Milton Keynes Clinical Commissioning Group

Subject:	**Bedfordshire, Luton & Milton Keynes Sustainability & Transformation Plan (STP)**
Meeting:	NHS Milton Keynes CCG Board
Date of Meeting:	22nd November 2016
Report of:	Matthew Webb, Chief Officer Maria Wogan, Director of Strategy and Planning

Is this document:

Commercially Sensitive	N
For the Public or Private Agenda	Public
To be publically available via the CCG Website	Y

1. SUMMARY

The Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP) was published on 15th November 2016 and is available on the STP website: www.blmkstp.co.uk/publications/

The STP public summary and full STP Submission are attached to this paper for review by the Board.

Publication of the plans marks the start of the public engagement period during which the draft proposals will be considered by the NHS, local authorities and stakeholders. The Boards/ governing bodies/ executive committees of all 16 partner organisations will receive these documents at the first available formal meeting after publication.

Initial public comments have been requested to be submitted by 15 December 2016, although there will be an ongoing engagement process beyond that date.

2. STP & MILTON KEYNES

Regular updates on the development of the STP have been provided to the MK Health and Wellbeing Board and the Health and Wellbeing Board held a

workshop on the STP in October. We will support a detailed review of the STP documents by the Health and Wellbeing Board as part of this stage of the engagement process.

We raised awareness of the STP with our member practices at the PLT on 20 October and have held more detailed discussions at the neighbourhood meetings during November. We will continue to engage with all our partners in developing the more detailed STP plans for MK.

3. JOINT CCG WORKING IN THE STP FOOTPRINT

In developing the STP submission, we have been working closely with our Bedfordshire and Luton CCG partners. To provide a more formal structure for this joint working and accelerate STP delivery, we are proposing the creation of a Joint Commissioning Executive. A paper on this proposal is attached as an Appendix for consideration by the Board. The same paper is being submitted to the Boards of Bedfordshire and Luton CCGs.

4. RECOMMENDATIONS

The Board is requested to:

(a) note the STP public summary and submission and identify any high priority issues for the CCG; and

(b) approve the Terms of Reference of the BLMK Joint Executive Committee, comprising of the three CCGs.

Appendix

Subject:	**Bedfordshire, Luton and Milton Keynes (BLMK) CCG Joint Commissioning Executive**
Meeting:	NHS Milton Keynes CCG Board
Date of Meeting:	22nd November 2016
Report of:	Clare Steward, STP Governance, Liaison & Consultative Workstream Advisor
Presented by:	Maria Wogan, Director of Strategy and Planning

Is this document:

Commercially Sensitive	N
For the Public or Private Agenda	Public
To be publically available via the CCG Website	Y

1. SUMMARY

This paper proposes the formation of a Joint Commissioning Executive to work across the three CCGs in Bedfordshire, Luton and Milton Keynes (BLMK).

This proposal is to be shared with the Boards of all three CCGs within the BLMK - Sustainability Transformation Plan (STP) footprint for approval.

With the creation of the BLMK - STP footprint further work is required to ensure that all the CCGs consider how they will align their statutory responsibilities with the strategic direction of the STP. As three CCGs there is a need to consider the implications of the STP plan on the future models of care and working of the CCGs, both collectively and individually, and make recommendations to their Governing Bodies.

2. RECOMMENDATION

The Milton Keynes CCG Board is asked to approve the Terms of Reference of the BLMK Joint Executive Committee, comprising of the three CCGs

BLMK CCG Joint Commissioning Executive

Purpose

This paper proposes the formation of a Joint Commissioning Executive to work across the three CCGs in Bedfordshire, Luton and Milton Keynes (**BLMK**). This proposal is to be shared with the Boards of all three CCGs within the BLMK - Sustainability Transformation Plan (**STP**) footprint for approval.

With the creation of the BLMK - STP footprint further work is required to ensure that all the CCGs consider how they will align their statutory responsibilities with the strategic direction of the STP. As three CCGs there is a need to consider the implications of the STP plan on the future models of care and working of the CCGs, both collectively and individually and make recommendations to their Governing Bodies.

Action Required:

The Governing Body is asked to approve the Terms of Reference of Joint Executive Committee, comprising of the three CCGs.

Paper for CCG Boards

Proposal from Bedfordshire, Luton and Milton Keynes CCGs to establish Joint Commissioning Executive.

Introduction

This paper is for approval by each CCG Board to establish a Joint Commissioning Executive to work across the three CCGs in Bedfordshire, Luton and Milton Keynes (BLMK) - Sustainability Transformation Plan (STP) footprint.

Why is the Joint Commissioning Executive being proposed?

CCG Chief Officers across the BLMK have been meeting together, within the STP Secretariat to consider how best the BLMK CCGs can support the development of the STP. As part of these discussions there are a number of areas of common interest/functions that have been discussed, which will not only require CCG leadership but are also matters that are shared across all three CCGs. In light of this the CCGs are proposing to form a Joint Commissioning Executive Committee to make recommendations to the CCG Boards on key pan CCG issues.

The rationale for proposing such a committee allows for the CCGs to work collectively over the forthcoming months and to explore what potentially more formal decision making arrangement may work best.

In addition to this, the developing pace of change in the BLMK: STP, there is value in establishing a more formal mechanism for the three CCGs to work together on their shared agendas. The way CCGs commission is a key structure within the BLMK footprint and can be used to drive change and improve the outcomes of our population. The BLMK footprint needs to be ensure greater consistency in terms of developing its commissioning approach and the way in which the system develops to meet the needs to its population. It is intended that the Joint Commissioning Executive will allow the ways in which this can best be achieved to be explored

As part of this arrangement the Joint Commissioning Executive will have no formal delegated powers and individual CCGs and Accountable Officers will remain responsible/accountable for meeting their own statutory duties.

Terms of Reference of the Joint Commissioning Executive

Whilst the detail of the BLMK plans are still in development, it is important that there is an aligned view of Commissioners. The Joint Commissioning Executive does not delegate any function to a single Joint Commissioning Executive or individuals. Rather it provides the opportunity for the three BLMK CCGs to develop common recommendations to their boards without, at this stage, the individual organisations being tied into an external delegated decision-making structure. The Joint Commissioning Executive does not have any delegated functions only the CCG Officers which collectively form it have delegated responsibilities.

The Schedule attached sets out the Terms of Reference and membership of the Joint Commissioning Executive. It is proposed that the Joint Commissioning Executive will have the following minimum membership from each CCG;

- One Accountable Officer;
- One Clinical Chair;
- One Additional Director from each CCG
- One GP Representative

Each CCG will have a minimum of four core members, with the scope to invite other Executive members to attend meetings as appropriate.

In bringing the three CCGs together via the Joint Commissioning Executive, it will provide the opportunity for collective discussion and recommendations to individual CCG Boards for a number of services commissioned by CCGs, where there is a benefit to be derived from collaboration across the CCGs. This is about ensuring we can get better value from commissioning some services together at a greater scale, both in terms of outcomes for patients and in the use of resources.

The three CCGs working together via the Joint Commissioning Executive would have within

the Joint Commissioning Executive's terms of reference the scope to consider the following areas.

a) Those services which may be proposed to be changed through the STP service reconfiguration programme,
b) Those services, if any, which the three CCGs currently or in the future wish to, commission together;
c) Management of the alignment of planning, policies and processes between the three Bedfordshire, Luton and Milton Keynes CCGs;
d) Providing a unified input from the health commissioners within the Bedfordshire, Luton and Milton Keynes to the BLMK Sustainability Transformation Plan; and
e) Developing the governance arrangements between the 3 CCGs to support more formal joint decision-making in the future, if required as part of the BLMK STP.

What does this mean for the future of CCGs?

The proposed development of the Joint Commissioning Executive does not make any assumptions about the future of the three CCGs or the future shape of commissioning. It is envisaged that commissioning will continue to develop, seek to improve the outcomes for the population and will need to change as new models of care appear.

The establishment of the Joint Commissioning Executive recognises the emerging models of commissioning as set out in the Five Year Forward View, for example an Accountable Care System. These emerging models will be considered in light of the BLMK footprint as part of the STP.

The Joint Commissioning Executive does not have any delegated decision-making authority, it is a mechanism to support joint work between the three CCGs. The Joint Commissioning Executive will make recommendations to individual CCG Boards, which retain the authority to make decisions for their geography and population.

Joint Commissioning Executive

Terms of Reference

1 Introduction

1.1 The Joint Commissioning Executive, gives CCGs an additional option for undertaking collective strategic discussion and make recommendation to the individual CCG Boards. This can also include NHS England, who may also may wish to work collaboratively with CCGs.

1.2 Individual CCGs and NHS England will still always remain accountable for meeting their statutory duties. The aim of creating Joint Commissioning Executive is to encourage the development of strong collaborative and integrated relationships and shared recommendations between partners.

1.3 The CCG Joint Commissioning Executive is comprised of Executive members from the following organisations:

- Bedfordshire CCG;
- Luton CCG;
- Milton Keynes CCG.

1.4 The CCG Joint Commissioning Executive has the primary purpose of allowing the three CCGs to collaborate more closely both from a planning perspective and in supporting the development of the Bedfordshire, Luton and Milton Keynes (**BLMK**) - Sustainability Transformation Plan (**STP**).

1.5 In addition the Joint Commissioning Executive will be able to meet collaboratively with NHS England to make shared recommendations in respect of those services, which are directly commissioned by NHS England.

1.6 The Health Leaders across the BLMK have collectively committed to change the way certain elements of health care are provided to the local population to deliver the highest quality of care possible within the resources available. The work of the Joint Commissioning Executive is designed to deliver key clinical standards consistently across the BLMK footprint so that all people receive the highest possible care and best outcomes.

1.7 Guiding principles - The three CCG Joint Commissioning Executive will adhere to the following principles as a minimum:

- Delivering a clinically and financially sustainable health and care system across BLMK footprint.
- Clinically-led, co-design and collaboration across BLMK footprint delivering integrated support.
- Aligning priorities across BLMK footprint and organisations – managing sovereignty and risk.
- Prioritised effort on greatest benefit – improving quality and outcomes efficiently and effectively.
- Ensuring VFM. Doing things right and doing the right things.
- Alignment of effort and resource – ‘twin citizenship’ of staff for across the BLMK footprint.

- People and patients come first – delivering parity of esteem and outcomes – fairness and timeliness of access to support.
- Built upon innovation, international evidence and proven best practice.
- Subsidiarity with clear framework of mutual accountability.

1.8 The Joint Commissioning Executive will work in partnership with the Secondary Care Transformation Board and other BLMK STP structures in relation to delivery of the BLMK STP.

2 Statutory Framework

2.1 The three CCGs named in paragraph 1.3 above have agreed to collaboratively work together as set out in Section 3. Bedfordshire, Luton and Milton Keynes CCGs individually remain responsible for compliance with their statutory responsibilities.

3 Function of the Joint Commissioning Executive

3.1 The role of the Joint Commissioning Executive shall be to carry out the functions relating to the CCGs as set out in Section 1.3. This includes, but is not limited to, the following activities:

a) The services which will be changed through the service reconfiguration programme, .
b) Those services, if any, which the three CCGs currently or wish to, commission together;
c) Management the alignment of planning, policies and processes between the three Bedfordshire, Luton and Milton Keynes CCGs;
d) Being the voice of the health commissioners within the Bedfordshire, Luton and Milton Keynes - Sustainability Transformation Plan.

3.2 At all times, the Joint Commissioning Executive, will act in accordance with the scheme of delegation of their respective organisations' constitutions and refer decisions reserved to the Governing Bodies back to their respective Boards.

4 Geographical coverage

4.1 Each CCG represented on the Joint Commissioning Executive covers it's own respective geography of Bedfordshire, Luton and Milton Keynes. This geography is consistent with Bedfordshire, Luton and Milton Keynes - Sustainability Transformation Plan footprint.

5 Membership for Each CCG Committees

5.1 Each of the three CCGs, which form the Commissioning Executive, will have the following membership.

- One Accountable Officer;
- One Clinical Chair;
- One additional Director from each CCG
- One GP Representative

5.2 Each of the Bedfordshire, Luton and Milton Keynes CCGs would have a minimum of four members

5.3 Individual committee members may nominate a suitable deputy (at Director Level) and further Executive Directors to attend when necessary and subject to the approval of each CCG Accountable Officer. All deputies should be fully briefed and the secretariat informed of any agreement to deputise so that quoracy can be maintained. Deputies will have the necessary authority to make recommendations on behalf of their CCG.

5.4 The Joint Commissioning Executive will nominate a rotating Chair (for a period of three months) and will oversee the secretariat to ensure the day-to-day work of the Committee is proceeding satisfactorily and that appropriate collaboration has been undertaken.

6 Meetings

6.1 The Joint Commissioning Executive shall adopt the standing orders of Milton Keynes CCG constitution insofar as they relate to the:

a) notice of meetings
b) handling of meetings
c) agendas
d) circulation of papers
e) conflicts of interest

7 Quorum

7.1 The Chair and/or the Accountable Officer will need to be present, as a minimum with at least two members from each CCG for the Committee to be quorate.

8 Frequency of meetings

8.1 Frequency of meetings will meet as agreed through discussions between the three CCGs as appropriate to transacting business.

9 Meetings of the Commissioning Executive

9.1 Members of the Joint Commissioning Executive have a collective responsibility for the operation of the Joint Commissioning Executive. They will participate in discussion, review evidence and provide objective expert input to the best of the knowledge and ability, and endeavor to reach a collective view on recommendations.

9.2 The Joint Commissioning Executive may call additional experts to attend meetings on an ad hoc basis to inform discussions.

9.3 The Joint the Commissioning Executive has the power to establish sub groups and working groups and any such groups will be accountable directly to the Joint Commissioning Executive.

9.4 Members of the Joint Commissioning Executive shall respect confidentiality requirements as set out in the respective CCG Standing Orders referred to above unless separate confidentiality requirements are agreed.

10 Secretariat provisions

10.1 The secretariat provision will be provided by one of the three CCGs to the Joint Commissioning Executive by mutual agreement. However, the minimum provision is set out below:

- Circulate the minutes and action notes of the Joint Commissioning Executive within three working days of the meeting to all members
- Present the minutes and action notes to the governing bodies of the CCGs set out in 1.3 above.

11 Reporting to CCGs

11.1 The three CCG Committees, which form the Commissioning Executive, will produce a note of each meeting, which will be shared with its own CCG Board.

12 Decision-Making Process

12.1 The Joint Commissioning Executive will be asked to make shared recommendations by consensus to individual CCG Boards, wherever possible.

13 Decisions

13.1 The Joint Commissioning Executive will make decisions within the bounds of the delegated authority of individual CCG members on the Executive. The Joint Commissioning Executive will make recommendations to individual CCG Boards on any decisions reserved to the CCG Boards.

14 Review of Terms of Reference

14.1 These terms of reference will be formally reviewed by CCGs as a minimum six monthly, taking the date of the first meeting, following the year in which the Joint Commissioning Executive is created and may be amended by mutual agreement between the CCGs at any time to reflect changes in circumstances as they may arise.

15 Signatures

15.1 Signed by .....on behalf of Bedfordshire CCGs

15.2 Signed by.....on behalf of Luton CCG

15.3 Signed by .....on behalf of Milton Keynes CCGs

15.4 This agreement is dated 2016

BLMK Joint Commissioning Executive

Terms of Reference

Schedule 1 - List of Individual Committee Members from each Constituent CCG

Bedfordshire CCG - Committee Members
Clinical Chair – Dr Alvin Low
Accountable Officer – Matthew Tait
Nominated Director – tbc
GP Member – tbc

Luton CCG - Committee Members
Clinical Chair – Dr Nina Pearson
Accountable Officer – Colin Thompson
Nominated Director – tbc
GP Member – tbc

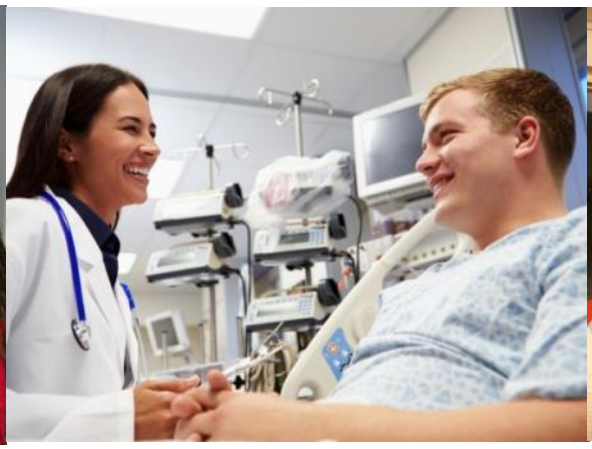
Milton Keynes CCG - Committee Members
Clinical Chair – Dr Nicola Smith
Accountable Officer – Matthew Webb
Nominated Director – tbc
GP Member – tbc

BLMK
Sustainability & Transformation Plan

Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan

October 2016 submission to NHS England

Public summary


15 November 2016

NHS

Contents

About this summary

This document summarises the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan (BLMK STP) submission to NHS England in October 2016. You can find more detail in the draft technical STP submission that is available on our website at www.blmkstp.co.uk.

The five year BLMK plan outlines the ideas that the STP partners have developed so far for transforming publicly-funded health and social care services in BLMK, building on already existing good practice. And it's not just about hospital services; the STP has a broad remit that includes social and community care, GP services, ambulance services, urgent and emergency care across the whole of Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.

We have produced this summary to share our ideas with you and invite feedback from everyone with an interest in our services, including those who use them and those who work within them.

It's important to note that we are at an early point in the process and no decisions have been made as yet. At this stage, we want to gather your thoughts – what do you think of our ideas? Are we on the right lines? Is there anything else we need to be considering? Your input will help to shape the STP's development and no decisions will be made without further discussions with patients, the public, staff, local politicians and voluntary sector organisations, as well as formal consultation on any major service changes, or decisions that impact on staff.

1. Introduction

What is the STP all about?

Sustainability and Transformation Plans (STPs) are an NHS England initiative. They give local NHS organisations and councils the opportunity to work together to improve the way health and social care is designed and delivered, so that local people receive the best possible service. Our staff and population are proud of our services, but we all know we can make them much better.

In Bedfordshire, Luton and Milton Keynes, 12 NHS organisations and four local councils[1] have been working together to find ways of improving and modernising services to meet the 'triple aim' – set out in NHS England's *Five Year Forward View*[2] – of delivering improved health and wellbeing, transforming quality of care delivery and making NHS finances sustainable.

Almost one million people live in Bedfordshire, Luton and Milton Keynes (BLMK) – three very different places that are also diverse within themselves. These differences affect what local people need from their health and social care services. For example in Milton Keynes, services must meet the needs of one of the most rapidly growing populations in the country. In Bedford Borough and Central Bedfordshire, services must meet the needs of a population with a higher than average number of people aged over 75. And in Luton, services must meet the needs of one of the most vibrant and ethnically diverse populations outside of London.

There are also significant differences in general health and wellbeing, depending on where people live. For example, there is a 10 year life expectancy gap between women from the most and least deprived areas of Bedford Borough, and a 12 year gap for men from the most and least deprived areas in Luton. This is unacceptable and we are committed to tackling these inequalities to ensure everyone lives longer, healthier lives.

We have to respond to rising demand for health and social care services, making sure that patients and their needs are at the heart of the care we plan and provide. We want to improve our services by working with you more effectively and must plan for the different ways that people want to access and use services. We also want to help people take greater control of their own health and wellbeing, and we must do all of this with the money we have available to us.

This summary sets out our vision for future health and social care in BLMK and outlines our ideas for responding to the challenges we face. It also sets out our commitment to involve you, the people who use our services, to further develop our plans and proposals for the future of local health and social care services.

In five years' time, if we deliver this plan, we will see people staying in good health for longer, with better care and more of it delivered closer to home. If someone does become unwell, they'll have access to the best possible services to get on their feet again, or manage their condition so they can have the best quality of life possible.

We see this as an exciting opportunity to develop health and social care services for the communities we serve. As users of the services we deliver, we want you to help us get it right.

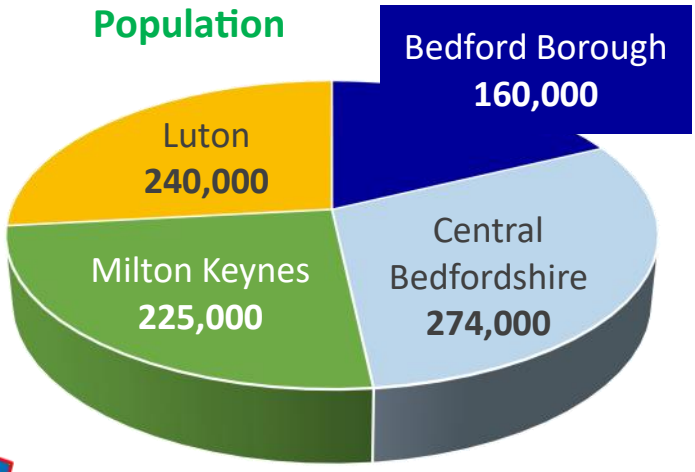
Pauline Philip

Chief Executive, Luton and Dunstable University Hospital NHS Foundation Trust and Lead for the BLMK Sustainability and Transformation Plan

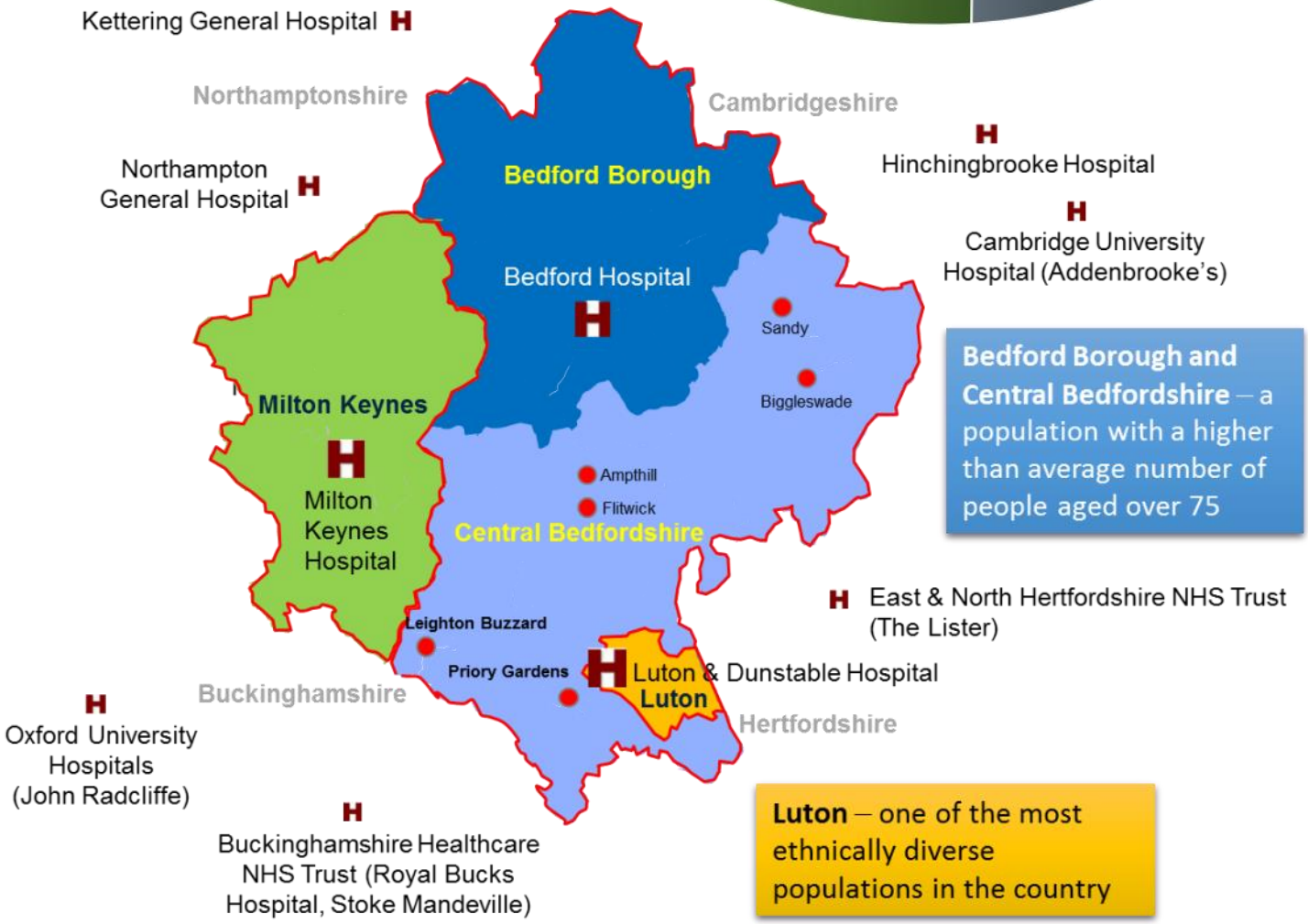
1. For a list of the BLMK STP partners, see section 4, on page 7 of this document
2. *NHS Five Year Forward View* (23 October 2015), available at **www.england.nhs.uk/ourwork/futurenhs**

2. Health and social care in BLMK

Almost one million people live in the BLMK area – 160,000 in Bedford Borough, 274,000 in Central Bedfordshire, 240,000 in Luton and 225,000 in Milton Keynes.



Milton Keynes – one of the fastest growing populations in the country



Bedford Borough and Central Bedfordshire – a population with a higher than average number of people aged over 75

Luton – one of the most ethnically diverse populations in the country

As with many areas of the country, the BLMK health economy is facing a number of challenges. We have a growing population which is also getting older. More people are living with long term health challenges, such as diabetes and arthritis, that cannot be cured but can be effectively managed. The quality of healthcare that people receive and also their general health and wellbeing vary across BLMK. We are also facing workforce shortages and significant financial pressures.

Some facts and figures

Health and wellbeing across BLMK

- Life expectancy is better than the national average in Bedford Borough and Central Bedfordshire, and worse or similar in Luton and Milton Keynes, but there are large inequalities in life expectancy across BLMK, depending where people live.
- One in five children are overweight or very overweight by the age of five, rising to one in three by the age of 11.
- Smoking remains the single greatest preventable cause of ill health and early death, and 1 in 10 expectant mothers smoke.
- Alcohol-related hospital admissions are rising across BLMK.
- The four main causes of early death are diabetes, cardiovascular disease, cancer and chronic obstructive pulmonary disease (COPD).
- Depression and severe mental illness is rising.
- The 85+ age group is predicted to grow faster than the rest of the population in the next 20 years.

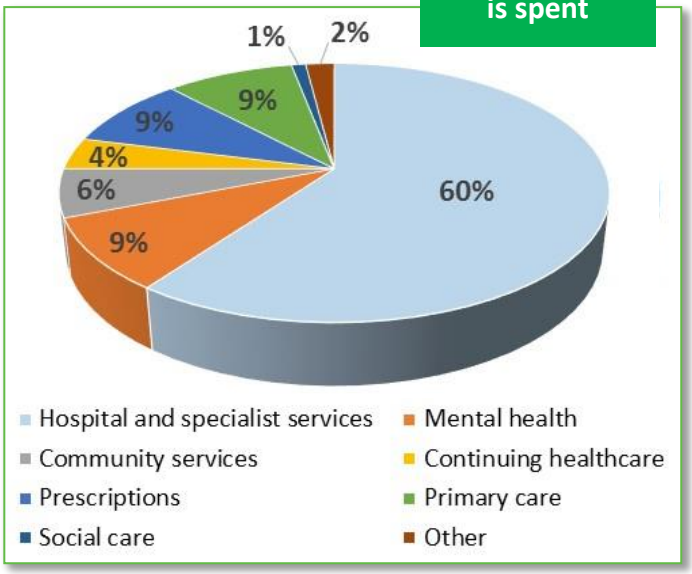
Ageing population

The 85+ age group is expected to grow fastest in the next 20 years

Care and quality across BLMK

- GP practices in BLMK have more registered patients per GP than the national average, which can mean some patients have difficulty getting an appointment.
- Our workforce is ageing and we face challenges recruiting health professionals in primary, community and social care.
- Patients are not always clear how to access urgent care services, with a number of different organisations operating NHS 111 and GP out-of-hours services across BLMK.
- Hospitals are struggling to meet demand while maintaining national standards.
- Ambulance performance, in particular their ability to meet national standards for attending emergencies, is under severe pressure.

How our money is spent



Funding and finance across BLMK

- The current combined annual budget for health and social care is £1.33bn (see the above chart for a breakdown of how this budget is used).
- The good news is that we expect to see this funding rise to 1.67bn by 2020/21, an increase of 26%. The not so good news is that, if we don't change anything, this increase will be absorbed by rising demand for services.
- If we don't make changes, by 2020/21 our spending will exceed our income by £311m a year.

Financial challenge

If we don't make changes, by 2020/21 our spending will exceed our income by £311m a year

3. Why do we need to change?

The NHS has a 'triple aim' – set out in NHS England's *Five Year Forward View*. It involves:

- Delivering improved health and wellbeing
- Improving the quality of care provided
- Making NHS finances sustainable, year on year

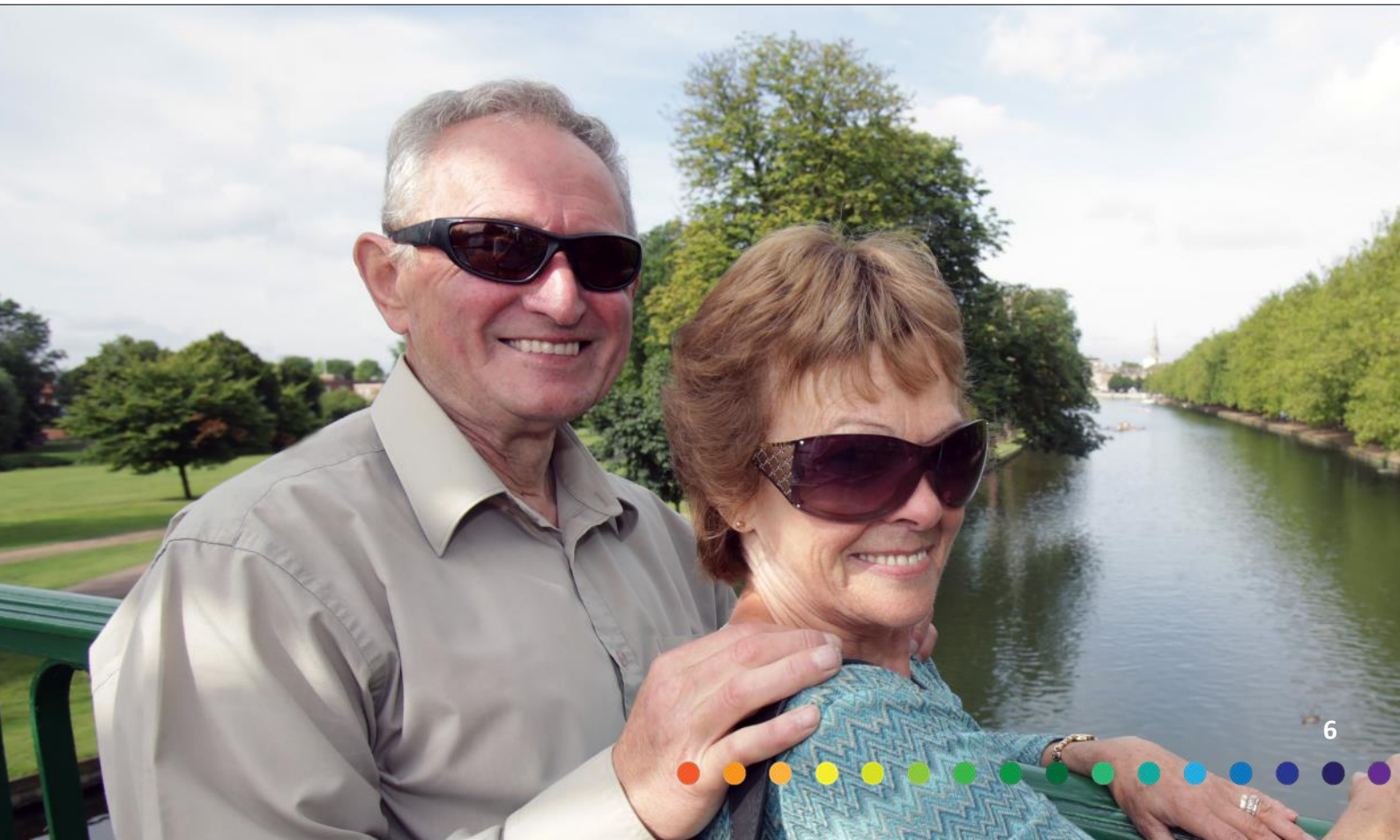
It is our responsibility to balance these three aims.

The health and social care system across BLMK has a significant financial challenge. If we do nothing, by 2020/21 the cost of meeting demand will far exceed the money that will be available to us. We must do something about this and, together, we need to determine what that is, and then work together to get on and achieve it.

NHS triple aim

In developing our plans to work together and work differently, we will need to show how those plans improve the quality of care we provide, the health and wellbeing of local people and how we can afford to do this within the funds available to us.

We, of course, need to deliver the best value possible for each taxpayer pound, but we will also ensure that we make informed, considered decisions involving local people, clinicians and other interested parties about how best to use the money available to us, while investing in and improving the care and services we provide.

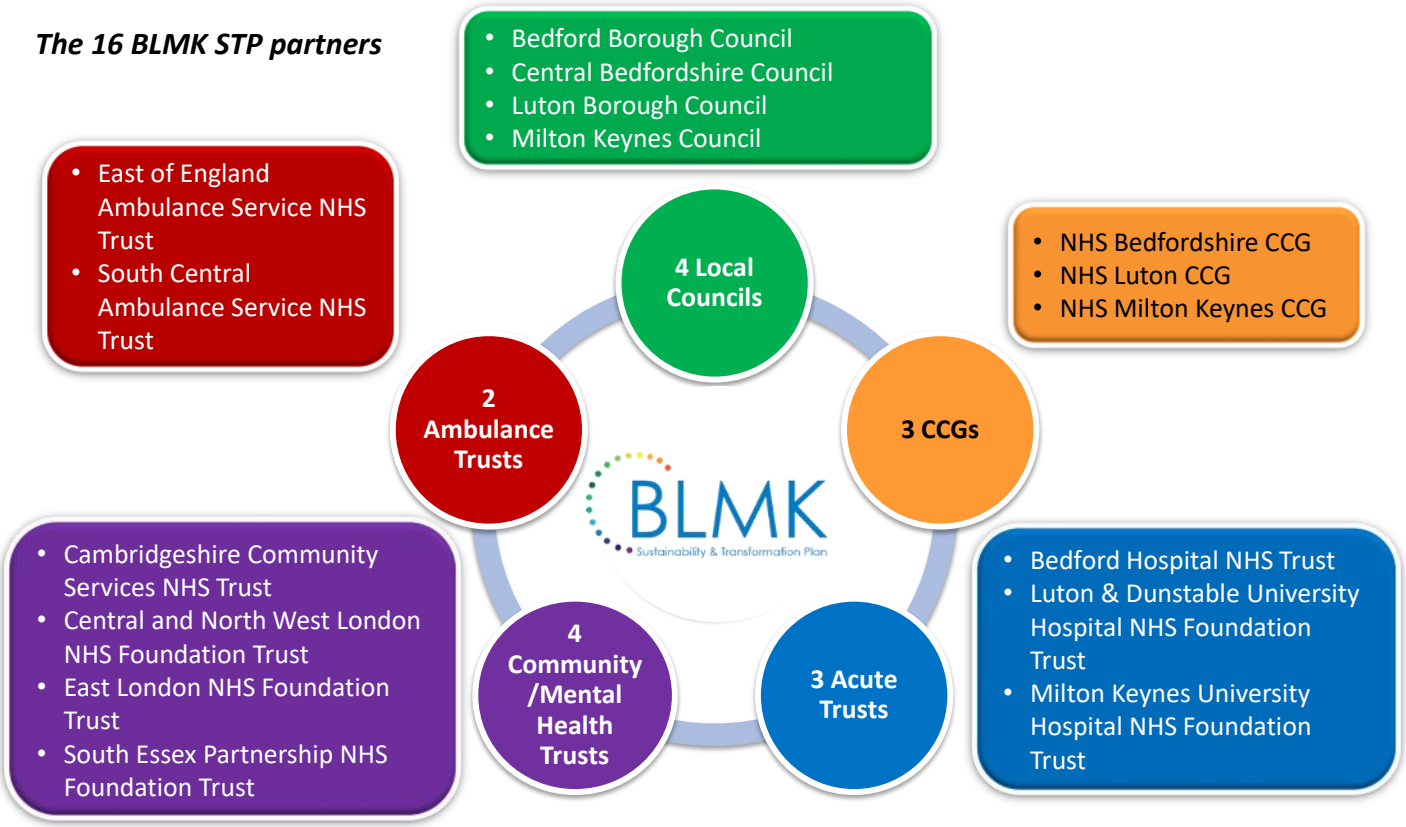


4. How the BLMK plan could address local health and social care challenges

The BLMK plan has brought together 16 partners to look collectively at how we can:

- Break down the boundaries between our local health and social care systems
- Address problems that threaten our clinical and financial sustainability
- Develop ideas and priorities to transform local services

The 16 BLMK STP partners



Note: our local councils provide social care services and the CCGs (Clinical Commissioning Groups) buy healthcare services for local people.

4.1 Our vision for the future

The BLMK partners have developed a shared vision for the future of local health and care services. This vision is grounded in an honest assessment of the effectiveness, fitness for purpose and affordability of existing services.

We have much to be proud of, some good things to build on and a strong appetite for improvement. However, there is some way to go if we are to achieve clinical and financial sustainability in the coming years.

What does the future of health and social care look like in BLMK?

People have the knowledge they need to make informed choices about their own health and wellbeing. People are aware of the local health and care services that are available, what these services offer and how to access them.

Our **GPs** act as the crucial gatekeeper for people needing to access physical and mental health services. They lead specialist teams of health professionals including community and specialist nurses, care co-ordinators, therapists, pharmacists, dietitians and other clinical and support professionals. Our GPs spend their own time with those most in need, for example those who are chronically ill or who have complex diseases. Our GPs and their teams use technology to co-ordinate the safe, effective delivery of care and services to patients in their local communities.

Community physical and mental health services are given equal focus and work together in partnership with GP practices for better patient care. **Community care workers** have mobile technology at their fingertips so they can spend more time out in the community with their patients. Having immediate access to securely **shared care plans** and digital technology and communication will allow more time to be spent providing hands-on care and support. Social workers, clinicians and clinical support teams work in an integrated way, meaning patients benefit from co-ordinated packages of care and not multiple separate visits from individual professionals.

Staff in **nursing and residential care homes** are treated as vital members of the wider integrated team, having immediate access to shared care plans. They are able to play a more proactive role in the care of their residents. Care home residents are supported by community clinicians who proactively manage their physical and mental health and wellbeing. NHS bodies and local councils collaborate closely to meet the demand for care home places and home support in a timely manner, and everyone supports the timely discharge of patients.

People are educated and informed so they understand the difference between an **urgent care need and a life threatening emergency**, supported by the development of responsive, trusted and well signposted urgent care services. Such services reach into people's homes, with community paramedics and rapid response community health teams providing urgent care and support for those who are unable to use the networks of walk-in urgent care centres that are in place. Only those who need emergency care and treatment for serious illness and injury feel the need to use hospital emergency departments.

Fewer people need to be admitted to hospital and are instead treated in community settings. When **local hospital services** are required, high quality hospital care is available in a timely way on BLMK's three existing hospital sites. These hospitals are no longer isolated from each other, but work in an integrated way. As a result, between the three of them, they are able to deploy the latest advances in medical practice and technology to provide a safe, high quality service, delivering the very best clinical outcomes. Hospitals support and care for patients' needs beyond their walls, making maximum use of technology to support patients and clinicians in the community. People don't stay in hospital any longer than they need to.

4.2 Transforming health and social care – our five priorities

The STP partners have identified **five priorities** that we intend to focus on immediately to transform our local health and social care systems and achieve our vision for the future.

Taken together, these five priorities signal an ambitious and far-reaching overhaul of the health and social care landscape in BLMK. Delivery of change against these priorities will help us build a high quality health and care system that is financially sustainable, now and into the future.

There are three 'front line' priorities (focused on health, wellbeing and patient care), combined with two 'behind the scenes' priorities (technology and system changes) that are required to support the transformation process. As this is a system-wide approach, each of the five priorities are reliant on each other, so they will all be worked on at the same time.

Three 'front line' priorities

P1

Prevention

Encourage healthy living and self care, supporting people to stay well and take more control of their own health and wellbeing.

P2

Primary, community and social care

Build high quality, resilient, integrated primary, community and social care services across BLMK. This will include strengthening GP services, delivering more care closer to home, having a single point of access for urgent care, supporting transformed services for people with learning disabilities and integrated physical and mental health services.

P3

Sustainable secondary care

Make our hospital services clinically and financially sustainable by working collaboratively across the three hospital sites, building on the best from each and removing unnecessary duplication.

Two 'behind the scenes' priorities

P4

Technology

Transform our ability to communicate with each other, for example by having shared digital records that can be easily accessed by patients and clinicians alike, using mobile technology (e.g. apps), for better co-ordinated care.

P5

System redesign

Improving the way we plan, buy and manage health and social care services across BLMK, to achieve a joined up approach that places people's health and wellbeing at the heart of what we do.

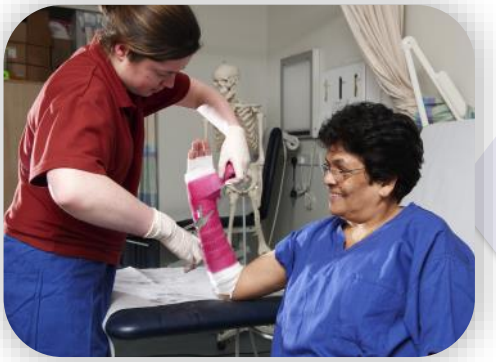
4.3 Transforming health and social care – our ideas

In this section, we look at some of the specific ideas we are considering to deliver change against our five priorities.

P1 Prevention

A focus on prevention

The STP partners need to ensure that a focus on prevention is embedded within their organisations and plans. This way, we can deliver major improvements in prevention and early intervention across the health and care system.



Prevention services

We are also considering development of specific prevention services including a fracture liaison service and a social prescribing hub.

P2 Primary, community and social care

Better care, closer to home

So we can provide better care, closer to home and ensure a joined up approach, we are considering the following:

Enhanced, supported GP services

Family doctors are the first port of call for most people when they are feeling unwell, but we also know that people can sometimes struggle to get a GP appointment.

To address this, we are looking to build a wider team of health professionals, such as clinical pharmacists and health coaches, aligned around GP practices so that family doctors can concentrate on managing the care of those patients with the most complex needs. We are also looking to remove from general practice work that is better undertaken elsewhere, so our GPs can concentrate on the work which only they can do.

To enable GP practices to deliver certain services for our growing population, some mergers, partnerships or other collaboration between GP practices may be required. We also need to improve and streamline the information available to GPs, so they have all the guidance at their fingertips to effectively refer patients to specialist physical and mental health providers in hospital, community or voluntary settings.

Co-ordinated, joined up care

A lack of joined up care between different parts of the health and social care system is an issue that's often raised by patients. To help address this, we are looking to bring together hospital specialists, primary care (GPs), community health and social care providers to deliver care at home, or close to home, and to locate other council services (such as housing) alongside healthcare services, for example in community hubs. We would also look to work more closely with voluntary organisations, charities etc to support local people's health and social care needs.

Co-ordination of hospital discharge

Patients tell us that another area where co-ordination of care can fall short is when they are waiting to be discharged from hospital. We are therefore proposing to provide dedicated teams to work between hospitals, GPs and social care providers to get people out of hospital quicker and reduce readmissions.

Improved care for patients with complex or multiple conditions

With people living longer and the number of people with long term conditions increasing, we are looking to recruit more than 80 additional healthcare workers across BLMK to enhance the care provided for patients with complex needs, with advanced illnesses or who are nearing the end of their lives. This care would most often be provided at home, in residential care homes and in community hospitals, supported by specialist GPs or community-based physical and mental health specialists for highly complex conditions.

Better use of medicines

To make sure we are prescribing the right medicines for the right people at the right time, we are looking to work in a more co-ordinated way to focus on innovative approaches and the effective, efficient and safe use of medicines across the health and care system.

Improved self care

We are looking to strengthen community support and develop individuals' and families' ability to look after their own health and wellbeing.

Single point of access (SPoA) for urgent care

We are looking to improve the quality and responsiveness of urgent care that takes place outside hospitals by creating a single hub dealing with urgent and non-urgent enquiries (calls, texts, chats, etc) that brings together 111, 999, NurseLine and other provider services. This service, which will require almost 100 additional staff, will offer informed, professional advice and guide patients to the most appropriate physical or mental health services for their particular needs.

This service will fully integrate with GP out-of-hours and other appropriate services to enable direct booking of phone consultations and face-to-face appointments.

P3 Sustainable secondary care

- The BLMK plan has now assumed responsibility for developing proposals to modernise the care provided at our local hospitals, so they can provide high clinical standards that are both fit for the future and financially sustainable. While the work of the previous Bedfordshire and Milton Keynes Healthcare Review has been fed into the STP process, the STP is looking more broadly across BLMK and more deeply at services outside of hospitals which significantly affect hospital demand.
- Our three local hospitals have committed to work together to plan, develop and provide a unified service across BLMK which reduces unnecessary duplication, with hospital services being located on the three existing sites in Bedford, Luton and Milton Keynes.
- The hospitals' chief executive officers, medical directors and directors of nursing are working closely together to create an integrated model of leadership, management and operations across the three hospitals, covering clinical services, support services and workforce requirements.
- We will fully discuss and consult with local people and staff on any significant changes to hospital-based care that might emerge from this work, before any decisions are made.

P4 Technology

- People have told us it can be frustrating to have to re-tell their story as they move through different parts of the health and social care system. To help address this, we are looking to introduce a Health Information Exchange to enable the safe, secure sharing of information, including the convergence of hospital records onto a single system across all three sites.
- Giving patients improved access to their own records, using mobile technology (e.g. apps), will enable them to better take ownership of their own health and wellbeing.
- Improved technology will also provide better evidence for clinical decision making and will help clinicians get a head start by, for example, managing and predicting the likelihood of a patient's condition worsening.

P5 System redesign

The STP partners have concluded that the current arrangements for analysing and assessing healthcare needs, and for buying and providing health and social care in BLMK, needs simplifying and streamlining.

A number of benefits are expected to arise from this:

- Commissioners will become more focused on the health and wellbeing of local people and on clinical outcomes where services are provided, rather than inputs and processes.
- Incentives between individual commissions and also between organisations delivering care will become better aligned, meaning service users and patients receive a more joined up service.
- More of BLMK's health budget will be spent on front line services and we will see administration costs fall.

5. What has happened so far?

Clinicians, public health professionals and senior managers from the 16 STP partner organisations started working together in March 2016. They have been looking at how can we can address the challenges faced by our local health and social care systems and have developed ideas and priorities to transform services so that our hospitals, GPs, primary, community and social care services can meet the needs of today's generation and the generations to follow.

In June 2016, the STP made a submission to NHS England establishing our five priorities and outlining initial ideas for transforming local health and care. This was followed by a more comprehensive submission in October 2016, which is summarised in this document. You can find more detail in the draft technical STP submission that's available on our website at www.blmkstp.co.uk.

The STP has been developed with strong input and involvement from local hospital, primary care and community clinicians. Our initial ideas for moving more care closer to home have also been discussed directly with local GPs and other healthcare workers.

6. What happens next?

Both NHS England and NHS Improvement are reviewing our October 2016 submission and will provide us with their feedback on our developing proposals.

The initial thinking and direction contained in the submission will now be shared more widely with interested parties so we can further refine and shape our plans. The more detailed technical STP submission that's available on our website at www.blmkstp.co.uk will be considered by STP partner boards and governing bodies. It will also be discussed with local authority scrutiny committees, Health and Wellbeing Boards, our local Healthwatch organisations and partnership forums.

During this time, we will continue to develop our plans, including fully working through the financial aspects associated with our proposals, adding detail around our priorities and establishing how we can start to effect some of the changes we have identified.

The chart below shows the proposed timeline for the STP and how we are planning to involve you at each stage.

The publication of this summary marks the start of a period of engagement with local people, staff and other interested parties to gather your thoughts and feedback on our current thinking. You can find more detail on how you can get involved in section 7 below.

7. How we are involving you

We want to make sure you are involved and engaged in developing plans for transforming health and care services across Bedfordshire, Luton and Milton Keynes.

We are planning a series of events over the coming months across Bedford Borough, Central Bedfordshire, Luton and Milton Keynes where we will be discussing our plans with you, give you the opportunity to meet the team involved in the STP and ask any questions you may have. Details of these events will be available on the STP website www.blmkstp.co.uk.

We will be keeping you informed through online channels, social media, information documents such as this summary and through our local newspapers.

We would stress that no decisions have been made as yet. Furthermore, no decisions will be made without further discussions with the public, staff, politicians and voluntary sector organisations. We will also consult formally on any major service changes or decisions that impact on staff.

Make your feedback count

As a first step, we are looking to gather your feedback on the thoughts and ideas contained within this summary to inform the next stages of the STP's development. By giving us your feedback, you can help shape the transformation of our local health and social care services for today, and for tomorrow.

Please tell us:

- What do you think of the ideas we have presented in this summary?
- Do you have any additional comments or suggestions around the ideas we have presented?
- Is there anything else you think we need to be thinking about?

You can give us your views in a number of ways

Online – complete the online feedback survey at **www.blmkstp.co.uk**

Email us at **communications@mkuh.nhs.uk**

Call us on **01908 996217**

By post – you can print off a hard copy feedback form at **www.blmkstp.co.uk** and post it to us, or send a letter to Bedfordshire, Luton and Milton Keynes STP, Milton Keynes University Hospital, H8 Standing Way, Eaglestone, Milton Keynes MK6 5LD

The deadline for sending us your feedback is 15 December 2016

BLMK
Sustainability & Transformation Plan

Working in partnership

NHS Bedfordshire Clinical Commissioning Group
NHS Luton Clinical Commissioning Group
NHS Milton Keynes Clinical Commissioning Group
Bedford Hospital NHS Trust
Milton Keynes University Hospital NHS Foundation Trust
Luton and Dunstable University Hospital NHS Foundation Trust
SEPT
NHS Cambridgeshire Community Services NHS Trust
NHS Central and North West London NHS Foundation Trust
East London NHS Foundation Trust
East of England Ambulance Service NHS Trust
South Central Ambulance Service NHS
Bedford Borough Council
Central Bedfordshire
Luton Borough Council
Milton Keynes Council

BLMK

Sustainability & Transformation Plan


Website: www.blmkstp.co.uk

If you would like this document as an audio file or in a different language, please contact us at communications@mkuh.nhs.uk or call us on 01908 996217.

Bedfordshire, Luton and Milton Keynes STP, Milton Keynes University Hospital, H8 Standing Way, Eaglestone, Milton Keynes MK6 5LD, tel: 01908 996217, email: communications@mkuh.nhs.uk, web: www.blmkstp.co.uk

BLMK STP Submission on 21st October

Summary for STP Partners

15th November 2016

Five Year Forward View

#futureNHS

What we will cover…

1. An overview of our October submission
2. The NHS "triple aim" and why we must change to achieve it
3. Our priorities and where we want to focus our effort
4. The transformational solutions we're seeking to implement
5. The benefits we expect to achieve
6. How we intend to go about realising those benefits
7. How we intend to communicate with, engage and involve local people, the community groups to which they belong, the representatives they democratically elect, our workforce and their elected representatives

Overview

So far…who has been involved in developing our ideas and in defining our priorities

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

NHS England

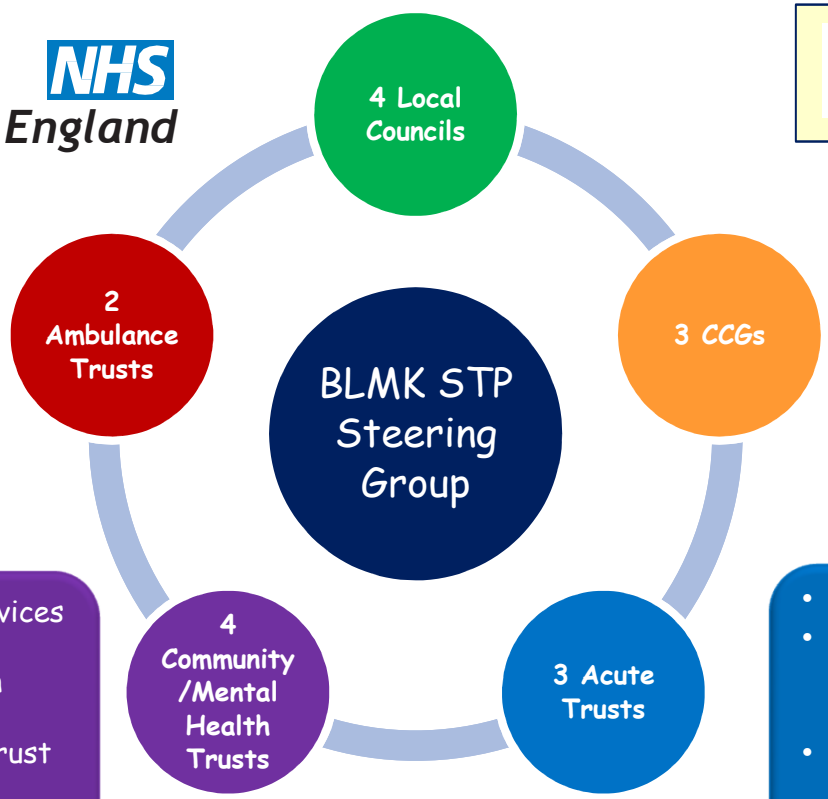
- East of England Ambulance Service NHS Trust
- South Central Ambulance Service NHS Trust

NHS Health Education England

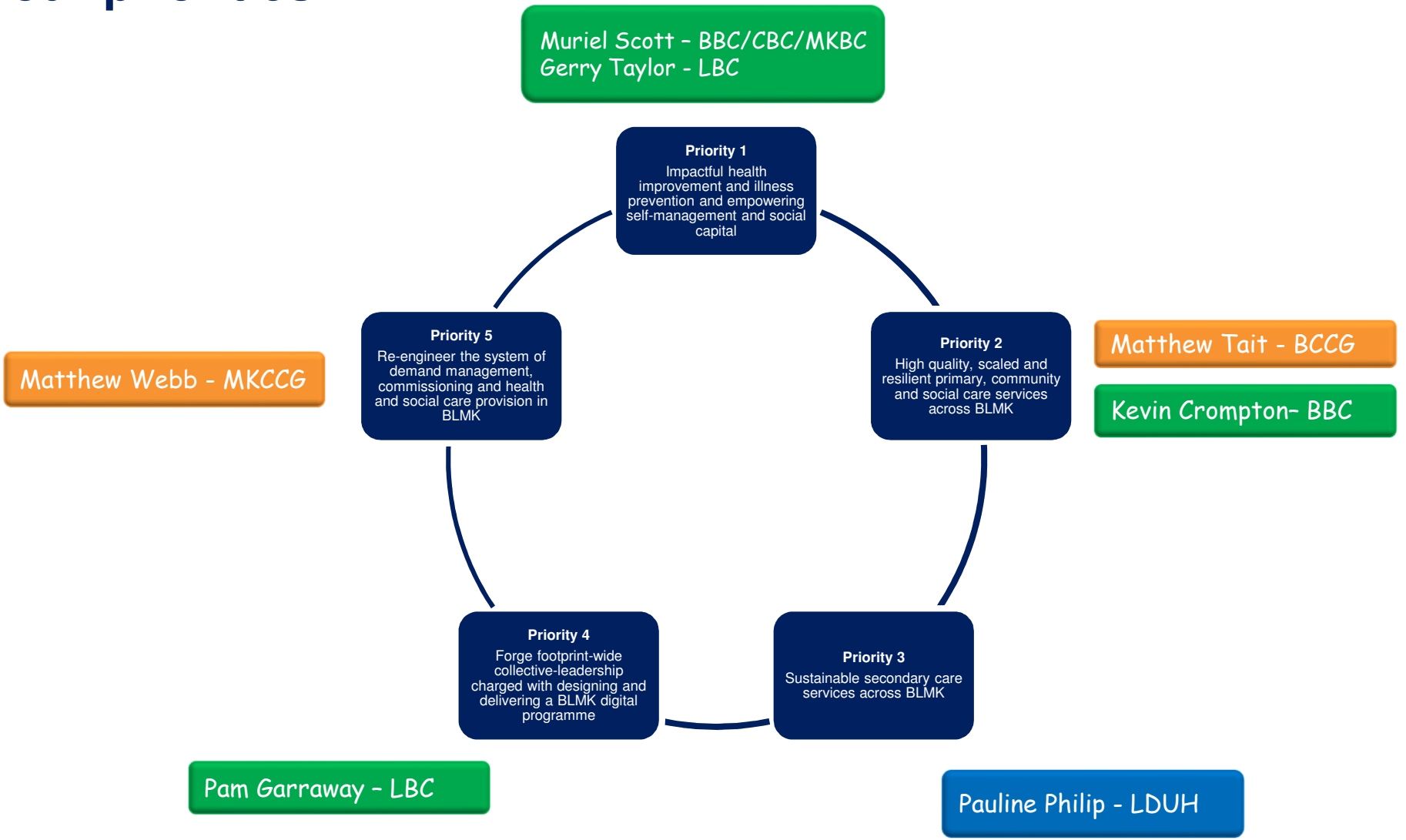
- Cambridgeshire Community Services NHS Trust
- Central and North West London NHS Foundation Trust
- East London NHS Foundation Trust
- South Essex Partnership NHS Foundation Trust

- Bedford Hospital NHS Trust
- Luton & Dunstable University Hospital NHS Foundation Trust
- Milton Keynes University Hospital NHS Foundation Trust

- NHS Bedfordshire CCG
- NHS Luton CCG
- NHS Milton Keynes CCG



So far… who has been leading the work on each of our priorities



Overview of our October STP submission

STP priorities

- STP Partners in BLMK have continued to build on the strategic direction signalled in our June 2016 STP submission.
- There have been no changes since June to the key priorities being pursued at the STP level.
- These continue to combine user-facing initiatives, in the areas of prevention, primary, community and social care and hospital services, with enabling work, designed to create the right tools (e.g. digitally communicable care records), levers and incentives to support the transformation process.
- Considerable effort has gone into refining BLMK's five STP priorities. This has involved defining and aligning the different work packages required to deliver change associated with each priority, as well as STP partners planning and resourcing how that change will be implemented. Each priority has now assembled an *Implementation Plan and Investment Case*, which sets out the key steps required to achieve STP goals.

STP solutions – improving care outside our hospitals

- Following recommendation in June, each STP partner (CCGs, local Councils, acute hospitals, community and mental health services providers and ambulance services providers) has now appointed Board-level (or equivalent) champions for prevention
- Preventative planning work to enable BLMK priorities to be achieved include:
  - ✓ Enabling Prevention (various work packages)
  - ✓ Organisation-specific Prevention Plans
  - ✓ Evidence-based service developments, initially involving:
    - ❖ Fracture Liaison Services Business Case
    - ❖ Social Prescribing Hub Business Case
- In September, BLMK took receipt of the population health analysis commissioned by STP Partners. This has been used to add precision to transformational solutions that will enable current and projected demand to be redirected from hospital into community settings and self-managed care.
- These solutions have been trailed extensively with primary care colleagues, at GP practice level, at CCG level and via cross-BLMK clinical engagement events.
- Working collaboratively across NHS bodies and local Councils, BLMK's Digitisation workstream has now identified seven key digitisation development themes, overseen by the newly created BLMK Digitisation Programme Board. This Board is chaired by one of BLMK's local Council Digitisation lead.
- Since July STP partners have been able to conclude that current arrangements for analysing and assessing need, and for commissioning, transacting and providing health and social care in BLMK, will not be fit for purpose going forward.
- All relevant NHS parties (i.e. both NHS commissioners and providers) across BLMK have expressed an appetite for adopting an accountable care approach to commissioning and delivering NHS services.
- Such an approach will continue to see care designed and delivered at the locality level (typically 30,000 to 50,000 population), sensitised to the needs of different localities, and in a way that list-based general practice remains front and centre.
- Some functions and activities could operate in patches co-terminous with local Council boundaries - others, such as health population analytics, information and communications systems and technology and administration will operate across the BLMK footprint.

STP solutions – improving care across our hospitals

- Since July, the STP has assumed responsibility for developing proposals to modernise secondary care services across BLMK, rendering them both clinically and financially sustainable. All three hospitals are centrally involved in this work.
- A tri-organisational Secondary Care Services Transformation Board (SCSTB) has been set up and is overseeing four discrete workstreams, covering clinical services, clinical support services, non-clinical support services and the non-medical clinical workforce.
- The SCSTB expects to complete plans for creating an integrated model of leadership, management and operations across the three hospitals by **31st March 2017**.
- It is highly likely that capital expenditure will be required to enable BLMK to achieve the transformation it is contemplating. We will clarify at this time the nature and level of capital expenditure required, albeit we will be mindful in formulating our plans of its limited availability in coming years.
- Where, in the meantime, opportunities arise that improve the way the three Trusts operate clinically and financially, these will be expedited, subject to BLMK fulfilling any statutory consultation obligations that may arise.
- Any significant changes to secondary care services that might emerge from this work will be taken forward through close engagement with STP partners, and will also involve appropriate statutory consultation with the general public.
- The three Trust Boards are currently examining options that would enable each to delegate and pool some formal decision-making powers to a jointly governed vehicle operating across the three Trusts.

The case for change across Bedfordshire, Luton & Milton Keynes

Balancing the three imperatives of the NHS's triple aim …

Our STP priorities must address current and foreseeable shortcomings in how we make most effective use of our local workforce and the technology we have available to us, and how we unleash the potential of individuals, their carers and our communities so that we maximise the health and well-being impact of funds available to us

The extent and the nature of change needed can be assessed by how well BLMK is currently performing against NHS England's triple aim

The NHS's "triple aim"

1. Sound health and well-being of our local population
2. High quality health and social care supplied to local people, with our service users, their family carers and others in receipt of that care, acknowledging a highly positive experience.
3. Live within the financial means available to us.

Why we need to change…health and well-being performance in BLMK

BLMK headlines

- Life expectancy is better than the national average in Bedford Borough and Central Bedfordshire, and worse or similar in Luton and Milton Keynes.
- Healthy life expectancy varies from 59.3 years for men in Luton to 67.2 years for women in BBC.
- There are significant health inequalities within our communities.

Maternal and Child Health

- One in ten mothers smoke at time of delivery.
- Less than half of mothers in BLMK breastfeed for at least six weeks.
- One in ten new mothers will suffer mild to moderate depression or anxiety.
- One in five children are overweight or very overweight by the age of five, rising to one in three by the age of 11.
- Asthma admissions in the under 19s are high and rising in three out of four local authority areas.

Working age adults

- The four "big killers" driving premature mortality and health inequality in BLMK are diabetes, cardiovascular disease (heart disease and stroke), cancer and chronic obstructive pulmonary disease (COPD).
- Smoking remains the single greatest preventable cause of ill health and premature mortality.
- Alcohol-related hospital admissions are rising across BLMK
- Less than two-thirds of people with a long term condition feel adequately supported by the GP to manage their condition.
- Screening performance across BLMK is patchy.
- Recorded prevalence of depression is rising.
- Prevalence of recorded severe mental illness is rising, and ranges from 0.68% in MK to 0.95% in Luton, which is higher than the England average (0.88%).

Older people

- The population aged 85+ is predicted to grow faster than any other age group in the next 20 years.
- Injuries due to falls in the over 65s are rising in Bedfordshire, over and above the increasing older population.
- Less than three-quarters of adults aged 65+ take up the offer of the seasonal flu immunisation.

Insights from Public Health Analysis across the BLMK Footprint

Child Health across BLMK

	BBC	CBC	LBC	MKC	England average	95th centile
Coverage Dtap/IPV/Hib (2 years old, %)	97 ↔	98.0 ↔	95 ↑	98 ↑	91.5	98.7
Coverage MMR two doses (5 years old, %)	91.6 ↑	92 ↑	84.4 ↑	92.4 ↑	87.9	95.4
% achieving good level of development at end of reception	60.9 ↑	63.6 ↑	60.4 ↑	67.0 ↑	66.3	74.1
% children very overweight – Year R (4 and 5 year olds)	8.8 ↓	7.2 ↓	10.2 ↓	8.9 ↓	9.1	6.6
% children very overweight – Year 6 (10 and 11 year olds)	18.6 ↔	14.4 ↔	23.4 ↑	19.4 ↑	19.1	14.0

Life Expectancy across BLMK

	BBC	CBC	LBC	MKC	England average	95th centile
Life expectancy – female (years)	83.9 ↑	83.8↑	82.2↑	82.6↑	83.2	85.1
Life expectancy – male (years)	80.2 ↑	81.5 ↑	78.4↔	79.1↔	79.5	81.8
Healthy LE – female (years)	67.2↔	65.4↔	59.9 ↔	66.1 ↑	63.9	69.0
Healthy LE - male (years)	66.7 ↑	63.6 ↓	59.3 ↓	63.5 ↑	63.3	68.0
LE gap between most and least deprived – female (SII, years)	10.4 ↓	5.7 ↑	5.7 ↓	6.3 ↑	-	2.8
LE gap between most and least deprived – male (SII, years)	9.1 ↓	4.8 ↓	12.0 ↑	6.5 ↓	-	4.9

Adult Obesity across BLMK

	BBC	CBC	LBC	MKC	England average	95th centile
% adults overweight or obese	60.9	69.1	59.0	72.5	63.8	51.2
% adults physically inactive	21.8 ↓	26.0 ↓	33.5 ↔	27.6 ↔	27.7	20.5

Diabetes across BLMK

	BBC	CBC	LBC	MKC	England average	95th centile
Total prevalence of diabetes (QOF, 17+ years)	6.8 ↑	5.9 ↑	7.5 ↑	5.4 ↑	6.2	-

	BCCG	LCCG	MKCCG	England average	95th centile
% completed 8 care processes (non-type 1 diabetes)	67.8 ↓	60.9 ↓	72.1 ↓	59.0	72.2
% achieving all treatment targets (non-type 1 diabetes)	37.4 ↔	39.8 ↑	40.4 ↔	41.3	48.3

Older People across BLMK

	BBC	CBC	LBC	MKC	England average	95th centile
% population aged 85+	2.33↑	1.89↑	1.45↑	1.47↑	2.30	-
Injuries due to falls in people aged 65 and over, per 100,000	2,076 ↑	2,016 ↑	1,899 ↑	2,023 ↓	2,125	1,440
Coverage flu vaccination (aged 65+, %)	72.9 ↔	73.8 ↔	71.5 ↓	72.8 ↑	72.7	77.0
Coverage flu vaccination (at risk individuals, %)	46.1 ↓	49.4 ↑	48.5 ↓	49.0 ↓	50.3	57.0

Why we need to change…quality and sustainability of health and social care provision in BLMK

BLMK headlines

Primary care

- At 2,349, the average list size per GP in BLMK compares unfavourably with England as a whole. Luton is a particular outlier at 2,699 patients per GP.
- Primary care infrastructure is fragmented and lacking resilience.
- Ageing GP workforce, and recruitment challenges for new GPs are considerable.

Urgent care outside hospitals

- 2016/17 has, so far, proven to be a difficult year for the NHS 111 service in both Bedfordshire CCG and Milton Keynes CCG.
- Plethora of providers operating across BLMK supplying NHS 111 and the GP Out-of-Hours

Community health services

- Workforce challenge in community health services is significant and pressing. High turnover and high vacancy rates feature prominently across BLMK.
- Community health workforce is ageing, particularly in the large peripatetic staff groups, like district nursing and health visiting.

Social care

- The workforce challenge being encountered in social care is considerable and pressing. Key features of the (wider) social care workforce include:
  - ✓ Average age is 43 but 22% are aged 55 and over, equating to nascent demand for approximately 4,000 posts in the next few years
  - ✓ BLMK has higher joiners/starters rates than is the average for England; staff turnover in BLMK is higher than both the eastern region and England as a whole
  - ✓ Vacancies in social care across BLMK are 9.7%, 12.6% and 15.1% respectively for Central Bedfordshire, Bedford Borough and Luton are all higher than the regional and national averages (respectively 7.3% and 6.1%) and such vacancies stay open for longer.
  - ✓ The independent sector care home market in BLMK is fragile and showing serious signs of distress

Mental health and learning disability services

- Current metrics indicate that significant improvements in performance have been evident in the last 12-24 months
- All three CCGs are confident that they will achieve NHS England's nationally defined mental health diagnosis, access and referral standards

Secondary care services

- BLMK secondary care services are challenged to achieve NHS Constitution standards and performance has deteriorated since June.
- A&E attendances are characterised by high levels of acuity of patients.
- Discharge difficulties are causing higher lengths of stay than are clinically necessary
- Delayed transfers of medically fit people is an issue with a combined 150 beds being occupied by such patients.
- Ambulance performance across the footprint has come under severe pressure during 2016/17.
- There are high vacancy rates in a number of non-medical posts across BLMK. Both the nursing and medical workforce is also ageing rapidly.

	Bedfordshire	Luton	Milton Keynes	BLMK	England Average
No. of GP practices	55	31	27	113	
No. of GPs	218	82	111	411	
No. of GP practice nurses	129	44	64	237	
Patients per GP	2,077	2,699	2,494	2,349	
Patients per GP practice nurse	3,511	5,030	4,326	4,073	
Patients per GP Practice	8,234	7,140	10,255	8,543	7,518
GPs per 1,000 patients	0.52	0.44	0.52	0.49	0.57
GP practice nurses per 1,000 patients	0.28	0.25	0.28	0.27	0.27
% of GPs age > 55	24%	23%	25%	24%	20%
% of GP practice nurses age > 55	28%	25%	27%	27%	

Workforce Challenge	Relevant staff groups affected
Current vacancy hotspots	• District Nursing (Milton Keynes 13%, Bedfordshire 25%, Luton 15%) • Health visiting (Bedfordshire 14%, Luton 20%) • Occupational Therapists (Milton Keynes 22%, Bedfordshire 11%) • Physiotherapists (Milton Keynes 12%, Luton 13%) • Dietetics (Milton Keynes 20%) • SALT (Bedfordshire 13%)
High turnover	All non-medical professional staff groups in particular: • AHP staff groups across BLMK running at over 20%. • Health Visiting at 15% • District nursing > 20%
High % of staff over 55	• Health Visiting (across BLMK 21%) • District nursing (across 20%)

NHS Body	Urgent and emergency access standards		
	A&E waits: 95% < 4 hours	Ambulance – 75% Category A responded to < 8 minutes	Achieve 18 week RTT for non-emergencies (target = 92%)
BHT	91.6%		93.7%
LDUH	99.1%		92.9%
MKUH	91.2%		88.8%
BCCG		76.3%	91.6%
LCCG		94.6%	93.3%
MKCCG		80.6%	90.2%

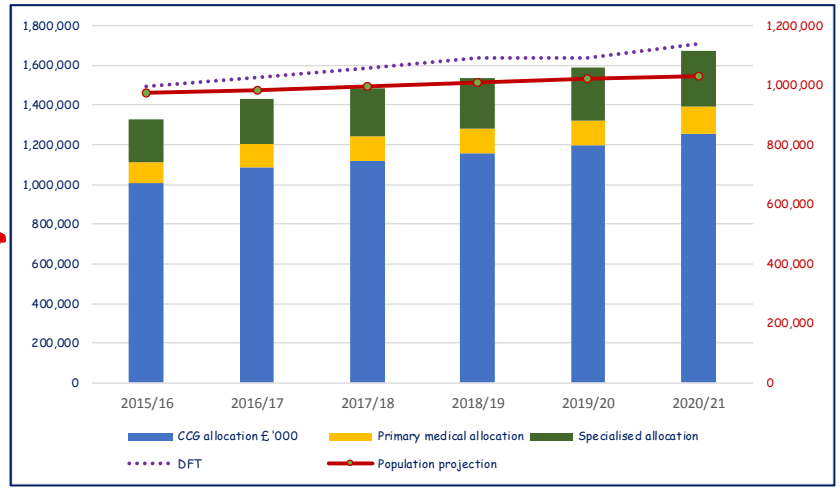
NHS Body	Achieve cancer access standards and increase early detection rates		
	Achieve 62-day cancer waiting standard (target = 85%)	Deliver two-week cancer standard (target = 93%)	Deliver 31-day cancer standard (target = 96%)
BHT	82.9%	94.4%	98.7%
LDUH	90.0%	96.1%	100.0%
MKUH	80.4%	95.7%	100.0%
BCCG	75.9%	95.1%	98.5%
LCCG	85.3%	95.3%	98.4%
MKCCG	74.0%	95.6%	100.0%

How we currently spend NHS funds made available to BLMK

How much do we have to spend across BLMK?

- Currently we have £1.33bn but this will grow to £1.67bn in five years (26% rise)
- Population growth will 6.1% over the same period
- DFT will reduce from £62m to £40m over the five years
- An earmarked "fair share" £62.5m recurrent STF funding is expected to be added from 2020/21

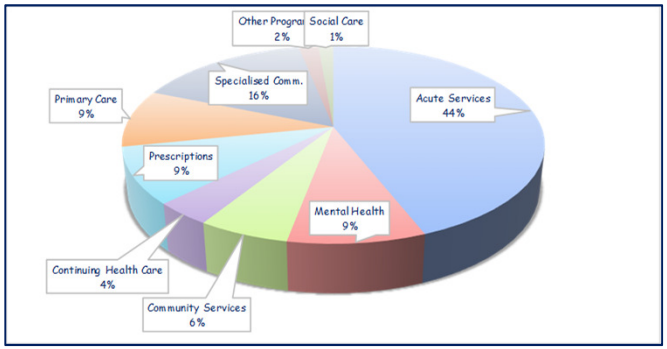
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total Growth
	£'000	£'000	£'000	£'000	£'000	£'000	Cum %
Population projection	*972,679*	*984,997*	*996,968*	*1,008,940*	*1,020,650*	*1,032,205*	*6.1%*
CCG allocation £'000	1,006,288	1,088,109	1,120,851	1,156,545	1,194,379	1,254,037	24.6%
Primary medical allocation	108,470	112,939	119,478	124,161	129,608	136,358	25.7%
Specialised allocation	213,153	230,702	242,933	255,035	267,655	282,361	32.5%
Total place-based allocation	**1,327,911**	**1,431,750**	**1,483,262**	**1,535,741**	**1,591,642**	**1,672,756**	**26.0%**



How do we currently spend it?

- Almost half (44%) goes on hospital and ambulance services
- Three quarters of this is spent with the three local hospitals
- Specialist services account for the next highest category of spend (16%).
- Remaining 40% is spent to fun care in community settings and in the home, with mental health (9%), primary care (9%) and prescribed medicines (9%) accounting for the lion's share.

Service	2016/17 Spend £m	%
Acute Services	590.9	44%
Mental Health	119.8	9%
Community Services	79.5	6%
Continuing Health Care	50.3	4%
Prescriptions	123.2	9%
Primary Care	126.6	9%
Specialised Comm.	209.5	16%
Other Programme	24.0	2%
Social Care	18.3	1%
Total	**£1,342**	**100%**



Why we need to change…more funding but much more demand on services

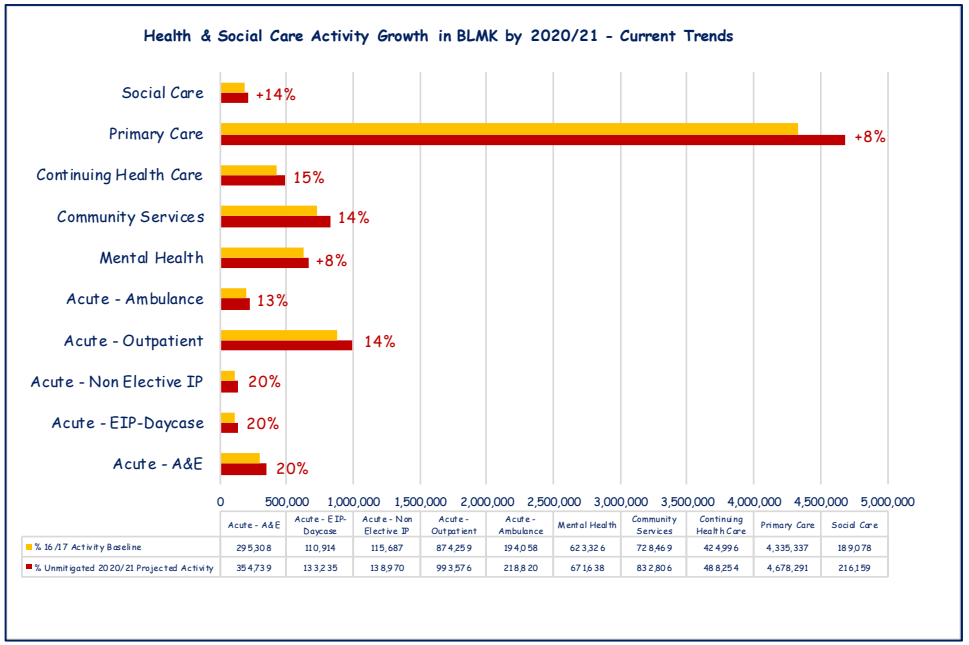
BLMK headlines

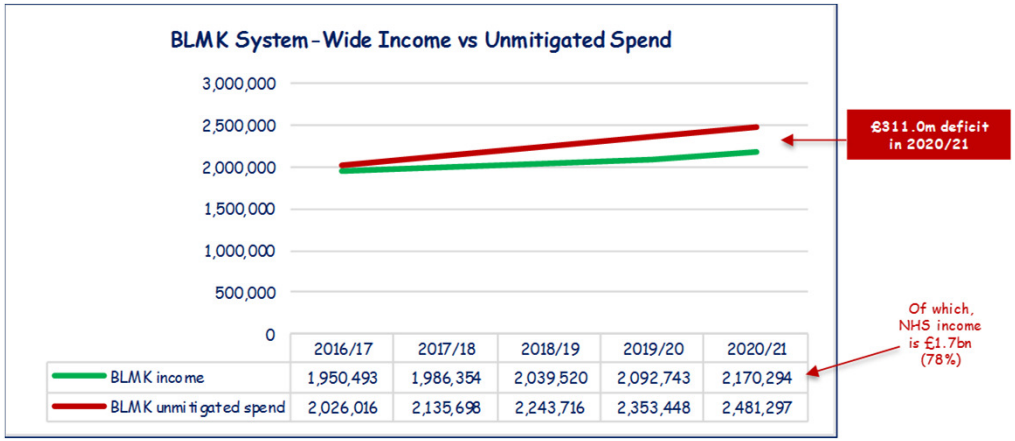
2016/17

- The BLMK health economy has significantly overspent its NHS allocation in recent years.
- Coming into 2016/17, the 3 CCGs brought forward a combined accumulated deficit totalling £84.5m (equivalent to 33% of the whole of England), whilst two of the three hospital Trusts had built up a combined accumulated deficit of £154.1m.
- The CCG's operating plans for the 2016/17 year indicate a significantly improved recurrent income and expenditure positon, helped, in part, by a step-increase in recurrent NHS allocations.
- The 3 CCGs are planning to generate a recurrent surplus of £21.9m in 2016/17.
- The 2 hospital Trusts in deficit look set to record broadly similar levels of deficits in 2016/17 as they did in 2015/16 (before applying 2016/17 STF funding).
- By comparison to a combined deficit of £75.6m incurred by CCGs and NHS Trusts domiciled in BLMK in 2015/16, 2016/17 will see this fall to a recurrent combined deficit of £24.4m before the application of STF of £22.2m

The future

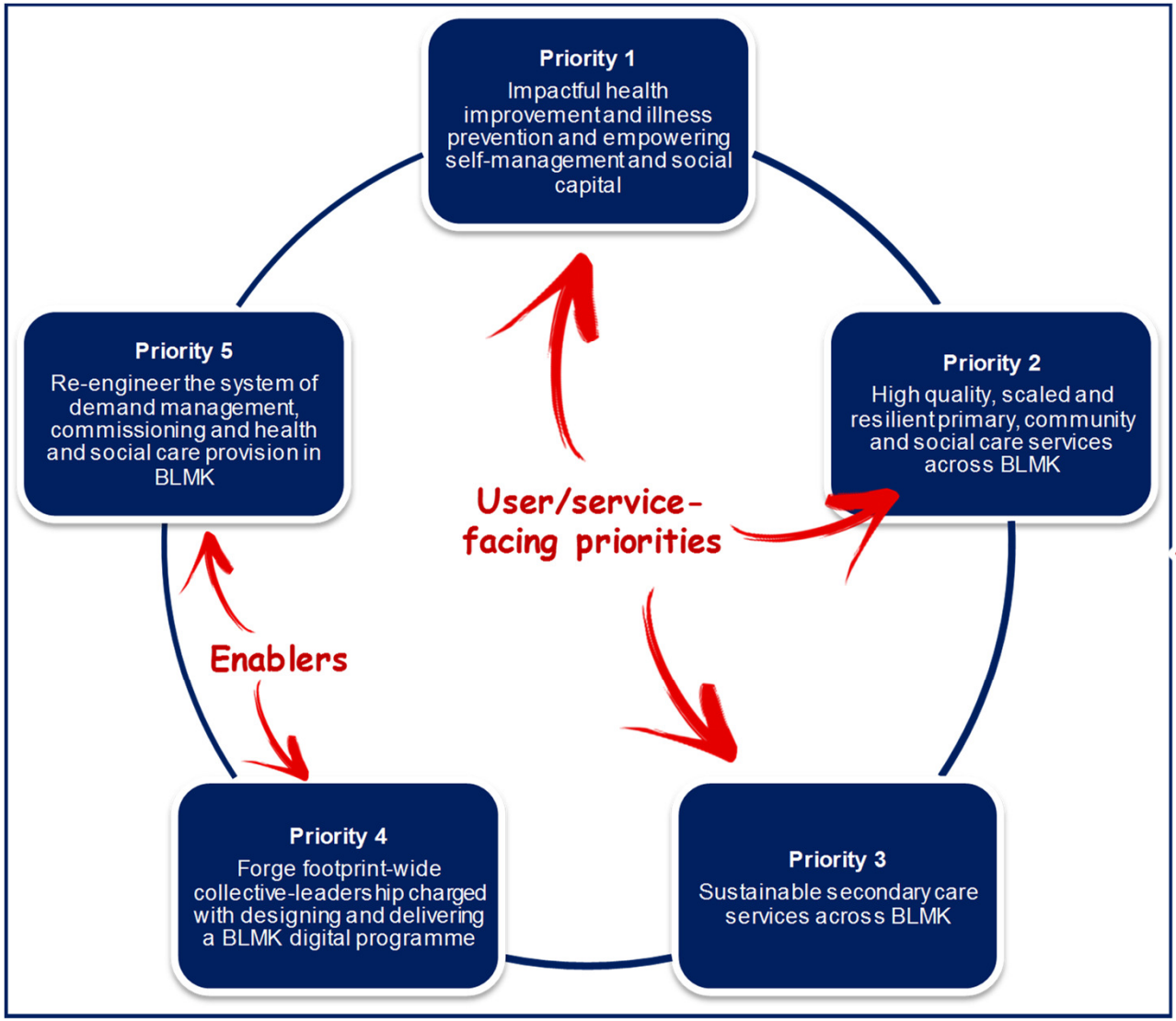
- System-wide demand and financial pressures will surface over the next five years
- This results in a consolidated BLMK deficit in 2020/21 of £311m
- BLMK's recurrent annual NHS deficit rises to £203m per annum by 2020/21.
- A further recurrent deficit, estimated at £108m per annum, would need to be added as a result of unavoidable cost pressures surfacing in Council health and social care budgets which are not recovered.





Our transformation priorities for the next 5 years

STP priorities – where we think we need to focus our transformation effort



Major inter-dependencies mean that all 5 STP priorities need to be progressed in parallel

Key sustainability and transformation priorities and goals for the next 5 years

P1 – Impactful health improvement and illness prevention and empowering self-management and social capital

- To radically upgrade prevention, early intervention and self-management of care by formulating system-wide prevention plans
- To secure systematic high-level support and intervention, at scale, across the footprint
- To embed ownership of prevention principles, and the practicalities of transformation in this area, with STP partners, with individuals and with communities at large

P2 – High quality, scaled and resilient primary, community and social care services across BLMK

- To strengthen primary care services to ensure sustainability and enable transformation
- To increase the health of the population by maximising prevention and self-care
- To shift activity away from acute services to community settings, closer to home
- To ensure that people are able to access appropriate urgent care services, reducing reliance on A&E and reducing avoidable unplanned admissions
- To achieve closer integration of health and social care services
- To support the transformation of services for people with Learning Disabilities
- To help to integrate physical and mental health services and achieve parity of esteem

P3 – Modern, sustainable, high quality secondary care services across BLMK

- To modernise secondary care services across BLMK, rendering them both clinically and financially sustainable, by adopting, from July 2016 onwards, a uni-institutional, tri-hospital campus planning and service delivery approach
- To ensure that changes to the configuration or operation of secondary care services across BLMK are planned and developed with all three hospitals centrally involved
- To ensure that any changes to the leadership, management, operation or location of secondary care services take full account of, and accord with, the overall vision for BLMK, the design principles agreed and the impact of BLMK's STP priorities in other care settings, such as prevention planning and primary, community and social care services

P4 – Forge footprint-wide collective-leadership charged with designing and delivering a BLMK digital programme

- To maximise use of existing systems such as System One across BLMK
- To increase digitisation of secondary care records - requiring convergence of hospital systems onto a single system across all three campuses.
- To deliver the underlying interoperability framework via a Health Information Exchange
- To monitor and respond to risk of disease exacerbation and development in real time via effective risk stratification and predictive analytics
- To enable proactive self-care and wellness through record access, technology and intelligence provided to patients and system users
- To deliver data and support tools for proactive decision making by service designers and clinicians using predictive analytics
- To enable greater use evidence in clinical decision support
- To enable citizens to self-serve through use of technology
- To enable citizens to take ownership of their health and wellbeing and data
- To ensure robust information governance is in place to assure our citizens of appropriate confidentiality whilst enabling effective sharing.
- To enable a system wide view of capacity and demand across all care settings in the footprint – (e.g. home care, care home to intensive care unit.)

P5 – Re-engineer the system of demand management, commissioning and health and social care provision in BLMK

- To recognise that current arrangements for analysing and assessing need, and for commissioning, transacting and providing health and social care in BLMK, will not be fit for purpose going forward.
- To create the systemic conditions for the successful realisation of the STP vision by binding together, and aligning, all key elements of commissioning and service provision, via system-wide, whole population, capitation based contracting
- To ensure the system acts in way that supports, rather than impedes:
  - ✓ The systematic capture of scale efficiencies
  - ✓ Consistency of approach, to be achieved in the mobilisation and operationalisation of "channel shift" solutions and the associated "system integrator" function
  - ✓ The organisation of direct clinical intervention teams to operate down and alongside locality-based care delivery channels, focusing on populations of between 30,000 and 50,000
- To enable NHS bodies in BLMK to accept, manage and control a BLMK system-wide STP control total, sitting alongside BLMK's acceptance of unconstrained demand risk, via capitation-based contracting arrangements

BLMK STP 5 year "plan on a page"

BLMK Priority		Health & Wellbeing Gap	Quality & Care Gap	Funding & Efficiency Gap	2016/17	2017/18	To 2020/21
User/service-facing initiatives	P1 Prevention	✔		✔	• Develop organisation-specific prevention plans (all STP partners)	• Implement and refresh organisation specific prevention plans	
		✔		✔	• Business cases for evidence based investment in prevention (1st two business cases)	• Implementation of enabling prevention business cases • Development of further enabling prevention business cases	
	P2 Primary, Community & Social Care		✔	✔	• Project plans for solutions developed ("*Better Care, Closer*" change programme; Single Point of Access and Clinical Hub etc.)	• Planning and delivery of primary and community settings support solutions (enhanced primary care, complex care management, acute-based care delivery, referrals management, medicine optimisation, community based outreach)	
			✔	✔	• Delivery of *Primary Care Home* work package (establishing GP clusters and community and social care teams) and developing transfer protocols	• Functional integration across the footprint for Urgent Care Services (including 999, 111 and GP OOH)	
	P3 Sustainable Secondary Care	✔	✔	✔	• All hospital clinical, clinical support and non-clinical services examined and target leadership, management and operational models determined, including any recommended service change	• Implementation of sustainable secondary care plans for services to new models • Where relevant, public consultation on sustainable secondary care plans determined, designed and completed	
			✔	✔		• Integrated clinical support service plan agreed and implemented • Where relevant, staff consultation determined, designed and completed	
				✔		• Implementation of integrated non-clinical support services plans • Where relevant, staff consultation determined, designed and completed	
Enablers	P4 Digitisation	✔	✔	✔	• Digitisation work programme planning proceeds e.g.: ✓ Health information exchange solution designed ✓ Pilot citizen facing architecture in primary care ✓ Remote support for Care Homes designed and piloted.	• Digitisation work programme implementation proceeds e.g.: ✓ Intermediate solution for shared health and care citizen record available. ✓ Full citizen access designed and being implemented	• Digitisation work programme implementation proceeds e.g.: ✓ Shared care record optimal solution implemented ✓ Risk stratification and care coordination goes live ✓ Citizen-facing technology enabled
	P5 System Re-engineering	✔	✔	✔	• Accountable Care System (ACS) options assessed and preferred solution determined	• Work programme to design and source the preferred ACS solution completed e.g. ✓ Development and procurement planning work completed ✓ NHSE/I new care models assurance process completed ✓ Public consultation on new models completed ✓ ACS solution procured and established	• Work programme to mobilise and establish the ACS completed e.g. ✓ Transformed commissioning counterparty ✓ ACO supply chain established ✓ Mobilisation and delivery of accountable care system, system integration activity and channel shift measures

Our transformational solutions – identified, developed or work-in-progress

Transformational solutions identified and under development – user-facing initiatives (1)

P1 Prevention

Solutions include:

- Enabling Prevention - a set of work packages that lay the ground work for current and future Prevention work packages. Establishing Prevention governance through the BLMK Prevention Steering Group will be established by November 2016. Programme management aims to set up the mechanisms and processes that enable work packages to deliver quality and engage with other work package/priorities. Engaging others in BLMK, such as the Health and Wellbeing Boards, through development of a Communications Strategy for Prevention will empower work package leads and others in BLMK to feel empowered to work towards the Prevention Goals.
- The principle mechanism through which "Prevention Goals" will be met is through the development and implementation of Organisation-Specific Prevention Plans. These plans will set out the agreed actions that each partner will take to will ensure that a culture of prevention becomes embedded within their organisation and to deliver a radical upgrade in prevention. It is expected that the Preventions Plans will be finalised and signed off by March 2017.
- The output of the 'Evidence-based service development' work packages are business cases – two of these are expected to be delivered by March 2017, namely
  - ✓ Fracture Liaison Services Business Case
  - ✓ Social Prescribing Hub Business Case

P2 Primary, Community & Social Care

Solutions include:

- **Programme 1** - "Better Care, Closer" aims to achieve a common integrated model for hospital care, community health services, primary care and social care through a place-based approach. Standardised BLMK approach to care co-ordination and delivery involving:
  - ✓ Developing primary care at scale (which may include mergers; partnerships or other practice collaboration)
  - ✓ Integrating the workforces providing primary care, community heath and social care to deliver linked/integrated care at/close to home and also bringing health and other Council services (such as housing) alongside each other through, for example co-location in community hubs
  - ✓ Sharing care records and securing technology/systems interoperability
  - ✓ Increasing use of risk stratification tools and focused case management approaches
  - ✓ Increasing evidence-driven interventions – focused on the 20% of local populations that use 70% of NHS resources
  - ✓ Providing care on a proactive and planned basis for the 20% of citizens with complex or chronic conditions
  - ✓ Empowering communities and individuals through strengthened community support and developing individuals/families ability to self care
  - ✓ Development of specific multi-disciplinary interventions to local residents that need intensive structured support (i.e. support to the care home sector; housebound patients; patients living in supported accommodation), delivered in clusters of 30-50,000 populations and centred around GP list
- New care solutions will support Better Care, Closer programme and will include:
  - ✓ Enhanced Primary Care - core general practice workforce is expanded strengthened to deliver better access, well-being and chronic disease management, including ambulatory care for those with high healthcare needs (the chronic "18%" and the complex "2%"). Through new roles and capacity, EPC will seek to enable clinical professionals to work "*to the top of their license*" (requires recurrent STP investment of additional 299 WTEs to 2020/21)
  - ✓ Complex care management - community based care (at home, in care homes and in community hospitals), supported by specialist GPs or community-based physical and mental health specialists. This solution focuses on non-ambulatory patients, with complex care needs and advanced illness. It targets those in residential care, the house-bound and those ate the end of their life (requires recurrent STP investment of additional 83 WTEs to 2020/21)
  - ✓ Acute-based care management – dedicates resource to coordinating patient health and social care plans between hospital, GPs and social care to reduce length of stay and readmissions to hospital (and covers admission, discharge and transition to other care settings).
  - ✓ Referral management – supporting, managing and helping direct GPs to specialist physical health or mental health referrals, in acute, community or voluntary settings, where appropriate, and to strengthen specialist expertise amongst primary care professionals.
  - ✓ Medicines optimisation – to support efficient and effective prescribing and use of medicines across the continuum of care (including hospitals) by establishing a system-focussed team that supports innovation, effective and efficient use of medications and safety. Involves developing pharmacy link to MDTs to ensure effective use of medicines in physical and mental health care management
  - ✓ Community-based outreach – to build and capitalise on the contribution the non-statutory sector can make in absorbing and managing some of the health and social care demands of the BLMK population
- BLMK will build on work in Luton developing the NAPC '*Primary Care Home Model*', the integration models being developed in Milton Keynes and the health and social care integration models being developed in Central Bedfordshire, to develop a standardised approach across BLMK to co-ordinated care
- **Programme 2** - BLMK will improve the quality and responsiveness of urgent care that takes place outside hospitals by:
  - ✓ Creating a single clinical hub and SPoA (via a single inbound call center, dealing with urgent and non-urgent enquiries (including calls, texts, chats, etc.) that brings together 111, 999 and NurseLine and other provider services) that offers informed triage to direct physical and mental health care and to guide service users requiring further support form statutory or non-statutory agencies (requires recurrent STP investment of additional 94 WTEs to 2020/21)
  - ✓ Fully integrating with GP OoH and other appropriate services to enable direct booking of face-to-ace appointments
  - ✓ Functionally integrating with the 999 Ambulance Service to enable the warm transfer of calls to and from clinicians in either service

Transformational solutions identified and under development – user-facing initiatives (2)

P3 Sustainable Secondary Care

Work-in-progress includes:

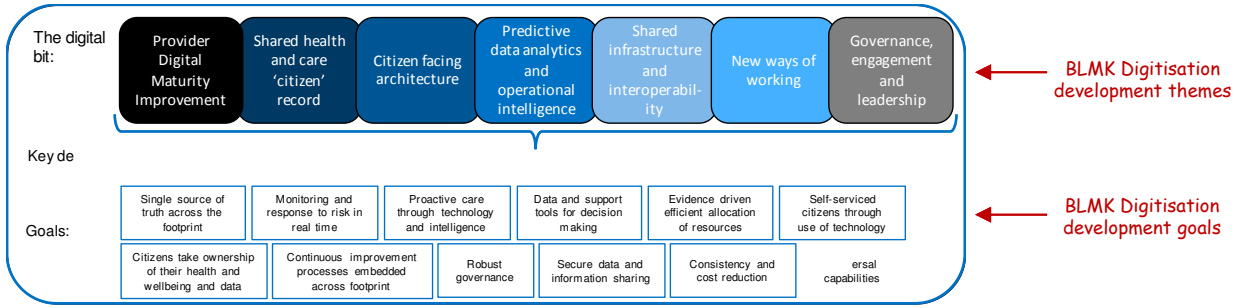
- Following the decision in July 2016 to ask the STP programme to formulate solutions that would bring about sustainable secondary care across BLMK, the 3 local hospitals have committed to work together to plan, develop and provide a unified acute service across BLMK, with hospital services located on the three existing campuses
- This work is being led by a BLMK Secondary Care Services Transformation Board (SCSTB). Core membership is as follows:
  - ✓ Priority 3 programme sponsor Pauline Philip (Chair)
  - ✓ 3 acute trust CEOS
  - ✓ 3 acute trust Directors of Nursing
  - ✓ 3 acute trust Medical Directors
  - ✓ Programme Director for Secondary Care
  - ✓ Medical Lead for Secondary Care
- The SCSTB is underpinned by the Secondary Care Services Clinical Working Group, which comprises 9 Clinical Champions (3 from each of the three hospitals) and the sub-priority leads.
- The SCSTB currently exercises authority through the delegated authority attaching to the postholders of SCSTB members.
- The three Trust Boards are currently examining options that would enable each to delegate and pool some formal decision-making powers to a jointly governed vehicle operating across the three Trusts. The interplay between the SCSTB and the three local CCGs is also being determined and formalised.
- Significant changes to secondary care services that might emerge will involve close engagement with STP partners and will involve appropriate statutory consultation with the general public, as well, where relevant, equality impact assessments. In such circumstances, pre-consultation processes overseen by NHSE/I would also be activated.
- The SCSTB is overseeing four discrete workstreams, namely:
  - ✓ Speciality clinical services – to develop transformational integration plans for each major clinical service to inform the overall configuration of secondary care services across BLMK. Understand the infrastructure and resource modelling that underpins the investment case for any newly proposed configuration. Deliver the optimised clinical services.
  - ✓ Clinical support services – to build on the recommendations of the Carter report, and identify opportunities arising from integrating clinical support services which support the design and implementation of optimally configured pathology, radiology, pharmacy and therapies services. Initiate transformational change as identified, and inform any overall investment case for secondary care.
  - ✓ Non-clinical support services - Design and configure non-clinical support services so as to maximise operational and economic effectiveness and support the emergent BLMK-wide operating model for secondary care services across the footprint.
  - ✓ Non-medical clinical workforce - compare current workforce configurations and develop and agree standardised models to reduce variation and ensure most effective use of non-medical clinical workforce resource, taking into account opportunities for arising for collaborative clinical input across BLMK.

Sub Priorities	Outputs	Outcomes
Speciality Clinical Services £25m savings challenge	• Set of integrated clinical operational models costed and collated into a single coherent clinical operational model across the three sites • Fully worked up resource plan and infrastructure specification to support the clinical model (including IT, equipment and estates) • Drawing on pre-July analysis, a place-holder of £25m savings has been identified (representing 3.5% of aggregate hospital cost base) from streamlining leadership, management and configuration of secondary care specialist clinical across the BLMK footprint.	• Collated into the overall investment case for secondary care which sets out the preferrec configuration for secondary care and is supported by a full resource plan. Leads to the production of an implementation plan which may include public consultation.
Clinical Support Services £6m savings challenge	• Operational Design and procurement model for single pathology service delivering reduced cost • Pharmacy, Imaging and therapies to have detailed savings plans for year 1 against specific work packages by Dec 2016. • Detailed integrated operational models will be completed for pharmacy and imaging by 31/03/17 and for therapies by 30/06/17 with clear resource plans and timescales.	• Services will have a single clinical leadership team and will integrated in terms of clinical standards, operational policies, workforce models and procurement. • The transformed operational models will be implemented, ensuring that clinical support services are delivered in the way that best support the emerging configuration for seconc care services. • Productivity and financial improvements will have been made through sharing best pract and collaborative working during the early years to support provider efficiency savings
Non-Clinical Support Services £7m savings challenge	• By end of 2017 there will be specific, timed and resourced plans in respect of non-clinical support services (ICT, finance, HR, estates maintenance etc.) with associated savings identified from a combination of procurement savings, integration efficiencies and standardising services and processes (to be implemented by 2020/21)	• Each service area will have aligned it's operational and resource model to most effective support the emergent clinical model for BLMK
Non-Medical Clinical Workforce (savings challenge incl in above)	• Standardised clinical workforce models across the three secondary care organisations and community teams with a goal to reduce bank and agency costs • Implementation plan to move from current state to standardised models • Incorporation of new roles and skill mix models into workforce design	• Sustainable workforce model for secondary and community non-medical clinical staff • Training and rigorous workforce planning in place to support workforce needs

Transformational solutions identified and under development – enabling initiatives

P4 Digitisation

- 7 key digitisation development themes developed by the Digitisation workstream with associated goals (see figure below):



- Key Digitisation programme activities:
  - ✓ NHS & Council improvement in digital maturity and convergence
  - ✓ Shared health and care 'citizen' record
  - ✓ Citizen facing architecture
  - ✓ Predictive data analytics and operational intelligence
  - ✓ Shared infrastructure and interoperability
  - ✓ New ways of working
  - ✓ Governance, engagement and leadership

P5 System Re-engineering

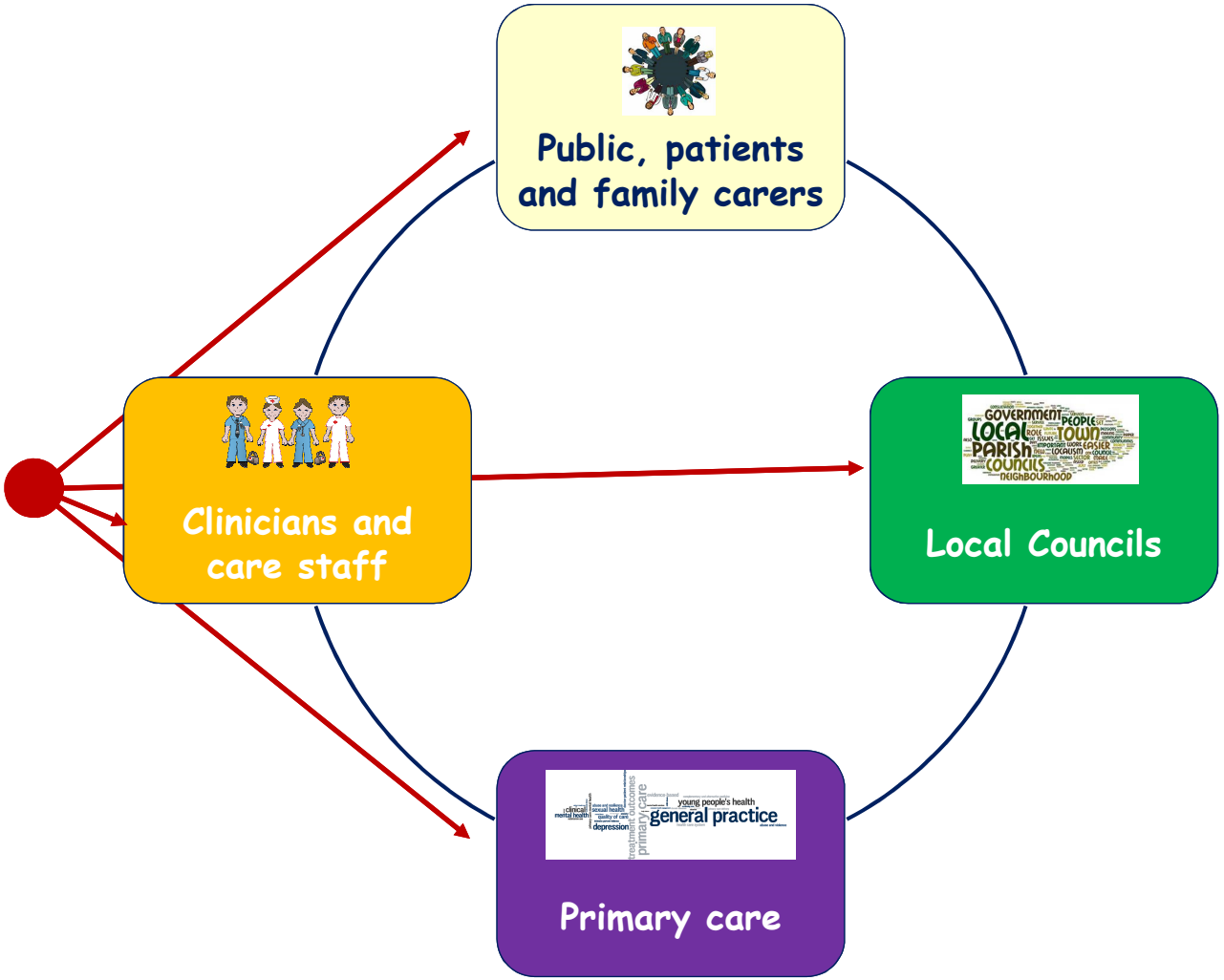
- Cross-STP acknowledgement that existing contractual and administrative arrangements used to commission, plan and deliver care are flawed. Weaknesses exists at three levels:
  - ✓ Technical – due to shortcomings in scarce skills, capacity, analytical and technical capability and experience
  - ✓ Scale - due to the absence of a sufficiently scaled commissioning function to create and operate new care models in BLMK
  - ✓ Scope – due to the multitude of contracts amongst NHS and other bodies, and poor alignment of incentives between them to maximise the patient experience, care quality and to minimise costs
- All relevant NHS parties (i.e. both NHS commissioners and providers) across BLMK are keen to adopt an accountable care approach to commissioning and delivering NHS services.
- Such an approach will continue to see care designed and delivered at the locality level (typically 30,000 to 50,000 population), sensitised to the needs of different localities, and in a way that list-based general practice remains front and centre
- Some functions and activities will operate in patches co-terminous with local Council boundaries - others, such as health population analytics, information and communications systems and technology and administration will operate across the BLMK footprint
- An accountable care approach is likely to require the boundaries between commissioning and provision to be redrawn, and will introduce new "systems integrator" capabilities
- The post 21st October remit would fall into four stages, namely:
  - ✓ Stage 1 – accountable care options assessment
  - ✓ Stage 2 – accountable care system design, development and, where necessary, procurement planning
  - ✓ Stage 3 – undertaking relevant procurement(s)
  - ✓ Stage 4 - accountable care system mobilisation and operational phase

The benefits we expect if we achieve our five priorities

Who do we expect to benefit from our collective efforts?

BLMK's transformation priorities for next 5 years

- Prevention — P1
- Primary, Community & Social Care — P2
- Sustainable Secondary Care — P3
- Digitisation — P4
- System Re-engineering — P5



Expected benefits … what is the STP doing for the public, patients and family carers?

- Put time, effort and investment into the 6 areas that will have the highest local impact on the health status of BLMK's citizens
  - ✓ Giving every child the best start in life
  - ✓ Improving screening and immunisations coverage
  - ✓ Tackling the four lifestyle behaviours (smoking, alcohol consumption, exercise and healthy eating)
  - ✓ Promoting mental health and well-being
  - ✓ Achieving healthy workforce and healthy estates
  - ✓ Empowering communities and self-management
- Develop stronger community and voluntary resources to increase community resilience to maximize personal independence

- Better access to clinicians based in the community to address emergency, urgent or non-urgent needs
- Earlier detection and intervention to prevent illnesses deteriorating or to manage the progress of chronic diseases
- More proactive management of individuals with complex or long term conditions
- Easier and timely discharge from hospital back to home or into community facilities

- Local access to high quality hospital services across all three BLMK campuses
- Reinvigorate and underpin vulnerable hospital services by closer working across the three hospitals
- Remove the threat of precipitous loss of services due to staffing, quality or financial challenges
- Eliminate or reduce boundaries for citizens who move between hospital and community settings

- Empower citizens to take much more control over their health and well-being
- Easier digital access for citizens to clinicians or care workers, via shared care records and digitised technology
- Digital support to empower communities, and increase self-management through apps, tele-health, tele-medicine, and digital alternatives to face-to-face consultations

- Users to experience, a more joined up service across health and social care and between community and hospital settings
- For members of the public, the ability to participate in the design, delivery and assessment of newly developing services
- Better value for money and more spent on front-line services

Expected benefits … what is the STP doing for local councils?

- Create new levers for Councils to lead effective, well-resourced and co-ordinated public health and illness prevention campaigns
- Force prevention planning to the top of the health & social care agenda across all health and social care partners
- Ensure that better value is achieved from current and future spend on prevention by the NHS and by Council

- Improve access for local citizens to health and social care facilities in community settings
- Retain locality delivery, enabling services to be sensitised to local needs
- Higher levels of investment in statutory and non-statutory community infrastructure, improving community resilience
- Greater integration between health and social care professionals across primary, community and social care, but also between health and other Council services, such as housing

- Improved and speedier access for local citizens to emergency and specialist services due to education, sign-posting and stronger and more responsive alternatives to A&E
- Integrated clinical leadership operating across hospital and community settings
- Removes continual uncertainty about the future of locally accessible hospital services

- Converging digitisation platforms across health and Council bodies enables greater integration and improve service quality
- Complements and supports initiatives in Councils to empower local citizens to be more self-reliant in meeting their health and social care needs, and for local communities to be more resilient

- Better integrated planning and service delivery across health and social care services in hospitals and community settings
- Provides new mechanisms by which joint stewardship over health and social care budgets can be achieved so that common risks can be addressed without inadvertent cost-shunting

Expected benefits … what is the STP doing for services delivered in primary and community settings?

- Increased appetite by, and capability of citizens (and their family carers) to self-care and to "partner" the GP and other members of the primary care team (such as pharmacists) in the delivery of their care
- Earlier presentation to clinicians should facilitate earlier detection and more effective, and less invasive, treatment

- Ready access to stronger multi-disciplinary clinical skills at the locality level
- Ready access to high quality decision-support systems & technology that will improve diagnostic and prescriptive expertise available to the front-line community clinician
- GPs and other members of the primary care team being able to operate at the "top of license", to develop specialist skills and to focus their scarce skills on citizens with complex or chronic needs
- Capacity to undertake anticipatory care and for primary care to in-reach into care hot-spots, such as care homes

- Closer co-ordination between GPs and hospital clinicians across care pathways
- Closer connectivity between GPs and hospitals so that there is an easy transition for citizens between care settings, either into or out of hospital
- Hospital clinicians with capacity and incentive to support the development of specialist clinical expertise in primary care

- More effective management of the health and social care needs of citizens on the GP list, via proactive, list-level referral management
- Easier and quicker access to shared care records to support work of the GP, other community clinicians, social care professionals, care home staff and family and other informal carers

- Via new care models, provides new ways of engaging with and incentivising GPs and other community clinicians to support vulnerable practices or to solve "hard to recruit into" areas/practices
- Create opportunities for GPs and other community clinicians to focus on care management and delivery and reduce administrative burden

Expected benefits … what is the STP doing for clinicians and care staff?

- Citizens are better informed about how to access the most effective care, most easily
- Citizens are more aware of the options available to them, including those provided by voluntary organisations
- These options are tried and tested, so they work and are trusted to work by citizens

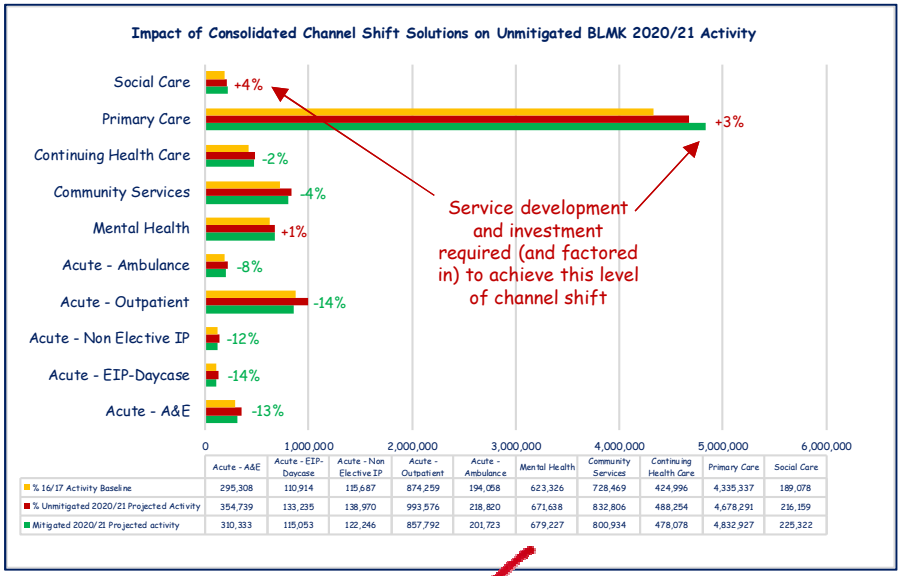
- Organised to serve localities of 30-50,000 people, community physical and mental health clinicians know their "patch" and are closely integrated with GP practices on that "patch"
- Community health clinicians work closely with, and in many cases, are integrated with social care professionals
- Opportunity for increased specialisation in primary care
- Hospital clinicians provide support and specialist leadership into the community
- Care workers in care homes are supported by close links with local primary care and community clinicians

- Long-standing medical and nursing staffing shortages are addressed by integrated clinical and operational leadership, operations and resources across the 3 hospitals
- New opportunities arise for clinical staff for professional development and specialisation by working across the 3 hospital campuses
- The chosen configuration of hospital services is now clinically and financially resilient and sustainable into the foreseeable future

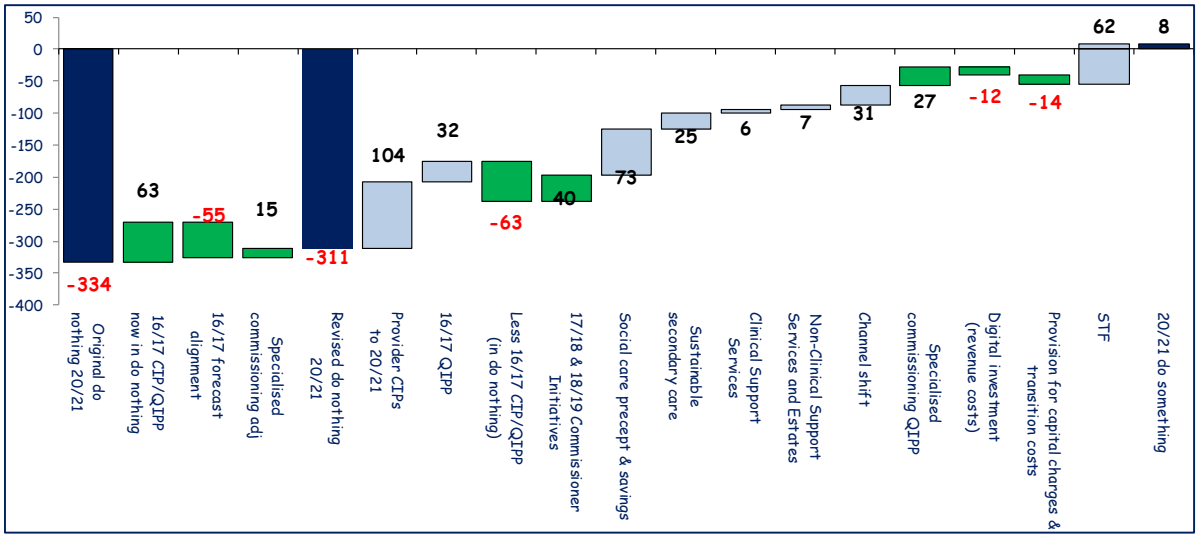
- Access to shared care record enables quicker and more comprehensive diagnosis
- Access to shared care records, and associated care plans, for community clinicians and care workers in care homes enables more effective local decision-making and risk assessment

- Via the introduction of systems integrator, improved co-ordination between clinicians around a citizen
- Incentives between individual clinicians and their organisations are much better aligned to achieve defined patient/clinical outcomes
- Administrative burden on clinicians is reduced

Demand management and reducing the financial pressures in BLMK



	Acute - A&E	Acute - EIP-Daycase	Acute - Non Elective IP	Acute - Outpatient	Acute - Ambulance	Mental Health	Community Services	Continuing Health Care	Primary Care	Social Care
% 16/17 Activity Baseline	295,308	110,914	115,687	874,259	194,058	623,326	728,469	424,996	4,335,337	189,078
% Unmitigated 2020/21 Projected Activity	354,739	133,235	138,970	993,576	218,820	671,638	832,806	488,254	4,678,291	216,159
Mitigated 2020/21 Projected activity	310,333	115,053	122,246	857,792	201,723	679,227	800,934	478,078	4,832,927	225,322



What are we doing to realise the benefits?

Work packages supporting the achievement of STP priorities – active and upcoming

Programme Structure and Management

- Comms and Engagements plans (strategic and Tactical)
- Population analysis
- Programme Governance
- Commons organisation change principles
- Leadership for systems and change management
- Comprehensive & accurate schedule of public sector assets
- Strategic Estates Plan

- Workforce Plan outline

Priority 1 Prevention

- Enabling Prevention
- Organisation specific prevention plans
- Evidence based service developments including Fracture Liaison Service and Social Prescribing Hub Business Case

- Implementation of FLS and SPH services

Priority 2 Programme Implementation Plan and Investment Case (October 16)

Priority 2 Primary, Community and Social Care

- SPOA
- Transfer Protocols
- Standardising BLMK approach to care coordination

- Information and education in respect of how best to access urgent and emergency services
- Risk stratification tools
- Enhanced Primary Care
- Complex Care Management
- Acute-based care management
- Referrals management
- Medicines optimisation
- Community based outreach

Priority 3 Secondary Care Transformation

- Pathology and Radiology baselining and immediate priorities plan
- Clinical Service Model for Stroke
- Sourcing strategy for Pathology services
- Therapies As Is baseline
- Integrating and optimally configuring back office services
- Pharmacy services transformation

- Collaborative Radiology & Pathology service
- Secondary care specialist support to system wide pathways
- Eliminating variation in clinical quality
- Joint leadership for Wave 1 & 2 spec.
- Standardising clinical protocols for Wave 1

Priority 4 Digitisation

- Citizen-facing architecture
- Digital Engagement in Care Homes

- Shared infrastructure and interoperability
- Predictive data analytics and operational intelligence
- Shared health and care citizen record

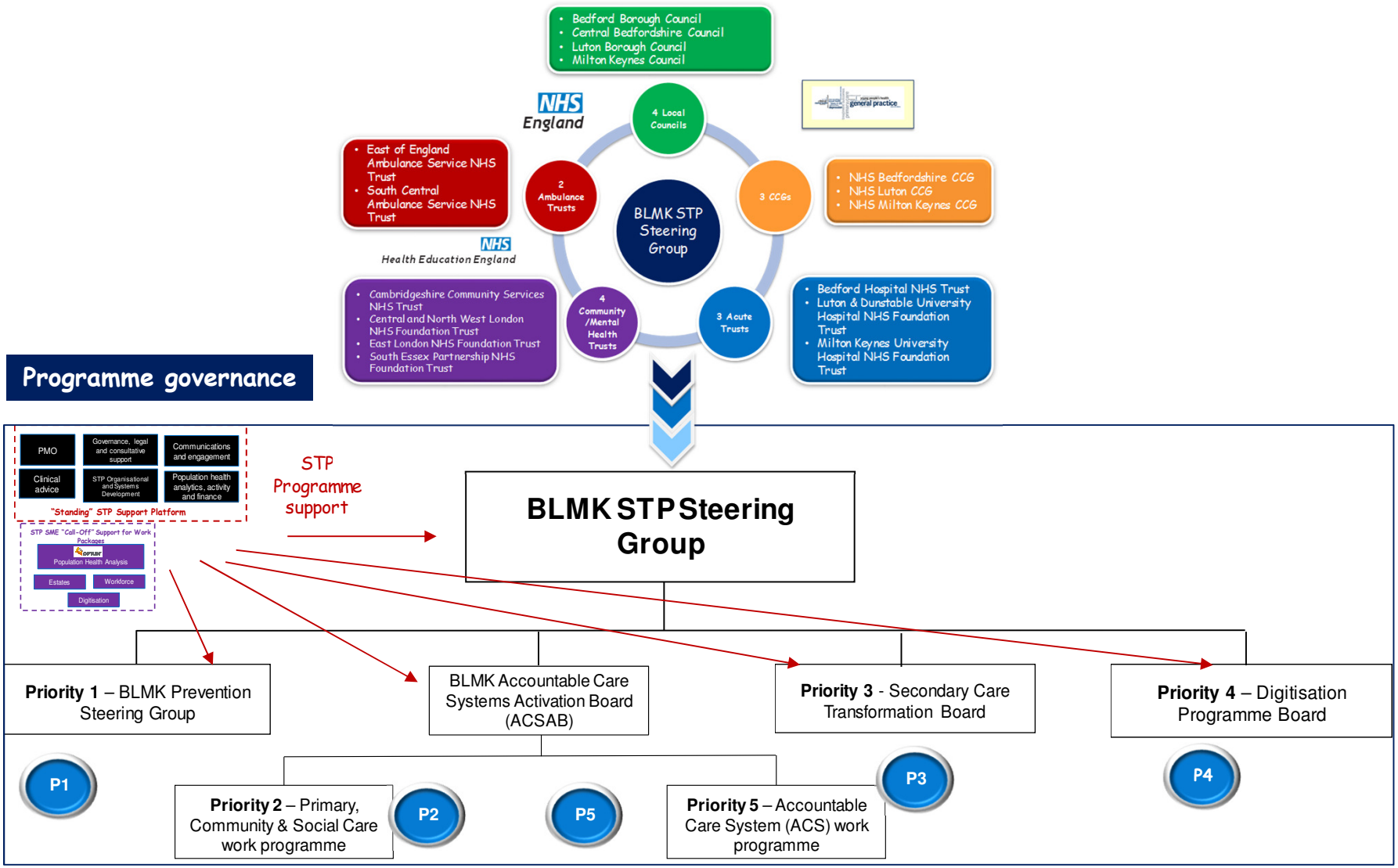
Priority 5 System Reengineering

- Review options available to re-engineer commissioning and clinical service provision
- Stage 1 – accountable care options assessment

Stage 2 – accountable care system design, development and procurement planning
Stage 3 – undertaking procurement(s)
Stage 4 - accountable care system mobilisation and operational phase

Priority 5 Programme Implementation Plan and Investment Case (October 16)

STP programme delivery – 2017/18 & 2018/19



BLMK STP critical path – 2017/18 & 2018/19

Key:
Milestone
Ongoing Delivery

#	Priority	Activity	SRO	Governance	Milestone	Year	2016/17		2017/18				2018/19			
						Quarter	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1	P1	Prevention Group and Champions established	Ian Brown	Prev. Group	Nov 2016											
2	P1	Organisation Prevention Plans drafted and agreed	Ian Brown	Prev. Group	Mar 2017											
3	P1	Organisational Prevention Plans implemented	BLMK Parters	Prev. Group	Q1 2017/18											
4	P1	Develop full business case for Fracture Liaison Service and Social Prescribing Hub	Jackie Golding / Derys Pragnell	Prev. Group	Mar 2017											
5	P1	Implement business cases for FLS and SPH into services	TBC	Prev. Group	2017/18											
6	P2	transfer protocols	TBC / David Kirby	ACSTB	Q4 2016/17											
7	P2	Planning for for 'Primary Care Home' work package	Liz Eckert	ACSTB	Q3 2016/17											
8	P2	Delivery of 'Primary Care Home' and developing transfer protocols	Liz Eckert	ACSTB	Q2 2017/18											
9	P2	Delivery of 'Better Care, Closer' solutions and SPOA	Liz Eckert	ACSTB	Ongoing											
10	P3	Clinical service model for stroke developed, agreed & implemented across BLMK	Cathy Jones	SCTB	Jan 2017											
11	P3	Clinical service model for wave 1-3 specialties developed and implemented	Cathy Jones	SCTB	Mar 2017											
12	P3	Clinical reconfiguration investment cases completed	Cathy Jones	SCTB	Mar 2017											
13	P3	Assurance check on investment cases by NHS E / I and Public Consultation	Cathy Jones	SCTB	Q1-Q2 2017/18											
14	P3	Implementation of secondary care reconfiguration for services to new models	TBC	SCTB	2018											
15	P3	Non-medical clinical workforce model (NMCWM) - investigated & defined	G Collins	SCTB	Dec 2017											
16	P3	NMCWM implementation	TBC	SCTB	Q4 2016/17											
17	P3	Costed solutions for fully integrated back office services for non-clinical support	NCSS working group	SCTB	Nov 2016											
18	P3	Implementation of agreed solutions for non-clinical support	NCSS working group	SCTB	Q4 2016/17											
19	P3	Integrated clinical support service plan agreed (Path/Rad/Therapies/Pharmacy)	Karen Ward	SCTB	Q4 2016/17											
20	P3	Integrated clinical support service plan delivered (Path/Rad/Therapies/Pharmacy)	Karen Ward	SCTB	Q1 2017/18											
21	P4	Health information exchange solution designed	Philippa Graves	Digi. Board	Q1 2017/18											
22	P4	Network selection procured	Philippa Graves	Digi. Board	Q1 2017/18											
23	P4	Pilot citizen facing architecture in primary care	Philippa Graves	Digi. Board	Q2 2017/18											
24	P4	Intermediate solution for shared health and care citizen record	Philippa Graves	Digi. Board	Q2 2017/18											
25	P4	Shared care record optimal solution implemented	Philippa Graves	Digi. Board	Q3 2018/19											
26	P4	Risk stratification and care coordination goes live	Philippa Graves	Digi. Board	Q1 2018/19											
27	P4	Citizen facing technology enabled	Philippa Graves	Digi. Board	Q3 2018/19											
28	P5	Preferred ACS determined and solution signed off by relevant statutory bodies	BLMK and Precedent	ACSTB	Q4 2016/17											
29	P5	Detailed design and development work on ACS completed	BLMK, policy bodies and Precedent	ACSTB	Q4 2016/17											
30	P5	Procurement planning work completed	BLMK, policy bodies and Precedent	ACSTB	Q4 2016/17											
31	P5	NHSE new care models assurance process completed	BLMK and policy bodies	ACSTB	Jul 2017											
32	P5	Public consultation on new models completed	BLMK and Precedent	ACSTB	Sep 2017											
33	P5	Agreed ACS solution ACO established	BLMK , policy bodies and Precedent	ACSTB	Mar 2018											
34	P5	Procurement of integration support	BLMK and Precedent	ACSTB	Mar 2018											

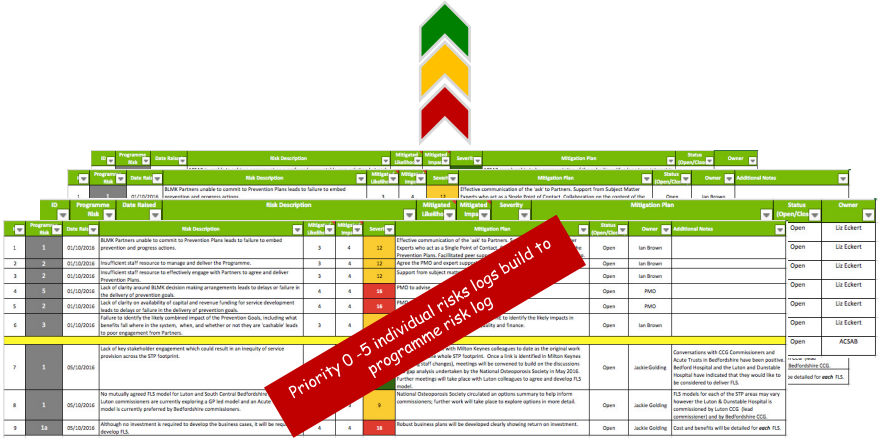
2016/17		2017/18			
Q3	Q4	Q1	Q2	Q3	Q4
2016/17 Key Outputs					
Board-level Prevention champions throughout BLMK	BLMK stakeholder commitment to Prevention	Delivery of Fracture Liaison Hub and Social Prescribing Service	New models of secondary care agreed by NHSE and public consultation	New models of secondary care across BLMK	ACO established and begin delivery along with the procured integrator
Standardised recommendations/plans/training for NMC BLMK roles	Models, business cases and project plans finalised across Priorities	All 'Better care, Closer' solutions initiated	Digitisation of partners across the footprint increases		
Data to inform decision-makers for integrating non-clinical support services	Agreement on ACS solution and completed design work	Clinical support solutions initiated			

Programme Management	
Governance	Continued refinement of governance model, membership and terms of reference
Management	Leading up to an integrator being procured, continue to support priority and work packages leads and facilitate SME's into the programmes
Comms/Engagement	Clear routes of communications/feedback to STP programme team and priorities; Support to priority/work package leads as required
Estates	Develop and implement an estates strategy
Workforce	Develop common organisational change principles and leader and change management strategy

STP programme risks – 2017/18 & 2018/19

Key programme level risks log

ID	Risk description	Mitigated Likelihood	Mitigated Impact	Severity	Mitigation Plan	Status (Open/Close	Owner
1	STP sign off process in April, June and October has only required a high-level of agreement and commitment by STP partners. Now need to localise and validate the STP plans, and priority programmes, with individual STP partners. Moving forward, lack of agreement and commitment across STP partners in respect of purpose and goals of STP could become surface	3	4	12	Deliver the robust comms and engagement plan across the STP footprint to encourage local input and ownership of the STP plan.	Open	Programme Director and STP Lead
1a	External stakeholders may not agree with purpose, goals or priorities of STP and mode of delivery	3	4	12	Communications Team designing how best to communicate STP plans and engage constructively with external stakeholders.	Open	Programme Director and STP Lead
1b	Clinicians may not agree with purpose, goals or priorities of STP or mode of delivery	2	5	10	Support each priority and work package to continue engagement with clinicians as soon as possible in the planning process.	Open	Programme Director and STP Lead
2	There is a lot of change to manage, especially in 16/17 and 17/18. If resources and capacity are not acquired quickly, BMLK could struggle with delivering at the pace it intends to.	4	4	16	Submit a detailed resource plan as part of the October submission to clearly articulate what resources is needed to continue at pace and scale.	Open	Programme Director and STP Lead
3	Expected impact from transformation solutions still needs detailed development and may not turn out as hypothesised	3	4	12	Localising, testing and validating priorities and underpinning solutions with key stakeholders across the footprint over the next three months.	Open	Programme Director and STP Lead
4	Priorities identified may not be based on comprehensive population need and understanding of services due to the scale and scope of BLMK	4	4	16	Localising, testing and validating priorities and underpinning solutions with key stakeholders across the footprint over the next three months.	Open	Programme Director and STP Lead
5	Governance mechanisms have been developed and mobilised but not all have yet been tested if they can deliver timely decision making	3	4	12	All programme governance apparatus to be up and running in next two months and fitness for purpose tested.	Open	Programme Director and STP Lead
6	The BLMK STP may not be aware of or fully understand the implications of existing initiatives	2	3	6	Building on the As Is baseline that has been developing since June, a gap analysis will be done to identify where the current gaps in "as is knowledge' are and a plan put in place to address them.	Open	Programme Director and STP Lead
7	There is a set of assumptions regarding the legal, assurance and consultative basis of the proposed delivery model in P5. These will be tested in the coming months.	3	4	12	Maintain close contact with NHSE/I policy leaders and ACS pathfindersacross England. Create escalation routes to the ACSAB and STP CEOs as necessary when challenges occur or decisions need to be made.	Open	Programme Director and STP Lead



Consensus reached so far amongst BLMK STP partners

- Bedfordshire, Luton and Milton Keynes (BLMK) is a new footprint, covering all of Bedfordshire, Luton and Milton Keynes. A total of 16 STP partners have taken part in the development of BLMK's Sustainability and Transformation Plan (STP).
- Significant progress has been made, from a standing start in April. Multi-organisational teams have come together to study and address stubborn problems that have, over the years, eroded BLMK's clinical and financial sustainability.
- Relationships at senior executive level and, just as importantly, amongst the leadership teams of STP partners, have developed and deepened over this period.
- STP partners in BLMK have used this October STP submission to reflect on our ongoing work programme, to take stock of the progress we have made, to assess the positon we have reached and to identify, discuss and develop a consensus around the priorities we wish to focus on going forward.
- Our STP priorities have been guided by our future vision for health and social care. This vision, the design principles that will guide its realisation and the delivery model implied by it, have strong support amongst system leaders involved in our STP.
- To meet our STP priorities, BLMK system leaders are aware they will need to unite around the transformation goals associated with each priority. They will also need to engage constructively and consistently with the BLMK public and their own staff and stakeholders to reveal and promote the benefits of the changes that need to be made to meet these priorities.
- However, the nature and depth of local consensus must unavoidably be qualified at this point in time, and in three important ways.
  - ✓ BLMK's local Council colleagues have yet to activate their democratic processes, by which officers can fully and formally engage their elected members, and relevant scrutiny mechanisms (such as HOSCs), to consider, scrutinise, debate and opine on the STP.
  - ✓ Clinical, staff and public engagement on our STP proposals and plans contained in our STP has, to date, been relatively light-touch. This now needs to accelerate if we are to benefit fully from input from these crucial constituencies
  - ✓ Solutions for achieving sustainable secondary care services across BLMK are not yet identified and the work to inform these solutions is still in progress for the STP. We expect our review work to start drawing up some recommendations towards the end of March 2017. The level of support from individual STP partners to different secondary care solutions will clearly be a matter that can only be determined at that time.
- Our overall vision is grounded in a frank assessment of the disposition, fitness for purpose and affordability of our existing delivery platform. We conclude that, whilst we have much to be proud of, some good things to build on and a strong appetite for improvement, there is a significant transformative journey ahead of us if we are to achieve clinical and financial sustainability over the next five years.
- Taken together, the five priorities we set out in this STP signal an ambitious and far-reaching shake-up of the health and social care landscape in BLMK. A raft of work programmes are now active. However, this STP highlights that a step-change in the pace and resource is required if we are to realise the STP's ambitions, especially over the next two years.

How do we intend to communicate, engage and involve?

BLMK STP communications, engagement & consultation

Our approach
We will **involve, consult** and **inform** our stakeholders throughout the process. Our decision making will be **informed by clinical, staff, democratic representative** and **public** feedback. **Best practice advice and guidance** will underpin all of our communications, engagement and consultation activities.

Our principles:

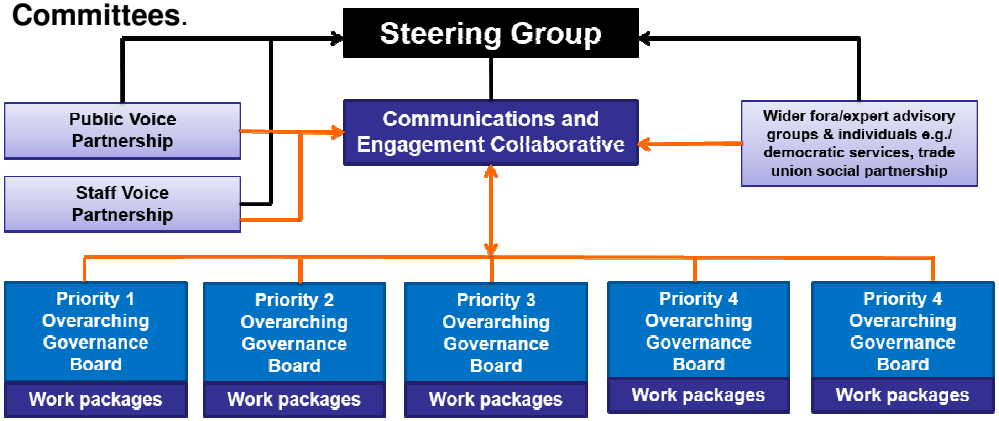
Open, honest and transparent
Accessible and inclusive
Clear, communicating without jargon
Accurate, balanced and fair
Two way – involving and listening
Timely and relevant
Effective and measurable

We will:

Involve people, communities and stakeholders at every step of the journey to co-produce our STP plans
Build on the *'six principles for engaging people and communities'* to **help build local understanding, ownership and support** for emerging proposals and to identify, at an early stage, potential areas for concern
Be aware of what people have already told us as part of previous engagement to support service changes
Work with existing community networks to maximise local knowledge, expertise and effectiveness
Be open and transparent about our decision making
Recognise the diverse communities we serve and engage with each of the nationally identified nine Protected groups through our work and statutory commitments to equality.

We will establish **governance arrangements** that ensure wide ranging input to our plans. Our STP communications and engagement activity will be guided by our **CCG Patient and Public Involvement Lay members,** and **relevant Council of Governors,** supported by our **Communications and Engagement Collaborative**.

We will maintain a close working relationship with all four local **Health & Well-being Boards**, **Healthwatch** and **Health Overview and Scrutiny Committees**.



The initial engagement will be in two phases:

Phase 1: Oct – Dec 2016. Socialisation of draft plan to generate stakeholder awareness and feedback prior to publication of final plan. Key audiences are: **clinical, staff, democratic and public.**

Phase 2: November onwards. Scope detailed communications, and engagement activities prior to fully developing and implementing detailed plans

1st order STP communications and engagement activity (October - December 2016)

Key tasks

- **Finalise communications and engagement plans** to support submission on 21 October
- **Summary STP plan published**. Post submission communication collateral prepared and disseminated to all key stakeholders
- **Proactive and reactive collateral and multi-channel platforms in place** (monthly newsletter, web content, team cascade, briefing docs, statutory body papers etc.)
- **Stakeholder mapping refreshed and events calendar in place** identifying all key partner governance meetings across partnership organisations in place
- **Engagement and associated infrastructure created to support public bodies undertaking statutory consultation with the public or with staff, and to ensure that responses to consultations inform and influence next steps;** such infrastructure will build on existing networks targeting clinical, staff, democratic and public audiences. Key events include Public and Staff Voice, Clinical Conversation, Health and Wellbeing Boards, Overview and Scrutiny Committees, Healthwatch, NHS Trust Boards & FT Governors meetings
- **Previous engagement activity reviewed** and collated to understand what key stakeholders have told us re service changes
- **Communications and Engagement Collaborative** in place
- **Work package communications and engagement requirements scoped** and detailed plans put in place.

STP Partner Leaders commitment

Each STP CEO leader is to be responsible for:

- Their **own organisational and key governing/ scrutiny body briefing and communications cascade**, using centrally produced material as appropriate
- **Ensuring the appropriate cascade of information to their own staff** and ensuring good practice in terms of delivery (i.e. using a variety of channels/ methods)
- **Ensuring Boards/ governing bodies (and etc) receive appropriate information to enable briefing and decision making** in accordance with statutory instruments
- **Ensuring staff side representatives in own organisations are appropriately informed and engaged**
- **Presenting and speaking on the STP and its work to own key stakeholders and key fora within their locality** (e.g. presenting at Overview and Scrutiny Committees; appropriate dialogue with elected members
- **Flagging areas of risk or concern** directly to the communications/ engagement lead for action
- **Securing further support** from the communications/ engagement lead as required.