Central Bedfordshire Council
Priory House
Monks Walk
Chicksands,
Shefford SG17 5TQ

please ask for Mel Peaston
direct line 01234 228200
date 14 April 2009

NOTICE OF MEETING

JOINT HEALTH SCRUTINY COMMITTEE

Date & Time
Tuesday, 21 April 2009 9.30 a.m.

Venue at
Room 15, Priory House, Monks Walk, Shefford

Jaki Salisbury
Interim Chief Executive

To: The Chairman and Members of the JOINT HEALTH SCRUTINY COMMITTEE:

Cllrs (Chairman), (Vice-Chairman), A B Carter, M Gibson, Mrs S Goodchild and S F Male (Central Bedfordshire Council)
Cllrs J Brandon, J Cunningham, C Meader and 1 Conservative vacancy (Bedford Borough Council)

[Named Substitutes:

Cllrs:]

All other Members of the Council - on request

MEMBERS OF THE PRESS AND PUBLIC ARE WELCOME TO ATTEND THIS MEETING

A buffet lunch will be provided at approximately 12.30pm for Members, witnesses and officers supporting the meeting.

AGENDA

1. **Election of Chairman**

   To elect a Chairman for the remainder of the municipal year

2. **Election of Vice-Chairman**

   To elect a Vice-Chairman for the remainder of the municipal year.

3. **Declaration of Interests**

   Members are requested to disclose the existence and nature of any personal and prejudicial interests as required by the Council's Code of Conduct.

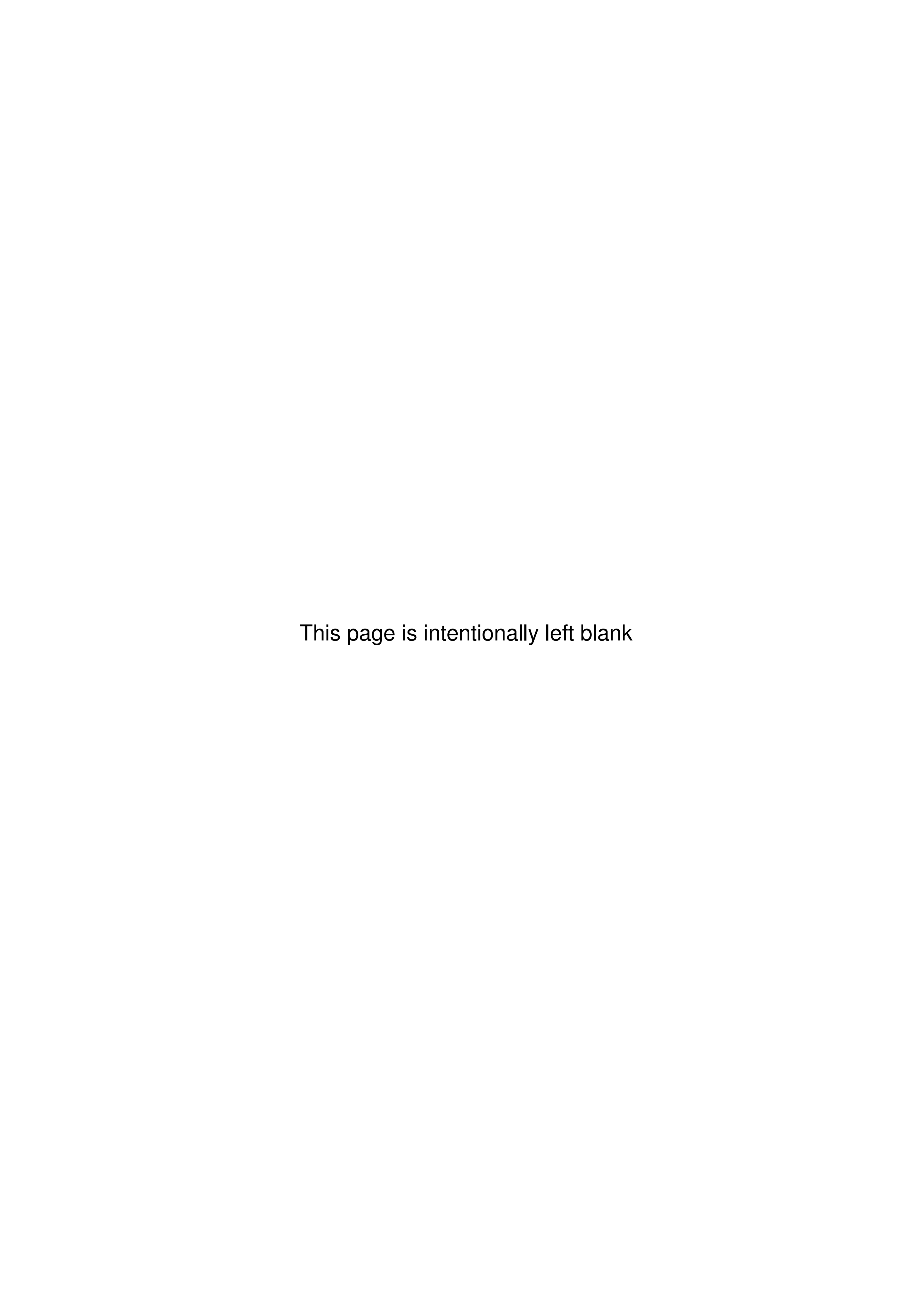
REPORTS

Item	Subject	Page Nos.
4	**Statutory Basis of the Joint Committee** To consider the attached report.	4/1
5	**Composition and size of the Joint Committee** To consider the attached report.	5/1
6	**Terms of Reference of the Joint Committee** To consider the attached report.	6/1
7	**Adoption of work already completed by Bedfordshire County Council's NHS Strategy Member Task Group** To consider the attached report.	7/1 – 7/13
8	**NHS Bedfordshire's Strategy Proposals** To receive and scrutinise NHS Bedfordshire's Strategy proposals in respect of:- • Staying Healthy (morning session) • Mental Health and Learning Disabilities (morning session) • Planned Care including Dental Health (afternoon session) • Children's Services (afternoon session)	8/1 – 8/2 Supporting Documentation Numbered separately

(This item is timed to start at 10.00am)

9 **Date of next meeting**

The next meeting will be held on Tuesday, 28 April 2009 at Priory House, Chicksands starting at 10.00am.


This page is intentionally left blank

Statutory Basis of the Joint Committee

1. The NHS Bedfordshire Strategy Joint Health Scrutiny Committee is established under powers set out in the Health and Social Care Act 2001 and under the Direction issued by the Secretary of State for Health on 17 July 2003 under statutory instrument 3048 of 2002 – the local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

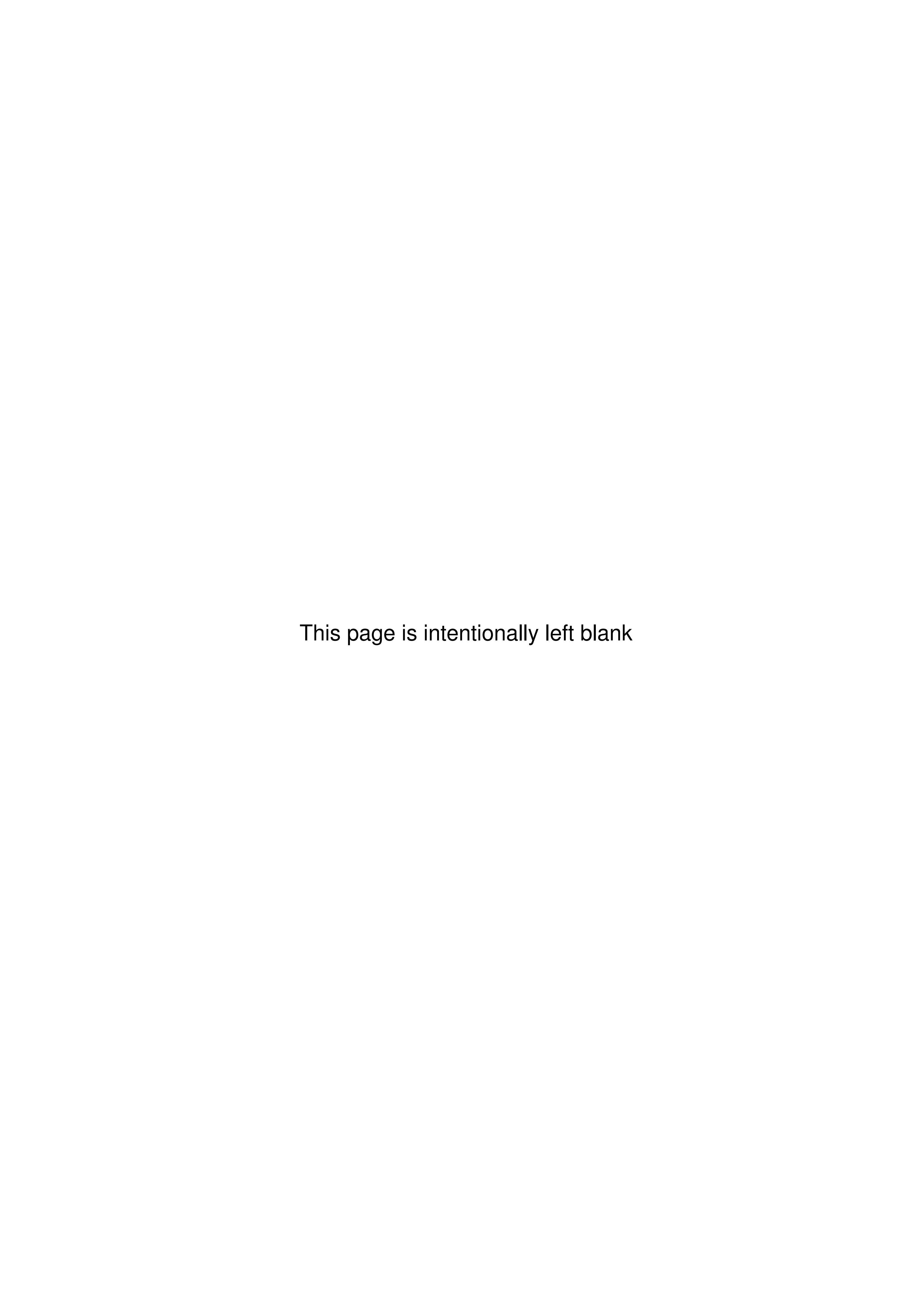
2. Paragraph one of the Direction relates to application, commencement and interpretation, including definitions of which local Social Services Authorities, it applies to. Paragraph 2 of the Direction states

   "Where a local NHS Body consults more than one overview and scrutiny committee pursuant to regulation 4 of the Regulations on any proposal it has under consideration for a substantial development of the health service or a substantial variation in the provision of such a service, the local authorities of those overview and scrutiny committees shall appoint a joint overview and scrutiny committee for the purposes of the consultation and only that joint committee may:

   a) make comments on the proposal consulted on to the local NHS body under regulation 4(4) of the Regulations:
   b) require the local NHS body to provide information about the proposal under regulation 5 of the Regulations: or
   c) require an officer of the lead local NHS body to attend before it under regulation 6 of the Regulations to answer such questions as appear to it to be necessary for the discharge of its functions in connection with the consultation."

3. The Joint Health Scrutiny Committee has been established by Bedford Borough Council and Central Bedfordshire Council to discharge the requirements of the Direction in relation to matters which affect the constituent Councils, specifically the consultation by NHS Bedfordshire proposing substantial changes and/or developments to health services in their areas arising from A Healthier Bedfordshire, NHS Bedfordshire's Strategic Plan for 2009 to 2013.

The Committee is recommended to agree this report.


This page is intentionally left blank

Composition and Size of the Joint Committee

1. The Committee will comprise four members from Bedford Borough Council and four members from Central Bedfordshire Council as the relevant Social Services authorities in the area served by NHS Bedfordshire. Members will be politically proportional to the membership of their local authority, unless both:

- that authority's full Council agrees, with no-one dissenting, to waive the political proportionality requirement for their own members; and
- Members of all authorities represented on the joint committee agree to waive that requirement.

Appointments to the Joint Committee have been made by the constituent bodies to reflect their own political proportionalities in accordance with the relevant legislation.

2. The Committee is requested to determine whether it wishes to allow for substitute members if a named member of the Committee is indisposed.

3. The Committee is also requested to determine a quorum for its meetings. It is suggested that this number be four, being one half of the Joint Health Scrutiny Committee, and that two of the quorum should be from Central Bedfordshire Council and two from Bedford Borough Council.

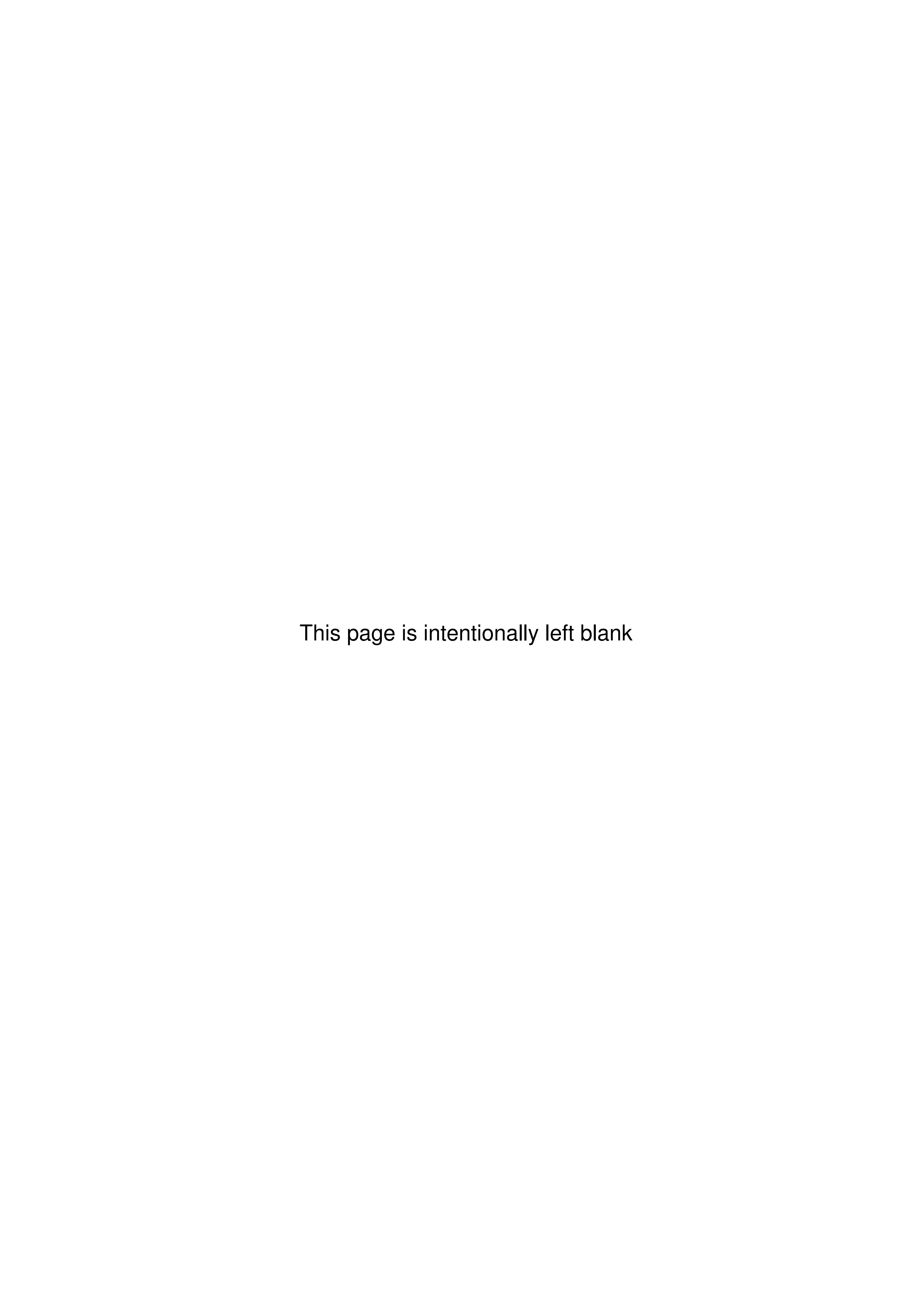
4. **Recommendation**

The Joint Health Scrutiny Committee is recommended to agree that:

a) the Committee comprise four members from Bedford Borough Council and four members from Central Bedfordshire Council as the relevant Social Services authorities in the area served by the East of England Strategic Health Authority;

b) named substitute members be allowed if the nominated member is indisposed;

c) the quorum of members be set at four, representing one half of the Committee, two of which should be from Bedford Borough Council and two from Central Bedfordshire Council.


This page is intentionally left blank

NHS Bedfordshire Strategy Task Group

Terms of Reference:

- To scrutinise the draft NHS Bedfordshire Strategy by:-

1. examining the proposals against the Regional Strategy, including checking whether the 8 main themes of the Regional Strategy have been covered

2. examining the proposals in the strategy in their own right

3. examining whether there is anything missing, or given inappropriate weight, having regard to the local health issues and the health priorities in Bedfordshire and subsequently the areas relating to Central Bedfordshire and Bedford Borough Council

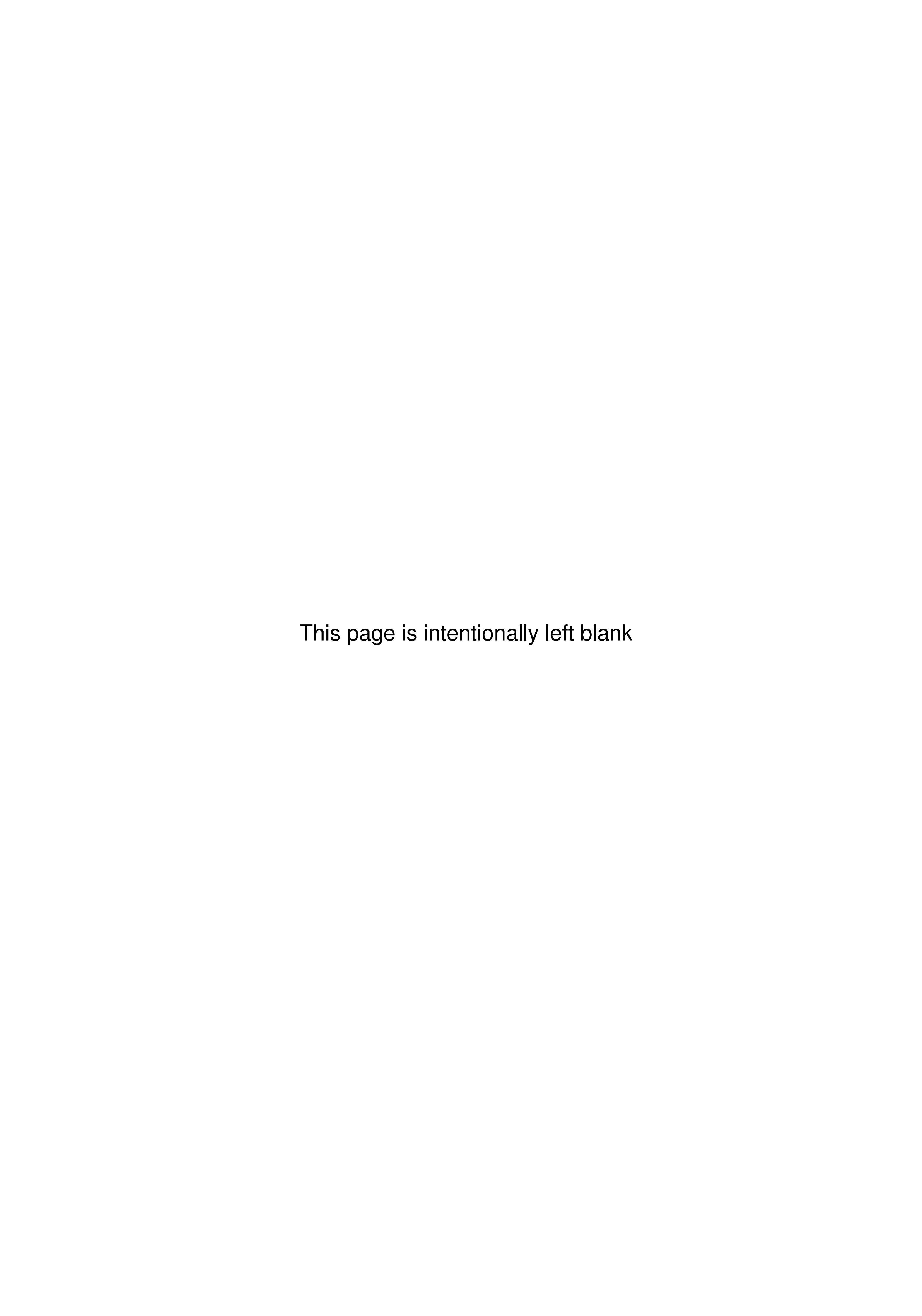
4. identifying whether there are issues raised by any patient group

5. considering the PCT's ability to fund the proposals given their relatively low funding allocation by central Government

6. consider whether the framework is in place so that the financial, IT, property assets and HR aspects of the local strategy are deliverable

7. covering any other matter arising from the exercise which has a significant impact regarding health in the local area

8. and consulting with patient groups and health professionals.


This page is intentionally left blank

NHS Bedfordshire Strategy Task Group
Meeting no 2: 11.02.09

Present: Councillors Male (Chairman) Carter, Mrs Cunningam, Sparrow.
Adviser: Bill Hamilton
Support: Mel Peaston.

Also Present: David Levitt, NHS Bedfordshire
Dianne Meddick, NHS Bedfordshire

Item	Discussion Points	What Action?	By whom?	By when?
1	**Transition from Bedfordshire County Council**. Noted that Central Bedfordshire and Bedford Borough Council (Unitaries) would be in place on 1 April 2009. Concerns were expressed about future arrangements which would enable the work of this Task Group to continue.	Agreed that Bill Hamilton would draft a letter to the Chief Executive of Central Bedfordshire which Devid Levitt would ask Andrew Morgan to sign asking who will be the body to be consulted with on the NHS Bedfordshire Strategy.	Bill Hamilton David Levitt	Done asap
2.	**Presentation of the NHS Strategy** The document dated 30.01.09 was tabled. Noted that it needs formal approval before it can be used publicly. DM outlined the background to the document. 2 organ-isations had been asked to draw up a template for what			

	must be included in the document and one template was selected.			
	Noted that the Task Group members needed to read the Regional Strategy “The Best Together” as background to the Bedfordshire Strategy.	Bill Hamilton to request copies of “The Best Together” from Stephen Dunn, Head of Strategy.	Bill Hamilton	Asap
	Discussion ensued about reader-friendly formats. The Chairman indicated he would use the A4 version of the NHS Beds Strategy dated 21.01.09 and asked for a new Finance section 8 in an accessible size.	David Levitt to provide a new section 8 in an accessible size.	David Levitt	Asap
	Noted that the document used by the Task Group, whilst available to the general public, was not designed for public consultation specifically. Discussion ensued on how the Task Group would approach the consultation. **AGREED** to address the consultation process on the dates and looking at the specific topics as set out on the attached sheet.	All to note the dates/topics for Task Group meetings	All	Ongoing
	Easy-read leaflet: Noted that any comments n this 4-page document should be sent to Mel Peaston who would pass them onto David Levitt.	All to consider any comments.	Mel Peaston	ongoing
3	**Sequence of meetings – Dates** Agreed as set out on the attached sheet. Next meeting on 5.3.09 at 2.00pm.	All to put dates in diaries if not yet done so.	all	asap

A Healthier Bedfordshire – Working for you – The NHS Bedfordshire Strategic Plan 2009-2013

Plan of Meetings of the Bedfordshire Health Strategy Task Group/Joint Committee - matters to be covered

The Consultation on the NHS Strategy runs from 5 March 2009 until 25 May 2009

Meeting 1 – 11.02.09 – 3pm	• Receive presentation of the draft strategy – David Levitt and Dianne Meddick
Meeting 2 - 05.03.09 – 2pm	• To receive a presentation on the current health of, and health issues facing, Bedfordshire and to scrutinise understand those issues
Meeting 3 - 24.03.09 – 2pm	• To receive a presentation on the proposed strategy to improve the health of, and address health issues facing Bedfordshire and to scrutinise that strategy
Meeting 4 - 07.04.09 – 2pm	• To receive a presentation on the proposed delivery of the strategy and to scrutinise the delivery proposals
Meeting 5 - 21.04.09 - All day meeting – 10.00am start	To receive and scrutinise the strategy proposals in respect of: • Staying Healthy • Mental Health and Learning Disabilities • Maternity and Newborn • Children's Services First two in the morning, second two in the afternoon
Meeting 6 – 28.04.09 - All day meeting – 10.00am start	To receive and scrutinise the strategy proposals in respect of: • Planned Care including Dental Health • Acute Care

	• Long Term Conditions • End of Life care First two in the morning, second two in the afternoon
Meeting 7 - 12 .05.09 – 2pm	To consider and approve submission of the Overview & Scrutiny response to NHS Bedfordshire
Meeting 8 - 30.07.09 – 2pm	To consider whether the decision of the NHS Bedfordshire Board on the strategy is in the interests of health locally and whether the consultation with the Committee has been adequate and to determine whether there is a need to refer the strategy to the Secretary of State.

Bedfordshire Health & Adult Social Care Overview & Scrutiny Committee.

Member Task Group to scrutinise *A Healthier Bedfordshire*, the strategy of NHS Bedfordshire.

Conclusions of the member Task Group meeting held at County Hall Bedfordshire on Thursday 5th March 2009.

1. **Present:** Councillors Male, Sparrow and Carter.

2. **Apologies:** Councillor Cunningham.

3. **Action Plan** from the meeting held on 11 February 2009 – It was agreed that the Chairman would contact Julie Ogley and Frank Toner, respectively Directors of Adult Social Care at Central Bedfordshire Unitary Council and Bedford Borough Council to ascertain their Council's views on the establishment of a statutory joint health scrutiny committee to carry on the work of the Member Task Group. Bill Hamilton confirmed that he would get in contact with the East of England Strategic Health Authority, NHS East of England, to seek copies of the consolidated (i.e. including the amendments made as a result of the SHA's consultation exercise) regional health strategy, *Towards the Best Together,* for onward transmission to members of the Task Group, and any successor joint committee, to provide a strategic backcloth briefing. Dianne Meddick circulated update sections 2 and 8 of the NHS Bedfordshire strategy.   .

4. **Presentation on sections 2 and 3 of the strategy**

4.1 Dianne Meddick and Edmund Tiddeman of NHS Bedfordshire gave a presentation on the first two sections of the proposed strategy, Section 2 - Bedfordshire Today and in the Future and Section 3 - Insights of Patients, Public, Clinicians and Partners. They advised that the Strategic Health Authority had established a template for local strategies and this had been adopted by NHS Bedfordshire.

4.2 Edmund Tiddeman explained that Bedfordshire was a growth area within the Milton Keynes and South Midlands overall growth area. There was both an ageing and a growing population, with demographic changes throughout each of the age bands resulting in a dramatic, 30% increase in the population of older people over the next ten years, including the next five years of the plan period. This would have a significant impact on the healthcare resources and the use of such resources and capacity at the current utilisation levels would significantly exceed the resources available over the plan period.

RECOMMENDATION 1

That the NHS Bedfordshire Board need to bring out and address the issue of the resource and healthcare capacity shortfall more clearly, especially the impact of the growth of older people.

4.3 Members were also concerned that in following the SHA's template there was still a gap between the analysis of the demographic and other healthcare data in Section 2 and the proposals set out in the strategy. It would be helpful for example to demonstrate the local demographic growth for Bedfordshire as compared to the position in England as whole, as a comparator. The Task Group recognised that the Bedfordshire population would both grow and grow older. This would impact on Government spending and the Government needing to spend. The focus on Bedfordshire could be sharper and the strategy could better focus on the impact of

the demographic issues facing Bedfordshire. A better link between the demographic forecasts and the specific actions/proposals set out in the strategy should be provided.

RECOMMENDATION 2
That the NHS Bedfordshire Board provides in the adopted strategy better logical linkages between the demographic and other data and the proposals set out in the strategy.

RECOMMENDATION 3
That the NHS Bedfordshire Board provides a "golden thread" linking local healthcare needs to proposed local actions.

4.4 The Task Group recognised that that the strategy was developed over a period of time during which the full impact of credit crunch was unknown. The impact of the credit crunch will delay some of the proposed house-building in the County. As such the demographic changes, especially those relating to a growing population may reveal themselves over a longer time period that the five plan period of the strategy. The Task Group believes that it would be prudent for there to be significant sensitivity testing of the demographic data and the financial projections that arise from them over the plan period. The Task Group accepts that some of the changes set out in the strategy may merely be delayed, but still consider that there is a need for the changes envisaged, and the necessary investment in services, to be synchronised in order to make the best use of the available resources.

RECOMMENDATION 4
That the NHS Bedfordshire Board commission detailed sensitivity analyses of the demographic data and the timing of financial investments in improved healthcare capacity to reflect the impact of the credit crunch.

4.5 The Task Group recognised that in such a strategy some of the data will always be out of date. However it believes that the recorded performance of the County's pupils in their GCSE examinations should be properly reflected in the strategy in that recent performance is somewhat better than that recorded in the strategy. To the extent that this is used as proxy indicator of health, (more qualified people are usually healthier and look after their health better), the most recent data should be used.

RECOMMENDATION 5
That the NHS Bedfordshire Board make use of the most recent data in respect of the GCSE performance of the County's pupils and, as necessary, adjust the strategy to reflect the recent improvement.

4.6 The Member Task recognised that NHS Bedfordshire was required to work to a template provided by the SHA, and that template aimed to translate the priorities set out in the regional health strategy, *Towards the Best Together* and other strategic documents such as the Darzi Report and the regional health promises. The position of Bedfordshire as one of the country's growth areas to a degree set it apart from other areas of the region. Accordingly it would be necessary to clearly establish whether the proposals and the priorities emanating from the regional health strategy were all equally applicable to Bedfordshire or whether the County's needs meant that the there would need to be variations of the regional strategy and its priorities to reflect local needs. For example the forecast ageing population could also result in an increase in Long Term Conditions with the consequent health resource, funding and capacity issues. The Task Group recognised that the strategy, *A Healthier Bedfordshire*, was a technical document to deliver the policies, priorities and commitments set out in the regional strategy, *Towards the Best Together*. However the Task Group was concerned to ensure that the local health strategy reflects the

local health needs. The Task Group welcomed and accepted the reassurances that the strategy would be monitored and updated over time and it that sense it would become a "living document", a strategy to provide context and guidance for operational decisions and not just "a document".

RECOMMENDATION 6
That the NHS Bedfordshire Board and the NHS East of England Board and senior officers ensure that the health strategy for Bedfordshire reflects and meets the needs of Bedfordshire and that it adjusted and amended over time to reflect the emerging healthcare needs of the County.

4.7 The Task Group was concerned to note the data set out in the first bullet point on page 20 of the strategy, that the number of people over 65 unable to manage at least one mobility activity on their own was forecast to rise from a current estimate of 9,300 to 11.400 by the year 2015. The Task Group believes that this is a very significant forecast development and believes that this is an issue which should be addressed not only by the NHS but also by the two new unitary authorities.

RECOMMENDATION 7
That the NHS Bedfordshire Board and the Executives of the new unitary authorities bring forward proposals to address the impact on health and adult social care services of the forecast increase in the number of people over 65 years of age unable to manage at least one mobility activity on their own.

4.8 In reviewing the data on ethnicity the Task Group was not convinced that the strategy adequately or properly reflected the needs of the different ethnic groups. The proposals set out in the strategy do not show an adequate linkage back to the analysis of ethnicity.

RECOMMENDATION 8
That the NHS Bedfordshire ensures that the strategy's proposals regarding the range of health services reflect the needs of the ethnic minority patients and that there is a clearer link between the analysis and the specific proposals.

4.9 The Task Group in reviewing the proposals set out in paragraph 2.6 – Deprivation and Current Health Inequalities – was concerned that thee was no mention of the differential life expectancy of men and women and as such there are no proposals to specifically address this specific health inequality. This was a matter raised in the scrutiny of *"Towards the Best Together",* the regional strategy, and the response from the East of England Strategic Health Authority was that *"The SHA notes this recommendation and will ask the Staying Healthy Programme Board whether there is anything we can do to address this issue".* The Task Group believes that this is still an issue and would wish to see the matter specifically addressed in the Bedfordshire health strategy.

RECOMMENDATION 9
That the NHS Bedfordshire Board specifically sets in place actions to address the differential life expectancy of men and women.

4.10 The Task Group was perturbed to see the respective analyses of geographical distribution of the Index of Multiple Deprivation and Life Expectancy set out in Figures 9 and 10 of the document, on page 24. The Task Group believes that the evidence presented does not show the pattern that it claims to show. The comparative data purports to show that mortality rates are higher in areas of multiple deprivation and the Task Group believes that this assertion is not justified by the evidence that is presented. Indeed there is some evidence from the data to link affluence with higher mortality rates. The Task Group believes that NHS Bedfordshire should revisit this

issue and set out policies and priorities to address the differential health conditions per se.

RECOMMENDATION 10.
That the NHS Bedfordshire Board should revisit the issue of links or correlation between the Index of Multiple Deprivation and the Life Expectancy in the County and set out policies, priorities and actions to address the differential health conditions in the County per se.

4.11 The Task Group noted with interest the data set out in Section 2.7 - Comparison of Key Health Indicators. The Task Group believes that there is a need for additional comparative data at two levels, first at the regional level and, secondly, that comparison with the Audit Commission family of similar areas should be undertaken. The Task Group also noted the absence of an indicator in respect of Mental Health was a glaring omission which should be remedied in the final strategy.

RECOMMENDATION 11
That the NHS Bedfordshire Board commissions and presents additional comparative data at two levels, first at the regional level and, secondly, with the Audit Commission family of similar areas.

RECOMMENDATION 12
That the NHS Bedfordshire Board commissions and presents an indicator in respect of Mental Health in the adopted health strategy for Bedfordshire.

4.12 The Task Group was concerned to note the absence of any real analysis of the impact on Acute Services and local hospitals as more services are provided in the community, as the strategy proposes. It believes that this is an omission which should be remedied, especially as local hospitals will also be affected by the proposed concentrations of specialised medical and surgical procedures within the acute sector over the coming years.

RECOMMENDATION 13
That the NHS Bedfordshire Board commission and publish, as part of their commissioning responsibilities, a detailed and full analysis of the impact on the acute sector and local hospitals of the twin policy objectives of delivering more care closer home and District General Hospitals specialising in medical and surgical treatments.

4.13 The Task Group noted the presentation of data set out sections 3.12, 3.13 and 3.14 of the strategy. The Task Group noted the measures to improve patient experience set out in paragraph 3.15.

5. Next Meeting

The Task Group agreed that its next meeting would be held on 24 March 2009 and would focus on the overall proposals set out in pages 49-116 of the strategy. At that meeting the Task Group would consider whether it would meet on 7 April 2009 and if it did what the focus of the meeting would be.

Councillor Stephen Male
Chairman
Bedfordshire Health & Adult Social Care Overview & Scrutiny Committee.

Bedfordshire Health and Adult Social Care Overview & Scrutiny Committee

Member Task Group to scrutinise *A Healthier Bedfordshire,* the strategy of NHS Bedfordshire

Conclusions of the member-led Task Group meeting held at County Hall on 24 March 2009.

Present: Councillors Male, Carter, Cunningham.
Adviser: Bill Hamilton
Support: Mel Peaston
Also Present: James Wilkes, Head of Market Intelligence, NHS Bedfordshire; Diane Meddick, Assistant Director Strategy, NHS Bedfordshire; Bernard Carter, Head of Scrutiny Central Bedfordshire; Jacqueline Gray, Principal Scrutiny & Overview Support Officer, Bedford Borough Council.

1. **Apologies for Absence**
   Apologies were received from Councillor Sparrow.

2. **Minutes of the Last Meeting**
   The minutes of the meeting held on 5 March 2009 were approved as a correct record.

3. **Health and Health Issues – Scrutinising the Strategy**

   Section 4 – So What Do We Need to Do?

The Task Group looked in detail at Section 4. It was noted that 3 strategic priorities would drive the implementation plans, and what those priorities were (listed in the blue box on page 49). The section showed what success would look like by providing illustrative scenarios (set in yellow boxes).

Comments were made regarding bullet 5 on page 49 relating to supporting carers. Whilst it was noted that Joint Carer Strategic Systems were in place for people with mental health problems, comments were made as follows:-

- Better signposting was needed to enable carers to access support
- People in deprived areas do not access leaflets from pharmacies so more resources should be expended on hard-to-reach people, and this must be budgeted for.

RECOMMENDATION 14
That the NHS Bedfordshire Board consider developing further their approaches to ensure that people in deprived communities and otherwise hard-to-reach people were aware of and could successfully access support for carers.

Members considered that some matters would more appropriately sit in a different place within the strategy, eg the final bullet on page 49 relating to

carers would be better placed in section 4.2 “Creating Effective Support in Local Communities”.

RECOMMENDATION 15
That the NHS Bedfordshire Board consider the lay-out of the Strategy and ensure that matters are addressed in the appropriate section.

The Task Group queried whether there was evidence that people living in deprived communities suffered poorer health and asked for such evidence to be included. Although information was contained in Appendix A (page 3 section 6) the conclusions needed to be drawn out for example that people suffering deprivation also suffer greater levels of heart disease.

RECOMMENDATION 16
That the NHS Bedfordshire Board consider including evidence that people with higher levels of deprivation suffer poorer health than others and that poorer health relates to people, not geographical areas. It should be clear that deprivation is not interpreted as a justification for poorer health, but that there is a link between prevalence of a disease and deprivation.

It was noted that between 2008/09 and 2013/14, NHS Bedfordshire would be spending £139m more. Of this amount, £4m would be spent on prevention. This represented less than 3% of the additional resources. Questions were asked as to whether this was enough, and it was noted that although it was only a small proportion of the total additional spend it nonetheless represented an increase. Some spending on prevention could lead to reduced hospital admissions and lead to savings there.

RECOMMENDATION 17
That the NHS Bedfordshire Board clarify that although more resources would be spent on preventive work in 2008/09-2013/214, this would not be significantly more as a proportion of the whole budget.

In response to a question as to why there was no section of the Strategy devoted to “improving the health of everyone” it was noted that the Strategy addressed this throughout, including through its prevention work. The three strategic priorities (on page 49) would drive improved health for all.

Comments were made about the problems with the Choose and Book system. It was noted that this had been poorly implemented in primary care.

RECOMMENDATION 18
That the NHS Bedfordshire Board take steps to ensure that problems with the Choose and Book system are solved both at the service delivery end and the patient end before it becomes operational in any further markets.

A discussion ensued on the structure of the Strategy. A comment was made that the three priorities were about *how* to achieve what was wanted, rather than *what* the strategy should achieve. The priorities were really mechanisms to achieve priorities which were not stated. There were also 8 plans, 3 themes and some demographic data – a comment was made that this represented over-analysing. It was not easily apparent how the themes linked together.

RECOMMENDATION 19
That the NHS Bedfordshire Board consider how the Strategy can simplify and link the themes of its approach within the confines required of it to present a strategy which is focused on Bedfordshire's health issues, problems and priorities.

Comments were made welcoming the information provided in the table on page 61 setting out the HCC rating for quality of service and use of resources for various providers of health services. It was noted however that some people found it hard to read type against a bright coloured background.

It was noted that the graph at 7.4 – figure 12 – was out of date as since the end of last year patients must be seen within 18 weeks.

RECOMMENDATION 20
That the NHS Bedfordshire Board ensure that baseline data for major commitments is correct within the Strategy, enabling Overview & Scrutiny Committees to monitor progress.

Members looked at the maps provided in section 7 and asked that full-size maps be provided to the Task Group / Joint Committee. It was also pointed out that the explanatory legends were missing. The bullet points at Figure 14 on page 68 were incomplete. There was also an error as there are two pharmacies in Flitwick.

It was noted that patients in Bedfordshire who lived near a boundary with another PCT area could access some healthcare provision across the boundary if that was closer.

RECOMMENDATION 21
That the NHS Bedfordshire Board ensure that mapping in the Strategy:

- **had clear explanatory legends where appropriate**
- **was complete**
- **was factually correct**
- **showed where people living near a county boundary could access NHS services more conveniently across the boundary.**

The Task Group noted the title of section 7.15 "Developing the local market" and clarified that a single purchaser with a multiple provider did not amount to a market. A discussion ensued but it was noted that this was jargon which the NHS was being encouraged to use.

The Task Group sought reassurance that Table 11 on page 85 showed accurate figures for worst-case scenarios.

RECOMMENDATION 22
That the NHS Bedfordshire Board be asked to review the worst-case financial projections at tables 10 and 11 on page 85

RECOMMENDATION 23
That the NHS Bedfordshire Board be asked to give greater clarity on table 13 – Spend Across 23 Programme Budgets – by breaking down further the category "other".

The Task Group was aware of difficulties regarding Government funding of NHS Bedfordshire.

RECOMMENDATION 24
That the two local unitary authorities, Central Bedfordshire Council and Bedford Borough Council, be asked to consider the financial allocation for NHS Bedfordshire and consider what action would be most appropriate to get this matter reconsidered in Whitehall.

The Task Group asked that a written answer be provided by the Bedfordshire NHS Director of Finance regarding Table 12 on page 88 on whether these were cumulative amounts.

The Task Group noted the table on page 105 (Table 18).

RECOMMENDATION 25
That the NHS Bedfordshire Board be asked to ensure that a full risk analysis is carried out on Table 18 at the earliest opportunity.

RECOMMENDATION 26
That the NHS Bedfordshire Board addresses with some urgency the need for proper workforce planning in terms of recruitment, training and development to ensure that there are sufficient numbers of staff with the right skill set to deliver the service changes and improvements set out in the strategy.

4. Matters for Future Meetings

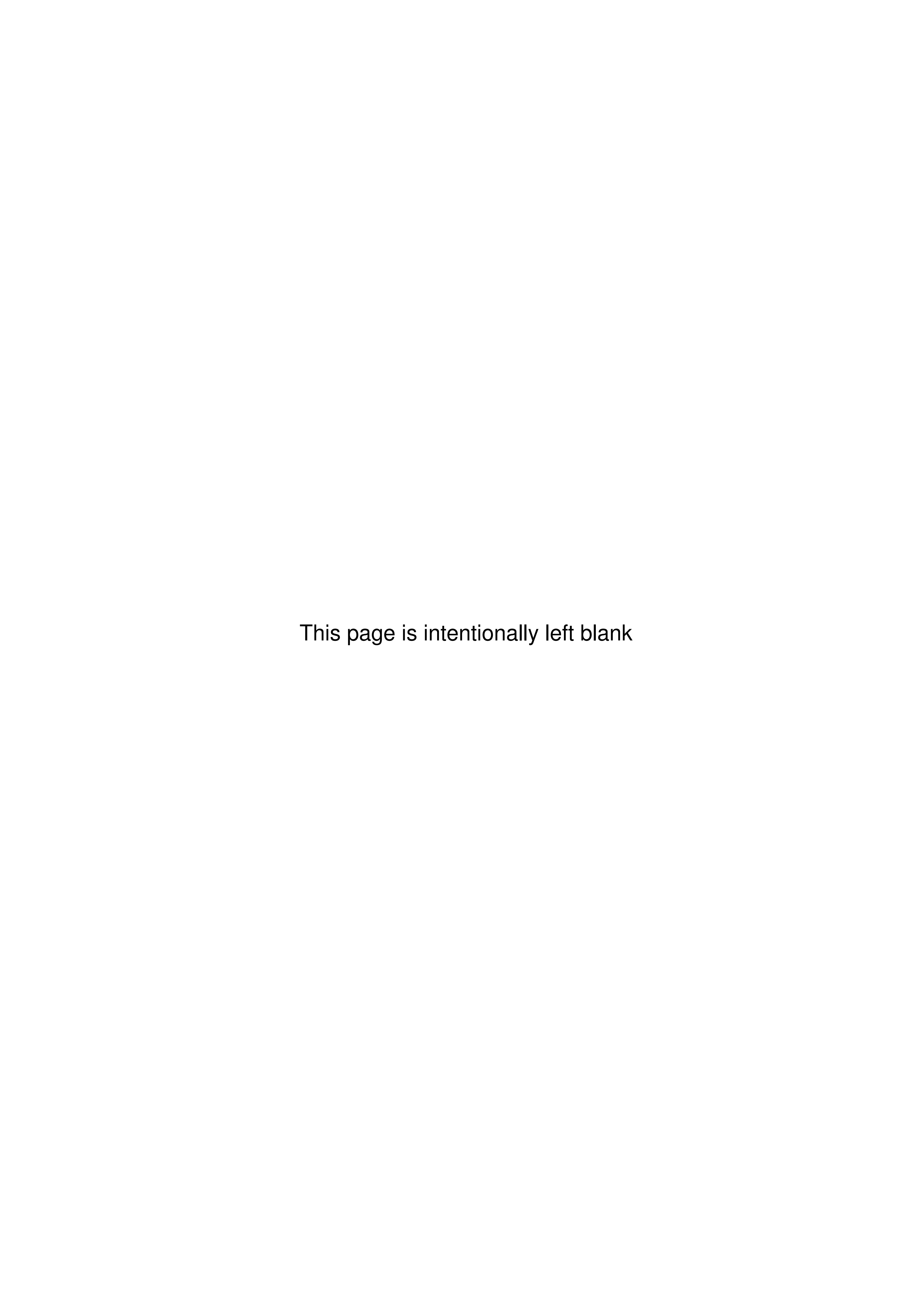
The Task Group agreed that the meeting on April 7 2009 should be cancelled.

The next meeting would be on April 21 2009. This would be a meeting of the Joint Committee comprising representatives of both Central Bedfordshire Council and Bedford Borough Council.

Governance issues would be addressed first, and the meeting would start at 09.30am to enable these to be resolved. The meeting would resume scrutiny of the Strategy starting at 10.00am.

This would include information on the Delivery Vehicle Programme.

The meeting concluded at 5.05pm.


This page is intentionally left blank

A Healthier Bedfordshire – Working for you – The NHS Bedfordshire Strategic Plan 2009-2013

Plan of Meetings of the Bedfordshire Health Strategy Task Group/Joint Committee - matters to be covered

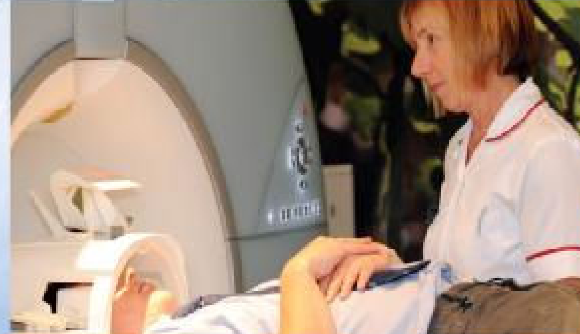
The Consultation on the NHS Strategy runs from 5 March 2009 until 25 May 2009

Meeting 1 – 11.02.09 – 3pm	• Receive presentation of the draft strategy – David Levitt and Dianne Meddick
Meeting 2 - 05.03.09 – 2pm	• To receive a presentation on the current health of, and health issues facing, Bedfordshire and to scrutinise understand those issues
Meeting 3 - 24.03.09 – 2pm	• To receive a presentation on the proposed strategy to improve the health of, and address health issues facing, Bedfordshire and to scrutinise that strategy
Meeting 4 - 07.04.09 – 2pm This meeting was CANCELLED	• To receive a presentation on the proposed delivery of the strategy and to scrutinise the delivery proposals
Meeting 5 - 21.04.09 - All day meeting – 09.30am start to deal with governance issues for the Joint Committee issues followed by scrutinising the proposals starting at 10.00am.	Governance issues re Joint Committee To receive and scrutinise the strategy proposals in respect of: • Staying Healthy • Mental Health and Learning Disabilities • Planned Careincl Dental Health (Tony Medwell) • Children's Services First two in the morning, second two in the afternoon
Meeting 6 – 28.04.09 - All day meeting – 10.00am start	To receive and scrutinise the strategy proposals in respect of: • Acute Care • Long Term Conditions • End of Life care • Maternity & Newborn (Chris Myers)

	First two in the morning, second two in the afternoon
Meeting 7 - 12 .05.09 – 2pm	To consider and approve submission of the Overview & Scrutiny response to NHS Bedfordshire
Meeting 8 - 30.07.09 – 2pm	To consider whether the decision of the NHS Bedfordshire Board on the strategy is in the interests of health locally and whether the consultation with the Committee has been adequate and to determine whether there is a need to refer the strategy to the Secretary of State.

A Healthier Bedfordshire

- working with you for life



Delivering our Strategic Plan 2009-2013

The Local Leader of the NHS

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Table Of Contents

1 VISION 9

1.1 OUR ONE AIM 9
1.2 OUR FOUR STRATEGIC GOALS 9
1.3 OUR EIGHT PLANS 11
1.4 OUR THREE STRATEGIC PRIORITIES 12
1.5 OUR VALUES 12

2 BEDFORDSHIRE TODAY AND IN THE FUTURE 14

2.1 THE CHALLENGES WE FACE 14
2.2 POPULATION 15
2.3 BEDFORDSHIRE'S GROWING POPULATION 16
2.4 BEDFORDSHIRE'S AGEING POPULATION 19
2.5 ETHNICITY 21
2.6 DEPRIVATION AND CURRENT HEALTH INEQUALITIES 21
2.7 COMPARISON OF KEY HEALTH INDICATORS 25
2.8 FUTURE HEALTH INEQUALITIES 29
2.9 IMPACT OF INCREASING TECHNOLOGY 29
2.10 RISING EXPECTATIONS 30

3 INSIGHTS OF PATIENTS, PUBLIC, CLINICIANS AND PARTNERS 31

3.1 DEVELOPING OUR STRATEGY 31
3.2 PATIENT AND PUBLIC ENGAGEMENT 32
3.3 STAYING HEALTHY 32
3.4 MENTAL HEALTH 34
3.5 MATERNITY AND NEW BORN 34
3.6 CHILDREN'S SERVICES 35
3.7 PLANNED CARE 36
3.8 ACUTE CARE 37
3.9 LONG TERM CONDITIONS 38
3.10 END OF LIFE CARE 39
3.11 PATIENT SURVEYS 39
3.12 BEDFORD HOSPITAL 2007/08 41
3.13 BEDFORDSHIRE AND LUTON COMMUNITY NHS TRUST 2007/08 42
3.14 LUTON AND DUNSTABLE NHS FOUNDATION TRUST 43
3.15 WORLD CLASS COMMISSIONING PATIENT EXPERIENCE METRIC 44
3.16 PALS ENQUIRIES AND COMPLAINTS 44
3.17 COMMENT CARDS 45
3.18 LISTENING TO AND SUPPORTING CARERS 45
3.19 DEVELOPING DELIVERY AND IMPROVING PRACTICE IN ASSESSMENT 46
3.20 ONGOING CLINICAL ENGAGEMENT AND CLINICAL LEADERSHIP 46
3.21 ENGAGEMENT WITH OUR PARTNERS 48

4 SO WHAT DO WE NEED TO DO? 49

4.1 INVESTING A GREATER PROPORTION OF OUR MONEY INTO PREVENTION 49
4.2 CREATING EFFECTIVE SUPPORT IN LOCAL COMMUNITIES 50
4.3 ENSURING THAT THE PEOPLE OF BEDFORDSHIRE HAVE MORE CHOICE AND CONVENIENCE 52

5 EXISTING TARGETS, LOCAL AND NATIONAL PRIORITIES 54

5.1 BEDFORDSHIRE'S LOCAL AREA AGREEMENT 2008-2011 55

6 OUR TRACK RECORD OF SUCCESS 57

6.1 FINANCIAL TURNAROUND 57
6.2 ONE CALL: REDUCING UNNECESSARY EMERGENCY ADMISSIONS 57
6.3 IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT) 57
6.4 IMPROVING COMMUNITY HEALTH SERVICES 58

Created by Neevia Document Converter trial version http://www.neevia.com

PDF created with pdfFactory Pro trial version www.pdffactory.com

6.5 Improving Access to General Practice ... 58
6.6 Improving Access to Dentists ... 58
6.7 Improving Mental Health and Well Being ... 59
6.8 Improving Access to Local Care ... 59

7 PROVIDER LANDSCAPE ... 60

7.1 Driving Up Quality and Safety ... 60
7.2 Relationship with Other Commissioners ... 62
7.3 Acute Hospital Providers ... 62
7.4 Access to Acute and Specialist Services ... 63
7.5 Strategic Priorities and Implications for the Acute Market ... 64
7.6 Community Services ... 64
7.7 Providers of Primary Care ... 65
7.8 Pharmacy Provider Landscape ... 67
7.9 Pharmacy Access and Choice – Market Stimulation ... 70
7.10 Dentistry ... 70
7.11 'Heat' Mapping of Geographical Dental Access ... 73
7.12 Community Health Services (PCT Managed) ... 75
7.13 Independent Care Providers (Nursing Homes) ... 76
7.14 Mental Health Services ... 76
7.15 Developing the Local Market ... 77

8 IMPACT OF CHALLENGES ON OUR FUTURE FINANCES ... 83

8.1 Current Financial Situation ... 83
8.2 Future Position ... 84
8.3 Allocation of Additional Resources ... 86
8.4 Strategic Themes ... 88
8.5 Prioritisation of Investment ... 88
8.6 Reshaping the Landscape through Programme Budgets ... 90
8.7 Capital Investment Plan ... 91

9 DELIVERING OUR STRATEGY ... 92

9.1 Overview ... 92
9.2 Links to Underpinning Plans ... 93
9.3 Strategic Initiative Summary Plans ... 94
9.3.1 Staying Healthy ... 94
9.3.2 Mental Health, Including Drug Users ... 95
9.3.3 Maternity and Newborn ... 97
9.3.4 Children's Services ... 97
9.3.5 Planned Care, Including Dental ... 98
9.3.6 Acute Care ... 100
9.3.7 Long Term Conditions ... 102
9.3.8 End of Life Care ... 102
9.4 How We Will Measure and Monitor Progress ... 104
9.5 Key Risks and Mitigating Actions ... 105
9.5.1 Most Critical Executive / PCT Level Risks ... 106
9.5.2 Most Critical Initiative Risks ... 106
9.6 Links to Underpinning Plans ... 108
9.6.1 Practice Based Commissioning ... 108
9.6.2 Communications and Public Engagement ... 108
9.6.3 Workforce ... 109
9.6.4 Information Technology ... 113
9.6.5 Capital and Estates ... 114
9.7 Change Management ... 116

10 APPENDICES ... 118

A. INITIATIVES. ... 118

B. TOWARDS THE BEST TOGETHER, MENTAL HEALTH IMPLEMENTATION PLAN ... 118

C. OPERATIONAL PLAN. ... 118

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

D. JSNA. 118

E. PERFORMANCE REPORT 118

F. PRIORITISATION POLICY. 118

G. PBC OPERATIONAL FRAMEWORK. 118

H. COMMUNICATIONS AND ENGAGEMENT STRATEGY. 118

I. ORGANISATIONAL DEVELOPMENT PLAN. 118

J. IM&T STRATEGY. 118

K. EQUALITIES IMPACT ASSESSMENT. 118

L. PRIMARY CARE STRATEGY. 118

M. EAST OF ENGLAND CHECK LIST. 118

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

List of Tables and Figures

Figure 1 - Our eight plans across life pathway from birth to end of life.. 11
Figure 2 - Bedford age structure 2008 15
Table 1 - Population summary (mid year 2008 estimate).. 15
Figure 3 - Bedford and Marston Vale growth area (Renaissance Bedford) 16
Figure 4 - Potential areas for development: Luton and South Bedfordshire 17
Table 2 - Bedfordshire - male population estimates and projections 2006 to 2013......................... 17
Table 3 - Bedfordshire - female population estimates and projections 2006 to 2013...................... 18
Figure 5 - Predicted age structure, males 2008, 2011 and 2013.. 18
Figure 6 - Predicted age structure, females in 2008, 2011 and 2013 19
Table 4 - Predicted population changes in Bedfordshire.. 19
Table 5 - Ethnic origin in Bedfordshire and Districts (percentages)... 21
Figure 7 – Residents living in five deprivation bands 22
Figure 8 – Life expectancy at birth 22
Figure 9 - IMD 2007 score at MSOA level... 24
Figure 10 - Life expectancy at MSOA level 24
Figure 11 - Key health indicators 25
Table 6 - Patient survey results 2004-2008.. 40
Table 7 - Healthcare Commission 2008 Annual Health Check Ratings.. 43
Table 8 - HCC ratings 2007/08 62
Figure 12 - Acute care availability of PCTs in East of England 63
Figure 13 - GP practices mapped over population density... 65
Figure 14 - Pharmacies provider landscape 68
Table 9 - Patients treated in last 2 years 70
Figure 15 - Patients seen in Bedfordshire, East of England & England.. 71
Figure 16 - Population per dentist.. 72
Figure 17 - Population within 5 miles of dental 73
Figure 18 - Population within 8 miles of dental 73
Figure 19 - Population within 12 miles of a dental 74
Figure 20 - Population within 15 and 30 minutes travel time of dental 74
Table 10 - Realistic case financial projection.. 85
Table 11 - Worst case financial projection.. 85
Figure 21 - Bridge diagram of additional spent between 2008/09 and 2013/14 86
Table 12 - Funding across 8 strategic priorities.. 88
Table 13 - Spend across 23 programme budgets.. 90
Table 14 - Block capital projection 91
Table 15 - Initiatives linked to goals 93
Table 16 - Initiatives linked to pledges 94
Table 17 - Measures of progress against initiatives.. 105
Table 18 – Most critical executive / PCT level risks 106
Table 19 – Most critical initiative risks 108
Table 20 - Workforce requirements at initiative level 111

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Foreword

Bedfordshire is a wonderful place to live and the people of Bedfordshire deserve better health and a world class health service. Our goal is to make sure that this becomes a reality.

A Healthier Bedfordshire paints a clear picture of our health and health services today, the challenges we face, where we want to be over the next five years and how we plan to get there.

The challenges are great.

Demand for healthcare will keep increasing as our population grows and more people live longer.

Health inequalities remain stubbornly persistent. It is not right or fair that people in some parts of Bedfordshire can expect to live up to ten years less than those in the most affluent areas. We must change this.

People rightly have higher expectations of their NHS and we have to rise to meet those expectations.

A Healthier Bedfordshire addresses these challenges.

We have set ourselves ambitious goals and we will not achieve them by doing more of the same.

Our strategy is about change. We need to change how healthcare is delivered, with more services provided safely and effectively in local communities, closer to home. That will free our hospitals to concentrate on more complex care. Our strategy sets out how we will shift investment, over time, from hospitals to communities to make this happen.

Our strategy is also about partnerships. We will work more closely with our partners to plan and deliver services. We will work with our residents to support and empower communities and individuals to improve their health and well-being.

At the heart of our strategy is the prize of securing a healthier Bedfordshire for all, helping people to enjoy a longer life and a better quality of life. Together we can do it.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Sarah Boulton
Chair, NHS Bedfordshire

Andrew Morgan
Chief Executive, NHS Bedfordshire

Approved By Board 21 January 2009

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Preface

The overall health of the people in Bedfordshire is better than the national average; additional progress is required to meet the higher East of England average life expectancy. However, across Bedfordshire there are important inequalities in health between different geographical areas and marginalised groups. We have an ageing population. As our population ages more people will suffer from long term conditions and will require more support to maintain healthy, independent lives. Bedfordshire is an area targeted for new housing developments. The resulting increase in population is unlikely to be matched immediately by a corresponding increase in central funding.

Our aim:

As the leader of the NHS in Bedfordshire, we will optimise the use of resources, in the context of a growing and ageing population, to deliver our goals to:

1. Improve the health and wellbeing of the population in Bedfordshire and its local communities in a fair and transparent way.
2. Reduce unfairness in health and reduce health inequalities.
3. Ensure a better healthcare experience for the population of Bedfordshire.
4. Ensure that the people of Bedfordshire have more choice and access to high quality, safe, clinically and cost effective local health services.

Three strategic priorities will drive our implementation plans

1. Investing a greater proportion of our money into prevention (healthy lifestyles, early intervention and promoting independence).
2. Creating effective support in local communities to reduce the reliance on hospital care, including in times of urgent need. This will mean:
   - Increasing the capacity within primary and community services to improve access to diagnostic and treatment services in local communities and focusing resources in acute hospitals on those that need it.
   - Ensuring shorter waiting times for treatment.
   - Respecting the wishes of patients about their care from birth to the end of their life.
3. Offering more choice and convenience, by commissioning quality services closer to home based on the needs and preferences of Bedfordshire patients.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Achieving our goals will require change across all services, covering the life pathway from birth to end of life. Clinical and public engagement have informed implementation plans setting out the change required across these eight areas:

- Staying healthy
- Mental health, including drug users
- Maternity and new born
- Children's services
- Planned care, including dental
- Acute care
- Long term conditions
- End of life care

NHS Bedfordshire has set ambitious goals. Money will be tight over the next five years. Delivering NHS Bedfordshire's strategy will require:

- Increased efficiency savings.
- Rigorous fair and transparent prioritisation.
- Selling assets which are not fit for purpose and reinvesting the proceeds in appropriate, modern facilities.
- Spend on acute and specialist services currently consumes circa 45% (£229m) of our income, whilst spend on out of hospital services consumes 55% (£276m). This balance will need to change.
- NHS Bedfordshire's income will rise from a current £505.6m in 2008/09 to £644.2m in 2013/14. Our investment plans demonstrate how this will be spent.
- Of this increase in income of circa £139m 16% (£23m) will be spent on acute and specialist services, the remaining 84% (£116m) will be spent on out of hospital services
- This represents a significant shift in the focus of our spend by 2013/14. The balance of spend shifts to 39% (£252m) on acute and specialist services and 61% (£392m) on out of hospital services
- The delivery of our strategy will require changes to the role and ways of working of existing hospitals

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

1 Vision

Our strategy is the culmination of two years' work, listening to local people from all walks of life in consultations, partnership boards, focus groups, stakeholder events, in meetings, in GP practice waiting rooms, through surveys. We have reviewed best practice, looked at the clinical evidence, assessed the health needs of all our communities and taken on board the views and advice of clinical experts.

1.1 Our One Aim

As the leader of the NHS in Bedfordshire, we will optimise the use of resources, in the context of a growing and ageing population, to deliver our goals

1.2 Our Four Strategic Goals

We have developed four goals that broadly describe our aspirations for a healthier Bedfordshire.

To improve the health and wellbeing of the population in Bedfordshire and its local communities in a fair and transparent way

A key aspiration for NHS Bedfordshire is to increase life expectancy for its residents and we are working hard with our partners to achieve set targets. To improve life expectancy in Bedfordshire, we must tackle the main causes of premature death, cancer, CHD/stroke, accidents, suicide and liver disease. These are also identified as priorities nationally and regionally.

Both the NHS in the East of England and NHS Bedfordshire are committed to placing as much emphasis on improving health and wellbeing as on providing treatment and developing and strengthening prevention programmes so that they are the best in England.

The aspiration to improve health and well-being in Bedfordshire and decrease health inequalities is shared by all key partners across Bedfordshire. In Bedfordshire, this shared aspiration is currently articulated in Bedfordshire's Sustainable Community Strategy. Over the last year through the Local Area Agreement, partners have agreed 23 priorities where change is required in Bedfordshire to take forward our shared strategy. NHS Bedfordshire will lead on reduction of smoking, decreasing childhood obesity, improving life expectancy and reducing health inequalities. A local priority is increasing the percentage of drug users engaged with treatment. These relate to our world class commissioning metrics.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

To reduce unfairness in health and reduce health inequalities

There are significant differences in health outcomes in Bedfordshire that are related to deprivation. It is not right that there is a ten year difference in life expectancy between different parts of the county. Inequalities are driven by differences in high risk lifestyle behaviours, such as smoking, obesity and physical activity, variations in access to healthcare and by wider socio-economic factors such as poverty, housing, employment and the built environment.

Inequalities do not relate only to deprivation and where you live; some members of our society experience inequalities more than others. There are complex reasons why people can become marginalised and our strategy seeks to address inequalities wherever they happen and whatever their cause.

NHS Bedfordshire has put in place specific and ambitious targets to reduce health inequalities. Our headline pledges are to ensure enhanced targets and uptake of services in the 20% most deprived areas and for vulnerable groups, with a focus on:

- Early access to antenatal care – increase in smoking in pregnancy quitters, promote healthy weight, increase breastfeeding rates
- Primary and secondary prevention – including smoking, cardiac and pulmonary rehabilitation
- Flu immunisation uptake and winter warmth payments

To ensure a better healthcare experience for the population of Bedfordshire

The views of service users must play a key part in our commissioning decisions. We cannot hope to commission world class healthcare services without understanding what is important to patients, what their current experiences are when they use the NHS and what we need to aim for.

Improving patients' experiences will mean we are improving health services and also improving people's health. We must take account not just of health needs, but of people's preferences and aspirations. There are many ways we engage with patients as set out elsewhere in this document and we need to build on this, making sure that their views help us to drive improvement across all services, making the best use of our resources.

To ensure that the people of Bedfordshire have more choice and access to high quality, safe, clinically and cost effective local health services

New ways of working and advances in treatments and associated technologies is enabling us to deliver an increasing range of healthcare services closer to home, in local communities. We know from national and local surveys that patients welcome more choice about where and when they are treated, through services that are

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

designed and delivered around their lives rather than the other way round. Delivery of our strategy will see new services developed that will reduce the reliance on acute hospitals.

1.3 Our Eight Plans

Achieving our goals will require change across all services, covering the life pathway, from birth to end of life. Clinical and public engagement has informed implementation plans setting out the change required across these eight areas:

- Staying healthy
- Mental health and Learning disabilities
- Maternity and new born
- Children's services
- Planned care, including dental
- Acute care
- Long term conditions
- End of life care

In keeping with the case for, and principles of, change, the working groups link together a whole service, whole life and vision for NHS Bedfordshire.

NHS Bedfordshire has identified some quick wins for achievement. These include:

- Change4Life – focusing on childhood obesity, promoting healthy eating and increased activity
- Developing health trainer programmes for vulnerable communities, with an initial focus on primary prevention
- Implementing Improved Access to Psychological Therapies
- Promoting Staying Healthy in the Workplace to surrounding employers to influence and lead change
- Implementation of 40-74 screening programmes

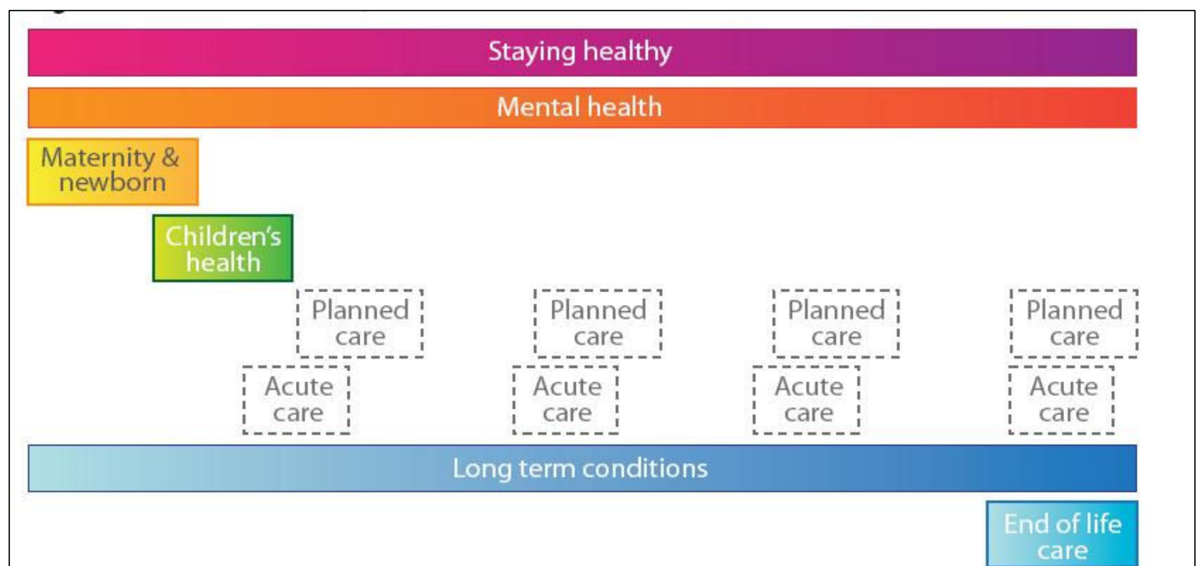


Figure 1 - Our eight plans across life pathway from birth to end of life

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

1.4 Our Three Strategic Priorities

Three strategic priorities have clearly emerged through the process of translating our strategic goals into the detailed plans that will deliver them. These can be thought of as 'golden threads' running through each of our eight implementation plans.

1. Investing a greater proportion of our money into prevention (healthy lifestyles, early intervention and promoting independence).
2. Creating effective support in local communities to reduce the reliance on hospital care, including in times of urgent need. This will mean:

- Increasing the capacity within primary and community services to improve access to diagnostic and treatment services in local communities and focusing resources in acute hospitals on those that need it.
- Ensuring shorter waiting times for treatment.
- Respecting the wishes of patients about their care from birth to the end of their life.

3. Offering more choice and convenience, by commissioning quality services closer to home based on the needs and preferences of Bedfordshire patients.

NHS Bedfordshire has set ambitious goals. Money will be tight over the next five years. Delivering NHS Bedfordshire's strategy will require:

- Increased efficiency savings.
- Rigorous, fair and transparent prioritisation.
- Selling assets which are not fit for the purpose and reinvesting the proceeds in appropriate modern facilities.

1.5 Our Values

We have developed, through extensive staff engagement, a set of values that we, in NHS Bedfordshire, will live by in our daily work. As the leader of the NHS in Bedfordshire, our values will underpin how we deliver this strategy across the local health system and will determine the behaviours we expect across the local NHS.

These are:

Work together

I am proud to belong to an organisation that delivers exceptional service.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Respect for all
I contribute to a caring and supportive environment that values everyone.

Aim for excellence
I take responsibility and strive to achieve the best at all times.

Be open to change
I am open to change. I challenge when necessary.

Be positive
I play my part in making this a great place to work.

Be clear and simple
I always listen, respond and act openly and honestly.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

2 Bedfordshire Today and in the Future

- **The health of people in Bedfordshire is generally similar to or significantly better than the England average. However, rates of breastfeeding initiation and GCSE achievement are both worse than the England average.**
- **Life expectancy in Bedfordshire is slightly lower than the East of England average.**
- **There are health inequalities within Bedfordshire by location, gender, income and ethnicity. For example, the largest difference in life expectancy between medium sized geographical areas within Bedfordshire is 10.6 years.**
- **Over the past ten years, rates of death from all causes have decreased. Early deaths due to heart disease and stroke have remained better than or close to the England average. Deaths from cancer remain below the current national levels, they have not reduced at the same rate as the England average.**
- **Smoking kills around 570 people each year in the county.**
- **Teenage conceptions is lower than the England average, however rates have risen in Bedford.**
- **Overall the level of childhood obesity is similar to that of England, this hides wide local variation. Almost one adult in four is obese.**
- **Generally affluent with pockets of extreme deprivation.**
- **Bedfordshire has an ageing population.**

2.1 The challenges we face

- Bedfordshire is an area targeted for new housing developments. The resulting increase in population is unlikely to be matched immediately by a corresponding increase in central funding.
- As our population ages more people will suffer from long term conditions and will require support to maintain healthy, independent lives.
- Advances in technology will enable us to do more for patients, but this will increase the pressure on our allocated budget.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- In a consumer-driven society, people will continue to expect more from their NHS.

2.2 Population

The current age and sex structure of Bedfordshire's population is shown below. It is similar to, but not identical to that of the East of England. The structure is a result of varying birth and death rates in the past as well as net in-migration which happens more in certain age groups.

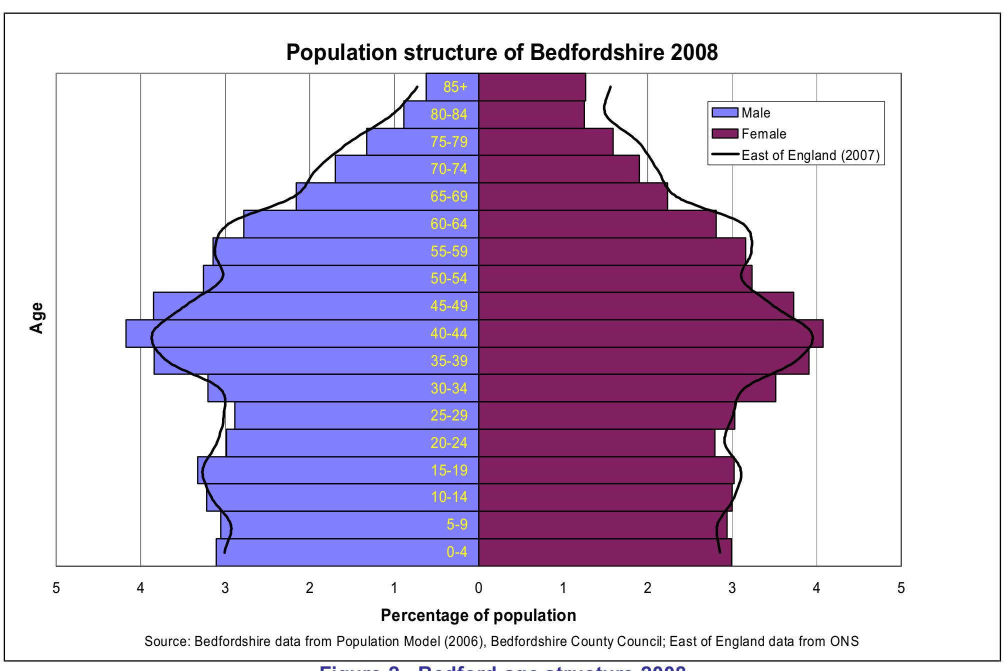


Figure 2 - Bedford age structure 2008

Births are predicted to remain relatively stable at approximately 5,000 a year across Bedfordshire over the next 12 years.

Proportions of people aged 0-15 or 65+ are similar across the districts, though Mid Bedfordshire has a lower percentage of older people compared to the other two districts. Bedfordshire has proportionally fewer older people than the East of England and slightly younger people, as shown Table 1

	Bedfordshire	Bedford Borough	Mid Bedfordshire	South Bedfordshire	East of England‡
Total	413,000	158,400	134,900	119,700	5,707,900
Aged 0-15	80,900 (19.6%)	31,200 (19.7%)	26,400 (19.6%)	23,300 (19.5%)	1,079,800 (18.9%)
Aged 65+	61,700 (14.9%)	24,500 (15.5%)	19,100 (14.2%)	18,100 (15.1%)	996,900 (17.5%)

Table 1 - Population summary (mid year 2008 estimate)

Source: Beds County Council Population Estimates and Forecasts 2007
‡ East of England estimate for 2007, source: Office of National Statistics via ERPHO:
http://www.erpho.nhs.uk/viewResource.aspx?id=18020

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

2.3 Bedfordshire’s Growing Population

Bedfordshire’s population is increasing as people live longer and new people move into housing developments. Bedfordshire is part of the Milton Keynes South Midlands Growth Area and significant development is planned around Bedford and the south of the county (see maps below). As one of the Government’s growth areas, the number of new houses built each year needs to increase by approximately 1,000 in order to meet the projected growth plans. It is estimated this will increase the amount of ‘built on’ land in Bedfordshire from 7.8% in 2005 to 12.2% by 2013.

The population model was developed by Bedfordshire County Council. Unlike the ONS population model, it takes into account the planned housing developments as well as the ageing population in the projections given in the tables and charts that follow.

The total population is set to increase over the next five years by 5.6% from 413,000 in 2008 to 436,300 by 2013.

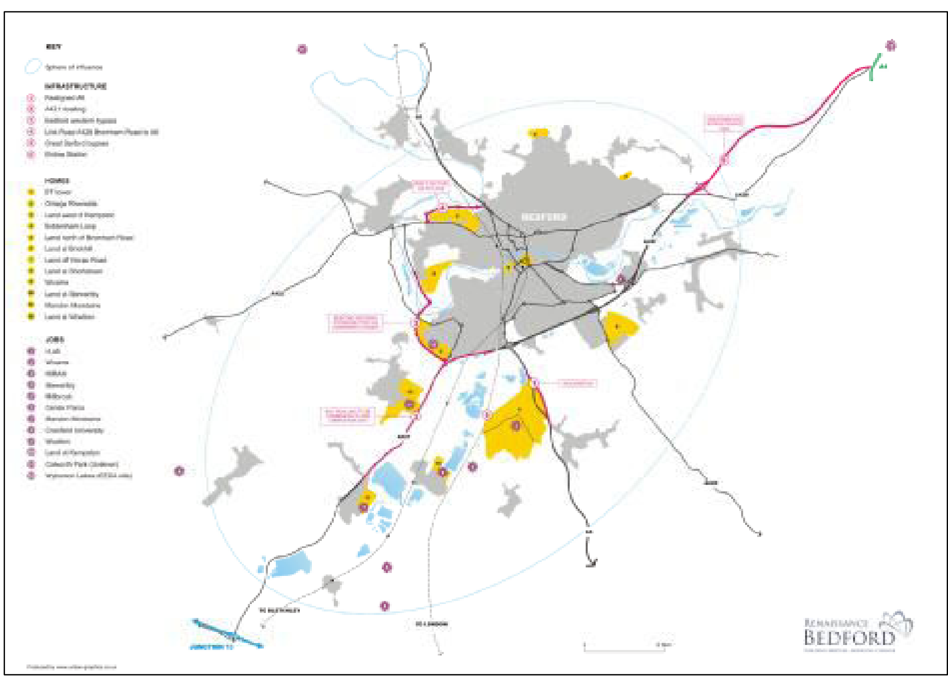


Figure 3 - Bedford and Marston Vale growth area (Renaissance Bedford)

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

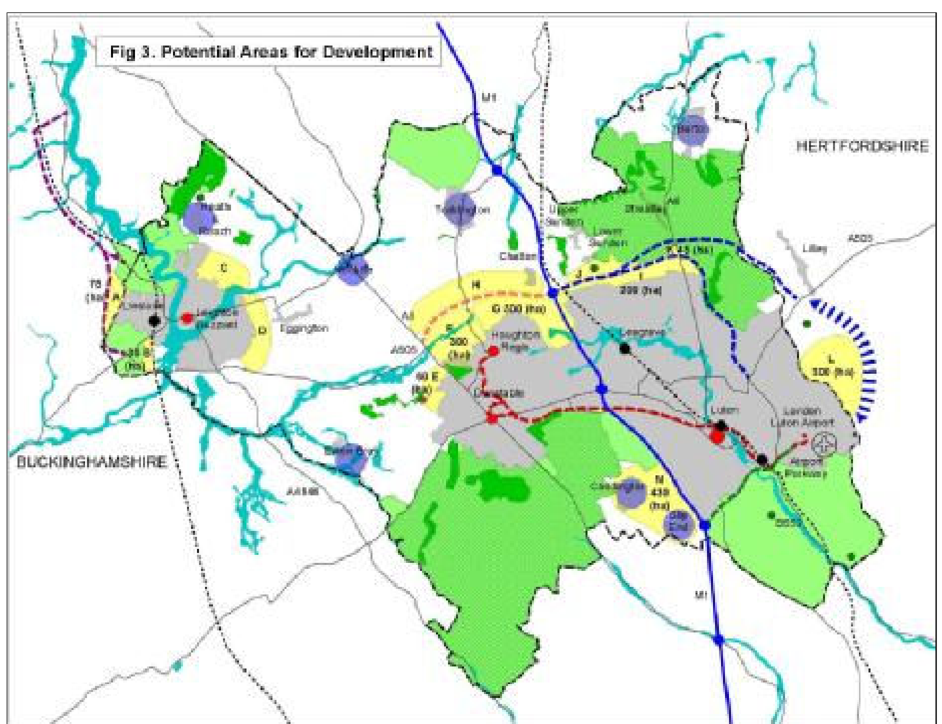


Figure 4 - Potential areas for development: Luton and South Bedfordshire

The changes in the age structure of the population for males and females over the next five years is shown in the following two tables.

	2006	2007	2008	2009	2010	2011	2012	2013
0 to 4s	12,438	12,657	12,826	12,990	13,155	13,133	13,187	13,239
5 to 9s	12,723	12618	12616	12652	12828	13156	13334	13488
10 to 14s	13608	13401	13308	13170	13077	13125	12880	12812
15 to 19s	13824	14018	13746	13525	13240	12879	12834	12820
20 to 24s	11712	11948	12314	12734	12943	13129	13598	13456
25 to 29s	11601	11767	11934	12100	12266	12432	12720	13007
30 to 34s	13219	13220	13222	13223	13225	13226	13423	13620
35 to 39s	16438	16147	15856	15565	15274	14983	15013	15043
40 to 44s	17115	17184	17252	17321	17389	17458	17184	16910
45 to 49s	15003	15449	15896	16342	16789	17235	17310	17384
50 to 54s	12540	13004	13468	13932	14396	14860	15306	15752
55 to 59s	13461	13230	13000	12769	12538	12308	12767	13226
60 to 64s	10585	11034	11483	11931	12380	12829	12617	12406
65 to 69s	8267	8586	8906	9225	9545	9864	10302	10740
70 to 74s	6654	6837	7020	7203	7385	7568	7880	8191
75 to 79s	5289	5390	5491	5592	5693	5794	5982	6171
80 to 84s	3413	3545	3678	3810	3943	4075	4189	4304
85 to 89s	1561	1686	1811	1935	2060	2185	2297	2409
90+	611	681	751	822	893	963	1061	1162
Total	200,062	202,403	204,575	206,843	209,019	211,203	213,885	216,139

Table 2 - Bedfordshire - male population estimates and projections 2006 to 2013

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

	2006	2007	2008	2009	2010	2011	2012	2013
0 to 4s	11862	12145	12366	12482	12481	12495	12549	12599
5 to 9s	12386	12232	12145	12174	12349	12540	12764	12961
10 to 14s	12614	12467	12390	12401	12533	12629	12403	12285
15 to 19s	12270	12635	12498	12383	12188	12017	12028	12028
20 to 24s	11110	11089	11540	11808	11857	11871	12564	12592
25 to 29s	12425	12473	12521	12569	12617	12664	12850	13036
30 to 34s	14525	14522	14520	14517	14514	14512	14593	14674
35 to 39s	16390	16272	16154	16036	15918	15800	15816	15832
40 to 44s	16698	16773	16847	16922	16996	17071	16965	16859
45 to 49s	14518	14960	15402	15844	16286	16728	16831	16933
50 to 54s	12604	12980	13356	13731	14107	14483	14924	15365
55 to 59s	13445	13243	13041	12839	12637	12435	12810	13186
60 to 64s	10711	11168	11625	12082	12539	12996	12807	12618
65 to 69s	8521	8877	9233	9589	9945	10301	10748	11196
70 to 74s	7629	7736	7843	7950	8056	8163	8510	8857
75 to 79s	6310	6445	6580	6715	6850	6985	7105	7225
80 to 84s	5078	5119	5159	5200	5241	5282	5428	5574
85 to 89s	3006	3141	3276	3411	3546	3680	3738	3796
90+	1743	1850	1957	2064	2171	2278	2409	2539
Total	**203,845**	**206,125**	**208,452**	**210,715**	**212,830**	**214,929**	**217,842**	**220,157**

Table 3 - Bedfordshire - female population estimates and projections 2006 to 2013

Source: Bedfordshire County Council

Three of the years (2008, 2011 and 2013) given in the tables above are shown diagrammatically in the two charts below. (Note: similar data at district level is available)

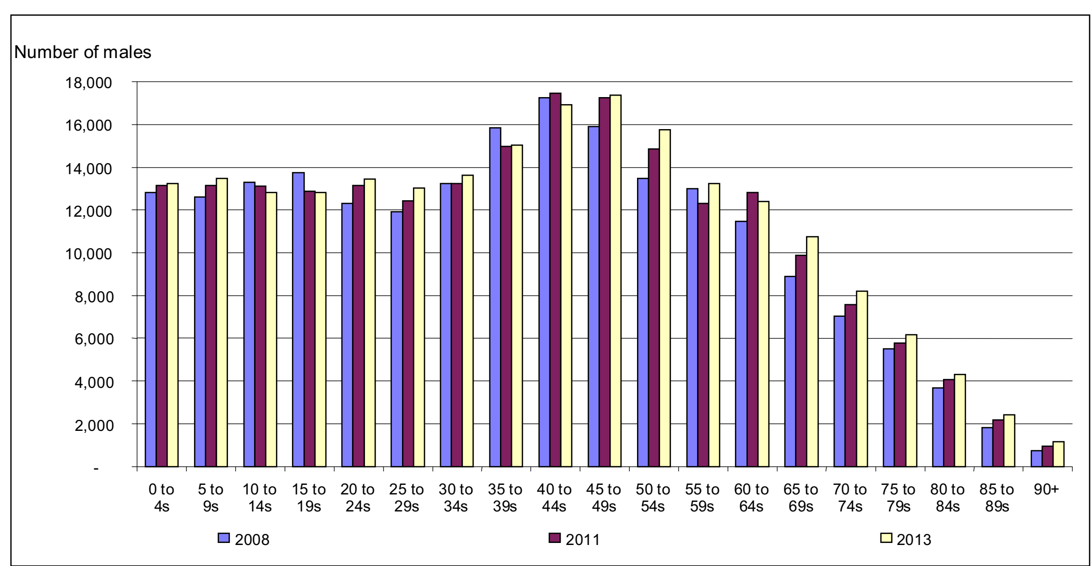


Figure 5 - Predicted age structure, males 2008, 2011 and 2013

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

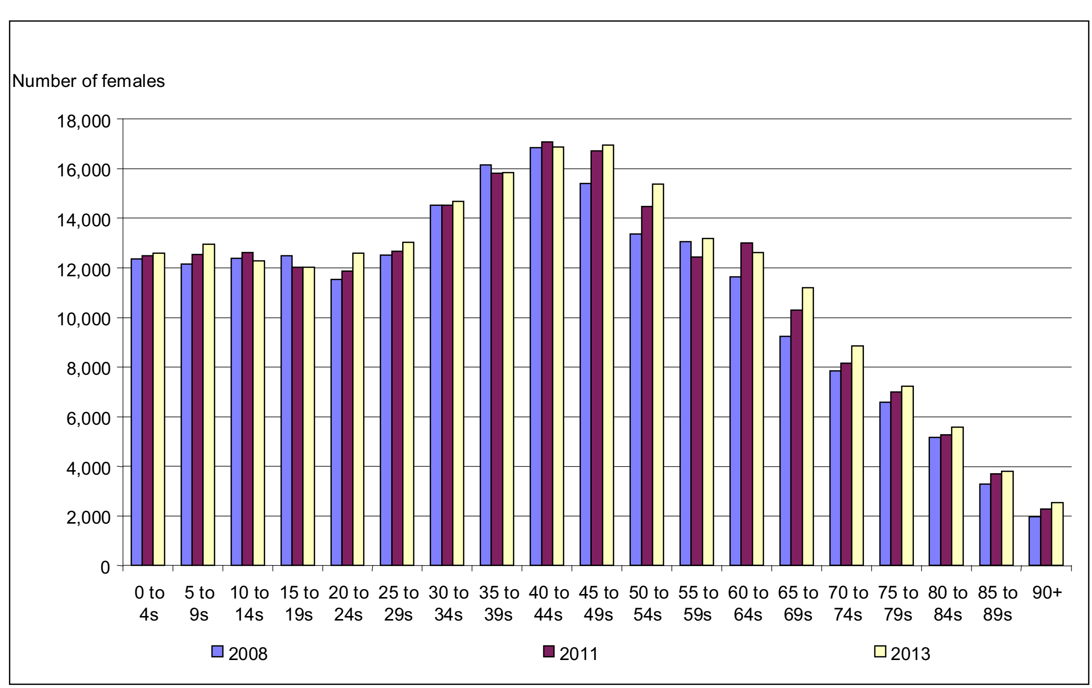


Figure 6 - Predicted age structure, females in 2008, 2011 and 2013

2.4 Bedfordshire's Ageing Population

The number of older people is increasing as people are living longer and the post-war 'baby-boom' generation age. The most dramatic percentage increases will be seen in those aged 85 and over. Between 2008 and 2013, the number of women in this age group is set to increase by 21% and the number of men will increase by 27% - more than 3,000 additional very old people in total.

	2006-2011	2011-2016	2016-2021
Pre-school (<5)	5.5%	1.9%	-0.2%
School age (5-15)	-0.7%	3.4%	2.7%
School leavers/FE (16-19)	-3.3%	-1.6%	0.4%
Working age (20-64)	5.3%	3.2%	1.8%
Post-retirement (65-74)	15.5%	21.5%	5.1%
Older people (75+)	15.7%	15.5%	18.9%
Very old people (85+)	30.0%	22.0%	20.7%
Total population	5.5%	5.4%	3.5%

Table 4 - Predicted population changes in Bedfordshire

Source: Population Estimates and forecasts Bedfordshire County Council 2007 Tables 4.2 - 4.8 and Appendix A3
http://www.blisonline.info/Download/Public/1025/DOCUMENT/8071/Population%20estimates%20and%20forecasts%202007.pdf

There are 61,700 people aged 65 and over living in Bedfordshire, which is predicted to rise to over 72,200 by 2013 and to 88,800 by 2021. The highest population of older people is in Bedford Borough, particularly in the rural wards of north east Bedfordshire. Population estimates suggest that Mid Bedfordshire will experience the largest growth of older people over the next 10-20 years.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

As Bedfordshire's population ages, the number of people with poor health in Bedfordshire will rise.

- Estimates have been made of the numbers of people aged 65 and over unable to manage at least one mobility activity on their own. Activities include: going out of doors and walking down the road; getting up and down stairs; getting around the house; getting to the toilet; getting in and out of bed. The numbers for Bedfordshire are currently 9,300, rising to 11,400 by 2015.

- Around 20% of people aged over 75 are registered blind or partially sighted, this equates to 5,600 people in Bedfordshire in 2008 and 6,700 by 2015.

- The number of obese people aged 65 and over with a body mass index (BMI) above 30 is estimated to be 14,800 in 2008, rising to 18,300 by 2015. Increasing obesity will drive rising levels of diabetes and associated complications.

- The prevalence of incontinence for people living at home is between 7-10% for men aged 65 and over and 10-20% for women aged 65 and over. For Bedfordshire this amounts to between 5,200 and 9,400 people aged 65 and over with an incontinence problem who live in the community in 2008, rising to between 6,500 and 11,600 by 2015.

- It is estimated that there are 4,230 people aged 65 and over who have a long standing health condition caused by a heart attack and that this will rise to 5,285 by 2015.

- It is estimated that there are 1,340 people aged 65 and over who have a long standing health condition caused by bronchitis and emphysema and that this will rise to 1,690 by 2015.

- The number of people aged 65 and over who attend hospital A&E departments as a result of falls in Bedfordshire is predicted to rise from 3,700 in 2008 to 4,500 by 2015. Hospital admissions' resulting from falls in the same age group is predicted to rise from 1,300 in 2008 to 1,500 by 2015.

- As a result of the ageing population, we expect substantial growth in the prevalence of dementia, which could rise by as much as 20% by 2016. The increases in other mental health problems are expected broadly to follow the overall population change, mostly in the range of 4-8% increases.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

2.5 Ethnicity

People from black and minority ethnic groups represent 11% of the county's total population and are mainly concentrated in the urban area of Bedford.

		Bedford	Mid Bedfordshire	South Bedfordshire	Bedfordshire	East Of England
White	British	80.8	94.6	93.3	88.9	91.5
	Irish	1.4	1.0	1.7	1.4	1.1
	Other White	4.8	2.0	1.9	3.1	2.5
Mixed	White and Black Caribbean	1.0	0.3	0.4	0.6	0.4
	White and Black African	0.1	0.1	0.1	0.1	0.1
	White and Asian	0.5	0.3	0.3	0.4	0.3
	Other Mixed	0.4	0.2	0.2	0.3	0.3
Asian or Asian British	Indian	4.3	0.5	0.8	2.1	1.0
	Pakistani	1.6	0.1	0.1	0.7	0.7
	Bangladeshi	1.4	0.0	0.0	0.4	0.3
	Other Asian	0.5	0.1	0.2	0.3	0.3
Black or Black British	Caribbean	1.9	0.2	0.4	0.9	0.5
	African	0.5	0.1	0.2	0.3	0.3
	Other Black	0.2	0.0	0.1	0.1	0.1
Chinese or other ethnic group	Chinese	0.4	0.3	0.3	0.3	0.4
	Other ethnic group	0.3	0.2	0.1	0.2	0.3

Table 5 - Ethnic origin in Bedfordshire and Districts (percentages)

Source: JSNA (section DEM – Demography and Geography)

People from some ethnic groups have a much younger age profile, particularly the Pakistani, Bangladeshi, and mixed White and Black Caribbean communities. These groups tend too have a higher fertility rate than average and can be expected to form a larger percentage of the population in future years.

2.6 Deprivation and Current Health Inequalities

It is difficult to 'measure' deprivation for an area. The Government therefore uses a classification system with five categories, called quintiles. These quintiles are numbered 1 (least deprived) 2, 3, 4 and 5 (most deprived).

Across the whole of England, there are an equal number of areas in each of the five quintiles. Figure 7 shows how many of areas within Mid Bedfordshire, Bedford and South Bedfordshire belong to each quintile.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

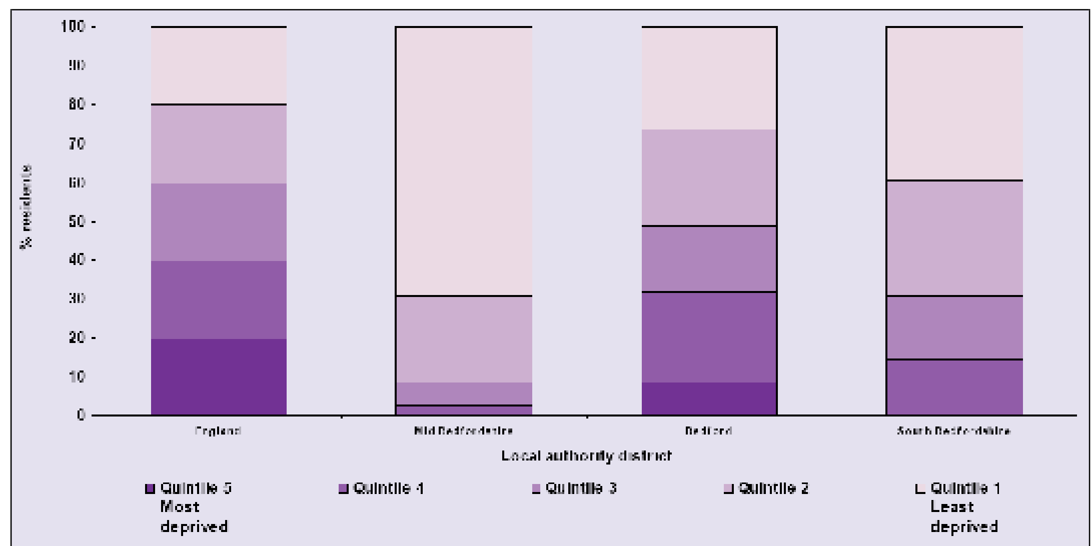


Figure 7 – Residents living in five deprivation bands

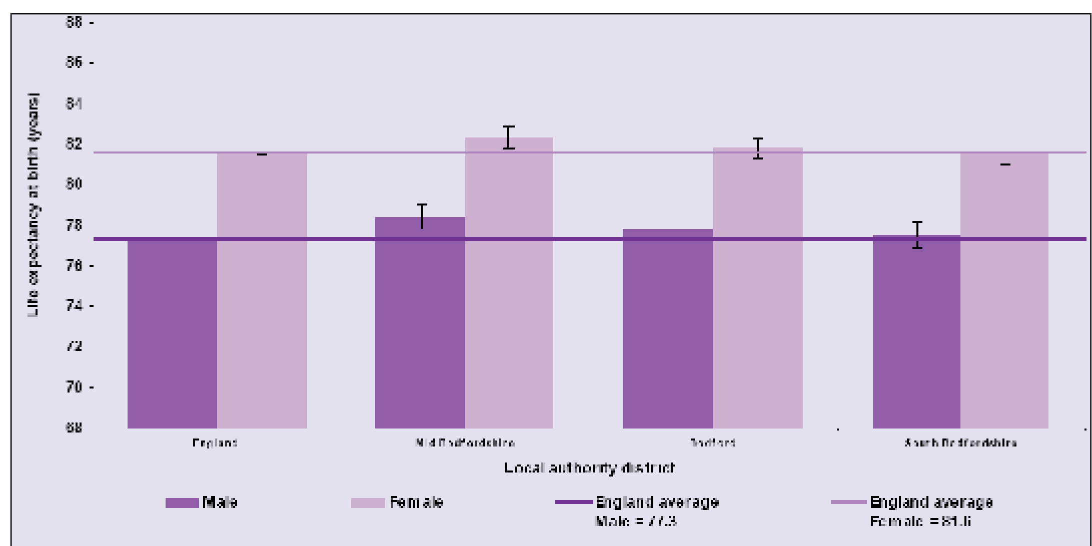


Figure 8 – Life expectancy at birth

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Wealth and health are unevenly distributed across Bedfordshire. The least deprived Medium Super Output Areas (MSOA) in Bedfordshire broadly equate to the following electoral wards:

- Ampthill
- Aspley Guise
- Bromham
- Clifton and Meppershall
- Cranfield
- Flitwick West
- Flitton Greenfield and Pulloxhill
- Harlington
- Shefford Campton and Gravenhurst
- Silsoe
- Southcott
- Shillington Stondon and Henlow Camp
- Stotfold
- Watling
- Westoning and Tingrith

The most deprived MSOAs in Bedfordshire broadly equate to the following electoral wards:

- Castle
- Cauldwell
- Goldington
- Harpur
- Kempston North
- Kempston South
- Kingsbrook
- Manshead
- Parkside
- Queens Park
- Tithe Farm

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

There are significant differences in health outcomes and these are related to deprivation, as can be seen by laying maps of deprivation and life expectancy at MSOA level along-side each other (see below). The maximum life expectancy was 84.5 years and minimum was 73.9 years, a difference of 10.6 years.

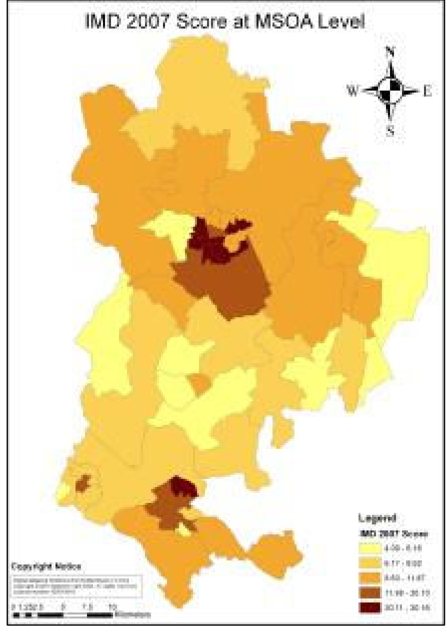


Figure 9 - IMD 2007 score at MSOA level

Health inequalities are driven by differences in high risk lifestyle behaviours such as smoking, obesity and physical inactivity; variations in access to healthcare; and by wider socio-economic factors, such as poverty, housing, employment and the built environment.

Inequalities not only relate to deprivation and where you live; some members of our society experience inequalities more than others. There are complex reasons why people can become marginalised.

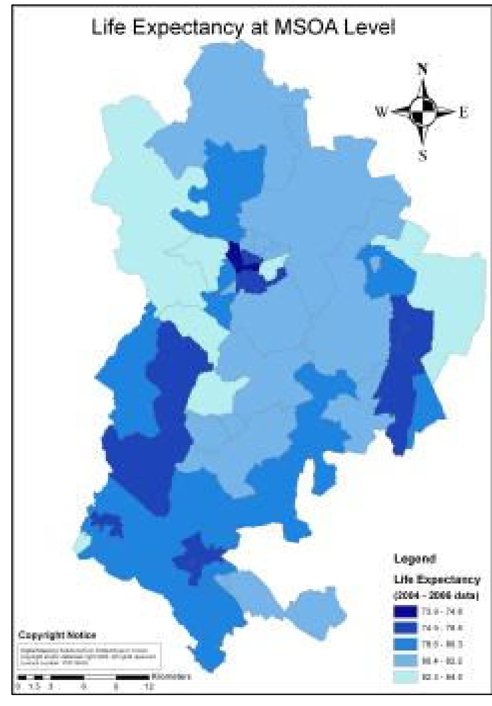


Figure 10 - Life expectancy at MSOA level

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

In Bedfordshire, wards and MSOAs are almost the same. We have identified 20% most deprived wards and have set up a dashboard to monitor uptake of services and interventions e.g. flu, counterweight. NHS Bedfordshire has enhanced smoking targets for 20% most deprived practices and will ensure that all interventions focus specifically on 20% most deprived.

Within Bedfordshire, with our partners we have identified the following groups as at risk of being marginalised:

- People who misuse drugs and alcohol.
- People with mental ill-health, including dementia.
- People with long-term conditions or disabilities.
- People from black and minority communities.
- Homeless and rough sleepers.
- Those in the criminal justice system, including young offenders.
- Gypsies and travellers.
- Looked after children.
- Pregnant teenagers and their children.
- Migrant workers and refugee communities.

2.7 Comparison of Key Health Indicators

The indicators below show how Bedfordshire compares with the rest of the East of England and with England as a whole.

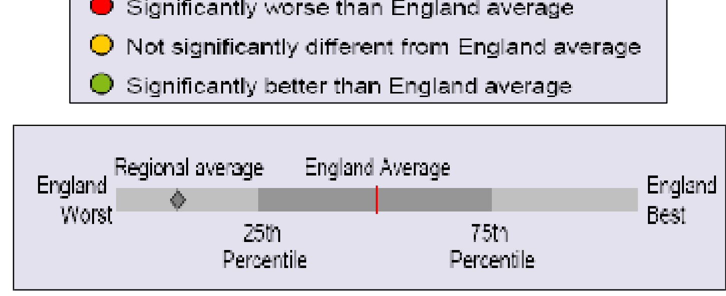


Figure 11 - Key health indicators

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

England Worst	Deprivation	England Best
80.2		0.0

% of people in this area living in 20% most deprived areas of England 2005

- Cardiovascular disease and diabetes disproportionately affect those in areas of high deprivation.
- Educational achievement is one of the predictors of life expectancy and is lower in areas of higher deprivation.
- There are important inequalities in health between different geographical areas and marginalised groups.

England Worst	Obese Children	England Best
16.1		4.9

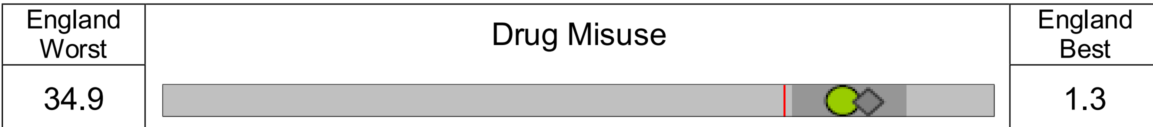
% of schoolchildren in reception year

- In 2006/07, 9.3% of 4-5 year olds and 15.1% of 10-11 year olds across Bedfordshire were obese. An additional 12.7% of 4-5 year olds and 12.9% of 10-11 year olds were overweight.
- Children who are obese are more likely to grow up to be obese adults and present a range of co-morbidities at an earlier age than if they where not obese.
- Obese children are more likely to suffer psychological abuse at school and in the community.

England Worst	Adults Who Smoke	England Best
40.9		13.7

%, direct estimate from health survey for England

- Smoking is the biggest single cause of preventable illness, inequalities in health and early death in the UK.
- Smoking kills more than 120,000 people in the UK each year and costs the NHS up to £1.7 billion a year in England.
- Current estimates are that 84,000 adults in Bedfordshire smoke and we are achieving reductions in prevalence.

England Worst	Drug Misuse	England Best
34.9		1.3

Crude rate per 1000 population aged 15-64

- Drug misuse is an issue that has an impact on our local community in a number of different ways, having social, financial and health related implications.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory trial version www.pdffactory.com

- In 2007/08 the number of problematic drug users in Bedfordshire was 1,946.
- A number of initiatives are in place locally to support individuals who misuse substances. In 2007/08 the number of problematic drug users in Bedfordshire who were engaged in an effective treatment programme was 788.

England Worst	GCSE Achievement (5 A* - C)	England Best
35.8		82.7

% at key stage 4 2006-2007

- The 5A* to C including English and Mathematics improved by 1.8%. This continues the upward trend from 2005.
- Two schools have now broken the 80% with a further four schools above 70%. Overall there has been an improvement of 4.7% lifting the result to 62.8% from 58.1% in 2007.
- Results in English and Mathematics continue to show progress with increases of 2.5% and 3% respectively.
- Where there has been a significant level of intervention by the LA, results have advanced by 13% on average. The universal programmes for Maths and English have led to improvements of around 3% with some more substantial gains for individual needs.

England Worst	Breast Feeding Initiation	England Best
33.2		90.9

% of mothers initiating breast feeding where status known 2006-2007

- Breastfeeding is accepted as the best form of nutrition for infants to provide all of the vital nutrients and to encourage optimum future health.
- Exclusive breastfeeding is recommended for the first six months of an infant's life.
- Breastfeeding initiation rates in Bedfordshire are continuing to rise. In 2006/07 the breastfeeding initiation rate in Bedfordshire was 58.5%, rising to 62.2% in 2007/08 and to 62.4% in quarter 1 of 2008/09.

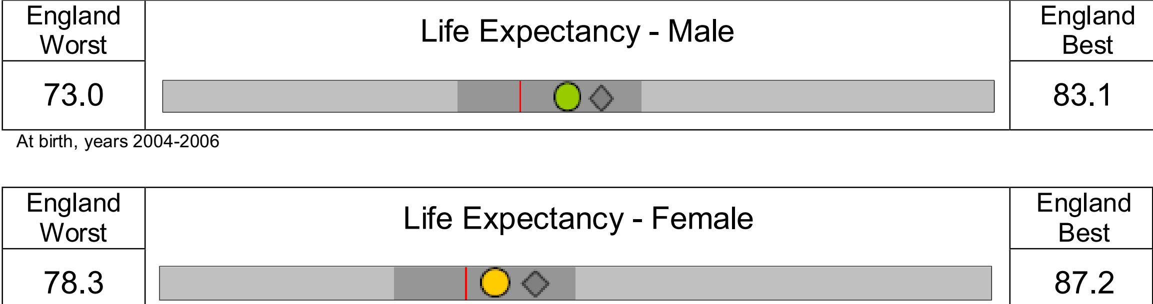
England Worst	Statutory Homelessness	England Best
14.4		0.0

Crude rate per 1,000 households 2005-2006

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- The number of households officially recognised as newly homeless in Bedfordshire in 2007 was 688. National league tables (CLG 2008) shows Bedford ranked as 70th highest in England (363 homeless), whilst South Bedfordshire was 145th (180 homeless) and Mid Bedfordshire 203rd (145 homeless).

- 70 -80% of households placed in temporary accommodation are likely to have complex and interrelated support needs which requires joined up working at strategic and operational level.



At birth, years 2004-2006

- On average, both men and women in Bedfordshire live longer than men and women in England. Life expectancy is increasing more rapidly in men, reducing the gap between female and male life expectancy.

England Worst	Obese Adults	England Best
31.2		11.9

%, direct estimate from Health Survey for England 2003-2005

- The Foresight Report (2007) identifies that levels of obesity will reach almost 60% by 2050, if unchecked.

- Unmanaged obesity can lead to a range of chronic conditions including type II diabetes, CHD, stroke, hypertension, several cancers, up to nine years lost life and a range of psychosocial issues.

- It is estimated that one fifth of the adult population in Bedfordshire are currently obese and 40% of men and 30% of women are overweight.

- The direct healthcare costs of managing overweight and obesity are predicted to rise by 700% by 2050.

England Worst	Early Deaths From Heart Disease And Stroke	England Best
142.4		39.7

Directly age standardised rate per 100,000 populations

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- The second most common cause of death in Bedfordshire is cardiovascular disease.
- The most common cause of death is all cancers. However, a death from CVD is higher in the Bedford area and is more closely linked to deprivation than cancers.

England Worst	People Diagnosed With Diabetes	England Best
5.9		2.1

% people on GP register with a recorded diagnosis of diabetes

- Diabetes type II is increasing due to an ageing population and rising levels of obesity.
- The number of people with diabetes on GP registers has increased from 13,500 in March 2005 to 15,950 in March 2008.

2.8 Future Health Inequalities

Predicting inequalities across small areas is complex. Over the period 2002 to 2005, the gap between average premature death rates in Bedfordshire's least and most deprived fifth of MSOAs increased. By contrast, the gap in all-age, all-cause mortality between these groups has decreased slightly. Due to the small numbers involved, additional years of information is needed to understand the true trend, although currently there is no robust local evidence that health inequalities are decreasing.

Nationally life expectancy at birth is increasing for both men and women, including in the most deprived areas (5th quintile) but it is increasing more slowly in these deprived areas so the gap continues to widen and it is widening more for women than men.

In the period 2004-2006, for males the relative gap was two percent wider than at the baseline (the same as in 2003-2005), for females 11% wider (compared to eight percent wider in 2003-2005). The 2010 target to reduce health inequalities remains challenging.

2.9 Impact of Increasing Technology

Medical advances can improve health outcomes, but will create budgetary pressures. Significant advances in medicine and surgery are anticipated, supported by the increasing insight offered by genetics. The 'capacity to treat' is increasing, especially the older frail. This magnifies the potential demand of an ageing population.

Advances in information technologies enable improved models of care. The capacity to share clinical information and expertise between professionals and patients offers many opportunities for patients to take a positive and active role in their care and improve the quality of patient care and outcomes.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

2.10 Rising Expectations

The expectations of society are changing. Rising education and income levels are helping to drive higher public expectations of health and healthcare services. In the future older people are expected to demand much more from health and social care services than older people do today.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

3 Insights of Patients, Public, Clinicians and Partners

We have performed significant consultation with our stakeholders to get to where we are. Their views have contributed to the development of this strategy and its eight implementation plans across the life pathway from birth to end of life.

3.1 Developing Our Strategy

In 2007, we published our early thinking on a medium term health strategy for Bedfordshire in a document that set out our strategic intentions in respect of:

- Improving health, preventing illness.
- Developing services for the future.
- Strengthening primary care.
- Supporting and enhancing local services.
- Developing mental health services.
- Services for children and young people.
- Modernising acute hospital services.
- Cancer services and palliative care.
- Workforce planning.
- Funding.

We presented this to the Bedfordshire and Luton Joint Health Overview and Scrutiny Committee (OSC) in February 2007. The OSC welcomed the strategy as a key element in framing the delivery of NHS services in Bedfordshire over the next five years. It made a number of recommendations in its response: the need to establish an underpinning vision; greater emphasis on desired outcomes, actions and SMART targets; more detailed financial context; inclusion of a substantial risk analysis; and more consideration of the impact of population growth and demographic change.

The full document and a 12 page summary were published on the NHS Bedfordshire website and sent to a range of stakeholders in March 2007, including:

- All 240 members of our Health Panel.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Our PPI Forum.
- Older people's groups.
- Patient, service user and carer groups.
- Third sector organisations.
- Health and Social Care statutory and professional bodies.
- Local government (County, Borough, District and Parish Councils).

In general, people welcomed the ambition and breadth of the draft strategy. They strongly supported partnership working, with more integration of health and social care over time. Some expressed concern about whether there would be sufficient funding to fully implement it. Others wanted to see more details on the impact of demographic change. Many welcomed the opportunity to offer their views and our commitment to ensure ongoing engagement as we develop and implement our plans. These and specific comments on each of the key sections has informed the further development of this strategy.

Our strategy is also informed by the national review of the NHS by Lord Darzi, by the ten year vision for the NHS in the East of England, *Towards the best, together* and by the eleven pledges, set out in *Improving Lives, Saving Lives*, to improve the NHS in this region over the next three years.

3.2 Patient and Public Engagement

Alongside this work to draw out and clarify our strategic goals and the strategic priorities that underpin their delivery, we have engaged with and involved many different people as patients, residents, clinicians and strategic partners to shape and test out our implementation plans for the eight clinical plans.

3.3 Staying Healthy

We have met with vulnerable and marginalised groups in a range of settings to talk to them about their health needs. This included:

- Meeting homeless people in day and night shelters.
- Going to traveller sites to talk to residents.
- Speaking to prisoners at Bedford Prison and to offenders in the community.
- Commissioning a voluntary organisation to find out about the health needs of looked after and vulnerable children and young people across Bedfordshire.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- We consulted widely on our obesity strategy, seeking views from voluntary, public and private sectors.

- Health and well being priorities for the Local Area Agreement were consulted on at two Countywide Assemblies, each attended by 150-200 stakeholders.

- Horizon Health Commissioning, the practice based commissioning group for Bedford, ran a workshop in December 2007 with health, social care, patient/service user and community representatives to inform the development of commissioning plans for obesity, diabetes and coronary heart disease. An inequalities questionnaire was sent to 125 Health Panel members and other stakeholders, which informed a second workshop on health inequalities in September.

- We participated in a series of events in April 2008 organised by Bedford Borough Council to seek the views of residents in two rural and two urban Super Output Areas.

- Patient and public engagement and consultation has been integral to informing the Bedfordshire sexual health strategy and the vision for sustained development and improvement.

What People Have Told Us

- The GP leisure referral scheme was seen as very useful in treating unfit people. We need to find creative ways to promote and encourage more walking, cycling and other everyday activities.

- People generally thought there should be a strong focus on initiatives aimed at improving the health of children and young people. We should consult and involve young people in developing physical activity and healthy eating initiatives and interventions.

- Smokers who have attended stop smoking classes said they benefited from having dedicated, specialist support rather than more general, lower level advice.

- People want to see more workplace support for health initiatives, such as stopping smoking and exercise activities.

- The majority of people thought it right to target resources at where there were greatest health inequalities.

- Young people want sexual health services provided at convenient times, including weekends, in community settings where they feel comfortable and not stigmatised.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

3.4 Mental Health

- NHS Bedfordshire and Bedfordshire County Council have carried out a range of consultation events and activities during the development of our strategic plan for people with mental health problems.

- We value the views and contributions of our service users and carers through the Bedfordshire Mental Health Partnership Board.

- Service users and carers provide organised 'expert' advice and consultation during commissioning and are now an integral part of monitoring service performance management arrangements.

What People Have Told Us

- People would prefer to have their mental health managed in primary care. They saw admission to inpatient units as not the most therapeutic and wanted contact with specialist mental health services only as a last resort.

- There was a strong sense of the need for robust crisis response services, particularly out of hours, with alternatives to admission being a high priority for many.

- Many people felt that housing and supported accommodation were a particular need.

- Service users should be given greater choice.

- Services should be improved for black and ethnic communities.

- Improvements should be made to mental health promotion.

3.5 Maternity and New Born

- The Audit Commission patient survey of maternity services at Bedford Hospital has informed the establishment of some priority areas for development as part of NHS Bedfordshire's maternity strategy.

- We engaged with service users as part of our review of maternity services in 2007. We are continuing to seek their views, through stakeholder groups and other activities, in developing our maternity strategy.

- There is an active Maternity Services Liaison Committee (MSLC) for Bedford Hospital, chaired by a service user and with clinical and service user representation. We are developing a recruitment pack and associated promotional activities to further strengthen user representation.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Regular commissioning meetings with maternity teams at Luton and Dunstable Hospital and Bedford Hospital ensure ongoing clinical engagement.

What People Have Told Us

- With mothers now more likely to be discharged earlier, women wanted more postnatal support, particularly in the early period.

- Provide better education and support, in general, to promote and increase breastfeeding.

- Women wanted more support to make healthy lifestyle choices during pregnancy, for example in diet and help to stop smoking.

- Provide targeted support for vulnerable mothers, for example among teenage mothers.

- Offer better perinatal mental health support.

3.6 Children's Services

- Multi-agency strategy groups for a range of clinical areas provide input into strategy development from clinicians, local authority and voluntary sector representatives.

- The annual national Tellus surveys and the local Balding survey provide views from children and young people on health services in Bedfordshire, which informs service planning and commissioning.

- We consulted with a range of stakeholders at a Children and Adolescents Mental Health Services (CAMHS) conference in October 2008. Earlier consultation on the CAMHS strategy in 2006 included focus groups, led by trained gap year students, with 68 children at one lower, two middle and two upper schools.

- Bedford Borough Council and Mid Bedfordshire District Council employ children's participation officers to promote engagement and gather views.

- Parents have been involved in a recent review of paediatric therapies through the local authorities' parent partnership initiative. This provides opportunities for planned and sustained public involvement in the development of children's services.

What People Have Told Us

- Early support and clear, reliable information is important to help children (and their parents) make healthy lifestyle choices.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Children and young people wanted more children's services provided in community settings, closer to home and in familiar places. They wanted more services grouped together as 'one-stop shops' that were open at weekends.

- The importance of good people skills was stressed. Staff needed special training and skills to build relationships with young people. Young people tended to feel that this to be more important than technical / clinical skills.

3.7 Planned Care

- We consulted patients of Putnoe Medical Centre as part of the process to develop a new GP-led health centre. Their views informed the service specification and the selection panel included patient and other lay representation.

- We consulted patients of the seven GP practices in Dunstable on GP-led proposals to build a new medical centre. Around 300 people attended public meetings and we received more than 4,700 responses by freepost, email and website.

- We are consulting 15,000 patients from October to January on GP-led proposals to build a new health centre in Shefford.

- NHS Bedfordshire, in collaboration with Bedford Hospital and Horizon Health Commissioning, was selected as one of 10 pilots nationally to develop ideas to improve communications with patients on 18 weeks. We are producing a patient held folder, developed with patient input, which we will be piloting and evaluating with up to 300 patients at four GP practices.

What People Have Told Us

- Local consultations revealed that people welcomed more care delivered in community setting closer to home. This included some less complex care more traditionally provided in hospitals and more diagnostic services. They tended to support proposals to build modern, larger health facilities to accommodate this, but these needed to be in convenient locations or have good public transport for easy access, particularly for older people, people with a disability and mothers with young children.

- People supported the separation of planned and emergency care and that hospitals should also concentrate on more complex, specialised care.

- Patients, particularly those who commuted, wanted longer opening times in the evening and at weekends in primary care.

- People wanted more flexible appointment systems in GP practices.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Patients welcomed more choice about where and when they are treated, but were not always aware of what was available.

- People wanted the choice to be treated by an NHS dentist. It has been clear that people have not been fully aware of the availability of NHS dental care within reasonable distances of their home.

- People welcomed shorter waiting times from referral to the start of their treatment, but wanted reassurance that this would not compromise the quality of the care they received.

3.8 Acute Care

- We have established an urgent care strategic planning group for Bedfordshire and Luton with a lay representative.

- A lay representative sits on the review and evaluation group for the single point of contact service, *1Call,* which we launched last year.

- We will be putting greater emphasis on patient feedback in A&E in our contract with Bedford Hospital, which is monitored by the Quality Schedule.

- NHS Bedfordshire commissioning managers will be spending time meeting patients in A&E at Bedford Hospital to gain a deeper insight into patient experiences of acute care.

- The 2008 Healthcare Commission report on urgent and emergency services rated Bedfordshire as 'best performing', giving us assurance that these services are meeting local needs.

- Bedford Hospital is participating in the Releasing Time to Care, Productive Series.

What People Have Told Us

- Patients had varying experiences of OOH GP services and wanted more consistency in provision.

- A patient survey of an in-hours GP urgent care pilot at Luton and Dunstable Hospital revealed that the service was well received. Such arrangements need to be well communicated to staff and patients.

- People do not want to stay in hospital any longer than they need, but want to know there is the necessary support in the community. They want to see more joined up services.

- A single point of contact for assessment and access to urgent care support was welcomed by referrers and patients.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Patients expressed some concerns that highly specialised centres might be further away, although they tended to accept that greater specialisation could make services more effective and safer, leading to better health outcomes.

3.9 Long Term Conditions

- We support four Expert Patient Programme follow-up groups, arranging quarterly meetings and speakers on a variety of health topics suggested by the groups. More recently these groups have taken part in focus groups on proposals for long term conditions.

- We have set up a steering group to oversee the delivery of our strategy for long term conditions. Membership includes representatives from the local authority and the Health Advisory Forum (now part of the Bedfordshire LINk), Bedfordshire Community Health Services and from secondary care. We are also setting up a task and finish group for the identified priorities, with involvement from other members of the local health community.

- This year we are focusing on people with CHD and diabetes and will seek their engagement.

What People Have Told Us

- In general, people supported early intervention with those at a high risk of developing a long term condition later in life. It was important to strike the right balance between prevention and treating those who were living with long term conditions.

- People welcomed more screening and other diagnostic activities that would identify and support people at an early stage of their long term condition.

- People with long term conditions often have a range of health and social care needs across different disciplines. They told us that they wanted to see a much stronger emphasis on better integration of services, particularly in areas such as psychological support, rehabilitation, medicines management and palliative care.

- There was very strong support for the Expert Patient Programme and many also wanted to see a short refresher course offered.

- There were mixed views on patient held budgets. Some saw it offering greater choice and flexibility. Others were concerned that it would overload them, particularly as they felt they would most need to make use of it at a time when their health was poor.

- People with long term conditions supported having an individual health plan to help them better manage health crises. When they needed urgent or emergency

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

care, they wanted rapid support. They strongly supported the idea of a single contact number.

3.10 End of Life Care

There have been a number of initiatives to support patient and carer involvement in palliative and end of life care across Bedfordshire. These include:

- Carers' focus group to explore the patient and carer experience of all palliative and end of life care services across mid Bedfordshire.
- Cancer focus groups which are a critical part of the service improvement cycle.
- Patient Partnership Group at St Johns, Sue Ryder Hospice in Moggerhanger.
- A strategy to build on this work has recently been written in collaboration with the local cancer networks and Macmillan Cancer Support. This links with NICE Improving Outcomes Guidance (2004) and the Department of Health End of Life Care Strategy (2008).

What People Have Told Us

- Patients and their families want a seamless transition across hospital, hospice and community. This would be helped by a greater emphasis on good communication with patients and their families.
- It is well documented generally and borne out by our focus groups that people want more control over where they die. Most do not want to die in hospital.
- There needs to be greater consideration and assessment of the needs of carers and families, providing practical and emotional support throughout end of life care and during bereavement.

3.11 Patient Surveys

Understanding what people currently think about the healthcare services they receive is crucial to their continuous quality improvement. Patient surveys of local health services in primary care have been carried for the Healthcare Commission in 2004, 2005 and 2008, providing a critical insight into the experiences of the patients and identify areas of healthcare that should be improved upon. The trust has developed action plans to address the key issues raised.

The information presented in the Healthcare Commission benchmark reports has been converted from responses to questions into scores. It is possible to discern trends in patient experience by comparing the raw data for similar questions rather than the constructed scores.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

The following information has been taken from the results of the patient surveys for Bedfordshire in 2005, 2006 and 2008.

Overall, the following changes can be identified (best, middle and worst):

	%age		
	2004	2005	2008
Patients who said they waited because they wanted to see a doctor of their choice.	**41**	**35**	**38**
Patients who said they were seen as soon as they thought necessary.	**60**	**83**	**82**
Patients who said they should have been seen a lot sooner.	**9**	**3**	**5**
Patients who said they were involved as much as they wanted to be about their care.	**65**	**72**	**71**
Patients who said they got no information on side effects, but wanted some.	**20**	**25**	**19**
Patients on a list with an NHS dentist.	**55**	**50**	**54**
Patients not on an NHS dentist's list who would like to be.	**68**	**73**	**79**

Table 6 - Patient survey results 2004-2008

Most indicators showed improving patient experience from 2004 to 2005 and from 2004 to 2008, but with some deterioration between 2005 and 2008. We will continue to analyse this year on year.

NHS Bedfordshire will establish arrangements through the contracting team for capturing patient feedback within two weeks of care. We have included this as one of the CQUIN indicators. We will participate in quarterly national and regional surveys, as required.

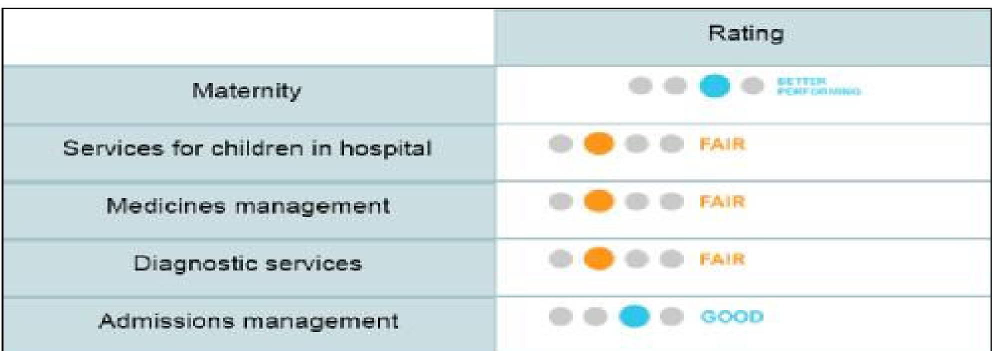
Patient experience is an integral part of the existing performance reporting arrangements against the pledges to the PCT Board. Regular reports on patient experience will be provided.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

We also consider other patient experience survey reports, including the Healthcare Commission inpatient survey (last published in 2007) and the Annual Health Check of provider trusts. The most recent results are set out below.

3.12 Bedford Hospital 2007/08

Services Focussed On



	Rating
Maternity	BETTER PERFORMING
Services for children in hospital	FAIR
Medicines management	FAIR
Diagnostic services	FAIR
Admissions management	GOOD

What Patients Say

Score (out of 10)	For questions about	How this compares with other trusts
7.4	the emergency / A&E department, answered by emergency patients only	ABOUT THE SAME
5.3	waiting lists and planned admissions, answered by those referred to hospital	ABOUT THE SAME
7.9	waiting to get to a bed on a ward	ABOUT THE SAME
7.2	the hospital and ward	ABOUT THE SAME
7.9	doctors	ABOUT THE SAME
7.7	nurses	WORSE
7.3	care and treatment	ABOUT THE SAME
8.2	operations and procedures, answered by patients who had an operation or procedure	ABOUT THE SAME
6.4	leaving hospital	ABOUT THE SAME
5.3	overall views and experiences	WORSE

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

3.13 Bedfordshire and Luton Community NHS Trust 2007/08

Services Focussed On

	Rating
Hospital services for people with acute mental health problems	FAIR
Substance misuse services	GOOD
Adult community mental health services	FAIR

What Patients Say

Score (out of 10)	For questions about	How this compares with other trusts
7.6	seeing a psychiatrist	WORSE
8.5	seeing a community psychiatric nurse (CPN)	ABOUT THE SAME
6.3	medications	ABOUT THE SAME
6.6	counselling	ABOUT THE SAME
6.7	their care-coordinator	WORSE
5.7	their care plan	ABOUT THE SAME
6.5	care reviews	ABOUT THE SAME
4.4	support in the community	WORSE
4.1	crisis care	ABOUT THE SAME
4.4	information and support for families or carers	ABOUT THE SAME
6.1	overall views and experiences	WORSE

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

3.14 Luton and Dunstable NHS Foundation Trust

Services Focussed On

	Rating
Maternity	LEAST WELL PERFORMING
Services for children in hospital	FAIR
Medicines management	FAIR
Diagnostic services	EXCELLENT
Admissions management	EXCELLENT

What Patients Say

Score (out of 10)	For questions about	How this compares with other trusts
7.4	the emergency / A&E department, answered by emergency patients only	ABOUT THE SAME
5.7	waiting lists and planned admissions, answered by those referred to hospital	ABOUT THE SAME
7.5	waiting to get to a bed on a ward	ABOUT THE SAME
7.7	the hospital and ward	ABOUT THE SAME
8.1	doctors	ABOUT THE SAME
7.8	nurses	ABOUT THE SAME
7.2	care and treatment	WORSE
8.1	operations and procedures, answered by patients who had an operation or procedure	ABOUT THE SAME
6.3	leaving hospital	WORSE
5.6	overall views and experiences	ABOUT THE SAME

Table 7 - Healthcare Commission 2008 Annual Health Check Ratings

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

3.15 World Class Commissioning Patient Experience Metric

The proposed metric for patient experience is the self reported patient experience scores from the patient experience surveys carried out on behalf of the Healthcare Commission. It is proposed to use a composite score based on the primary care and acute inpatient scores. These are also Vital Signs (VSB15_01 and VSB 15_05).

The composite score will be the average (mean) of the acute inpatient score for the local acute trust and the primary care score for NHS Bedfordshire.

The 2007/08 provisional composite score for NHS Bedfordshire is 75.0 (78.1 for primary care and 71.9 for inpatients). This will provide a baseline against which to assess future performance.

The realignment of directorates, as part of our delivering our world class commissioning capability, has seen the establishment of a Directorate of Public Engagement and Communications. This dedicated resource signifies the importance NHS Bedfordshire places on putting patients and the public at the centre of all we do. Our Communications and Engagement Strategy sets out additional measures and processes for gaining a deeper insight into patients' views, preferences and experiences. Appendix H

3.16 PALS Enquiries and Complaints

NHS Bedfordshire operates a successful Patient Advice and Liaison Service (PALS) service with 700-800 enquiries each year. PALS is the first point of contact for many patients who are unhappy about the service they have received and patients are given a number of methods to contact the service: face to face, telephone, email, letter, fax and through website enquiries.

Patients' concerns investigated and resolved through the PALS service provides a speedier alternative to the formal complaints procedure.

All enquiries are logged on a dedicated database to monitor trends in service areas. Reports are made quarterly to the Board and to quality monitoring committees to highlight issues, how they have been addressed and to identify gaps in service. PALS also shares feedback at a regional level to identify trends within the East of England area.

There has been a year-on-year fall in the number of formal complaints from 50 in 2005/06 to 38 in 2006/07 and 34 in 2007/08, which may be seen as reflecting the effectiveness of PALS in securing early resolution of issues raised by patients.

We record where there has been a specific service change as a result of PALS contacts and complaints. This has been evidenced in service delivery in community health services and we are now starting more detailed engagement with commissioners. In particular, reports are produced on a quarterly basis to the

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

commissioning senior managers meetings, which highlights the types of enquiries by PbC area.

The PALS team has also been involved in making sure the patient experience is taken into consideration in the review of the trust's exceptional treatment process. PALS and complaints will now feature within the new process and the team will work with commissioning managers in identifying trends.

PALS feedback has influenced commissioning decisions and service changes. For example, PALS enquiries identified a gap in NHS dental provision in Leighton Buzzard. This formed part of the evidence that enabled the trust to support the opening of a new practice in the town in 2008.

3.17 Comment Cards

Comment cards are available in all health centres and are distributed by frontline staff in patient information materials. The comments cards enable patients to rate services as excellent, good, fair or poor and add their comments on clinical, reception and support staff, facilities and environment, and information.

The PALS team contact all patients who have completed a card to thank them for their enquiry and provide details of what action has been taken as a result of their feedback. The comments made are shared with the services they relate to and are reported in the quarterly reports to close the loop in patient feedback

3.18 Listening to and Supporting Carers

NHS Bedfordshire has been working in partnership with Bedfordshire County Council to develop a carers' strategy (2007-2010) that uses the knowledge experience and dreams of carers and those who work with them. Our vision for Bedfordshire is that carers have:

- Support to continue caring for as long as they want to.
- Quality and well-being in the social, educational and employment aspects of their lives.

Carers play an active part in the Bedfordshire Carers' Strategy through countywide forums and other engagement initiatives. They receive information about assessments and the support available in Bedfordshire through a range of resources. These include newsletters, leaflets, the internet and radio, as well as awareness raising events such as Carers' Week.

This is what carers and those who work with them said needs to happen for Bedfordshire. We recognise that carers are experts at caring and will work with them to deliver this strategy, valuing them by reimbursing them for their time and expertise. We will work to reach those carers who are not currently in touch with services, such

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

as black and minority ethnic carers and those who care for people with HIV and AIDS. We will also work to support those whose caring role has come to an end.

Each year we will produce an action plan that sets out how we will meet the aims of this strategy.

We will involve carers in monitoring and evaluating progress on the strategy through the countywide carers' and specialist mental health forums and take into account results from carer and service user led patient/carer satisfaction surveys. The view of the forums will inform the work of the practitioners groups in delivering the strategy, the commissioning group responsible for its performance and other key partners such as health.

We will gather statistics and evidence of what difference the strategy is making to carers. The needs and aspirations of carers may change and we will use this information with our partners to review the strategy and make sure it is a strategy for Bedfordshire.

We intend to improve the identification of carers and subsequent signposting to existing support and information by healthcare professionals as this is something many carers identified as being weak at a workshop held in October 2008.

The delivery of carer education and support programmes and the Caring with Confidence programme will be linked into the development of Mental Health services.

3.19 Developing Delivery and Improving Practice in Assessment

We are committed to improving individual needs assessment and provision of advice, support and guidance for carers across Bedfordshire, involving them more centrally in a caring role with service users. This will require considerable practice change.

We will employ practice development workers to raise awareness with the multidisciplinary teams and with carers to accelerate and enable this carer focus. They will model good practice and facilitate change over a three year period, exploring the needs of carers, sourcing information, providing training and building networks.

During this time we would expect to see a considerable change in practice, resulting in new deals for both carers and patients.

3.20 Ongoing Clinical Engagement and Clinical Leadership

Clinical engagement and clinical leadership is essential in commissioning effective services. It is recognised that clinicians have the vision to redesign services to ensure they are both responsive and effective.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Strong clinical leadership is also vital to effect transformational changes which help to overcome barriers across organisations both within and outside of the NHS. Clinicians are uniquely placed to lead change by utilising evidence based practice and challenging perceived wisdom, whilst keeping the focus on the patient.

Clinicians have been engaged in redesigning services and providing better care for the population of Bedfordshire:

- Bedfordshire and Hertfordshire Heart and Stroke Network is engaged in redesigning the stroke care pathway and the cardiac care pathway, including cardiac rehabilitation in the community.
- North Bedfordshire and South Bedfordshire Diabetes Networks are engaged in redesigning the diabetes care pathway.
- Bedfordshire Locality Cancer Group is engaged in redesigning the cancer care pathway.
- South Bedfordshire Clinicians Group is engaging in dialogue between GPs and consultants at Luton and Dunstable Hospital.
- Bedfordshire and Hertfordshire Priorities Forum is engaged in defining the clinical priorities and access / exit criteria for services in the region.
- Bedfordshire and Luton Joint Prescribing Committee is engaged in implementing a clinically effective and cost effective prescribing policy for the region.
- Bedford Hospital Quality Committee is engaged in trying to provide better quality healthcare for the patients of Bedford Hospital.
- Bedfordshire and Luton Programme Management Board for Diabetic Retinopathy screening ensures that national screening programme quality assurance standards are met.
- Bedfordshire and Luton Programme Management Board for the Bowel Cancer Screening programme ensure quality assurance standards are met.
- GPs have been engaged in designing the PCTs 'end of life' strategy.
- There has been clinical engagement with Bedford Hospital in trying to reduce Bedford Hospital's mortality rates.

Our Professional Executive Committee (PEC) plays a key role in further supporting this approach. Within NHS Bedfordshire all PbC lead clinicians are members of the PEC with additional support from PbC Chief Officers.

PEC clinicians act as clinical champions and sit on key committees, as do other clinicians. This ensures that clinicians are involved in developing Bedfordshire wide

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

strategies, policies and service redesign and making sure they are then implemented to reflect local needs.

We will continue to explore if there are other or better ways to communicate with our local clinical colleagues and to identify any areas of work that would benefit from clinical representation from the PEC.

3.21 Engagement with Our Partners

The aspiration to improve health and well-being in Bedfordshire and decrease health inequalities is shared by all key partners across Bedfordshire. This shared aspiration is currently articulated in Bedfordshire's Sustainable Community Strategy.

Within the Local Area Agreement NHS Bedfordshire will lead on reduction of smoking, decreasing childhood obesity, improving life expectancy and reducing health inequalities. A local priority is increasing the percentage of drug users engaged with treatment.

Achieving these goals will require changes in how we provide health care services and how we work with partners. Bedfordshire is in the midst of a local government review. On 1 April 2009, Bedfordshire County Council and the three existing district councils will be re-organised into two new unitary authorities: Bedford Borough and Central Bedfordshire. Each of these organisations will launch their Sustainable Community Strategy in the coming year. NHS Bedfordshire is working closely with the shadow authorities to inform these new strategies, which will provide the high level vision for partnership working across all organisations in Bedfordshire spanning statutory, voluntary organisations and commerce.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

4 So What Do We Need To Do?

Three strategic priorities will drive our implementation plans

- **Investing a greater proportion of our money into prevention (healthy lifestyles, early intervention and promoting independence).**
- **Creating effective support in local communities to reduce the reliance on hospital care, including in times of urgent need.**
- **Offering more choice and convenience, by commissioning quality services closer to home based on the needs and preferences of Bedfordshire patients.**

4.1 Investing a Greater Proportion of Our Money into Prevention

The NHS must invest in prevention, not just catch people when they fall ill. A significant percentage of the changes set out in NHS Bedfordshire's implementation plans support prevention. See Appendix A.

We will:

- Support more people to give up smoking working with primary care, pharmacists, hospital and local communities. We will target areas of deprivation to drive down health inequalities.
- Reduce childhood obesity working with schools and their local communities to remove the factors which promote obesity and promote factors, such as exercise, which reduce it.
- Identify people at risk from heart disease and provide advice and treatment to reduce their risk. Again there will be specific initiatives in areas of deprivation to drive down health inequalities.
- Help people to book early when they know they are pregnant so they can access the full range of advice and support.
- Support carers to enable them to continue to support the people they care for even during complex times.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

What Success Will Look Like in 2013/14

Users' perspective

I've been encouraged and supported to be as healthy as possible. This support has extended across my whole family, with help and support I have been able to give up smoking, my husband was a heavy drinker. He has been given the information so he can understand what is happening to him from drinking too much alcohol. I buy more fruit and vegetables as a result of being given help to understand why the food my family choose to eat can effect how we feel. My little girl is able to attend an exercise class to help her lose weight and keep her fit.

Clinicians' perspective

Prevention is now embedded into the care pathway. It's rare for me now to operate on someone who hasn't managed to give up smoking before their operation. Infection rates and complication rates are down. While I am still seeing obese patients, the increasing numbers seem to have stabilised. It is encouraging to see that more and more patients, especially the young are really starting to understand how weight can affect their health in the future.

Commissioners' perspective

Prevention is embedded into contracts. Commissioning is on outcome and this includes improvement in healthy lifestyles and patient experience. We commission activity that only a few years ago would have been seen outside of the scope of the NHS such as exercise classes and healthy eating support groups.

4.2 Creating Effective Support in Local Communities

The fundamental role of the hospital and specialist acute services in treating patients needs is crucial but there are many areas where services could and should be provided outside of a hospital setting, closer to peoples homes. Many of the actions set out in our implementation plans will support this shift in the care setting.

We will:

- Increase capacity within primary and community services
- Invest in the infrastructure of primary care to support the transfer of services to high quality, locally based care.
- Develop direct access to diagnostics and availability of results prior to consultant appointment, including community based diagnostics.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Intervene early in primary care when people have mental health problems through initiatives such as Increased Access to Psychological Therapies
- All planned services will be accessed within the clinically appropriate waiting time – maximum of 18 weeks.
- Improve access to specialist services for assessment and treatment for children, particularly therapy services.
- Offer more choice to women about how they access antenatal and postnatal services.
- Ensure end of life care is well co-ordinated and delivered seamlessly with the emphasis on improved communication.
- Develop 24/7 rapid access to community nurses backed by specialist advice to enable patients to die at home if that is their choice.

What Success Will Look Like in 2013/14

Users' perspective

My mum is 90, and we know that she is getting weaker and old age is catching up on her, we live about an hour's drive away from the hospital where she normally goes to. She never liked being there; it was lonely for her because it was difficult for us to see her every day. It was sad for my grandmother who passed away 20 years ago, alone in her hospital bed without her family around her. I am so glad it won't be like that for my mum because we have her at home, where she wants to be, we get to see her every day. It's really good to see everybody helping us to give mum what she really wants.

Clinicians' perspective

As a GP I have the confidence to manage complex patients in the community as I can access the diagnostic and nursing support I need when I need it and patients can quickly access specialist support when they need it. Where appropriate and where needed the services have become well integrated, and patients are getting increased access to care especially during evenings and weekends. I have increased access to increasingly sophisticated technology which allows me to be mobile and take care to the patents in a way which is safe, and allows care to be provided in places that were just not possible in the past.

Commissioners' perspective

The role of the hospital has changed; they are doing what they do best and care for patients with more complex and acute needs. The rest is carried out in the community. We commission local services for local people; we consider the health inequalities of the local people and the fairness of health provision when we provide

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

those services. We have a wide range of contracts with providers; many of which are now jointly provided with the local authority. These are underpinned by appropriate system wide estate facilities and IT. We use feedback from patients, carers and clinicians to continually drive up the range and quality of these services. We work with the local population to plan the changes that will enhance and improve the outcomes for patients.

4.3 Ensuring That the People of Bedfordshire Have More Choice and Convenience

Choice must be available across the whole life pathway, from the choice of where to give birth to supporting the increasing number of people who want to die at home. There are many initiatives within the implementation plans aimed at increasing the choice of services available to the people of Bedfordshire.

We will:

- Commission multiple providers of IAPT.
- Roll out of the Choose and Book system to non consultant led services.
- Develop midwifery led units.
- Move more care into the community with a range of providers.
- Utilise the “in control” programme for people with complex health and social care needs which allows them to direct how NHS and social care money is spent to meet their needs.
- Roll out personal management plans to help people with long term conditions to understand and make best use of the range of services available to them.
- Continue to develop the expert patient programmes lay-led self-management programme that has been specifically developed for people living with long-term conditions. The aim of the programme is to support people to increase their confidence, improve their quality of life and better manage their condition.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

What Success Will Look Like in 2013/14

Users' perspective

I used to think choice was just about which hospital provided treatment. I now know that it's also about how I am cared for and the options for the different treatments, I can choose from a menu of options that might be appropriate to me. It is nice to be recognised as a person rather than a clinical condition and it's nice to know that I have been consulted about benefits and risks, because after all I'm the best person to make the choice about what's right for me.

Clinicians' perspective

When I used to ask people which treatment option they preferred I'd often be told "you know best". Now with the new information and ways of communicating risk more and more people are able to choose for themselves. It's important that my patients can get information about their condition and treatments that allow them to make a real informed choice. I feel as though I am in partnership with the patient when they are choosing what is right for them, rather than me telling them what is right for them.

Commissioners' perspective

Choice is driving quality and reducing health inequalities. By commissioning health trainers, expert patient programmes and setting standards for personal management plans we are ensuring everyone has access to choice, not just about where they are treated but also how.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

5 Existing Targets, Local and National Priorities

NHS Bedfordshire began this year in financial balance and with relevant performance measures in place to ensure the organisation is on course to achieve 'balance' year-on-year. NHS Bedfordshire has focused priorities set out in the Operating Framework including:

- **Improving cleanliness and reducing healthcare associated infections.**
- **Improving access through achievement of the 18 week referral to treatment pledge, improving access (including at evenings and weekends) to GP services.**
- **Keeping adults and children well, improving their health and reducing health inequalities.**
- **Improving patient satisfaction, experiences and engagement.**

The NHS Operating Framework set priorities over a three-year spending period, 2008/09 to 2010/11 and the accompanying planning guidance set out the specific deliverables and milestones that PCTs are required to include in their Operational Plans for 2008/09.

NHS Bedfordshire is also required to measure progress made against a set of indicators called the 'vital signs'. The vital signs include measures of progress against the national priorities, as well as a broader set of health indicators, for benchmarking. This enabled us to decide on local priorities.

There is also a requirement to deliver new commitments by 2010/2011, including national strategies for stroke and cancer. We also need to continue delivering on existing national targets, for example, 98% of patients to be seen in A&E in less than four hours. Maintaining standards at national level is a minimum requirement and tackling variation in performance locally is essential for NHS Bedfordshire.

We aim to ensure that local people receive the standards of care they expect from the NHS.

We monitor performance robustly and ensure that contractual targets are met and to the quality expected.

We provide performance reports to our Board at every Board meeting and also to sub committees of the Board for scrutiny. These report progress for all performance indicators and exception reports in detail. Our reporting matrix aims to give greater consistency and transparency in its approach to tackling underperformance, supporting recovery and holding all commissioned service providers to account.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

We want to achieve continuous improvement in all areas of service delivery and have introduced 'balance scorecards' for all service providers. This has given us a way of ensuring that our strategies and detailed plans have been thought through and visibly linked to wider goals. It is a system for managing the performance in delivering services to the public of Bedfordshire.

The underpinning approach in relation to the development of the balanced scorecard is about more than simply measuring performance. It is about aligning the organisation's overall vision, key strategic actions, performance measures and performance management. This is set out in our Operational Plan 2008/09, attached as Appendix C.

We will identify areas of good practice/innovation as well as identifying areas that have not reached the required performance level.

Our performance against targets is included as Appendix E.

5.1 Bedfordshire's Local Area Agreement 2008-2011

The new Local Area Agreement (LAA) is a three year agreement between central government and local authorities and their partners that operates from June 2008 to March 2011. Where possible, targets have been broken down to district / borough level for each of the three years of the agreement. This enables the Local Area Agreement to operate at a county-wide level in year one, after which targets can be disaggregated to reflect the boundaries of the two new unitary councils from April 2009.

The vision is for *Bedfordshire to be an even better place to live, work and visit.*
This vision will be achieved by delivering the following priorities:

- Growing our economy and raising the profile and identity of the county as a great place to live.
- Protecting and enhancing our environment, green infrastructure and spaces, promoting sustainable housing growth, and preparing for climate change.
- Raising the aspirations of our children and young people.
- Building cohesive, strong, safe and sustainable communities with well planned, decent and affordable housing, where people have a shared identity and sense of belonging.
- Reducing health inequalities and delivering good health and well-being for our communities.

Key health and social care priorities and targets include:

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- NI51 To increase the effectiveness of children and adolescent mental health services.
- NI56 To reduce the number of children in year 6 who are obese.
- NI115 To reduce substance misuse by young people.
- NI120 All Age cause mortality rates – to increase healthy life expectancy and reduce inequalities in health.
- NI123 To reduce age 16+ current smoking prevalence.
- NI130 To increase the number of social care clients receiving Self Directed Support.
- NI135 Increase the number of carers receiving needs assessment or review and a specific carer's service or advice and information.
- NI141 To increase the percentage of vulnerable people who have moved into independent living.
- NI142 To increase the percentage of vulnerable people who are supported to maintain independent living.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

6 Our Track Record of Success

NHS Bedfordshire has an ongoing track record of achievement since its inception in October 2006. It has the capability and skill to continue to deliver complex and innovative change.

6.1 Financial Turnaround

NHS Bedfordshire delivered a Turnaround programme amounting to £37m in 2007/08 and ended the year with a surplus of £133k on a resource limit of £474m. This followed a deficit of £17.6m on a resource limit of £416m in 2006/07.

Systems and processes were changed and a more rigorous approach to budget management was introduced. All of the lessons learned from turnaround have been embedded in the organisation in 2008/09. One of the results of the improved approach to financial management was an improved use of resources rating in the 2008 Annual Health Check.

6.2 One Call: Reducing Unnecessary Emergency Admissions

The Practice Based Commissioning (PBC) groups commissioned a new service to provide a single point of contact for healthcare professionals requiring urgent care for their patients. Through analysis of SUS data, reviewing case management of frequent flyers, and seeking the views of primary care professionals and patients, the PBCs determined that urgent community care was difficult to access, with 66 different routes of access; leading to many patients unnecessarily accessing emergency care, and many being admitted as a result.

By taking access points from 66 down to one, through implementation of *One Call,* a single local-call number, this has reduced unnecessary admissions to hospital and meant that more patients have been able to be cared for at home. By the 31 March this year, the service had dealt with 502 referrals from health and social care professionals.

In line with our strategy, this service has been commissioned as a joint venture between the East of England Ambulance Trust and the PCT Community Health Services in order to encourage plurality of provision and support NHS Bedfordshire's strategic priorities.

6.3 Improving Access to Psychological Therapies (IAPT)

It is nationally recognised that access to talking therapies is limited by the capacity of current providers. This was the situation in Bedfordshire. NHS Bedfordshire, in partnership with local PBCs developed a successful bid and are one of three

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

commissioners in the East of England to be given additional resources to develop locally delivered enhanced access to psychological therapies.

Delivery of this service is a partnership between a PBC provider and mental health services across primary, community and third sector care. This has involved recruiting high intensity and low intensity workers, which in line with our strategy has redefined the role of providers and stimulated the market in relation to plurality e.g. the role of the third sector.

6.4 Improving Community Health Services

PBCs, working closely with the Bedfordshire Community Health Services management team, reviewed community nursing and intermediate care services and recommended changes that have recently been implemented. The outcome was to ensure that services that were commissioned promote faster recovery from illness, prevent any unnecessary acute hospital admission, support timely hospital discharge and maximised independent living. The reviews involved extensive clinician and patient engagement and led to revised service specifications and, through partnership working the PBCs, have successfully delivered a new model of service provision.

6.5 Improving Access to General Practice

NHS Bedfordshire opened the first Darzi health centre in the country.

NHS Bedfordshire consulted with patients of the Putnoe Medical Centre in Bedford when the GPs at the practice decided to end their partnership, and decided to tender nationally for a new provider to take over the running of the practice, as part of the Equitable Access programme. The focus of the programme is on achieving the visions of a fair and personalised NHS (whilst upholding the values of safe and effective primary care services). Patients were involved throughout the process, including representation on the selection panel that chose a local GP practice in competition with national companies and other providers.

The new GP team took over the practice in the summer of 2008 and a new eight-till-eight, seven days a week walk in centre opens on 1 December 2008.

6.6 Improving Access to Dentists

A number of gaps in provision were identified, resulting in patients having difficulty accessing NHS Dental services in Bedfordshire. In addition to commissioning further Unit of Dental Activity from existing service providers in these areas a new NHS Dental provider was commissioned in Leighton Buzzard providing a service for up to 4,000 patients.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

The new service was opened earlier this year and offers appointments 8.00am to 8.00pm weekdays and a service on Saturdays from a new state of the art dental surgery providing a comprehensive range of dental services and excellent facilities.

6.7 Improving Mental Health and Well Being

Supporting people on incapacity benefit to understand and manage their health condition better so that they can successfully return to work has been the key driver for the *Healthier Steps to Employment* project established between NHS Bedfordshire, Job centre Plus, the Local Authority and a range of voluntary sector organisations last year. The health and well being programme includes opportunities for referral to pain management sessions, support for mental health conditions and physical activity sessions.

6.8 Improving Access to Local Care

Over the last 18 months local PBCs have established a number of locally based services that allow people to access assessment and treatment locally rather than attending hospital. Examples of this are:

- In West Mid Beds a number of ‘closer to home’ services have been developed that have improved access and enhanced patient experience. They are:
    - Consultant led Ophthalmology one stop service at Ampthill.
    - Practice based 24 hours ambulatory cardiac monitoring service.
    - GPSI services are now available to all patients in the locality: Musculoskeletal service at Flitwick; Dermatology service at Ampthil (including a 2-tier skin service); ENT service at Ampthill.
- Horizon Healthcare in Bedford have designed and commissioned an evidence based community pulmonary rehabilitation service (on behalf of Horizon Health Commissioning, West Mid Beds and Ivel Valley Health Partnership).
- Horizon Health have also designed and commissioned a much needed home oxygen service for the population of north Bedfordshire. This service has saved approximately £125,000 since it began in March 2008.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

7 Provider Landscape

NHS Bedfordshire commissions services from a wide range of providers.

These services have traditionally been segmented as secondary care, mental health, primary care and community services. However, as we move forward it will be important to overlay this understanding with an understanding of provision by clinical pathways and by programme budgets.

NHS Bedfordshire will promote choice in provider of care.

Bedfordshire residents are already able to access a wide range of providers, especially from secondary care. Although there are a number of general and specialist providers this does not always correlate with quality of provision.

The 2007/08 Health Commission (HCC) ratings identify a range of weaknesses across our provider landscape.

Some acute trusts are not currently on target in relation to reduced Healthcare Acquired Infection. This needs to be resolved.

7.1 Driving Up Quality and Safety

NHS Bedfordshire embraces the vision set out in “High Quality Care for All” and has already done much to support the vision becoming a reality in Bedfordshire. A system of monitoring the quality of providers has been in place since April 2007 as part of provider’s contracts and utilises Standards for Better Health as a framework. This allows the PCT to review key safety, quality and patient experience metrics on a regular basis with providers, to identify concerns and ensure action is taken to improve. This has also enabled us to set local as well as national measures and will support the new national Quality Metrics and Patient Reported Outcomes measures when they are introduced.

The agenda is challenging locally, with further improvement still required in relation to reducing Health Care Acquired Infection and the unacceptably high MRSA rate and ensuring high quality mental health services. We have also set targets to further reduce Hospital Standardised Mortality Rates. There is significant progress required as a number of local providers are not in a strong position in relation to the HCC ratings. See table 8

However, work already undertaken has ensured that providers are working with us in an open and transparent way to make improvements. Building on the existing quality framework NHS Bedfordshire will hold all providers to account against increasingly stringent standards for quality and safety.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

In the future:

- NHS Bedfordshire will ensure our residents are aware of the strengths and weaknesses of providers by making information available on NHS Bedfordshire's web site, local papers, within surgeries, clinics and local libraries, thus promoting informed choice and driving up the quality of our providers.

- Developments in primary and community settings will ensure there are more providers in the market so choice will increase.

- To further improve choice and stimulate the market, consideration will be given to utilising capacity in private and voluntary providers.

As stated we need to ensure locally that as well as effective and safe care, and choice, patient experience and the quality of caring people receive are also of paramount importance.

We will utilise the existing Quality Frameworks including Quality Outcome Framework and development of a balance scorecard for GPs, in order to drive up quality in primary care, and the NHS Bedfordshire Quality schedule for commissioned contracts. These tools are to monitor and drive improvements in patient experience, ensuring that privacy and dignity, care closer to home and patient's choice, needs and preferences are key elements within this. We will set challenging targets and robustly monitor progress in these areas.

Provider Name	HCC rating category	
	Quality of Services	Use of Resources
Bedford Hospital NHST	Weak	Fair
Luton and Dunstable NHST	Fair	Excellent
Cambridge University Hospitals NHST	Excellent	Excellent
East and North Hertfordshire Hospitals NHST	Fair	Fair
Buckinghamshire Hospitals NHST	Fair	Good
Milton Keynes NHST	Good	Excellent
Chelsea & Westminster	Good	Excellent
Barts & the London	Fair	Good
Hammersmith Hospital (now Imperial)	Good	Good
St.Marys Hospital (now Imperial)	Good	Good
Northampton General	Good	Good
Nuffield Orthopaedic Centre	Fair	Good
Oxford Radcliffe	Excellent	Fair
Royal Free	Excellent	Excellent
St.Georges Healthcare	Good	Fair
Royal National Orthopaedic Hospital	Weak	Weak
West Hertfordshire	Fair	Fair
Guy's & St. Thomas	Good	Excellent
Moorfields	Fair	Excellent
Royal Marsden	Excellent	Excellent
University College London Hospital	Good	Excellent
Hinchingbrooke	Good	Weak

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Provider Name	HCC rating category	
	Quality of Services	Use of Resources
Kings College Hospital	Fair	Excellent
North West London	Fair	Weak
Papworth Hospital	Good	Excellent
Mount Vernon	Good	Good
Royal Brompton & Harefield	Excellent	Good
East of England Ambulance Service	Weak	Weak
Bedfordshire and Luton Partnership Trust	Good	Good

Table 8 - HCC ratings 2007/08

7.2 Relationship with Other Commissioners

We will focus on sharing information to drive forward change, to improve quality and accommodate the strategic direction of all commissioners. This will also take into account the requirements of practice based commissioning groups as key partners in commissioning.

We will ensure that we appropriately inform lead commissioners of our requirements and in return we expect them to represent these in negotiations with providers.

7.3 Acute Hospital Providers

The largest share of Secondary Care provider services within the boundaries of NHS Bedfordshire is Bedford Hospital NHS Trust. The Trust operates from a number of sites across Bedfordshire but its primary site is Bedford Hospital in Bedford. NHS Bedfordshire currently commissions £90m worth of acute care services from Bedfordshire Hospital NHS Trust. This constitutes over 39% of the total spending £229m on acute service by NHS Bedfordshire.

Other local providers of secondary care for the PCT include:

- Luton and Dunstable NHS Foundation Trust.
- East and North Hertfordshire NHS Trust.
- Cambridgeshire Universities NHS Foundation Trust.
- Milton Keynes Hospital NHS Foundation Trust.
- Buckinghamshire Hospitals NHS Trust.
- London acute and specialist providers.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

7.4 Access to Acute and Specialist Services

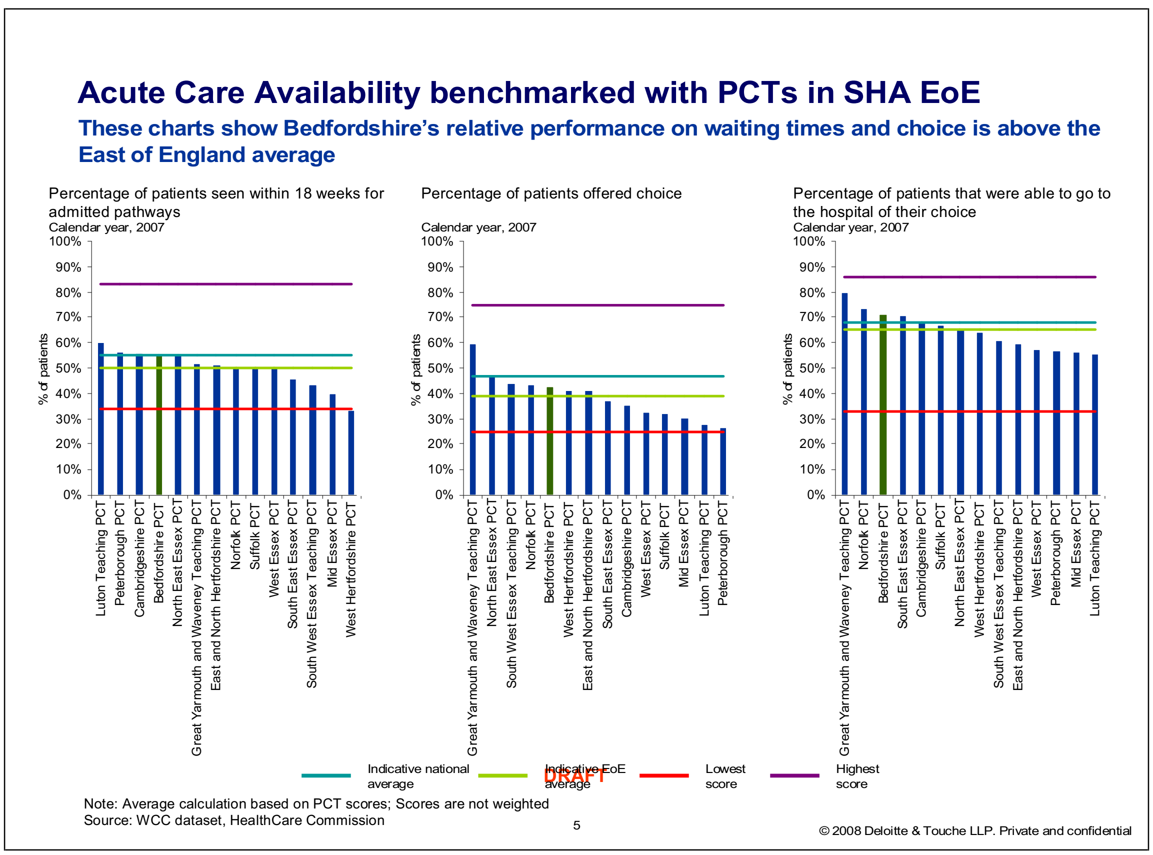


Figure 12 - Acute care availability of PCTs in East of England

By analysing programme budget expenditure against clinical pathways NHS Bedfordshire will be able to review current care delivery models and identify where shifts of activity are intended. This will in turn stimulate market development and facilitate change in the future provider landscape. NHS Bedfordshire will take steps to proactively communicate and publicise new provider market opportunities.

NHS Bedfordshire will decommission certain activities to reshape provision as the move to relocate services into the community picks up pace.

There are still a number of patients attending London hospitals who could benefit from having care provided closer to home. This activity could be commissioned from services more accessible to Bedfordshire residents. A number of Trusts are looking at their portfolio of services and have expressed interests in undertaking more specialist activity, these aspirations will be managed to ensure supply does not significantly outstrip demand.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

7.5 Strategic Priorities and Implications for the Acute Market

NHS Bedfordshire's priority is to drive the benefits from competition to achieve a consistent high quality of provision and strong performance against key performance indicators from all our key providers and to offer high quality choice.

We will need to use all the contracting mechanisms available to us to achieve these aims. Where appropriate we will market test services, both in response to identified problems but also to stimulate innovation, and increase patient choice and drive up standards.

We will continue to work effectively with other lead commissioners.

It will also be important that the PCT continues to use choice as a key mechanism for delivering quality improvements.

Market Development is another key lever which in turn will enable us to stimulate change and drive up quality. NHS Bedfordshire has started to work with new providers and will continue to do so to enable new skills and expertise to re-energise the health system.

NHS Bedfordshire will work with providers to ensure contracts are linked to care pathways through programme budgeting and will ensure providers report activity and outcomes against the 23 programme budgets.

7.6 Community Services

NHS Bedfordshire has committed to spend an additional £46million to increase capacity within Primary and Community Care services.

NHS Bedfordshire will proactively stimulate the market to ensure a range of effective community services that support the shift of emphasis from Acute care is commissioned.

Services currently provided by Bedfordshire Community Health Services will be covered by waiting time guarantees from April 2009. These include the following:
Adult: Acquired Brain Injury, Nutrition and Dietetic Service, Podiatry, Continence, Occupational Therapy, Community Nursing, Intermediate Care, MacMillan Nursing, Neurorehabilitation, Speech and Language Therapy
Child: Nutrition and Dietetic Service, Podiatry, Continence, Paediatric Medical Service, Paediatric Community Nursing, Health Visiting, Intermediate Care, School Nursing, Speech and Language Therapy.
Progress in Wheelchairs and Dental Services.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

7.7 Providers of Primary Care

We have 277 GPs in 58 practices across NHS Bedfordshire. Of these, 27 practices operate under the nGMS (new general medical services contract), 28 are PMS (personal medical services) practices, two are APMS (alternative provider medical services) and one is PCTMS (PCT medical services).

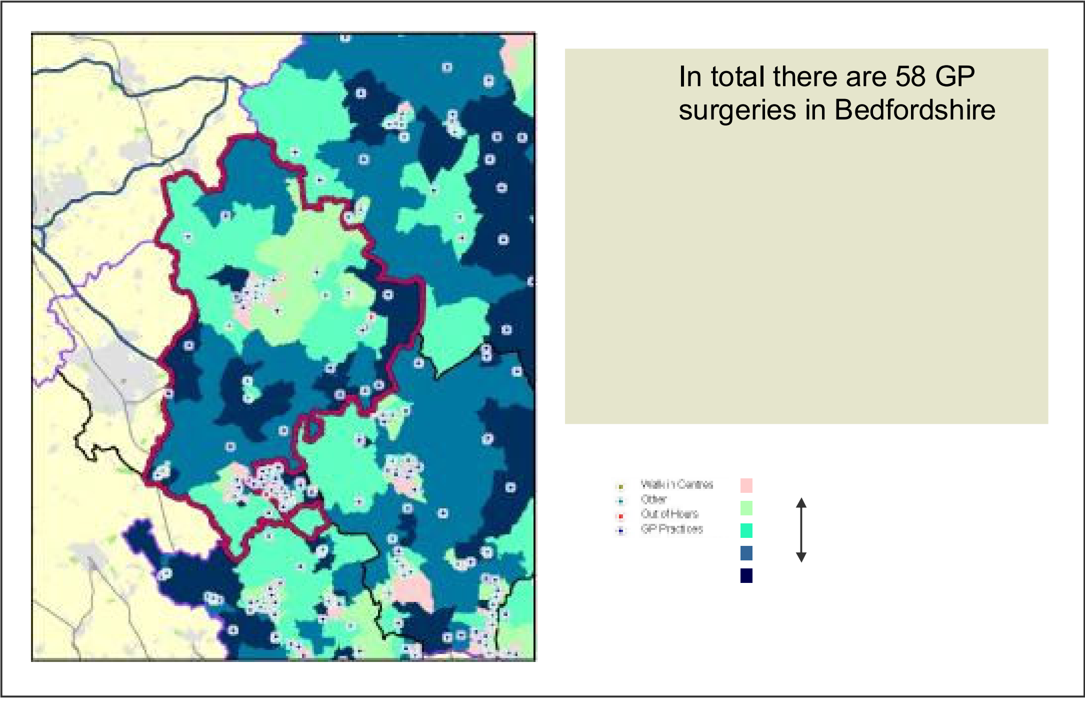


Figure 13 - GP practices mapped over population density

General practitioners in Bedfordshire are formed into four Practice-Based Commissioning (PbC) groups and a number of individual practiced based commissioners.

GPs, practice nurses and teams are required to provide essential and additional services, under the terms of their contract. These are defined as:

- Cervical screening services.
- Child health surveillance services.
- Minor surgery.
- Maternity medical services (excluding intrapartum care).
- Contraceptive services.
- Childhood immunisations and vaccinations.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Enhanced services are commissioned separately. These are broken down as follows:

• Directed Enhanced Services	PCTs must commission these but GPs do not have to provide them.
• National Enhanced Services	PCTs may commission according to local priorities, GPs can choose to provide them.
• Local Enhanced Services	Developed and agreed locally by PCTs together with GPs.

There are 26 dispensing practices serving rural areas where a pharmacy may not be viable and 23 training practices across NHS Bedfordshire.

The majority of general practice services in Bedfordshire are developed from premises owned and maintained by GPs. The primary care estate is variable in quality and much is no longer fit for purpose.

In areas of high demand new models of commissioning primary care access are being considered alongside the premises redevelopment, for example early consultation with the population on the new Station Quarter premises redevelopment has shown that their priority is a Walk in Centre. Therefore in areas of high demand and deprivation additional resources will be invested to address health improvement and reduce inequalities.

We will utilise all available contract levers, outcome measures, patient satisfaction measures, and available quality in order to drive up quality of providers of primary care. A balanced scorecard and set of key performance indicators have been developed which identify initial standards required.

Shortfalls in GP premises and facilities capacity was measured and quantified in 2007, LIFT was established in July 2008 as the delivery vehicle to work alongside other procurement of capacity routes.

NHS Bedfordshire has identified insufficient primary care capacity and in response a major improvement programme is in development including improved and expanded primary care facilities in:

- Queen's Park, Bedford
- Goldington, Bedford
- Shortstown, Bedford
- Cauldwell, Bedford
- Bedford town Centre (2 sites)
- Kempston
- Cranfield
- Wixams (new town)
- Sandy
- Biggleswade
- Shefford
- Flitwick

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Leighton Buzzard
- Houghton Regis
- Dunstable (2 sites)

All include additional capacity for primary care and enhanced services and many bring together 2 or more existing practices.

NHS Bedfordshire is committed to delivering high quality cost effective and appropriate care. It is important to ensure care delivered meets the needs of the population of Bedfordshire. Appropriate access to all care provision is essential and primary care is seen as the gateway to health services.

Patient Access Survey results are mainly satisfactory although there is the occasional failure related to contingency arrangements. Each patient access survey will be formally reviewed and the strategy will be to ensure that practices are responding to the needs of patients and have appropriate contingency arrangements in place. These results will also form part of the new PBC Scorecards and practice reviews. Links between access to a GP and secondary care usage will also be monitored through PBC.

As well as the Patient Access Survey the PCT will use other local intelligence to triangulate the results in a more local context. This will include public consultation before commissioning new premises, a PCT commissioned qualitative patient survey. In addition, this will include focus groups which will target vulnerable groups who may be experiencing difficulty in accessing primary care. The results from these will support both monitoring of current services and future action plans.

7.8 Pharmacy Provider Landscape

Bedfordshire has 72 community pharmacies (one of which is an internet pharmacy). Two pharmacies are contracted to open at least 100 hours a week, many others also open extended hours. NHS Bedfordshire also has 24 Dispensing GP practices which provide medication for rural patients. The areas with greatest deprivation generally have good access to community pharmacies or dispensing practices.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

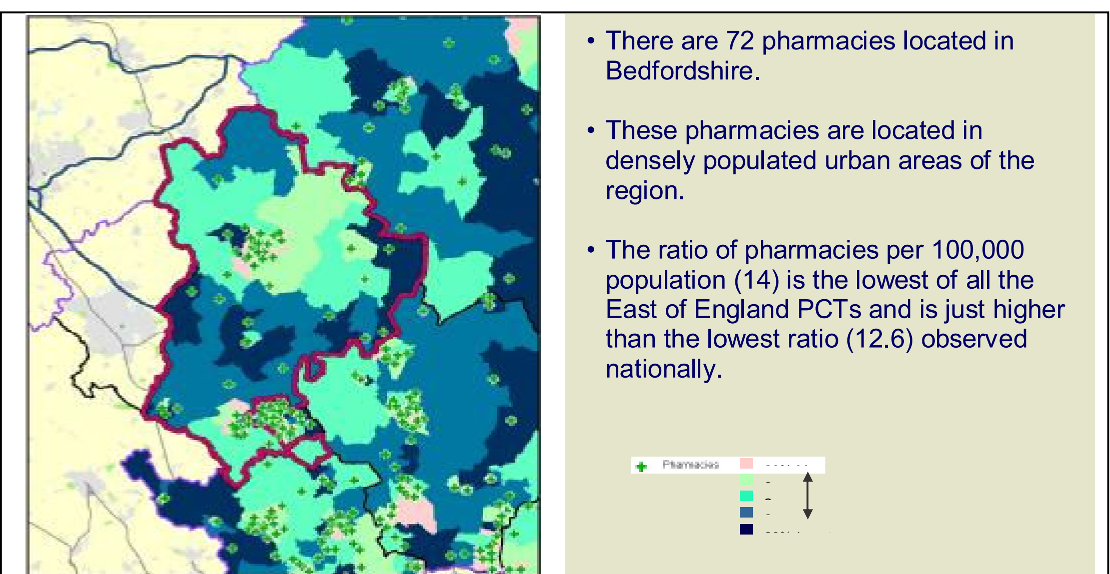


Figure 14 - Pharmacies provider landscape

Medication is the most common interaction with patients, however many patients would additionally benefit from further healthcare interactions whether relating to an existing long term condition or to prevent ill health. Utilising contracting flexibility would allow patients more choice and convenience.

The majority of NHS spend on community pharmacy is currently for dispensing prescriptions. Traditionally pharmacies and pharmacists have been poorly utilised by the NHS to provide other services for the local population. Pharmacies are required to provide Essential services under their contract and may also provide Additional and Enhanced services.

Additional and enhanced services currently provided by community pharmacies in NHS Bedfordshire are:

- Medication usage reviews.
- Needle exchange.
- Supervised methadone consumption.
- Provision of emergency hormonal contraception (EHC).
- Smoking cessation and other health improvement advice.

Community pharmacy needs to be utilised more effectively to achieve the strategic health objectives of NHS Bedfordshire. To stimulate an innovative market community pharmacy need to be aware of the health needs of the PCT and fully engage with the commissioning process. Commissioners too need to be aware of the strengths and potential of community pharmacy as highlighted in “Pharmacy in England: Building on strengths – Delivering the future” (White Paper).

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

NHS Bedfordshire aims to:

- Maximise the use of generically available drugs.
- Ensure evidence based prescribing to improve health and prevent illness.
- Implement a local strategy to reduce waste medication.
- Improve use of repeat dispensing and electronic prescribing.
- Develop clear, robust, evidence based guidelines to support safe, effective and cost-effective use of medicines within all commissioned services.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

7.9 Pharmacy Access and Choice – Market Stimulation

NHS Bedfordshire will utilise any changes to the pharmacy control of entry regulations, which might arise following the publication of the white paper on Pharmacy, to further ensure that provision of pharmacy services meet the health needs of the population, particularly in areas of greatest deprivation. Pharmacies will also be able to deliver a much wider range of healthcare services directly commissioned by NHS Bedfordshire to meet the specific local needs of the population. This will include Darzi health centres and other developments set up to meet the needs of the growing and ageing Bedfordshire population.

Community pharmacies traditionally attract a mixed client group from the local community, not just the unwell. Areas with greatest deprivation have good access to community pharmacies, many of which open extended hours. Medication is the most common healthcare intervention, which makes pharmacists the healthcare professionals that many people most see. This makes them well placed to deliver a range of additional services, particularly around health promotion.

7.10 Dentistry

Over half of the dental providers in NHS Bedfordshire are currently accepting new NHS patients. Since the new contract for dentists was introduced in April 2006 the number of patients seen under the NHS in the previous 24 months in NHS Bedfordshire has risen from 201,929 to 215,822.

	Number of patients treated in the previous 2 year period
March 2006	201,929
March 2007	216,574
June 2007	216,168
March 2008	217,135
June 2008	215,822
% Change since March 2006	+6.9%

Table 9 - Patients treated in last 2 years

The first year of the new dental contract saw the proportion of the population of Bedfordshire to be seen by an NHS dentist increase from 51% to 55%. This increase compares favourably with both national and regional figures, see table below. In Luton there has been a slight drop from almost 53% to around 51% over the same period.

	31 March 2006			31 March 2007		
	Adult	Child	Total	Adult	Child	Total
NHS Bedfordshire	45.9%	67.1%	50.8%	49%	73.1%	54.5%
Luton PCT	50.3%	59.3%	52.6%	50.7%	52.6%	51.2%
England	51.7%	70.6%	55.8%	52%	70.7%	55.7%
East of England SHA	54.2%	71.6%	58.0%	55%	72.2%	58.5%

Source: NHS Dental Statistics for England 2006-07

Comparison of the proportion of patients seen (by adult/child) at local, national and regional level, in the previous 24 months ending 31 March 2006 and 31 March 2007

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

These data are supported by a postal survey of patient satisfaction sent to a random sample of patients from NHS Bedfordshire by the Dental Service Division of the NHS Business and Services Authority. From a total of 289 respondents, 89% reported that they were able to get an NHS dental appointment 'as soon as was necessary' and 76% were 'completely satisfied' with the dental treatment they received.

NHS Bedfordshire operates a "Patient Portal" which has been marketed locally and is proving effective through improved access via a single point of contact.

This increase in patient flow puts us in the 'green' category for Department of Health vital signs, which measure from March 2006, but do not look as healthy with respect to the East of England monitoring, which is measured from June 2007. However our overall increase compares well with decreases over the same period in the East of England and England as a whole.

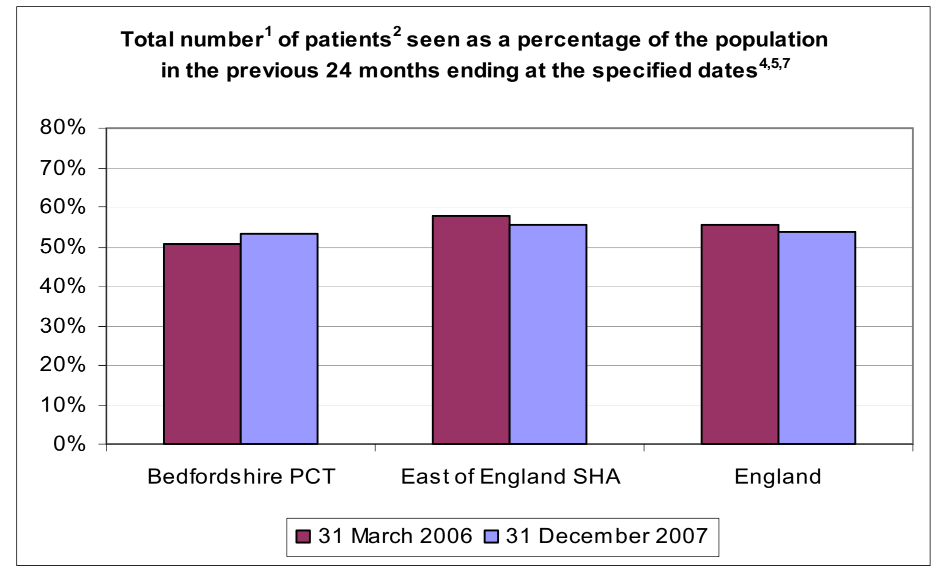


Figure 15 - Patients seen in Bedfordshire, East of England & England

Source: The Information Centre, NHS Dental Statistics for England – 2007-2008; Quarter 3; December 2007. PCT Fact Sheet, Bedfordshire PCT

NHS Bedfordshire commissions dental services that have an evidence-based preventative focus and are committed to adopting the *Delivering Better Oral Health* guidance. NHS Bedfordshire is reasonably well supplied with NHS dentists in comparison with the rest of the SHA and England (Figure 14)

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

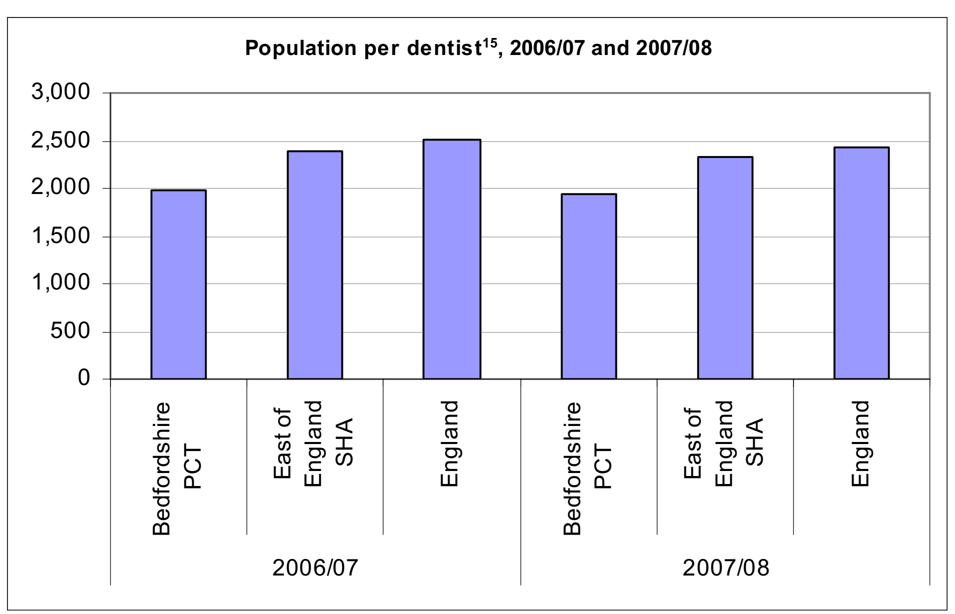


Figure 16 - Population per dentist

Source: The Information Centre, NHS Dental Statistics for England – 2007-2008; PCT Fact Sheet, Bedfordshire PCT.
http://www.ic.nhs.uk/cmsincludes/_process_document.asp?sPublicationID=1215441705907&sDocID=3249

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

7.11 ‘Heat’ Mapping of Geographical Dental Access

The East of England Public Health Observatory (ERPHO) was commissioned by the Strategic Health Authority to provide mapping of distance and time for dental access within each PCT. This exercise was designed to visually demonstrate locations with poor access.

The dental practices mapped are those that have contracts for a full range of NHS patients. The geographical distribution of general dental practices in NHS Bedfordshire with the blue area depicting those areas within a certain area of a dentist

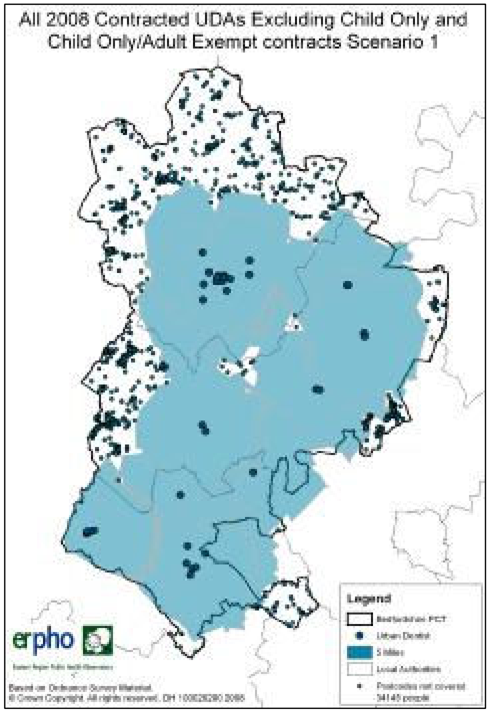
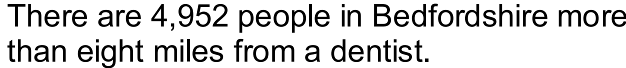


Figure 17 - Population within 5 miles of dentist

There are 34,145 people in Bedfordshire more than five miles from a dentist.



There are 4,952 people in Bedfordshire more than eight miles from a dentist.

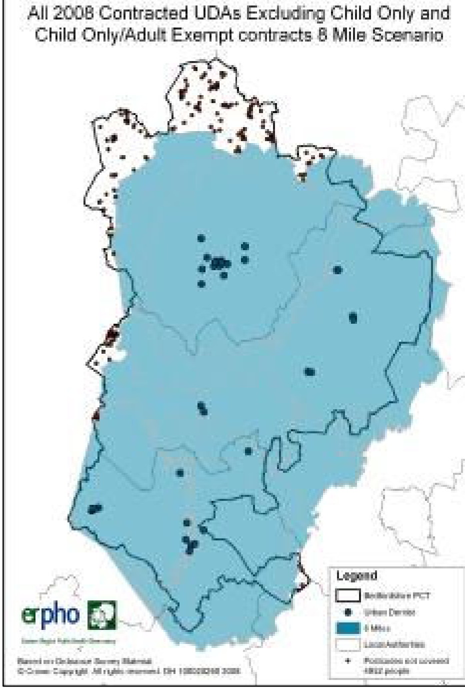
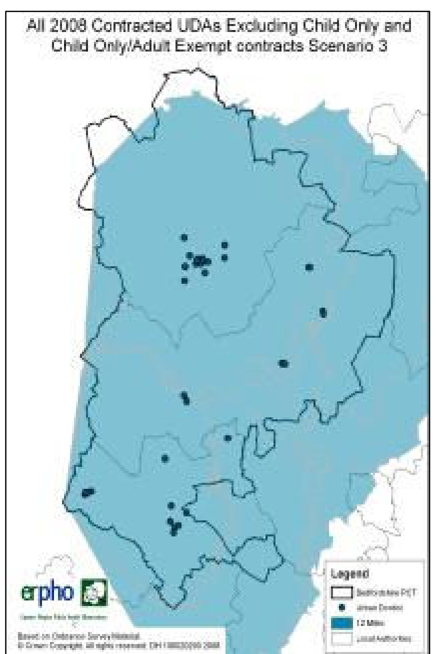


Figure 18 - Population within 8 miles of dentist

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com



The population of Bedfordshire within 12 miles of a dentist.

Figure 19 - Population within 12 miles of a dentist

The East of England Strategic Health Authority has also asked PCTs to consider the time taken for patients to travel to dental services. The areas of NHS Bedfordshire within 15 and 30 minutes travel time of a general dental practice. The majority of the population is within 15 minutes of a dental practice, and all except the very north of Bedfordshire are within 30 minutes.

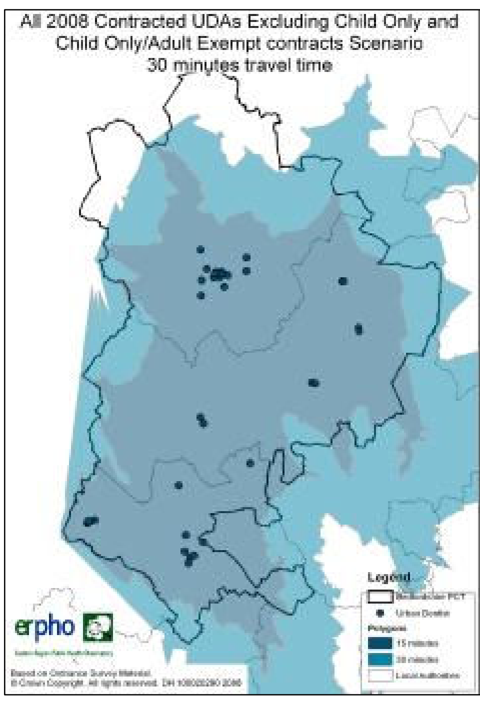


Figure 20 - Population within 15 and 30 minutes travel time of dentist

The 2003 Act states that a 'PCT has a duty to provide or secure primary dental services to the extent it considers reasonable'. In the light of this and the national and East of England targets, a draft of this paper and the mapping produced by ERPHO

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

were discussed at the Bedfordshire and Luton Oral Health Strategy and Commissioning Group on 2 September 2008. This group includes a range of dental professionals, NHS Bedfordshire representation and patient representatives. This group felt that a 12 mile distance to a dental practice would be set for those areas not already covered by the five and eight mile distances. Nevertheless, the salaried dental services do provide mobile and domiciliary services for those people who are housebound and immobile.

Overall NHS Bedfordshire has good levels of access to primary dental services. This is evidenced within the Oral Health Needs Assessment for Bedfordshire and Luton PCTs Working Document September 2008 and from the NHS Dental Statistics for England and a recent postal survey patient satisfaction survey.

The Bedfordshire JSNA identifies specific groups of concern. These include homeless, looked after children, prisoner and young offenders, people with mental illness, black and minority ethnic groups, travellers and those with disabilities.

7.12 Community Health Services (PCT Managed)

The provider services operate as an Arms Length Trading Organisation (ALTO) under the name of Bedfordshire Community Health Services. This incorporates a range of services provided outside of hospital, many of which are not natural partners. These include: adult and children's community nursing; intermediate care; therapies; dentistry; drug and alcohol services; health services within HMP Bedford; and community bedded units in Biggleswade and Bedford.

Pathway Redesign

As part of pathway redesign, we have commissioned a series of service reviews to ensure that services meet the needs of the Bedfordshire population and that the services have the skill set and capacity to deliver appropriate, high quality care in a timely way (maximum referral to treatment of 18 weeks for planned services) as part of an overall patient pathway. The reviews will measure quality, accessibility, cost effectiveness and priority. Wherever possible, they will be undertaken with the Local Authority.

Future Position of Community Health Services

The Board of NHS Bedfordshire has decided to pursue service and pathway integration with other providers, as the preferred option for the next steps for the ALTO. This will result in NHS Bedfordshire ceasing to be a provider of services by April 2010.

This will help to improve the responsiveness of community services, whilst ensuring choice, competition and contestability.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Our strategy sets out ambitious targets for investment into primary and community services. The range of high quality and safe community services that we commission will be central to the success of this strategy.

As a World Class Commissioner we will specify the range of services required to support care closer to home in the community. We will actively use the market to secure these services

7.13 Independent Care Providers (Nursing Homes)

There are 30 independent Nursing Homes in Bedfordshire, which provide directly and indirectly commissioned care to the population of Bedfordshire. The PCT has developed a contract in conjunction with the local authority for directly commissioned care, in order to drive up the quality of care provided. The independent sector is key in delivery of continuing health care and continuing care. The PCT will work in partnership to ensure safe and effective care is maintained e.g. NHS Bedfordshire will support programmes of infection control training. This partnership will also investigate their future role in the shift from secondary to primary care.

7.14 Mental Health Services

There are three main providers of mental health services to Bedfordshire. The largest contract is with Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (BLPT). The other providers are Cambridgeshire and Peterborough Foundation Trust and Hertfordshire Partnership NHS Foundation Trust.

BLPT provides the majority of mental health and learning disability services to Bedfordshire residents. NHS Bedfordshire has been working closely with the Board of BLPT to improve patient experience and outcome. The option to market test mental health services has not been ruled out.

Unlike acute and specialist provision there is a lack of Mental Health providers locally, and secure facilities are more limited. This has the potential to reduce the benefits related to competition and impacts on choice.

NHS Bedfordshire purchases a number of placements from private providers, particularly for people with learning disabilities and for those requiring Elderly Mentally ill nursing and residential care.

NHS Bedfordshire will market test the Improving Access to Psychological Therapies service, following the initial pilot period across a range of providers including the Third Sector. We are also considering market testing for specialist Learning Disability provision and future dementia care.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

7.15 Developing the Local Market

Background

The NHS is making the transition from a centrally controlled system with prescribed pathways of care and single, controlled means of supply to a more competitive, diverse system in which patients can exercise greater choice of provider and treatment. The Provider Landscape is already changing as Foundation Trusts are established, private provision is increasing and the third sector is playing a greater role in the provision of services to the NHS. The healthcare marketplace that is emerging, although opening up to new providers, remains very structured and one in which Primary Care Trusts (PCTs) play a leading role in managing as leaders of the local health system. PCTs build local health system.

NHS Bedfordshire will play its full role as a PCT building local health systems by delivering the following benefits for their patient population

- Improving quality and safety in service provision
- Improving health and wellbeing
- Improving standards of, and reduced inequalities in, access and outcomes
- Informed patients – with a 'voice and choice'
- Greater confidence in the NHS
- Better value for money

Benefits of managed choice and competition are:

- Providers encouraged to be innovative and respond to need
- Efficient use of resources
- Fair and effective competition
- A strong reputation and NHS brand
- Nationwide consistency of approach

In order to achieve the realisation of these benefits the following is required:

- Empowered patients
- Empowered commissioners
- A self-improving system that lives within its means
- High-quality information
- A wide range of providers
- Service continuity where needed
- Regulatory clarity
- Clear system rules
- Innovative suppliers who embrace patient choice

How will NHS Bedfordshire develop local healthcare markets?

Over the next five years, starting in 2009/10 the delivery of NHS Bedfordshire's strategic objectives will require more services to be delivered differently if the

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

challenges of population change and healthcare needs are to be met. Effective and well managed market development is recognised as a powerful tool to stimulate the entry of new and different providers as well as stimulating innovation across the health system.

To ensure that these benefits can be fully realised locally NHS Bedfordshire will be adopting a five year strategic plan to identify areas where a market development approach can be used to realise greatest potential benefits.

Local Market Development Activities

During 2009/10 NHS Bedfordshire will be undertaking the following activities in relation to developing the local healthcare market.

1. Disaggregate and rationalise provider services previously delivered by an internal 'provider arm' organisation. Where appropriate these services will be opened to a market approach in order that high quality and value for money can be realised.

2. Develop improved intelligence regarding current and potential providers and use this information to inform the commissioning and contracting processes.

3. Develop an online provider directory to support commissioning and contracting processes.

4. Develop a commercial strategy with the appropriate support of the East of England Strategic Health Authority, Commercial Unit and independent consultants as required. This will set out the organisations' approach to engaging in commercial activity and will provide further detail as to how NHS Bedfordshire will:

    - Develop a framework for commercial activity
    - Develop partnerships with contracted suppliers
    - Manage the potential impact upon staff resulting from changes to the supplier landscape
    - Manage the entry into the market place for all potential providers ensuring a 'level playing field'

5. Develop a communication platform that will provide our patient population with information with which informed choices can be made regarding their health care.

Locally managed markets need a sustainable framework that is supported by thorough contract and supplier management, delivering high quality care for patients and the best value for taxpayers. In order to do this it is necessary to assess the local health care market to understand the drivers in the market and how they operate to create potential areas for future market development. East of England Strategic Health Authority (SHA) commissioned Price Waterhouse Coopers (PWC) to deliver a Health Market Analysis (HMA) toolkit for each of the region's 14 primary care trusts. This is important as a toolkit for the expanding professional team engaged within NHS Bedfordshire to develop the provider landscape and it is explained in summary in the next section.

Created by Neevia Document Converter trial version http://www.neevia.com

PDF created with pdfFactory Pro trial version www.pdffactory.com

Market Analysis: Methodology

The Health Market Analysis toolkit uses a number of datasets related to NHS transactions (programme budgets), population and lifestyle factors. The variables are modelled in the toolkit and demonstrate how they combine to change demand for services in the future.

The underlying principal objectives of Health Market Analysis are to:

- Present a structured approach to market analysis and stimulation
- Support building the case for change
- Develop internal capacity to analyse markets

Health Market Analysis (HMA) uses a six stage process to enable commissioners to understand areas for potential market development and therefore inform the contract landscape.

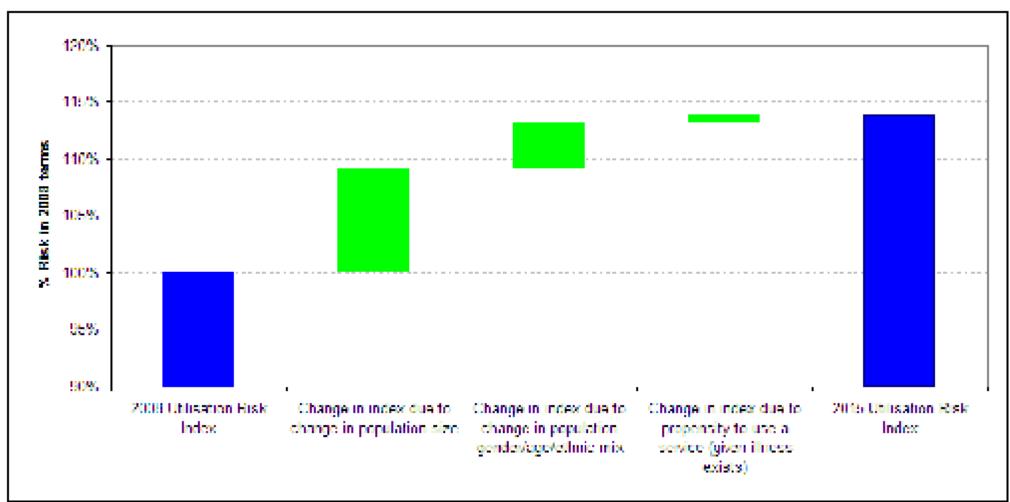
1. Market Segmentation
2. Demand Forecasts
3. Service Analysis
4. Economic Attributes
5. Priorities
6. Options

The HMA process is a tool for forecasting potential demand and therefore helps in determining clinical services as candidates for market development. Demand Forecasts provide the 'case for change'. Nationally available population and lifestyle data sets are used to assess likely future demand.

The outcome of the demographic analysis is an 'utilisation risk index' for each Programme Budget category that quantifies the risk of an increase in service utilisation resulting from changes in the population variable in the previous box. This is presented in the form of a bridge diagram that describes how the changes in the six criteria listed above are likely to change the level of expenditure for a given programme budget category.

The diagram below shows the current utilisation risk of 100% for maternity services in Bedfordshire in 2008, in the left hand blue column. The right hand blue column shows the adjusted risk in 2015 taking into account the changes in population and the features of the population. This shows that there is likely to be a 13.2% increase in demand for maternity services by 2015, which is greater than the estimated 9.2% growth in population.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com



Headline Results of Bedfordshire Health Market Analysis

The seven stage market analysis for Bedfordshire described above enables forecasting of where the potential greatest areas of need are likely to be in the next 5-10 years and therefore where the likely areas for market development may occur. Areas for market development currently identified in the HMA are:

1. Delivering more maternity services outside of the acute setting
2. Delivering more CHD services outside of the acute setting
3. Enhancing and managing competition in mental health services
4. Enhanced market management for cancer services
5. Improving access to services for those with circulation problems

Programme Budgets

Underpinning the analysis of markets is the use of Programme Budgets. Programme Budgets are used by the NHS to produce clear information as to where funding is spent according to clinical areas. The Health Market Analysis toolkit uses the 23 programme budget categories identified in the following table as the baseline data upon which the potential size (£) of markets can be determined.

Programme Budget data is collected as part of the financial returns commissioning organisations make to the Department of Health each year[1]. The data is retrospective and provided by suppliers however national guidance states:

> "Aspiration is that responsibility for the production of the programme budgeting data will lie solely with commissioning PCTs….. It is the opinion of the NHS that Programme Budgeting can only

[1] As per instructions set out in Chapter 11: Programme Budgeting Guidance 2007-08 of the NHS Finance Manual (for more information see http://www.dh.gov.uk)

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

become a pure commissioner return when HRG version and tariff align. This being the case, 2009-10 is likely to be the earliest opportunity for this to occur."[2]

Anticipating this, from 2009/10 NHS Bedfordshire will use Programme Budgeting to underpin the implementation of the organisation's five year strategic plan in addition to the development of local healthcare markets.

[2] Chapter 11: Programme Budgeting Guidance 2007-08 of the NHS Finance Manual, p10.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Programme Budget (PB) Categories

PB category number	PB category
1	Infectious Diseases
2	Cancers & Tumours
3	Blood Disorders
4	Endocrine, Nutritional and Metabolic Problems
5a	Substance Misuse (sub-category of Mental Health Disorders)
5b	Organic Mental Disorders (sub-category of Mental Health Disorders)
5c	Psychotic Disorders (sub-category of Mental Health Disorders)
5d	Child and Adolescent Mental Health Disorders (sub-category of Mental Health Disorders)
5x	Other Mental Health Disorders
6	Learning Disability Problems
7	Neurological
8	Eye/Vision Problems
9	Hearing Problems
10a	Coronary Heart Disease (sub-category of circulation problems)
10b	Cerebrovascular disease (sub-category of circulation problems)
10c	Problems of Rhythm (sub-category of circulation problems)
10x	Other - Problems of circulation (sub-category of circulation problems)
11a	Obstructive Airways Disease (sub-category of RSP)
11b	Asthma (sub-category of RSP)
11x	Other - Problems of the respiratory system (sub-category of RSP)
12	Dental Problems
13	Problems of the gastro intestinal system
14	Skin Problems
15	Musculo Skeletal System Problems (excludes trauma)
16	Trauma & Injuries (includes burns)
17a	Genital tract problems (sub-category of Genito Urinary System)
17b	Renal problems (sub-category of Genito Urinary System)
17c	STD (sub-category of Genito Urinary System)
17x	Other - Problems of Genito Urinary System (sub-category of GUS)
18	Maternity & Reproductive Health
19	Neonate Conditions
20	Adverse effects of Poisoning
21	Healthy Individuals
22	Social Care Needs
23a	GMS/PMS
23b	Training (Workforce Development Confederation) Expenditure
23x	Miscellaneous

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

8 Impact of Challenges on our Future Finances

NHS Bedfordshire has set ambitious goals. Money will be tight over the next five years. Delivering NHS Bedfordshire's strategy will require:

- **Increased efficiency savings.**
- **Rigorous fair and transparent prioritisation.**
- **Selling assets which are not fit for purpose and reinvesting the proceeds in appropriate, modern facilities.**
- **Spend on acute and specialist services currently consumes circa 45% (£229m) of our income, whilst spend on out of hospital services consumes 55% (£276m). This balance will need to change.**
- **NHS Bedfordshire's income will rise from a current £505.6m in 2008/09 to £644.2m in 2013/14. Our investment plans demonstrate how this will be spent.**

8.1 Current Financial Situation

NHS Bedfordshire ended 2007/08 with a small revenue surplus of £133k, after successfully implementing a financial 'turnaround' plan in excess of £35m.

The Trust therefore moved into 2008/09 in overall financial balance and with no historic deficit.

A balanced financial plan for 2008/09 totalling £505m was approved by the Trust Board in May 2008. This represented a set of realistic but challenging budgets, and included a small uncommitted contingency sum of £3.2m (0.6%).

The lessons learned from last year's turnaround process have been incorporated into updated systems and processes across the organisation. A programme of re-skilling all budget managers and supporting finance staff has been implemented, and on-going financial monitoring and forecasting procedures have been strengthened.

NHS Bedfordshire remains on target to achieve a break-even out turn for 2008/09. Under-spending evident during the first half of the current financial year will not be maintained at the same level in the coming months as the recruitment process continues to fill staff vacancies frozen during the financial recovery of last year.

Financial pressures remain evident on acute activity levels/costs, and the implementation of NICE guidance will increase other costs during the second half of this year. Expenditure linked to the restructuring of 'corporate' NHS Bedfordshire into

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

a World Class Commissioning organisation will also increase towards the end of 2008/09.

All of these costs, together with those relating to other financial pressures that may become evident will be contained within the existing overall budget provisions thus enabling statutory targets to be met for the year end.

The full year implications of these pressures and initiatives will be built into the financial plans for 2009/10 and future years.

8.2 Future Position

Revenue resource allocations for 2009/10 and 2010/11 have now been announced by the Department of Health which confirm an increase in resources for NHS Bedfordshire of 11.9% over the two year period.

The baseline allocation for 2009/10 is confirmed as £552.0 million, and for 2010/11 £585.4 million, and these details now form the basis of the financial plan for the early years of the strategy.

The total for 2010/11 does however still leave the resources allocated to NHS Bedfordshire some 3.5% below the Department of Health calculation of fair share allocation.

For 2011/12 and beyond, resource assumptions have been made based on best available current information, but given the continuing uncertain national economic situation, a series of 'realistic' and 'worst' case scenarios have been built into our plans.

Assumptions are:

- Future "health inflation" to commissioners reflects a 3% productivity gain. The net average increase is 2.5% in acute service prices for the first 2 years including CQVI, reducing to 1% for the remaining 3 years. The same assumption has been made for non tariff based costs at this stage.

- Prescribing costs assume a year on year 6% uplift.

- No additional central funding will be made available to cover predicted population growth during the period, and that costs associated with this will need to be contained within funding parameters noted below.

- The return of deposits held by NHS East of England have been factored into the resource totals over the period, with a residual figure of £3m assumed as still being retained at the end of 2013/14.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Realistic Case Financial Projections	Financial Year					
	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Growth Assumptions:	5.46%	5.50%	6.05%	4.00%	4.00%	4.00%
Closing Recurrent Baseline	**483,955**	**510,389**	**551,987**	**585,386**	**608,801**	**633,153**
Non-Recurrent Adjustments made recurrent in 2009/10	0	12,821	0	0	0	0
Opening Recurrent Baseline	**483,955**	**523,210**	**551,987**	**585,386**	**608,801**	**633,153**
Growth Uplift	26,434	28,777	33,399	23,415	24,352	25,326
Recurrent Resource Baseline	**510,389**	**551,987**	**585,386**	**608,801**	**633,153**	**658,479**
RAB Carry Forward Surplus/(Deficit)	133	0	0	0	0	0
East of England Strategic Deposit	-9,000	1,500	3,500	450	300	55
Non-Recurrent Adjustments	4,155	-9,143	-12,686	-13,193	-13,720	-14,269
Brokerage Repayment	0	-2,000	0	0	0	0
Total Available Resource Limit	**505,677**	**542,344**	**576,200**	**596,058**	**619,733**	**644,265**
Total Resource Expenditure inc Cost Pressures, Inflation & Population Growth and Initiatives	**505,677**	**542,344**	**576,200**	**596,058**	**619,733**	**644,265**
Surplus/(Deficit) for investment	**0**	**0**	**0**	**0**	**0**	**0**

Table 10 - Realistic case financial projection

The ‘realistic’ case produces a break even position across the strategic period whilst ensuring that a reasonable level of contingency funds is maintained.

Worst Case Financial Projections	Financial Year					
	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Growth Assumptions:	5.46%	5.50%	6.05%	2.50%	2.50%	2.50%
Closing Recurrent Baseline	**483,955**	**510,389**	**551,987**	**585,386**	**600,020**	**615,021**
Non-Recurrent Adjustments made recurrent in 2009/10	0	12,821	0	0	0	0
Opening Recurrent Baseline	**483,955**	**523,210**	**551,987**	**585,386**	**600,020**	**615,021**
Growth Uplift	26,434	28,777	33,399	14,635	15,001	15,376
Recurrent Resource Baseline	**510,389**	**551,987**	**585,386**	**600,020**	**615,021**	**630,396**
RAB Carry Forward Surplus/(Deficit)	133	0	0	0	0	0
East of England Strategic Deposit	-9,000	1,500	3,500	450	300	55
Non-Recurrent Adjustments	4,155	-9,143	-12,686	-13,193	-13,720	-14,269
Brokerage Repayment	0	-2,000	0	0	0	0
Total Available Resource Limit	**505,677**	**542,344**	**576,200**	**587,277**	**601,601**	**616,182**
Total Resource Expenditure inc Cost Pressures, Inflation & Population Growth and Initiatives	**505,677**	**542,344**	**574,940**	**596,123**	**616,819**	**636,359**
Surplus/(Deficit) for investment	**0**	**0**	**1,260**	**-8,846**	**-15,218**	**-20,177**

Table 11 - Worst case financial projection

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

The ‘worst case’ resource assumptions would mean a reduced level of new growth money equivalent to £28m per annum by 2013/14. This would clearly have a significant impact on investment plans for 2011/12 and beyond and would mean that a number of the planned initiatives for that period would need to be re-phased or deferred.

8.3 Allocation of Additional Resources

The bridge diagram below shows how the additional funding of £139m between 2008/09 and 2013/14 will be spent.

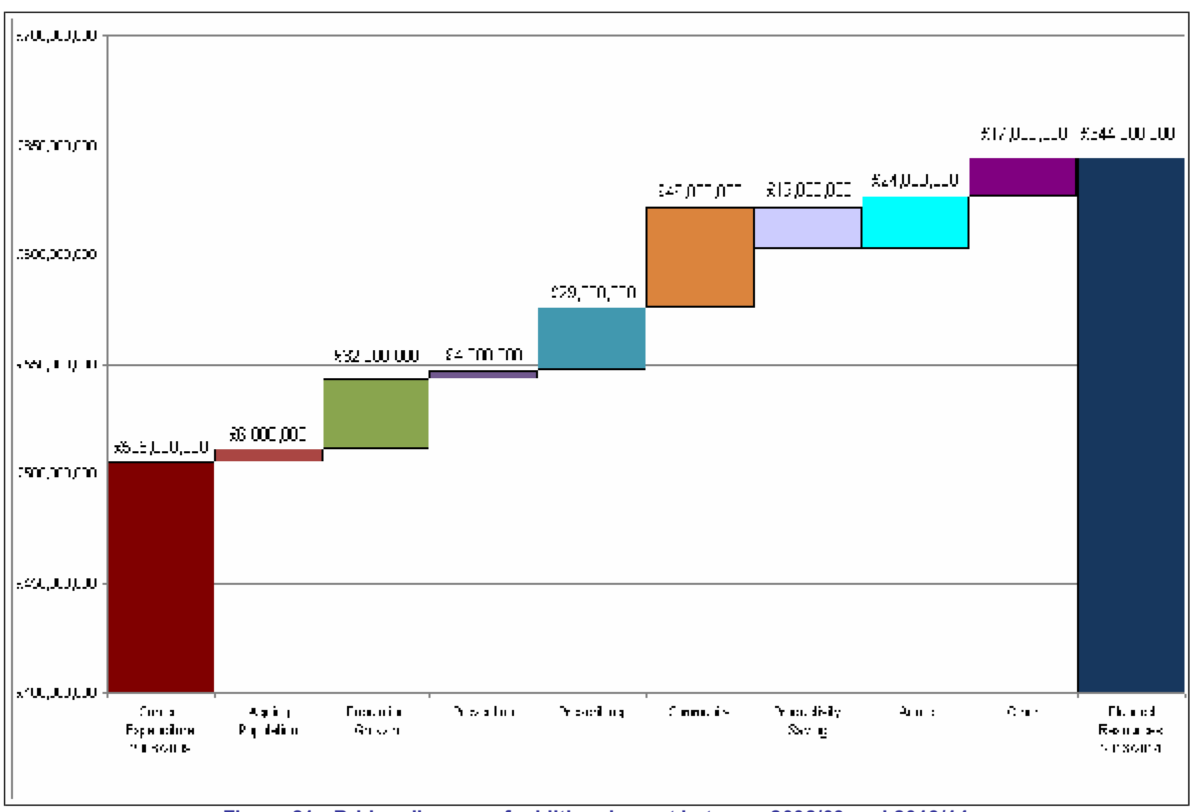


Figure 21 - Bridge diagram of additional spent between 2008/09 and 2013/14

Specifically, we must compare the position now with the position in 2013/14:

- The population of Bedfordshire is expected to increase as people live longer. This will cost an additional £6m.

- Bedfordshire is also an area targeted for new housing developments and its population is expected to increase by 5.6% by 2013/14. It is estimated that the additional cost of health service provision relating to population changes will be £32m.

- We plan to invest more money (£4m) into prevention.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- This is likely to be supported by an increase in prescribing and we estimate that this will cost an additional £29m.

- We also plan to increase the capacity within primary and community care and an additional £46m funding has been allocated to this strategic priority.

- This will be partly financed by productivity savings of £19m in hospital referrals and emergency admissions.

- We intend to focus resources in acute hospitals on those that need it. Although funding for this sector will increase over the period by £24m, the allocation will be less than inflation and therefore funding will be reduced in real terms.

> - Of this increase in income of circa £139 million 16% (£23m) will be spent on acute and specialist services, the remaining 84% (£116m) will be spent on out of hospital services.
> - This represents a significant shift in the focus of our spend by 2013/14. The balance of spend shifts to 39% (£252m) on acute and specialist services and 61% (£392m) on out of hospital services.
> - The delivery of our strategy will require changes to the role and ways of working of existing hospitals.

Created by Neevia Document Converter trial version http://www.neevia.com

PDF created with pdfFactory Pro trial version www.pdffactory.com

8.4 Strategic Themes

Detailed implementation plans in Appendix A of this document set out the changes required across the life pathway from birth to life:

- Staying healthy
- Mental health, including drug users
- Maternity and new born
- Children's services
- Planned care, including dental
- Acute care
- Long term conditions
- End of life care

The funding associated with these themes are detailed below

Pathway £'000		09/10	10/11	11/12	12/13	13/14
Staying Healthy		333	609	1,423	1,437	1,452
Mental Health, Including Drug Users		380	390	393	397	401
Maternity and New Born		693	710	717	725	732
Children's Services		145	1,675	2,620	2,646	2,673
Planned Care, Including Dental	Productivity Gain	(1,310)	(2,620)	(2,646)	(2,673)	(2,699)
	Service Redesign (savings)	(4,721)	(7,161)	(7,233)	(7,305)	(7,378)
	Service Redesign (costs)	5,000	10,000	10,100	10,201	10,303
Acute Care	Productivity Gain	(3,522)	(3,610)	(3,646)	(3,683)	(3,719)
	Service Redesign (savings)	0	(5,922)	(4,752)	(4,800)	(4,848)
	Service Redesign (costs)	1,857	9,000	9,090	9,181	9,273
Long Term Conditions		2,000	3,000	3,030	3,060	3,091
End Of Life Care		1,004	4,000	4,040	4,080	4,121
Total		**4,859**	**10,071**	**13,136**	**13,266**	**13,402**

Table 12 - Funding across 8 strategic priorities

8.5 Prioritisation of Investment

NHS Bedfordshire's strategy is ambitious. Resources, in terms of money, change management capacity and infrastructure are limited. Resources are likely to be further stretched as our population grows. Delivering the strategy will require us to focus

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

efforts where they have the greatest impact. The operational plan sets out what actions we will take to do this each year.

Over the life of the strategy, we will increasingly require cash releasing savings and new growth money to support the introduction of new initiatives which cannot be delivered through redesign of existing pathways and use of existing budgets. A high priority for NHS Bedfordshire, therefore, is to drive efficiency.

It is recognised that focusing hospital services on those that need it and maximising the impact of local out of hospital services will not only improve patient experience but also drive the effective use of resources. The pace of change will be driven by our ability to identify efficiency savings in more traditional ways of working that we can reinvest into doing things in new, more effective ways.

We will keep this under continual review and closely monitor progress in achieving cash releasing efficiency savings.

We have put a scheme of delegation in place with Practice Based Commissioners to facilitate innovation and the speedy introduction of change in line with this strategic theme. Building on this, we are developing a system to support PBCs to take a similar approach with each of the 23 programme budgets: reviewing care within the programme budgets in line with NHS Bedfordshire's strategy to identify efficiencies.

Reducing Health inequalities will also require a move from funding based on history to funding informed by an assessment of need. In order to drive the reduction of health inequalities, future Practice Based Commissioning funding will be informed by an estimate of need and population changes. It is expected that PBC gaining resources not only invest in treatment to respond to immediate need but also in prevention and work to reduce health inequalities.

In order to inform future years of the operational plan, we will also review initiatives through a prioritisation panel which considers:

- Fit with NHS Bedfordshire's strategy
- Health outcome
- Clinical effectiveness
- Cost effectiveness
- Equity
- Access
- Patient choice
- Affordability
- Needs of the community
- Quality
- Policy drivers
- Exceptional need

This will further drive the efficient use of resources. Our operational plan sets out each year's implementation plans.

As the panel develops, it will review not only new interventions but interventions within existing programme budgets to assess whether the current balance of funding across programme budgets is appropriate to meet our goals.

For further details also see Appendix F, Prioritisation Policy.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

8.6 Reshaping the Landscape through Programme Budgets

Our current resource limit of £505m is attributed across 23 programme budgets. We will assess current spend across providers and re-commission care against evidence based care pathways. This will mean changing what we spend across the 23 programme budget areas.

Shifting care closer to home will mean re-defining the role of acute hospitals. Capacity freed up within the secondary care sector provides an opportunity for secondary care providers locally to re-focus their skill and competencies in order to provide some additional services closer to home.

Programme Budget Analysis	2008/09 £'000
Cancers & Tumours	29,937
Mental Health	66,315
Circulation (CHD)	43,077
Respiratory	27,329
Gastro-Intestinal	31,865
Infectious Diseases	6,057
Blood Disorders	3,143
Endocrine, Nutritional and Metabolic	15,360
Learning Disability	18,632
Neurological	24,472
Eye / Vision	9,726
Hearing	1,451
Dental	26,561
Skin	9,694
Musculoskeletal System	19,513
Trauma And Injuries (including Burns)	24,650
Genito Urinary System	18,779
Maternity And Reproductive Health	21,548
Neonate's	1,078
Adverse Effects Of Poisoning	6,208
Healthy Individuals	6,947
Social Care Needs	7,628
Other	85,707
TOTAL	505,677

Table 13 - Spend across 23 programme budgets

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

8.7 Capital Investment Plan

A summary of the presently proposed capital investment plan is noted below.

The figures reflect the on-going block capital requirements for the replacement of IT and other equipment assets. They also include estimated sums for the future investment in the NHS Bedfordshire owned estate from 2009/10 onwards. These details will be reviewed and updated on completion of the PCT's estates strategy.

	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000	2013/14 £'000
Backlog maintenance and premises upgrades	740	760	780	800	820
IT/other equipment replacements	740	760	780	800	820
TOTAL BLOCK CAPITAL	**1480**	**1520**	**1560**	**1600**	**1640**
Completion of 08/09 projects (including Bedford Health village schemes)	820	0	0	0	0
Shires House Development	300	5000	1000	0	0
New Primary Care Facilities	2120	800	5000	5000	2000
Grants to Third Parties	2100	400			
Land Sales	(350)				

Table 14 - Block capital projection

Funding sources for these developments will be a combination of Department of Health capital resource allocation and funding secured via LIFT Co.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

9 Delivering our Strategy

Three strategic priorities will drive our implementation plans

1. **Investing a greater proportion of our money into prevention (healthy lifestyles, early intervention and promoting independence).**
2. **Creating effective support in local communities to reduce the reliance on hospital care, including in times of urgent need. This will mean:**
   - **Increasing the capacity within primary and community services to improve access to diagnostic and treatment services in local communities and focusing resources in acute hospitals on those that need it.**
   - **Ensuring shorter waiting times for treatment.**
   - **Respecting the wishes of patients about their care from birth to the end of their life.**
3. **Offering more choice and convenience, by commissioning quality services closer to home based on the needs and preferences of Bedfordshire patients.**

9.1 Overview

Detailed implementation plans in Appendix A of this document set out the changes required across the eight areas:

- Staying healthy
- Mental health, including drug users
- Maternity and new born
- Children's services
- Planned care, including dental
- Acute care
- Long term conditions
- End of life care

The three strategic priorities set out above emerge throughout all eight implementation plans.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

9.2 Links to Underpinning Plans

The table below illustrates how the initiatives link to our goals and world class commissioning metrics.

Goals	Better patient experience	Access to quality, safe clinically and cost effective local services.			Improving Health		Reducing Unfairness			
WCC Metrics / Initiatives	Patient experience	GP access	Access to dental care	Safety	Life Expectancy	Variation in emergency admissions	Drug Users in Effective care	Reducing Health inequalities	Cut smokers by 140,000	Childhood obesity
Staying Healthy	✔	✔		✔	✔	✔		✔	✔	✔
Mental Health, Including Drug Users	✔	✔		✔		✔	✔	✔	✔	
Maternity and New Born	✔	✔		✔	✔			✔	✔	
Children's Services	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Planned Care Including Dental	✔	✔	✔	✔	✔	✔		✔		
Acute Care	✔	✔	✔	✔	✔	✔				
Long Term Conditions	✔	✔		✔	✔	✔		✔	✔	
End of Life Care	✔	✔		✔		✔				

Table 15 - Initiatives linked to goals

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Pledges	Delivering A Better Experience For Patients				Improving Peoples Health			Reducing Unfairness In Health			
Towards the best, together / Initiatives	We will deliver year on year improvements in patient experience	We will extend access guarantees to more of our services	We will ensure that GP practices improve access and become more responsive to the needs of all patients	We will ensure that NHS primary dental services are available locally to all who need them	We will ensure fewer people suffer from, or die prematurely from, heart disease, stroke and cancer.	We will make our health service the safest in England	We will improve the lives of those with long term conditions	Working with our partners, we will reduce the difference in life expectancy between the poorest 20% of our communities and the average in each PCT	We will ensure healthcare is as available to marginalised groups and looked after children as it is to the rest of us	We will cut the number of smokers by 140,000	We will halt the rise in obesity in children, and then seek to reduce it
Staying Healthy	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔
Mental Health Including Drug Users	✔	✔	✔		✔	✔	✔		✔		
Maternity and New Born	✔					✔		✔	✔	✔	✔
Children's Services	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔
Planned Care Including Dental	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Acute Care	✔	✔	✔		✔	✔		✔	✔		
Long Term Conditions	✔	✔	✔		✔	✔	✔	✔	✔	✔	
End of Life Care	✔	✔	✔			✔	✔				

Table 16 - Initiatives linked to pledges

9.3 Strategic Initiative Summary Plans

The next section provides a summary of what the strategy will deliver. Appendix A contains detailed plans as to how this will be achieved.

9.3.1 Staying Healthy

A key aspiration for Bedfordshire is to increase life expectancy for its residents. To do this we must tackle the main causes of premature death: cancer, CHD/stroke; accidents; suicide and liver disease through:

- A life long prevention pathway.
- Promoting wellbeing.
- Reducing unfairness.
- Health partnerships.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

We will:

- Implement risk assessment for heart disease across all GP practices.
- Tackle childhood obesity through the implementation of EPODE type prevention approaches with schools and MEND obesity management programmes.
- Reduce the number of people who smoke.
- Develop a joint alcohol strategy with the local authority to reduce alcohol related harm.
- Develop integrated and personalised approaches to delivering lifestyle support services.
- Reduce inequalities in health through initiatives such as: targeting smoking cessation work on the 20% most deprived wards and GP practice populations; promoting the uptake of CVD prevention in most deprived wards; carry out a health equity audit of breast and cervical screening uptake; carry out a baseline audit of access to antenatal care to identify areas of late booking and provide teenage pregnancy programmes and projects.
- Continue to work very closely with the local authority to identify baselines, targets and effective interventions for current and future Local Area Agreement achievement.
- Develop Staying Healthy in the Workplace and roll this out across the county.

9.3.2 Mental Health, Including Drug Users

Bedfordshire's Joint Mental Health strategy aims to improve the outcomes and life prospects of people with mental health problems. This means that services will be based on evidence, are acceptable and accessible to local people, are relevant to the needs of the local population and delivered in a fair and equitable way. The focus of care will move away from acute settings to prevention and primary care.

We will:

- Develop a new approach to the early identification of mental health and develop locally based health promotion initiatives.
- Implement the stepped care arrangements for depression and anxiety and common mental health problems, ensuring these are delivered.
- Invest in mental health services in primary care through improved access to psychological therapy. Appendix B

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Move away from institutional to personalised care focusing on recovery and enhanced social inclusion and utilising personalised budgets in conjunction with the local authority transforming social care agenda where possible.
- Earlier identification and treatment of dementia, developing more community focused services and addressing individual needs throughout the pathway.
- Improve therapeutic quality of acute inpatient care.
- Improve the integration of care co-ordination and care management in mental health services for older people.
- Deliver the 'Valuing People' objectives for people with a learning disability based on four key principles of rights, independence, choice, and inclusion.
- Ensure services effectively meet the mental health needs of people with a learning disability.

The current programme budget for mental health and learning disabilities can support this agenda through the shift from acute hospital based care to primary and community based services.

Drugs Treatment

Drug misuse is an issue which has an impact on our local communities in many different ways. This agenda is managed through a multi agency Drug and Alcohol Partnership Board whose main focus is to implement consistent, evidence based interventions that reduce levels of drug use in the county, improve detection and arrest rates and increase the numbers of drug users entering successful treatment programmes.

We will:

- Enable specific crime related interventions to include: closure of crack houses and cannabis factories; seizure of assets of convicted dealers and disrupt drug markets.
- Develop and implement IDTS at HMP Bedford.
- Target drug misusing offenders through drug testing on arrest throughout the county.
- Develop consistent drug services across the county – targeted in areas of greatest need.
- Improve the local treatment system and deliver better outcomes for individuals.
- Support local campaigns such as RAT on a RAT.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Continue close multi agency working.

There is a need to invest in this agenda up to an additional £1m a year

9.3.3 Maternity and Newborn

NHS Bedfordshire's maternity strategy aims to improve local maternity services for all women and families, in particular:

- To reduce health inequalities by reconfiguring antenatal and postnatal services.
- To offer more choice to women about how they access antenatal and postnatal care.
- To improve the quality of care women receive when they have their baby, including ensuring women receive one to one midwifery care in established labour

We will:

- Ensure broader access to antenatal and postnatal care by providing services through children's centres and providing services at a time convenient to women and their families.
- Improve pathways and partnership working with support services such as smoking cessation to reduce the number of women smoking in pregnancy.
- Improve support to women who experience pre-natal mental health problems.
- Target resources to areas of greatest health inequalities – low breastfeeding rates, low birth rates, areas with high levels of teenage pregnancy).
- Develop local midwifery led birthing units co-located with maternity units at BHT and the L&D and ensure this choice is offered to all women.
- Maintain level 1 Cots at BHT and level 3 at the Luton and Dunstable
- Promote normality of birth and ensure all women have a choice of where to give birth, based on the assessment of mother and baby.

The current programme budget for maternity can support this agenda

9.3.4 Children's Services

Taking a pathway approach to the provision of services for children across Bedfordshire will ensure that children's health needs are considered at all stages and across all agencies, and that seamless provision delivers year on year improvements in the health of Bedfordshire's children. Although much work has already started this

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

pathway work will require a comprehensive review, and potential reconfiguration, of children's services across the county. This will be undertaken over the winter 2008/9

We will:

- Implement the Child Health Promotion Programme (CHPP) working with families, communities and children's centres addressing childhood obesity, sexual health, teenage pregnancy, drug and alcohol abuse and smoking reduction.

- Support and develop the Healthy School Programme.

- Workings with the Local Authorities develop 32 multi agency children's centres.

- Improve access to specialist services for assessment and treatment for children, particularly therapy services.

- Improve support to Looked After Children and strengthen local Child and Adolescent Mental Health services.

- Ensure the needs of adolescents are properly addressed as close to home as possible, including local services for complex mental health needs.

- Redesign services to significantly improve the lives of disabled children in the county.

- Develop community based children's assessment services and review current acute inpatient services across the county.

The current programme budget for children can currently support this agenda although that may need to be reviewed in light of the full review.

9.3.5 Planned Care, Including Dental

The aim is to deliver convenient, planned care closer to home, away from acute hospitals working closely with primary care. There is a strong focus on localisation, choice, and co-ordination across organisational boundaries and a split from acute services.

We will:

- Ensure a waiting time from referral to treatment of less than eighteen weeks, other than clinical exception and patient choice.

- Ensure equitable access to a full range of high quality primary care services provided by General Practice, dentists, optometrists and pharmacists.

- Invest in the infrastructure of primary care to support this transfer to high quality, locally based care.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Develop direct access to diagnostics and availability of results prior to consultant appointment, including the development of some community based diagnostics.

- Provide complex treatments in specialist centres to improve patient safety and clinical outcomes. This will involve some Bedfordshire patients being treated out of county.

- Increase the number of minor and routine procedures undertaken in primary care. 40% of OPDs in the community; 60% of minor planned surgery and 20% of non complex planned medicine.

- Roll out choose and book to non consultant led services and ensure choice of planned services is available.

- Ensure effective rehabilitation and community based services are in place to minimise hospital stays and maximise recovery.

The current budget for planned care can support this agenda and release about £1m to support investment in other work streams through the shift from acute hospital based care to primary and community based services.

Dental Services

Our aim is that everyone served by NHS Bedfordshire will be able to access an NHS dentist if they wish to and that the appropriate age group get timely 18 week compliant access to orthodontic treatment.

We will:

- Increase the Units of Dental Activity (UDAs) commissioned from general dental practitioners.

- Ensure compliance with the contract by all existing providers, to deliver maximum yield from commissioned services

- Increase case starts for Orthodontics.

- Address long waiting times for treatment.

- Promote waiting list management.

- Ensure all key practice staff receive the level of training and support they require.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

9.3.6 Acute Care

The aim is to put in place joined up, co-ordinated, responsive and patient focused services for people that require urgent or emergency care. The focus is on community based alternatives to hospital care whilst recognising that specialising in some areas of acute care will save lives.

We will:

- Ensure patients have equitable access, quality of assessment and safe treatment consistent with their condition when requiring urgent care. This should be focused in primary care.

- Establish a memorable number for the population to call for health information and self care advice, onward signposting and referral and booking into planned and unplanned care. This is likely to be a regional initiative.

- Ensure wider, easier emergency access to emergency contraception, GP services and pharmacy.

- Extend the single point of access concept as a responsive route for clinicians and patients into 24/7 rapid response community services to facilitate people staying at home.

- Ensure faster and more responsive ambulance services that can offer alternatives to admission for patients.

- Establish primary care led urgent care centres 24/7 at A&E at BHT and the Luton and Dunstable.

- Ensure acute hospital care is organised to support rapid assessment, diagnosis and discharge back into primary care whenever possible.

- Centralise services where additional lives will be saved and better clinical outcomes achieved, this includes 24/7 stroke centres at both BHT and the Luton & Dunstable.

- Develop a pathway for Bedfordshire patients to specialist Heart Attack Centres at Papworth and Harefield Hospitals with local services for thrombolysis, rehabilitation and follow up.

- Ensure that fewer people suffer from, or die prematurely from heart disease, stroke and cancer by ensuring that access to NHS health checks for people between 40 and 74 that include and record all 10 key areas – age, gender, smoking, physical activity, family history, ethnicity, BMI, cholesterol, blood pressure and risk of diabetes, including appropriate follow up as necessary. Baseline and trajectories for each of the 5 key stroke metrics and heart failure have been set within The Operational Plan.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

The current budget for acute services can support this agenda and release about £3m to support investment in other work streams through the shift from acute hospital based care to primary and community based services.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

9.3.7 Long Term Conditions

The aim is to put in place joined up, co-ordinated, responsive and patient focused services for people with Long Term Conditions. Wherever possible the services will be personalised, empowering, effective and integrated to ensure improvement in the quality of people's lives.

We will:

- Focus on prevention through the identification of vulnerable groups, implementing smoking cessation and weight management programmes and targeting general prevention.
- Ensure personal health plans for everyone with a LTC, starting with CHD and diabetes.
- Introduce individual patient held budgets to support integrated more patient centred care. NHS Bedfordshire and the Local Authorities is a national Staying In Control pilot.
- Ensure information and support is available to patients 24/7 at the point of care and through the single point of contact. This will also ensure rapid access to community based services to avoid hospital admission when possible.
- Further develop case management within primary care to support identified vulnerable people and ensure 24/7 support is available to maximise their health and minimise hospital admission. This will include timely access to diagnostics in primary care.
- Further develop cardiac and pulmonary rehabilitation in the community.
- Ensure comprehensive disease registers are in place for long term conditions.

The current programme budget for LTCs can support this agenda

9.3.8 End of Life Care

The aim is to ensure all patients nearing the end of their life are empowered to make choices regarding their level of treatment; where they receive their treatment and their place of death. There is a strong focus on partner organisations working together to ensure that: patients receive holistic assessment, carer assessments are undertaken and patients and carers feel supported in the choices that they make

We will:

- Ensure end of life care is well co-ordinated and delivered seamlessly with the emphasis on improved communication. This will be supported by rapid access to

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

24/7 community services backed by specialist advice to enable patients to die at home if that is their choice.

- Raise awareness with the public about death and dying to encourage patients and families to discuss preferences and choices about treatment and place of death.

- Ensure services, including GPs can deliver NICE supportive and palliative care and national End of Life Care quality measures.

- Implement the End of Life Care clinical pathway across all relevant services. This covers: open and honest communication with patients and families; development of a care plan for the patient; assessment of carers needs; co-ordinated care across all settings; support for the patient in the dying phase; after death care and timely certification of death and emotional and practical bereavement support.

- Implement training and education programmes for all involved in End of Life Care. This includes emergency care staff to ensure they are able to support patient's choices.

- Establish a Bedfordshire and Hertfordshire Palliative and End of Life Care network to support joint working and sharing best practice.

- Ensure comprehensive disease registers are in place for long term conditions.

There is a need to invest in these services up to £1 million.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

9.4 How We Will Measure and Monitor Progress

Goal	Pledge	PCT Goals/outcome measures
Improving Health	**Fewer Premature Deaths**	**Life expectancy at time of birth, Years** Nutrition – Standard 15 quarterly VSA 09 – Breast screening VSA 10 – Bowel cancer screening VSA 11, 12, 13 – Cancer VSA 14 – Quality stroke care VSB 01 – AAAC mortality NI 120 – AAAC mortality(LAA) VSB 02 – CVD mortality VSB 04 – Suicide & injury
	Long term conditions *We will improve the lives of those with long term illnesses* Chronic Heart Disease Diabetes	**Managing variation in emergency admissions calculated for a suite of 19 long term conditions[2] Source: Better Care Better Value indicators NHS Institute for Innovation and Improvement http://www.productivity.nhs.uk/ Quarterly** % individuals with personal health plan against no on 19 LTC QOF registers: QOF – annually VSB 02 – CVD mortality VSB 03 – Cancer mortality VSB 04 – Suicide & injury VSC 15 – Death at home VSC 20 – Emergency bed days VSC 21 – ACS hospital admissions NI 141 – Vulnerable people NI 130 – Independent living VSB 09 – Childhood obesity NI56 – Childhood obesity
Reducing Unfairness	**Health inequalities** *We will work with partners to reduce the difference in life expectancy between the poorest 20% of our communities and the average in each PCT*	**Average IMD (deprivation index) score** • LAA reduce the gap in life expectancy between the worst 20% and the best 20% • Measure share across East of England reduce the gap in life expectancy between the worst 20% and the average VSB 06 Maternity SVS VSB 08 – Teenage pregnancy VSB 10 Immunisation VSB 11 Breastfeeding 6-8 weeks
	Reduce Smokers *We will cut the number of smokers by 140,000*	**No of quitters at four weeks: Vital Signs VSB05 http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services Quarterly (also available monthly through Unify 2) http://nww.unify2.dh.nhs.uk/Unify/interface/homepage.aspx** **NI 123 Smoking prevalence**
	Marginalised groups and looked after children *We will ensure healthcare is as available to marginalised groups and "looked after children" as it is to the rest of us* (?Should this stay)	**Percentage drug users recorded as being in effective treatment** VSB 04 – Suicide & injury **Monitoring recommendations from needs assessments of marginalised groups**
	Reduce childhood obesity *We will halt the rise in obese children and then seek to reduce it*	**Prevalence of obesity in year six Vital Signs VSB09 Source: National Child Measurement Programme Unify 2 http://nww.unify2.dh.nhs.uk/Unify/interface/homepage.aspx Annual**

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

Better patient experience	**Patient experience** *We will deliver year on year improvements in patient experience*	**Vital Signs VSA06 (average of five domains)** **Source: GP Patient Survey (GPPS)** **http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatientsurvey2007/index.htm** Self reported patient experience scores: VSB15 – annually Discharge information: Standard 6 – quarterly Patient satisfaction: Standards 14c/16/17 - quarterly Pain management: Standard 5 – half yearly Pressure ulcer prevention: Standard 5 – quarterly VSB 15 – User satisfaction VSB 17 – Staff satisfaction VSC 32 – Respect & dignity
Access to quality, safe clinically and cost effective local services.	**GP access** *We will ensure GP practices improve access and become more responsive to the needs of all patients*	: VSA06 – Access to GP – annually VSA07 – Extended opening Emergency readmissions: HCC Developmental Standard 1
	Dentistry *We will ensure NHS Primary Dental Services are available to all who need it*	**Number/Proportion of population (adult and children) visiting an NHS dentist within the preceding 24 months Vital Signs VSB18** **Source: NHS Dental Statistics for England** **http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry** **Quarterly**
	Access guarantees *We will extend quicker access to our services*	VSA 04 – Elective care access VSB 13 – Chlamydia screening VSC 21 – ACS hospital admissions
	Safety *We will aim to make our healthcare system the safest in England*	**Cases of *C. Difficile* per 10,000 population Vital Signs VSA03** **Source: Health Protection Agency. Clostridium difficile infection surveillance data.** **Unify** 2 http://nww.unify2.dh.nhs.uk/Unify/interface/homepage.aspx Office of National Statistics population estimates http://www.statistics.gov.uk/statbase/Product.asp?vlnk=601 Monthly VSA01 – MRSA Incident reporting: Standard 1 – quarterly Medicines management: Standard 4d – half yearly Record keeping: Standard 9 - annually Reduction in hospital standardised mortality rate

Table 17 - Measures of progress against initiatives

9.5 Key Risks and Mitigating Actions

We have an effective assurance framework in place. It provides a simple but comprehensive method for the effective and focused management of identified principle risks which may prevent strategic objectives being met.

The Board Assurance Framework is underpinned by the other control mechanisms in place such as the risk register and the declaration of compliance against the core standards in the Healthcare Commission's *Annual Health Check*. Action plans arising from the audit recommendations are monitored by the Audit Committee.

A summary of key risks to delivery of the initiatives and mitigation of these risks are set out in table format below.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

9.5.1 Most Critical Executive / PCT Level Risks

ID	Initiative Impacted	Risk	Impact (1-5)	Likelihood (1-5)	Mitigation
1	All	NHS Beds losing the capacity and capability across the organisation to deliver our initiatives.	4	2	• Recruit into vacant posts. • Bring in skills and capabilities via Third party resources and fixed term contactors.
2	All	Insufficient funding after year 1 to deliver strategic initiatives (especially pertinent given current financial constraints).	4	3	• Clear prioritisation and maintain strong financial management. • Focus on cash releasing savings from within current spends.
3	All	Failing to gain clinical and public engagement with initiatives due to lack of resource.	4	2	• Communication & Engagement strategy.
4	All	Ability to successfully stimulate the local market.	4	2	• Filling vacant posts in structure. • Deliver on WCC competencies.
5	All	IT infrastructure not fit for purpose.	4	3	• Review current service level agreements in place. • Identify IT requirements. • Buy in expertise where necessary.
6	All	Estate not fit for purpose.	4	2	• Review of current real estate. • Model future requirements. • Implement estate strategy.
7	All	Insufficient capacity and capability of workforce across NHS Beds and providers.	4	2	• Implement OD strategy.

Table 18 – Most critical executive / PCT level risks

9.5.2 Most Critical Initiative Risks

ID	Initiative Impacted	Risk	Impact (1-5)	Likelihood (1-5)	Mitigation
8	Staying Healthy	Local Government reorganisation and formation of two new unitary authorities may impact on health care rating.	3	3	• Work closely with two new unitary authorities to ensure a co-ordinated approach across health. • Agreement has been made that the director of public health post will be a jointly funded post across NHS Bedfordshire and the new unitary authorities.
9	Staying Healthy	Over activity in acute and demand lead services.	4	2	• Strengthen primary and secondary prevention which will have an impact on acute and demand led services.
10	Mental Health, including drug users	Failure to ensure we have the correct staff skill mix to provide our IAPT primary care work plan.	4	2	• Review of current skills in organisation. • Focused recruitment campaign. • Detailed service re-design programme.
11	Mental Health, including drug users	Failure to redirect investment from secondary settings.	3	2	• Closely monitor progress of initiative

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

12	Drug Treatment	Increase in drug using offenders impacting the local community.	4	3	• Identification of increased mainstream funding for drug treatment.
13	Maternity & Newborn	Unable to fund, as new initiatives as they provide limited short term financial returns.	3	3	• Ensure extra investment underpinned by robust service specifications and quality schedules with acute providers, in order to assure that the PCT would receive value for money from these extra funds.
14	Maternity & Newborn	Providers unable to recruit sufficient midwives.	4	2	• The PCT has responsibility for co-ordinating county-wide workforce planning. A detailed action plan to support this area of work is due for completion by April 2009, and whole-systems work is already underway locally and regionally to address these challenges.
15	Children's services	Workforce issues may cause some staffing difficulties.	3	3	• Involve HR at early stage.
16	Children' services	Initiative will rely heavily on the new unitary authorities sharing the vision and priorities with the NHS.	3	3	• Work closely to engage unitary authorities, promoting joint commissioning, funding, and planning.
17	Planned care, including dental	Successful delivery of this strategy can only be achieved through collaboration with all partners.	3	2	• Work closely with clinicians and colleagues across primary & secondary care, East of England, local authorities, the voluntary sector and individual carers / users to make it happen.
18	Planned care, including dental	Standard of acute care may fall as funding / activity diverted to community settings.	4	2	• Work closely with acute providers to manage migration of care settings.
19	Dentistry	Key risk is that we will not meet targets for population in very north of the county, because the sparsely populated area will not provide sufficient work to support local dental practices.	4	2	• Close monitoring and support for the development and maintenance of practices on the borders of the rural areas. • If this fails then mobile provision may be needed, and possibly a service model that includes the PCT provider service or any successor.
20	Acute care	Lack of resources to deliver urgent care centre.	4	2	• Resource identified within growth. • Capital investment programme in primary care.
21	Safety	C diff causes rise above upper threshold compromising patient safety. Financial penalty would impact ability to deliver high patient experience.	5	1	• Closely associated monitor key performance indicators and metrics.
22	Long term conditions	Increase demand.	4	2	• Demonstrate flexibility and adaptive commissioning approach to ensure there is sufficient provision.
23	Long term conditions	Pace of change is too slow.	4	3	• Ensure dedicated project management / external support if necessary.
24	End of life care	The number of additional staff identified by the community service teams maybe under estimated.	3	2	• Processes for monitoring and reporting, on a regular basis, increases in the clinical lists for the community nursing disciplines. •

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

25	End of life care	The number of SPC and respite bed palliative care provision may need to be reviewed and increased.	3	3	• Regular monitoring and reporting the increase in referrals for SPC and respite beds. • Audits on reasons for referral.
26	End of life care	Independent care homes ability to recruit and retain staff that have End of Life Care skills and training.	3	2	• Implement sustainable permanent training programmes that link to university or college recognised qualifications.

Table 19 – Most critical initiative risks

9.6 Links to Underpinning Plans

This section sets out key plans that underpin the successful delivery of our strategy:

- Practice Based Commissioning operational framework. Appendix G
- Communications and public engagement strategy. Appendix H
- Workforce and organisational development plan. Appendix I
- Information management and technology plan. Appendix J
- Capital and estates.

9.6.1 Practice Based Commissioning

Practice Based Commissioning will play a key role in the delivery of our strategy as well as in NHS System reform. They enable primary care clinicians to commission appropriate healthcare services for their local populations. PbC will use their knowledge of the healthcare requirements of their patients coupled with robust local health needs assessment to improve patient care and ensure that the best possible value is derived from available financial resources. This will effectively deliver NHS Bedfordshire's strategic vision.

9.6.2 Communications and Public Engagement

The Communications and Engagement Strategy sets out how NHS Bedfordshire will communicate, involve and manage relationships with all of its stakeholders, including patients, carers, members of the public, staff, service providers, partners, the media and others.

NHS Bedfordshire will

- Ensure that communication and engagement is both planned and linked to the trust's aim and goals, as expressed in A Healthier Bedfordshire, underpinned by the seven domains within Standards for Better Health and monitored through the Board Assurance Framework.
- Establish a baseline against which progress can be measured.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Support organisational change as the trust develops as a high performing commissioning body, as described by the World Class Commissioning (WCC) Framework and monitored through achievement of the 11 World Class Commissioning competencies.

- Set out and prioritise communication and engagement objectives to ensure that consequent activities are realistic and deliverable within current resources.

9.6.3 Workforce

It is critical that we have the capacity and capabilities within our workforce and external provider partners to deliver upon our strategic initiatives.

Internal Capability Requirements

At an executive level, to deliver the strategic plan and the goals which will achieve this we will need to ensure our people have world class skills in a wide range of competencies, including:

- Strong leadership and direction, ensuring that the vision we set out I this plan is communicated and acted upon throughout the organisation.

- Commissioning / contact management.

- Market management.

- Project management.

- Information analysis and trend analysis.

- Financial / budgetary control.

- Ability to monitor progress of initiatives and plan interventions where necessary.

We need to lead the development of the skills of managers and clinicians in the health system and ensure collaborative working is effective with providers and other partners including patients. Systems have been established to undertake this work including the County Workforce Group which will lead on our strategic system wide workforce planning. We have created additional capacity and expertise in this area and will continue to work closely with the Workforce Directorate at the East of England to enable integrated strategic workforce planning to take place

Created by Neevia Document Converter trial version http://www.neevia.com

PDF created with pdfFactory Pro trial version www.pdffactory.com

Key Workforce Requirements at Initiative Level

Initiative Area	Workforce Requirement
Staying Healthy	• Increase the health promotion and health advisory capabilities of all staff. In the past, there has not been a clear career path for the development of public health and health improvement specialists and this needs to be addressed. • The role of health trainers and support roles need to be developed to enable people and patients to make healthier choices. • The health visitor and school nurse development needs to be changed to reflect the increased health improvement role they will take on. These roles will be in primary care, community services and hospital based services.
Mental Health, including drug users	• The workforce developments in mental health will need to support the improved delivery of mental health care in primary care, with projects such as an integrated approach to psychological therapies (IAPTs) and the development of primary care mental health workers. • Psychological therapy staff is already an area of shortage and population increases indicate a need to increase the number of staff. • Reviews of acute mental health and dementia services required. • There is a need to increase the knowledge in primary care regarding drug use and referral to the specialist services.
Maternity and New Born	• We need to recruit and retain more midwives, to increase capacity in community midwifery services and to increase the capacity for ante natal scanning and post natal support, including breast feeding based around children's centres. • There are also concerns about the level of medical support available in this speciality and the training time to develop more medical specialists.
Children's Services	• Need to recruitment around speech and language therapy and occupational therapy posts. • Increased use of rotational schemes for post qualified therapists to increase expertise in paediatric services in mental health, learning disabilities and physical disabilities. • The training for health visitors and school nurses will be reviewed to develop a modular based programme, including the skills identified through this indicator. The role and effectiveness of health trainers will also be explored.
Planned Care including Dental	• Workforce analysis and planning needs to focus on identification of workforce competencies from the Health Needs Assessment, the development of appropriate training programmes including non medical prescribing and management of long term conditions, and the development of self care programmes for patients which will impact on their expectations of the workforce.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

	• There are high vacancy levels amongst many of the specialist needed to ensure the delivery of these targets and this will need to be addressed in robust workforce planning and development. • The increasing population in Bedfordshire will impact on the need to develop, recruit and retain more staff working in dentistry.
Acute Care	• A review of care pathways over the next 2 years will enable the development of a workforce plan to accommodate the required change in focus (i.e., more critically ill patients). • The will be a review of care pathways over the next 2 years.
Long Term Conditions	• Education and training for existing and future staff (clinicians, support workers, reception staff and social care workers) will ensure professionals have the 7 Core Common Principles/competencies to support self care. • The roles of GPs and community matrons will need to be reviewed and developed to support the care pathway.
End of Life Care	• Likely impacts will be on the development of community based staff to provide 24/7 care and support as well as enhanced advice and support to a larger number of patients. • There will also be a need to review the impact in primary care and improve the skills and knowledge of staff to support the increase of patients wishing to stay at home.

Table 20 - Workforce requirements at initiative level

Health System Capability Gaps

To ensure we have the relevant skills with our organisation, we have developed a county wide programme lead and workforce planning post. We will work with providers and other partners in the system to ensure integrated workforce planning and development takes place.

The timetable and process for developing our health system workforce plan is:

- October 08 — Darzi care pathway workforce identification workshop, involving commissioners, clinicians and managers as well as workforce planning leads.
- November 08 — Workforce planners and service leads review workforce figures to realign with care pathways and priorities.
- December 08 — First draft workforce plan and education commissioning plans produced.
- March 09 — More detailed integrated workforce plan and talent management plan for the health system.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

New Ways of Working

Many of the new service models across the Clinical Pathway Groups will require changes to existing roles and / or the introduction of new roles. There are risks associated with the time taken to develop and implement new roles or to make changes to existing staff functions. Areas of risk include; lead in time for the development and validation of curricula, access to appropriate clinical placements and supervision, wider fit to multi disciplinary team approach etc.

Demographics

Regional workforce demographic data shows there are current shortages of staff in the following areas:

- General practice.
- Primary and community nursing (specialist vs generalist roles).
- Pharmacists.
- Shortages of NHS Orthodontist specialist and trainers for practitioners.

In addition, local intelligence identifies shortages in the following areas:

- Paediatric Occupational therapists.
- Midwifery.
- Health care scientists.

There are also anticipated shortages through retirement and an ageing workforce which could pose risks to the delivery of our strategy.

The integrated workforce plan will address how the local health system will overcome these shortages through role redesign, recruitment and retention strategies.

Education Curricula

In order to deliver new roles and functions, changes to training curricula will need to take place. This is equally important for Continuing Professional Development of the existing workforce, to support delivery of the improving Lives: Saving lives Pledges over the next three years, as well as Pre-Registration programmes. Key themes arising from the risk assessments identify the following risks;

- The capacity for clinical placements.
- Non medical prescribing.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Enhancing clinical leadership.
- Education curricula for bands 1-4.
- Enhancing education needs for patients and carers via programmes such as Expert Patients / Carers Programmes, etc.

We will work closely with local higher education and further education providers through the County Workforce Structure, to ensure the necessary changes to training curricula take place.

Talent and Leadership Development

The County Workforce Group is in the process of agreeing and implementing a talent and leadership plan for the health system. This will ensure that there is strong leadership both clinical and non clinical throughout organisations to ensure successful delivery of our strategy.

People and Process

Within NHS Bedfordshire, competence to deliver better health outcomes to the people of Bedfordshire will be developed through the implementation of World Class Commissioning. The organisation has already realigned its functions and is currently increasing its capacity in line with the World Class Competencies. Management and reporting systems will work in a matrix management structure around care pathways and programme budgets, in order that contracts can be agreed with providers and performance managed to meet the goals of NHS Bedfordshire.

Bedfordshire Health System

We will continue to develop effective partnership working arrangement with key stakeholders through a variety of mechanisms. The planned changes in local government from April 2009 will impact on the effectiveness of some of the current systems and these will be reviewed to re-establish links with new Unitary Authorities as appropriate. We have restructured to increase the leadership available to facilitate and lead service redesign across the system, engaging with our partners, patients and public.

9.6.4 Information Technology

NHS Bedfordshire has a system wide IM&T plan which identifies the various IT systems and processes that we will be putting in place across the health system to underpin the delivery of our strategy. Our key responsibilities are:

- Providing overall leadership and direction to the local health system for the IM&T programme.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Establishing an IM&T programme as an enabler of overall 'service transformation' for the LHC – service change, not just IM&T implementation.
- Ensuring realisation of benefits from the IM&T programme which together ensure LHC achieves its desired outcomes in terms of service change.
- Establishing governance structures and processes required to support the effective management of an IM&T programme 'aligned' with LHC's service change programme.
- Ensuring the LHC has an effective and transparent approach to risk management.
- Ensuring the LHC has the capacity and capability to resource the programme – including change management, not just IM&T delivery.
- Ensuring the LHC has a clear and transparent framework for prioritisation, approval and funding of projects within the programme.

Our IM&T plan details how we are addressing each of the above areas and what the key IM&T enables are for the different clinical care pathways. See appendix J.

9.6.5 Capital and Estates

NHS Bedfordshire is in the process of developing a new Estates Strategy that will respond to emerging service strategies and allow commissioners the flexibility to manage a dynamic provider market, in particular around local services.

The majority of the facilities available for NHS services in Bedfordshire have historically been controlled by service providers. The Board of NHS Bedfordshire has resolved to move increasingly towards taking direct control over key strategic estates and locations.

In each case, a commissioning-led approach will be taken to identifying and securing appropriate capacity for the provision of local services. Locations already identified include:

- Bedford North / Town Centre
- Bedford South
- Kempston
- Wixams
- Sandy
- Biggleswade
- Ampthill
- Flitwick
- Houghton Regis
- Leighton Buzzard
- Linslade
- Dunstable North
- Dunstable Town Centre

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

The anticipated shift of services out of the hospital sector needs to be mapped geographically, linked to the known short-falls in capacity for existing community services, to develop a clear set of commissioning-led requirements for strategic estate within local communities.

The PCT is a core member of the Assemble Community Partnership LIFT Company. We will use the partnership (which also includes Milton Keynes PCT and East and North Hertfordshire PCT) to maximise the benefits of working across the public and private sectors and as a delivery vehicle for change that can catalyse refurbishment and development of estate.

The planned growth of the local population is described in detail in Chapter 2 in relation to patient numbers and demography; however it is important to also note that the impact of the geographic nature of this growth on the local capacity to deliver services is modelled on a locality by locality basis.

Planning for New Services

As plans emerge to invest in building capacity in the community for a wider range of services, including those moving out of the hospital sector, the requirements to deliver planned care within local communities need to be described in terms of the populations they will serve.

This geographic modelling of services is needed to inform the subsequent estates requirement within localities and thus the commissioning of facilities for health care. This planning also needs to take account of parallel planning of other local services such as children's centres, extra-care housing and social care.

Examples emerging include:

- Staying Healthy: Lifestyle support services need to be integrated, well publicised and easy to access.
- Mental Health and Learning Disabilities: Reduce the number of acute inpatient beds, but provide them in a better quality and more therapeutic environment. Commission, a modern pattern of day care services in keeping with the principles of valuing people.
- Children's Services: 30% of planned services currently delivered in acute settings shifting to the community resulting in 1860 additional appointment slots across Bedfordshire.
- Long term conditions: 65% of current hospital-based outpatient appointments are for people with long term conditions. Over the next 5 years, people will be treated sooner and nearer to or at home.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

- Planned Care: Shift 40% of outpatient appointments; 60% of minor planned surgery and 20% of non complex planned medicine into the community. Commission community based diagnostic services, intermediate care centres and integrated rehabilitation and treatment services.

The estates strategy for NHS Bedfordshire will need to explore the detailed thinking behind service development plans in the key areas identified above to take forward local planning for facilities and estates.

9.7 Change Management

In order to implement the strategy and achieve the health outcomes for the people of Bedfordshire, extensive service redesign will need to take place across the system.

This will involve partners, providers, patient and public representative groups to ensure the changes in services and in the way the services are provided have the support of all stakeholders. This will also involve identifying potential new providers.

At the core of the change and service redesign will be the vision, values and goals of NHS Bedfordshire and the intentions detailed in the Care Pathways. We will drive the change required across the local health system by continuing with our strong performance management culture and by holding our providers to account. We recognise that a major part of this will be ensuring that effective clinical leadership is in place both within NHS Bedfordshire and across the local health system.

NHS Bedfordshire will invest in change management expertise to implement sustainable change, retaining staff in the health system with skills, expertise and enthusiasm for improving health and providing care locally.

We have recently reviewed and implemented our internal structures to ensure that clinical service redesign capability is strengthened within our Health System Management function. This function will lead and develop Pathway Redesign Groups as the major change vehicle to bring together Commissioners, Clinicians, Providers and patient/public representatives to advise the Commissioners on service change and specifications. These groups will be supported by Finance, Workforce, IM&T, Estates, Public Engagement and Communication as appropriate to ensure effective matrix working across NHS Bedfordshire. The groups will provide strong change management leads to work with providers to enable sustainable change to take place. This will mean that we will be developing some internal capability in this area as well as purchasing expert specialist support when required. These groups will follow a systematic process for managing change and changing behaviours.

We recognise the importance of actively engaging with patients and the public to understand their needs and to help them help us design services in the most satisfactory way. Therefore we will ensure that the views of patients and public are built into the commissioning cycle as appropriate. In order to do this we have created a dedicated public engagement and communications directorate and are in the

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

process of increasing capacity and expertise in this area. This will enable us to provide enhanced advice and practical support to the care pathway redesign groups, utilising a broad range of engagement and involvement activities. These include service user representation and participation on key groups; focus groups; formal statutory consultations; patient surveys; deliberative events and other market research methodologies to monitor and evaluate patient experience.

Identifying and managing changes needed in the workforce and making these changes happen will be an integral feature of the work of the Pathway Redesign Groups. To achieve this, we have established and are leading the Bedfordshire County Workforce Group, with representatives from clinicians, service providers, social care, Higher and Further Education, Learning Skills Council, Skills for Health and Staff Representatives. The group will develop and align the local health system workforce plan to our service and financial strategies to ensure that resources are invested appropriately. This will also ensure that we are able to commission the appropriate education and training for the local health system.

All of this work will be underpinned by working in partnership with staff and their representatives to deliver change sensitively, providing appropriate time, access and support for training and development.

During 2008/09, the County Workforce Group will develop and agree a 3-5 year local strategic workforce plan. Ensure local stakeholders are involved in the development of these plans. Ensure resources delegated to the Group are invested wisely and that excellent governance arrangements are in place. Develop a talent management and capability plan that identifies and develops more leaders across the local health system. Develop and discuss strategies for improving staff satisfaction and engagement.

Having set up a knowledge management function within NHS Bedfordshire, this will act as a key lever for change across the system as it will enable us to use information and intelligence to identify our priority areas for action and to benchmark our services. In addition, this function will enable us to ensure better data quality which in turn will lead to evidence based decision making.

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

10 Appendices

A. **Initiatives.**

B. **Towards The Best Together, Mental Health Implementation Plan.**

C. **Operational Plan.**

D. **JSNA.**

E. **Performance Report.**

F. **Prioritisation Policy.**

G. **PBC Operational Framework.**

H. **Communications and Engagement Strategy.**

I. **Organisational Development Plan.**

J. **IM&T Strategy.**

K. **Equalities Impact Assessment.**

L. **Primary Care Strategy.**

M. **East of England Check List.**

Created by Neevia Document Converter trial version http://www.neevia.com
PDF created with pdfFactory Pro trial version www.pdffactory.com

This document is available in large print, Braille, audiotape and other languages on request.

NHS Bedfordshire
Gilbert Hitchcock House
Kimbolton Road
Bedford MK40 2AW

01234 795714 • enquiries@bedfordshire.nhs.uk • www.bedfordshire.nhs.uk

© Bedfordshire PCT 2008. This document may not be reproduced in part or full without the consent of Bedfordshire Primary Care Trust.

Doc ref: 86/EO/AHB01/01/09

Created by Neevia Document Converter trial version http://www.neevia.com

PDF created with pdfFactory Pro trial version www.pdffactory.com

APPENDIX A

NHS Bedfordshire Initiatives

Staying Healthy

1 Overview

A key aspiration for Bedfordshire is to increase life expectancy for its residents and it is working hard with its partners to achieve set targets. To improve life expectancy in Bedfordshire, NHS Bedfordshire must tackle the main causes of premature death, cancer, CHD/stroke, accidents, suicide and liver disease.

Both the NHS in the East of England and NHS Bedfordshire are committed to placing as much emphasis on improving health and wellbeing as on providing treatment and developing and strengthening prevention programmes so that they are the best in England. The four cornerstones of Staying Healthy are:

- A lifelong prevention pathway
- Promoting wellbeing
- Reducing unfairness
- Health partnerships.

2 SMART goals addressed

This initiative addresses key vital signs and LAA targets including:

- Reduce the number of smokers in Bedfordshire and ensure enhanced uptake of smoking cessation within 20% most deprived areas
- Smoking in pregnancy targets, enhanced targets given to practices who service the 20% most deprived SAO (LAA1 specific target for number of quitters from 30% most deprived SOA) and targets for routine and manual workers
- Reduce the number of 4 week smoking quitters in line with NICE recommended levels
- Achieve yearly National Child Monitoring Programme targets
- Reduce childhood obesity
- Increase life expectancy and reduce the difference between the poorest 20% of our communities and the average for NHS Bedfordshire
- Achieve screening uptake rates with a specific focus on 20% most deprived areas
- Achieve immunisation uptake rates with a specific focus on 20% most deprived areas
- Reduction of teenage pregnancy rates
- Ensure early access to antenatal care with a specific focus on areas with late uptake
- All of the above have three year vital signs targets.

3 Reasons for selecting this initiative

A Lifelong Prevention Pathway

- It has been recognised that the NHS needs to apply the same rigour to prevention of ill health as to clinical treatment services. The lifelong prevention pathway begins with a healthy start in life, including pre-conception care and high quality maternity services and ends with support for older people to help them enjoy their later years as fully as possible.

Created by Neevia Document Converter trial version http://www.neevia.com

Tackle childhood obesity

- Obese children are more likely to become obese adults with increased risk of serious health problems more usually seen in adulthood, including high blood pressure, type II diabetes and CHD. A negative self image and low self esteem in children and young people makes them more vulnerable to teasing, social exclusion and isolation

NCMP combined figures school year 2006-07 – overweight and obesity:

	Year R	**Year 6**
Bedfordshire	22% (12.76% OW, 9.3% Obese)	28.05% (12.92% OW, 15.1% Obese)
EoE SHA	22% (12.9% OW, 9.1% Obese)	29.5% (13.8% OW, 15.7% Obese)
National	22.9% (13% OW, 9.9% Obese)	31.6% (14.2% OW, 17.5% Obese)

Reduce the number of smokers

- Smoking is the principal avoidable cause of premature death and ill health in England today. Reducing prevalence is a key priority in improving the health of the population in Bedfordshire. Chronic disease mortality and severity can be decreased and emergency admissions for stroke, MI and COPD can be reduced by commissioning services and interventions which increase the rates of stopping smoking.

Reduce alcohol related harm

- Nationally, alcohol related disease accounts for up to 35% of all A&E attendances. Brief interventions can reduce the number of repeat visits. Over the last 10 years, although the numbers are relatively small, deaths from chronic liver disease have increased whereas deaths from all circulatory diseases and all cancers have been going down.

Integrated and personal approach to delivering lifestyle support services

- Personal support to improve health such as smoking quitting support, weight management and brief interventions to reduce alcohol related harm are delivered separately and in an ad hoc fashion. Neither professionals nor communities are aware of or fully accessing the services that are available. Lifestyle support services need to be integrated, well publicised and easy to access.

Reducing inequalities in health

- Health inequalities are differences in health experience and health outcomes between different population groups that are unnecessary and avoidable but in addition are also considered unfair and unjust. People living in deprived areas, from lower socio-economic groups and marginalised groups have poorer health, poorer access to healthcare and die earlier than others
- 2004-2006 data shows that life expectancy ranges from 73.9 to 84.5 for people in Bedfordshire.

4 Input from stakeholders

Key consultations with stakeholders include:

- Bedfordshire Obesity Strategy was widely consulted on
- LAA NI 120 – AAACMR and LAA 123 was widely consulted on at two Countywide Assemblies
- A draft alcohol strategy is being developed which will be consulted on

Created by Neevia Document Converter trial version http://www.neevia.com

- Prison Health Needs Assessment
- Homeless Health Needs Assessment (Bedford)
- Offenders Health Needs Assessment in the process of being completed.

5 Value for money

- There is a strong evidence base of value for money in relation to reducing childhood obesity as part of an approach to obesity in all age groups, reducing smoking rates and reducing alcohol related harm
- Alcohol treatment studies show that for every £1 spent on treatment, the public sector saves £5
- This is largely a community based initiative, which will help us to focus on preventative measures, reducing acute admissions in the long term
- It has been estimated that smoking costs the NHS up to £1.7bn a year in England
- The risk of type II diabetes is almost 13 times greater in obese women. Adult obesity levels are rising in Bedfordshire.

6 Timescale for goals to begin

A lifelong prevention pathway

Assessment for risk of heart disease for everyone aged 40–74
08/09

- Start rolling out assessment for risk of heart disease within most deprived GP practices in Bedfordshire.

10/11 – 12/13

- Roll out across Bedfordshire in line with the national assessment of risk programme.

Full coverage of NHS immunisation and screening programmes
08/09

- Continue to increase quality and uptake of breast and cervical screening in line with national guidance
- Ensure a step change in Chlamydia screening uptake rates
- Introduce HPV immunisation programme
- Introduce bowel screening from December 08
- Introduce combined screening for Downs.

09/10–12/13

- Develop planning for age extension to breast and bowel screening in line with national guidance
- Monitor uptake and quality of all screening programmes.

Promote wellbeing
Tackle childhood obesity (prevention)
08/09

- Pilot Change4Life in three school communities across Bedfordshire from September 08
- Change4Life is based on the French EPODE type approach (Together we can prevent obesity in children). This programme focuses on prevention and treatment advocating a varied diet and regular physical activity through action in schools and communities. Initially we will start with communities within the catchment area surrounding schools with higher levels of obesity and overweight working with one lower and one middle school within each

Created by Neevia Document Converter trial version http://www.neevia.com

borough/district council boundary.

09/10
- Mid pilot project evaluation of the impact of Change4Life March 2010.

10/11–12/13
- Wider roll out from April 2010 if impact is positive.

Tackle childhood obesity (treatment)
08/09
- Roll out six MEND obesity management programmes and 2-3 BeeZee Bodies obesity management programmes
- MEND (Mind, Exercise, Nutrition…Do it!) is accepted nationally as best practice and is already in place in Luton and being rolled out on a limited scale in south Bedfordshire. It is an evidence based intervention for children aged 7 to 13 years and their parents/carers which delivers significant results against a range of health markers
- BeeZee Bodies is a local obesity management model which has not been evaluated to the extent that MEND has, but initial findings appear to be positive.

09/10
- Compare the results between MEND and BeeZee Bodies
- Roll out further MEND and BeeZee Bodies programmes.

10/11–12/13
- Commission childhood obesity management programmes in line with the evidence base of effectiveness including cost effectiveness.

Reduce the numbers of people who smoke
08/09
- Increase the numbers of quitters to reflect NICE recommendations of 40.7 quitters per 1000 smokers in 2009/10
- Increase stop smoking support to workplaces

10/11
- Increase the numbers of quitters to reflect NICE recommendations of 44.8 quitters per 1000 smokers

09/10–12/13
- Ensure enhanced quitter numbers from 20% most deprived wards and 20% most deprived practices
- Increase stop smoking support to workplaces.
- Increase the numbers of quitters to reflect NICE recommendations of 50 quitters per 1000 smokers

Reduce alcohol related harm
08/09
- Finalise Bedfordshire's alcohol strategy, including a mapping of services being commissioned.

09/10–12/13
- Commission alcohol services in line with the recommendations of the strategy
- Monitor and evaluate the impact of commissioned services.

Created by Neevia Document Converter trial version http://www.neevia.com

Integrated and personal approach to delivering lifestyle support services
08/09
- Review of primary and secondary prevention across Bedfordshire and identify models of care ensuring an integrated and personal approach across both urban and rural areas.

09/10–12/13
- Develop models to ensure an integrated and personal approach to delivering lifestyle support services with monitoring, evaluation and review mechanisms in place.

Reduce inequalities in health
08/09
- Ensure enhanced uptake of smoking cessation within 20% most deprived wards and GP practice populations
- Review uptake of CVD primary/secondary prevention in most deprived wards and GP practice populations and identify what is needed to ensure enhanced uptake of primary and secondary prevention
- Start to roll out assessment for risk of heart disease to everyone aged 40–74 within most deprived GP practice populations in Bedfordshire
- Carry out a health equity audit of breast and cervical screening uptake
- Carry out a baseline audit of access to antenatal care to identify areas which need focussed action to reduce late booking
- Provide targeted teenage pregnancy programmes and projects with a specific focus on ‘hotspots’
- Carry out a health equity audit to identify issues in relation to uptake of flu vaccination and monitor uptake in 20% most deprived wards and GP practice populations
- Raise awareness of winter warmth payments as part of the flu campaign
- Review uptake of counterweight programmes within 20% most deprived wards and GP practice populations and develop a programme to increase uptake of counterweight
- Ensure up to date health needs assessments have been carried out or are in the process of being carried out for vulnerable groups including prison population, offenders, looked after children and young people, ethnic minority populations, people with disabilities, people with mental health problems, homeless and traveller populations
- Start to develop the health trainers programme to support marginalised communities in accessing lifestyle support.

09–13
- Ensure enhanced uptake of smoking cessation within 20% most deprived wards and GP practice populations
- Ensure enhanced uptake of CV primary and secondary prevention within 20% most deprived wards and GP practice populations
- Provide assessments for the risk of heart disease to everyone aged 40–74 and lifestyle intervention support where needed
- Ensure high uptake of breast, cervical and bowel screening within 20% most deprived wards and GP practice populations
- Implement actions to ensure early uptake of antenatal care within areas identified with late uptake
- Ensure an ongoing targeted approach to teenage pregnancy to ensure that rates decrease and the decrease is maintained
- Implement recommendations of health needs assessments carried out with a focus on vulnerable groups
- Ensure high uptake of flu vaccination and ongoing winter warmth campaigns
- Further develop the health trainer programme to support marginalised communities in accessing lifestyle support.

Created by Neevia Document Converter trial version http://www.neevia.com

Health partnerships
LAA
08/09

- Agree on LAA priority areas for 2008–2011 including:
    - NI156 – obesity among primary school age children in year 6
    - NI120 – All Age All Cause Mortality Rates with a focus on narrowing the gap in AAACMR between the best and the worst fifth of the population
    - NI123 – 16+ current smoking prevalence
    - NI130 – social care clients receiving self directed support independently through social services
    - NI141 – number of vulnerable people achieving independent living
    - NI135 and NI 142 identified as local indicators
- Identify baselines, targets and effective interventions to achieve targets 08–11
- Ensure successful implementation of LAA targets ensuring maximum partner involvement.

Staying healthy in the workplace
08/09

- Launch Staying Healthy in the Workplace with NHS Bedfordshire staff and encourage other NHS organisations in Bedfordshire to launch or re-launch Staying Healthy in the Workplace within their organisations
- Identify key employers in Bedfordshire and work with them on tailored packages and commitment to launching Staying Healthy in the Workplace.

09–13

- Roll out Staying Healthy in the Workplace across Bedfordshire.

7 High level requirements

A lifelong prevention pathway
Assessment of risk of heart disease for everyone aged 40–74

- New programme to be delivered through primary care
- 08/09 Will start to roll out to 20% most deprived GP practice populations
- 09/10 Will complete roll out to 40% most deprived GP practice populations
- 10/11 Will start wider roll out across Bedfordshire

Full coverage of NHS immunisation and screening programmes
New programmes:

- Bowel cancer screening
- Combined screening for Downs
- HPV vaccination.

Promote wellbeing
Childhood obesity

- 08/09 - new funding allocated
- Within present budgets – 1 WTE Health Improvement Specialist – childhood obesity
- 09/10 - need to ensure funds on an ongoing basis.

Reduce the numbers who smoke

- 07/08 - budget needs to increase in line with increase in quitter numbers.

Reduce alcohol related harm

Created by Neevia Document Converter trial version http://www.neevia.com

- Very limited services commissioned
- Will require increased provider capacity.

Reduce inequalities in health
- Funding for health trainers.

Health partnerships
- LAA – will be mainly from social care and health mainstream budgets
- Staying healthy in the workplace – new funding required for programme in NHS Bedfordshire.

NHS Bedfordshire and its partners have agreed to work together to improve health and well being. Local area agreements are:
- Healthier Communities and Older People
- Children and Young People
- Safer and Stronger Communities
- Economic Development and Enterprise.

8 How success will be measured

A lifelong prevention pathway
- Assessment for risk for heart disease for everyone aged 40–74
- Need to set targets for the next three years.

Full coverage of NHS immunisation and screening programmes

Vital signs targets for screening and immunisation (next three year targets):
- Immunisation rate for children aged one who have been immunised for diphtheria, tetanus, polio, pertussis, haemophilus influenza type b (Hib) – (DtaP/IPV/Hib) 95.1%, 95.1%, 95.0%
- VSB10_08 Immunisation rate for children aged two who have been immunised for pneumococcal infection (PCV) – (PCV) 85.9%, 90.0%, 95.0%
- VSB10_09 Immunisation rate for children aged two who have been immunised for haemophilus influenza type b (Hib), meningitis C (MenC) – (Hib/MenC) 95.1%, 91.5%, 95%
- VSB10_10 Immunisation rate for children aged two who have been immunised for measles, mumps and rubella (MMR) – (MMR) 85.1%, 90.0%, 95.0%
- VSB10_14 Immunisation rate for children aged five who have been immunised for diphtheria, tetanus, polio, pertussis (DtaP/IPV) 95.0%,95.0%, 95.1%,
- VSB10_15 Immunisation rate for children aged five who have been immunised for measles, mumps and rubella (MMR) 85.0%, 90.0%, 95.1%
- VSB10_18 Immunisation rate of 90% for human papilloma virus vaccine for girls aged around 12-13 years 75.0%, 83.0%, 90.1%
- VSB10_21 Immunisation rate for children aged 13 to 18 who have been immunised with a booster dose of tetanus, diphtheria and polio 71.1%, 80.1%, 90.2%.

Promote wellbeing

Childhood obesity

Vital signs targets for height and weight monitoring and reduction in childhood obesity for next three years:
- VSB09_05 Percentage of children in Reception with height and weight recorded who are obese: 08/09 9.2%, 09/10 9.1%, 10/11 9.0%
- VSB09_07 Percentage of children in Reception with height and weight recorded: 08/09 89%,

Created by Neevia Document Converter trial version http://www.neevia.com

09/10 89%, 10/11 89%

- VSB09_12 Percentage of children in Year 6 with height and weight recorded who are obese: 08/09 15.0%, 09/10 14.9%, 10/11 14.8%
- VSB09-14 Percentage of children in Year 6 with height and weight recorded: 08/09 86%, 09/10 88%, 10/11 88%.

Vital signs childhood obesity targets for next three years

- NI 52 - take up of school lunches
- NI 55 - obesity among primary school age children in Reception Year PSA 12
- NI 56 - obesity among primary school age children in Year 6 DCSF
- DSO NI 57 - children and young people's participation in high quality PE and sport DCSF DSO.

Reduce the numbers who smoke

To add in:

- Vital signs targets for smoking quitter numbers for next three years: 08/09 2700, 09/10 2600, 10/11 3050.

Reduce alcohol related harm

- Need to set targets for the next three years.

Integrated and personal approach to delivering lifestyle support services

- Need to set targets for the next three years.

Reduce inequalities in health

Vital signs targets for the next 3 years for access to antenatal care

- Percentage of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risk and choices of pregnancy: 08/09 80%, 09/10 85%, 10/11 90% (in the 1st Trimester, 12 weeks)

- N126 - Early Access for Women to Maternity Services

- Vital signs targets for the next three years for flu vaccination

Vital signs targets for the next three years for breastfeeding

- VSB11_05 - number of children recorded as being breastfed at 6-8 weeks plus the number of children recorded as receiving both breast milk and infant formula as a percentage of the number of infants due for a 6-8 week check in each quarter: 08/09 30%, 09/10 40%, 10/11 54.8%
- VSB11_06 - number of children with a breastfeeding status recorded as a percentage of all infants due for a 6-8 week check in each quarter: 08/09 85%, 09/10 90%, 10/11 95%
- NI 53 - prevalence of breastfeeding at 6-8 weeks from birth PSA 12

Health partnerships
LAA targets

- NI120 – All Age All Cause Mortality Rates: Same as signs targets for next three years

	2008/09	2009/10	2010/11
Males	630	610	590
Females	460	450	440

Created by Neevia Document Converter trial version http://www.neevia.com

- NI123 – Smoking quitter numbers: same as vital signs targets for next three years.

Staying Healthy in the Workplace

- Need to set targets for the next three years.

9 Impact on health outcomes and inequalities

NHS Bedfordshire will focus on those area in which the most serious health inequalities have been identified:

- The 20% most deprived wards in Bedfordshire – Kingsbrook, Cauldwell, Castle, Parkside plus most of Tithe Farm, Queen's Park, Goldington, Harpur, Kempston North, Kempston South, Manshead, Northfields plus west half of Chiltern
- The 20% most deprived GP practice populations - Ampthill Road surgery, Ashburnham Road surgery, Clapham road surgery, Dr V Das and partner Goldington Road, Houghton Regis Medical Centre, Landsdowne Road surgery, London Road Health Centre, Queen's Park Health Centre, Shakespeare Road surgery, Shortstown Medical Centre, Wheatfield Surgery
- Marginalised groups – homeless, people and rough sleepers with mental health problems, people with long term conditions or disabilities, ethnic minorities, gypsies and travellers, migrant workers and refugee communities, looked after children and young people, offenders and prison population and people who misuse drugs.
- We will focus on pockets of deprivation within rural areas.

Expected results include:

- Improved life expectancy
- Reduced death rates from cancer, heart disease, stroke, accidents and liver disease in areas of high prevalence
- Reduced levels of childhood obesity and associated co-morbidities, diabetes, CVD, obesity related cancers, some psychological disorders (eg, self-esteem)
- Reduced incidence of childhood infectious diseases.

10 Other impacts

- Offer plurality of choice and stimulate local healthcare market by offering range of services in community settings (ie, workplace, schools)
- Inform the community on preventative lifestyle choices
- Develop capacity of community to take ownership of and action issues relating to health and well being.

11 Impact on providers

- Need to develop community based service capacity so that prevention is mainstreamed across all service areas
- Efficient contact / commissioning management of independent contactors in order to provide greater plurality of choice in local health market
- Ramping up on community based derives within deprived area and with marginalised communities
- Provider contacts will need to demonstrate quality and how targets being met.

Created by Neevia Document Converter trial version http://www.neevia.com

Mental Health and Learning Disabilities

1 Overview

The joint commissioning strategy for mental health which has been formally signed off by NHS Bedfordshire and Bedfordshire County Council will support the delivery of the mental health related pledges in the East of England document 'Towards the Best, Together'. These are:

- Recognise the importance of prevention and the need to tackle the stigma associated with mental health problems
- Ensure mental health services are recovery focused
- Introduce a maximum wait of 18 weeks for services with a shorter guarantees where appropriate
- Seek to detect dementia earlier
- Help more people with dementia live at home as long as possible
- The East of England will recruit 350 psychological therapists. We will employ Bedfordshire's share of this target
- Deliver a new deal for carers through an expert carers programme.

The overall aim of this initiative is to improve the outcomes and life prospects of people with mental health problems. We know that outcomes are improved if services are:

- Provided in ways which are proven by research to be effective
- Accessible in times and places which are convenient for local people
- Delivered in ways which are acceptable to their users
- Available fairly and equitably to the whole community
- Relevant to the needs of people in Bedfordshire.

The key needs emerging from the strategic assessment of need are considered to be:

- Secure improvements to the therapeutic quality of acute inpatient services
- Review the provision of continuing care services for people with dementia and develop a sustainable plan for development
- Enhance integrated approaches to care co-ordination and care management in mental health services for older people
- The development of a dementia commissioning strategy in collaboration with the East of England SHA
- To deliver the 'Valuing People' objectives
- Enhanced carer and service user involvement with future commissioning of MH services
- Detailed capacity planning and modelling is currently being carried out. The Joint Mental Health Commissioning Strategy has an implementation plan that is being monitored by the Joint Commissioning Team
- A number of key initiatives from the Mental Health Commissioning Plan have already commenced. Some initiatives have already been achieved, others remain ongoing
- The key areas of review and implementation over the next two years will include eating disorder services review, a recommissioning of day care services, development and implementation of the dementia commissioning strategy and prison needs assessment
- The ongoing monitoring of the commissioning plan will continue to involve service users and carers in addition to other key stakeholders.

2 SMART goals addressed

Main goals set out in Appendix B

Mental Health goals include:

- Implementation of improved access to psychological therapy

Created by Neevia Document Converter trial version http://www.neevia.com

- Improved access to primary care
- Improved patient safety
- Improved patient experience
- Improve the life of those with long term conditions
- Bring down suicide rate by 2010.

Learning Disability goals include:

- Ensure people with a learning disability, as a significant marginalised group, receive appropriate health care
- To meet DH learning disability targets
- To address health inequalities in compliance with the Disability Equality Duty
- To ensure that people with a learning disability receive NHS commissioned services that are safe
- To ensure that progress is made in meeting the objectives of Valuing people

3 Reasons for selecting this initiative

- This initiative was chosen as the main enabling mechanisms to deliver the aspirations of the Bedfordshire Mental Health Strategy and Towards the Best, Together
- Following the publication of "Healthcare for All" NHS Bedfordshire demonstrates how it prioritises and meets the needs of people with a learning disability
- The Bedfordshire Needs Assessment has predicted a 26% increase in the prevalence of dementia by 2016. Demographic trends have clearly signified the need for enhanced Mental Health services in Bedfordshire:

- People with Learning Disabilities:

Population Forecast			
Learning Disability	2008/09	2009/10	2010/11
	2,006	2,018	2,031

- Older People with Mental Health Problems:

Population Forecast			
	2008/09	2009/10	2010/11
Dementia	12,960	14,288	15,396
Other MH problems	28,000	29,700	31,800

- 30% of GP consultations have a mental health component and 90% of all people with a mental health problem are managed entirely in primary care
- Depression and mixed anxiety/depression are the most common mental health disorders with a combined prevalence of 14%. The WHO predicts that depression will be the most common chronic disorder by 2010
- Between 15% and 20% of presentations of depression may go undetected by GPs
- Each year about 2.75 million people of working age consult a GP for a mental health disorder with 80% of these not seeing any other professional.

4 Input from stakeholders

We have undertaken substantial consultation with local communities across Bedfordshire. A range of consultation events were held across Bedfordshire. The main issues to emerge were:

- People would prefer to have their mental health managed in primary care. They saw admission to inpatient units as not the most therapeutic and wanted contact with specialist mental health services only as a last resort
- There was a strong sense of the need for robust crisis response services, particularly out of hours, with alternatives to admission being a high priority for many
- Many people felt that housing and supported accommodation were a particular need
- Service users should be given greater choice

Created by Neevia Document Converter trial version http://www.neevia.com

- Services should be improved for black and ethnic communities
- Improvements should be made to mental health promotion.

5 Value for money

- Traditionally investment in mental health services was targeted to those with a severe and enduring mental health problem and focused primarily on secondary care. The focus was largely bed based with a high dependence on traditional costly models of care. Through investment in the primary care sector in the delivery of IAPT and community based models of care it will be possible over time to significantly reduce investment in secondary settings
- Re-specifying and recommissioning both day services and the more institutional models of continuing care, using cost efficient individual budgets, where appropriate, to support this process
- By establishing robust alternatives to secondary specialist services in primary care, it will be possible to reduce reliance significantly on secondary specialist services allowing further funding to be redirected into the new services and/or secondary services. This initial investment should therefore be regarded as pump-priming
- We aim to increase our contracting of services with the voluntary sector.

6 Timescales for goals to begin

Goals to commence in 2008/2009. Key actions include:

- Start implementation of three year IAPT programme commencing
- Redesign of specialist community mental health services
- Review of Specialist Learning Disability services
- Ongoing development of specialist services during 2008/09 to include eating disorder services; perinatal mental health services; complex needs services for individuals with a personality disorder and Autistic Spectrum disorder services
- Development of a commissioning strategy for dementia

7 High level requirements

- From an investment perspective it is not anticipated that additional resource will be required before 2012. In relation to partnership working, NHS Bedfordshire will require high level and strategic commitment to formal commissioning arrangements with the emerging unitary authorities
- Increasing the investment in, and improving the delivery of, mental health services in primary care through delivery of the IAPT programme
- A substantial review of services for people with dementia, to ensure our preparedness for demographic change
- Investment needs to reflect the 'shift' from current 'inpatient' beds to a more community based model in keeping with the principles of *Valuing People*
- Ramp up primary care counselling services and primary care psychological therapy services in order to successfully implement IAPT
- Delivery of the *Valuing People Now* objectives for people with a learning disability based on four key principles of rights, independence, choice and inclusion
- Ensure that, as a system, we effectively meet the physical and mental health needs of those with a learning disability
- To ease the burden on those who care for people with either a mental health problem or a learning disability through a bespoke programme of support in partnership with local authority colleagues and the non statutory sector
- Successfully complete capacity planning across all MH areas, due by April 2009, which will allow us to make commissioning decisions for the future provision of MH services.

Created by Neevia Document Converter trial version http://www.neevia.com

8 How success will be measured

- Central to the delivery on an improved mental health service in Bedfordshire will be the successful implementation of our IAPT programme
- Measuring outcome based reductions in symptomatology will be achieved by the implementation of improved health and wellbeing outcome measures. E.g. PHQ9 and GAD7. These measures will be used as one dimension of performance monitoring
- A range of tools for monitoring user satisfaction has been included within the PCT contracting processes specifically within a performance framework and quality monitoring schedule. These will apply to all providers of IAPT
- An agreed set of activity monitoring schedules will be agreed with providers as part of a detailed SLA and as laid down in IAPT Outline Service Specification (CSIP)
- We have more than five years to achieve a further 25% reduction in acute beds and a 35% reduction in specialist community health services. This resource will be ring fenced for reinvestment in service gaps and future pressures e.g. dementia services and specialist personality disorder services
- Early identification and appropriate intervention for those experiencing mental health problems to ensure rapid recovery and retention of employment and normal routine
- Improve the quality of service outcomes for people with mild and moderate depression
- Improved care and support to those with longer term and enduring mental health problems particularly psychotic illness and severe depression through the development of programmes for social inclusion
- An integrated care pathway across all aspects of the patient experience.

9 Impact on health outcomes and inequalities

- The development of a new approach to the early identification and management of common mental health problems in primary care
- The development of stepped care arrangements for depression and anxiety and common mental health problems
- Improve accessibility of services for local people e.g. supporting local service developments for people with a personality disorder, or eating disorder
- Reduce number of acute inpatient beds, but provide them in a better quality and more therapeutic environment
- Review care pathways for referrals into services to ensure process efficiencies
- Redirect investment on inpatient personality disorder services into local community based alternatives
- Review and develop a plan to replace NHS provided continuing care with community based supported accommodation for adults of working age
- To provide ‘a modern’ pattern of day opportunities, enabling people with mental health problems to participate better in the community
- Recovery and social inclusion ethos strengthened
- Enhanced social inclusion, including the development of personal budgets, achieved jointly with the local authority in “transforming social care”.

10 Other impacts

- Improved access to psychological therapies through increased NHS Bedfordshire investment enabling a reduction in the number of people receiving incapacity benefit as a result of long term anxiety and depression
- Improve the implementation of practice mental health registers
- Specify the requirements for eating disorder services and use to achieve best value for money invested.

11 Impact on providers

- Currently secondary mental health services and specialist learning disability services are provided through a block contract with BLPT. This arrangement is not conducive to commissioning across the care pathway nor does it lend itself to person centred planning. It is contrary to the concept of market development and does not guarantee quality assurance

Created by Neevia Document Converter trial version http://www.neevia.com

- In the future it will be necessary to align the commissioning and provision of services across segments of the care pathway. This will result in new entrants into the market place who will be able to specialise in defined elements of care delivery. In particular, it is expected that an increased number of services will be provided in non statutory setting
- We will monitor the recruitment of new primary care mental health workers
- In implementing the overall mental health strategy, NHS Bedfordshire is working with mental health strategies on a capacity modelling exercise. This will help to determine the resource and capacity requirements across the spectrum of care based on different capacity scenarios.

Created by Neevia Document Converter trial version http://www.neevia.com

Drug treatment

1 Overview

Drug misuse is an issue which has an impact on our local communities in many different ways. This initiative sets out to tackle these issues at the root cause.

Key components of our initiative include:
- Reduce drug related offending and re-offending
- Increase the number of individuals retained in drug treatment
- Apply tougher sanctions
- Closure of crack houses and cannabis factories
- Seize assets of convicted dealers/disrupt drug markets
- Develop and implement IDTS at HMP Bedford
- Target drug misusing offenders
- Provide effective treatment and better outcomes for individuals
- Improvement in the local treatment system, ensuring effective treatment for individuals
- Integration of the children and young people's agenda
- Support communities with neighbourhood policing
- Support communities with campaigns such as 'Rat on a Rat'
- Multi-agency work to support work with persistent prolific offenders
- Continue to develop the Drug Interventions Programme
- Multi-agency joint commissioning and budget identification

'Models of Care' provides a conceptual framework against which to commission a four tiered drug treatment system. The treatment domains fall into four key areas:

- Drug and alcohol use
- Physical and psychological health
- Social functioning
- Criminal involvement.

The treatment modalities aim to respond to these issues through the following initiatives:
- Tier 1 – non-substance misuse specific services requiring interface with drug and alcohol treatment
- Tier 2 – open access drug and alcohol services
- Tier 3 - structured community based drug treatment services
- Tier 4 - residential services for drug and alcohol misusers.

Key milestones and monitoring mechanisms are in place to report back on a quarterly basis from providers to commissioners and from commissioning groups to high level partnership board reporting.

2 SMART goals addressed

- Number of drug users in effective treatment – N140.

3 Reasons for selecting this initiative

- This initiative was chosen in response to the new Public Service Agreement for 2008-11: Reduce the harm caused by alcohol and drugs. It is also informed by the national rationale for providing services for individuals with drug problems, 'Models of Care' and in response to the 10 Year National Drugs Strategy Drugs: protecting families and communities
- There are a range of issues that drug misuser's experience and it is the aim of this treatment system to improve or achieve better outcomes in these areas
- Initiatives also take into account and link in with housing provision and employment and training opportunities, without which it is difficult to support individuals with their drug

Created by Neevia Document Converter trial version http://www.neevia.com

treatment needs.

4 Input from stakeholders

Local patients, clinicians, and partners have been consulted in defining the initiatives through:

- Bedfordshire Drug Action Team adult treatment services review 2005
- Crack Market in Bedfordshire 2004
- Adult Drug Treatment Needs Assessment 2007
- BDAT research into the substance misuse needs of underserved groups in Bedfordshire
- Assessing the housing needs of drug and alcohol users in Bedfordshire 2006
- Adult drug treatment needs assessment 2007.

5 Value for money

- Locally unit costings have been developed for drug treatment programmes for drug using offenders and Bedfordshire has been identified as providing best value for this initiative in the eastern region at £1,407 per patient. This is calculated by the number of patients in the initiative against the funding allocated by the Home Office
- Unit costings for non offenders in treatment can be identified by using the Department of Health calculation that for every £1 spent on drug treatment, the cost saving to society is £9.50.

6 Timescales for goals to begin

- All goals to begin in 08/09.

7 High level requirements

Key requirements include:
- Joined up approach with local law enforcement agencies - closure of crack houses and cannabis factories
- Seize assets of convicted dealers/disrupt drug markets
- Develop and implement IDTS at HMP Bedford
- Strong partnership working
- Identification of shared agendas
- Clear identification of local need
- Robust data collection and information sharing
- Integration of the children and young people's agenda
- Support communities with neighbourhood policing
- Support communities with campaigns such as 'Rat on a Rat'
- Multi-agency work to support work with persistent prolific offenders
- Continue to develop the Drug Interventions Programme
- Multi-agency joint commissioning and budget identification.

8 How success will be measured

Performance will be measured against two separate treatment populations:
- PDU (problematic drug users) - clients, of any age, including young people, presenting for treatment with either opiates or crack cocaine as their main, secondary or tertiary problem substance
- All adult - over 18s presenting with any problem substance (as in 2007-08).

Effective treatment is defined as:
All individuals in contact with tier 3 or 4 services during the period who are recorded as having begun a drug treatment intervention and who fulfil either of the following criteria:
- They were retained in treatment for 12 or more weeks after their triage date
- They were subject to a planned discharge following successful completion of their treatment within 12 weeks of their triage date. A successful completion is denoted by use of the discharge reasons 'Treatment completed' and 'Treatment completed drug free'.

Created by Neevia Document Converter trial version http://www.neevia.com

Target numbers have been calculated as detailed in the table below. In line with LAA and PCT targets, increases of 3%, 2% and 2% have been applied to years 2008-09, 2009-10 and 2010-11 respectively. Further increases of 2% have been applied to years 2011-12 and 2012-13. All increases have been referenced to the 2007-08 baselines shown.

	2007-08 (Baseline)	2008-09	2009-10	2010-11	2011-12	2012-13
PDU in Effective Treatment	788	812	828	844	859	875
Adults in Effective Treatment	875	901	919	936	954	971

9 Impact on health outcomes and inequalities

- As detailed previously these initiatives aim to address issues for individuals around drug treatment. The aim is to address their drug use, to improve their outcomes both physically and psychologically, to improve their social functioning and issues around criminal involvement
- The high level outcomes we strive to improve include reduced numbers of individuals with physical health problems, reduced numbers with psychological problems, reduction in risky behaviours, a reduction in the rate of BB viruses which is currently an issue for public health
- As there is a correlation between drug use and deprivation, targeting drug use will help to reduce health inequalities in Bedfordshire.

10 Other impacts

- All of these issues have an impact on our local communities and impact the need for NHS services and other public services, affecting the health economy. The cost to society is high and through the initiatives outlined we are striving to address this
- A reduction in crime rates.

11 Impact on providers

- The implications for providers of this initiative will include increased expansion of staff teams, overheads and rental increases for buildings, increased prescribing costs for Methadone scripts, increased in-patient detoxification provision, community detoxification programmes, residential and respite rehabilitation services, remuneration for GP provision for substitute prescribing, pharmacy provision of supervised consumption schemes, Provision of harm reduction interventions including HEP B vaccination for all drug users and HEP C screening for current or previously injecting drug users and an expansion in services HMP Bedford and community based services to provide drug treatment for offenders.

Created by Neevia Document Converter trial version http://www.neevia.com

Maternity and New Born

1 Overview

The Bedfordshire vision is for choice, high quality and safe maternity services to be a reality for all, including those at the greatest risk as a result of health inequalities.

Our Maternity and New Born strategy aims to improve local maternity services for all women and their families, in particular:

- Reduce health inequalities by reconfiguring antenatal and postnatal services
- Offer more choice to women about how they access antenatal and postnatal care, and where they have their baby
- Improve the quality of care women receive when they have their baby; including ensuring women receive one-to-one midwifery care in established labour.

Local health inequalities data (e.g. breastfeeding rates, low birth weight rates, areas with high levels of teenage mothers), user focus groups, and improved assessment protocols will be used to target additional resources and support to areas and women with greater needs to help achieve improved health outcomes for all local women and their babies. Systems for monitoring these outcomes will need to be improved simultaneously to help continually improve maternity service planning and performance management.

All women are already offered the choice of a home birth (where this is safe and appropriate), or a delivery in one of a number of local hospitals supported by a maternity team. By December 2009, all women will also be offered the choice of giving birth in a local midwife-led birthing unit, co-located with their acute maternity unit.

Underpinning local choice is our commitment to provide safe services; maternity care must be as safe as possible. Practice must be based on available evidence and delivered according to relevant clinical guidelines. NHS Bedfordshire will use its contracts with acute providers to drive improvements in the quality of local maternity services, in particular to ensure all local women receive one-to-one midwifery care in established labour from 2010/11, wherever their baby is delivered.

2 SMART goals addressed

SMART goals addressed include:

- Ensure midwife-led birthing units are available at all local acute trusts by the end of 2009
- Ensure one-to-one midwifery care in established labour by 2010/11
- Increase in percentage of women accessing maternity services for assessment within 12 completed weeks of pregnancy to 90% by 2010/11
- Increase in number of infants breastfed at birth from 62.2% to 75% by 2010
- Increase in number of infants breastfed at 6-8 weeks to 52% by 2010/11
- Decrease in number of women who smoke during pregnancy to 15% or less by 2010
- Achieve the choice guarantees in *Maternity Matters* by the end of 2009.

3 Reasons for selecting this initiative

- Good maternal health and high quality maternity care throughout pregnancy and after birth can have a marked effect on the health and life chances of newborn babies, on the healthy development of children and on their resilience to problems encountered later in life
- The Audit Commission review of maternity services in 2007 identified some significant areas for improvement within a number of local maternity service providers. The Bedfordshire review of maternity services carried out last year also identified some key priorities for improvement in relation to reducing health inequalities and improving the quality of local services
- Breastfeeding initiation rates in Bedfordshire are amongst the lowest in the East of England, with significant variation in uptake between different communities and significant drop-off

Created by Neevia Document Converter trial version http://www.neevia.com

rates for those women who do start breastfeeding. The overall benefits of breastfeeding to mother and baby are well documented and we are clear that increasing breastfeeding rates must continue to be a priority for local maternity services over the next few years
- Bedfordshire has significant numbers of teenage mothers, many of whom could benefit from extra support during and after their pregnancy to help prevent negative lifestyle choices being made and to minimise some of the significant poor outcomes often associated with becoming a parent as a teenager
- Information about the number of women smoking during pregnancy is poor and needs to be improved. However, we are aware that there are significant numbers of women smoking throughout their pregnancy and we aim to help more women give up smoking before and during their pregnancy
- The local priorities complement the national direction of travel for maternity services. The local strategy will help the trust to achieve the vision and national choice guarantees set out in the Department of Health's strategy, *Maternity Matters*, the vital signs targets relating to maternity services and the East of England vision for maternal and new born care.

4 Input from stakeholders

- Ongoing consultation with stakeholders, including service users, through Maternity Services Liaison Committee
- NHS Bedfordshire led consultation process for *TTBT*
- Local patient surveys conducted by Audit Commission as part of national review of maternity services
- Stakeholder away day involving local clinicians and user representatives in September 2009 to consult on our strategy for maternity services
- Children and Young People Group.

5 Value for money

The national tariff provides funding for acute trusts for all the care they provide in relation to the delivery of babies. All improvements within this area of care will be delivered through achieving better value for money from local providers and any national uplift to the tariff. The establishment of midwife-led birthing units will support trusts in achieving this. We will be involved in the pilot of a new national commissioning toolkit for maternity services, which will hopefully develop our ability to commission these services more effectively.

Reconfiguring antenatal and postnatal care will require additional investment. From this investment, the PCT will expect to achieve the following outcomes:
- Increase in percentage of women accessing maternity services for assessment within 12 completed weeks of pregnancy
- Significant increase in breastfeeding rates
- Decrease in number of women who smoke during pregnancy
- Improved support for teenage mothers
- Improved choice for local women and increased patient satisfaction

In the long term, these outcomes will contribute towards a healthier population, reducing the financial demands on our healthcare system.

6 Timescales for goals to begin

All goals to begin by 09/10 (to meet deadlines within *Maternity Matters*)
- Revision of service specifications for antenatal and postnatal care from Bedford Hospital and Luton and Dunstable Hospital by April 2009 (to include increased capacity levels by September 2009)
- Revision of Quality Schedule within contracts for all local acute trusts providing maternity services by April 2009 (to include targets for staffing ratios and percentage of women receiving one-to-one midwifery care)
- Minimum of two midwife-led beds to be available each at Bedford Hospital and Luton and Dunstable Hospital by December 2009 (this may have workforce/estates implications, but these will be the concern of the two acute trusts, primarily)
- Review of demand and available capacity for midwife-led beds to be conducted during 2010,

Created by Neevia Document Converter trial version http://www.neevia.com

with a view to potentially increasing capacity by 2011/12
- County-wide workforce plan to be in place by April 2009
- Establishment of postnatal care in children's centres by end of 2009 (this may have IT / estates implications, but these will be the concern of the two acute trusts, primarily).

7 High level requirements

- The majority of this initiative will be achieved through more robust commissioning arrangements with maternity service providers. Delivering some of the objectives will require significant investment by the trusts (to bring them in line with national standards as funded by the national in-patient tariff) in order to achieve a significant increase in staffing levels, particularly midwifery staff
- Contracts with Bedford Hospital and the Luton and Dunstable Hospital will need to include more detailed service specifications for community midwifery services, and more challenging quality targets from 2009/10. Senior clinicians from these trusts have been involved in creating our maternity strategy and there is a strong commitment to working in partnership to deliver this agenda
- In order to deliver this work programme, NHS Bedfordshire recently created a new senior post responsible for the effective commissioning of children and maternity services. This post should ensure the necessary dedicated commissioning capacity required is in place to deliver this strategy.

8 How success will be measured

KPIs:
- Percentage of women accessing maternity services for assessment within 12 completed weeks of pregnancy. (Not all hospitals supply quarterly. Baseline currently being calculated. System for routinely monitoring this information to be in place by April 2009)
- Number of infants breastfed at birth (already measured quarterly, but not all hospitals supply. Will be included as mandatory information requirement in all relevant acute contracts for the PCT from April 2009)
- Number of infants breastfed at 6-8 weeks (already measured quarterly)
- Number of women who smoke during pregnancy (currently measured quarterly but not all hospitals supply. Will be included as mandatory information requirement in all relevant acute contracts for the trust from April 2009)
- Under-18 conception rate per 1,000 females aged 15-17 (already measured)
- Number of home births (already measured quarterly)
- Number of women giving birth in midwife-led unit (not currently measured as no facility available yet. To be measured quarterly from April 2009).

Trajectories (where robust information is currently available)

	2009/10	2010/11	2011/12	2012/13	2013/14
No. infants breastfed at birth	75%	77%	79%	80%	80%
No. infants breastfed at 6-8 weeks	41%	52%	54%	56%	58%
U18 conception rate	23.2 per 1,000 females aged 15-17	20.4	19.6	-	-

9 Impact on health outcomes and inequalities

One of the main aims of the NHS Bedfordshire's maternity strategy is to provide targeted support and resources to reduce health inequalities relating to maternal and new born care in Bedfordshire. In particular, this strategy aims to achieve the following:
- Improve access to antenatal and postnatal care
- Deliver greater choice for women on where they have their baby, and an increase in midwife-led and home births
- Improve quality and patient experience in relation to maternity services

Created by Neevia Document Converter trial version http://www.neevia.com

- Decrease in caesarean section rates
- More women accessing antenatal support at an early stage of their pregnancy and receiving comprehensive assessment of their health and social care needs
- Decrease in women smoking during their pregnancy
- Increase in infants breast-fed and increase in the duration of breastfeeding
- Targeted support for teenage mothers
- Reduction in low birth weight babies
- Decrease in infant mortality
- Reduction in pre-natal mental health problems and improved access to support services.

10 Other impacts

- Activity**:** increase in antenatal activity, approx additional 1,000 ante-natal contacts per annum[1]; increase in postnatal contacts for higher-risk women/families, approx 1,000 additional contacts per annum. This will affect the services at Bedford Hospital and Luton and Dunstable Hospital only (as the only providers of antenatal and postnatal care for Bedfordshire women)
- Finance**:** additional revenue costs for commissioning community midwifery services (acute commissioning budget/maternity and reproductive health programme budget).

11 Impact on providers

- Reconfiguration and increase in capacity for existing community midwifery services
- Significant workforce implications, particularly recruitment of approx additional 19 wte midwives at both Bedford Hospital and the Luton and Dunstable Hospital (although only 1/3 of Luton and Dunstable activity relates to Bedfordshire patients). Bedford Hospital and the Luton & Dunstable Hospital will each need to recruit an additional 18.5 wte midwives to achieve the nationally recommended staffing ratios. We will need to support the trusts with ensuring robust county-wide workforce planning arrangements are in place
- Acute trusts offering greatest choice of delivery facilities may see an increase in activity, attracting new patients away from neighbouring trusts.

[1] Based on the following assumptions: 5,000 deliveries per annum, 10% more pregnant women accessing midwife within 12 completed weeks of pregnancy, resulting in additional 2 antenatal contacts for each of these women

Created by Neevia Document Converter trial version http://www.neevia.com

Children's services

1 Overview

Children's strategy
Our aspiration is to improve the lives and health of children and young people in Bedfordshire through the delivery of appropriate, integrated, effective, evidence based and needs led services and to improve the experiences and satisfaction of children, young people and their carers with the services provided for them and deliver year on year improvements in the health of Bedfordshire's children.

The East of England Core Children's Pathway identifies stages to consider for children's health and we have developed our strategic direction based on this.

Children and young people will be fully involved in designing services, we will use the "You're Welcome" framework to plan and develop plans for this in Bedfordshire.

Prevention
- Prevention of ill health is a vital part of our work. It enables us to address key lifestyle choices that have major impacts on future health and an increased focus will be placed on this over the coming five years
- Key to this is access to primary care services, which will be increased through increased availability of GP services and the implementation of the Child Health Promotion Programme (CHPP). We will redesign services to in order to provide an effective CHPP across Bedfordshire. With spend on Health Visiting and School Nursing being in line with neighbouring PCTs, CHPP will be developed from existing resources.

Identification
- Appropriate Identification of possible health problems is crucial to early assessment and treatment
- We will work to increase the level of training and support to all those working with children in order to raise their levels of skills and knowledge of specific health problems and enable them to identify potential health problems at an early stage. Providing accurate information about services available, referral criteria and process is also key to assist the progress of referrals along the pathways.

Assessment
- Access to some secondary care and specialist services for assessment and treatment is a concern for parents. Reducing waiting times for services such as speech and language therapy and occupational therapy services in particular are a priority. Services will be redesigned to meet future need
- In collaboration with the East of England SHA, we will develop new Children's Assessment Units and review whether every acute hospital needs an inpatient ward.

Management
- An increasing amount of health care for children is being provided in community settings. This increase will continue over coming years with non urgent care being focussed in a community setting. Work needs to take place to review the appropriate setting for current provision and make plans for moving services into appropriate settings
- Child and Adolescent Mental Health Services (CAMHS) is vital to ensure that Bedfordshire's children lead healthy, productive and happy lives. We will strengthen services to improve the mental wellbeing of our children and young people
- There is a commitment through the Local Area Agreement to reduce the year on year levels of drug and alcohol use in Bedfordshire's children
- We will develop common information systems, integrated care and co-located staff to deliver better services for children
- Children's centres are providing the focal point for early identification and targeted intervention programmes. Integrated teams increasingly operating from children's centres will be the core element of providing the child health promotion programme and will include

Created by Neevia Document Converter trial version http://www.neevia.com

staff from education, health social care and the voluntary sector
- Bedfordshire has national recognition for some of its integrated care and co located staff. One example of this is the Child Development Centre in Kempston. Opportunities to develop integrated teams in other areas of provision will be pursued with key providers such as the new unitary authorities and the voluntary sector
- With Bedford Borough and Central Bedfordshire Councils, we will be partners in developing two new children's trusts, leading to integrated provision for children across Bedfordshire.

Long term support
- Work will focus on redesigning services to best meet the needs of the population
- We will ensure that the needs of adolescents are properly catered for and there is a seamless transition to adult services. Transition protocols will be developed for all services based on agreed principles
- We will significantly improve the lives of disabled children and those with life limiting conditions by implementing the key recommendations of **'**Aiming high for disabled children' We will work with all relevant local authorities to significantly increase the range and number of short breaks In partnership with local authority colleagues, ensuring that by the end of March 2009 we are able to demonstrate that we are ready to transform short break services using funding in accordance with forthcoming programme guidance for the development and improvement of short break services for disabled children
- We will implement the key recommendations of 'Better Care, Better Lives Palliative Care Strategy'. We will develop a comprehensive Palliative care strategy for Bedfordshire and work closely with partners to improve services.

2 SMART goals addressed

- **CHPP** - improve the health and well-being of children in the early stages (pregnancy and the first five years of life). Specific measures will include performance against targets for teenage pregnancy, breastfeeding, childhood obesity
- **ESP** – 1. improve quality of life for child and family 2.Child and family feel accepted in their chosen communities 3.Improvements in the health of children 4.Confident, knowledgeable parents and professionals, including school staff
- **Children's therapies** – reduce waiting times to 11 weeks by end 2010/11
- **Non urgent care** – 3,100 outpatient appointments will be provided in community setting by 2014/15
- **Drug and Alcohol use** – year on year reduction in use by young people
- **CAMHS** – achieve a 'comprehensive CAMHS by 2010/11 – metric self assessment score 2008/9–14 (target for 2010/11-16)
- **Common information systems, integrated care and co located** staff - 50% of community health staff in collocated teams by 2012/13
- **Transition protocols** – year on year increase in transition protocols
- '**Aiming high for disabled children'** – core offer fully implemented by 2010/11
- '**Autistic spectrum disorders'** – services developed by 2010/11
- **Children and young people's involvement** – commissioning strategies informed by awareness of user needs – 2010.

3 Reasons for selecting this goal

NHS Bedfordshire recognises the importance of children's health in delivering the five Key 'Every Child Matters' outcomes for children. 25% of our population are aged 19 or under, they have their own needs which are best met by all agencies working closely together to achieve the best outcomes for our children. Working in partnership will be a key theme running through all workstreams over the coming five years.

Improving the health of our children is also the best way to improve the health of our future adults. We are clear that we want Bedfordshire's population to live healthy lives and to do this, we must focus our attention on prevention and early intervention in childhood
- **CHPP** – chosen because of the need to develop preventative services designed to meet the individual needs of children and young people in partnership with different agencies
- **ESP** – It has traditionally been the case that disabled children are likely to have poorer outcomes across a range of indicators compared to their non-disabled peers. A lack of

Created by Neevia Document Converter trial version http://www.neevia.com

appropriate and timely support for disabled children to allow them to fulfil their potential not only affects disabled children and their families, it also prevents communities benefiting from the contribution that disabled children can make

- **Children's therapies** – children's therapy services (speech and language, occupational therapy and Physiotherapy) have been highlighted by the Healthcare Commission as in need of improved access
- Non urgent care – Children should not have to go to hospital unless absolutely necessary. This work is key to improving the experiences of children and young people who use our services. Currently, there are 6,200 outpatient appointments per year for Bedfordshire children.
- Children and young people in Bedfordshire continue to highlight drugs and alcohol as something that is an important issue for them (Child and Young Peoples Partnership Review 08/09). It is an indicator in our LAA which reflects the importance partners place on the issue locally
- **CAMHS** – Bedfordshire invests less in CAMHS by comparison with similar PCTs (see table). The £2.7m provides direct services to approximately 1000 children per year across Bedfordshire. ONS statistics indicate that one in 10 children and young people are suffering from a mental health problem at any one time. This equates to 9,900 children and young people in Bedfordshire and indicates a significant unmet need. Clearly, not all of these children will require direct specialist intervention. However, current resources only provide limited services and there is a significant gap in provision below the threshold for specialist tier 3 services. An additional £5 per head per annum would bring us closer to the resource level provided by similar PCTs and enable the development of services required for a 'Comprehensive CAMHS'.

CAMHS			
County	**Spend 2007/08**	**Population 0-19 year olds**	**Spend per head**
Bedfordshire	£2.7 m	99,278	£27.20
Cambridgeshire	£6.7 m	135,089	£49.60
Hertfordshire	£9.8 m	261,597	£37.46
Northamptonshire	£4.6 m	164,078	£28.03

- Improving CAMHS is an LAA target for Bedfordshire
- Common information systems, integrated care and co located staff - we have strong links with partner agencies in Bedfordshire and want to build on these to provide seamless services to meet all the needs of children and young people. Health professionals should be co-located in children's centres, extended schools and other community settings to enable this to become a reality.
- Transition protocols – transition from child to adult services is not always smooth, especially for those with chronic health problems. We are determined to make these transitions easier and therefore improve the experience of young adults using our services
- 'Aiming high for disabled children'' - provision of services for disabled children can be more effective in promoting the life chances of the children who use them. With our partners we have agreed to improve services for this group of children across Bedfordshire
- Autistic Spectrum Disorders – national estimates place the numbers of children with Autistic Spectrum Disorders (ASDs) at between 60 and 90 per 10,000. For Bedfordshire, that would equate to between 594 and 891 children. Bedfordshire County Council figures on those children with special educational needs, identify 477 children as having a primary need of ASD. 91% of whom are male, and 75% of whom would not be eligible to access services for children with a learning disability. Many PCT's have developed specialist service provision in partnership with local authorities for this group of children and young people. Bedfordshire does not at present have such services and many of the needs of this group of children are unmet
- **Children and young people's involvement** – This will be a key theme running through all of our work and will help us to ensure that we develop services designed to meet the needs of children and young people.

4 Input from stakeholders

Multi agency strategy groups currently exist for a range of clinical areas including:

- CAMHS

Created by Neevia Document Converter trial version http://www.neevia.com

- Children with disabilities
- Paediatric therapies
- Children's centres
- Young offenders

These groups include clinicians, local authority and voluntary sector representatives.

- Children and young people have been consulted about a range of health services as part of the Tellus2 survey. Tellus3 is currently taking place and will provide updated information to be used as part of the process for planning and commissioning services
- Children's participation officers are employed by both Mid Bedfordshire and Bedford Borough District councils
- A CAMHS conference is being organised for 22 October 2008, in order to consult with a range of stakeholders. On relevant issues such as self harm pathways and IAPT
- Parent partnership is a key local authority initiative supporting parents and helping to give them a voice in local service and processes. As a result, parents have been involved in the recent review of paediatric therapies and will continue to be encouraged to become involved in a more systematic way in health services.

5 Value for money

The planning assumption is that no new investment will be required to deliver this strategy, unless nationally allocated for specific programmes, such as 'Aiming High for disabled children'. The emphasis is about using current resources more effectively.

Being able to provide appropriate assessment and treatment at an earlier stage and to more children and young people will provide long term financial savings that will last into adult lives and have a positive financial impact on adult budgets:

- Prevention – our increased focus on prevention and changes in lifestyle will enable us to gain long term financial benefits due to the general health improvements that are accrued
- Identification – the shift in resources to earlier identification and the development of those with relevant skills and knowledge will have a positive impact on financial resources
- Assessment – increasing community based capacity to assess in multi agency settings will lead to timely appropriate and cost effective services
- Management – management of services closer to home and at an earlier stage will bring cost benefits
- Long term support – appropriate support for those with long term conditions such as ASDs will provide more effective and lessen the levels of inappropriate referrals of children and families currently isolated.

6 Timescales for goals to begin

- **CHPP** – Plans included in Operational Plan – March 2009
- **ESP** – 2009/10
- **Children's Therapies** – 2009/10
- **Children's Assessment Units** – roll out 2010/11
- **Non urgent care** – 2009/10
- **Drugs and alcohol**. – from 2009/10
- **CAMHS** – Activity from 2009/10
- **Common information systems, integrated care and co located staff** - will begin in 2010/11
- **Transition protocols** – this programme will start in 2009/10
- **'Aiming High for disabled children'** – Plans in place for 2009/10. core offer fully implemented by 2010/11
- **Autistic Spectrum Disorders** – services developed by 2010/11
- **Children and young people's involvement** – user groups established – March 2009.

Created by Neevia Document Converter trial version http://www.neevia.com

7 High level requirements

This initiative is dependent on ownership by:

- PBC consortia
- Children and Young Peoples Partnership
- The new Unitary authorities

There is an expectation that these initiatives can in some way be delivered through service re-design within the NHS. However there are likely to be start up and double running costs as new initiatives are started until whole services switch over to the new provider.

Currently we spend £2,050,930 (08/09) on hospital based paediatric outpatient provision. Assuming we wish to move 50% of these services into community based settings over the next five years, we will require additional community based facilities capable of providing 6,300 appointments across the county. Although this may save resources in the long run, it will require capital investment to develop community facilities.

8 How success will be measured

- **CHPP** - improve the health and well-being of children in the early stages (pregnancy and the first five years of life) specific measures will include performance against targets for Teenage pregnancy, breastfeeding, childhood obesity **– will be measured by key VS** targets
- **ESP** – 1. Improve quality of life for child and family 2.Child and family feel accepted in their chosen communities 3.Improvements in the health of children 4.Confident, knowledgeable parents, and professionals including school staff. – will be measured by a range of 'soft' outcome measurements. Satisfaction questionnaires, including confidence of adults in dealing with the difficulties of this group and 'hard' outcome measures such as the Therapies Outcome Measure – with targets of 85% agreement from parents that child's health has improved to the degree expected
- **Children's Therapies** – reduce waiting times to 11 weeks by end 2010/11 – Waiting time data will be measured on a monthly basis to ensure referral to treatment time is below 18 weeks
- **Children's Assessment Units** – metrics to be provided by SHA.

Non urgent care – 3,100 outpatient appointments will be provided in community setting by 2014/15. Annual targets to be set for number of additional appointment from baseline seen in the community:

- 2009/10 – 200
- 2010/11 – 400
- 2011/12 – 900
- 2012/13 – 1800
- 2013/14 – 2500
- 2014/15 – 3100

Local interim Drugs and Alcohol measure:

- The % of Young People in Year 10 who report drinking 21 units or more prior to the Balding Survey

Local interim targets – Males:

- North Bedfordshire – in the 2008 Balding Survey, to record less than 6% documented in 2006
- Mid & South Bedfordshire – In the 2008 Balding Survey, to record less than 27% documented in 2006

Local interim targets – Females

- North Bedfordshire – in the 2008 Balding Survey, to record less than 5% documented in 2006. Mid & South Bedfordshire - In the 2008 Balding Survey, to record less than 13% documented in 2006

- **CAMHS** – achieve a 'comprehensive CAMHS by 2010/11 – metric self assessment score 2008/9–14 target for 2010/11-16

Created by Neevia Document Converter trial version http://www.neevia.com

Common information systems, integrated care and co located staff - baseline needed for 08/09:

- 20% of community health staff in collocated teams by 2009/10
- 30% of community health staff in collocated teams by 2010/11
- 40% of community health staff in collocated teams by 2011/12
- 50% of community health staff in collocated teams by 2012/13
- Transition protocols – year on year increase in transition protocols
- Audit needed of current services with transition protocols 09/10
- 50% with transition protocols by 11/12
- 100% with transition protocols by 12/13
- 'Aiming High for disabled children' – core offer fully implemented by 2010/11 – Nationally set metrics
- 'Autistic spectrum disorders' – services developed by 2010/11
  Multi agency agreement for planning – 2009/10
- Audit of current provision and service plans 09/10
- Investment and implementation of services 10/11.

9 Impact on health outcomes and inequalities

- **CHPP** – we will begin to see levels of childhood obesity fall, breastfeeding increase and teenage pregnancy decrease, leading to an increase in the health of children and young people and a related fall in demand for specialist services
- **ESP** – 1.Improve quality of life for child and family 2.Child and family feel accepted in their chosen communities 3.Improvements in the health of children 4.Confident, knowledgeable parents, and professionals including school staff
- **Children's Therapies** – we will see an improvement in the patient experience
- Common information systems, integrated care and co located staff - 50% of community health staff in collocated teams by 2012/13
- Transition protocols – yr on yr increase in transition protocols
- 'Aiming High for disabled children' – core offer fully implemented by 2010/11
- Autistic spectrum disorders – services developed by 2010/11.

10 Other impacts

- There will be closer working relationships with partner organisations, especially Bedford Borough and Central Bedfordshire. Integrated teams, systems and services, possibly within a children's trust arrangement, will be central to many of the key priorities. Joint funding and commissioning of services will also help set the key underpinning framework to enable the identified priorities to make progress
- Joint resources will have capital implications and it is important that Unitary authorities are engaged and signed up to the NHS strategic direction as soon as is practically possible.

11 Impact on providers

- Acute trusts and specialist Mental Health trusts will see a reduction in the amount of work expected to be provided from hospital and specialist settings as increasing amounts of resources are diverted into prevention and early intervention
- Community based healthcare providers across all sectors will need to be supported to grow their capacity to deal with non urgent care cases
- Workforce developments will need to be carefully planned to enable the appropriately skilled professionals to be available in the right place and at the right time.

Created by Neevia Document Converter trial version http://www.neevia.com

Planned Care

1 Overview

The aim is to deliver convenient planned care closer to home, away from acute hospitals. There is a strong focus on localisation, choice, co-ordination across organisational boundaries and a split from acute services. All planned services will be accessed as quickly as clinically appropriate with an absolute maximum wait of no more than 18 weeks from referral to first definitive treatment.

Key aims in each area:

Assessment

- Ensure equitable access to a full range of high quality primary care services provided by GPs, dentists, optometrists and pharmacists
- Improve public satisfaction on access and responsiveness of primary care services
- Identify where there is unmet need for dentistry/other primary care services. Provide patient information about available community services. Improve access to GPs by rolling out the online booking of appointments, and offering patients the opportunity to access email/telephone consultations.

Diagnosis and Routine treatment:

- Direct access to diagnostics and availability of results prior to consultant appointment
- To develop a holistic integrated plan for community diagnostics, with services being co-located as appropriate, e.g. X-Ray/CT
- Fully engage with PBC Groups to develop a comprehensive strategy of community diagnostic services together with the infrastructure to underpin these, which will in turn enable a wide range of outpatient services to be offered from local primary care settings.

Complex treatments:

- Achieve provision of complex treatments in specialist centres to improve patient safety and clinical outcomes. For Bedfordshire residents this will require some patients to be treated in specialist centres outside of the county. Addenbrookes Hospital is already a hub for North Bedfordshire in specialities such as gynaecology whilst East and North Herts Trust is the Bedfordshire hub for OMF
- It is likely that the central hubs for complex surgery will mirror those for cancer services. However in Bedfordshire this is a complex arrangement of networks due to the geography and traditional professional links within specialist services. NHS Bedfordshire links formally into two cancer networks, Anglia Cancer Network and Mount Vernon Cancer Network. In addition some patients in the West of the county access both Thames Valley and East Midlands Cancer Networks depending on which DGH they access for initial assessment
- Appropriate diagnostic tests and early pre assessment will be arranged before specialist opinion is sought. Patients care will be managed by specific multi disciplinary teams specialising in their condition and ensuring continuity of care. It will be important to have an identified member of the team to support the patient with informed choices throughout their care pathway. It will be essential to have information networks to support these services with reporting of results etc available across the network from GP practice to the specialist unit
- A review of all tertiary services will be undertaken and where appropriate and safe services will also be repatriated to local DGHs.

Review and rehabilitation:

- Ensure that treatment reviews are more accessible and convenient. Availability of effective rehabilitation and community based services to ensure minimum length of hospital stay and short recovery time will be essential
- Ensure that the ratios of new to follow up for hospital based outpatient appointments achieve the top ratings in national bench marks (work already underway). In order to support this initiative work with GPs and consultant medical staff is underway in partnership with Bedford Hospital to consider and develop alternatives to hospital based follow up such as GP led follow up and telephone treatment review follow up. Community based consultant follow up

Created by Neevia Document Converter trial version http://www.neevia.com

will only be considered where there is no alternative

- To facilitate a reduction in the length of time patients need to spend in acute hospital services it will be important to ensure that access to community services is easy through, for example, a single point of access. Community services will be commissioned to deliver a level of rehabilitation that is currently provided in hospitals through the training and development of staff with development of opportunities for staff to rotate across settings. Seamless pathways of care for patients will be further supported through reviewing opportunities for joint staff bases for health and social care staff
- The use of community beds such as Biggleswade Hospital will be reviewed to ensure that they are able to provide a base for comprehensive intermediate care services with coordinated rehabilitation and treatment centres.

2 SMART goals addressed

- 75.9% of practices to offer extended hours outside of Mon to Fri 8am-6.30 by April 2009 – those areas with the greatest inequity of access will be give priority. (Level 2 facility)
- Target for QOF performance of 95% achievement.

Other goals include:

- Convenient planned care outside of hospital
- Separation of planned from acute care
- Improved safety and clinical outcomes by delivering complex care in specialist centres.

3 Reason for selecting this initiative

GP-led Health Centres (Equitable Access Programme)

- As outlined in the PCTs Primary Care Strategy, the DH announced the Equitable Access programme in December 2007. This required all PCTs to open at least one GP-led health centre by December 2008. Following a partnership dissolution in December at a large, GP PMS practice in Bedford, we had to go out to tender for a new service. This gave rise to the opportunity to provide the service in line with the proposals set out in Lord Darzi's interim report. The new service will commence on 1 October 2008 and services will be available 12 hours per day, seven days per week and to both registered and non-registered patients. At least two other such health centres are planned.

Pharmacy Services

- The recently announced DH White Paper on Pharmacy Services sets out a vision for building on the strengths of pharmacy and the new Pharmacy contract and seeks to involve pharmacists in the mainstream NHS. Medicines review work, smoking cessation, Chlamydia screening, emergency hormonal contraception, influenza vaccination and weight management services are all areas where pharmacists are ideally placed to contribute.

Dental Services

- In Bedfordshire, access to NHS dentistry is generally good but there are priority areas, namely Leighton Buzzard, where improvement is needed. Work has begun to develop an Oral Health Strategy in Bedfordshire - this need to be fully integrated with all future PBC plans.

4 Input from stakeholders

Clinicians

- Clinical leadership and effective engagement are critical in the delivery of this strategy. A clinical champion will be identified to support the delivery of this strategy and chair the steering group. Other clinicians will be invited to participate in the task and finish groups
- Local ownership is critical and the PBC consortia will work closely with the PCT to engage the GPs, nurses, and other allied health professionals. Where appropriate, the PBC consortia will take a lead role to drive forward the actions.

Users and carers

- Public and users are at the heart of this commissioning strategy, and they will have key roles in the task and finish groups

Created by Neevia Document Converter trial version http://www.neevia.com

- Useful and relevant feedback will be taken into account, to ensure the commissioned services are appropriate and responsive to the needs of the users and carers. The PCT will also be working with the Service User Engagement Team at the LA on future workshops or consultations.

5 Value for money:

- The provision of secondary care services is a significant drain on PCT resources and is not always the most appropriate setting for patients to receive their care.
- Therefore, the Primary Care Strategy and supporting initiatives have been developed to ensure that patients can access Primary Care Services in a timely and appropriate manner.
- A reduction in inappropriate referrals to secondary care, A&E attendances and more cost effective and equitable access to primary care will ensure a more cost effective use of local NHS resources as well as ensuring patients receive the right care in the right setting at the right time.

6 Timescale for goals to begin

- Activity will begin in 08/09
- New health centre to open 12 hours daily 7 days per week by December 2008 in Bedford (Putnoe Health Centre), with further centres to be developed in 2009/10 and beyond, including the Dunstable Medical Centre and Bedford Health Village. (Level 3 facilities)

During 2008/09 we will also:
- Commission an EHC service (part of re-design of sexual health services)
- Work closely with the LPC, PBC groups and local pharmacists to prioritise other appropriate developments, particularly to help meet key national targets
- Finalise and implement the Oral Health Strategy, including needs assessment
- Ensure optimal dental access for our population
- Plan dental access for population growth (Wixams and Shortstown).

7 High level requirements

- This initiative is dependent on local ownership by PBC consortia, clinical engagement and working in partnership with East of England, local authorities, local providers and third sector
- There is an expectation that these initiatives can in some way be delivered through service re-design within the NHS. However there are likely to be start up and double running costs as new initiatives are started until whole services switch over to the new provider
- Community based (a combination of mobile/static solutions) availability of a greater range of diagnostics e.g. X-Rays, US, blood tests and simple MRIs (D Dymers). Level 3 facilities will be developed that will offer a comprehensive range of diagnostic services, which would typically support a population of 60-80K
- Improved GP access to diagnostics results (through web based clinical information systems)
- Direct access to surgery for cataracts, hernia repair etc
- NHS Bedfordshire will develop a range of premises in order to deliver a range of high quality outpatient services in the community. These will range from a level 3 facility (open 12 hours per day offering a full range of primary care led services including diagnostics, urgent/emergency care on a walk-in basis and direct access to therapy services) through level 2 which will provide access to GP, Nurse, Pharmacy and therapy services and offer visiting services, to a level 1 facility that will be open 5 days per week (50-60 hours) and serve a registered population
- Telephone assessment pre and post procedure for non complex surgical procedures
- GP practices to hold Prevention Registers for cardiovascular and other preventable diseases
- A Locally Enhanced Service (LES) to address uptake of beta blockers for patients on secondary prevention register
- Ensure GP practices achieve targets in relation to Choose & Book and other bookable services
- A comprehensive range of outpatient appointments in the community
- Specialist centre for pancreatic cancer surgery
- Specialist centre for cleft lip and palate surgery
- BHT provision of OPD, diagnostics and FUs for complex treatments undertaken at the larger

Created by Neevia Document Converter trial version http://www.neevia.com

hospitals
- Increased radiotherapy capacity
- Increased community based chemotherapy
- Implementation of IOG for palliative care
- Implementation of IOGs for rarer cancers
- A review of specialised and complex orthopaedic surgery provision
- A review of specialised and complex urology provision
- A review of specialised and complex OMF surgery provision
- A review of specialised and complex ENT surgery provision
- A review of complex and major gynaecology oncology provision.

8 How success will be measured

- NHS Bedfordshire will ensure that high quality care is provided to patients through the commissioning and contractual processes and via a robust clinical governance framework. A comprehensive monitoring system for the Quality Outcomes Framework (QOF) is already in place and this will be built on by mapping QOF outcomes to Standards for Better Health and to referral patterns, and use of secondary care services.
- Public health information will also be incorporated to enable improved data verification and improved monitoring of progress to prevent disease and improve health. Strong clinical governance networks are in place which also support year on year improvements and encourage and maintain collaborative relationships.
- The PCT will use the existing GP appraisal process to prepare for the introduction of re-licensing and re-certification for GPs, liaising with local GP tutor.

During 2008/09 we will:
- Develop a clear outcomes based performance monitoring framework covering all aspects of the GMS/PMS/APMS contract for general practice, including the development of objectives, benchmarking and quality indicators (balanced scorecard).
- Support our independent contractors to comply with ***Standards for Better Health for Independent Contractors.***

9 Impact on health outcomes and inequalities

.
- The aim is to put in place a joined up, co-coordinated, responsive and patient-focused services for people with conditions that require planned care. Wherever possible, the services will be personalized, empowering, effective, integrated, and delivered outside of hospital, ensuring an improvement in quality of life. Whilst complex services will be delivered in designated specialist centres in order to improve patient safety and clinical outcomes, using a hub and spoke model to delivery of care
- In particular, it will help deliver more care closer to home and away from acute hospitals, guarantee better access to GP services and dentists, and provide direct access to specialist advice and diagnostics, including improved local provision of diagnostics.
- It will also ensure that all patients have a full and free choice of where to go for planned care, develop better local support for post operative recovery, and agree and measure, new clinical, quality of life and experience outcomes
- Through the development of fully integrated clinical care pathways, in association with acute/specialist providers, the PCT will need to ensure that there is appropriate centralisation of complex care, particularly specialised surgery.

10 Other expected impacts

- The successful implementation of the Primary Care Strategy will see a continued shift from secondary to primary care provision, with patients only being admitted to hospital for highly complex or urgent care needs. The consequences for primary care will be a significant increase in services being carried out in this setting, through GP Practices, health centres/clinics, community hospitals or indeed intermediate care settings
- Services should be re-provided in the community at no less than a cost neutral basis, but in many cases such services can be provided at less than the acute tariff, which will enable wider and faster access to these services
- The future of the provision of community based provider services is currently being reviewed

Created by Neevia Document Converter trial version http://www.neevia.com

to ensure the appropriate provision is in place by April 2010. In the mean time NHS Bedfordshire continues to provide services which are monitored through a robust process of performance management including quality, activity and cost effectiveness.

During 2008/09 we will:

- Implement a robust performance management regime to support the development of provider services and monitor patient outcomes
- Work with provider services to review those services currently provided by us and establish appropriate timescales and maximise outcomes.

11 Impact on providers

Increased numbers of minor and routine procedures that are undertaken in primary care Community based services for:

- 40% of OPDs
- 60% of minor planned surgery
- 20% of non complex planned medicine
- Children's diagnostic services will increasingly be provided in community facilities
- Roll out of choose and book to non consultant – led services
- Walk-in centre to be provided through GP Led Health Centre in Bedford
- Ensure provision of countywide NHS services and additional NHS dental services to be developed in areas of population growth e.g. Wixams
- Walk-in centre to be provided through GP Led Health Centre in Bedford
- Ensure provision of countywide NHS services and additional NHS dental services to be developed in areas of population growth e.g. Wixams
- In order to deliver the necessary changes in service provision from secondary to primary care and to ensure greater access to primary care services the PCT will have to 'manage the market' and ensure that as new services are developed (or where existing providers no longer wish to continue provision) that these are effectively tendered to ensure they are provided in a safe and clinically appropriate manner but also represent value for money
- Existing providers will need to decide if they wish to continue to provider certain services and indeed be prepared to develop and reconfigure their services if we require it
- We need to ensure that the proliferation of providers does not mean a reduction in the quality or safety of services and will need to work closely with a rage of new providers including the third sector providers to ensure that services truly meet the needs of the local population.

In terms of workforce development during 2008/9 we will:

- Identify workforce competencies from the Health Needs Assessment
- Work with education providers to develop appropriate programmes
- Work with service providers to develop and implement programmes of workforce change
- Develop training and competencies in the management of long term conditions
- Encourage the continued development of non medical prescribing
- Empower patients to take responsibility through self care programmes.

Created by Neevia Document Converter trial version http://www.neevia.com

Dentistry

1 Overview

Our aim is that everyone served by NHS Bedfordshire will be able to access an NHS dentist if they wish to and that the appropriate age group get timely 18 week compliant access to orthodontic treatment.

Key aims include:

- Increase the Units of Dental Activity (UDAs) commissioned from general dental practitioners, targeted at vulnerable groups, elderly and areas of growth and development
- Ensure compliance with the contract by all existing providers, to deliver maximum yield from commissioned services
- Increase case starts for Orthodontics
- Address long waiting times for treatment
- Promote waiting list management
- Ensure all key practice staff receive the level of training and support they require.

2 SMART goals addressed

Enabling everyone served by NHS Bedfordshire:

- to access an NHS Dentist if they wish to
- to get timely (18 week compliant) access to orthodontic treatment for the appropriate age group)
- (Access criteria as Board Report on Dental Access September 08; Orthodontics 18 week pledge on the same basis as other 18 week referral to treatment targets).

3 Reason for selecting this initiative

- Directly related to delivery of East of England pledges and national targets
- The Oral Health Needs Assessment for Bedfordshire and Luton, which provides a comprehensive overview of the needs that have led to the development of this initiative.

Orthodontic PDS in Bedfordshire

- If we accept that children only require orthodontics once and the optimum age is usually around 12, approximately half of all 12-year olds are likely to score IOTN 3.6 and above and approximately 35% will present for treatment. Bedfordshire and Luton has a population of about 6,60012-year olds so would need to make provision for approximately 2,310 case starts each year to meet the potential demand. The BASCD co-ordinated survey of dental health in 12 yr olds, 1996/97, piloted an orthodontic examination. The results for Bedfordshire and Luton would support this estimation. The following table summarises orthodontic activity in primary care since the start of the new dental contract.

Summary of Orthodontic Activity Provided in Primary Care
April 2006 – March 2008

	BEDFORDSHIRE PCT			LUTON PCT		
Orthodontic Activity	**Treatment Starts**	**Assess and Review**	**Assess and Refuse**	**Treatment Starts**	**Assess and Review**	**Assess and Refuse**
April 2006 – March 2007				1,058	927	216
April 2007 – March 2008	1,371	1,962	455	758	711	223

Created by Neevia Document Converter trial version http://www.neevia.com

4 Input from stakeholders

- The Oral Health Strategy Group has reviewed the proposals and endorsed them. This includes clinicians and managers local service providers, including GDPs. There has not been consultation with patients and public, and given these are national targets the PCT takes it that those where set with appropriate public input.

5 Value for money

- Costs are to be based on extending existing provision, at average levels of unit cost. NHS Bedfordshire will review the value for money that it achieves from all its commissioning of dental services, including the additional services to be commissioned under this Initiative, on a schedule to be developed.

6 Timescales for goals to begin

The Oral Health Strategy Group has reviewed the proposals and endorsed them. This includes clinicians and managers local service providers, including GDPs. These are national targets NHS Bedfordshire takes.

2008-2009 plan:

- Confirm plan to commission additional UDAs
- Agree with PEC / DoHSM commissioning group
- Confirm additional dental allocation
- Plan additional UDAs to achieve 17% total increase in patients
- Monitoring visits to all dental practices
- Commission additional UDAs
- Monitor patient numbers and treatment provided
- Incorporate activity, service and requests for NHS Dentists into routine reporting into DoHSM
- Assess availability of capacity needed to achieve 18 weeks
- Review current waiting lists and waiting list management
- Commission short term capacity to address long waits
- Commission long term increase in capacity (300 starts rec.)
- Active monitoring process developed
- 18 week delivered by national target

7 High level requirements

- Access to NHS GDS: Increase in UDAs commissioned from General Dental Practitioners - 32,000 additional UDAs to be commissioned on an annual basis, in addition to 27,100 extra UDAs already commissioned in 08/09, but there will be a part year effect in 08/09
- Orthodontics: Recurring increase required in 'case starts' of approximately 300 (x21 UOAs each = approx £300k) based on an analysis of current levels of provision to the target age group, which shows that there is less than would be expected for a service that is achieving the aims of the best available outcome for the population
- There is a requirement for a non-recurring investment to address some current long waiting times for treatment. Once this backlog has been treated it is expected that it will be possible to maintain waiting times at levels that allow the 18 week pledge to be met. It will be important that there is a monitoring system in place, and that the best techniques for waiting list management are promoted. This may require NHS Bedfordshire to provide some training and support to key practice staff
- There is a requirement to deliver the following within local commissioning plans:
  - year on year improvements in the number of patients accessing local dental services
  - commission high quality services to achieve improved oral health
  - ensure that commissioned services prioritise prevention as well as treatment
  - tailor services to need with special attention paid to hard to reach groups
  - provide better patient information about what services are available and how to access them

Created by Neevia Document Converter trial version http://www.neevia.com

8 How success will be measured

Access to GDS:

- Need to use the East of England defined metrics related to this pledge (VSB18)
- The trajectory is for short to medium term delivery, with achievement of a 17% increase in patient attendances by the end of 2009/10 (This is the NHS East of England target for NHS Bedfordshire) – with a baseline to be confirmed. The translation of this increase in patient attendances into the relevant East of England / national metrics needs to be modelled
- Additional metrics that will be used internally within NHS Bedfordshire are numbers of members of the public contacting the PCT, and the Dental Access Centre (contacts and attendances) for advice on obtaining general dental services.

Orthodontics:

- NHS Bedfordshire will use standard 18 week metrics to ensure the pledge is met. It is acknowledged that here are some specific issues in defining the point of referral to the orthodontist, and the start of treatment (which may be delivered over a period of two years or more).

9 Impact on health outcomes and inequalities

- The initiative will ensure that NHS Bedfordshire can provide a comprehensive dental service. While oral health in Bedfordshire is comparatively good, with provision in areas of need being given priority in additional commissioning already undertaken, there is an issue of equity and delivering a universal service
- In particular, there is limited provision locally in the very north of the county. While the increased service will not be located there, as it is not viable for a dentist to establish a service in areas of very low population density, it will ensure there is provision in areas that border the rural north, so providing access within the standards currently being agreed by the NHS Bedfordshire board
- The Orthodontic service will provide sufficient treatment to ensure that those who can benefit from it are able to get access within a significantly shorter period of time than some wait currently.

10 Other expected impacts

- Ring fenced dental allocation will be deployed to achieve these targets, as opposed to being used for other dental services, or (to the extent that this could be financially managed) for other priorities
- The direct impact on the provider landscape will be minimal, as this will be delivered through increased commissioning from existing contractors
- Workforce requirements are to be determined.

11 Impact on providers

- The principle resource requirement is for funding to commission the necessary level of service from GDPs and Orthodontic practices (largely already allocated in 2008/09 budgets and to some extent ring fenced)
- PCT requirements are for commissioning and contract monitoring staff with the skills and capacity to define, and performance manage delivery of, necessary service and activity levels. This is dependant on recruitment to posts already agreed within the Directorate of Health Systems Management, and necessary training of staff
- It is judged that there is sufficient General Dental Practitioner and Orthodontist capacity already in place to deliver the requirements, though this needs to be confirmed.

Created by Neevia Document Converter trial version http://www.neevia.com

Acute

1 Overview

NHS Bedfordshire is committed to placing as much emphasis on improving health and wellbeing as on providing treatment and developing and strengthening prevention programmes so that they are the best in England.

To invest in a shift from treating poor health to investing in a life long prevention pathway NHS Bedfordshire will need to be the catalyst for change. This change will focus on investing more in primary care and less in acute care. It is crucial that a profile of alternative providers is developed to make informative choices in disinvestment of current services and the development of more efficient and effective care pathways that produce better health outcomes.

This will ensure that acute care is focused on providing specialised treatment for those who require it most.

Urgent care
- Ensure patients have equitable access, quality of assessment and safe treatment consistent with their condition when requiring urgent attention
- Design and commission a 'form follows function 'approach to urgent care delivery
- PPCI: As agreed nationally, will be rolled out across Bedfordshire with 24/7 access at Papworth and Harefield. There are work streams in progress to ensure that invasive cardiology, including PCI, is developed across the two sites to improve local access for Bedfordshire residents.

A memorable number for patients: to call for appropriate response in Bedfordshire (SHA pilot site (2008/9) which includes:
- Health information
- Self care advice
- Onward signposting
- Referral and booking into planned and unplanned care
- Instigation of an emergency response.

Primary care
- Provide emergency contraception
- Provide urgent care in GP practices - Aetna review underway
- Provide pharmacy services to support - Pain, LTCs 24/7.

A Single Point of Contact (1 Call) as a direct responsive route into community services and intermediate beds
- Review consistency, quality and capacity for referral.(2008)
- Provide intensive case management to assess impact on admissions (pilot October – March 2009)
- Provide single point for nursing and residential homes.

A faster, responsive ambulance service
- Review data to develop service initiatives- frequent fliers for those with diabetes, epilepsy, falls, asthma
- Offer alternatives to admission for patients receiving community services for end of life care, LTCs
- Support the call connect standard with category A response.

Integrated out of hours GP services
- Audit and review all out of hours contracts to ensure quality of care and value for money Care UK, Bedoc, MDoc (PCT signed up to an SHA audit using Primary Health Foundation Oct 2008)
- Ensure GP practices are aware of out of hours usage and impact on acute activity.

Created by Neevia Document Converter trial version http://www.neevia.com

Urgent care centres

- Ensure primary care filters will be co-located or integrated with the A&E departments at Bedford and the Luton and Dunstable hospitals to reduce care in the acute setting where appropriate.

Admission avoidance schemes

- Initiate GP on call pilot to reduce GP heralded admissions by supporting GPs
- Provide advanced booking of primary care and diagnostic appointments
- Offer care plans for those with palliative care and long term conditions to offer alternatives to admission
- Provide rapid intervention and rehab and enablement
- Provide intensive case management.

Acute care

- Offer senior consultant assessment and review in A&E and follow up ward rounds.
- Record expected date of discharge within 48 hours
- Offer discharge planning from day one of admission
- Start review and monitoring of occupied bed days and length of stay by speciality
- Achieve reduction in delayed discharges and transfers of care
- Ensure failsafe handover systems between clinical teams
- Provide staff training and development for care of the critically ill
- Provide access to conventional radiology and CT scan reporting within 24 hours
- Ensure we are working to PCT/national targets and reporting mechanisms.

Centralisation of services

- Centralise the services where additional lives will be saved and better clinical outcomes achieved
- NHS Bedfordshire is a member of the Bedfordshire and Hertfordshire Cardiac and Stroke Network.

CVD, stroke and cancer services

- NHS Bedfordshire will meet our 48% target by 2009/10 for high risk stroke patients to be assessed and scanned within 48 hours; 71% by 2009/10 for all stroke patients to spend 90% of their treatment time on a stroke unit
- Develop and implement plans for the provision for thrombolysis for stroke, first achieving blanket 9-5 access and then plans for 24/7 access across the Network. NHS Bedfordshire will ensure by 2009/10 that 68% of all appropriate patients will receive thrombolysis within 60 minutes (call to needle time)
- The aim of the network is to ensure that providers work within a managed clinical network with patients under the care of a stroke specialist at all times. The network is also working towards ensuring that patients receive appropriate timely emergency care at specialist stroke centres
- Both DGHs in Bedfordshire have a stroke centre however the services delivered require further development to ensure they are able to deliver treatment to the standards required. In south Bedfordshire 24/7 access to a brain scan with reporting within one hour will be delivered at Luton and Dunstable Hospital with the planned Monday – Friday service developing to cover the additional hours
- At Bedford Hospital this 24/7 service will be delivered via a telemedicine link through a clinical network arrangement with Addenbrookes hospital and will ensure access to neuro-radiological opinion. This will ensure that 100% of stroke patients where time of onset is clear and who call 999 have access to 24/7 thrombolysis within three hours of onset of stroke symptoms
- Luton and Dunstable Hospital already provide direct admission to an acute stroke unit with specialist MDT whilst Bedford Hospital are actively recruiting to a vacant stroke consultant post in order to ensure that their service can provide services to the required standard. Further investment will be required in order to develop stroke services with two or more stroke physicians/ consultants with a special interest and a clinical network arrangement is likely to be the most cost effective way to provide this service
- Luton and Dunstable Hospital currently provides TIA clinics with MRI within seven days for patients and is working towards a target of 24 hours for high risk patients. Bedford Hospital is

Created by Neevia Document Converter trial version http://www.neevia.com

developing a dedicated TIA service and aim to achieve the above access targets
- NHS Bedfordshire is a pilot site for 'Staying in Control'. The PCT is working with the Local Authority to introduce personalised health budgets in 2009 which will be trialled with people who have suffered a stroke
- NHS Bedfordshire will increase CVD registers in primary care through a trajectory to achieve 100% delivery by 2010/11.
  Increase numbers of patients with CHD being treated with a beta blockade – 76.1% by 2009/10
- Cardiac rehabilitation will be available for all patients who are newly diagnosed with heart failure and angina and any patients who have undergone a percutaneous cardiac infarct
- NHS Bedfordshire is developing a local cancer strategy in line with Towards the Best Together.

Primary angioplasty
- The aim of the Bedfordshire and Hertfordshire Cardiac Network is to facilitate the commissioning of specialist heart attack centres and the commissioning of local services for thrombolysis, rehabilitation and follow up
- In order to facilitate delivery of the access target to deliver primary angioplasty within 2.5 hours of a heart attack the heart attack centres commissioned by NHS Bedfordshire will be Papworth and Harefield Hospitals which will ensure delivery of a maximum ambulance transfer time of 75 minutes. These centres will provide a cardiologist on call rota of 1:6 and multi skilled cath labs with anaesthetic cover 24/7
- NHS Bedfordshire will commission local rehabilitation and follow up to support the discharge of patients from these hospitals within 48 hours
- In addition NHS Bedfordshire will support Bedford Hospital in the development of a local primary angioplasty service Mon to Friday 9-5. Luton and Dunstable Hospital are also being encouraged to develop a service and the PCT has made it clear that they wish to commission the two providers to work together on developing seamless services across both sites. The cardiac cath lab development at the Luton and Dunstable Hospital will also facilitate the repatriation of cardiac catheterisation work from Harefield to ensure that patients can access this service closer to home
- Currently pre hospital thrombolysis delivery by ambulance staff needs further development therefore NHS Bedfordshire is working with the network to facilitate this
- To reduce the risk of cardiac events to Bedfordshire residents the PCT will encourage GPs to develop and maintain risk registers for cardiac disease through introduction of a LES. In addition the network is undertaking a review of cardiac rehabilitation to support the PCT to increase the service it commissions.

Major injury services
- NHS Bedfordshire will work with the East of England to commission services from their designated major injury centre for patients with severe or multiple trauma. Spinal injury services will also be commissioned in this way. These services will provide 24/7 access to CT, MRI, vascular surgery, plastic surgery, cardiothoracic surgery and neuro surgery
- Services for less severe injury will be commissioned from the local DGHs who will work within strategic partnerships and clinical networks. This will support the development of protocols to support the safe and timely return of patients from the major injury centre to Bedford Hospital and Luton and Dunstable Hospitals for ongoing care.

Emergency Surgery
- NHS Bedfordshire will commission Bedford Hospital and Luton and Dunstable Hospital to provide emergency general surgery which is clinically safe, with sustainable staff rotas and that is financially viable. It will encourage the providers to implement consultant of the week rotas and to develop clinical networking, joint on call rotas for emergency out of hours ophthalmology, vitreo-retinal surgery, ENT and major emergency gynaecology surgery.

2 SMART goals addressed

- Co-ordinated access to acute care services 24/ 7 including alternatives to hospitals. Improved safety and clinical outcomes by specialisation and delivering complex care in specialist centres
- At Bedford Hospital 24/7 service will be delivered via a telemedicine link through a clinical network arrangement with Addenbrookes hospital and will ensure access to neuro-

Created by Neevia Document Converter trial version http://www.neevia.com

radiological opinion. This will ensure that 100% of stroke patients where time of onset is clear and who call 999 have access to 24/7 thrombolysis within three hours of onset of stroke symptoms.

3 Reasons for selecting this initiative

- We want to disinvest in acute hospital services to increase the range of locally based safe, clinically effective and cost effective services
- There is a need to modernise acute hospital services
- A review of care pathways over the next two years will require the development of a workforce plan to accommodate the required change in focus. This will also need to take account of those staff where there is already a shortage of specialist skills.

4 Input from stakeholders

Clinicians

- Clinical leadership and effective engagement are critical in the delivery of this strategy. A clinical champion will be identified to support the delivery of this strategy and chair the steering group. Other clinicians will be invited to participate in the task and finish groups
- Local ownership is critical and the PBC consortia will work closely with the PCT to engage the GPs, nurses, and other allied health professionals. Where appropriate, the PBC consortia will take a lead role to drive forward the actions.

Users and carers

- Public and users are at the heart of this commissioning strategy, and they will have key roles in the task and finish groups
- The Local Authority (LA) has done a lot of work to consult the public on their strategies. Useful and relevant feedback will be taken into account, to ensure the commissioned services are appropriate and responsive to the needs of the users and carers. NHS Bedfordshire will also be working with the Service User Engagement Team at the LA on future workshops or consultations.

5 Value for money

- The provision of secondary care services is a significant drain on PCT resources and is not always the most appropriate setting for patients to receive their care
- Therefore, the Primary Care Strategy and supporting initiatives have been developed to ensure that patients can access primary care services in a timely and appropriate manner
- A reduction in inappropriate referrals to secondary care, A&E attendances and more co-ordinated, cost effective and equitable access to primary care will ensure a more cost effective use of local NHS resources as well as ensuring patients receive the right care in the right setting at the right time.

6 Timescale for goals to begin

- Activity will begin in 08/09 – Full details of sub initiatives in monitoring plan.

7 High level requirements

- This initiative is dependent on local ownership by PBC consortia, clinical engagement and working in partnership with East of England, local authorities, local providers and third sector.

- There is an expectation that this initiative can in some way be delivered through service re-design within the NHS. However there are likely to be start up and double running costs as new initiatives are started until whole services switch.

8 How success will be measured

- NHS Bedfordshire will ensure that high quality care is provided to patients through the

Created by Neevia Document Converter trial version http://www.neevia.com

commissioning and contractual processes and via a robust clinical governance framework. A comprehensive monitoring system for the Quality Outcomes Framework (QOF) is already in place and this will be built on by mapping QOF outcomes to Standards for Better Health and to referral patterns, and use of secondary care services.

- Public health information will also be incorporated to enable improved data verification and improved monitoring of progress to prevent disease and improve health. Strong clinical governance networks are in place which also support year on year improvements and encourage and maintain collaborative relationships.

- NHS Bedfordshire will use the existing GP appraisal process to prepare for the introduction of re-licensing and re-certification for GPs, liaising with local GP tutors.

During 2008/09 we will

- Develop a clear outcomes based performance monitoring framework covering all aspects of the GMS/PMS/APMS contract for general practice, including the development of objectives, benchmarking and quality indicators (balanced scorecard).
- Set a target for QOF performance of 95% achievement.
- Support our independent contractors to comply with ***Standards for Better Health for Independent Contractors***
- We will continue to commission Bedford Hospital as the vascular centre for Bedfordshire and will support it to introduce consultant rotas of 1:6.

Metrics require baselines and yearly targets

Year on year improvement in patient experience

The East of England Patient and Public Survey:

The 2008/09 data will be used as a baseline.
- % of patients saying access to acute care has improved
- % of patients admitted via A&E within four hours
- % of current A&E attendances seen elsewhere
- % of patients seen in urgent care centres
- % of admitted patients with a management and monitoring plan
- % of patients satisfied with the management of their care
- % of patients satisfied with their level of involvement in decision making
- quality of life

Improve timely access to specialist advice and diagnostics in primary care and ensure comprehensive disease registers are in place.

Cardiac

Patient level acute data to be collected monthly:
- Acute cds – Inpatient
- Acute cds – outpatient

9 Impact on health outcomes and inequalities

The aim is to put in place a joined up, co-coordinated, responsive and patient-focused services for people with conditions that require acute care. Wherever possible, the services will be personalized, empowering, effective, integrated, and delivered outside of hospital, ensuring an improvement in quality of life. Whilst complex services will be delivered in designated specialist centres in order to improve patient safety and clinical outcomes, using a hub and spoke model to delivery of care.

The implementation of the PCTs Primary Care Strategy and related initiatives will support the PCT to deliver pledges 1, 2, 3, 4, 5, 6 and 7 as outlined in the NHS East of England's Clinical Vision, 'Towards the best, together'.

Created by Neevia Document Converter trial version http://www.neevia.com

In particular, it will help deliver more care closer to home and away from acute hospitals, guarantee better access to GP services and dentists, and provide direct access to specialist advice and diagnostics, including improved local provision of diagnostics.

It will also ensure that all patients have a full and free choice of where to go for acute care, develop better local support for recovery, and agree and measure, new clinical, quality of life and experience outcomes.

Through the development of fully integrated clinical care pathways, in association with acute/specialist providers, the PCT will need to ensure that there is appropriate centralisation of complex care, particularly specialised surgery.

10 Other expected impacts

The successful implementation of the Primary Care Strategy will see a continued shift from secondary to primary care provision, with patients only being admitted to hospital for highly complex or urgent care needs. The consequences for primary care will be a significant increase in services being carried out in this setting, through GP Practices, health centres/clinics, community hospitals or indeed intermediate care settings.

Services should be re-provided in the community at no less than a cost neutral basis, but in many cases such services can be provided at less than the acute tariff, which will enable wider and faster access to these services.

The future of the provision of community based provider services is currently being reviewed to ensure the appropriate provision is in place by April 2010. In the mean time the PCT continues to provide services which are monitored through a robust process of performance management including quality, activity and cost effectiveness.

During 2008/09 we will:

- Implement a robust performance management regime to support the development of provider services and monitor patient outcomes
- Work with provider services to review those services currently provided by the PCT and establish appropriate timescales and maximise outcomes.

In terms of workforce development during 2008/9 the PCT will:

- Identify workforce competencies from the Health Needs Assessment
- Work with education providers to develop appropriate programmes
- Work with service providers to develop and implement programmes of workforce change
- Develop training and competencies in the management of long term conditions
- Encourage the continued development of non medical prescribing
- Empower patients to take responsibility through self care programmes.

11 Impact on providers

- In order to deliver the necessary changes in service provision from secondary to primary care and to ensure greater access to primary care services the PCT will have to 'manage the market' and ensure that as new services are developed (or where existing providers no longer wish to continue provision) that these are effectively tendered to ensure they are provided in a safe and clinically appropriate manner but also represent value for money.

- Existing providers will need to decide if they wish to continue to provider certain services and indeed be prepared to develop and reconfigure their services if required by the PCT. Acute hospitals will need to increase their access to diagnostics beyond 24/7 and improve clinical staff rotas.

NHS Bedfordshire will need to ensure that the proliferation of providers does not mean a reduction in the quality or safety of services and will need to work closely with a rage of new

Created by Neevia Document Converter trial version http://www.neevia.com

providers including the third sector providers to ensure that services truly meet the needs of the local population.

Created by Neevia Document Converter trial version http://www.neevia.com

Safety

1 Overview

- All providers must meet high standards for quality and safety. High quality care is care where patients are treated with respect and dignity and feel in control, have effective access to treatment, are safe and where illnesses are not just treated but also prevented.
- NHS Bedfordshire embraces the vision set out in “High Quality Care for All” and has already done much to support the vision becoming a reality in Bedfordshire. A system of monitoring quality of providers has been in place since April 2007 as part of provider’s contracts and utilises Standards For Better Health as a framework. This allows the PCT to review key safety, quality and patient experience metrics on a regular basis with providers, to identify concerns and ensure action is taken to improve. This has also enabled us to set local as well as national measures and will support the new national Quality Metrics and Patient Reported Outcomes measures when they are introduced.
- The agenda is challenging locally, with further improvement still required in relation to Health Care Acquired Infection and the high MSRA rate and ensuring high quality mental health services. We have also set targets to further reduction in Hospital Standardised Mortality Rates.
- Work we have done to date has ensured that providers are working with us in an open and transparent way to make improvements. Building on the existing quality framework NHS Bedfordshire will hold all providers to account against increasingly stringent standards for quality and safety.

2 SMART goals addressed

- Goal (1) national: reduction in number of cases of MSRA, Reduction in C diff associated disease by 30% by 2011
- Goal (2) 08/09: no more than 98 cases of C diff detected after day 1 of admission in Bedford Hospital and no more than 11 cases of MSRA
- Goal (3) 08/09: financial penalty to be applied to Bedford Hospital as per standard contract if number of cases detected after day one of admission exceeds the equivalent number for 07/08 (around 150, to be confirmed)
- Goal (4) 08/09: no more than 295 cases in the population
- Goal (5): A reduction in HSMR of 10% over three years
- EoE Pledge 6: “We will aim to make our healthcare system the safest in England”. NHS Bedfordshire aims to reduce HSMR in providers. Baseline HSMR is 107: Bedford 2005/06 99.1; 2006/07 104.2; 2007/08 102
- TTBT target: Planned care
- VSA03: Incidence of C diff
- VSA01: Incidence of MSRA
- C Diff ceiling of 81 has been agreed for Bedford Hospital 09/10 and 70 for 2010/11.
- C Diff ceiling of 202 has been agreed for NHS Bedfordshire for 09/10 reducing to 159 for 10/11.
- MRSA ceiling of no more than 9 cases for 09/10 agreed with Bedford Hospital.

3 Reason for selecting this initiative

- Avoiding harm associated with healthcare is the mainstay of the patient safety agenda. Infections are a key element of this. While not all infections are avoidable, acquiring infections in a healthcare setting may indicate poor infection control practice; and can be mitigated by good infection control
- MSRA bacteraemias are a cause of considerable morbidity in patients and in some cases may resulting death
- Clostridium difficile (C diff) associated disease is the most important cause of hospital-acquired diarrhoea. It can lead to severe illness and even contribute to death
- Infections from C diff and MSRA are the two types of infection which are routinely well recorded (through mandatory reporting) and therefore comparable data are available

Created by Neevia Document Converter trial version http://www.neevia.com

- Data are signed off each month by an acute trust's chief executive and thus data are available to monitor progress in a timely fashion
- It is one of two areas of acute care for which breaching the agreed ceiling is contractually associated with a financial penalty
- The number of cases of C diff and MSRA is newsworthy, commonly reported in the media, and is familiar to the general public
- While needless death remains a rare event in hospitals, paying attention to the system issues that under lie "needless deaths" will raise the quality and reliability of care throughout the system.

4 Input from stakeholders

Clinicians

- NHS Bedfordshire is the lead commissioner for Bedford Hospital. The hospital has a weekly meeting specifically on healthcare associated infections, and a representative from NHS Bedfordshire regularly attends. This is the forum for the detailed discussion of new initiatives with the key clinicians involved in C diff and MSRA. These clinicians represent report back their wider discussions with the greater numbers of clinical staff involved in direct patient care. Hospital walk rounds are jointly undertaken by senior hospital and NHS Bedfordshire staff, and by nursing and cleaning staff. Contractual issues are discussed separately. A quarterly system-wide meeting is held to discuss developmental issues across the health economy. A NHS Bedfordshire hospital performance meeting is held each month. NHS Bedfordshire a member of the Hospital Patient Safety Committee.
- All patient safety issues are reviewed on a quarterly basis as part of the Quality Monitoring Framework which both primary care and secondary care clinicians present as well as the local PBC.
- A whole systems health meeting focusing on HCAIs has been set up with representation from all providers
- C diff and antibiotic prescribing is the subject of the next county educational session for GPs
- NHS Bedfordshire's infection control team is responsible for infection control in community care.

Health Protection Agency

- The health protection agency is involved in all aspect of NHS Bedfordshire's management of C diff other than contractual issues. A letter to GPs was sent jointly from the HPA and NHS Bedfordshire.

5 Value for money

- Protecting patient safety is the single most important priority of NHS care
- It is estimated that C diff associated disease increases bed days by an average of 21 days for each case and 11 days for MSRA. Patients with HCAI are three times more expensive to treat
- VFM can be achieved through maximising the efficiency of existing hospital systems by increasing the reliability and quality of the systems of care and ensuring they are effective and evidenced based
- Needless deaths could lead to the possibility of litigation.

Created by Neevia Document Converter trial version http://www.neevia.com

6 Timescale for goals to begin

- Goals to begin in 08/09

Goals/Objectives	Present Position	Target Position	Key Action
• Improve timeliness of isolation of symptomatic patients	Time to isolation data will be routinely recorded from September 2008	Isolation of symptomatic with 2 hours (before confirmation of C diff)	Audit of isolation policy Identify remedial actions if necessary to ensure isolation is timely Explore options for increasing number of side rooms
• Set standards for Key performance indicators (the next step of operationalisation of concept of zero tolerance)	Routine monitoring of additional indicators is in place from September 2008	Incorporate standards for KPIs into quality schedule	Incorporate standards for KPIs into quality schedule Identify required actions to meet targets Include the number of deaths per 1000 bed days as an indicator of performance
• Reduce further the prescribing of broad spectrum antibiotics	PCT position is below regional average. Some outliers remain	Agree a standard for a practice Reduce variation and overall prescribing	Ensure routine feedback to practices Additional work with outlier practices
• Standard analyses of root cause of all cases and deaths associated with C diff	Root cause analysis has been undertaken for all cases arising since March 2008	Detailed analysis of each case Summary of all cases to identify trends	Review root cause analyses for all cases of C diff from March 2008 Include medicines review Review template if necessary
• Reduce numbers of cases of C diff associated disease	Below year-to-date ceiling for the total number for the PCT in 08/09	To have no more than 98 hospital cases of C diff in 08/09	Compliance with Hygiene Code and Standards for Better Health, including full compliance on decontamination.

7 High level requirements

- Quality must be delivered within tariff
- High level requirement is continued cultural change to prioritise safety
- Monitoring infrastructure and infection control capabilities.

8 How success will be measured

Success will be seen in a reduction in the total number of cases of C diff for 2009/10. This should be fewer than the ceiling of 81 for Bedford Hospital and fewer than 202 in the population of NHS Bedfordshire.

Other acute sector metrics (stratified by division and ward)
- Time to isolation of a symptomatic case
- Cleaning score
- Number of non clinical bed moves
- Hand hygiene scores
- Number of samples tested
- Number of positive samples
- Prescribing of broad spectrum antibiotics
- Number of C diff associated deaths per 1000 bed days
- Coverage of infection control training
- VSA03: Incidence of C. diff.

Primary care sector metrics
- Prescribing of broad spectrum antibiotics
- Location of cases of C diff (to identify potential clusters)

Community setting metrics are being developed but will be based on those for the acute sector

Created by Neevia Document Converter trial version http://www.neevia.com

as applicable

HSMR 10% reduction over three years.

9 Impact on health outcomes and inequalities

- A reduction in the number of people developing MRSA and C diff associated disease. An inequality gradient has not been identified with MRSA and C diff
- Achievement of HSMR target
- Improve patient confidence in local healthcare providers
- Improve patient experience
- Improve patient outcomes.

10 Other impacts

- Increased efficiency within providers

11 Impact on providers

- Minimal provider impact.

Created by Neevia Document Converter trial version http://www.neevia.com

Long Term Conditions

1 Overview:

The aim is to put in place a joined up, co-coordinated, responsive and patient-focused service for people with LTCs. Wherever possible, the services will be personalised, empowering, effective, and integrated, ensuring an improvement in quality of life.

- There will be a strong focus on health promotion and prevention, screening and early diagnosis, and support. People will receive the care that is appropriate and timely to their needs. This will in turn prevent crises and deterioration, enabling those with chronic conditions to lead independent and full lives. This approach will also enable both staff and patients to achieve a high level of satisfaction from their experiences
- The East of England LTC generic pathway framework outlines the key elements needed to be considered in each stage of the patient journey, alongside with the desirable outcomes. This framework will be adopted to inform commissioning priorities for services.

In particular, it will consist of the following features:

Prevention
- Evidenced based interventions will be commissioned which are known to prevent LTCs The PCT intends to identify vulnerable groups, implement effective smoking cessation and weight management programmes, use appropriate tools to address need and target general prevention activities at children.

Case finding and diagnosis
- NHS Bedfordshire will commission services that have target screening for those at risk to implement a structured and proactive process for opportunistic screening
- Targeted screening for those at risk
- Implement a range of basic clinical decision making tools
- Improve the management of those with hypertension
- Ensure examination of the observed patients are compared to expected prevalence
- Make sure that this is undertaken with close involvement of other primary care providers.

An additional initiative is to implement direct access to diagnostic tests and associated interpretation and management advice. To develop a contract for advice for community based professional services.

Bedfordshire is a pilot site for staying in control and will be piloting individual health budgets alongside the Local Authority direct payments system during 2009.

Management plans, including palliative care
- The PCT intends to work with the Local Authority to ensure that patients with more than one condition are supported by a range of multidisciplinary services, creating a seamless service between services and agencies
- This will include particular attention to psychological support, transition, rehabilitation, medicines management and palliative care
- This model will provide a structured and consistent approach for shaping the way in which local health and social care partners work together to deliver integrated long term care locally

Created by Neevia Document Converter trial version http://www.neevia.com

- This will be supported by a range of structured education, information and support including expert patient programmes (EPP)
- People with LTC should be treated as individuals and people first by ensuring that individual care planning and agreed personal health plans are in place. Individuals and their carers should be aware of the range of support services available in order to increase individual level of independence and self care through the introduction of patient held budgets. The number of community matrons has been increased and one locality is piloting intensive case management as a way of reducing hospital admissions and ill health.

Exacerbations

- The PCT intends to use a range of predictive tools to identify high risk patients and very high intensive users of services (PARR and the Unique Care Calculator tool (NHS Alliance)). This should reduce frequent attendance and admissions to hospital
- By introducing individual health plans for patients with LTCs and a range of education and support, the PCT will be able to predict and prevent patients' deterioration. NHS Bedfordshire will put in place a range of plans to implement rapid access to specialist services when required
- People with exacerbations will receive a consistent response regardless of entry point and timing through 'one' phone number (1call) available 24 hours a day, seven days a week. This will provide a high level assessment and immediate access to a range of multi agency and multidisciplinary services in community based settings in order to prevent inappropriate admissions (see Delivery Section B) using Rapid Intervention Services. This will also reduce the number of inappropriate admissions and interventions in hospital.

Diabetes / CHD

- The two long term conditions chosen by NHS Bedfordshire to undertake detailed actions against

2 SMART goals addressed

Delivering good health and well being indicators from Bedfordshire Local Area Agreement 2008-2011:

- All-age all cause mortality rate (NI 120)
- Stopping smoking (NI 123)
- Social care clients receiving self directed support – direct payments & individual budgets (NI 130)
- Carers receiving needs assessment or review, and a specific carer's service or advice & information (NI 135)
- The percentage of vulnerable people who have moved into independent living (NI 141)
- The percentage of vulnerable people who are supported to maintain independent living (NI 142)

3 Reasons for selecting this initiative

- The NHS East of England has estimated that there are 1.6 million adults in East of England with a long term condition. Amongst them, 26% of them have three or more conditions. This is equivalent to 110,377 people in NHS Bedfordshire
- People with complex LTCs and high intensity needs are often frequent users of the acute hospital services on an unplanned basis. At the end of March 2008, there were a total of 450 patients on the caseload of the community matrons
- Based on the current projections, the numbers of people with LTCs are to be increased

Created by Neevia Document Converter trial version http://www.neevia.com

significantly in the next five to 10 years. In particular, services for those with depression, diabetes, cardiovascular and respiratory conditions, stroke, dementia, and cancer have to be developed to meet the demands. People with LTCs use disproportionately more primary and secondary care services, and this pattern will increase over time with an ageing population. They are also high users of social care and community services

- The ability to support people with LTCs effectively directly impacts on the delivery of key targets, both financially and qualitatively. The PBCs also recognise more focus will need to be put on health prevention and proactive management of patients with LTCs.

Demographics:

- It is estimated that by 2025 there will be 47% more people in East of England aged 65 or over. In line with the national and regional trend, the number of older people in Bedfordshire will increase over the next 10 years. Please see table 2 for the growth of the population

	2008	2013	2018	2021
Age 55+	110,800	123,580	139,320	149,700
% age 55+	27%	28%	31%	32%
Growth on 2008 no. of age 55+		12%	26%	35%

Population and Forecast for Bedfordshire (Source: Beds County Council)

Estimations on population growth and age profile are routinely produced by the Bedfordshire County Council. Using this information, the numbers of people on the disease registers in five and 10 years time can be predicted. There are two ways to calculate the prevalence rate: using the whole population or using a subset of the population. The second approach has been adopted in this strategy as the methodology is more sensitive to the impact of an ageing population.

	Age band for prevalence calculation	2013			2018		
		Total	No. of Increase	% of Increase	Total	No. of Increase	% of Increase
Depression	16+	37,276	2,400	6.9%	39,178	4,302	12.3%
Asthma	0+	26,552	655	2.5%	27,771	1,874	7.2%
Diabetes	45+	18,103	2,161	13.6%	19,858	3,916	24.6%
CHD	55+	14,729	1,742	13.4%	16,605	3,618	27.9%
Hypothyroidism	0+	10,652	263	2.5%	11,141	752	7.2%
Chronic Kidney Disease	0+	9,799	242	2.5%	10,248	691	7.2%
Stroke	65+	6,872	1,175	20.6%	7,932	2,235	39.2%
Atrial Fibrillation	65+	6,338	1,084	20.6%	7,315	2,061	39.2%
COPD	65+	5,930	1,014	20.6%	6,845	1,929	39.2%
Cancer	45+	4,814	575	13.6%	5,280	1,041	24.6%
Heart Failure	75+	3,682	586	18.9%	4,302	1,206	39.0%
Severe Mental Health	16+	2,597	64	2.5%	2,716	183	7.2%
Epilepsy	0+	2,286	56	2.5%	2,391	161	7.2%
Dementia	75+	1,758	280	18.9%	2,054	576	39.0%
Learning Disabilities	0+	942	23	2.5%	985	66	7.2%
Total		152,330	12,320	8.8%	164,621	24,611	17.6%

Estimated numbers of people with LTCs on QMAS

The above table shows the estimated number of people with LTCs in 2013 and 2018. The biggest increases in numbers are seen in depression, diabetes, CHD, stroke, atrial fibrillation

Created by Neevia Document Converter trial version http://www.neevia.com

and COPD.

4 Input from stakeholders

Stakeholder involvement

Clinicians

- Clinical leadership and effective engagement are critical in the delivery of this strategy. A clinical champion will be identified to support the delivery of this strategy and chair the steering group. Other clinicians will be invited to participate in the task and finish groups
- Local ownership is key and the PBC consortia will work closely with the PCT to engage the GPs, nurses, and other allied health professionals. Where appropriate, the PBC consortia will take a lead role to drive forward the actions.

Users and carers

- Public and users are at the heart of this commissioning strategy, and they will have key roles in the task and finish groups
- The Local Authority (LA) has done a lot of work to consult the public on their strategies, many of which are related to people with LTCs. Useful and relevant feedback will be taken into account, to ensure the commissioned services are appropriate and responsive to the needs of the users and carers. The PCT will also be working with the Service User Engagement Team at the LA on future workshops or consultations.

5 Value for money

- Programme budgeting could be a potential, but further development has to be put in place locally in order to capture the expenditure for chronic conditions. Data accuracy also needs to be improved to ensure the information is reliable
- Information from Department of Health suggests people with LTC/s account for 65% of all outpatient appointments and 72% of all in patient bed days. For NHS Bedfordshire, this is equivalent to £88,861,304 (excluding day cases and elective admissions) in 2007/8. There is clear evidence that a strong focus on disease prevention and proactive management of people with LTCs will significantly reduce the expenditure on secondary care. The planning assumption is that no ‘new’ investment will be required to deliver this strategy, and the emphasis is about using the current resources differently and effectively. Successful delivery of this strategy could free up resources for other service development.

Created by Neevia Document Converter trial version http://www.neevia.com

6 Timescale for goals to begin

Priority	Objectives	Actions	Complete By
Pulmonary rehabilitation	Achieving NICE guidance	• The agreed plan for pul rehab is: 232 (2008/09), 464 (2009/10), 232 (2010/11). This gives a total of 929 which is the number we should have according to NICE.	2010/11
Empowering the individual and carer	Development of care / health plans for people with a LTC	Develop and introduce personal health plan: • CHD & Diabetes • 3 LTCs conditions in 2009/2010 • Roll out to all other key conditions	 Mar 2009 Mar 2010 Mar 2011
	Introduce individual / patient held budgets	• Test out the concept with patients with CHD & Diabetes • Build on the experience of 'Staying in Control', and apply to be a DH individual health budget pilot site.	Mar 2009 Dec 2009
Patient Education Programme	Commissioning of structured EPP programme	Commission EPP programmes of 5k per course for 16/20 people 09/10 – 108 = £30,000 10/11 – 108 = £30,000 11/12 – 108 = £30,000 12/13 – 126 = £35,000	2012/13
Personal Health Plans	Establishing PHPs for all people with a long term condition	• There will be a PHP pilot / road testing from Jan to Apr 2009 in EoE. It makes sense to wait for the learning before rolling it out in Bedfordshire. Currently, the expectation is that the PHP will be implemented for 2 conditions in Sept 09, 3 further conditions by Sept 10, and all conditions by Sept 11. The PHP will be introduced to patients with diabetes and CHD in Sept 2009. No decisions have been made regarding the patient groups beyond then.	2010/11
Pathways Review	Two pathways reviewed by March 2009	• Two pathways will be reviewed by 2009 and then recommissioned by September • Three other pathways to be reviewed by 2010 and recommissioned by September 2010 and all others to be reviewed by March 2011 and recommissioned by 2011. Diabetes and CHD / HF pathways will be reviewed by March 2009. No decisions have been made at this stage regarding future reviews.	2011
Information Sharing	Information available at the point of care 24/7	• Agencies to identify priority areas for development and	Mar 2010

Created by Neevia Document Converter trial version http://www.neevia.com

	Shared information systems	areas for development and develop shared information systems.	
Whole system Commissioning	Ensuring that local plans and joint plans take account of peoples' needs	• To ensure the needs of people with LTCs are incorporated in the JSNA, Public Health Report and LAA.	Mar 2010
	Use of the Health Plan as the smallest commissioning unit	• Aggregate the service requirements identified in the health plans for CHD & Diabetes. • Aggregate the service requirements identified in the health plans for another 3 conditions • Use the information in the health plans to inform the commissioning intentions.	Mar 2010 Mar 2011 Mar 2011
	Development of care pathways from a person centred perspective	• Review & re-commission CHD & Diabetes services • 3 LTCs conditions / groups. • Review and re-commission the other LTCs pathways.	Mar 2009 Mar 2010 Mar 2011
	Contracts with clear standards and outcomes	• To develop a formal contract regime with all providers with clear and measurable outcomes • To use 'unbundling' as a lever to facilitate developments in care provision.	Mar 2011 Mar 2011
	Rapid access to appropriate advice	• To incorporate this requirement into the personal health plan for patients with Diabetes & CHD where appropriate • To consider a range of procurement options including independent sector.	Mar 2010
Workforce Development	Robust workforce planning to determine changes required to the workforce	• Ensure user input in workforce planning • Actively participate in the County Workforce Group, and influence strategic workforce development & education commissioning.	Mar 2010
	Education and training for existing and future staff (clinicians, support workers, reception staff and social care workers) to ensure professionals have the 7 Core Common Principles/competencies to support self care	• The education contract for post registration training is with the University of Bedfordshire. The PCT need to influence and quality manage the course provision to ensure the clinical staff is competent.	Mar 2012
	Ensuring that existing and potential providers have the necessary skills, including care home staff	• To ensure the training needs are competency based, and the competencies are tested together with the knowledge base. The training needs will reflect the health needs assessment outcome for Bedfordshire, the workforce development strategy and the primary care strategy.	Mar 2012

Created by Neevia Document Converter trial version http://www.neevia.com

		• Clarity re: different types of education and training are available locally and access route.	
Prevention	Effective smoking cessation and weight management programmes	• Put in place smoking cessation plan • Ensure successful implementation of the stop smoking delivery plan including a focus on groups with higher rates of smoking • Ensure successful implementation of the LAA counterweight programme.	Mar 2010
	Targeting general prevention activities at children	• Identify priorities and commission a range of programmes to tackle childhood obesity.	Mar 2010
Screening & Diagnosis	Structured proactive processes including : • Opportunistic screening • Targeted screening • Targeted and opportunistic screening for those with risk • Clinical decision support tools • Improving the management of those with hypertension • Examination of the observed patients compared to expected prevalence • Involvement of other primary care providers	• Implement bowel cancer screening programme • Carry out a health equity audit of the uptake of adult screening programmes with recommendations for action based on results • Implement Local Enhanced Scheme for cardiovascular risk registers • Review 'observed to expected' prevalences for CHD, heart failure, diabetes, hypertension & obesity with action plan.	Mar 2010
	Direct Access to diagnostic tests and associated interpretation and management advice	• To review CHD & Diabetes pathways • To review pathways of 3 other LTCs, and commission services where appropriate • To review pathways for other LTCs and commission services where appropriate.	Mar 2009 Mar 2010 Mar 2011
	Contract for advice for community based professionals		
	Use appropriate guidance and commissioning toolkits	To incorporate in the service reviews: • CHD & Diabetes • 3 other LTCs • all other LTCs	Mar 2009 Mar 2010 Mar 2011
Management Plans (including palliative care)	Integrated multidisciplinary service provision and support , with particular attention to psychological support, transitions, rehab, medicines management and palliative care	• Working with the local authority, ensure patients with more than one condition are supported by integrated, multi-disciplinary services • Seamless service needs to be provided between services and agencies particularly at time of transition i.e. child to young person to adult • Commissioners need to ensure that Cognitive Behavioural Therapy (CBT) is available to people with LTCs and commission relevant services • Introduce personalised management care plan as per trajectory • Availability of rehabilitation	Mar 2012

Created by Neevia Document Converter trial version http://www.neevia.com

		services need to be increased ensuring sufficient capacity to permit rapid access. Initially focus will be put on cardiac and pulmonary rehab • Medicine management support needs to be agreed in personal management plans. • 100% sign up from GP practices to the Gold Standard Framework for palliative care • Ensure comprehensive disease registers are in place for LTCs • Increase the emphasis on self care and trial patient held budgets In partnership with local authority ensure all appropriate staff are trained in delivering a self care approach.	
	Access to a full range of equipment with appropriate expert advice	• Delivery of appropriate assistive technology to those who would benefit • Investigate the potential and further use of internet and mobile phone communication for ongoing support and advice • Stimulate the retail market.	Mar 2013
	Monitoring delivery of optimum clinical care for all on disease registers	• Learn from successful experience elsewhere, and adopt where appropriate • Develop local public health intelligence systems to monitor the care delivery.	Mar 2011
	Increased access to rehab programmes • cardiac • pulmonary	• Work towards and achieve the NICE guidelines for case findings by 2011.	Mar 2011
Exacerbations	Individual Health Plans responding to those with exacerbations	• Patients with LTCs to have individualised Health Plans to include: - Education, support and supplies - Palliative care and end of life support and plan - Plans for rapid access to specialist services when required - Access to use of media for lodging personalised care plans • Other actions under ' Management Plans' section.	Mar 2011
	A whole system approach in and out of hours	• Work with out of hours providers, ambulance trust and social services ensuring whole system approach • Use electronic flagging and single contact point.	Mar 2010
	Palliative care prognostic indicators	• Implement recommendations as in the End of Life Care	Mar 2013

Created by Neevia Document Converter trial version http://www.neevia.com

		Strategy.	
	Appropriate assistive technology to aid early id of/response to exacerbations	• Usage of predictive technology to aid identification of potential exacerbations • Delivery of appropriate assistive technology to those who would benefit • Investigate the potential and further use of internet and mobile phone communication for ongoing support and advice.	Mar 2013
	Consistency in response regardless of entry point and timing	• Consistent and equitable response to urgent health care needs • Use of flagging system to highlight those patients with LTCs and "frequent fliers".	Mar 2010
	Rapid access to community based intermediate care services to avoid inappropriate admission	• Multi agency and multidisciplinary services offered in community based intermediate care services preventing inappropriate admissions • Provision of timely access to specialist advice and diagnostics in primary care.	Mar 2010

7 High level requirements

- This initiative is dependent on local ownership by PBC consortia, clinical engagement and working in partnership with local authorities, local providers and third sector
- There is an expectation that this initiative can in some way be delivered through service re-design within the NHS. However, this initiative will not be successful without the investment required by our local authority partners in introducing individual patient held budgets.

8 How will success be measured

Year on year improvement in patient experience

The East of England Patient and Public Survey:
The 2008/09 data will be used as a baseline.

- % of patients saying their care has improved in the last 12 months
- % of patients satisfied with the management of their care
- % of patients satisfied with their level of involvement in decision making
- quality of life.

Ensuring personal health plans and empowerment of the individual carer

- % individuals with a personal health plan compared to the numbers of people on the 19 LTC Quality Outcome Framework (QoF) registers: CHD, HF, stroke and TIA, Hypertension, diabetes, COPD, epilepsy, hypothyroid, cancer, palliative care, MH, asthma, dementia, depression, chronic kidney disease, AF, obesity, learning disabilities, and smoking. This will be an annual assessment
- Number and % of patients with a LTC taking up an EPP or condition specific programme

Created by Neevia Document Converter trial version http://www.neevia.com

(e.g. DAFNE) compared to numbers offered. This will be monitored 3–6 monthly.

The effective management of people with LTC

- Variation in the emergency admissions calculated for a suite of 19 long term conditions (From Better Care Better Value - BCBV). The 0708 data will be baseline for benchmarking future performance. This assessment will be carried out on a quarterly basis.

Improve timely access to specialist advice and diagnostics in primary care and ensure comprehensive disease registers are in place

- % of patients diagnosed with a particular LTC for which a robust prevalence model exists i.e. diabetes and COPD, compared with numbers on QOF registers. The 08/09 QoF data will be the baseline, and this assessment will be carried out 3 – 6 monthly.

Data source

Patient level acute data will be collected monthly:

- Acute cds – Inpatient
- Acute cds – Outpatient

9 Impact on health outcomes and inequalities

The impact of LTCs on people's lives will be reduced. Over the next five years, people will be treated sooner, and nearer to or at home. They will be given information and support to be independent and in control of their lives, including the end of life.

Effective management of people with LTCs will also reduce health inequalities and improve life expectancy. Progress will be made to ensure fewer people suffer from, or die prematurely from, heart disease, stroke and cancer. More prevention measures will be put in place e.g. smoking cessation and weight management programmes, and there will be more structured and proactive screening services.

Other patient orientated features include:

- Remember that people with LTCs are people first – a person with diabetes but not a diabetic
- Personal health plans and individual health budgets for people with LTCs
- More patient education & support programmes such as expert patient programmes
- Improve timely access to specialist advice and diagnostic in primary care
- Guarantee access to cardiac and pulmonary rehabilitation
- Reduce the need for emergency admissions
- Reduce the number of people admitted to the hospital as a result of fall
- Access to assistive technology to support independence.

10 Other impacts

- NHS Bedfordshire will be working as closely with local authorities, local clinicians and users / carers themselves to ensure services are making a real difference
- Reduction of outpatient appointments up to 65% of 07/08 baseline
- Reduction of inpatient bed days up to 72% of 07/08 baseline
- A different type of workforce that promotes and supports independence, and empowers people with LTCs.

Created by Neevia Document Converter trial version http://www.neevia.com

11 Impact on providers

- Provider development, work with new and existing providers to improve patient value and achieve the objectives
- Assess demand and supply and develop the market
- Opportunities for third sector organisations
- Different education and training requirements for post registration training
- Workforce development.

Created by Neevia Document Converter trial version http://www.neevia.com

End of Life Care

1 Overview

The aim is to ensure that all patients nearing the end of life are empowered to make choices regarding their levels of treatment; where they receive their treatment and their place of death i.e. home; hospital or hospice etc. There will be a strong focus health working closely with it's partner organisations, involved in delivering end of life care, to ensure that:

- Patients receive holistic assessments at regular intervals
- Carers' assessments are performed
- Patients and their carers/families feel supported in ensuring that the choices they make as part of their advanced care plan are fulfilled.

This will be a joined up, co-ordinated, responsive, patient-focused approach for delivering the services required by patients, their carers and their families, ensuring they receive the care that is appropriate and timely to their needs. This will require a number of sub initiatives.

The raising of public awareness to address issues around death and dying, to encourage patients, their carers and families to discuss their preferences and choices regarding treatment and place of death.

Ensure that EOLC is well co-ordinated and delivered seamlessly across all of the disciplines involved, with increased emphasis on communication. This will be supported through rapid access to the appropriate service 24/7 and also the further implementation of EOLC Tools, the GSF and LCP in primary care i.e GP Practices and Care Homes.

Supporting services in their ability to deliver the NICE Supportive and Palliative Care and expected national EOLC quality measures.

Public Health input to address inequalities in access to palliative EOLC.

Implementation of the East of England End of Life Care Clinical Pathway. This will underpin the services and interventions that will be required during the phases of the dying patient; it will integrate with the disease specific pathways. The pathway will focus on:

- Open and honest communication with the patient as end of life approaches
- The development of a care plan with the patient, this will be regularly reviewed as the needs and preferences of the patient changes
- The assessment of carers needs
- The strategic co-ordination and delivery of high quality service by health and its partner organisations, in different settings i.e. home; hospital; hospice
- The co-ordination of individual patient care
- Identification and supporting the patient and carer in the dying phase
- Care after death the timely verification and certification of death
- Emotional and practical bereavement support for the carer and family

The implementation of education and training programmes for all staff involved in the delivery of EOLC/Palliative Care. This will ensure that staff are able to recognise when patients are approaching end of life and feel confident to initiate discussions about their preferences and

Created by Neevia Document Converter trial version http://www.neevia.com

choices for care.

Implement systems and processes for the collection, analysis and reporting of data, to enable service planning, commissioning and evaluation of the quality of services provided.

Establishment of Beds & Herts Palliative and EOLC Network to support working across boundaries and sharing of best practice with neighbouring health trusts.

2 SMART goals addressed

To increase the number of individuals who choose to die at home over the next five years from 21.8% to 27.8% by 2011/12.

VSC 15		2008	2009	2010	2011
	Number of deaths at home registered in the respective calendar year	974	1,039	1,100	1,156
	Number of total deaths registered in the respective calendar year	4,469	4,367	4,264	4,160
	Proportion of deaths at home registered in the respective calendar year	21.8%	24%	27%	30%

3 Reason for selecting this goal

- Services will be focused in ensuring patients have appropriate care packages to ensure in their final year of life that all services are targeted appropriately
- The National End of Life Care Strategy published in July 2008 and highlights the need for all patients are consulted regarding their preferences and choices in relation to levels of treatment, place of treatment and place of death
- During 2007-08 136 deaths occurred at St Johns Hospice, the principle hospice for NHS Bedfordshire. July 2007-July 2008 (thirteen months) 1,424 deaths occurred in hospital
- Approximately 50% of the deaths identified above could have been supported at home with the right support from community services. NHS Bedfordshire will act as the catalyst to ensure that the necessary infrastructure is available within the community to support patients to choose to die at home
- The population forecasts and predictions show that not only are people with a long term condition set to increase but also the age group, 65 years and over is set to increase by 14.1% over the next five years. This means that need will increase and impact on the services involved in delivering End of Life Care,

4 Input from stakeholders

- An End of Life Baseline Review was conducted by NHS Bedfordshire in 2007. All of the key stakeholders involved in delivering palliative and end of life care were involved in the process to ensure a clear, concise picture of all services and their different stages of development, see attached EOLC Baseline Review

The following groups will be set up to assist the delivery of the End of Life Strategy:

- The Beds & Herts Palliative & End of Life Network Group will have representation from the key stakeholder organisations i.e. Marie Curie; Macmillan Cancer Support, East of England

Created by Neevia Document Converter trial version http://www.neevia.com

Ambulance Trust; Social Services etc. These organisations will work with Commissioners and Clinical Leads within Beds & Herts to ensure a network wide approach when implementing local End of Life Care /Palliative Care Services

- The local Palliative/End of Life Care Implementation Group will include clinical representation for all conditions, commissioner and local voluntary sector organisations
- Involvement of the clinicians and local voluntary sector will be paramount to the successful development and implementation of the End of Life initiative
- Public and user involvement will have a key role in the development and implementation of the End of Life strategy. Using patient experience through focus groups and witness testimonies from carers and families will support the local implementation of the East of England End of Life Clinical Pathway.

5 Value for money

- The assumption for End of Life Care is that whilst we will be able to reduce the number of deaths that occur in hospital by giving patients who have a specific disease or LTC a choice, we will not necessarily reduce the in-patient stays for those requiring interventions at the different stages of their disease. In fact the costs of nursing someone at home will increase and the main focus for End of Life Care is about providing the best quality of life for the patient in their final year of life
- There would be an expectation that the increase in deaths at home would reduce the number of emergency admissions into secondary care. However this would be dependant on the nature of the disease and the home situation for the patient, which is likely to change as the patient progresses through the disease pathway. An assumption can be made that some patients may require interventions at different stages of their disease, this could result in a number of in-patient admissions occurring during their final year of life e.g. blood transfusions; chemotherapy; radiotherapy etc. Some of these interventions could be delivered at the patient's home or at another setting e.g. local community hospital or hospice. A recent 3 month audit was undertaken by the Macmillan CNS Team in Mid Beds and Ivel Valley to review the appropriateness of referrals into secondary care for the patients under their care. A total of 21 admissions were made, each of the admissions were found to be appropriate this would have been an approximate cost of £58,800, based on an in-patient spell of 5 days at a cost of £2,800
- In addition to the increase in activity for the Community Nursing Service there would almost certainly be a need to review the types of activity delivered by the hospices. There will always be patients that die in a hospice, not necessarily because this is their choice but due to the nature of their disease. To assist in sustaining a patient at home there may be a need to commission respite beds for patients and also hospice at home services to support carers and the families. There are currently inequities in NHS funding for hospices, also the different types of services they deliver, NHS funding for hospices ranges from 23% - 45% and is set to increase. The assumption is that there will be an increase in the hospice budget of 5% each year to:
    - Bring all hospice funding in line to 45%
    - Support any new activity as part redesigning EOLC Services.

- The full implementation of GSF and LCP in Primary Care would ensure that patients are tracked, their disease monitored and pro-actively managed by the GP and Nursing staff through regular multi-disciplinary team meetings, preventing emergency admissions into secondary care. The cost of implementing the GSF and LCP would be based on 10p per head of population. An approximate cost to implement this in the first year is £40,600.

Cancer Patients

- The introduction of the Cancer Commissioning Toolkit will enable NHS Bedfordshire to

Created by Neevia Document Converter trial version http://www.neevia.com

identify the number of in-patient beds used through emergency admissions and interrogate the reasons for these admissions. The reduction of in-patient admissions should free up resources to further develop services in the community to allow patients and carers to be properly supported during the End of Life phase of their disease.

LTCs

- Information from Department of Health suggests people with LTCs account for 65% of all out-patient appointments and 72% of all in patient bed days, some of which could include patients in their last year of life. For NHS Bedfordshire, this is equivalent to £88,861,304 (excluding day cases and elective admissions) in 2007/08
- There is clear evidence that proactive management of people with LTCs and cancer in their final year of life can significantly reduce the expenditure on secondary care. However, implementing the services required to support this initiative will not be cost neutral.

NHS Hospital

- Specialist Palliative Care Teams – approx. £266,902

Third Sector

- Hospice Care - £921,030
- Marie Curie - £115,303
- Hospice at Home Volunteer Sitters - £45,059

6 Timescale for goals to begin

- Baseline review of End of Life Care Services performed in 2007 in preparation for the National End of Life Care Strategy which was eventually released July 2008
- Activity to commence September 2008 with the first meeting of the Beds & Herts End of Life Network Group, the local development of the Beds & Luton End of Life Care Strategy and a needs assessment of palliative/end of life care services for Bedfordshire. This will assist in identifying the commissioning intentions of the PCT particularly community nursing requirements, hospice services and access to palliative care beds in the community.

7 High level requirements for this goal

- The initiative will require local and cross boundary ownership by PBC Consortia, clinicians and partner organisations from both the public and voluntary sectors to ensure their commitment to a joined up approach in delivering seamless services
- There is an expectation that End of Life Care will be delivered through service redesign. However, to support the shift from Secondary Care into the community setting, some services in the community may require initial investment
- The End of Life programme will require a commitment of recurrent investment to support gaps in service that may be identified in the Palliative/End of Life needs assessment, to support the generalist and specialist workforce to deliver care closer to home.
- End of Life Care education/palliative care competencies will be compulsory for generalist staff to attend.

Created by Neevia Document Converter trial version http://www.neevia.com

8 How success will be measured

	2008/09	2009/10	2010/11	2011/12
After Death Analysis Audit/ Achieving patient choice	To be developed	35%	70%	90%
Proportion of Deaths at Home	21.8%	24%	27%	30%
Uptake of EOLC LES (GSF/LCP)	To be developed	25%	50%	97%
Uptake of QOF Indicators PC1 & PC2	89%	91%	93%	97%
Reduction of complaints for all End of Life Care Services across Bedfordshire. (Acute & Community)	Baseline to be identified.	Reduction by 5% from previous year	Reduction by 5% from previous year	Reduction by 5% from previous year
Audit of Patients transferring onto the EOLC Clinical Pathway	To be developed	35%	80%	100%

The Implementation of systems and processes for the collection, analysis and reporting of data, to enable service planning, commissioning and evaluation of the quality of services provided.

This will be regularly monitored at the Bedfordshire Locality Pal/EOLC Implementation Group.

Pledge 1

- After Death Analysis Audit of the individual patients Advanced Care Plans regarding:
    - Their levels of treatment.
    - Where they receive treatment i.e. home; hospital or hospice etc.
    - Their place of death i.e. home; hospital or hospice etc.
- Witness testimonies from Carers and families
- Complaints registers to be kept by all service providers, these will be regularly monitored to assist service improvement.
- Compliments registers to be kept by all service providers, these will be regularly monitored to assist service improvement and support developments in best practice
- Vital Signs – VSC15. The proportion of all deaths that occur at home
- Quarterly monitoring of Secondary Care Activity using the Cancer Commissioning Toolkit

Pledge 2

- Uptake of End of Life Care LES (GSF/LCP)
- QoF Data for indicators PC1 & PC2

Pledge 3

- Compilation of an End of Life Care Register for Bedfordshire
- Audit of patients transferring from Specific Disease Pathway onto End of Life Care Pathway.

Created by Neevia Document Converter trial version http://www.neevia.com

9 Impact on health outcomes and inequalities

- To provide seamless care to patients and support to carers and families as the patient progresses through the disease pathway, ensuring that inequalities in access to EOLC Services are reduced
- Palliative and EOLC will be delivered by a team of multi-skilled professionals from Health and Social Care, to be responsive to patients' preferences and choices resulting in a higher proportion of patients choosing to die at home
- The provision of interventions currently delivered in secondary care settings to be provided in the patient's own home or closer to their home
- Seamless care will be provided to patients and support to carers and families as the patient progresses through the disease pathway, ensuring that inequalities in access to EOLC Services are reduced.

10 Other expected impacts

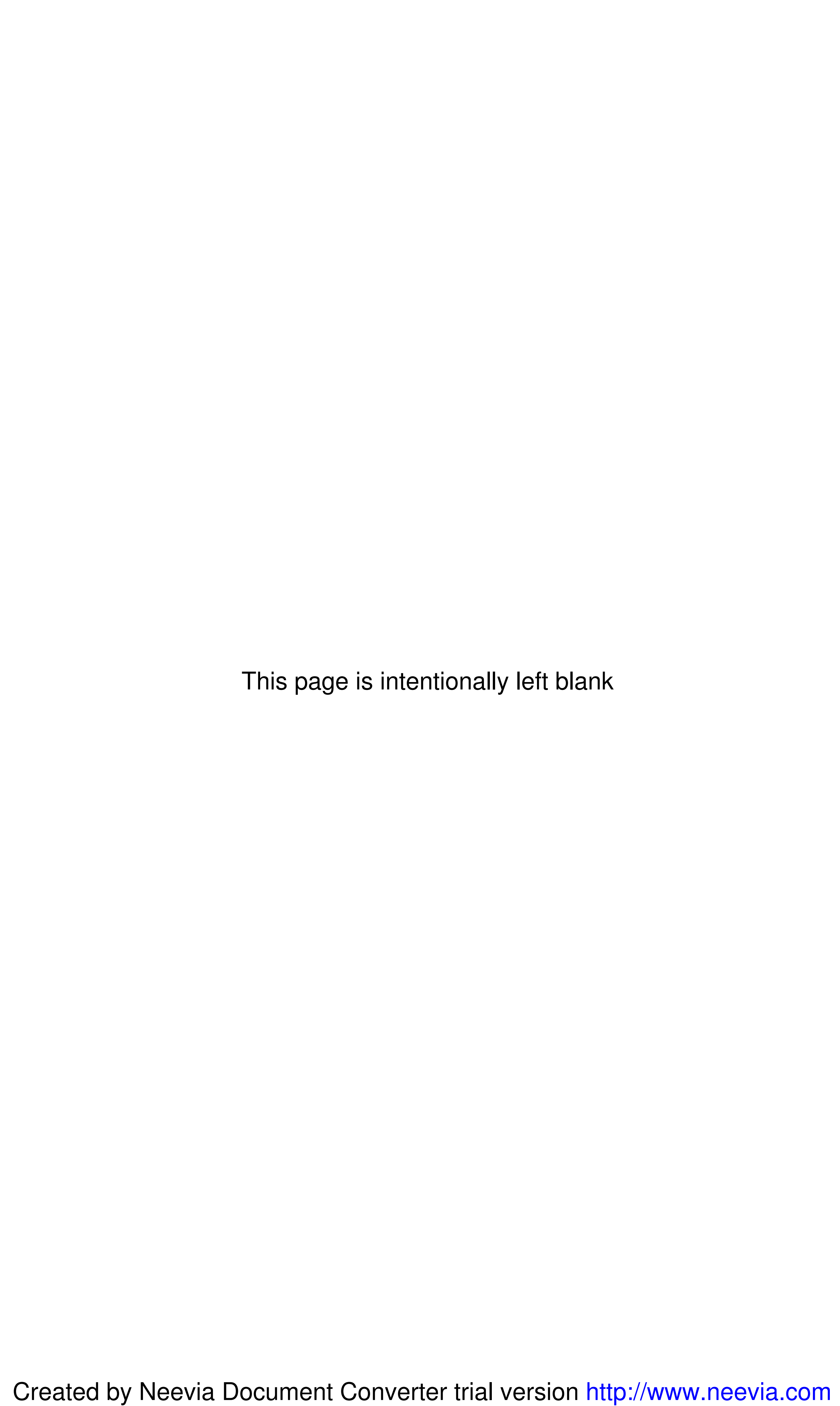
Impacts on in-patient activity to be established once the cancer commissioning toolkit has been introduced. This will need to link with the LTCs.
Other impacts would be:

- 24/7 access to and prescribing of controlled drugs in primary care, shift in costs from secondary care to GP Prescribing
- Disposal of unused controlled drugs in the community
- Increase in activity for community nursing services i.e. Macmillan CNS; DN; Community Matron
- 24/7 Community Nursing Service
- Impact on hospice services i.e. 24hr advice line; in-patient beds; day services etc.
- Initial investment in services i.e. Palliative/End of Life Care LES (GSF/LCP)
- Increased Training & Education programme for health/social care professionals.

11 Provider Requirements

- Implementation of Gold Standards Framework in Care Homes, training is currently taking place for Care Homes. Care Homes will need to ensure that all staff are fully trained in GSF, this will be an ongoing training programme within the care home due to the high turnover of staff
- EOLC Facilitation to support the delivery of the 3 EOLC Tools across all care settings
- End of Life LES to implement GSF, LCP & ACP in primary care
- Education and training – resources and release of staff to attend training on the Palliative Care Competencies, DoH Advanced Communication Skills training programme, GSF in Care Homes.

Created by Neevia Document Converter trial version http://www.neevia.com


This page is intentionally left blank

Created by Neevia Document Converter trial version http://www.neevia.com