Appendix 3

Working towards a collaborative health and wellbeing system

What we are trying to achieve by having a Sustainable Transformation Partnership (STP)

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

The BLMK plan has brought together 16 partners[1] to look collectively at how we can break down the boundaries between our local health and social care systems, address problems that threaten our quality and financial viability; and develop ideas and priorities to transform local services. This includes a shared vision for the future of local health and care services. This vision is grounded in an honest assessment of the effectiveness, fitness for purpose and affordability of existing services.

The 'triple aim', as set out in NHS England's Five Year Forward View (see diagram), highlights three key areas where we can focus our collective effort. In developing our plans to work together and work differently, we will need to show how our plans improve the quality of care we provide, the health and wellbeing of local people and how we can afford to do this with the funds available to us.

NHS triple aim

Realigning the system to help us achieve our aims

We need to develop a model which will help us achieve this aim, organising ourselves so that we are thinking more about health and quality of care. We need to evolve and improve existing arrangements to collaborate better across the health and care system. To do this, we are seeking to create a single system that is designed around the needs of individuals, that removes organisational barriers and that works in partnership across the whole of Bedfordshire, Luton and Milton Keynes so that we provide the best possible health and wellbeing outcomes for our communities, with the resources available to us.

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[1]The 16 BLMK STP partners are: Bedford Hospital NHS Trust; Luton and Dunstable University Hospital NHS Foundation Trust; Milton Keynes University Hospital NHS Foundation Trust; NHS Bedfordshire Clinical Commissioning Group ; NHS Luton Clinical Commissioning Group; NHS Milton Keynes Clinical Commissioning Group; Bedford Borough Council; Central Bedfordshire Council; Luton Council; Milton Keynes Council; Cambridgeshire Community Services NHS Trust; Central and North West London NHS Foundation Trust; East London NHS Foundation Trust; South Essex Partnership; University NHS Foundation Trust; East of England Ambulance Service NHS Trust; South Central Ambulance Service NHS Trust

The 'Triple Tier' approach

Discussions are still ongoing, however we believe that the model that would be best suited to BLMK would involve a 'triple tier' approach. This means looking at our population of around 1 million people at three different levels, and organising our services, and the way we plan and commission them, around these three levels. See the table below for how this might work:

By **LOCALITY**	Hubs or Primary Care Home models (GP practices working together)	Primary, community and social care working together based around families of GP practices serving localities of around 30,000-50,000 people. The blend of services will differ from locality to locality, depending on need. *For example, In Central Bedfordshire, Integrated Health and Social Care Hubs with integrated health and social care teams working with community and voluntarily groups to deliver integrated outcomes and reduce health inequalities. This includes empowering people to look after themselves better.*
By **PLACE** i.e. Local Authority level	Bedford Borough Central Bedfordshire Luton Milton Keynes	• Defining population health and well-being outcomes for local populations • Strategic commissioning • Accountability to our communities e.g. via H&WB • Place-sensitised delivery of health and well-being services • Empowering self-managed care *For example, multidisciplinary and integrated health and social care teams aligned to deliver place based care including support to care and residential homes to develop anticipatory care plans that promote health and wellbeing for people.*
At **SCALE**	BLMK-wide	• Specialised commissioning • Population health analysis and data sharing • Supply chain assembly and management • Inter-operable digital platforms • Service quality and risk management

The benefits of a more collaborative approach

Following an invitation from NHS England, we recently submitted an expression of interest in becoming what NHSE is calling a "lead Accountable Care System (ACS)[2]". The BLMK Partnership has been announced as one of eight STP footprints in England recognised as being sufficiently advanced in their collaboration and partnership working to be able to move forward at pace with integration plans.

There are several benefits associated with achieving lead status including greater local autonomy, particularly in relation to primary care, preferential access to capital, and greater local prioritisation of recurrent transformation funding (£18.8m in 17/18) to help 'fast track' system improvements. In return, STPs that achieve lead status are expected to evidence system leadership commitment, shared performance plans and collective management of funding across CCGs and NHS providers for the defined population in 2017/18. There is also a requirement to demonstrate robust and effective collective decision making and governance.

[2] Accountable Care System (ACS) is the terminology being used by NHSE to describe systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health to provide more joined up, better coordinated care. At its simplest, accountable care is a way of working that rewards those involved in keeping us healthy, and for planning and delivering health and social care services on the basis of the outcomes achieved.

How we are developing our collaborative model

Through 2017/18 partners in BLMK are exploring new ways of working with a view to formalising arrangements in 2018/19. In Central Bedfordshire, discussions have commenced between Bedfordshire CCG and the Council to develop a framework and an outline plan for an integrated approach to strategic commissioning. Proposals outlining this approach will be taken through respective governance forums, as well as the Transformation Board and the Health and Wellbeing Board later this year.

What would be different?

Within BLMK, as with other parts of the country, there are challenges to overcome if we are to achieve our vision of communities and organisations working together to improve the health and wellbeing of our people. However, we are not starting with a blank sheet of paper. Our local research already reveals several live examples where partners across BLMK are collaborating to achieve wider system goals, and indeed, partners have registered an aspiration to do much more of this in the coming months. This also builds on integration work that CCGs and Councils have been undertaking in recent years.

Through our STP work, we have recognised some of these challenges – a fragmented system with different rules that results in inequality of service provision; a system based on incentives that drives competition between organisations rather than co-operation; multiple IT systems that prevent efficient information sharing; too much focus on treatment and not enough on prevention. We also know that our staff is a precious and scarce resource and that we won't have enough money to do everything we want.

Our goals will only be met through significant transformation of organisations, services and behaviours. Collaboration needs to become the "new normal". The hallmarks of such behaviours include openness and transparency, knowledge sharing, joint learning, coordination and cooperation, collaboration, harmonisation and, as we move forward, integration.

We believe we can achieve our goals more quickly by working together as a partnership, learning from each other as we progress. Everything we do together will be tailored to meet the needs of our local communities in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. We will work closely with local Health and Wellbeing Boards to make sure this happens.

What impact will this have on the Council and on residents?

Partnership working across BLMK allows more joined up thinking and shared responsibility for health and wellbeing outcomes and associated health and care services, creating the best opportunity we must tackle growing challenges to provide high quality and sustainable health and social care services for the future. By taking a more holistic view, we can consider how we collectively spend the funding we have to ensure we get the best

outcomes. This will include helping people to actively manage their own health and wellbeing within an environment that is focused on the individual. People will enjoy improved health and wellbeing because the BLMK community, care organisations and environment enables this to happen in a seamless way. The easiest way to describe the impact of adopting a more collaborative system-wide approach is to consider a person's experience today with what that might look like in the future if we are to realise our ambitions.

Local case study: How working at 'place' level could improve patient access to services and help people to stay well at home for longer

George is 90 years old and is living independently in his own home. His daughter is worried he is becoming more frail, sleeps a lot, and is forgetting things more frequently. She telephones his GP practice which has a multidisciplinary team consisting of a range of health and social care professionals and they make arrangements for his GP to visit him.

During the visit, the GP identifies a number of actions that can be progressed as part of a centrally coordinated personal care package. This includes a medication review by the pharmacist who ensures both George and his daughter understand what they are for and how to take them; blood tests and a referral to the memory assessment service. Arrangements are also made for a social care worker to meet with George and his daughter to agree extra support, as well as ongoing assessment and support from the community matron to get his health as good as it can be.

This integrated approach across health and social care means that George has the support he needs at home and is less likely to end up in hospital because his conditions are being proactively managed:

Local case study: How can a more joined up approach managed at locality level improve care for patients?

Let's consider Mrs Jones' story. She is 77 years old, lives at home alone (following the death of her husband a few years ago) and is generally well. Following a fall, she is admitted to hospital and diagnosed with a simple fracture to her lower leg, dehydration and possible early dementia. While in hospital, Mrs Jones becomes confused, struggles with getting around and develops a urinary tract infection, which means she ends up spending almost two weeks in hospital. She is keen to return home as soon as possible and arrangements are made to assess her need for home support. However, Mrs Jones son, who lives and works in London, is worried that his mother shouldn't remain at home alone and requests information from the social care team on local care homes. Whilst waiting to be discharged from hospital, Mrs Jones is convinced by her doctors, son and daughter who is living abroad, that the safest place for her to be is a nursing home, so she reluctantly agrees. A place is found for her in North London, near to her son, but she never really adapts to life in a care home. Without the familiarity of her own surroundings and routines, she becomes lonely

and depressed. Gradually her health deteriorates and 18 months after the initial fall, she passes away in her sleep.

Throughout, Mrs Jones has many people making decisions about her health and wellbeing and the care she receives. From the initial assessment by paramedics, to the A&E/ ward consultants and doctors/ medical team at Lister Hospital (she moves wards three times), the hospital social work team, physiotherapist, Central Beds Council rehabilitation team, Occupational therapists (one to assess home equipment requirements and one to assess her need for home adaptations), her family and eventually the nursing home manager.

What would be different if there was a more integrated approach to Mrs Jones health and social care?

Following her fall, Mrs Jones would be assessed through the ambulance call centre and her case would be passed to the Integrated Health and Care Hub. A clinical nurse lead would be assigned to liaise with her family and all other health and care workers regarding her care and treatment eg. fracture clinic technicians, rehabilitation and therapy team, GP, community assessment officers and physiotherapist. Working with a local charity they establish a Care at Home team that can support Mrs Jones rehabilitation at home and she is able to return home, fully supported, in 3 days. 10 years later, Mrs Jones is still at home and considering a move into Extra Care.

What are the benefits?

By evolving the way we plan, buy and deliver health and social care services and work in partnership across the entire BLMK footprint, there are many opportunities for improvement and some real benefits that can be achieved. This includes:

- A more **joined up service** across health and social care and between community and hospital settings, with the individual's health and wellbeing at the core
- **Better value for money**, increasing the proportion of funding spent on front-line services
- Establishing a **common approach, shared 'rules' and drivers** (including financial) and **improving information sharing** to provide better patient experience and outcomes
- A real **focus on prevention and wellness** rather than just on treatment
- **Re-aligning the system** and the way we work to ensure that people get the right care in the right place, first time
- **More sustainable approach** to delivering quality healthcare services within our means

What happens next?

As part of the development of the programme we would need to identify, review and mitigate any risks associated with implementing this approach. Following notification of BLMK's ACS status, work will now progress to establish a work programme for designing and developing a framework for strategic commissioning.

May 2017	June 2017	2017-2018	2018-19
Lead ACS EoI submitted	Lead ACS status confirmed	Design/ development of BLMK collaborative health and wellbeing system model	Formal system realignment agreed and will go 'live' (System control total and performance agreements in place)