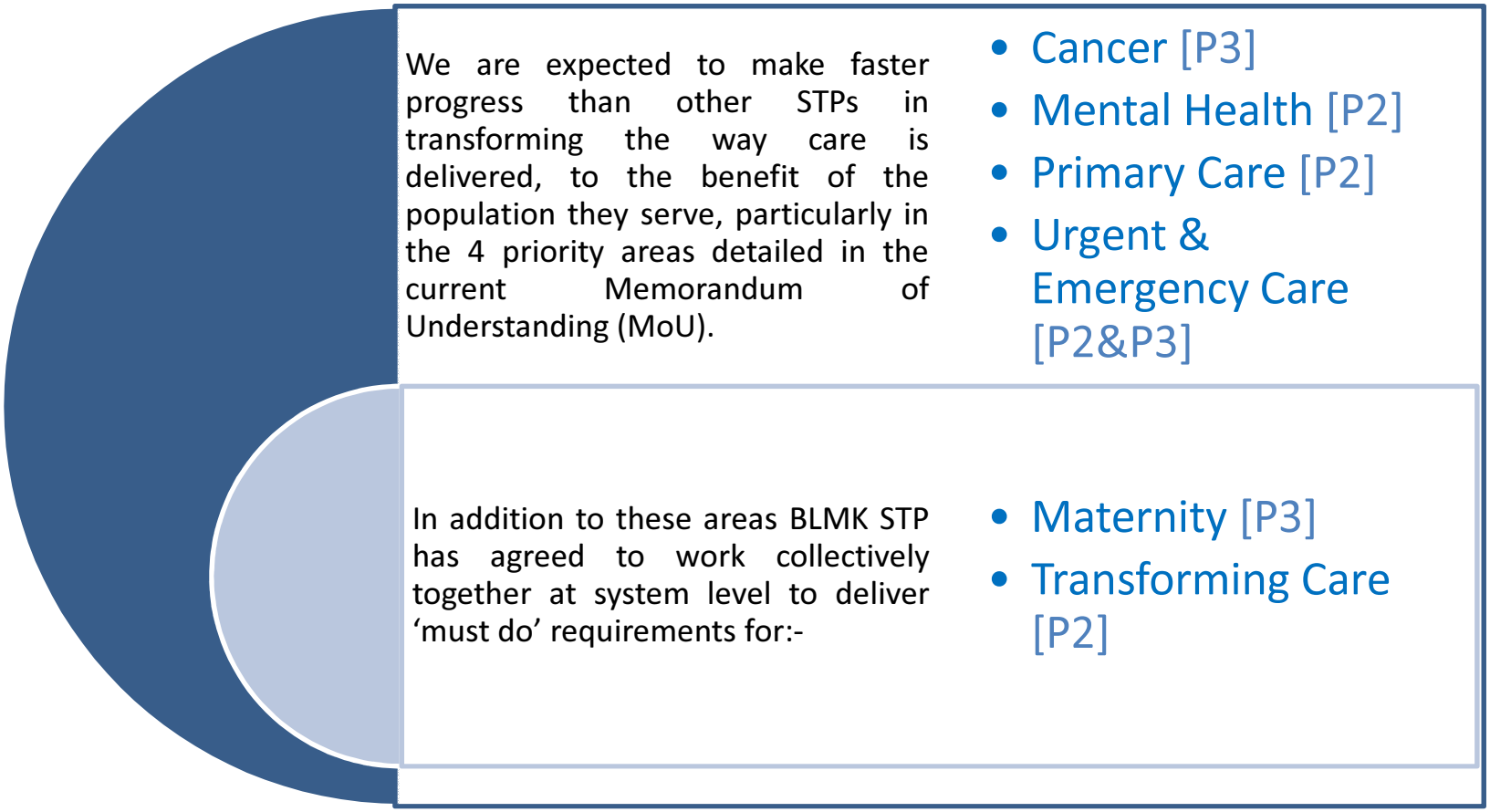
Paediatric NE admission rate, 0-4 for respiratory conditions	Number and YTD Rate per 1,000
Transitions Of Care	
A&E attendance	Rate per 1,000
Non Elective Admissions (General & Acute)	Rate per 1,000
Non Elective Admissions (General & Acute)	Rate per 100K population
Non Elective Admissions (G&A)	Actual Number of admisisons
30 day Non Elective Re-admissions	Rate per 1,000
Delayed Transfers of Care	Days / Trust % / Rate per 1,000
Care Homes	
Call Outs	Monthly Average and Range
Conveyance	Monthly Average and Range
Primary Care Home	
% registered population covered by network (cluster/neighbourhood)	
Networks with MOU or formal agreement to collaborate	
Networks actively demonstrating sharing between practices eg. Back office - premises, IT solutions	
% of practices that have recruited to new roles: Physicians Associate, Clinical pharmacist, Emergency Care Practitioner, Physiotherapist	
Networks with Information Sharing Agreement in place	
No of networks that have completed self-assessment and have developed an iterative PCH plan	
Networks with GP led MDT in operation	
Networks signed up to BLMK incentive scheme	

NHS England and Improvement Five Year Forward View Must Do's

As laid out in *Next Steps*, ICSs involve all NHS organisations in a local area working together and in partnership with local authorities to take collective responsibility for resources and population health. BLMK developed an STP Five Year Forward View milestone plan back in June 2017 which it is continuing to implement.



Our Opportunity for Increasing Local NHS Decision Making

- As a 1st Wave Integrated Care System we have the opportunity to take greater local control of oversight and intervention, historically made at NHS Regional and Central levels. This can potentially reduce the bureaucratic burden within the system, and give more ownership of solutions, so is seen as welcome by NHS partners.
- NHSE/I has developed an ICS progression model which indicates how an ICS role in oversight will change as it develops and demonstrates its maturity as a system.

- There are three levels;
  - Level 1 – where BLMK are now - *Coordinated Oversight*, where the ICS will join, or be sighted on, oversight discussions between the NHS Region, and our NHS providers and NHS commissioners.
  - Level 2 – our ambition for 2019/20 – *Joint Oversight*, where the ICS will be formally part all oversight, and thus formally part of all decision making
  - Level 3 – our ambition for 'go live' in late 2019/20 – *ICS Led Oversight* - Decision making process for NHS oversight led by the ICS (encompassing existing statutory frameworks) with appropriate escalation when necessary on an exceptional basis.

BLMK will mature as an ICS during 2018/19.

Maturity →

	Beginning	Developed
Accountability as a system	• Strong but part-time leadership. • Collective decision-making but governance is fragile. • Regulators act alongside system leaders. • System is building the capacity to execute. • Subsidiarity/who does what still being worked out.	• Full time leadership with the capacity to execute. • Decisions are taken on each other's behalf. • Collective performance goals managed by systems. with delegated regulatory functions. • Systems get things done; clarity in division of labour.
Resilient & integrated primary care	• Practices are coming together and beginning to share assets and to deliver extended access. • Data on variation between practices in routine use. • Integrated teams work to reduce hospital admissions. • Investment in primary care: capital, revenue, time.	• Networks serving 30-50k operating across the system. • Fully interoperable systems in place, including shared care record, highly integrated workforce and estate. • Population data used to prevent acute illness. • Practices sharing in hospital utilisation gains/risks.
Interlinked hospitals	• Hospitals are active participants in system leadership. • Providers collaborate, sharing some shortage staff. and assets to improve resilience. • They work together to achieve efficiencies. • Mental health trusts are involved on par with acutes.	• Standardised care 'protocols' that reduce variation. • Highly coordinated acute & support services with economies of scale & little unnecessary duplication. • Shared workforce, teams and rotas. • Hospital groups/chains to formalise collaboration .
Population health management	• Integrated services being formed between primary, acute, mental health and social care. • Data shared between services to improve population intelligence. • Care models redesigned to serve 'at risk' groups.	• Population needs are analysed and segmented using validated analytical approaches. • Clinical and other interventions designed to prevent illness and/or acute deterioration. • Highly integrated teams between services.
Reformed payments and collective financial mgt	• System control total that permits offsets. • System operating plans determine organisations'. • Move away from PbR to block contract + collective. management of activity and financial risk. • Organisations collaborate in resource allocation.	• Capitated population budget, with risks and gains shared through agreed mechanism. • 'Open book', whole system accounts. • Resource allocation decisions follow system plans and are made through system governance.

Agenda Item 8

For publication

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE – SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

WORK PROGRAMME 2018/19

16 July 2018

TO BE PROGRAMMED

Mental Health Services	To consider the programme of STP future funding bids
Mental Health Services	To consider the Mental Health Enforcement Plan
"*Better Births*"	To consider Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care
Pharmacy	To consider the local representative and engagement of STP to assist with reducing the use of GP services and how funds can be saved
Finance	To receive a report regarding funding and finance to ensure that services can be delivered
Emergency Services Collaboration	To receive a progress report on emergency services collaboration

Off Agenda Briefings

Site Visits

Agreed Work Programme Schedule

Date of Meeting	Topic	Detail and purpose of item
16 July 2018, Bedford Borough Council		
	BLMK STP Single Operating Model	To receive a briefing regarding the BLMK STP's first Single Operating Model
	Primary Care Development regarding access to GP Services	To receive further information on the Primary Care developments under access to GP Services
25 September 2018 *OR* 3 October 2018 *(tbc)*, Central Bedfordshire Council		
	National Association of Primary Care (NAPC) Programme from December 2017	
10 December 2018, Luton Borough Council		
12 *OR* 26 February 2018 *(tbc)*, Milton Keynes Council		
	Working arrangements of the JHOSC	To consider the working arrangements of the JHOSC
	Terms of Reference	To review the Terms of Reference of the JHOSC

Previous Meetings

Date of Meeting	Topic	Detail and purpose of item