Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Bedfordshire, Luton and Milton Keynes

Health Services Strategy

2024-2040

Contents

Foreword

Why do we need a Health Services Strategy?

The rate at which medical science has continued to advance over the last 15 years is hard to believe: it is estimated that the weight of medical knowledge now doubles every 73 days! We find ourselves in awe at the innovations which transition from 'the laboratory bench to the patient bedside', and which now have a positive impact on people across many parts of the world. These new treatments are being adopted at pace in the National Health Service (NHS), including here in Bedfordshire, Luton, and Milton Keynes (BLMK). Examples include:

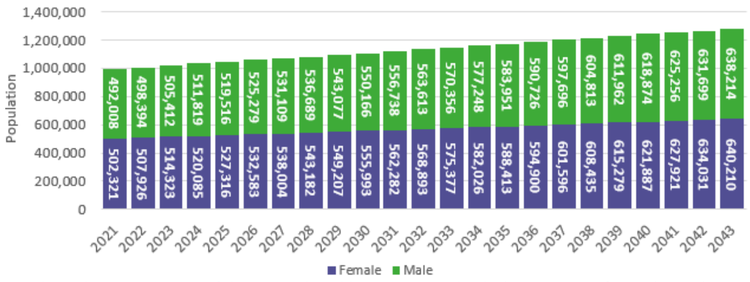
- **Clot-busting medicines** and other interventions used in acute stroke, reducing the long-term burden of significant disability due to cerebrovascular disease.
- Highly **effective vaccines** developed for use within a year of the COVID-19 pandemic.
- A new generation of **surgical robotics**, bringing minimally invasive surgery to more and more patients.
- The use of **genetic tests** to aid the diagnosis and targeted, personalised treatment of a range of conditions.
- New pathways of care for the early diagnosis and treatment of **Alzheimer's dementia**, slowing the loss of independence.
- Modern **insulin therapy** for people with diabetes, including pump and hybrid closed-loop systems, leading to improved quality of life and better long-term outcomes.
- Developments in **organ transplantation**, including living donor transplant, transforming the lives of recipients.
- **New medicines** leading to a revolution in the management of common conditions including heart failure and obesity.
- Technological advances in how we access and deliver our health services – from the **NHS App** and video consultation through to **Virtual Wards**.

These advances, and many others, should be celebrated. They make a real difference to the lives of residents. However, over the same 15 years, not all developments have been so positive:

- Increases in **life expectancy** seen over the first decade of the 21st century have stalled, an effect evident prior to the pandemic and exacerbated by it.
- **Healthy life expectancy** has reduced with both men and women spending more years in poor health.
- Human activity is placing an intolerable strain on our planet, threatening its ecosystems, and creating additional health burdens for populations – healthcare provision both contributes to this **environmental burden** and is impacted by it.
- Advances such as those described above are **costly**, and 'medical inflation' tends to outstrip 'general inflation'.
- Expectations for **economic growth** in the United Kingdom are modest over the medium term with the OECD predicting just 1% growth in 2025.
- The **population** of England and Wales is growing, with the contribution of net migration being greater than that of births and deaths. Notwithstanding, there is a shift in the proportion of the population that is economically active (reducing) and the proportion that is dependent (increasing).
- We have seen a significant decline in most of the **performance indicators** used in the NHS over recent years, exacerbated by the pandemic. Many of the standards contained in the NHS Constitution (Health Act 2009) are not being routinely met across England. This includes high profile metrics such as referral to treatment (RTT) and the 4-hour A&E waiting time, but also the oft overlooked mental health and community services for which waiting lists have surged and where long waits risk being normalised.[1]
- **Health inequalities** persist – and in some cases widen – with access and outcomes for residents varying according to their economic status and protected characteristics.

We are not immune from any of these challenges in Bedfordshire, Luton, and Milton Keynes (BLMK). Indeed, Population growth across BLMK has far exceeded – and will continue to exceed – the England and Wales average: the population of England and Wales has increased by approximately 6.3% over the last decade and is projected to continue this trajectory over the next decade. Growth across BLMK has been approximately double the national rate. Over the next 20 years, the BLMK **population is projected to increase by 25%**, primarily driven by housing growth across Bedford, Central Bedfordshire, and Milton Keynes, and through natural demographic growth in Luton.

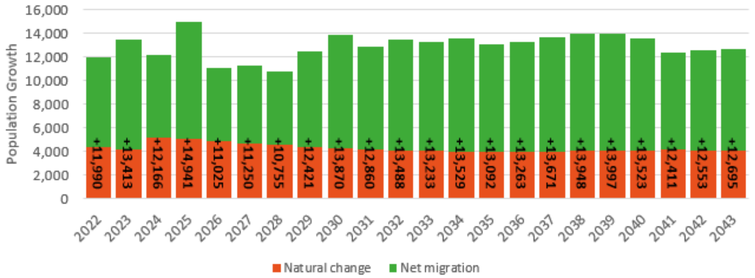
Figure 1: BLMK Population by Year and Sex



1. Independent Investigation of the National Health Service in England, The Rt Hon. Professor the Lord Darzi of Denham, September 2024

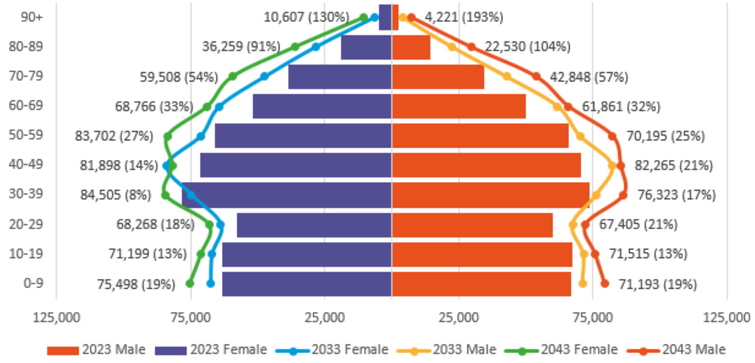
- Across BLMK, international migration will account for 40% of growth, with domestic migration and natural demographic growth accounting for the remainder.

Figure 2: BLMK Population Change from Births, Deaths and Migration



- The age profile of the population in BLMK is changing much more rapidly than the national picture, with significant growth in the population over the age of 50 years. Projected increases in all age bands over 50 years exceed the overall 25% growth projection. The population in BLMK **over the age of 79 years will double** over the next two decades.

Figure 3: Population Pyramid for BLMK in 2023, 2033 and 2043



This leads to an inevitable increase in the incidence of cancer, musculoskeletal and cardiovascular disease. The growth in the elderly population – a subset of whom will experience frailty and dependency – is markedly acute. This is particularly so in our urban centres and is notable in **Milton Keynes** as the 'New City' reaches maturity (and its hospital passes its 40th anniversary): in Milton Keynes, the total population over 77 years of age will double over the twenty years ahead.

- BLMK is not a homogenous geography: as the Denny Review of Health Inequalities makes clear, **significant health inequalities exist** and demand real focus – the populations of Luton and Bedford towns can expect to live significantly fewer years in good health than the England average.

Given these population changes and significant inequalities, health services across BLMK will inevitably need to grow and 'deliver more activity', as they have been doing over the last 15 years. However, the challenge moving forward is of such a scale that **we need not just to 'do more' but to 'do differently'**.

In these challenging times, we must see our role as guardians of health services for future generations, rather than as managers of the status quo. As we look out to 2040, **we need to ensure publicly funded health services are sustainable and they achieve the best health outcomes possible for the BLMK population within available resources**.

The integration of health and care is a key foundation to enable us to **'do differently'** in BLMK. However, the statutory basis of the Health and Care Act 2022 is not in itself sufficient. A range of partners from across BLMK – many of whom are members of our Integrated Care Partnership – need to work ever more closely together, with and in the interests of residents, to establish new models of care. There will need to be an emphasis on joined up working and collaboration, forensic attention to high quality evidence and improvement science, and an intolerance of waste and duplication. Whilst this shift applies to all partners including Local Authorities and social care, it will perhaps be most challenging to achieve for our health services where the purchaser-provider split and the identities of 'sovereign organisations' within our NHS cast a long shadow. **'Doing differently' will not just happen. It will require openness, thought and active planning – it requires a Health Services Strategy.**

The remainder of this document – the BLMK Health Services Strategy – describes how we as leaders in the provision of health services in BLMK commit to working together over the years ahead: the **direction of travel** that we believe our services need to take; the **expectations that we have of one another**; and, the **priority programmes of work** which we believe must be undertaken as a collective (programmes of real significance to our residents, in which 'the whole will be greater than the sum of the parts' through our joint endeavour).

The strategy is intentionally high level. It will be responsive to important work evolving elsewhere across health and care. It is consistent with the health and wellbeing strategies developed in our four constituent Places (Luton, Bedford Borough, Central Bedfordshire, and Milton Keynes), and the BLMK Joint Forward Plan.

Figure 4: Our Strategies and Plans

In particular, the statements, expectations and priority work programmes are structured in such a way to incorporate and deepen our commitment to the **ICB Strategic Priorities**:

Figure 5: BLMK ICB Strategic Priorities

Like the Joint Forward Plan, the Heath Services Strategy spans the period out to 2040. However, with medical knowledge growing exponentially, and societal change moving at a rapid pace, the strategy is designed to develop by iteration: the direction of travel and the commitments described are expected to stand the test of time, whilst the programmes of work will evolve with science and society.

In addition to describing 'what the strategy is', it is important to be clear on 'what it is not'. The Health Services Strategy is not intended to include each and every aspect of health service provision in BLMK: in many areas, existing collaborative mechanisms work well. Examples include joint management of the Better Care Fund[2] between each Local Authority and the ICB; commissioning and contracting arrangements around the provision of specific health and care services; and, effective relationships between primary care practitioners and local hospitals. Quite rightly, the strategy has relatively little to say on such matters.

The strategy does not seek to 'replace' or 'take over' work being undertaken at place, and in the case of Bedfordshire, through the alliance of organisations delivering services across the three places. Rather, it aims to enable and propel that work, recognising and supporting the uniqueness of each place, but also throwing light on variations that are unwarranted and unwelcome.

Bedfordshire, Luton and Milton Keynes's success as a system depends on it unleashing the potential of individuals, organisations, places and alliances across its footprint. The strategy seeks to support individual NHS organisations in fulfilling their statutory duties, whilst driving forward collaboration between organisations, and between them and the populations they each serve. If a particular topic is not covered in detail within the programmes of work proposed in the strategy, it does not signify that the topic is unimportant: rather the strategy focuses on those areas where we believe a coordinated and streamlined approach will improve our chances of success.

2. Better Care Fund: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/

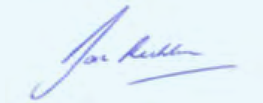
This strategy belongs to the organisations providing publicly funded health services in BLMK - with whom we share this journey.

The strategy has been developed in discussion with NHS providers and through the engagement of those who provide publicly funded health services and are key in the delivery of joined up integrated care.

It is signed by the leaders of these key organisations and partners. We commend it to you.

Dr Rima Makarem, Chair,
BLMK ICB

Felicity Cox, Chief Executive Officer,
BLMK ICB



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Claire Murdoch CBE, Chief Executive Officer,
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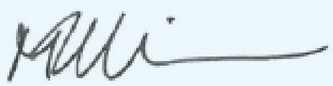

Matthew Winn, Chief Executive Officer,
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Our direction of travel

The challenges facing our health services going forward are stark. To meet these challenges, we will require not 'more of the same' but fundamental changes in the way we work, within and across organisations. Emerging thinking describes a new framework for the provision of health and care, refreshed pathways based on population need rather than traditional distinctions between primary, secondary and tertiary care: an emphasis on digital enablement to support self-care, prevention and access; appropriate and timely access to acute care as and when needed; and, focused efforts through integrated community teams in the management and support of people with complex health issues and those nearing the end of life.

Individuals and organisations have different appetites for the adoption of innovation and change more broadly. We should retain a healthy skepticism about 'change for change's sake' yet remember that whilst '**not all change is an improvement, all improvement is change'**.

Meeting our future challenges will require a lot of change: the journey must be faced with sufficient maturity that we embrace innovation, evaluate impact, mitigate, and share risk and become tolerant – within reason – of some failures as part of that journey.

The statements which follow will guide us on the journey ahead and at the forks in the road which we shall doubtless encounter. We believe that each statement should persist through the scientific, societal, and political changes which are not yet known. Each begins with **"We will"**. This is intentional. We as **leaders in the provision of health services in BLMK**, have together agreed these statements will guide the choices we make in our organisations and as partners in our system.

"We will" Statements

1. **We will** make decisions which support a shift from healthcare intervention to the prevention of ill health.
2. **We will** encourage and enable residents to take an active role in managing their own health and wellbeing and to contribute to the development of healthcare provision.
3. **We will** provide care as close to the resident's home as possible and design services that are 'seamless' for patients and carers.
4. **We will** embrace technology in the design and delivery of health services.
5. **We will** protect access to planned healthcare including operations and procedures.
6. **We will** make investment decisions which promote a narrowing in health inequalities.
7. **We will** ensure that the shape and size of our workforce meet the needs of BLMK's population and support our people to make best use of their individual skillsets.
8. **We will** ensure that value (financial and social) is key to all decision-making.
9. **We will** act to ensure parity of esteem between physical and mental health.
10. **We will** work to deliver healthcare in an estate which is fit for purpose.
11. **We will** embrace measurement and a culture of continuous improvement.
12. **We will** achieve excellent outcomes in maternity services and reduce neonatal harm.
13. **We will** prioritise the health of children and young people, including those who are carers.
14. **We will** cultivate a healthy research landscape – improving access to portfolio studies and providing a fertile environment for collaborative local research.
15. **We will** own our roles as anchor organisations within the communities we serve and work to enhance social value.

STATEMENT 1:

We will make decisions which support a shift from healthcare intervention to the prevention of ill health.

At some point in our lives, we will all experience ill health. Many of us will experience chronic illness in the form of a 'long term condition'. When that happens, people should receive support that meets their specific needs and helps them to continue to live a life which is as healthy and fulfilling as possible. Our interventions must be empowering rather than paternalistic. This is directly linked to one of our system's core aims: increasing the healthy life expectancy of our population.

Much of the ill health that we experience is preventable. Our current systems are – to a large extent – set up to manage illness when it presents, rather than to prevent that illness. Preventing avoidable illness through initiatives such as: health education; supporting self-management; smoking cessation; supporting people to stay in good employment; encouraging physical activity and healthy diet; and, maximising the uptake of screening and vaccination will over time lead to less illness – or in a BLMK context, reduce the rate at which the prevalence of ill health increases given our population growth and demographic changes. Proactive interventions and health promotion – particularly through an inequalities lens – will require our primary, secondary and community healthcare teams to support patients in new ways.

The ICB already has co-developed a Primary Care Prevention Plan and this Health Services Strategy provides an opportunity to expand this emphasis on prevention into and beyond secondary care and community services. We recognise of course that poverty, housing, and education are the most significant drivers of ill health and therefore key vehicles for prevention. As a group of anchor institutions, recognising the wide influence of health services, we will work with partners to influence 'wider determinants' through the integrated neighbourhood plans being led at place – the building blocks for good health.

STATEMENT 2:

We will encourage and enable residents to take an active role in managing their own health and wellbeing and to contribute to the development of healthcare provision.

Agency and self-empowerment are key to health and wellbeing, and foundations for effective and appropriate use of health services. We will ensure that people have more choice and control over the way in which their care is planned and delivered, based on 'what matters to them' and their individual strengths, needs and preferences. Services and interactions will be personalised where possible and appropriate.

We will work with (and not 'do to') residents in designing and delivering services, embedding co-production and supporting our communities to thrive. BLMK has published an updated Working with People and Communities Strategy which underpins this work, alongside our system's two Memoranda of Understanding with our **Healthwatch** and **Voluntary Sector** partners.

STATEMENT 3:

We will provide care as close to the resident's home as possible and design services that are 'seamless' for patients and carers.

We recognise that in some areas, health services can deliver better outcomes when delivered at scale with a critical mass of resources and expertise. In BLMK, we are fortunate to be close to several international centres of excellence to which our residents can have access. We will maintain and develop these partnerships. However, for many residents, receiving care as close to home as possible is a priority. All too often, patients travel to receive care rather than care coming to them with services being configured as they are for historical reasons, or for the convenience of the care provider.

We will work to ensure care currently delivered to our residents from outside of BLMK is provided locally in association with our **Integrated Care System (ICS)** partners unless there are very persuasive quality or economic barriers. Where appropriate we will ensure care is provided in the community rather than in our acute hospitals, and on an outpatient basis rather than through admission to a hospital bed where possible.

In doing this, the experience of patients will improve, and we can reduce the risks of deconditioning and additional healthcare-associated illnesses.

For people who do fall ill, the traditional structure and processes of the NHS have created services that can be inequitable and confusing. We will reduce complexity and duplication in order to deliver more joined-up care, with the patient less aware – or even unaware – of organisational boundaries.

Going forward, **integrated neighbourhood working** is a key foundation for our delivery. We will continue to support our place partnerships to build healthier communities through community-led approaches to health and wellbeing: Achieving integrated care through community and neighbourhood working – A High Impact Change Model is critical in setting out a future vision for primary care services as active partners in neighbourhood working.

STATEMENT 4:

We will embrace technology in the design and delivery of health services.

We are all aware of the huge advances driven by technology, particularly over the last 20 years. Most of us carry smartphones in our pockets with technical capability dwarfing the desktop personal computers of just a decade ago. As private consumers, we access information and services and make major choices about our lives from a device in our palm. Whilst there is advanced technology embedded in all parts of the NHS, it is not often known for good accessibility and intuitive user interface.

BLMK has been a testing platform for technological innovations – a new generation of surgical robotics, digital dictation, telemedicine, remote consultations, comprehensive electronic health records (allowing 'paper light' working), live linkage between freestanding record systems, cloud-based telephony in Primary Care, patient portals providing personal access to records and a platform for service interaction.

However, there remains unwarranted variation across our system, and many opportunities to 'go further faster', including in our use of the **NHS App**. We will prioritise digital enablement within our health services – for the empowerment of residents, for ease of access to services and in the delivery of those services themselves.

The BLMK Digital Strategy was developed in 2022 and sets out a wide-ranging programme of work, whilst remaining mindful of the potential of digital to impact healthcare inequalities for better or worse.

STATEMENT 5:

We will protect access to planned healthcare including operations and procedures.

In the summer of 2024, over 150,000 people were on waiting lists for planned care with acute providers in BLMK. Of these, 45% have been waiting for over 18 weeks to receive their first definitive treatment, with 10,000 people waiting for over a year.

Whilst long waits are found across the NHS and there are a multitude of contributing factors (including the pandemic, industrial action, current and historical funding constraints, rapid population growth, and increases in healthcare demand), it is not a satisfactory state of affairs. Secondary care services are failing to meet the needs or the reasonable expectations of residents and primary care is stretched to capacity holding the care needs of those awaiting the definitive specialist intervention that they require.

We are working hard with partners to recover from this poor position and to eradicate waiting times beyond thresholds set by NHS England, understanding how difficult it is for patients and their families to be waiting for the care they need. In the context of our population growth and demographic change, we should be under no illusion about the scale of the challenge in returning to acceptable and constitutional standards for waiting times, particularly for admitted care.

Going forward, we will find ways in which to prioritise and protect elective capacity whilst maximising the efficiency of our available physical estate (including operating theatres and procedure rooms for diagnostics and intervention). BLMK is one of only two systems in England without a dedicated 'elective care hub'. Whilst such hubs are no panacea, we will develop and progress plans to provide a dedicated and ringfenced footprint for elective care. We will also develop existing and new community diagnostic centres to increase diagnostic capacity, reduce waits and provide services closer to home. This will include work on progressing a community diagnostic centre for Luton and South Bedfordshire.

STATEMENT 6:
We will make investment decisions which promote a narrowing in health inequalities.

Significant differences exist in health outcomes across society. The differential impact of the pandemic on our communities offers a stark reminder of the advantages that some enjoy but others do not.

Here in BLMK, there are relatively modest differences in life expectancy for boys and girls born in each part of the ICS. However, **healthy life expectancy** varies across our four constituent Places (local authority areas). Women in Bedford and Luton can expect significantly fewer years of healthy life than the England average, whilst women in Milton Keynes and Central Bedfordshire can expect significantly more. Men in Central Bedfordshire can expect 8.7 more years of healthy life than their peers in Luton.

There is a strong association between these differences in outcome and socio-economic status. Around 122,000 BLMK residents live in areas amongst the 20% most deprived nationally. Other factors, including ethnicity, contribute towards the variation in outcome.

Whilst some outcome inequalities are driven by rates of disease which may in turn be influenced by genetic factors or risk factors associated with the environment, others may result from difficulties residents face in accessing preventative, diagnostic and treatment services.

The roles of poverty, housing and educational attainment are significant, and with only a limited set of levers available within the NHS to influence. However, by working together in our ICS, we commit to doing ever more to tackle these drivers of inequalities. Fundamental to this is developing our services alongside our disadvantaged populations such that inequalities are narrowed rather than widened.

BLMK is leading a significant programme of work in response to the publication of The Denny Review in late 2023: we are committed to following through on this work with meaningful actions over the long term. Our partnership with the **Institute for Healthcare Improvement (IHI)** is supporting us to learn from national and international best practice. Our improvement work and investment decisions will take account of the **'CORE20PLUS5'** approach advocated by NHS England. This approach focuses actions on **'5'** clinical areas in populations which sit within the **'20%'** most deprived in England and supports the local identification of other population groups who are outliers for access or outcomes – **'PLUS'**.

STATEMENT 7:
We will ensure that the shape and size of our workforce meet the needs of BLMK's population and support our people to make best use of their individual skillsets.

The NHS is amongst the largest employers in BLMK. In meeting the health challenges on the horizon, we must make the best use of all the expertise and skills available to us and foster a culture of integrated and collaborative working across health and care.

The NHS Workforce Plan articulates current concerns about staff shortages in the NHS which affect its ability to deliver timely and high-quality care and looks to increase the number of staff available for health services each year over the next decade. It does not however tell us how this can best be done.

We will develop systems and services that support a healthy, happy, and productive workforce, making BLMK a place of choice for health service staff. We know that highly trained healthcare staff are in short supply, and this will be exacerbated as the proportion of our population in work is set to fall with the demographic changes projected. It is imperative that highly trained staff spend more of their time doing things that only they can do, operating 'at the top of their licences', and making best use of their hard earnt and scarce specialist skills.

The BLMK Workforce Strategy looks to adapt and enact the national NHS Workforce plan for our population and its future needs. This work is also supported by the **Primary Care Strategy**[3] and we will continue to champion the work of our leading Primary Care Training Hub as an important part of this work.

3. Update to be published Autumn 2024.

STATEMENT 8:
We will ensure that value (financial and social) is key to decision-making.

The resources available for health services are not unlimited and additional resources are frequently sought. However, we recognise that we are already responsible for significant public expenditure each year and we must ensure these public funds are spent wisely. We must be mindful of the evidence base for expenditure (in terms of improved health outcomes) and intolerant of duplication and waste.

The Joint Forward Plan describes how the ICB medium-term financial planning model and associated financial principles inform how our organisations will work together to ensure resources are allocated fairly, with accountability and for the good of residents. These principles and an unremitting emphasis on value (financial and social) must be core to all of those working within the BLMK system.

STATEMENT 9:
We will act to ensure parity of esteem between physical and mental health.

The impact of poor mental health pervades our society. People with mental illness experience inferior physical health outcomes and are less likely to fulfil their life goals and economic potential. **Adults living with a 'severe mental illness' die 15-20 years earlier** than their peers from a range of conditions including cancer, cardiovascular, respiratory, and liver disease. The impact of the Covid pandemic on the mental health of children and young people has been particularly marked – at a national level, there are over three times as many children and young people in contact with mental health services than there were seven years ago.

Every part of society has a role to play in supporting positive mental health and wellbeing and in reducing associated stigma. We will agree a common approach to care across our services that places equal value on peoples' mental and physical wellbeing. Our work in this area is driven through the **BLMK Mental Health, Learning Disability and Autism Collaborative.**

STATEMENT 10:
We will work to deliver healthcare in an estate which is fit for purpose.

The physical estate from which we provide health services in BLMK is very variable. We face challenges in providing more space for services as demand grows, whilst also ensuring existing premises are replaced or renewed. The variation, and in some places the inadequacy of existing facilities, is perhaps most evident in primary care where we are supporting the development of integrated neighbourhood teams.

We will do all we can to attract capital investment into BLMK and ensure our use of available funds supports the delivery of services across each of our Places. Our collective plans for investment and development will be shared and coherent. We will continue to value and exploit the benefits of a shared public estate wherever possible, and to work collaboratively to ensure that section 106[4] funding and the Community Infrastructure Levy associated with new housing is put to best use.

We will ensure that the choices we make around the health services estate and service delivery favour low-carbon models that are suitably adapted to our changing climate. BLMK is currently refreshing its Infrastructure Strategy and sustainable estate is one of the elements of the ICS Green Plan.

4. Ministry of Housing, Communities and Local Government. Available at: publishing.service.gov.uk (accessed July 2024).

STATEMENT 11:
We will embrace measurement and a culture of continuous improvement.

Maintaining and improving the quality of service provision requires focus and commitment: it does not just happen. We will ensure **measurement and evaluation** are core to the commissioning, delivery and decommissioning of health services in BLMK. The pace of change required now is such that there must be a higher tolerance for experimentation and failure: the risks of such failure must be mitigated by forensic attention to data and a readiness to change.

Improvement science is a growing field but open-mindedness, measurement, and transparency – aligned to cycles of Plan, Do, Study, Act (PDSA) – are foundations for most methodologies. We will embrace the work of NHS Impact[5] in our system and make full use of our growing partnership with the IHI. The work of the **System Transformation Team (STT)** will be driven in large part by actively chosen priorities, including those articulated within this strategy. This work will be guided by our system's **quintuple aim[6]** – the advancement of health equity.

5. NHS Impact: www.england.nhs.uk/nhsimpact. 6. The Quintuple Aim for Health Care Improvement: Institute for Healthcare Improvement (ihi.org).

STATEMENT 12:

We will achieve excellent outcomes in maternity services and reduce neonatal harm.

Poor outcomes in maternity services can be devastating for families and are associated with long term socio-economic and health care costs. There are also known to be significant health inequalities in relation to maternity outcomes – Maternal and perinatal mortality reports show worse outcomes for those from Black, Asian, and Mixed ethnic groups and those living in the most deprived areas.[7]

We will apply improvement science and peer support in optimising our maternity and neonatal pathways. **BLMK's Local Maternity and Neonatal System (LMNS)** leads this work.

7. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK). Available at: MBRRACE-UK (accessed July 2024).

STATEMENT 13:

We will prioritise the health of children and young people, including those who are carers.

Life chances are often shaped prior to birth and reinforced in the early years. This truth is a key driver of inequities in health outcomes which persist throughout life. Providing high quality health services for children and young people presents challenges, notably in relation to the highly skilled workforce required.

We will look to maximise the potential of collaboration and joint planning across our system to ensure that services concerned with child development, learning disability, and physical and mental child health become and remain sustainable. We will fully support the delivery of the Early Years Strategies that exist in each of our four Places (Luton Education Strategy, Bedford Borough Early Years Strategy, Central Bedfordshire Council Early Help, Central Bedfordshire Council Education & All age Skills, Milton Keynes Early Help Strategy).

STATEMENT 14:

We will cultivate a healthy research landscape – improving access to portfolio studies and providing a fertile environment for collaborative local research.

An environment which contributes to the development of new knowledge through research is one which will value education, professional development and putting evidence into practice.

Research covers a broad spectrum: from multi-centre randomised controlled trials of a specific intervention through to pragmatic qualitative evaluation of practice, opinion, clinician behaviour or patient experience. Many frustrations evident in healthcare are not borne of a lack of knowledge, but rather barriers to implementing evidence, knowledge, and innovations in everyday practice. These various types of research each have value.

BLMK has unique opportunities. Located in the 'golden triangle' between the academic centres of Oxford, Cambridge, and London, we are home to several universities with distinct character and expertise.

Despite this, our great resource is largely untapped – the large and diverse population which is open to involvement in health service research.

Going forward, we will maximise the access of our patients to the National Institute for Health and Care Research (NIHR) portfolio studies, actively seek to develop and host studies examining wider pathways across health and social care and develop local capability to attract grant funding and deliver high quality home-grown research. Our approach will be driven by the strategy being developed by the **BLMK Research and Innovation Network**.

STATEMENT 15

We will own our roles as anchor organisations within the communities we serve and work to enhance social value.

Studies have shown that **80% of health outcomes are determined by non-health related inputs**, such as education, employment, income, housing, and access to green space.[8] With the introduction of the ICS structure in England, and the ambition for these new health systems to contribute to social and economic development, the role of the NHS as a collection of key anchor institutions has never been more important.

Acting as anchor institutions across BLMK, we can have a positive impact on our communities in the local economy and the environment which in turn have the potential to improve the health of individuals and communities. Some of the ways we can deliver our roles as anchor organisations include:

- **Employment (widening access to quality work):** Being an inclusive employer, paying the real living wage, creating opportunities for local communities to develop skills and access jobs in health and care
- **Procurement (purchasing for social benefit):** Purchasing supplies and services from organisations that embed social value to make positive environmental, social, and economic impacts
- **Housing, Estates and Land use (using buildings and spaces to support communities):** Widening access to community spaces, working with partners to support high-quality, affordable housing, and supporting the local economy and regeneration
- **Sustainability (reducing our environmental impact):** Taking action to reduce carbon emissions and consumption, reduce waste and protect and enhance the natural environment. In this, we will continue to build on the ambitions of the ICS Green Plan
- **Skills and Development (working closely with communities and local partners):** Collaborating with communities to help address local priorities, build on their energy and skills; and work with other anchors and partners to increase and scale impact.

8. NHS England Guidance. Available at: NHS England » Anchors and social value (accessed July 2024).

Expectations we have of one another

Our Commitments

We have set out the scale of the challenge facing health services in meeting the needs of residents over the years ahead, and we have presented the 15 statements above which describe the direction of travel and will act to guide us on the journey ahead.

However, this journey does not simply require a map and a compass; it requires us to all to have a common understanding of the desired destination and (both ourselves and our peers) to actually get there. In meeting the challenges within our integrated care system, we will be **only as strong as our weakest link**. The change that is envisaged cannot be limited to primary care and community services, with the commissioner and acute providers looking on passively. Likewise, if the commissioner and acute providers move forward together without mental health services and social care alongside, progress will be very limited.

We – and our residents – are **'in it together'** which in practice represents a major paradigm shift for the providers of health services. For some decades, health services have been composed of individual businesses (in the case of primary care) and sovereign organisations aiming to generate a financial surplus (in the case of acute providers) whilst engaged in the provision of high-quality healthcare. There was a 'commissioner-provider split', competition felt real and, at times, collaboration and working together were concepts which could be perceived as counter-cultural.

Relationships across BLMK have matured significantly since the geography was first described as a **Sustainability and Transformation Plan (STP)** in 2016. Partners across the system, and within the Places, know each other and there is more openness than in times past. The pandemic showed us all in a very real way how each part of the system had its strengths and contribution to make.

BLMK's Integrated Care Partnership (ICP) includes a diverse range of NHS organisations, four local authorities, wider public sector partners, multiple voluntary and community sector organisations and our Healthwatch partners. The Health and Care Act 2022[9], which established the integrated care systems, enshrined a duty to collaborate. Looking to the years ahead, it is timely to remind ourselves of what collaboration needs to mean in practice – behaviours we must commit to as individuals and organisations.

The ICP has previously articulated **shared 'principles and values'** and these are pertinent as we agree and then implement this Health Services Strategy:

- Co-production
- Learning and adapting
- Honesty and transparency
- Supportive
- Trusted relationships
- Person and community focused
- Integrity.

As is often the case with principles and values, they are expressed at a high level and are hard to disagree with. In the context of the Health Services Strategy, we must consider what they might mean in practice for the ICB and the many organisations which deliver publicly funded health services for the residents of BLMK.

With these statements, we ask ourselves **'What specific commitments do we need to make to each other?'**

9. Health and Care Act 2022: www.legislation.gov.uk/ukpga/2022/31/contents.

"We Commit" Statements

1. **We commit** to supporting and being respectful of one another, we will engage in peer review and act as critical friends.
2. **We commit** to always acting in the best interests of the population we serve recognising this may mean resources are invested elsewhere in the system.
3. **We commit** to being open and transparent in our dealings with one another, including with respect to data and financial information.
4. **We commit** to making decisions together and explicitly sharing risks associated with the actions we take.
5. **We commit** to calling out waste and duplication, and to being intolerant of silo working, even if this is not advantageous to our own organisations in the short term.
6. **We commit** to not act unilaterally. Where our decisions are likely to have an impact on our partners, we will engage them in the appraisal of options.
7. **We commit** to providing our staff with the skills to work collaboratively, and to leading by example within our organisations.
8. **We commit** to working together to bring additional resources into BLMK for the benefit of our residents.

Priority Work Programmes and Initial Workplans

With the statements and commitments outlined above, we can begin to consider how we might operationalise the strategy as we look to achieve our mission for 2040 – **ensuring that publicly funded health services are sustainable and that they achieve the best health outcomes possible for the BLMK population within available resources.**

We have been developing the strategy in the context of both the work that has already taken place in BLMK and that which may be taking shape now (for example, innovative models of care). We have reviewed the organisation and Place-based strategies, and the Denny review, and consider that the content of the Health Services Strategy is consistent and supportive. Where there is overlap, we see that as a positive thing.

Through the collaborative work already started across BLMK, we have several established 'vehicles' for implementing our strategy and delivering our mission, including:

- BLMK Mental Health Learning Disability and Autism Collaborative
- BLMK Local Maternity and Neonatal System
- BLMK Elective Collaboration Board
- BLMK Long Term Conditions Programme
- BLMK Cancer Board.

These vehicles will either continue in their current form and develop their important work or they will evolve. Overall, there will be **six priority work programmes** for the implementation of the Health Services Strategy.

The extant BLMK Clinical Senate will develop into a **Health and Care Professional Leadership Group (HCPLG),** established as a multi-professional clinical steering group to monitor, and influence the implementation of the Health Services Strategy going forward. The HCPLG will receive progress reports from each of the priority work programmes. As well as subsuming the current functions of the BLMK Clinical Senate, the HCPLG will act as a consultative forum on key issues and decisions being considered by the ICB.

It is important to note that although this is explicitly a health services strategy – as opposed to a health and care strategy – the priority work programmes will require a collaborative approach from health and care. The HCPLG will seek the wholehearted involvement of local authority leaders in adult social care and children's services.

The six priority work programmes, including three new programmes, which will together act as delivery vehicles for the Health Services Strategy are described below, along with the rationale for their creation. The work programmes are deliberately high level – the work upon which they focus will iterate and develop over the years as issues are dealt with and new challenges emerge. Potential areas of focus for the first two years of the priority work programmes are articulated in more detail and will be soon translate into **SMART** (**S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime-bound) goals and objectives.

The use of data (population health and other) will be absolutely core to the six work programmes. We know a lot about the health and needs of our population and have been working alongside our Public Health colleagues in developing the strategy. Whilst the detail of this information is not explored in the strategy document, it must and will guide the work programmes in its implementation.

Table 1: Six Priority Work Programmes

		Priority Work Programmes	Led by
ESTABLISHED	1	BLMK Mental Health Learning Disability and Autism (MHLDA) Collaborative	As presently
	2	BLMK Children and Families (To incorporate Local Maternity and Neonatal System – LMNS)	As presently
	3	BLMK Cancer Board	As presently
NEW	4	Long Term Conditions – Health Optimisation (To incorporate the current BLMK Long Term Conditions Programme)	ICB and Primary Care
	5	Improving urgent and emergency care (UEC) and reducing unnecessary hospital stays	Local Authorities, Acute and Community Providers
	6	Fragile Services – Access to secondary care, critical mass, peer support and learning (To incorporate the current BLMK Elective Collaboration Board)	Acute Providers

1 The BLMK Mental Health Learning Disability and Autism (MHLDA) Collaborative

BLMK has amongst the **highest levels of mental health need in the region**, with significant growth (in both demand and acuity) in the aftermath of the pandemic. In 2022/23, there were:

Around **8,000** adults registered in primary care with a serious mental illness (5% growth since 2019/20)

Around **6,500** adults with dementia (↑19% since 2018/19)

Around **90,000** adults with depression and/or anxiety (↑33% since 2018/19)

Around **12,000** referrals to child and adolescent mental health services (CAMHS) in 2021/22 (↑200% since 2018/19)

The NHS spends approximately £224m on specifically commissioned mental health, learning disability and autism services in BLMK. Our Mental Health Investment spend stands at £176 per head of weighted population, which is just below the England average.

BLMK has made considerable progress delivering the NHS Long Term Plan for Mental Health whilst tackling quality and financial pressures. We have:

- Opened **new services** including Evergreen (BLMK-wide inpatient ward for children and young people); additional mental health teams in schools; additional crisis cafes; and the East of England Gambling Service
- Begun an ambitious programme of **transformation of community mental health services**, building community teams around neighbourhoods and working in a more integrated way with GPs, voluntary, and social care
- **Begun to expand and diversify our workforce**, including new roles such as peer support workers, mental health pharmacists, mental health practitioners in educational settings, clinical associates in psychology, and community connectors
- Worked with local authorities to develop **prevention initiatives** (through the prevention concordat for better mental health[10]), and a suicide reduction partnership and plan.

Despite progress, improvement in focus and investment over recent years, multiple challenges and opportunities remain. People are staying for longer in hospital and we have seen an increase in out of area placements. There are also opportunities for us to work together to improve accommodation options for people with mental health conditions to be more recovery orientated and support independent living.

We know that people with mental health conditions, people with learning disabilities, and people with autism continue to achieve poorer physical health, employment opportunities, opportunities for social connection, lower income, and poorer housing than the general population. This is compounded for some communities including people in poorer areas, and those from black and minority ethnic communities: parity of esteem for mental health continues to be a pressing challenge.

The **BLMK Mental Health Learning Disability and Autism Collaborative (MHLDA)** is a partnership between BLMK ICB, ELFT (East London NHS Foundation Trust) and CNWL (Central and North West London NHS Foundation Trust) to deliver a **"one team"** approach to improve outcomes, quality, value, and equity for people with, or at risk of, mental health problems, learning disabilities and autism. Our vision puts a focus on place, with service user voice at the centre. It refocuses our efforts on addressing inequalities and unwarranted variation and working at scale where it makes sense to do so.

At the heart of the collaborative approach is to understand what the real issues are for local people and working together to deliver the solutions. Our priorities are set by service users, carers and our communities starting with, **'what matters most to service users and carers':**

- Improved communication.
- Access to care and support being appropriate and timely
- Care being more informed, consistent, connected, and seamless
- Better access to key resources and services which empower service users
- Care that is person-centred and tailored around the individual not the condition.

Specific areas which the MHLDA Collaborative will focus on over the medium to long term:

1. Development of **sustainable early intervention and crisis recovery pathways** for children, young people, and adults.
2. Develop capacity to deliver early local diagnosis and support for people with **autism and autistic spectrum disorder**.
3. Development and implementation of sustainable recovery-focused models of care for people with **complex needs**. This includes complex placements being provided within the ICB area as standard.
4. **Capital development in core services**, for example mental health inpatient development in Bedford.
5. Improving **physical health access and outcomes** for people with serious mental illness, learning disability and autism, as part of the delivery of the BLMK Learning Disability and Autism Strategy.

The MHLDA, led by **Mental Health Providers**, will involve all partners and will incorporate the work of the Learning Disability and Autism Transformation Board, the BLMK Mental Health Programme Board and the BLMK Children & Young People's Local Transformation Plan.

10. www.local.gov.uk/prevention-concordat-better-mental-health.

2 BLMK Children and Families – Incorporating the work of the LMNS

The BLMK Joint Forward Plan sets out some stark reminders of the problems children and their families may face across our system:

- Too many of our children in BLMK live in **poverty**
- Over a third of children in BLMK are **overweight** – this is a key risk for future health & wellbeing
- Not all children and young people have **early key interventions** during primary school years to enable them to thrive (communication, diagnosis and support for dyspraxia, autism spectrum disorders, emotional resilience)
- There is more we can do to **support transition to adulthood** for young people with complex needs
- Children and young people are **waiting too long** to access mental health and wellbeing services
- **Maternity inequalities** – poorer outcomes for BAME communities – with higher risk of death in this cohort in pregnancy. Higher risks of still birth, maternal, neonatal and infant mortality in 20% most deprived.

The **BLMK Early Years Seminar** in November 2023 brought together partners to further develop the four Places' Early Years Strategies. Each local Place has also launched a guide to help young people looking for mental health support. These steps represent commitment to the start of a long but critical journey to improve the lives and physical and mental health of our young people.

The BLMK Children and Families programme will work closely with the MHLDA work programme to ensure that the mental and physical health of children and young people is championed and joined-up, with the young resident and their family at the centre.

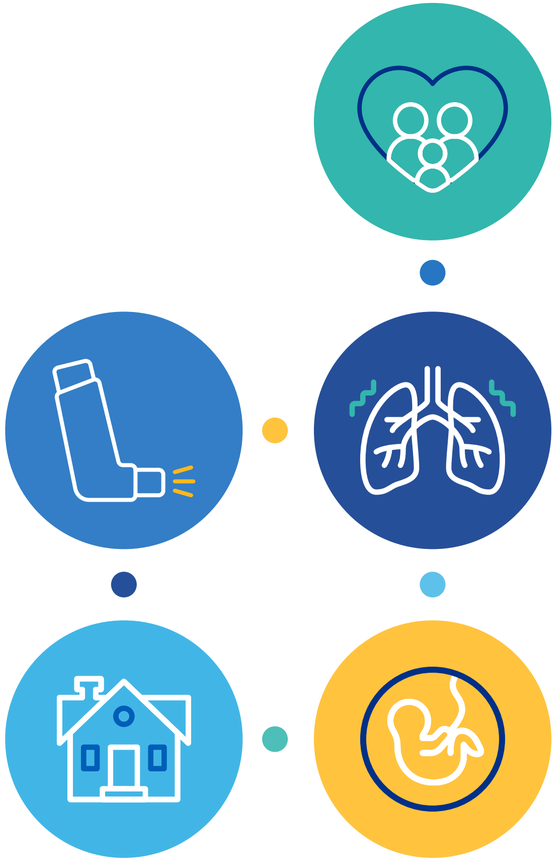
PRIORITY ACTION: Improving asthma management for children and young people with the highest risk of exacerbation, admissions, and poor outcomes

Hospital admissions for asthma for children and young people under 19 years old are significantly higher in BLMK when compared to the England average, particularly in Luton.[11, 12] We aim to decrease the number of people with asthma diagnoses without record of spirometry, reduce the proportion of people with asthma who have an over-reliance on 'reliever' inhalers, and reduce the gradient of socioeconomic deprivation with respect to asthma outcomes. We will work toward this aim through a range of interventions:

- Continue to encourage a **proactive approach to care**, with additional reviews for people with objective evidence of unmet need – improving outcomes and reducing inequalities
- Use **system alerts and tools** to support identification of cohorts for intervention
- Encourage evidence-based practice to avoid **SABA (short-acting beta-agonist) overuse**, incentivising primary care partners to review those with frequent SABA scripts and address unmet need
- Encourage evidence-based diagnostics according to national best practice guidelines, continue to invest in **spirometry equipment and staff training**
- Explore further **digital education tools for children** about asthma and inhalers, and learn from evaluations of current tools
- Promote greater adoption of inhaled **therapies with reduced environmental** impact for managing common respiratory conditions
- Build on existing work with partners across the ICS focused on the **wider determinants of health** e.g. the asthma friendly school scheme in Luton; housing and health group; working with Public Health teams on smoking cessation and work to address childhood vaping; outdoor air quality, green spaces and exploring the link between asthma management and outcomes with ethnicity and deprivation.

11. Office for Health Improvement and Disparities (data from 2020/21 – 22/23). Available at: Fingertips Public Health Data (accessed June 2024).

12. Data from Arden and GEM Clinical Support Unit.



BLMK Local Maternity and Neonatal System (LMNS)

The LMNS has a crucial role in ensuring women, babies and families receive safe, personalised and equitable care during pregnancy, childbirth and the early postnatal period. In BLMK this comprises of two hospital trusts, providing maternity and neonatal services across three hospital sites, two **Neonatal ODNs**[13], local **Maternity and Neonatal Voices Partnerships (MNVPs), Public Health** and wider partners.

Our vision for maternity and neonatal services across BLMK is to offer safer, more personalised, and family friendly care, where our residents have access to the information they need to make the most informed decisions about their care.

Women and their babies should be able to access support that is centred around their individual needs and circumstances and our plan is committed to reducing health inequalities in maternity and neonatal care.

13. Operational Delivery Network: Developing Operational Delivery Networks (england.nhs.uk).

Below are the priorities which the LMNS has set out to deliver, as part of this health strategy, in line with the NHS England Three-Year Delivery Plan for Maternity and Neonatal Services' four key aims:

1 Listening to women and families with compassion

- Involving service users in co-production of services by establishing local MNVP to ensure inclusion of the patient voice throughout the programme.

2 Meeting and improving standards

- Commissioning sustainable Smoke-free Pregnancy Pathways that reduce the number of women who smoke at time of delivery
- Preconception Care Programme offering support for mothers before pregnancy including managing a healthy weight and clinics to support with complex long-term conditions
- Social Prescribing to support pregnant women in East Bedford and Caritas Medical Primary Care Network, to increase uptake of early booking and engagement with maternity services
- Culturally Sensitive Genetic Risk Services Project improving access to genetic services and raising awareness – Luton is identified as one of 10 areas across the country for this pilot
- Supporting the implementation of **Neonatal Critical Care Review Action Plan**[14] priorities.

3 Developing and sustaining a culture of safety

- Promoting good practice for safer care including ambition for system wide delivery of the **Saving Babies Lives Care Bundle**[15] to reduce maternal and neonatal deaths, still birth and premature births
- Working to reduce variations for women from ethnic minority backgrounds, and those living in the most deprived areas
- Improving access to perinatal mental health services
- Improving prevention work with public health to improve women's health before, after and during pregnancy
- Transforming neonatal critical care in partnership with specialist commissioning ODNs
- Development of an LMNS Dashboard to set out variation and inform quality Initiatives
- Overseeing and monitoring the implementation of **Ockenden**[16] immediate and essential actions.

4 Supporting our workforce

- Working with NHS England to ensure the right skills and workforce to deliver against local workplans
- Developing the Maternity Support Workers programme across the Trusts
- Monitoring and implementation of the **Core Competency Framework for Maternity**[17].

14. Implementing the Recommendations of the Neonatal Critical Care Transformation Review - www.england.nhs.uk.

15. Saving Babies Lives Care Bundle - www.england.nhs.uk.

16. Ockenden report: Findings, Conclusions and Essential Actions from the Independent Review of Maternity services are The Shrewsbury and Telford Hospital NHS trust: assets.publishing.service.gov.uk.

17. Core competency Framework for Maternity: england.nhs.uk.

3 BLMK Cancer Board

The NHS Long Term Plan sets out clear objectives for how cancer services should be delivered to meet the ambition to transform cancer services. The **BLMK Cancer Board** established in 2017 has led the effective planning and implementation of strategic objectives for cancer services across the BLMK health economy and will lead this workstream.

The Board has four overarching focus areas:

1. **Preventing cancer** by addressing cancer risk factors
2. **Diagnosing more cancers early**, increasing the proportion of cancers diagnosed at stage 1 and 2 resulting in fewer cancers diagnosed as an emergency, and an increase in one and five-year survival rates
3. **Improving cancer treatment and care**. All patients should have access to high-quality modern therapeutic services. They will be cared for during and after their treatment, with increased support to live well after treatment. Patients will have a better experience of their care, with less unwarranted variation
4. **Proactive patient engagement** to ensure that the patient is at the centre of service delivery and their views are actively sought and incorporated.

PRIORITY ACTION: Improving prevention, screening, and early diagnosis of cancer in women

There is already a programme of work in place linked to delivery of the NHS Long-Term Plan and National Cancer Transformation Programme, however the variation in cancers affecting women has become a clear priority that will require a system lens to deliver and must therefore be a priority for us:

- Cancer is one of the **leading causes of death** in women
- Evidence suggests that cancer treatment is more successful and survival rates higher when the disease is **diagnosed early**[18]
- There is **variation in cancer screening uptake,** and in the **uptake of HPV vaccination**
- **Mortality rates** from cancer are higher for women than men across all four Places within BLMK[19]
- Feedback received from women on **perceived barriers to accessing healthcare** give us insight to improve
- We see **increased risk factors linked to obesity**.[20]

Breast cancer is the most common cancer in the UK for women, accounting for almost a third (30%) of all female cases (2017-2019). The next most common are lung cancer (13%) and bowel cancer (11%). Cancers of the uterus and ovary are the 4th and 6th most common respectively.

Gynaecological cancer referrals to secondary care have increased significantly over the last 3 years. For the gynaecology urgent suspected cancer pathway, referrals are now at circa 150% of pre-pandemic levels impacting on cancer performance and increasing the demand for diagnostics. This rise in demand demonstrates the need to be able to appropriately triage, confirm or rule out cancer quickly to avoid unnecessary anxiety for women.

In November 2023 the NHS made a pledge to **eliminate cervical cancer by 2040**. To meet this challenge, the NHS needs to ensure as many people as possible are being vaccinated against the human papilloma virus (HPV) and coming forward for cervical screening.

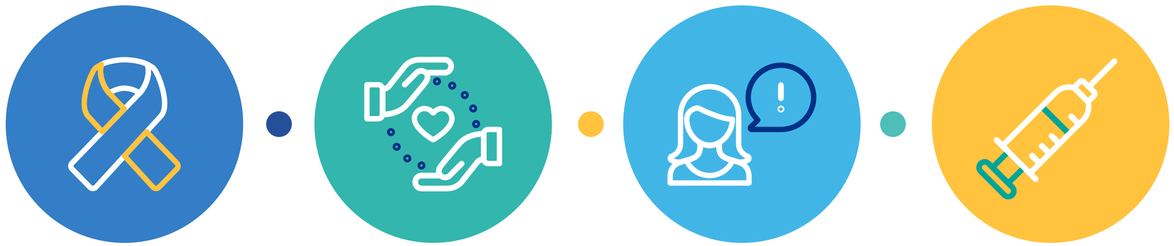
Across BLMK, HPV vaccination uptake of two doses in both males and females aged 13-14 years old is significantly lower than England average and this pattern is seen across all our four Places.[21]

18. Cancer Research UK. Available at: Why is early cancer diagnosis important? | Cancer Research UK. (Data sources referenced: 1. Office for National Statistics. Cancer survival in England: adult, stage at diagnosis and childhood - patients followed up to 2018. 2019 2. National Institute for Health and Care Excellence (NICE). Suspected cancer: recognition and referral. 2021. 3. NHS Digital. Cancer survival in England; cancers diagnosed 2015 to 2019, followed up to 2020. 2022).

19. BLMK Place Based Profiles, 2022 refresh document.

20. Cancer Research UK. Available at: Overweight and obesity statistics | Cancer Research UK (accessed July 2024).

21. Office for Health Improvement and Disparities (data from 2022-23). Available at: Fingertips Public Health Data (accessed June 2024)



Early Detection Opportunities:

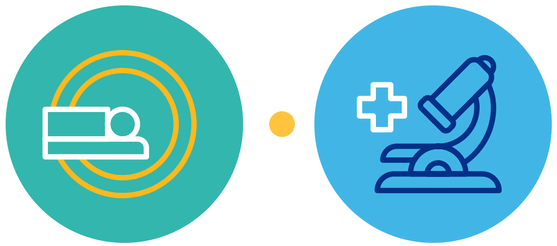
Cancer screening is an example of secondary prevention[22], designed to detect cancer early, increasing the chances of successful treatment outcomes.

In England, there are three national screening programmes:

- **Bowel cancer** screening offered every two years to those aged 60-74
- **Breast cancer** screening offered to women aged between 50 and 70 years
- **Cervical cancer** screening available to women and people with a cervix aged between 25 and 64 years in England. Cervical cancer is the most common cancer in women under 35. If all eligible women attended cervical screening regularly, **83% of cervical cancer deaths could be prevented.**

Targeted **lung cancer screening** has recently been recommended by the UK National Screening Committee, advising that screening be offered to the high-risk group of people aged 55 to 74 years with a history of smoking.

In BLMK, with the exception of breast cancer, uptake of cancer screening has been below the England average over the last 10 years. In the younger cohort (age 25 to 49) for cervical screening and bowel screening, there is some correlation between uptake and deprivation.



Opportunities for improvement:

- Increased focus on **preventing** cancers in women – interventions such as smoking cessation programmes, HPV uptake and tackling rising obesity
- Finding more ways to help women **recognise cancer signs** and the benefits of national screening programmes, particularly for communities who do not typically come forward, increasing the risk of late presentation
- Encouraging awareness and continued adoption of **NICE guidelines** amongst primary and secondary care clinicians
- Having the right **screening and diagnostic capacity** and resource for the projected rise in need for services – building an agile workforce that can flex across organisation, sector, and geographical boundaries to make sure this is not a cause of avoidable delays in diagnosis and treatment
- Intelligent use of **population health data** to understand the future incidence of cancers that affect women to plan service provision and design proactive targeted intervention to better serve areas with poor outcomes
- There is good compliance against the 62-day standard for cancer treatment from point of referral for Breast cancer. However, we have more work to do to improve performance for **Gynaecology, Lung**, and **Colorectal** treatment pathways:
    - Continued **innovation** to support personalised, targeted treatment of cancer such as genetic testing and use of AI, ensuring seamless embedding and scale across the system to avoid a "postcode lottery"
    - **Improved access** to radiotherapy and other oncology services as well as clinical trials.

This work programme will be led by the **BLMK Cancer Board** and will in particular involve **Primary Care** partners who are major participants in the work of the Board and will inevitably play a critical role in working towards a proactive and preventative approach to treating cancer.

22. Secondary prevention: systematically detecting the early stages of disease and providing treatment before full symptoms develop.

4 Long Term Conditions – Health optimisation

Healthy life expectancy varies significantly across BLMK. In Central Bedfordshire, men can expect to live healthily until the age of 68 on average, whilst in Luton, only 59 years of age. Whilst the life expectancy of men in the two places differs by only 2.5 years, the men of Luton can expect over 6 years more living in ill health. Often, people will have several co-existing long-term conditions and the impact of these on quality of life may be cumulative.

The burden of long-term conditions is significant, and the management of each is increasingly complex. We have developed a system in which the role of the clinical specialist is much valued: however, **patients with multiple long-term conditions often benefit from the input of an expert generalist clinician**. General practice and broader primary care are under significant pressure in the context of this burden and ever-growing volumes of relatively straightforward 'transactional' urgent care demand which prevent the required focus on optimal long-term disease management.

The **long-term conditions programme** will bring partners together to ensure that the prevention agenda and the optimal management of long-term conditions are championed. It will work to ensure that contracts, funding, and primary care expertise are aligned to the needs of residents: receiving care from the most appropriate member of the team as close to their home as is feasible. **Care delivery models should be determined by the needs and wishes of patients, and not by custom and practice**.

A key metric for this work will be a **reduction in premature mortality** (specifically, all-cause mortality under the age of 75 years). Cardiovascular disease (CVD), respiratory disease, and cancer are the leading causes of death across BLMK, and collectively they contribute the most to the life expectancy gap seen between our most and least deprived neighbourhoods.

The work undertaken beneath the umbrella of long-term conditions will iterate over time as there is a vast array of long-term conditions which would benefit from focused collaborative working. However, a surfeit of priorities results in a failure to prioritise anything.

Initial areas of focus which will be confirmed by the priority work programme are likely to include:

1. Identifying hypertension in the population and treating effectively to target – BLMK is the poorest performing ICB in the country at **treating people with known hypertension to target**
2. Reducing the prevalence of **musculoskeletal (MSK) conditions** and improving timely management
3. Reducing number and duration of **admissions to hospital with heart failure – age-standardised rates of admission to hospital with heart failure in 2023 were higher in BLMK than any other ICB in the East of England (data from the East of England Cardiac Clinical Network). The optimisation of medicines for heart failure, particularly SGLT2i and MRA, is currently suboptimal**
4. Optimising information and access for residents living with long-term conditions through roll out of the **NHS App**.

PRIORITY ACTION: Improving identification of hypertension in the population of BLMK and treating effectively to target

Across BLMK, **approximately 40% of people with hypertension are not managed to their BP target**.[23] There is significant variation between deprivation deciles and between both primary care networks and practices across BLMK. Improving hypertension management is the area of greatest potential for BLMK to prevent future cardiovascular events and deaths and will undoubtedly have a beneficial impact on other areas of secondary prevention, including lipid management and care for people with diabetes.

Work on this has already begun in Primary Care and significant steps forward have been made: promoting of **population health management approaches** in primary care for managing long term conditions, including hypertension, with resourcing through the **BLMK Primary Care Framework**.

- Rollout of the **BLMK Hypertension Protocol**, recommending evidence-based approaches to treatment with optimal efficiency, thereby minimising therapeutic inertia, loss to follow-up and health service utilisation
- Local **incentivisation to BLMK GP practices** for BP recording in people with hypertension, noting that higher levels of BP recording are directly linked to improved levels of treatment to target
- Commissioning of an **SMS-based tool to support self-monitoring** of blood pressure, medication concordance, lifestyle change and data recording in GP systems
- **Additional capacity** for clinical reviews to manage blood pressure through place-based inequalities funding in Bedfordshire.

23. CVD Prevent. Available at: cvdprevent.nhs.uk (accessed June 2024)

We aim to improve further blood pressure monitoring and recording for people with known hypertension, and to increase the proportion of people treated to NICE-recommended targets (aiming for >80% by end of 2025), whilst also reducing the gradient by socioeconomic deprivation. There will be a particular focus on high-risk groups of people with hypertension – such as those with known cardiovascular disease, diabetes, or renal disease. Specific areas of focus to achieve this include:

- Enhanced upstream detection and intervention in respect of the **risk factors associated with hypertension** (including smoking cessation, weight management and support for drug and alcohol misuse)
- Working with ICS partners to **increase referrals to preventative services**
- Encouraging increased recording of blood pressure (BP) in people with known hypertension. Continue ongoing work between the ICB, Primary Care Networks (PCNs), practices and public health to encourage a **proactive approach to care**, using population health management tools to support the identification of people who have not had their annual review
- Expanding and identifying further opportunities for funding to provide reviews for people with objective evidence of **unmet need**
- Greater awareness and use of the streamlined **BLMK Hypertension Protocol**
- Increased use of an existing SMS-based tool and further digital technology to support BP management including tools to help people with **home recording and self-management**.

PRIORITY ACTION: Reducing the prevalence of musculoskeletal (MSK) conditions and improving timely management

Across BLMK there are **approximately 80,000 referrals made each year into community MSK services**. MSK conditions are a leading cause of disability and sickness absence across BLMK, with significant inequalities by deprivation and ethnicity.[24, 25, 26] We know that MSK conditions are more common in older age groups,[27] therefore we predict a significant increase in demand for MSK services with the forecast demographic change in our population which is outlined elsewhere in this strategy.

Currently MSK services vary across BLMK, and there is the opportunity for redesign to improve outcomes, as well as patient experience, whilst navigating through what is currently a complex pathway. In partnership with **HealthWatch** we have undertaken resident and stakeholder engagement, both with general population and underrepresented groups, to understand views on the current services and to identify key themes for improvement. This will support the co-design of the service specification going forwards as we work to optimise the service offer in BLMK for people with MSK conditions:

- We look to implement a stratified care model, where the level of intensity of support is dependent on the level of a service user's complexity and need, delivering a personalised approach. This model will:
  - Have a greater focus on **preventing** key risk factors associated with MSK conditions including: smoking cessation; support with weight management; and, menopause support. Health professionals will have access to health promotion materials and knowledge of the local and national preventative services available, and patient information will be available to empower service users.
  - Promote **self-care, earlier intervention, and timely access to appropriate interventions** (surgical and non-surgical) and fostering prehabilitation and rehabilitation.
  - Identify how service users wish to be communicated with and have adaptable resources and communication channels to meet service users' needs.
  - Provide a responsive service which will see the person as a whole. In particular, for those with additional mental or physical health conditions, identify a **spectrum of needs in order to develop a bespoke and complete treatment plan**. For example, this might include referral for talking therapy or signposting to local physical activity offers.

The long-term conditions programme will continue to build on this work. It will be **led by Primary Care and the Integrated Care Board** and will involve all partners.

24. Global Burden of Disease Study, CBD Compare. IHME. Available at: vizhub.healthdata.org/gbd-compare (accessed August 2024).

25. Official Census and Labour Market Statistics. Nomis. 2018. Available at: www.nomisweb.co.uk/datasets/besa (accessed 2024).

26. BLMK Work, Worklessness and Health completed by Public Health Evidence and Intelligence team. Data sources include: HSE. Work-related musculoskeletal disorders statistics in Great Britain, 2021. Available from www.lancashire.gov.uk and HSC HSE's Health & Safety at Work Stats for 2021/2022 Are Here (2022) Available from: hcssafety.co.uk.

27. Office for Health Improvement and Disparities. Musculoskeletal health: local profiles. Available from: fingertips.phe.org.uk (accessed 2024)

5 Improving urgent and emergency care (UEC) and reducing unnecessary hospital stays

We are all aware of the unrelenting pressure on urgent care and increases in the number of non-elective admissions to the acute hospitals. This pressure has direct cost and opportunity cost in relation to the negative impact on planned care. Unnecessary admissions to an inpatient environment cause deconditioning, institutionalisation, and loss of independence for residents.

Up to 20% of emergency hospital admissions are avoidable with the right care in place. Improving and supporting the capability of primary care and community-based services to avoid admission and hasten discharge is vital in the context of growth projections for the older population. Collaborative team working, managing clinical risks across the system aligned with the patient (rather than within the silo of an organisation) will be key to this work.

Initial areas of focus will be:

- Development of services which aim to **avoid overnight hospital admissions**
- Expansion of **virtual ward services** with a focus on outcomes and value for money
- Positively identifying those likely to be in the final two years of life and **improving end of life care**
- Supporting the growth of **new care models** focusing on local need and development of integrated neighbourhood teams.[28]

28. Integrated Neighbourhood Teams based around Primary Care Networks, which is part of the BLMK response to the Fuller Stocktake Report.

The Improving UEC programme, **led by Local Authorities, Acute and Community Providers**but will involve all partners. Collaborative team working, managing clinical risks across the system aligned with the patient (rather than within the silo of an organisation) will be key to this work. This programme will recognise the need for a range of interventions across the boundaries of neighbourhoods, places, the county of Bedfordshire and the wider ICB geography. It will capitalise on the excellent work commenced by the Bedfordshire Care Alliance (BCA) and MK Joint Leadership Team (JLT).

6 Fragile Services – service sustainability, access to planned care, critical mass, peer support and learning

Clinical services may be fragile for many reasons including workforce, finances, and quality. Some services may struggle to reach or maintain a critical mass in the modern context of clinical acuity, working patterns and sub-specialisation. Our context in BLMK is an unusual one; we do not have a traditional tertiary centre[29], and our geographical situation within the 'golden triangle' can be seen as both a gift and a curse.

In the recent past, the environment has not encouraged acute providers to share their challenges or operational weaknesses. **Now, in 2024, shared data and peer benchmarking, although imperfect, represent major steps forward in understanding our challenges as a system:**

- We need to make meaningful attempts to **understand significant variation** between local services (in relation to cost or quality outcomes) so that we can identify pragmatic improvement actions
- We use large numbers of **premium temporary staff** across our services, without first exploring the potential for mutual aid from peers
- Neighbouring services are not routinely looking at their granular performance data such that **symbiotic support can be offered** in specific service lines.

The fragile services programme will work to ensure that services within organisations form links and connections with peers, and that apparently unwarranted variation is explored and understood. Through building relationships and trust, services will have the opportunity to learn from one another and over time, the potential to develop alliances, reducing the bureaucracy and duplication inherent in aspects of process and governance. There will also be an opportunity to understand variation within the services offered to residents by the various tertiary providers.

Initial areas of focus may include:

1. Laboratory sciences
2. Vascular surgery
3. Diagnostics
4. Ophthalmology
5. Audiology
6. Neurology
7. Dermatology.

The initial areas of focus identified sit largely within the acute sector. Whilst primary, community and mental health have fragile services too, we are mindful of the risk of reducing focus on the major issues facing the acutes that require urgent attention.

An acute provider collaborative is necessary and overdue, and the fragile services programme will predominantly involve the **Acute Providers**, forming the basis of a meaningful acute provider collaborative in BLMK. That said, the full participation of community providers in the fragile services group will be encouraged and the workstream will maintain a specific interest in interface services (for example, Paediatric Audiology).

This work programme will subsume the current **Elective Collaboration Board**.

29. Tertiary care refers to "highly specialised treatment such as neurosurgery, transplants and secure forensic mental health services" (www.nhsproviders.org - © NHS Providers 2024).

Engagement in the development of the Health Services Strategy

The Health Services Strategy has been developed over the course of 2023 and 2024 and belongs to the organisations providing publicly funded health services in BLMK – many of which are partners in the BLMK Health and Care Partnership. These organisations have been involved in the inception and development of the strategy.

We have engaged with leaders of these organisations over a period of several months and the strategy has matured by iteration.

In addition to these specific engagement sessions, colleagues from across the system have contributed their thoughts and ideas on the strategy as it has evolved. The strategy is richer as a result.

Table 2: Key engagement sessions have included (non-exhaustive):

Date	Event	Locality	Sector
17 Apr 2024	BHFT / ICB Board to Board Seminar	Bedfordshire	Acute
23 July 2024	BHFT Executive Group	Bedfordshire	Acute
04 July 2024	MKUH / ICB Private Board	Milton Keynes	Acute
01 July 2024	Session with Executive Leads of ELFT and CNWL	BLMK	Community and Mental Health
18 July 2024	Session with MK Joint Leadership Team	Milton Keynes	Place
23 July & 20 August 2024	BLMK Clinical Leaders and PCN Clinical Directors Meeting (including representatives of Local Medical Committees, LMCs)	BLMK	Primary Care
31 July 2024	ICB Executive Meeting	BLMK	ICB
19 & 30 August 2024	Sessions with ICB Non-Executive Members and Primary Medical Services Providers Partner Members	BLMK	ICB and Primary Care
29 Aug 2024	Place Board	Central Bedfordshire	Place
09 Sep 2024	Executive Delivery Group (Bedford Borough Council)	Bedford Borough	Place
10 Sep 2024	Place Board	Luton	Place
11 Sep 2024	Healthwatch - Chief Executive Officer	BLMK	ICS – resident voice
13 Sep 2024	Quality and Performance Committee	BLMK	ICB
19 Sep 2024	Health and Care Partnership Meeting	BLMK	ICB
19 Sep 2024	BLMK CEO Group Meeting	BLMK	ICB
27 Sep 2024	Integrated Care Board Meeting	BLMK	ICB

Implementation of the Health Services Strategy

This strategy was presented to the Board of the ICB in September 2024 and approved for formal adoption. Once published, we will move to the implementation phase of the Health Services Strategy which initially focuses on the setting up, reshaping, and resourcing of the six priority work programmes (delivery vehicles) and the **Health and Care Professional Leadership Group (HCPLG)**.

Each of the six priority groups will develop an initial 24-month work programme with detailed goals around the initial areas of focus in this strategy and guided by **SMART** metrics. These will be presented to the Integrated Care Board for agreement within six months of the ICB's adoption of the strategy.

Establishing a culture of measurement and improvement is included as one of the 15 commitments of our strategy, and a focus will be to establish key clinical metrics to assess performance on and provide the board with clarity on how we are trying to move things at a population health level. Each of the work programmes will also wish to pay attention to **workforce modelling** and will be supported in this through the **BLMK People Strategy** and our **Primary Care Training Hub** as appropriate.

A formal appendix to the strategy will be published (within 8 months of its adoption) detailing these six SMART priority work programmes.

Next Steps – Building to 2040

As the work programmes evolve and grow, so too will their priorities. After the first 24-month cycle of work initially laid out, the programmes will agree updated priorities and work plans for the next period. These will continue to iterate over time supported and guided by the Health and Care Professionals Leadership Group. The workstreams will continue to provide updates to the Board of the ICB which will hold our organisations to account against the statements and commitments made within this strategy.