Bedfordshire, Luton and Milton Keynes ICS:

Population Health Management Strategy

Version Control

Version	Date	Author	Notes
V0.1	12/4/2021	Simon Puchtler	Creation of template version
V0.2	13/4/2021	Simon Puchtler	Inclusion of additions and revisions from Clare Steward and Alli Dalziel
V0.3	14/4/2021	Simon Puchtler	Further revisions
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V0.11	23/4/2021	Alli Dalziel	Minor amendments.
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V0.21	30/6/21	Clare Steward Ross Graves	Revised version proposed for Partnership Board

Contents

1 Executive Summary

1.1 This Population Health Management Strategy sets out our collective vision is to work with our population to optimise health and wellbeing, advance equality in our communities and make the best use of our resources. The need for change is driven by the likelihood that demand on health and social care will outstrip growth in budgets, the requirement to address the wider determinants of health and tackle health inequalities, and the need to ensure that parts of the health and care economy work together as effectively and efficiently as possible. BLMKs Population Health Management Roadmap is at Appendix 1.

1.2 Population Health Management uses insights driven by data to design new models of proactive care for local partnerships to improve outcomes and make best use of collective resources. Its adoption is specified in the NHS Long Term Plan, and the requirement to focus on preventing ill health and user need is emphasised in the Government's Green Paper on prevention[1]. BLMK shares many of the challenges of the rest of the UK, and its relative economic success can mask underlying inequalities. As a system we have many of the necessary conditions for success, including: well-developed partnerships between the NHS and Local Authorities, Care Alliances each with a shared vision for health and wellbeing; a single, streamlined Clinical Commissioning Group covering the population of BLMK; and involvement in the national Population Health Management Development Programme.

1.3 The Vision for Population Health Management in BLMK is as follows:

Working together to deliver integrated, proactive health and care through realising our shared data potential

A shared understanding of BLMK's Population Health needs will empower people, communities and partnerships to take collective ownership of local issues at every level of our system and help the people of BLMK stay well and receive joined-up, integrated support when they need it. By drawing on timely, relevant and responsive linked data and expertise from all partners, we will drive a thriving, community-focused integrated health and care system. This will enable us to take informed choices and make best use of our combined resources across BLMK, to provide a healthier, happier and fairer place to live and work.

1.4 The programme will be built around the following principles:

a. The programme's aims will be based around realising **five benefits**:
- increasing health and wellbeing;
- reducing health and care inequalities;

[1] Advancing our health: prevention in the 2020s – consultation document (published July 2019), https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document

- reducing costs and improving value;
- enhanced individual experiences; and
- increased workforce engagement and wellbeing.

b. The programme will support the delivery of an operating model which will describe the necessary processes, organisation, information and technology at **all levels of the system**: individual, neighbourhood, place, alliance and system. The BLMK ICS is statutorily required to develop and lead a PHM strategy for BLMK, however the critical added value and leadership of our maturing Care Alliances must be recognised in delivery of PHM, and design of PHM is built around their central role.

c. The programme of work will be based around **four dedicated workstreams** which support the implementation of Population Health Management:

1) **Implementation** and design of interventions. This will primarily take place at Care Alliance level, with the ICS undertaking only those functions and activities which cannot effectively and efficiently be undertaken by Care Alliances, Place or Neighbourhood. Interventions will be linked to segmentation of patient cohorts and entail design of cohort-specific evidence-based interventions (the impact of which is analysed in near-real time).
   <u>Supporting enablers:</u>
2) **Infrastructure.** This workstream will deliver the necessary enabling support capabilities for the system to conduct PHM, and engage with Partnership Boards, Information Governance, system-wide linked data and digital tools.
3) **Intelligence.** Capability (including a Population Health Insight Team comprising of a network of business intelligence and analysts) will be developed to support a deep understanding of local needs and design of impactful interventions.
4) **Incentives.** Governance arrangements and financial frameworks will be developed which promote the collaborative outcomes-focused behaviours required to achieve the benefits of PHM

The Executive Director of Partnerships and Commercial Development within CNWL will be the programme Senior Responsible Owner, supported by the Chief Officer of Public Health for Bedford Borough, Central Bedfordshire and Milton Keynes as the Subject Matter Expert (SME), and the BLMK ICS Programme Director The BLMK Population Health Management Programme Collaborative will report via the System Delivery Group to the BLMK ICS CEO Group (subject to revisions to the ICS governance structure).

Benefits. Related to each of these aims, the programme will enable the system to realise a series of intended benefits, measuring the financial and non-financial

impact of any investment. Agreement of these benefits from the outset, in consultation with key stakeholders, will clarify objectives and align accountability with the appropriate resources. Evaluation of the programme's impact will ensure it remains fit-for-purpose as the environment evolves.

1. **Improved Population Health and Wellbeing**.
2. **Reduced health and care inequalities**.
3. **Reduced Cost and Improved Value**.
4. **Enhanced individual experiences**.
5. **Increased workforce engagement and wellbeing**.

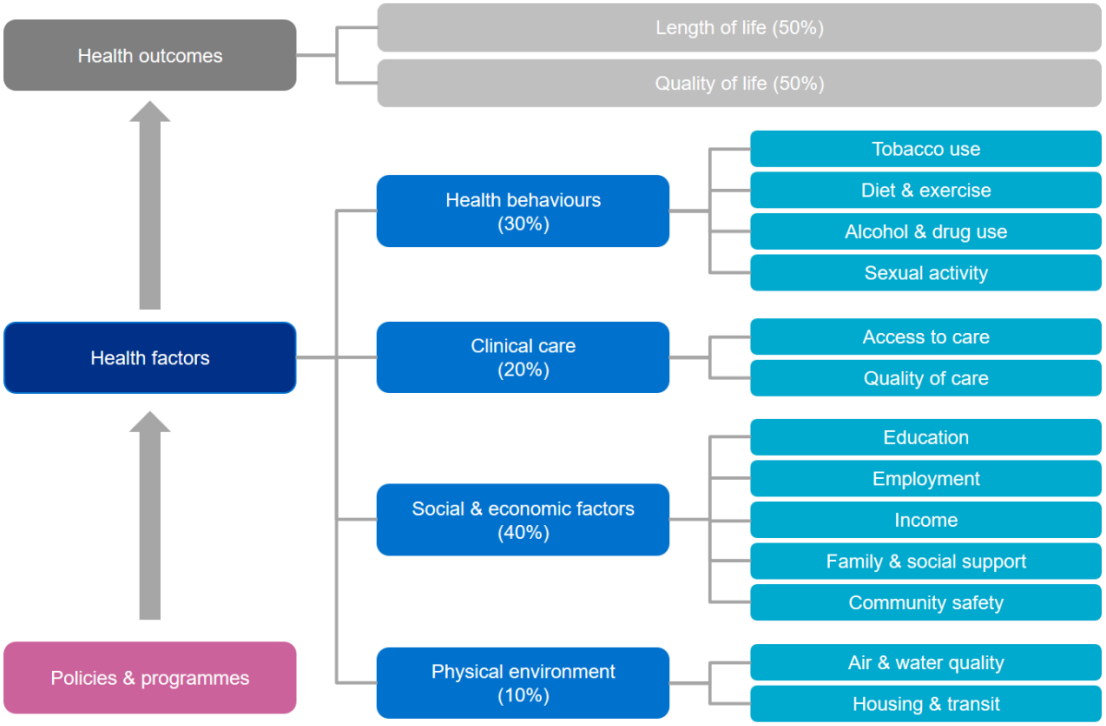
"For doctors, nurses, social care, therapists and other frontline staff the PHM approach enables care and support to be designed and delivered to meet individual needs, it means less duplication and a reduction in workload pressures as it ensures the right care is given at the right time by the right person. Health and care professionals are being empowered to redesign their services, to reduce the reactive episodic nature of their workload and take a more proactive approach to supporting their local population live healthier lives."[i]

2 Introduction and Context

2 - 1. This document sets out our collective vision for a population health-centric approach which will support the Health and Wellbeing strategies of Bedfordshire, Luton & Milton Keynes, along with the framework of activity we will pursue to deliver it. Its purpose is to mobilise the development and subsequent embedding of population health as a key driver of our future health, care and wellbeing system.

2 - 2. The need for change is driven by four factors:

1) the likelihood that demand on health and social care will continue to increase in a way which will outstrip growth in NHS and local authority budgets.
2) the consensus that healthcare is only one of several determinants of health, which include individual choices and wider factors like housing, education and employment, as demonstrated in the diagram below; and that these may have a more significant impact on health and wellbeing than interventions by healthcare professionals.[ii]
3) the recognition of unwarranted and unfair differences in outcomes between different groups, driven by socio-economic factors, geography and specific characteristics, including those protected in law.[iii]
4) the need for all parts of the local health and care economy to work together as effectively and efficiently as possible to deliver the best possible outcomes with the resources we have available.



2 - 3. Population Health and Population Health Management are widely recognised as concepts which will help us to address these challenges.[iv]

Population Health
is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.

Population Health Management
is an emerging technique for local health and care partnerships to use data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.

2 - 4. Together, these concepts aim to broaden our focus beyond reactive treatment to include the proactive management of the entire population's wellbeing and address all determinants of health, as seen in the diagram above.

2 - 5. This proactive approach requires a refocusing of individual organisation's activities to consider the outcomes enabled by the system as a whole. This will support the integration of primary and specialist care, of mental and physical wellbeing, and of health and social care as part of a broader population health economy which includes its citizens and the voluntary sector.

2 - 6. The Department of Health and Social Care has made a clear commitment to advancing the aims of population health.

a. **The NHS Long Term Plan**. Local organisations will increasingly focus on population health and partnerships with local authority-funded services, through new Integrated Care Systems (ICS).[v] These are to be made up of three major pillars: Primary Care Networks, personalised care and population health management. Together, they would make up an offer to local people of tailored care, delivered as close to home as possible.[vi]

b. **Prevention in the 2020s**. The Green Paper on prevention further outlined how, at a local level: *"we expect different organisations to be working together on prevention. This means moving from dealing with the consequences of poor health to promoting the conditions for good health and designing services around user need, not just the way we've done things in the past."*[vii]

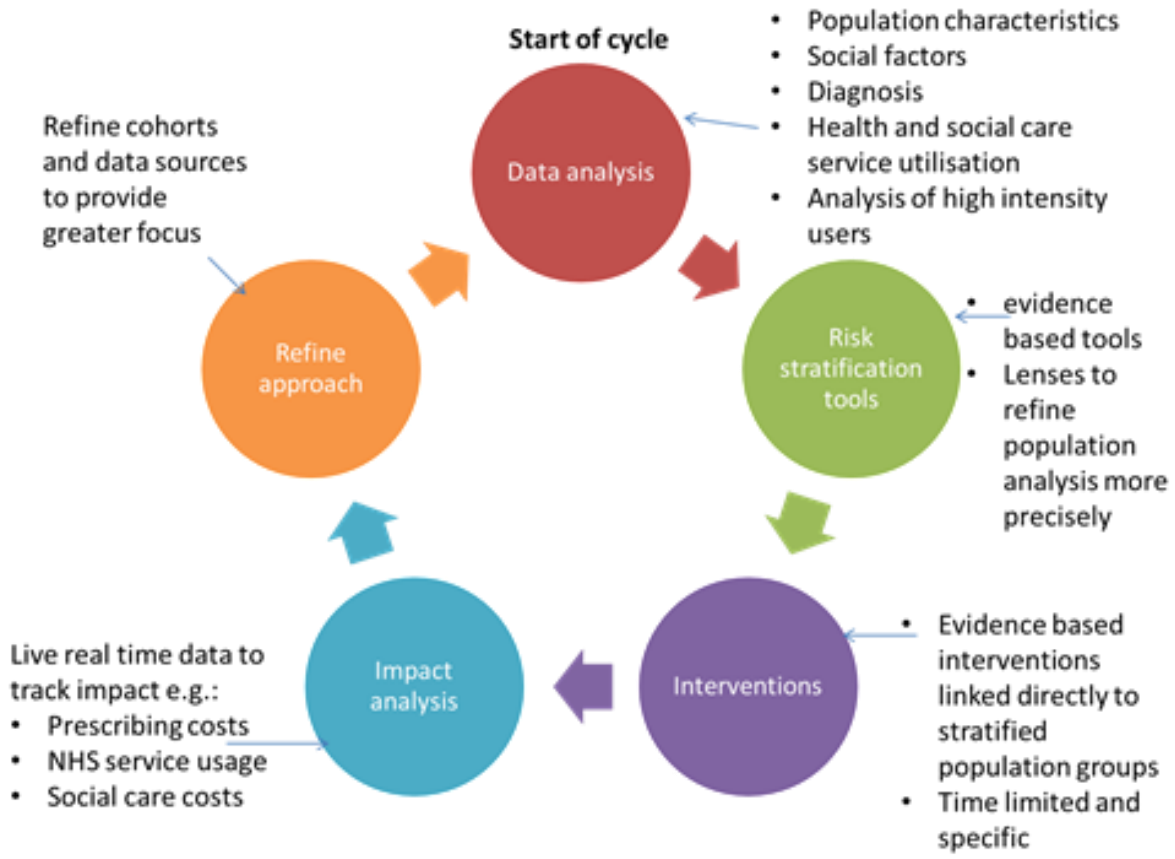
c. Integration and Innovation: working together to improve health and social care for all. The White Paper notes that the "*experience of the pandemic underlines the importance of a population health approach, informed by insights from data: preventing disease, protecting people*

from threats to health, and supporting individuals and communities to improve their health and resilience."[viii]

d. **NHS 2021/22 priorities and operational planning guidance[ix].** PHM is a vital or at least beneficial component to the response to each of the 2021/22 priorities. In particular, the reduction in health inequalities, the acceleration of preventative care programmes and ensuring timely and accurate data.

> "Our new integrated care systems (ICSs) will help deliver as the NHS continues to move from reactive care towards a model embodying active population health management"[x]

2 - 7. The PHM approach will ensure that the models of care across BLMK will be more focused on the use of data to drive change, with the introduction of standardised outcomes across different population groups (that will need to be tracked and evaluated), with the 'How' in relation to the design and the delivery varying by place and population needs. The diagram below sets out the core elements of PHM.



2 - 8. Currently this strategy (and the accompanying road map) seeks to set out the structures and underpinning data architecture required. To improve outcomes for local residents, these elements need to be balanced with a similar focus on interventions and real-time data used to evaluate the impact of our agreed approaches. These elements will need to be developed further through the respective workstreams at ICS, Care Alliance, Place, and Neighbourhood level.

2 - 9. BLMK shares many of the same challenges as other areas of the UK. Nearly one million people live in BLMK, and the population could increase by nearly 90% by 2050. The number of people aged 85 and over is projected to double by 2035, and we are also predicting higher than average growth in the number of adults aged 65 and over. As more people in these older age groups tend to have long-term, and sometimes multiple, health conditions, this presents a significant challenge for both health and social care. We are also expecting a higher than average growth in the number of children and young people aged between 10-19 years old.

2 - 10. There are large inequalities in life expectancy across BLMK depending upon where people live. The average life expectancy for a female in Central Bedfordshire is 84.6 years, 1.9 years longer than the average for a female in Luton (82.7 years). There is a life expectancy gap of 10 years between males from the least and most deprived areas of Bedford Borough, whereas in Luton the gap between females from the least and most deprived areas is 5 years. In BLMK the Health and Wellbeing Boards, as well as the maturing ICS and CCG have clear responsibilities and increasing capabilities to reduce these inequalities.

a. **Health & Wellbeing Boards**. Bedford Borough, Central Bedfordshire, Luton and Milton Keynes Health & Wellbeing Boards have all set out priorities in each respective Health & Wellbeing Strategy; each includes the reduction of health inequalities.

b. **BLMK ICS**. BLMK was one of the first ten ICSs and is well established to facilitate the coordination and collaboration between the partner organisations. By working collaboratively and drawing on the expertise of others such as local charities and community groups, BLMK ICS can help local people to live healthier lives for longer, and to stay out of hospital when they do not need to be there.

c. **BLMK CCG**. NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (BLMK CCG) was formed on 1 April 2021 following the merger of Bedfordshire Clinical Commissioning Group (BCCG), Luton Clinical Commissioning Group (LCCG) and Milton Keynes Clinical Commissioning Group (MKCCG). The creation of the single CCG presents a real opportunity to meet the wider healthcare

needs of our communities, utilising the greater joint working across health and social care that has developed in recent years.

2 - 9. **The National Population Health Management Development Programme**. The national Development Programme is helping health and care systems to develop capabilities to improve patient care and outcomes, informed by data and analysis. In 2019 BLMK was successful in a bid to become part of the second wave of systems to undergo a 22-week package with support from the national programme. Its aims are to improve outcomes for selected population cohorts through pilot schemes across four Primary Care Networks and both Care Alliances and advance the system's Population Health Management infrastructure and build a sustainable capability.

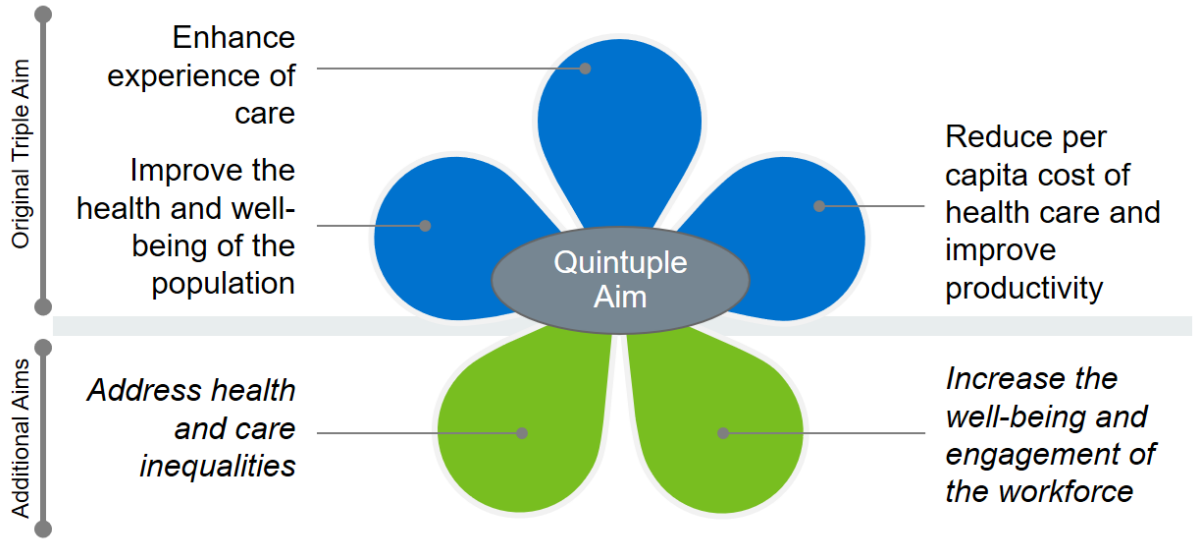
3 Vision, Aims, and Benefits

3 - 1. **Vision**. The vision for the BLMK Population Health Management Programme is:

Working together to deliver integrated, proactive health and care through realising our shared data potential

A shared understanding of BLMK's Population Health needs will empower people, communities and partnerships to take collective ownership of local issues at every level of our system and help the people of BLMK stay well and receive joined-up, integrated support when they need it. By drawing on timely, relevant and responsive linked data and expertise from all partners, we will drive a thriving, community-focused integrated health and care system. This will enable us to take informed choices and make best use of our combined resources across BLMK, to provide a healthier, happier and fairer place to live and work.

3 - 2. **Aims**. There are five aims of population health management:[xi]



3 - 3. **Benefits**

Related to each of these aims, the programme will enable the system to realise a series of intended benefits, measuring the financial and non-financial impact of any investment. Agreement of these benefits from the outset, in consultation with key stakeholders, will clarify objectives and align accountability with the appropriate resources. Evaluation of the programme's impact will ensure it remains fit-for-purpose as the environment evolves.

a) **Improved Population Health and Wellbeing**. Better use of data will improve understanding of patterns of poor health and wellbeing, identifying groups of citizens who are at higher risk of poor outcomes based on bio-psycho-social risk factors have and tailoring interventions according to their 'impactability'. Proactive interventions will allow providers to meet their needs more flexibly, helping them to stay independent and healthy for longer. The system will meet increasing demand by focusing on upstream prevention, involving a wide range of partners working together to tackle the root causes of poor health and wellbeing, including issues like housing and the environment.

b) **Reduced health and care inequalities**. Linked data and shared understanding will enable the system to address variation in outcomes (for example, in healthy life expectancy) between different groups, including those with protected characteristics and who have difficulty accessing support. This will provide the granularity to take specific, targeted action that achieves a measurable reduction in health and care inequalities.

c) **Reduced Cost and Improved Value**. New analytical techniques will support decision-making to return the system to financial balance while moving payment models away from activity-based funding. Instead, commissioning will incentivise and measure proactive behaviours which focus on population health outcomes and cooperation. In turn, interventions like unplanned hospital admissions will be less frequent for targeted cohorts, reducing costs per head for those with complex needs and directing resources at interventions for a greater proportion of the population.

d) **Improved citizen experiences**. Greater shared appreciation (derived through data analysis alongside participation and co-production with local residents) of all factors affecting a person's health and wellbeing will allow care pathways to be tailored to the needs of the individual. Data analytics will support the development of more treatments in a community or primary care setting; a more complete picture of the population's health will inform the development of capabilities which will reduce waiting times and coordinate care for those with multiple morbidities. Finally, linked data will empower

citizens with the knowledge to take more responsibility for their health and wellbeing.

e) **Increased workforce engagement and wellbeing**. Working together will allow front-line staff to take the initiative, supported by the analytical capability to generate the evidence needed to transform local care, thereby improving their morale and retention.

An illustrative example of one of the case studies produced as part of the BLMK PHM Development Programme is included as Appendix 3.

> "For doctors, nurses, social care, therapists and other frontline staff the PHM approach enables care and support to be designed and delivered to meet individual needs, it means less duplication and a reduction in workload pressures as it ensures the right care is given at the right time by the right person. Health and care professionals are being empowered to redesign their services, to reduce the reactive episodic nature of their workload and take a more proactive approach to supporting their local population live healthier lives."[xii]

4 Operating Model

4 - 1 **From Person to System**. The programme will work towards an operating model which will embed Population Health Management as business as usual. It is important to establish population-centric ways of working throughout the system for two reasons. First, there is no 'one size fits all' model. Different populations will have different needs, so a layered approach will allow the right decisions to be taken by the right people. The delivery model of PHM will to be different for each of the two alliance footprints, based on the recognition of the two separate and distinct geographies and separate statutory partners that exist within BLMK ICS. Second, a 'single version of the truth' will build shared understanding and allow stakeholders to speak a common language based on the actual needs of the population they jointly serve. A summary of the different considerations based on the following levels is in the appendices ('Population Health Management considerations throughout the system').

a. **Individual**. Population Health Management places the individual at the centre of their care and asks how the whole system can work better together to meet their individual needs to stay healthy, make informed choices and be supported by joined-up, integrated care when necessary.

b. **Neighbourhood (population 30-50k)**. This level is the bedrock of integrated care, served by community networks which include Primary Care Networks comprising of GP practices, community and mental health services, social care, the voluntary sector and other providers to deliver better coordinated and more proactive services.

c. **Place (population 173 - 286k).** Through interdependent health and social care partners working together within each Local Authority footprint and using a targeted population health management approach, the way that care is provided will be transformed to reduce the health and social care costs and improve the outcomes of local residents.

   By linking data, organisations will be able to come to a shared understanding of the challenges and problems faced by their residents, and be better able to collaboratively transform the delivery of care and address the wider determinants of health. Much of the rich data will come from local authorities (given their oversight of housing, environmental health, planning and other issues), and providers, voluntary and community organisations will each have valuable parts to play in the delivery of this approach.

d. **Care Alliance (populations of ~230k and ~770k)** Care Alliances will each develop standards and interventions based on local needs and circumstances, aimed at improving the outcomes for local residents and reducing health and social care costs. These interventions will be tracked

and evaluated by the Care Alliance using real-time data to ensure maximum impact within the resources available.

To achieve the greatest benefit, PHM will be an integrated part of core services, teams, and organisations

e. **System (population ~1M+)**. The ICS operating model will be shaped and built from the Care Alliances, through Place and neighbourhoods in support of delivering change for care users. As a system we are keen to ensure that the critical added value of our Alliances, Places and Neighbourhoods is recognised, and that system design is built around their respective governance structures. At ICS level, partners will agree the BLMK strategic priorities, share decisions, agree the strategic direction and develop economies of scale. This should involve transformation goals, workforce planning, capital, estates, digital infrastructure and spreading best practice. They should jointly manage critical resources, including analytical and business intelligence capability which may be in short supply. Modelling and projections should identify how best to allocate resources across providers and share risk, identify gaps and inform the development of new pathways. Evaluating the outcomes of interventions will manage performance across the system and provide assurance that it is working well and providing value for money.

4 - 2 **Population Geography**. Health and local authority boundaries in BLMK lend themselves well to system and place-base co-ordination. The operating model allows all partners to contribute, leaves nobody behind and caters for the individual choices of its citizens. The benefit of looking beyond the health system to include local councils, for example, will include the following:

a. Clearly defined, unambiguous and inclusive geographic boundaries which capture the entire population (for example, including those not registered with a local GP practice). Wherever possible these will be co-terminus and compatible with commonly used definitions that support collaboration across health, social care and public health (e.g. LSOA[2]s).

b. Leveraging the democratic accountability of local government to increase citizen engagement.

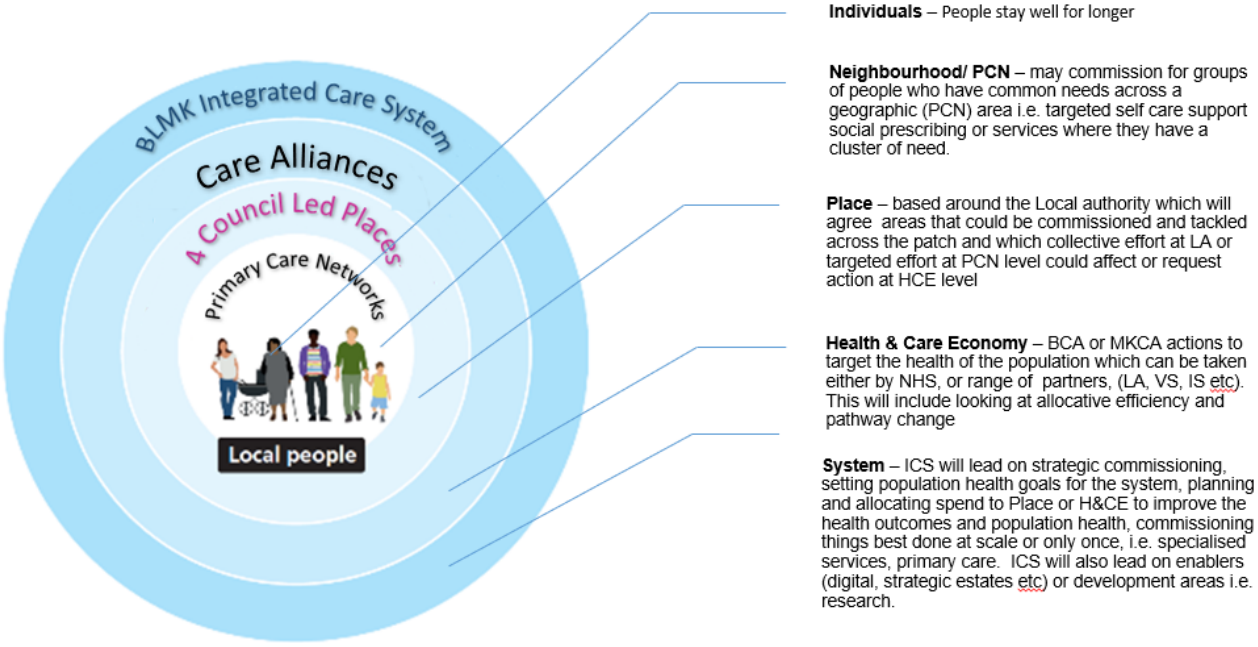
c. Oversight of issues which contribute to the wider determinants of health, like housing and the environment.

d. Better alignment with other agencies (for example, police, fire and rescue services) to deliver the BLMK vision for 2030.

[2] Lower Super Output Areas - standard statistical geography produced by the Office for National Statistics for the reporting of small area statistics.

Table 1

	Local Authority		Health & Care	
System 	**One Integrated Health and Care System** serving a population of nearly 1M, including Bedfordshire, Luton and Milton Keynes. Strategy, governance and accountability across the system, implementing strategic change, managing performance and financial resources, sharing best practice and reducing unwanted variation and inequalities.			
	Lead	**Responsibilities**	**Lead**	**Role**
Place 	**4 Borough Councils**, each unitary authorities serving a population between 173k and 286k.	Education Fire Highways Social care Strategic planning Trading standards Transport Waste collection and disposal Council tax and business rate collection Environmental health Housing Leisure centres Local plans Planning applications Public conveniences Local Democracy	**Two Care Alliances**, the Bedfordshire Care Alliance serving a population of 670k+ and the MK Health and Care Alliance a population of ~270k.	Integrating primary, acute, community, mental health and social care services, developing new models for anticipatory and out-of-hospital care around specialties, and for hospital discharge and admission avoidance
Neighbourhood 	**Parish and town councils**	Local issues like: Community centres Cemeteries Allotments Play areas Local grants Planning consultation	**23 Primary Care Networks** serving on average a population of 43k	Forming integrated Multidisciplinary Teams, working across GP practices and health and social care, social prescribing to draw on other services
Individual 	Individuals develop the skills, knowledge and confidence to take ownership of their own health and wellbeing Multidisciplinary teams provide personalised care according to need			



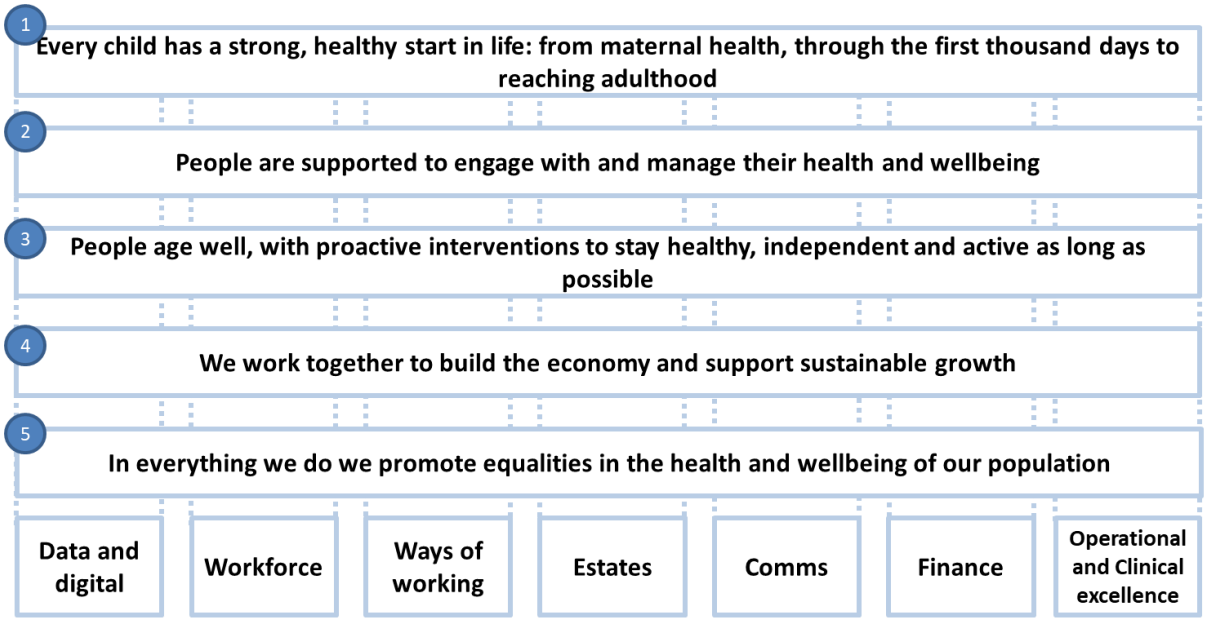
4 - 3 **Partnership Boards and Key Stakeholders**. Population Health Management requires working with communities and partner agencies, and the leadership team driving this forward at every level must include representatives from all areas of the system. These should be involved from the outset to ensure a broad range of opinions are heard and ensure maximum buy-in when identifying cohorts and interventions. The image below outlines some of the partners, alongside VCSEs and the public.

4 - 4 **National and regional links**. BLMK will continue to develop links and draw upon support available from networks such as the PHM regional and National Communities of Practice, Academic Health Science Networks (AHSNs) and NHS England's regional and National PHM teams. PHM is being developed throughout the NHS in England, with significant opportunities to draw upon best practice and share learning.

5 Enabling Capabilities

5.1 Strategic priorities

BLMK have identified the following five strategic priorities which will underpin and define our vision for change and priorities for our population.



Our approach is based on introducing the PHM methodology throughout our ICS, transforming services and pathways across care settings which will require an improvement approach rooted in population need and addressing inequalities – An approach which will traverses organisational boundaries and clinical pathways and will:

- Support an understanding of risk within the population and drivers of ill-health and hospitalisation this will enable the shift from reactive to proactive health and well- being management.
- This in turn will capitalises on the cultural shift and social movement around population health and use the insights to drive inclusive restoration and target unmet need, maximising out of hospital care models.
- By spreading the progress on data and with digitally enabled care together with a frictionless workforce model will put the citizen and needs of our communities at the heart of local partnerships and decision making.

5.2 ICS System Seven Enablers. (Aims and benefits)

To support our five priorities and achieve our ultimate goals there are seven enablers across our ICS (as set out in the diagram above). The four PHM workstreams complement these enablers, and together this system-wide framework will provide a PHM driven structure by which BLMK can improve health and care outcomes (detail of the relationship between the ICS system enablers and the PHM workstreams can be found in Table 3 below).

5.3 PHM Enabling Workstreams

The BLMK PHM Collaborative seeks to support four complementary workstreams (described below in Table 2). High level deliverables for these workstreams are set out in section 7, with more detailed plans being set out in the BLMK PHM Roadmap. Whilst these PHM workstreams span the ICS they will inevitably be delivered through a range of Delivery and Task and Finish groups through the respective ICS Tiers, such as the Care Alliances and the ICS cross cutting enabling workstreams

Table 2

Infrastructure	The infrastructure is a set of basic building blocks that are core for a system to manage the health and well-being of a population This includes having shared and effective leadership, co-ordinated and collaborative deployment of the system's analytics resources, having an agreed information governance and basic elements of digital and data infrastructure.
Intelligence	PHM involves intelligence led planning and delivery of services, aligning services with population need to improve outcomes. Once the right infrastructure is in place, the first step in the intelligence process is to understand population need at each level of the system, and ensure that
Implementation and design of Interventions	Through the leadership of Care Alliances we are seeking to build upon and utilise the analytics available to make decisions on the services provided to the public; identifying effective, evidence-based interventions and implementing them, and adapting existing services system and community assets to be more relevant and useful for the population. This will enable us to rebalance services in favour of prevention and long-term well-being, informed by the evidence of what works. PHM provides a framework for Care Alliances and their constituent partners to identify opportunities, design and implement interventions, along with monitoring and evaluation of outcomes.
Incentives	Incentives align with value and population health based contracting and blended payment models. Incentives also empower workforce development by enabling the re modelling and upskilling of teams, re-aligning and creating new roles, enhancing career development and energising the workforce to realise the 'art of the possible'. Finally, incentives enable governance to empower more agile decision making within integrated teams.

PHM enablers will support those of the ICS; commonalities and examples of support and interfaces are set out in the table below. Monitoring the delivery of these enablers will be key to ensuring that we are able and on track to achieve the intended benefits set out in this strategy.

Table 3

Enablers	Implementation of interventions	Intelligence	Infrastructure	Incentives
Data and Digital	Interventions informed by reliable, timely and easily accessible data and digital capabilities	Cross-organisational collaboration to co-ordinate and combine insights (single source of the truth)	Co-ordination between the PHM infrastructure and ICS digital strategy to ensure alignment, complimentary capabilities	Staff and organisations enabled and incentivised to make best use of the available digital assets
Workforce	Front-line staff given the knowledge, support capabilities and space to implement new models of care tailored to patient cohorts	Front-line staff supported to interpret and use available PHM data to for patient care and service design	Economies of scale delivered by single provision of technical infrastructure freeing up staff time for greater value-adding activities	Culture and framework developed to promote staff behaviours which focus on outcomes regardless of organisational boundaries
Ways of working	New multi-disciplinary cross-organisational patient interventions spread across system	New ways of working developed using PHM insights	Shift to sharing of trusted communal assets across system	Culture and framework developed to promote delivery models which focus on outcomes regardless of organisational boundaries
Estates	Novel care delivery models which make use of shared estates and remote working to make better and more efficient use of system estate	Insights to be used to inform estates strategy (e.g. the development or repurposing	More efficient use of system estate through reduction of duplication	Organisations incentivised to collaborate to make most effective and efficient use of available estates assets

		of sites of care delivery)		
Communications	Spread of PHM informed interventions across system	Tailored engagement with public based on PHM insights	Capabilities in place to engage with specific patients identified via PHM analysis (as required and where IG compliant)	Development of a collaborative culture with common aims across the system
Finance	Contracting arrangements in place which support organisations and staff to adopt new PHM-informed outcomes-focused patient interventions	Insights available which inform the development and refinement of new contracting models	Systems in place which support the ongoing maintenance of new contracting models	Development of new financial and contracting arrangements which promote collaborative outcomes-focused behaviours
Operational and Clinical Excellence	Development of novel health and care interventions which improve performance in terms of outcomes	Insights generated which support and promote clinical best practice and operational innovation	Greater efficiency delivered by automation and the reduction of duplication (where possible)	Alignment of incentives across the system to support the delivery of operational and clinical excellence

6 Governance

6 - 1. **ICS Boards**. Key oversight boards and their relationships with statutory bodies and Care Alliances are:

Health & Wellbeing Boards	The 4 H&WB Boards (Bedford Borough, Central Bedfordshire, Luton and Milton Keynes) act as the strategy-setting boards for each place. The H&WB Boards **set the long-term vision and strategy looking across all public services and taking into account the wider determinants of health and wellbeing**, driving the requirements for Population Health Management across the system.
BLMK Partnership Board (via BLMK Chief Executives Meeting)	The ICS Partnership Board comprises of representation from commissioners and all providers across BLMK (see Appendix 4 for details). It oversees the BLMK ICS strategic priorities. It provides the **strategic direction** for the Population Health Management Programme through the BLMK ICS Chief Executives Forum, in relation to the BLMK 5 strategic priorities, by way of approving investment, defining the direction of the programme and ensuring overall alignment with strategic objectives. In this role it will be supported and advised by the **BLMK Population Health Programme Collaborative** to ensure appropriate support at Executive level from the BLMK system leaders (see Figure 1 below)
Care Alliances	Within each Care Alliance, constituent health and social care partners will work together using a targeted population health management approach to identify variation and opportunities to improve care. Care Alliances will each independently develop interventions based on local needs and circumstances, aimed at improving the outcomes for local residents and reducing health and social care costs. Care Alliances will seek to support people to be healthy and independent for as long as possible, through the collaboration of place partners to provide care for people when they need it, close to home, and in a planned and coordinated approach which maximises the combined resources and assets at their disposal.

BLMK Population Health Programme Collaborative	The ICS Population Health Programme Collaborative will support the development of the PHM approach across BLMK and will hold some of the shared infrastructure extant from the PHM Wave 2 programme while infrastructure develops in each Alliance. It will support partners to co-design and embed the PHM capability within Care Alliances, Places and Neighbourhoods. Reporting to the ICS Delivery Group on behalf of the ICS Partnership Board, the Programme Collaborative will provide **oversight** for the BLMK ICS Population Health Management Programme at an ICS level, recommending programme investment, co-ordinating and supporting the direction of the programme and ensuring overall alignment with the strategic objectives. Further detail on the role and functions of the Collaborative is set out below.

The current BLMK ICS Architecture is set out in the diagram below

Figure 1 – Please note that the ICS structure is currently under review.

6 - 2. **The Population Health Management Collaborative**. The Collaborative provides oversight of the PHM work on behalf of the ICS, including the development of PHM capabilities and infrastructure across BLMK Care Alliances, Places and neighbourhoods. This group will drive the PHM programme forward to deliver its benefits and ensure the appropriate coordination across projects and activities that comprise the programme.

The key functions and appointments relating to the Collaborative are:

a. **Senior Responsible Owner. The Chief Executive Sponsor acts as the link to the BLMK Partnership Forum to ensure that the PHM programme is supported across the respective health and social care partners and embedded as part of business as usual**

b. **Subject Matter Expert**. The Chief Officer for Public Health is the PHM subject matter expert, chairs the Programme Collaborative and is accountable for the programme realising the identified benefits.

c. **Programme Director**. The BLMK ICS Programme Director supports the SRO in establishing the governance framework and for the day-to-day oversight of the programme. The Programme Director is responsible for the staff who will drive the delivery of the programme to ensure that the objectives are clearly defined and achieved within the agreed time, cost and quality constraints.

d. **System Partners**. The programme will include significant work with various partner representatives for the relevant business areas that will be critical to the success and / or likely to be affected by the programme. Ideally each organisation will be represented individually on the Programme Collaborative: **System partners** will define the benefits, assess and steer the progress while enabling the successful transition of support available into business as usual for their respective areas of responsibility. System partners will include representatives from the following areas:

(1) Local authority services, including social care and public health.

(2) NHS commissioners and providers, including primary care

(3) Data and technology, business analytics and Information governance.

(4) Charities, the voluntary sector, patient and community groups.

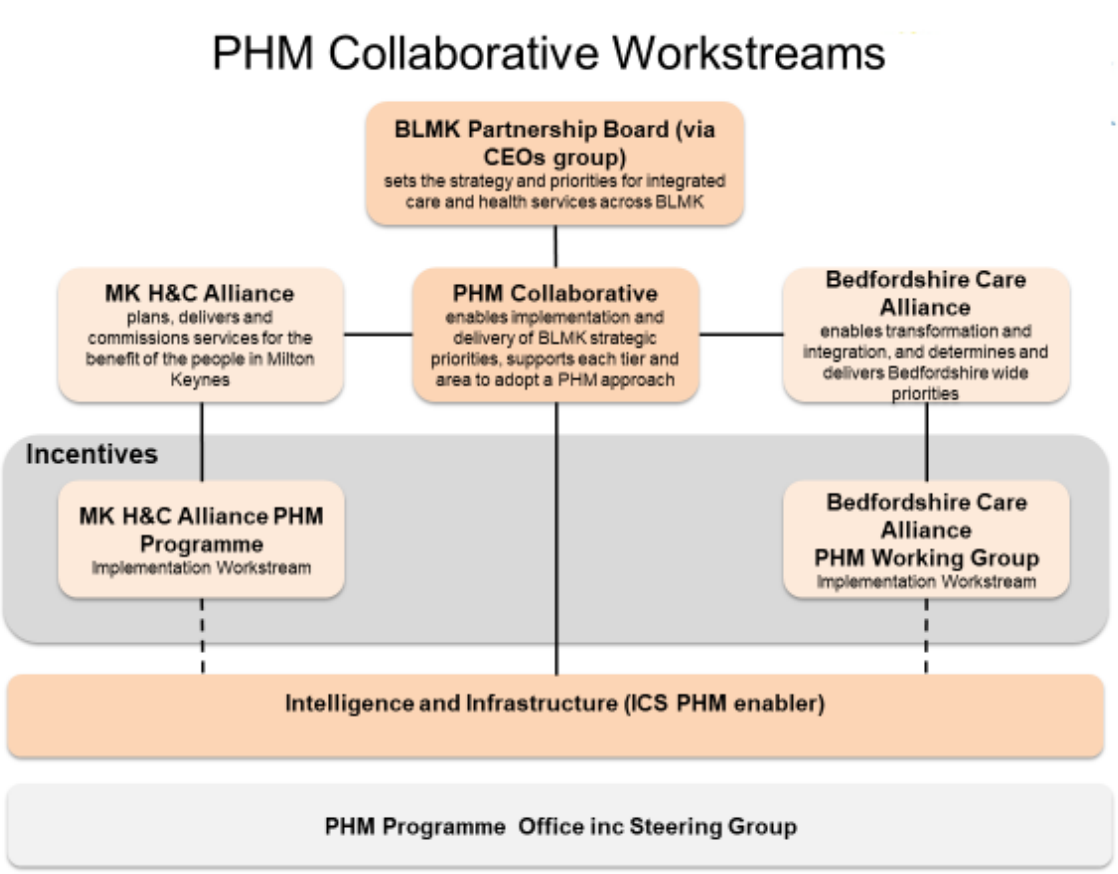


Figure 2 - subject to CEO approval. These groups will adapt and adopt the PHM Roadmap as part of their own workstream planning, with decision making and accountability sitting within each individual place and its governance structures.

7 Deliverables

The following goals and associated deliverables have been identified as part of the BLMK PHM Roadmap in detail and will be key to the successful implementation of this strategy. During Year 1 the PHM Collaborative will work with the BLMK system regarding how these deliverables will map across the different parts of the ICS, in line with any future devolution of financial resources. Ownership, detailed workplans and associated timescales are to be developed and tracked initially through the BLMK PHM Roadmap (and subsequently through the groups identified above as appropriate). The overall progress will be periodically reviewed against the PHM Maturity Matrix.

Infrastructure

The infrastructure is a set of basic building blocks that are core for a system to manage the health and well-being of a population and will be aligned to the ICS enabling workstreams accordingly:

- Cross-system leadership for PHM with a vision
- A virtual team of clinicians, managers and analysts are committed to realising the ambitions for PHM across the system and within our emerging Care Alliances
- BLMK-wide linked data and data warehouse that can be accessed by analysts from across the system, with re-ID capabilities for clinicians to enable direct care applications
- Plans for linking to a wider range of data sources including social care and wider determinants
- ICS-wide IG arrangements in place to enable data sharing and linkage

Intelligence

PHM involves intelligence led planning and delivery of services, aligning services with population need to improve outcomes:

- PHM capabilities set as a core requirement of single CCG/System business intelligence service
- A virtual network of analysts across BLMK focused on driving insight and analytics across the system in support of the Care Alliances alongside Place and Neighbourhoods
- Map of PHM functions across Care Alliances and ICS, and analytics teams
- Identified resource to support PCNs to conduct PHM
- Wider determinants data incorporated with health and care data within PHM products
- Knowledge from wider system stakeholders (inc. Social Care) used to better understand impact of wider determinants on populations
- Cohesive analytical support across system, place and PCNs
- Understanding of the visual outputs which teams find most useful
- Accessible data (e.g. dashboards) available to front-line staff in a way that is not reliant of significant analyst support
- Analysts develop actuarial outputs to inform planning and resource allocation
- Identified resources to continue actuarial work beyond the programme

Implementation of Interventions

By building on the analytics gathered to make decisions on the services provided to the public, effective, evidence-based interventions will be identified, designed and implemented at Alliance level, in partnership with Place(s) and Neighbourhoods (PCNs).:

- Tailored interventions developed based on local PCN population cohorts for PCNs with clear methodology to roll out across all PCNs
- PCN PHM champions who will sustain and support the spread across PCNs

- Analysis of PCNs' local insight, aligned with work already commenced and in support of the DES specification
- Programmes or work will focus on particular cohorts, as set out by the Care Alliances, Place and Neighbourhoods, informed by PHM analytics. This includes various priorities which follow from the Covid-19 pandemic, such as multiple-waiting lists, cancer, vaccinations, etc.
- A clear identified list of cohorts of focus being analysed
- Work undertaken to enable the system to move to outcomes-based contracts across health and care settings, with aligned incentives based on PHM data
- Clear working arrangements between PCNs and VCSEs, with integrated offers of support for specific patient groups
- VCSE community and Social Prescribing representation at each level
- Links between PHM leads and ICS and Care Alliance workstreams to ensure that service redesign is driven by PHM insight
- Continued use of the PCN maturity matrix to measure progress

Incentives

To make the greatest possible success of PHM, the BLMK system will be developed to ensure that the behaviours conducive to success are encouraged and supported at the different levels within the system.

- Patient / citizen empowerment and motivation
- Workforce development and modelling – upskilling teams, re-aligning and creating new roles, frictionless movement of workforce between settings, cross-organisational workforce planning
- Foster the kinds of behaviours and agile decision making within integrated teams through a robust governance structure. This will enable the success of PHM by supporting clinical and non-clinical leadership to navigate a holistic system transformation.
- Incentives alignment to value and population health based contracting and blended payment models.
- Using data population analysis and health ensuring data analytics are available to all sectors e.g. commissioning and contracting. Development of an approach to using data for commissioning and contracting to enable these functions to transform from organisation focused to being around future health needs of the population, ability to focus on cohorts and value-based contracting and other approaches, and the appropriate methods for evaluating and tracking these. Including population health segmentation approaches and being able to capture outcome metrics.
- Supporting General Practice preparedness by aligning Anticipatory care and Equalities DES
- Payment models linked to quality and outcomes for the citizen/patient by adopting payment approaches that shift the focus from organisations to the needs of the population and agreeing the principles and strategy that sit

behind these new ways of payment. Alignment at system and place on the adoption of new national policy of aligned contract and payment approaches.

8 Measuring Success

To demonstrate the value of adopting the PHM approach, it is vital that the extent of the success be measured. Measurement will focus on the following areas (with specific measures to be developed as part of the PHM planning arrangements):

- Implementation of deliverables
- Number of PCNs adopting a recognisable PHM approach (i.e. reviewing their data, identifying an opportunity, working in partnership to develop and intervention and then evaluating it)
- Outcomes measures relating to:
    - Reduction of health inequalities
    - Personal wellbeing (such as with established ONS wellbeing data)
    - Life expectancy and healthy life expectancy
    - Health and social care outcomes measures, relating to the interventions and partnership working undertaken

Appendices

Appendix 1 – BLMK PHM Draft Roadmap

Draft BLMK ICS Roadmap

Appendix 2 – PCN case study – identification of and tailored intervention for a particular patient cohort has led to significant benefits to patient wellbeing

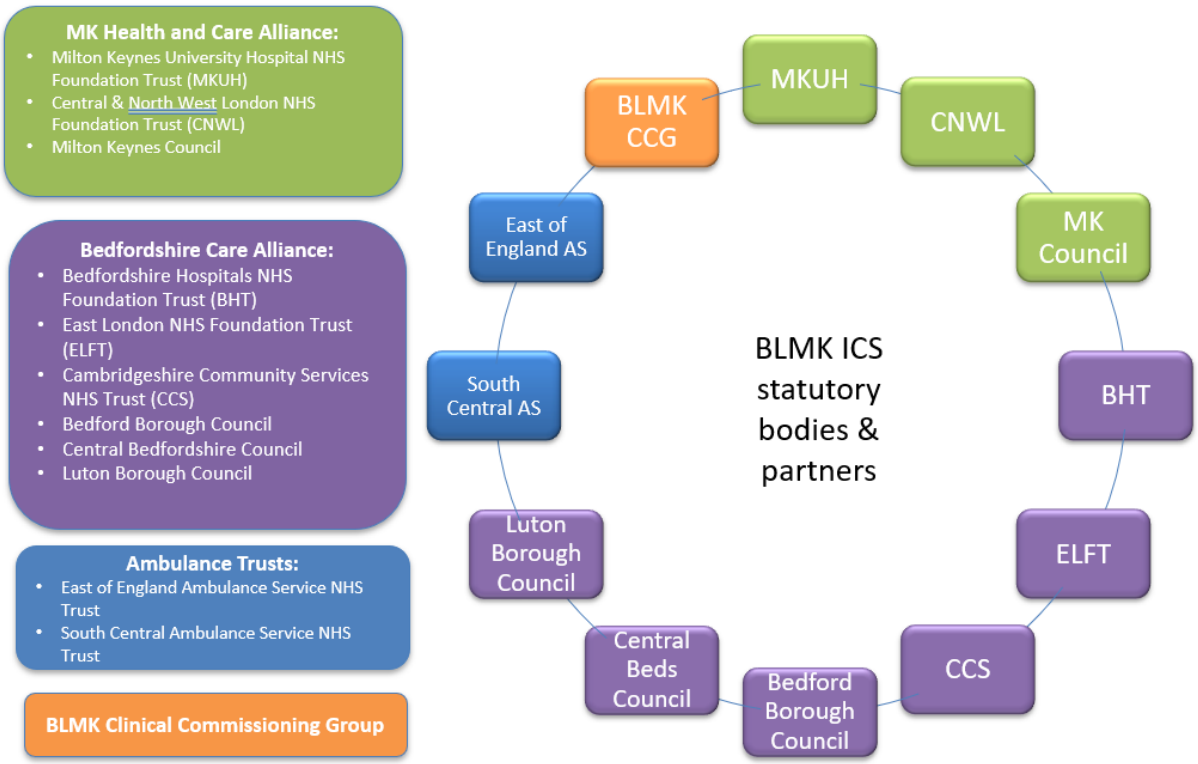
Caritas Case Study

Appendix 3 - BLMK System Contributors / reviewers of the PHM Strategy

PHM Strategy contributors and revi

Appendix 4 – BLMK IC Partnership

BLMK ICS Partnership



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