NHS

Bedfordshire Clinical Commissioning Group

Strategic Commissioning Plan

2012-2015

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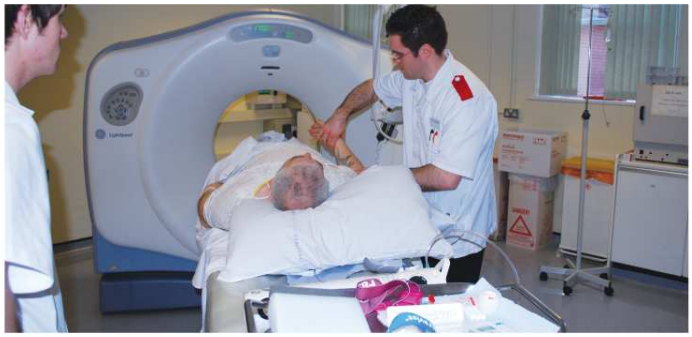

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Description	2012 strategic commissioning plan for Bedfordshire Clinical Commissioning Group. It sets out the framework for commissioning decisions for the next 3 years, based on information about current needs, demands and national and local context.
Associated documents	NHS Bedfordshire and Luton PCT Cluster Integrated Plan 2012/13-2014/15 NHS Constitution Bedfordshire Clinical Commissioning Group corporate business plan
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Equality impact assessment	In progress

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Foreword

It is with great pleasure that I present the first strategic integrated commissioning plan of the new Bedfordshire Clinical Commissioning Group, an organisation run and led by local clinicians to take over responsibility for planning, organising and purchasing healthcare for the people of Bedfordshire. BCCG is firmly built on the foundations of our five localities – Chiltern Vale, Horizon (Bedford Borough), Ivel Valley, Leighton Buzzard and West Mid Bedfordshire – and we already have a strong track record of local commissioning.We intend to be in the vanguard of the new clinically led commissioning organisations developing across England, starting as we mean to go on, amongst the first to go forward for assessment to be granted full statutory responsibility for local NHS commissioning.

Our approach is straightforward and realistic. We are now living in tougher economic times with rising demand for healthcare as our population grows and gets older. But that should not stop us from delivering the high quality health services that people rightly expect and deserve. We firmly believe that higher quality means better value, less waste, and people getting the right care in the right place, first time. This may mean difficult decisions on the future shape and form of local healthcare. We want our residents to be confident that we are making decisions with them.

The key to our success is in our local knowledge and presence:through the leadership and involvement of Bedfordshire clinicians, and the participation of and feedback from Bedfordshire residents, both directly and via their elected representatives in Bedford Borough and Central Bedfordshire Councils. We are establishing a public membership scheme for BCCG that will set the organisation firmly amongst the communities it serves.

This first strategy sets out our commissioning ambitions for the future. Our business and organisational development objectives are set out in the sister document to this, our corporate business plan. During the 2012-13 transition year, we will develop and refine our implementation plans as the newly liberated NHS settles down and our experience with the new levers in the system evolves.

Dr Paul Hassan, Chair
May 2012

Executive summary

This strategic integrated commissioning plan picks up from the NHS Bedfordshire & Luton Cluster Integrated Strategic Operating Plan (ISOP) and refines it with a Bedfordshire-specific approach. It provides further detail of our strategic approach, aims and commissioning intentions, and describes more clearly how we plan to achieve these. In so doing, it encompasses our 2012-13 operating plan, draft commissioning intentions for 2013-14, and high level strategic plan for 2014-15.

1. What is Bedfordshire Clinical Commissioning Group?

Bedfordshire Clinical Commissioning Group (BCCG) has delegated responsibility in 2012/13 for commissioning services estimated at £478million. Its members are 56 general practices organised into five localities based around natural population flows and well-established Practice Based Commissioning groups: Chiltern Vale, Horizon, Ivel Valley, Leighton Buzzard and West Mid Bedfordshire. The Bedford locality is co-terminous with Bedford Borough Council, and the remaining four localities collectively cover the population of Central Bedfordshire Council. The locality structure is the main vehicle through which the roles and responsibilities of the Clinical Commissioning Group will be exercised.

Although in general, Bedfordshire's population is similar in health profile to the population of England, each locality's population profile has unique aspects, as demonstrated in the Joint Strategic Needs Assessments for Bedford Borough and Central Bedfordshire Councils. For example, in Bedford, the population is generally younger and more ethnically diverse than in other localities. In Chiltern Vale, there are significant pockets of deprivation in an otherwise affluent area. Ivel Valley and West Mid Bedfordshire cover largely rural areas with generally good overall population health.

Patient flows also vary by locality. Bedford Hospital Trust is the main provider of acute care for Horizon and some parts of other localities. Luton & Dunstable Hospital Foundation Trust serves patients in especially Chiltern Vale locality. However, patients also frequently travel for care at Lister Hospital, Addenbrooke's Hospital, Stoke Mandeville Hospital, and Milton Keynes Hospital Foundation Trust.

Demographic shifts, financial pressures and external reconfiguration drivers are now injecting challenge into the status quo. Three of the hospitals used by BCCG patients are included in the scope of the 'Healthier Together' acute services review across South East Midlands, and, as a result, over the next three years BCCG is likely to oversee significant changes in acute care configuration, with greater centralisation of specialist care, to achieve better patient outcomes. BCCG must unlock the funding currently invested in this sector if it is to be able to commission

the necessary resulting increases in breadth and volume of care provided in communities and primary care.

Whilst making these changes at a macro level, BCCG must also ensure it addresses the inequity of care for its most vulnerable parts of the population, and it can best achieve this by working in close collaboration with both its unitary authorities.

2. What does BCCG stand for?

To invigorate change towards better value in healthcare locally, BCCG must adopt a fresh approach to commissioning which focuses on outcomes from both the patient and clinical perspective. Higher quality means better value and less waste, with patients getting the right care in the right place, first time. BCCG's mission is:

To ensure, through innovative, responsive and effective clinical commissioning, that our population has access to the highest quality health care providing the best patient experience possible within available resources.

3. What BCCG will do?

BCCG has broken down the totality of the healthcare to be commissioned into three key areas of focus, each of which has an associated outcome indicator (taken from one of the national Outcomes Frameworks). The three areas and their respective indicators are:

1. *CARE RIGHT NOW*

We will improve patients' experience of urgent care services, including walk-in centres, GP out of hours services and A&E services, so that more than 85% patients rate their overall experience as good or very good by 2015.

2. *CARE FOR MY CONDITION INTO THE FUTURE*

We will increase the proportion of people with a long term condition who feel they have had enough support from local services to help manage their condition from 66% (in 2011) to 80% by 2015.

3. *CARE WHEN IT'S NOT THAT SIMPLE*

We will work with social care to increase to at least 85% the proportion of people aged 65 and over who are still at home three months after leaving hospital for rehabilitation in the community.

In improving care in these three key areas, BCCG will also use the underpinning themes of:improving safety and patient experience; increasing prevention and early intervention; and ensuring sustainability of resources.

4. The BCCG approach

Our starting point is the health needs of the people of Bedfordshire. With the knowledge of our clinicians and the experience and support of our patients, we will build on what works well and change what needs to work better. We will do this by:

- *WORKING IN PARTNERSHIP with our member practices and localities, with patients and the public, with local councils, and with other healthcare providers*
- *USING CLINICAL LEADERS to challenge and champion, and to develop new ways of providing care in general practice*
- *FOCUSING ON OUTCOMES, by using our purchasing power to improve co-ordination of patient care*

By working in this way, using clinicians and patients to drive change and focusing on a key set of outcome-based priorities, we believe we can both produce the improvements in quality and efficiency required of the QIPP plan and provide financial and reputational 'head room' to invest in future priority areas.

5. Delivering the strategy: implementation plans

BCCG's commissioning changes are developed and implemented at locality level and through five programme boards: urgent care; planned care; mental health; prescribing; and children and maternity. Each board includes clinicians and patients in its membership and has a CCG clinician as Senior Responsible Owner (SRO), who is supported by a programme manager and a team of project managers.

(a) 2012-13 operating plans:

In this, the transition year for BCCG, the organisation is building its capacity and capability to take on the full range of commissioning responsibilities. It continues its leadership of the planned care and prescribing programmes, and takes over responsibility for urgent care and mental health programmes. For these latter two programmes, BCCG's focus is on developing clear strategic intentions (including refreshing joint commissioning strategies with Bedford Borough and Central Bedfordshire Councils) and establishing clear work programmes to ensure

delivery of improvements in quality of care and sustainable delivery of care as resources become tighter. It is also developing new programme approaches to children and maternity care and cancer care.

(b) 2013-14 commissioning intentions:

In its first formal year as a statutory organisation, BCCG will be responsible for starting to implement as commissioners the final decisions on the 'Healthier Together' programme. This could have wide-reaching effects on not just hospital-based care, but on the nature and volume of care delivered in the community and primary care. Therefore, with the Bedfordshire-wide contract for community healthcare services expiring in 2014, the year of 2013-14 will include a focus on redesigning and procuring community services that will fit the future shape of the healthcare landscape. With the main mental healthcare contract also expiring during 2013-14, a second focus will be on the procurement (in association with Bedford Borough and Central Bedfordshire councils) of mental healthcare that adopts a proactive approach to managing the needs of an ageing population and improving value.

(c) 2014-15 strategic objectives

By this point, implementation of the 'Healthier Together' programme will be well underway and new contracts will be in place for both mental healthcare and community healthcare. BCCG will be reviewing the impacts of all these changes on the local population's outcomes of care, ensuring that they do not deteriorate during transition and that the new healthcare landscape delivers safe, affordable and high quality care.

The use of programme boards to oversee the development and implementation of projects and delivery of programme objectives ensures regular and consistent input from CCG localities, local authority commissioning partners, health and social care providers, patients and carers, and patient/public representatives such as LINks/HealthWatch and service user groups. This is in line with the BCCG strategy on patient and public engagement.

6. Delivering the strategy: financial plan

The anticipated financial challenge for BCCG between 2012-13 and 2014-15 is £18.8m. Plans to meet this financial gap have been developed by the programme boards, and include allowance for contingency reserves.Further details are given in the full strategic commissioning plan.

7. Managing the process

As a new entity, BCCG is developing its organisational structure and governance arrangements during the 2012-13 transition year. There are already established performance monitoring arrangements and risk management processes, starting at locality and programme board level and escalating to BCCG Board level.

8. Conclusions

By the end of 2014-15, the health and social care landscape is likely to look very different to that of 2012. General practices will be collaborating to share skills and services in the best interests of patient care. More people with long term conditions will be receiving support and information from community-based specialist teams to understand and live more comfortably with their condition. Primary care, supported by decision support and risk stratification software, will be working with multidisciplinary teams using telehealth and telecare technologies in each locality to focus on those most in need and maintain people safely in their own homes for as long as possible. Community and mental health services will have been re-commissioned by BCCG (in partnership with both local authorities) against new specifications, ensuring greater integration between physical and mental health, primary/community/ secondary care, and healthcare and social care.

The 'Healthier Together' programme will have completed its task of recommending options for reconfiguration of acute care, and the implementation process will have begun. Specialist (consultant) care will be provided where possible either virtually or within localities, so that patient journeys are reduced both in number and distance.

By commissioning for outcomes, BCCG will have a better understanding of the value for money it receives from provider systems. It will systematically and routinely use patient and clinical intelligence to evaluate the quality of the experience delivered by commissioned providers, and, through its seats on Health & Wellbeing Boards in both Bedford Borough and Central Bedfordshire, will be using its commissioning power to improve the health of the local populations.

1.0 Bedfordshire as a health economy

Bedfordshire sits in the middle of the Midlands and the East region, traditionally part of the East of England, but with links into London and the Midlands. The 'county' is comprised of two unitary authorities: Bedford Borough in the north, and Central Bedfordshire in the south. There are also strong geographical and administrative links with Luton, not least through the NHS Bedfordshire and Luton PCT Cluster and shared use of services at the Luton & Dunstable Hospital Foundation Trust.

1.1 Population demographics and health needs

Detailed information on Bedfordshire's demographics and health needs can be found in public health annual reports, joint strategic needs assessments, and in health profiles.

1.1.1 Population size and characteristics

Bedfordshire CCG serves a total population of 437,650, split between the two unitary authorities as shown in Table 1.

Table 1: Bedfordshire populations by age group, 2011-12

Age group	Bedford Borough	Central Bedfordshire	Bedfordshire CCG
0-4	10,530	17,110	27,630
5-19	29,790	48,230	78,030
20-44	55,910	88,180	144,090
45-64	41,450	76,550	118,000
65-74	13,380	24,940	38,310
75+	12,190	19,400	31,590
Total	163,240	274,410	437,650

(Source: GP practice population Exeter Database, quarter 4, 2011-12)

BCCG's population is similar in age structure to the England population: 19% of the Bedfordshire population are aged under 15 (compared with 17% of the England population), and 15% are aged 65 and over (compared with 16% in England).

(a) Bedford Borough

Almost two-thirds of Bedford Borough's population are based in Bedford/Kempston, with the remainder living in smaller towns and villages in the borough's rural areas. The population is predicted to grow by another 10,000 over the next five years. The number of older people is expected to grow at a much faster rate between now and 2021, with numbers of people aged 65+ and 80+ both rising by approximately 30%. The population of Bedford/Kempston is younger on average than the more rural areas of the Borough, with 55% aged under 40 in the towns and

45% in the country. Life expectancy for those best-off in Bedford Borough is around ten years greater than those worst off (11.3 years for women; 9.1 years for men), and this gap is widening, with life expectancy decreasing in the most deprived parts of the Bedford population.Bedford Borough has an ethnically diverse population. In 2001, 19.2% of the population was from minority ethnic groups (BME), compared to 13% nationally, and there has been a substantial increase since 2001 due to significant international in-migration, especially from European Union accession countries. The BME population is largely concentrated in the urban area of Bedford and Kempston with particularly large BME communities in Queens Park (57.8% in 2001) and Cauldwell (43.6%) wards.

(b) Central Bedfordshire population

Central Bedfordshire has a growing and ageing population that is expected to increase to 290,000 by 2021 and 335,000 by 2031 due to increasing life expectancy, a rising birth rate and inward migration. The biggest increase - of around 30% - will be in the number of people aged 65 and over.Average life expectancy at birth in Central Bedfordshire is increasing and is currently 79.5 years for men and 83.0 years for women. These are similar to East of England and better than the England averages. In 2009 an estimated 13% of people in Central Bedfordshire were from ethnic minority communities, compared to 17% in England. The largest of these groups were: Asian (3.9%); White Other (3.5%); Black (1.9%); and White Irish (1.2%). The black and ethnic minority (BME) populations make up a higher proportion in younger age groups.

1.1.2 Population segmentation

(a) Localities

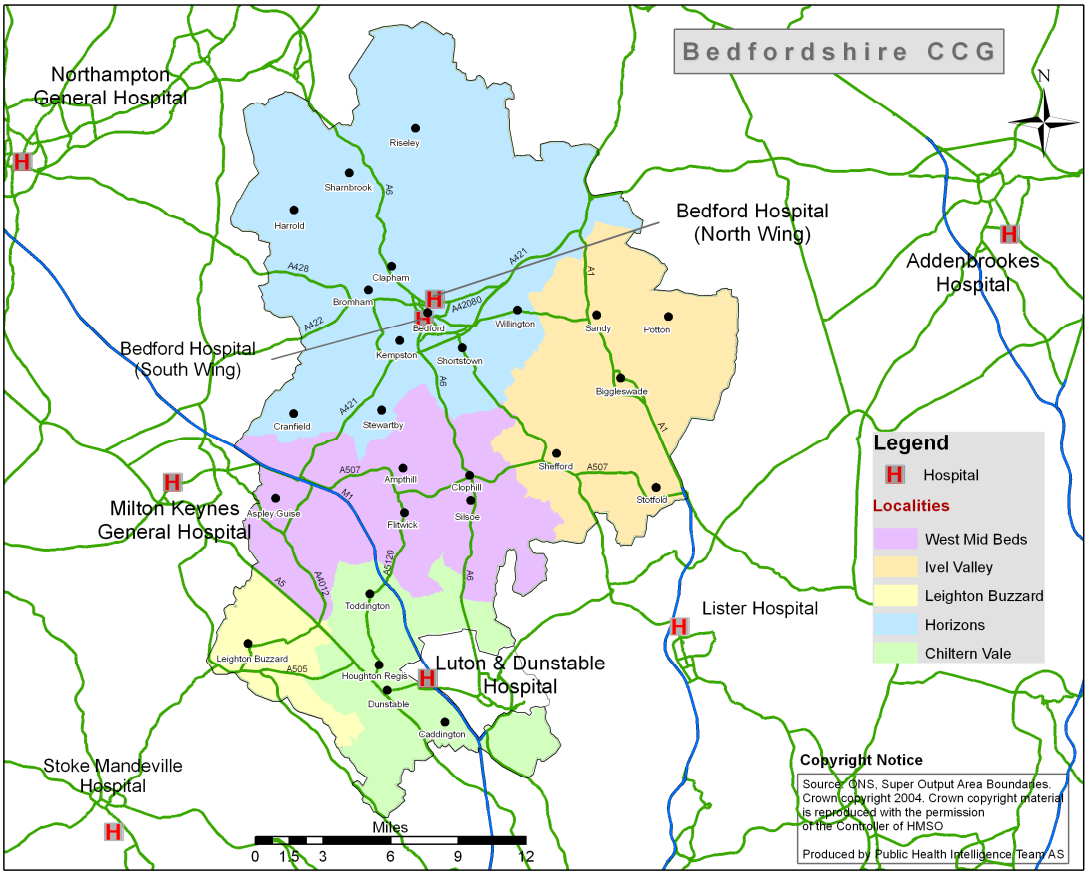
BCCG is composed of five localities, as shown in Table 2 and Figure 1.

Table 2: Bedfordshire CCG locality populations

Locality	Number of GP surgeries	Registered population
Chiltern Vale	10	78,100
Bedford	26	173,000
Ivel Valley	9	85,000
Leighton Buzzard	4	44,000
West Mid Beds	6	57,200

(Source: GP practice population Exeter 2011-12, quarter 4)

Figure 1: Map of Bedfordshire CCG localities



Bedford (Horizon) locality is almost co-terminous with Bedford Borough Council with which it shares the same health issues of a largely urban population. Chiltern Vale covers the towns of Dunstable and Houghton Regis, both of which contain significant pockets of deprivation. Leighton Buzzard locality, although one of the smallest, covers a town with an active town council and strong community engagement. Ivel Valley and West Mid Bedfordshire cover largely rural areas with generally good overall population health.

(b) Mosaic segmentation

The Mosaic database uses hundreds of data elements to create a national classification system of the population, illustrating general themes in attitude, behaviours and preferences. This classification system can help describe local populations and inform how best to engage them in their health and involve them in decisions on healthcare; the top ten most common population types in Bedfordshire are listed in the table below.

Table 3: Mosaic classification of Bedfordshire population

Mosaic Public Sector Groups	Number in Bedfordshire	% of total Bedfordshire population	% of England population (comparison)	Index
Middle income families living in moderate suburban semis	80,194	18.51	13.01	142
Successful professionals living in suburban or semi-rural homes	75,569	17.44	8.68	201
Couples with young children in comfortable modern housing	49,566	11.44	5.71	200
Residents of small and mid-sized towns with strong local roots	39,167	9.04	8.67	104
Owner occupiers in older-style housing in ex-industrial areas	36,402	8.40	8.06	104
Residents with sufficient incomes in right-to-buy social housing	34,604	7.99	9.10	88
Couples and young singles in small modern starter homes	31,608	7.30	4.62	158
Lower income workers in urban terraces in often diverse areas	18,665	4.31	8.33	52
Young, well-educated city dwellers	16,015	3.70	8.80	42
Families in low-rise social housing with high levels of benefit need	11,106	2.56	5.70	45

The profiles behind these data suggest two things: firstly, that healthcare receptive to children and family needs is important in Bedfordshire; and secondly, that the internet and telephone are likely to be effective ways to reach large parts of the local population. BCCG will use these key attributes, and other information from Mosaic profiles, to help inform its engagement tactics.

1.1.3 Long term conditions and major killers

Given the similarities of BCCG's population to the England population, it is not surprising to find that the health of the people in Bedfordshire is generally typical of the country as a whole, with a standardised mortality ratio of 97 (compared to an England SMR of 100). The estimated prevalence of long term conditions, such as coronary heart disease, chronic obstructive pulmonary disease, hypertension and stroke, are comparable to those expected nationally (see Table 4). However, for each of these conditions, significant proportions of BCCG patients are not being diagnosed and therefore not being treated appropriately.

Table 4: Estimated prevalence of long term conditions in Bedfordshire CCG and comparative rates of recorded prevalence

	Observed prevalence (BCCG)	Estimated prevalence (BCCG)	England prevalence	Ratio of recorded versus expected prevalence
Coronary heart disease	3.1%	4.8%	5.8%	0.64
Chronic Obstructive Pulmonary Disease		2.1%	2.9%	0.60
Hypertension	13.4%	28.3%	30.6%	0.47
Stroke	1.5%	2.3%	2.5%	0.64

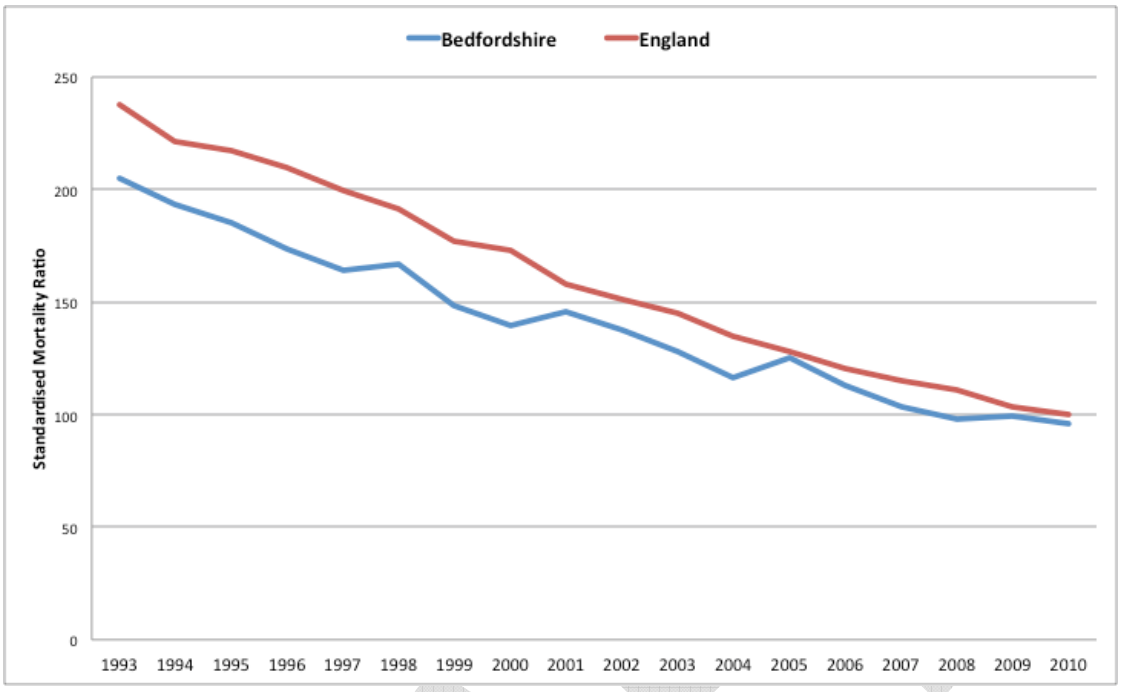
(Source: National General Practice Profiles, and Cardiovascular Disease profile for Bedfordshire, both Association of Public Health Observatories, 2012)

Around 3,300 deaths happen each year, of which one third are of people aged under 75, i.e. premature deaths. As with many parts of England, the majority of deaths in Bedfordshire are due to three main conditions:

- Circulatory disease is responsible for more deaths than any other disease each year (31% of deaths in 2010)
- Cancers are responsible for over 5,500 years of life prematurely lost in Bedfordshire each year and 28% deaths in 2010, with breast, colorectal and lung cancers causing the most premature deaths
- Respiratory diseases (chronic obstructive pulmonary disease [COPD] and pneumonia) caused 9% of all deaths in 2010

Data are also collected on deaths from causes considered amenable to healthcare, i.e. those conditions for which timely, appropriate and high quality healthcare might have prevented or delayed death in some. Bedfordshire has had relatively low, and falling, rates of such deaths compared with national rates, but, as Figure 2 shows, the rate of decline has slowed and the gap between Bedfordshire and England has narrowed. This plateauing of the mortality rate in Bedfordshire could suggest that innovations in cost-effective care are not being introduced as quickly here as they are in the rest of the country.

Figure 2: Mortality from causes considered amenable to healthcare in people aged under 75, trend in standardised rates over time, Bedfordshire and England



As well as access to high quality healthcare, death rates are also affected by lifestyle factors. In order to pursue the Wanless objective of a "fully engaged" population and if health is to be improved in the medium term, further progress must be made on addressing the risk factors for these long term conditions. The common theme is that insufficient numbers of people are accessing key preventive services that address the major killers (e.g. stop smoking services, weight management services).

- Tobacco use: an estimated 20% of the adult population in Bedfordshire still smokes, with smoking prevalence greater in the most deprived parts of the CCG
- Obesity: almost one quarter (24%) of Bedfordshire's adult population are clinically obese
- Alcohol misuse: an estimated 18% of the Bedfordshire adult population binge drink

BCCG has a vested interest in ensuring its population lives healthy lifestyles, and can promote good health and wellbeing through programmes such as NHS Health Checks, and Making Every Contact Count, and through working in partnership with its two Health & Wellbeing Boards.

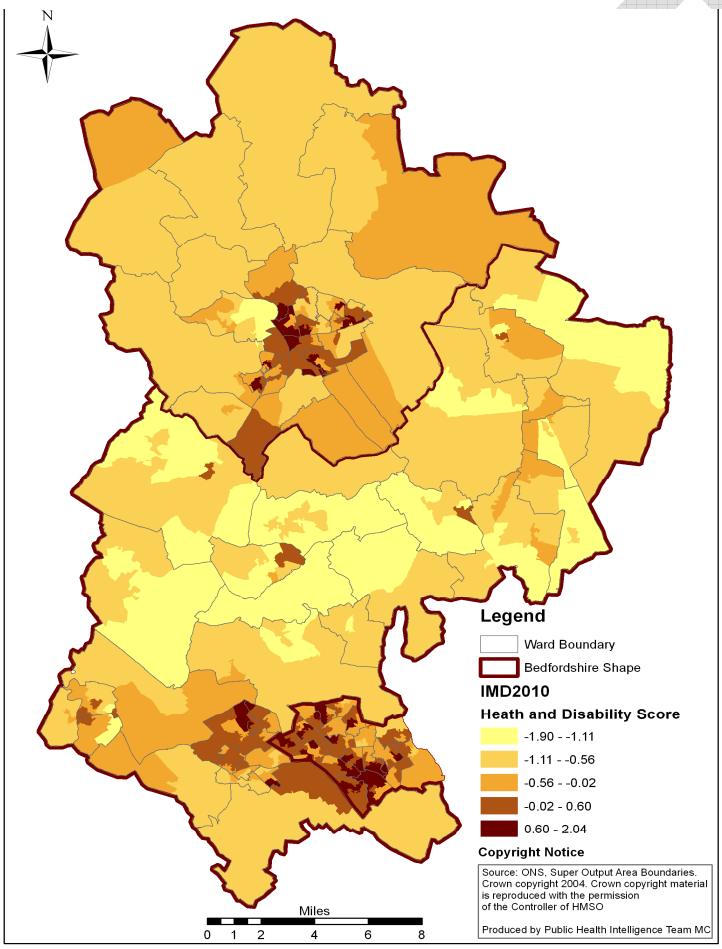
1.1.4 Inequalities in health

Bedfordshire's overall deprivation score is lower than that for England overall (14.6 vs 21.5), although this hides pockets of deprivation in especially urban areas such as Bedford and Dunstable.Income deprivation affects 20% of people aged 65 and over in Bedfordshire,

compared to 18% in England: non take-up of benefits is one major cause. Income deprivation also affects 20% of children in Bedfordshire, compared to 22% in England. These deprivation indices are worse in Bedford Borough than in Central Bedfordshire.

'Health deprivation and disability' is one of the domains that make up the national Index of Multiple Deprivation, and measures premature death and the impairment of quality of life by poor physical and mental health. Figure 3 shows the relatively worse concentrations of poor health and disability in Bedford, Dunstable, and Leighton Buzzard, but with pockets in smaller towns within Central Bedfordshire. (The 20% of areaswith the worst health and disability scores are those shaded in the darkest colour on the map.)

Figure 3: Health Deprivation and disability scores, Bedfordshire, 2010



Source: Index of Multiple Deprivation, Office for National Statistics

The 'big killers' of circulatory diseases, cancers and respiratory diseases are significant contributors to the life expectancy gap, as they are to overall life expectancy. In particular, the rates of premature mortality have a large impact on life expectancy, with cardiovascular disease

the single biggest driver of the life expectancy gap between the most deprived and least deprived.However, with revascularisation rates for those living in the most deprived areas of Bedfordshire 1.7 times greater than those in the least deprived areas, it seems thatthe inverse care law is not operational in this instance.

1.2 Clinical quality

Quality and safety of care are of paramount importance to Bedfordshire Clinical Commissioning Group. Information on clinical quality comes from routinely reported data sets, regulator reviews, and the work of BCCG's Quality and Safety team. Together, these sources provide rich evidence on the state of care experienced by patients.

1.2.1 Community-based care

Whilst there is general agreement that community-based care in Bedfordshire has improved over recent years, there remains significant evidence pointing to continued focus on healthcare for particularly vulnerable people. For example:

- Routine performance measures for Bedfordshire highlight the following key issues during 2011-12:
    - Low proportions of people who have depression and/or anxiety disorders who receive psychological therapies
    - Low rates of health checks for people with learning disabilities
    - Low uptake of personal care plans and patient education by people with long term conditions
    - Low use of Choose & Book to arrange first outpatient appointments (a proxy measure of patients being offered choice of provider)
    - Slow roll-out of summary care record programme
- Recent CQC reviews of healthcare services for looked after children in both Bedford Borough and Central Bedfordshire found significant room for improvement. Action plans are now in place to address the issues identified.
- A recent mental health bed review identified a lack of suitable community-based beds in Bedfordshire for people with dementia, in the context of being in the quintile of health economies with the lowest per capita spends on mental health in England

1.2.2 Acute providers

(a) Bedford Hospital:

In general, the quality of care provided at Bedford hospital is good. The Quality Observatory's Spring 2012 acute trust quality dashboard for Bedford Hospital demonstrates the following positive outcomes:

- Low rates of hospital mortality in low risk conditions
- Low readmission rates for patients within 2 days of an emergency admission
- High proportion of patients discharged home
- High proportions of patients reporting improvements after hip replacement and varicose vein surgery in Patient Reported Outcome Measures (PROMs)
- Low numbers of patients with delayed transfers of care
- Low rates of medication errors
- Low rates of "inappropriate" A&E attendances

However, the following areas are significantly worse than national average performance:

- Percentage of emergency admissions for cellulitis and DVT (ambulatory care sensitive conditions)
- Waits for diagnostic tests of over 5 weeks
- Percentage of patients leaving A&E without being seen by a healthcare professional

In addition to these indicators, through its lead role in quality review groups for Bedford Hospital, BCCG is aware of backlogs of 18 week activity, especially in orthopaedics and urology. The Trust has plans in place to address these issues, but they will need close monitoring to ensure completion and identify any unintended consequences in other pathways.

(b) Luton & Dunstable Hospital Foundation Trust ("the L&D"):

The quality of care provided at the L&D has been inconsistent. The Spring 2012 acute trust quality dashboard demonstrates the following strong points in the L&D:

- Average or below average emergency readmission rates after elective and emergency admissions
- High proportion of patients discharged home
- High proportions of patients reporting improvements after knee replacement and hernia surgery in Patient Reported Outcome Measures (PROMs)
- Low numbers of patients with delayed transfers of care

The following areas were significantly worse than national average performance:

- Hospital mortality from conditions amenable to healthcare
- Percentage of patients leaving A&E without being seen by a healthcare professional
- Breaches of mixed sex accommodation regulations

- Inpatient and outpatient patient experience
- Percentage of babies born by emergency Caesarean section
- Percentage of staff that recommend the hospital as a place to receive treatment

BCCG works closely with Luton CCG, the L&D's main commissioner, to ensure robust quality monitoring. In addition, BCCG has assigned a specific GP clinical director to liaise with L&D consultants and directly input into quality and contract monitoring at the Foundation Trust.

1.3 Insights from patients, public and local partners

Feedback and input from patients and the public are a rich source of information on the quality of care and suggestions for future improvements. BCCG aims to ensure the voices of the patient, the public and their representatives in Bedfordshire are heard; the following are the messages received so far.

1.3.1 Health and wellbeing boards

(a) Bedford Borough Council

The Health & Wellbeing Board in Bedford Borough Council has nominated the GP lead for BCCG's Bedford locality as its vice-chair. It recently consulted on its draft Health & Wellbeing strategy in which the Board sets out eight priority areas, underpinned by five crosscutting principles, and all derived from the Borough's joint strategic needs assessment. The eight priority areas are:

- Teenage pregnancy
- Health and educational outcomes in looked after children
- Mental wellbeing (children and adults)
- Tobacco control (children and adults)
- Healthy weight (children and adults)
- Safeguarding (children and adults)
- Independence in older people
- End of life care

The five crosscutting principles are:equity, accessibility, integration, effectiveness, and sustainability.

(b) Central Bedfordshire Council

In Central Bedfordshire, the shadow Health & Wellbeing Board is chaired by a Councillor with BCCG's GP chair acting as Vice Chair. It is considering priority areas for its strategy, again based on the joint strategic needs assessment (JSNA) for this area. The key priorities agreed by the Health & Wellbeing Board are:

- For children:
  - Reducing teenage pregnancy
  - Reducing childhood obesity
  - Improving mental health for children and their parents
  - Improving the health of looked after children
- For adults and older people:
  - Prevention and early intervention
  - Improve outcomes for frail older people
  - Improving mental health and wellbeing
  - Safeguarding and patient safety
  - Promoting independence and choice

1.3.2 LINks and patient participation groups

BCCG has input from and works closely with two LINks groups: Bedford LINk (co-terminous with Bedford Borough Council and Horizon locality); and Bedfordshire LINk (co-terminous with Central Bedfordshire Council and the remaining four BCCG localities).

Each LINk has its own priority areas; these include:

- Care and dignity(especially for older people) in hospital (Bedford and Bedfordshire LINks)
- Ensuring appropriate and high quality mental health care (Bedfordshire LINk)
- Care in nursing and care homes (Bedfordshire LINk)

As both LINks groups transition to HealthWatch groups, BCCG will continue to engage and involve them in reviews and redesign of local healthcare services by ensuring regular proactive contact and reacting quickly and appropriately to issues raised by either group.

As well as LINks/HealthWatch, BCCG plans to establish a public membership scheme, similar to those run by Foundation Trusts, and building on NHS Bedfordshire's Patient Panel.

1.3.3 Regional and cluster priorities

The 2012-13 National Operating Framework requires particular attention to be focused on the following key areas for improvement:

- Dementia and the care of older people
- Local implementation of the national Carers Strategy
- Military and veterans health
- Further expansion of health visiting and family nurse partnerships

In addition, the Midlands & East SHA cluster has set out five priorities it expects each health community to address:

1. The elimination of avoidable Grade 3 and 4 pressure ulcers by December 2012
2. Significantly improving quality and safety in primary care
3. Creation of a revolution in patient and customer experience
4. Making every contact count through systematic healthy lifestyle advice delivered through front line staff
5. Ensure radically strengthened partnerships between the NHS and local government

Finally, BCCG is aware of its requirement to monitor and improve the measures described in NICE's Commissioning Outcomes Framework and contribute to improving outcomes in Bedfordshire as described in the outcomes frameworks for the NHS, public health and adult social care.

1.4 Provider landscape

In 2012-13, Bedfordshire CCG will invest over £455 million in healthcare from a range of NHS, private and voluntary agencies. The main providers and their characteristics are described below.

1.4.1 Secondary care

Bedfordshire contains one local hospital (Bedford Hospital NHS Trust, 2012-13 contract size £119.5 million). As a traditional district general hospital, Bedford is currently considering future organisationaloptions in light of the national requirement on all hospital trusts to become Foundation Trusts. Bedford Hospital's relative small size (403 beds) and historical financial deficit are balanced by generally good quality care and strong loyalty from patients and local clinicians. BCCG is working with Bedford Hospital to provide the commissioner perspective on the implications of the various options for the Trust, the wider health economy, and patients and the public.

The Bedfordshire population also routinely use the services of five other hospital sites:

- Luton & Dunstable Hospital Foundation Trust (used especially by patients from Chiltern Vale and Leighton Buzzard, contract size £57.6 million)
- Lister Hospital, part of East & North Hertfordshire NHS Trust (used especially by patients from Ivel Valley, contract size £18.1 million)

- Addenbrooke's Hospital, part of Cambridge University Hospitals Foundation Trust (used especially by patients from Ivel Valley and for tertiary care by a greater proportion of the population, contract size £16.1 million)
- Stoke Mandeville Hospital, part of Buckinghamshire Healthcare NHS Trust (used by patients from Leighton Buzzard, contract size £11.4 million)
- Milton Keynes Hospital Foundation Trust (used especially by patients from West Mid Beds, contract size £10.0 million)

Given this range of provision, BCCG must ensure, in conjunction with neighbouring clinical commissioning groups, that quality of care is maintained in all six hospitals. Furthermore, with no hospital within the boundaries of Central Bedfordshire Council, BCCG must ensure the population living there have sufficient and equitable access to healthcare.

BCCG is also an active participant in the review ('Healthier Together') of healthcare services, especially acute care, across South East Midlands, incorporating three of the hospitals commonly used by the Bedfordshire population (Bedford Hospital, L&D, and Milton Keynes Hospital). Stoke Mandeville Hospital is part of a separate acute services review in Buckinghamshire. Therefore, whilst BCCG isactively involved in the 'Healthier Together' programme (and the BCCG GP chair is chair of the programme's commissioners' group), it must ensure its opinions are also taken into account in reviews affecting other trusts.

1.4.2 Community care

Most community services in Bedfordshire are provided by South Essex Partnership Foundation Trust (SEPT), with a contract valued at £36 million and running until 2014. They oversee community bedded units at the Archer Unit (Bedford), Biggleswade Community Hospital, and beds within two nursing homes (the Taymer and the Knolls, both in Central Bedfordshire). However, their strategic direction is to move to greater, potentially universal, use of virtual wards with patients cared for within their own homes.

Bedford Hospital currently acts as an arms-length host for Milton Keynes Community Health Services (MK CHS) whilst its future organisational form is decided. However, MK CHS does not provide any services directly to Bedfordshire residents.

1.4.3 Mental healthcare

SEPT is the largest provider of mental healthcare in Bedfordshire, with a total contract value of £34 million from the NHS in Bedfordshire, £1 million from Bedford Borough Council, and £2 million from Central Bedfordshire Council.The contract and service also spans Luton and runs to 2013 with the option of up to four three-month extension periods. Their service covers community mental health teams, a memory and dementia service for the over-65s, and a crisis

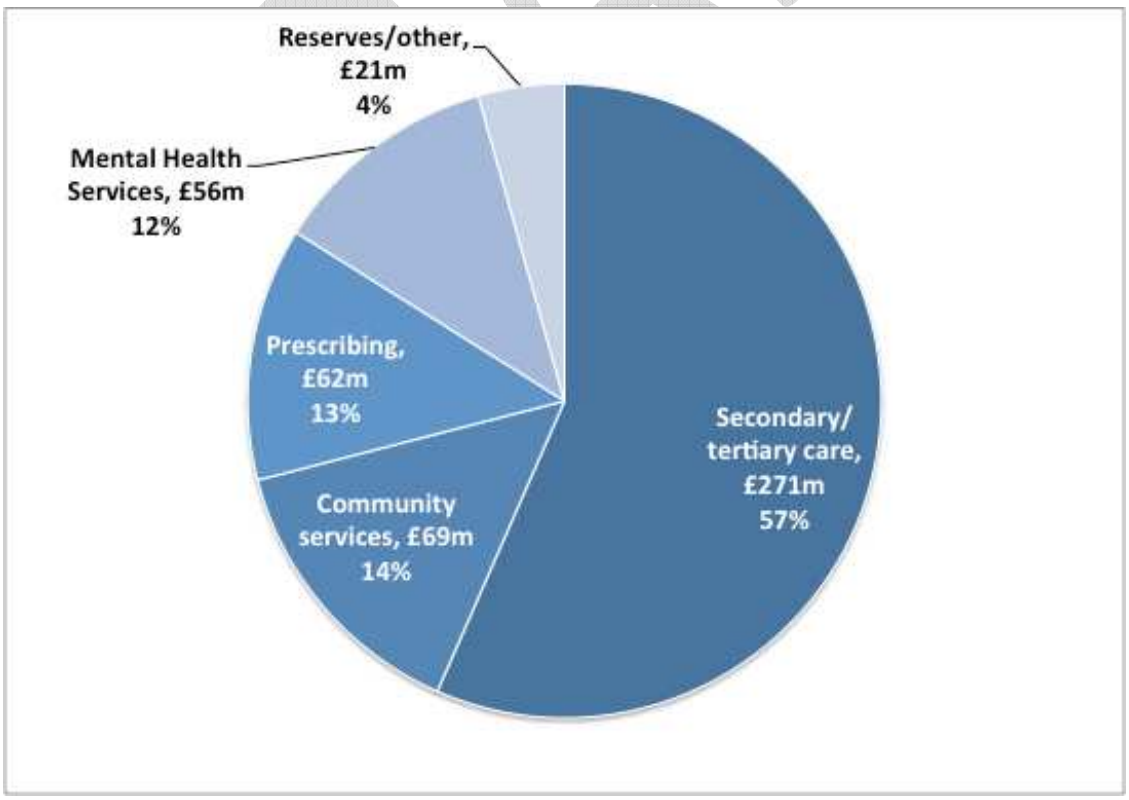
team. SEPT has invested capital monies in building a new mental health inpatient and assessment unit in Bedford, due to be completed in late 2013. They have set out clearly their strategic intent to integrate physical and mental health more closely.One gap clearly identified by BCCG is the need for a liaison psychiatry service in hospitals to ensure the smooth passage of patients with dementia or mental health issues through their hospital stay.

Access to psychological therapies is provided by "Step by Step", supplemented by an independent counselling service working out of GP surgeries.

1.5 Financial Analysis

The NHS in Bedfordshire has a strong track record for maintaining financial balance through effective financial governance and control. During 2011/12 Bedfordshire CCG managed assigned budgets from the PCT, amounting to £247m of the total £628m available to NHS Bedfordshire.From 1 April 2012, the CCG in shadow form has delegated budget responsibility for all commissioned services, estimated at £478m. The distribution of these budgets between sectors is illustrated in the figure below.

Figure 4: Commissioned activity by sector, 2012-13



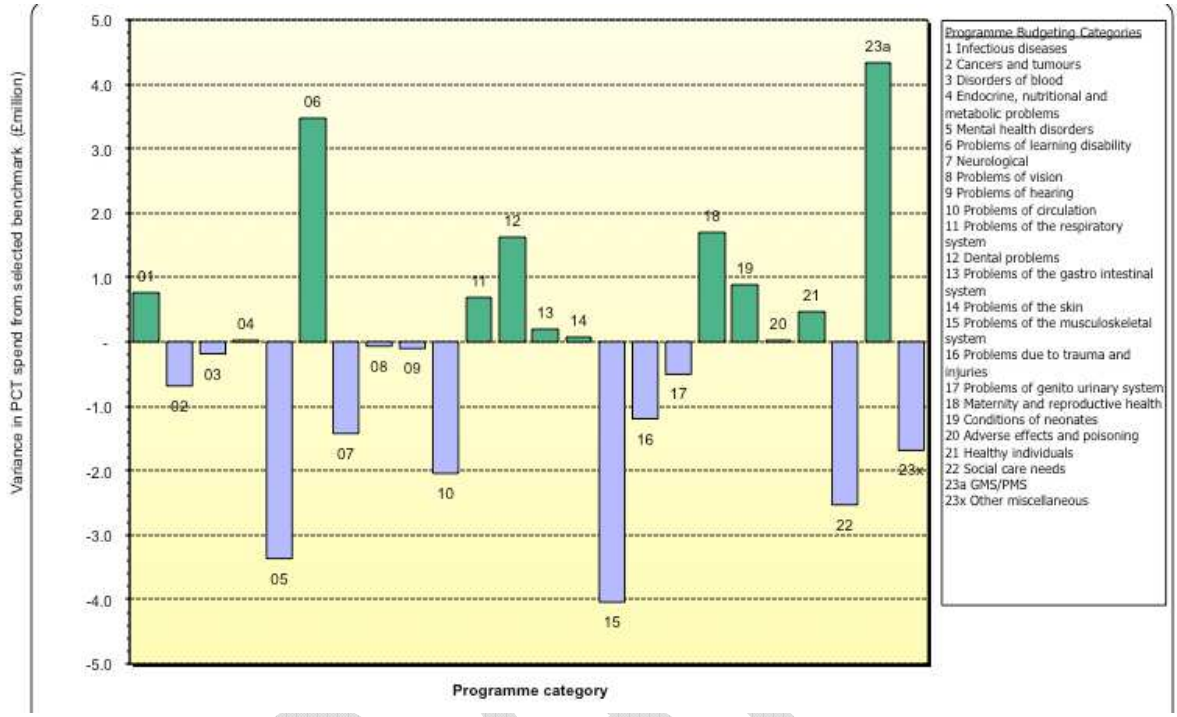
The budgets delegated to the CCG include an assumption that efficiency savings of £13.7m are achieved in 2012/13.Key to achieving this will be the re-design healthcare services so they are delivered in the most appropriate setting and ensuring more care will be undertaken in primary and community care settings, rather than in secondary care.

With the exception of Bedford Hospital NHS Trust, the financial position of providers within the Bedfordshire system is relatively strong. Bedford Hospital, however, has been under financial pressure for a number of years and has relied on non-recurrent funding to deliver a balanced financial position. In 2011/12 the Trust had an expected recurrent shortfall of £4m, due to non-recurrent measures having been used in year, and it faces a very challenging outlook for 2012/13 of an expected efficiency requirement of at least £14m. External consultants have been brought in to support the acceleration of the Trusts CIP (cost improvement plan) delivery and identify further strategic opportunities. The output from this review is a robust CIP programme for 2012/13 and 2013/14, which is being put in place, and a radical two year transformation programme that will require commissioner support and transitional funding.

1.5.1 Programme budgeting

Figure 5 below sets out how Bedfordshire per capita spend compares with its ONS Cluster group of health economies in each main disease category. In terms of categories for which BCCG has commissioning responsibilities, learning disabilities, maternity and neonatal care seem all to be comparatively better resourced than in peer areas. In total, these conditions account for approximately 14% of the CCG-responsible budget. By contrast, mental health, musculoskeletal, and circulatory conditions appear relatively under-resourced, but collectively account for 26% of the total budget. This mismatch between relative sizes of ‘over-resourced’ and ‘under-resourced’ categories means the commissioning task is not simply to shift monies from relatively over-resourced to relatively under-resourced areas, but to ensure high value healthcare is provided for all conditions, with best quality achieved for the resources available.

Figure 5: Comparison of per capita 2010-11 spend on programme budget categories in Bedfordshire with ONS Cluster peer health economies



1.6 Summary

Bedfordshire Clinical Commissioning Group inherits a health economy that is, on the whole, average: the population make-up is similar to the national picture; the health of the population is similar to that of the country as a whole; and the conditions that have most impact on the local population (cardiovascular disease, cancer and respiratory disease) are the same ones impacting at national level. Financially, BCCG starts with a healthy balance sheet and significant experience in delegated responsibility for a significant proportion of the previous year's PCT budget. It is using a stable locality structure that reflects natural patient flows in and around the larger market towns and the boundaries of two unitary authorities, and reflects an established history of general practices working together and sharing best practice.The provider landscape has also been relatively stable for the past few years, producing average results and with little perceived imperative to significantly change or remodel care pathways.

However, demographic shifts, financial pressures and external reconfiguration drivers are now injecting challenge into the status quo. Over the next three years, BCCG is likely to oversee significant changes in acute care configuration, with greater centralisation of specialist care.BCCG must unlock the funding currently invested in this sector if it is to be able to

commission the necessary resulting increases in breadth and volume of care provided in communities and primary care.

Whilst making these changes at a macro level, BCCG must also ensure it addresses the inequity of care for its most vulnerable parts of the population, and it can best achieve this by working in close collaboration with both its unitary authorities.

As a new organisation, and one created as a result of a heavily scrutinised government policy, BCCG will need to build credibility with its public, politicians and media and continue to ensure fairness and probity in its decision-making. That trust must extend internally too, as much of the success of BCCG will be in improving the scale and quality of care delivered by its own GP members.

2.0 The strategic approach to commissioning in Bedfordshire CCG

To invigorate change towards better value in healthcare locally, Bedfordshire Clinical Commissioning Group must adopt a fresh approach to commissioning which focuses on outcomes from both the patient and clinical perspective. This chapter sets out that approach and the priorities in the early years of the organisation. It starts with the organisation's vision:

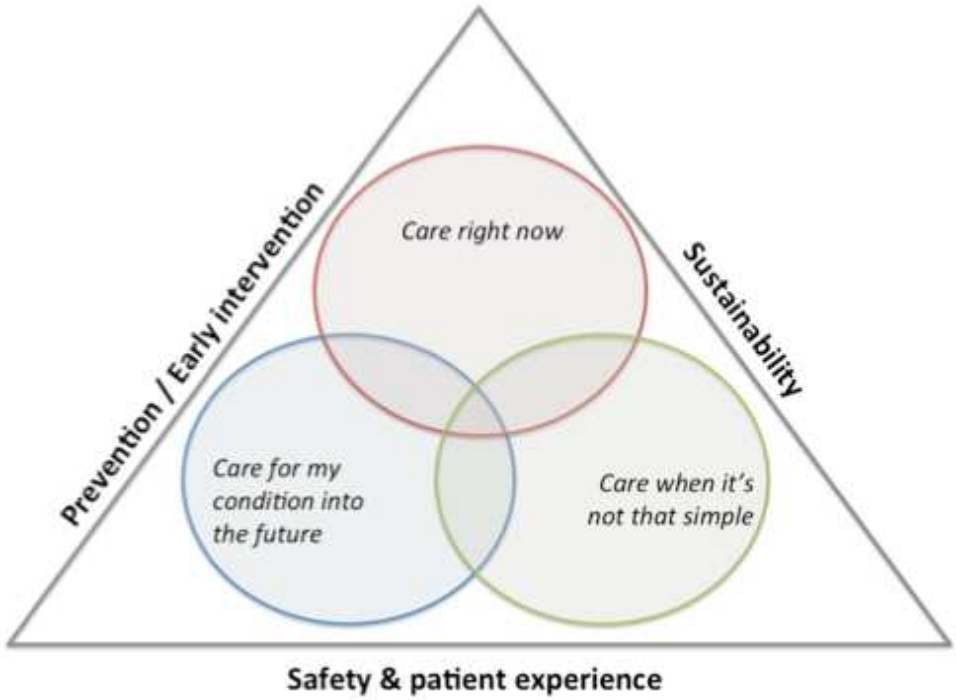
Bedfordshire Clinical Commissioning Group Vision:

"To ensure, through innovative, responsive and effective clinical commissioning, that our population had access to the highest quality healthcare providing the best patient experience possible within available resources."

The proposed strategic approach to commissioning better value healthcare for Bedfordshire residents breaks down the totality of the healthcare we must commission into three key areas of focus with three cross-cutting themes, each of which have associated priority outcome indicators (taking into account the NHS Outcomes Framework and local Health & Wellbeing priorities) that we aim to achieve.

The three key areas of focus with their crosscutting themes are set out in the figure below.

Figure 6: Proposed key areas of focus and themes



2.1 Cross-cutting themes

The cross-cutting themes of prevention, sustainability and safety and customer care will underpin all activities of the CCG.

2.1.1 Prevention and early intervention: making every contact count

The Wanless reports from last decade demonstrated how greater measures were needed to prevent illness and slow down deterioration if healthcare is to remain affordable. NHS-funded care must play its part by 'making every contact count', ensuring staff take the opportunity to recommend healthy lifestyles to patients and embrace that advice in their own lives. This starts in childhood, and we are committed to continuing the supportive approach adopted by health visitors and the Family Nurse Partnerships. We will work in conjunction with partners, especially the unitary authorities and the NHS Health Checks programme, and see our role as reinforcing public health messages, leading by example and ensuring that those that need extra support are identified and directed towards suitable care.

2.1.2 Sustainability: financial, environmental, social

The CCG has a role as a corporate citizen, committing to promote sustainability of environmental and fiscal resources internally through its actions as a corporate body and externally by the way in which it commissions. Efforts to ensure sustainability can be integrated with improving outcomes for patients, improving productivity, and ensuring financial balance.

2.1.3 Safety and patient experience:

Our patients expect care to be provided safely and we will work to the regional ambitions of eliminating avoidable pressure ulcers, having zero tolerance for healthcare-acquired infections and 'never' events, and working to prevent falls at home and in hospital. But more than that, patients should expect to be treated courteously and with respect and dignity, with services fitting around them rather than vice versa.

2.2 Key areas of focus

The CCG strategy sets out, for each key area, how it envisages healthcare could be provided at best possible value and optimalpatient experience. Outcome indicators are based on the NHS Outcomes Framework 2012/13 and reflect similar indicators in the Health & Wellbeing strategies developed/in development by the Health & Wellbeing Boards of Bedford Borough Council and Central Bedfordshire Council.

2.2.1 *Care right now*: urgent or unscheduled care

The existing system can be confusing and duplicative, resulting in a less than optimal patient experience and inefficient use of resources. Patients who need medical advice, diagnosis and/or treatment quickly should be able to have a consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need from a joined up system of care, irrespective of the day of the week or time of the day that the need arises. We will review how patients access 'care right now' and the co-ordination of that care back to their general practice so that any necessary follow-up can be undertaken promptly.

Indicator:

We will improve patients' experience of urgent care services, including walk-in centres, GP out of hours services and A&E services, so that more than 85% patients rate their overall experience as good or very good by 2015.

Workstreams:

- Introduction of '111' non-emergency advice telephone line to Bedfordshire residents
- Redesign of care for ambulatory-care sensitive conditions at Bedford Hospital A&E department

- In conjunction with the outputs of the 'Healthier Together' programme, ensure that urgent care services for children are provided to modern standards of care,and advice and support for parents on how best to manage acute illness in children is readily available
- Working with colleagues in Bedford Borough and Central Bedfordshire, develop and evaluate a joint ambulance/social care response to people who fall at home that avoids when possible the need to take them to hospital

2.2.2 *Care for my condition into the future*: planned care and long term conditions

As the Bedfordshire population ages, long term conditions (conditions that cannot be cured but can be managed through medication and/or therapy) are becoming more prevalent. Evidence points to best value care in long term conditions being provided through empowering and supporting patients such that they are informed and ready to self-manage. In Bedfordshire, through system redesign and in conjunction with the outputs of the 'Healthier Together' programme, we will develop prepared, proactive community-based teams that can work in partnership with patients to improve outcomes. This means fewer outpatient appointments, more happening in GP surgeries and community settings, and specialist skills being used appropriately.

Indicator:

We will increase the proportion of people with a long term condition who feel they have had enough support from local services to help manage their condition from 66% (in 2011) to 80% by 2015.

Workstreams:

- Pilot and implementation ofa primary care quality framework and full roll-out of 'GP Ref' online referral resource as tools to incentivise and drive practice organisational development and improvements in the quality of patient experience, relative use of specialist resources, and outcomes of care.
- Redesign of cardiology care, and evaluation of the diabetes and COPD integrated care systems
- Redesign of musculoskeletal care, dermatology, gynaecology, ophthalmology and urology care
- Refreshed cancer strategy and development of subsequent implementation plans
- Increasing patient choice through implementation of the national Any Qualified Provider programme
- Development of a robust three year strategy for mental healthcare (including dementia care) in Bedfordshire and implementation plans in conjunction with Bedford Borough and Central Bedfordshire Councils

2.2.3 *Care when it's just not that simple*: addressing complex care needs

Once people need on-going assistance with their care and/or activities of daily living because of physical or mental impairment or both, it becomes more important than ever for healthcare and social care services to work together in partnership. In Bedfordshire, we will work with Bedford Borough Council and Central Bedfordshire Council to bring together the planning, payment and provision of health and social care into integrated systems of care for those with complex needs. Through system redesign, we will create primary care-based multidisciplinary teams that interface with urgent care services in order to maintain patients' independence for as long as is safely possible and ensure a good quality of life.

Indicator:

We will work with social care to increase to at least 85% the proportion of people aged 65 and over who are still at home three months after leaving hospital for rehabilitation in the community.

Workstreams (all in conjunction with local authorities):

- Reintroduce the primary care based multidisciplinary team, with input from medical, social care, mental health, therapies and nursing, to maintain people's independence as long as is safely possible
- Introduce the comprehensive use of risk stratification (incorporating information from social care) and case management of those at highest risk(including input to and collaboration with care homes)
- Use learning and experience from innovations such as the Department of Health's Year of Care programme to commission for patient outcomes and fund according to patient need rather than diagnosis or intervention
- Commission across Bedfordshire a model of subacute care that ensures people who have experienced a deterioration in their health are supported to return to their full potential in the most appropriate environment
- Conduct and use in commissioning a review of the volume and purpose of bedded units within local communities, ensuring appropriate provision of high value care for patients requiring slow stream rehabilitation (including for strokes and acute brain injuries) and respite care, and taking into account the evidence for benefits of rehabilitation at home
- Conduct and use in commissioning a review of provision of bedded units for people with dementia, taking into account the ageing population in both local authority areas
- Ensure technologies such as telecare/telehealth are built into commissioning of new services and facilities

2.3 The BCCG approach

To achieve our vision and deliver in the priority areas described above, we must, from the outset, work differently from our predecessor organisation. This will be evidenced and experienced in three ways.

2.3.1 We will work in partnership:

- We will embrace the experience of the public and patients to tell us how services are now, advise us on how they could be better, and help us evaluate the impact of the commissioning decisions we make on the quality of care delivered in the future.
- We will work with our local authority colleagues to promote greater integration of planning, payment and provision between the NHS and social care
- We will plan with neighbouring health economies sensible and higher value configurations of specialist services through the 'Healthier Together' programme, reviewing acute services across the South Midlands

2.3.2 We will make best use of clinicians' expertise and leadership

- We will use clinical leaders to challenge existing institutional boundaries, bringing primary care closer to patients' homes, specialist care out of hospital buildings and into the community, and both primary and specialist care into closer working relationship with each other
- We will encourage clinicians to champion examples of high value healthcare and practice, promoting and supporting take-up across the localities
- We will develop and support the CCG's constituent practices to be able to take on a significantly different model of care in the future – one that sees more care co-ordinated through the practice, greater provision of care closer to and in patients' homes, and increased collaboration with other providers, including voluntary sector and social care. This may require reconsideration by practices of, for example, their space utilisation, staff skill mix, and use of technology.
- We will increasingly make all clinicians more accountable for quality, financial probity, and incident reporting.
- We will involve clinicians in the capture of soft intelligence from their patients on the experiences of healthcare, good and bad.

2.3.3 We will focus on outcomes

- We will concentrate on 'strategic' commissioning that uses a programme budgeting approach to align financial incentives across the system. In practice, this means, for a given clinical area, describing the outcomes to be achieved and the overall budget

available, and then placing an expectation on providers to work together to describe and implement the optimal service model to achieve those outcomes within budget.

- We will reduce levels of inappropriate variation in care between clinicians in similar disciplines, both in general practice (using peer review and the locality structure of the CCG) and in specialist care.

By working in this way, using clinicians and patients to drive change and focusing on a key set of outcome-based priorities, we believe we can both produce the improvements in quality and efficiency required of the QIPP plan and provide financial and reputational 'head room' to invest in future priority areas.

3.0 Delivering the strategic plan

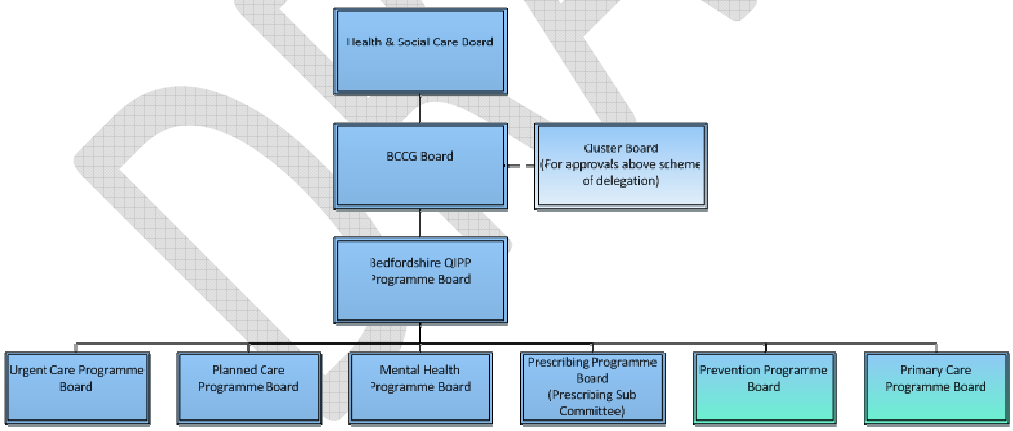
This chapter sets out the three year plans that Bedfordshire Clinical Commissioning Group will use to deliver in its three key areas of focus and how it will implement those plans.

3.1 Organising delivery

BCCG's commissioning changes are developed and implemented through five programme boards: urgent care board; planned care board; mental health board (jointly with Luton CCG); children and maternity (in development) and prescribing board. Each board includes clinicians and patients in its membership and has a CCG clinician as Senior Responsible Owner (SRO), who is supported by a programme manager and a team of project managers. All programme SROs are accountable to the Bedfordshire QIPP Programme Board, which is chaired by a CCG GP Board memberand is in turn accountable to the BCCG Board (see Figure 7 below). The Prevention and Primary Care programme boards, whilst not under CCG leadership, also report to the Bedfordshire QIPP programme board).

The central Programme Management Office supports the QIPP programme board in monitoring each programme board's delivery against their plans and providing programme and project management advice to the clinicians and staff involved.

Figure 7: BCCG governance structure for programme management



3.1.1 Urgent Care

BCCG took on responsibility for the urgent care programme in Bedfordshire in April 2012 and redesigned it to develop two sub-boards: the Unscheduled Care Sub-Board oversees most of the projects aiming to improve *Care Right Now* and concentrates on ambulatory care. The

Integrated Care Sub-Board oversees most of the projects addressing *Care when it's not that simple*.

3.1.2 Planned Care

BCCG's planned care programme has been running since 2011 and concentrates on improving *Care for my condition into the future*. It hastaken two complementary approaches: early improvements in resource utilisation are achieved by reducing unwarranted clinical variation in general practice using peer comparison and support. In parallel, but delivering most of their improvements in later years, redesign projects use a programme budget approach to bring together providers to develop sustainable systems of care. Both are underpinned by access to accurate and timely data on activity, finance and outcomes and strong clinical leadership and engagement.

3.1.3 Mental health

With a single contract covering mental healthcare provision across both Bedfordshire and Luton, the mental health programme board is a joint Bedfordshire/Luton board, with SROs from the two CCGs ensuring delivery of both CCG-specific projects and their CCG's share of joint projects. The board, which includes local authority representation as well, considers all three BCCG key areas of focus as they relate to mental healthcare.

3.1.4 Prescribing

The BCCG medicines management team works in partnership with member GP practices, Area Prescribing Committee, local community pharmacies, community services and secondary care to develop, lead and successfully implement programmes of work that focus on both improving quality through safe and effective use of medicines along with making substantial savings to the health economy. Each locality and each practice within a locality will continue to have a clear prescribing plan so that each practice has up to five specific objectives that they are committed to achieving. Together these build up into the Bedfordshire CCG Prescribing QIPP plan. The 'big ticket' lines include continuing to use generically available drugs within cardiovascular, diabetes, respiratory and mental health treatments where they have the strongest evidence base for safety and effectiveness.

Working with clinicians to redesign services within programme budgets, through improved targeting of newer medications, money has been released from prescribing to fund additional improved services for patients with long term conditions.

Objectives are moving increasingly towards optimising the use of medicines so that patients are adhering to safe and cost-effective treatments. Improving quality and speed of communication

across prescribing interfaces is an ambition for the CCG. This will improve the quality of patient care and improve patient safety.

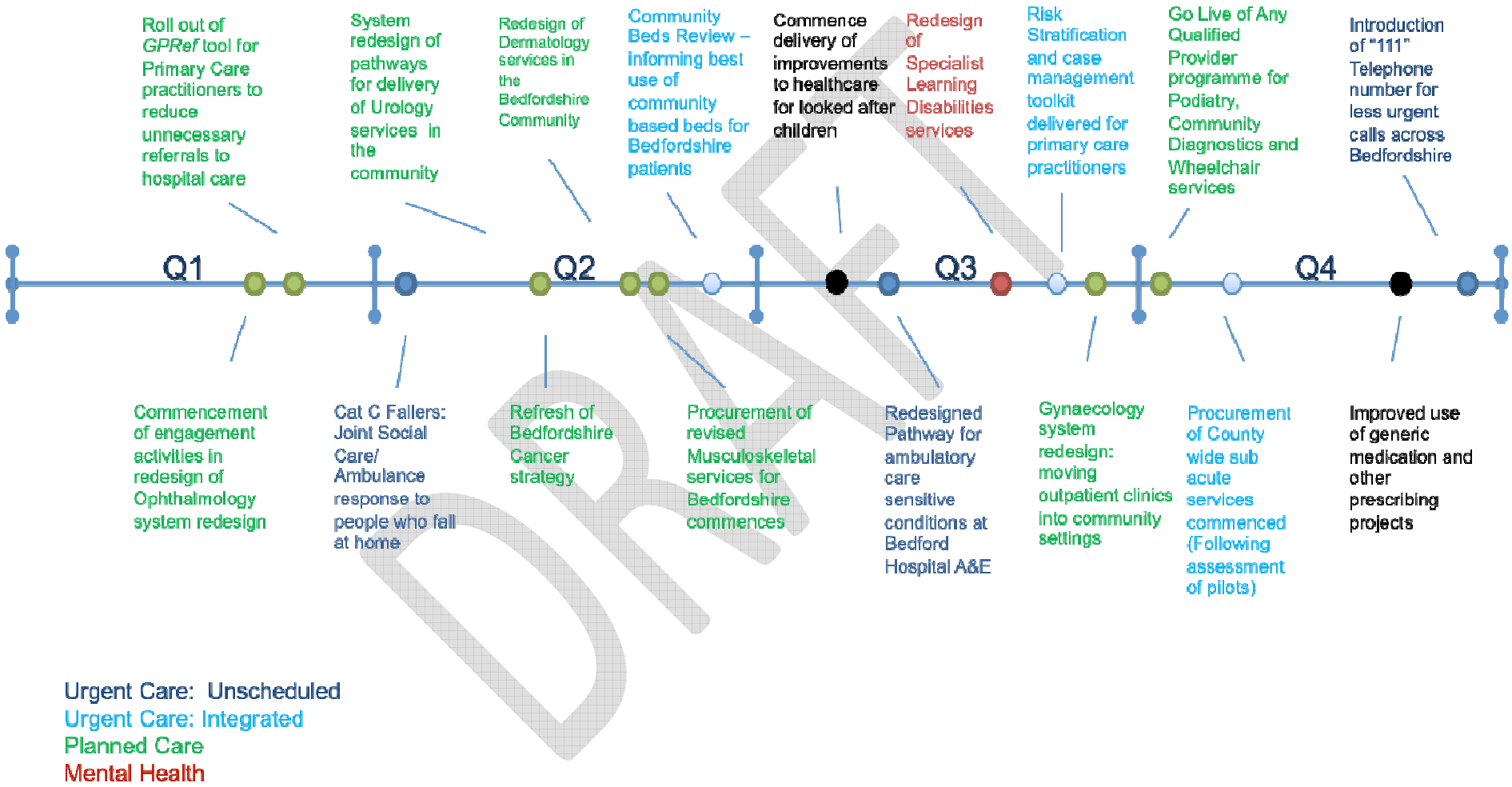
3.2 Delivery between 2012-2015

3.2.1 2012-13 operating plans

In this, the transition year for BCCG, the organisation is building its capacity and capability to take on the full range of commissioning responsibilities. It continues its leadership of the planned care and prescribing programmes, and takes over responsibility for urgent care and mental health programmes. For these latter two programmes, BCCG's focus is on developing clear strategic intentions (including refreshing joint commissioning strategies with Bedford Borough and Central Bedfordshire Councils) and establishing clear work programmes to ensure delivery of improvements in quality of care and sustainable delivery of care as resources become tighter. It is also developing new programme approaches to children and maternity care and cancer care.

The timeline in Figure 8 sets out the key milestones for delivery during 2012-13.

Figure 8: 2012-13 Operating plan delivery timeline

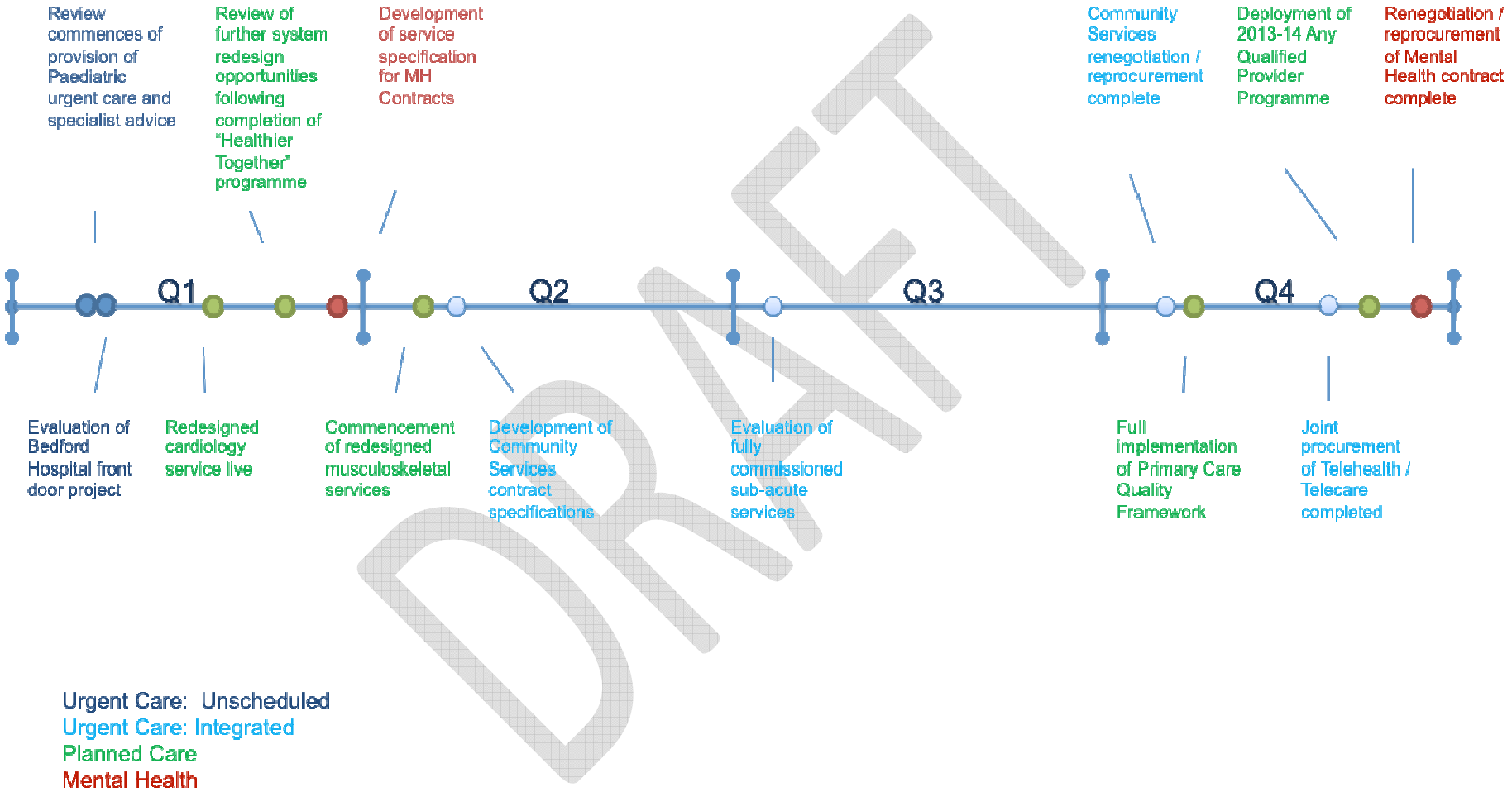


3.2.2 2013-14 commissioning intentions

In its first formal year as a statutory organisation, BCCG will be responsible for starting to implement as commissioners the final decisions on the 'Healthier Together' programme. This could have wide-reaching effects on not just hospital-based care, but on the nature and volume of care delivered in the community and primary care. Therefore, with the Bedfordshire-wide contract for community healthcare services expiring in 2014, the year of 2013-14 will include a focus on redesigning and procuring community services that will fit the future shape of the healthcare landscape. With the main mental healthcare contract also expiring during 2013-14, a second focus will be on the procurement (in association with Bedford Borough and Central Bedfordshire councils) of mental healthcare that adopts a proactive approach tomanaging the needs of an ageing population and improving value.

The anticipated timeline for delivery of key project and programme milestones is illustrated in Figure 9.

Figure 9: 2013-14 Commissioning intentions timeline



3.2.3 2014-15 strategic objectives

By this point, implementation of the 'Healthier Together' programme will be well underway and new contracts will be in place for both mental healthcare and community healthcare. BCCG will be reviewing the impacts of all these changes on the local population's outcomes of care, ensuring that they do not deteriorate during transition and that the new healthcare landscape delivers safe, affordable and high quality care.

The table below sets out the known objectives for each main programme as they currently stand.

Table 5: 2014-15 programme objectives

Programme		**Strategic objective**
Urgent care: "QIPP challenge" = £2.48 million	Unscheduled care	Ensure value for money from out of hours care Review use of A&E services by Bedfordshire patients
	Integrated care	Review year 1 of new community services contract Evaluation of year 1 of subacute service
Planned care: "QIPP challenge" = £844,000		Evaluation of year 1 of MSK system Further system redesign projects in conjunction with implementation of 'Healthier Together' programme
Mental health: "QIPP challenge" = £0		Review year 1 of new mental health contract
Prescribing: "QIPP challenge" = £300,000		Continue to encourage use of generic medications as patents expire Evaluate and improve primary care/secondary care prescribing interface initiative Evaluate and improve patient adherence initiative

3.3 Stakeholder engagement

The use of programme boards to oversee the development and implementation of projects and delivery of programme objectives ensures regular and consistent input from CCG localities, local authority commissioning partners, health and social care providers, patients and carers, and

patient/public representatives such as LINks/HealthWatch and service user groups. This is in line with the BCCG strategy on patient and public engagement.

Project plans must include, from the outset with the project brief, details of how stakeholders have and will be engaged, along with details of who has and will be involved. Stakeholder mapping and analysis ensures that identified stakeholders continue to be involved in the most appropriate way. Each project should have a clinical champion, usually from primary care. In many cases, projects will start with needs assessments that set out the case for change from patient and clinician perspectives. Project implementation will then involve workshops that attract input from a wide variety of clinicians and patients from across Bedfordshire, as well as providers from neighbouring areas. Each redesign project aims to start bydevelopingan agreed clinical model, leaving the vehicle for contracting that model as a secondary concern, with the principle that the clinical model should drive the contract form rather than the other way round. By ensuring this focus on the clinical model at the outset and involving local clinicians from across health and social care sectors in the development of the model, key delivery partners are encouraged to feel that they "own" and can adapt to the change required.

When a decision is made to formally procure a new model of care, that decision is usually communicated early to any incumbent providers so that they may start to assess as soon as possible the impact of the procurement on them.

Regular meetings are held between BCCG and each unitary authority to schedule the presentation of projects to both Councils' Health Overview and Scrutiny Committees. BCCG has developed and agreed with its Health Overview and Scrutiny Committees a process for determining 'substantial variations' or development of services and the appropriate engagement of stakeholders, including service users, carers and patient representatives. Equality Impact Assessments are undertaken on all projects and proposals to engage and involve stakeholders and reflect the importance of inclusivity and addressing equality and diversity issues. Where public consultation is required, a consultation management plan will include how it is intended to ensure broad participation from the public to promote understanding and support for proposals through meetings, drop-in sessions within communities, utilising community contacts and community development workers, a range of online activities (including social media) and printed consultation literature in a range of formats. Social marketing techniques are also employed to encourage behaviour change to support projects, such as in a campaign to reduce medicines waste.

BCCG uses its locality structure to engage its member general practices. In addition, it has identified three GP clinical directors that represent and engage with other stakeholders. One clinical director works with each unitary authority, sitting on its Health & Wellbeing Board, as well as having her own specialist interests, such as quality of care at Bedford Hospital Trust and the care of older people in general (for the northern clinical director), and mental health and respiratory care (for the southern clinical director). The third clinical director focuses on Luton

&Dunstable Hospital Foundation Trust, building clinical networks and establishing a route for dialogue between Bedfordshire GPs and the L&D's consultants, as well as being prescribing lead for BCCG.

3.4 Working with providers

BCCG engages openly and frequently with the full spectrum of providers of local healthcare beyond simply in the redesign process as outlined above.

3.4.1 Contract mobilisation and monitoring

Contracts with new providers may be negotiated and agreed using expert procurement support, either from the local Commissioning Support Service (see below) or from NHS Elect. New contracts with existing providers are negotiated and agreed by senior BCCG managers and the lead CCG clinician for that area (often one of the clinical directors).

During the term of each contract, regular monitoring meetings are held, covering financial and quality performance; these occur monthly for the largest contracts. The aim of BCCG is to have a CCG clinician present at every contract monitoring meeting, and to expect the same of each provider. Providers are held to account for delivery against financial, performance and outcome indicators, agreed at the start of the contract. Should a provider fail to deliver against these indicators, BCCG will require a remedial action plan and increase frequency of monitoring. If the actions in the provider's remedial plan not be met within appropriate and agreed timescales, then BCCG will have the right to serve a breach of contract notice to the provider.

3.4.2 Market management

The aim of market management is to develop an optimal and sustainable market structure, supported by robust contract and provider management, to deliver the best patient care and value for money.

BCCG will effectively stimulate and manage the healthcare market to improve health outcomes and reduce health inequalities. This will be achieved through 3 key areas of development:

- Knowledge of current and future provider capacity and capability
- Alignment of provider capacity with health needs projections
- Creation of effective choices for patients

By recognising that the NHS is an integrated system rather than a true market, it is acknowledged that providers may require CCG support to improve service quality and/or enable market entry. BCCG will develop greater plurality in the healthcare market as well as integrating services and providers through contractual mechanisms. The approach taken is dependent upon

the situation, the objectives, system sustainability, needs of the population and the availability of willing and able agents within the market.

Each BCCG redesign project will include an assessment of the current provider landscape, and the project implementation plan should discuss the options for using existing provision and any need or imperative to procure more formally. Formal procurement may require efforts to develop the market locally; this will take time and should be built into the project timescales.

Whilst increasing competition and encouraging additional providers to enter the market may be powerful tools to improve health outcomes and efficiency, it is not the right approach for all services or under many circumstances. Effective market management must also include working with current providers of patient care (NHS or private sector or charitable) to establish and maintain closer and more commercially sound relationships.

BCCG's approach to commissioning and market management will focus on making sure that how we commission and from whom we commission addresses the market failures (e.g. where the current system is not sufficiently competitive or has insufficient capacity) which contribute to poor patient health and wellbeing, such as health inequalities, failures of access, unmet needs and failures in service capacity and quality. It will also take into account our responsibilities to our local populations to ensure they have the best quality and most cost-effective care delivered as close to home as possible.

3.5 Commissioning support

Bedfordshire is geographically associated with the GEM (Greater East Midlands) commissioning support service (CSS), which has successfully passed the national Checkpoint 2 process for CSS evaluation. Although GEM CSS is in the early stages of its development, it has installed a client relationship manager for BCCG, which assists BCCG in understanding the opportunities available to it from such a geographically large CSS.The main services BCCG expects to commission from GEM CSS include human resources, payroll, information, and communications and engagement.BCCG and GEM CSS agreed a commissioning support draft service level agreement in April 2012.

During 2012-13, as its transition year and whilst GEM CSS develops, BCCG has chosen to manage most other services, including financial accounting, programme management and contract management, within its own structures. It has developed a shared quality and safety directorate with Luton Clinical Commissioning Group, building on the PCT Cluster's joint team and strengthening both commissioners' ability to monitor quality and safety at Luton & Dunstable Hospital Foundation Trust.

Additional specialist procurement advice may be sought where necessary from other (probably private) providers, as per BCCG's agreed standing financial instructions and OJEU procurement rules.

3.6 Track record

Although the CCG was only established as an entity in mid-2011, it has been quick to use the opportunities of clinical leadership to improve the quality and effectiveness of clinical care. BCCG achieved a small surplus in 2011/12 and met all of its headline performance indicators such as 18 week maximum waiting time, cancer waiting times, stroke services, A&E and infection control trajectories. The following examples (case studies) are early demonstrations of our commitment to developing better value healthcare for Bedfordshire.

3.6.1 Developing an integrated diabetes service

The number of people with diabetes and total spend on diabetes care in Bedfordshire has been rising rapidlyand is predicted to continue to increase due to increasing levels of obesity and an ageing population. The previous model of diabetic care was based largely on secondary care, without a specialist community nurse service. A low proportion of patients were receiving all the key interventions required for good diabetic care. Evidence and research showed that most people with diabetes could be managed in a primary care setting, enhancing their ability to self care and improving their compliance.

In 2010, a new model of care was developed through a multidisciplinary working group, informed by wider patient views gathered through questionnaires and individual one to one discovery interviews. The new model was translated into a service specification that was then procured during 2011 through a managed dialogue process with the two main local providers of healthcare, Bedford Hospital NHS Trust and Luton and Dunstable Hospital Foundation Trust. The new service includes the following elements of care:

- Up skilling and further educating primary care staff around diabetes care
- A service that encourages and motivates patients to self care and improves patient education to allow them to do this
- Reduction of reliance on secondary care by reducing first and follow up appointments
- Reduction of secondary care admissions

As a direct result of the engagement undertaken to redesign this system, a local diabetes network has been developed and launched in May 2010. Annual diabetes conferences are now

held within Bedfordshire Clinical Commissioning Group. To date, the service is still in its infancy so hard data is not available yet. However, the staff working within the integrated teams are reporting better communication between primary and secondary care, renewed enthusiasm within their role, and enhanced working relationships between the two acute hospitals. They have also identified increased flexibility and capacity within diabetes care, and staff feel they can provide a more reactive service in response to the patient's needs.

3.6.2 Practice matrons and case management in Chiltern Vale

There are approximately 5,500 patients over 75 registered with Chiltern Vale locality practices.Following a successful business case in 2008, Chiltern Vale Locality developed a Pilot for case management thatembeds Practice Matrons in general practice teams. The deployment of these Practice Matrons follows the Principles of Guided Care developed by Johns Hopkins Medical Centre, Baltimore. They developed an overall case register of 493 high risk patients living at home (January 2012) using a combination of PARR++ and practice knowledge of those with deteriorating conditions. The Unique Care Calculator was also used at the beginning of the project to help identify vulnerable older patients. The practices and their Matrons have also aligned themselves to residential care and nursing homes in the locality and a further 380 residents of those facilities are under the surveillance of the Practice matrons. An analysis of A&E attendances and urgent admissions of nursing and care home residents in the locality identified that the principle clinical reasons for admissions were falls, respiratory conditions and urinary tract infections. Practices developed new care pathways with community services and care home staff.

Evaluation of the pilot has shown:

- A 30% reduction in urgent admissions and associated A&E / Ambulance conveyance costs in 2011/12 for patients living at home in case management compared with 2010/11
- A 30% reduction in urgent admissions and associated costs of patients resident in nursing and care homes in 2011/12 compared with 2010/11

This represents a reduction in urgent admissions, A&E attendances and ambulance conveyances for around 200 patients generating a saving of approximately £600k per annum for these two patient groups.

4.0 Financial plan

The expected commissioning budget for BCCG in 2012-13 is £478 million.

4.1 Assumptions

The CCG financial plan forms part of the overall NHS Bedfordshire and Luton Cluster plan, and represent the element of the resources spent on the Bedfordshire population. Key assumptions underpinning our financial plans are set out in Table 6 below:

Table 6: Financial assumptions underpinning CCG financial plans

Assumption	%
Resource Growth	2.80
Tariff Efficiency	-4.00
Tariff Inflation	2.50
Prescribing Uplift	5.00
Primary Care Uplift	1.00
Population/Activity Growth	2.69
Transformation Fund (2%)	2.00
CQUIN	1.00

The financial assumptions used in estimating the financial challenge to the health economy in Bedfordshire reflect the SHA planning assumptions and population growth projections for Bedfordshire, prepared by the Office of National Statistics, adjusted for local activity changes.

The plan follows national guidance and key financial drivers include the requirement to:

- Achieve annual surplus of £0.5m per annum until 2015.
- Maintain a 0.5% contingency reserve to cover unplanned fluctuations in activity demand.
- Hold 2% non recurrent fund to support system change and re-design costs
- Continue support of Local Authority reablement funds
- Invest to support key health priorities as set out in the Operating Framework e.g. health visitors, bowel cancer screening campaign, cancer drugs, Improving access to psychological therapies (IAPT)

All PCTs received 2.8% growth (plus reablement funding) in allocations for 2012/13 as the 'pace of change' policy was suspended to support system stability through transition. The plan assumes that growth in 2013/14 and 2014/15 will reduce to 2.5%. These assumptions are based

on the insight into the additional funding the NHS is likely to receive in the period through to 2014/15 detailed in the Comprehensive Spending Review (CSR) published in October 2010.

4.2 Financial Challenge

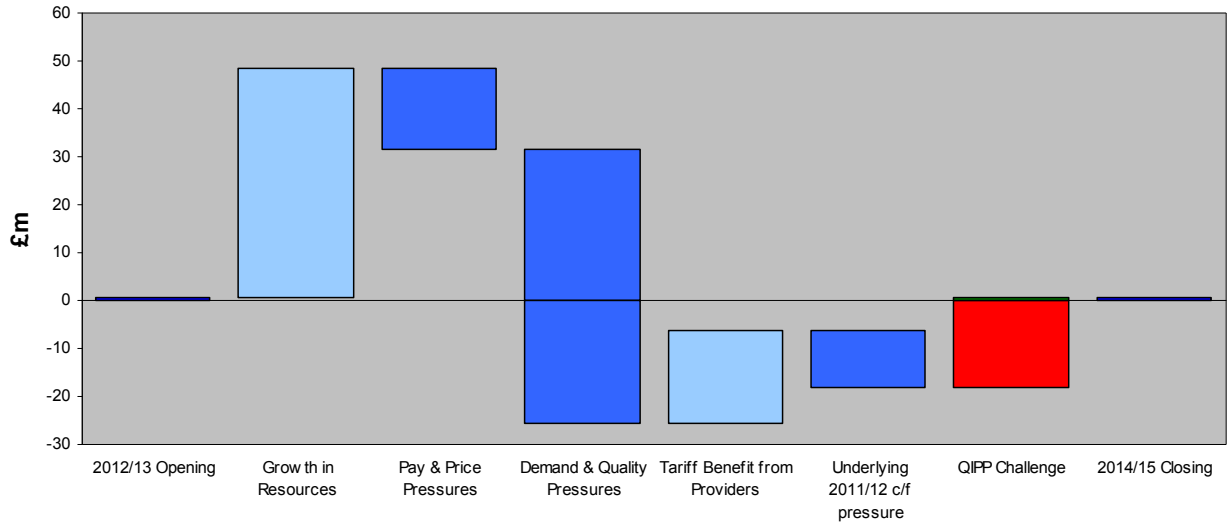
The challenge for the CCG is the difference between its anticipated resource growth and the pressures it faces from pay and price pressures (i.e. increasing costs of drugs and devices), demand and quality pressures (growing and ageing population) and underlying pressures carried forward from 2011/12, less the benefit it receives from providers from the nationally agreed 1.5% reduction in tariff.

Applying the assumptions detailed above the financial challenge (the "QIPP challenge") for Bedfordshire CCG over the next 3 years is £18.8m, as set out in the table and figure below.

Table 7: Financial challenge for Bedfordshire Clinical Commissioning Group 2012/13-14/15

	2012/13 £'m	2013/14 £'m	2014/15 £'m	Total £'m
Opening Surplus/(Deficit)	**0.50**	**0.50**	**0.50**	**0.50**
Resource Growth	16.28	15.62	16.01	47.91
Pay & Price Pressures	(5.62)	(5.62)	(5.62)	(16.86)
Demand & Quality Pressures	(18.69)	(19.26)	(19.26)	(57.21)
Tariff Benefit Derived from NHS providers	6.52	6.52	6.52	19.56
Underlying 2011/12 Pressure C/F	(12.17)	0.00	0.00	(12.17)
QIPP Challenge	13.68	2.74	2.35	18.77
Closing Surplus/(Deficit)	**0.50**	**0.50**	**0.50**	**0.50**

Figure 10: Source and application of funds 2012-15

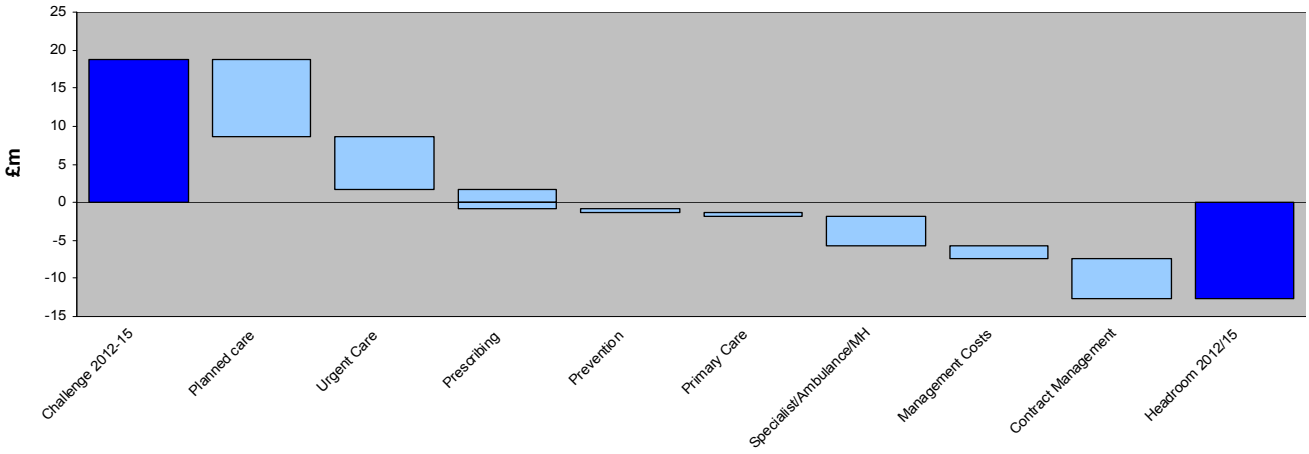


4.3 Financial Opportunities

In response to the potential gap in resources over the next 3 years, the PCT/CCG has, through the integrated planning process, identified a number of opportunities to ensure financial balance whilst improving quality through innovation, productivity and prevention.

Analyses of financial opportunities identified within Bedfordshire are detailed in the figure below.

Figure 11: QIPP opportunities 2012-15



The identified opportunities total £31.4m over the 3 years,providing total headroom of £12.6m or 67% over the period to mitigate against further, as yet unknown, pressures emerging, potential partial delivery of work streams, and supporting any variations from planning assumptions.

4.4 Risks and sensitivity analysis

In preparing the financial model detailed above, BCCG has utilised the planning assumptions developed regionally, adjusted for known local variations i.e. local demographic change.

There are a significant number of up and downside risks to the assumptions included in the plan and as a consequence, work has been performed to review the impact of different scenarios, a process which continues as new information becomes available. The modelling assumptions for all scenarios are included in Appendix 3.

Risks within the plan include:

- Delays or non delivery of QIPP plans
- Inflationary pressures are higher than planned
- Activity growth may exceed demographic projections
- Future resource allocations are lower than anticipated

The figures below illustrate the outputs of the scenario modelling for the 3 years to 2015 for both additional scenarios.

Figure 12: Source and application of funds 2012-15 (upside scenario)

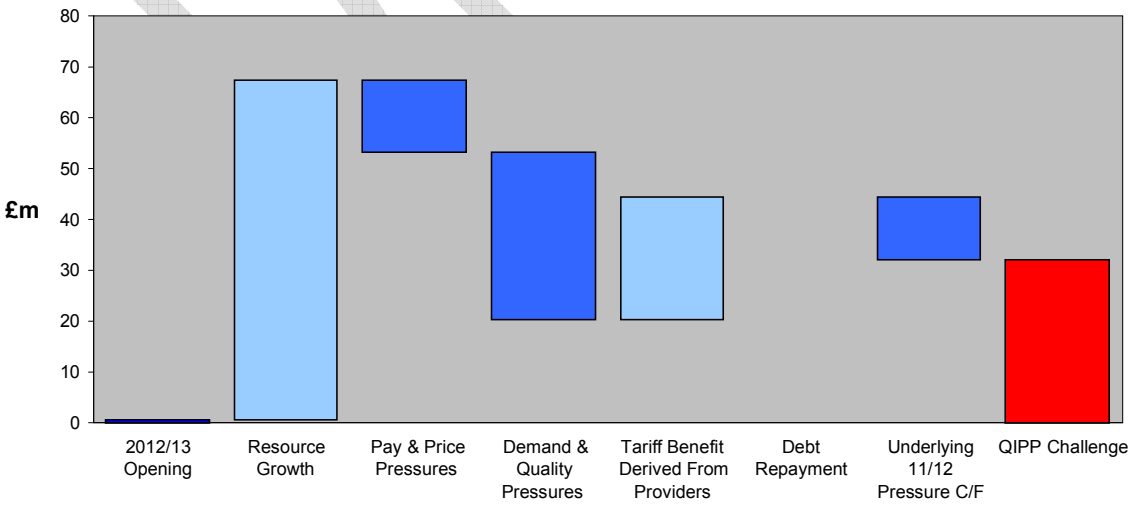
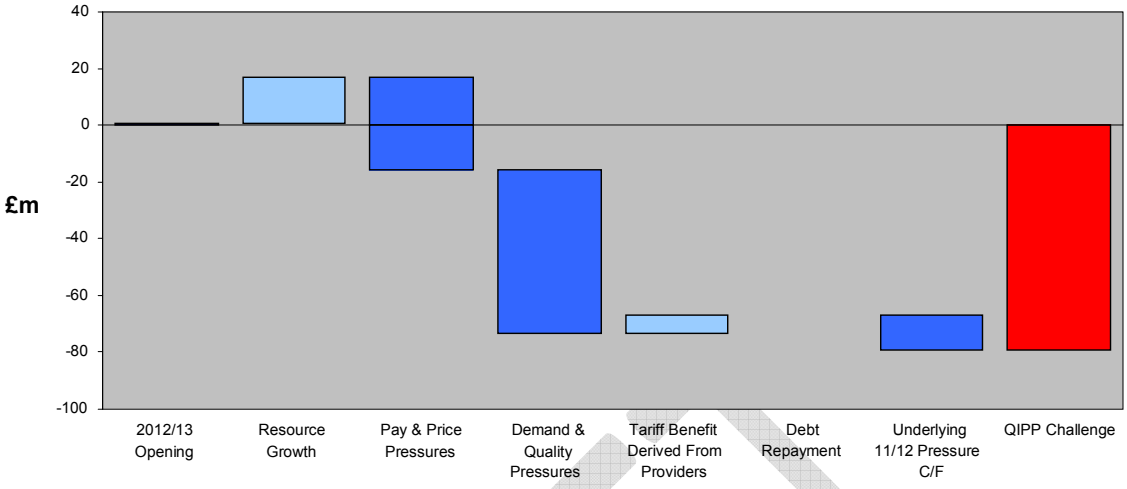


Figure 13: Source and application of funds 2012-15 (downside scenario)



A key goal of the CCG is sustainable financial health: the ability to flex the financial plan to take account of new and as yet unforeseen requirements and opportunities, whilst remaining in recurrent balance, is very important.

The establishment of a contingency reserve is just one element of the approach to risk management. Another is the approach to investment planning, which has proven to be successful within the PCT in previous years in effectively managing the planning process without exposing the organisation to excess financial risk. A third is the flexing of the timing and scope of implementation of some of the initiatives identified in line with the QIPP agenda, and increasing the pace of service redesign/innovation to secure a more cost effective delivery of services to patients.

In terms of upside risks (or opportunities), the CCG has been very prudent in its assumptions around securing new income from sources other than the general allocation from the Department of Health. It may also be possible to bring forward the profile for delivery of certain efficiency savings within the QIPP programme. Both could result in the ability to accelerate the healthcare investment programme.

On the downside, the assumptions around limiting the growth in hospital activity may prove too optimistic, and future national decisions on tariff uplifts and pay increases could add further cost pressures. Whilst this could be addressed using general contingency reserves, investment profiles will need to be kept under continuous review and the drive to secure best value for money in all areas of operations must be relentless.

4.5 Running costs

The 2012/13 NHS Operating Framework states that the expected running cost allowance nationally for CCGs is £25 per head of GP registered population for 2013/14. For Bedfordshire CCG this equates to £10.7m based on a GP registered population (moderated for ONS projections of population) of 431,900 to invest in the management structure that will oversee the statutory responsibilities and operational delivery of our CCG and also to purchase the technical commissioning support necessary to do this efficiently and effectively.

The CCG will remain within its allotted running cost allowance throughout the period to 2015.

We have confirmed our management and operational structure for the shadow CCG at the end of March 2012 and signed a Memorandum of Understanding with Greater East Midlands Commissioning Support Unit for provision of commissioning support services from 1 April 2012. The CCG plans to market test all potential commissioning support services in its first 18 months of operations.

4.6 Transformation Fund

The CCG has set aside 2% transformation funding (£12.2 million) to help support the non-recurrent costs associated with the delivery of better value healthcare. Principally, it is proposed that the funds are used to facilitate change by:

- Backfilling clinicians' time so they can be involved in and lead system redesign projects
- Pump-priming the costs of change, such as short-term 'double running' of old and new systems until the old system can be decommissioned completely
- Funding project management training and capacity specifically to providers where they are undertaking significant service change programmes
- Covering redeployment/redundancy costs

4.7 Transition

The underlying financial principles weredetailed in the NHS Operating Framework for 2012/13:

- CCGs will not be responsible for resolving PCT legacy debt that arose prior to 2011/12. It is expected that aspirant CCGs will continue to work closely with PCTs and PCT Clusters in 2012/13, to ensure that no PCT ends 2012/13 in a deficit position
- The final year end aggregate surplus generated by SHA/PCTs in 2012/13 will be carried forward to the NHS Commissioning Board in 2013/14, with an exception that PCT originated surpluses will be made available to local health systems in future years

Initial work has been undertaken by the Department of Health to determine future CCG baselines. This work has been based on 2010/11 spend, but at present the figures are indicative, and further work will be undertaken in 2012/13 to inform the CCG allocations for 2013/14. A key challenge and risk to the emerging CCG will be to ensure that allocations are set at the right level: historically, the resources available to NHS Bedfordshire have been significantly below the target share of resources nationally. The table below details Bedfordshire's historic position in terms of distance from target.

Table 8: Distance from target financial allocation and annual growth in funding, NHS Bedfordshire

	Distance from Target		Growth
	%	£m	%
2009/10	-3.5%	-20.2	5.5%
2010/11	-3.5%	-21.4	6.1%
2011/12	-4.7%	-30.7	2.7%

5.0 Managing the process

5.1 Organisational governance

Bedfordshire Clinical Commissioning Group came into being during the early part of 2011. It was awarded Pathfinder status in April 2011 and held its first full shadow Board meeting on 7 September 2011. The CCG Board evolved from the former Clinical Executive Committee (PEC), with a clinical majority (including secondary care) as well as Local Authority and lay members. All 56 general practices engaged with the CCG, signing an early Compact to reflect the respective commitments, which has now been superseded by practices' sign-up to the BCCG constitution.

Since it has been based on an established locality structure, the CCG has been able to develop rapidly:

- Fully 'green' rated 'Risk assessment of Configuration: November 2011
- Key Clinical Director appointments: November 2011
- Organisational Development Plan: December 11, refreshed March 2012
- 100% delegation of budgets: April 2012
- Patient and Public Engagement Strategy: May 2012
- Confirmation as a Wave 1 applicant: May 12
- CCG Constitution May / June 12

Following a workshop with key stakeholders in April 2012, the BCCG Board received and agreed a proposal for a new Governing Body composition, which will start from June 2012 and meet monthly. The Board of Directors, as it will be known, is chaired by the BCCG interim clinical chair (until the appointment of a Chair) and will include (once appointed) the Accountable Officer (a GP), clinical representation from all five localities, a secondary care consultant and nurse from a separate health economy, the director of public health for Bedford Borough and Central Bedfordshire Councils (representing both unitary authorities), two lay members, and the CCG directors of strategy& system redesign and quality & safety, the chief financial officer, and the chief operating officer. The Board has a clinical majority.The Board and its membership are set out in the CCG Constitution, which has been consulted on with all member practices and is compliant with the requirements of the Health Act 2012. The Scheme of Delegation allows for delegated budgets and commissioning responsibilities to Localities within a clear Locality Accountability Agreement.The organisational structure is shown in Appendix 4.

The BCCG Board will have subcommittees for Quality & Safety and remuneration and audit, ensuring financial probity and the maintenance of a Register of Interests for Board members and BCCG staff.

The Board will be supported by an executive team meeting weekly and comprised of the five locality GP chairs, the three GP clinical directors, BCCG's chair and accountable officer, the chief operating officer, the chief financial officer, the director of strategy and system redesign, and the director of quality and safety.

A Corporate Business Plan has been produced that sets out for 2012/13 the aims and corporate/organisational objectives of the CCG. The detailed objectives are grouped under five priority areas that underpin the transition year for BCCG. These are:

1. Through a focus on improving quality and safety, lead commissioning and drive service improvement
2. Engage Members
3. Develop the organisation, its workforce and leaders
4. Strengthen Partnerships
5. Manage Transition

Each priority has a set of objectives with measurable outcomes. Progress will be monitored by the CCG Board and will form the strategic risks reflected in the Integrated Risk Register (see 5.3)

5.2 Performance monitoring and reporting

Since its inception BCCG has adopted a rigorous approach to performance management against its national, regional and local performance metrics, value for money, quality and safety improvements and QIPP delivery. This has enabled BCCG to meet financial balance, deliver against is 11/12 QIPP responsibilities and meet all headline performance indicators. However, we wish to use our Organisational Development plan to achieve high levels of organisational health which will strengthen our performance and that of our providers.

Our escalation based approach to effective performance management and equitable contribution management of our member practices takes many forms:

- Monthly BCCG Board meetings have as a standing item monthly integrated quality and performance reports which covers deliver against key metrics such as eliminating avoidable pressure ulcers, net promoter patient experience scores and national waiting time standards. Performance management is carried out at each level of the

organisation with particular focus on patient safety at our Board sub-committee, Patient Safety Committee.

- Budgets and metrics allocated down to each of the five localities and monthly reports are then produced on the performance of each locality against its identified budget and associated quality and performance metrics. These are discussed both within the locality and at the monthly BCCG Board meeting, with corrective action being taken where appropriate.
- The CCG is managing the delivery of QIPP using a twin approach of monitoring project delivery through a set of agreed gateways and a KPI monitoring process for projects which are in delivery.
- The commissioning cycle gateway process assures the Programme Board of the delivery of key control measures, such as Business case, service specification, stakeholder consultation, and deployment planning. Progress against these gateways is assessed by the PMO producing a monthly dashboard and highlight report which is then examined in a system wide QIPP Programme Board.
    - The QIPP Programme board examines progress of projects, risk registers (ensuring that escalations are made in a timely and effective fashion); provider Cost Improvement Plans (CIP) and activity data. The board is chaired by a local clinician, involves representation from providers and Senior Responsible Owners of the delivery workstreams.
    - Use of a Programme Board approach meets guidance found in the Cabinet Office *Management of Successful Programmes, PRINCE2 and Management of Portfolios* standards, enabling early identification of problems and an approach to solving them. Under CCG leadership the boards take on a significant aspect of Quality management – with Quality and safety being assessed alongside value for money and effective use of resources.
    - The QIPP Programme board reports directly to the CCG board, and provides regular reports and updates to it; in turn the QIPP board holds the various workstream boards to account.
- BCCG has purchased MedeAnalytics to enable our clinicians to quickly leverage value from fragmented information, retaining the control over the design of what gets produced and how it is used. Our ongoing development of the system to meet ever-changing national metrics and/or local priorities ensures that the solution is future-proof as well as cost-effective. The rich information provided through this platform offers our clinicians and staff access to the current financial and performance position of the CCG. The practice and locality based scorecards enables clinicians to assess the equity of contribution to the success of their CCG.

5.3 Risk management

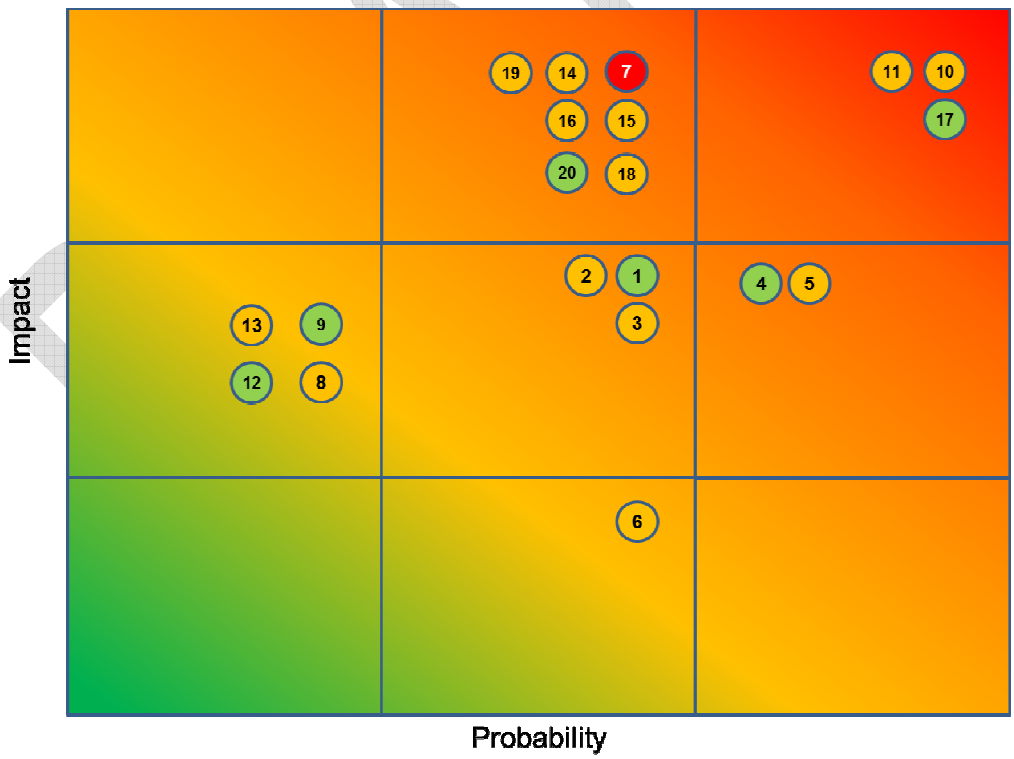
Bedfordshire CCG has an Integrated Risk Management Framework that allows the identificationof significant risks and clear and rapid decisions to be made about the

management of those without adequate control or mitigating actions.This framework quantifies impact levels of the various domains of risk, allowing effective and repeatable risk assessment. The framework includes a strategic approach to risk based on HM Treasury standard good practice: Management of Risk (M_o_R), a policy and procedure for risk assessment and an integrated risk register that sets out those significant risks traditionally presented on a Board Assurance Framework and Corporate Risk Register. This process is based around the programme management process, and is able to identify at early stages clinical, financial or reputational risks from service or system redesign projects. An organisational Risk Maturity assessment was undertaken in April 2012 and a set of recommendations to enhance risk management and develop a positive risk culture across the CCG have been accepted and are being implemented.

The CCG is making use of summary risk profiles to assist in the proactive management of risk – embedding it into management practice and taking away the 'check box' nature of risk register review.

The most recent review of the risk portfolio is show below, with a copy of the risk register appended in Appendix 5.

Figure 14: BCCG summary risk profile, April/May 2012



5.4 Organisational development

To support the process of embedding its ways of working, BCCG has developed an Organisational Development (OD) Plan that provides detailed analysis and comment on the immediate and medium-term needs of the CCG in order to deliver against its ambitions of ensuring access to the best possible value healthcare delivered to the highest possible customer standards in the most sustainable way.

The OD Plan sets out seven local priorities for developing the organisation. These are shown in the figure below.

Figure 15: The seven organisational development priorities for BCCG

There is an associated implementation plan and 'roadmap', and progress is monitored at an OD Steering group chaired by a Locality GP Chair. The plan has been recommended as an exemplar by Midlands and the East Strategic Health Authority.

6.0 Conclusions

This is the first integrated strategic commissioning plan for Bedfordshire Clinical Commissioning Group. It has been developed from the starting point of the joint strategic needs assessments of Bedford Borough and Central Bedfordshire, and using other soft and hard information available about the quality and efficiency of care for the people of Bedfordshire. Its content has been discussed and developed in conjunction with the localities of the CCG, patient groups and CCG staff groups.

By the end of 2014-15, the health and social care landscape is likely to look very different to that of 2012. General practices will be collaborating to share skills and services in the best interests of patient care. More people with long term conditions will be receiving support and information from community-based specialist teams to understand and live more comfortably with their condition. Primary care, supported by decision support and risk stratification software, will be working with multidisciplinary teams using telehealth and telecare technologies in each locality to focus on those most in need and maintain people safely in their own homes for as long as possible. Community and mental health services will have been re-commissioned by BCCG (in partnership with both local authorities) against new specifications, ensuring greater integration between physical and mental health, primary/community/secondary care, and healthcare and social care.

The 'Healthier Together' programme will have completed its task of recommending options for reconfiguration of acute care, and the implementation process will have begun. Specialist (consultant) care will be provided where possible either virtually or within localities, so that patient journeys are reduced both in number and distance. Planned surgery and other interventions will take place in units that have optimal volume and numbers of staff to ensure best possible outcomes. Patients needing emergency care will know how and where to access the advice and assessments they need, and established ambulance routes will be in place to ensure highly specialist emergency care (such as trauma and acute stroke care) is provided in the closest and most appropriate facility. Once medically stable, patients will move, if necessary, into the care of specialist rehabilitation and recovery teams to ensure they return home having reached their full potential.

By commissioning for outcomes, BCCG will have a better understanding of the value for money it receives from provider systems.It will systematically and routinely use patient and clinical intelligence to evaluate the quality of the experience delivered by commissioned providers, and, through its seats on Health & Wellbeing Boards in both Bedford Borough and Central Bedfordshire, will be using its commissioning power to improve the health of the local populations.

Some of the ambitions within this strategic commissioning plan are bold. However, the arrival of the Health and Social Care Act 2012 and the financial pressures on public sector funding both mean that this is indeed the time for boldness and innovation in healthcare commissioning. We are confident that Bedfordshire Clinical Commissioning Group is ready and able to take on these ambitions, and succeed.

Appendix 1: 2012-13 Operating Plan detail

Programme		Project	Delivery milestone
Urgent care: "QIPP challenge" = £2.2million	Unscheduled care	Introduction of '111' telephone number	Procurement commenced with ITT issued April 2012 Go-live expected March-April 2013
		Redesigned pathway for ambulatory care sensitive conditions at Bedford Hospitals A&E department ("BHT front door project")	Business case submission May 2012 Dependency on procurement of new general practice next to hospital site, likely to go-live September 2012
		Cat C fallers: joint social care/ambulance response to people who fall at home	Go-live June 2012
	Integrated care	Risk stratification and case management	Prioritisation bid May 2012 Procurement of software and project support June-August 2012 Implementation of software and staff training Sept-Nov 2012
		Sub-acute pilot programme (north)	Finalised evaluation report May 2012 Decision on continuation of pilot June 2012 Full procurement of substantive service Q3-4 (in conjunction with sub-acute south)
		Sub-acute pilot programme (south)	Pilot go-live April 2012 6-month evaluation October 2012 Procurement of substantive service based on evaluation results November 2012-March 2013
		Community beds review	Terms of reference agreed across

			Bedfordshire & Luton May 2012 Establishment of CCG/LA project steering group June 2012 Project completion September 2012
Planned care: "QIPP challenge" = £5.03 million		Reduce unwarranted variation in GP referrals	Roll-out of 'GP Ref' June 2010 Pilot primary care quality framework Q2-3 and evaluate Q4
		Cardiology	Project scoping May-June 2012
		Musculoskeletal system redesign	Implementation of agreed referral proformas June-September 2012 Market development sessions May-June 2012 Notice served / Procurement starts early autumn 2012
		Dermatology system redesign	Procurement to start June 2012 System go-live September 2012
		Gynaecology system redesign: moving outpatient clinics into community settings	Business case submission June 2012 Service go-live December 2012
		Ophthalmology system redesign	Project scoping May-June 2012
		Urology system redesign	Managed dialogue process June-July 2012 System go-live September 2012
		Cancer strategy refresh	Present to Cancer Board September 2012
		Implementation of 2012-13 Any Qualified Provider programme (podiatry, community diagnostics, wheelchair services)	Briefing to CCG Exec May 2012 Go-live for podiatry and community diagnostics by end-Q3 Selection of services for 2013-14 programme
		Impact assessment on community	'Healthier Together' consultation

	and primary care services of 'Healthier Together' consultation options especially recommended option	starts October 2012 Impact assessment completed Q3 Plans for subsequent system redesigns (in tandem with implementation plans for 'Healthier Together') Q4
Mental health: "QIPP challenge" = £111,000	Refresh of mental healthcare strategy and joint mental health strategies with local authorities	Present to Mental Health Board July 2012
	Redesign of dementia care pathway	Project scoping May-June 2012
	Redesign of pathway for common & severe mental health disorders into an integrated stepped care model	Project scoping May-June 2012
	Redesign of adult and child eating disorders pathway	Project scoping May-June 2012
	Redesign of specialist learning disabilities services	Development of new clinical model Q2 Business case submission Q3 Contract variation Q3 Service go-live Q4
Prescribing: "QIPP challenge" = £1.4 million	Improved use of generically available medication	Prescribing incentive schemes agreed with localities Q1 Monthly monitoring: ePACT data circulated as RAG rated charts by GP practice Mid-year evaluation September 2012
	Increased use of alternatives to prescribed sip feeds	Transformation funding until end-July 2012 Decision to continue with model June 2012
	Use of generically available antipsychotic drugs	Mental health contract sign-off May 2012

		Locality prescribing incentive schemes agreed Q1 GP practice audits August 2012 Evaluation against SEPT contract September 2012 Re-audit by GP practices January 2013
	Reduced prescribing of hypnotic drugs	QOF Med 6 sign-up by high prescribing practices Q1 Evaluation November 2012
	Maintain low antibiotic (including cephalosporin and quinolone) prescribing rates	Agree action plans with high prescribers Q1 GP audits and peer review Q1 Re-audit Q3 OOH provider audits and peer review Q3 Monthly monitoring: ePACT data circulated as RAG rated charts by GP practice
Other	Improve the healthcare of looked after children	Implement action plan drawn up after Ofsted/CQC inspections Q2-3

Appendix 2: 2013-14 Commissioning Intentions detail

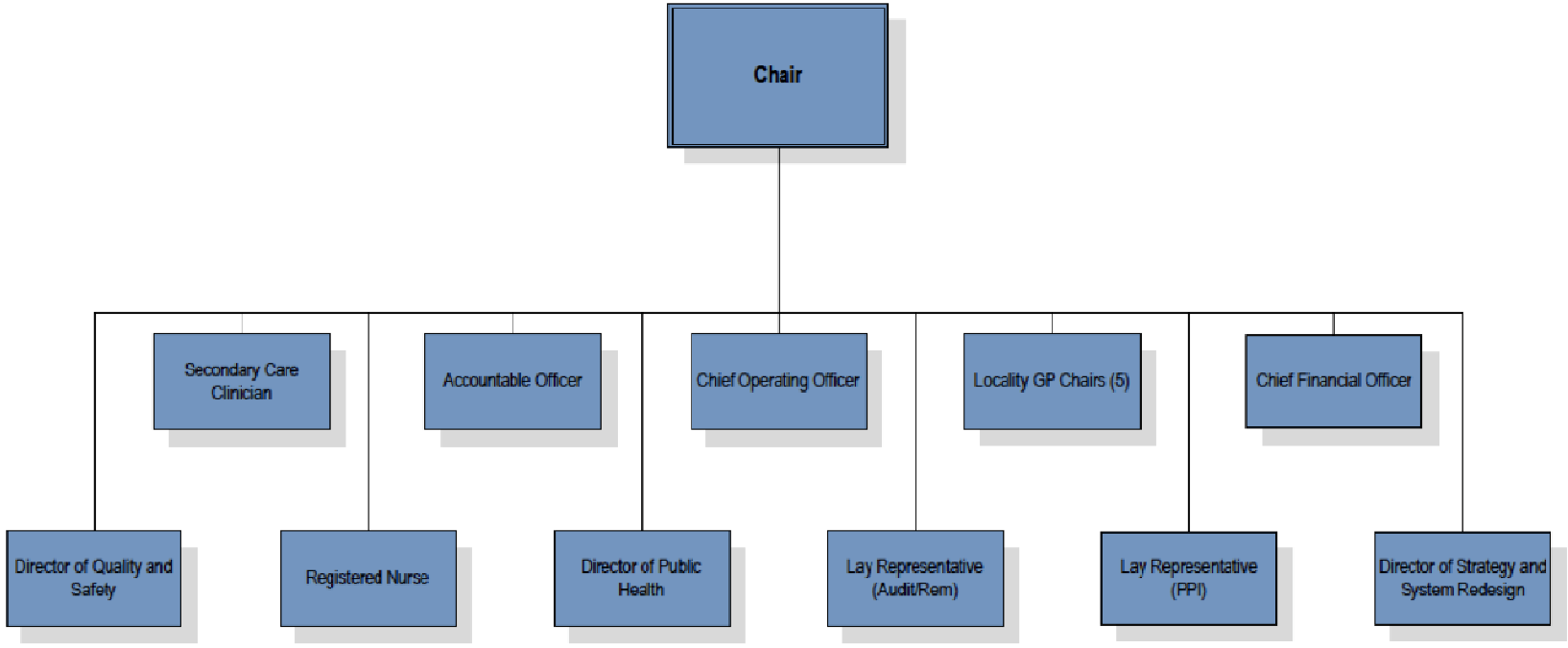
Programme		Project	Delivery milestone
Urgent care: "QIPP challenge" = £2.2 million	Unscheduled care	Review the provision of paediatric urgent care and specialist advice	Project scoping Q1
		BHT front door project	Evaluation of new service Q1
	Integrated care	Sub-acute programme	Evaluation of newly commissioned service Q3
		Preparation for managing end of SEPT community healthcare contract	Review of integrated care MDT resource across localities Q1 Development of service specifications Q2 Renegotiation/reprocurement by Q4
		Joint commissioning of telehealth/telecare	Service spec and procurement completed by Q4
Planned care: "QIPP challenge" = £4.3 million		Reduce unwarranted variation in GP referrals	Full implementation of primary care quality framework
		Cardiology	Service go-live Q1
		Musculoskeletal system redesign	System go-live early summer 2013
		Implementation of 2013-14 Any Qualified Provider programme	Market assessment and development Q1 Notice served on existing providers Q2 Service go-live Q4
		Further system redesign projects, e.g. neurology, gastroenterology	Review in light of 'Healthier Together' programme outputs Q1
Mental health: "QIPP challenge" = £0		Preparation for managing end of SEPT mental health contract	Development of system specification Q1 Renegotiation/reprocurement by Q4
Prescribing: "QIPP challenge" = £1m		Reduced use of high dose inhaled steroids in COPD	Prescribing guidelines agreed at area prescribing committee December 2012 Review integrated COPD service contract March 2013

		GP incentive scheme April 2013
	Use of generically available antipsychotic drugs	Mental health contract sign-off March 2013 Re-audit by GP practices July 2013
	Primary care/secondary care prescribing interface	Business case agreement October 2012 Seek providers December 2012 Go-live April 2013
	Improve patient adherence with, and use of, existing medication	Business case agreement October 2012 Seek providers December 2012 Go-live April 2013

Appendix 3: Financial Modelling Assumptions

	Assumptions		
Downside Scenario	**2012/13**	**2013/14**	**2014/15**
Resource Growth	2.80%	0.00%	0.00%
Tariff Efficiency	-4.00%	-4.00%	-4.00%
Tariff Inflation	2.50%	4.00%	4.00%
Prescribing Uplift	5.00%	6.00%	6.00%
Primary Care Uplift	2.00%	2.00%	2.00%
Population/Activity Growth	3.50%	3.50%	3.50%
Downside Total			
Base Case Assumptions	**2012/13**	**2013/14**	**2014/15**
Resource Growth	2.80%	2.50%	2.50%
Tariff Efficiency	-4.00%	-4.00%	-4.00%
Tariff Inflation	2.50%	2.50%	2.50%
Prescribing Uplift	5.00%	5.00%	5.00%
Primary Care Uplift	1.00%	1.00%	1.00%
Population/Activity Growth	2.69%	2.69%	2.69%
Base Case Total			
Upside Scenario	**2012/13**	**2013/14**	**2014/15**
Resource Growth	2.80%	2.80%	2.80%
Tariff Efficiency	-4.00%	-4.00%	-4.00%
Tariff Inflation	2.50%	2.00%	2.00%
Prescribing Uplift	4.00%	4.00%	4.00%
Primary Care Uplift	1.00%	1.00%	1.00%
Population/Activity Growth	2.00%	2.00%	2.00%

Appendix 4: Bedfordshire Clinical Commissioning Group Board, June 2012



16 members
9 clinicians

Appendix 5: Bedfordshire Clinical Commissioning Group Corporate Risk Register 27 April 2012

Risk ID	Risk Type	Date	Description of Risk	Probability (Likelihood)	Impact	Overall Risk Rating	Repsonse Category	Response (Control)	Residual Risk	Responsible Governance Group	Owner	Updated	Review Date	Risk Status
1	Strategic	24/02/2012	As a result of a lack of agreement between PCT Cluster and both local CCGs on CSS, there is a risk that this will distract attention from other key priorities of authorisation and thus have an adverse affect upon BCCG's ability to submit a successful application.	Medium	Medium	Medium	Reduction	BCCG has agreed MoU and SLAs for the transition period. To be reviewed in May.	Low	PCTC and CCG Boards	JR	25/04/2012	25/04/2012	Closed
2	Project	24/02/2012	As a result of a lack of practice level engagement there is a risk that member practices will not sign up which will negatively affect the pre-assessment phase of authorisation.	Medium	Medium	Medium	Reduction	Significant stakeholder activity has already commenced, and support to practices through the use of practice development managers reduces the likelihood of this from occuring. Locality Chairs are leading work on practices agreements. There was a CCG wide event on 18 April to develop the Constitution. There is a BCCG Newsletter in place that has recevied positive feedback. Consultation over CCG Constitution with all practices from w/c 7 May. CCG-wide event 17 May.	Medium	CCG Board	JG/MT	25/04/2012	15/05/2012	Open
3	Strategic	24/02/2012	As a result of the draft commissioning plan for 12/13 being in early stages of development, there is a risk that the CCG may not be able to provide adequate evidence of plans and engagement process for the pre-assessment phase leading to negative assessment by SHA.	Medium	Medium	Medium	Reduction	Draft plan received by CCG Board on 2 May. Further consultation with members and stakeholders in May and final sign off in June 2012.	Medium	CCG Board	DG	25/04/2012	15/05/2012	Open
4	Strategic	17/10/2011	As a result of the CCG not being supported sufficiently by the PCT Cluster there is a risk that BCCG will not develop enough to enable authorisation within national timescales	Medium	High	High	Reduction	BCCG will engage in regular dialogue with the PCTC regarding support needs. There will be a £9 per head cash development fund available. Limited assigned roles to directly support authorisation. Full utilisation of national diagnostic and support tools. New Cluster CEO is fully supportive of CCG authorisation. Cluster transition plan in development to support effective transfer of responsibilities.	Low	CCG interim Management Team	JR	25/04/2012	15/05/2012	Open
5	Strategic	17/10/2011	As a result of the CCG not developing the capacity and capability it requires,in, for example clinical leadership, there is a risk that the capacity and capability criteria for authorisation will not be met resulting in BCCG not becoming authorised.	Medium	High	High	Reduction	OD plan developed. Workshop held for CCG leaders on patient safety, joint working, locality roles etc. Emerging CCG diagnostic completed. Shadow Board in place and senior leadership roles in place (but awaiting national recruitment process).	Medium	OD Steering Group	PH	25/04/2012	15/05/2012	Open
6	Project	23/11/2011	As a result of a lack of clarity between BCCG and the PCT Cluster around the delegation of budgets, responsibilities and functions, there is a risk that BCCG will not be in a position to be fully accountable for delivery of objectives, which may result in insufficient track record and thus becoming authorised with conditions or not authorised at all.	Medium	Low	Medium	Transfer	BCCG senior management are participating fully with the PCT Cluster in discussion and events in order to reach agreement and future trajectory for the transfer of responsibility. Revised SFIs approved by cluster Board Jan 12. Full delegation within agreed framework from April 2012. Accountability arrangements in place. Board to Board meetings commence 25 April. Clear performance responsibilities will support track record.	Medium	PCTC and CCG Boards	JR	25/04/2012	15/05/2012	Open

7	Project	12/01/2012	As a result of a HR Transition Plan not being developed and implemented by the PCTC, there is a risk that there will be an unstructured approach to the transfer of PCT staff to BCCG, which may result in a lack of resource to complete the work required for the track record, resulting in an insufficient track record and thus becoming authorised with conditions or not authorised at all.	Medium	High	High	Transfer	This risk remains high as staff will not be assigned to new structures until May/June ie until application and impact on some functions is not yet known.	High	PCTC Exec team	JR	25/04/2012	15/05/2012	Open
8	Operational	12/01/2012	As a result of work not yet done on the Locality and Practice Agreements (original due date 31/1/12), there is a risk that the internal governance arrangement will not be in place in time which may impact upon the application for authorisation.	Low	Medium	Medium	Reduction	Following an event held on 29/3/12 to discuss agreements, Locality Chairs are leading the development of the agreements with input from practices. A further event on 18 April, facilitated by PwC took place. The draft version of the Constitution is scheduled to be consulted on w/c 7 May and presented to the CCG Board for sign off on 6 June.	Medium	Locality Boards	MT	25/04/2012	15/05/2012	Open
9	Project	12/01/2012	As a result of the Membership Scheme not being in place there is a risk that the CCG will have insufficient evidence to demonstrate competence against the authorisation criteria for "meaningful engagement with patients, carers and their communities", which may result in the CCG not becoming fully authorised by October 2012.	Low	Medium	Medium	Reduction	The actions from the PPE Strategy, including the development of a Membership Scheme, are being implemented. A Workshop on the development of Board governance, in particular stakeholder involvement, took place on 18 April. Local Trusts agreed to allow access to member databases to enable effective recruitment. Final decision on members council will be made early May and this will not impact the authorisation timetable.	Low	PPE Group	MT	25/04/2012	15/05/2012	Open
10	Strategic	24/02/2012	A lack of evidence to support the development of a track record of delivery pre April 12 means the CCG will not pass the pre-assessment phase of authorisation.	High	High	High	Reduction	Process for evidence retrieval and collation established. Following publication of draft national process there remains a risk that "CCG achievements' prior to Jan 12 are not clearly attributable. Specific sub-project to be put in place to ensure evidence meets authorisation requirements. National process requires 5 case studies and sufficient examples to enable case studies to be evidenced. SHA have confirmed readiness for application in Wave 1.	Medium	CCG Management Team	JR	25/04/2012	23/04/2012	Closed
11	Operational	24/02/2012	No draft SLAs available for CSS as per national milestones means the CCG cannot sign up to performed CSS mentions, adversely affecting authorisation.	High	High	High	Transfer	MoU agreed, some SLAs in place with more to be developed	Medium	PCTC and CCG execs	JC	25/04/2012	15/05/2012	Open
12	Project	01/11/2011	As a result of there not being a suitable organisation development plan published in time for pre-assessment, there is a risk that certain authorisation criteria will not be met and the CCG will not achieve authorisation	Low	Medium	High	Reduction	The draft OD plan was approved by the CCG Board on 7/12/11 with an updated version submitted to the Board on 7 March in order to meet a national milestone (of having an updated OD plan in place by 30 March 2012). A further refresh is scheduled in advance of authorisation, ie June.	Low	OD Steering Group	LB	25/04/2012	30/05/2012	Open
13	Operational	01/02/2012	As a result of the CCG not succeeding in leading the 12/13 contract negotiations, there is a risk that the CCG will fail to meet the national milestone and thus fail in the authorisation process	Low	Medium	High	Reduction	BCCG has established specific CIPP projects to be implemented in 12/13 and has quantified their impact. This will allow BCCG to be aware during negotiations of where compromises can be made. BCCG will complete work that can be done prior to the release of national guidance.	Medium	CCG Management Team	JR	25/04/2012	15/05/2012	Open
14	Operational	01/02/2012	As a result of delayed restructuring of the PCT Cluster to properly resource the CCG, there is a risk that BCCG will not deliver the Integrated Care CIPP workstream, which could adversely impact CCG authorisation.	Medium	High	High	Reduction	BCCG intends to manage it's priorities and be clear who the individual(s) responsible for delivering this workstream are throughout any reorganisation	Medium	CIPP Leadership Group	JR	25/04/2012	15/05/2012	Open
15	Operational	01/02/2012	As a result of insufficient engagement from clinicians, lack of consensus among GPs to progress initiatives, IT systems not being available on time and insufficient increase in expertise in primary care to reduce reliance on hospital services, there is a risk that the Planned care: reducing variation CIPP workstream will not be delivered. This will impact negatively on BCCG's ability to become authorised.	Medium	High	High	Reduction	BCCG will focus upon engagin clinicians and incentivise if appropriate, identify cost of IT systems early on and establish contracts to agree the introduction of secondary care knowledge into primary care.	Medium	CIPP Leadership Group	JR	25/04/2012	15/05/2012	Open
16	Operational	01/02/2012	As a result of a lack of consensus on appropriate thresholds for Residual Planned Care CIPP GPs not implementing agreed thresholds due to aversion of risk and delays in introducing community based services, there is a risk that this CIPP workstream will not be delivered, thus impacting negatively upon BCCG's ability to achieve authorisation.	Medium	High	High	Reduction	BCCG will use an evidence based approach to agree thresholds, invite input from many clinicians but select a smaller group to agree thresholds, monitor GPs to confirm adherence to thresholds intervening if necessary.	Medium	CIPP Leadership Group	JR	25/04/2012	15/05/2012	Open

17	Operational	01/02/2012	As a result of difficulties in achieving compliance with guidelines by patients, GPs, pharmacists and care homes, there is a risk that the prescribing QIPP workstream will not be delivered, resulting in BCCG failing to meet authorisation criteria in this area.	High	High	High	Reduction	BCCG will focus upon communicating rationale behind guidelines clearly, monitor adherence, intervene where necessary, provide support to achieve compliance and include targets in contracts when commissioning support. Monthly monitoring through QIPP governance structures, and established track record of delivery give confidence of satisfactory response.	Low	QIPP Leadership Group	AC	25/04/2012	15/05/2012	Open
18	Operational	01/11/2011	As a result of a lack of agreement over the transfer of budgets, there is a risk that reporting challenges may arise as a result of segmented budgets. This may result in BCCG failing to build a sufficient track record of managing budgets and therefore not meet the authorisation criteria	Medium	High	High	Reduction	All budgets agreed and to be delegated by the PCT Cluster Board from 1/4/12	Medium	PCTC and CCG execs	JR	25/04/2012	15/05/2012	Open
19	Operational	01/12/2011	As a result of BCCG not having a governing body in place on time due to a delay in national guidance, there is a risk that BCCG will fail to meet the relevant criteria for authorisation resulting in an unsuccessful application for authorisation	Medium	High	High	Reduction	The SHA are supporting a project to define a split model of governance. A workshopwith PwC is scheduled for 15 March with key stakeholders. A proposed Board model is being presented to the BCCG Board on 4/4/12 for approval.	Medium	CCG Board	PH	25/04/2012	15/05/2012	Open
20	Operational	01/12/2011	As a result of difficulties in agreeing H&WB strategies there is a risk that the strategies may not align or be completed on time. This may result in authorisation criteria not being met and BCCG failing to become authorised.	Medium	High	High	Reduction	BCCG commenced discussions early to identify areas of greatest importance whilst considering areas where compromise might be possible. BCCG has highlighted early the need for strategies to align and communicates developments regularly to both H&WB boards. BCCG Chair and Vice Chair sit on the H&WB Boards. Joint strategies are in development.	Low	CCG Board	MS	25/04/2012	15/05/2012	Open
21	Strategic	27/04/2012	As a result of member practices not agreeing the CCG's Constitution including Governing Body composition by the end of May, there is a risk that the CCG's Wave 1 application would not be met, resulting in a default to Wave 4.	Medium	High	High	Reduction	On-going informal consultation, CCG-wide governance event 18 April. Draft Constitution to be issued w/c 7 May. 10-14 day response period. Further CCG-wide event on 17 May. Final CCG Board approval 6 June. Planned contingency period allowed for pre-1 July application.	High	CCG Board	PH	27/04/2012	04/05/2012	Open