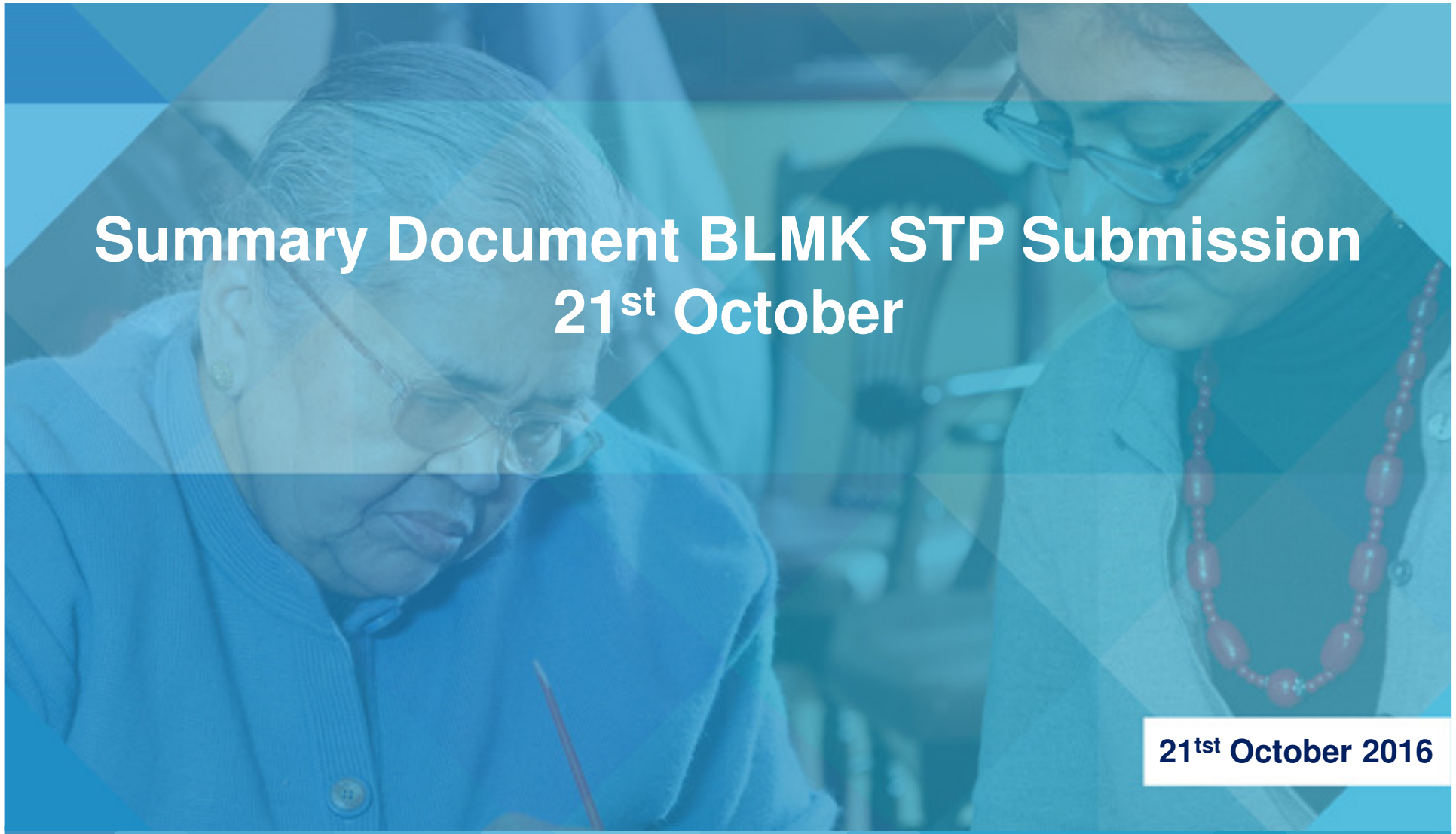
Summary Document BLMK STP Submission 21st October



21tst October 2016

BLMK STP partner overview of October submission

- STP Partners in BLMK have continued to build on the strategic direction signalled in our June 2016 STP submission.
- There have been no changes since June to the key priorities being pursued at the STP level. These continue to combine user-facing initiatives, in the areas of prevention, primary, community and social care and hospital services, with enabling work, designed to create the right tools (e.g. digitally communicable care records), levers and incentives to support the transformation process.
- Considerable effort has gone into refining BLMK's five STP priorities. This has involved defining and aligning the different work packages required to deliver change associated with each priority, as well as STP partners planning and resourcing how that change will be implemented. Each priority has now assembled an **Implementation Plan and Investment Case**, which sets out the key steps required to achieve STP goals.
- In September, BLMK took receipt of the population health analysis commissioned by STP Partners. This has been used to add precision to transformational solutions that will enable current and projected demand to be redirected from hospital into community settings and self-managed care. These solutions have been trailed extensively with primary care colleagues, at GP practice level, at CCG level and via cross-BLMK clinical engagement events.
- Since June, the STP has assumed responsibility for developing proposals to modernise secondary care services across BLMK, rendering them both clinically and financially sustainable. All three hospitals are centrally involved in this work.
- A tri-organisational Secondary Care Services Transformation Board has been set up and is overseeing four discrete workstreams, covering clinical services, clinical support services, non-clinical support services and the non-medical clinical workforce.
- The SCSTB expects to complete plans for creating an integrated model of leadership, management and operations across the three hospitals by **31st March 2017**. It is highly likely that capital expenditure will be required to enable BLMK to achieve the transformation it is contemplating. We will clarify at this time the nature and level of capital expenditure required, albeit we will be mindful in formulating our plans of its limited availability in coming years.
- Where, in the meantime, opportunities arise that improve the way the three Trusts operate clinically and financially, these will be expedited, subject to BLMK fulfilling any statutory consultation obligations that may arise.
- Any significant changes to secondary care services that might emerge from this work will be taken forward through close engagement with STP partners, and will also involve appropriate statutory consultation with the general public.
- The three Trust Boards are currently examining options that would enable each to delegate and pool some formal decision-making powers to a jointly governed vehicle operating across the three Trusts.
- Working collaboratively across NHS bodies and local Councils, BLMK's Digitisation workstream has now identified seven key digitisation development themes. The work programme to define and progress these seven themes will be overseen by the newly created BLMK Digitisation Programme Board. This Board is chaired by one of BLMK's local Council Digitisation lead.
- BLMK will also benefit from LDUH's selection (since June) as one of only 12 national Global Digital Exemplars. This programme is working closely to ensure it is aligned with the STP Digitisation programme, and can share lessons and solutions to engage fast followers across the footprint.
- Since June STP partners have been able to conclude that current arrangements for analysing and assessing need, and for commissioning, transacting and providing health and social care in BLMK, will not be fit for purpose going forward. All relevant NHS parties (i.e. both NHS commissioners and providers) across BLMK have expressed an appetite for adopting an accountable care approach to commissioning and delivering NHS services.
- Such an approach will continue to see care designed and delivered at the locality level (typically 30,000 to 50,000 population), sensitised to the needs of different localities, and in a way that list-based general practice remains front and centre. Some functions and activities will operate in patches co-terminous with local Council boundaries - others, such as health population analytics, information and communications systems and technology and administration will operate across the BLMK footprint
- The post 21st October work programme in respect of accountable care falls into stages, namely:
  - ✓ Stage 1 – accountable care options assessment – complete by **January 2017**
  - ✓ Stage 2 – accountable care system design, development and procurement planning – complete by **October 2017**
  - ✓ Stage 3 – undertaking procurement(s) – complete by **March 2018**
- Close interplay and significant inter-dependencies between the development of BLMK's community clinical model and the development of BLMK's approach to accountable care has persuaded STP partners to combine governance oversight of these two work programmes

Our vision, our design principles and our transformation priorities for the next 5 years

BLMK vision, design principles and transformation priorities

A glimpse into the BLMK's future

- People are increasingly knowledgeable about their physical and mental health. They also take far greater personal responsibility than previous generations.
- People feel much more in control of their health and well-being and indeed, enjoy exercising this control.
- Strong voluntary support is available and the local NHS and our Councils have very close links
- GPs are the pivot point for those needing access to the NHS. They lead extended multi-disciplinary teams. Technology and a multi-disciplinary primary care team enables GPs to continue to coordinate the care of all individuals on their lists whilst enabling GPs to direct much of their own time to those most in need, such as the chronically ill and those with multiple or complex morbidities.
- Children's and adult community physical and mental health services are organised on a locality basis (around 30,000 to 50,000 population), and are wrapped-around GP practices.
- Mobile working in the community is now the norm. Shared care records, digitisation and 21st century communications allows more time to be spent on providing hands-on support to children and their families, and to the house-bound elderly. Expert opinion and support can be delivered beyond the hospitals walls
- More integrated working between clinicians, therapists and social workers has all but removed the boundaries between these professions. The days of multiple visits to the same person by different professionals are long gone.
- Staff working in nursing and residential care homes are seen as a vital cog in the health and social care machine. Immediate access by them to shared care plans and remote expertise, has been a crucial tool in enabling them to playing a more proactive role in the care of their residents.
- Care home residents are supported by community clinicians, who operate an anticipatory, in-reach model, by which they proactively manage the physical and mental health and well-being of residents.
- NHS bodies and local Councils in BLMK collaborate closely to meet the demand for care home places and domiciliary support in a timely manner.
- Those working in community settings are now better able to meet the demands put on them. People being marooned in hospital, due to no support being available to get them home, is a thing of the past.
- The general public easily navigate to the most appropriate urgent and emergency care option for their need. This has been helped by the development, over recent years, of responsive, trusted and well sign-posted urgent care services across BLMK. Such services can now reach into people's homes, where needs can be dealt with remotely or by urgent community paramedics or rapid response community health clinicians.
- For people able to present "on foot", a network of "walk-in" urgent care centres operate across BLMK. Likewise, genuine emergency care is well-delineated in the public's mind. This means that only the acutely ill call on this most specialist and expensive component of the statutory sector's service offer.
- When local hospital services are required, high quality hospital care is available, and in a timely way, on BLMK's three hospital campuses. These hospitals are no longer isolated from each other, but work in an integrated way. As a result, across the three of them, they are able to deploy the latest advances in medical practice and technology to provide a safe, high quality, service and to obtain the very best clinical outcomes.

System design principles that will shape BLMK's transformation

1. Decisions informed and supported by 1st-class population-health analytics, conducted at scale
2. This analytic platform should critically inform resource allocation and investment
3. Pathways should be designed around the patient and should to draw on and embed into clinical practice the best evidence available so that they deliver consistent clinical excellence.
4. Connections should be made between the analytics, practice and practitioners, so that insights can shape health and care practice.
5. Solutions reducing inequalities in access to care and reducing unwarranted variations should be prioritised.
6. Effort required to secure attitudinal change required in preventing illness and promoting good physical and mental health and well-being should be built into local plans.
7. Activities that provide early warnings, and that lead to early interventions should be prioritised.
8. Self-managed care (including input provided by informal carers) should be enabled and barriers to it removed.
10. Care for those with long term conditions and/or of those with multiple morbidities, should be wrapped around the patient/service user, their informal care network and their home.
11. Approaches that co-ordinate and integrate physical and mental health well-being for those needing both need to be prioritised and built into local plans.
12. Hospitalisation rates must be reduced through a combination of:
    - Strengthened capacity and capability of services in community settings
    - Significantly improved coordination and continuity between these services
    - Placing care as close to the home as is clinically feasible.
13. Hospital services must be organised so that they ensure the safety of the patient during a hospital stay, and that they maximise our ability across the footprint to provide clinically excellent care, year-in, year-out.
14. Hospital services and senior hospital clinicians must also work proactively and effectively with and across the pre-acute and post-acute care pathways to optimise patient outcomes and resource consumption.
15. BLMK must be able to live within its financial means, year-on-year.

BLMK's transformation priorities for next 5 years

- Impactful health improvement and illness prevention and empowering self-management and social capital — P1
- High quality, scaled and resilient primary, community and social care services across BLMK — P2
- Modern, sustainable, high quality secondary care services across BLMK — P3
- Forge footprint-wide collective-leadership charged with designing and delivering a BLMK digital programme — P4
- Re-engineer the system of demand management, commissioning and health and social care provision in BLMK — P5

The case for change in BLMK

BLMK's STP priorities must address weaknesses in the disposition and the fitness for purpose of our existing resources. The extent of change required can be assessed by how well BLMK is currently performing against NHS England's triple aim of achieving:

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

Health and well-being performance in BLMK – some headlines

Maternal and Child Health

- Life expectancy is better than the national average in Bedford Borough and Central Bedfordshire, and worse or similar in Luton and Milton Keynes.
- Healthy life expectancy varies from 59.3 years for men in Luton to 67.2 years for women in BBC.
- There are significant health inequalities within our communities.
- One in ten mothers smoke at time of delivery.
- Less than half of mothers in BLMK breastfeed for at least six weeks.
- One in ten new mothers will suffer mild to moderate depression or anxiety.
- One in five children are overweight or very overweight by the age of five, rising to one in three by the age of 11.
- Asthma admissions in the under 19s are high and rising in three out of four local authority areas.

Working age adults

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

Older people

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

Quality of health and social care in BLMK – some headlines

Primary care

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

Urgent care outside hospitals

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

Community health services

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

Social care

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

Mental health and learning disability services

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

Secondary care services

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

BLMK's financial position

2016/17

- The BLMK health economy has significantly overspent its NHS allocation in recent years.
- Coming into 2016/17, the 3 CCGs brought forward a combined accumulated deficit totalling £84.5m (equivalent to 33% of the whole of England), whilst two of the three hospital Trusts had built up a combined accumulated deficit of £154.1m.
- The 2 hospital Trusts in deficit look set to record broadly similar levels of deficits in 2016/17 as they did in 2015/16 (before applying 2016/17 STF funding).

The future

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

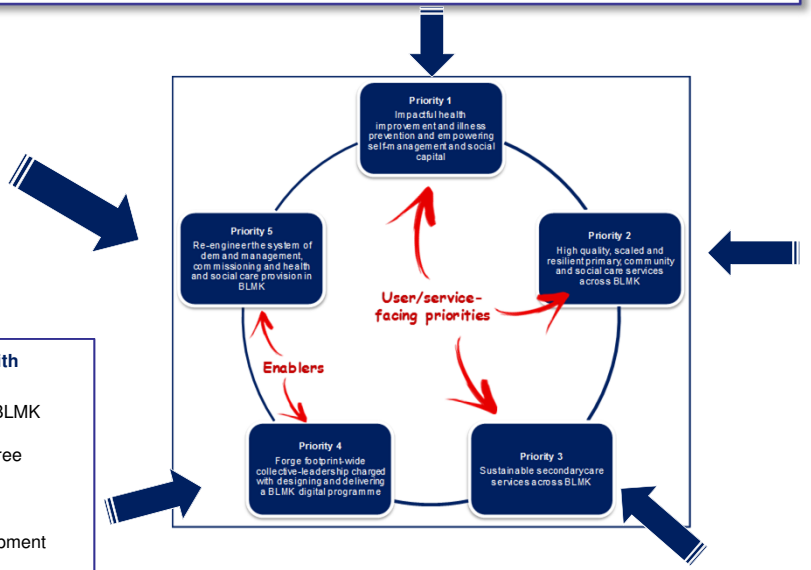
Aide memoire – key sustainability and transformation priorities established by BLMK in June STP submission

Priority 5 – To re-engineer the system of demand management, commissioning and health and social care provision in BLMK

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

Priority 1 - Impactful health improvement and illness prevention and empowering self-management and social capital

1. To radically upgrade prevention, early intervention and self-management of care by formulating system-wide prevention plans.
2. The prevention challenge must secure systematic high-level support and intervention, at scale, across the footprint.
3. Success will depend on embedding ownership of prevention principles, and the practicalities of transformation in this area, with STP partners, with individuals and with communities at large.



Priority 2 - High quality, scaled and resilient out of hospital services across BLMK

The key goals of Priority 2 are:

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

Priority 4 – Forge footprint-wide collective-leadership charged with designing and delivering a BLMK digital programme

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

Priority 3 - Sustainable secondary care services across BLMK

The key goals of Priority3 are:

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

How do BLMK's STP priorities contribute to the nine NHS England "must-haves"?

NHS England's "Must Dos"	Priority 1 Impactful health improvement and illness prevention and empowering self-management and social capital	Priority 2 High quality, scaled and resilient primary, community and social care services across BLMK	Priority 3 Sustainable secondary care services across BLMK	Priority 4 Footprint-wide collective leadership charged with designing and delivering a BLMK digital programme	Priority 5 Re-engineer the system of demand management, commissioning and health and social care provision in BLMK
1. Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.	◎	◎	◎	◎	◎
2. Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.		◎	◎	◎	◎
3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.		◎		◎	◎
4. Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.		◎	◎		
5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.		◎	◎		
6. Deliver the NHS Constitution 62-day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31-day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.		◎	◎		◎
7. Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.		◎			◎
8. Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.		◎			
9. Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.	◎	◎	◎	◎	

◎ = STP Priority expected to have direct impact on BLMK achieving nine national "must-haves"

Latest acute hospital performance stats against NHS Constitution standards

- BLMK secondary care services are challenged to achieve NHS Constitution standards and performance has deteriorated since the STP June submission.
- In the absence of transformation, performance is likely to continue to deteriorate.
- A&E attendances are characterised by high levels of acuity of patients. The conversion of attendances in to admissions varies across the hospitals. There is also evidence that discharge difficulties are causing higher lengths of stay than are clinically necessary
- Ambulance performance across the footprint has come under severe pressure during 2016/17.
- There are high vacancy rates in a number of non-medical posts across BLMK. Both the nursing and medical workforce is also ageing rapidly.

NHS Body	Urgent and emergency access standards			Achieve cancer access standards and increase early detection rates		
	A&E waits: 95% < 4 hours	Ambulance – 75% Category A responded to < 8 minutes	Achieve 18 week RTT for non-emergencies (target = 92%)	Achieve 62-day cancer waiting standard (target = 85%)	Deliver two-week cancer standard (target = 93%)	Deliver 31-day cancer standard (target = 96%)
BHT	91.6%		93.7%	82.9%	94.4%	98.7%
LDUH	99.1%		92.9%	90.0%	96.1%	100.0%
MKUH	91.2%		88.8%	80.4%	95.7%	100.0%
BCCG		76.3%	91.6%	75.9%	95.1%	98.5%
LCCG		94.6%	93.3%	85.3%	95.3%	98.4%
MKCCG		80.6%	90.2%	74.0%	95.6%	100.0%

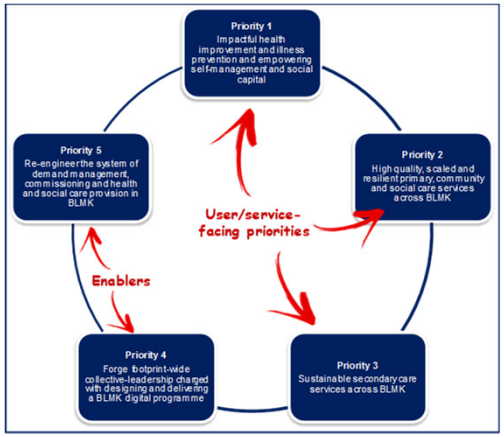
Expected benefits … what is the STP doing for…?

NHS

BLMK's transformation priorities for next 5 years	 Public, patients and family carers	 Local Councils	 General practice	 Clinicians and care staff
P1 Impactful health improvement and illness prevention and empowering self-management and social capital	• Invest time, effort and funding to address the 6 areas that will have the highest local impact on the health status of BLMK's citizens • Stronger community and voluntary resources to increase community resilience support citizens seeking to maximise their independence, despite potentially limiting health conditions	• Create new levers for Councils to lead effective, well-resourced and continuous public health and illness prevention campaigns • Force prevention planning to the top of the health & social care agenda across all partners in BLMK • Ensure that better value is achieved from current and future spend on prevention by the NHS and by Council	• Increased appetite by, and capability of citizens (and their family carers) to self-care and to "partner" the GP in the delivery of their care • Earlier presentation to clinicians can facilitate earlier detection and more effective and less invasive treatment	• Citizens are better informed about how to access the most effective care, most easily • Citizens are more aware of the options available to them, including those provided by voluntary organisations • Such options both work and are trusted by BLMK citizens,
P2 High quality, scaled and resilient primary, community and social care services across BLMK	• Easier access to clinicians based in the community to address emergency, urgent or non-urgent needs • Earlier detection and intervention to prevent illnesses deteriorating or to manage the progress of chronic diseases • More proactive management of citizens with complex or long term conditions • Easier and timely discharge from hospital back to home or into community facilities	• Improved access for local citizens to health and social care facilities in community settings • Planning and delivery conducted at a locality level (30-50,000 citizens), enabling services to be senstised to local needs • Higher levels of investment in statutory and non-statutory community infrastructure, improving community resilience • Greater integration between health and social care professionals across primary, community and social care, but also between health and other Council services, such as housing offered by investment in community infrastructure	• Ready access to stronger multi-disciplinary clinical skills • Ready access to high quality decision-support systems & technology • Able to operate at the "top of license", develop specialist skills and to focus their scarce skills on citizens with complex or chronic needs • Capacity created to undertake anticipatory care and to in-reach into care hot-spots, such as care homes	• Organised to serve localities of 30-50,000 people, community physical and mental health clinicians know their "patch" and are closely integrated with GP practices on that "patch" • Community health clinicians work closely with, and in many cases, are integrated with social care professionals • Opportunity for increased specialisation in primary care • Hospital clinicians provide support and specialist leadership into the community • Care workers in care homes are supported by close links with local primary care and community clinicians
P3 Modern, sustainable, high quality secondary care services across BLMK	• Retain local access to high quality hospital services across all three BLMK campuses • Underpin vulnerable hospital services by closer working across the three hospitals • Remove the threat of precipitous loss of services due to staffing, quality or financial challenges • Eliminate or reduce boundaries for citizens who move between hospital and community settings	• Improved access for local citizens to emergency and specialist services due to education, sign-posting and stronger and more responsive alternatives to A&E • Integrated clinical leadership operating across hospital and community setting • Removes continual uncertainty about the future of locally accessible hospital services	• Closer co-ordination between GPs and hospital clinicians across care pathways • Closer connectivity between GPs and hospitals facilitates and smoothes the transition of citizens between care settings, either into or out of hospital • Hospital clinicians supporting the development of specialist clinical expertise in primary care	• Long-standing medical and nursing staffing shortages are addressed by integrated clinical and operational leadership, operations and resources across the 3 hospitals • Opportunity for clinical staff professional development and specialisation by working across the 3 hospital campuses • The chosen configuration of hospital services is now clinically and financially resilient and sustainable into the foreseeable future • Diagnostic tests are more readily and rapidly accessible to support clinical decision-making, both inside and outside the hospital
P4 Forge footprint-wide collective-leadership charged with designing and delivering a BLMK digital programme	• Empower citizens to take much more control over their health and well-being and to support patient-activation mechanisms • Easier digital access for citizens to clinicians or care workers, via shared care records and digitised technology • Digital support to empowering communities, and increasing self-management through apps, tele-health, tele-medicine, and digital alternatives to face-to-face consultations	• Converging digitisation platforms across health and Council bodies enables greater integration and removes unnecessary boundaries • Complements and supports initiatives in Councils to empower local citizens to be more self-reliant in meeting their health and social care needs, and for local communities to be more resilient	• More effective management of the health and social care needs of citizens on the GP list, via proactive, list-level referral management • Easier and quicker access to shared care records to support work of the GP	• Access to shared care record enables quicker and more comprehensive diagnosis • Access to shared care records, and associated care plans, for community clinicians and care workers in care homes enables more effective local decision-making and risk assessment
P5 Re-engineer the system of demand management, commissioning and health and social care provision in BLMK	• From a user's perspective, a more joined up services across health and social care and between community and hospital settings • From a member of the public's perspective, the ability to participate in the design, delivery and assessment of newly developing services • Better value for money and increasing the proportion of funding spent on front-line services	• Better integrated planning and service delivery across health and social care services in hospitals and community settings • Provides an innovative framework to co-ordinate budget management across health and social care to eliminate inadvertent cost-shunting	• Via new care models, provides new ways of engaging with and incentivizing GPs and other primary care clinicians to support vulnerable practices or to solve "hard to recruit into" areas/practices • Offers opportunity for GPs and other primary care clinicians to focus on care management and delivery and reduce administrative burden	• Via the introduction of systems integrator, improved coordination between clinicians around a citizen • Incentives between individual clinicians and their organisations are much better aligned to achieve defined patient/clinical outcomes • Reduces administrative burden on clinicians

Our progress since our June submission

Feedback on BLMK's June STP submission



BLMK STP work programme priorities (July to Oct)

- Identify key interventions to be worked up between now and September, informed by deliverables from Optum
- Long-lists to be refined, sifted and prioritised, in the light of the 5 STP Priorities
- Planning activity in each workstream to be channelled via STP Priority leadership.
- Test and validate the scope of activities that each workstream is examining.
- Having determined, key interventions, move on to implementation planning. Key elements of an Implementation Plan will include:
  - ✓ Measurable goals and benefits to be realised
  - ✓ Timescale to achieve goals, including key milestones
  - ✓ Investment required to achieve the goal
  - ✓ Monetised impact on recurrent budgets of achieving goals
  - ✓ Risk management and benefits realisation planning

NHSE _ Midlands & East

I. What are the priorities of the plan?

1. Impactful health improvement and illness prevention and empowering self-management and social capacity
2. High quality, scaled and resilient primary, community and social care services across BLMK
3. Sustainable secondary care services across footprint
4. Forge footprint-wide collective leadership, charged with designing and delivering a BLMK digital programme
5. Re-engineer the system of demand management, commissioning and health social provision

II. What are the 3-5 critical decisions (if any) to be made

- **Acute reconfiguration** - alignment of Bedfordshire/Milton Keynes Healthcare Review (HCR) within STP and decision on way forward for HCR.
- **Acute partnerships to support sustainability**:
  - collaborative working across three hospitals (Milton Keynes, Bedford and Luton & Dunstable)
  - understand acute pathway flows from Milton Keynes outside of STP footprint and associated impact.
- **Stroke Reconfiguration**: clarity on decision re Stroke Services and Hyper Acute Stroke Unit (HASU) development across STP, given the need to improve clinical outcomes.
- Development and agreement of the **preferred model for Primary Care/Community services**.

III. What is being requested and what are the benefits?

- Capital investment – NHSI to establish a placeholder in its schedule of capital expenditure arising out of STPs.
- Investment of STF existing allocations.

IV. Summary recommendations / observations from Regional Team

Preliminary cohort allocation to cohort 1/2/3 (Note: this is no formal decision at this stage)	2
Strategy / vision of the plan	some support needed
Deliverability of the plan	some support needed
Strength and unity system leadership and governance	some support needed
Reach and quality local engagement process	some support needed
Extent of local support for the proposal	partial

V. Region suggested next steps for footprint

- Acute reconfiguration - alignment of Bedfordshire/Milton Keynes Healthcare Review (HCR) within STP and decision on way forward for HCR (2 months)
- Development of acute partnerships to support sustainability (3 months)
- Capital investment linked to HCR to be confirmed (2 months)
- Understanding impact and plan for Optum, including assumptions for the loss of income to acute providers as a result of planned shift to community based care settings (2 months)
- Development and agreement of the preferred model for Primary Care/Community services.
- Decision on stroke reconfiguration and HASU development (1 month)
- Development of Governance and accountability structures (2 months)
- Develop communication and engagement strategy to ensure key stakeholders are aware of, and where possible, are involved in decision making (3 months)
- Assessment of the deliverability of high level milestones and ongoing programme plan development (3 months)

VI. Advice which topics to discuss during visit

- **Acute reconfiguration:** How is the Bedfordshire/MK review aligned with the STP and how are acute partnerships developed to support sustainability?
- **Primary Care/Community model:** How are quality challenges to be met through the design of this model?
- **Engagement:** How ware clinicians being engaged in decision making?
- **System alignment:** What is the current level of political and organisational buy in to work on a collective solution to the challenges presented in the plan?
- **Prevention:** Are prevention schemes being utilised to their full potential?

National ALBs

Element of feedback	Progressed	STP October Submission - Summary	Further Informaiotn
1. Have greater depth and specificity	✓	See Slides 11, 16-28	Programme Implementation Plan and Investment Case P1- P5
2. Provide year on year financial trajectories for the overall STP programme and for solutions	✓	See Slide 36	Oct 2016 STP Financial Template
3. Articulate more clearly the impact on quality of care	✓	See Slide 32	Programme Implementation Plan and Investment Case P1- P5
4. Include stronger plans for primary care and wider community services	✓	See Slide 18-19, 24-25	Programme Implementation Plan and Investment Case Priority 2 & Priority 5
5. Set out more fully your plans for engagement	✓	See Slide 44-47	STP Communications and Engagement Plan
6. Priority 5 should be taken forward at the same pace and purpose as the other priorities	✓	See Slide 24-25	Programme Implementation Plan and Investment Case Priority 5
7. Stronger plans for mental health	✓	See Slide 16, 18, 20	Programme Implementation Plan and Investment Case P1- P5
8. An increase in the resources to support and deliver the STP programme	✓	See Slide 26-27	Programme Implementation Plan and Investment Case Priority 0

BLMK STP priority work packages process and October deliverables – activated and upcoming

Priority 0
Programme Structure and Management

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

- Workforce Plan outline

Priority 1
Prevention

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

- Implementation of FLS and SPH services

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

Priority 2
Primary, Community and Social Care

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

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

Priority 3
Secondary Care Transformation

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

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

Priority 4
Digitisation

- Citizen-facing architecture
- Digital Engagement in Care Homes

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

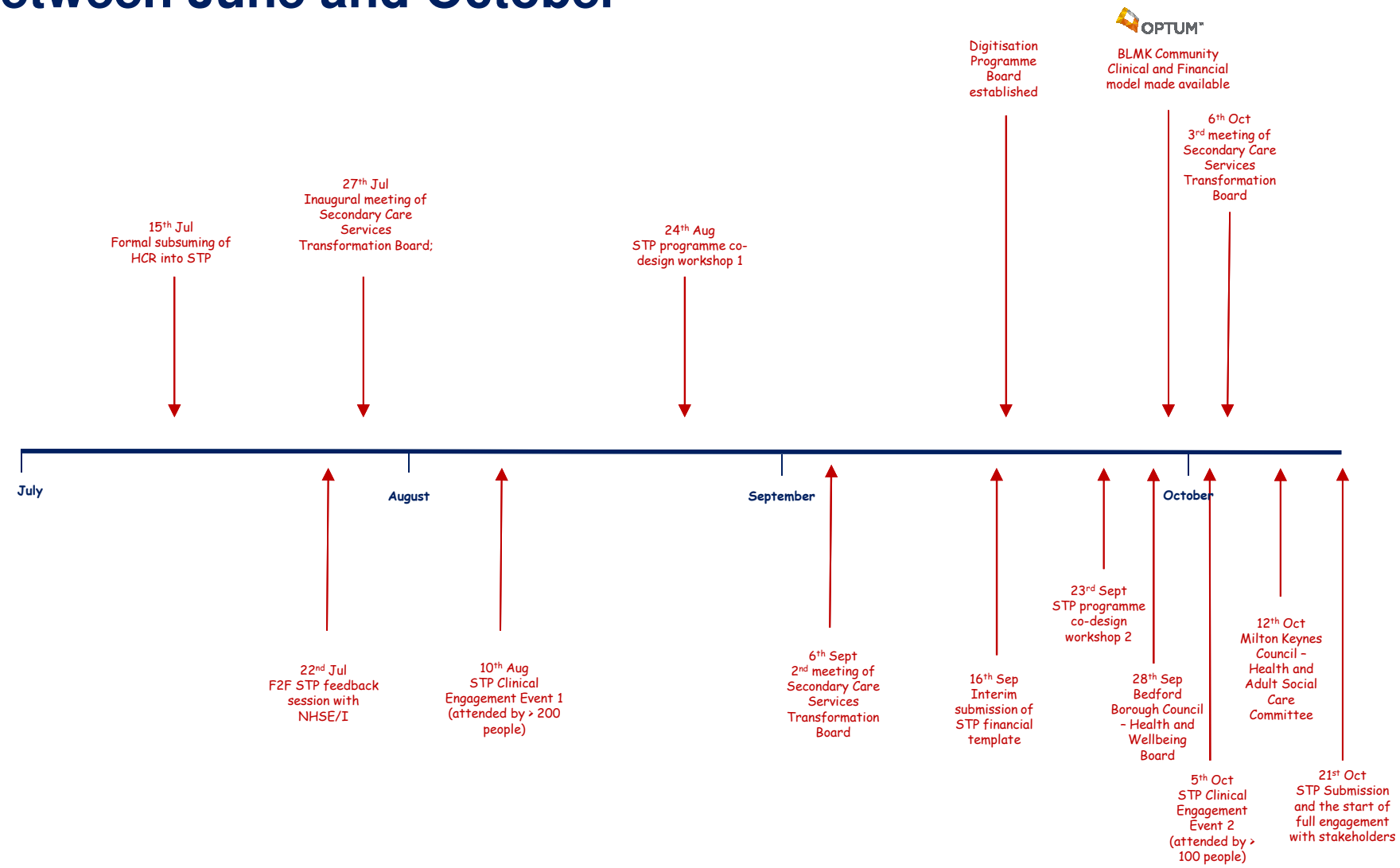
Priority 5
System Reengineering

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

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

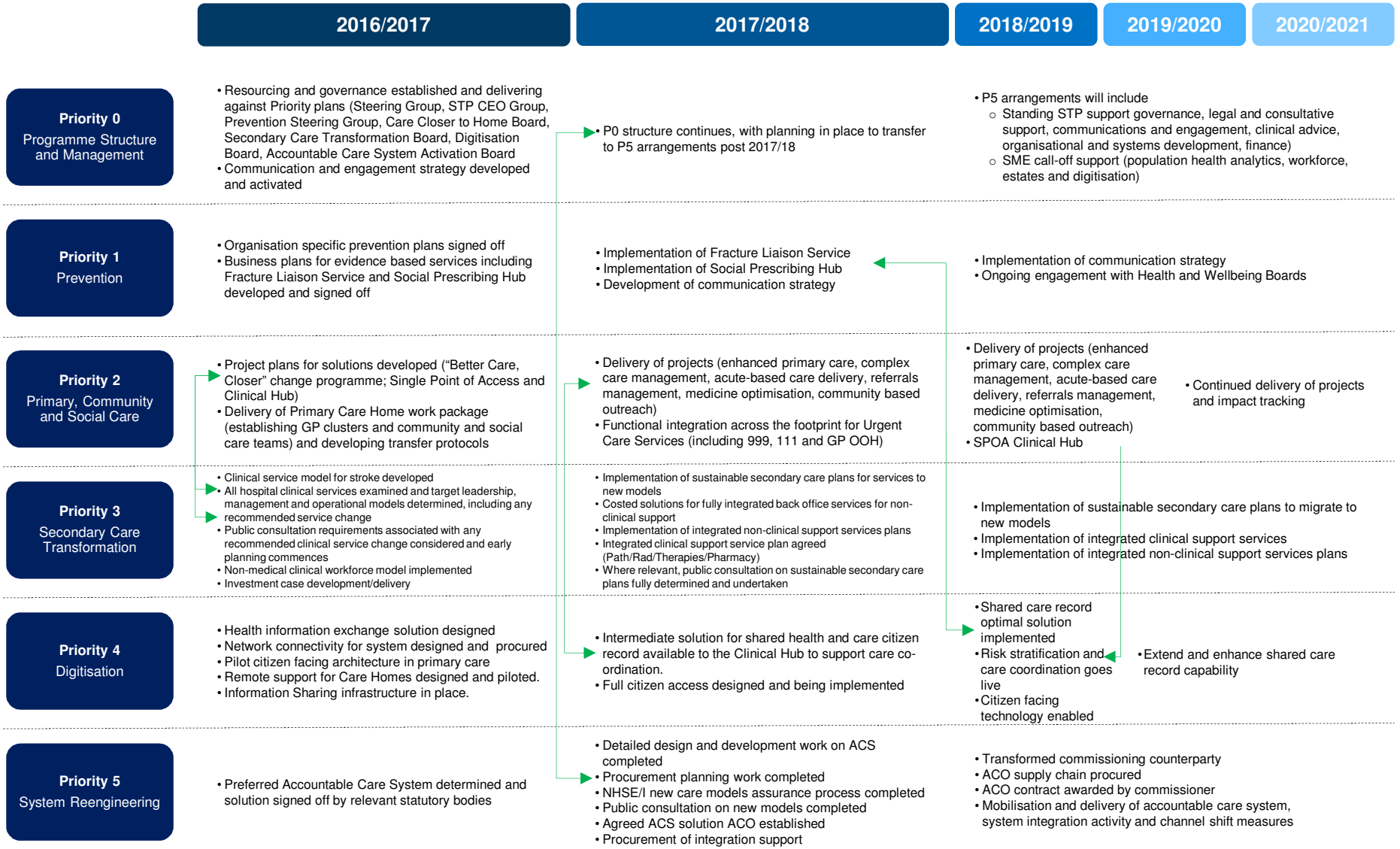
Priority 5 Programme Implementation Plan and Investment Case (October 16)

BLMK STP programme diary – some key events between June and October



Key messages from our STP work over the summer and our ongoing work programmes

BLMK STP 5 year "plan on a page"



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

Key:
Milestone
Ongoing Delivery

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

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

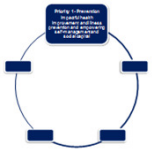
Programme Management	
Governance	Continued refinement of governance model, membership and terms of reference
Management	Leading up to an integrator being procured, continue to support priority and work packages leads and facilitate SME's into the programmes
Comms/Engagement	Clear routes of communications/feedback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

Priority 1 – prevention: our key messages

- Prevention effort at the BLMK footprint level is to be focused on six priority areas:
  1) Giving every child the best start in life
  2) Improving screening and immunisations coverage
  3) Tackling the four lifestyle behaviours (smoking, alcohol consumption, exercise and healthy eating)
  4) Promoting mental health and well-being, prioritising, in particular, peri-natal mental health and the emotional well-being of vulnerable children and young people
  5) Achieving healthy workforce and healthy estates
  6) Empowering communities and self-management
- The six priority areas reflect triangulation of the public health baseline position, national STP guidance and the output of two workshops, with broad stakeholder engagement.

Making it happen

- Public health directors from the four local Councils are leading the Priority 1 work programme
- Work packages that will enable these priority areas to be met include:
  - ✓ Enabling Prevention (various work sub-packages)
  - ✓ Organisation-specific Prevention Plans
  - ✓ Evidence-based service developments, initially involving:
    - ❖ Fracture Liaison Services Business Case
    - ❖ Social Prescribing Hub Business Case
- Enabling Prevention is broken down into further sub-packages, namely:
  - ✓ Establishing Prevention Governance (via the Prevention Steering Group which will be established by November 2016)
  - ✓ Programme Management (to establish mechanisms and processes to enable work packages to deliver quality and engage with other work package/priorities).
  - ✓ Engaging Health and Wellbeing Boards
  - ✓ BLMK-wide Communications Strategy for Prevention
  - ✓ Develop and quantify the outcomes and impact of the Prevention Programme
- The output of the 'Evidence-based service development' work packages are business cases – two of these will be finalised by March 2017.
- Promoting prevention up the strategic agenda in BLMK by:
  - ✓ Following the recommendation in June, each STP partner (CCGs, local Councils, acute hospitals, community and mental health services providers and ambulance services providers) has now appointed Board-level (or equivalent) champions for prevention (one champion appointment remains outstanding in October) – their role is to ensure their organisation commits to keeping people healthy by:
    - ❖ Championing a culture of prevention inside the organisation
    - ❖ Working with the BLMK STP Prevention Team to develop and implement an organisation-wide Prevention Plan
    - ❖ Enabling and advocating for successful implementation of the Prevention Plan within and outwith their organisation
    - ❖ Encouraging staff from across the organisation to get involved
    - ❖ Acting as the single point of contact for prevention matters for their organisation
    - ❖ Updating BLMK STP Prevention Group on progress and challenges of achieving the goals of the Prevention Plan.
  - ✓ Formulating and implementing an annual BLMK Prevention Communications Plan involving:
    - ❖ Sharing plans with system leaders and political representatives as they develop
    - ❖ Updating local Health and Well-being Boards, Scrutiny Committees and Executives as required
    - ❖ Engaging Healthwatch and facilitating it to exercise specific oversight for ensuring that "*the voice of the local community is listened to and acted on*".
  - ✓ STP partners become exemplars for workplace well-being
- Enabling a step-increase in the contribution of self-managed care by:
  - ✓ Empowering service users and family carers to do more
  - ✓ Extending the role of pharmacists in care management.
  - ✓ Supporting active patient programmes, especially in respect of those with long term conditions.



BLMK STP priority 1 – our ongoing work programme

Priority 1 logic model

Context / External Factors
In BLMK there is significant complexity in the patterns of demography, ethnic diversity and deprivation across the footprint. A life-course approach has been used to address the health and wellbeing gap in BLMK.

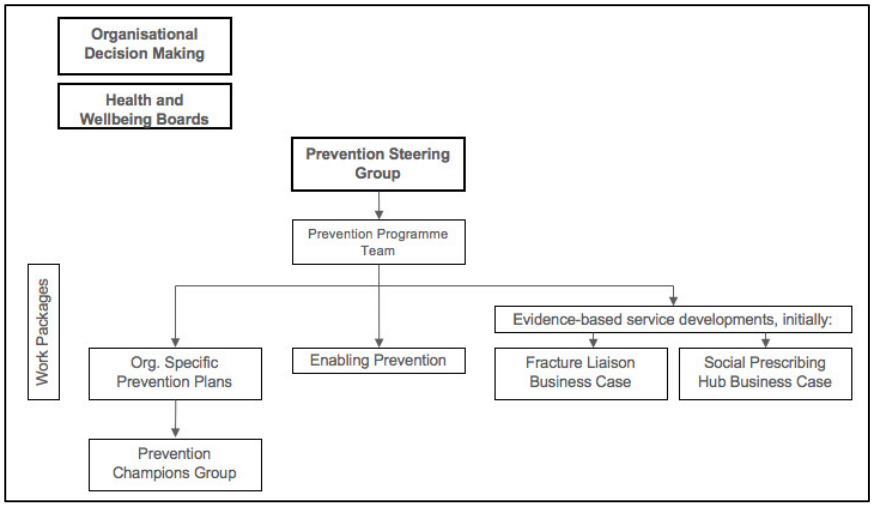
Rationale
A life-course approach has been used to address the health and wellbeing gap in BLMK looking at: Maternal & Child Health, Working age adults and Older People.

Objectives
1. Giving every child the best start at life
2. Improving screening and immunisation coverage
3. Tackle four lifestyle behaviours
4. Promoting mental health and wellbeing
5. Achieving healthy workforces & estates
6. Empowering communities & self management

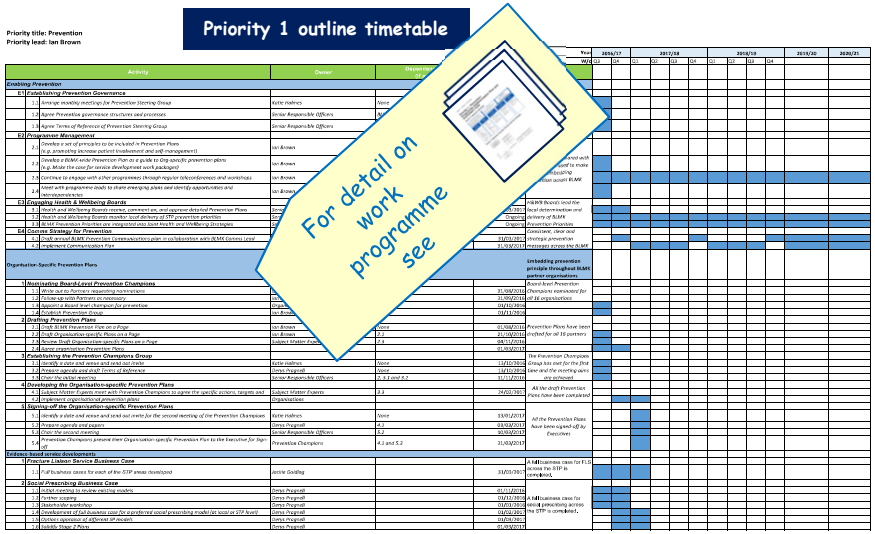
INPUTS resources & data	PROCESSES Activities	OUTPUTS Solutions & deliverables	OUTCOMES Short and medium term	IMPACT Longer term

People
• SRO
• Programme Lead
• SME
• Programme Support
• Prevention Champions
• Work Packages will utilise existing human resources
• Public & stakeholder involvement
• Work package admin support
	• Identify Prevention Champions
	• Governance arrangements set up
	• Work packages including:
	  • Enablers
	  • Organisation-specific prevention plans
	  • Fracture Liaison Service
	  • Social Prescribing Hub
		• Ownership of Prevention Plans by relevant organisations
		• Ownership of BLMK STP Prevention Plan
		• Business cases for specific evidence-based prevention solutions
			• Upgrade in prevention, early intervention and self management
			• Ownership of Prevention Plans by relevant organisations
			• Ownership of BLMK STP Prevention Plan
				• Improve Health and reduce health inequalities, and thereby constrain future growth in demand for health and care services.

Priority 1 programme governance



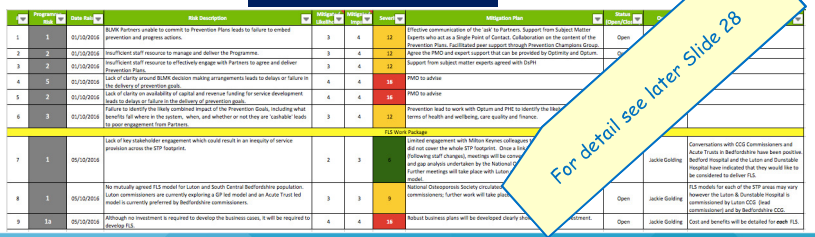
Priority 1 outline timetable



Priority 1 outline resource requirements

Role	*FTEs*	*Estimated cost PA**
Prevention Programme Senior Responsible Officers	2 × 0.05	£10,000
Prevention Programme Lead	0.2	£16,000
Subject Matter Experts	6 × 0.1	£33,000
Programme Support	0.2	£4,000
BLMK Programme "Standing Support" (e.g. health and financial modelling)	TBC	TBC
Total Prevention Delivery Group		**£63,000**
Board-Level Prevention Champions	12 × 0.05	**£60,000**
Total Human Resource Cost		**£123,000**

Priority 1 key risks log



Priority 2 – primary, community and social care: our key messages

The key goals of Priority 2 are:

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

Making it happen

- Delivered through two delivery and one enabling programme: "Better Care, Closer" and a Single Point of Access/Clinical Hub which serves both Priorities 2 and 3.
- Programme 1 - "Better Care, Closer" aims to achieve a common integrated model for hospital care, community health services, primary care and social care through a place-based approach. It will be delivered through the development of a standardised BLMK approach to care co-ordination and delivery involving:
  - ✓ Developing primary care at scale (which may include mergers; partnerships or other practice collaboration)
  - ✓ Integrating the workforces providing primary care, community heath and social care to deliver linked/integrated care at/close to home and also bringing health and other Council services (such as housing) alongside each other through, for example co-location in community hubs
  - ✓ Sharing care records and securing technology/systems interoperability
  - ✓ Increasing use of risk stratification tools and focused case management approaches
  - ✓ Increasing evidence-driven interventions – focused on the 20% of local populations that use 70% of NHS resources
  - ✓ Providing care on a proactive and planned basis for or the 20% of citizens with complex or chronic conditions
  - ✓ Empowering communities and individuals through strengthened community support and developing individuals/families ability to self care
  - ✓ Development of specific multi-disciplinary interventions to local residents that need intensive structured support (i.e. support to the care home sector; housebound patients; patients living in supported accommodation), delivered in clusters of 30-50,000 populations and centred around GP list
- New care solutions will support Better Care, Closer programme and will include:
  - ✓ Enhanced Primary Care - core general practice workforce is expanded strengthened to deliver better access, well-being and chronic disease management, including ambulatory care for those with high healthcare needs (the chronic "18%" and the complex "2%"). EPC will build on the registered list and GP practice, EPC will support population health management and prevention by directing the efforts of an enhanced EPC team focused on proactive and anticipatory care. Through new roles and capacity, EPC will seek to enable clinical professionals to work "*to the top of their license*" (requires recurrent STP investment of additional 299 WTEs to 2020/21)
  - ✓ Complex care management - community based care (at home, in care homes and in community hospitals), supported by specialist GPs or community-based physical and mental health specialists. This solution focuses on non-ambulatory patients, with complex care needs and advanced illness. It targets those in residential care, the house-bound and those ate the end of their life (requires recurrent STP investment of additional 83 WTEs to 2020/21)
  - ✓ Acute-based care management – dedicates resource to coordinating patient health and social care plans between hospital, GPs and social care to reduce length of stay and readmissions to hospital (and covers admission, discharge and transition to other care settings). It focuses on improving throughput and flow to deliver effective and efficient hospital care, integrated with community based care, and thereby, maximises capacity across the acute sector for sustainable high-quality specialist physical and mental health care
  - ✓ Referral management – supporting, managing and helping direct GPs to specialist physical health or mental health referrals, in acute, community or voluntary settings, where appropriate, and to strengthen specialist expertise amongst primary care professionals. To be established via cross-specialty designed care pathways with clear standards and processes to ensure shared decision making, choice and access against national standards, with the twin goals of reducing variation and maximising effective and efficient use of capacity across the continuum of care
  - ✓ Medicines optimisation – to support efficient and effective prescribing and use of medicines across the continuum of care (including hospitals) by establishing a system-focussed team that supports innovation, effective and efficient use of medications and safety. Involves developing pharmacy link to MDTs to ensure effective use of medicines in physical and mental health care management
  - ✓ Community-based outreach – to build and capitalise on the contribution the non-statutory sector can make in absorbing and managing some of the health and social care demands of the BLMK population by working alongside BLMK Council partners to strengthen community capacity, using the voluntary sector more effectively and supporting individuals and their family carers
- BLMK will build on work in Luton developing the NAPC '*Primary Care Home Model*', the integration models being developed in Milton Keynes and the health and social care integration models being developed in Central Bedfordshire, to develop a standardised approach across BLMK to co-ordinated care
- Programme 2 - BLMK will improve the quality and responsiveness of urgent care that takes place outside hospitals by:
  - ✓ Creating a single clinical hub and SPoA (via a single inbound call center, dealing with urgent and non-urgent enquiries (including calls, texts, chats, etc.) that brings together 111, 999 and NurseLine and other provider services) that offers informed triage to direct physical and mental health care and to guide service users requiring further support form statutory or non-statutory agencies (requires recurrent STP investment of additional 94 WTEs to 2020/21)
  - ✓ Fully integrating with GP OoH and other appropriate services to enable direct booking of face-to-ace appointments
  - ✓ Functionally integrating with the 999 Ambulance Service to enable the warm transfer of calls to and from clinicians in either service
- Transforming Learning Disabilities services is a package of work that is well-developed and progressing across the footprint. Going forward, we will look to underpin and enable progress with this work package via sponsorship by and links to our Priority 2 work programme and governance apparatus
- Enabling investment programme - Making planned, measured investment in creating a single BLMK new care models resource centre, accommodating additional staff (55 WTEs by 2020/21) and a fit for purpose technology and software platform, designed to support new ways of working across BLMK and including:
  - ✓ Clinical programme management - administrative staff to oversee the clinical staff supporting new care model solutions (roles include clinical managers, medical directors, and Chief Medical Officer(s) and Chief Nurse Officer(s))
  - ✓ Programme management - business management and operational staff responsible for the operations of the resource centre and the BLMK-wide clinical staff directly supporting clinical delivery (i.e. the 476 WTEs above) and the associated clinical interventions (roles include operations manager, data governance lead, and mobilisation personnel to implement the clinical programmes)
  - ✓ Back-office support functions – including supply chain management, sourcing and managing outsourced contracts, outcomes monitoring, communications and engagement, workforce organisation and development and financial management (control, analysis and actuarial presence)
  - ✓ Infrastructure required to deliver the solutions – including the local technology and software platform (such as the data warehouse, population health technology and care management tools that will form the technology backbone), call centre facilities and software to enable single point of access capabilities across BLMK, referral facilitation technology and operational support and formulary and prior authorisation medicines optimisation technology with supporting infrastructure

BLMK STP priority 2 – our ongoing work programme

Priority 2 logic model

Context / External Factors

Primary, community and social care across BLMK is currently fragmented, with multiple providers in place. Population demographics have resulted in increasing needs, in the face of key local challenges

Rationale

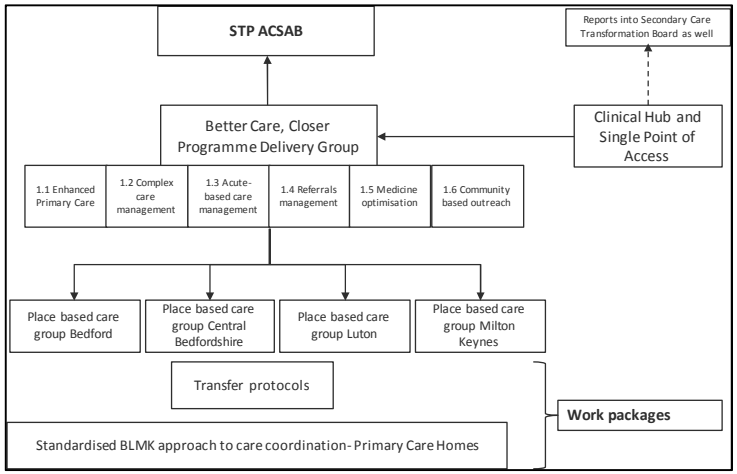
Whilst the system is working towards being more joined up, services can currently be difficult to access and navigate, sometimes resulting in ineffective care and duplication. There is not an option to continue as we are –a radical change is needed to deliver cost effective, sustainable, high quality services.

Objectives

To transform out of hospital care so that it becomes central to the delivery and coordination of healthcare across BLMK. In doing BLMK will move from the current system which is reactive, organisation driven and paternalistic to population health management that puts the biopsychosocial needs of the individual central to the purpose of the system.

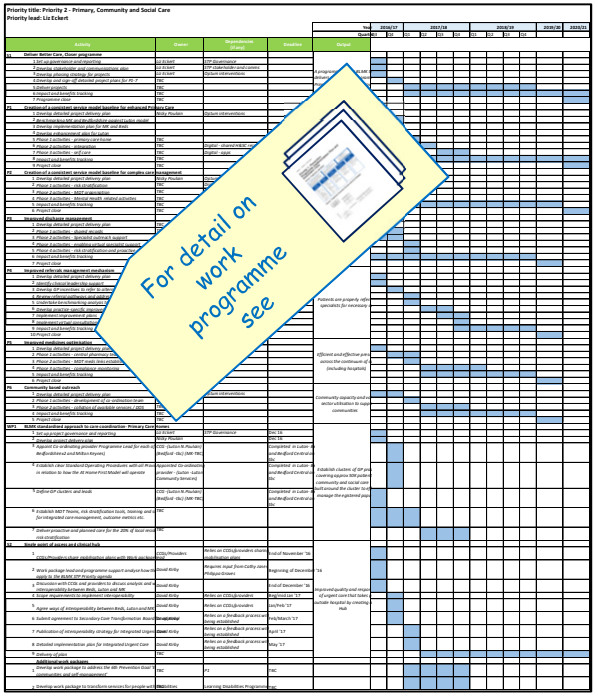
INPUTS resources & data	PROCESSES Activities	OUTPUTS Solutions & deliverables	OUTCOMES Short and medium term	IMPACT Longer term
• Senior responsible officers • Programme Lead • Programme Manager • Project managers • Programme analyst • Stakeholder management and comms lead • HR advice/staff re-deployment coordinator • BLMK new care models resource centre • Additional technology and software platforms e.g. shared health and care record • Staff for identified solutions • Risk stratification tools • Tools for self management	• Development of Better Care, Closer interventions through the development of Primary Care Home • Development of single point of access and clinical hub	• Change Programme across BLMK • Care management teams around GPs • Co-ordinated care plans between hospitals and GPs • Effective specialist referrals • Improvements to prescribing • Development of community and voluntary sector capacity • Inbound call centre	• GPs are able to focus on patients with multiple chronic conditions • Core general practice provides better access and wellbeing services • Better discharge processes • Appropriate referrals and use of specialist services • Pathways and access are simple	• Reduced inappropriate non-elective admissions • Increase in self-care/ exacerbation management • Lower levels of readmission/shorter length of stay • Improved patient experience • Effective use of workforce / increased productivity

Priority 2 programme governance



Priority 2 outline timetable

Note: The pooled system integrator platform is a key enabler for the delivery of the P2 solutions



Priority 2 outline resource requirements

Programme Management	FTEs	Estimated cost PA
PCSC Programme Senior Responsible Officers	2 × 0.05	£10,000
Programme Lead (top of 8c / 8d)	1 FTE	£66,582 + on costs
Programme manager (band 7)	1 FTE	£36,250 + on costs
Project Managers (band 8a)	2.5 FTE	£107,595 + on costs
Programme Analyst (band 8a)	0.5 FTE	£21,519 + on costs
Stakeholder management and comms lead (band 8a)	0.5 FTE	£21,519 + on costs
HR advice / staff re-deployment co-ordinator (band 7)	0.2 FTE	£7,045 + on costs
Total Human Resource Cost		**£270,510**
Plus on costs at 26%		**£340,843**
Enhanced primary care	***Additional FTEs***	***Total investment needed***
GP	No increase in capacity	£40,973
Nurse	81 FTE	
Care coordinator	211 FTE	
Registry manager	GP practice based	
CPN	85 FTE	
Physiotherapist	85 FTE	
Complex care management	***Additional FTEs***	***Total investment needed***
GPSI/Community Specialist	No increase in capacity	£19,188
AHPs	8 FTE	
Nurse	194 FTE	
Pharmacist	51 FTE	
Social care	57 FTE	
Admin staff	8 FTE	
Acute-based care management	***Additional FTEs***	***Total investment needed***
Nurse/clinical case manager	22 FTE	TBC
Social care	3 FTE	
Analytic support staff	Included in PMO staff	
Referrals management	***Additional FTEs***	***Total investment needed***
Analytics support	Included in PMO	TBC
Clinical leadership	NA	
Medicine management	***Additional FTEs***	***Total investment needed***
Central Pharmacy responsible for compliance	captured in EPC, CCM, ACM	TBC
Central pharmacist	5 FTE	
Pharmacist	16 FTE	
Community based outreach	***Additional FTEs***	***Total investment needed***
PMO coordination of community based services	included in PMO staff	TBC
Single point of access		***Total investment needed***
BLMK STP U&EC Lead	1 FTE (min band &)	£12,981
Project admin support	1 FTE (min band 5)	
Call handler	TBD	
Clinician (paramedic or nurse)	TBD	
Dental nurse	TBD	
CPN	TBD	
Social care worker	TBD	
GP	TBD	
Quality coach/auditor	TBD	

Priority 2 key risks log

ID	Programme Risk	Date Raised	Risk Description	Mitigated Likelihood	Mitigated Impact	Severity	Mitigation Plan		Owner
1	1a	07/10/2016	Resources required to deliver the work packages are not available and work package cannot therefore be implemented	3	2	6	Investment Business Case to be prepared regarding resource and required for consideration and approval by NHS England		Liz Eckert
2	1a	07/10/2016	Appetite for significant change amongst providers - if there is limited appetite for change the plans are unlikely to be accepted or implemented fully	3	2	6	Strengthen the provider input in discussions around the d		Liz Eckert
3	6	07/10/2016	Impact on planned procurements e.g. Bedfordshire Community Services	3	4	12	Maintain watching brief and respond as quickly as operational waste		Liz Eckert
4	6	07/10/2016	Alignment with individual system plans	3	2	6	A meeting will be scheduled between the alignment of the STP Priority with the		Liz Eckert
5	3	07/10/2016	Interdependence with other workstreams - ability of digital workstream to provide a shared record facility within required timeframe	3	4	12	Explore work-arounds to enable sha available for use		Liz Eckert
6	2	07/10/2016	Interdependence with other workstreams - dependence on the right skill mix being available to enable delivery (workforce)	2	4	8	Maintain strong links to workfo		Liz Eckert
7	3	07/10/2016	Assumptions for the interventions have not been tested, validated or localised	4	4	16	Test assumptions with stakeho from other areas that have tested	system and look for evidence	ACSAB

For detail see later Slide 28

Priority 3 – sustainable secondary care: our key messages

The key goals of Priority3 are:

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

Making it happen

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

Sub Priorities	Outputs	Outcomes
Speciality Clinical Services	Set of integrated clinical operational models costed and collated into a single coherent clinical operational model across the three sites Fully worked up resource plan and infrastructure specification to support the clinical model (including IT, equipment and estates)	Collated into the overall investment case for secondary care which sets out the preferred configuration for secondary care and is supported by a full resource plan. Leads to the production of an implementation plan which may include public consultation.
Clinical Support Services	Operational Design and procurement model for single pathology service delivering £4.5m reduced cost Pharmacy, Imaging and Therapies to have detailed savings plans for year 1 against specific work packages by Dec 2016. Detailed integrated operational models will be completed for pharmacy and imaging by 31/03/17 and for therapies by 30/06/17 with clear resource plans and timescales.	Services will have a single clinical leadership team and will integrated in terms of clinical standards, operational policies, workforce models and procurement. The transformed operational models will be implemented, ensuring that clinical support services are delivered in the way that best support the emerging configuration for secondary care services. Productivity and financial improvements will have been made through sharing best practice and collaborative working during the early years to support provider efficiency savings
Non-Clinical Support Services	By end of 2017 there will be specific, timed and resourced plans to save £5.5m against current costs through procurement savings, integration efficiencies and standardising services and processes by 2021	Each service area will have aligned it's operational and resource model to most effectively support the emergent clinical model for BLMK
Non-Medical Clinical Workforce	Standardised clinical workforce models across the three secondary care organisations and community teams Implementation plan to move from current state to standardised models Incorporation of new roles and skill mix models into workforce design	Sustainable workforce model for secondary and community non-medical clinical staff Training and rigorous workforce planning in place to support workforce needs

- The "channel shift" required in BLMK (see Priority 2) acts to halt the growth in secondary care. Further productivity improvements in secondary care present the opportunity to reduce the cost of hospital infrastructure. Priority 3 integration and transformation plans will be developed that enable a reduction in hospitalisation rates and which ensure that secondary care services are configured to support and adapt to ongoing channel shift

BLMK STP priority 3 – our ongoing work programme

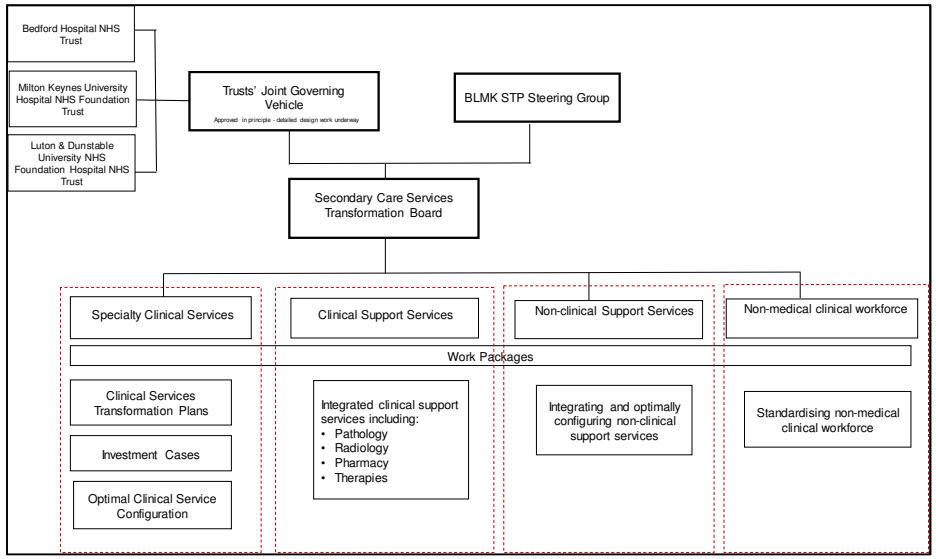
Priority 3 logic model

Context / External Factors	Rationale	Objectives
BLMK secondary care services generally perform well but are running at an aggregate financial deficit and have areas of significant pressure (e.g. workforce gaps and estates). The Healthcare Review identified reconfiguration options for Bedford and Milton Keynes Hospitals – and the ability to reduce cost of delivery by £25m. There is a need to transpose these options to the wider BLMK footprint.	Need to eliminate variation in clinical standards across BLMK, improve clinical outcomes and design the most resource effective model for sustainable secondary care services to ensure affordability. This requires design and development of consistent, coherent and integrated clinical models across BLMK. This will inform the design an development of estates plans and clinical configuration.	To modernise secondary care services (SCS) across BLMK and ensure they are clinically and financially sustainable by adopting a uni-institutional, tri-hospital campus planning and service delivery approach. The purpose of this is to (1) ensure changes to SCS across BLMK are planned and developed with all three hospitals centrally involved and (2) to ensure changes take account of and are calibrated to STP priorities.

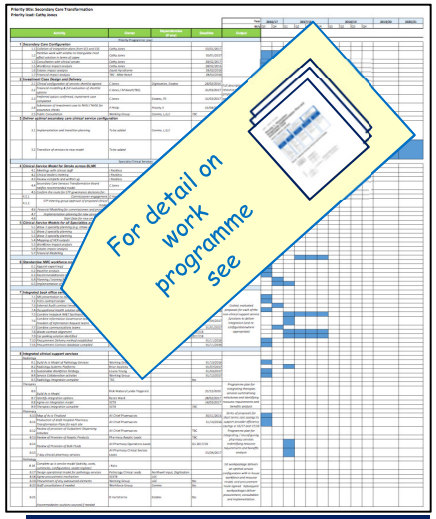
INPUTS resources & data	PROCESSES Activities	OUTPUTS Solutions & deliverables	OUTCOMES Short and medium term	IMPACT Longer term

• Work package inputs
• Programme Director
• Prog. Medical Lead
• Prog. Admin
• Service Improvement lead
• Information support
• Public consultation programme
• From the PMO "Standing Resource"
  • Financial Modelling
  • Legal/Consultative/Governance Support
  • Estates Design and planning
	• Iterative design of the integrated secondary care model across BLMK for specialty clinical services, clinical support and non-clinical support functions
	• Development of secondary care investment case including the capital plan and resource model
	• Public consultation on relevant elements
	• Transition and implementation including associated infrastructure
		• Detailed integrated clinical service models for all specialties and support services
		• Full investment case
		• High level estates plan
			• Model run through NHSE/I assurance process and then out to public consultation late 2017
			• Implementation of new service models phased during 2018-2021
			• Changes that do not require consultation pre-implementation will be made during YR0 and YR1 of planning phase, contributing to annual 2% provider productivity savings
				• £42m overall savings realised
				• Stable long-term model in place that reflects and is congruent with the channel shift that has occurred and the new interfaces across the health system
				• Workforce planning and strategy in place to support long term needs of secondary care, with reduced dependency on hard to recruit staff groups

Priority 3 programme governance



Priority 3 outline timetable



Priority 3 outline resource requirements

Programme Level Resources			Cost PA
Human Resources including:	WTE	Programme Years	
Sponsor: Pauline Philip		Years 1-5	
Programme Director	.3 (+.3 for Specialty Clinical Services sub-priority)	Years 1-2	£30k (+£30k)
Programme Medical Lead	0.1	Years 1-2	£16k
Programme Admin	0.6	Years 1-2	£18k
Service Improvement Lead	0.4	Year 1	£29k
Support from PMO standing resource including:			
Financial Modelling	0.1	Year 1-2	£10k
Information Support	0.2	Year 1-2	£18k
Legal/Consultative/Governance Support	0.2	6 Months	£28k
Estates design and planning	0.2	Years 2-3	£28k
Public consultation programme		Years 2-3	A guess at this cost could be up to £75,000

Priority 3 key risks log

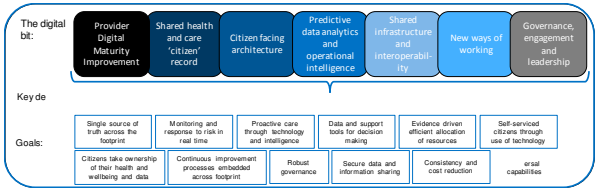
Priority 4 – digitisation: our key messages

The key goals of Priority 4 are:

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

Making it happen

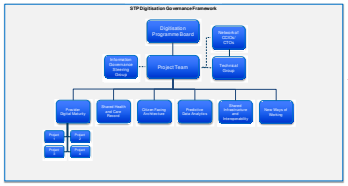
- "As-Is" analysis across BLMK demonstrates considerable variation between relevant STP partners (including local Councils), with implications for average performance across BLMK. The "As-Is" also highlighted:
  - ✓ Absence of footprint-wide digital leadership
  - ✓ Nervousness about an STP approach to information governance, including trust and confidence concerning how personal and other data will be leveraged
  - ✓ Variations in systems between different STP partners and other relevant health and social care providers and, associated with this, the array of third-party contracts, their varying scope and different tenors
  - ✓ Uncertainty about readiness by relevant STP partners for the cultural change that needs to accompany a step-change in digital functionality across BLMK
  - ✓ Funding the non-recurrent and recurrent investment required to transact transformational digitally-enabled change
  - ✓ Data quality issues, including timeliness, relevance, classification (coding), ownership and consistency
- BLMK to benefit from the selection of LDUH as one of only 12 national Global Digital Exemplars (GDE). This programme is working closely to ensure it is aligned with the STP Digitisation programme, and can share lessons and solutions to engage fast followers across the footprint.
- 7 key digitisation development themes developed by the Digitisation workstream with associated goals (see figure below):



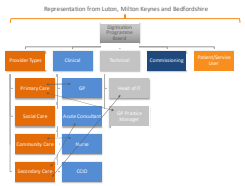
BLMK Digitisation development themes

BLMK Digitisation development goals

- Digitisation leadership progressed by establishment in September 2016 of BLMK Digitisation Programme Board and associated governance and programme delivery apparatus. Board is chaired by local Council Digitisation lead.

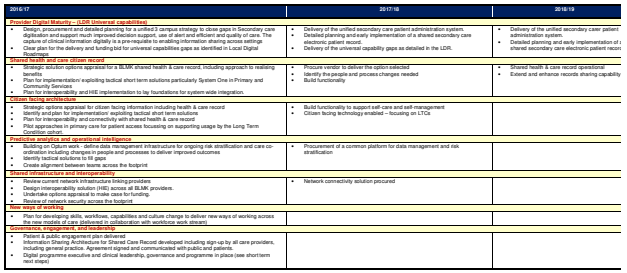


BLMK Digitisation governance apparatus



BLMK Digitisation Programme Board membership

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



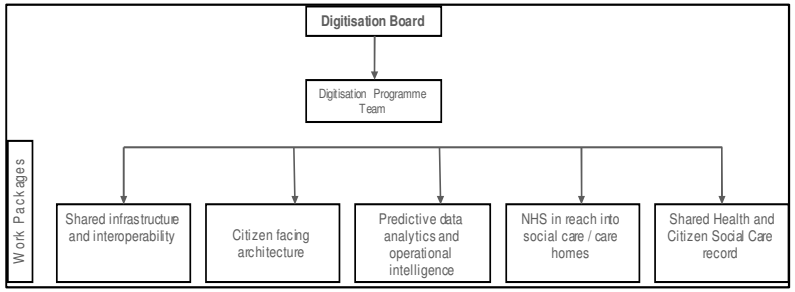
BLMK STP priority 4 – our ongoing work programme

Priority 4 logic model

Context / External Factors	Rationale	Objectives
In BLMK there is significant variation in providers and commissioners level of digital maturity; the recent Local Digital Roadmap illustrates this.	To support BLMK work packages digitally, provider organisation across the footprint will need to work differently together and have different types of conversations. There are no funds/appetite for re-inventing the wheel – as a result, key principles underpinning this work stream are building on capabilities that already exist across the footprint and identifying opportunities to learn from good practice locally and nationally.	To deliver the Digitisation programme set out in the work packages and goals by: 1. Coordinating and facilitating work packages 2. Planning and prioritising programmes of work based on goals 3. Managing and filling in resources to deliver 4. Route between work packages and STP Steering Group

INPUTS resources & data	PROCESSES Activities	OUTPUTS Solutions & deliverables	OUTCOMES Short and medium term	IMPACT Longer term
People • Programme Director • Programme Manager • Digitisation Board Members • Work package leads • Working groups members • Finance support • Procurement support Information/Data • Programme reporting Data Other: • Accommodation • IT equipment • Facilities for working sessions	• Digitisation Board Governance Work packages include: • Shared Health and citizen social care record • Shared infrastructure & interoperability • Citizen-facing architecture • Predictive data analytics and operational intelligence • NHS in reach into social care/care homes • Shared Health and citizen social care record	• Digitisation Board mobilised • Delivery of universal capability gaps as detailed in LDR • Shared health and care citizen record • Technology for self care and self management • Analytics and decision support at point of care. • Risk stratification tool • Health information exchange • Strategy to develop digital skills and competencies in workforce	• Measurable progress against the work packages and level of digitisation across the BLMK footprint	• Citizens, patients, carers, care providers, clinicians and manager make maximum use of information to delivery the best outcomes with maximum efficiency.

Priority 4 programme governance

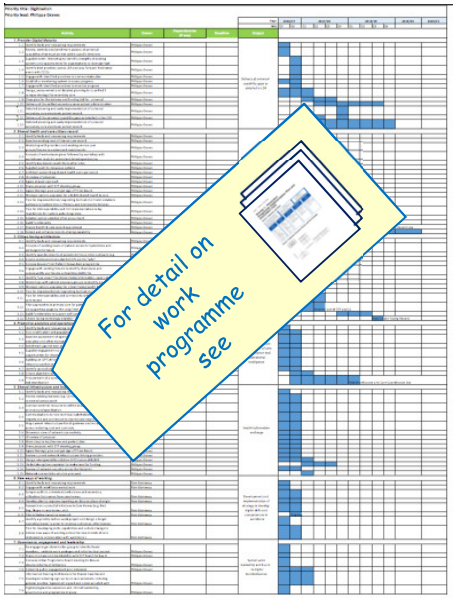


Priority 4 outline resource requirements

Solution Themes	FTE YEARS	COST	TECHNOLOGY SOLUTION
Shared health and care 'citizen' record	88	£1,700,000	£5,000,000
Citizen facing architecture	28	£797,250	£2,000,000
Predictive data analytics and operational intelligence	27	£793,750	£2,450,000
Shared infrastructure and interoperability	45	£1,520,000	£5,000,000
New ways of working - linked to work package 3, 7 & 2	42	£1,186,500	£50,000
Governance, engagement and leadership	17	£885,500	350,000
TOTALS	247	£6,883,000	£14,850,000

£6,883,000	FTE
£14,850,000	Tech
£21,733,000	TOTAL

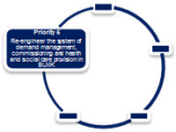
Priority 4 outline timetable



Priority 4 key risks log

	Program Risk	Date Ri	Risk Description	Mitig Likeli	Mitig Impa	Seve	Mitigation Plan
1	1	17-Jun-16	Lack of prioritisation, engagement and buy-in of stakeholders in the benefits and process to deliver increased digitisation to support the STP vision	3	4	12	• Engage with the STP leaders to determine how best to create a narrative concerning the proposed changes across the system including models of care, digital solutions, the LDR and initiatives, and ensures proactive's with stakeholders • Design and implement a targeted communication strategy for different stakeholder groups, including the development of visual artefacts to support communication • Engage STP Steering Group and Senior Leader for endorsement and to create leaders who can be evangelists • Early identification of champions/evangelists within the system and target individually through individual and engagement events • Develop and implement a support programme and network for CCIOs to generate stronger clinical buy-in to the technology developments, and help develop further clinical leadership for the design and delivery of programmes
2	3	17-Jun-16	Lack of well positioned and sufficiently detailed programme definition to inspire confidence	1	4	4	• Create a digitisation programme definition approach, in the light of the STP –wide programme which specifies the clear interrelationships and accountabilities
3	3	17-Jun-16	Insufficient understanding and process in place to create a pragmatic and realistic approach to data / information sharing	2	3	6	• Review the workplan of the information governance group in order to determine whether it is likely to deliver an appropriate information/data sharing approach • Alignment with Caldicott principles
4	3	17-Jun-16	Lack of joint understanding of the technical challenges facing the STP to achieve a digitally supported footprint	2	3	6	• Ensure there is appropriate linkage between this group and the development of a citizen-led data ownership approach • Use the LDR as a basis to identify the very simple functions in laymans terms, that need to be in place
5	2	17-Jun-16	Insufficient funding to support the digitisation agenda	3	5	15	• Supporting the communication process by creating assets such communicate these issues in plain English and an easy to understand plan • Create a robust business case linked to measures of the digital initiatives identified. This should needs to include programme level changes technical solutions and costs • Seek funding from all possible • It is expected that rev funding needs to be
6	2	17-Jun-16	Insufficient internal staff / capacity and expertise to deliver STP digitisation vision	3	5	15	• Need to meet interdepende
7	1	17-Jun-16	Stakeholders may have more loyalty to their organisation than the STP footprint.	3	4	12	
8	6	17-Jun-16	Momentum is not created and existing assets/initiatives are not built from	1	3		
9	2	14-Oct-16	Projects are procurement intensive and lack of procurement support will cause delays	2			
10	2	14-Oct-16	Programme is complex and without full time finance support, forecasts and business case information will be low quality and late	2			a full time finance manager to work on the programme
11	7	14-Oct-16	There will be contractual complexities because of the BLMK structure which may cause delays or allow costly mistakes	2	3		Obtain legal support from Health Trust Europe and cost into the programme.

For detail see later Slide 28



Priority 5 – new care models: our key messages

The key goals of Priority 5 are:

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

Making it happen

- Led by MKCCG, BLMK's Priority 5 working group has acknowledged a compelling case for significant change to existing contractual and administrative arrangements used to commission and deliver care in BLMK. This case exists at three levels:
  - ✓ Technical – due to shortcomings in scarce skills, capacity, analytical and technical capability and experience
  - ✓ Scale - due to the absence of a sufficiently scaled commissioning function to create and operate new care models in BLMK
  - ✓ Scope – due to the multitude of contracts amongst NHS and other bodies, and poor alignment of incentives between them to maximise the patient experience, care quality and to minimise costs
- All relevant NHS parties (i.e. both NHS commissioners and providers) across BLMK are keen to adopt an accountable care approach to commissioning and delivering NHS services.
- NHS stakeholders see considerable merit in local Councils becoming party to such arrangements in the future, and a full dialogue will commence with Council colleagues to discuss how this might be best achieved and what benefits such an approach might bring to Councils
- Such an approach will continue to see care designed and delivered at the locality level (typically 30,000 to 50,000 population), sensitised to the needs of different localities, and in a way that list-based general practice remains front and centre
- Some functions and activities will operate in patches co-terminous with local Council boundaries - others, such as health population analytics, information and communications systems and technology and administration will operate across the BLMK footprint
- An accountable care approach will require the boundaries between commissioning and provision to be redrawn, and will introduce new "systems integrator" capabilities
- Immediately following our 21st October STP submission, an Accountable Care System Activation Board (ACSAB) will be established, reporting into the STP Steering Group.
- Close interplay and significant inter-dependencies between the development of BLMK's community clinical model (that sits with Priority 2) and the development of BLMK's approach to accountable care (which falls to Priority 5) persuades STP partners to combine governance oversight of the (post-Oct) Priority 2 and Priority 5 work programmes under the ASCAB.
- ACSAB membership is still to be fully determined. It is likely to comprise CEOs (or senior alternates) from the 3 CCGs and the 3 acute Trusts. Each of the local Councils will be invited to nominate one of its senior officers to become members of the ACSAB. Likewise, the CEOs of BLMK community and mental health service providers will also be invited to nominate, in aggregate, up to two of their number as members. Discussions will also be held with GPs (as providers) to determine how their influence can be best brought to bear on the proceedings of the ACSAB (which may include nominated membership)
- The post 21st October remit would fall into four stages, namely:
  - ✓ Stage 1 – accountable care options assessment
  - ✓ Stage 2 – accountable care system design, development and, where necessary, procurement planning
  - ✓ Stage 3 – undertaking relevant procurement(s)
  - ✓ Stage 4 - accountable care system mobilisation and operational phase
- The post 21st October work programme is novel and complex, with a number of 1st order issues that need to be resolved in completing this work programme
- An outline timetable has been assembled mapping key activities and establishing the following broad timings:
  - ✓ Determine the preferred accountable care system arrangements to be pursued in BLMK – 2 months between October 2016 to January 2017
  - ✓ Design and develop capacity and capabilities in the commissioning authority and the ACO to satisfy external assurance requirements, to successfully consult locally and to mount the respective procurement(s) - 9 months between January 2017 to October 2017
  - ✓ Complete the procurement(s) and award relevant contracts - 6 months between October 2017 to March 2018

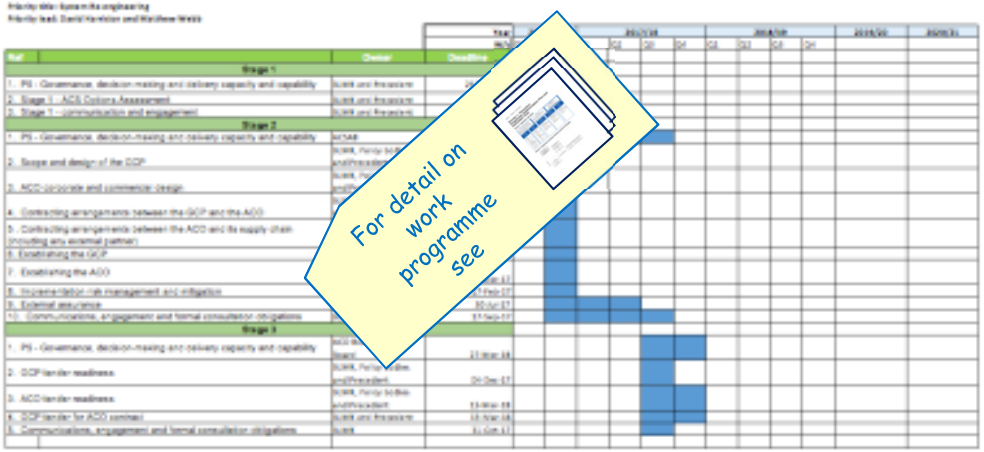
BLMK STP priority 5 – our ongoing work programme

Priority 5 logic model

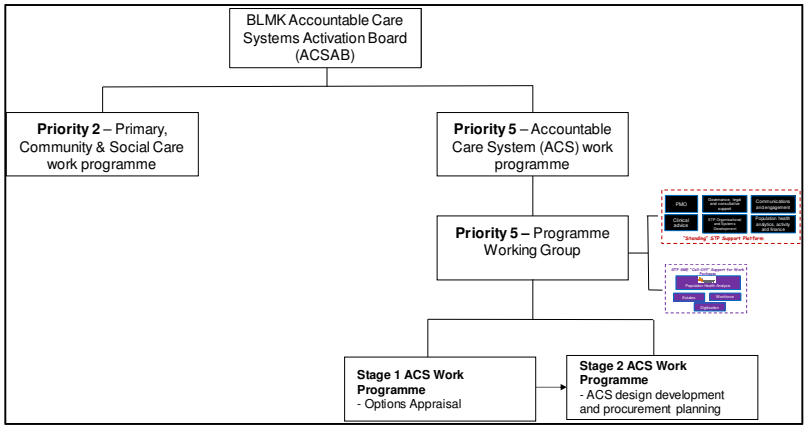
Context / External Factors	Rationale	Objectives
Current arrangements for analysing and assessing need, for managing demand and for commissioning and transacting and providing health and social care in BLMK, are unlikely to be fit for purpose going forward. The lessons from the Vanguard programme and the PACS and MCP frameworks recently published by NHS England, point to accountable care as the direction for travel to deliver against the triple aim.	Three factors will re-shape the health and social care landscape of BLMK in the coming years: 1. Three local acute hospitals will unify its leadership/management/operations - not through merger 2. Demand for health & social care will far outstrip funding 3. BLMK will be forced to radically change the way it delivers care and the "points of delivery" (or care settings)	The goal is to bind together key elements of supply including: i. Secondary care services to be led, organised and delivered in an integrated manner across the whole of BLMK ii. Scale efficiencies and consistency of approach iii. Direct intervention teams mobilised alongside locality-based care delivery channels iv. BLMK to accept and manage an STP system control total.

INPUTS resources & data	PROCESSES Activities	OUTPUTS Solutions & deliverables	OUTCOMES Short and medium term	IMPACT Longer term
• Create and populate ACS governance mechanisms • Ongoing STP programme support, including specialist advisers (e.g. legal, commercial) • Close liaison with NHSE/I (NHSI has volunteered some technical capacity to help address key issues – see Priority 5 Issues Log) • Governance, legal and consultative support from STP GLC platform • Communicators and engagement support, including informal and formal consultation with the public, with staff groups, with members (FT & GPs) and governors, with statutory bodies etc.	• Stage 1: the options assessment • Stage 2: an accountable care system design and development phase, alongside procurement planning by the GCP and the ACO • Stage 3: Procurement Stage • Stage 4: Implementation	• Stage 1: an accountable care options assessment • Stage 2: an accountable care systems design • Stage 3: procurement • Stage 4: Mobilisation and operations	• An ACO system that covers BLMK	• Creating the conditions for commissioning and delivery of a new model of care that meets the over-arching triple aim of the STP for BLMK

Priority 5 outline timetable



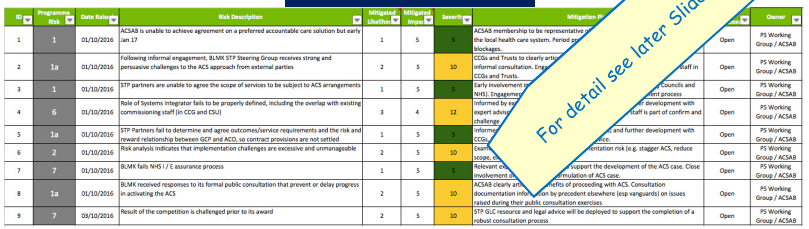
Priority 5 programme governance



Priority 5 outline resource requirements

Role	*Days per Week*	*Estimated cost PA*
ACS programme lead (STP partner appt)	2	£30,800
External advice - STP programme resource	1	£44,000
Internal direct support to programme (from STP partners)	2	NA
GLC support	0.5	£13,200
Comms & Engagement support	0.05	NA
3rd party Subject Matter Experts (legal, contractual and procurement)	NA	£75,000
Total pay cost		**£163,000**
Non-pay cost - consultation and assurance support	NA	£30,000
Total cost per annum		**£28**

Priority 5 key risks log



ID	Programme Risk	Date Raised	Risk Description	Mitigated Likelihood	Mitigated Impact	Severity	Mitigation	Status	Owner
1	1	01/10/2016	ACSAB is unable to achieve agreement on a preferred accountable care solution but early Jan 17	1	5	5	ACSAB membership to be representative of the local health care system. Period of blockages.	Open	PS Working Group / ACSAB
2	1a	01/10/2016	Following informal engagement, BLMK STP Steering Group receives strong and persuasive challenges to the ACS approach from external parties	2	5	10	CCGs and Trusts to clearly articulate informal consultation. Engagement of staff in CCGs and Trusts.	Open	PS Working Group / ACSAB
3	1	01/10/2016	STP partners are unable to agree the scope of services to be subject to ACS arrangements	1	5	5	Early involvement of Councils and NHS). Engagement	Open	PS Working Group / ACSAB
4	6	01/10/2016	Role of Systems integrator fails to be properly defined, including the overlap with existing commissioning staff (in CCG and CSU)	3	4	12	development with expert advice challenge	Open	PS Working Group / ACSAB
5	1a	01/10/2016	STP Partners fail to determine and agree outcomes/service requirements and the risk and reward relationship between GCP and ACO, so contract provisions are not settled	1	5	5	and further development with	Open	PS Working Group / ACSAB
6	2	01/10/2016	Risk analysis indicates that implementation challenges are excessive and unmanageable	2	5	10	risk (e.g. stagger ACS, reduce	Open	PS Working Group / ACSAB
7	7	01/10/2016	BLMK fails NHS I / E assurance process	1	5	5	support the development of the ACS case. Close	Open	PS Working Group / ACSAB
8	1a	01/10/2016	BLMK received responses to its formal public consultation that prevent or delay progress in activating the ACS	2	5	10	benefits of proceeding with ACS. Consultation documentation information by precedent elsewhere (esp vanguards) on issues raised during their public consultation exercises	Open	PS Working Group / ACSAB
9	7	03/10/2016	Result of the competition is challenged prior to its award	2	5	10	STP GLC resource and legal advice will be deployed to support the completion of a robust consultation process	Open	PS Working Group / ACSAB

Priority 0 – programme structure, governance and delivery: key messages

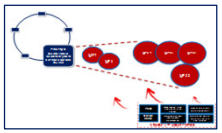
The key goals of Priority 0 are:

- To respond to July feedback to the BLMK STP that BLMK's "*STP programme has not been sufficiently resourced to-date. The footprint now needs to make a stepped increase in the level of resource managing and delivering its STP plan to become 'business as usual.*"
- To establish a "standing" STP support platform:
  - ✓ To provide the programme management, change management and specialist expertise that the STP programme will need to deliver the goals of a complex multi-year programme.
  - ✓ To support the STP Steering Group and the STP CEOs Group to plan and prioritise programmes of work
  - ✓ To source and manage insourced and outsourced resources to deliver planned work
  - ✓ To effectively identify and manage programme risks
  - ✓ To report delivery against plan to the STP Steering Group and the STP CEOs Group
- To ensure that STP development plans meet assurance requirements of relevant regulators

Making it happen

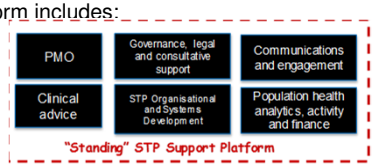
- Two programme co-design workshops have been completed since June and which have informed BLMK's approach to programme governance and management.
- These workshops articulated a number of programme design principles to which the governance and management apparatus should adhere. These are:
  - ✓ Simple and flexible – allows the programme or work package lead to access the expertise needed to deliver the outputs effectively and at pace
  - ✓ Footprint representation – all major stakeholders that are pertinent to delivery are all involved in the design and delivery of the work package
  - ✓ Transparency of engagement – the programme or work package will be transparent in its operations and inclusive of other stakeholders using the principles of RACI (responsible / accountable / consulted / informed)
  - ✓ Decision making for the programme is clear: Formal and informal, governance mechanisms, delegated authority, escalation.
  - ✓ Local resources are used when possible
  - ✓ Feedback routes exist between Steering Group, Boards and Priority / Work Package Leads
  - ✓ Commissioner involvement on Work Packages will be sought as best practice
  - ✓ Deliverability considerations and acceptability are taken into account at the planning stage
- A Work package operating model to be adopted so that each of the 5 priorities comprises a series of work packages. A work package is defined as a package of work that has:
  - ✓ Defined scope of delivery of a specific output
  - ✓ Short duration (3-6 months)
  - ✓ May cut across priorities
  - ✓ Will be accountable to one of the programme boards
  - ✓ Staffed by multi-functional and multi-organisational teams where appropriate
  - ✓ Draws on support from the "standing" support platform including SME as required

  Example of work package relationship to STP priorities



- Since June, the STP Programme Team has been working with BLMK workstream leads to identify a number of high impact Work Packages which BLMK should pursue. A total of 45 such Work Packages have been identified
- Programme delivery is being supported by a "standing" STP support platform, and an STP subject matter expert (SME) panel that can be called down to support work packages
- BLMK's "standing" STP support platform is dual-facing so that it supports the STP Programme overall by progressing cross-STP matters, as well as the development of the STP work packages. The STP support platform includes:
  - ✓ The STP Project Management Office
  - ✓ Governance, legal and consultative support
  - ✓ Communications and engagement
  - ✓ Clinical advice group
  - ✓ STP organisational and systems development
  - ✓ Population health analytics, activity and finance

  STP "standing" support platform



- 3rd party SME call-off support is expected to thread across a number of the 5 STP Priorities through work package support, including. This includes:
  - ✓ Analytics
  - ✓ Estates
  - ✓ Workforce
  - ✓ Digitisation

  STP SME "Call-Off" support

- The current structure of Priority 0 will continue into 2017/18, but will be revisited and reconfigured according the to solution identified under Priority 5 from year 2 onwards.

BLMK STP priority 0 – our ongoing work programme

Priority 0 logic model

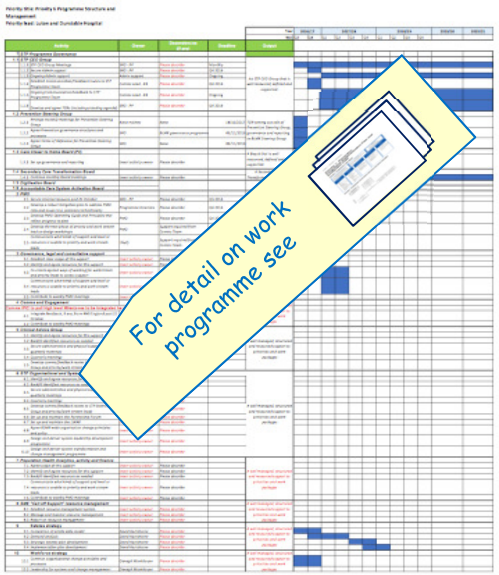
Context / External Factors
The FYFV sets out the policy context for the BLKM STP Programme and 5 priorities have been agreed. These require system level response bringing together 16 partners (providers and commissioners across BLMK. STF is being made available in support of this programme.

Rationale
An STP-wide programme management infra-structure will be required to ensure that this long-term and highly complex programme is delivered in ways that are compatible with good practice for major and complex change programmes where the outcomes are uncertain.

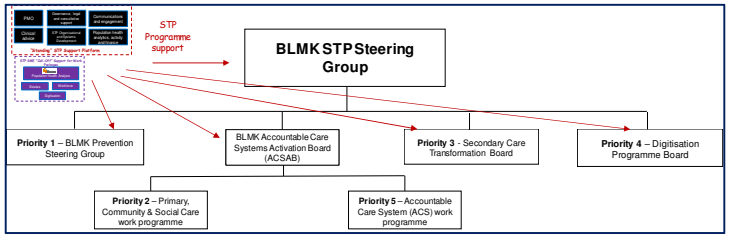
Objectives
1. To deliver the STP programme to the objectives set out in the 5 priority programmes by:
   1. Planning and prioritizing programmes of work
   2. Managing resources to deliver planned work
   3. Managing programme risk
   4. Reporting delivery against plan within governance

INPUTS resources & data	PROCESSES Activities	OUTPUTS Solutions & deliverables	OUTCOMES Short and medium term	IMPACT Longer term
People: The standing STP resource platform = Programme Director Programme Advisor (PS) Programme managers GLC support OD support CAG Coms and engagement support Population analysis support Training and dev for PMO Information / Data: Programme reporting data Other: Accommodation IT equipment Facilities for working sessions	• Finalise programme plans • Develop detailed work package plans • Recruit resource • Establish governance • Set up operating model for PMO including metrics and reporting arrangements • Support early delivery or work packages • Support transformation board operations • OD strategy • Estates strategy • Comms and engagement strategy	• PMO or "standing resource platform" in place and operational • All programme boards up and running • Delivery of early work packages within time and to budget	• Measurable progress against the STP plan submitted in October 2016	• Measurable impact against the impacts set out as part of the triple aim for each of the priority programmes.

Priority 0 outline timetable



Priority 0 programme governance



Priority 0 key risks log

ID	Risk description	Mitigated Likelihood	Mitigated Impact	Severity	Mitigation Plan		
1	STP sign off process in April, June and October has only required a high-level of agreement and commitment by STP partners. Now need to localise and validate the STP plans, and priority programmes, with individual STP partners. Moving forward, lack of agreement and commitment across STP partners in respect of purpose and goals of STP could become surface	3	4	12	Deliver the robust comms and engagement plan across the STP footprint to encourage local input and ownership of the STP plan.		Programme Director and STP Lead
1a	External stakeholders may not agree with purpose, goals or priorities of STP and mode of delivery	3	4	12	Communications Team designing how best to communicate constructively with external stakeholders.		Programme Director and STP Lead
1b	Clinicians may not agree with purpose, goals or priorities of STP or mode of delivery	2	5	10	Support each priority and work package to ... soon as possible in the planning process	Open	Programme Director and STP Lead
2	There is a lot of large amount of change to manage, especially in 16/17 and 17/18. If resources and capacity are not acquired quickly, BMLK could struggle with delivering at the pace it intends to.	4	4	16	Submit a detailed resource plan ... what resources is needed to ...	Open	Programme Director and STP Lead
3	Clarity of hypotheses and expected impact underpinning the solutions isn't clear	3	4	12	Localising, testing and ... stakeholders across ... with key	Open	Programme Director and STP Lead
4	Priorities identified may not be based on comprehensive population need and understanding of services due to the scale and scope of BLMK	4	4	16	Localising, testing ... stakeholders ... olutions with key ...	Open	Programme Director and STP Lead
5	Governance mechanisms have been developed and mobilised but not all have yet been tested if they can deliver timely decision making	3	4	12	All progra ... running in next two months and fitness fo ...	Open	Programme Director and STP Lead
6	The BLMK STP may not be aware of or fully understand the implications of existing initiatives	2	3	6	Building o ... developing since June, a gap analysis will be done to ... gaps in "as is knowledge' are and a plan put in place to address ...	Open	Programme Director and STP Lead
7	There is a set of assumptions regarding the legal, assurance and consultative basis of the proposed delivery model in PS. These will be tested in the coming months.	3	4	12	Maintain close cont ... policy leaders and ACS pathfindersacross England. Create escal ... odes to the ACSAB and STP CEOs as necessary when challenges occur or decisions need to be made.	Open	Programme Director and STP Lead

For detail see later Slide 28

Priority 0 - outline resource requirements

	Role	2016/17 FTEs	2016/17 Estimated cost (£)	2017/18 FTEs	2017/18 Estimated cost	2018/19 FTEs	2018/19 Estimated cost (£)	2019/20 FTEs	2019/20 Estimated cost (£)	2020/21 FTEs	2020/21 Estimated cost (£)	TOTAL FTEs	Total Cost
	Priority 0: Programme Structure and Management												
Standing support	PMO coordinator	1.0	£50,467	1.0	£50,467							2.0	£100,934
	Chief of staff	0.5	£75,000	0.5	£75,000							1.0	£150,000
	Programme Special Advisor -	0.2	£44,000	0.2	£44,000							0.4	£88,000
	PMO admin support	1.0	£21,909	1.0	£21,909							2.0	£43,818
	Programme Lead/Director	2.5	£188,382	2.5	£203,382	2.1	£172,582	2.1	£172,582	2.1	£172,582	11.3	£909,510
	Senior Project Manager	2.0	£72,500	2.0	£72,500	2.0	£72,500	2.0	£72,500	2.0	£72,500	10.0	£362,500
	Project Manager	11.1	£426,945	18.6	£764,095	15.7	£606,095	14.7	£599,595	2.7	£111,595	62.8	£2,507,225
	Project Administrative Support	1.2	41909.0	1.2	41909.0	1.2	2000.0	1.2	2000.0	1.2	2000.0	6.0	£89,818
	Population health analytics, activity and finance	1.6	£58,519	2.1	£78,038	1.5	£46,519	1.5	£46,519	0.5	£21,519	7.2	£249,114
	Comms and engagement	0.7	£39,671	0.7	£39,671	0.7	£37,519	0.7	£37,519	0.7	£37,519	3.5	£191,899
	Clinical advice	0.0	£0	0.0	£0							0.0	£0
	Organisational and systems development	1.4	£54,090	1.6	£61,135	1.2	£47,045	1.2	£47,045	1.2	£47,045	6.6	£256,360
	legal, consultative and governance support	1.7	£141,200	1.5	£113,200	1.0	£25,000	1.0	£25,000	0.0	£0	5.2	£304,400
Cut-off support	Required **3rd Party Support, Legal and Commercial** across the programme: -Legal -Procurement -Technology -Public Consultation -Clinical External Advisory -Models of Care -Estates -Digitisation -Population Health Analysis -Organisational Development	0.0	£300,000	0.0	£700,000	0.0	£300,000						£1,300,000
	TOTAL P0 inputs and costs		**£1,512,492**		**£2,265,336**		**£1,308,260**		**£1,002,760**		**£484,760**		**£6,553,576**

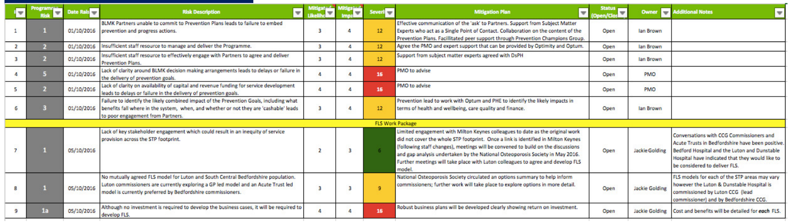
BLMK STP programme level risks and links to STP priority programme plans

NHS

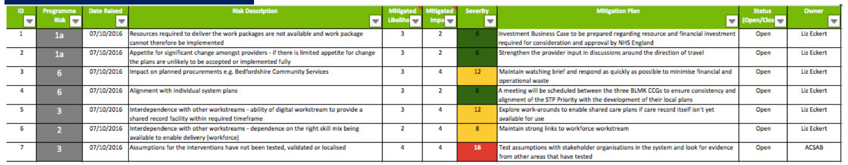
Key programme level risks log

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

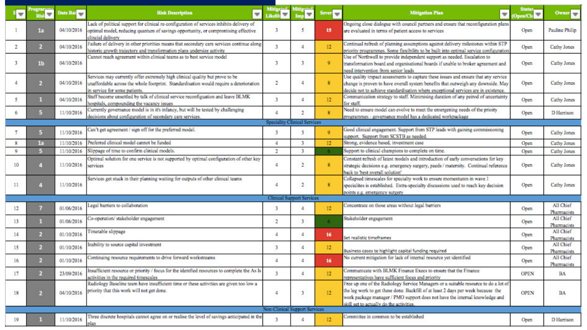
Priority 1 key risks log



Priority 2 key risks log

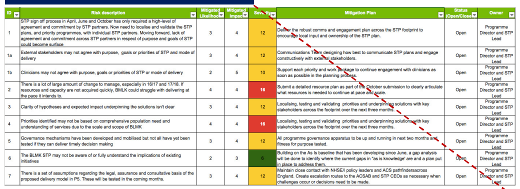


Priority 3 key risks log

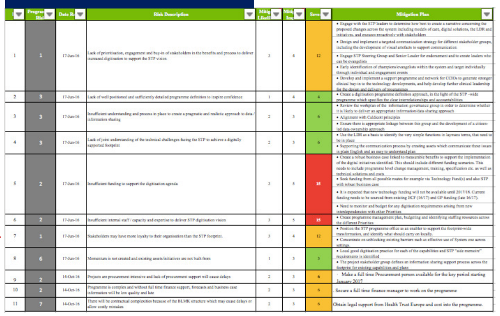


Mitigation of programme level risks are embedded in actions being taken and monitored as part of Priority risk logs (see examples)

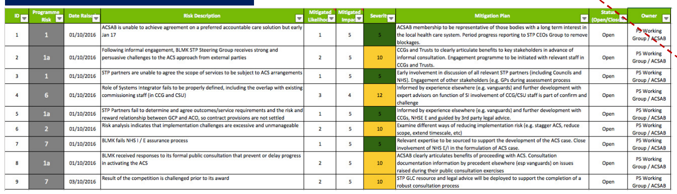
Priority 0 key risks log



Priority 4 key risks log



Priority 5 key risks log



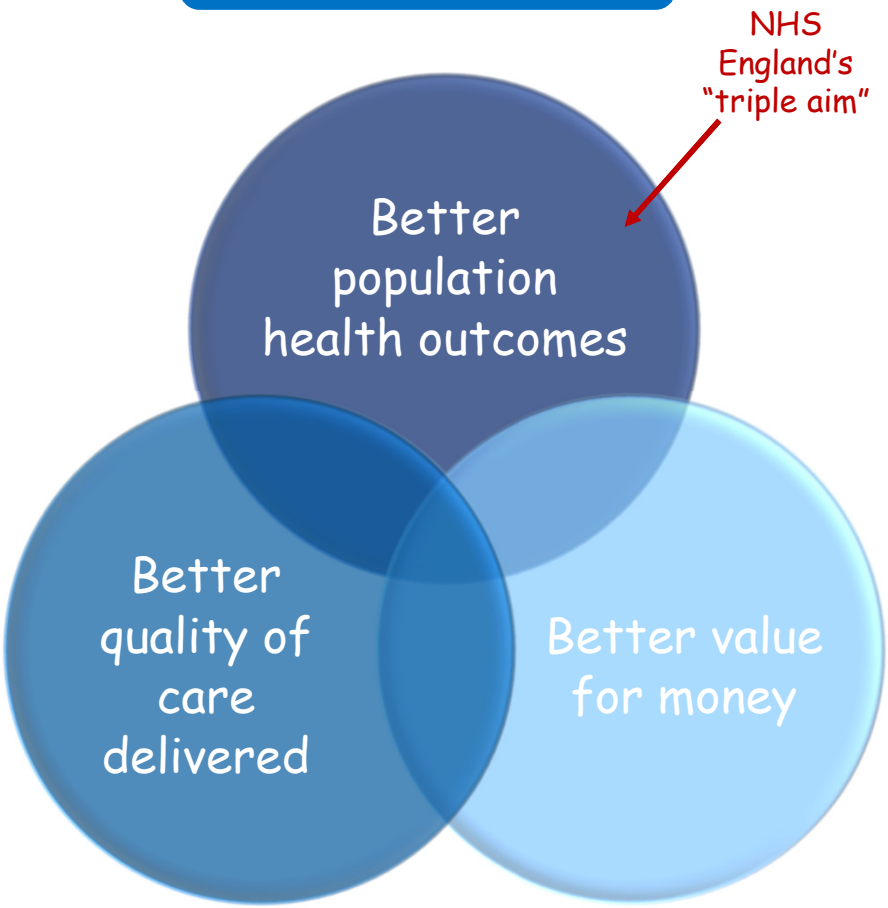
How we will measure our performance against NHS England's triple aim

Measuring the impact of BLMK's STP solutions – our principles

Our Principles

- We have defined the population we are looking to impact
- We will gather data over time
- We will measure at different levels (outcome and process)
- We will measure leading and lagging indicators
- We will use data to benchmark and compare

Domains in which impact will be measured



Our Measures

- Existing routine data sets
- New data sets

The logic model we have used to develop our STP programme

Context / External Factors

BLMK is a new planning footprint.
A total of 16 STP partners have taken part in the development of this BLMK Sustainability and Transformation Plan (STP).
This is the first time this group of organisations has worked together.
Significant progress has been made in identifying and planning to address significant and growing challenges, from a standing start, between April and October.

Rationale

The STP Priorities have been guided by our future vision for health and social care.
The vision is grounded in assessment of the disposition, fitness for purpose and affordability of our existing delivery platform.
We have good things to build on and a strong appetite for improvement
There is a significant transformational journey ahead if we are to achieve clinical and financial sustainability over the coming 5 years.

Objectives

- To deliver the BLMK vision for health and social care, in accordance with our design principles
- To meet the triple aim in full by, at the latest, 2020/21

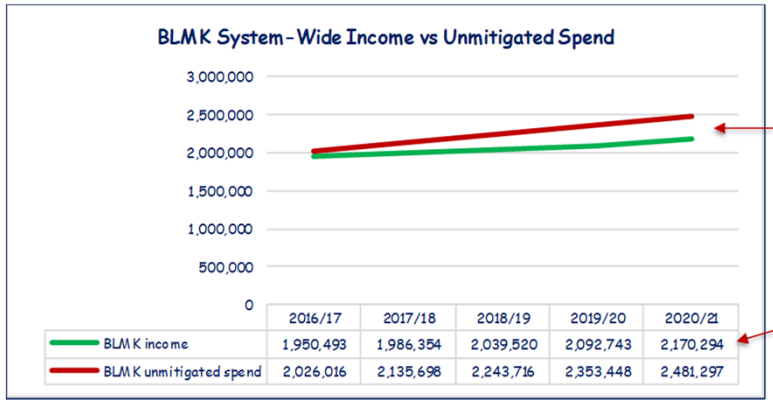
INPUTS resources & data	PROCESSES Activities	OUTPUTS Solutions & deliverables	OUTCOMES Short and medium term	IMPACT Longer term
• Programme support platform • Priority and Work Package leads • SME leads • Backfilling roles of STP working group(s) members • Funding ✓ Recurrent investment in STP solutions ✓ Capital investment ✓ Investment in change management • Workforce • Technology • Operations • Estates	• Impactful health improvement and illness prevention and empowering self-management and social capacity (P1) • High quality, scaled and resilient primary, community and social care services across BLMK (P2) • Sustainable secondary care services across footprint (P3) • Forge footprint-wide collective leadership, charged with designing and delivery a BLMK digitisation programme (P4) • Re-engineering the system of demand management, commissioning and health social provision (P5) • Communications and stakeholder, staff and public engagement	• Delivery of P1-P5 work packages and associated outputs • Integrated services across the STP footprint • Integrated leadership and management structures • A supportive system, which aligns incentives across BLMK to achieve high quality, affordable services, wrapped around the citizen's needs • NHS Constitution performance standards are met and health inequalities in access to care reducing, unwarranted variations in quality and outcomes are reduced	• 6 prevention goals (see P1) make measurable impact on the health and well-being of BLMK's citizens • Step-change in attitudes and behaviour of BLMK's population, increasing contribution of self-managed care • Strengthened social capital and greater community resilience • A proactive case management approach to health and social care, especially for citizens with complex and chronic conditions • Statutory and independent sector providers are rated outstanding or good	• BLMK's health and wellbeing gap being improved by focused effort on a combinations of interventions • Our care quality gaps being improved by the combined impact of stronger, better resourced, scaled and re-purposed primary and community health and social care platform and unified and co-ordinated secondary care services • BLMK's health economy living within the financial means made available to it by local and national taxpayers

How we will measure our impact against the triple aim

Triple aims	Inputs and Processes	Impacts	Proposed measures
Improved population health outcomes	• Board level prevention champions for all STP partners to embed a culture of prevention and to prioritise prevention action • Organisation specific prevention plans • Enhanced primary care • Citizen-facing digital architecture to enable and promote self-care • Community-based outreach	• Every child has the best start • Improved immunisation and screening coverage • Reducing the burden of our four highest priority lifestyle behaviours • Increase mental health and well being • Improve the health of the workforce • Increase community empowerment to self-care	• Quality of life (using EQ5D score) • Population risk stratification metrics • Disease burden (from JSNA) • Mortality (e.g. life expectancy, years of life lost or health life expectancy, standardised morality rates)
Improved quality of care delivery	• Enhanced primary care • Single point of access • Complex care coordination • Proactive case management approach to citizens with complex and chronic physical or mental health conditions • Anticipatory care, including in-reach into health and social care demand “hot-spots” (such as care homes) • Integrated and appropriately scaled secondary care specialty leadership, management and clinical operations across BLMK’s three hospital campuses	• Resilience ✓ Ensuring most providers are rated outstanding or good– and none are in special measures ✓ Increases resilience of vulnerable services in primary, community and hospital settings • Experience ✓ Citizen’s satisfaction with care received/enabled ✓ Citizen participation in care planning and self care • Effectiveness ✓ Improved performance (including reduction of variation across BLMK) against key clinical targets • Safety ✓ Achieving a significant reduction in avoidable deaths ✓ Improved antimicrobial prescribing and resistance rates	• CQC ratings • Use the Outcomes Framework routine data ✓ Friends and Family Survey results ✓ Patient activation measures • Clinical Services Quality Measures • Mortality • Infection rates
Better technical and allocative efficiency adding up to better value for money	• Acute productivity ✓ Clinical specialties ✓ Clinical workforce ✓ Clinical support services ✓ Non-clinical support services • Increased role of population health analytics and evidence to support clinical decision making • Enabling role of information and communications systems and technology to enable more self-managed care • Workforce transformation	• Technical ✓ X% [to be determined] reduction in emergency admissions ✓ X% [to be determined] reduction in zero length of stay admissions ✓ XX% [to be determined] improvement in delayed transfer of medically fit patients • Allocative ✓ Channel shift from acute to primary and community services ✓ Financial savings realised as a result of reduced utilisation of higher cost services • Other ✓ More stable workforce resulting in lower agency and other costs ✓ Evidence driven decision-making at all levels	• Emergency admissions derived from secondary user service (SUS)/hospital episode statistic (HES) data. • Total bed days, derived from SUS/HES data. • Routine financial reporting data (TBD) • Workforce planning data sets • Meaningful use of technology metrics (TBD)

STP financial projections – funding, cost pressures, “business as usual” savings and transformational savings

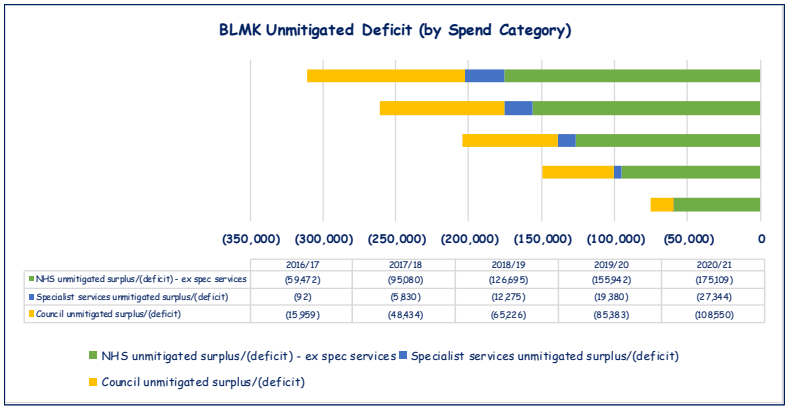
BLMK's financial gap in 2020/21 – the challenge that transformational solutions must meet



	2016/17	2017/18	2018/19	2019/20	2020/21
BLMK income	1,950,493	1,986,354	2,039,520	2,092,743	2,170,294
BLMK unmitigated spend	2,026,016	2,135,698	2,243,716	2,353,448	2,481,297

What is this telling us?

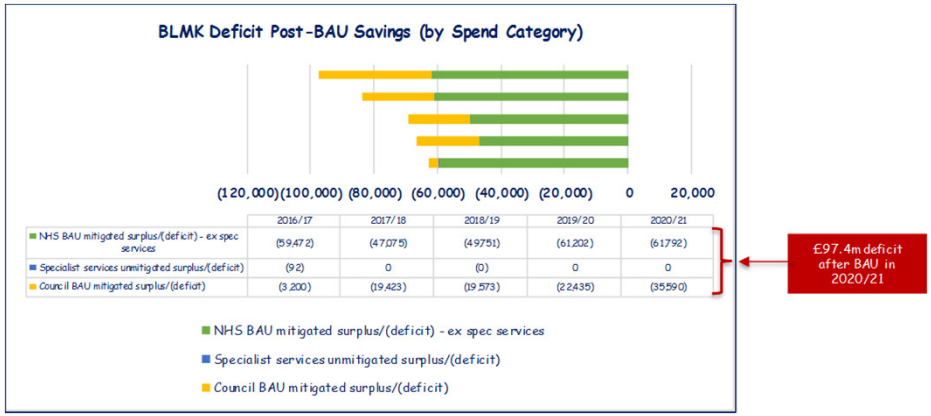
- Unmitigated BLMK system deficit by 20/21 is £311.0m (after £62m STF in 2020/21)
- £108.6m of this deficit comes from unmitigated cost pressures on Councils' spend



	2016/17	2017/18	2018/19	2019/20	2020/21
NHS unmitigated surplus/(deficit) - ex spec services	(59,472)	(95,080)	(126,695)	(155,942)	(175,109)
Specialist services unmitigated surplus/(deficit)	(92)	(5,830)	(12,275)	(19,380)	(27,344)
Council unmitigated surplus/(deficit)	(15,959)	(48,434)	(65,226)	(85,383)	(108,550)

What is this telling us?

- Unmitigated Council unmitigated deficit grows from £15.9m to £108.6m in 2020/21
- Specialist services unmitigated deficit grows from zero to £27.3m in 2020/21
- NHS (ex Spec Services) unmitigated deficit grows from £59.5m to £175.1m in 2020/21

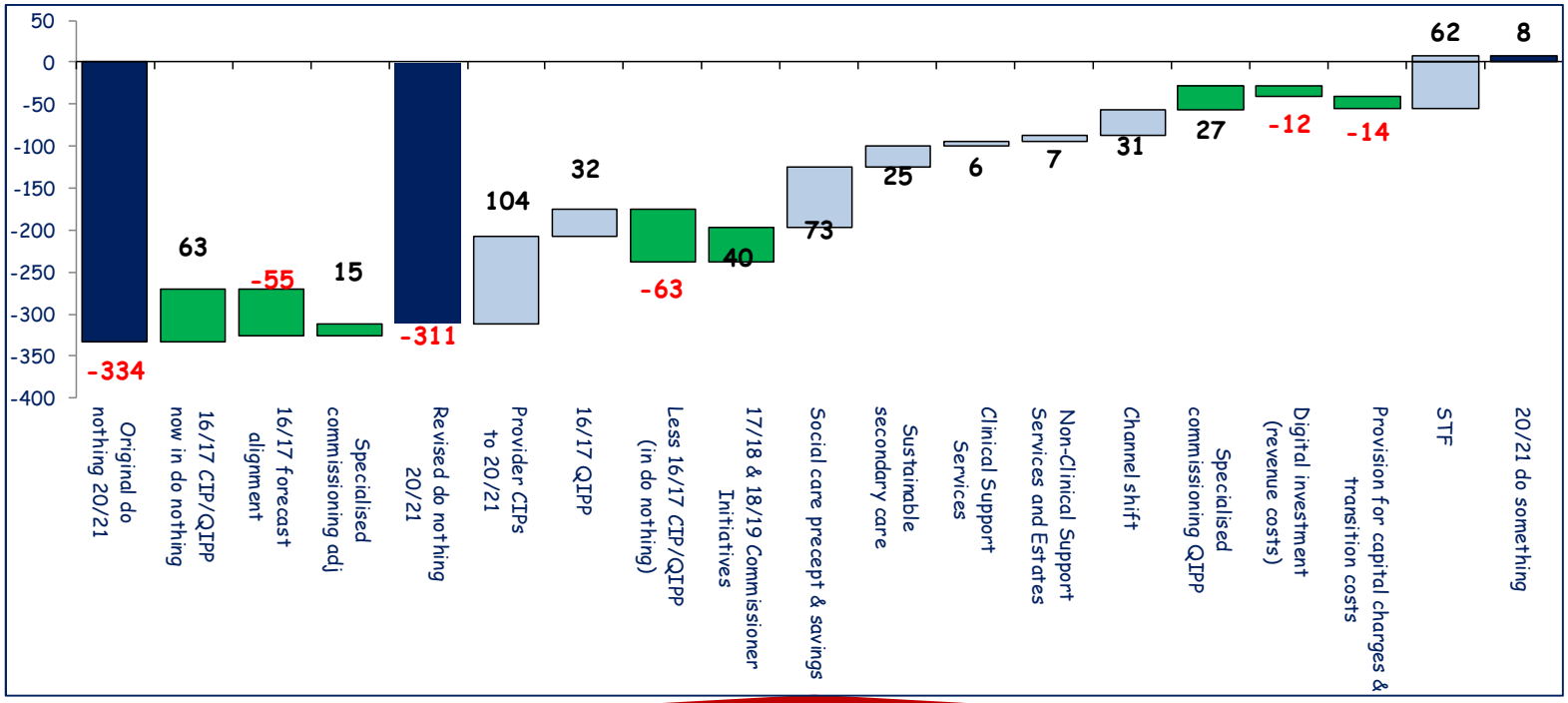


	2016/17	2017/18	2018/19	2019/20	2020/21
NHS BAU mitigated surplus/(deficit) - ex spec services	(59,472)	(47,075)	(49,751)	(61,202)	(61,792)
Specialist services unmitigated surplus/(deficit)	(92)	0	(0)	0	0
Council BAU mitigated surplus/(deficit)	(3,200)	(19,423)	(19,573)	(22,435)	(35,590)

What is this telling us?

- Business as Usual (BAU) savings make a very significant contribution to addressing the BLMK system-wide unmitigated deficit (growing to £213.6m in 2020/21) and reducing the unmitigated deficit from £311.0m to £97.4m
- After taking account of business as usual savings, by 2020/21 NHS spend exceeds NHS income (by £61.8m),
- After taking account of business as usual savings, by 2020/21 Council spend exceeds Council income (by £35.6m),
- £97.4m represents the projected financial gap that transformational solutions need to meet

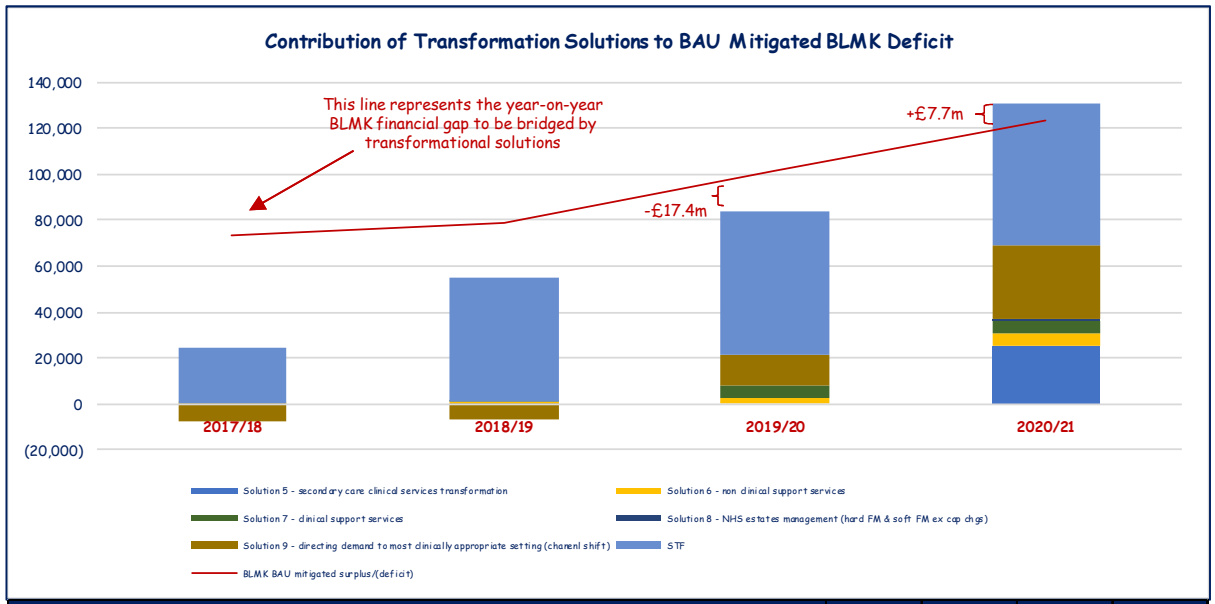
STP system financial projections – bridging BLMK's financial gap by 2020/21



NB – BLMK's bridge has been computed without taking account of 21st Sept NHS Planning Guidance setting out the requirement for CCGs to repay accumulated deficits. BLMK's accumulated CCG deficit totals £72m at the end of 2016/17, assuming 16/17 control totals are met. We estimate that this represents approximately **33% of all such deficits in England**. We have not included the claw-back of these amounts for the following reasons:

- After seeking (and receiving) assurances in the run up to our June submission (from regulators) that repayment of deficits should be ignored for STP purposes (and having received no subsequent feedback to the contrary), BLMK's "solutioning" has focused on eliminating future financial gaps
- BLMK CCGs have assembled cases under NHSE's "exceptionality" provisions to disapply the requirement. These cases are based, in part, on the disproportionately adverse "distance from target" allocations that BLMK CCGs have received during the years in which the deficits arose, and which was recognised by NHSE in the unprecedented correcting of this recurrent shortfall in the 2016/17 allocations
- BLMK's stakeholder management activities and our associated communications efforts have not, so far, factored in this supplementary challenge – if required, it would have the effect of moving the 2020/21 financial gap from a positive £8m to a negative £64m. This would also require:
  - ✓ BLMK to find and develop major new STP solutions (albeit non-recurrent in nature)
  - ✓ BLMK to defer its aspirations to move to an accountable care system, given that capitation risks would not be funded by full capitation budgets until accumulated deficits had been repaid

STP system financial projections – bridging BLMK's financial gap (year-on-year profile)

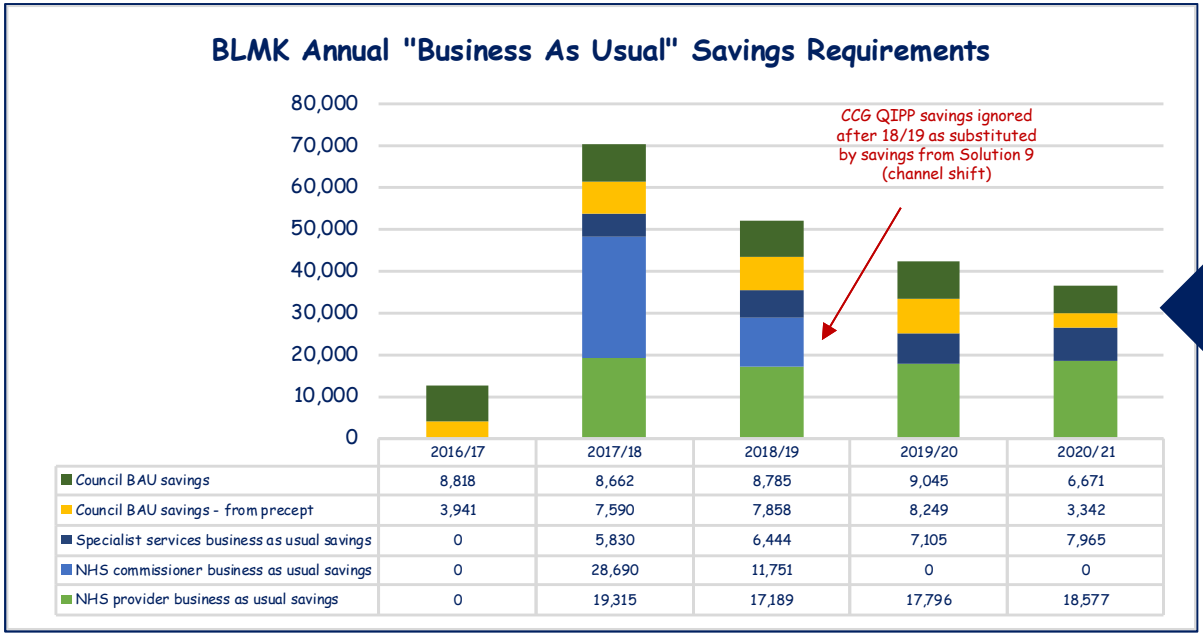


Transformational Solutions in BLMK	2017/18	2018/19	2019/20	2020/21
BLMK BAU mitigated surplus/(deficit)	(66,498)	(69,323)	(83,637)	(97,382)
Solution 11 - recurrent investments in systems and digital infrastructure	(6,453)	(9,160)	(10,688)	(11,616)
Solution 12 - contingency (e.g. new cap charges, additional investment costs and shortfall on savings)	0	0	(7,000)	(14,000)
BLMK BAU mitigated surplus/(deficit) after investments (incl contingency) to fund transformational s	**(72,952)**	**(78,483)**	**(101,325)**	**(122,998)**
Solution 5 - secondary care clinical services transformation	0	0	0	25,000
Solution 6 - non clinical support services	329	1,047	2,711	5,838
Solution 7 - clinical support services	0	200	5,500	5,500
Solution 8 - NHS estates management (hard FM & soft FM ex cap chgs)	0	0	0	1,000
Solution 9 - directing demand to most clinically appropriate setting (channel shift)	(7,794)	(6,539)	13,139	31,340
BLMK mitigated surplus/(deficit) pre-STF	**(80,416)**	**(83,776)**	**(79,975)**	**(54,319)**
STF	24,431	53,660	62,528	62,000
BLMK fully mitigated surplus/(deficit)	**(55,986)**	**(30,115)**	**(17,447)**	**7,681**

What is this telling us?

- The year-on-year shortfall when comparing projected spend with available income
- STF funding has been assumed of £24.4m in 17/18 rising steadily to £62m in 20/21 (which represents BLMK "fair share" of national transformation monies

BLMK's "business as usual" savings



	2016/17	2017/18	2018/19	2019/20	2020/21
Council BAU savings	8,818	8,662	8,785	9,045	6,671
Council BAU savings - from precept	3,941	7,590	7,858	8,249	3,342
Specialist services business as usual savings	0	5,830	6,444	7,105	7,965
NHS commissioner business as usual savings	0	28,690	11,751	0	0
NHS provider business as usual savings	0	19,315	17,189	17,796	18,577

What is this telling us?

- NHS provider based on 2% efficiency savings not counting savings from transformational solutions
- CCG savings fall to zero from 18/19 as displaced by "channel shift" savings
- Council savings combine cost efficiencies and impact of 2% precept

NHS "business as usual" savings – examples of additional opportunities arising from collaborative working across the three hospitals

Provider programme - 2017/18 & 2018/19

Provider schemes for 2017/18 and 2018/19 are still under development; however, the main saving opportunities are expected to be in the following areas:

- Agency spend, both in terms of converting posts to substantive and reducing the rates paid.
- Improving productivity through, for example, reductions in length of stay, with a particular focus on medically fit to discharge patients. The extent to which this can be realised is dependent on the system operating in a more integrated way achieved through the longer term STP strategic objectives.
- Procurement savings, consistent with the Lord Carter programme.
- Reducing variation in the cost and quality of care and spreading best practice at a local and STP level.
- Identifying opportunities for joint appointments across the footprint.

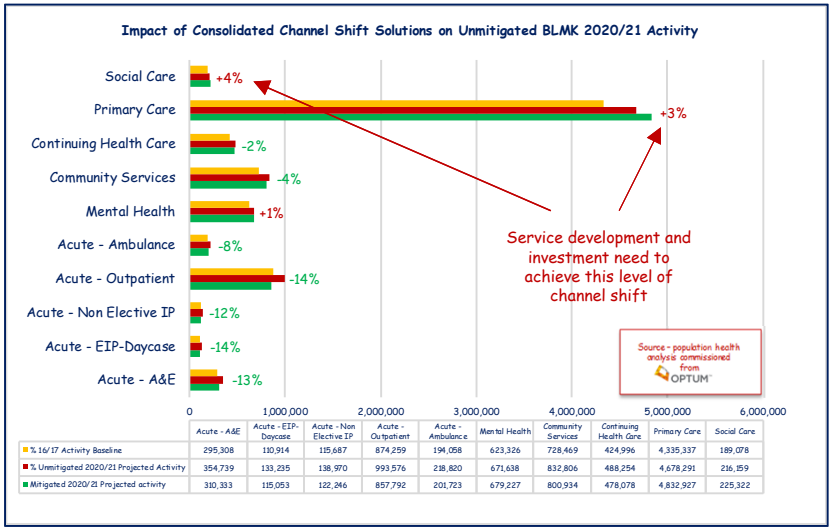
Some specific examples of the schemes being explored across the footprint include:

- Children's services: BHT has a very strong ambulatory care model for children. Replicating this model across the three sites is expected to have a positive impact on occupied bed-days needed and have a positive knock-on impact on use of agency staff.
- Merging the GI bleed rota would reduce the on-call payments. Similar rota merger opportunities might include micro, haemo, pharmacy, gynae, and urology.
- Reduced bed-days from cross cover and transfer of patients needing urgent interventional radiology procedures
- Paeds orthopaedics substantive joint appointment to reduce locum costs at LDUH and BHT
- Supporting cross booking of patients for breast 2-week wait appointments to cope with surge / annual leave
- Spreading best practice - e.g. reducing BHT and LDUH orthopaedic elective length of stay to match Milton Keynes

Commissioner QIPP programme (2017/18 and 2018/19)

- Channel shift is not projected to commence until 2018/19,
- CCG BAU (QIPP) savings has been earmarked at an average of 2.5% across all patches for 2018/19. The total contribution to the position to achieve this is £29m.
- Close joint working between commissioners and providers will be necessary to achieve reductions that are. Some decommissioning of services may be required. A working assumption has been made that 1.5% of savings will come through decommissioning lower priority services and 1% through joint QIPPS, and CIPs.
- Further savings will be required within other CCG programme budgets. This includes CCGs slowing or reversing the growth in spend on prescribing and continuing healthcare, and also reducing through efficiency and prioritisation of spend, within other provider contracts.
- This will be supported by mechanisms such as referral management services, RightCare, and GP variation analysis.

STP "allocative" efficiency solution(s) (9) - directing demand to the most clinically appropriate setting ("channel shift")



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

What is this telling us?

- Channel shift solutions require investments, especially in primary and community care
- Total projected investment over five years = £184m
- 3 solutions (EPC, CC & SPOC) require direct investment, with an additional staff requirement of 476 WTEs by 2020/21
- Investment in Pooled Solution Support (pay and non-pay) of £77m supports all solutions (with 55 WTEs by 2020/21)

Investing in transformational solutions for BLMK

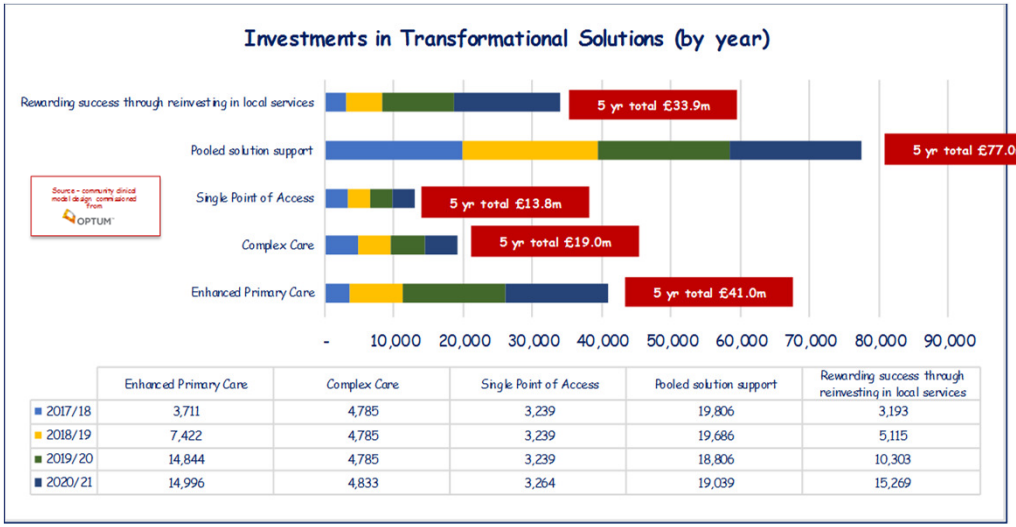
Enhanced primary care (EPC) - building on the registered list and GP practice, EPC supports population health management and prevention by directing the efforts of an enhanced EPC team focused on proactive and anticipatory care. Through new roles and capacity, EPC seeks to enable existing clinical professionals to work "*to the top of their license*"

Complex care management - community based care (at home, in care homes and in community hospitals), supported by specialist GPs or community-based specialists. This solution focuses on non-ambulatory patients, with complex care needs and advanced illness. It is linked to, but distinct from, EPC teams

Single point of access - a single inbound call center (dealing with urgent and non-urgent enquiries), intended to triage and direct care and which brings together, in a single clinical hub 111, 999 and NurseLine capabilities.

Acute-based care management - acute hospital based care (covering admission, discharge and transition to other care settings) and focuses on improving throughput, so that use of secondary care capacity for specialist care is maximised

Referral management - managing and directing GP to specialist referrals, with clear standards and processes to ensure shared decision making, choice and access against national standards with the twin goals of reducing variation and maximising effective and efficient use of capacity across the continuum of care



	Enhanced Primary Care	Complex Care	Single Point of Access	Pooled solution support	Rewarding success through reinvesting in local services
2017/18	3,711	4,785	3,239	19,806	3,193
2018/19	7,422	4,785	3,239	19,686	5,115
2019/20	14,844	4,785	3,239	18,806	10,303
2020/21	14,996	4,833	3,264	19,039	15,269

Capital investment requirements & update on estates strategy

	2017/18	2018/19	2019/20	2020/21	Total
	£'000	£'000	£'000	£'000	£'000
"Business as usual" investment					
Depreciation and other internally generated funds	29,498	27,707	27,494	27,213	111,912
DH Loan - already approved	-	-	-	-	-
DH Loan - still to be approved	-	-	-	-	-
Other - MKCCG existing bid (still to be approved)	1,714	-	-	-	1,714
Total BAU CapEx	**31,212**	**27,707**	**27,494**	**27,213**	**113,626**
Digitisation					
Solution 1 - LDR- Secondary Care Digitisation - BH / LDUH / MKUH	6,679	10,386	8,467	4,856	30,388
Solution 2 - LDR- Shared Care Record	2,800	3,800	1,100	100	7,800
Solution 3 - LDR Citizen Facing Architecture	2,100	1,050	500		3,650
Solution 4 - LDR Predictive analytics and operational intelligence	1,250	2,200	500		3,950
Solution 5 - LDR - Shared Infrastructure	3,100	500			3,600
Solution 6 - Primary Care - Enhanced System Linkage and Co-ordination	2,000	800			2,800
Digitisation sub-total	**17,929**	**18,736**	**10,567**	**4,956**	**52,188**
Infrastructure to support "channel shift"					
BHT - on-site primary care hub	250	1,750	-	-	2,000
Primary & community infrastructure (part funded by local Councils)	TBD	TBD	TBD	TBD	TBD
Primary & community infrastructure - other	TBD	TBD	TBD	TBD	TBD
Channel shift sub-total	**250**	**1,750**	**-**	**-**	**2,000**
Secondary care					
Sustainable secondary care services	TBD	TBD	TBD	TBD	TBD
GRAND TOTAL (incl in BLMK STP financial template)	**49,391**	**48,193**	**38,061**	**32,169**	**167,814**

- **NB** – Achieving sustainable secondary care in BLMK will require **non-trivial** amounts of capital.
- CapEx requirements cannot be determined until service reviews are completed (planned for 31 Mar 17
- Once determined, sustainable secondary care CapEx requirements, and associated estates strategy, will be registered with NHSE/I

Ref	Theme	Description	£,000
1	LDR Universal Capability Delivery	This solution brings all secondary care within BLMK to a digitally mature status enabling much better integration and delivery of care across the system. It assumes leveraging existing contracts and capabilities within BLMK and spreading the benefits across all sites.	£30,388
2	Shared health and care 'citizen' record	Creating integrated care records capability across the BLMK footprint, enabling care professionals to work collaboratively across organisational and physical boundaries. Undertake strategic options appraisal to identify optimum way forward to create integrated records capability, taking account of existing systems and market intelligence for alternatives (e.g. integration portal). Initiate clinical and public engagement in the use case and requirements for shared care records. Implement tactical solutions for records sharing via capabilities of existing systems (phase 1 integrated care records programme). Extend and enhance records sharing capability, through a combination of additional functionality (e.g. care plans) and / or connections with new care settings – to be determined by programme phasing choices.	£7,800
3	Citizen facing architecture	Currently patient facing clinical data and technologies are very limited. There are some Personal Health Records held electronically for a small cohort of chronic Irritable Bowel Disease (IBD) patients who use patient-owned (Patients Know Best) portal to self-assess their condition. This is remotely monitored by specialist nurses, and has seen much reduced hospitalisation and improved outcomes and experience. Whilst citizen held paper records have been present in maternity, home based care, and some other services for some time, little progress has been made in digitising this capability, or taking this design principle into other areas of care.	£3,650
4	Predictive data analytics and operational intelligence	As well as supporting patient-level clinical decisions, integrated real-time data offers opportunities for real-time demand management by tracking activity across the whole system to, for example, raise alerts when urgent care capacity is likely to be breached. System resilience being electronically monitored in the way some Acutes might monitor flow via an Operations Centre is an aspiration. These are new application areas which will increasingly become feasible as the scale and scope of real-time digital records becomes reality. The bringing together of financial, operational and clinical outcome data centred around patients provides an opportunity for deriving whole system intelligence to support population health management, effective commissioning, outcome based contracting, planning, clinical surveillance, service re-design and research. This, in turn, should enable more effective prioritisation and targeting of resources, increased opportunities for joint initiatives and finding common solutions.	£3,950
5	Shared infrastructure and interoperability	It is recognised that there are likely to be potential economic, strategic and operational benefits from further sharing of the IT infrastructure across the footprint and that conceivable that potential future opportunities including shared data centres, regional network infrastructure, shared technical support arrangements, joint cloud initiatives, shared access to Wi-Fi services across whole health / social care estate all merit investigation on a cost/benefit basis. In addition, there is a need to put in pace robust system integration at all elves, beginning with a robust network connection to allow communication between providers, up to the creation of a Health Information Exchange to ensure Care Co-ordination is supported by the most robust of shared information artefacts.	£3,600
6	New Ways of working including - Primary Care - Enhanced System Linkage and Co-ordination	New ways of working and culture change will be critical to enabling the workforce to work across organisational boundaries and in different care settings and for example in supporting the implementation of a single heath and care record. The workforce will need to develop a set of skills and competencies in using and leveraging the new technologies and digital tools that will become an integral part of their day to day working life. The digital transformation work stream will need to work closely with the STP workforce work stream to support the development of a workforce strategy that empowers and motivates people to embrace the benefits of digital work flows. This should build on areas of success within BLMK such as General Practice or Acute prescribing and administration. This solution covers tactical changes to the existing system architecture to extend the access to Primary and Community Care systems (TPP) into the Acute and Social care settings, putting in place the required system building blocks of a Message and Information Gateway (MIG), and building capacity within BLMK to implement and support the deployment and uptake of the coordinated functionality.	£2,800
7	Governance, engagement and leadership	System wide leadership (both clinical and non-clinical) is critical to the success of digital transformation in setting the overarching digital vision and direction of travel and bringing people on that journey. The success of digital transformation will be contingent on the buy in of patients, their Carers, citizens and the health and care workforce. Early engagement is essential for stakeholders to understand "why" and "what will be different for them". There are going to be a number of tough decisions that are going to have to make in the next stage of planning and organizations are going to have to make some choices and ultimately compromises. To do this effectively, a robust governance structure will need to be in place to facilitate open and transparent conversations and decision making.	Incl above

BLMK system-wide control total management

- The lion's share of any risk around achieving BLMK's aggregate position in respect of 2016/17 control totals sits with the three CCGs and the three local acute NHS Trusts
- The STP and these six keystone partners have a shared ambition to declare that, subject to repatriating BLMK CCGs' 1% contribution to the national transformation fund in 2016/17, BLMK will achieve the aggregate 2016/17 control total across these six bodies
- Collaborative work, facilitated by the STP, has been going on for some weeks now to examine the nature and quantum of risks that have already crystallised and those that remain at large across BLMK
- This work is expected to conclude by 31st October 2016, at which point relevant STP partners expect to be able to make a joint statement about projected financial performance when measured against the control total for 2016/17, along with the extent to which system-level commitments can underpin those provided by individual NHS bodies during this 2016/17
- Recent collaborative activity bodes well for our ability to adopt STP-wide control totals for 2017/18 and 2018/19
- Work is currently underway to define, design and develop the internal control apparatus that will be put in place to monitor and manage effective oversight of system-level control totals, both for the remainder of 2016/17 and thereafter
- It is the current intention of BLMK's (relevant) STP partners to declare an interest in securing system-level control totals for 2017/18 and 2018/19. Equally, we currently expect to apply for flexibility in operating those control totals
- We expect to be in a position to submit a draft application for registration to secure system-wide management of control totals during November 2016. This application will include a detailed description of the internal control apparatus referred to above.

Local consensus amongst BLMK STP partners

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

How we envisage better integration in health and social care…

- Priority 1 workstream is led by the four local Councils in BLMK
- Priority 1 has already pushed prevention up the agenda of all NHS bodies by brokering the appointment of Board level prevention champions for all. These champions are responsible for ensuring their organisation commits to keeping people healthy by, *inter alia*, working with the BLMK STP Prevention Team to develop and implement an organisation-wide Prevention Plan and enabling and advocating for successful implementation of the Prevention Plan within and outwith their organisation

- BLMK's Priority 2 workstream is co-led by one of BLMK's CCG and one of its local Councils.
- Priority 2 is recommending two service development programmes, one of which, "Better Care, Closer", involves, amongst other things, integrating the workforces providing primary care, community heath and social care, for both adult and children's services, to deliver linked/integrated care at/close to home
- Investments in new care models will see closer support of care homes by local primary and community clinicians
- STP estates planning in BLMK is seeking to lever work already being undertaken by Councils under the government's *One Public Estate* initiative. BLMK's STP investment plans signal a strong appetite to develop and co-fund, with some local Councils, locality centres, accommodating multi-disciplinary health and social care staff, alongside other local public services, such as housing

- BLMK's Priority 3 workstream focuses on the organisation and configuration of high quality, accessible, sustainable and affordable secondary care services across BLMK.
- Crucial that BLMK's plans for hospital services are well-calibrated with the transformational solutions being planned to enhance BLMK's community clinical and social care offer and the increased independence of local citizens (and their family carers) who currently rely on the statutory services

- BLMK's Priority 4 workstream is led by one of its local Councils. BLMK Councils have invested funding in the STP to develop a co-ordinated approach to a cross-footprint Digital Roadmap
- Priority 4 is recommending both investment and convergence in information and communication systems and technology, across both NHS bodies and the four local Councils
- Priority 4 is expected to enable jointly accessible care records and links to associated care plans. This should benefit the real-time decision making of both health and social care practitioners, accelerate the pace at which integrated services can be operationalised and reduce duplication of effort and resource across health and social care

- Up to October, BLMK's Priority 5 workstream has proceeded largely without Council input. The shift to an accountable care system, and the associated changes to commissioning, are being observed by Councils with interest.
- Local Councils have expressed interest is understanding the pros and cons of including Council commissioned services in the scope of the accountable care system. They are also interested in its efficacy in enabling the delivery of the transformational solutions being prosecuted under Priority 2.
- Local Councils will be formally involved in the development of Priority 5 by becoming members of the ACSAB. Amongst other things, the ACSAB will consider the service scope of an accountable care system. This would not prevent NHS budget-holders proceeding more rapidly into the accountable care system than local Council colleagues.

How we intend to communicate and engage with our communities, our staff and other stakeholders to enrich the ideas set out in our STP

BLMK STP communications, engagement & consultation

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

Our principles:

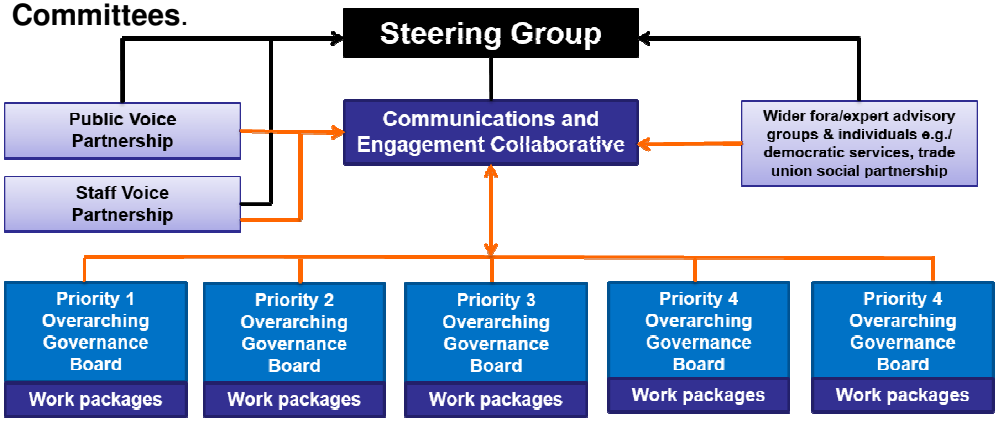
Open, honest and transparent
Accessible and inclusive
Clear, communicating without jargon
Accurate, balanced and fair
Two way – involving and listening
Timely and relevant
Effective and measurable

We will:

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

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

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

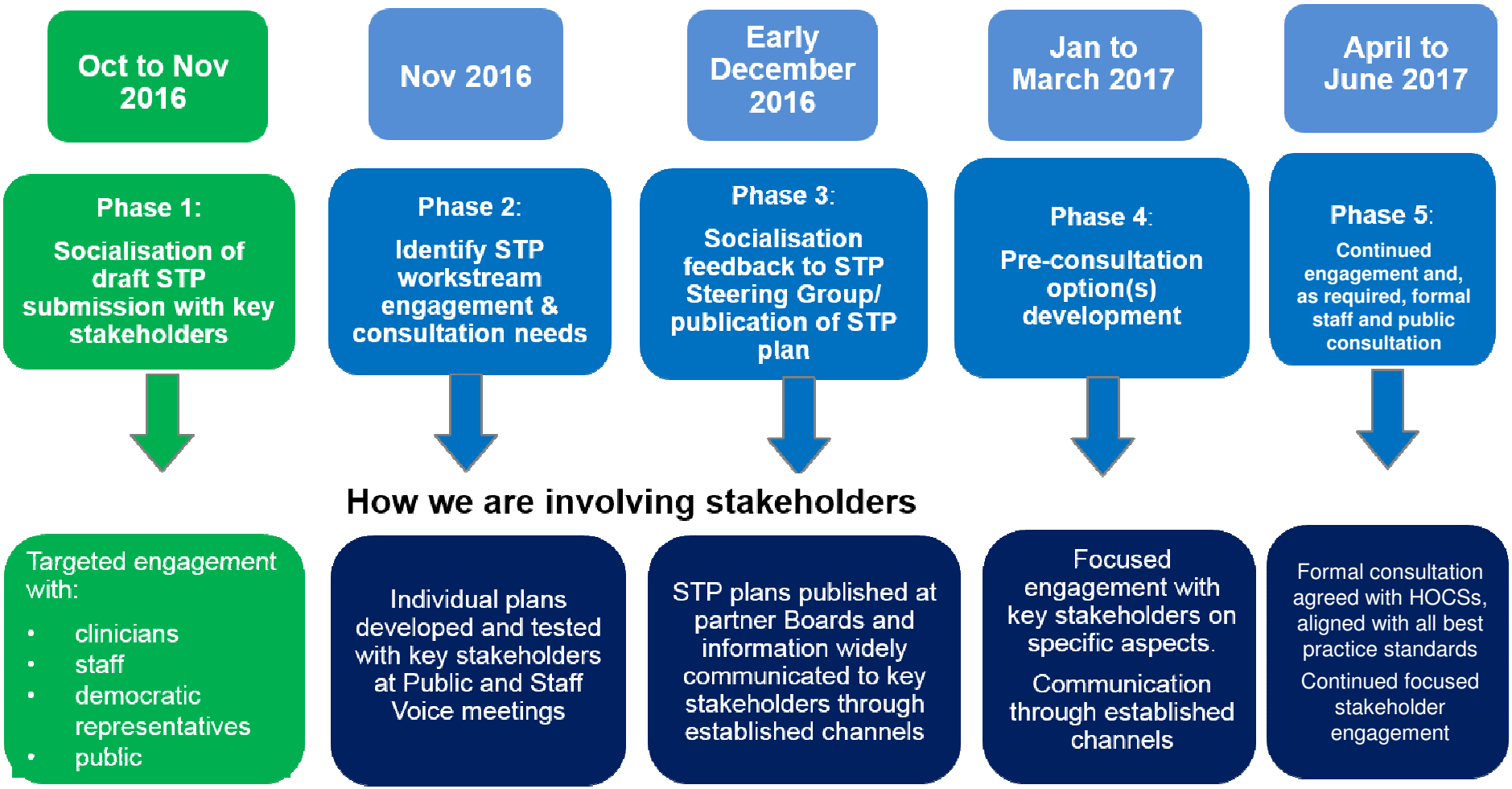


The initial engagement will be in two phases:

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

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

BLMK STP communications and engagement phased timeline



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

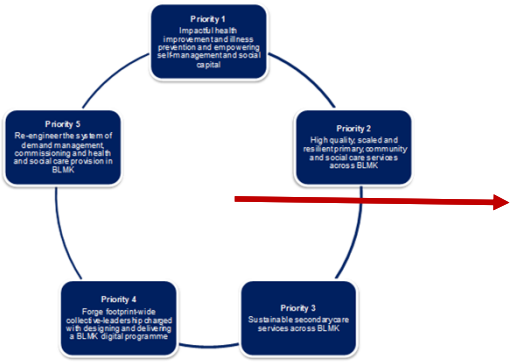
Key tasks

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

STP Partner Leaders commitment

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

Communications and engagement post 21st October submission



BLMK Communications & Engagement Collaborative

STP partners leading Comms and engagement facilitated by Comms Collaborative and progressed through, amongst others, key fora for staff and community voice

Public Voice Partnership

1. Healthwatch: Bedford
2. Healthwatch: Central Bedfordshire
3. Healthwatch: Luton
4. Healthwatch: MK
5. Community Action: MK
6. Voluntary Works Bedfordshire
7. Voluntary Action Luton
8. Luton Assembly
9. Age UK (single nominated representative)
10. Carers UK (single nominated representative)
11. Mencap (single nominated representative)
12. Luton Council of Faiths
13. Bedford Council of Faiths
14. MK Council of Faiths
15. Citizens MK
16. Bedford Youth Council
17. Luton Youth Council
18. MK Youth Council
19. Voluntary and Community Action Central Bedfordshire
20. Bedfordshire Rural Communities Charity
21. Central Bedfordshire Youth Parliament
22. MKUH Council of Governors (single nominated representative)
23. LDUH Council of Governors (single nominated representative)
24. Bedford Hospital Patient Council (single nominated representative)
25. Nominated representatives of the Communications Collaboration (no more than three)

Staff Voice Partnership

Hospitals – Per Provider

1. Nominated medical representative
2. Nominated nursing representative
3. Nominated health care support worker representative
4. Nominated AHP representative
5. Nominated admin and clerical staff representative

CCGs – Per Locality:

1. Five (maximum) nominated representatives from each of the three CCGs

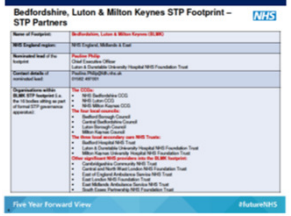
Primary, Community and Social Care – Per Provider

1. Nominated clinician
2. Nominated AHP representative
3. Nominated admin and clerical representative

Local Authorities

1. Five (maximum) nominated representatives from each of the four Local Authorities

STP Partners



STP Partner CEOs to engage, communicate and cascade to their own direct stakeholders including:

- Governors
- Boards
- Local politicians and MPs
- Cabinet/sub-committees
- Staff
- Staffside
- Statutory committees (e.g. HWBs)