Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Living a longer, healthier life

Bedfordshire, Luton and Milton Keynes Joint Forward Plan

This document has been produced in collaboration with partners from across the BLMK health and Care Partnership.

All the Health and Wellbeing Boards in BLMK have agreed that the JFP is a fair representation of the Health and Wellbeing Strategies.

Bedford Borough Council

Central Bedfordshire

Luton

Milton Keynes City Council

Cambridgeshire Community Services NHS Trust

NHS East of England Ambulance Service NHS Trust

NHS Bedfordshire Hospitals NHS Foundation Trust

NHS Central and North West London NHS Foundation Trust

NHS East London NHS Foundation Trust

NHS Milton Keynes University Hospital NHS Foundation Trust

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Foreword from BLMK ICB Accountable Officer

Welcome to the Bedfordshire, Luton, and Milton Keynes Integrated Care Board Joint Forward Plan.

The BLMK Joint Forward Plan is the start of the journey we must make together if we are to enable more people to stay well throughout their lives.

Our aim is to increase the years of healthy life that every one of our residents have – adding life to years, not just years to life.

To achieve this, we must **change how we work**. We need to collaborate and co-ordinate with all our partners. That starts with Bedfordshire, Luton and Milton Keynes residents. It includes community networks, the voluntary sector, employers and all our public services. The result should be that no matter where you live in our area, you see and feel the benefits of health and care services which are working together to deliver better services.

The NHS was created 75 years ago to help people who have ill health. We still do that, but we now need to do more, focusing on preventing people becoming unwell in the first place.

Prevention means working in a way that fits with people's lives, making sure that the services we offer are as easy as possible to navigate. They need to be effective and efficient, offering the right support at the right time. To do this we need to work with other services, especially our local council partners and our residents, to address the 80% of things which affect everyone's health, not just the 20% which are affected by the NHS.

We are at the start of this way of working, and we are excited about its potential. This Plan outlines our approach and the change that we as partners in the ICB want to make. In the NHS, long-term tends to mean 5-10 years. However, we believe that this work should look to 2040 and beyond, and this is reflected in our plans.

In this document, you will find what we are doing in collaboration to help keep you healthy, and how we are listening to our communities to root out health inequalities wherever we find them. We also set out our longer term, strategic programmes and the things that make them happen.

This Plan is based on the health of the whole person, rather than specific organisations or clinical specialities. Our commitment is to work as close to residents as possible, something we call subsidiarity. That means building change together with you, co-producing services so that residents' voices are heard, and acted upon, every step of the way. That can only be a good thing.

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We will measure how interventions have better enabled residents to live fulfilling lives. This is all about measuring how you are and your health outcomes. This work should result in fairer access and outcomes across the population.

The changes involve both how we work and what we are trying to deliver. It promises better outcomes for residents across Bedfordshire, Luton and Milton Keynes, and that's what really matters.

In the Plan you will find out more about the issues we are trying to tackle, how we intend working with our partners to keep people healthier, and how we want to improve outcomes and tackle inequalities for our residents. We give a big-picture overview of what we are intending to do. We will, over the rest of this year, work with residents and partners to set out further detail on how, together, we will achieve these ambitious changes.

Finally, your involvement matters so much. If you want to get involved in our ongoing work, please contact blmkicb.communications@nhs.net. We would love to hear from you.

Dr Rima Makarem
Chair - BLMK Integrated Care Board

What is a Joint Forward Plan?

Every Integrated Care Board (ICB) in England is required to develop a Joint Forward Plan. It must set out how the Councils, NHS, wider public sector and voluntary organisations intend to arrange or provide our services to meet their population's physical and mental health needs, and tackle inequalities.

The purpose of the Plan is to bring together all the operational and strategic plans for the partners of the ICB to:

- Deliver our Integrated Health and Care Strategy to improve health outcomes and tackle inequalities;
- Deliver our strategic objectives in accordance with the statutory requirements of ICBs, including supporting our partner NHS and Local Authority organisations to deliver their own mandates;
- Delivery the health service's objectives set out by NHS England; and
- Provide a medium-term view of how these will be delivered, for a minimum of five years.

The Joint Forward Plan is the medium-term, over-arching Plan that sets out how ICB partners will work together to support our communities to thrive.

Our four pillars

Every ICB has four core purposes, which we call our pillars. These are:

- Improving outcomes in population health and healthcare;
- Tackling inequalities in outcomes, experience and access;
- Enhancing productivity and value for money; and
- Helping the NHS to support broader social and economic development.

Helping to overcome difficult challenges

The Joint Forward Plan does not replace individual organisations' own strategic and operational plans. It covers areas where we need to work together to overcome difficult challenges. If we can do that, we will better deliver the outcomes to enable our residents to live more years in good health.

This Plan sets out our most complex, important, and stubborn challenges. We need to tackle them together to make a real difference to our communities and help us to deliver services with our available resources. It brings the direct voice and experiences of residents too, particularly through the Healthwatch and elected councillors, without which we cannot tackle known health inequalities across BLMK. Our Joint Forward Plan also summarises how the ICB partners will adapt to deliver our shared Target Operating Model – that's how we organise ourselves together as a partnership.

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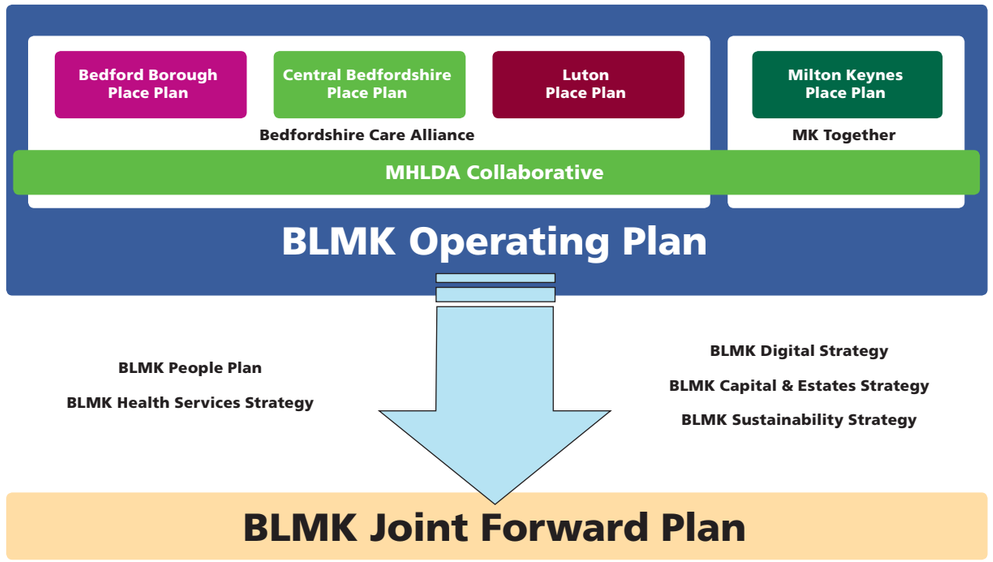
Putting residents at the heart of our Plan

We are committed to making sure the voice of the resident is heard, and that's why we've been listening to residents across BLMK to inform what this Plan presents. Our Joint Forward Plan is centred on the resident. Our focus is on the needs of our communities in each of our four Places. These are Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.

The Integrated Health and Care Partnership

The Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Health and Care Partnership is made up of locally elected councillors, NHS and council chairs, Healthwatch, Voluntary, Community and Social Enterprise Organisations and wider public sector partners, such as police, fire and criminal justice representatives. It brings together the needs of all our residents, as identified in each Borough's Joint Strategic Needs Assessment, with the strategic priorities of each Place's Health and Wellbeing Board. As our ICB matures, the role of the Integrated Health and Care Partnership will be to hold us account.

The Joint Forward Plan is a medium to long-term strategic Plan. As such it integrates several other strategies and operational plans. This is a complex relationship, summarised below:



The experience of residents

With so many relationships between organisations, it is no surprise that some residents find health and care services to be fragmented. Residents rightly express frustration at having to repeat their story to different health and care professionals. This health and care landscape means that some of our most disadvantaged residents can experience the worst access to healthcare – something the Denny Review of Health Inequalities makes clear, and which is explained further in the Enabler section of this Plan. The Denny Review, led by local community leader Rev Lloyd Denny, has seen partners come together to listen in depth to the experience of seldom heard communities across BLMK.

Residents are also clear that they find it difficult to access primary care, and the real stress of the "8am rush" for an appointment. Residents are worried about backlogs for elective surgery - they want to move on with their lives, recover, and reach their full potential. Residents also tell us about the interaction with many professionals in different organisations which results in residents reporting that they feel like a set of individual symptoms rather than a whole person and important aspects of their care are missed. We understand this, and addressing these issues now is vital to our future success as a system.

Our Integrated Health and Care Strategy says "No-one left behind". A big part of our collaborative efforts is to tackle unfairness, inequality and the root causes of poor health and wellbeing for all our residents.

Our focus

We need to meet population growth and changing needs of residents within the resources we have. We must work together to tackle our most difficult an important shared challenges so that our communities can thrive. Specifically, our Plan will:

- **Focus on working together to meet changing population needs**;
- Develop our **processes and partnerships to build an integrated system**
- **Develop and deliver infrastructure strategies** to tackle inequalities, improve health outcomes and reduce avoidable costs.

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Our population

The people of Bedfordshire, Luton & Milton Keynes

Our area covers four places Bedford, **Central Bedfordshire, Luton and Milton Keynes** - all vibrant, unique and rich in cultural heritage. Our population is diverse with more than 100 languages spoken.

With **2 million jobs** we are one of the fastest growing economies in England, contributing £110bn to the economy. We are served by excellent air, rail and road transport links.

BLMK has a **diverse population**.
Of our population of one million people, 69% Asian, 8% 'Other White and 6% Black.

We are one of the fastest growing areas in the country. Our population is expected to exceed **1.2m** within the **next decade** and could increase by nearly **90%** by **2050**.

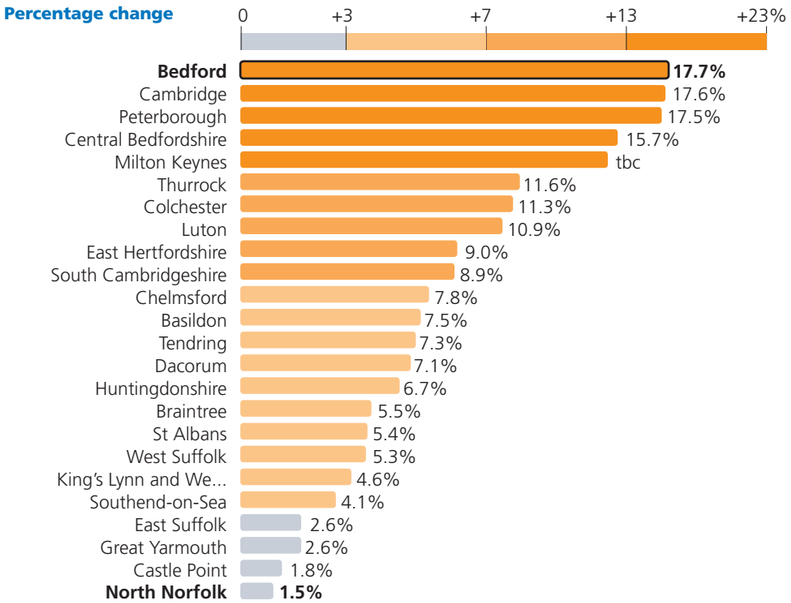
The four Places within Bedfordshire, Luton and Milton Keynes are diverse, and all have rapidly growing population. Over the last 10 years, around 5,000 homes were completed per year across our area. This is likely to increase. Local plans and housing strategies from our Borough Councils suggest around 6,000 new homes will be built each year to 2040.

This is significantly more than population projections from the Office for National Statistics (ONS) which assumes growth of around 2,400 homes per year; new housing built in our area is likely to be 2.5 times higher than official, national estimates.

We have one of the fastest growing populations in the UK, and this trend is expected to continue.

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

Population change of selected local authority areas in the East of England between 2011 and 2021



Under 18	18-39	40-64	65-74	75+
+13%	+10%	+14%	+33%	+25%

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

This Joint Forward Plan is clear that we cannot do more of the same with our resources to meet this growing and changing population need.

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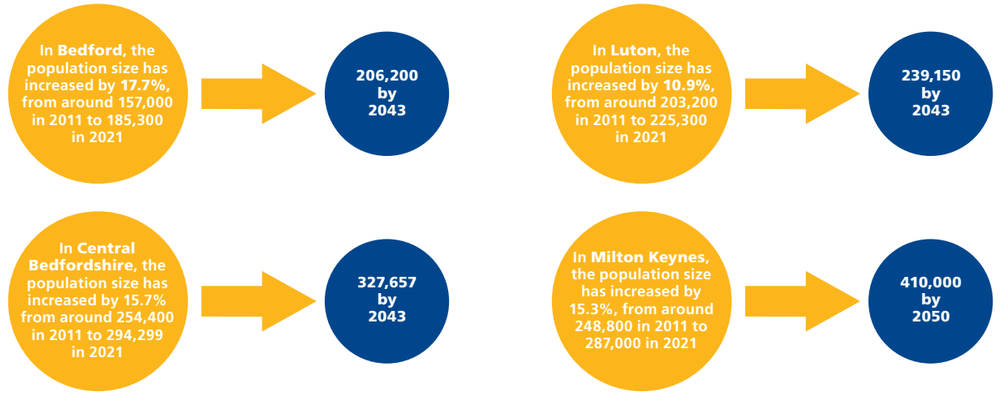
The most difficult issues which this Plan addresses

The known and shared complex, critical and stubborn issues for BLMK are:

- Rapid population growth and demographic shifts, specific to each Place



- Challenges accessing core primary care, including GP and dental services;
- Life challenges experienced by people in our communities including poverty, poor education and other things that may make a person vulnerable to inequalities as set out in the Denny Review of Health Inequalities;
- Impact of COVID on residents, including:
  - Deconditioning of people with frailty
  - Increased safeguarding and mental health issues for children and young people
  - Delays in accessing routine elective surgery;
- Cost of living crisis affecting families; and
- Poor health of the population including obesity and long-term conditions.

SECTION TWO: Medium-term affordability

Making sure we can afford the services residents need

The ICB developed a medium-term financial planning model in 2022 for the period 2023-24 to 2026-27.

The outputs show a potential 'do-nothing' scenario deficit across NHS partners hosted within the ICS (the ICB, Bedfordshire Hospitals NHS Foundation Trust and Milton Keynes University Hospitals NHS Foundation Trust) **of around £580m by end 2026-27**.

As part of future development, we will be seeking to incorporate the medium-term financial forecasts for the local authorities within the ICB boundary.

The key financial pressures for the NHS in BLMK in the medium term are as follows:

Revenue

- Demand for services;
- Inflationary costs;
- Significant levels of efficiencies needed;
- Achieving elective recovery targets;
- Reduction in ICB running cost allowance of 30% by 2024-25; and
- Impact of delegation of pharmacy, ophthalmology and dental services and future delegation of specialist commissioning.

Capital

- Overall affordability of plans within the Capital Departmental Expenditure Limit (CDEL)
- Ensuring capital allocations are equitably and fairly distributed; and,
- Investment to increase capacity in the primary care estate

To manage these pressures the ICB will need to work in partnership to improve performance and productivity. It will also need to explore alternative and innovative funding mechanisms.

The ICB is currently developing a health services strategy. It will likely lead to the redevelopment of specific clinical pathways across the system. The strategy will consider future population growth and demographic changes. It will look at our population's health needs and how these will be delivered in the future given technological advancements and digital delivery. This work will drive and inform financial strategies going forward.

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Local authorities' affordability challenges

All four of our unitary councils are under substantial and sustained financial pressures. If they are not addressed, these pressures will total many millions over the next five years.

The main drivers of these pressures are increasing demand (especially in adults and children's social care and homelessness), inflation and a sustained reduction in central Government financial support for services. A fundamental challenge for local government partners is the short-term nature of the finance settlements which makes planning difficult.

Mitigations

This Joint Forward Plan sets out an ambitious range of High Impact Programmes (Section 7). These are designed to tackle our shared, complex problems to better meet the needs of our residents with our available resources .

One of the High Impact Programmes is the efficiency and effectiveness programme which includes the following programmes that span multiple organisations.

- **Clinical peer-to-peer productivity challenges** (sharing best practice to maximise productivity in clinical services, and reduce waiting times)
- **Multi-agency pathway redesign** - reducing the number of steps in clinical pathways to treat people who need it more quickly)
- **Maximising the effectiveness of clinical support and corporate functions** – in areas such as pathology, prescribing, procurement and agency spend
- **Cross-sector innovation** – for example, introduction of a digital app to monitor epilepsy in children
- **Intra-region (ICB)** – working with other ICBs to share functions and reduce costs
- **ICB internal efficiencies** – for example, continuing health care (CHC), non-pay costs.

Outstanding risk

There are three key risks to affordability over the medium-term:

- Revenue does not keep up with rapid population growth, and the increase in need and demand;
- Having sufficient financial headroom to facilitate transformation of services; and,
- The short-term nature of the finance settlements which makes planning difficult.

This applied a range of inputs and assumptions in respect of funding, inflation, and demand for NHS services. The plan is being updated for final resource allocations published for the period 2023-24 to 2024-25 and will be estimated for later financial periods. Each ICB partner organisation has its own effectiveness and efficiencies programme designed to improve quality, outcomes and reduce avoidable costs. These are overseen by each organisations' own governance and accountability structures and further information.

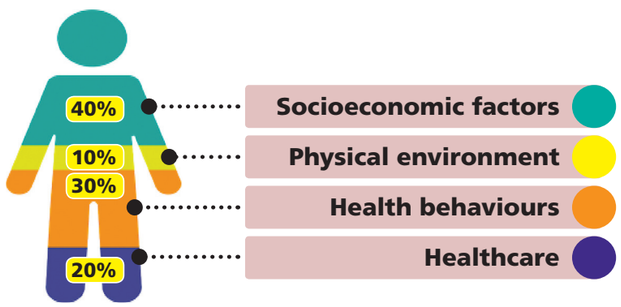
SECTION THREE: Our strategy

Our BLMK ICB strategy sets out our ambition for improving health outcomes and reducing inequalities. Our goal is for everyone in our city, towns, villages, and communities to live a longer, healthier life. It means increasing the number of years people spend in good health and reducing the gap between the healthiest and the least healthy in our community.

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

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

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



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

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SECTION FOUR: A Joint Approach – maximising benefit to residents

Our Joint Forward Plan highlights the shared complex, critical and stubborn issues. These are where an innovative, collaborative approach is needed to deliver outcomes for all residents to 2040 and beyond.

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

1. **Prevention and earlier intervention** – preventing or reducing things that have a negative impact on people's health and well-being

2. **Local interventions that meet the needs of residents at a Neighbourhood, Place or System-level** – based on the demographic and health needs of local communities

3. **Right Care, First Time**, especially for those residents who have the:
   a. Worst outcomes, highest risk factors or the greatest inequalities, like those population groups we've listened to through the landmark Denny Review, like people who are homeless or identify as LGBT;
   b. Highest and most complex needs, or unmet needs driving high volumes of interaction with health, care and public sector services, e.g. police;
   c. Highest volume, lowest complexity demand for health care, including elective and same day urgent care.

4. **Co-production with local communities** – working with (not doing to) our residents to design and deliver services and support that enable communities to thrive

5. **Leverage the inter-dependencies and interfaces across health and care services** to:

   a. Make every contact count – build opportunistic prevention, and support for residents to self-care, into existing pathways of care;

   b. Reduce low value and repeat interventions for residents; and

   c. Optimise use of resources, including our workforce, estates and finance.

6. **Optimise the operating environment for health, care and civic services** – across traditional service and organisational boundaries to:

   a. Identify and tackle all tackle all health inequalities, wherever we find them;

   b. Stimulate local employment and economic development;

   c. Support the sustainability and green agenda;

   d. Develop the workforce over long term; and,

   e. Invest in the digital and estates assets.

There are significant differences between existing local authority and NHS planning approaches. The NHS is focused on short-term delivery, with a three-year funding cycle and a one-year operating plan. Local authority plans for infrastructure and population growth are over a 15-20 year period. NHS operating objectives are focused on the standards that clinical services must achieve for the patients who access these services. In contrast, local authorities consider the whole population living in a specific geographical area.

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

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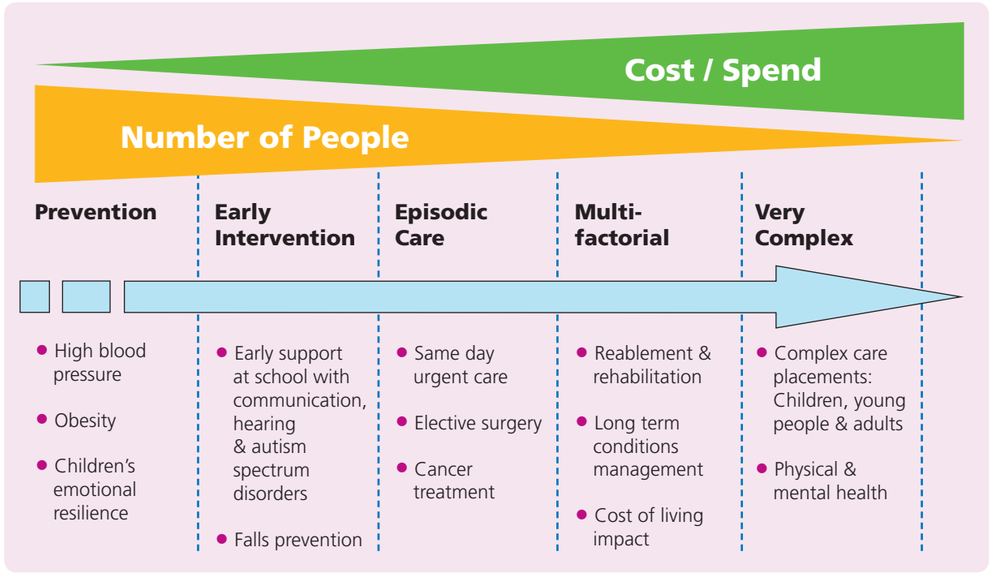
SECTION FIVE: Our approach

Addressing our shared, major challenges will require a systemic approach, split into different levels, as shown below:



This will shift our focus from: 'What can we afford to do?' to 'Can we afford NOT to do it?'

When the question is changed like this the focus is different. It becomes much more about the people living in BLMK, and how best we tackle inequalities and improve health outcomes. We will focus on:

1. Developing a consistent approach to framing and investigating our shared complex, critical and stubborn issues. The focus will be on defining our target population, supporting co-production and personalisation and using collective resources;

2. Ensuring interventions are evidence-based. Challenging ourselves to achieve and sustain performance within the top 10% of ICBs. Drawing on and contributing to research and innovation, and applying learning from best practice; and

3. Taking an approach to improvement which can adapt according to different circumstances. Measuring outcomes as well as activity and considering both the impact of our actions and the impact on the health and care system or wider society if we fail to act.

Examples of this approach could include:

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

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

The rationale for this earlier intervention would be to support children to meet their earlier developmental and education milestones, rather than delay intervention until the special educational needs and disability (SEND) threshold is met later in childhood.

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

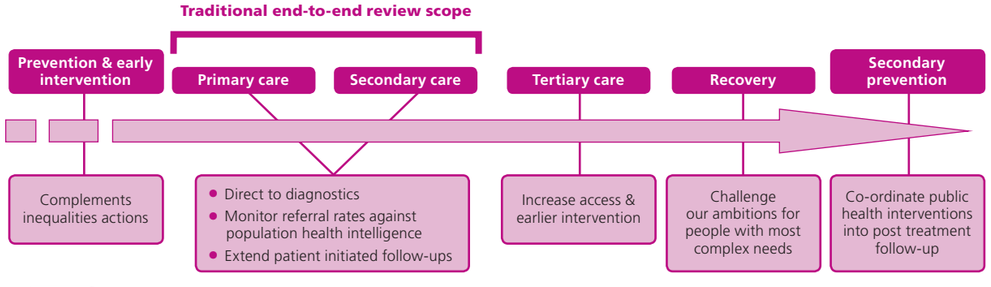
- Creating sufficient supported independent living accommodation within local authority areas to meet local need;
- Extended capacity to bring crisis support to the individual at times of highest need. This would reduce Emergency Department attendance and acute psychiatric admission unless clinically required; and
- An approach which supports the individual to address root causes, manage distressing emotions and achieve their potential.

This population are some of the most disadvantaged in our society. This approach sets out how our whole system can come together to support residents to thrive.

c) Elective clinical pathways review

An end-to-end clinical pathway review typically spans looks at the full journey a resident would take when seeking health and care support. This would start in primary care, when a resident first sees a healthcare professional, to secondary care, if specialist support is required, and the return to primary care for those who access healthcare.

Adopting a truly end-to-end clinical pathway review could better tackle inequalities and improve health outcomes, as shown below:



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Anchored in Places, this approach will:

- Identify populations whose risk profile or barriers to access indicates they are at higher risk and require support at a neighbourhood or council ward level;
- Provide engagement tailored to the residents' different needs, such as health promotion and uptake of screening programmes;
- Provide oversight for Place partners – giving a clear view and feedback on managing unwanted variation in services.
- Reduce bureaucracy for GPs in the referral processes. It will encourage greater autonomy for providers of acute care to determine the right clinical pathway
- Inform decision-making on how best to use specialised clinical pathways, known as tertiary care. These are currently under-used in BLMK,
- Allow residents to get the best public health interventions for them

The outcomes sought from this approach are two-fold:

1. To ensure timely access that maximises health outcomes for all residents
2. To manage demand and cost through more effective, targeted interventions based on population need.

d) Partnership in 'Fuller' Neighbourhoods to support residents to tackle the root causes of their need and not just manage symptoms.

The development of Fuller Neighbourhoods is based on a report by Dr Claire Fuller which sets out the future vision for Primary Care services.

It sets out how by bringing together all the professionals who can support residents in specific neighbourhoods with primary care needs we can better sustain delivery of;

- Same day access for urgent care
- Support to people living with long term conditions
- Working with communities and our voluntary sector partners to help people improve their health & well-being
- Working with our partners in emergency services, education and civic functions such as libraries and leisure centres to enable people to access urgent support for mental health crises when they need

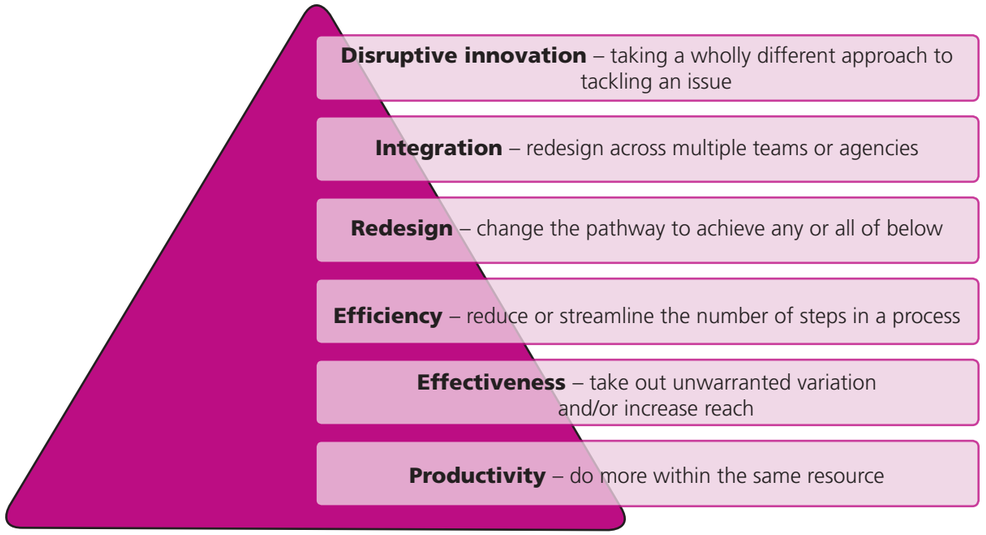
These four examples demonstrate how, when we collaborate to the benefit of specific residents, we can improve outcomes for the individual and reduce avoidable costs.

As illustrated in these examples, the Joint Forward Plan will aim to move us away from the traditional way we deliver care, which is often not joined up. We will be able to:

- Define our goals by the needs of our population at Place rather than episodes of care or care pathways;
- Move resource to improving prevention and early intervention, to benefit residents and reduce future need and cost; and
- take a long-term view wherever possible.

We will deliver this through quality improvement interventions that are locally owned. They will make it easier for our teams to do the right thing for the resident, first time.

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



We are excited about growing this work together with our partners and the major impact it will have on residents' lives across BLMK

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SECTION SIX: Mobilising the Joint Forward Plan

There are several key actions that need to be completed for the Plan to be delivered to maximum effect, and to enable us to measure the difference are we making for our residents.

Population growth and change

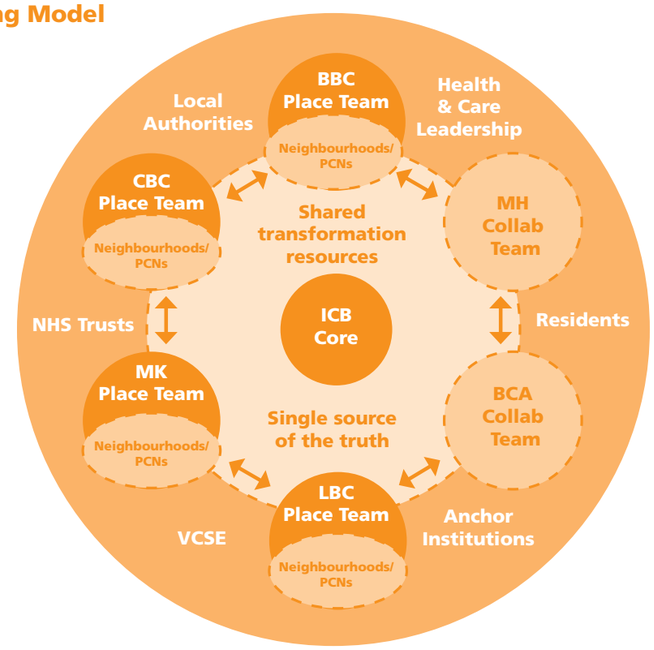
There is a critical need to accurately model how the population will grow and the demographics will change for each of our four Places up to 2040. At the same time, the demographic make-up of each Place is changing, with each one specific to its local population. Changes to the numbers of people of different ages, for examples, will have an impact on the services required.

We cannot build, deliver, and assess the impact of a Joint Forward Plan without clear future modelling scenarios of our population size, demographic, and likely future health and civic needs, including where, when and how individuals are most likely to experience health inequalities. The new Population Health Intelligence Unit will lead this work on behalf of the four Places and the ICB. It will give enable us to test the benefits to residents of our High Impact Programmes. This initial work is expected to be completed by December 2023.

Implementation of the ICS Target Operating Model

The ICB will implement a new Target Operating Model during 2023-25. This reflects its role as a system convenor, bringing together different services to address difficult challenges, and its' own organisational requirement to reduce its own running costs by 30% by 2025. this will reduce the number of staff employed directly with the ICB. It involves changes in ways of working and extending the responsibilities of Place and Provider Collaboratives to improve health outcomes and tackle inequalities.

The Target Operating Model is shown below. It shows that, by 2025/26, there will be a core ICB team, four Place teams working with neighbourhoods and Primary Care Networks, a shared transformational resource, and Provider Collaborative teams. This model presents a way of working which is more flexible and responsive, with a focus on convening and working with a wide range of partners to deliver improvements for our residents.



The diagram of the TOM is illustrative and not drawn to scale.

SECTION SEVEN: High Impact Programmes

We – and our partners – must work differently together to achieve our ICB core aims and NHS England Operating Plan targets. This includes, crucially, improving health outcomes and reducing inequalities for our residents – ambitions which are at the centre of our Health and Care Strategy, and of this Joint Forward Plan.

The effects of the COVID pandemic, cost of living crisis and rapid projected population growth means this is a significant challenge. It will require a fundamental shift in how public sector and VCSE services engage and support residents.

ICB partners recognise that we need to take steps to tackle the root causes of poor health outcomes and inequalities. Section Five summarised the approach the ICB will take to achieve this shift towards a focus on prevention of health issues. Section Six described the actions we need to take.

In this section we set out our BLMK High Impact Programmes. These are programmes which ICB partners will deliver in collaboration to realise our Integrated Care Partnership strategy and ICB objectives.

The below therefore sets out:

- The 'problem statements' outlining the root causes we are tackling;
- The short, medium, and long-term outcomes we are seeking for residents; and
- The projects within each of the High Impact Programmes.

The following sections of the Plan will:

- Clarify how these overarching programmes will come together and enable the delivery of our medium-term Place plans, based on population needs;
- Describe the emerging role of our provider Collaboratives to shape and lead delivery of clinical and professional-focused programmes;
- Provide a summary of our key enabler programmes, such as the People Plan or Digital Strategy;
- Detail how this Joint Forward Plan will deliver the standards and targets of the NHS England Operating Plan; and
- Describe the extent to which the Joint Forward Plan will mitigate the risks outlined in the ICB's Board Assurance Framework, and key risks currently beyond the direct control of ICB partners.

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The ICB High Impact Programmes are those interventions where we can only achieve the outcomes sought for our residents through collaboration, partnership and innovation.

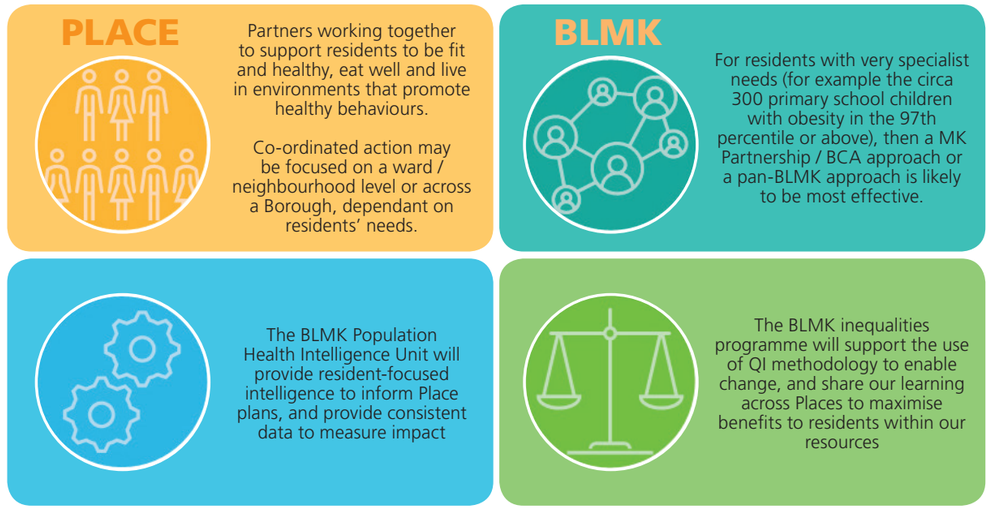
The ICB's governance and ways of working are based on the principle of **'subsidiarity'**. This means that decisions and responsibility for delivering agreed changes sit as close to the resident as possible.

This principle determines who needs to be involved in leading which aspects of our High Impact Programmes. For example:

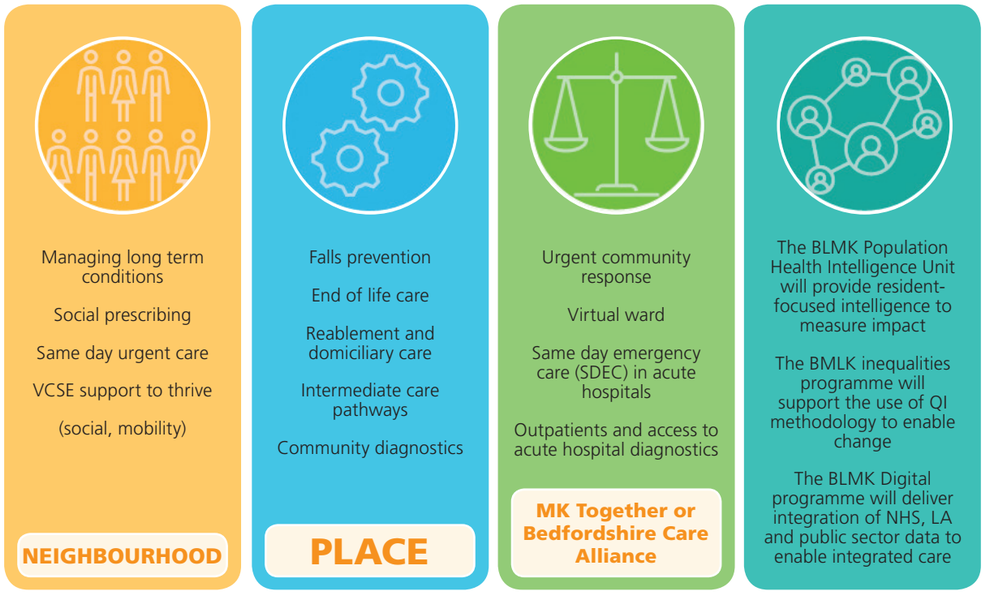
- A single organisation and managed within that organisation's own governance;
- Across partners working together at Place;
- A Collaborative of different health and care Providers and
- Where there is high complexity, acute need and very low numbers of residents, an approach across the whole of our area may deliver the best outcomes

Focusing on residents' needs, rather than the service or intervention required, allows subsidiarity to function effectively.

Example 1 – Obesity



Example 2 – Frailty



So, what are our High Impact Programmes?

1. Advancing Equity, (reducing harm and promoting safety through the introduction of quality improvement methods and tools)

- Supporting all system partners to develop a population health management approach to tackle the socio-economic and environmental disadvantages in life, and improving the access, experience and outcomes for all our residents
- Adoption across BLMK of consistent Quality Improvement tools to enable all staff to identify, tackle, test and measure improvements in access, outcomes and experience across our NHS and civic services
- Support to system partners in working to support patient safety by maximising the things that go right and minimising the things that go wrong in health care provision, improving effectiveness and patient experience. Delivering a system supported collaborative approach to new framework for patient safety and reducing harm (NHS patient safety incident response framework- PSIRF)
- continue to deliver on statutory function to keep people safe from abuse and neglect and look to use quality improvement approach to learn lessons and improve the circumstances of vulnerable people.

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2. Efficiency & Effectiveness Improvement Programme

- Rolling programme to identify and reduce unwarranted variation in clinical and integrated health and care pathways, tackle inequalities and to reduce unnecessary cost
- Focus on multi-agency pathways and clinical support / corporate delivery (local productivity & improvement is overseen within organisation-specific and Place governance)
- Shared oversight of all efficiency and effectiveness programmes (organisation-specific, issues in common, multi-agency and ICB) to assure overall delivery of required impact / benefits and mitigate unintended consequences of inter-intra-dependency
- Establish digital / automated feedback loops to empower local teams to deliver best practice and address unwarranted variation as close to the service as possible

3. Enabling our Children and Young People to Thrive

- Earlier intervention to support children and young people to thrive (education, long term conditions and mental health and well-being)
- Sustainable recovery-focused strategy for complex needs / placements
- Preparing for adulthood
- Focus on children and young people experiencing the poorest outcomes / most disadvantaged: looked after children, children living in poverty, children who are displaced or experiencing abuse

4. Improved Access and Treatment

- Delivery of elective and emergency care recovery through integration and innovation
- Development of diagnostics and screening to address inequalities of access and outcomes
- Focus on ensuring that our most disadvantaged populations have parity of access and health outcomes, for example those living in deprivation, displaced people, vulnerable children and adults
- Promoting digital innovation to improve diagnostic and elective accessibility whilst safeguarding against digital exclusion.
- Make best use of capacity across all health care sectors and promoting choice where applicable
- Prioritising care for those with the most urgent clinical need ensuring equity between both children and adults.

5. Improving Outcomes for people with Mental Illness, Learning Disabilities and / or Autism Spectrum Disorders (MHLDA)

- Development of sustainable early intervention and crisis and recovery pathways for children, young people and adults
- Develop capacity to deliver early local diagnosis and support for people with autism spectrum disorders
- Development and implementation of sustainable recovery-focused models of care for people with complex needs, including shift to default of complex placements being delivered within BLMK
- Capital development in core services, for example mental health inpatients
- Improving physical health access and outcomes for people with severe mental illness, learning disabilities and autism spectrum disorders

6. Integrated Neighbourhood Working

- Delivery of 'Fuller' Neighbourhoods – proactive multi-disciplinary teams focused on local populations to provide same day urgent care and support to manage long term conditions
- Acceleration of prevention and support to tackle the wider determinants of health (falls prevention, optimised end of life care at home, rehabilitation, reablement and recovery post-health crisis, supporting people furthest from employment or training)
- Optimise delivery and outcomes from delegated primary care services (optometry, dental and community pharmacy)
- Continued delivery of the GP recovery plan – together with Place-based strategies to expand primary care capacity to meet population growth

7. Intelligence-led Quality, Outcomes, Performance, & Inequalities Improvement

- Implementation of the Public Health Intelligence Unit and outcomes-based reporting based on specific populations
- Sustainable re-development of business intelligence and analytics capability / capacity to shift performance reporting (i.e. NHS Operating Plan Targets) to be viewed through the lens of impact on local communities
- Digital integration strategy – integration of NHS, LA and public sector data to enable integrated care and embedding digital solutions in care pathways

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8. Integrated Care System Target Operating Model

- Structuring ICB staff to focus on core ICB / Place & Collaborative / pan-BLMK / pan-East of England region statutory & mandated responsibilities and delivery of high impact programmes (and deliver required ICB running cost allocations efficiencies)
- Development of Place / Health & Well-being Boards and their relationship with NHS and LA organisational governance
- Evolution of Integrated Health & Care Partnership Board
- Developing ICB Leadership roles and responsibilities to deliver the Target Operating Model
- Develop training to embed the new ways of working
- Due diligence and mobilisation of delegation of specialised commissioning for BLMK population

9. Thriving Eco-systems and Prosperous Communities

- Embed environmental sustainability into decision-making at all levels of the health and care system, to achieve the co-benefits of health improvement, whilst reducing the impact on our ecosystems and the negative impact on people's health and wellbeing.
- Deliver the BLMK ICS Green Plan to achieve a net zero health system, working with partners, VCSEs and residents.
- Establish a collaborative of anchor institutions
- Develop pathways for those furthest from stable employment due to their health to obtain, return to, and stay in work.
- Grow our own workforce across all health and care careers in partnership with educational institutions
- Ensure inward investment through supply chains
- Implement the BLMK Research Hub at the University of Bedfordshire, and build the system Research and Innovation portfolio across all our institutions.

Delivering the Benefits of our High Impact Programmes

'So what?' This is the question we in the ICB have challenged ourselves to focus on when developing our High Impact Programmes.

Each of our High Impact Programmes have clearly defined problem statements. These are focused on our population's needs rather than how services are currently delivered.

This shift in focus is crucial to enable the ICB to:

- Support the health and wellbeing of our residents, using local assets to enable communities to thrive;
- Make best use of resources within current and future constraints; and
- Embed sustainable solutions to chronic and growing gaps between demand and capacity. This includes urgent and emergency care, care at home or in residential care, elective demand, special educational needs and complex needs placements.

What is the problem we are trying to solve?

The problem statements for each of our High Impact Programmes are summarised below:

BLMK High Impact Programme	Problem Statements
1. Advancing Equity	• Too many BLMK residents live in poverty, which is the single biggest predictor of inequalities and poorer health & well-being • Maternity inequalities- poorer outcomes for BAME communities – higher risks mortality in this cohort in pregnancy. Higher risks of still birth, maternal, neonatal and infant mortality in 20% most deprived. • Health promotion challenges – smoking in pregnancy – more to understand current numbers – digital data collection • Residents, including health inclusion groups such as homeless, Roma and Gypsy travelling communities and migrants, experience inequalities in access to health services, impacting health outcomes • Obesity affects over a third of our population, especially those living in deprived areas with constrained income / poorer access to healthy food • Core20+5 highlights populations in BLMK with poorer access / uptake / outcomes in key health areas • Safeguarding numbers and complexity of presentation have increased for example, self-neglect, alcohol related issues, increase in domestic abuse and violence • Sustained improvement in health outcomes and reducing inequalities is complex and takes time to achieve
2. Efficiency & Effectiveness Improvement Programme	• The cost of continuing to provide services in the current configuration for our growing population exceeds the available resources • There are chronic workforce gaps (mirroring national picture) increasing pay costs and limiting effectiveness. • There are insufficient feedback loops for local teams to monitor compliance with best-practice and assess impact of improvement initiatives • Productivity in key health and care interventions is below top decile in specific services in BLMK
3. Enabling our Children and Young People to Thrive	• Too many of our children in BLMK live in poverty • Over a third of children in BLMK are overweight – this is a key risk in for future health & well-being • Not all children and young people have early key interventions during primary school years to enable them to thrive (communication, diagnosis and support for dyspraxia, autism spectrum disorders, emotional resilience) • There is more we can do to support transition to adulthood for young people with complex needs • BLMK has insufficient 'recovery & thrive' capability and capacity to meet the needs of our most complex children's placements within the patch • There is more we can do to prevent and proactively manage long term conditions for children & young people • Children and young people are waiting too long to access mental health and well-being services
4. Improving Access & Treatment	• Patients are waiting too long for routine elective interventions, compromising health & well-being • Barriers to accessing screening & early diagnosis are adversely impacting the health outcomes of some residents • Cancer diagnostic and treatment capacity in key modalities is insufficient given the increase in demand, and difficult to access for some populations • Urgent & emergency care pathways have higher demand than capacity, adversely impacting patient experience and increasing clinical risk • Uptake of very specialist clinical services in East of England is lower than national average, compromising health outcomes • Delays in paediatric elective treatments can have an impact on development and educational progress. • Traditional face to face elective care delivery models are inflexible and no longer meet the societies work and lifestyle expectations, leading to missed treatment opportunities and poorer outcomes. • There is more we can do to enable greater choice about how and where people access healthcare, especially for those with the poorest access currently

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BLMK High Impact Programme	Problem Statements
5. Improving Outcomes for MHLDA	• People in acute mental crisis / distress are not consistently able to access rapid mental health support in their local community • Crisis pathways are focused on immediate safety with insufficient recovery provision • People with severe mental illness and / or learning disabilities are more likely than the general population to die early due to long term conditions • BLMK has insufficient 'recovery & thrive' capability and capacity to meet the needs of our most complex mental health, learning disabilities and ASD placements within our geography • Current Bedfordshire adult inpatient mental health services estate is insufficient for modern models of care and local need / demand
6. Integrated Neighbourhood Working	• Population growth in specific geographies will exceed primary care capacity (dental, pharmacy and primary medical) without transformation of the current service model. • There is more we can do to help connect people together within the community to address isolation, loneliness including those with caring responsibilities • Our approach to health screening (including cardio-vascular, respiratory, diabetes and cancer screening) needs to adapt and be agile to deliver an acceptable offer to our diverse population • There is more we can do by working with our voluntary sector to help residents live a happy life and to help them to confidently manage their long-term conditions • Seldom heard communities need a bespoke in-reach community offer to increase vaccination rates • The proportion of residents living in a care home with complex care needs continues to increase requiring multidisciplinary proactive anticipatory care to enable residents to be safely managed in an out of hospital setting • There is more we can do to support people/communities to address the root causes of their problems including the wider determinants of health to and reduce reliance on health care or medical interventions • We do not consistently use opportunities to promote wellbeing and physical activity or to sign post residents to community events or activities that support prevention of poor health.
7. Intelligence-led Quality, Performance, Outcomes, and Inequalities Improvement	• Not all health & care data is digitally integrated, causing gaps, duplication and delays in treatment – and requiring residents to repeat their story • There is more we can do to embed population health view into NHS metrics to identify inequalities in access, outcomes and experience; and assess the impact of actions to improve health outcomes and tackle inequalities • There is more we can do to enable residents to manage their health and wellbeing using digital technology • Duplication of reporting has an adverse impact on staff productivity & morale
8. Integrated Care System Target Operating Model	• Our current ways of working don't always make it easy to provide joined-up care for residents • There is more we can do to work with communities to enable them to thrive • There is more we can do to work in partnership with our VCSE to optimise experience and well-being for residents • Our governance will need to adapt as the ICB matures to optimise the impact of Health & Well-being Boards, and ensure collaborative and sovereign governance aligns • We have yet to explore the opportunities to conduct core ICB functions at scale across the East of England Region
9. Thriving Eco-systems and Prosperous Communities	• Environmental concerns are not yet seen as a core part of delivery of services to improve health and reduce avoidable illness. • Climate change and environmental pollution are not bound by geography, sectors, or organisational footprints, and have the greatest impact on those in the most-deprived communities. • We need to better understand accountabilities and responsibilities for delivering thriving ecosystems and prosperous communities across the different partners, organisations and sectors (public, private, VCSE) within the ICS, and develop appropriate governance and sensitive measurement systems to oversee progress. • We need to develop innovative approaches to health improvement, employment, procurement and estates with partners in all sectors, whilst working within the parameters of legislation.

Outcomes of our High Impact Programmes

This section summarises the benefits of High Impact Programmes to residents and to the sustainable delivery of NHS and local authority services. This is a shift from traditional reporting against performance targets, with a focus on volume and waiting times. Though these remain crucial to monitor the experience of our residents, this approach does not give assurance that we are improving the years lived in good health for all our residents.

The ICB is committed to understanding our performance data against key NHS and local authority standards and targets, with a focus on the local population's health and wellbeing. This shifts the assessment of our impact from 'are we working hard enough to meet demand?' to 'are we doing our best to improve health outcomes and tackle inequalities for all our residents?'

Here is an example of why this population perspective is so important.

Luton radiotherapy example:

Cancer performance is Luton was generally above average before the pandemic but there was a perplexing contradiction in terms of health outcomes for residents. There was a long-standing question as why the cancer outcomes for residents in Luton were poorer than other areas of the country.

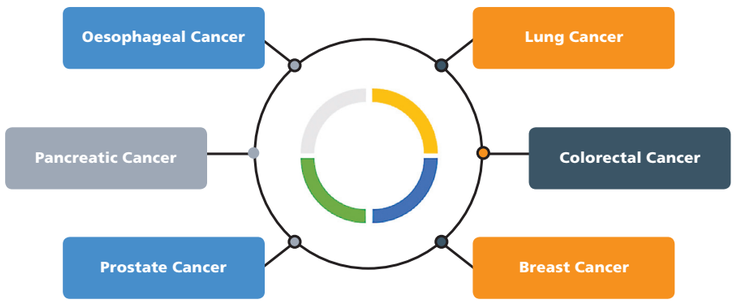
The Luton Cancer Outcomes project was set up to identify the main factors – **medical, behavioural, social and others** – which contribute to variations in cancer outcomes amongst the residents of Luton and make recommendations for improving cancer outcomes.

The project looked at four key **outcome measures**:

1. Stage at diagnosis 2. Emergency presentation 3. One year survival, and 4. Five year survival

And focused on the **six cancers** with the greatest levels of premature mortality for Luton in 2019:

We asked residents of Luton what the barriers were to accessing cancer services and one of the stories we heard was so powerful it formed our driver for change. Nam's story illustrates the complexities that lack of knowledge around how and when to seek help, services able to meet needs of their local population and access to transport or other economic factors can shift patient decision making and therefore patient outcomes.



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Patients and carers from Luton have told us about geographical, cost, transport, cultural and socio-economic factors that make accessing care difficult.

For example:

- We have heard about women unable to travel to an appointment without their husband, unable to see a male doctor, or unable to travel very far from home, and whose diagnosis or treatment is delayed as a result.
- We have heard about single parents who cannot afford childcare support and have no one to babysit whilst they attend appointments – the further away those appointments are, the more impossible this becomes.
- We have repeatedly heard about journeys of 90 minutes each way to the current cancer centre and stories of patients who have decided not to have treatment because of the current lengthy travel times or complicated journeys.

The project worked in 4 key workstreams looking at health inequalities, health outcomes data patient experience and strategic factors such as resources, workforce, partnership working. These workstreams developed a set of recommendations which are now in implementation phase.

Key learning

- The factors contributing to poor cancer outcomes in Luton are complex and wide ranging;
- Patients and carers told us about geographical, cost, transport and socio-economic factors that made accessing care difficult
- Barriers to accessing cancer screening are likely to be linked to ethnicity and culture, but barriers to accessing treatment are likely linked to wider determinants such as access to transport and being able to take time off work.
- Prostate cancer diagnosis has been impacted by COVID with men not seeking help early on, we need to reach these men in a different way.
- Patient experience is generally good but we are not hearing from all communities
- People are still presenting late with cancer symptoms and this will continue to have an impact on survival rates if not addressed
- There are opportunities to make small but significant changes to cancer pathways - specifically between Luton & Dunstable and Mount Vernon - to improve experience and outcomes

This example illustrates how working together a on a shared problem can help us deliver a solution that addresses the issues that matter most to our residents.

The table overleaf sets out the outcomes we expect our High Impact Programmes to achieve:

BLMK High Impact Programme	JFP Mobilisation / Operating Plan Actions 2023-5	Summary of Outcomes: JFP Delivery 2025 - 2030	Summary of Outcomes: JFP Delivery 2031 - 2040
Advancing Equity	• Detailed population growth & demographic shift modelled for BLMK to 2040 • Population health intelligence unit established • Shared Quality Improvement approach embedded across BLMK services • Inequalities targeted funding is aligned to Place JSNA priorities, with clear actions and metrics to evaluate benefit to residents	• Slow or reduce obesity in population • Improved Maternity & neonatal outcomes • Reduced variation in health outcomes, plus increasing access to services, especially for those who are most disadvantaged / have poorest outcomes • BLMK spread of Better Lives campaign of 0-25 year-olds	• Outcome measures demonstrate more residents spending more years of life in good health • Reduce incidence of still births, neonatal, maternal and infant mortality • Reduce smoking rates in our most deprived population • Increase in activity resulting in reduction in obesity in 11-16 year-olds
Efficiency & Effectiveness Improvement Programme	• Programme pipeline established – identification of opportunity • Governance established (organisation-specific, issues in common, pan-BLMK, ICB) • Effective impact metrics established to ensure sustainable shift in use of resources	• Programme supports improvement in health and outcomes and reductions in inequalities through effective use of resources • Programme has sufficient impact to enable local LA and NHS to deliver within resources • Teams will routinely have access to feedback loops highlighting variation to make it easier to ensure treatment pathways are delivered within best practice clinical guidelines	• Investment in our services and infrastructure is configured to anticipate future need as well as current population demand • We can evidence across our services that we are spending public money wisely and achieving optimum outcomes for residents • Our research and innovation is driving improvements in health outcomes, reducing inequalities and delivering sustainable resources
Enabling our Children and Young People to Thrive	• Working jointly with Councils at Place and wider to develop affordable and sustainable placements and/or capacity for children with the most complex needs. • Working at Place to support families to prevent and intervene early for overweight children. • To develop multi-disciplinary pathways of care that provide evidence based, resourced early intervention for children in their early years – to include, hearing, communication, sensory. • Roll-out national pathways for asthma, epilepsy and diabetes to improve outcomes for children and prevent avoidable admissions and deaths. • Provide free, universal, digital mental health support offer for all young people in BLMK Options evaluation with each Borough on sustainable model for complex needs placements completed and plan agreed	• Developing a market management strategy that plans and predicts what will be needed for children with the most complex needs over the next decade. • Speedy access to family support and evidence-based programmes to reduce excess weight in children and manage those requiring specialist services. • Develop place-based pathways of support on a multi-agency basis with a single 'local offer' that is easily accessible for all children and families. • Drive quality improvement through focus on reducing inequalities in the 20% most deprived families (deep-dive practices) • Continue to build early intervention services so that mental health services are focusing on those children with diagnosable mental health problems, providing speedy access and sustained follow-up where appropriate.	• There is sustainable infrastructure for local provision of complex needs placements • Local services work together to prevent, intervene, and manage obesity in children in line with international best practice • An online 'local offer' of services and support, including self-referral ensures developmental needs are addressed at the earliest opportunity. • Readmissions to hospital are reduced and preventable mortality in children is eradicated. • Children and young people know how to access support for their emotional wellbeing and where specialist services are required they can access them within days. This will reduce the number of young people being admitted to mental health beds.

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BLMK High Impact Programme	JFP Mobilisation / Operating Plan Actions 2023-5	Summary of Outcomes: JFP Delivery 2025 - 2030	Summary of Outcomes: JFP Delivery 2031 - 2040
Improving Access & Treatment	• Earlier and faster cancer diagnosis • Health services strategy methodology agreed & implemented • End-to-end pathway reviews and peer-productivity challenges embedded • Community diagnostic centres completed • Flow programmes reduce preventable admissions and delays waiting for discharge	• Cancer infrastructure accessible to all as population grows. Cancer services at point of diagnosis and after treatment are integrated • Access and health outcomes are improved, especially for those currently most disadvantaged • People with frailty are supported to remain well at home or recover better after acute hospital admission • Waiting time for routine hospital and community health treatments are at / close NHS Constitutional standards	• Outcome measures demonstrate more residents spending more years of life in good health • Impact of life's disadvantages on health outcomes has reduced • Cancer survival rates at 1 and 5 years are at / above national mean, including those people who are most disadvantaged • Respiratory and cardiovascular outcomes are at or above national average outcome measures, with systemic attention to prevention, long term conditions management and preventing avoidable admissions
Talk about people with Mental Health, Learning Disabilities and ASD.	• Community crisis and recovery pathways developed and implemented • Options evaluation with each Borough on sustainable model for complex needs placements completed and plans agreed • Implementation of capital investment to increase crisis capacity in Bedfordshire and Milton Keynes	• People in crisis have prompt access to local support to keep them safe and support recovery • Adults requiring inpatient admission can be treated within BLMK • More adults with severe mental illness, learning disabilities and autism spectrum disorders are supported into employment • Increased access to diagnosis and support for people with autism spectrum disorders	• There is sustainable infrastructure for local provision of complex needs placements • We have significantly redressed the poorer long term physical health outcomes experienced by people with severe mental illness, learning disabilities and autism spectrum disorders • All residents in mental health crisis can access local community-based support quickly and easily
Integrated Neighbourhood Working	• Co design meaningful neighbourhoods across the 4 places and put in place the appropriate infrastructure and support for neighbourhood working • A system-wide approach for integrated urgent care to guarantee access for people who require same day primary care services • LTC transformation programme via multi agency groups for diabetes/respiratory/ CVD using bespoke outcome measures (including patient reported outcomes, clinical measures and health inequality metrics)	• All residents of BLMK have access to wellbeing facilities and can access same day primary care services with confidence • Residents and families impacted by long term conditions have access to prevention, advice and support to help them stay well at home • Stay well at home initiatives with local voluntary sector are supporting older people to stay warm, and reduce loneliness and isolation	• We have sustainable primary care capacity to meet population needs (same day urgent care access, support to manage long term conditions) • We will be able to demonstrate the benefit to residents of integrated neighbourhood working based on the things that matter most to residents; and in key health outcome measures

BLMK High Impact Programme	JFP Mobilisation / Operating Plan Actions 2023-5	Summary of Outcomes: JFP Delivery 2025 - 2030	Summary of Outcomes: JFP Delivery 2031 - 2040
Intelligence-led Quality, Performance, Outcomes and Inequalities Improvement	• Business intelligence / analytics solution identified & delivered • Population Health Intelligence Unit established • NHS performance reporting is routinely split by Place, and understood in the context of health population needs • Benefit measures underpinning transformation quantify the changes in health outcomes and in reducing inequalities – the wider determinants of health (as well as NHS performance, access and value for money)	• High Impact Programmes and QI are driven by integrated data highlighting inequalities and variation in outcomes • NHS and social care data is digitally integrated, enabling more joined up care for residents • Integrated Neighbourhood teams and Place Boards will have intelligence to understand who is not accessing health interventions in a timely way, and tools to engage with residents to ensure that those who find health services most difficult to access are not disadvantaged in their health outcomes	• Residents can manage their long-term conditions with digital support • Population health management intelligence routinely informs service development; and evidences benefit to residents of quality improvement actions • Integrated data enables multi-disciplinary working across settings and organisations to provide seamless, joined-up care for residents • Strategies to support communities to improve their health and well-being are bespoke to local population needs
Integrated Care System Target Operating Model	• Transformation Programme for ICB – including 30% reduction in running costs. • Place based boards established • Compact with VCSE & Healthwatch agreed • ICB approach to contracting with VCSE in place • Denny review report agreed and recommendations implemented • Co-production training delivered • Remuneration approach for co-production implemented • Big conversation delivered to develop our joint forward plan April 24 • Investment in VCSE infrastructure agreed	• Integrated workforce planning to enable planning at a system and place level • Integrated working and shared QI approaches enable staff to work across organisations & settings • Evidence of co-production as part of High Impact Programmes and delivery of Place Priorities • Evidence of positive impact on resident outcomes from VCSE work • VCSE playing a larger role in service delivery and co-production • VCSE partners integral to ICB and place planning and delivery • Evidence of transfer of power to residents via co-production approach	• Joint working across neighbourhood and place supporting organisation models like collaboratives in providers to deliver joined up resident focussed services. • As anchor institutes, all YP & adults furthest from employment have access to support • Improve health outcomes for population groups most affected by health inequalities • Increased resident and stakeholder satisfaction in annual sentiment surveys • Improved sustainability and resilience in VCSE sector • Evidence of transfer of power to residents via co-production approach has supported improved health & well-being for residents
Thriving Eco-systems and Prosperous Communities	• Embed sustainability checklist and environmental literacy into leadership, change-management and governance processes • Delivery plans for Green Plan themes • Establish anchor coalition • Resident co-production of future environmental sustainability strategy • Procurement systems developed to maximise social value and inward investment opportunities • Build on employment and employability pathways, with existing organisations and the proposed MK STEM university • Maturation of the Research and Innovation Hub	• Reduced carbon-equivalent emissions from all sources, with NHS achieving ~48% reduction against 2019/20 baseline by 2032 • Focus on improving health and environment as co-benefits (e.g. air pollution, active travel, diet, and severe weather events) • Barriers to employment within health and care are reduced • Supply chain delivering greater social value benefit for BLMK residents	• NHS is net zero on Scopes 1 and 2 carbon emissions, with overall emissions >80% lower than 2019/20 • Realisation of health co-benefits relating to the environment such as air pollution, active travel, diet, and severe weather events • The healthcare workforce is more representative of the local population, with a greater proportion coming from within BLMK • Within legal frameworks, a greater share of goods and services in the health and care supply chain come from BLMK-based businesses, through improved knowledge, skills and capacity of those businesses to successfully bid for tenders.

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Improving health services quality, access, and outcomes for our population

Our population health view focuses on the resident and how services are benefiting our residents. It means that we are committed to understanding the quality, performance, and outcomes of our NHS services as it relates to local populations.

Addressing all the determinants of health

Research shows that health services play only a small part in what supports people and communities to thrive. It is estimated the NHS directly impacts only 20% of what determines an individual's health. The other 80% is determined by wider factors like access to green spaces, educational attendance, attainment and skills, and crime rates.

We are therefore designing a new way of measuring our performance that is solely NHS-focused and more about how we as a system are together improving health outcomes for our population.

At the heart of this new performance framework are three distinct categories or domains, based on the Office for National Statistics (ONS) Health Index:

Healthy People – this domain covers health outcomes that include mortality, and the impact of physical and mental health conditions;

Healthy Lives – covers risk factors for health that relate directly to individuals. This includes factors that can be changed by individuals, and social factors that cannot always be controlled by individuals but can affect them; and

Healthy Places – includes social and environmental risk factors that affect the population at a collective level. These relate to circumstances that can influence health outcomes and risk factors. However, they often cannot be addressed solely at the individual level.

If we were to apply the Health Index framework in Bedfordshire, Luton and Milton Keynes, an example of the cross-cutting measures forming part of this approach is set out below.

Health Index		
Healthy People	**Healthy Lives**	**Healthy Placess**
Difficulties in Daily Life • Disability • Frailty	**Behavioural Risk Factors** • Alcohol Misuse • Drug Misuse • Healthy eating • Physical Activity • Sedentary Behavious • STIs • Smoking	**Access to Green Space** • Private Outdoor Space
Mental Health • Children's and Young Peoples' MH • Mental Health Conditions • Self Harm • Suicide	**Children and Young People** • Early Years Development • Pupil Absences • Pupil attainment • Teenage pregnancy • Young People in Edu/Emp	**Access to Services** • Distance to GP surgeries • Distance to pharmacies • Distance to sport/leisure facilities • Internet access • Patients offered acceptable GP appointments
Mortality • Avoidable Mortality • Infant Mortality • Life Expectancy • Mortality from all causes	**Physiological Risk Factors** • High Blood Pressure • Low Birth Weight • Overweight/Obesity in Adults • Overweight/Obesity in Children	**Crime** • Low level crime • Personal crime

Health Index		
Healthy People	**Healthy Lives**	**Healthy Placess**
Personal Wellbeing • Activities in Life are Worthwhile • Feelings of Anxiety • Happiness • Life Satisfaction	**Protective Measures** • Cancer Screen Attendance • Child Vaccination Coverage	**Economic and Working Conditions** • Child poverty • Job realted training • Unemployment • Workplace safety
Physical Health Conditions • Cancer • Cardiovascular • Dementia • Diabetes • Kidney and Liver disease • MSK • Respiratory		**Living Conditions** • Air pollution • Household overcrowding • Noise complaints • Road safety • Rough sleeping

Partner organisations within the ICB will continue to be responsible and accountable for their own delivery through their statutory governance arrangements.

SECTION EIGHT - Place and Provider Collaborative Key Objectives

There are four Places within the ICB area: Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. Each has a Place plan, identifying local priorities that partners can work on together to improve the health and wellbeing of local residents.

These are summarised as below:

BEDFORD BOROUGH COUNCIL

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

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

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

The priority partnership actions identified in Bedford Borough are:

- Tackling obesity; and
- Improving access to primary care.

Central Bedfordshire

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

- **Promoting fairness and social inclusion** – identifying and tackling underlying inequalities in social and wider determinants of health, promoting better, equitable access to services;
- **Living well** – so everyone has the right and opportunity to live their best life, with the required support and infrastructure to make healthy choices and maximise wellbeing; and
- **Ageing well** – to provide support and services required to meet the needs of an ageing population, adapting to changing demands and new models of care.

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Given the breadth of the ambition, the Board has identified five initial priorities of focus which are:

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

Luton

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

This is supported by:

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

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

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

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

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

The Milton Keynes Health and Council partners have formed **MK Together**. It formalises the commitment of the main local NHS partners in Milton Keynes and the City Council to work more closely together, with a focus on:

- **Improving system flow** – targeting urgent and emergency care services for older, frail or complex service users;
- **Tackling Obesity** – helping people lose weight and maintain a healthy weight through easily accessible weight management programmes, use of technology, pharmacological therapies, and education and prevention work;
- **Children and young people's mental health** – good mental health in children and young people helps build resilience, develop healthy relationships and lays the foundation for better mental and physical health and wellbeing throughout their whole lives. Early intervention is key for lifelong wellbeing. 75% of adult mental health issues are present by the age of 24; and
- **Complex Care** – focussing on improving the planning, assessment, commissioning, and case management for people who have the most complex needs
- MK has started a research phase on a Bletchley Pathfinder project to develop integrated neighbourhood working

Bedfordshire Care Alliance

The Bedfordshire Care Alliance is a Provider Collaborative. It aims to ensure that, where scale and complexity requires us, to provide standardised care across the three Bedfordshire boroughs.

The Alliance has agreed an initial focus on four priority areas:

- **Supported discharge** – improving rehab, reablement and recovery outcomes;
- **Alternatives to acute admission** – stay well at home;
- **Digital infrastructure** – to enable integrated pathways of care across Bedfordshire; and
- Support to Places to optimise **care closer to home**.

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Mental Health, Learning Disability and Autism Spectrum Disorder Collaborative

The Mental Health, Learning Disability and Autism Collaborative is a collaboration between several ICB partners - Central and North West London NHS Foundation Trust, East London NHS Foundation Trust and the ICB. It aims to improve outcomes, quality, value, and equity for residents.

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

Specific areas where the Collaborative will add value will include:

a. Development of sustainable early intervention and crisis and recovery pathways for children, young people and adults;

b. Develop capacity to deliver early local diagnosis and support for people with autism and autistic spectrum disorder;

c. Development and implementation of sustainable recovery-focused models of care for people with complex needs. This includes complex placements being provided within the ICB area as standard;

d. Capital development in core services, for example mental health inpatients; and

e. Improving physical health access and outcomes for people with serious mental illness, learning disability and autism.

SECTION NINE: BLMK ICB Principal Risks

The BLMK ICB Joint Forward Plan is designed to deliver the core objectives of the ICB for our residents. As such it aims to tackle within the High Impact Programmes and Enablers all the most critical risks the BLMK Partners face in delivering our core services, and our collaborative plans to improve health outcomes, tackle inequalities, provide value for money and support growth in our local economies.

Our key risks are held in the ICB Board Assurance Framework & overseen by the ICB Board.

The extent to which our High Impact Programmes & Enablers mitigate these known principal risks - and the outstanding risk which cannot be mitigated locally – is summarised below:

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BAF Prefix	Strategic Priority	Risk Detail	Risk Mitigations in Joint Forward Plan Programmes & Enablers	Outstanding Risks
BAF0001	Live Well	**Recovery of Elective & Cancer Services** There is a risk that the NHS is unable to recover elective and cancer services and waiting times to pre-pandemic levels due to Covid and Urgent and Emergency Care pathway related pressures, workforce constraints or demand led pressures. This may lead to poorer patient outcomes and reputation damage.	**Improving Access & Treatment** • Health services strategy • End-to-end pathway review & peer productivity challenges to improve effectiveness & productivity • Implementation of community diagnostic hubs • Cancer programme Integrated Neighbourhood Working • Place-based plans to increase prevention & early diagnosis • Increasing primary care & neighbourhood capacity	Capital investment required in targeted areas to: • unblock existing acute flow bottlenecks in urgent emergency care and elective capacity • ensure diagnostic capacity aligns to population need • accommodate sufficient primary care capacity as population increases
BAF0002	Growth	**Developing suitable workforce** If system organisations within BLMK ICS are unable to recruit, retain, train and develop a suitable workforce then staff experience, resident outcomes and the delivery of services within the ICS, ICB People Responsibilities and the System People Plan are threatened.	**Improving Access & Treatment** • Health services strategy **Improving Outcomes for MHLDA** • Workforce strategy to deliver mental health investment standard **Intelligence-led quality, performance, outcomes & inequalities** • Use of digital technology, quality improvement & tackling inequalities skills to support effective pathways of care **Integrated Care System Target Operating Model** • Staff to move to Integrated Care System Target Operating Model • Delivery of co-production training across teams	National training pipeline shortages in key speciality roles, including; • Histopathology • Midwifery • Primary Care • Social Care Impact of long-term sickness absence from wider workforce across all employers, including public sector employers e.g. treatments and operations delayed, impacts public service delivery & slows economic growth Impact of the anticipated NHSE Long Term Workforce Strategy is not yet known.
BAF0003	Live Well	**System Pressure & Resilience** As a result of continued pressure on services from various factors there is compromised resilience in the health and social care system which threatens delivery of services across BLMK. This may lead to poorer patient outcomes and reputational damage.	**Delivery over the medium-term of the 'left shift':** • Increasing prevention and early diagnosis • Integrated Neighbourhoods proactive intervention to help older people stay well at home • Children & Young People – actions to improve long term conditions management, and reduce avoidable admissions • MHLDA – crisis and recovery pathway development to support more people to stay well in the community	Multiple reporting requirements at times of peak / sustained pressure will divert from efforts to deliver the sustainable 'left shift'

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BAF Prefix	Strategic Priority	Risk Detail	Risk Mitigations in Joint Forward Plan Programmes & Enablers	Outstanding Risks
BAF0004	Reduce Inequalities	**Widening inequalities** There is a risk that inequalities and outcomes for specific demographic groups within BLMK population will widen compromising our ICS purpose to improve outcomes and tackle inequalities.	Focus on health population & impact of all High Impact Programmes & Enablers is core to all our delivery. This is enhanced by: • Implementation of the population health intelligence unit, and NHS performance reporting by local population need • Specific actions to tackle inequalities & improve health outcomes • Co-production & working with VCSE to maximise access to our most deprived populations	Revenue funding shortfalls to core Local Authority functions such as adult & children's social care & SEND to support our most vulnerable populations
BAF0005	Growth	**System Transformation** There is a risk that sustained operational pressures and complexity of change, there will be reduced delivery and benefit from strategic transformational change to deliver improved outcomes for our population.	BLMK ICB transformation is enabled by: • Subsidiarity to Place & Provider Collaboratives • Shift to Integrated Care System Target Operating Model • Streamlined reporting & performance management regime • Operational plans at Place / Provider Collaborative to address UEC demand pressures • Capital investment in key areas such as diagnostics capacity Transformation across all High Impact Programmes & Enablers is targeted to deliver the greatest benefit to residents through effective use of our resources	Risk that multiple requirements from central policy-makers will divert attention from BLMK population-centric key deliverables – and compromise efforts to improve health outcomes, reduce inequalities & deliver sustainable services that are value for money for our residents Need for joined-up medium-term capital and revenue investment in digital and business intelligence capacity & capability to enable transformation of care
BAF0006	Growth	**Financial Sustainability & Underlying Financial Health** As a result of increased inflation, significant operational pressures, patient backlogs and the enduring financial implications of the Covid pandemic - there is a risk to the underlying financial sustainability of BLMK that could result in failure to deliver statutory financial duties.	This is supported by: • Enhanced digital capability to reduce duplication of effort • Effective Infrastructure and People strategies • Health services strategy and Research & Innovation to improve outcomes within resources • Focus on prevention and early diagnosis to support residents' health & well-being, and slow increases in population need & demand • Effectiveness & efficiency programme to tackle unwarranted variation & thus reduce avoidable cost	Condition of BLMK estates & infrastructure requires significant investment to maintain the status quo Requirement for ongoing cost improvement delivery in the context of rising operational pressures may not be fully deliverable

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BAF Prefix	Strategic Priority	Risk Detail	Risk Mitigations in Joint Forward Plan Programmes & Enablers	Outstanding Risks
BAF0007	Live Well	**Climate Change** Due to climate change and wider impacts on the environment and biodiversity, there is a significant risk of increased pressure on health and care services, due to: i) exacerbation of existing health conditions; ii) new health challenges iii) extreme weather events resulting in harm; iv) disruption to day-to-day healthcare provision; and v) a deterioration in population health outcomes.	Clear strategy in our Joint Forward Plan to maximise our collective impacts on sustainability & growth, supported by: • Place Plans • BLMK People Strategy, including our actions as anchor institutes Our Infrastructure strategy will highlight key areas of risk caused by infrastructure fragility most likely to compromise sustained delivery of health, care and civic services contingent to delivery of our ICB shared objectives.	Fragility of some key infrastructure means that service interruption is more frequent as weather variation becomes more extreme Cost of sustainable products is prohibitive to the public purse Challenges in achieving sufficient capital to meet increased health need due to population growth
BAF0008	Live Well	**Population Growth** As a result of fast rate of population growth in BLMK, there is a risk that our infrastructure will not keep pace with the needs of our population, which will exacerbate widening inequalities and outcomes.	Joint Forward Plan will be based on modelling of population growth & demographic shift generated by our local housing plans. This will enable more accurate & strategic demand / capacity modelling. Delivery of future services is informed by our health services strategy, MHLDA and children & young people's plans and our People strategy	Challenges in achieving sufficient capital and revenue to meet increased health need due to population growth
BAF0009	Live Well	**Rising Cost of Living** As a result of rising cost of living there is a risk that our staff and residents will not be able meet their basic needs resulting in deteriorating physical and mental health resulting in pressure on all public services	Our 4 Boroughs all have strong plans to support people into training & employment; grow the local economy and enable our communities to thrive. Our Joint Forward Plan High Impact Programmes & Enablers ensure that our efforts improve the years lived in good health by all our residents. Our collective focus on health outcomes improvements and tackling the wider determinants of health are crucial to ensure we tackle the inequalities experienced by our most disadvantaged communities	

Bedfordshire, Luton and Milton Keynes
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