BLMK
Integrated Care System

Living longer in good health

Bedfordshire, Luton and Milton Keynes Longer Term Plan (2019 – 2024) for improving health and care

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Bedfordshire, Luton and Milton Keynes Longer Term Plan

Foreword

This is our plan for health and care in Bedfordshire, Luton and Milton Keynes (BLMK) for the next five years.

It is clear on our aims and partnership focus. Only by working together can we achieve the improvements in people's wellbeing and health that we want to see.

We are signing this document off at a moment in time, but we recognise that we will fail if what is contained here is set in stone. We will need to keep improving and developing in how we work and what we are seeking to achieve. More detailed work will follow, establishing the key implementation steps as part of operational planning for 2020-2021.

Richard Carr
SRO for BLMK Integrated Care System
on behalf of Our Partnership
3rd March 2020

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Summary

Summary

The organisations responsible for health and care in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes are working together to improve the wellbeing and health of the population they serve.

This partnership has been going since 2016 and has already made some improvements (see box below).

What we have achieved together

- Acknowledged leader in Primary Care Network Development.
- Delivered more support for children and young people's mental health, including mental health support teams in schools and Kooth, a new online service.
- Secured £99.5 million capital money for the redevelopment at the Luton and Dunstable Hospital site.
- Social prescribing (identifying non-medical solutions to wellbeing issues) in place across the partnership.
- Obtained national resources for programmes to improve population health management, strengthen the role of the voluntary sector and make greater use of volunteering.
- Award winning High Intensity User service spreading from Milton Keynes to Luton, Bedford Borough and Central Bedfordshire.

Now we are setting out our plans for the next five years. The goal in everything we are doing is to achieve the vision we have agreed as a partnership:

"Improving our people's health, enhancing their quality of care and being a great place for our staff to work, all whilst delivering value for money."

We want people to live longer in good health. When people need care they should get the very best available. We should be good employers that retain high quality staff and we have a duty to spend public money wisely on the services that will make the biggest difference.

To determine our priorities at the next level of detail, we have spoken to our population (see box below), we have responded to the commitments in the national *NHS Long Term Plan* and we have built on national and international best practice.

What we have heard

- People are enthusiastic about the local nature of health and care services and the fantastic staff who work in them.
- There is a desire for more pro-active and preventative care, especially in areas such as mental health.
- People want better access to primary care and are willing to explore alternatives to face-to-face GP consultations (such as online consultations or seeing other health professionals).
- There is an expectation that information is shared to provide better, more joined-up care.
- Communities are willing to work with public services to help improve wellbeing and health.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Summary

Our Partnership Focus

Priorities

1. **Working in and with communities to improve wellbeing and health,** including tackling social isolation and reducing health harming behaviours.

Public services don't have all the answers, but must work with communities to help people stay well and healthy.

2. **Focusing on wider determinants of wellbeing and health** with action on:
   - Housing and Growth
   - Education
   - Poverty and Prosperity
   - Reducing Carbon Footprint.

Factors such as good jobs and housing affect our wellbeing and health more than health services, so we need to work together to improve these.

3. **Proactive, multi-agency/disciplinary primary and community care.** Aligned at Primary Care Network level and delivering holistic care based on using population health management approaches.

We are creating joined up teams of health and care professionals dedicated to keeping people healthy and well in their own homes.

4. **Merger of Bedford and Luton Hospitals** to create more efficient and resilient secondary care.

Having one Hospital Trust for Bedfordshire (with hospital buildings in Luton and Bedford) will lead to higher quality, more efficient services.

Immediate Focus

Going to hospital unexpectedly is not great for people and is expensive for public services. It is better for everyone if we can help people stay well and healthy.

Reducing avoidable unscheduled care across the system.

Personalised care and support from all sectors.

Social Prescribing – Supporting and coaching people to address non-medical needs.

High Intensity Users – Helping those frequently accessing services through proactive support.

We will start from the perspective of what matters to people, designing care and support to meet their needs, building on the success of existing work.

Enablers

Digital health and care services lag behind our experiences in other aspects of our lives. This must change if we want more convenient and efficient care and services.

Digital
Need shared information across LA and NHS care services for population health management and shared best practice on digital services.

Integrated Care Partnerships
Being developed in Milton Keynes and for Bedford Borough, Central Bedfordshire and Luton.

Public services need to work in partnership to maximise their impact. This is a change from a previous focus on individual organisations excelling.

Summary

Making this Partnership Focus happen will require us to work together in new ways. The most significant change is the Primary Care Network (PCN). Primary Care Networks bring together a number of GP practices, community health services, mental health services and social care to serve populations of 30-50,000 people. The 22 PCNs in Bedfordshire, Luton and Milton Keynes are the foundations of our partnership.

The four place-based plans for Bedford Borough, Central Bedfordshire, Luton and Milton Keynes are the result of cooperation between the Councils and the NHS.

Sometimes there will be opportunities to collaborate at a bigger scale between providers (Integrated Care Partnerships) across partners (what is known as the Integrated Care System) and beyond (on issues such as specialist pathways and workforce).

Our partnership must also expand to include a greater role for the voluntary sector which particularly excels at improving wellbeing through forging strong communities. We are developing a Board for the partnership that will make it easier for them to be involved.

At all levels of partnership we will be seeking to achieve our vision. Some of the tangible differences people will experience as a result are set out here.

Two examples of public support for joining up care.

What differences will people see?

By 2020 new facilities open including Whitehouse Health Hub in Milton Keynes and a mental health crisis café in Luton.

By 2021 all GP practices will be offering online consultations.

By 2022 we will introduce multi-disciplinary respiratory community hubs to identify and manage complex respiratory disease, closer to home.

By 2023 there will be personalised (known as stratified) care pathways for all types of cancer.

By 2024 there will be a comprehensive 24/7 mental health crisis response service appropriate for all ages.

This plan is not the start, nor the end. It is a staging post on a journey to improved wellbeing and health for the people of Milton Keynes, Luton, Central Bedfordshire and Bedford Borough.

There is lots of work to do over the next five years to deliver the commitments contained in here. This work will be done in a cooperative, transparent and inclusive way.

Our commitment is that the improvements set out in this longer term plan will be made with the public using an approach of co-production and in doing so we will remain focused on our vision:

"Improving our people's health, enhancing their quality of care and being a great place for our staff to work, all whilst delivering value for money."

The Structure of this Plan

Chapter 1 sets out why we need to change and improve, considering our current population, their burden of ill-health (including inequalities), what our population think about health and care and how our population will grow.

Chapter 2 considers how we will work in partnership, including our vision and aims and the focus of our partnership.

Chapter 3 looks at our plans at the level of our places (Bedford Borough, Central Bedfordshire, Luton and Milton Keynes).

Chapter 4 is the largest chapter, looking at how we plan to improve health and care over the next five years. It is divided up into sections on major types of care (e.g. urgent and emergency care) and illness groups (e.g. cancer and mental health). Where possible these sections follow the structure:

- What is the context for delivery?
- What do we know people are concerned about?
- What progress has been made as a system so far?
- Future Ambition: What do we plan to do next?
- What difference will this make to people across BLMK?
- How will we know we're making a difference?

Chapter 5 then considers some of the big enablers to the changes we are seeking in Chapter 4. These are workforce, digital information sharing and estates.

Finally, **Chapter 6** details how there is much more supporting information underpinning this plan.

The golden threads of personalisation (health and care meeting people's individual needs), prevention, integration and localised care through Primary Care Networks, run throughout the plan.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Why we need to Change and Improve

Our Population
Health Inequalities in BLMK
Wider Determinants of Health
The Case for Change for reducing unplanned care
What our population has told us
Understanding what is important to our communities
Population change in recent years
Population change in the future

Our Population

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

The number of **people aged 85 and over is projected to double by 2035** and there will be higher than average growth in the number of adults aged 65 and over and the number of children and young people aged 10-19 years old.

Luton is the most urban, most deprived and most ethnically diverse. Bedford Borough and Milton Keynes are mostly urban with significant ethnic minority communities and some rural areas (especially north of Bedford). Central Bedfordshire has smaller towns, is the least deprived and least diverse of the four areas. It does however have pockets of deprivation and around 30% of its residents use hospitals outside of our area.

Health Inequalities in BLMK

Stubborn health inequalities persist across Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. As well as being unfair, health inequalities are costly, putting a strain on employment and productivity, hitting national and local economies and impacting our public services. Everyone deserves the same opportunities to lead a healthy life, no matter where they live or who they are and the ingredients for a healthy life are relatively straight-forward: a good education, a decent job, safe and secure accommodation, friendships and networks to feel part of.

Evidence suggests that health care services only determine about 20% of how healthy we are.[1] Other determinants of health include social-environmental factors, genetics and behaviour choices. It is because these social and environmental factors are so important, and a combination of actions from all parts of this system are needed to reduce inequalities, that our local authorities and partners have set out our priorities for action in the Joint Health and Wellbeing Strategies:

Bedford Borough
https://www.bedford.gov.uk/social-care-health-and-community/health-and-wellbeing-board/

Central Bedfordshire
https://www.centralbedfordshire.gov.uk/info/31/meetings/223/health_and_wellbeing_board_-_meetings_and_agendas/5

Luton
https://www.luton.gov.uk/Health_and_social_care/health/publichealth/public-health-reports/Pages/Health-and-wellbeing-strategy.aspx

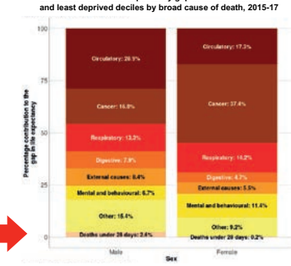
Milton Keynes
https://www.milton-keynes.gov.uk/social-care-and-health/health-and-wellbeing-board

Health outcomes in BLMK: Life expectancy

A baby **girl** born in Central Bedfordshire today can expect to live for **84.4** years, over six years longer than a baby **boy** born in Luton (**78.3 years**).

Babies born in the most affluent parts of BLMK will live longer than those born in the most deprived areas. The biggest gap for men is in **Bedford Borough (10 years)** and the smallest is for women in **Luton (6 years)**.

Breakdown of the life expectancy gap in MK between most and least deprived deciles by broad cause of death, 2015-17



The life expectancy gap mainly reflects higher deaths from circulatory diseases, cancer and respiratory diseases in more deprived areas, reflecting the impact of the wider determinants of health on the development of these conditions.

These causes contribute around 60% of the gap in life expectancy within each local authority, except for **women in MK and Bedford Borough**, where they explain around **two thirds** of the gap, and for **men in Bedford Borough** where they explain nearly **three quarters** of the gap.

Health outcomes in BLMK: Mortality

Infant mortality is higher in Luton than in similar areas. The rate of stillbirths is also high in Bedford Borough.

Deaths under the age of 75 are higher in Luton and MK than in similar areas.

Compared to similar areas, premature mortality is high from **cardiovascular disease** in **Luton heart disease** in **Bedford Borough** and **stroke** in **Luton** and **MK**.

Premature mortality from **cancer** is high in MK. Early deaths from **colorectal cancer** are particularly high and rising in MK and Luton, notably among **women**, compared to a declining trend nationally. Premature mortality from **breast cancer** is high in Central Beds.

The MK mortality rate from causes considered **preventable** is declining but remains **significantly higher** than similar local authorities. Preventable deaths from **cancer** are particularly high.

In Bedford Borough, preventable deaths from cardiovascular disease are high.

In MK, mortality rates from **lung cancer** and **COPD** are significantly higher than in similar areas and more **years of life are lost** to smoking related illnesses.

1. D Buck et al, A Vision for Population Health, The King's Fund, November 2018

Wider Determinants of Health

Action is happening at Local Authority level to increase the availability of safe and secure accommodation, reduce the educational attainment gap and tackle poverty. The links below provide some of the detail:

The Bedford Borough Jobs hub provides bespoke careers advice and guidance to people of all ages, backgrounds and abilities. In 2018/19 the Jobs Hub helped 697 people into employment and training. https://www.bedford.gov.uk/jobs-and-careers/jobs-hub/

Central Bedfordshire is working with schools to ensure they have the right school places, in the right locations, delivering the best education.

https://www.centralbedfordshire.gov.uk/info/3/schools_and_education/527/schools_for_the_future

Luton has set itself an ambitious target to eliminate poverty by 2040 and its procurement strategy outlines the approach it is embedding

https://www.luton.gov.uk/Council_government_and_democracy/Lists/LutonDocuments/PDF/Corporate Finance/Procurement/procurement-strategy.pdf

Milton Keynes has commissioned a long-term Housing First service following a successful 12 month pilot, where 85 rough sleepers were supported into permanent accommodation, with only one person returning to rough sleeping.

Money and resources

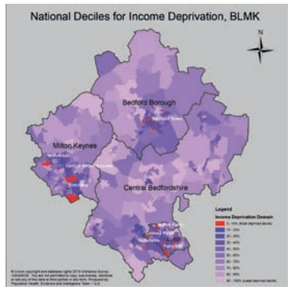
Poverty damages health and poor health increases the risk of poverty. An inadequate income makes it more difficult to avoid stress and feel in control, access experiences and material resources, adopt and maintain healthy behaviours, and feel supported by a financial safety net

In the most healthy small areas of BLMK, women enjoy **22 years** longer in good health than in the least healthy small areas. For men the gap is **15 years**.

A 2019 analysis by Loughborough University estimates that **24%** of children living in Central Bedfordshire, **31%** of children in MK and Bedford Borough and **46%** of children in Luton live in **poverty**, after housing costs are taken into account.

Two thirds of children are living in poverty in Biscot and Dallow wards in Luton and Queens Park ward in Bedford.

Nationally, **2/3** of child poverty is within working families.



Good work

Good work pays fairly and offers security, ensures good working conditions, promotes a good work life balance and provides training and opportunities to progress. People who are well are more likely to be in employment and people who are employed are more likely to be in good health. People in higher status roles are more likely to be healthy and less likely to die of heart disease.

There are 1.15 jobs per person of working age in MK and 0.75 jobs per person elsewhere in BLMK

Earnings are highest in those **working** in MK (£622 per week) and lowest in those **living** in Luton (£543 per week). Residents of Luton and MK earn less than those working in their borough; residents of Bedford Borough and Central Beds earn more than those working there.

Unemployment ranges from 2.9% in Central Beds to 4.6% in Luton, compared to the national average of 4.2%. The rate is over **four times higher** in South ward in Luton than in Kempston Rural ward in Bedford Borough.

The employment rate gap is:

- 10 percentage points worse for people with a long term health condition
- 67 percentage points worse for people with a learning disability
- 70 percentage points worse for people in contact with secondary mental health services

Around one in ten households across BLMK have **no one in work**

Overall, nearly **1/5** jobs pays less than the living wage.

Nationally, 16.5% of all people in paid work were employed in the public sector in March 2019

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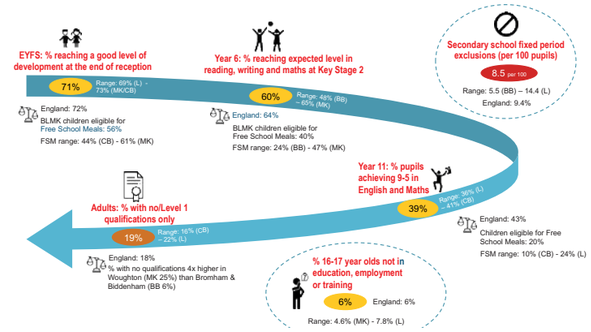
Wider Determinants of Health

Education and skills

A good education helps build strong foundations for supportive social connections, accessing good work, life-long learning and problem solving, and feeling empowered and valued. By the age of 30, those with the highest levels of education are expected to live four years longer than those with the lowest levels of education.



Housing

Housing conditions influence our physical health, mental health and wellbeing. A healthy home is affordable and offers a stable and secure base, is able to provide for all the household's needs, and is connected to community, work and services.

One in five homes in England doesn't meet the decent home standard, with a cost to the NHS of at least £1.4billion per year. Children living in crowded homes are more likely to be stressed, anxious and depressed, have poorer physical health and attain less well at school.

1/10 households **experience fuel poverty**

1/10 homes have fewer rooms than the household needs

There are over **2,300** households in **temporary accommodation**, with the highest numbers in Luton (1,300) and MK (680).

156 people were estimated to be **sleeping rough** across BLMK in autumn 2018.

The cost of buying a home in BLMK has increased by around **75% in the last 10 years**, compared to 50% across England overall.

Housing is **less affordable** than average in BLMK.

35,400 new homes were completed ir BLMK between 2010 and 2018 (**4,400 homes per year**). Two thirds of new homes were in Central Beds and MK.

BLMK is estimated to need **7,000 new homes** per year. The government's aspiration to deliver one million homes across the **Oxford-Cambridge Arc** could see build rates rise to over 11,000 per year.

The Case for Change for reducing unplanned care

Currently too much of the health care provided in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes is unplanned care, with people going to A&E, accessing a GP out of hours and being unexpectedly admitted to hospital. Across our partnership, an average of 2,750 GP Out of Hours face to face appointments are booked into each month; an average of about 600 GP Out of Hours home visits are made each month and an average of 4,900 GP Out of Hours telephone triage cases are undertaken each month. In our hospitals there are an average of 18,900 A&E attendances and over 4000 unplanned admissions per month.

Although some emergency care will always be needed, unplanned care which could have been prevented is bad for people:

- Unplanned care is inconvenient for people e.g. waiting in A&E.
- Stays in hospital can make it harder for people to regain their independence through lack of mobility and reduced muscle mass.[1] There is also the risk of a healthcare acquired infection.

It is therefore much better for problems to be avoided before unplanned care (especially hospitalisation) is needed.

It is also an inefficient use of resources: Each person seen by a GP Out of Hours service (in a face to face appointment, home visit or telephone triage consultation) costs approximately £52 compared with an average of £30 for an in hours GP appointment [2].

The average cost of a stay in hospital following a fall which has broken a hip is £3,727. [3] By contrast, a home visit to identify and fix falls and trip risks, commissioned in a pilot programme from Bedfordshire Fire Service, costs less than £100.

The NHS will be able to have more impact if it reduces the need for unplanned care and there is the potential to create a virtuous circle, with money saved from reducing unplanned care invested in more pro-active interventions, which in turn reduces unplanned care.

So, there is a clear patient and value for money argument for reducing unplanned care usage.

1. NHS Improvement, Guide to Reducing Long Hospital Stays, June 2018, https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf

2. NHS England, 2019 National average cost of an in hours GP appointment.

3. Average costs from Bedfordshire CCG

What our population has told us

We recognise the need to understand what is important to local people in delivering on the priorities set out in the NHS Long Term Plan. Our local plan is based on what we know from previous engagement and that carried out by local Healthwatch, as well as recent conversations with a range of groups and individuals held during summer 2019.

Understanding what is important to our communities

Following the publication of the NHS Long Term Plan in January 2019, we started to consider what this meant for people living in Bedfordshire, Luton and Milton Keynes and how we might deliver on the priorities set out in the NHS Long Term Plan while meeting the needs of local residents. In order to do this, we needed to understand what is important to local people in relation to health and care services.

We recognised that we already knew a lot about this from previous engagement activity undertaken as individual organisations within our places (Bedford, Central Bedfordshire, Luton and Milton Keynes) and across our partnership. Healthwatch were commissioned nationally to support STPs/ICSs with local engagement around the NHS Long Term Plan and during March and April 2019 this was undertaken across BLMK. As well as conducting a general survey, Healthwatch ran focus groups to explore people's views on cancer and mental health. These findings were captured in a report and shared with health and care leaders and the general public (see Chapter 6 – NHS Long Term Plan BLMK 'What would you do?'). A summary of these key areas is below:

Cancer health and care services

Treatment and care after diagnosis was seen as working well, however many of the respondents said that:

- More health education, with campaigns not just focusing on screening, but providing other information, such as increases in survival and new treatments;
- Screening not restricted by age;
- Better communication: improved and more timely, throughout the cancer journey to help people make informed choices; raised awareness of the services that are available, both community and NHS.

Mental health services

Access to online information and services were seen by focus group attendees as an area that worked really well but most felt that there were significant areas that needed to be transformed. These were:

- Better access to services and a more holistic approach – therapies that work in conjunction with each other and are delivered together would provide a more comprehensive treatment, particularly for complex needs;
- More support in prevention and early intervention before people get into crisis;
- Better awareness and signposting of services that do exist.

Understanding what is important to our communities

We used Healthwatch's work as the basis of our engagement approach, which aimed to build on this work and other work already in progress, while considering new ways to ensure that residents' voices and views are at the core of our future plans. We will continue this approach throughout delivery of the NHS Long Term Plan.

We worked with our partners and networks to identify opportunities to go along to forums/meetings to talk to a variety of individuals. In 12 weeks, we attended **over 40 events to engage with local people**. At the events we talked to residents to find out what mattered to them in relation to health and care services. In addition, we coordinated with partners to utilise existing channels and networks to undertake targeted engagement. Our work with partners supported our aim to ensure views from young people and other seldom heard groups were heard and these included youth voices and faith groups.

What do we know people are concerned about?

We captured wide ranging views and some key themes emerged.

1. **Access to services, including getting to see a GP quicker as a key concern**. This issue was of particular concern to a significantly large number of people both demographically and culturally. This was also supported by Healthwatch's findings through their survey.

   80% said "improved access to GP services would help them stay well" [1]

2. **Information and access to support a healthier lifestyle**. This particular issue was important to some of our seldom heard groups and again supported by Healthwatch findings.

   58% said that "better information to help with self-care and health and wellbeing would be good"

3. **Better signposting to services and using technology** to support more joined up care, for example, shared care records.

   Over 60% highlighted that "shared access to records would be helpful and 49% said that "greater use of technology to monitor health remotely would be useful"

1. *The survey had 760 respondents*

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Understanding what is important to our communities

We attended a number of youth groups through Healthwatch and our local authority colleagues who run youth groups.

Youth voices

For young people, the overwhelming area of concern was the provision of mental health services and the ways they could access them. Many respondents remarked that there should be more support, signposting and information provided in schools. Many respondents said that worries and issues surrounding exams had a significant impact on their mental health.

> *Mental health support in schools – mental health is discussed in life skills lessons but there isn't any practical support available. This is especially acute during exam periods in school.*

Another key area of concern was accessibility to facilities for fitness and health. Over 16s expressed a concern that after GCSEs there wasn't any timetabled fitness/exercise or access to facilities within schools. Many of the respondents would like to see access provided at schools as it was easier and free. A significant number of respondents felt that private and council health and fitness facilities were simply out of reach because they were so expensive.

Faith groups

The events we attended gave us the opportunity to engage with around **150 people from within Asian communities**. This included attending faith groups within the Sikh, Hindu and Muslim community. For a significant proportion of these groups there is a desire to have information and support to lead a healthier lifestyle to tackle obesity and diabetes in their communities but one of the key barriers is language. One person explained that cooking skills and recipes still contain traditional ingredients which are detrimental to health. However, due to lack of language appropriate advice, many people continue to cook in this way as they simply didn't know any different. There was also a desire to have information and support through targeted events as opposed to leaflets.

> *Have more facilities and education for people of Asian origin to do with their diets and heritage leading to diabetes and heart conditions*

Understanding what is important to our communities

What progress has been made before?

In recent years we have worked with communities to help inform and shape services and this work has informed many of the areas of development outlined throughout this local plan. We continue to develop our system-wide and co-design approach to engagement, following successful working together on areas such as maternity services.

What do we plan to do next?

We are committed to ongoing engagement with local communities. We have further meetings planned already with a range of groups to support delivery of the priorities that have been agreed locally and at scale. We will continue local conversations to understand what matters to local people and in implementing the commitments in this plan will take a co-design/production approach.

What difference will this make to people across BLMK?

We want to build on the opportunity the NHS LTP presents to have broader conversations – informed and regular with representatives from across our diverse communities. This will ensure the patient voice guides us and enables us to plan and deliver services that will best meet local needs and change things together.

How will we know we're making a difference?

We monitor performance as well as patient and public experience/feedback in different ways. As we demonstrate improvements in experience as a result of local involvement e.g. local maternity services; patient forums/groups, we expect to see more people wanting to get involved. If we are getting it right, we would also expect to see a reduction in concerns being raised to Healthwatch and through our own channels.

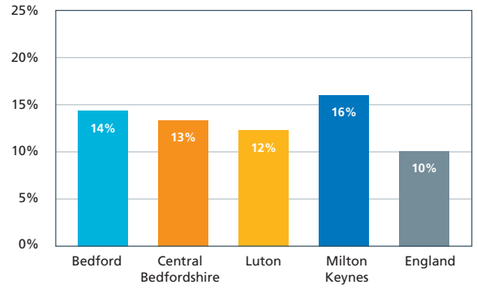
Population change in recent years

BLMK's population has grown faster than average over the last 10 years, **rising by 13%** from 830,900 in 2008 to 935,500 in 2018, compared to 8% across England overall.

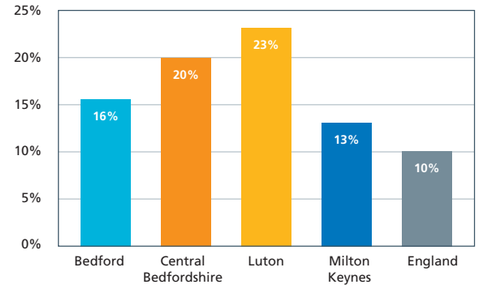
Growth has been **highest in Milton Keynes** and **Central Bedfordshire**. These changes reflect the impact of high levels of house-building as well as 'natural' change (the balance of births and deaths).

As the population has changed, services have had to adapt. While growth in the working age population has been modest, there has been **significant growth in the school-age population** (14% increase in children aged 5 to 14 in the last five years) and the **older population** (18% increase in the over 85s in the last five years), putting pressure on schools and services for children as well as health services generally.

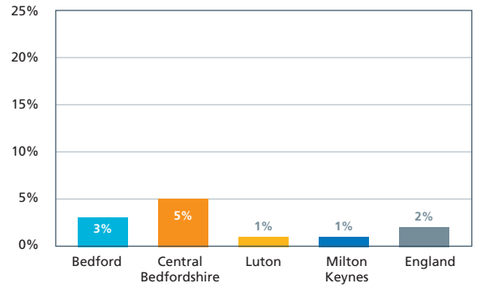
% change in population aged 5 to 14, 2013–2018



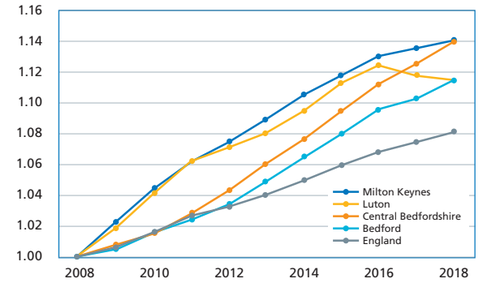
% change in population aged over 85, 2013–2018



% change in population aged 15 to 64, 2013–2018



Population change index



Population change in the future

In addition to current local commitments, the 2017 Report of the National Infrastructure Commission on the Cambridge-Milton Keynes-Oxford Arc raised potential expectations for growth in our area, calling for a million new homes by 2050. This report has since been endorsed by government, however, discussions continue between local leaders and national government about where this level of sustainable growth could best be accommodated. Our partnership is at the centre of the Arc and may need to provide up to 300,000 new homes, a near doubling of homes in our area over the next 30 years. We don't yet know the exact level of growth or where additional homes would be located as sites would be agreed through the local planning processes, influenced by the planned Oxford to Cambridge road and rail links.

Our local authorities' Local Plans outline agreed planned housing growth:

Local Authority	Current planned annual housing delivery	Future Forecast annual housing delivery
Bedford Borough	970	1342 (from 2023)
Central Bedfordshire	1,600	2473 (from 2023)
Luton	890	595 (from 2022)
Milton Keynes	1,766	1876 (from 2024)

Future Local Plan reviews are expected, which will have to revise plans in line with the government's "New Standard Methodology" for assessing housing need.

Population implications

Continued housing growth will have significant population implications. If the levels of growth continue in line with the New Standard Methodology, the population will increase by 45% by 2050, however the potentially higher levels of growth associated with the Arc could see the population increase by nearly 90%.

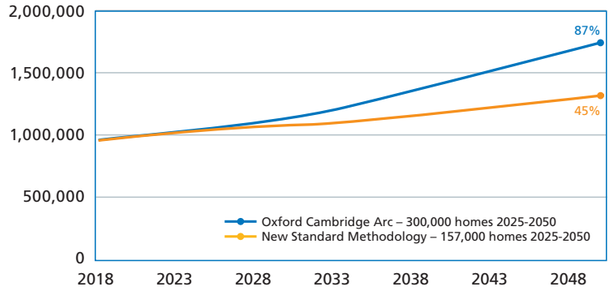
This would include an 80% increase in the number of children and young people, a 70% increase in the working age population and nearly 150% increase in the population aged over 65. As plans evolve, we will refine these forecasts.

Health and Care Infrastructure and Workforce

Our health and care services will need to grow significantly to serve this continued growth. If services continue to be delivered as they are now, this level of growth would require around 20 additional Primary Care Networks, double the current acute hospital capacity, and around 400 additional extra care homes. Similar increases in workforce would be required. This is addressed later in the plan in the Workforce section in Chapter 5. During the next five years we will be taking this growth into account in our plans to improve health and care.

As our population grows it is vitally important that health and social care resources grow to match, to avoid our population being disadvantaged. We will work with NHS England and Improvement to ensure that happens.

Potential population growth scenarios to 2050



The 2017 Report of the National Infrastructure Commission

Bedfordshire, Luton and Milton Keynes Longer Term Plan

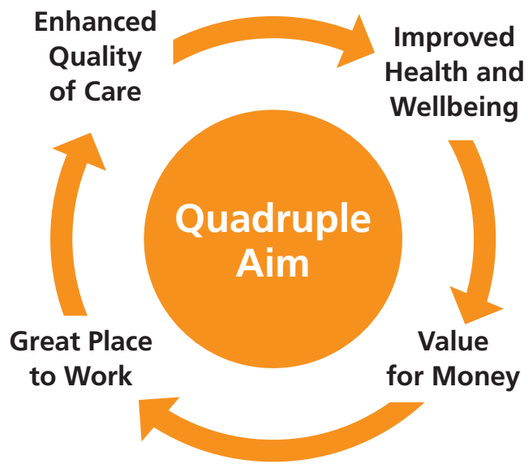
Our Partnership

Our Vision
Our Partnership Focus
Our Partnership Working

Our Vision

The original BLMK STP (Sustainability and Transformation Partnership) is committed to the **Institute of Healthcare Improvement's triple aim**. Our 2019/20 System Operating Plan **broadened it out to the quadruple aim**, including a supportive environment for our staff (see Figure 1).

This is a nationally endorsed approach which NHSE/I are considering putting into legislation. Other ICSs (e.g. Frimley Health and Care) have adopted the quadruple aim as their focus. It is consistent with what we have heard in our engagement and **provides a clear focus**.



Our vision is therefore 'Improving our people's health, enhancing their quality of care and being a great place for our staff to work, all whilst delivering value for money.'

Our Aims

Aim	What this will mean for people	How will we know we have succeeded?
Improved Health and Wellbeing	We want every person in Bedfordshire, Luton and Milton Keynes to live healthy lives for as long as possible.	• Increase in healthy life expectancy. • Reduced gap in life expectancy at birth. • Proportion of people with moderate or high life satisfaction from Annual Population Survey
Enhanced Quality of Care	People have access to personalised, high quality health and social care that considers what matters to them as individuals.	• All organisations in BLMK to be assessed as good or better by quality regulators. • Other measures of quality being developed with BLMK co-production group.
Value for Money	In achieving the other three aims, the best use is made of the public sector pound.	• Living within our resources. • Best use of public sector pound. • Directors of Finance are defining these measures.
Great Place to Work	We want those working in health and care in BLMK to feel valued and to enjoy their work.	• Measures being developed to align with the NHS People Plan.

Our Partnership Focus

Adding to the wider vision, and drawing on the rationale of why we need to change and improve, we have agreed some specific areas of focus as a partnership. Our Partnership focus is the golden thread running through our longer term plan.

Priorities

1. **Working in and with communities to improve wellbeing and health,** including tackling social isolation and reducing health harming behaviours.
2. **Focusing on wider determinants of wellbeing and health** with action on:
   - Housing and Growth
   - Education
   - Poverty and Prosperity
   - Reducing Carbon Footprint.
3. **Proactive, multi-agency/disciplinary primary and community care.** Aligned at Primary Care Network level and delivering holistic care based on using population health management approaches.
4. **Merger of Bedford and Luton Hospitals** to create more efficient and resilient secondary care.

Immediate Focus

Reducing avoidable unscheduled care across the system.

Personalised care and support from all sectors.

Social Prescribing – Supporting and coaching people to address non-medical needs.

High Intensity Users – Helping those frequently accessing services through proactive support.

Enablers

Digital
Need shared information across LA and NHS care services for population health management and shared best practice on digital services.

Integrated Care Partnerships
Being developed in Milton Keynes and for Bedford Borough, Central Bedfordshire and Luton.

Our Partnership Working

We can only achieve our vision and our partnership focus by organising and integrating in different ways. This "architecture and wiring" will be of limited interest to our population, but in the interests of transparency we are setting out the key elements of how our partnership works.

Primary Care Networks (PCNs)

PCNs are where GP practices, community, mental health and social care services join together to deliver proactive and integrated care for a defined population. Looking after a population of 30-50k, we have 22 in BLMK. This is where the majority of people's health and care needs are met.

Places

Our four places (population circa 200-300k) are our Local Authority areas – Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. They provide the footprints for effective joint working between health and local authorities on issues such as prevention. The next Chapter looks at priorities in our four places.

Integrated care partnerships (ICP)

ICPs will integrate hospital, mental health, community and primary care teams/services to achieve high quality care and ensure the most effective use of resources. There is an opportunity for councils to be part of these arrangements which we are actively exploring. Milton Keynes will have an ICP and there will be an ICP (the Bedfordshire Care Alliance) covering Bedford Borough, Central Bedfordshire and Luton.

Integrated care systems (ICS)

Our health and care partnership is a first wave ICS (this means our statutory and finance performance was good), looking after a population of circa 1 million. Working as an ICS allows for whole system strategy and planning where appropriate, sharing of best practice and some economies of scale on specific issues.

Region

We are part of the NHS Eastern Region with a population of 7 million. There will be opportunities for collaboration and some more specialised services (like radiotherapy) will be commissioned across the Region. In the future, we will work with colleagues to explore the potential for our partnership having greater influence on specialised services.

How our Partnership will develop

We are developing how we will work, forging effective new approaches to collaboration.

This includes establishing a Partnership Board for the Integrated Care System. By the end of March 2020 we will have settled the remit and membership of this board and have concluded the selection of an Independent Chair for Our Partnership.

Health and care professionals will be central to leading the development of this plan. We are establishing clinical networks to support this and will have clinical leadership within each ICP.

Development of a Strategic Commissioner

The three CCGs have agreed to establish a strategic commissioner to become operational by 1 April 2021.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Summary of Place Priorities

Summary of priorities for Milton Keynes
Summary of priorities for Luton
Summary of priorities for Bedford Borough
Summary of priorities for Central Bedfordshire

Summary of priorities for Milton Keynes

ONE MK: Our Partnership

Our partnership is a collaboration between commissioners and providers.

Our partnership includes:

- CNWL NHS Foundation Trust;
- Healthwatch MK;
- Milton Keynes Clinical Commissioning Group;
- Milton Keynes Council;
- MK GP Federation;
- MK University Hospital NHS Foundation Trust;
- Primary Care Networks;
- Public Health;
- Voluntary and community partners.

Together, our vision is to be a place of strong communities in which everyone is able to stay well, take control of their wellbeing and when support is needed, receive the best wraparound, integrated health and care services.

Our Priorities

Our priorities are interconnected with our Health & Wellbeing priorities for **Staying Well** – a strong focus on prevention, **Closing the Gap** – reducing inequalities in life chances and **One MK** – an integrated, innovative approach to health and wellbeing.

- **Health Communities and Prevention** – Reducing health inequalities, focusing preventions for vulnerable groups, support for dementia and self-care.
- **Primary and OOH Care** – Urgent *on the day care*; proactive care and personalisation.
- **Maternity, Children and Young People** – A stronger start in life for children and young people; children with complex care; improving maternity care.
- **Major Health Conditions** – Better care for major health conditions and improving outcomes such as Cancer, Mental health, Cardiovascular Disease and Stroke. Shorter waits for planned care.
- **New Models of Care & Enabling Work streams** – Population health management reducing inequity and increasing system resilience.

Our Population

The resident population of Milton Keynes is predicted to rise to around **305,300 by 2035**, with the greatest increase expected to be those aged **80 years and over**.

- The most deprived wards in Milton Keynes are Woughton and Fishermead.
- Out of 326 Local Authority areas, Milton Keynes is ranked as **181st most deprived in England**.
- In Milton Keynes the life expectancy from birth in the most deprived area is at least **seven years less than in the least deprived area**.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Summary of priorities for Milton Keynes

What do we plan to do?

Working in partnership and making decisions collectively is essential to our plans.

- **Improve outcomes** through prevention, community resilience and self-care.
- Build **local integrated working** across all ages both for physical and mental health wellbeing.
- A **'complete care community'** built *around* residents and for residents.
- Have **access to the right information, advice and care services** to assess and treat people.
- Streamline pathways to **personalise care** focusing on the individual's needs and goals.
- Increase **system resilience** by developing joint plans on system enablers – including workforce, digital and estates.
- **Engaging MK people** in our system transformation.

An integrated, innovative approach to health and wellbeing

Summary of priorities for Luton

Our Place

The Luton Transformation Board is the forum where senior partners across the Luton health and social care system undertake collaborative planning, regular reviews and assessment of the impact of Primary, Community and Social Care Services.

Our Transformation Board includes health and social care partners from statutory, voluntary and community organisations, including:

- Luton CCG;
- Luton & Dunstable NHS University Hospital Foundation Trust;
- East London NHS Foundation Trust;
- Herts Urgent Care (111 and GP out-of-hours service);
- Healthwatch Luton;
- Age UK;
- Voluntary Works;
- Beds and Herts Local Medical Committee;
- Luton Borough Council;
- Cambridge Community Services NHS Trust;
- Primary Care Networks;
- East of England Ambulance Service NHS Trust;
- Keech Hospice;
- Virgin Care;
- Bedfordshire Local Pharmacy Committee.

Our ambition: Luton is a more equitable place where people thrive, have the opportunity to live a healthy life mentally, socially and physically, and maximise their potential.

Our Priorities

1. Every child in Luton achieves the level of development needed in their early years to provide the **foundation for a healthy life**.
2. Every child is **healthy, including having a healthy weight** and **good oral health**.
3. Every child and young person has access to **good educational support** when needed.
4. Every young person in Luton is **safe, skilled and equipped to be successful** throughout their life.
5. Every adult in Luton is **physically and mentally healthy** and able to thrive.
6. Every adult in Luton has **access to training to develop skills**, and access to the **good employment** required to drive our commitment to eradicate poverty.
7. Everyone in Luton lives in **good quality housing**, has **access to green space** and **good air quality**.
8. Everyone in Luton has the level of **meaningful social contact** that they want.
9. Everyone in Luton lives the **end of their life with dignity** in the **place of their choice**.

Our Population

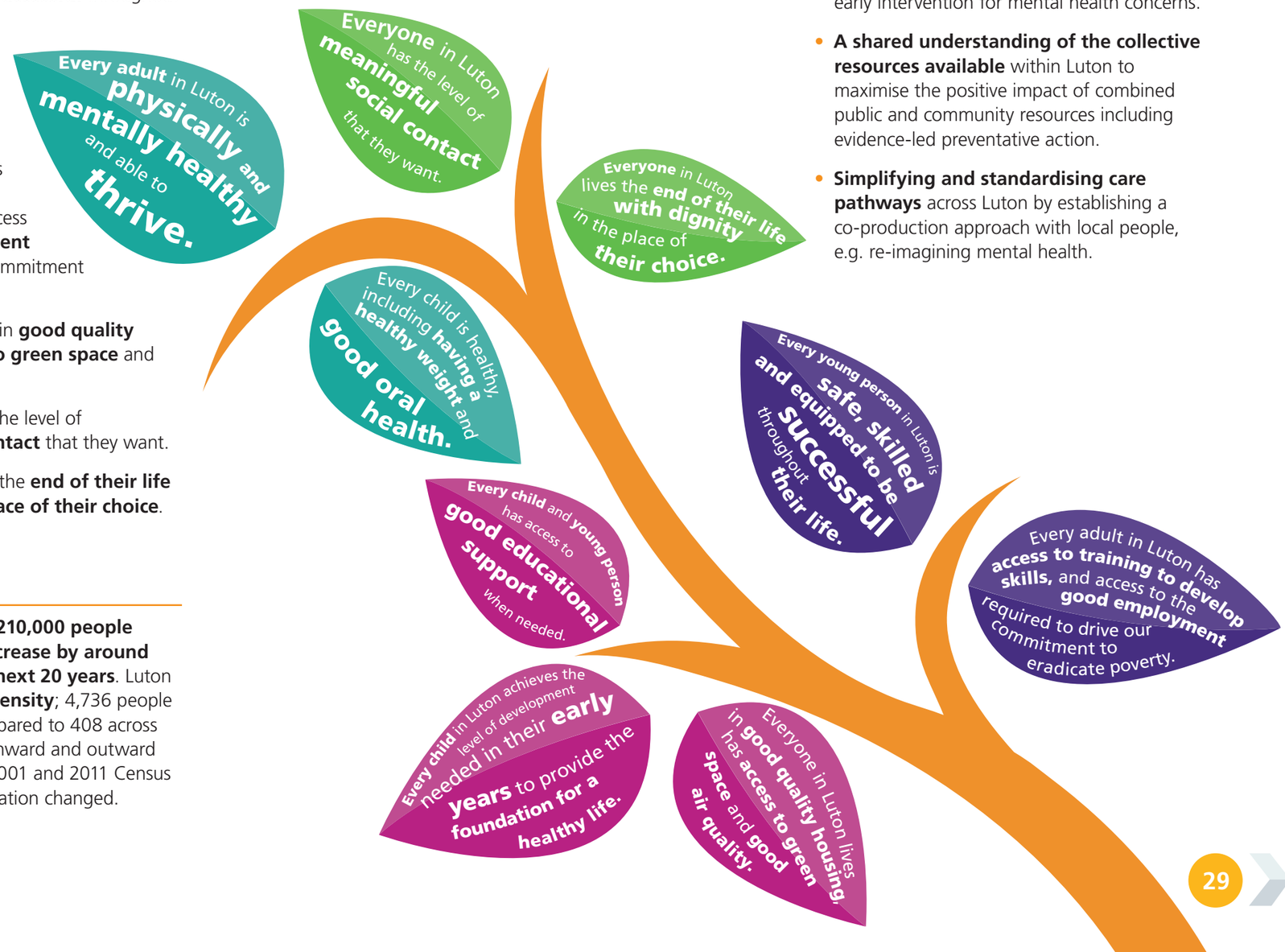
Luton is home to around **210,000 people** and this is expected to **increase by around 30,000 people** over the **next 20 years**. Luton has a **high population density**; 4,736 people per square kilometre compared to 408 across England, plus significant inward and outward migration. Between the 2001 and 2011 Census around 70% of the population changed.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Summary of priorities for Luton

Luton is ethnically diverse with around **55% of the population** from Black, Asian and Minority Ethnic groups and **75% of school pupils** from Black, Asian and Minority Ethnic groups. **Half of our children do not speak English as their first language**.

Luton has high levels of deprivation and low levels of life expectancy (compared to England as a whole) and there is a large gap between the least and most deprived areas within Luton **(7.1 years for males and 5.3 years for females)**.



What do we plan to do?

The Transformation Board will ensure delivery of the overarching place-based strategy through:

- Working in partnership with local health and care organisations to **agree shared priorities to address inequalities**.
- **Making better use of health and care data** to improve how health and care services address the wider health determinants such as housing, access to good employment and early intervention for mental health concerns.
- **A shared understanding of the collective resources available** within Luton to maximise the positive impact of combined public and community resources including evidence-led preventative action.
- **Simplifying and standardising care pathways** across Luton by establishing a co-production approach with local people, e.g. re-imagining mental health.

Summary of priorities for Bedford Borough

Our Population

Our population will reach **200,000 by 2035**, and the number of **over 85s will double to 8,300**.[1] The **most deprived areas** of the Borough are in the Castle, Harpur, Cauldwell, Goldington, Kingsbrook and Queens Park wards.[2] Life expectancy at birth for males from the most deprived areas is **11.4 years less** than those from the least deprived areas. **For females the difference is 7.0 years**.[3]

Our ambition

Our ambition is that:

1. Bedford Borough residents are able to **live healthy, thriving lives**.
2. Health and care services are **high quality, good value** and **designed around people's needs**.
3. Residents, service users and carers are **active and equal partners** in their health and care.

In everything we do we will seek to **reduce health inequalities, give equal prominence to mental and physical health**, and **protect the most vulnerable from abuse**.

Our priorities and what we plan to do

1. Understanding our communities

Finding out **what matters to them** and **improving our understanding** of what drives poor health, **unwarranted variation** and **demand for services** so that we can make a difference.

- **Engage with communities** to understand what is important to them and co-produce solutions.
- Develop a **better understanding of the factors driving demand and growth** and work together to address them.

2. Enabling people to live healthy, thriving lives

Prioritising prevention in all our services, but also measures to **address wider determinants of health** such as encouraging inclusive employment practices.

- Work collaboratively to implement the Population Health Framework for Healthcare Providers.
- **Increase referrals to local behaviour change services**, with a particular focus on pregnant women and people with long term physical and mental health conditions.
- **Increase the uptake of routine screening**, immunisations and NHS Health Checks by addressing unwarranted variation and inequalities.

1. Office for National Statistics. Subnational population projections for England: 2016-based.

2. Office for National Statistics. English Indices of Deprivation 2015.

3. Public Health England. Public Health Outcomes Framework, Indicator 0.2iii, Inequality in life expectancy at birth, 2015-2017.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Summary of priorities for Bedford Borough

3. Transforming the local health and care system

Working with residents to ensure they have the knowledge and confidence to look after their own health where possible and have access to high quality local health and care services when they need them.

- **Oversee development of the Primary Care Networks**, including the new clinical pharmacist and social prescribing link worker roles.
- Work together to address the **immediate pressures** facing the local health and care system.
- Support the development of the hospital to **meet the growing demand for acute services**, including development of a 'Same day Emergency Admissions Unit'.
- **Oversee local implementation** of the BLMK Local Maternity System Plan, BLMK Children and Young People's Commissioning Strategy and Urgent Care Strategy for Children and Young People
- **Ensure the school-based mental health workforce is integrated effectively** with school nursing and primary care services.
- Reduce unwarranted variation in treatment and outcomes for **cardiovascular disease, diabetes and respiratory disease**.
- Work with the BLMK Cancer Board to **implement best practice pathways** for Breast, Lung, Colorectal and Urology services, including 7-day access to diagnostic services.
- **Oversee local implementation of the 5-Year Forward View** for Mental Health, including improvements to crisis care and the integration of psychological support with long term conditions services.
- **Redesign outpatient services** to increase access in primary care settings, for example teledermatology.
- Ensure that **interventions that support older people** with frailty and disabilities to remain independent are **integral to the Primary Care Network model**.
- **Oversee implementation** of the Falls and Fragility Fracture Prevention Strategy.

Summary of priorities for Central Bedfordshire

Our Partnership

Central Bedfordshire Health and Wellbeing Board and its Transformation Board bring together partners across the system who, together, are determined to improve outcomes for local people and reduce inequalities, now and for future generations.

Our Boards include:

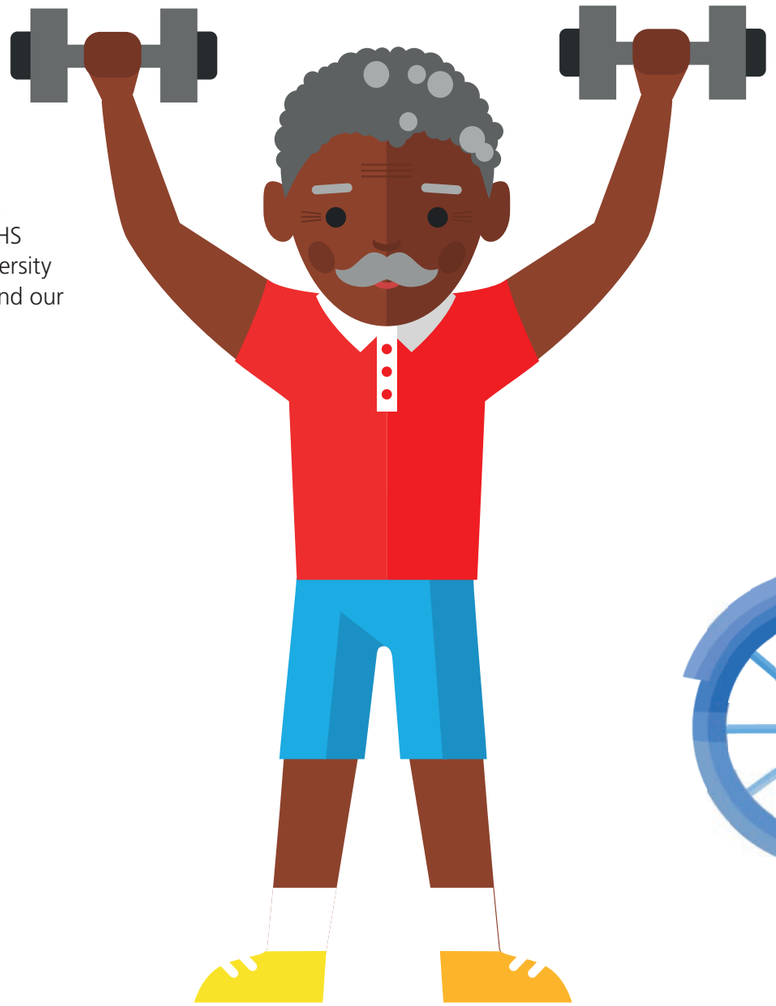
- Central Bedfordshire Council;
- Bedfordshire Clinical Commissioning Group;
- Healthwatch Central Bedfordshire;
- Bedford Hospital NHS Trust;
- Luton & Dunstable NHS University Hospital Foundation Trust;
- East London NHS Foundation Trust and Primary Care.

Our partnerships also extend to hospitals, including East and North Hertfordshire NHS Trust (Lister Hospital), Milton Keynes University Hospital (MKUH) NHS Foundation Trust and our Independent Care Providers.

Our Priorities

Our Health and Wellbeing Strategy sets out three main priorities to:

- **Drive change to improve mental health and wellbeing** for people of all ages.
- Enable people to **optimise their own and their family's health and wellbeing.**
- Ensure that **growth delivers improvements in health and wellbeing** for current and future residents.



Bedfordshire, Luton and Milton Keynes Longer Term Plan

Summary of priorities for Central Bedfordshire

Our Population

The resident population of Central Bedfordshire is **currently around 288,000** and is predicted to rise to around **335,000 by 2035**, with the greatest increase expected to be of those aged **85 years and over**. This growth presents both opportunities and challenges to ensure that everyone benefits equally from the developments.

Central Bedfordshire is a relatively affluent area where overall **life expectancy** for men is **81.4 years** and for women it's **84.4 years**. However, Healthy Life Expectancy shows that residents live **15 to 17 years in poor health** and there are unacceptable inequalities illustrated by a **life expectancy gap** between the least and most deprived areas, of **seven years** for men and **six years** for women.

What do we plan to do?

By embedding a population health approach, we will:

1. Ensure that **we focus on what matters to service users and carers**, understand how they use services now and how we can build stronger neighbourhoods.
2. **Support people in making positive changes to their lifestyle** and ensure we tackle the wider determinants of health, requiring a partnership approach.
3. **Transform health and care for our communities and staff** – providing accessible integrated care around people and communities.
4. **Develop our partnerships** so that we can work more effectively to deliver our vision.

This will ensure that:

- Children and young people **have the best start in life.**
- **People take responsibility** and are able to manage their own wellbeing and health.
- **Older people age well,** with proactive interventions to stay healthy and active as long as possible.
- **Inequalities are reduced.**

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Improved Health and Care

Our approach to population health
Action on wider determinants of wellbeing and health
Population Health Management
Proactive, multi-agency and multi-disciplinary primary and community care
New NHS Offer of Urgent Community Response and Recovery Support
Primary and Community Care - Enhanced Health in Care Homes
Direct Digital Care
Elective Care
Personalised Care
High Intensity Users
Urgent and Emergency Care
Mental Health
Cancer
Cancer - Earlier and Faster Diagnosis
Cancer - Screening
Treatment
Personalised cancer care
Workforce
Specialist Cancer Care
Primary Care
Maternity
Children and Young People
Children and Young People: Improving resilience and meeting more complex needs
Learning Disability & Autism – Children, Young People and Adults
Long Term Conditions – Cardiovascular Disease, Stroke, Diabetes and Respiratory
Medicines and Prescribing
Merger of Luton and Dunstable University Hospital and Bedford Hospital
Research and Innovation

Our approach to population health

Population health means going beyond providing great care and treatment to people. It means working with communities and partners to tackle the wider determinants of health and addressing inequalities to improve physical and mental health and wellbeing.

The wider determinants of health

- Good work
- Our surroundings
- Money and resources
- Housing
- Education and skills
- The food we eat
- Transport

Our health behaviours and lifestyle

Major issues:

- Excess weight and physical inactivity
- Alcohol and drug misuse
- Smoking
- High Blood Pressure
- Mental health and resilience
- Screening and immunisation

The places and communities we live in

Major opportunities:

- Engaging with and listening to communities
- Connecting neighbourhoods
- Building healthy workplaces
- Supporting early years and schools

Underpinned by an effective health and care system:

- A digitally enabled, integrated health and safety care system using a population health management approach
- Delivering integrated pathways and care to prevent, detect, manage and recover from ill health

Adapted from: King's Fund Four Pillars of a Population Health System and Morecambe Bay's Double Pentagon

What this means in terms of our Partnership Focus – working with communities to improve wellbeing and health

We are working in and with communities to improve wellbeing and health, including tackling social isolation and reducing health harming behaviours.

There are several examples where communities have been supported to build on the assets already existing to improve health and wellbeing e.g. development of social movements in Milton Keynes and Luton. Social Prescribers and Village Agents in Bedford Borough and Central Bedfordshire are helping to connect people within their communities as well as building capacity.

However, we know that there is more to do and we are one of four areas participating in this year's cohort of the Building Health Partnerships programme. This will enhance relationships between the Voluntary, Community and Social Enterprise sector and our partnership to deliver improvements to care and health for local people. Alongside tangible benefits for people, the process will also support culture change and new ways of working.

We are also considering the role of volunteering, both in terms of additional capacity in health and care and as a means of tackling social isolation.

The forthcoming "Be Part of Something" campaign we are planning will emphasise the potential for people to connect with local communities through groups or volunteering opportunities. This will be supported by online resources to find groups and for people to create their own group where one doesn't exist. This will go live in 2020.

Specifically with regard to obesity, we are attempting to address the multiple and complex causes of obesity through a set of coordinated actions which together will help to create a local environment where healthy choices are easier. Our approach is being developed with local communities but initiatives could include working with businesses and schools to make healthy food choices more accessible, and supporting local communities to be more active through their travel, work and education.

Action on wider determinants of wellbeing and health

Housing and Inclusive Growth

Housing growth is significant across our area.

In BLMK we will seek to apply the Putting Health into Place principles.[1] We will ensure that adequate health and social care infrastructure is developed to meet the needs of new communities, and that as far as possible, new facilities are developed in a way that enables integrated care and promotes community cohesion.

Good quality, safe and secure housing is fundamental to good health and wellbeing. There is a particular focus on improving quality across the private rented sector as well as meeting overall demand for housing.

The recent Public Health Reports in Bedford, Central Bedfordshire and Milton Keynes outline the links between housing and health, with recommended actions to improve outcomes. Luton's report is focused upon inclusive growth. Links can be found in Chapter 6.

Anchor Institutions

The term 'Anchor institutions' refers to organisations such as hospitals and councils that are rooted in an area by virtue of their mission, buildings and relationships with local people.[2] All our partners have important roles as Anchor Institutions including their ability to help address wider determinants such as poverty and reducing carbon footprints.

In terms of spending locally, in pursuit of their goal of eliminating poverty by 2040, Luton Council are proposing that over the next five years they will increase the proportion of their goods and services bought locally.

Similar discussions and commitments are being considered by other organisations as part of the broad range of initiatives to increase prosperity and reduce worklessness.

We recognise the impact of the delivery of care on climate change and the impact of climate change on health e.g. air pollution and flooding. Our organisations are committed to minimising their carbon footprint, looking at the delivery of care and procurement of services. Each NHS organisation either has a Sustainable Development Management Plan in place, or is developing one during 2019/20, which sets out how they are reducing their carbon footprint.

Anchor institutions also need to support the health and wellbeing of their workforce, patients and visitors. This includes adopting and implementing Smokefree Trusts [3] and by taking every opportunity to embed prevention as part of care and not just tackling the presenting condition.

By adopting a partnership focus we can reduce inequalities, increase healthy life expectancy, reduce social isolation and improve wellbeing

1. *Putting Health into Place, https://www.england.nhs.uk/wp-content/uploads/2018/09/putting-health-into-place-v4.pdf*
2. *Sarah Reed et al., Building healthier communities: the role of the NHS as an anchor institution, Health Foundation, August 2019*
3. *See Duncan Selbie Blog https://publichealthmatters.blog.gov.uk/2018/05/31/progressing-a-smokefree-nhs/*

Population Health Management

What is the context for delivery? 1

Population health management improves population health by data-driven planning and delivery of proactive care to achieve maximum impact.

Population health management includes population segmentation and other methods to identify 'at risk' groups; designing and targeting interventions to prevent ill-health, to improve care and support for people with ongoing health conditions and reduce unwarranted variation in outcomes.

The NHS Long Term Plan expects that the NHS will deploy population health management solutions to support systems to understand the areas of greatest health need and match NHS services to meet them.

De-personalised data extracted from local records will enable more sophisticated population health management approaches, and by 2021/22 it is expected that every Integrated Care System in England will have systems that support population health management.

What progress has been made as a system so far?

Our Population Health Management approach is based on understanding our population at a Primary care Network Level. All Primary Care networks in BLMK have segmented their population as per the table below.

Ivel Valley South 35763	Generally well 24955		Long term conditions/ Long term needs 9162		Complexity of LTC(s) and/or disability
	Low risk 15041	High risk 9914	Low risk 1527	High risk 7635	High risk 2187
Children and Young People (0-25)	8236	1808	371	377	55
Working Age Adults (26-65)	6144	7208	914	4519	517
Older People	661	898	242	2739	1074

The most advanced Primary Care Networks are then developing their multi-disciplinary care responses for these different segments of the population. For instance, following the completion of their population segmentation, The Watling Network have developed a multi-disciplinary team approach to caring for those with frailty. This includes nurses working across the Primary Care Network to care for vulnerable over 66 year olds. In addition to this, the Network is working with their Patient Participation Group to deliver exercise programmes for this group and are now exploring greater integration with hospital care.

1 https://imperialcollegehealthpartners.com/wp-content/uploads/2018/07/Population-Health-Management-Flatpack-Version-1.0-Final-Sent.pdf

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Population Health Management

Future Ambition: What do we plan to do next?

1. Developing our vision for population health management

We will work with national experts to develop our vision; ensuring that our population health management approach uses the wealth of data we already have, encompasses prevention and early intervention across the life course, and addresses the wider determinants of health such as housing, employment and education.

2. Strengthening the foundations for population health management

- We will map and develop our population health management workforce capabilities.
- We will support our Primary Care Network leaders to develop their population health management skills and literacy.

3. Enabling data-driven system planning and quality improvement

- We will ensure that system and place-based planning continues to be informed by population health intelligence, and develop a more sophisticated understanding of the impacts of anticipated demographic growth.
- We will develop a shared approach to monitoring population health outcomes, and provide resources for Primary Care Networks to identify and address unwarranted variation in health outcomes.

4. Supporting Local Innovation

- We will support each 'place' to evaluate, refine and – where appropriate – scale up Primary Care Network and other population health management solutions.

We have just been successful in our bid to join Wave 2 of the NHS England and Improvement Population Health Management Development Programme. We aim to use this accelerated 20 week programme to enhance the population health management capabilities of a group of Primary Care Networks so that by 2020/21 the majority of our Primary Care Networks will be using Population Health management approaches.

What difference will this make for people in BLMK?

- Preventative interventions like screening and immunisations are accessible to those people who are least likely to seek them out.
- People with long term conditions receive the support they need to effectively manage their conditions, in a way that is more tailored to their personal circumstances.
- Professionals are able to better anticipate when someone is likely to develop additional health or care needs, and intervene to prevent or mitigate those additional needs.
- Health and care resources are used more effectively and matched to the needs of local communities.

How will we know we're making a difference?

- Patients report greater confidence in managing their own health.
- Professionals are able to recognise, record and support patients to address the social factors that often underlie physical and mental ill health issues.
- Reduced unwarranted variation in treatment and outcomes for cardiovascular disease, respiratory disease and cancer.
- Reduced growth in inappropriate hospital attendances and admissions, a key aspect of Our Partnership Focus.

Proactive, multi-agency and multi-disciplinary primary and community care

What is the context for delivery? 1

This is one of our top priorities as a partnership – we believe being more proactive in providing support to those with the highest and most complex needs is fundamental to better, more sustainable care.

Responsive, proactive and accessible primary and community health care is based around the lists of registered patients held by GP practices and must be delivered in partnership with a wide range of professionals who are supported to better understand the health and wellbeing needs of the local communities they serve.

GPs will play a central clinical leadership role for patient care, supporting and directing the provision and coordination of high quality healthcare for those that are ill.

Population health management (see previous section) will mean that increasingly, care will be more proactive in support of our local residents with the highest and most complex needs.

What do we know people are concerned about?

Engagement has consistently shown that people want improved access to primary care. This was a clear message from the Healthwatch engagement and 80% of survey respondents said that "improved access to GP services would help them stay well." Our survey also showed that people are willing to consider alternatives to a GP with 78% saying that they would be willing to see another healthcare professional (such as a pharmacist or a paramedic) if they could be seen more quickly.

The issue of the join-up of service was also raised. When organisations work separately, patients and residents are not always at the centre of services. This means that care starts and stops at the door of the organisations responsible for providing it or people, often at their most vulnerable, have the challenging task of navigating a complex health and care system.

What progress has been made as a system so far?

Working with the National Association of Primary Care (NAPC) since April 2018 we have developed the Primary Care Homes (PCH) model of care. The new model of care 'a complete care community' is built fundamentally around patients, for patients to ensure that they get the right care in the right place at the right time.

We are utilising the 22 PCNs across BLMK to bring together like-minded practices to formalise the 'Primary Care Home' model of care which can be described as:

- Provision of care to a defined, registered population of approximately 30,000 - 50,000.
- An integrated workforce, with a strong focus on partnerships spanning primary, secondary, community and mental health and social care.
- A combined focus on personalisation of care with improvements in population health outcomes (shared decision making and supported self-care).
- Aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Proactive, multi-agency and multi-disciplinary primary and community care

So far we have co-designed and tested an approach for developing fully integrated community-based healthcare through expanded community teams focused on identified and agreed priority patient population cohorts in seven out of the 22 BLMK PCNs.

We have also worked with local health and social care clinicians and service leads to describe what an multi-disciplinary team (MDT) workforce model would look like at PCN level and beyond. This helps us plan for future education and training, new roles and ways of working more effectively (see below).

core team

- MDT Manager/Co-ordinator
- GP (with expertise in care of the elderly)
- GP (generalist input)
- Case lead (drawn from the roles below)
- Social care professional
- Indivudal's GP (or practice representative)
- Nursing professional
- Pharmacist professional
- Therapy professional
- Mental health worker
- Voluntary and Community Sector expert
- Social prescribing link worker
- Administrator

- Hospital geriatrician or other acute input
- Specialist nurse (e.g. diabetes, COPD)
- Palliative care specialist
- Housing, police

Future ambition: What do we plan to do next?

Next, we need to help the 15 other PCNs move to a model of fully integrated community-based healthcare.

All our PCNs will be supported to develop in line with the NHS maturity matrix [1] with many being encouraged in future to go further and faster utilising opportunities including the eight modules outlined in the national PCN development prospectus.

We will implement the seven national service specifications on time. These are:

From April 2020:

- Structured medication reviews and optimisation.
- Enhanced health in care homes.
- Supporting early cancer diagnosis.

From April 2021:

- CVD Prevention and Diagnosis.
- Tackling neighbourhood inequalities.
- Anticipatory care.
- Personalised Care.

1. NHS England and NHS Improvement, PCN Maturity Matrix, August 2019

Proactive, multi-agency and multi-disciplinary primary and community care

What difference will this make to people across BLMK?

The implementation of the Primary Care Home model will mean that:

- Health, social care and voluntary community services work together so that our people receive care from the appropriate service or professional.
- There will be more focus on enabling people to be seen and treated in a community setting or their own home.
- The GP remains central to patient care, the ability to coordinate care across all elements of physical and mental health and social care needs will reduce the need for people to be referred from one team to the next.
- People will be able to see a greater range of healthcare professionals directly in Primary Care starting with clinical pharmacists in 2019/20, physiotherapists, pharmacy technicians, care co-ordinators, health coaches, dietitians, podiatrists, occupational therapists and physician's associates in 2020/21 and mental health professionals and paramedics in 2021/22 [1]. This should free up GP time and improve access.
- Social prescribing will be in place incorporating Social Prescribing Link Workers. This will help people to get access to local groups, activities and new hobbies. Individuals will have support tailored to their needs, ranging from very regular, intensive support to single-contact interventions.
- Patients will benefit by being able to access services quickly and will be helped to be more independent and manage their own health needs, understanding when and who to call for assistance if their condition exacerbates.
- People at End of Life will be supported, through advanced care planning, ensuring they have choice and control over the decisions that influence the way they are cared for.
- As outlined in the section on Population Health Management, our care model will become proactive – identifying local residents who are susceptible to their health deteriorating and provide a much improved care coordination service for those with complex needs or without any formal/informal networks.

How will we know we're making a difference?

All Primary Care Networks are encouraged to consistently evaluate their progress as they develop their new ways of working. This includes:

- Identifying and agreeing system and PCN population health priorities.
- Having a clear definition of the change that is required as a result of population health interventions.
- Contributing to improved patient access to primary care.

1. *The benefits of paramedics in primary care can already be seen at one practice in Luton https://www.england.nhs.uk/2019/01/gp-practices-free-up-3000-extra-patient-appointments-through-primary-care-network/*

New NHS Offer of Urgent Community Response and Recovery Support

What is the context for delivery? 1

Our partnership is committed to honouring the NHS Long Term Plan goal of more investment in community health services. The Long Term Plan proposes that by 2024 the responsiveness of community health crisis response services will have improved to two hours of referral (in line with NICE guidelines), where clinically judged to be appropriate. In addition, all parts of our partnership should be delivering rehabilitation/reablement care within two days of referral to those patients who are judged to need it.

What progress has been made before?

Across our partnership there are teams in each place delivering an urgent care response and rehabilitation services, often jointly with Council teams. However none of the teams are currently delivering a two hour response consistently seven days a week. The Home1st team in Milton Keynes and Rapid Response team in Luton all have the constituent parts and clinical leadership to meet this aspiration, but need to be connected with other parts of the system better and to increase their capacity.

What do we plan to do next?

Reducing avoidable unscheduled care is a clear priority. Therefore we are eager to bid to become an Accelerator site as part of the national Ageing Well programme.

This will cover the whole of our partnership and involve the three community health providers collaborating to a single model of delivery; fully involve the two 111 and Ambulance providers and work hand-in-glove with the three hospitals and four place based social care teams. All these organisations fully support the application to become an accelerator site.

What difference will this make to people across BLMK?

- Fewer people will need to be admitted to hospital – both for zero length of stay and longer admission periods.
- We will focus on reducing the numbers being admitted into hospital from all types of care homes as a priority.
- More people will retain their independence after they are discharged from hospital in a timely manner.
- We will consistently deliver the national standard for the 2 hours and 2 day response by the first quarter of 2023/24.
- All relevant health and care professionals will have access to the capacity available in urgent care teams on a live basis and will therefore use the teams more readily.
- Delivering this change will also reduce the bed usage in the three local hospitals

How will we know we're making a difference?

Our urgent response and re-ablement teams will be rigorously evaluated to determine :

- Whether this approach is succeeding on all aspects of the quadruple aim.
- Whether this approach is delivering the national specification (that will be developed during this time).
- Are we maintaining a high proportion of older people still at home 91 days after discharge from hospital?
- Have rehabilitation goals for local residents improved?
- Are we constraining the rate of growth per 100,000 of older people admitted into residential and nursing homes?

Primary and Community Care – Enhanced Health in Care Homes

People living in care homes have some of the greatest needs for health and care. We are making good progress in implementing the Enhanced Health in Care Homes Framework across BLMK. This contains a number of practical steps to improve care such as reviews of medication, the use of the Red Bag Scheme to help people going into hospital and more multi-disciplinary working. Details of implementation can be seen in Figure 1.

Preparation is underway, in anticipation of the Primary Care Network (PCN) Direct Enhanced Service, to further enhance the clinical elements delivered by PCNs.

BLMK* Priorities: NHSE Enhanced Health in Care Homes Framework *System-wide schemes. There are other additional schemes at local level – CCG/LA		**Bedford Borough** 36 care homes in scope	**Central Bedfordshire** 38 care homes in scope	**Luton** 21 care homes in scope	**Milton Keynes** 27 care homes in scope
Element 1: Enhanced primary care support	Red Bag scheme	All residential and nursing homes 34/34 and 40 LD homes.	All residential and nursing homes 38/38 and LD homes.	21/21 Care Homes.	27/27 Care Homes.
	Medication reviews programme	All residential and nursing homes 34/34 All care homes (CQC registered) have access to an annual clinical pharmacist review, anticipated coverage, 100%, subject to capacity.	All residential and nursing homes 38/38. All care homes (CQC registered) have access to an annual clinical pharmacist review, anticipated coverage, 100%, subject to capacity.	17/21 Care Homes. Plans in place to increase coverage via risk stratified approach. Interface pharmacist in post to review medications prior to discharge to care home.	27/27 Care Homes.
	NHS 111 *6 bypass for care homes	All residential and nursing homes 34/34.	All residential and nursing homes 38/38.	All residential and nursing homes 21/21.	Not required as already in place for 27/27 care homes.
Element 2: Multi-disciplinary team (MDT) support 35 care homes in BBC and 32 in CBC	Complex case management	Referral to fortnightly cluster MDT. 1/34 care homes has commissioned enhanced primary care support. GP alignment progressing within PCNs in readiness for Apr 2020.	All residential and nursing homes 38/38. *Enhanced service pilot Ferndale NH and Flitwick practice commenced.*	All residential and nursing homes 21/21 Community Enhanced Model of Care across all Care Homes.	27/27 Care Homes. *Home first rapid response.*
	Telehealth and telemedicine schemes	Whzan live in 4/34 care homes.[1] Plan for wider roll out to 10 additional homes.	Whzan in 7/38 homes. Wider roll out planned initially for additional 10 homes. QTUG falls risk assessment equipment in 4 homes.	4/6 Nursing homes. 2/15 Residential homes. *Pilots: Whzan and LDH Video-conference triage*	Local agreement – not required.
	Trusted Assessors	BHT assessor supporting majority of BBC care homes 35/36.	Trusted Assessor role is in place at L&D and BHT. TA supporting 38/38 care homes.	Local agreement – not required.	27/27 Care Homes. *Newly appointed to cover all homes*
Element 4: High quality care	Hydration training (reducing UTIs)	36/36 Care Homes. Assistant Practitioner leading Drink Well project.	38/38 Care Homes. Assistant Practitioner leading Drink Well project.	21/21 Care Homes.	*27/27 Care Homes.*
Element 5: Joined-up commissioning & collaboration between health, social care – and care home sector	Shared workforce planning for care home and domiciliary care staff	Phase 1: Joint BLMK Care Course Directory & Information Portal.	Joint workforce planning in place for 38/38 via CBC Care Association.	Phase 1: Joint BLMK Care Course Directory & Information Portal.	Phase 1: Joint BLMK Care Course Directory & Information Portal.
Element 6: Joined-up commissioning & collaboration between health, social care – and care home sector	Nhs.net	18/36 care homes have NHS.net address, 6 in progress.	24/38 care homes have NHS.net address, 6 in progress.	17/21 Care Homes, 4 in progress.	*18/23 Care Homes* *Plans progressing to introduce to all.*
	Enhanced WiFi	33/36 Wi-Fi audits completed. 33/36 Wi-Fi audits completed.	35/38 Wi-Fi audits completed.	21/21 Wi-Fi audits completed. Financial modelling underway.	Wi-Fi audits underway. *Planning for procurement & roll out.*
	SystmOne care home module	2 Residential homes confirmed for pilot.	1 NH, 1 RH, 1 LD home confirmed for pilot.	3 Nursing homes confirmed for SystmOne proxy-access.	*4 Care Homes. Plans progressing for rest.*

100% coverage across all care homes in scope
> 50% coverage across all care homes in scope – or project plan to roll out by 31/3/19
< 50% coverage across all care homes in scope
Alternative plan agreed for implementation at 'Place'

1. For more on Whzan see https://www.whzan.com/public/Home.aspx

Direct Digital Care

What is the context for delivery? 1

In our daily lives, the use of technology has transformed the way we live, with many of us now using digital platforms and Apps to do our shopping, banking, holiday bookings etc. Routinely, many of us also use technology to source information and manage our health and wellbeing. Previously, the use of technology across healthcare and wellbeing services has been limited and where technological solutions have been available, awareness and adoption has been partial.

The NHS Long Term Plan states that 'people will be empowered and their experience of health and care will be transformed, by the ability to access, manage and contribute to digital tools, information and services' adding that over the next five years, 'every patient will be able to access a GP digitally, and where appropriate, opt for a virtual outpatient appointment.' [1]

We are aiming to improve our digital technology to enable individuals to access, manage and contribute to their health and wellbeing journey. This includes developing alternatives to face-to-face consultations i.e. video and online consultations, patient apps to enhance personal management of outpatient appointments, remote monitoring to support early diagnosis and reduce unnecessary admission to hospital, and the use of wearable technology to improve health and wellbeing and manage specialised conditions such as diabetes.

What do we know people are concerned about?

- The potential for greater use of technology in service delivery was raised in our engagement, particularly amongst younger groups.
- 69% of our survey respondents said they would be happy to have telephone or online consultations as an alternative to face-to-face appointments. Those who were not happy to use alternative options often had specific reasons e.g. hearing difficulties and a requirement to lip read.
- When asked what would help 'support you to stay well?' the greater use of technology such as remote monitoring was highlighted by 49% of respondents, with those who didn't choose this option thinking it was not relevant at this stage of their lives.

What progress has been made in the system so far?

- **GP Consultations**
  48% of GP Practices are now offering online consultations, which allows a patient to contact the surgery by email or text to report a new condition or send updated information via email or text. This covers approximately 50% of our population.

  96% of GP practices in our partnership area now incorporate online options as part of their service (booking, repeat prescriptions and access to records). We are also piloting primary care video conference patient contact.

- **Care Homes**
  In Luton, a pilot with care homes is testing the adoption of a remote monitoring app for the most vulnerable patients to identify and treat health issues earlier, reducing unnecessary admissions to the Emergency Department. Early indications suggest this has reduced emergency presentations by 17% in this area.

1. NHS England and Improvement, NHS Long Term Plan, January 2019, pages 93 and 95

Direct Digital Care

- **Primary & Secondary Care**
  In Milton Keynes, virtual clinics have been adopted within several specialities across the patient pathway including; Ophthalmology, Urology, Colorectal, Trauma and Orthopaedics (fracture clinic) resulting in improved pathways for patients and reduced visits to their local hospitals.
- **Mental Health**
  Young People in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes have access to "Kooth," an online counselling and support platform.
- **Outpatients**
  Bedfordshire are introducing a tele-dermatology clinic, to provide faster access and reduce the need for consultant outpatient appointments.

What is the MyCare Patient App?

Milton Keynes Foundation NHS Trust has developed the new MyCare Patient App. The MyCare App is a portal that currently enables people referred to MKUH outpatients department to; confirm their attendance for outpatient appointments, cancel their appointments or change the date/time of their appointment.

Patients can also see their test results online and view letters that have been sent from the hospital to their GP. At this time, over 70,000 patients have registered to use this App to manage their outpatient appointments.

Any other developments planned?

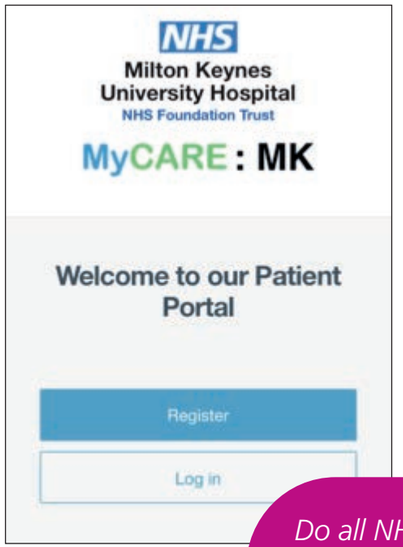
Our clinicians are coming up with opportunities to engage with patients via the app all the time. The next batch of developments may include;

- Allowing patients to utilise devices to inform their health care record
- Electronic consent forms
- Viewing your hospital patient record via your mobile.

What do patients say about MyCare app?

The MyCare patient portal survey carried out in 2019 showed that:

- 98% have no concerns about using the app.
- 95% found it Very Easy or Easy to register.
- 100% found it Very Easy or Easy to use the service.



Do all NHS hospitals have a solution like this? It's fab!

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Direct Digital Care

How will it benefit clinicians?

- The app enables patients to cancel and change appointments which means these can be freed up and rescheduled, improving utilisation of clinic slots.
- Where patients choose to go 'paperless' it reduces costs for the hospital.
- Where test results show no reason for concern, patients can be reassured in a timely manner and managed within a virtual clinic saving them the time of coming onto the hospital campus.

What do we plan to do next?

We will continue to transform the way we adopt and use technology to support and deliver our health and wellbeing services to our residents, so that patients and clients experience an optimum care pathway.

Our ambitions for the future include:

- All GP practices will be offering online consultations by April 2021.
- Currently, video consultations for patients are offered in two practices in Bedfordshire; plans are currently being developed to offer this functionality to all other practices across our partnership.
- Continuing to raise awareness and increase the availability and uptake of patient online services and the NHS App where available.

What difference will this make to people across BLMK?

- The increased use of digital technology in primary and outpatient care will ensure residents and patients have a greater range of options, improved support and appropriately joined up care at the right time, in the optimal setting for their needs.
- The ability to take photographs and have them immediately available in the patient's record has transformed things for both the patient and clinicians at MKUH. Patients attending the dermatology clinic can now see their image electronically and immediately whilst they are still in the consultation room with the consultant to support diagnosis and plan of care. They also have the ability to see images at subsequent visits and can see the progression of conditions over the course of treatment cycles, improving their care experience.
- Adoption of the remote monitoring Apps and shared care records will reduce the number of non elective admissions in hospital and ensure patients' needs are assessed at the point of need and alert carers and clinicians to any deterioration, so that necessary actions can be taken with limited delays.

How will we know we're making a difference?

We will monitor inputs, outputs and outcomes, which demonstrate:

- An increase in the number of GP Practices offering online and video consultations.
- Sustained reduction in face-to-face outpatient appointments by a third by 2024.
- Increased patient satisfaction levels in accessing GP and outpatient services.
- Earlier identification of health issues for care home residents, reducing the need for unnecessary transfer and admission to hospital.
- Reduction in unnecessary patient travel, helping achieve our priority of reducing our carbon footprint.

Elective Care: First Contact Practitioners

What is the context for delivery? 1

The NHS Long Term Plan expects that systems should have scaled their provision of First Contact Practitioners (qualified autonomous physiotherapists who are able to assess, diagnose, treat and discharge) so that all patients across England have access by 2023/2024.

National evaluation of the First Contact Practitioners pilot sites has demonstrated faster access to diagnosis and treatment for people with Musculoskeletal (MSK) conditions.[1] The First Contact Practitioners have supported more patients to effectively self-manage their conditions.

Health Education England (HEE) are supporting implementation of First Contact Practitioners, embedded within Primary Care Networks, from 1st April 2020. HEE have committed to funding 100% of the First Contact Practitioner roles in 2020/2021.

What do we know people are concerned about?

- Variation in waiting times for Physiotherapy.
- Limited capacity in General Practice with difficulties in booking appointments and having access to MSK-expertise.

What progress has been made as a system so far?

Bedfordshire CCG expanded its pilot to cover 60% of the population in Bedfordshire based on the initial MSK First Contact Practitioner specification. This has led to an increase in patients with MSK conditions being managed within their GP practice with a reported positive patient experience.

MK are piloting with a group of practices covering a population of 50,000 (20% of total MK population).

Luton are scoping the First Contact Practitioner model with alignment to the developing Primary Care Networks.

Future ambition: What do we plan to do next?

In line with 1st April 2020 requirement, Primary Care Networks will be supported to implement First Contact Practitioners' roles for MSK.

Following full implementation of First Contact Practitioners across BLMK Primary Care Networks, further scoping of non-MSK roles will be carried out including dieticians, occupational therapists and podiatrists.

There will also be promotion of MSK digital self-care applications to support MSK related exercises and pain management.

What difference will this make to people across BLMK?

- Faster access to diagnosis, advice and treatment for MSK problems.
- Increase in patient confidence in self care and self management.
- Access to physiotherapy closer to home.
- Freeing up GPs to deal with other health problems.

How will we know we're making a difference?

- Improved patient experience and outcomes.
- Contributing to improved access to GP Practice appointments.
- Reduction in the proportion of people within MSK requiring referral to specialist services.

1. NHS England and Improvement, Elective Care High Impact Interventions: First Contact Practitioner for MSK Services, May 2019

Elective Care: Waiting time for planned surgery

What is the context for delivery? 1

Patients should not expect to wait more than 18 weeks from the point of referral to treatment times (RTT). We therefore need to increase the amount of planned surgery year on year to cut long waits and reduce waiting lists.

What do we know people are concerned about?

Delays to planned treatment can be detrimental to a patient's health and wellbeing and can place strain on the wider health and social care system, including pain relief prescriptions, absence from work and in some cases, an increase in emergency presentations.

Patients would like to be informed of waiting times at the point of referral.

Being seen in the right place first time with access to health records and test results helps patients understand and manage their care.

What progress has been made as a system so far?

- Processes are in place across both provider and commissioners to review and monitor delivery against the constitutional standards for 18 weeks Referral to Treatment Time and 52 week long waits. Where indicated, recovery plans are agreed to address the causes.
- Milton Keynes CCG and Milton Keynes University Hospital are a Wave 1 implementer site for the NHS E-Referral Capacity Alerts which provided a flag to referrers indicating that patients were unlikely to be seen within 18 weeks. This flag influenced the patient's choice of provider at the point of referral.
- All three CCGs have been assessed as compliant with the NHS Choice framework[1] and we continue to monitor and promote the offering of Choice at the point of referral.

1. NHS England, NHS Choice Framework, April 2016

Future ambition: What do we plan to do next?

We commit to delivering the standards set out in the NHS Long Term Plan and Implementation Framework regarding NHS-managed choice for patient's waiting at 26 weeks for treatment and the full roll-out of NHS E-Referral Capacity Alerts.

The acute providers and commissioners will undertake a review of the waiting lists across our system to identify capacity risks and solutions to ensure patients are treated in line with the NHS Constitution rights.[2]

Standardisation of measuring our system performance against RTT targets.

What difference will this make to people across BLMK?

- People will have a greater choice of provider and earlier access to treatment.

How will we know we're making a difference?

- Reducing the time patients have to wait to receive treatment.
- Reduction in number of 52 week long waits.
- Improvement in patient experience.

Personalised Care

What is the context for delivery? 1

Our Partnership Focus makes clear that we want personalised care and support for all. To support this we are an exemplar site for the Personalised Care Programme, working to embed the Comprehensive Model of Personalised Care across our health and care system.[1]

What do we know people are concerned about?

Some people feel they would benefit from a more person-centred approach to their care planning and to have more control over the care and support that is offered to them.

There are some people for whom our standard services do not fully meet their needs and/or achieve the outcomes they would like to achieve.

What will help me to be as healthy and well as possible is "being involved in decision making"

Luton resident

My future NHS looks like "a seamless service for all people, empowering the patient"

Bedford resident

Personalised Care

What progress has been made as a system so far?

Local Authorities have led the way in personalisation through direct payments and personal budgets for social care. We are seeking to emulate this and we have made good progress in implementing the Comprehensive Model of Personalised Care.

Personalised care and support planning

300 staff have had training on providing personalised care, with more sessions planned for this year to include a "train the trainer" model. We are reviewing care plan documentation and processes to ensure they encourage a person-centred approach.

Patient Activation Measure and Social Prescribing

Patient Activation Measure [2] questionnaires are now used across our system as part of social prescribing pathways.

Social Prescribing is available and expanding across our system. As of April to September 2019 there had been 1333 social prescribing referrals, with 518 in Bedfordshire, 425 in Luton (April-August) and 390 in Milton Keynes.

Shared Decision Making

We are establishing shared decision-making (clinicians supporting patients to make a decision) initially with Chronic Obstructive Pulmonary Disease patients.

Personal Health Budgets

All patients now have a personal wheelchair budget.

We are working to expand personalised care and budgets to more people across our system.

Co-production

We regularly consult across our system to support decision-making and have a co-production group of service users.

Future ambition: What do we plan to do next?

We continue to expand the personalised care approach, initially targeting the following groups of patients:

- Mental Health (S117) and Learning Disabilities.
- Long term conditions and frailty.
- Maternity.
- End of Life.

1. NHS England, Comprehensive Model of Personalised Care, November 2018

2. The Patient Activation Measure helps to identify how confident people are in having the skills and knowledge to manage their own care.

Personalised Care

Mental Health and Learning Disabilities

We are developing a personalised offer for those entitled to Section 117 aftercare (people who have been admitted to hospital under the Mental Health Act 1983). This will include personal health budgets in readiness for the legal 'right-to-have' such budgets.

We recognise that Local Authorities have been leading work on personalisation for a decade and they, and mental health providers, will develop the skills and knowledge of people and staff to manage personal budgets and empower people with serious mental health illness to self-care.

Some people with complex mental health needs or Learning Disability clients are living in their own homes or supported accommodation and receive complex packages of care, whilst being assessed for suitability of personal health budgets.

Continuing Healthcare (CHC)

We will continue to work together to further develop CHC functions, processes and policies in order to ensure a high-quality personalised approach. We are committed to Personal Health Budgets being the default position for those receiving domiciliary care.

Long-term Conditions and Frailty

We will continue to make use of frailty index risk assessment tools in order to identify those who would benefit from personalised anticipatory care and support planning, self-care management, health coaching, community support, advice and guidance, navigation and rapid response MDT intervention, to identify and monitor those at risk of acute admissions.

Maternity

Particular focus will be on ensuring that all women have a personalised care plan by 2021, developed with midwife and other health professionals' support, which sets out personal decisions about care, and wider health needs and is kept up to date as pregnancy progresses. We will ensure that Personal Maternity Budgets are developed as part of our core offer.

End of Life (EOL)

We are currently transforming EOL care to include a focus on advanced care planning in Primary Care, training and education.

Children and Young People

We will continue to embed the personalised care approach within our offer for Children and Young People, including those entitled to Continuing Healthcare, as well as Looked After Children. This will include person centred care plans as well as personalised healthcare budgets, where appropriate.

Person Centred Care and Support Planning

We are committed to ensuring that people receive a truly person centred approach to care planning, continuing the shift to 'what matters to you?' rather than 'what is the matter with you?'. We will continue to expand on this approach through further comprehensive staff training and review. We expect the number of people with Personalised Care and Support Planning to increase from 7266 in 2018/19 to 18400 in 2023/24.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Personalised Care

Self-Care and Self-Management

Within the self-care/self-management programme, there are two main areas of activity:

1. Directory

We will further develop local directories to ensure they are a trusted source of current information for services and support to help people to manage their conditions in the community.

2. Health coaching – capacity building

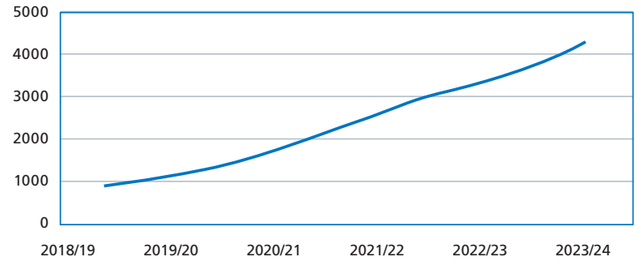
There will be continued training for various professional groups, including adult social care, housing, GPs and practice staff covering the following:

- Conversational skills.
- Behaviour change theory.
- Motivational interviewing.
- Goal-setting.

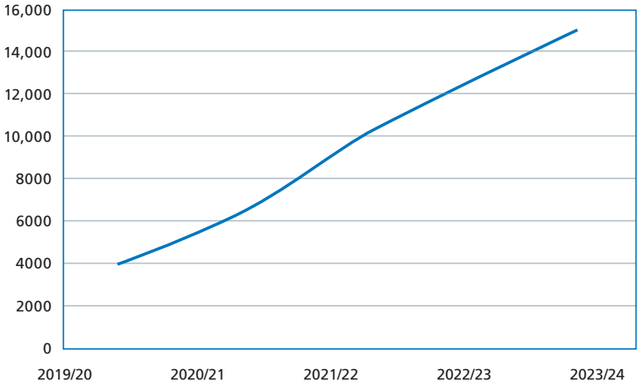
What difference will this make to people across BLMK?

- People will feel able to have a shared decision-making conversation about their care and treatment, including medication, where they are able to discuss what truly matters to them and the outcomes they wish to achieve.
- The increasing numbers of people with a Personal Health Budget (see Graph 1) will have choice over the care and support they receive in order to meet their needs and goals. Also, those using a Personal Health Budget to employ personal assistants should receive more consistent care.
- Everyone who can benefit will have access to non-medical wellbeing solutions through social prescribing, with a significant increase in referrals (see Graph 2).

Graph 1:
Total number of Personal Health Budgets that have been in place in the financial year to date



Graph 2:
Social Prescribing Link Worker Referrals



How will we know we're making a difference?

- Evaluation of the impact of the personalised approach, including patient surveys and feedback.
- Measurement of the changes in the Patient Activation Measure at patient level as well as Primary Care Network level.
- Contributions to reduction in unplanned care.

High Intensity Users

High Intensity Users

All of our partnership is now in the process of adopting and adapting the successful High Intensity User (HIU) programme first developed in Blackpool.

The HIU group is varied but is often those of working age with a range of conditions and extensive users not just of health, but wider public services.

Milton Keynes was the first in BLMK to introduce this personalised response to each individual's circumstances working with the Charity P3 to provide tailored support.

Results show that 999 Ambulance calls and hospital admissions dropped by about 90% among the group. The impact was not just felt by the health community as calls to the police 999 and 101 numbers from this group also reduced by 52%.

The MK programme is now multi-award winning and we are replicating it across BLMK, having held a system conversation on how we do this involving over 70 health and care professionals on 9 October 2019. This personalised intervention will clearly support Our Partnership Focus on reducing unplanned care.

The journey from Blackpool to Bedfordshire, Luton and Milton Keynes

2012/13
High Intensity Service Users launched in Blackpool

September 2018
CCG Planning Guidance for 2019/20 commits everywhere to establish an HIU scheme

October 2018
MKCCG 'Live Life' combined HIU/social prescription scheme goes live

April 2019
Development of HIU 'place' models supported by partnership wide group sharing learning

November 2019
Luton HIU lead embedded in Luton Lifestyle Services Offer

November 2019
Bedfordshire appoints two HIU care co-ordinators and adopts model

1. *For more information see: https://www.england.nhs.uk/rightcare/workstreams/high-intensity-user-programme/*

Urgent & Emergency Care

What is the context for delivery? 1

By expanding and reforming urgent and emergency care services, our practical goal is to ensure patients get the care they need fast, relieve pressure on A&E departments and better offset winter demand spikes.

What do we know people are concerned about?

The number of patients treated in A&E is much higher than five years ago. Some hospitals find it difficult to achieve the target of 95% of patients to be seen, treated and discharged/admitted within four hours. A&E attendances and Non-Elective admissions have increased by around 1.5% locally and 2.7% nationally in the year to date.

A&E attendances and Non-Elective admissions up by 1.5%

What progress has been made as a system so far?

Streaming:
A&E Front Door streaming is in place across BLMK.

Direct Bookings:
Many services across BLMK are receiving direct bookings from 111, including Urgent Treatment Centres (UTCs), Extended Access and GP practices.

Winter Planning:
There is a single winter plan in place which is implemented across BLMK.

What do we plan to do next?

Streaming:
A scale and place review of opportunities to increase the numbers of patients streamed away from Acute settings.

Direct Bookings:
An expansion of directly bookable services via 111 and maximising utilisation of all directly bookable services.

Winter Planning:
A scale and place development and enhancement of BLMK winter plans.

The development of a communication plan, informing the public of the transformation of the urgent care system.

What difference will this make to people across BLMK?

By encouraging patients to access a fully integrated out-of-hospital urgent and emergency care service, patients can be triaged and directed to the appropriate service.

How will we know we're making a difference?

There will be reduced waiting times in A&E and a reduction in the growth of A&E attendances.[1]

1. *There is a current clinical review of NHS Access Standards. For more information see: https://www.england.nhs.uk/clinically-led-review-nhs-access-standards*

Urgent & Emergency Care

What is the context for delivery? 2

Supporting patients to navigate the optimal service 'channel', we will embed a single multi-disciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out-of-hours services from 2019/20.

What do we know people are concerned about?

The NHS system is a complicated one, often leading to confusion for our patients who don't know who to call or where to go. In turn, many end up attending A&E or calling 999, especially during the out-of-hours period.

What progress has been made as a system so far?

A multi-disciplinary CAS is currently active across BLMK, integrated with 111 and GP out-of-hours.

CAS clinically validates ambulance and A&E dispositions.

What do we plan to do next?

Develop an integrated technical and clinical pathway between 999 and 111.

What difference will this make to people across BLMK?

A Clinical Advisory Service will provide a rapid clinician response where required. This will reduce the need for patients to be sent to hospital, or for an ambulance to be called when an urgent care response can fulfil patient need. Patients will be able to talk to a clinician in the comfort of their own home. Where needed, they will be seen by an Urgent Care practitioner, via a suitable booked appointment, improving the patient experience.

How will we know we're making a difference?

There will be reduced A&E attendances for those who could be managed in urgent care services, a reduction in A&E waiting times and a reduction in unnecessary ambulance call outs and conveyances.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Urgent & Emergency Care

What is the context for delivery? 3

We will fully implement the Urgent Treatment Centre model by autumn 2020 so that all localities have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111.

What do we know people are concerned about?

The variation across counties and localities is often confusing for patients with services that are similar but different, which are often given completely different names.

What progress has been made as a system so far?

Urgent Treatment Centres fully implemented across BLMK with UTCs located in Bedford, Milton Keynes and Luton. Appointments are bookable via 111 12 hours a day, seven days a week.

What do we plan to do next?

To develop an integrated urgent care pathway across BLMK incorporating GP Extended Access and other Urgent Care Provision to ensure a consistent offer.

What difference will this make to people across BLMK?

Patients can be booked into the UTC via 111 (if appropriate after triage) and they can also walk in/be streamed via A&E where the UTC is co-located on a hospital site (Bedford and MK) for an improved patient experience.

This enables prompt and effective management of those patients with life threatening conditions.

How will we know we're making a difference?

Reduced waiting times for patients being booked in and streamed.

Urgent & Emergency Care

What is the context for delivery? 4

We will continue to work with ambulance services to eliminate hospital handover delays.

What do we know people are concerned about?

Long waits in hospital for the handover of patients, therefore causing a delay in the ambulances getting back on the road to take the next call.

What progress has been made as a system so far?

Handover delays vary across BLMK, however, close working between the ambulance services, acute hospitals and commissioners continues to ensure we improve this.

What do we plan to do next?

Reduce handover delays via shared action plans between Acute Trusts, Ambulance Services and CCGs.

What difference will this make to people across BLMK?

- Patients not having to wait in major departments' reception areas.
- Improved response times for high priority ambulance call outs.
- Improved patient experience.

How will we know we're making a difference?

A reduction in unnecessary ambulance conveyances resulting in ambulances being available to attend to patients sooner.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Urgent & Emergency Care

What is the context for delivery? 5

We will also increase specialist ambulance capability to respond to terrorism.

What do we know people are concerned about?

The threat to our population from terrorism and our emergency preparedness and response.

What progress has been made as a system so far?

EAST and SCAS Terrorism Plan in place.

Future ambition: What do we plan to do next?

Review EAST and SCAS Terrorism Plan, currently working with NHSE/I to increase specialist ambulance capability to respond to terrorism.

What difference will this make to people across BLMK?

Assurance that there is sufficient specialist ambulance capability in place which is regularly tested with system partners to ensure that our system can effectively manage terrorism incidents.

How will we know we're making a difference?

By having sufficient specialist capability in place, which is regularly tried and tested.

Urgent & Emergency Care

What is the context for delivery? 6

Safely reduce avoidable conveyance.

What do we know people are concerned about?

A number of patients being conveyed to hospital unnecessarily due to insufficient access to pathways across BLMK, particularly during the out-of-hours period.

What progress has been made as a system so far?

Elements of the national Ambulance Improvement Programmes are in place across BLMK relating to:

- Falls.
- Mental Health Crisis.
- Care Homes.
- Access to GP/HCP Advice.
- Optimising the response.
- Optimising the clinical skills of the workforce.

Future ambition: What do we plan to do next?

- Work with both Ambulance Services to produce a gap analysis against the Ambulance Improvement Programme.
- Develop an action plan against the gap analysis.

What difference will this make to people across BLMK?

Patients will be signposted, referred to and booked into appropriate services to suit their healthcare needs at the right time, therefore reducing unnecessary conveyance to hospital.

How will we know we're making a difference?

- Reduced A&E attendances, with a reduction in subsequent hospital admissions.
- Reduced volume of ambulance conveyances, resulting in ambulances being available to attend to patients much sooner.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Urgent & Emergency Care

What is the context for delivery? 7

Every acute hospital with a type 1 A&E department will move to a comprehensive model of Same Day Emergency Care. This will increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third.

What do we know people are concerned about?

Patients are being admitted to wards due to minimal Same Day Emergency Care, which can be scattered across different areas of the Acute, and badged with different names such as Ambulatory Care, Acute Assessment Unit, Surgical Assessment Unit, Clinical Decision Unit etc.

What progress has been made as a system so far?

Luton & Dunstable hospital has an existing Ambulatory Care Centre running 12 hours a day.

Bedford and Milton Keynes hospitals also have existing Ambulatory Care Services, however, these are only available Monday to Friday. Bedford is developing its approach to enable patients who are 'safe to sleep at home' to receive Same Day Emergency Care.

Future ambition: What do we plan to do next?

- Benchmark the current percentage of emergency admissions which are SDEC against the national target.
- Work with providers to extend the availability of Same Day Emergency Care to seven days a week, 12 hours a day across the whole of BLMK.
- Re-badging of Ambulatory Care to Same Day Emergency Care.

What difference will this make to people across BLMK?

- Reduce pressure on hospital bed stock by optimising the number of patients receiving SDEC.
- Better patient experience, not needing to be admitted into a bed, where appropriate enabling discharge on the same day.
- Reduced volume of admissions, increasing flow through the hospital with a safer Bed Occupancy percentage.

How will we know we're making a difference?

- Same Day Emergency Care increases to a third of admissions by 2024.
- Contribute to reductions in A&E waiting times.

Urgent & Emergency Care

What is the context for delivery? 8

We will, as part of the NHS Clinical Standards Review being published in the spring, develop new ways to look after patients with the most serious illness and injury, ensuring that they receive the best possible care in the shortest possible timeframe.

What do we know people are concerned about?

Current clinical standards can be confusing and difficult to achieve with a requirement for significant investment.

What progress has been made as a system so far?

Field Testing taking place in Luton & Dunstable hospital during the summer of 2019 reviewing:

- Time to initial assessment.
- Time within one hour for emergency treatment for critically ill and injured patients.
- Time in A&E.

Future ambition: What do we plan to do next?

BLMK to roll out the recommendations when published in Autumn 2019.

What difference will this make to people across BLMK?

Patients will be treated in a timely and clinically appropriate manner, spending the right time in an acute setting and being treated more quickly.

There will be a standardised approach to emergency care.

How will we know we're making a difference?

Reduce risk of patient harm through long waits and avoid overnight stays giving the right treatment quickly.

Urgent & Emergency Care

What is the context for delivery? 9

The NHS and social care will continue to improve performance in getting people home without unnecessary delay when they are ready to leave hospital.

What do we know people are concerned about?

Medically Optimised patients can be delayed leaving hospital due to a number of factors, including insufficient discharge planning and higher levels of complex clients, often with behavioural issues.

What progress has been made as a system so far?

Delayed Transfer of Care across BLMK remains on target, with pathways in place to facilitate, discharge and reduce delays.

Future ambition: What do we plan to do next?

Development of Discharge App to help identify patients and expedite discharge (Bedfordshire and Luton). MK may follow at a later date.

Introduction of the DPTL lists may encourage earlier discharge planning, and a focus on working to EDDs.

What difference will this make to people across BLMK?

Patients will spend less time in hospital, being proactively managed in an integrated way whilst in hospital or intermediate units. This will not only free up acute and intermediate beds and increase flow but will also result in lower demand for services as there is reduced risk of muscle wastage, particularly amongst older and more frail members of the population.

How will we know we're making a difference?

- Reduced length of stay in hospitals.
- Better patient experience.
- Lower risk of muscle wastage in the elderly due to unnecessary hospital delays in discharge.
- Increased hospital flow.

Mental Health

Mental health is a priority for our partnership. We know that mental health is a significant concern for the populations we serve (see quotations), and that they expect us to deliver better prevention for people at risk, improved community and crisis care for those who need it, and to tackle the health inequalities that people with mental health problems often experience. We also know that mental health problems are often a factor in the complexity that impacts across the health and care system and beyond. For these reasons, we are committed to working together to help people and communities to build resilience, and to support people with mental health problems and their families to achieve their health and life goals through good quality person-centred services.

To do so, we will ensure that mental health is at the heart of the development of our partnership, with sustainable mental health providers working together with primary, secondary, social care and the voluntary sector to develop integrated whole person services and deliver the NHS Long Term Plan. Mental Health provision will be increasingly integrated with physical health through Primary Care Networks and Integrated Care Partnerships.

The rest of this section summarises our plans on mental health.

Mental health inequalities can have significant impact on an individual's wellbeing.

Mental ill health during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of a mother and her baby, as well as for her partner and other family members.

We need an appointment-based mental health service in local schools.

Central Bedfordshire resident

Being lonely and isolated has a huge impact on mental health so I would like to see more done to improve this.

Milton Keynes resident

Have mental health posters and details everywhere.

Bedford resident

You should not have to reach crisis point before mental health services are available.

Luton resident

Mental Health

What is the context for delivery? 1

Mental health inequalities can have a significant impact on an individual's wellbeing.

What do we know people are concerned about?

Mental health inequalities are often linked with wider cultural and societal systems of disadvantage which impact on a person's wellbeing, including adverse childhood experiences, stigma and discrimination.

What progress has been made before?

We are identifying health inequalities within our Bedfordshire, Luton and Milton Keynes footprint.

What do we plan to do next?

We will formulate localised solutions to overcome barriers to access, experience and outcomes. These will include personalised care plans and more locally-based access to mental health support.

What difference will this make to people across BLMK?

By recognising mental health inequalities, we can work to reduce stigma, improve people's health outcomes and people will live healthier lives for longer.

How will we know we're making a difference?

- A greater number of people will access care closer to home and report improved care outcomes.
- People will live healthier lives for longer.

Mental Health

What is the context for delivery? 2

Mental ill health during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of a mother and her baby, as well as for her partner and other family members.

What do we know people are concerned about?

Women and their families do not always get consistent advice about what care is available or about their medication. They worry about being mentally unwell in pregnancy or with a baby.

What progress has been made before?

The Bedfordshire and Luton Specialist Perinatal Mental Health Community Service has been established and the Milton Keynes Specialist Perinatal Mental Health Community Service has been expanded.

What do we plan to do next?

Expand the service to support women from pre-conception to 24 months after birth and further support for their partners.

What difference will this make to people across BLMK?

There will be earlier intervention and support to prevent mental health crisis for women. Almost 1,000 new mothers who will experience mental health difficulties will be able to access quality support quickly by March 2021.

How will we know we're making a difference?

There will be a continued improvement of experience for women and their partners and they will receive timely holistic care.

Mental Health

What is the context for delivery? 3

Children and young people have additional access to support via NHS-funded mental health services and school or college based Mental Health Support Teams.

What do we know people are concerned about?

Between the ages of 5-15, one in every nine children has a mental disorder. Half of all mental health problems are established by the age of 14, with 75% established by the age of 24.[1]

In talking to young people, mental health is their number one health issue.

What progress has been made before?

There has been increased access to mental health support for children and young people and there has been year-on-year progress made in providing psychological therapies for more residents.

What do we plan to do next?

There will be three new Mental Health Support Teams and expansion of mental health crisis support. There will also be the development of children and young people's eating disorder services. Access to treatment will increase, including the expansion of support for people who have a long term condition.

What difference will this make to people across BLMK?

The Mental Health Support Teams will work in schools and colleges to support children and young people experiencing mental health issues to help children and young people get the right support and stay in education.

How will we know we're making a difference?

Children and young people with mild to moderate mental health needs will be supported, with a focus on those struggling to access education.

1. NHS England and Department of Health, Future in Mind, September 2015

Mental Health

What is the context for delivery? 4

Improving Access to Psychological Therapies (IAPT) services will be expanded with a focus on older people and Long Term Conditions.

What do we know people are concerned about?

There is an increasing need for residents to access timely psychological therapies, particularly for people who have a long term condition.

What progress has been made before?

There has been year-on-year progress made with providing psychological therapies for more residents.

What do we plan to do next?

Access to treatment will increase, including the expansion of support for people who have a long term condition.

What difference will this make to people across BLMK?

People will have greater access to talking therapies and will recover well. There will be further integration with primary care.

How will we know we're making a difference?

National targets for access and recovery will be met and people with long term conditions will have increased access to talking therapies.

Mental Health

What is the context for delivery? 5

By 2023/24 there will be new models of integrated primary and community care for adults and older adults with severe mental illnesses, built around Primary Care Networks. There will be an increased focus on improving access to psychological therapies, improving physical health care, access to employment and support for self-harm and coexisting substance misuse. There will be the further development of dedicated services such as Early Intervention in Psychosis (EIP) Services and Adult Community Eating Disorder Services. There will be a particular focus on addressing the mental health needs of older adults wherever they may arise or present.

What do we know people are concerned about?

People may not be receiving the care they need due to current thresholds for services and that people discharged from services are vulnerable. People with severe mental illnesses have poorer physical health outcomes than the general population and there is a need to assist people with severe mental illnesses to gain and keep paid employment. There is a concern that there is not an integrated approach to older people's care and support needs across mental and physical health.

What progress has been made before?

Integrated primary and community services are under development, which should remove thresholds to ensure that people can access the care, treatment and support at the earliest point of need. There are now systems in place to undertake physical health checks in primary care settings. There are Individual Placement and Support services across Bedfordshire and Luton and there is the mobilisation of a new service for Milton Keynes.

What do we plan to do next?

We will roll out new models of care across Primary Care Networks from 2020/21, aiming for full coverage by 2023/4. There will be increased monitoring of physical health checks achieved in each Primary Care Network.

Individual Placement and Support Services will operate across Bedfordshire, Luton and Milton Keynes. There will be the further development of Early Intervention in Psychosis (EIP) Services and Adult Community Eating Disorder Services.

What difference will this make to people across BLMK?

People will be able to access the care, treatment and support at the earliest point of need so that they can live as well as possible in their communities. There will be improved physical health and access to employment for people with severe mental illnesses. There will be improved experience and outcomes for people with a first episode of psychosis, adults with eating disorders and older people with mental health needs.

How will we know we're making a difference?

People will receive the care they need to help them recover and stay well. We expect to see reduced inpatient admissions, reduced crisis incidence, improved employment and increased access to psychological therapies. There will also be improved physical health and improved outcomes and experiences for older adults and carers to address their mental health needs.

Mental Health

What is the context for delivery? 6

By 2023/24 there will be 100% coverage of 24/7 age appropriate crisis care, via NHS 111. This will include 100% coverage of 24/7 mental health crisis care provision for children and young people which combines crisis assessment, brief response and intensive home treatment functions.

What do we know people are concerned about?

There is a concern that there is not all-age 24/7 Crisis Resolution and Home Treatment Team support. People want alternatives to A&E for when they are in crisis. Children and young people face difficulties accessing appropriate out-of-hours crisis services which results in the reliance on A&E.

What progress has been made before?

There is currently the mobilisation of adult and older adult Crisis Resolution and Home Treatment Teams that will be able to operate 24/7. Crisis provision for children and young people is being developed. There is a plan to develop crisis cafés/sanctuaries across BLMK as an alternative to A&E and all acute hospitals have psychiatric liaison services.

What do we plan to do next?

Crisis provision for children and young people will be implemented. Crisis cafés/sanctuaries will be opened across Bedfordshire, Luton and Milton Keynes. The first crisis café will open in Luton in January 2020. We will work with the ambulance services to improve the mental health response.

What difference will this make to people across BLMK?

- People of all ages will have access to crisis support 24/7.
- Adults will have alternatives to A&E when in crisis.
- People will have better support from the ambulance services when in mental health crisis.
- People will be well informed regarding their options if they are in crisis.

How will we know we're making a difference?

For those experiencing a mental health crisis there will be reduced use of A&E, reduced admissions to inpatient beds and people will feel better supported when in a crisis. There will be increased support for children and young people and for their families at a time of crisis.

Mental Health

What is the context for delivery? 7

By 2023/24 the therapeutic offer from inpatient mental health services will be improved by increasing investment in interventions and activities, resulting in better patient outcomes and experience in hospital.

What do we know people are concerned about?

There is a concern that people may not be receiving the quality of care they need and have unnecessary lengths of stay in inpatient mental health services.

What progress has been made before?

We have eliminated inappropriate adult out of area placements. East London Foundation Trust are working to develop a re-provided Bedfordshire Inpatient Centre of Excellence, with the aim of providing high quality inpatient multi-disciplinary treatment and care for people in mental health crisis, in a modern environment. Initial scoping is complete, with land options under review.

What do we plan to do next?

We will review care and the therapeutic offer on our inpatient wards. Full business case development and procurement will take place through to October 2020; planned implementation through to April 2023.

What difference will this make to people across BLMK?

There will be a reduction in lengths of stays and there will be better patient outcomes and experience whilst in a mental health inpatient service.

How will we know we're making a difference?

There will be improved experience of care for people who require inpatient mental health services. This will be due to increased therapeutic staffing levels as well as improvements to the inpatient environment.

Mental Health

What is the context for delivery? 8

There is a focus on suicide prevention and suicide bereavement support services providing timely and appropriate support to families.

What do we know people are concerned about?

There is a need to reduce the risk of suicide in key high risk groups; provide better information and support to those bereaved or affected by suicide and to reduce rates of self-harm.

What progress has been made before?

The mental health providers have developed zero-suicide ambition plans for their mental health inpatients units. Bereavement support services are being provided across BLMK.

What do we plan to do next?

We will develop a real-time data system for Bedfordshire, and continue with place based risk reduction. We will further develop bereavement support services.

What difference will this make to people across BLMK?

- There will be more support for our residents to prevent suicide and to reduce self-harm.
- There will also be improvements to mental health services such as 24/7 crisis care.

How will we know we're making a difference?

There will be a reduction in suicide rates and improved suicide bereavement support for families and staff.

Mental Health

What is the context for delivery? 9

By 2023/24 20 high-need areas will have established new specialist mental health provision for rough sleepers.

What do we know people are concerned about?

People who are rough sleepers have problems accessing the mental health support they need.

What progress has been made before?

Luton has been selected as a test site to establish a new service for rough sleeping specialist mental health support.

What do we plan to do next?

Specialist mental health provision for rough sleepers will be developed across BLMK.

What difference will this make to people across BLMK?

There will be an integrated approach to meeting the needs of rough sleepers.

How will we know we're making a difference?

There will be increased access and continuity of care for rough sleepers.

Cancer

What is the context for delivery?

1 in 2 people will get cancer in their lifetime. Across Bedford Borough, Central Bedfordshire, Luton and Milton Keynes approximately 4,500 people are diagnosed with cancer each year and 40% of those diagnoses will lead to death.

The most commonly diagnosed cancers are breast cancer, prostate cancer and colorectal cancer. There are approximately 1,769 preventable cancers in BLMK each year. Smoking is a major cause. Smoking rates are higher in Luton than the England average at 18.9% and the smoking prevalence has stopped decreasing in BLMK. Lack of physical activity and obesity are also significant. In order to achieve world-class outcomes for patients, we must tackle these preventable risk factors.

Our context for improvement on cancer is:

- The incidence of cancer is predicted to increase.
- Work by NHS RightCare and our Patient Experience survey suggest that improvements can be made in certain areas of cancer care. For instance, one year survival rates for breast cancer are worse than England for Luton and Milton Keynes CCG, one year survival for lung cancer is worse than England for Bedfordshire CCG and one year survival for colorectal cancer is worse than England for Luton CCG. We have therefore identified Early Diagnosis and Personalised Care as key priorities.
- Cancer services should be localised where possible and centralised where necessary.
- The NHS Long Term Plan set out requirements to improve diagnostic capacity and improve the way cancer services are organised. We have already started a programme of work around this.
- We want to reduce health inequalities over the next ten years. In some parts of our partnership there is an 11 year difference in life expectancy between the least and most deprived areas, with the main cause of death attributed to cancer.
- Our partnership works with three different Cancer Networks (with tertiary centres in Cambridge, Oxford and London) which adds to a complex system of delivery.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Cancer

Cancer performance against the NHS Constitutional Standards has been a challenge for some providers, in particular around the 62 day standard. The expectation behind this Cancer Waiting Time standard is that 85% of patients have their first definitive treatment within 62 days from GP referral. Whilst ICS performance has been generally good, some of our providers have struggled to meet this standard due to rising demand in two week wait referrals and capacity challenges in diagnostic services. There is a commitment across the system to support providers in achieving the NHS Constitution Standards by introducing the National Best Practice Timed Pathways, increasing diagnostic capacity and exploring networking opportunities across providers to support challenged pathways.

The NHS Long Term Plan sets two bold ambitions for improving cancer outcomes. These build on and accelerate the significant progress already made through delivery of the recommendations of the Independent Cancer Taskforce (2015):

- **By 2028, 55,000 more people will survive cancer for five years or more each year; and**
- **By 2028, 75% of people will be diagnosed at an early stage (stage one or two).**

Our cancer transformation programme is supported by NHS England Improvement East of England Alliances (North/South). Their funding has enabled much of the cancer work programme progress to date. This funding is expected to continue for the next four years giving the system some stability in terms of resourcing plans to deliver the NHS Long Term Plan ambitions.

Our partnership has produced a 'plan on a page' summary of our work on cancer for the delivery of the transformation programme, and a local cancer strategy is being finalised following workshops and events with key partners, clinicians and stakeholders.

The rest of the cancer section then looks in detail at each area. In developing this plan for Cancer, Healthwatch supported us by bringing together focus groups of people with cancer and their views have helped shape our next steps.

Cancer – Earlier and Faster Diagnosis

2 What is the context for delivery?

The NHS Long Term Plan sets three ambitions for improving cancer outcomes.

By 2020, the Faster Diagnosis Standard will be introduced to ensure that most patients receive a definitive diagnosis or rule out cancer within 28 days of referral.

By 2023 we intend to increase the achievement of the Faster Diagnosis Standard by 8%.

By 2028, 55,000 more people will survive cancer for five years or more each year; and

By 2028, 75% of people will be diagnosed at an early stage (stage one or two).

What do we know people are concerned about?

- Are we doing enough to raise awareness of cancer signs and symptoms?
- We still have a high proportion of cancers diagnosed through emergency route at stage 3 and 4.
- We will not achieve the LTP ambition of 75% diagnosed at stage 1 and 2 without a joint approach to Early Diagnosis.
- One year survival is below the England average, particularly in Luton.
- Cervical screening coverage has fallen across our area, in line with the national trend (PHE, NHAIS 2018).

What progress has been made as a system so far?

- Implementation of the national best practice timed pathways for prostate, colorectal, and lung so that patients are diagnosed within 28 days from referral.
- Roll-out of Faecal Immunochemical Testing (FIT) in primary care to try to catch bowel cancer early.
- Introduced multi-parametric magnetic resonance imaging diagnostic test for prostate cancer pathway at Bedfordshire Hospital.
- Introduced Straight to Test pathway at Milton Keynes hospital for colorectal cancer pathway.
- Introduced faster radiology reporting at Luton and Dunstable Hospital for lung cancer pathway.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

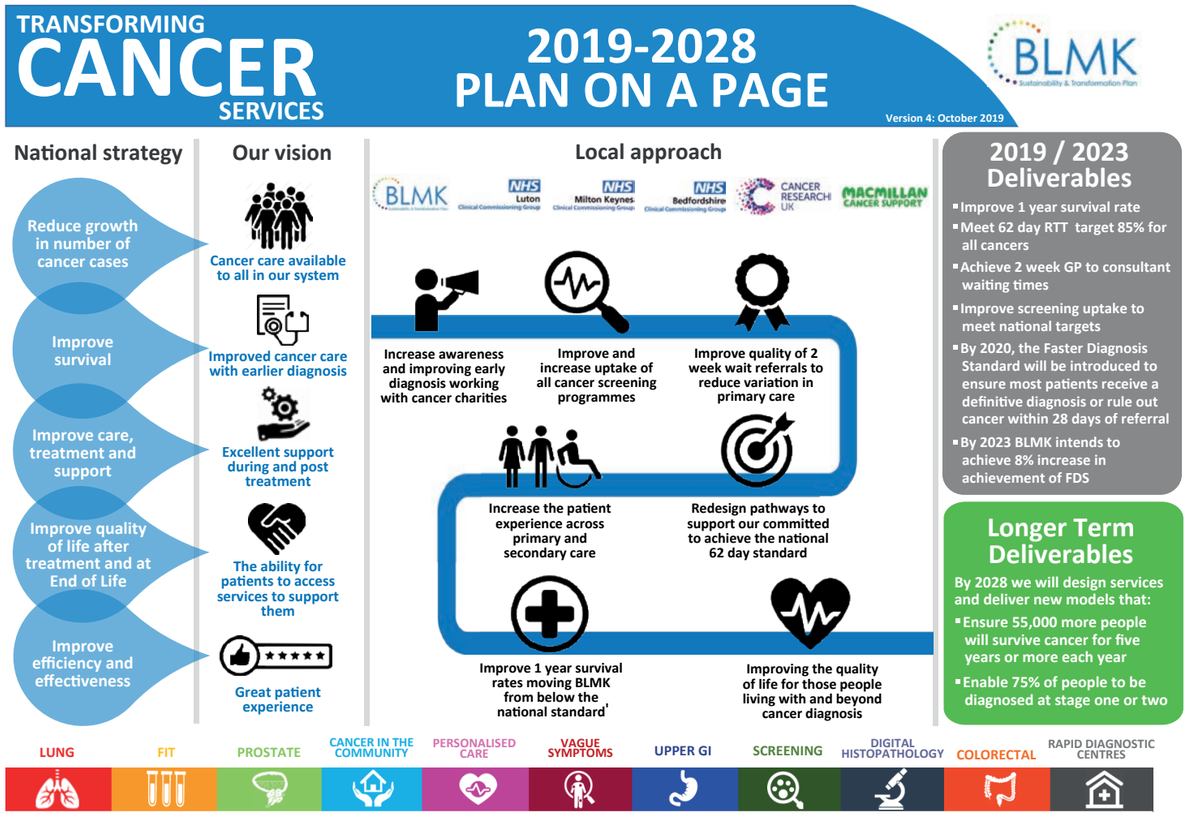
Cancer – Earlier and Faster Diagnosis

Future ambition: What do we plan to do next?

- First phase of targeted Lung Health checks Programme in Luton CCG.
- Develop joint CCG Early Diagnosis Plan.
- Improve GP referral practice.
- Development of Rapid Diagnostic Centre within our partnership starting with the Vague Symptoms pathway.
- Improve primary care education and public awareness on recognising signs and symptoms of cancer.
- Improve access to patients in primary and community care avoiding A&E – right care, right time, right place.

What difference will this make to people across BLMK?

- Reduce the people diagnosed at a later stage which will improve survival rates. The current target is 56% and will be 75% by 2028.
- Improve the patient experience particularly in Milton Keynes.
- Improve cancer performance against the NHS Constitutional standards so that all Acute Trusts are maintaining the 62 day target.
- Improve one and five year survival rates.
- Achievement of new Faster Diagnosis Standard from April 2020.



Cancer – Screening

What is the context for delivery? 3

Our deliverable is to improve the uptake of the national bowel, breast and cervical cancer screening programmes, to meet the minimum published programme standards. This can be achieved by addressing inequalities, improving access to services and reducing variation so that providers consistently meet the national standard.

What do we know people are concerned about?

- There is significant variation in uptake across our partnership. Screening uptake rates have been declining over the years. Bedfordshire and Milton Keynes screening uptake is generally in line with national average, Luton is significantly below the national average.
- Healthwatch found that people feel the screening programmes should not be restricted by age, so we need to better explain the value for money and quality of care reasons for doing so.

What progress has been made as a system so far?

- There are already place-based plans around screening uptake.
- Luton CCG undertook a campaign specifically aimed at increasing cervical screening uptake in conjunction with Luton Borough Council.
- Bedfordshire CCG and Cancer Research UK are working with practices with the poorest screening uptake as part of a targeted piece of work. The team is looking at how GP practice IT systems can flag non-responders more effectively to the primary care team for action.

Future ambition: What do we plan to do next?

- Support Public Health England with the implementation of introducing the FIT Test to the national Bowel Screening Programme.
- Support Public Health England with the roll-out of HPV screening programme initiatives to reduce the risk of HPV-related cancers. (HPV for boys was implemented in September 2019 and HPV for girls is complete).
- Develop a common approach to increasing screening uptake in partnership with primary care and Cancer Research UK local facilitators.
- Take forward successful screening bid as part of the Cancer Transformation Programme. The proposal aims to improve screening uptake in the Bowel, Breast and Cervical screening programmes. The work programme has been developed starting with practices in the most deprived areas across BLMK.

From September 2019, all boys aged 12 and 13 will be offered the HPV vaccination.

By 2020 HPV primary screening for cervical cancer will be implemented across England.

From summer 2019, the Faecal Immunochemical Test will be implemented across England.

By 2023/24 significant improvements will be made on the uptake of the screening programmes.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Cancer – Screening

What difference will this make to people across BLMK?

- The earlier cancer is detected the more likely it is that outcomes are improved.
- Increased uptake rates across Bedford Borough, Central Bedfordshire, Luton and Milton Keynes, particularly for cervical screening will help detect cancer sooner.
- If successful in our screening bid in December 2019, outcomes for screening will be improved, as set by the EOE Cancer Alliance for 2023/2024 for significant improvements on the uptake of screening. (See EOE Cancer Alliance Five Year Plan) with a special focus on cervical cancer.

Treatment

What is the context for delivery? 4

The aim is that patients will receive the most effective, precise and safe treatments, with fewer side effects and shorter treatment times.

What do we know people are concerned about?

- There is variation across Bedford Borough, Central Bedfordshire, Luton and Milton Keynes in terms of the proportion of patients treated within 62 days.
- Many of the Long Term Plan ambitions are commissioned by other stakeholders – specific concerns have been raised as to how our views are represented in relation to co-commissioning with regional specialised commissioners.

What progress has been made as a system so far?

- Cancer Board established to have oversight of all *NHS Long Term Plan* ambitions.
- Well established cancer transformation programme in place to improve cancer waits.

Future ambition: What do we plan to do next?

- Work with the Cancer Alliance to implement the safer treatment ambitions.
- Support the delivery of an updated specification for radiotherapy and children and young people.
- Explore local opportunities to redesign pathways to improve diagnostic and treatment options.
- Currently, we are exploring innovative AI Solutions with IBM and other commercial collaborators to improve patient pathways and clinical decision making.
- Use transformation to increase capacity within diagnostics services across our area.

What difference will this make to people across BLMK?

- Improve patient outcomes.
- Improve the patient experience (this will be done via the Bedfordshire, Luton and Milton Keynes Patient Forum, Patient Stories and the continuation of national and local surveys).
- Improved performance.
- Increase in survival rates.
- Reduced variation in diagnosis and treatment.

How will we know we're making a difference?

Maintaining cancer waiting times.

Introducing genomic testing.

Improving radiotherapy access and outcomes.

Continuing to improve access to clinical trials.

Enhancing cancer services for children and young people.

Personalised cancer care

What is the context for delivery? 5

To roll out personalised care interventions, including supported follow up pathways to improve quality of life.

What do we know people are concerned about?

- A key Patient Experience survey and focus group feedback theme is that people want more information to help them make informed choices. They would also like raised awareness of services available across Health and Social Care.

What progress has been made as a system so far?

- The programme has already achieved the 19/20 planning guidance deliverable for personalised care in Breast Cancer services.
- It has introduced new roles across Acute and Community services to support patients at the point of diagnosis and throughout their treatment.
- GP practices are participating in a pilot in conjunction with the East of England Cancer Alliance and Anglia Ruskin University to provide Cancer Care Reviews at GP practice level.
- Introduced health and wellbeing opportunities at the point of diagnosis in response to patients' feedback that they wanted tailored support at the start of their treatment journey.
- Increased access to physical activity with trained professionals.
- Rolled out Cancer Care in the Community model in Luton.

Future ambition: What do we plan to do next?

- Work with Acute, Community and Macmillan partners to continue to roll out and improve the quality of personalised care interventions such as needs assessments, care planning and health and wellbeing support in key specialities – Breast, Urology and Colorectal.
- Work with lead nurses and the EoE Cancer Alliance to develop Patient Centred Follow Up pathways supported by IT Remote Monitoring systems.
- Continue to expand Cancer Care in the Community as part of place-based plans and linked to Primary Care Networks.
- Develop IT tools as a routine part of the patient pathway to support self-management i.e. NHS Apps and patient portals.
- Roll out further Cancer Care Reviews in Primary Care as part of Primary Care Network development.

What difference will this make to people across BLMK?

- Improve the patient experience.
- Move cancer care into a more integrated approach to delivery providing seamless care to patients.
- Patients and carers feeling more in control of their health.
- A reduction in A&E attendances by a place-based care approach to cancer care in the community.

How will we know we're making a difference?

By 2020 all breast cancer patients will move to a personalised (stratified) follow-up pathway once their treatment ends, and all prostate and colorectal cancer patients by 2021.

By 2021 everyone diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.

From 2021, the new Quality of Life (QoL) metric will be in use locally and nationally.

Workforce

What is the context for delivery? 6

Over the next five years, it is expected that additional clinical and diagnostic staff will be recruited. All patients, including those with secondary cancers, will have access to the right expertise and support, including a Clinical Nurse Specialist or other support worker. We will also recruit an additional 1,500 new clinical and diagnostic staff across seven priority specialisms by 2021 (recruitment started in 2018).

What do we know people are concerned about?

- Our workforce challenges are consistent with the national picture in terms of recruitment and retention in key professional groups such as Radiology, Pathology, specialist nursing and consultant posts.
- The workforce issues relating to cancer will be addressed through the wider BLMK workforce plan.

What progress has been made as a system so far?

- We are participating in an East of England workforce project led by General Electric to understand the gaps and opportunities for skill-mix redesign.
- We are implementing an agile multi-disciplinary team concept which will make the best use of clinical time and improve productivity. This model of care will be an integrated and multi-disciplinary approach to patient care.

Future ambition: What do we plan to do next?

- Provide in-house training opportunities for staff to develop into – the 'grow our own' concept.
- Provide an appropriate infrastructure matrix working, IT connectivity and a virtual environment.
- Develop digital solutions for enhancing workforce gaps with efficiency.

What difference will this make to people across BLMK?

- Improved patient experience.
- Reduction in delays to treatment as a result of staff vacancies.
- Reduction in workforce gaps in key specialities.

Specialist Cancer Care

What is the context for delivery? 7

The incidence of cancer is predicted to increase and therefore we need to ensure that providers and commissioners are adequately prepared to manage the increasing demand.

What do we know people are concerned about?

- Cancer services should be localised where possible and centralised where necessary.
- Patients have identified that pathways in secondary care are good, however the link into primary and community care needs improvement.
- Patients have identified transport as an issue, with the requirement for travel to specialised services being recognised.

What progress has been made as a system so far?

- We have participated in a review of specialist cancer services at one of our tertiary providers.
- We have reviewed fragile services and explored opportunities for shared services across providers; there are opportunities through the merger of two of our local providers.

Future ambition: What do we plan to do next?

- Manage capacity issues by allowing staff to work in sites across our system, providing peer support and a one team approach.
- Forge better communication and links with our tertiary centres.
- Developing a Cancer Strategy for our partnership is a key enabler of developing new care models and identifying innovation and research.

What difference will this make to people across BLMK?

- An improved patient experience.
- A reduction in delays to treatment.
- Improved pathways and integrated care.
- The development of more sustainable services.

Primary Care

What is the context for delivery? 8

The *NHS Long Term Plan* set an expectation from 2020 that Primary Care Networks will support Early Diagnosis through a programme of enhanced services to the GP contract. The *NHS Long Term Plan* also states that systems should have plans to improve GP Referral practice.

What do we know people are concerned about?

- 'I had to see my GP eight times before I was referred to hospital' [1]
- GP scores are not improving on the annual National Cancer Patient Experience Survey.

What progress has been made as a system so far?

- Significant Event Audit undertaken in Primary Care to understand reasons for high emergency presentations of Lung Cancer.
- A number of GP training events undertaken.

Future ambition: What do we plan to do next?

- Continue targeted GP training events.
- Work with Primary Care Networks on developing the Early Diagnosis Direct Enhanced Service contract (service specification due out in December 2019).
- Work with Cancer Research UK to develop the BLMK plan for supporting primary care with screening uptake initiatives.

What difference will this make to people across BLMK?

- Cancers will be found earlier which results in earlier curative treatment leading to better patient experience and survival rates.
- Care closer to home will be a model that Primary Care Networks will be developing in the areas of earlier diagnosis, diagnostics closer to home and patient education which will lead to personal ownership and empowerment.

1. Person with cancer spoken to by Healthwatch

Maternity

What is the context for delivery? 1

In February 2016 Better Births set out the five year improvement plan for NHS maternity services in England which would see maternity services become safer, more personalised, kinder, professional and family friendly. Better Births recognised that such a vision could only be delivered through locally led transformation. The Local Maternity System (LMS), a partnership of those working on maternity services for Bedfordshire, Luton and Milton Keynes (BLMK) was established, in response to this, in March 2017.

Our Vision – 'To deliver seamless, system wide maternity care with comparable high standards across the Local Maternity System which is co-produced with service users offering choice, safe, kind and personalised care provided in the right place to improve user experience'

We will expand the implementation of Better Births up to 2021 to incorporate the NHS Long Term Plan commitments up to 2024.

What do we know people are concerned about?

- BLMK LMS has developed strong relationships with the three local Maternity Voice Partnerships (MVP) and the local communities.
- The LMS Co-production Steering Group is made up of public representatives, clinicians, childbirth groups, mental health and disability groups.
- Over a three month period in 2018, we listened to 900 women and asked about everything, from the experience they had with their GP, to the hospital and in the community.
- In June 2019 we hosted a 'Whose Shoes?' event which brought together parents and health care workers to discuss their experiences of maternity care in BLMK.
- Key themes emerging from these engagement events include:
  - Breastfeeding support.
  - Continuity of carer.
  - Adherence to birth plans.
  - Support for mental health.
  - Post natal care.
  - Care on maternity wards.
  - Choice and decision-making.
  - Language and Communication.

What progress has been made as a system so far?

The implementation of our LMS Maternity and Neonatal Transformation Plan is progressing well and a number of key milestones have been achieved. It is challenging and complex work that has gained huge commitment and input from across our partnership. Since 2017 the LMS has developed strong, more joined up working relationships, underpinned by a transformation programme with effective governance and reporting arrangements in place. Particular achievements include the securing of funding to deliver perinatal mental health care across BLMK, establishing a regular programme of serious incident review panels and a successful bid for specific continuity of carer training. This training has been completed across all relevant teams.

1. More detail on maternity and neonatal care is contained in a separate appendix (see Chapter 6)

Maternity

Future ambition: What do we plan to do next?

- Fully implement the Saving Babies' Lives care bundle (version 2) by March 2020. A gap analysis is currently being undertaken and actions will be added to the LMS-wide safety action plan, which includes actions to reduce maternal smoking rates.
- Work with the clinical network to learn from the pilot Maternal Medicine Networks.
- Build on the pilot phase of our Continuity of Care (CoC) programme to progress plans towards 35% CoC by March 2020 and over 50% by March 2021 specifically focused on target populations.
- Progress the development of a local personalised care plan that is co-produced with our service users and learns from the pilot schemes in each trust.
- Milton Keynes Midwifery Led Birthing Unit to go live in 2020.
- All women to receive improved postnatal care, in line with an agreed improvement plan.
- Continue investigating and learning from incidents, and sharing this learning through the LMS and with others. We are also working with Healthcare Safety Investigation Branch where appropriate.
- Improve access to postnatal physiotherapy to support women who need it to recover from birth.
- Continue to develop public sector services and reach out to community and voluntary sector support to create a system-wide alliance that can support women to breastfeed in the communities where they live.
- All trusts to progress through the BFI levels of accreditation.
- Work to implement the recommendations of the Neonatal Critical Care Review.

In all these actions we will adopt the principle of co-production to develop excellent services with the people who use them.

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Maternity

What difference will this make to people across BLMK?

- Service users will have a voice in making improvements to the local maternity system.
- Safer maternity services will deliver standardised care, with the majority of women reporting that they have experienced personalised care.
- Women will have continuity of carer and choice to be able to access midwifery-led care (wherever this is safe and realistic) for the birth of their baby.
- There will be reduced rates of stillbirth, neonatal death, maternal death and brain injury. Fewer mothers and families will be traumatised by tragic pregnancy and birth-related events. There will be fewer babies and children with disabilities relating to birth trauma.
- Improved outcomes for women and babies particularly in vulnerable 'target groups'.
- There will be learning from incidents to improve care.
- Women will be able to access and input to their personalised care plan.
- Fewer women will be affected by genitourinary and continence issues following child birth.
- Babies will be healthier with improved short, medium and long term health outcomes.
- There will be an improved experience for mums, partners and families when a baby is in Neonatal Intensive Care.

How will we know we're making a difference?

- Feedback from mothers, families and staff.
- We will monitor the rates of stillbirth, neonatal death, maternal death and brain injury during birth aiming for a reduction of 20% by the end of 2020/21, and 50% reduction by 2024 (as shown in table below).

Indicator	2016 baseline	2023/24
Stillbirth (rate per 1,000 live and still births)	3.43	1.71
Neonatal death (rate per 1,000 live and still births)	2.03	1.02
Brain Injury (rate per 1,000 live births)	4.19	2.09

- Increasing numbers of women will receive continuity of carer – we expect 60% of women to have such continuity by 2023/24, up from 9.3% in 2018/19.
- We will monitor documentation to ensure that all pregnant women have a personalised care plan and can make choices about their maternity care, during pregnancy, birth and postnatally.
- We will monitor activity for women giving birth in midwifery settings (at home and in Midwifery Led Birthing Units).
- Increased breastfeeding initiation rates and continuation of breast feeding at six-eight weeks.
- Maternity Voice Partnership is able to report good engagement and work progressed in a co-produced manner.
- We will see a reduction in serious incidents where themes have emerged across the system.
- We will see a reduction in the number of women affected by genitourinary issues following childbirth.

Children and Young People

What is the context for delivery? 1

Across our area we are seeking to deliver services that offer person-centred and age appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need so that:

- Children and young people in BLMK will have better physical health, mental health and wellbeing.
- Children and young people and their parents and carers will experience a seamless service delivered by an integrated health and care system.
- There will be a skilled workforce that listens to them, responds and meets their needs.

Improving effective prevention and early intervention

As per Our Partnership Focus priorities 1 and 2, we are seeking to ensure children have the best start in life. Through the Healthy Child Programme we are identifying needs early and ensuring appropriate support and interventions. We are also seeking to increase and protect investment in universal health visiting and school nursing services.

As a result, our aim is to be in the top 5% nationally on these indicators:

- Immunisations and vaccinations uptake.
- Decayed, missing or filled teeth at age five.
- Childhood obesity.
- Level of development at age five.

How will we know we're making a difference?

As a result, our aim is to be in the top 5% nationally on these indicators:

- Vaccinations uptake.
- Decayed, missing or filled teeth at age five.
- Childhood obesity.
- Level of development at age five.

Children and Young People

What is the context for delivery? 2

Children and young people account for 26% of A&E attendances and are the most likely age group to attend A&E unnecessarily.[1]

Children aged 0-4 have the highest number of attendances at A&E.

The Royal College of Paediatrics and Child Health estimates that 15-40% of children's A&E attendances could be seen out of hospital.

What do we know people are concerned about?

Each one of these A&E attendances tells us that a parent was worried, and either unable or unsure of how to access a more appropriate service.

What progress has been made as a system so far?

Care pathways have been developed, promoted and used for high-volume acute care conditions. This includes: respiratory conditions, fever, gastroenteritis, abdominal pain, head injury, seizure and self-harm.

Future ambition: What do we plan to do next?

- Reduce avoidable attendances at emergency departments (and zero length of stay hospital admissions) through learning programmes for community and primary care, expansion of rapid response nursing, care coordination and improving self-care.
- Reduce variation across practices, working with Primary Care Networks to deliver high quality children and young people services.
- Support parents, carers and their children to better manage minor illness and long term conditions e.g. asthma and epilepsy.
- Scope integrated services for children and young people with epilepsy, constipation and asthma and wheeze based on NICE recommended clinical guidance for 2020/21.

1. Royal College of Paediatrics and Child Health, Child health in 2030 in England, 2018

What difference will it make to people across BLMK?

- Increased availability of urgent care in the community.
- A better patient experience for children and young people and their families.
- Improved outcomes for children and young people with long term conditions, especially asthma, diabetes and epilepsy.

How will we know we're making a difference?

A reduction in attendance and emergency admission rates.

Children and Young People: Improving resilience and meeting more complex needs

What is the context for delivery? 3

A local needs assessment undertaken in July 2019 found that:

There needs to be a whole system approach to early identification of the signs of poor mental health.

There needs to be more targeted prevention and access to low level support particularly for vulnerable groups at risk of poor mental health.

Future ambition: What do we plan to do next?

- We are strengthening mental health support in schools including a Designated Senior Lead for mental health and mental health support teams.
- We will be seeking to improve access to health and care through digital technology, building on successful examples such as Kooth.
- We will ensure coordinated and multi-disciplinary support for more vulnerable children and families with complex needs, using an approach informed by adverse childhood experiences and trauma.
- We will continue to safeguard vulnerable children and young people by improving identification and help for children affected by abuse, neglect and child sexual exploitation; Female Genital Mutilation; domestic violence and children living in families affected by mental ill health, drugs and alcohol.
- We will review the quality and provision of health assessments for Looked After Children.

What difference will it make to people across BLMK?

- Families will experience more joined up and seamless care.
- Families, children and health and care professionals will understand how health and care is organised across our partnership.
- Families will be able to access help early.

How will we know we're making a difference?

As few children and young people as possible will need to access more specialist health and care services.

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Children and Young People: Improving resilience and meeting more complex needs

Children and Young People with Special Educational Needs and Disabilities (SEND)

There is a considerable rise in the numbers of children and young people needing SEND support and we know, following inspection by Ofsted and Care Quality Commission in 2018, that we need to improve SEND services in Luton, Central Bedfordshire and Bedford Borough.

Therefore we will take the following actions:

We will develop improved services and meet need, in partnership with the Parent Carers Forums for those with SEND children.

We will improve outcomes for children and young people with SEND by ensuring that access to services is based upon 'need' as opposed to 'diagnosis.'

One way we plan to improve is by increasing the numbers of children and young people benefiting from Personal Health Budgets. This will be supported by better Education, Health and Care plans.

We will improve the information and advice available online.

We will work with partners to bring hearing, sight and dental checks into special schools.

We will know we have succeeded based on the feedback from parent carers. We also hope it will lead to positive re-inspections in Luton, Central Bedfordshire and Bedford Borough.

Learning Disability and Autism: Children, Young People and Adults

What is the context for delivery? 1

People with Learning Disabilities and/or Autism (20-30% of those with a learning disability also have autism) [1] have worse health outcomes, dying sooner than people in the general population. Care has not always been as good as it can be for people with Learning Disabilities and Autism, with the most notorious example of poor care taking place at Winterbourne View in Gloucestershire. This has lead to a national drive through the Transforming Care Programme to improve services in the community so that that fewer people need to go into hospital for their care.

What do we know people are concerned about?

Those with learning disabilities are not always receiving the care they should e.g. rates of annual health checks are too low.

Parents of children with learning disabilities and autism say that care is fragmented and that they often end up being the care coordinator for their child.

Health and Care professional and parents are worried about there being a gap in service provision for those with learning disabilities and/or autism who experience crisis.

We are also working with the National Development Team for inclusion, to develop our approach to engagement with adults with Learning Disabilities and/or autism and their carers. This will help us in developing better services.

What progress has been made as a system so far?

We have established new priorities in February 2019 to improve the health, wellbeing and life chances for people with learning disabilities and/or autism. These focus on: Early Help and Prevention; Market Shaping and Developing Small Supports; Improving Physical and Mental Health; and All-age Intensive Support.

For children and young people we have made some specific improvements with Care (Education) and Treatment Reviews developing alternatives to hospitalisation when the child or young person has a crisis.

Since 2015, the number of children, young people and adults with a learning disability and/or autism in inpatient care has reduced. We currently have six children and young people and 26 adults with learning disabilities and autism in inpatient care.

Future ambition: What do we plan to do next?

We will develop keyworkers for children and young people with the most complex needs and their carers/families from 2020/21. Initial funding will focus on supporting children and young people who are in mental health inpatient units.

We will work with local partners and providers to offer internship programmes for people with a learning disability and/or autism, implementing the national support programme in partnership with NHS Employers.

We are working with Primary Care Networks to stop the over-medication of adults and children in line with the National initiative (Stopping Over Medication of People with a learning disability or autism and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP)) [1] to reduce inappropriate prescribing of psychotropic medication.

1. Emerson, E. & Baines, S. (2010) The Estimated Prevalence of Autism among Adults with Learning Disabilities in England. Improving Health and Lives: Learning Disabilities Observatory

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Learning Disability and Autism: Children, Young People and Adults

We will decrease the numbers of people with a learning disability and/or autism in inpatient care (we are aiming to reduce to 19 adults by 2023/24 and three children and young people by March 2021) through a number of actions including:

- Putting in place discharge plans (known as 12 point plans).
- Increasing provision of support in the community when people with a learning disability and/or autism are having a crisis, to reduce the likelihood of admission.
- Making use of Individual Service Funds (including Personal Health Budgets) to allow people to get the support they need to stay healthy and well in their community.
- Use capital investment to support the development of new housing options and suitable accommodation in the community.

We will improve the timeliness of the Learning Disabilities Mortality Review Programme, which reviews deaths of those with learning disabilities. All reviews will be undertaken with six months of the notification of death and the learning used to improve services.

We will implement the National Learning Disability Improvement Standards in all NHS funded services, including private providers, ensuring greater consistency of provision.

To help joined up provision, by 2023/24 a digital flag in the patient record will ensure staff know someone has a learning disability and/or autism.

We are improving the uptake of Annual Health Checks for people with learning disabilities and/or autism so that 75% of those eligible have one each year.

What difference will this make to people across BLMK?

Those with a learning disability and/or autism should experience more personalised care that focuses on helping them stay healthy and well in the community.

1. Public Health England (2015) Prescribing of psychotropic drugs to people with learning disabilities and/or autism by general practitioners in England

In particular:

- By 2023/24 children and young people with learning disabilities and/or autism will have a designated key worker, beginning with those most at risk of admission to inpatient care.
- People with a learning disability and/or autism will have greater control over their care e.g. through the use of personal health budgets and personalised care plans.
- By 2023/24, fewer people will be in inpatient care (all of which is outside the local area).

How will we know we're making a difference?

People with learning disabilities and/or autism will live healthier and longer lives, with improved physical and mental health.

There will be a reduction in the number of people with learning disabilities and autism admitted to hospital due to mental health crisis and when this cannot be avoided, the length of stays will be reduced.

Carers and parents will feel supported and empowered.

There will be a reduction in the prescribing of psychotropic medication for people with learning disabilities and/or autism. [1]

There will be a reduction in family breakdown and children and young people with learning disabilities and/or autism being cared for in residential settings, leading to reduced costs for local authorities.

Health and care professionals working with people with learning disability and/or autism will feel they are providing a better quality of care.

Cardiovascular Disease, Stroke, Diabetes and Respiratory

What is the context for delivery? 1

The strategic approach for Cardiovascular Disease (CVD), Stroke, Diabetes and Respiratory will be developed with our communities recognising their different needs. We will seize the opportunity to operate within a common framework and tackle important issues at scale, delivering a sustainable healthcare system. The overarching principle of the approach for CVD, Stroke, Diabetes and Respiratory is to optimise care through risk stratification, evidence-based treatments and best practice pathways, with support for self-care and prevention.

What do we know people are concerned about?

Our population with Long Term Conditions tell us that:

- They want to be involved in and have information to support decisions about their care, enabling them to self manage their condition but have rapid access to advice and support when they need it most.
- They want to be treated as a whole person and to have coordinated care – to tell their story once - and where possible, have fewer appointments.

What do we need to improve?

We know we need to improve prevention, diagnosis and treatment for long term conditions because:

- 24% of deaths in BLMK are caused by circulatory diseases.
- There is a lower recorded prevalence of hypertension than the national average (13.1% vs 13.9%). A lower proportion of people with hypertension have their blood pressure controlled than the average nationally (76.4% vs 79.1%).
- There is a low prevalence of atrial fibrillation compared to the prevalence expected.
- There is a high number of strokes and the highest prevalence of strokes per 100,000 population.
- There is a rising prevalence of Type 2 Diabetes, largely driven by unhealthy lifestyle behaviours. Across BLMK, 66,231 people have either Type 1 or Type 2 diabetes. (8.5% of the population).
- Achievement of the three diabetes treatment targets (HbA1c, Blood Pressure, Cholesterol) is lower than the national average.
- There is a lower prevalence of COPD compared to the prevalence expected (meaning people are undiagnosed).
- Though smoking prevalence is lower than the national average (16.9% vs 17.2%), as a key risk factor for CVD, respiratory disease and cancer, this must be further reduced.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Cardiovascular Disease, Stroke, Diabetes and Respiratory

What progress has been made as a system so far?

- BLMK has held Right Care programme workshops covering CVD and Respiratory to produce system-level plans to address the variation and improve outcomes.
- Integrated working between community services, such as specialist respiratory services and IAPT to support people with long term conditions and co-existent psychological needs.
- Healthy Hearts pilot to identify undiagnosed hypertension (particularly in deprived areas).
- Nationally recognised for high engagement with the NHS Diabetes Prevention Programme.
- Appointed as an early adopter site for Healthy Living for People with Type 2 Diabetes.
- Successful bid to become a pilot site for the NHS Low Calorie Diet Programme in Type 2 Diabetes.
- Multi-disciplinary foot care teams for people with diabetes, with reductions already seen in rates of major amputations.
- Diabetes inpatient specialist nurses in all our acute trusts and evidence of reductions in lengths of stay.
- Mobilising an Asthma Mentorship Support education programme to increase management of asthma patients by practice nurses.
- Launched a BLMK workforce development programme that includes access to Cambridge Diabetes Education Programme and EDEN ‘train the trainer’ modules.
- Expanded provision and access for patients to Diabetes Structured Education programmes.

Identification:
Work with Primary Care Networks to implement a population health management approach; stratifying on the basis of risk with appropriate assessment and support, and using standardised tools to close the gap in prevalence and reduce unwarranted variation.

Timescale: March 2022

What difference will this make to people across BLMK?

Being identified with a disease or risk factors earlier with appropriate proactive management and support should result in a greater number of years in good health and reduced premature mortality.

How will we know we’re making a difference?

- A reduction in the gaps between expected and observed prevalence for CVD, Respiratory disease and Diabetes.
- Improved long-term outcomes for people identified to have chronic diseases with reduced morbidity and premature mortality.

Cardiovascular Disease, Stroke, Diabetes and Respiratory

Smoking:

Launch a refreshed smoking cessation strategy, working closely with Public Health.

Timescale: March 2022

What difference will this make to people across BLMK?

Better access to support and information to help stop smoking.

How will we know we're making a difference?

Reduced smoking prevalence and impact on respiratory illnesses.

Wellbeing and Self-Management:

Develop a comprehensive and holistic self-management strategy directed at reducing unhealthy lifestyle behaviours and optimising physical health and psychological wellbeing.

Timescale: March 2022

What difference will this make to people across BLMK?

Empowering our population to take more control over their physical and psychological wellbeing and support self-management of chronic health conditions.

How will we know we're making a difference?

- Improving rates of physical activity.
- Reducing the rise in prevalence of obesity.
- An increase in the uptake of talking therapies.

Wellbeing and Self-Management:

Engage with patients living with Long Term Conditions and co-produce the offer with them to ensure a personalised approach.

Timescale: December 2021

What difference will this make to people across BLMK?

Services are better suited to meet the needs and access requirements of our populations.

How will we know we're making a difference?

- Improved patient satisfaction rates.
- An increase in the proportion of people living with a long term condition who report they are confident in self-managing their condition.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Cardiovascular Disease, Stroke, Diabetes and Respiratory

CVD:

Design and implement a system-wide strategy to identify and manage hypertension and atrial fibrillation in line with the Public Health England ambition.

Timescale: March 2022

What difference will this make to people across BLMK?

Reduced numbers of people who are living with hypertension or AF but have not been identified and/or are not receiving appropriate treatment, leading to improved long-term outcomes.

How will we know we're making a difference?

- Reduced rates of cardiovascular events including myocardial infarction and stroke.
- Reduced incidence of heart failure.
- Higher QOF achievement for proportion of people with hypertension meeting BP targets and high risk AF receiving anticoagulation.

Stroke:

Develop an Integrated Stroke Delivery Network (ISDN) involving all services from pre-hospital through to early supported discharge, community care and life after stroke to ensure the delivery of optimal stroke pathways and support the delivery of the NHS's seven-day standards for stroke care.

Agree a new model of care for stroke in line with national guidance that ensures consistent access to high performing stroke units and equity of access to best practice post-acute stroke care including rehabilitation (ESD and stroke specialist bed-based rehabilitation where indicated).

Timescale: March 2021

What difference will this make to people across BLMK?

People will have access to the highest quality care following a stroke, with reduced variation, leading to better long-term recovery with the possibility of living independently.

How will we know we're making a difference?

- Consistent improved performance recorded on SSNAP across all domains.
- Increased completion of six and 12 month stroke reviews.
- A greater proportion of people living at home independently after a stroke.

Cardiovascular Disease, Stroke, Diabetes and Respiratory

Diabetes:

Implement Healthy Living for People with Type 2 Diabetes and support a greater proportion of the population to access Structured Education.

Timescale: December 2021

What difference will this make to people across BLMK?

There will be universal access to Structured Education, both face-to-face and digital, allowing a choice of options to support people with Type 2 Diabetes, according to their individual needs and preferences.

How will we know we're making a difference?

Higher recorded uptake of Structured Education Increased achievement of the NICE 3 treatment targets for people with Type 2 Diabetes and, in the long-term, a reduction in the incidence rate of the complications of Type 2 Diabetes.

Diabetes:

Develop the evidence-base for real-world implementation of Low Calorie Diets in Type 2 Diabetes.

Timescale: March 2021

What difference will this make to people across BLMK?

People newly diagnosed with Type 2 Diabetes will have access to an evidence-based intervention to potentially achieve diabetes remission.

How will we know we're making a difference?

Increased numbers of people achieving remission of Type 2 Diabetes improved glycaemic control and long-term outcomes for people who have been recently diagnosed with Type 2 Diabetes.

Respiratory:

Introduce multi-disciplinary respiratory hubs to identify and manage complex respiratory disease closer to home and improve outcomes. This will include improved quality of diagnostics (accredited spirometry), increased uptake of vaccinations (influenza and pneumonia) and increased uptake of Pulmonary Rehabilitation.

Timescale: March 2022

What difference will this make to people across BLMK?

Earlier identification of respiratory disease, with evidence-based support and management to improve symptoms and increase number of years in good health.

How will we know we're making a difference?

- Greater recorded prevalence of respiratory diseases.
- Increased uptake of pulmonary rehabilitation.
- Reduced exacerbation of respiratory disease and reduced unplanned admissions.

Medicines and Prescribing

What is the context for delivery? 1

Medicines are the most common intervention in healthcare and in the NHS we spend over £1 in every £8 on medicines. [1]

Medicines are used across all settings and by an increasing number of professionals.

Pharmacy professionals are a highly skilled workforce who can contribute significantly to the Longer Term Plan.

What are the current issues?

The NHS medicines bill is rising every year. 5-10% of hospital admissions are medicines related, and two thirds of these are preventable. [2]

What progress is being made this year?

- We have developed a Medicines and Prescribing Programme Board for our partnership with the vision and strategy needed to focus on ensuring we are maximising the value of medicines locally.
- We are adopting a joint medicines formulary across Bedfordshire and Luton.
- We are focusing on medicine safety. This includes supporting improvements in primary care prescribing and dispensing, with more use of clinical pharmacists and technology. We are also improving information on discharge medicines via better links with hospital and community pharmacists to reduce errors where care transfers.
- We are developing a systemwide approach to antimicrobial stewardship, one of the major challenges facing healthcare systems globally.
- We are establishing better relationships with local community pharmacists who are supported to take on clinical roles e.g. to manage patient demand for minor illnesses from urgent care settings.
- We are working to expand our pharmacy professional workforce – through a joint approach with local pharmacy leadership and the refinement of a ten-point plan to support all pharmacy professionals in all care settings. This includes supporting the recruitment and utilisation of clinical pharmacists in practices in patient facing roles to reduce harm from medicines and improve patient outcomes.

Future ambition: What do we plan to do next?

- We will look to achieve economies of scale in our approach across our partnership, including developing a joint medicines formulary and streamlining decision-making processes for medicines.
- We will continue medicines safety and antimicrobial stewardship activities through collaboration with professionals, patients and the public.
- We will support local community pharmacy teams to deliver a pharmacy contract with an emphasis on their clinical contribution and supporting collaboration with Primary Care Networks.
- We will use the best prescribing data, informatics and safety software to ensure patients are supported to getting the best from their medicines, whilst reducing pharmaceutical waste and medicines harm.

1. The King's Fund, The rising cost of medicines to the NHS, April 2018
2. See https://www.england.nhs.uk/medicines/value-programme/

Merger of Luton and Dunstable University Hospital and Bedford Hospital

There will be a merger of Bedford Hospital NHS Trust and Luton and Dunstable University Hospital NHS Foundation Trust. The proposed name of the new organisation is Bedfordshire Hospitals NHS Foundation Trust.

A shadow joint board will be operating from now and the proposed date for the merger is 1 April 2020 (subject to NHSE/I agreeing the business case submitted on 1 December 2019).

The merger will not mean a reduction in the status of the Bedford site, which will continue to provide:

- 24 hour A&E.
- Inpatient paediatrics.
- Consultant-led obstetrics.

The benefits include:

- Improved clinical resilience through clinicians working together and across the two sites. This will lead to better access, seven day services and research portfolios.
- The goal will be for the joint Trust to achieve a CQC rating of Outstanding.
- Better patient experience measured via friends and family test, national patient surveys and waiting times.
- Better patient outcomes through standardisation of protocols and policies, using national data such as Getting it Right First Time and Model Hospital to enable best practice and continuous improvements across sites.
- Shared recruitment and staff training.
- Shared governance, Statutory Instruments and peer review opportunities.
- Economies of scale from a larger organisation (for instance merging of back office functions).

This is an important development within BLMK and so a successful merger is part of Our Partnership Focus for the next five years.

Research and Innovation

What is the context for delivery? 1

There is huge potential for new innovations in health and care from genome sequencing to the use of artificial intelligence. To help develop and spread innovation, Academic Health Science Networks (AHSNs), partnering Universities with health and care providers, are in existence across England and their funding has been guaranteed until 2023.

BLMK has three AHSNs involved in our system – Milton Keynes is part of the Oxfordshire AHSN, Luton is part of the UCL Partners AHSN, whilst Bedfordshire is part of the Eastern AHSN, based in Cambridge. This gives us access to three internationally renowned universities.

What do we know people are concerned about?

Innovation and research was not a prominent theme in the engagement, but it is a reasonable assumption that people want access to the latest treatments.

What progress has been made as a system so far?

Oxford AHSN developed *Good Hydration!* This is an award-winning programme to help ensure that care home residents are getting enough fluids. It has been rolled out across care homes in Milton Keynes.

Future ambition: What do we plan to do next?

- We will share successful innovations that have come from one AHSN with the other areas of BLMK.
- We will ensure our health and care providers are playing a full and active part in their respective AHSN.
- The three AHSNs are coming together to develop a proposal for diagnosing and supporting those with Atrial Fibrillation (irregular heartbeat) who have increased risk of Strokes.

What difference will this make to people across BLMK?

People across BLMK will continue to be at the forefront in accessing the latest interventions. Examples are contained throughout this plan, such as the piloting of Lung Cancer Screening in Luton.

How will we know we're making a difference?

Individual innovations will be rigorously evaluated to ensure they are cost effective.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Enabling Improved Health and Care

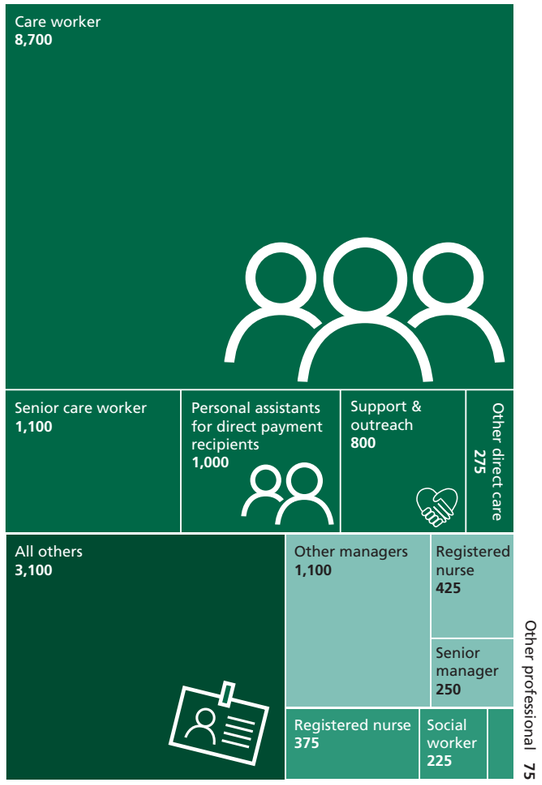
Workforce
Digital Information Sharing
Estates
Finances

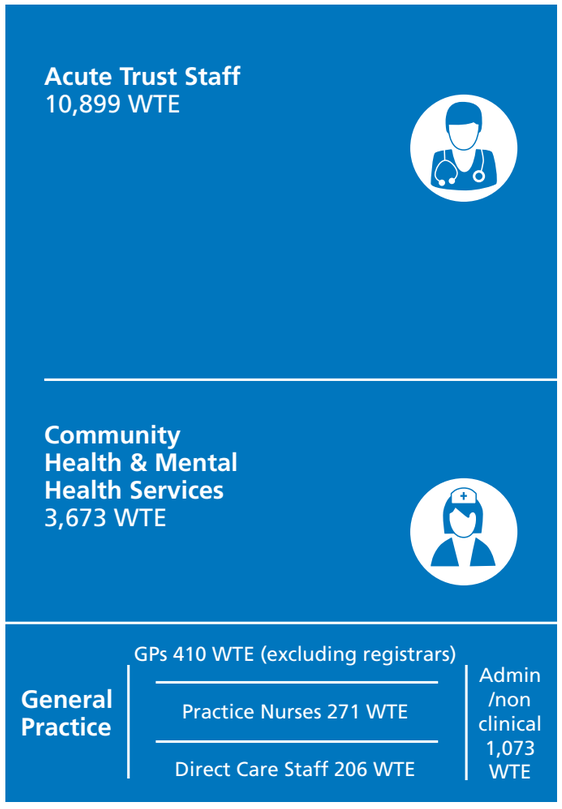
Workforce

Having the right numbers of health and care staff equipped with the skills, values and behaviours to deliver the best, integrated care services now and for future generations, is critical to the successful delivery of our plans.

Our current health and care workforce across Bedford Borough, Central Bedfordshire, Luton and Milton Keynes is detailed below.

SOCIAL CARE: 15,000 WTE





HEALTHCARE 14,160 WTE

Workforce

What progress has been made as a system so far?

We are working to deliver national priorities for the expansion of numbers of staff in critical groups such GPs, nursing and mental health. Our focus, however, is also upon introducing new roles and ways of working, alongside a digitally enabled approach, which means that integrated health and social care teams are offering personalised, needs-based care, within primary care networks, supporting the priorities of Our Partnership Focus.

Key recent achievements have included:

Grow Our Own

Our GP Retention plans and New to Practice Programmes are focused on retaining our new and experienced staff through developmental opportunities, portfolio career options as well as targeted support via mentorship and coaching. We continue to grow our GP & Practice Nurse numbers as well as increasing the number of new roles such as clinical pharmacists, social prescribers and physician associates. We are working with our experienced Practice Managers to develop and career pathways within General Practice and Primary Care Networks.

Adaptable Skills; Flexible Approach

A Home-Based Staff BLMK workforce development group is developing an education and training framework, learning portal and training passport to support skills development for staff in nursing, residential and domiciliary care settings for Dementia, Falls and End of Life Care.

BLMK; A great place to work and learn

We have launched a BLMK staff facing 'Live, Learn and Work' website, focused on supporting staff development, attracting staff to work locally and retaining our existing staff. This website currently has over 500 hits a month, with further development on-going.

Developing leaders and organisations

We have created a 'Stepping Into My Shoes' staff interchange initiative. Staff have the opportunity to shadow, mentor and share learning across our organisations and health and care sectors, supporting the development of system values and behaviours and enabling staff to identify and address some of the barriers to working in an integrated way. Hundreds of staff have also come together through our System Conversations on topics such as mental health and prevention to discuss how we can best work together to meet the needs of residents.

Workforce

What do we plan to do next?

The launch of the NHS Long Term Plan and the Interim People's Plan provides us with the opportunity to revisit our strategy against these requirements and ensure our people planning and workforce transformation delivers a fit for the future workforce aligned to our vision for integrated health and care services.

Within this Long Term Plan we have described how Primary Care Networks are the underpinning model for out of hospital care. Integrated Health and Care teams will provide coordinated, joined-up, personalised care for local communities. To support this development we have undertaken a strategic workforce modelling approach to enable us to plan for workforce transformation at scale.

How will we know we're making a difference?

As a partnership we will collectively monitor a range of workforce metrics that help us to understand to the impact of the delivery of our workforce plans and how well our staff are feeling engaged and supported in their health and wellbeing needs. These will include :

- Staff Wellbeing.
- Staff Retention.
- Staff Sickness.
- Staff Diversity.
- Proportion of health providers with an outstanding or good rating from the CQC for the "well led" domain

We will also monitor input data for new roles, workforce growth, changes in skill mix.

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Workforce

What is the context for delivery? 1

To make the NHS the best place to work we are:

Creating a healthy inclusive and compassionate culture (including ensuring equality and diversity, tackling bullying and reducing violence).

Enabling great development and fulfilling careers (including CPD and ensuring recognition of qualifications between employers).

Ensuring everyone feels they have a voice, control and influence (including freedom to speak up, health and wellbeing and flexible working).

Immediate 2019/2020 actions

1. System review of staff survey results with identification and spread of best practice employment initiatives across NHS partners.
2. Embed and monitor nationally developed 'balanced scorecard' within the NHS Oversight Framework to support excellence in performance for our employment practices.
3. Continued development of our staff facing website https://work-learn-live-blmk.co.uk to support staff attraction into BLMK and promote opportunities to learn and develop together.
4. As part of this development launch an interactive recruitment microsite to promote vacancies that are difficult to recruit to and attract younger people into health and social care careers.

What do we plan to do next?

1. Build upon our interactive recruitment microsite to develop a shared approach to engaging with schools, colleges, carers officers and job centres, including for recruitment fairs and initiatives.
2. Review the opportunity to establish collaborative banks across partner Trusts.
3. Continue to participate in the East of England Streamlining programme to remove practical barriers to movement of staff between organisations; support employers to streamline induction and onboarding processes.
4. Build upon our existing individual organisation examples of best practice staff engagement activities e.g. 'event in the tent' to provide system-wide engagement events across health and care partner organisations.
5. Implement a BLMK staff Health & Wellbeing charter.
6. Develop and implement BLMK offer including support for families of recruited staff (see Chapter 6 appendix).

Workforce – Improving the Leadership Culture

What is the context for delivery? 2

Improving the leadership culture includes:

System leadership; joining up local health and care services for local communities.

Quality improvement; established quality improvement methods.

Inclusive and Compassionate Leadership.

Talent management; fill senior posts and develop future leadership pipelines.

Immediate 2019/2020 actions

- Alongside our governance review, revisit our system Leadership Charter to ensure our individual and collective behaviours, values and competencies are lived experiences.
- Continue the implementation of our system leadership and OD plan, including our masterclass series, 'Stepping into my Shoes' initiative and focus on developing QI approaches across our organisations.
- Launch our system leadership programme, 'Leading Beyond Boundaries'; working in partnership with Frimley 2020 to develop 30 system leaders from health, social care, fire and police and partner with Herts & West Essex STP in the Accelerated Director Development Programme.
- Participate in our regional talent board.
- Support the expansion of NHS Graduate Management Training Scheme; including offering an ICS workforce flexi-placement.

What do we plan to do next?

- Continue to implement our programme of work to support primary care networks to create multi-professional teams that collaborate across traditional boundaries.
- Embed a co-design approach to service transformation, with staff increasingly developing personalised care competencies, moving from a 'what is the matter with you?' to adopting a 'what matters to you approach.

Workforce – Addressing Workforce Shortages

What is the context for delivery? 3

Addressing workforce shortages includes:

Immediate focus on nursing workforce shortages, including retention, return to practice, clinical placements and international recruitment.

Entry routes into the profession building on the nurse apprenticeship and nurse associate routes.

Greater focus on primary and community nursing.

Immediate 2019/2020 actions

- Implement our BLMK system level job guarantee approach.
- Increase clinical placement capacity across our partner organisations.
- Continue to evolve our system approach to relationship management and performance review with local university providers.
- Continue to implement our general practice nursing workforce plan to increase attraction, retention and staff development.
- Provide senior system leadership to workforce development through our Director of Nursing partnership group.
- Continued expansion of nurse apprenticeship and nurse associate routes. With local leadership of our regional Training Nurse Associate workstream from BLMK, we aim to increase Training Nurse Associate learners to 91.

What do we plan to do next?

- Review the opportunity to develop a collaborative system approach to international recruitment.
- Develop collaborative approaches across Trusts to support workforce hotspots e.g. across our mental health trusts, across our acute trust, aligned to service redesign.
- Develop a Nursing Cadet Scheme pilot, through to the nursing associate apprenticeship and nursing degree programme.

Workforce – Delivering 21st Century Care

What is the context for delivery? 4

Delivery of 21st century care entails:

A transformed workforce with a more varied and richer skill mix, new types of roles and different ways of working.

The scaling up of new roles via multi-professional credentialing and more effective use of the Apprenticeship levy.

Immediate 2019/2020 actions

- Continued implementation of our General Practice Workforce plan, demonstrating how new roles and new ways of working, will create integrated health and social care teams supporting the development of our 22 Primary Care Networks (PCNs).
- Commence pilot with East London Foundation Trust to determine the mental health competencies required within the PCN non-mental health workforce and the physical health competencies required within the PCN mental health workforce.
- Continued implementation and expansion of our mental health, maternity and transforming care and learning disability workforce plans.
- Launch of our place-based pilots for Health and Social Care Rotational Apprenticeships for support worker roles.
- Launch of a pilot for rotational posts to support system resilience e.g. rotational paramedics.
- Develop our approach to supporting staff to deliver digitally enabled solutions to care, responding to the recommendations of the Topol Review.

What do we plan to do next?

- Build upon our initial development of 43 Advanced Care Practitioner roles across partner organisations to expand the opportunity for staff to maximise their skills.
- Implement a training and education framework to enable the development of personalised care competencies and skills with our health and care workforce.
- Align workforce transformation initiatives that repurpose our health and care workforce with Integrated Care Skills.

Workforce – A New Operating Model

What is the context for delivery? 5

A new operating model for our workforce would be the devolution of responsibility to the Integrated Care System, as, over time, we will 'take on greater responsibility for people planning and transformation activities, in line with developing maturity.'

Immediate 2019/2020 actions

- Our partnership workforce event on 4th October 2019 reviewed our existing workforce strategy against the Long Term Plan and Interim People's Plan.
- Continued development of skills and capabilities for workforce modelling and planning, which will include triangulation of our PCN Strategic workforce modelling with our wider plans and completion of Cancer Workforce modelling, undertaken in partnership with the East of England Cancer Alliance.
- More cross-system action:
  - Education Partnership to maximise shared learning and consolidate commissioning for common courses, with aspirations to collectively deliver in-house training programmes utilising local expertise.
  - Apprenticeship Group to review levy underspend and consider alignment to non-levy paying organisations.
  - Primary Care Training Hub with oversight of delivery of the general practice workforce plan and system GP clinical leadership.

What do we plan to do next?

BLMK Local Workforce Action Board (LWAB) has undertaken a review of capacity and capability requirements against existing functions and responsibilities, aligned to a maturity assessment of both LWAB and our Primary Care Training Hub.

Recommendations for a build, buy and share approach have been made. Workforce leads will work with regional and national leads to build the functions and capacity required to adopt an increasingly devolved role for people planning and transformation.

Digital Information Sharing

What is the context for delivery? 1

The move to more pro-active, multi-agency and multi-disciplinary care can only be achieved if information is shared. This will allow continuity of care whoever is seeing a member of the public.

We also need 'one version of the truth' data that can be used as part of Population Health Management approaches to predict and plan health care interventions and proactively meet the demand for services and immediate care requirements.

What do we know people are concerned about?

People expect health and care services to be sharing information so they only have to tell their story once.

Over **60%** of respondents to our public survey said that shared access to medical records across healthcare professionals would help people stay well and reduce hospital usage.

What progress has been made as a system so far?

We have an over-arching digital strategy (established in June 2018) setting out how we will use technology to deliver improved quality and efficiency.

GP Bookings

- We have **100%** access from 111 services to allow bookings directly into extended access appointments.
- We have **96%** of all GP practices able to receive direct bookings from 111 services.
- **98** GP practices are able to book and interact with each other's system.

Complex planned discharges

Luton and Dunstable hospitals have developed a multi-agency digital discharge planning tool that reports the live situation of patients for multi-agency discharge planning to reduce hospital discharge delays. During 2020 we will spread this approach to Bedford Hospital.

Access to shared Information

Across BLMK **96%** of GPs have the ability to see the records of community health care services and community services can see GP records. For instance, as part of its Digital improvement programme, Milton Keynes has implemented the Cerner Health Information Exchange. This has now been rolled out across GP practices and Milton Keynes University Hospital which means that healthcare records can be shared across services and professional groups to improve decision-making and patient experience.

Milton Keynes University Hospital is an established 'Fast Follower Trust' partnered with West Suffolk Foundation NHS Trust who are a Global Digital Exemplar Site. This means that the hospital is at the forefront of rolling out established proven models of care supported by the latest digital technology. Frontline staff now have the information and technology at the point of care with their patients. The Trust's digital strategy has been updated to focus on a 'mobile first' approach wherever possible and examples of this include the Introduction of PowerChart Touch (PCT) which provides clinicians with mobile access to eCARE records of their patients when required both on and off site.

Integrated data in Luton

In Luton an Integrated Data Model has been developed, initially to support the Luton Frailty programme focused on preventing hospital admissions/re-admissions for the frail and elderly. The technology developed, links daily acute activity data with monthly primary care, social care, mental health, community, OOH/111 and hospice data to produce a complete record of patient touch points across the system. The insight supports a daily 'huddle/ MDT' conversation to facilitate faster and more informed patient intervention within Primary Care Networks.

Care Homes

A programme of delivering digital access in care homes across BLMK has been initiated with **85%** having completed Information Governance. **80%** of all care homes across BLMK have, or have agreed to have, public access Wi-Fi for clients, visitors and staff. Plus, over **50%** of care homes now having access to secure NHS email to support sharing of secure email (patient identifiable data) between health providers across the BLMK system as well as clinical access to patient information for care professionals. As a next step we will introduce digital tools allowing assessments to be undertaken in the care home to reduce unnecessary A&E attendances.

Information Governance

A system Information Governance Group has been established, which is helping to break down barriers in sharing information, including working with other Sustainability and Transformation Partnership areas.

Cyber Security

A Joint Cyber Security group has already been established with Hertfordshire and to the East of England. All our Provider Organisations and CCGs are on track to be fully compliant ahead of the summer 2021 national deadline.

What do we plan to do next?

Funding has been secured from the Health System Led Investment Programme for the first phase of the development of a shared care record across our system. Our work to create a shared care record (which will share health and care data through the national patient record locator) will be split into work in Milton Keynes and work in Bedfordshire. It will also include the development of portals for the public to access their own care record, facilitating self-care and patient activation.

As a result, shared care records will start becoming available from now and will be accessible across BLMK by March 2022.

Digital Information Sharing

We are also working with neighbouring STPs and the Thames Valley Local Health and Care Record Exemplar (LHCRe) to ensure we support delivery at the point of care based on the national open data architecture standards, both wherever our residents present or where we provide health and care support for members of the public from outside our area.

We will continue to work with patients and staff to improve knowledge and understanding of healthcare records and choice linked to the sharing of data to support people's health and care. As part of the East of England accord, we will use localised branding but have a common message across six million residents.

In addition, as part of the Wave 2 PHM development programme we will be progressing work to bring together data sets so that we can risk stratify our population – Milton Keynes is particularly advanced in this and the Luton work will also be beneficial here.

The majority of local care homes are engaged in a national pilot for cyber security and will be sharing their findings.

What difference will this make to people across BLMK?

- Automation, integration and interoperability of systems to allow staff to have the test results, history and evidence they need to make the best decisions for patients.
- Enable redirection of resources to where they add most value.
- Improve people's experience and make it easier to access services.
- Create simple online access for staff and residents.
- Use technology to help health and care professionals communicate better and enable people to access the care they need quickly and easily, when it suits them.
- Utilise websites and apps that make care and advice easy to access wherever people are, building on the success of digital maternity and adolescent mental health support.
- Work smarter to provide better care than ever before.
- Heath care professionals will have full access to information at the point of care, for example pathology results and radiology images from multiple sources where appropriate.

How will we know we're making a difference?

- Feedback that our population are only having to tell their health and care story once.
- Increased interoperability and access between partner organisations in health and social care.
- Increased number of 'paper free/light' pathways across the system, supported by increased numbers of E-Referrals, Electronic prescription rates and electronic discharge summaries.
- Continued development and expansion of a broader perspective and understanding of patient activity linked to the Luton Integrated Data Model, including its applicability for expansion across other parts of our partnership.

Estates

What is the context for delivery? 1

The buildings and land we have for delivering health and care are a key enabler to help bring about the service transformation envisioned in Our Partnership Focus.

We currently have significant housing-led population growth against a backdrop of inadequate primary, community estate and acute hospital sites, all of which require significant investment to maintain.

Our Estates Programme focuses on delivering strategic estates solutions to support our transformation programmes. Our Estates Strategy is aligned with other key enablers of workforce and digital.

Joint working is a key component of this work programme, reflecting strong shared ambitions to shift from a reactive, intermittent and often fragmented health and social care model to one which is preventative, proactive and integrated.

We have shared ambitions to deliver a new enhanced primary, community and social care offer to our population. The Integrated Health and Care Hub Programme seeks to ensure that these developments are locally owned and designed to meet the specific needs of each community. This is important given the range of demographics and geographies within BLMK, from rural Central Bedfordshire to diverse, urban Luton. The new hubs will support the proactive, multi-agency and multi-disciplinary primary and community care we need.

What do we know people are concerned about?

Effectiveness: The configuration of the local estate does not always enable efficient or effective delivery of services in our primary and community care settings. The condition and configuration of the local acute estate leads to inefficiencies and presents backlog maintenance challenges.

Capacity: The current estate does not have the capacity to meet the needs of the local population – and this will be compounded by housing and population growth.

Meeting local needs: Feedback from the public is that they really value local services, but we currently do not always provide equitable access to high quality joined-up care, and some communities and patient groups have to travel significant distances to access specialist care.

Affordability: The current model, with an over-reliance on acute hospital care, is not affordable or sustainable. Transformation of the system is dependent on the right estate.

What progress has been made as a system so far?

The BLMK Estates Workbook developed in 2018 (not publicly available as it contains commercially sensitive information) set out the estates challenges and priorities across our partner organisations.

Estates

Built:

- Urgent Treatment Centre on Bedford Hospital site opened 2018.
- Brooklands Health Centre in Milton Keynes opened 2018.
- Whitehouse Hub in Milton Keynes under construction, to open in 2020 (will bring together primary care, outpatients, ambulance and police services).

Significant levels of capital funding have been secured from a variety of sources to support delivery of our estates programme.

Funding secured:

- **£99.5m** secured for merger-enabling capital programme across Luton & Dunstable Hospital Foundation Trust and Bedford Hospital Trust.
- **£9.95m** secured for the development of a Pathway Unit at Milton Keynes University Hospital FT – Outline Business Case in progress.
- **£766k** capital secured for the development of stroke rehabilitation unit – Clinical Pathways in progress.
- Access to funding to develop a Business Case for future capital spend at Milton Keynes University Hospital from 2025 [1].
- **£6m** national capital secured for development of primary care Hub in Gilbert Hitchcock House (Bedford).
- Local Authority capital allocated for Dunstable and Biggleswade Hubs.

There are also a range of primary care premises (spokes) schemes in planning/delivery using a variety of funding sources.

1. Department of Health and Social Care, Health Infrastructure Plan, October 2019

Future ambition: What do we plan to do next?

- We will continue to develop the business cases for (and deliver) the Integrated Health and Care Hubs already in progress across Milton Keynes and Bedfordshire, and progress the pipeline of further Hubs across BLMK to provide focal points for the delivery of integrated services within many of the local Primary Care Networks.
- The **£99.5** million capital will allow improvements to the Luton and Dunstable site. This will include new Maternity accommodation, Neonatal Intensive Care Unit, Operating theatres and Critical care. The work will commence in 2020/21 and be completed by 2023/24, the end of this longer term planning period.
- We will develop proposals for developments at Milton Keynes Hospital for post-2024.
- We will commence development of an Outline Business Case for local mental health inpatient unit/s following the completion of a feasibility study.

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Estates

- We will prepare and prioritise further bids for funding to support the delivery of the next phase of the BLMK estates programme, to maximise opportunities for the national Wave 5 capital funding expected in spring 2020.
- In developing a new primary care infrastructure, we will maximise opportunities around developer contributions and involvement.
- We will review estates implications for Rapid Diagnostic Centre development and other priorities associated with NHS Long Term Plan delivery, and establish work programmes accordingly.

What difference will this make to people across BLMK?

Improved quality of care and patient experience: Care provided from higher quality and clinically safer facilities, which also enable more efficient care delivery.

Improved access to sustainable primary and community care services: Delivery of new facilities/increased capacity to enable services to grow and flourish and to maintain high quality care provision and ease of access.

More person-centred and integrated health and social care: The Primary Care Network model, supported by a network of integrated health care hubs and spokes, will offer a greater range of more joined-up services with a focus on improving the health and wellbeing of local people.

Local provision of care: A range of services to be delivered within integrated health and care hubs will improve access to care and the development of BLMK mental health inpatient services will enable more people to receive care in a local setting.

How will we know we're making a difference?

- Reduction in the capacity gap for primary community estates and expansion of services in line with population growth.
- Greater range of services delivered in primary care settings.
- Continued improvements in patient experience measures, including access.
- Continued improvements against acute estate performance metrics, including a reduction in critical backlog maintenance.
- More co-location of services which enable access to a wide variety of health and wellbeing services in one place, improving communication and pathways between services, and reducing the need for patients to have appointments in multiple locations.
- Improved facilities for staff and patients, assisting in recruitment and retention.
- Reduction in demand for secondary care services, particularly urgent care, as a result of enhanced and proactive primary care offer supporting people to take greater control of their own health and wellbeing.

Scheme	Activities
Merger-enabling (Luton and Bedford) Capital Programme	Mobilisation of programme, with work commencing in 2020/21
MKUH Pathway Unit	Outline Business Case (OBC) – submitted for national approval in November 2019, expecting three to six month timescale for national approval
Dunstable Hub	OBC – local approval by April 2020
Gilbert Hitchcock House Hub	OBC – submission for national approval April 2020
Submission of Wave 5 capital bids	Expected spring 2020
Milton Keynes Hospital	Development of business case for post 2024 capital spend

Finance

We received a 6% uplift in our financial allocation in 2019-20. Over the next four years of this plan, we will be in receipt of a funding increase of between 3.2-4.4% each year.

This will enable us to invest in the priority areas identified in the NHS Long Term Plan (local GP and community services, mental health and cancer) as well as targeting funding towards the local needs identified in this plan. The increased funding will enable us to deliver services better and smarter by investing in technology, prevention, earlier intervention and treatment.

	2019/20	2020/21	2021/22	2022/23	2023/24
Clinical Commissioning Groups' allocation (£bn)	1.393	1.452	1.499	1.563	1.627
Year on year increase (£m)	75	59	47	65	64
Year on year % increase	6.0%	4.2%	3.2%	4.4%	4.3%

Additionally, the NHS Long Term Plan includes targeted funding which will be deployed against specific Long Term Plan commitments through regional and national programmes. We will seek to bid for this funding when it will help us deliver better health and care for our population (and have already done so successfully in a number of areas, see below).

Targeted funding and resources successfully bid for by our System
Mental Health Support teams in schools, perinatal mental health and mental health support for rough sleepers in Luton.
Funding for development of NHS Comprehensive Model for Personalised Care.
Awarded pilot status for low calorie diets to prevent/mitigate diabetes.
Funding to pilot Lung Health Checks in Luton.
Part of Population Health Management Wave 2 programme, supporting the adoption of population Health Management approaches.
Funding to pilot Lung Health Checks in Luton.

Finance

One of our aims is to provide value for money, being as efficient as possible with taxpayers' money. We are committed to tackling waste and improving our service, and our plans reflect a productivity improvement of around 3% each year.

	2019/20	2020/21	2021/22	2022/23	2023/24
Efficiencies	3.7%	3.4%	3.0%	2.9%	2.9%

This will include:

- Investments in technology will be a key enabler to drive efficiency – the digital programme will ensure that health information is accessible when needed, that high risk patients are identified and treated and that digital tools ('apps') are used more widely.
- Teams in our Primary Care Networks comprising GPs, social workers, nurses, pharmacists and mental health workers will provider more coordinated care.
- Hospitals will work more closely with GPs (e.g. advice and guidance by hospital consultants direct to GPs) and with social workers and community services to reduce unnecessary hospital admissions and get patients home sooner when they are ready – reducing the length of stay at hospital will free up funding and capacity.
- Our hospitals will work more closely together to serve patients better and deliver services more efficiently. The planned merger of Bedford and Luton & Dunstable hospitals will bring economies of scale and enable better demand balancing across the two sites.

Organisations with the system [1] have been set financial targets by NHS England and Improvement. We are taking a collective approach so that some of our organisations achieve a surplus to offset deficits in other organisations.

The NHS has created a new Financial Recovery Fund (FRF) to support systems' and organisations' efforts to make all NHS services sustainable and we expect to confirm support from this scheme at a later stage of the planning process. The aggregate financial position before receipt of the FRF is set out below, which is showing a reducing (improving) annual net deficit position reflecting the savings and efficiencies built into our planning assumptions.

All figures in £m	2019/20	2020/21	2021/22	2022/23	2023/24
BLMK Overall financial position	-8.0	-12.6	-10.1	-7.5	-4.6

Finance

Our financial planning means that we positively meet the five financial tests set out in the NHS Long Term Plan:

Test 1: plans to show financial recovery – this test has been met by our improving financial balance over the period of the plan.

Test 2: cash savings – the plan demonstrates savings across providers and commissioners of about 3% over the five year plan period.

Test 3: moderate growth demand – we are committed to reducing growth in demand for care and this is reflected in the assumed levelling out of demand for acute services over the plan period through investment in out of hospital care and proactive and earlier intervention.

Test 4: reduction in unwarranted variation – we are targeting areas where we know we are doing less well than our peers such as respiratory and CVD.

Test 5: best use of capital investment – the estates and capital plan incorporates the objectives of delivering better and more appropriate care in the right setting.

1. East London NHS Foundation Trust and Central North West London NHS Foundation Trust are very important providers of mental health and community services in BLMK, but for financial purposes are treated as part of the North East London and North West London systems respectively.

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Supporting Information

Appendices and Feedback

Appendices

We have tried to keep this document as streamlined as possible (considering the wide range of issues to cover). More detail on particular areas can be found in our appendices.

Appendices
Engagement Appendix
Healthwatch Report: https://healthwatch-centralbedfordshire.org.uk/wp-content/uploads/2019/07/HW-BLMK-NHS-Scale-Report-July-2019.pdf
Primary Care Strategy
Workforce Appendix
Mental Health Appendix
Maternity and Neonatal Appendix
Public Health Reports
Bedford Borough https://www.bedford.gov.uk/social-care-health-and-community/bedford-borough-jsna/public-health-publications/
Central Bedfordshire https://www.jsna.centralbedfordshire.gov.uk/jsna/info/17/additional_reports/99/dph_reports
Luton https://www.luton.gov.uk/Health_and_social_care/health/publichealth/Pages/Luton-annual-public-health-report.aspx
Milton Keynes https://www.milton-keynes.gov.uk/social-care-and-health/2016-2017-joint-strategic-needs-assessment/director-of-public-health-reports

Feedback

We want to hear from you if you have feedback on our longer term plan and/or want to get involved in co-designing/co-producing improvements.

Please contact the relevant Healthwatch based on where you live and/or access services:

Bedford Borough Healthwatch
Call: 01234 718 018
Email: enquiries@healthwatchbedfordborough.co.uk

Central Bedfordshire Healthwatch
Call: 0300 303 8554
Email: info@healthwatch-centralbedfordshire.org.uk

Luton Healthwatch
Call: 01582 817 060
Email: info@healthwatchluton.co.uk

Milton Keynes Healthwatch
Call: 01908 698800
Email: info@healthwatchmiltonkeynes.co.uk


BLMK
Integrated Care System