Summary Overview: the BLMK Plan for our Joint Forward Plan

It is an NHS England requirement for every ICB to produce a 5-year Joint Forward Plan, which complements the ICB Strategy and NHS 1-year Operating Plan to set how we will:

- Use our ICB to deliver the Place Plans in the medium-term, supported by our Provider Collaboratives, and focused on local population need (JSNA)
- Outline our approach to deliver the ICB's responsibilities ('4 pillars' of tackling inequalities, improving health outcomes, providing value for money, and supporting growth and sustainability)

The Joint Forward Plan (JFP) is due for submission from ICBs on June 30th 2023. However, NHS England have required all ICBs to submit a draft together with our 2023-4 NHS Operational Plan submission at the end of March.

This paper sets out the proposed BLMK approach to developing our JFP by June 30th – it is a Plan for Our Plan.

ICB members are asked to review the outline draft, provide responses to specific questions detailed in the cover sheet, and – pending adoption of feedback – approve this approach to creating the BLMK Joint Forward Plan.

SECTION ONE: Joint Forward Plan Introduction

The Joint Forward Plan does not require new content – it is the medium-long term view of how we deliver the aims and objectives of our Place Plans in partnership. Key to this medium-long term view is not just how we meet population growth and changing needs within our resources – but how we collaborate to tackle our most 'wicked' issues to support our communities to thrive.

The BLMK Joint Forward Plan will focus on those areas where collaboration at Place is required to achieve this. Specifically, our Joint Forward Plan will:

- **Focus our collaborative long-term plan on meeting the changing needs of our population** (not individual organisations or service lines)
- Develop our **processes and partnerships to build an adaptive, integrated system** which can respond to local population need sustainably within our resources
- **Develop & deliver infrastructure strategies** to tackle inequalities, improve health outcomes AND reduce avoidable cost

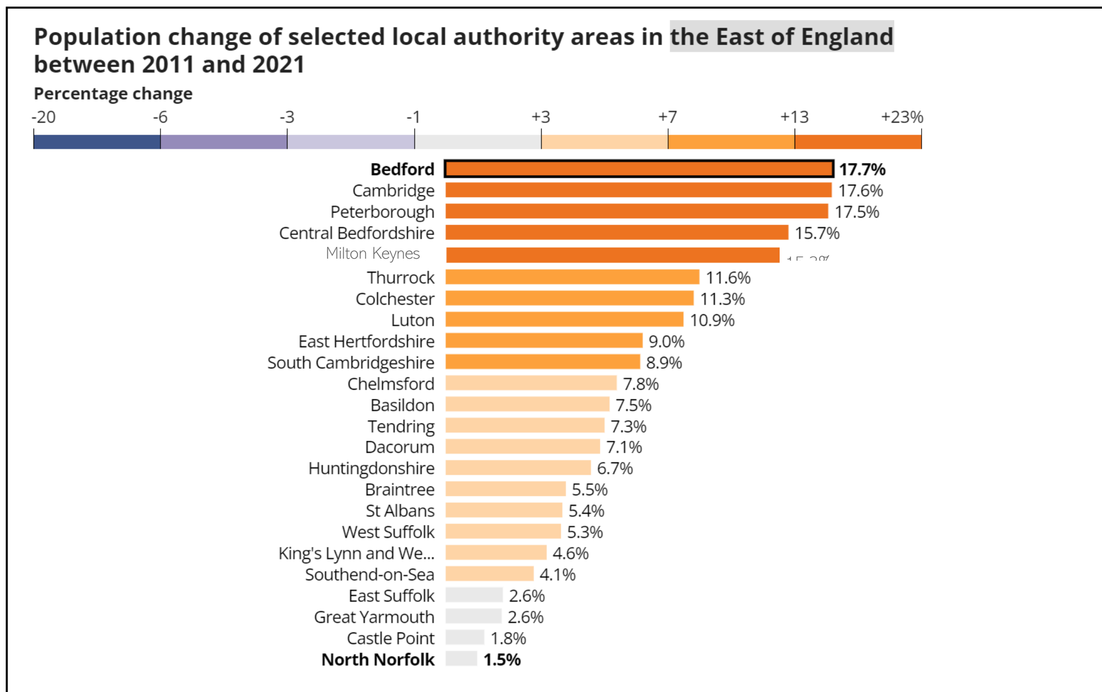
These plans are the long-term/ strategic delivery plan for Place Plans. Where Provider Collaboratives span multiple Places, and Place Plan actions are best delivered at scale, Provider Collaboratives (for example, the Bedfordshire Care Alliance) will work across multiple Places to deliver a consistent delivery model across the constituent Places.

Our Population

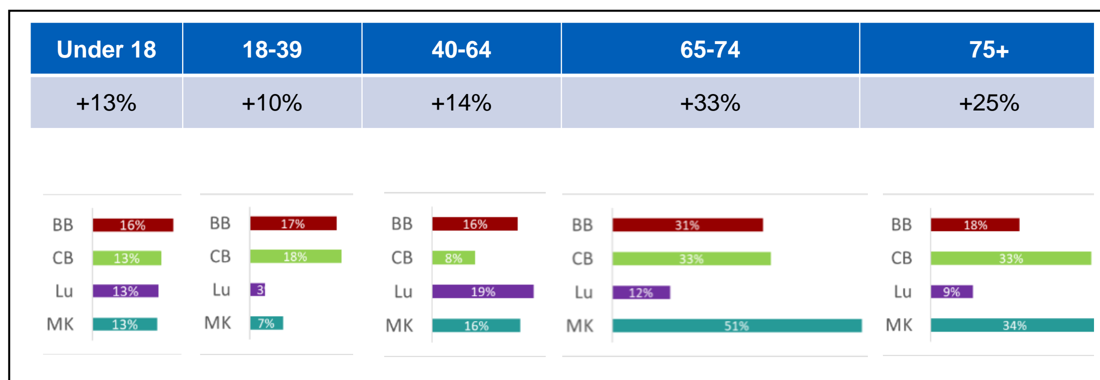
The Boroughs within BLMK ICB are diverse with a rapidly growing population.

Over the last ~10 years, roughly 5,000 homes were completed per year across BLMK (CBC > MK > BBC > Luton). Local Plans / housing strategies suggest around 6,000 new homes will be built across BLMK per year over the next ten years. This is significantly more than National (ONS) population projections assume a growth of c.2,400 homes per year across BLMK.

The ONS new housing projections for BLMK are out by a factor of 2.5, as BLMK is one of the fastest growing populations in the UK, and this trend is expected to continue.



Not only will there be more residents in the area over the next 15-20 years, but the demography, health needs and demand of our population will also change significantly.

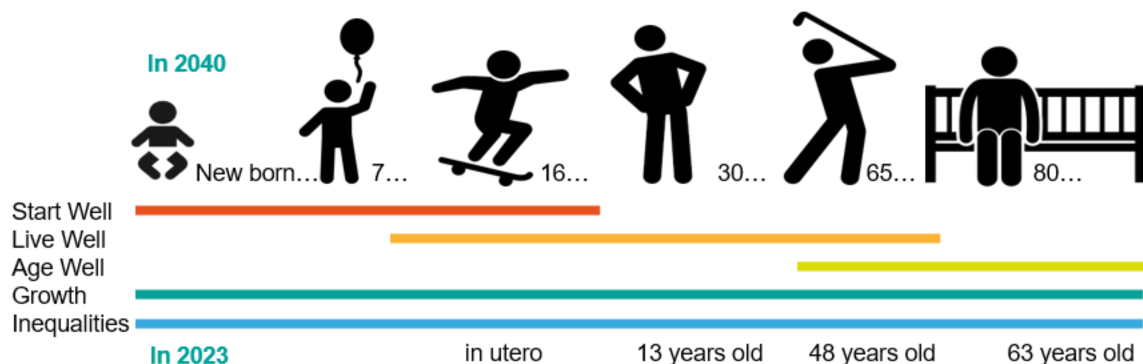


All of our Boroughs have strong plans to grow housing, employment opportunities and prosperity in a sustainable way, focused on the needs of specific communities within each Borough.

[examples from each Place to be added]

The BLMK Joint Forward Plan recognises that we cannot do more of the same with our resources (workforce, infrastructure such as estates and digital and finance) to meet this growing and changing population need.

The Plan aligns to our strategic priorities and the recognition that the actions that we take now will have a significant impact on our ability to improve the health and outcomes for our population in the future.



Given the variation in inequalities and health outcomes, people across BLMK hit the thresholds for start well, live well and age well at different ages across their life.

The known wicked issues for BLMK are:

- Rapid population growth and demographic shifts (specific to each Borough)
- Challenges accessing core primary care (including GP and dental services)
- Inequalities experienced by communities within BLMK
- Impact of COVID on residents
  - Deconditioning of people with frailty
  - Increased safeguarding and mental health issues for children and young people
  - Delays in accessing routine elective surgery
- Cost of living crisis affecting families
- Poor health of the population
  - Obesity
  - Long term conditions

SECTION TWO: Medium Term Affordability

[NHS & LA headlines – to be added for June submission]

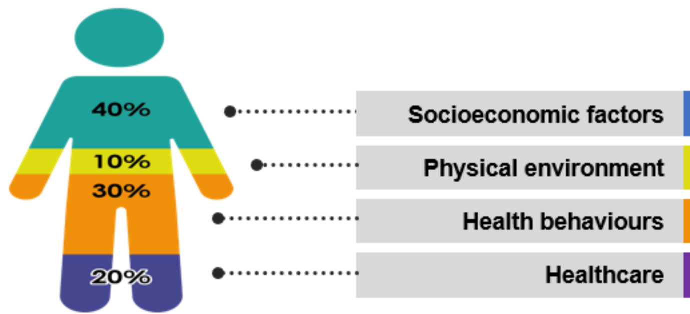
SECTION THREE: Our Strategy

Our system strategy sets out our ambition for improving health outcomes and reducing inequalities so that everyone in our city, towns, villages and communities can **live a longer, healthier life**. This means increasing the **number of years people spend in good health and reducing the gap between the healthiest and the least healthy in our community**.

Our strategy set out three questions which we aim to answer by working in partnership:

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

The benefit of working in partnership is the opportunity this affords us to look at all of the factors that affect our changes of living a longer, healthier life.



Our system strategy builds on our health and wellbeing strategies at Place and our understanding of what matters to our residents.

Our Joint Forward Plan will also be firmly grounded in this understanding of what matters to our people and communities, our Joint Strategic Needs Assessments, Health and Wellbeing Strategies and emerging priorities at Place.

SECTION FOUR: A Joint Approach – Maximising Benefit to Residents

Our Joint Forward Plan highlights the shared 'wicked issues', where an innovative and collaborative approach is needed to deliver the Boroughs' Place Plans and the NHS targets for access and outcomes for all residents sustainably to 2040 and beyond.

As such the BLMK Joint Forward Plan is built on a strong shared ethos between all partners in the ICB as to how best to achieve this sustainably:

1. **Prevention and earlier intervention**

2. **Locally configured interventions that meet the needs of residents at a Neighbourhood, Place or System-level**

3. **Getting It Right First Time**, especially for those residents who have the
    a. Worst outcomes / highest risk factors / greatest inequalities
    b. Highest and most complex needs/ unmet needs driving high volumes of interaction with health, care and public sector services, including police, fire and criminal justice systems
    c. Voice least often heard/ face the most barriers to access
    d. High volume, low complexity demand for health care (elective and same day urgent care)

4. **Co-production with local communities**

5. **Leverage the inter-dependencies and interfaces across health and care services** to
    a. make every contact count – build opportunistic prevention & support to self-care into existing pathways of care
    b. reduce low value and repetitive interventions for residents and our teams
    c. optimise use of resources (workforce, estates, finance)

6. **Optimise the operating environment for health, care and civic services** – across traditional service and organisational boundaries with co-ordinated actions to:
    a. Tackle inequalities

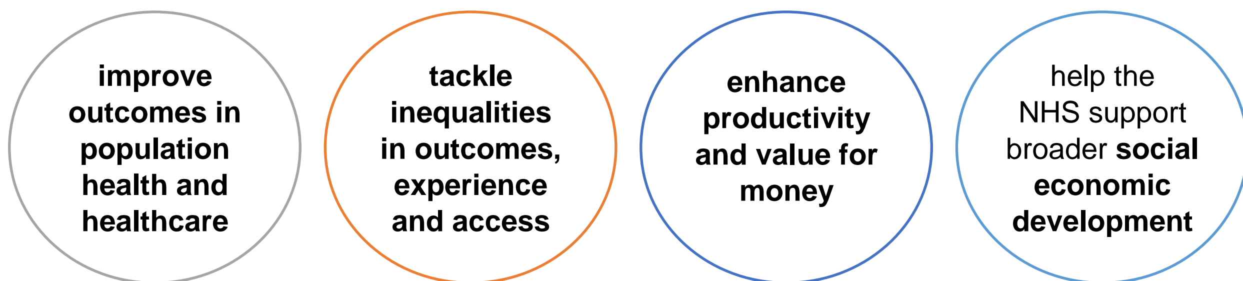
b. Stimulate local employment and economic development
c. Sustainability and green agenda
d. Long-term workforce development,
e. Market management
f. Strategic investment and utilisation of digital and estates assets

The key differences between existing Local Authority and NHS planning approaches are:

- NHS focused on short-term delivery (3-year funding cycle, 1-year operating plan) / LA plans for infrastructure and population growth are over a generation (15-20 year plans)
- NHS operating objectives are focused on the standards that clinical services must achieve for the patients who access them / LA considers the whole population living in a specific geography

All health and LA partners in ICBs have a shared responsibility to the populations they serve in their use of public money:

The four pillars of an ICS are to:



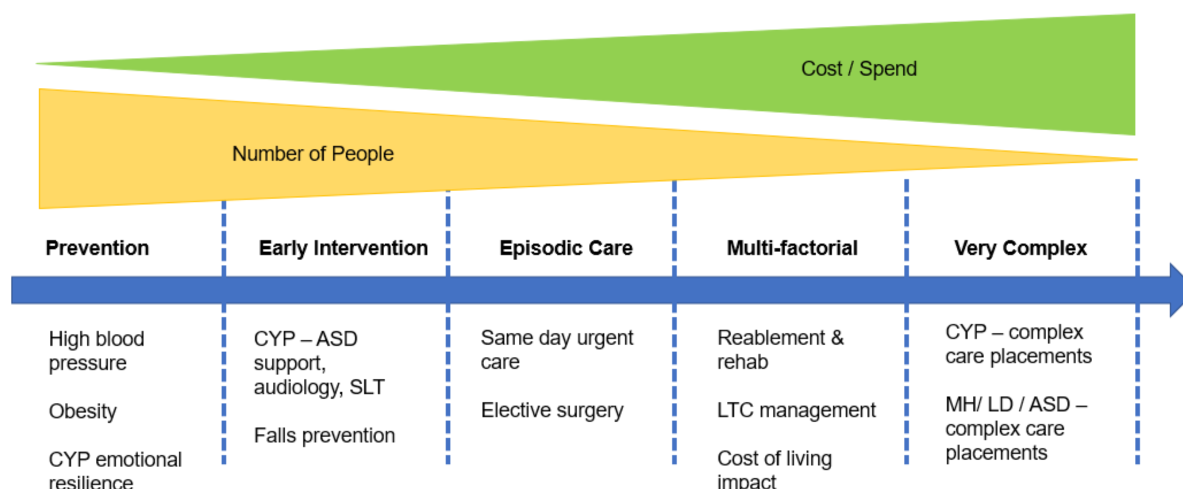
The BLMK Joint Forward Plan will therefore:

1. Focus on the needs of all residents at Place (not service lines / public sector institutions)
2. Extend to 2040
3. Identify the methodology by which we will:
   - Understand the growth, changing demographic and needs of our populations at Place to 2040
   - Outline key milestones and critical delivery points based on population size and need, incorporating existing 'wicked issues' and known changes in the operating environment (for example, devolution of specialised commissioning, or the creation of new towns in BLMK Boroughs)
   - Confirm the methodology for systematic review and strategic planning across key domains where a joint intervention between NHS and LA is required, utilising benchmarking, the evidence-base and innovation / research, applied through quality improvement methodology co-produced with local residents
   - Outline the key enabling strategic plans for workforce, infrastructure (estates and digital), and management of the operational environment (e.g. market management)

SECTION FIVE: The BLMK Approach

The purpose of the Joint Forward Plan is to determine how best we will work in partnership to address these known 'wicked issues' to the benefit of residents; and how these actions will enable sustainable delivery of NHS services to the standards set out in the NHSE Operating Plan.

Addressing these twin challenges will require a systemic and stratified approach, as depicted below:



Based on local JSNAs and Place Plans, the Joint Forward Plan will highlight those areas where a collaborative and different approach is required.

This will shift our focus from 'what can we afford to do?' to

'Can we afford NOT to do it?'

This latter question focuses on the needs and outcomes of the population, and how best we tackle inequalities and improve health outcomes to enable our communities to thrive AND deliver sustainable public sector services within resources.

This innovative and collaborative approach will involve:

- Developing a consistent approach to framing and investigating our 'wicked issues', with a focus on defining our target population, supporting co-production and personalisation, using collective resources and focusing on how we apply our different 'routes to Thrive'.
- Ensuring interventions are evidence based and challenge ourselves to achieve and sustain top decile performance, drawing on and contributing to research and innovation, and applying learning from best practice.
- Taking an adaptive approach to improvement, measuring outcomes as well as activity and considering the impact of our actions/failure to act on health and care (and wider society).

Examples of this approach could include:

a) Earlier intervention for children and young people who would benefit from:

- Speech and language help at a younger age / lower threshold of need
- Autism spectrum disorder support and diagnosis at a lower threshold of need
- Occupational therapy input for children identified above to support communication and social interaction at home and school

The underpinning rationale for this earlier intervention is to support children to meet their earlier developmental and education milestones, rather than delay intervention until the SEND threshold is met later in childhood.

Not only is this better for the individual child but also reduces higher system costs in SEND and (often) mental health support as children become aware of their 'difference' and struggle to keep up at school.

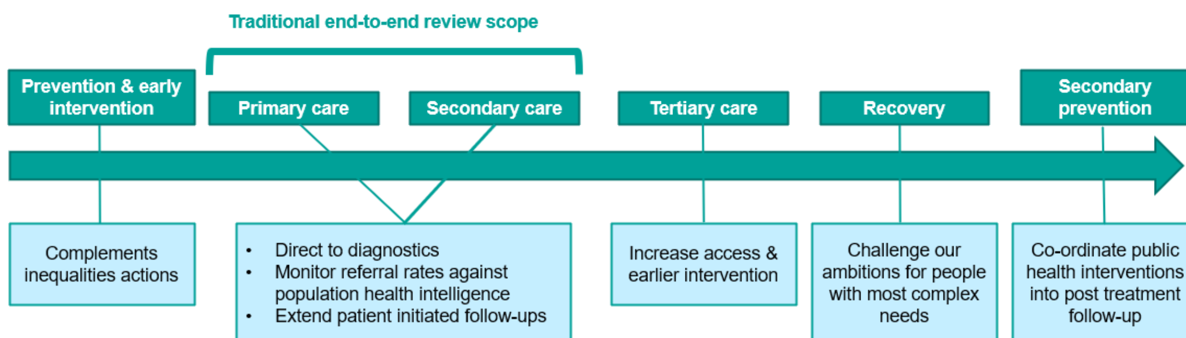
b) Local integrated offer for people with complex mental health and/ or learning disability needs, whose placement needs are currently met through contracting with independent sector providers. This could encompass:

- Creation of sufficient bespoke Supported Independent Living accommodation within Boroughs to meet local need
- Extended capacity to bring crisis support to the individual at times of highest need, reducing Emergency Department attendances / acute psychiatric admission unless clinically required
- Recovery approach that supports the individual to tackle root causes / manage distressing emotions and achieve their potential

This population are some of the most disadvantaged in our society, and this approach sets out a whole-system to tackle these inequalities and support these residents to thrive. This approach is also likely to drive better quality and more financially sustainable support.

c) Elective clinical pathways review

'End-to-end' clinical pathways review typically span the course of the pathway from primary care to secondary (acute) care and the return to primary care for residents who do access healthcare. Adopting a truly end-to-end clinical pathway review could better tackle inequalities and improve health outcomes, as depicted below:



Anchored in Places, this approach will:

- Identify populations whose risk profile / barriers to access indicates they require, using risk stratification at Neighbourhood / ward level
- Provide bespoke engagement (health promotion and uptake of screening programmes)
- Provide oversight for Place partners – giving a clear view (and feedback loop) on managing unwarranted variation not least in:
    - Over-referral that does not convert into increased diagnosis
    - Under-referral / late referral impacting on health outcomes
- Reduce bureaucracy for GPs in referral processes: encouraging greater autonomy for acute providers to determine the right clinical pathway based on diagnostic results
- Inform decision-making on how best to target current under-utilisation of BLMK residents for tertiary (specialised) clinical pathways, including earlier preventative interventions and/ or bespoke local pathways with tertiary providers
- Optimise public health interventions into post-treatment follow-up to maximise health outcomes

The outcomes sought from this approach are two-fold:

1. to ensure timely access that maximises health outcomes for all residents regardless of their barriers to accessing health and care
2. to manage demand and cost through more effective (targeted) interventions based on population need

d) Partnership in Fuller Neighbourhoods to support residents to tackle the root causes of their need (not solely manage symptoms). This approach goes beyond social prescribing to locally-determined offers that:

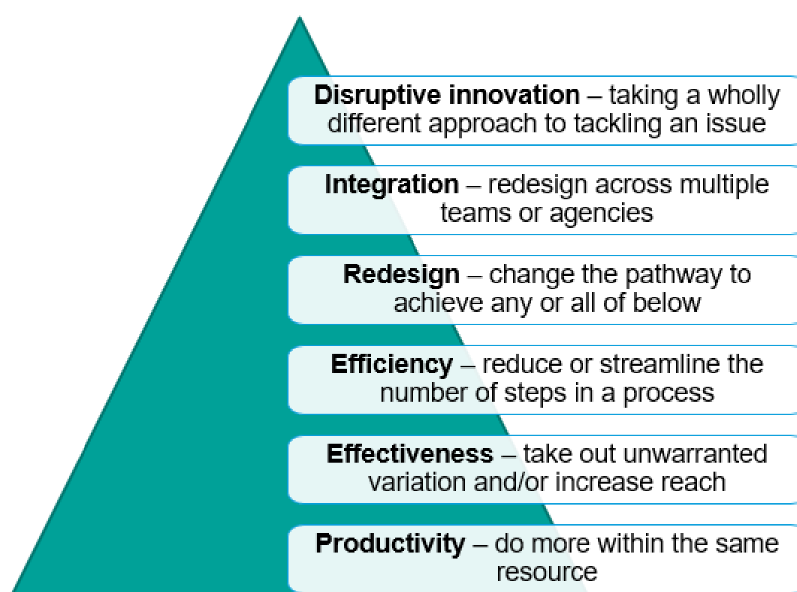
- Simplifies access to support, reducing the multiplicity of 'front doors'
- Draws on local communities' own assets and those of the VCSE to support people to thrive
- Offers co-ordinated support across civic, care and health partners reflecting residents' needs (not our service configuration and referral processes)

These examples demonstrate how, when we collaborate to the benefit of specific residents, we can improve outcomes for the individual and reduce avoidable cost across the public sector. In this way the plan will aim to move us away from the traditional focus on episodic and siloed care to:

- Define our goals by the needs of our population (at Place) rather than episodes of care or care pathways
- Drive the 'left shift', by moving resource to improving prevention and early intervention (to benefit residents and reduce future need and cost)
- Focus our collective attention on where disruptive innovation is required to meet complex need and high demand within resources
- Challenge ourselves to take a long-term view (outcomes & cumulative cost) wherever possible

We will deliver this through Quality Improvement interventions that are locally owned and driven to make it easier for our teams to do the right thing for the resident, first time.

Based on population growth and need we will deploy a range of actions in delivery of the elements of the Joint Forward Plan:



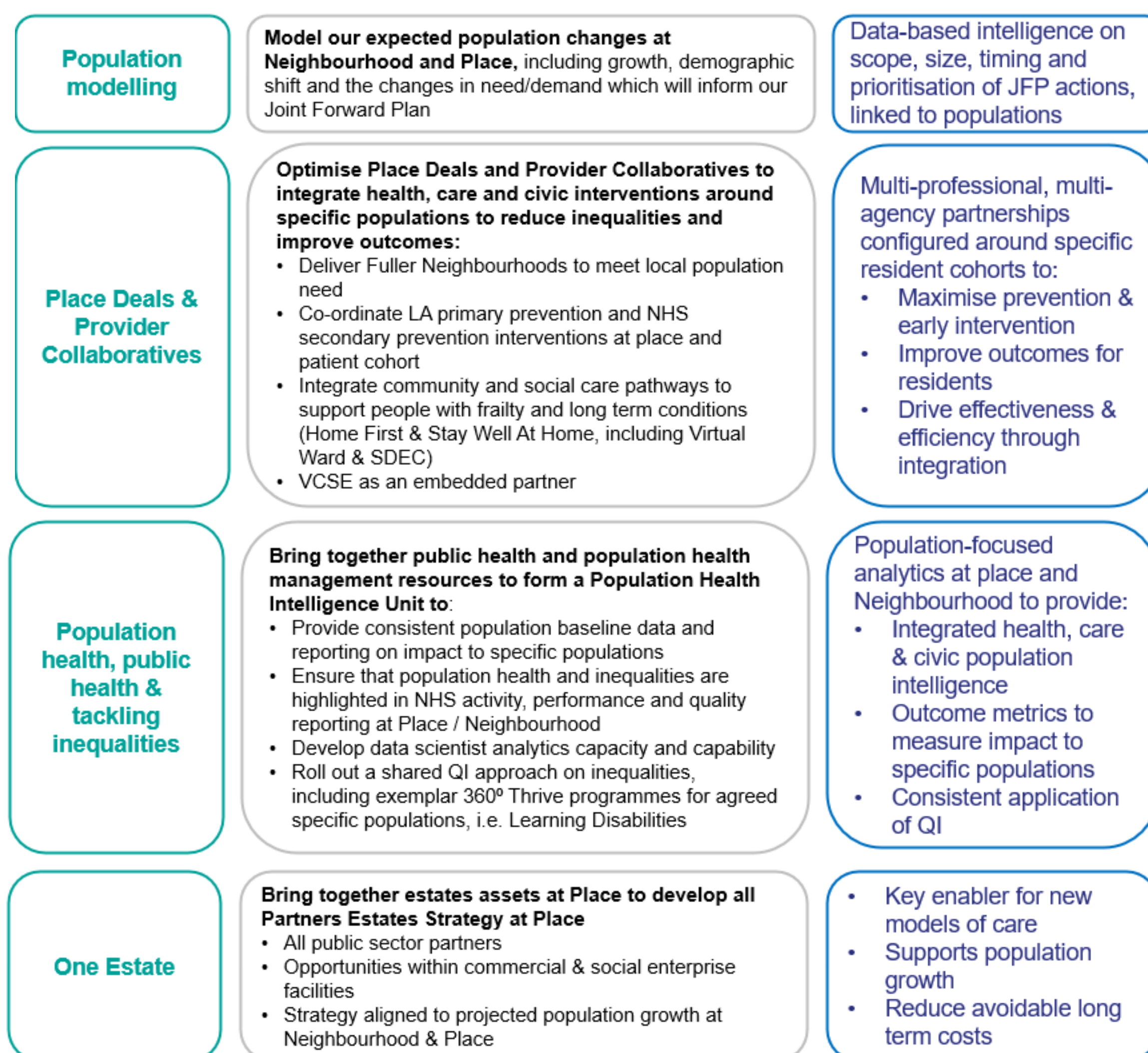
SECTION SIX: preparing the Joint Forward Plan

There will be several phases to the delivery of our Joint Forward Plan

- **Preparation phase** – establishing population-focused intelligence and delivery structures to inform and enable ICB core objectives for residents at neighbourhood and Place.
- Delivery of **Place and Provider Collaborative plans** – to meet local population need sustainably and within resources
- **Delivering the 'left shift'** – with a consistent focus on high volume/low-cost prevention and low volume/high-cost and complex interventions to maximise impact within resource
- **Building tomorrow** – building prosperity for our communities
- Achieving and **sustaining top decile** – getting ahead of the curve to drive sustainable excellence

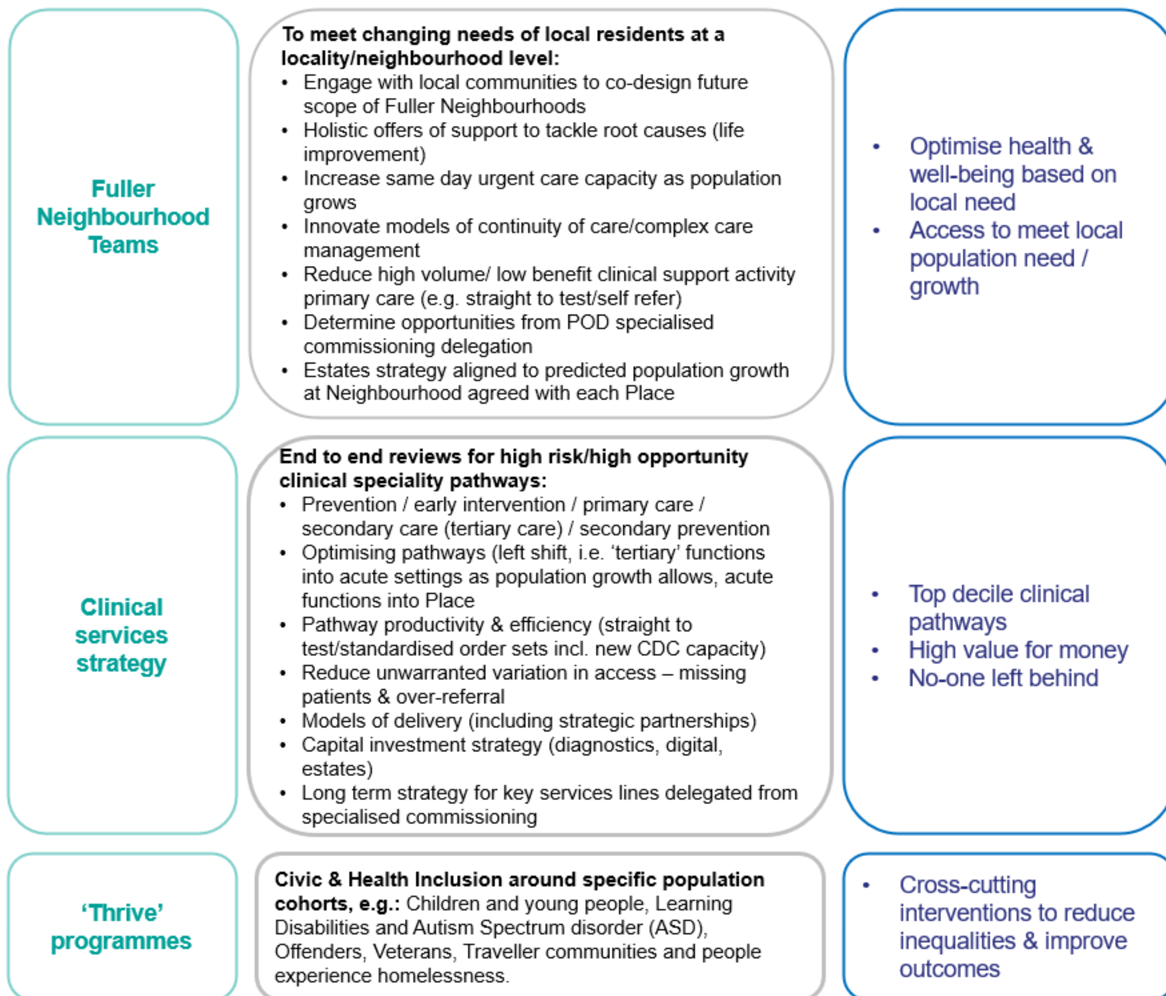
Phase 1: Preparation for the Joint Forward Plan July 2022 – March 2024

Establish population-focused intelligence and delivery structures to inform & enable ICB core objectives to residents at Neighbourhood and Place



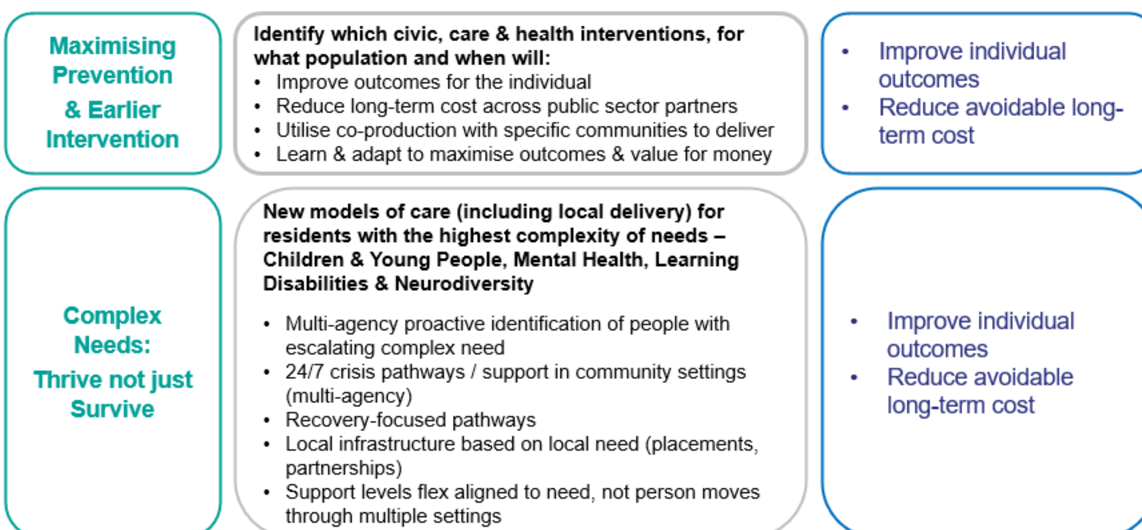
Phase 2a: Delivery of Place & Provider Collaborative Plans July 2022 – 2040

To meet local population need sustainably within resources



Phase 2b: Delivering the Left Shift April 2024 – March 2040

Consistent focus on high volume/ low-cost prevention AND low volume/ high cost & complexity to maximise impact within resources



Phase 2c: Building Tomorrow July 2022 – 2040

Building Prosperity for our Communities

Sustainability

Achieving net zero across the system by 2035, ensuring we work in harmony with the environment and remain within the 'ecological ceiling':

- Improved models of care to support the circular economy – focusing on fuel poverty and improving food and nutrition
- Remote and digital strategies to reduce carbon footprint
- Review of medicines and supply chain with a focus on supplier carbon reduction plan and e.g. inhaler replacement.
- Travel and transport 'modal shift' to improve air quality, supported by an ICS Clean air framework and system wide adaptation plan.
- Embedding sustainability planning and decision making across organisations, supported by increased capability and capacity, carbon literacy and intelligence, governance assurance to underpin delivery

- Building a 'circular economy'
- People stay well & make best use of resources
- Better physical and natural environment

Opportunities for prosperity

Improving opportunities for prosperity in all our population now and in the future:

- Promoting sustainable procurement and use of our public sector estate – aligning procurement policies and procurement pipeline
- Aligning our long term estate plan with LA population growth projections
- Developing the BLMK research and innovation strategy and networks

- Use of public sector assets
- Local investment
- Promoting research

Building our workforce

Taking a strategic approach to workforce development in line with population projections:

- Focus on improving the uptake of health and care roles amongst the local population,
- Growing our own future workforce, taking advantage of our education and research institutions

- Well-resourced public services
- Increased employment

Social value

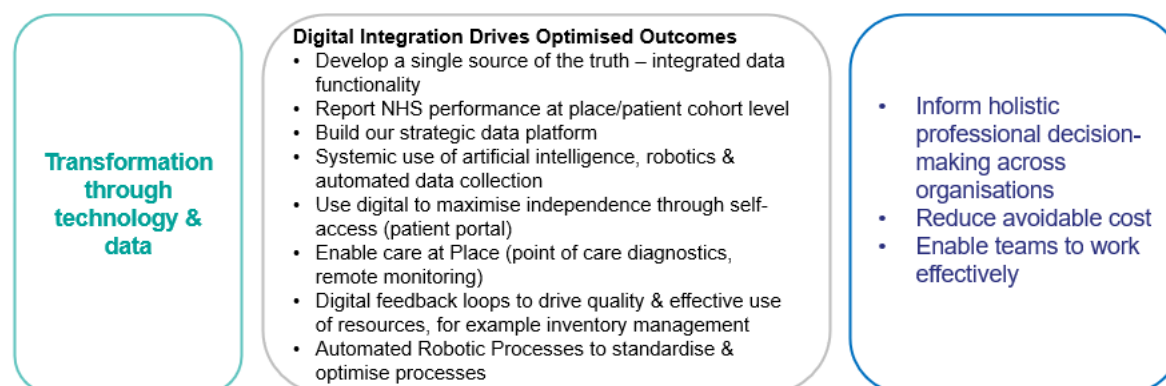
Making sure our work contributes to our whole society, ensuring everyone has the chance of a decent standard of living 'above the social foundation'

- Keeping people healthy in their homes and communities
- Focus on alleviating the effects of the cost of living crisis
- Nurturing partnerships with VCSE partners and local employers
- Developing our anchor institutions

- Keeping people healthy
- Nurturing local partnerships

Phase 3: Achieving & Sustaining Top Decile July 2022 – 2040

Getting ahead of the curve to drive sustainable excellence



Top Decile Challenge	**Benchmarking & Disruptive Innovation Across Partners** • Develop standardised methodology to review clinical speciality pathways end-to-end (including prevention, Left Shift including tertiary NHS care, & secondary prevention) • Systemic programme of effectiveness and efficiencies on clinical support and operational pathways that span multiple organisations, using professionally determined standardisation & feedback loops, i.e. radiology & pathology order sets (primary & acute), logistics (co-location of services, and patient transport) • Opportunities to deliver transactional processing (finance, medicines dispensing) at scale through automated processes • Audit on effectiveness / outcomes (pathway operational processes & patient/ resident outcomes) as part of BAU, enabling teams to flex and innovate to optimise outcomes within sustainable resources	• Improve individual outcomes • Enable teams to work effectively • Reduce avoidable long-term cost

SECTION SEVEN: Place and Provider Collaborative Key Objectives

[for completion ahead of Health and Wellbeing Boards]

Each of the four Places in BLMK have been developing Place plans, identifying local priorities that partners can work collectively on to improve the health and wellbeing of local residents.

[Note – text below is place holder only – requires Place partners' engagement to complete – to include wicked medium/long term issues that we need to address in partnership at Place and Provider Collaboratives]

Bedford Borough

Bedford Borough's vision is to thrive as a Place that people are proud of, want to live in and move to. Local plans recognise a growing and strong local economy and an active response to climate change as two important factors in achieving this. From this foundation residents will be able to thrive and realise their potential, supporting and celebrating Bedford Borough's diverse and inclusive communities.

The Bedford Borough Place plan has been developed by the Health and Wellbeing Board and commits to:

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

The priority partnership actions identified in Bedford Borough are:

- Tackling obesity
- Improving access to primary care

Central Bedfordshire

The Central Bedfordshire Place Plan includes three over-arching ambitions set out below:

- **Promoting fairness and social inclusion** – identifying and tackling underlying inequalities in social and wider determinants of health, promoting better equitable access to services.
- **Living Well** – so everyone has the right and opportunity to live their best life, with the required support and infrastructure to make healthy choices and maximise wellbeing.

- **Ageing well** – to provide support and services required to meet the needs of an ageing population, adapting to changing demands and new models of care.

Given the breadth of the ambition, the board has identified 5 initial priorities of focus which are:

1. **Cancer** – prevention, early detection and reducing premature mortality.
2. **Children and Young People's Mental Health** – delivering the ambitions to promote positive mental health and wellbeing
3. **Mental health, learning disability and autism** – reducing stigma, improving the experience of care and physical health of people with these conditions and access in crises.
4. **Primary care access, including dentistry** – developing the fuller plan for integrated care and developing new models of care
5. **Developing a one team approach to intermediate care services** – ensuring more joined up and timely care

Luton

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

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

The Luton Place Board has developed a Place plan which commits to:

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

The key priority actions identified to deliver this in Luton are to work in partnership to build:

- **Community hubs** and healthy places
- Improved **mental health services** and interventions to tackle the causes of poor health
- The Luton **digital programme**, connecting health and care services and helping people stay independent at home
- Capacity and capability across the **VCSE sector**

Milton Keynes

The Milton Keynes Health and Care Partnership, has developed and a 'MK Deal' which formalises the commitment of the main local NHS partners in MK and the City Council to work more closely together, with a focus on:

- **Improving system flow** – with a focus on urgent and emergency care services for older and/or frail and/or complex service users.
- **Tackling Obesity** – helping people lose weight and maintain a healthy weight through easily accessible weight management programmes, use of technology, pharmacological therapies and education/prevention work.
- **Children & Young People's Mental Health** – recognising that good mental health in children and young people helps build resilience, develop healthy relationships and lays the foundation for better mental and physical health and wellbeing throughout their whole lives. Early intervention is key for lifelong wellbeing: 75% of adult mental health issues are present by the age of 24.
- **Complex Care** – focussing on improving the planning, assessment, commissioning, and case management for people who have the most complex needs

Bedfordshire Care Alliance

The Bedfordshire Care Alliance is a provider collaborative which aims to ensure that where scale and complexity requires us to standardise care across the three Bedfordshire boroughs.

The Alliance has agreed a focus on four priority areas:
- **Supported discharge** – improving rehab reablement and recovery outcomes
- **Alternatives to acute admission** – stay well at home
- **Digital infrastructure** – to enable integrated pathways of care across Bedfordshire
- Support to Places to optimise **care closer to home**

Mental health, Learning Disabilities and Autism Collaborative

The BLMK Mental Health, Learning Disability and Autism Collaborative is a collaboration of the BLMK ICB, CNWL, ELFT the Bedfordshire Care Alliance, Milton Keynes Health and Care Partnership and Place based partnerships to improve outcomes, quality, value and equity for people in BLMK.

The initial vision of the Collaborative, which will be developed with input from service users, carers and system partners, will put service user voice and a focus on Place at its heart, refocusing efforts on addressing inequalities and unwarranted variation, and working at scale where it makes sense to do so.

Specific areas where the Collaborative will add value will include:
1. **Workforce** – training a new generation of mental health professionals
2. **Emotional wellbeing for young people** – responding to the increase in referrals since the pandemic
3. **Support for adults with autism** – so that even those without a formal diagnosis can get access to the support they need.

SECTION EIGHT: Sustainable delivery of NHS Operating Plan Targets

[to be updated following submission of the 2023/24 Operational plan]

Our approach to planning, transformation and contracting will look to address wicked issues which relate to our ways of working and operational realities, including:

These issues include:

- Vulnerabilities highlighted through winter pressures and the need to promote **admission avoidance and supported discharge** – workforce is a significant issue in this regard.
- **End of life care**, and in particular the need to develop a Place based delivery model
- Long waits in **elective care**, with a focus on ophthalmology, ENT, cardiology and MSK, and links to theatre productivity and vulnerabilities in paediatric surgery provision.
- **Diagnostics** including the development of community diagnostic hubs and refurbishments required to support endoscopy pathways.
- Ongoing pressures on **cancer services** including increased demand and complexity of cancer presentations and impacts on recovery of services, and the need to balance this with a push for early referral and diagnosis of cancer.
- Support for **children and young people** – especially those with the most complex needs, and to improve the experience of transition between services
- Improving uptake of **childhood vaccinations**, improving mental health and tackling obesity in children and young people.
- Recruitment and retention within the **maternity workforce** and addressing inequalities in experience and outcomes for our residents.
- Increased demand across all ages **autism, ASD and ADHD** pathways, and the need to find alternative solutions to the delays in care associated with long waits for formal diagnoses.
- Cost pressures and increased demand on **section 117** services, and variation in access and provision across the system.
- Capacity across **primary and same day urgent care** – including workforce, IT and estates.
- Capacity and capability to develop **multidisciplinary working across primary and secondary care** based around population need.
- An agreed system approach to **prevention** – including long-term sustainable investment – ensuring this is developed in partnership with the VCSE.

[place holder – additional content on known milestones including Community diagnostic centres, MKUH new hospital build, Mount Vernon re-provision to be added ahead of final submission in June]

SECTION NINE: Summary of key risks *[to be expanded for June submission]*

Principle risks, controls and mitigations are detailed in in the ICBs Board Assurance framework.

Key risks which are likely to impact our ability to deliver our Joint Forward Plan are summarised below:

1) insufficient capital/CDEL will be available to meet increased population growth/need.
2) insufficient impact on population wellbeing of left shift interventions – failure to deliver this will result in unaffordable need and cost
3) a gap or delay in resourcing as population growth/need increases
4) head space to lead transformation (operational pressures)
5) workforce transformation required

[Question - where are we holding/assuring Joint Forward Plan risks at Place and Provider Collaboratives?]

APPENDICIES *[to be added for June submission]*

a) Strategic Workforce Plan

Linked to

- population growth and demographic shift
- planned job creation in Boroughs
- LA and NHS workforce long term needs

b) Estates and capital strategy

c) Digital & Inequalities/ Health Intelligence Strategy

d) Joint sustainability & Green Plan

e) Medium Term Financial Plan