NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
30 January 2020

Title	Strategic Activity Update
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Purpose of the report

The aim of this report is to provide the Trust Board with an update on key areas of the Trust's strategic decision-making, planning and management. It is structured to provide information on national policy developments and our partnership working in local integrated care systems.

Summary of key issues

The Bedfordshire, Luton and Milton Keynes Integrated Care System and the North East London Sustainability & Transformation Partnership have submitted final draft Five Year Plans to NHS England/Improvement. The process for approval and publication of plans nationally is scheduled for the Spring 2020/21. Next steps include operational planning for 2020/21, with a focus on delivering Five Year Plan commitments.

The Trust has worked with partners across both BLMK and North East London to develop the final draft plans, including in particular, detailed mental health plans in line with the national requirement. The Trust is working with partners to develop more detailed plans for community health services.

Both BLMK and NEL have begun work to design and deliver Integrated Care System governance arrangements, including reconfiguration of Clinical Commissioning Groups, and the development of providers to support system leadership.

Strategic priorities this paper supports

Improved experience of care	☒	This paper covers the Trust's strategic planning process and strategy development, and therefore supports all of the Trust's strategic priorities.
Improved population health outcomes	☒	
Improved staff experience	☒	
Improved value	☒	

Committees/meetings where this item has been considered

Date	Committee/Meeting
	This report is routinely submitted to the Executive Service Delivery Board

Implications

Equality Analysis	The Trust strategy has specific goals to address health inequalities, and this will be a focus of both our population health and equalities workstreams.
Risk and Assurance	The developments in this report provide assurance that the Trust is effectively engaging with external partners, developing services to improve patient care and outcomes, and maintaining value for money.
Service User/Carer/ Staff	The service developments in this report should have a direct beneficial impact on service users and carers.

Financial	The acquisition of additional income has positive financial benefits for the Trust.
Quality	Service developments are specifically designed to improve quality.

Supporting documents and research material

N/A

Glossary

CCG	Clinical Commissioning Group
STP	Sustainability & Transformation Partnership
ELHCP	East London Health & Care Partnership
NELCA	North East London Commissioning Alliance
BLMK	Bedfordshire, Luton & Milton Keynes
5YFV	Five Year Forward View
CQC	Care Quality Commission
INEL STB	Inner North East London System Transformation Board
FYFVMH	Five Year Forward View Mental Health
IHI	Institute for Healthcare Improvement
ICS	Integrated Care System
PCN	Primary Care Network
Place based system	The Trust works with six place based systems: BLMK: Bedford Borough, Central Bedfordshire, Luton ELHCP: City & Hackney, Newham, Tower Hamlets

1.0 Background/Introduction

1.1 The Trust operates in an increasingly more complex and diverse health and social care economy which is continually changing and developing the landscape of health and social care commissioning and service provision.

1.2 The external drivers for change place increasing demands upon the Trust's capacity for strategic decision-making, planning and management. The pace and volume of change is increasing and it is therefore important that senior decision-makers within the Trust are kept abreast of strategic developments, both internally and externally. This report aims to fulfil this requirement.

1.3 The Trust is part of two Sustainability and Transformation Partnership (STP) footprints: East London Health & Care Partnership (ELHCP, the North East London Sustainability & Transformation Partnership); and Bedfordshire, Luton & Milton Keynes (BLMK, which is a "first wave" Integrated Care System). The footprints are comprised of local NHS providers, Clinical Commissioning Groups (CCGs), Local Authorities, and local other health and care services who together have developed STPs for accelerating the implementation of the NHS Long Term Plan

2.0 Sustainability & Transformation Partnerships/Integrated Care Systems Update

2.1 The Trust has worked closely with partners in BLMK and ELHCP to develop Five Year Plans, which were submitted to NHS England & Improvement in November 2019, and which are currently due for final publication in Spring 2020.

2.2 As part of the five-year financial settlement supporting the Long-Term Plan, £2.3bn has been ear-marked for mental health, and £4.5bn for primary and community care.

2.3 NHS England has produced detailed guidance to support mental health activity, workforce and financial planning. Whilst the Trust is still working with commissioners to determine the detail, it is anticipated that there will be in the region of £70m investment into mental health services by 2023/24 across the area covered by the Trust.

2.4 Whilst some of the new funding will go to other providers, and an element will fund the pay and prices uplift on core contracts, it is anticipated that there will be significant new funding to support service developments that substantially increase access and improve quality in mental health services provided by the Trust over the course of the five year plan.

2.5 Work to develop final triangulated activity, workforce and finance plans is not yet complete, however it is anticipated that the new funding will support significantly improved access for people with mental health problems, as below:

By 2023/24 (compared to 2019/20)	Bedfordshire	Luton	City & Hackney	Newham	Tower Hamlets	Total
New Women will be supported to access community perinatal care	302	198	246	329	250	1325
More children & young people accessing CAMHS services	407	211	275	334	273	1500
More 18-25 year olds accessing mental health services	146	72	97	112	92	519
More people accessing physical health checks	838	471	900	864	872	3945
People accessing employment support	431	210	284	330	269	1524
People accessing new models of community mental health care	2896	1416	1909	2217	1810	10248
More people accessing talking therapies services	2070			3375	3331	6706

2.6 Both STP five year plans also include commitments to:

- Perinatal: develop perinatal services further, providing treatment for up to two years where necessary, treatment for partners and maternity outreach clinics
- Children and young people: develop 24/7 crisis services for children and young people, and ensuring 95% children and young people with urgent needs are able to access eating disorders services within one week
- Adults with common mental health problems: developing psychological therapies for people with physical long term conditions
- Adults with serious mental illness: developing new models of community care and support for people with serious mental illness in teams working around neighbourhoods/primary care networks; deliver 24/7 crisis teams for adults, as part of a pathway of support including crisis alternatives.

2.7 The Trust is working with partners to develop detailed plans to deliver against the Long Term Plan commitments for primary care and community health services. Draft specifications for Primary Care Networks have recently been consulted upon by NHS England, which include areas where there are also community health service responsibilities, for example:

- guarantee NHS support to people living in care homes, by implementing the Enhanced Heath in Care Homes (EHCH) vanguard model.
- implement 'anticipatory care' for complex patients at risk of unwarranted health outcomes right across the country… and… for the first time we will create national service specifications for community services within their NHS contracts, carefully phased in line with the extra investment they will be receiving under the new funding guarantee
- improve responsiveness of community health crisis services to within two hours of referral in line with NICE guidelines, where clinically judged to be appropriate, and reablement care within two days of referral to those patients who are judged to need it.
- tackling the workforce challenges in community services. The above goals – particularly (i) and (iii) - require a big workforce expansion.

2.8 Transformation funds are allocated to each STP to develop community health services via the "Ageing Well" programme, with substantive transformation funding due in 2022/3.

2.9 Operational planning guidance is due to be published imminently to support organisational and system planning for 2020/21, with the expectation that plans will be consonant with STP Five Year Plans.

3.0 East London Health & Care Partnership (North East London STP)

3.1 The ELHCP Five Year Plan, now referred to as the ELHCP "Strategic Delivery Plan" is available here: https://www.eastlondonhcp.nhs.uk/ourplans/.

3.2 Key next steps are highlighted in the attached slides, and include:

- further engagement on the plan and the approach to delivery
- the development of an STP accountability framework
- developing the infrastructure and capability to support a population health management approach
- development of primary care networks, and community and mental health services around them
- delivery of LTP commitments to improve urgent and emergency care, mental health, and outpatients.

3.3 Critical to the next phase of delivery across London is the appointment of the new STP chairs, including the appointment of Marie Gabriel to the post of STP Chair for North East London. A key next step will be the development of ICS governance: including reconfiguration of clinical commissioning groups to function across the ICS footprint, and the development of providers to take on a greater system leadership role more locally, including on a borough basis, and across the three STP systems City & Hackney, Waltham Forest & East London, and Barking Havering & Redbridge.

3.4 The North East London STP mental health plan includes a specific commitment to address priorities identified by service users across the STP, and led by a new North East London Patient Participation and Leadership group. These priorities include peer support, cultural awareness, parent support, first contact, and patient leadership.

3.5 Across Waltham Forest, Newham and Tower Hamlets, work is underway to develop a refreshed vision and delivery plan for out of hospital services, including community health services, which will shortly be finalised.

4.0 <u>Bedford, Luton and Milton Keynes STP (BLMK)</u>

4.1 The BLMK plan is now in final draft form, with the support of all key statutory partners. A summary is attached.

4.2 Key next step include:

- final drafting to ensure smart objectives and success measures for 2020/21
- developing the infrastructure and capability to support a population health management approach
- development of primary care networks, and community and mental health services around them
- delivery of LTP commitments to improve urgent and emergency care, mental health, and outpatients.

4.3 BLMK CCGs are working together to develop a new single CCG across Bedfordshire, Luton and Milton Keynes (disestablishing the existing three CCGs), which will act as a “strategic commissioner”, operating in shadow form by April 2020. As part of the new arrangements, there are two developing Integrated Care Partnerships in Milton Keynes, and in Bedfordshire (across Bedford, Central Bedfordshire and Luton), in which the Trust is involved.

4.4 BLMK mental health plan also includes a number of other commitments, for example to improve the therapeutic environment for inpatients in Bedfordshire, to deliver the STP suicide prevention plan, to deliver the mental health for rough sleepers pilot in Luton.

4.5 The Trust is working with partners through the emerging Bedfordshire Care Alliance to support primary care networks and develop next stage plans for integrated teams working around them.

5.0 Action being requested

5.1 The Board is asked to **RECEIVE** and **NOTE** the report.

East London Health & Care Partnership

The NHS Long Term Plan

How we plan to deliver on our commitments

January 2020

Simon Hall
Director of Transformation

NHS Long Term Plan

East London Health & Care Partnership

- The NHS Long Term Plan was published in January 2019 and sets out an ambitious vision for the NHS over the next ten years and beyond.
- It outlines how the NHS will give everyone the best start in life; deliver world-class care for major health problems, such as cancer and heart disease, and help people age well
- We have been working locally to plan how we will deliver the Long Term Plan's commitments over the next five years. We are calling this our Strategy Delivery Plan (SDP)
- On 15 November we submitted our document to NHS England as a draft because of the pre-election purdah period.
- This draft is now on our website www.eastlondonhcp.nhs.uk/ourplans/ to allow people the opportunity to have their say on the content.
- A summary version is in development and will be shared online.

Engagement On The Plan

East London Health & Care Partnership

- The plan is a working document, and we are also developing a plain English summary and easy read version
- Undertaking formal engagement on our LTP response at key stakeholder meetings: ELHCP and CCG forums, Health & Wellbeing Boards, Integrated Care Partnerships, Overview and Scrutiny Committees and Provider Boards
- Reviewing our commitments across the LTP and developing tailored engagement plans for our programmes
- A rolling lunch and learn programme for CCG staff, to be extended to provider and local authority teams
- Engagement through an ELHCP public newsletter and the launch of a regular stakeholder briefing

Delivery and reporting

East London Health & Care Partnership

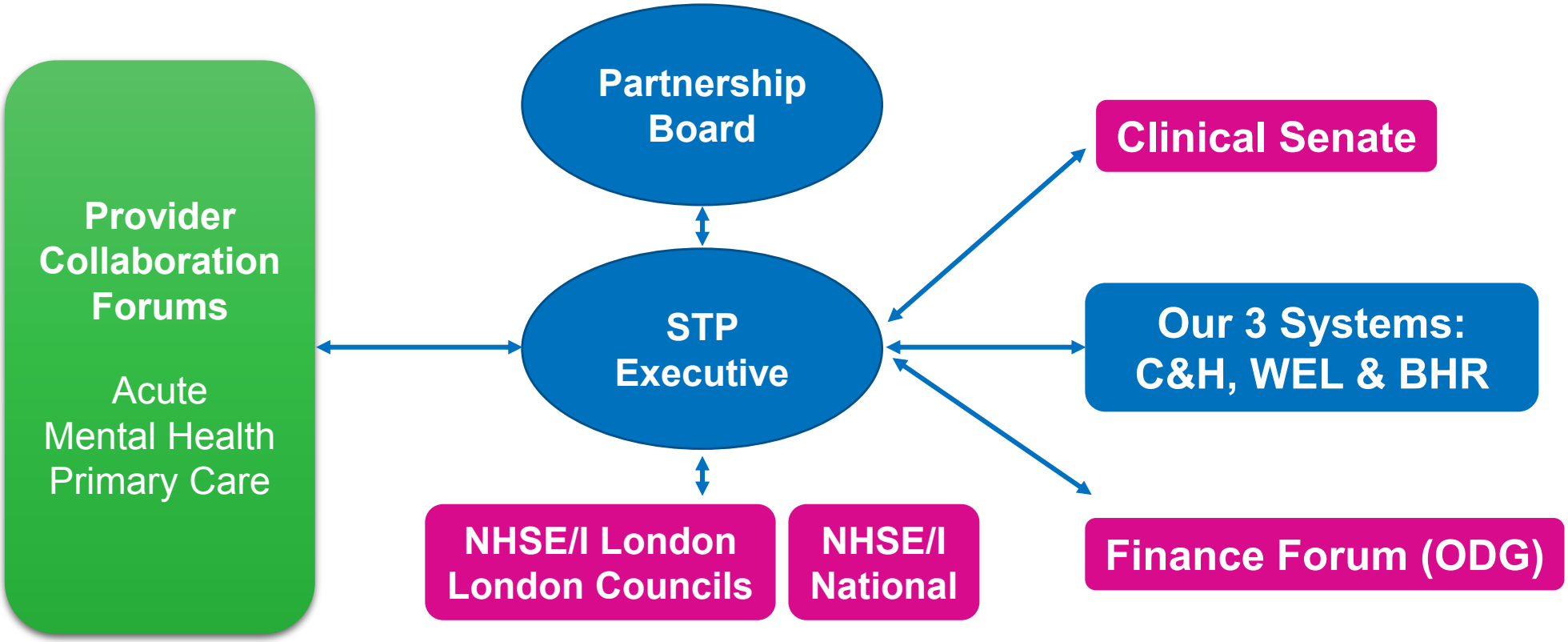
- Agree an accountability framework with each part of our ICS in order that we are all clear on what is being delivered where
- Work more closely with our elected representatives, particularly to secure integrated service delivery and to provide independent scrutiny
- Report annually on progress and what we've achieved

The following slides highlight our planned high-level governance and programme approach, as well as existing progress reporting and planned trajectories

Our governance (at high level)

East London Health & Care Partnership

Bringing together the way we work at a north east London level



Programmes

Improving population health

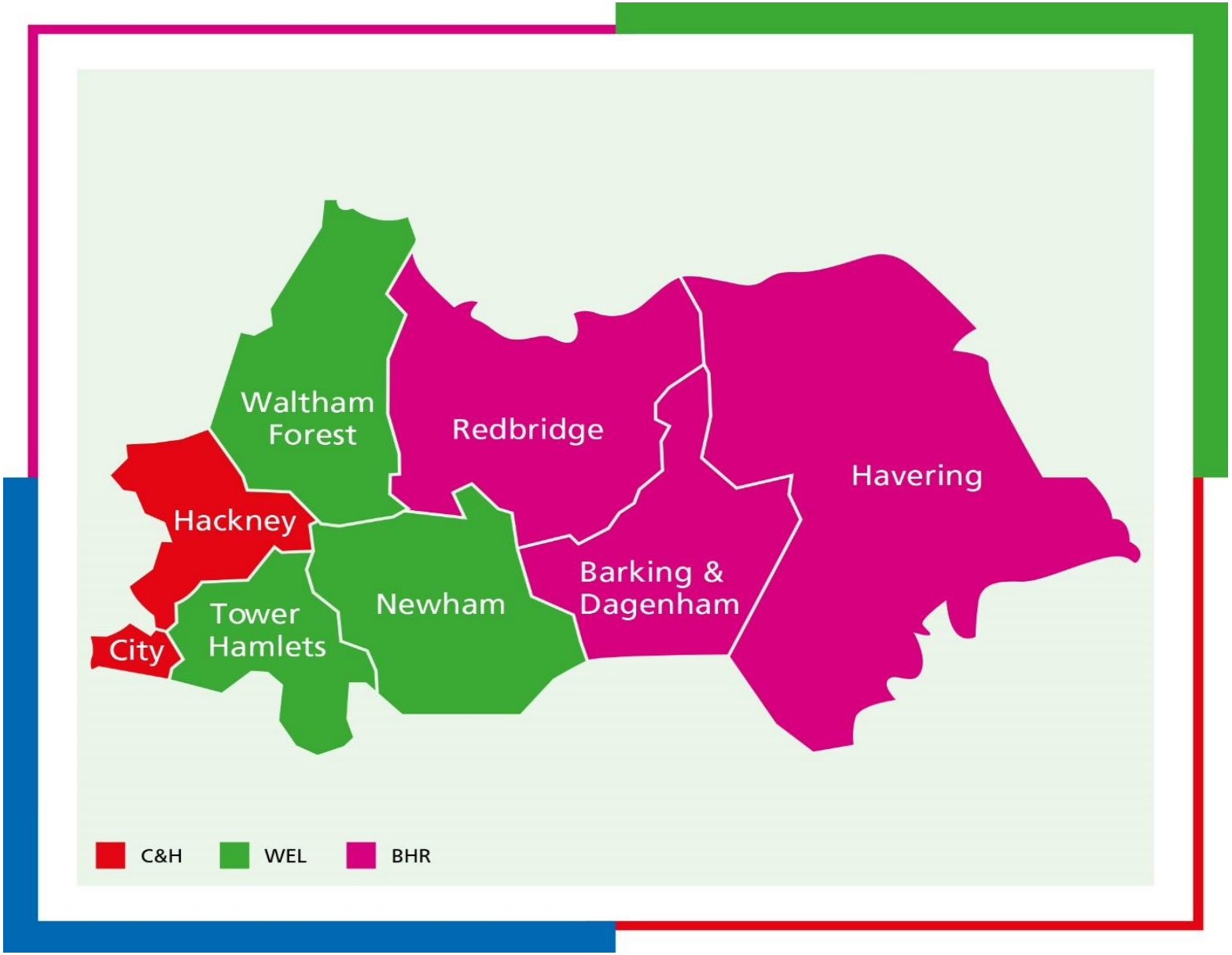
Priority areas for improving outcomes

System change and integration

Enablers

Our three Local Systems

East London Health & Care Partnership



Visual representation of how our system works

East London Health & Care Partnership

Our basic principle is that decisions about health and care take place closest to the resident/family as possible, and only where there is good reason to do so will programmes operate at NEL level.

We will need to recognise that NEL ICS will be the vehicle for Transformation Funding, and therefore need a governance process to reflect this going forward.

Programmes of work

East London Health & Care Partnership

Improving Population Health

- Prevention
- Health inequalities
- Wider determinants of health e.g. housing, poverty
- Personalised care

System Change And Integration

- Primary/community care
- Urgent and emergency care
- Improving planned care and outpatients
- Provider collaboration
- Mental health

Priority Areas for Improving Outcomes

- Cancer
- Learning disabilities and autism
- Children and young people
- Maternity
- Medicines optimisation
- Major LTCs
- End of life care

Enablers Supporting Work Programmes

- Workforce
- Digital
- Estates
- Demand and capacity – business intelligence
- Research and innovation

Improving population health

East London Health & Care Partnership

Population Health

Developing an ELHCP approach to population health will be a priority during 2020, with the following activities planned:

- An in-depth review into how we can strategically influence the development of new infrastructure, particularly around areas of significant re-generation, to maximise the population health impact. This will be brought through our ELHCP forums in January, with an STP Executive discussion planned for February.
- A review and re-launch of our prevention work stream through a workshop with Directors of Public Health during January.
- We will be bringing a proposed outline approach to population health to the STP Executive in March, taking into account best practice from national and regional work. There is also a planned engagement event in June, at which prevention and population health will be a headline topic.

Personalisation

- A review is currently underway to align the personal health budgets (PHBs) and social prescribing elements of the programme more closely. This will result in a new personalisation group across ELHCP from February, and there will be an event in March. We have also secured a resource from NHSE/I to assist us with this alignment going forward.
- A specific programme to improve the take up of PHBs in the BHR system will go live during January 2020, and it is hoped to extend learning from this initiative (with NELFT) at our stakeholder event.
- We propose an in-depth review of the personalisation programme at the April STP Executive.

System change and integration

East London Health & Care Partnership

Primary and Community Care

- Developed 48 Primary Care Networks (PCNs) across NEL
- Support by targeted organisational development and transformation funding
- Digital accelerator programme for WEL system established, as well as training hub board for PCN workforce

Improving Planned Care and Outpatients

- Range of improvement actions being implemented
- Performance vs constitutional standards (RTT/Diagnostics) challenged at BH & BHRUT.

Urgent and Emergency Care

- Current focus on managing winter pressures through funded support initiatives
- Ensuring grip during winter through VIPER meetings and following activities: working to right time/right place by digital assessment, bookings & communications, expanding appropriate care pathways criteria and further UEC integration testing.

Mental Health

- Good progress developing LTP for mental health and transformation plans via funding
- Challenges persist in achieving IAPT trajectories, CYP, out of area placements and perinatal access across parts of NEL

Priority areas for improving outcomes

East London Health & Care Partnership

Better start in life

- Mature local maternity system meeting national trajectories; no current midwifery vacancies
- Plans for ongoing CPD via cross-site rotational programmes to further support retention
- Review current/future activity across sites to develop sustainable maternity/neonatal service
- Children/young people's programme managing transitions into adult services priority for 2020 together with developing personalised care

Living well and long term conditions management

- Cancer focusing on smooth transition to new north east London operating model, but will need to ensure performance metrics return to trajectory during Q4
- Diabetes transformation funds successfully utilised, diabetes dashboard showing improvements across NEL on key metrics
- Cardiovascular prevention group in development, to share learning and support systems to prepare for STP-level transformation funding
- Medicines optimisation supported many transformation projects and plans greater links with primary care networks to enhance recruitment/retention of pharmacy workforce in PCNs.

A better end to life

- Local hospices to receive non-recurrent allocation of £875k to improve adults/children's end of life services.
- ELHCP match-funding bid for children's end of life care made to NHS E/I (awaiting outcome).

Enablers supporting work programmes

East London Health & Care Partnership

Workforce, Digital and Estates: ELHCP has well developed enabler programmes, with delivery across a range of initiatives. Main areas to highlight are:

- ***Digital:*** maximising impact of 'One London' investment will be priority area, as well as preparing organisations for introducing Patient Held Records
- ***Estates:*** introducing infrastructure plan and phased capital pipeline key priorities. Also ensuring development of health promoting environments at forefront of strategic planning approaches for NEL "new town" developments.
- ***Workforce:*** excellent progress implementing initiatives with stakeholders but scale of the recruitment and retention challenges remain significant with detailed STP Executive review in March 2019 and consideration to be given on how support and progress can be monitored on an ongoing basis given the importance of this enabler programme.

Demand and Capacity – Business Intelligence

- Strategic planning currently happening individually by providers, and the Provider Collaboration forums have identified that there is a gap at system level.
- A demand and capacity mapping across all of NEL has been agreed, commencing in January 2020 initially focusing on acute services and taking into account population growth projections for the next 10-20 years.
- This mapping will be expanded to mental health and community services over the next few months.

East London Health & Care Partnership

Metrics Reporting

Outline of metrics by programme area

The metrics are currently based on planned trajectories, existing baseline monitoring and tracking to begin in early 2020

Improving Population Health: Funding And Metrics

Ref	Measure	Area	Target	Compliant
EN1	Personal health budgets	PHB	Varies by CCG	Y
EN3	Personalised care and support planning	PHB	Varies by CCG	Y
EN2	Social prescribing referrals*	Social Prescribing	Varies by CCG	N

Enablers Supporting Work Programmes: Metrics

Ref	Measure	Area	Target	Compliant
ED21	Cybersecurity	Digital	100% by Y5	Y

* **Referrals below trajectory due to lower than expected forecast numbers of link workers in place. Review of recruitment and retention of link workers to take place, reporting to February ELHCP personalisation group**

System change and integration: Primary care and acute services metrics

Ref.	Measure	Area	Target	Compliant
ED16	Proportion population with access to online consultations	Pcare	75%	Y
ED20	Proportion population registered to use NHSApp	Pcare	30%	Y
EK3	Learning Disability Registers/Annual Health Checks by GPs	Pcare	75%	Y

Ref.	Measure	Area	Target	Compliant
EM23	Ambulance Conveyance to ED	Acute	TBC	N/A
EM24	Delayed Transfers of Care	Acute	National Level	Y
EM25	Length of stay for patients in hospital for over 21 days	Acute	TBC	Y
EM16	Mental Health Liaison in general hospitals meet “core 24” service standard	Acute	70% in 23/24	Y

System change and integration: Mental health metrics

Ref.	Measure	Area	Target	Compliant
EA3	IAPT roll-out *	MH	50%	N
EH9	Access Children/Young People's Mental Health Services	MH	Varies by CCG	Y
EH12	Inappropriate adult mental health Out of Area bed days	MH	0 from 2021/22	Y
EH13	Annual physical health check in severe mental illness	MH	60%	Y
EH15	Women accessing specialist perinatal mental health service	MH	TBC	Y
EK1a	Inpatient care learning disability/autism: CCG commissioned	MH	<30	Y
EK1b	Inpatient care learning disability/autism: Sp Com commissioned	MH	<30	Y
EK1c	Inpatient care learning disability/autism: CCGs/NHS England for children	MH	15 children <30	Y
EH17	People accessing Individual Placement and Support	MH	TBC	Y
EH18	EIP Services achieving Level 3 NICE concordance	MH	95% by 23/24	Y
EH19	People receiving new models integrated primary/community care for severe mental illness	MH	Varies by CCG	Y
EH20	24/7 crisis provision for children and young people	MH	100% by 23/24	Y

* **Review of prevalence to take place, as NEL has higher prevalence and greater IAPT trajectories based on most recent calculations. Appraisal and benchmarking of NEL IAPT services (finance and service model) to be undertaken, including benchmarking against other services, to understand variance against trajectory.**

Priority areas for improving outcomes: Metrics

Ref.	Measure	Area	Target	Compliant
ES1	Patients directly admitted to stroke unit within 4 hours	Acute	80% 23/24	Y
ES2	Applicable stroke patients are assessed at 6 months*	Acute	>60% 23/24	N
ER1	People supported by NHS Diabetes Prevention Programme	Diabetes	Varies by CCG	Y
EP1	One Year Survival from Cancer	Cancer	Set by CA	Y
EP2	Proportion of cancers diagnosed at stages 1 or 2	Cancer	Set by CA	Y
EQ1	Still birth rate	LMS	TBC	Y
EQ2	Neo-natal mortality rate	LMS	TBC	Y
EQ3	Percentage of women placed on a maternity continuity of care pathway	LMS	TBC	Y
EQ	Brain Injury Rate	LMS	Undefined	Y

* **It is expected that there will be compliance against this trajectory from 20/21 onwards. There will be a review of reporting on this metric via the stroke database (SNAP), as well a review of post-discharge stroke pathways and service capacity, to provide assurance of future compliance against this metric.**

WORK IN PROGRESS

BLMK
Integrated Care System

Living longer in good health

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

Introduction

What's this about?

The organisations responsible for health and care in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes are working together to develop a plan for the next five years, responding to the NHS Long Term Plan[1] that was published in January 2019. At the heart of the plan is making sure that you get the care you need, when you need it.

Our ambition - why we've written this plan and what it means for you and your family

The purpose of our plan is to improve our services so that it's easier for you to manage your own care as much as possible. When you do need us, we want to make sure that you can get an appointment quickly, with the best person to help you in a place that is near to where you live. This will also help our hospitals work better, so that if you or your family needs specialist treatment, we can get you seen and treated without delay.

[1] www.longtermplan.nhs.uk

Making the best use of our skills and resources

Since 2016 hospitals, clinical commissioning groups, GPs, community and mental health trusts, ambulance trusts and local councils in Bedfordshire, Luton and Milton Keynes have been working more closely together. This means we can contribute better to the overall health and care needs of the people we serve and get the most out of the skills and resources we have available.

We share a common purpose – we want people to live longer in good health. When people need care, we want them to get the very best available. To do this we need to look after our staff, recruiting and retaining the highest quality people. And we have a duty to spend public money wisely on services that will make the biggest difference to local people.

Our priorities for the future are very much in line with those set out in the NHS Long Term Plan. We've talked to colleagues to understand and learn from them about what is working well. But most importantly, we've talked to you, local people, to find out what matters most.

One of the biggest changes we're making is to create teams of health and care professionals who will work with GP practices and with community and mental health services, social care workers and volunteers to provide more tailored services in your area.

We want to work with communities to help people stay healthy and well

Factors such as good jobs and housing affect our physical and mental health, so while we need to look at how we can continue to improve local health services, we can't do this alone. This is why the NHS, your local councils and other organisations are working more closely together than ever, to really make a difference.

We know that local people want local services, and so local health and care providers are planning to work together to break down barriers and make it simpler for you when you are in need of help.

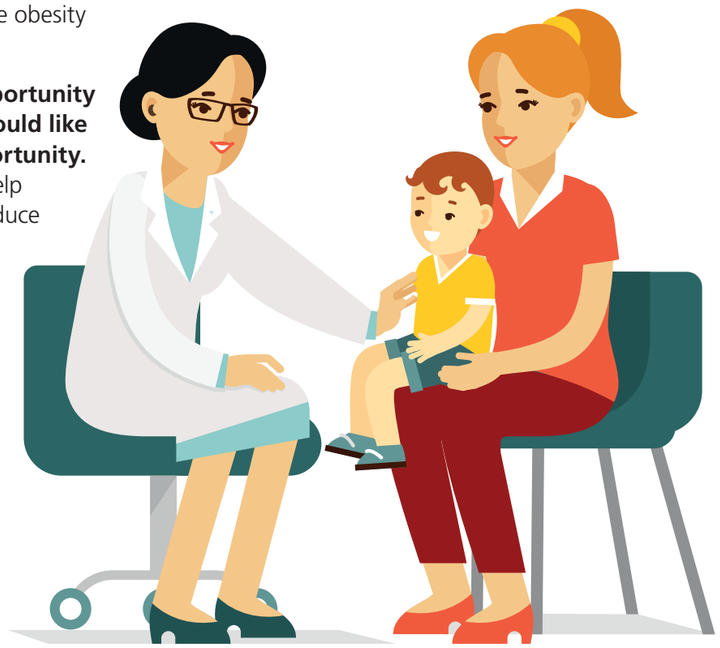
These are ambitious plans and we're excited about the positive improvements we'll be making for you and your family. Over the next five years we will continue to work with you to shape our future together.

What you have told us is important to you and your family

During the course of this year we have listened to local people, supported by local Healthwatch[2], to get a better idea of what's important to you and what you think we could do better.

We know that people want to keep local services and to access healthcare when they need it. Here are some common themes we've heard:

1. **You want to access local services, like GP services and hospital referrals, quicker.** People would like to get appointments sooner, with 80% of people we surveyed saying improved access to GP services was the most important thing.
2. **Improving mental health services for both children and young people and adults should be a priority.** People of all ages should be able to get the help and support they need quickly and easily.
3. **You would like more support and information to help you lead a healthier life.** Our communities want to be healthier, but need support to tackle things like obesity and diabetes.
4. **New technology provides an opportunity to improve people's care. You would like us to make the most of this opportunity.** By investing in technology we can help people access services online and reduce the pressure on our services.
5. **Our staff are excellent, but stretched. Therefore, we must recruit more people to work in health and care.** To provide high quality, compassionate and person-centred care we need to recruit new people to work in the health and care sector, as well as do more to retain our existing workforce.
6. **You don't want to have to repeatedly tell your story to different health and care staff.** You want your care to be better coordinated across the different staff group, organisations and services and for us to use technology to help us do this.
7. **When people are diagnosed with cancer, they want to feel confident they can access better information and support.** People recognise that treatment and care after diagnosis works well but they would like to see improved information to help them make informed choices throughout their diagnosis and treatment.



[2] https://www.healthwatch.co.uk/report/2019-09-04/what-people-have-told-us-about-health-and-social-care-april-june-2019

Living longer in good health

Bedfordshire, Luton and Milton Keynes Longer Term Plan

We have been out and about asking local people what their future NHS looks like and what would help them to stay as healthy and well as possible. Here are some of the things you told us:

The big issues we currently face as a local health and care system

The NHS has for some time been challenged by a number of big issues. These are slightly different depending on where you are in the country. Across our region we are working hard with partners to face these big issues head on.

Almost one million people live in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes, one of the fastest growing areas in the country. The characteristics of these different places affect what local people need from their health and social care services.

With a 20 year gap in life expectancy and healthy life expectancy, more people will mean more care will need to be provided. Without action now, keeping people healthy and happy in the future will be much, much harder.

Some specific challenges we have are:

We have a growing population. Our population could increase by nearly 90% by 2050. This would include an 80% increase in the number of children and young people, a 70% increase in the working age population and nearly 150% increase in the population aged over 65. We need to make sure we have the right health and care services in place to support this.

More people are living with long term health conditions, such as diabetes and arthritis that cannot be cured but can be effectively managed. The quality of healthcare that people receive and their general health and wellbeing varies.

We have considerable health inequalities. A baby girl born in Central Bedfordshire today can expect to live for 84.4 years, over 6 years longer than a baby boy born in Luton (78.3 years).

The number of people seeking treatment at our A&E departments continues to rise and this places pressure on ambulance and hospital providers. Our plans are aimed at supporting people to seek appropriate treatment and only attending A&E departments when really necessary.

We could be doing better on circulatory and respiratory diseases. Coronary heart disease admission rates are higher than nationally in our area. Hospital admissions for asthma in under 19s are high in Milton Keynes. Admissions for cardio-pulmonary disease are high everywhere except Luton.

We are also facing workforce shortages and significant financial pressures. We can't continue to provide both the high quality and wide range of services we do today without making changes; to work smarter and more efficiently to get better value for every pound of taxpayers' money.

We need to make sure we can meet these challenges head on and that is why we have put together this plan, which shows what we will change over the next five years and what difference it will make to you and your family.

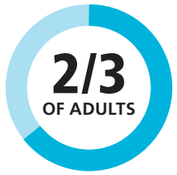
Living longer in good health

Bedfordshire, Luton and Milton Keynes Longer Term Plan

People are living on average as much as 20 years in poor health (the gap between healthy life expectancy and life expectancy).

Only 45% of people using social care in BLMK feel they have as much social contact as they would like.

In the most deprived areas of Luton and Bedford Borough, two thirds of children are living in poverty.



Two thirds of adults in BLMK are overweight or obese.

Almost 1 million people live in Bedfordshire, Luton and Milton Keynes

4 local councils

3 acute hospital trusts‡

3 clinical commissioning groups*

3 community health providers

2 mental health providers

2 ambulance trusts

102 GP Practices

22 Primary Care Networks (PCNs)

‡ Bedford Hospital and Luton & Dunstable Hospital will become Bedfordshire Hospitals Foundation Trust in April 2020
* The 3 CCGs will create a single, new CCG in April 2021

Our goals – what we want to achieve

We recognise that getting the fundamentals right will help us successfully deliver the rest of our five year plan. There's lots of things we can do, but we think these are four of the most important:

1. **Making sure that every person in Bedfordshire, Luton and Milton Keynes lives as healthy a life as possible, for as long as possible:** People living in some parts of our area currently suffer significantly poorer health than others and on average, tend to die younger. We have to do something about this.
2. **Making sure we're there for you when you need us most:** Sometimes people can't get the right appointments quickly, or they have to wait too long to see a specialist. And then they have to tell their story over and over again. We have to make our services work better together.
3. **Making sure that Bedfordshire, Luton and Milton Keynes is the best health and care system to work in:** In order to look after you, we need to look after our people. If we can help them to work better together and feel more supported, they'll be better able to give you consistently high standards of compassionate care.
4. **Making the most of our funding:** The NHS Long Term Plan provides future investment into local services which, for our area, means we have an extra £234 million over the period of the plan, including an allowance for inflation. By achieving our six changes (see next section), we will be making the best use of public money and ensuring as much money as possible goes into patient care.

Our top six changes for helping you live longer in good health

As you'd expect, our plan is extensive. There are lots of things we need to do differently to make a positive change to the health and care services you and your family can access. The biggest of these are set out here. They are our top six changes and they're aligned to the promises set out in the NHS Long Term Plan.

1. Creating opportunities for you to see a range of staff in your community, offering you more coordinated and personal care
2. Improving the way our hospitals work so you get faster treatment in an emergency and don't wait too long for an operation or other hospital care
3. Giving you better information and support to help you stay well and manage illness sooner
4. Giving you choice and control over the way your care is planned and delivered
5. Making sure the right people are there to support you
6. Getting the most out of technology

1 Creating opportunities for you to see a range of staff in your community, offering you more coordinated and personal care

Our GPs, nurses, social workers, mental health workers and other staff need to work together, in teams, in the community to better meet your needs. This means you will be able to see the right person, when and where you need to and your care will be better organised to meet your individual needs.

Many of you have told us that you'd prefer to be cared for at home as much as possible, near to your family and friends, rather than having to be in hospital or residential care. In order to make this happen we need to spend more money on your local GP and community health services. In the last year or so, many of our GP practices have provided evening and weekend appointments so that working families can see a GP at a time to suit them. Over the next four years we'll be continuing this investment and introducing some new approaches.

Since July, we've created 22 teams of different health and care staff across BLMK who are now working more effectively together to meet your health and care needs. These teams are called Primary Care Networks (or PCNs). They are led by local GPs and include Nurses, Physiotherapists, Mental Health Workers, Pharmacists, Social Workers and others. There are lots of advantages to working in this way, one of which is that you don't have to repeat your story time and time again and our teams of staff are quicker at gathering the information they need from you and others to organise your care. As these teams have only been in place for a short period of time, you might not be aware of these changes in your own GP practice. **Over the coming years we plan to further develop these PCNs and the staff who work in them.**

Here are some examples of the changes you can expect to see in your local PCN:

From 2020 you'll be able to see a **clinical pharmacist**, who will use their specialist knowledge of medicines to assess and treat you as needed. There will be staff who can provide you or your family with mental health and wellbeing support when needed. There will also be **social prescribers**, whose job it is to connect people, especially the more frail and vulnerable, with non medical support, day centres, charities or community groups to improve wellbeing and help tackle loneliness or social isolation.

Further support in PCNs will continue and from 2021 this will include **physiotherapists who have completed extra orthopaedic training** to enable them to support you and your family with injuries or illnesses involving muscles, bones or joints. In some instances, you'll be able to self-refer to see these staff and in others, you might be directed by key staff. You'll see new staff, such as **Physician Associates**, who are trained to do some of the work of your GP and some of the work of the Practice Nurse, like examining you, interpreting your test results and diagnosing what's wrong.

By March 2022 we'll introduce the **Advanced Paramedic Practitioner,** who will be there to support 'same day clinics' for minor illness and injury, assessing and treating you as required, as well as carrying out health check reviews and home visits on behalf of your GP.

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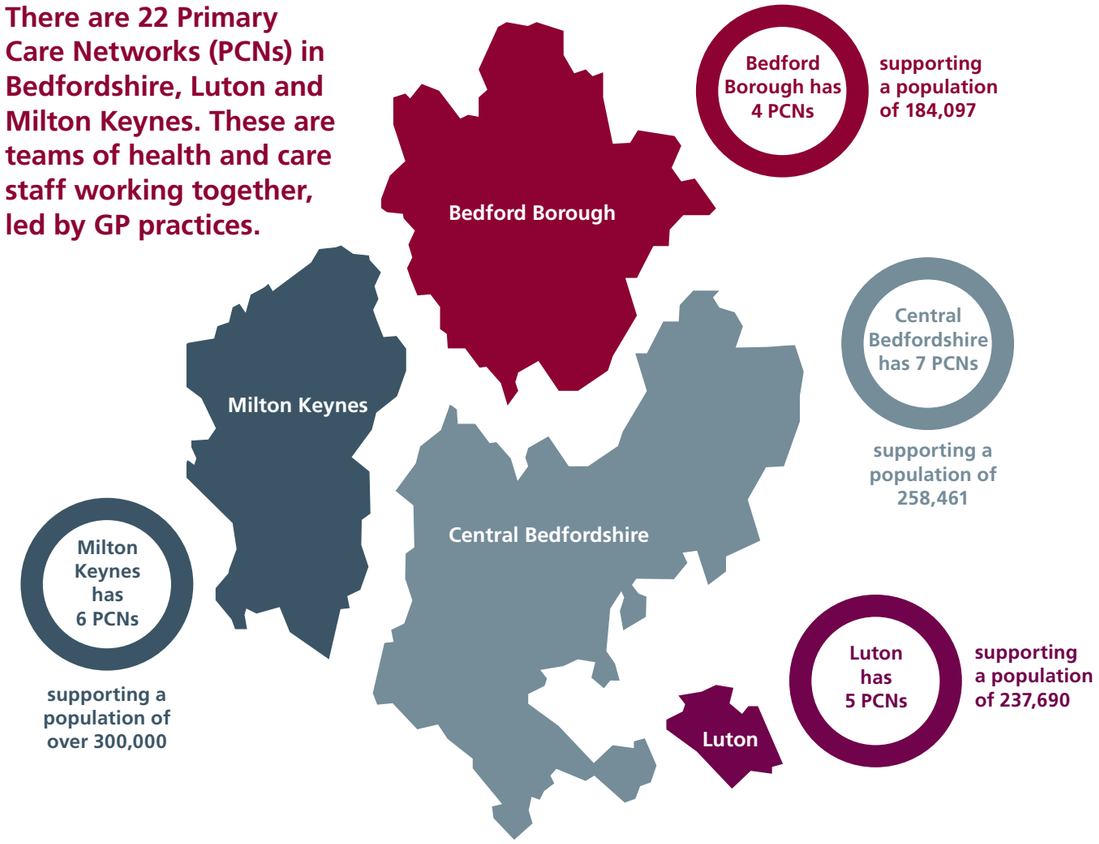
There are 22 Primary Care Networks (PCNs) in Bedfordshire, Luton and Milton Keynes. These are teams of health and care staff working together, led by GP practices.



You will also see the introduction of some new ways of working to get you the support and help you need quicker.

About half of our GP practices already offer online consultations and this will become more widely available during 2020. The opportunity to talk to a GP via a telephone appointment will also continue and expand. We are testing video consultations in some of our practices, so you can talk to a GP 'live' from home, without having to come to the surgery. This will become more widely available during 2020. And for some patients with particular Long Term Conditions we'll be testing group sessions in the practice to help manage diabetes, high blood pressure and similar conditions, as well as ensuring these patients always see a GP and are offered longer appointments.

We are planning to introduce an urgent service for people who need crisis support at home, so we can prevent them from being admitted to hospital, unless it's necessary. This will mean that by 2022 if you or your family are clinically judged to need urgent care from our community services, we'll see you at home within two hours. If you then need further services to help you return to daily life, we'll provide this within two days.

And for people who live in Care homes, there'll be extra support to help them manage what is often a wider range of health needs, meaning faster and more effective help from a range of staff according to need. This support will be available to all BLMK care homes by 2021.

2 Improving the way our hospitals work so you get faster treatment in an emergency and don't wait too long for an operation or other hospital care

At the moment when people can't see their GP when they want to, they sometimes go to A&E. This means that our hospitals slow down and planned operations can sometimes get cancelled while we deal with more emergencies. We need to reduce the pressure our hospitals are under and that's why we're investing in more opportunities for you to see the right health staff in the community. This will help our hospitals work faster and better and ensure you get the treatment you need more quickly and conveniently. Here are some of the things we have started and will be rolling out:

Making sure that everyone across BLMK gets the same access to the NHS 111 service. We want to make sure that, where appropriate, you can access our Clinical Advisory Service or CAS for short. This is a telephone service run by GPs, Clinical Advisors, Nurses, Paramedics, and Pharmacists which allows you to talk directly to a healthcare professional from the comfort of your own home. If necessary, you will be booked directly into an appointment with your own GP surgery.

We're currently working to extend this service more widely in care homes, so that staff there can speak with a clinician at any time, day or night. We want to ensure that this service is available to all care homes across BLMK. We believe this will help support care home residents better, so they're don't have to go to hospital unless necessary.

We will improve the way you are managed when you arrive in A&E. You will be greeted by a healthcare professional who can quickly decide which one of our urgent services is best for you, whether this is one of our Urgent Treatment Centres, Urgent GP Clinics or Same Day Emergency Care services or whether you'll need to be seen in A&E. This will ensure you get the treatment you need, in the quickest and most appropriate way. We also plan to improve the availability of emergency ambulance services across our area, ensuring delays are minimised. We'll make sure that when you don't need to go to hospital, you can be treated at home or where the emergency has occurred.

We'll also ensure you get the latest up to date information about where and when you can access Urgent and Emergency Care services. This will help everyone to use urgent and emergency services more effectively, so that our hospitals can continue to treat you and your family quickly in an emergency and routine operations and procedures aren't cancelled unnecessarily. Soon we will extend our Same Day Emergency Care service, enabling you or your family to be treated on the same day, without the need for admission to hospital.

We want to make sure you don't wait any longer than necessary for an operation. We recognise that waiting for an operation for too long can have a negative impact on your health and wellbeing. When this happens it impacts the rest of our service as more people end up needing extra support while they're waiting, like prescriptions for pain relief, time off work and sometimes even having to go to A&E for emergency treatment.

We're increasing the amount of planned operations we do, year on year, so that we can reduce the long waiting lists and speed up the time it takes for you to get your operation (currently a maximum of 18 weeks from when your GP first sent you for a specialist opinion). As well as this, we're improving the way we keep you up to date with information about how long you'll have to wait, so that when your GP refers you, you'll know straight away how long it's going to be before your operation.

We understand that waiting for treatment is difficult for everyone. None more so that those diagnosed with cancer and to this end we want to ensure that everyone in our region receives the best possible care in the unfortunate event of a cancer diagnosis. This includes ensuring consistency across primary care so that everyone with an urgent two week cancer referral is seen by a cancer specialist within this timeframe.

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3 Giving you better information and support to help you stay well and manage illness sooner

In future we need to do more to reach out to people who we know are likely to be at greater risk of becoming ill, or those whose health might deteriorate to the point where they need hospital care.

We want to help you reduce your risk of developing avoidable health conditions by enabling you to make healthy choices where possible e.g. by stopping smoking, being active or staying a healthy weight. However we recognise that your health is influenced by many things such as where you live and work, so support will be tailored to your needs and help you make the best possible choices. Public services don't have all of the answers so we will work with communities to help you and your family stay well and healthy e.g. to reduce social isolation and loneliness.

As well as this, we want to ensure that anyone at risk of developing health conditions, is identified and supported as early as possible. We have a lot of information available to us. By using this data better, we'll be able to spot people who might not realise they have conditions like High Blood Pressure, Diabetes or Stroke, so that together we can support you to manage your health. You can help us by taking up any offer of screening or immunisations.

Modern technology provides us with new ways to provide this kind of proactive care such as helping you to monitor your own health and share information with those supporting you.

As a result, we expect you will have greater confidence in managing your own health and there will be less variation in treatment and outcomes for people with conditions such as cardiovascular disease, respiratory disease and cancer.

We also anticipate that fewer people will need to attend or be admitted to hospital as they will be skilled at looking after themselves when appropriate. This reduces pressure on our system, so that care can be provided for those who need it most.

4 Giving you choice and control over the way your care is planned and delivered

You've told us that you think you'd benefit from care that is built around your individual needs and that you'd like support to build the knowledge, skills and confidence to manage your health conditions and improve the way you live. We want to help support this, so we've developed a range of measures that will give you more choice and control over your health and care needs.

The first of these is a process to give you support from your clinician to take decisions, choose tests and treatment options based on evidence and your personal preferences. We will build on this **'shared decision making'**, initially focusing on people with Chronic Obstructive Pulmonary Disease but extending this to include people with mental health and learning disabilities and those with long term conditions such as cancer, diabetes and stroke. We will also use this approach for people with frailty and those at the end of their life.

Other support includes questionnaires that help us understand your level of knowledge and confidence about your long term condition. This helps us support you in developing your own capability to manage your health and care, giving you tailored information and support you can act on. This is known as a **Patient Activation Measure or PAM** for short. Linked to this we are using more and more **social prescribing**, which is when we refer you to a range of local non-clinical services to help improve your health and wellbeing.

Personal Health Budgets are an amount of money to support your health and wellbeing and are available to adults who are receiving NHS funded long term health and personal care outside hospital. We've now made these available for wheelchair users and will be expanding this to more people across our area. These approaches are collectively called a **Comprehensive Model of Personalised Care.**

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5 Making sure the right people are there to support you

Demand for health and care services is growing, largely as a result of there being more people in our area and that generally we are living longer. To properly meet this growing demand we recognise we need to do things differently in the way that we recruit, train and retain our people. This includes improving the working lives of staff, so that people feel more supported at work and better able to balance the challenges of their working lives with those they may face at home.

In order for our staff to continue to offer compassionate, responsive and understanding care and to develop a more joined-up, personalised approach, we need to value and invest in our staff through the delivery of a workforce plan that enables health and care staff to work as teams around local communities.

We will require not just continued growth in our workforce, but also a shift in our thinking and the way in which we train and compose our teams in health and care settings. We do need 'more', but we also need 'different'.

Different will mean there will be much stronger links between integrated health and care teams within Primary Care Networks. There will be new roles and existing staff will increasingly develop skills that support joined up approaches. We will release staff time to care as technology and scientific innovation transforms care pathways.

Here are some of the key things we've already started to do:

Growing our own people; by engaging better with local schools and colleges to attract young people as they consider careers and at recruitment fairs and local initiatives for those seeking a change of career. We want to make sure there are opportunities across a broad range of levels, so anyone who wants to join us has the chance to do so. We are offering job guarantees following successful completion of local training programmes.

Addressing our workforce shortages; we have challenges across many of our health and social care roles and our initiatives to recruit, train and retain staff are targeted at all health and care staff. We are taking a specific focus on key areas, including addressing nursing shortages, with current vacancy rates averaging at 14%. We will attract more nurses through nurse cadet schemes and creating ambassadors for nursing within local schools. We are also increasing the number of clinical placements available for students. With GP vacancies at 10-12% we are also supporting new GPs with coaching, mentoring and training opportunities and more varied job roles.

Supporting and developing our staff; we are focusing on making our organisations the best place to work through offering flexible ways of working, more opportunities for training and development and staff health and wellbeing services. We are also attracting those who have left health and care jobs to return and recruiting, where we can, from overseas. We are developing rewarding roles that enable staff to develop more integrated care skills and rotate across services. This includes rotational health and social care apprenticeships, paramedic rotations across ambulance and GP services, specialist children's nurses working across hospital and community services and cancer care teams offering mobile lung checks and working alongside GP and community teams. We will also support our staff with the skills to work with evolving technologies, which enable teams to share information and work more effectively to support care needs.

We are developing a range of new roles including:

- Physician Associates, who are trained to support our doctors. As well as carrying out some patient examinations, they are able to interpret test results and diagnose illnesses.
- Nurse apprenticeships and nurse associate roles are two new ways of getting into nursing, working with registered nurses and healthcare support workers to care for a wide range of patients in different settings. Our numbers of nurse associates in training will increase to 91 within 2020 and we are also growing support roles within maternity and within mental health services, such as Peer Support Workers.
- Advanced care practitioners are existing professionals from a range of traditional backgrounds such as pharmacists, nurses paramedics or occupational therapists, who undertake further education so that they have more skills to support local communities.

All these new roles, together with a greater focus on training and development, will mean our people are even better equipped to support patients, in some instances freeing up other professionals like GPs, to concentrate on those with more complex health needs.

Improving our culture and leadership by creating a more supportive environment for our people. This will include the introduction of a new 'Leading Beyond Boundaries' programme to strengthen and support healthy, inclusive and compassionate leadership at all levels. As part of our shared learning, we have already started to create opportunities for our clinicians to meet and discuss key issues. We will evolve this over time to create clinical networks bringing together local clinicians to shape future working, based on their own experience and industry best practice.

Looking after our people better, using our staff in the right way to make the most of their skills and expertise will ultimately help us give you the best possible treatment in whatever setting you may need our care and support.

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6 Getting the most out of technology

Our lives are all now heavily influenced by advances in technology and innovation and in health and care we know that there are constantly new ways in which we can support you, your families and our own people to improve the services we provide. In the next five years there will be new and exciting changes in IT, but in the meantime we want to harness the best of today's technology to improve the way we communicate between our hospitals and GP practices, the information we share and the speed with which we can respond to your needs.

Importantly, we want to ensure you are involved in your personalised health care plan, adding in details of how you prefer to be treated and monitoring your own conditions and alerting your doctor or community nurse if there's a problem. We also want to make sure that the treatment we're providing is consistent, has worked to make you better, and is good value for money.

Some of our other priorities include:

- **Hospital based health care staff being able to write in your notes**, so your GP or other community health professional can see relevant details about your care and treatment.
- **In an emergency, all healthcare staff being able to see an extract from your GP record**, so they can make faster and more accurate clinical decisions.
- **We're currently testing remote monitoring of high-risk residents in care homes,** so we can act quicker when there's a problem.

We're already setting up systems so you can get advice from your GP practice via an online consultation and we've recently introduced a new app for outpatients at Milton Keynes University Hospital. This allows you to view and amend your appointments and access other information. We will be looking to expand this offer across our other hospitals. In Luton a pilot with care homes is testing the adoption of a remote monitoring app for the most vulnerable patients to identify and treat health issues earlier, thereby reducing unnecessary admissions to the Emergency department. Early indications suggest this has reduced attendances at A&E in this area by 17%.

All these innovations will help us to support you and your family, creating a single digital care record for all health and care organisations, so that you don't need to tell your story time and time again and we can provide you with more joined up care.

Improving Care for Major Health Conditions

As well as the big changes we've set out above, we're also taking action to improve care for major health conditions, such as cancer, diabetes, stroke and mental health, and for people at key stages of their life. These include:

- **Improving uptake for bowel, breast and cervical screening programmes** to reduce the number of people diagnosed with cancer at a late stage. This will improve survival rates and provide faster cancer diagnosis, with most people receiving a definitive diagnosis that will confirm or rule out cancer, within 28 days of referral.
- **Establishing three new mental health support teams** to work in schools and colleges. They'll support children and young people who may be experiencing mental health issues to get the right support, so that they can stay in education.
- **Expanding mental health services** to provide earlier intervention and support for mothers from pre-conception to 24 months after birth, and further support for their partners, to prevent problems escalating into a crisis situation.
- **Taking a proactive approach to identify people with high blood pressure** and provide supported self-management to control this. This will mean a better experience, reduced risk of heart failure and stroke, and fewer unnecessary visits to hospital.
- **Introducing multi-disciplinary respiratory hubs** to identify and manage complex respiratory disease closer to home, and improve outcomes. This will include improved quality of diagnostic tests, increased uptake of vaccinations (influenza and pneumonia) and increased uptake of Pulmonary Rehabilitation.
- **Developing stroke services** so there is consistent access to high performing stroke units and rehabilitation, so people have the best chance of long-term recovery with the possibility of living independently.
- **Providing universal access to structured education,** both face-to-face and digital, to help people with Type 2 Diabetes manage their condition, according to their individual needs and preferences, which means they are likely to have fewer complications, and need fewer visits to their GP or hospital.
- **Ensuring health, care and therapeutic services work better together** and have the capacity to meet the needs of children and young people with special educational needs.

Living longer in good health

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How will we pay for this?

Under the NHS Long Term Plan published in January 2019, the NHS will receive increased funding of £20.5 billion per year by the end of five years. Under this deal, funding for our local area is increasing by between 3.2% and 4.4% per year over the period of the Long Term Plan which is greatly welcomed.

This will enable us to invest in the priority areas identified in the NHS Long Term plan (local GP and community services, mental health and cancer) as well as target funding towards local needs.

The increased funding will enable us to deliver services better and smarter by investing in technology, prevention, earlier intervention and treatment.

What happens next?

Some changes will take longer to implement, particularly those that address long-standing health inequalities across our area.

This plan is designed to be live and agile, helping us to drive continual improvement. We recognise we won't get everything right first time – but we will ensure that we test and learn from different approaches elsewhere and challenge our understanding of what we can do here.

We have a responsibility to work together to respond to the challenges we face so that by 2024 people's health and wellbeing in our area is better, our health and care services are better, and we get better value for money.

As we have used your feedback to help guide and develop our plans, we want to continue to involve you as we develop more detailed plans to help us achieve what we have set out in this Longer Term Plan.

You can find out more about our plans for the future by watching this short animation: Together we can grow a healthier future for everyone.
If you have any feedback please share with the Healthwatch in the council area you live.

BLMK
Integrated Care System