Bedfordshire, Luton and Milton Keynes Health and Care Strategy

January 2023

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WHO WE ARE

Our vision is for everyone in our towns, villages and communities to live a longer, healthier life

Your health and wellbeing matters to us.

We know that not everyone enjoys the same good health and opportunity across their lives. As the providers of public services, we also know that there is more we can do to support our residents to live longer, and live more of those years in good health.

That's why we are publishing this strategy. It aims to make sure everyone involved in your health and care is working much more closely together, including our local Councils and our NHS.

We use the money we receive from your taxes to help our residents have good health and care at each stage of life. To Start Well, Live Well and Age Well.

By June 2023 we will have published our five year Joint Forward Plan. It will clearly show the steps we will take and how our work will be measured.

Our work is based on partnerships. With you and your family; with voluntary and community groups who keep people connected and well, as well as our Councils and our NHS.

We know times are tough. But together we can, and will, improve services to help you, your family and your community to thrive.

Cllr Tracey Stock
Chair, Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Our purpose

The Bedfordshire, Luton and Milton Keynes Health and Care Partnership aims to improve the health and wellbeing of our population.

The partnership is made up of local Councils, the NHS and voluntary, community and social enterprise (VCSE) sector partners in your area. We are looking to answer three questions to help us change services for the better:

1. **Are we doing the right things to improve health outcomes and tackle inequalities for all our residents?**
2. **Are we making the best use of the partnerships between public services, the VCSE sector and local communities?**
3. **Are we working with local communities to understand what matters to our residents, and co-designing and co-producing sustainable solutions?**

This strategy sets out our ambition for improving health outcomes and reducing inequalities. It shows how we will work together, and what this will mean for people and communities across Bedfordshire, Luton and Milton Keynes.

The mandate of our Health and Care Partnership is to…

improve outcomes in population health and healthcare

tackle inequalities in outcomes, experience and access

enhance productivity and value for money

help the NHS support broader **social economic development**

Our overarching ambition is…

to **increase the number of years** people spend **in good health** and **reduce the gap** between the **healthiest and least healthy** in our community.

This is the right goal but it is ambitious and will take a long time to achieve. The impact of COVID and cost of living challenges have made it harder.

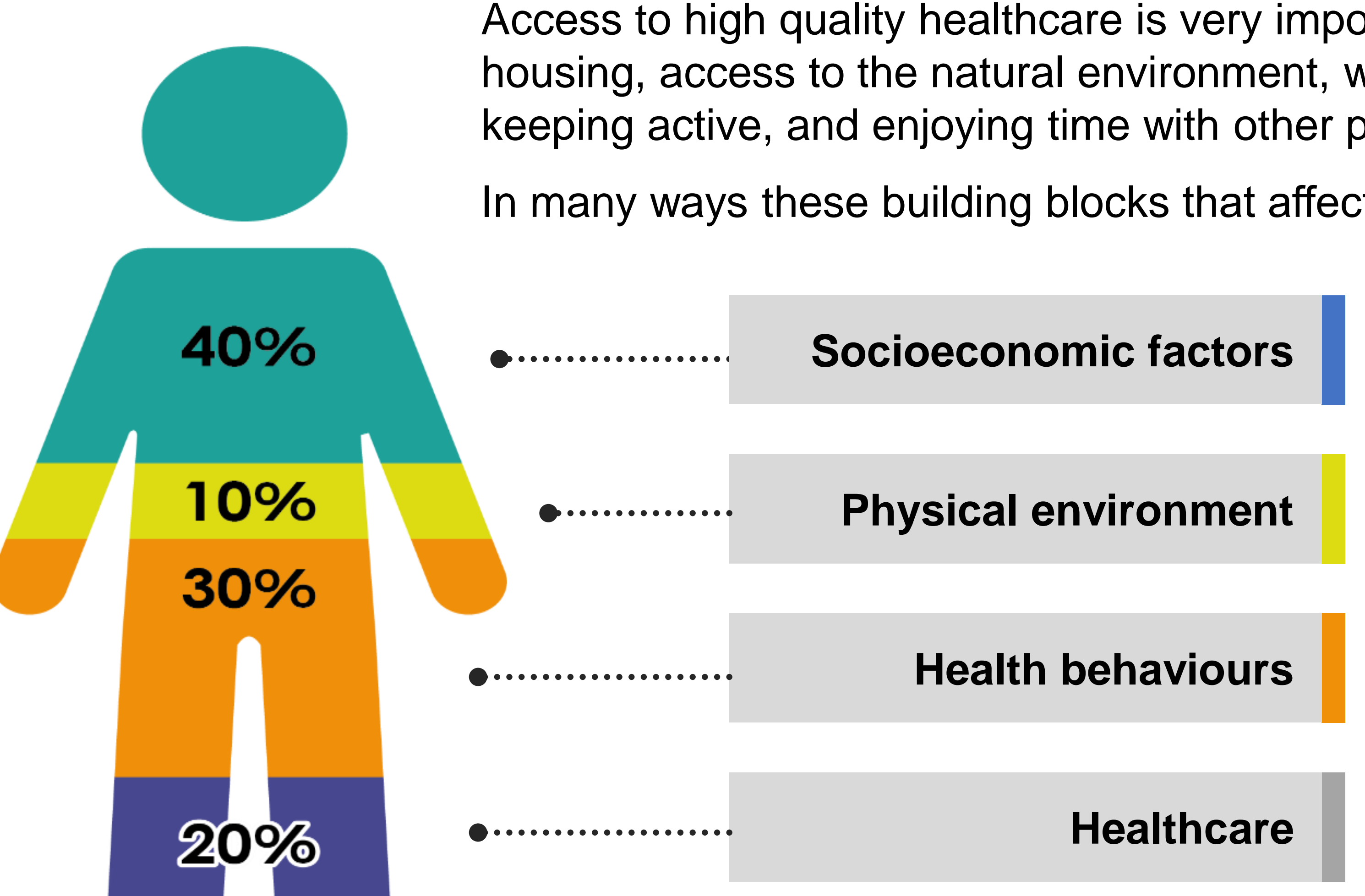
The only way to achieve our goal is by working together. Our Health and Care Partnership allows us to do more for residents than as separate organisations, keeping the needs and assets of our residents at the centre of everything we do.

Supporting our communities to thrive

There are lots of factors that affect our chances of living a **longer, healthier life**.

Access to high quality healthcare is very important. But a good education, decent housing, access to the natural environment, working in a growing local economy, keeping active, and enjoying time with other people all have an important part to play.

In many ways these building blocks that affect a person's health are all connected.



That's why we are developing closer and more collaborative ways of working with residents, communities, our Councils, our NHS and the charity and community organisations that make up the VCSE sector.

We also prioritising personalised and preventative care, to give people greater control over their own health, to stay well and live longer, healthier lives.

Our health and care partners

There are many organisations which make up our Health and Care Partnership. From local Councils and the NHS, people providing education and housing, to the police and ambulance services, they all play a vital role. Our partners also include people living and working in our communities, our local businesses and universities.

Thousands of voluntary, charity and social enterprise (VCSE) organisations work to support and understand our population's needs, from directly providing prevention and care services to linking into our communities to help tackle inequalities.

Bedford Borough Council
Central Bedfordshire Council
Luton Borough Council
Milton Keynes Council

4
Local councils

2
Acute Trusts

Bedfordshire Hospitals NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust

South Central Ambulance Service NHS Foundation Trust
East of England Ambulance Service NHS Trust

2
Ambulance Trusts

BEDFORD BOROUGH
MILTON KEYNES*
CENTRAL BEDFORDSHIRE
LUTON

1
Integrated Care Board

Bedfordshire, Luton and Milton Keynes Integrated Care Board

East London NHS Foundation Trust
Central and North West London NHS Foundation Trust
Cambridgeshire Community Services NHS Trust

3
Community/ Mental Health Trusts

4
Healthwatches

Healthwatch Central Bedfordshire
Healthwatch Bedford Borough
Healthwatch Luton
Healthwatch Milton Keynes

Over 2,000 registered charities and voluntary organisations, supported by a similar number of community and mutual aid groups

Over
2,000
VCSE partner organisations

23
Primary Care Networks

*The area covered by the ICB also includes the following Lower Layer Super Output Areas in the County of Buckinghamshire: E01017695, E01017696, E01017669, E01017670

How our partnership will work together

All partners, including Healthwatch and the VCSE sector, come together as the **Bedfordshire, Luton and Milton Keynes Health and Care Partnership** to oversee the development and delivery of our integrated care strategy.

Our **Integrated Care Board** brings together senior leaders from our Councils and NHS partners. The Board holds responsibility for actions to:

- Improve outcomes in population health & healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social economic development

Each local Council area – Bedford Borough, Central Bedfordshire, Luton and Milton Keynes – has a **place-based partnership** at which the NHS, local Council and VCSE partners agree priorities and take decisions about services for their residents, so they meet local needs.

Provider collaboratives work together across a wider geography than at place. In our area this includes the Bedfordshire Care Alliance and the all-ages Mental Health, Learning Disabilities and Autism Collaborative. These are supported across the East of England by collaboratives for children and young people and specialised mental health.

OUR POPULATION HEALTH CHALLENGES

Our local area

Our area covers four places **Bedford Borough, Central Bedfordshire, Luton and Milton Keynes City** – all vibrant, unique and rich in cultural heritage. Our population is diverse with more than 100 languages spoken.

With **2 million jobs** we are one of the fastest growing economies in England, contributing **£110bn** to the economy. We are served by excellent air, rail and road transport links.

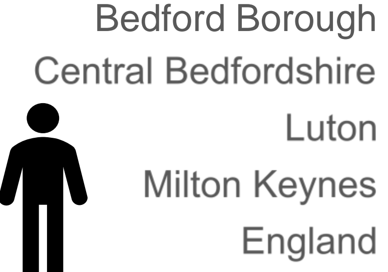
BLMK has a **diverse resident population**. Of our population of one million people, 62% identify as White British, 15% Asian, 10% 'Other White' and 7% Black.

We are one of the **fastest growing areas in the country.** Our population is expected to exceed **1.2m within the next decade** and could increase by nearly **90% by 2050**.

Supporting our residents to live longer, healthier lives

We want everyone in our city, towns, villages and communities to live a **longer, healthier life.** This means improving life expectancy and increasing the number of years people live in good health.

Life expectancy varies widely across our area, and can lag behind other parts of the country. Years lived in good health or without disability are also better for people in some other places.



By looking at the factors which make up the building blocks of health we can start to understand why some of these differences exist.

Smoking in some parts of our area is higher than the England average and is more common in certain population groups. Two thirds of deaths in 50-70 year old smokers are attributable to smoking.

Around 40% of children aged 11 are overweight or obese, and the percentage is higher in deprived neighbourhoods. This can lead to serious conditions like diabetes and asthma, and reduce life expectancy.

One in four UK households are living in **fuel poverty** and 25% of the coldest homes in the East of England are in our area. Living in a cold, damp house worsens airway and heart disease, risk of stroke and mental health.

Air pollution also has a significant impact on health and inequality, and is responsible for 6% of deaths in Bedfordshire, Luton and Milton Keynes.

Factors driving our health challenges

There are **more low birth weight babies** in our area than the England average**.** This increases death in childhood, asthma, infections, and diseases in adulthood.

The uptake of **childhood vaccinations is below target and falling**, increasing the risk of serious outbreaks.

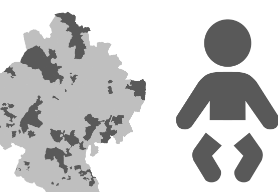
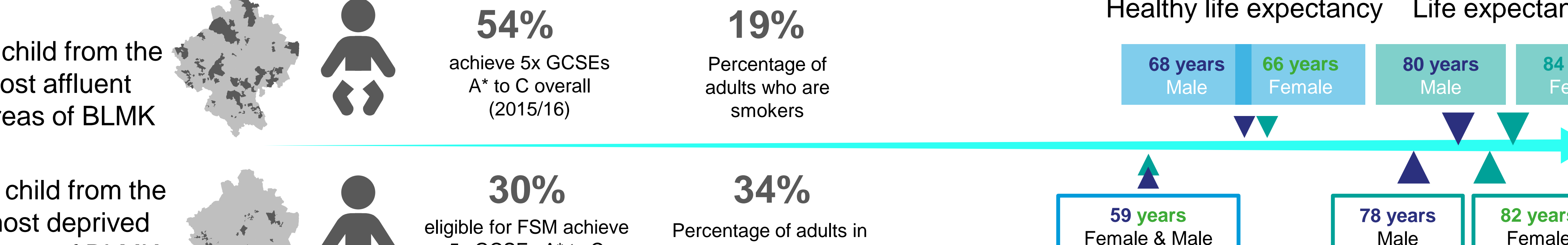
Limiting face to face appointments in the pandemic was necessary, but now people are **waiting longer** and are more likely to have **conditions go undiagnosed**.

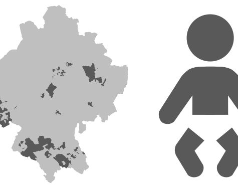
The number of **registered carers has nearly doubled since 2019.** Carers are twice as likely to have a mental health problem and almost three times more likely to have a long-term condition.

People with a learning disability or autism are less likely to attend screening, face long waiting times, and die on average 14 years before the rest of the population.

Cancer screening coverage varies and is lower in some population groups. Screening can reduce the risk of dying by 38% for breast cancer. 83% of cervical cancer deaths could be avoided if everyone attended screening.

Referrals to mental health services are increasing. **One in three** people with a long term condition also have mental health needs. People with a severe mental illness are more likely to die earlier, yet **40% did not receive their health check** across our area last year.



Tackling the causes of ill health

There is a saying that ‘prevention is better than cure’.

Prevention includes keeping people well, and supporting them to maintain independence for longer. Screening and early detection can help prevent advanced disease and improve outcomes for conditions such as diabetes and cancer.

We can also work to prevent mental ill health. By building resilience in young people and supporting families, we can help people to better understand their own mental health needs and how to get support when they are in crisis.

It is not just illness and injury that cause poor health and reduce wellbeing. Our life circumstances and environment also have an impact.

Things like good education and meaningful employment, a secure and warm home, strong family support, and a healthy environment all contribute to the building blocks of health.

Preventing long term conditions in Bedfordshire, Luton and Milton Keynes

Doctors have been looking for ways to support more people, particularly from the south Asian community, who are at risk of diabetes.

They used data to find out which people were most likely to be at risk, and test them for the condition.

One of these people was Nasreen, a young mother from Milton Keynes, who was diagnosed as pre-diabetic after blood was taken by her GP.

She is now taking part in a diabetes prevention programme. This has helped her understand how things such as her diet and exercise, can improve her health and avoid the complications associated with diabetes.

In each of our places, we are determined to work with residents to tackle the causes of poor health and improve wellbeing.

Our system challenges

In addition to the factors determining good health, we also have two significant challenges across our system.

Living Well is more difficult for everyone

- The cost of living has increased, and many families are struggling to pay their bills.
- Our local Councils, NHS, and our suppliers, are also feeling the pressure of rising costs and the need to manage greater demand within stretched budgets.
- Our staff are feeling the effect of their huge contribution during COVID. Vacancies have been increasing, and are now around 14% for staff in the NHS and 10% in adult social care, and this further affects staff morale.
- Environmental factors, including air pollution and access to green spaces, and climate change events such as heat waves, storms, floods, and pandemics are increasingly affecting our health and livelihoods.

Residents' health and care needs have changed over the pandemic

- Children and young people's lives have been disrupted. There are now more referrals to Councils for safeguarding, and to the NHS for conditions such as anxiety and eating disorders.
- Demands on primary care, especially GP and dental services, are increasing, and local people report access to a GP as one of their greatest concerns.
- People coming forward for support are more likely to have conditions diagnosed at a later stage or more than one condition, making care more complicated.
- More people are using our urgent care services and we need to work to reduce waiting times for planned care in the wake of the COVID pandemic.
- People who are discharged from hospital need more complex packages of care, requiring more staff time and more involvement from specialists.

Our strengths – what we are proud of

There is no doubt that improving health outcomes and tackling inequalities against the backdrop of increased demand for health and care services, the impact of COVID, and cost of living challenges is not easy. We will need to work together, and much smarter, to achieve a greater impact for our residents.

The Bedfordshire, Luton and Milton Keynes Health and Care Partnership has some real strengths we can draw on to help us achieve our shared vision. These include:

- **The commitment across Councils and our NHS to improve health outcomes and tackle inequalities**, reflected in our work to support residents to live longer, and live more years in good health.
- **Our VCSE organisations in all our communities**, who bring a wealth of specialist expertise in meeting the needs of our population, and boost investment in our system through charitable funding.
- **Strong partnerships between local Councils and NHS organisations**, demonstrating that we are willing to develop ways of working together to support our communities to thrive.

Supporting people with the cost of living crisis

With more people reporting increases in the cost of living having a negative impact on their health, we are working to find ways to support our residents.

Councils across Bedfordshire, Luton and Milton Keynes are using funding from the Health and Care Partnership to work with local VCSE organisations to provide warm spaces, where residents can get a hot drink and join in activities with others. Volunteers are also on hand to advise on issues from managing bills to homelessness and loneliness.

In Bedford Borough, GP services have invited over 1,500 people with health conditions that could be made worse by living in cold or damp houses to access advice and support from their local Better Housing Better Health scheme.

Where we* will focus our efforts

Our Health and Care Partnership has five priorities which inform our work. These focus on improving health outcomes and tackling inequalities for people of all ages.

They reflect the impact that growth and sustainability has on inequalities, on physical and mental health, and on social factors such as the environment, housing, employment and isolation.

These priorities are supported by seven enabler programmes, which will help us to make progress.

For each priority we will use what we know about our population health to help us understand where inequalities exist, and identify actions to address them. We will focus our actions through our partnerships at place.

** 'We' means our whole system: you, your families and friends, communities, Councils and NHS; people working in the public sector, businesses, universities, charities and voluntary, community and social enterprise organisations.*

OUR SYSTEM AND PARTNERS

Going further through partnership

Integrating care across our system

At the heart of our system are the new **Neighbourhood Teams.** These are NHS, local Council and VCSE sector teams working with a group of GP practices.

Much of the proactive and preventative care for residents is provided by these teams. This includes GP, dental, ophthalmology and community pharmacy services, VCSE service organisations, local authority services, community healthcare, and mental health and learning disability services.

They work together to serve a local population of 35,000 – 50,000 people and have four core aims:

- **Shared responsibility** for improving the health and wellbeing of residents
- **Continuity of care** provided in an integrated way for those who might benefit
- **Streamlined access** to same-day urgent care
- **Proactive identification and intervention** for those who need it the most

The local partnerships shaping care for children and young people

Our system partners are already working together to support children and young people, with a focus on those who are most vulnerable or have complex care needs.

Across Bedfordshire, Luton and Milton Keynes there are over 1,300 'Looked After Children', and safeguarding referrals continue to increase. Councils, the NHS and VCSE partners work together across early years, education, children's centres, health, social care and youth justice to keep children safe and ensure their needs are met.

One in six children will have a special education need and/or disability. Support for these children often involves a number of public sector agencies and can sometimes be fragmented.

Work is underway across all our places to ensure all children can fulfil their potential, including:

- strong leadership at place to ensure care is joined up
- an early offer of support for parents and children
- speedy access to specialist support where needed.

It’s all about you

Our aim is to make working with people and communities as equal partners with statutory services a reality in Bedfordshire, Luton and Milton Keynes.

We are making a commitment to work in a way that represents the **views of all our communities.**

We will engage and involve our staff and residents to get involved in designing and delivering care at every stage.

Our principles of co-production

Build Leadership that supports and promotes co-production.

Train staff and citizens in co-production and how to make it happen.

Use open and fair ways to get input from **full range of people** who use services, carers, and communities.

Review and **report progress**: from ‘you said, we did’ to ‘we said, we did’.

Reward and **recognise** people’s contribution.

Embed co-production until it becomes ‘how we work’.

Identify where co-production can have the greatest impact, and **start from there** - involving people in the earliest stages of design.

Our principles of co-production recognise and value the lived experiences of people in our communities.

Ownership, understanding and support of co-production by all

A culture of openness and honesty

A commitment to sharing power and decisions with citizens

Clear communication in plain English

A culture in which people are valued and respected

We will learn from and work with our four local Healthwatch organisations and VCSE partners who are experts in co-production and co-design and have good routes into our local communities.

Our places: Bedford Borough

Bedford Borough includes the vibrant urban area of Bedford and Kempston, surrounded by picturesque rural parishes. It has significant diversity, with 100 different community languages spoken and one of the largest concentrations of Italian immigrants in the UK.

The River Ouse runs through the town. The town has a rich heritage in the lace industry, brewing and aircraft building. Bedford Borough has an elected Mayor.

Bedford Borough's vision is to thrive as a place that people are proud of, want to live in and move to.

Local plans recognise a growing and strong local economy and an active response to climate change as two important factors in achieving this. From this foundation residents will be able to thrive and realise their potential, supporting and celebrating Bedford Borough's diverse and inclusive communities.

The Bedford Borough place plan commits to:

- Understanding our communities
- Promoting prevention and health promotion
- Transforming care with primary care and VCSE

Total population ≈ 185,300 in 2021

Age profile:

- one in six people are aged 65 years and over

Diversity:

- 64% White British, 10% Other White, 13% Asian, 5% Black

Deprivation:

- 14% of neighbourhoods are in the most deprived in England.
- 15% of children (5,000) live in low income households.

Our places: Central Bedfordshire

Central Bedfordshire is the most rural of our four areas. It is made up of 62 small market towns and villages from Sandy in the north to Dunstable in the south. The large area covered by Central Bedfordshire Council means that one-in-three residents travel to hospitals outside of our system.

Central Bedfordshire's strategic plan focuses on continuing to be a great place to live and work:

- Protecting the environment with sustainability plans
- Supporting the health and wellbeing of residents
- Building schools for the future to meet the needs of all our young people, including those with Special Educational Needs and/or Disabilities
- Delivering homes to meet the needs of all residents
- Delivering and improving services such as roads and transport.

The Central Bedfordshire place plan commits to:

- Improving access and supporting healthy choices
- Supporting independence for older people
- Tackling inequalities and the wider determinants

Total population ≈ 294,200 in 2021

Age profile:

- almost one in six people are aged 65 years. Central Bedfordshire has the greatest number of over 65s in our area.

Diversity:

- four out of five people identify as White British

Deprivation:

- only 2% of neighbourhoods are in the most deprived in England.
- Dunstable-Manshead, Parkside and Flitwick contain the most deprived neighbourhoods.

Our places: Luton

Luton is the most urban and ethnically diverse of our four local authority areas, with nearly half of the population made up of ethnic minority groups. Luton has a rich heritage, including the Vauxhall factory, which continues to be a major employer in the town.

London Luton Airport has undergone significant redevelopment in recent years, becoming the country's number one airport for private aviation.

By 2040, the vision is for Luton to be a healthy, fair and sustainable town, where everyone can thrive and no-one has to live in poverty, supported by:

- A town built on fairness – tackling inequality
- A child friendly town – investing in young people
- A carbon neutral town – addressing the impact of climate change

The Luton place plan commits to:

- Giving every child the best start in life
- Sustainable communities, and tackling inequalities
- Reducing frailty and supporting independence

Total population ≈ 225,300 in 2021

Age profile:

- one in nine people are aged 65 years and over

Diversity:

- most ethnically diverse population in our area (32% White British, 37% Asian, 11% Other White, 10% Black)

Deprivation:

- one in four neighbourhoods are in the most deprived in England
- 10,000 (nearly one in five) children live in low income households
- unemployment levels are high at nearly one in ten of the population (9.6% vs. 5.3%)

Our places: Milton Keynes

The city of **Milton Keynes** is the largest place in Buckinghamshire with one of the UK's most successful economies. It ranked fifth highest for business start-ups, with a strong jobs market and lively cultural activities.

Milton Keynes has the youngest population of all our places, with a quarter of the population under 18. It has excellent road and rail connections.

Milton Keynes City Council and the city's health partners are taking on additional responsibility for improving residents' health and local health and care services.

Called **The 'Milton Keynes Deal'**, they are pioneering new inclusive ways of working.

The Milton Keynes Deal commits to:

- Supporting children & young people's mental health
- Tackling obesity
- Supporting people with complex needs
- Improving how services work together to reduce avoidable hospital admissions

Total population ≈ 287,000 in 2021

Age profile:

- 25% of people are under 18
- 14% of people are aged 65 years and over

Diversity:

- ethnically diverse population (62% White British, 12% Asian, 10% Black, 9% Other White)

Deprivation:

- 12% of neighbourhoods are in the most deprived in England.
- 8,500 children (15%) live in low income households.
- higher levels of employment (68% vs. 65%) than other parts of our area

Provider collaboratives: mental health, learning disabilities and autism

Our mental health, learning disability and autism services already work closely together. We are now forming a provider collaborative to tackle issues such as:

- **Workforce** – training a new generation of mental health professionals to support our expansion in mental health services so that all people can get rapid and fair access to care.
- **Emotional wellbeing for young people** – responding to the increase in referrals since the pandemic, we are developing early support for young people in distress, joined up with family, schools and communities. Children and young people who need mental health inpatient support, will have access to a new unit from January 2023.

Working in partnership to support people in crisis

The Mental Health Street Triage service supports patients experiencing a mental health crisis in Luton with fast access to care.

This team combines a police officer, a paramedic and a mental health professional in one car to respond to mental health crisis calls 365 days a year. Operating from 12pm-12am, the team acts where there is an immediate threat to life – to help someone in danger of self-harm, or suicide.

The team works with similar teams has a dedicated phone and is linked to both police and ambulance control rooms.

- **Supporting Adults with Autism** – supporting the high proportion of adults with autism who don't have a formal diagnosis to ensure these people can get access to support for them, their family, and from their employer.

Provider collaboratives: Bedfordshire Care Alliance

Bedfordshire Care Alliance (BCA) is a provider collaborative, which spans the three places of Bedford Borough, Central Bedfordshire and Luton.

The BCA focuses on the aspects of integrated health and care that are best done for the whole of Bedfordshire. In particular, the BCA is looking at how to prevent ill health and deterioration and support people to stay well at home.

This will involve joining up the planning and delivery of care across social care, community, hospital, and primary care.

Some of the Alliance's priorities are:

- **Home First** – providing care at home to help people with frailty recover after a hospital visit.
- **Stay Well at Home** – providing a 'virtual ward' so people can access medical, nursing, therapy and care support at home instead of going into hospital.
- **Ensuring communities have fair access to resources** – for Neighbourhood Teams, and to support Home First and Stay Well at Home plans.

Supporting people at home

The Bedfordshire, Luton and Milton Keynes Virtual Ward programme is building on strong partnerships to promote earlier discharge from hospital, and help people be cared for at home.

The Virtual Ward uses remote monitoring, and gives people access to treatments at home, home oxygen, and specialist palliative care, whilst allowing them to keep in touch with their clinical team.

The BCA is supporting the roll out of two new Virtual Ward schemes in Bedfordshire. These are designed to help people with frailty, or those with a severe respiratory illness, who would otherwise have to stay in hospital. By closer working across community, primary care and hospital teams, and better use of technology, these Virtual Wards both support individuals and help to free up much needed space inside our hospitals.

WHAT THIS MEANS FOR ME & MY FAMILY

What can I expect to be different?

Equity in access – no one left behind

The way we provide services makes a big difference in how they are used by our residents, and how they impact on health and wellbeing. We are determined that across our partnership, services and support will be fair and accessible to all.

This applies to the NHS, providing universal healthcare for all, and services from your local Council including social care, public health, schools and education, planning and housing, waste and recycling, children's services, transport, roads and parking, leisure, environmental services, and community safety.

Tackling inequality in outcomes from heart disease

High blood pressure can increase the risk of heart attacks and strokes. Caught early, hypertension is easy to treat, but rates of detecting this are much lower in some populations.

GPs across Milton Keynes are working with pharmacies to identify people who are at risk of hypertension but may not be coming forward for treatment.

Community support to improve mental health

Community connectors have been integrated into local mental health teams across Bedford Borough to support people with emotional, social and practical needs.

With an in-depth knowledge of local VCSE and community services, these individuals are helping people access a range of local non-medical offers to improve confidence, social inclusion and independence, looking both at the building blocks of good health, as well as addressing specific mental health needs.

Our VCSE organisations also provide many of these services from prevention right through to specialist mental and physical health support. They are excellent at advocating for patients' and community members voices to be heard, and are experts at engaging and supporting communities that experience health inequalities.

Start well: Every child has a strong start in life

Our most disadvantaged babies and their families are offered tailored support through the first 1,001 days of life.

Young people are ready for adulthood and supported across health and care services as well as through education and into employment.

Transforming young lives in Milton Keynes

There are a significant number of young people who experience serious harm, violence and abuse in Milton Keynes. Thames Valley Police, Milton Keynes Hospital and YMCA volunteers are working in the Emergency Department at the local hospital to help these young people.

Ben is one of the young people who is using this scheme. He has been given a dedicated keyworker to provide one-to-one mentoring, coaching and support to help him break out of the cycle of violence.

Luton's family partnership service

The family partnership service provides intensive support to vulnerable children, young people and their families.

This service has been built on the strong belief that children belong in natural networks with people they know and who love them and keep them safe.

The service takes several approaches to identify the right support for children and their families, including:

- Direct support by a family support worker
- Linking to services provided by other partners within community or specialist services.

All our children are enabled to thrive. They have the tools to stay fit and healthy. They have support to manage complex care and mental health needs, with extra support for the most disadvantaged children.

Live well: People are supported to manage their health and wellbeing

People have control of their life, wellbeing and health and access to services and tools they need.

Care is built around neighbourhood teams that deliver support in communities, with accessible primary care, and personalised care – using innovative ways to support the whole person.

Rapid mental health support, focused on prevention, including early intervention in psychosis and talking therapies, help people with mental health conditions to stay well.

More conditions are prevented and detected early so they are easier to manage and treat – particularly heart disease, respiratory illness, diabetes and cancer.

Care is tailored to an individual's needs – for example, for people with Learning Disabilities, veterans, and people in end of life care.

Improving cancer outcomes in Luton

When Nam missed a routine smear test last year, because she didn't know she could request to see a female practice nurse, rather than her male GP, she didn't get her cervical cancer diagnosed until it was at a more advanced stage.

Once diagnosed, she was referred to Mount Vernon Cancer Centre for radiotherapy. But because Nam can't drive and her husband couldn't get time off work, she wasn't able to get the treatment she needed and is now in palliative care.

The Luton Cancer Outcomes project, led by the local Council, NHS and VCSE sector, is looking at how we can change this story in the future. Using information about who is missing out on treatment, and why, partners are working to find solutions that work for local people. This includes targeting people who are missing out on screening and providing support, including transport, to help people get the care they need.

Age well: People age well, staying healthy and independent for as long as possible

Older people are supported to stay well at home, tackling loneliness and isolation. People stay connected to their community and neighbourhood teams to get the help they need.

Supporting people with dementia in Central Bedfordshire

When Dianne was diagnosed with dementia, her GP referred her to the Working Together Leighton Buzzard team (WTLB). This programme brings together GP practices, mental health services and social care to ensure care is joined up.

The team set up a visit from a district nurse and a social worker, who created a care plan for Dianne, with her husband. They referred her to an occupational therapist and ordered a new bed so she could safely sleep downstairs. Dianne's medication was reviewed and her husband, as the main carer, was also offered support.

By working together across organisations, the team prevented Dianne from having to go into hospital.

Preventing falls in Bedford Borough

Bedfordshire Fire Service offers Falls Prevention Checks in resident's homes. Officers check for trip hazards at the same time as advising residents of fire safety measures, such as smoke alarms.

The service also offers to refer people for advice on housing, and stopping smoking, to improve their safety and health.

Community services, including falls prevention, Virtual Wards and medication reviews, help **older people to maintain independence** and manage conditions, including dementia.

People are supported with recovery, rehabilitation and reablement after a period of illness, at home or in hospital.

People are supported to die at home if that is their wish, with support for them and their family.

Growth and sustainability

People are more likely to live happy, healthy lives if they have the best start in life, use their skills, and have control over their lives. This includes access to good, fair employment, a decent standard of living, with help to stop people getting ill, and access to healthy sustainable places and communities.

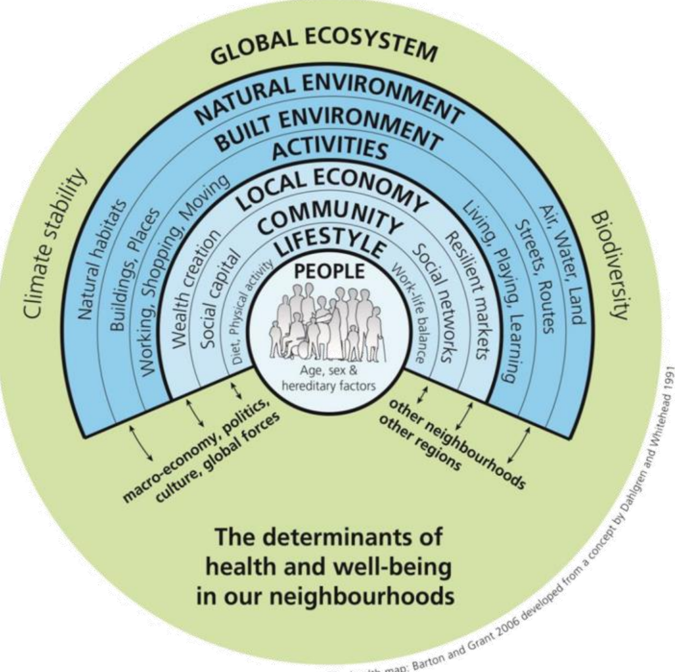
Environmental sustainability: with net zero carbon emissions by 2035, to work in harmony with our environment and reduce the risks of climate change.

Sustainable economic growth: improving opportunities for prosperity for all our population, now and in the future.

Delivering social value: ensuring our work contributes to our whole society, so everyone has the chance of a decent standard of living.

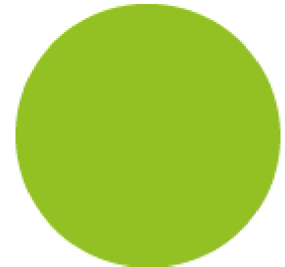
- Creating a "circular economy" (reduce, reuse, repair, repurpose and recycle) with no waste.
- Building infrastructure (buildings, processes, transport) that helps us be sustainable.
- Making decisions with the future of our environment in mind.

- Increasing employment opportunities for local people and support to develop skills.



- Effective, efficient use of public assets.
- Investing in research and innovation.
- Supporting people to work and shop locally, and businesses to invest here.

- Keeping people healthy in their homes and communities.
- Nurturing partnerships across large, public-sector, and VCSE organisations, and local employers to improve the lives of our residents.



OUR APPROACH

How we will use our skills and resources differently

Our workforce

Our health and care workforce are at the heart of our efforts to improve population health.

We need to have enough trained, engaged, and valued staff. We want our workforce to represent our population, drawing people from all backgrounds.

To do this, we need to make sure that careers in health and social care are accessible, fair and equal, and support people with their own mental and physical health.

Keeping Well BLMK

This specially designed service provides wellbeing and psychological support for NHS staff, and those providing care in the community, residential homes, and in VCSE organisations.

Keeping Well practitioners run sessions tailored to an individuals' needs and issues to help them better manage physical and mental health both at home and at work.

Supporting our staff in primary care

People working in primary care have been under increasing pressure, and have reported an impact on their health and wellbeing.

Our Integrated Care Board wanted to help, introducing an app, called ShinyMind, specifically tailored to increase resilience and reduce stress in NHS staff.

Nine out of ten staff who have used the app report an improvement in wellbeing after using the programme, while seven out of ten said their job satisfaction had improved.

We will innovate in the roles we offer, giving staff flexibility in their working lives, and embracing technology to work smarter and increasing innovation and research.

Our **one workforce** approach is based on solutions that enable staff to work across settings, and demonstrate positive outcomes for staff and residents.

Our leadership values:

Support to provide excellent care, every time

Our **Clinical Services Strategy** will support and develop clinical and professional teams to work at the top of their game to achieve the best health outcomes for residents.

A big part of this is learning from what we and others do. We will compare our care pathways with best practice and current evidence and adapt our approach accordingly. We will involve patients, carers and staff in co-design and co-production of pathways based on residents' need. By embedding ways of improving quality our health and care teams will provide excellent care, every time.

Promoting research across our system

Our newly created Bedfordshire Research and Innovation Hub will focus on research into health and social care inequalities.

By building research capacity and capability, this hub will identify new ways of working to reduce inequalities. Priorities include building an inclusive workforce and resilience in the helping professions, and safeguarding children and adults with complex needs. This hub will help act as a catalyst for further investment in health and care research across the system.

Using innovative approaches to speed up diagnosis and care

When Margaret collapsed while walking her dog near her home she was rushed to Milton Keynes Hospital.

Doctors were able to view her CT scans instantly on their smartphones using new AI-powered software, analyse and identify any areas of the brain that may be damaged, and share images with colleagues in Oxford for expert advice.

Margaret was quickly diagnosed with stroke and transferred for treatment. The speed of this response allowed her to return home after a few days in hospital to recover from this serious illness.

We will promote research to find new and improved ways to support people. We will build our new research hub and work with Academic Health Science Networks to evaluate and spread innovation.

We will also work to prevent ill-health, and the causes of poor health, and maximise recovery after illness or injury.

Improving the safety of our care

Working together is vital, and especially when we are looking at quality issues with patient services.

The Patient Safety Incident Response Framework (PSIRF) is the new national way of improving patient safety in the NHS. It will help us to respond quickly and appropriately if and when we identify similar problems across patient pathways in different health settings, or where the same problem happens across a number of health settings. The principles which this framework supports are:

1. **Kindness and respect to the person affected and their family, with honesty about what happened.** We will always listen, respect and involve all people who raise a safety concern.
2. **Supporting our staff, and addressing the root causes of when things go wrong.** Avoiding a 'blame culture' where staff are blamed for issues beyond their immediate control. we will take responsibility for these factors, and work with clinical teams to address them.
3. **We will identify the major quality improvement programmes needed in instances where we haven't got care right**, and work together to make sure changes are sustained.
4. **We will work on quality improvements along the whole health and care pathway**, working to improve patient experience and outcomes as people move between different health settings.

Learning from the pandemic to improve our safety

To embed learning around infection control following the pandemic, care homes across Bedfordshire, Luton and Milton Keynes have been introducing a raft of measures to improve safety.

Regular care home forums allow staff to bring concerns and share good practice across our homecare network. Study days around frailty and the vulnerable person, linked to the risk of infections, are also in place. These will be rolled out to Learning Disability homes this year.

Planning care around our population's needs

Good information is essential to plan, deliver and improve services and support residents to live longer, healthier lives.

We are working together to establish a single, shared data platform. This will ensure we have a consistent view of our data and intelligence.

The platform will include anonymised information in areas such as performance, population health and inequalities, as well as capturing insights from residents.

This information will give us a rounded understanding from which to make decisions. It will support us to learn from best practice and tailor our activities to residents' needs.

We will share these insights across the system, working together to understand what it is telling us, and take decisions together.

Using health intelligence to provide personalised care

90% of people who are socially vulnerable live on their own. They often rely on out of hours GP services or 999 for help, sometimes ending up in hospital unnecessarily.

To help improve care for some of these people, Titan Primary Care Network in Central Bedfordshire used linked primary and secondary care data to identify people who could benefit from being reviewed by their team.

Jane was one of those people. On visiting her home, a social prescribing practitioner found she wasn't managing her health and her home was in a bad state of disrepair.

Working with the local council, the team arranged improvements to her home, reviewed her medicines and helped her to better look after herself. She's now eating better, able to get out more and feeling less isolated.

We will publish our information as part of our commitment to accountability and benchmark ourselves against others to make improvements where necessary.

Using technology to join up and improve care

Our system-wide digital and data strategies set out how data and technology can help to deliver the best outcomes for our residents.

This means using information in a smarter way. A single shared health and care record will join up information to help provide seamless care and help people to get the right care, every time.

Patients will be able to access information easily and technology will support Virtual Wards and help people to be cared for in their own homes.

Using information to get the right support, first time

The 'yellow bracelet' scheme for people in contact with homecare services in Bedfordshire, Luton and Milton Keynes, means professionals can access real-time data about a person's care package, their needs and the support they have at home.

This can speed up risk assessments, decision-making and ensure people get access to the right care, first time, and maintain independence at home.

So that patients can…

- Spend less time at appointments
- Not have to repeat their information more than once
- Have care informed by every touch point with the NHS or Council
- Access information about past and future appointments, conditions, allergies, treatments, prescriptions, lab results and vaccinations
- Be more independent in activating and managing self-care.

So that care practitioners can….

- Understand the whole patient, their lifestyle and health journey
- Access test results and scans quickly and easily
- Co-ordinate care across professionals, wrapping care around an individual
- Deliver high quality, safe care each and every time.

So that people planning care can…

- See how residents are using care at any given moment, for example the number of patients at A&E, or on waiting lists
- Forecast demand based on previous trends and live data
- Predict demand for high risk patients and provide pro-active care
- Intervene earlier to improve outcomes and reduce 'reactive' care
- Focus resources closer to the resident and their individual needs.

Managing our resources

Our health system has a budget of around £1.8 billion, managed by the Integrated Care Board. We will work collectively to allocate and spend this money as efficiently as possible to deliver better health outcomes for our population.

We will be working more closely between NHS, local Councils and VCSE partners to make sure that funding is targeted to have the greatest impact. Our place-based approach will help us make the right decisions to support our communities to thrive.

Giving people control of their care

People with Multiple Sclerosis and Epilepsy are being offered a new service, called Patient Initiated Follow Up (PIFU), which allows people to take control of their own care, reduces unnecessary hospital visits and improves waiting times.

This service provides an alternative to a regular scheduled follow-up appointment, and supports people to get help, review their medication, get test results and flag concerns without having to make an appointment with their GP.

Supporting carers in Central Bedfordshire

Primary Care Networks in Central Bedfordshire are working to ensure that carers are looking after their own health.

They have been contacting carers who have not been to see their GP in the last 12 months or who have a long-term condition, to give them a full health check and offer them a care plan personalised around their needs.

How we use our buildings has fundamentally changed since the pandemic. Much more healthcare is now delivered on-line or in places other than hospitals.

The move to more preventative and personalised care outlined in this strategy will mean this continues to evolve in the future. Our NHS and Councils are reviewing how we use our estates to provide integrated care at place.

Across our communities we also have other valuable resources in VCSE organisations, our networks and our communities. This includes thousands of informal carers, who work alongside our Councils and NHS to support our residents to live longer, healthier, lives.