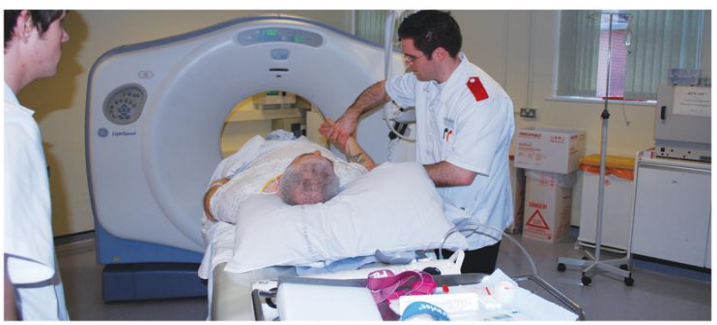
NHS

Bedfordshire Clinical Commissioning Group

Draft

Commissioning Intentions

2013-14



better care, better value, better health

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BACKGROUND AND CONTEXT

1. Bedfordshire and its people

Bedfordshire CCG (BCCG) population is split between the two unitary authorities Bedford Borough and Central Bedfordshire. BCCG is composed of 5 localities: Bedford, Chiltern Vale, Leighton Buzzard, Ivel Valley and West Mid Bedfordshire (See Figure 1). Bedford locality is almost co-terminous with Bedford Borough Council with which it shares the same health issues of a largely urban population. The remaining localities form the area covered by Central Bedfordshire. 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.

Population Demographics, Health Need, and Clinical Quality	• BCCG serves a total population of 437,650 (2011/12), set to rise by approximately 12% by 2021. • Numbers of people above 65 years are expected to grow at a faster rate, rising by approximately 30% by 2021. • The gap of around ten years between life-expectancy for those best off in Bedford Borough and those worst off (11.3 years for men; 9.1 years for women), is widening, with life expectancy decreasing in the most deprived parts. • Life expectancy for those best-off in Central Bedfordshire is significantly greater (by 7.4 years for men and 5.5 years for women) than for those worst off. • People from minority ethnic groups (BME) constitute 19.2% of the Bedford Borough population and 13% in Central Bedfordshire, compared to 17% in England. Particularly large BME communities reside within in Queens Park (57.8% in 2001) and Cauldwell (43.6%) wards • Causes of death: Circulatory disease 31%, Cancer 28%,Respiratory disease 9% (2010)

(Bedfordshire Borough Council And Central Bedfordshire Joint Strategic Needs Assessment)

Figure 1. BCCG 5 Localities

The Bedford Borough Council Health & Wellbeing Strategy 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

Equity Accessibility Integration Effectiveness Sustainability

The key priorities agreed by the Central Bedfordshire Council Health & Wellbeing Board are:

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

2. Context for 2013/14 Planning

During 2012 Bedfordshire Clinical Commissioning Group set out its vision *"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".* With that in mind, these commissioning intentions set out our priorities for 2013/14, building on the national strategy for health care, as described in the Health and Social Care Act (2012). Further refinements to our commissioning intentions will come as the impact of the NHS Commissioning Board Planning Guidance for 2013/14 and CCG financial are fully explored and the final decisions on the local 'Healthier Together' (acute services review) programme are made. This will form our Integrated Plan for 2013/14 which will be finalised in March 2013.

Our Strategic Commissioning Plan sets out the framework for commissioning decisions for the next 3 years, based on information about current needs, demands and national and local context. 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:

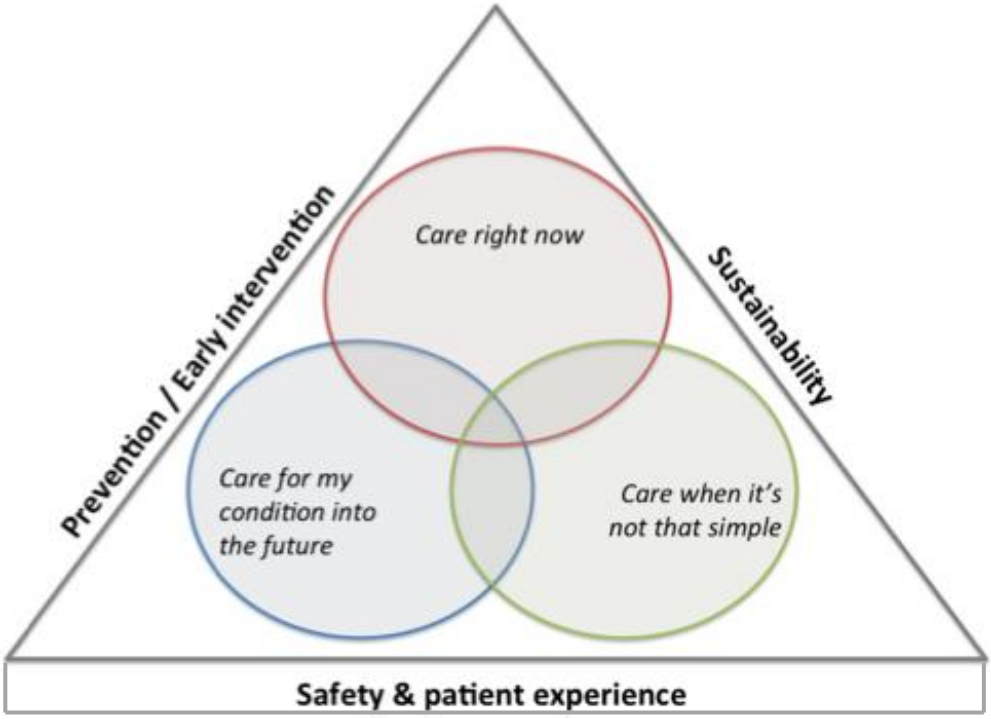
- WORKING IN PARTNERSHIP with our member practices and localities, with patients, carers, HealthWatch and the public, with local councils, and with other healthcare providers
- USING CLINICAL LEADERS to challenge and champion, and to develop new ways of providing care in general practice
- FOCUSING ON 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 improvements in quality and efficiency and provide financial and reputational 'head room' to invest in future priority areas. Our approach will be underpinned by a core set of values:

VALUES	
	TRUST We will do what we say we will do so that patients and other stakeholders have confidence in us to commission healthcare services for our patients. DECISIVENESS We will make our commissioning decisions at an appropriate pace, ensure our systems remain fit for purpose and are aligned to delivering values. DELIVERY We will achieve the goals and objectives that we set for ourselves, ensure our systems remain fit for purpose and are aligned to delivering our values. INCLUSION We will commission healthcare services in a fair, equitable and transparent way to meet the needs of the population in Bedfordshire. ACCOUNTABILITY AND PERFORMANCE We are accountable for commissioning healthcare services for our local population and we will do this within a framework of effectiveness, efficiency and transparency, remaining within our resource limits.

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 2: Proposed key areas of focus and themes



The three key areas are:

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.

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.

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 support carers and 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.

Cross-cutting themes

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

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.

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.

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.

Financial Context

At the time of writing these commissioning intentions the Planning Guidance for 2013/14 and CCG allocations have just been published alongside the Road Test Tariff for 2013/14.

The full impact of the new tariffs and the planning guidance has yet to be fully worked through in terms of financial impact, however a number of uncertainties have been clarified as follows:

- the indicative baseline CCG allocation for 2013/14 is £429.5m increasing from £419.8m from 2012/13 after including the nationally announced uplift for CCGs of 2.3%
- the running cost allowance of £25 per head is allocated separately to the baseline allocation above and for Bedfordshire CCG is £10.73m
- the CCG will plan to set aside 2% of income and spent non-recurrently following approval of plans from the Commissioning Board Local Area Team
- the CCG will plan to make a cumulative surplus of 1% during 2013/14, this will be carried forward to 2014/15
- the national tariff deflator is a net 1.3% reduction assuming inflation of 2.7% and provider efficiency requirement of 4.0%
- the level of Commissioning for Quality and Innovation payments (CQUIN: the proportion of healthcare provider that depends on achieving agreed improvement and innovation goals) will remain at a minimum of 2.5%
- the CCG will plan to budget for all non elective admissions at 100% tariff and the NHS Commissioning Board will administer the 70% balance for local investment in relevant demand management schemes in partnership with the CCG.
- the CCG will hold a minimum 0.5% contingency to mitigate local health economy risk, this is in addition to the 2% set aside for non-recurrent investment mention above.

In addition to the plan requirements set out above, the CCG plans to set aside funding to ensure that it starts the year in recurrent balance by funding known baseline financial pressures such as continuing care and also set aside funding to support local provider transformation.

At this point some uncertainties still exist and will become clearer over the next few months as the CCG finalises its contracts and develops its service and financial plans for next year and beyond. These include:

- the actual and anticipated level of demographic led activity growth
- any significant structural changes to the final published tariff
- the impact of business rules for reablement, social care transfers to LA

Our latest assumptions suggest that we will have a gap between recurrent income and recurrent expenditure of c £25.4m in 2013/14, comprising the following:

	Latest Assumptions	
	£m	%
Baseline allocation 2012/13	**419,818**	
Income:		
Resource Uplift	(9,656)	-2.30%
Tariff Deflator	(3,640)	-1.30%
Expenditure:		
Demographic/Activity – Change & Growth	11,293	2.69%
CQUIN change	0	2.50%
1% CCG Surplus Requirement	4,198	1.00%
2% Transformation Reserve	8,396	2.00%
Fund pressure on Continuing Health Care	6,000	1.43%
Contingency Reserve	2,099	0.50%
Provider Transition support	5,000	1.19%
30% Marginal Rate adj held by NHSCB	1,700	0.40%
Savings Requirement	**25,391**	**6.05%**

Clinical Commissioning

The Health and Social Care Act (2012) makes Clinical Commissioning Groups (CCGs) responsible for commissioning services they consider appropriate to meet local health needs. By April 2013 all Primary Care Trusts will be abolished. The differences between how we approach commissioning are:

- BCCG is rooted in our communities through Health and Wellbeing boards, GP membership and patient and public engagement.
- GPs are providing active clinical leadership for commissioning, working with providers to make key decisions over resource utilization at a population level.
- BCCG is changing the nature of negotiations with health care providers from discussion ton numbers of procedures and visits to patient outcomes and value.
- BCCG is leading meaningful engagement with patients and the public to understand what outcomes matter, what currently works well and what needs to change to improve the quality of their experience and the outcomes of their care.

The relevant context in which BCCG adopts this approach is:

- The current economic situation: there is no real term increase in health care funding. The potential for real term decreases in funding from next Comprehensive Spending Review means we must ensure providers offer value for money services that focus on improving patient outcomes.

- Due to changing commissioning responsibilities there is a greater need to work collaboratively with the NHS Commissioning Board and Local authorities to commission better outcomes for complete pathways of care.
- Policies such as 'Any Qualified Provider' encourage competition and the introduction of new healthcare providers. Alongside service reconfiguration local hospitals will face increasing challenges to ensure excellence in quality service provision and value for money.

3. Developing our 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 (this latter one in development). 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. During September-October 2012, planning workshops have been held with programme boards and localities, with Local Authority and with patients and health care providers, where themes and proposals for commissioning changes have been developed.

These proposals are considered within the context of priority-setting. It is increasingly accepted that priority setting in publicly-funded health care systems is inevitable. As demand for health care has increased – driven by an ageing population, advances in medicine and higher patient expectations – the need to establish procedures for allocating scarce resources has become more pressing. Developments in the field of priority setting have become especially urgent in the current context of economic austerity, in which the welfare system of England is subject to greater financial constraint.

To facilitate robust decision making that ensures our population has access to the highest quality health care providing the best patient experience possible within available resources, BCCG has developed a prioritisation process that supports commissioners in determining or refining our priorities. The agreed criteria are based upon BCCG's Ethical and Commissioning Principles.

The criteria are shown below:

Criteria	Assessment
Strategic Fit	How does the proposal demonstrate that as a minimum there is a major contribution to the BCCG Strategy and one or more key national targets?
Governance (Legal & Clinical)	Is there a legal requirement for the CCG to undertake this proposal or is this covered by NICE Technology Appraisal Guidelines?
Assessed Needs	Has population need been assessed through a health needs assessment?
Evidence Based	Is the proposal clearly supported by robust evidence of effectiveness?
Effect on Inequalities	Is the proposal proven to reduce inequalities?
Access	Does the proposal include a health equity audit to assess access? What is the impact on access e.g. reduced waiting times, increased choice or convenience, earlier identification of risk or diagnosis, closer to home care
Financial Impact	Is there any cost or saving implications to the proposal?
Value for Money	Is the proposal proven to be cost effective for the outcomes it will achieve?
Achievability	Does the proposal have a clear plan with realistic timescales and assumptions? Has evaluation been planned?
Acceptability	Is there strong evidence of supporting patients and stakeholders in the service design? Is there support from patients and the public?
Magnitude of health gain	Who will benefit and how? E.g. what is the impact on life expectancy/mortality, quality of life/health status, healthy behaviour change, patient experience, quality of care etc.
People who will benefit	How many people within our population will the proposal benefit?
Risks of not implementing	What is the impact if this proposal is not prioritised?

The scope of BCCG commissioning programmes and interventions included for consideration this year are taken from the following areas:

- Locality Plans
- Urgent , Integrated Care and End of Life Care
- Planned Care, Long Term Conditions and Cancer Care
- Mental Health and Learning Disabilities
- Children's and Maternity Care
- Medicines Management

4. Stakeholder Engagement

To facilitate meaningful stakeholder engagement, ten merging themes were taken from the planning workshops and developed into patient stories that depicted how the patient experience is today, and how, by making changes to the ways care is delivered, patient experiences may differ next year. These emerging themes were then shared, discussed and debated at deliberative engagement events with patients, public, carers and service users and the local health and social care provider organisations.

The 10 areas are only part of the suite of health care changes being considered as priority areas/identified as developments that will commence next year. The deliberative events highlighted

four top priorities as expressed by represented patients, public and carers and provider organizations. These will have been highlighted as important areas within our prioritisation process:

- Care Coordination (Health & Social Care Coordinator; a trained member of staff that supports individuals, families and carers to navigate and coordinate the range of health and social care services available to them)
- Developing the primary health care multi-disciplinary team
- Integrated Care
- Dementia Care

The outcomes of the deliberative events are summarised in appendix 1.

Next Steps to continue engagement

This document provides an opportunity to continue the dialogue we have started with patients, the public, and providers. It is being published openly within the public domain and promoted through local channels, in order to encourage further comment and discussion on shaping our proposals as they are refined and implemented.

Clinical Leadership

CLINICAL LEADERS will challenge and champion, and develop new ways of providing care in general practice:

- 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.

Patients and the public

We will WORK IN PARTNERSHIP with patients, carers and the public to build on what works well and change what needs to work better.

- We will embrace the experience of the public, patients and carers 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 local LINKs and then Healthwatch and other patient representative organisations to develop new ways of engaging and informing people, especially those who sometimes struggle to be heard.

Public consultation

We will work with our Local Authorities and scrutiny committees to identify substantial developments to health services and then coordinate formal public consultation process to gather feedback from the public, local authority, third sector, clinicians and other service providers.

Local Authority partners

We will work in partnership with our local authority colleagues to promote greater integration of planning, payment and provision between the NHS and social care. Joint commissioning strategies are in place for the following client groups:

Bedford Borough Council:

- Dementia
- Mental Health
- Older people

Central Bedfordshire Council:

- Dementia
- Mental Health
- Older people

Through Health & Wellbeing Boards and their respective joint commissioning groups, we will identify and act on priority areas for greater joint working between local commissioners. BCCG Commissioning Intentions are summarised by Local Authority in Appendix 2.

Service providers

We will plan with neighbouring health economies the commissioning of care from sensible and higher value configurations of specialist services through the 'Healthier Together' programme, which aims to improve the quality, safety and affordability of health services provided across the South East Midlands area.

The significant service reconfiguration ambitions of this programme for acute hospitals will take time to deliver. Alongside supporting the changes required of 'Healthier Together' we will need to work with our acute providers to develop new contracting and payment methods that ensure resources follow patients, i.e. where care is provided closer to home, specialist staff, equipment and finances are

available to do this. This will require both greater use of local tariffs and a move away from traditional activity-based contracts towards contracts and specifications focused on systems of care (e.g. musculoskeletal care, care for frail older people) and that reward improved outcomes for patients.

The Health & Social Care Programme Board and the BCCG QIPP leadership board provides an opportunity to bring together senior representatives from across the health and social care local system – commissioners and health care providers – to monitor, challenge and hold to account the implementation of these changes. This assures that the impact to the entire local health system and the impact of change on patient pathways is clearly understood and articulated. Integration will be a key agenda; reviewing the development of Integrated Services between hospital and community e.g. Diabetes Services and ensuring that these specialist services also integrate with other relevant services e.g. Cardiology.

5. *Care right now*: urgent or unscheduled care

In order to deliver the outcome of:

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.

We have been working on a variety of service reviews and changes throughout 2012 which will contribute to improving patient experiences of services for urgent care.

Achievements over the last year

- *Minor illness Care pathway*

A new GP service in close proximity to Bedford Hospital Trust is working with the hospital to provide services for patients with a minor illness. This means if patients present to A&E with a minor illness that could be better treated by primary care services, they are redirected to the practice to receive the appropriate clinical care.

- *Urgent Care Services and older people who fall*

When an older person falls over and a paramedic crew assesses them as medically fit, a social worker then visits and assesses their home situation to ensure the patient's ongoing safety. This service is jointly provided by the East of England Ambulance Service and social care from Bedford Borough and Central Bedfordshire councils.

We will be taking further steps towards improving patient experiences of urgent care services.

Priorities and Challenges for 2013/14

- *Falls Prevention*

Integrated Health & Social Care Falls Prevention Management Service – a full review of all falls-related projects will be undertaken and clear plan of action to respond to gaps and best practice to be developed in conjunction with both Local Authorities and Public Health.

- *Out of Hours Dressings*

Review of the delivery of out of hours dressing's services and commission services to meet the needs of localities. Consider the removal of the term 'housebound' as it is seen as a block to getting good patient care in the community and is becoming less meaningful as more care moves into home settings in general.

- *Review of walk-in centre services*

We will look holistically at the model of walk-in urgent care, including our expectations of Accident & Emergency departments and the part played by other access points such as walk-in centres and general practice. In doing so, we will actively seek patient and public feedback through engagement and consultation.

- *Out of Hours GP services*

We will review these services in order to:

- Examine the impact of opening hours of OOH on A&E visits.
- Examine the impact of out of hours GP services being able to perform basic diagnostics e.g. ECG and blood tests, on A&E demand.
- Explore the options for out of hours service provision where there are opportunities to improve patient experience

- *Maternity Tariffs*

We will undertake a shadow exercise in preparation for new forms of maternity tariffs in 2013/14 to look at financial implications for local acute trust maternity services. Examine in detail differences in admission rates for local maternity units and develop plans to address any inconsistencies in line with best practice.

- *Paediatric urgent care services*

Prompted by higher than expected emergency admissions for long term conditions in children and young people and changing evidence of best practice in paediatric urgent care, we will look at the patterns of urgent care received by our children and young people and work in conjunction with the Healthier Together programme to commission an up to date model of care.

Notice of Changes and Planned Service Reviews

- **Review all falls-related projects in conjunction with Public Health and Local Authorities**
- **Review of the delivery of out of hours dressing's services and commission services to meet the needs of localities**
- **Review of walk-in centre services**
- **Review of scope of out of hours GP services**
- **Review Of Maternity Services Liaison Committee (MSLC) arrangements to ensure arrangements are effective**
- **Review of the Paediatric urgent care pathway**

6. *Care for my Condition into the Future:* planned care and long term conditions

In order to deliver the outcome of:

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

We have been working on a variety of service reviews and changes throughout 2012 in order to increase the proportion of people who feel they have had enough support to manage their condition.

Achievements over the last year

- *Reducing Variation*

The variation between GPs when making referrals into secondary care has been under significant review and a number of initiatives to support GPs in decision making implemented. The launch of benchmarked, standardized information, peer review of referrals, clinical education and training programmes , a referral information web site (GPRef), the development of GP checklists for procedures of lower clinical value, and the implementation of Practice Development Managers roles within localities have supported GPs to ensure referral pathways are evidenced-based and clinically appropriate, with optimum high quality care being provided within a primary care setting. This has resulted in improvements in the quality of care provided within primary care and an overall reduction in the numbers of referrals being made by GPs to specialist services.

- *Best Practice approach to outpatient follow up appointments*

Acute hospital contracts have been performance managed against national best practice Follow Up ratios, ensuring that hospital follow up visits are clinically appropriate.

- *High Cost Drug Validation*

The prescription of high cost drugs within hospital settings has been regularly reviewed to ensure evidence-based prescribing

- *New Diabetes & COPD Services*

Integrated Services that span primary care and secondary care settings, providing care and support delivered closer to home, instead of having to attend hospital appointments. Led by clinicians, the innovative services are provided by staff at both Bedford Hospital and Luton and Dunstable Hospital but in a variety of community facilities. A review of the services will be completed by December 2012.

- *Dementia*

This initiative involves working in partnership with Local Authority Colleagues to implement the National Dementia Strategy. It focuses upon early diagnosis and intervention, increased quality of care in general hospitals, living well in dementia care homes and a reduction in the use of antipsychotic drugs. Achievements include:

  - More appropriate anti-psychotic prescribing by working with pharmacies, care homes and GPs locally.

- A new Improving Access to Psychological Therapies Service for children is being delivered by 'CHUMS': child bereavement, trauma and Emotional Wellbeing service.
- "Singing for the Brain" service is in place and operating across Central Bedfordshire and Bedford Borough.
- Two additional Dementia support workers have been appointed by the Alzheimers Society and are providing increased support and information to carers and their cared for.

- *Eating Disorders*

The development of an Integrated Eating Disorder Pathway encompasses a smooth transition from children's and young people's services into adult services and reduces the requirement for out of area care.

- *Mental Health*

We are working in partnership with Local Authority colleagues to implement a Mental Health and Wellbeing Integrated Stepped Care Model aimed at improving the transition of care from children's and young people's services into adult services and the interface between services. This includes:

- A new model to deliver care close to home to support people with mental health conditions to stay well.
- Four link workers are now in place in Primary Care settings

- *Autism*

An evidence-based multi-agency diagnostic pathway for Autistic Spectrum Disorders for children and young people across Bedfordshire and Luton has been designed and will be implemented in early 2013. A review of the impact of the new pathway is planned for autumn 2013. Work focusing on adults with Autism has included:

- The development of a Local Strategy
- An education program which has resulted in over 350 people having training in understanding Autism
- A review of the model for social skills development provided by Autism Bedfordshire has led to increased opportunities for support.

- *Learning Disabilities*

A Health facilitation Service is in place and supporting more people with learning disabilities to access Primary Care services.

Medicines Management

- Improved use of antibiotics in line with local guidelines. This has been associated with a reduction in *Clostridium difficile* infections to less than half the rate from 2009-10.
- Improved adherence to local blood glucose monitoring guidelines, reducing unnecessary testing for patients
- Generic medicines provide better value for the NHS and overall have more data to support patient safety. 200,000 more prescriptions were written and dispensed as generically available medicines in Bedfordshire than in the previous year.

- 10,000 fewer prescriptions dispensed for non-steroidal anti-inflammatory drugs (NSAIDs) associated with a higher risk of cardiovascular events.
- Through an award winning dietetic service (Food First) commissioned by the Medicines Management Team we have improved use of regular food for patients rather than issuing cartons of liquid feed to frail patients. This has resulted in improvements in weight for patients and their quality of life. BCCG now uses 77% fewer cartons than the England average.
- Improved access to dressings for district nurses so that they can use dressings without the need to obtain a prescription.
- Improved access for patients with coeliac disease to gluten free foods. Patients can now obtain these directly from community pharmacies without the need for a prescription.

We will be taking further steps towards increasing the proportion of people who feel they can manage their condition.

Priorities and Challenges for 2013/14

- *Musculoskeletal Services*

Based upon recommendations within the National Musculoskeletal (MSK) Service Framework, a clinical network has developed clinical recommendations on a new proposed system of care across elective orthopedic, rheumatology, podiatry, chronic pain and physiotherapy care. GPs across all five localities of the BCCG and patient representatives are continuing to develop a clinical system specification.

A procurement process will result in the BCCG commissioning an integrated MSK system through an outcome based incentivized prime contract. This prime contract and system approach will incentivize clinicians and providers to use their expertise to design and lead integrated services based around the patient, delivering seamless, coordinated care across the MSK system. The new integrated MSK system will improve the patient experience, delivering the best possible outcomes to patients within the resources available, whilst bringing care closer to home using hospital facilities only when necessary.

- *Cardiology*

A System redesign project is underway which will deliver a revised model of care focusing on prevention and providing more care with Consultants and specialist staff supporting services in community-based settings, closer to home and reducing the need to visit hospital.

- *Ophthalmology*

A system redesign project is underway which will deliver greater community provision and closer working amongst primary care practitioners. A joint commissioning model with local authority partnership is being adopted and this initiative is part of a national UK Vision project which is working with only three CCGs within the UK to implement the national Vision Strategy.

- *Dermatology*

A series of engagement events and steering group work, including patient representatives, hospital and community clinicians, local GPs, public health and commissioning staff have developed a new integrated model of care that will shift a significant proportion of dermatology services out of hospital into closer to

home in community based settings. A procurement process will commence in 2012 and result in a new model of delivery aimed at improving patient experience, patient determined population health & wellbeing outcomes, increased quality, improved value for money and a reduction in health inequalities.

- *Gynaecology*

Initially steered by a local pilot to provide consultant led gynaecology outpatient appointments in a community, this project will be evaluated to determine if a CCG wide model of care will provide high quality care, closer to home, improving patient experience and value for money.

- *Neurological disorders*

Opportunities are being explored to develop a multidisciplinary approach to the treatment and management of pre and post neurological disorders. Up until now, these have been considered individually as separate neurological conditions, including Epilepsy, Chronic Fatigue syndrome (CFS/ME), Multiple Sclerosis (MS) and Acquired Brain Injury (ABI).

- *Stroke*

A national review of the whole Stroke pathway is underway, existing national performance indicators demonstrate there is a need to significantly improve aspects of service provision and will locally form part of the 'Healthier Together' programme for clinical service change. The findings of this review will be considered in terms of local need and commissioning requirements for increasing independence following stroke.

- *Cancer Pathways*

Cancer specific service specifications are being developed to support future pathway commissioning. These will include expectation for full implementation of enhanced recovery pathways, reduction in cancer follow up where clinically appropriate and delivery of care closer to home.

- *Community Mental Health Teams*

We will explore a model of care where Community teams operate seven days a week and provide a service to all ages (from 18 years old) There will be a specialist CMHT that will deliver services to people suffering with an organic disorder e.g. Dementia.
There will be increased support for people with physical conditions that impact on their mental wellbeing.

- *Primary Care Mental Health Services*

Primary care mental health services will deliver an increased range of interventions and support. There will be an increase in the availability of psychological therapies and this will be equally accessible for hard to reach groups. There will be increased support for people with physical conditions that impact on their mental wellbeing.

- *Dementia*

Increase the support to early assessment and diagnosis for dementia to ensure the best possible outcomes for treatment. To ensure people with dementia maintain their independence as long as possible and that there is adequate support in place for carers.

- *Multi-Agency Transition Tool*

To ensure smooth transition from children to Adult services an audit of current transition pathways will be undertaken with the purpose of testing the effectiveness and implementation of the Multi Agency Transition Tool (MATT), which will be used across all agencies.

- *Looked After Children*

To improve health service provision and outcomes for Looked After Children through implementation of the new service model in March 2013, with a service review planned for September 2013.

- *Children with Long Term Conditions*

To work with local acute and community providers to develop local pathways to support a effective treatment for children and young people with long term conditions, in particular Asthma, Epilepsy and Diabetes.

- *Medicines Management*

The focus for medicines management in 2013/14 will change to include 'Helping patients to get the best from their medicines' (medicines optimisation). This will be achieved through greater engagement with patients and by working more effectively across health and social care settings.

We know that:

- Provision of medicines is the most frequent healthcare intervention within the NHS.
- Between 5% and 17% of unplanned hospital admissions in the UK are due to medication issues.
- Most long term conditions are managed using medicines and yet full adherence to these medications is only about 60%.
- Across England £300m is wasted each year on unused medicines (half of which is avoidable), however at least £500m a year is wasted through not getting the expected benefits of medicines due to patients not taking medicines properly.

The work plan for 2013-14 will consist of a number of individual projects which will have commonality and overlap within an overall medicines optimisation plan. Projects which will be underway by 1st April 2013 include:

1. A new programme to improve communication of medicines between acute trusts, community in-patient units, GP practices and community pharmacies so as to ensure that information is accurate and timely and that community pharmacy skills are utilized more fully, in particular NHS Medicines Usage Reviews (MURs) and the New Medicines Service (NMS).
2. A new programme across health and social care to improve medicines support given to patients with dementia and their carers.

3. As part of our expansion of support for care homes we will implement a project working with care homes staff to support improved use of inhalers and eye preparations within care homes
4. Development and accreditation of Healthy Living Pharmacies (HLPs) promoting self-care and improved access and choice of care through our community pharmacy network.
5. Development of a range of resources available for patients and carers to support improved adherence with prescribed medication for long term conditions such as diabetes and asthma.
6. A follow up to our 2011 medicines waste campaign to further reduce the amount of medicines wasted each year in Bedfordshire

In addition, we will continue to optimize value and safety through appropriate prescribing of medication including:

1. Increase the proportion of prescribing as generic medication where clinically appropriate.
2. Use of human insulin in preference to analogue insulin for patients with type 2 diabetes mellitus.
3. Reduce the use of high dose inhaled corticosteroids in asthma and COPD where clinically appropriate.
4. Reduce the amount of benzodiazepines prescribed for more than 28 days
5. Further reduce the amount of prescribing of non-steroidal anti-inflammatory drugs (NSAIDs) associated with higher cardiovascular risk.
6. Further reduce prescribing of antibiotics for viral or self-limiting infections so that resistance levels are minimized.

The medicines management team within Bedfordshire CCG will lead these projects through both direct support and facilitation. However medicines optimisation isn't a pharmacy-only issue, but will involve collaboration across all health and social care along with patients and public.

Notice of Changes and Planned Service Reviews

- **Review of new Integrated COPD and Diabetes Services**
- **Procurement of new MSK System Model complete and service delivery starts**
- **Procurement of new Dermatology System Model complete and service delivery starts**
- **Commission Community Cardiology Services**
- **Joint Commissioning of Vision services with Local Authorities**
- **Review of Community Gynaecology Pilot**
- **Review and re commission of Neurological Disorders model of care**
- **Implement recommendations of Stroke Pathway Review**
- **Commission Cancer Specific evidence-based pathways**
- **To review community mental health teams to ensure that mental health support is appropriate, accessible, responsive and recovery focused**
- **To develop a comprehensive primary care mental health model that promotes wellbeing and ensures that people are assessed and treated at the earliest point in their illness.**
- **Review of redesigned looked after children service**

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

In order to achieve the outcome:

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.

We have been working on a variety of service reviews and changes throughout 2012 in order to increase the proportion of people aged 65 and over who are still at home three months after leaving hospital for rehabilitation in the community.

Achievements over the last year

- *Integrated Care*

A joint community beds review is being undertaken by BCCG, Bedford Borough Council and Central Bedfordshire Council, supported by a Public Health led evidence review. Its findings will inform the strategic commissioning of community-based recovery and rehabilitation jointly by BCCG and the local authorities. It will consider the opportunities from combining purchasing power between NHS and local authority commissioners and improving value for money on community-based care. Its findings are due to be released in early 2013.

- *Complex care in community settings*

This initiative is an innovative 12 month pilot where a whole patient pathway has been commissioned for the care of older people presenting or at risk of presenting at Luton and Dunstable NHS Foundation Trust. The pathway includes clinical navigation teams actively seeking out patients who could be cared for in the community setting and arranging their transfer from A&E, assessment units and wards. The team has access to a short stay medical unit in Houghton Regis that is led by a Consultant Geriatrician, and rapid intervention teams and rehabilitation & enablement teams, working together with social workers to track and manage the patient journey.

- *End of life care*

A 12-month pilot called Partnerships for Excellence in Palliative Support (PEPS) delivers a hub and spoke model of end of life care. Providers (including from the third sector) have come together to deliver the service in partnership, and the greater coordination of care has been shown in an interim audit, to have improved the number of people dying in their preferred place of death and reduced lengths of stay in hospital. A 12-month evaluation of the service is due in December 2012.

- *Additional support to care homes*

A multidisciplinary team consisting of Pharmacists and advanced nurse practitioners are working with Bedford locality GPs to deliver case management model within residential and nursing homes. Following a successful pilot, the 3 year service has been commissioned to provide nursing assessments and medication reviews for this vulnerable group. During the pilot phase, commissioners saw a reduction in A&E attendances and non-elective admissions from participating homes.

Priorities and Challenges for 2013/14

- *Integrated Care*

NHS Bedfordshire, practice based commissioning groups and Bedfordshire Clinical Commissioning Group have engaged and supported a number of redesign projects in urgent care in previous years. The collective learning of these initiatives can be summarised as;

1. Small scale projects do not deliver the scale of change now required within healthcare
2. Addressing individual elements of the patient pathway e.g. discharge, do not yield whole system improvement
3. There is interdependency between providers that means greater partnership is required

As a result of the things we have learned from previous years, Bedfordshire CCG has a vision for integrating services for the benefit of local people. We have a lot of work to do to reach this ambition. We need to work in partnership with other commissioners and we need to plan the journey from the fragmented model we currently have, to the joined up provision we wish to see.

Bedfordshire CCG will be working with each Local Authority to develop local plans for addressing challenges. We expect to deliver a shift in care provision away from acute hospitals toward community solutions where it is safe and effective. We will develop commissioning plans for implementing the outcomes and recommendations of the community bed review and aim to deliver more joined up care for the benefit of local people. Where there is joint funding of services, commissioners will come together to jointly manage performance e.g. SEPT community health services.

In order to move the health economy toward this way of planning and providing care, we expect to deliver the following changes in 2013/14. We would also value discussions with providers to see how they can come together to deliver greater partnership working in 2013/14.

- *Developing the 'Primary Care Health Team'*

This includes a community geriatrician to support comprehensive older people's assessment and advice for complex patients enhancing quality of care, enabling older people to receive care where they reside and preventing unnecessary hospital admission.

- *Community Nursing*

This will align community nursing teams to GP practices. This will be with the aim of providing holistic care, maximizing and maintaining independence and working with GPs to provide effective case management of people at risk of hospital admission.

- *Navigation of health and Social Care*

Test the efficacy of a Health and Social Care 'Broker' (Care Coordinator) to help patients/relatives/carers navigate the health and social care system. This was tested in Torbay and was considered to be the single biggest impact role. It should begin to align disparate teams towards an integrated model.

- *Falls Prevention*

Integrated Health & Social Care Falls Prevention Management Service – a full review of all falls-related projects will be undertaken and clear plan of action to respond to gaps and best practice to be developed in conjunction with both Local Authorities and Public Health.

- *Personal Health Budgets (PHBs)*

Work is underway in preparation to implement PHBs from April 2014 within health and social care systems.

- *Liaison Psychiatry*

Develop a system wide model for liaison psychiatry which will include all aspects of Mental Health provision including dementia, learning disability liaison and general support to acute hospitals.

- *Complex needs*

We will review services for people with complex needs and develop a service model that will enable people to access local services in a timely manner.

- *Children with Special Education Needs and Disability*

To work with Local Authority partners to develop integrated systems and processes outlined in the Special Educational Needs and Disability (SEND) green paper, including: - single assessment, joint funding/budget, personalised budgets – for 0-25 year olds with special educational needs, by September 2014.

Notice of Changes and Planned Service Reviews

- **Re-commission community beds configuration as a result of community beds review**
- **Review the impact of the Sub Acute Programme South and (re)commission as appropriate**
- **Commission a Community Geriatrician (older peoples consultant) model to support the primary health care team**
- **Commission community nursing teams to align to GP practices within a 'GP attachment' model**
- **Commission a 'Care Coordinator' model to support patients and carers to navigate the health and social care system**
- **Review CHC processes and arrangements for Adults and Children in order to work with our Local authorities to review areas for integrated working and complete retrospective reviews in line with National frameworks and timelines**
- **Review of Personalised Health Budget national recommendations**

8. Quality in Primary Care

Essential and additional primary medical services through the GP contact, pharmaceutical services, primary ophthalmic services, all dental services, health services for people in prisons, custodial settings and health services for members of the armed forces (registered with DMS) will be commissioning by the NHS Commissioning Board.

The Clinical Commissioning Groups will be responsible for commissioning Local Enhanced Services; secondary ophthalmic services e.g. cataract pathways, health services for offenders serving community sentences and those on probation and health services for veterans or reservists when not mobilized.

Each of the 5 localities will also adopt a strong focus upon improving the quality and productivity of primary care services.

Achievements over the last year:

- *Reducing variation between GPs when making referrals into secondary care*

All localities had made significant improvements to the quality of primary care services by reducing variation between GPs when making referrals into secondary care. GPs have ensured referral pathways are evidenced-based and clinically appropriate, with optimum high quality care being provided within a primary care setting. In addition to these achievements:

- ***Chiltern Vale*** have piloted the community Matron model; providing effective case management for patients with complex care needs and a reduction in emergency admissions, developed 'step up' community beds that provide intensive rehabilitative support as opposed to hospital admission and supported GPS with Care Quality Commission requirements.
- ***West Mid Bedfordshire*** have secured significant clinical engagement within a primary care quality outcomes framework, have continued to improve and develop a number of community based services enabling more people to be treated closer to home, and improved primary care management of long term conditions has resulted in a reduction in emergency admissions.
- ***Bedford*** have led the redesign and implementation of new community-based Diabetes and Chronic Obstructive Pulmonary Disease services, implemented a primary care anticoagulation service which provides outreach care to the housebound and community-based services, supported the Health & Wellbeing teams to address inequalities in care by targeting deprived populations within practices and delivering NHS Health Checks, supported the health & wellbeing teams to develop Health Champion Trainers, undertaken the evaluation of complex care team pilot within residential homes and its impact upon improving care coordination, reducing emergency admissions, medicines optimization etc.
- ***Leighton Buzzard*** GPS have focused on supporting the urgent care pathways developed to support people with complex care needs in the community, ensured that local people have improved access to diabetic retinopathy screening and seen a significant improvement to GP Practice facilities.
- ***Ivel Valley*** GPs have provided GP clinical commissioning leadership of Musculoskeletal, Mental Health and Diabetes redesign projects and patient, public and carer engagement activities, lead

BCCG involvement in the national Macmillan research project which explores GP referral styles and the impact upon early cancer diagnosis, implemented a mental health Link worker to support local population need, supported local and regional project groups with primary care expertise in relation to Enhanced Recovery pathways. The locality has also implemented a preventative social worker project, a joint project with Central Bedfordshire Council.

Priorities and Challenges for 2013/14

- *Driving up the quality of care provided by local care organisations e.g. hospitals, community services etc.*

GP clinical commissioning leads have been identified for larger local care organisations and all localities intend to work closely with these leads to influence improved patient experience, outcomes and quality of care. A focus upon performance management e.g. ensuring services are providing the care and delivering the outcomes intended, improved communication e.g. timeliness and content of discharge summaries, improved information e.g. accuracy of coding are all crucial for GPs to understand and improve commissioning of patient journeys within and through services. In addition to these priorities:

- ***Chiltern Vale*** will continue to ensure referral pathways are evidenced-based and clinically appropriate and also ensure that the care that occurs in hospital is clinically appropriate to an acute hospital setting, will work with programme boards in the local implementation of new services and care pathways for people with musculoskeletal, opthalmology, gynaecology,, mental health, eating disorders and dementia care and intervention needs.
- ***West Mid Bedfordshire*** will work with programme boards in the local implementation of new services and care pathways for people with ophthalmology, dermatology and cardiology care and intervention needs, continue to improve how we help people with urgent care needs through closer working with local community teams, community-based facilities and out of hours GP services, and will take forward a program of work around improving early help and support for people with mental health problems.
- ***Bedford*** will commence multidisciplinary staff team (e.g. district nurse, practice nurse social worker and GP) meetings within GP practices to improve the coordination of care for patients with complex needs, ensure that local clinical care pathways for minor surgery lead appropriately into dermatology services, will work with programme boards in the local implementation of new services and care pathways for people with cardiology, mental health and cancer care and intervention needs, and support the outcomes of the community review.
- ***Leighton Buzzard*** focus on patient, public and carer engagement, ensuring that urgent care pathways are effective for local people by monitoring A&E attendances and emergency hospital admissions, improve the quality of primary care by reviewing any variations in care delivery, improve liaison with local care homes and out of hours care providers to enhance the quality of care.
- ***Ivel Valley***, will work with programme boards in the local implementation of new services and care pathways for people with ophthalmology, mental health and community beds care management, focus upon patient, public and carer engagement initiatives.

9. Prevention

Prevention work has been led by Public Health. From April 2013 Public Health will transfer to Local Authority which encompasses Bedford Borough Council and Central Bedfordshire Council.

Achievements over the last year:

SUBSTANCE MISUSE

- Alcohol Arrest Referral Service & Community Alcohol Liaison Service

These services ensure people with alcohol related problems receive appropriate and timely care and treatment, including referral/signposting on to the appropriate Alcohol treatment service, thereby reducing alcohol related harm and subsequent attendance and admission to hospital. They have implemented new workforce roles including; 2 x Alcohol Outreach Worker2 x Alcohol Arrest Referral Workers and Community Alcohol Liaison workers.

- Adult Substance Misuse Service Redesign

This new service has amalgamated the historic adult services for substance misuse and the adult alcohol services. The Service was successfully tendered and the new provider commenced from Sept 2012.

TOBACCO CONTROL

- Babyclear, Kick Ash and Stop before your Op

These initiatives increase healthy life expectancy for the local population and reduce health inequalities by making it easier for smokers to quit, reduce smoking prevalence and reduce the likelihood that children will become smokers. BabyClear and Kick Ash are now business as usual within their delivery areas and are therefore no longer reportable under QIPP.

Priorities and Challenges for 2013/14

- *NHS Health Checks*

NHS Health Checks is a mandatory deliverable within the Public Health Outcomes framework. This initiative will systematically offer preventative checks to all those aged 40 to 74 years to assess their risk of vascular disease (heart disease, stroke, and diabetes and kidney disease) and this risk will be communicated and subsequent lifestyle and medical management provided.

- *Healthy Weight*

Through public health interventions, stop the year on year increase in levels of obesity, by increasing the population recognition of obesity and related health issues and increase the habitual levels of healthy eating and physical activity.

- *Substance Misuse*

Through public health interventions, ensure that people with substance misuse problems receive timely and appropriate care and treatment, including referral/ signposting onto appropriate substance misuse services. Thereby reducing alcohol related harm and associated A&E attendances.

- *Tobacco Control*

Through public health interventions, continue to support people to stop smoking and hence work towards reducing smoking prevalence within Bedfordshire.

- *Making Every Contact Count*

To deliver systematic brief healthy lifestyle advice and signposting to existing health and social care services at a scale that will lead to improved population health and a reduction in lifestyle preventable disease. The project will target smoking prevalence, obesity, healthy eating and physical activity, prevalence of harmful drinking.

10. Quality, Outcomes and Patient Safety

The objectives for BCCG quality and safety team are to:

- Agree and ensure that indicators relating to patient safety and clinical quality are included in all provider contracts and monitored continuously. This ensures that any early warnings regarding possible deterioration in service quality is identified and acted upon.

- Review and analysis of all quality data and information about providers to ensure recognition of early warning signs e.g. Integrated Performance and Quality Dashboards, Quality profiles and other data/intelligence about providers.

- Review and consideration of relevant published reports or data in relation commissioned providers. Agree corrective action and reporting for any concerns identified.

- Review all information and data including Serious Incidents, Never Events, complaints trends and Serious Case Reviews, ensuring that corrective and preventative action is taken and that lessons learned are widely disseminated

- Ensure providers have processes in place to report incidents in a timely manner.

- Review Safety Alerts and consider implications to commissioned services and ensure providers implement actions within timeframes

- Ensure that Commissioning, Quality and Innovation (CQUIN) proposals are appropriate, challenging and lead to significant improvement in quality of services and outcomes for patients

- Review of all patient experience and engagement intelligence to ensure it is utilised to inform and influence the design of services.

11. Working in Partnership – Joint Commissioning

The decrease in public sector funding combined with the current changes in the NHS commissioning landscape mean that now, more than ever, local 'health' commissioners must develop partnership-working approaches.

We are building on existing relationships created by Bedfordshire PCT with social care commissioners in both Bedford Borough and Central Bedfordshire councils, but refreshing them with more clinical input and refocusing on improving both patient outcomes and value for money. Although we have in place joint strategies for the commissioning of key services (such as care for those with mental health conditions), joint commissioning between health and social care services in Bedfordshire is not as advanced today as it is in many other parts of England. This is indicative in part of the significant organizational changes that have taken place, firstly in the move from county/district councils to unitary authorities and then most recently within the NHS. As we enter a period of relative structural stability, external assessors are noting how strong the relationships are between BCCG and BBC and CBC, and all three organisations are expressing clear intentions to accelerate our joint commissioning arrangements. We can start quickly by, for example, using the positive experiences of a successful joint procurement of community equipment to procure more together. Where both the 'health' commissioners and the local authorities have contracts with the same provider (for example, for mental health services and community health services), in 2013-14, we will move to monitor those contracts together and jointly hold those providers to account for the quality and value of services they provide.

In addition to strengthening these existing relationships, we will be creating new commissioning relationships with both public health and the NHS Commissioning Board's Local Area Team (LAT). The local public health team is moving out of the NHS and into the two unitary authorities, taking with them commissioning responsibilities for, amongst other areas, sexual health, substance misuse, and smoking cessation. It would be difficult to commission outcomes for these services without considering the impact on use of emergency departments, general practice, and other CCG-commissioned healthcare resources. Similarly, whilst the CCG retains commissioning responsibility for care of infectious diseases, we are reliant on public health support to ensure our commissioning specifications have taken into account issues such as outbreak management and contact tracing. Therefore, in 2013-14, we will continue to develop our partnerships with the local authority-based public health teams to ensure the fragmentation of commissioning responsibilities does not lead to loss of resilience within overall healthcare provision.

The NHS Commissioning Board LAT is responsible for commissioning primary care services, including general practice, dentistry and optometry, and screening and immunisations. As a CCG, we retain responsibility for improving quality in primary care, vision services overall, and we will also feel the impact of the success or otherwise of screening and immunization programmes. It is therefore in our strong interests to develop close working relationships with the new teams in our LAT, and we look forward to doing so once they are in post.

The place where all health and social care commissioning– CCG, social care, public health and NHS Commissioning Board – comes together in each unitary authority is at the Health and Wellbeing board. Each of the two local Health & Wellbeing Boards served by BCCG have agreed priority areas on which we

will all focus (see section 1). The Boards will hold us to account on our collaborative efforts to address those priority needs, as well as improve the overall health of the local populations. The CCG plays a strong lead role in both Boards already. Each Board has as its vice-Chair, a clinical leader from the CCG: the CCG's chief clinical officer was appointed as vice-chair for Central Bedfordshire's Board, and the Bedford Borough locality chair for Bedford Borough's. Although constituent members of the board were involved in the development of this set of CCG commissioning intentions, in future, as the new commissioning entities (such as the LAT) take shape, we will involve the Boards themselves to a greater extent than has been possible so far in the development of subsequent commissioning intentions.

12. Business rules and contractual proposals

As we move into the contracting round for 2013/14, BCCG would like to draw providers' attention to our headline intentions, business rules and contracting proposals for 2013/14.

The health economy continues to face a period of unprecedented change and financial challenge thereby increasing the need for our providers to deliver both improved productivity and performance. Our aim is to ensure that resources are targeted effectively to maximise patient treatment and care, and that parity of charging and coding exists between providers.

This is not an exhaustive list, and will be further informed by our plans together with the Midlands and East Commissioning Framework and by the recent publication of the Planning Guidance for 2013/14 and CCG financial allocations alongside the Road Test Tariff for 2013/14. However, we thought it would be helpful to draw providers' attention to some of the key areas of focus for the coming year.

Finance

2012/13 was a challenging year financial for the PCT/CCG. During 2013/14 Bedfordshire CCG will be working hard with our partners in the local health system to ensure we balance our books, however it is clear that the challenge will continue into 2014/15 and beyond, with further requirements for improving productivity and ensuring that our commissioning plans are cost effective with no compromise on quality. Providers should therefore ensure that their own plans reflect these requirements, and should not anticipate the same level of income for 2013/14 that they have received in previous years. To achieve financial resilience, reductions on 2013/14 outturn are required across all providers, and further reductions will be necessary in the coming year to ensure the health system is in balance going forward. We expect the system wide QIPP plan and implementation to support the delivery of this.

- Block elements to Cost per Case or shadow – for elements where we currently operate a block arrangement, what remains block or what moves to either cost-per-case from 01 April or use first 6 months to identify appropriate levels, etc.
- Continued process for emergency re-admissions with reduction in contract value to reflect these rates.
- Non PBR Prices (Excluded HRGs/Other non PBR) – comparison with range of other provider prices and discussion on variances. Expectation of national deflator being applied when information is published.
- Where applicable agree a local tariff for 'one stop shop' activity or a local price / pathway price for agreed clinical pathway changes i.e. clinical triage and signposting at A&E.

Contract management

At the current time we continue to assess the full impact of the Planning Guidance for 2013/14 and CCG financial allocations. It is the intention to agree contracts that incorporate the key requirements of these documents once published and we will seek to update our intentions and introduce such national or regional requirements into the discussions as they become available. We will undertake a review of the key schedules within our contracts as per the requirements of the relevant contract Guidance. As a minimum this will include:

- Activity & Finance schedules
- Quality and Performance indicators
- Information requirements
- CQUIN schemes

As part of the transition of responsibility for commissioning to CCGs and other statutory bodies, the CCG requires that all contracted activity, whether PbR or non-PbR, be provided at an individual patient level. In particular, it is essential that all non-PbR activity and costs are attributed to practices at MDS level using the standard practice codes. This will allow all activity and spend to be validated and reconciled to each GP practice at a CCG level to ensure accurate activity and financial performance monitoring. We will stipulate the minimum data requirements that all providers will need to comply with to ensure that data is supplied in a consistent and standardised format to aid and improve performance analysis. Unless specifically agreed in writing in advance of contract signing, BCCG will not pay for any activity which does not meet these minimum requirements to identify a patient and their practice.

Coding & counting

To ensure fairness and parity between all our providers in their coding, counting and charging of service activity, all providers contracted with in 2013/14 will be required to abide by our policies and protocols, including low priority and prior approval, even if these are not consistent with the Trust / Provider host. For clarity, this includes those Trusts where BCCG will not be the host commissioner. Referrals will specify clearly when patients are being referred for a clinical opinion. We intend to adopt any PbR mandatory tariff items, including without limitation, Best Practice Tariffs (payments in respect of the treatment of the individual patient not as a cohort), new Critical Care (adult and neonatal) tariffs and any new PbR terms which link the tariff (or a percentage of the tariff payable) to a delivered outcome.

Where providers claim / seek to claim Best Practice tariff they will need to demonstrate and evidence best practice is being delivered and adherence to the full requirements of the Best Practice tariff.

Coding review/monthly query processes

During 2013/14, BCCG is undertaking a full coding review of activity undertaken at its main providers. This will incorporate a review of local pricing and reference cost submissions by the trust and the application of PbR Guidance. Recommendations from this review will be taken forward in the Activity & Finance plan for 2013/14 and will be incorporated into the CCG's routine query processes.

High costs drugs & devices

Drugs excluded from contracts will be commissioned in line with the Midlands and East Commissioning Arrangements for high cost drugs and devices and processes outlined within this document. This requires providers to use notification and prior approval forms for certain excluded high cost drugs. It also outlines the minimum dataset required to validate high cost drugs and chemotherapy.

If the processes outlined are not followed and if the data fields for Drugs, Devices and chemotherapy (including indication) are not fully completed then BCCG will not fund costs outside tariff. Where a drug is not on the relevant hospital formulary, the secondary care clinician cannot refer back to the patient's General Practitioner for prescription of this drug. BCCG require a full open book accounting and patient administration recording systems on such purchasing.

Productivity metrics

We will seek to build on existing schemes, developing new metrics to support improved quality and patient experience and cost effective use of resources. This will include a review of:

- Surgical threshold policies
- Further Improvement in New to Follow Up Ratios
- Areas for clinical audit
- Low clinical priorities and interventions with limited therapeutic value
- Conversion ratios to be achieved in key areas ie Elective Spells following an Outpatient Appointment and Non Elective spells following an A&E attendance
- Penalties where discharge summaries or outpatient letters are not received or the information contained in this type of correspondence is incomplete, incorrect or missing.

Prior approval schemes, surgical threshold policies and low clinical priorities

BCCG will monitor providers rigorously against all such schemes and where activity is not in accordance with these, payment will not be made.

Discharge communications

We would expect providers to be demonstrating tangible and measurable improvements in the quality of discharge communications from A&E, outpatient, admitted patient care and other services. The quality should include:

- Timeliness – in line with contractual parameters
- Appropriateness – information that is useful to manage patients in primary care
- Diagnostics – information should include what tests have been conducted and what results were found

Treating patients in turn

The CCG will agree with providers appropriate average duration of waits by specialty so as to maintain, as a constant, the throughput in planned care. This is to ensure that as far as is practicable patients are

treated in turn at the specialty level within the 18 week pathway, and that activity is demand and not capacity led.

Consultant to consultant referrals

The CCG will be undertaking a review of its Consultant to Consultant referral protocol and activity under this heading. The aim is to ensure that pathways are clear, patients are referred to the right specialty first time and the number of consultant to consultant referrals is significantly reduced from historic levels. There is an increase in the "other" referral category, and the CCG will be reviewing this to ensure that referrals are appropriate.

Outpatient procedures V day case

The CCG expects that where a procedure can be delivered in an outpatient setting, where appropriate this should be undertaken rather than as a day case. These procedures should be coded accordingly; as a principle BCCG will not pay the day case rate where a procedure should be delivered as an outpatient, unless a clinical justification can be made.

Should there be any subsequent issues that arise that would have a material impact on this contract, we will notify you as soon as possible as part of our contractual negotiations. We look forward to discussing these elements with you and your team in the coming weeks.

Contract Tolerances

To incentivise providers to work together to jointly manage demand and the financial risk associated with it more effectively we will seek to agree contract tolerances and marginal rates for over performance on elective work in addition to any provisions as set out in the 2013/14 PbR guidance or Operating Framework.

13. Summary and conclusions

The BCCG strategic approach to commissioning better value healthcare for Bedfordshire residents is the key focus for moving our strategic intentions for 2013/14 forward. Our commissioning intentions to deliver the vision and commitments outlined in this document will be followed through with robust delivery plans, developed in partnership with providers.

The commissioning intentions outlined in this document will inform contract negotiations for 2013/14; however, amendments may be necessary as the implications of the 'Healthier Together' programme and the Planning Guidance for 2013/14 and CCG financial are fully explored.

We have used the prioritisation process to determine and refine our commissioning intentions to achieve the highest quality health care providing the best patient experience possible within available resources. Where it is determined this is not possible we will work with providers to identify further initiatives, re-commissioning or potential decommissioning required to balance within the funding available. We are an evolving organisation, and as our partnerships with patients and the public, the NHS Commissioning Board, Local Authorities and other clinical commissioning groups mature, our intentions and plans will evolve with us, becoming increasingly responsive to the best patient experience possible within available resource.

Appendix 1

You told us....we did!

You told us....we did!

Here are a few examples of some of the plans we are working on because of the things that patients, carers and the public and health care provider organisations and charities told us during the commissioning intentions workshops:

Integrated Care

You told us that today…

- There are a number of different care providers serving one community with inconsistencies in the quality of care that is provided, particularly within the services you pay for
- Services are not joined up, when there are issues with care patients are unsure about which organisation or service this should be raised with.
- There is a lack of continuity of care. People with long term conditions may have times when they are well and need less care; however, if a condition then deteriorates it feels like you start at square one again when you need to access services.
- People should be able to stay in their own home as long as they want
- Care organisations are concerned with who will pay when needs span health and social care
- ***Care pathways are fragmented, they do not integrate, there needs better understanding between care providers about how patient pathways move through services***
- ***There is a lack of financial incentive to integrate care***

That your priority is….

- A care coordinator role that understands the links with Social Services, Charities, Schools, Citizens Advice to direct people to the right care when needed.
- Developing the Primary Care Health team to include older peoples consultants, working alongside GPs, Practice Nurses and district nurses etc. to provide expertise and support for complex care needs
- Patient information systems and care records need to be able to share information across services; *Interoperability to improve integration of IT systems*
- ***Joint contracts for health and social care services that are based on patient outcomes***
- ***Look at the bigger picture; work closely with other Clinical Commissioning Groups which share services, avoid piecemeal changes and fragmented commissioning***
- ***Everyone understands their part of the patient journey***
- ***Carers needs being met***

We did …..

- **Identify Integration of care as key focus for 2013/14.**

An integrated care pathway is a multidisciplinary outline of anticipated care, involving all relevant services and staff, placed in an appropriate timeframe to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes. By listening to both patient's, public, carers and care provider organisations we heard that a number of the service improvements we highlighted were closely linked to providing an integrated, joined up approach to care, e.g. the Care coordinator role and developing multidisciplinary teams within primary care. We heard that small, piecemeal changes have minimal impact upon ensuring that services are joined up and well-coordinated. We have therefore considered each of the service improvements that are interdependent to developing integrated, joined care and included them in a system wide programme of change in order to deliver integrated services.

Bedfordshire CCG will be working with each Local Authority to develop local plans for addressing challenges between health and social care and voluntary services. We expect to deliver a shift in care provision away from acute hospitals toward community settings where it is safe and effective. We will develop commissioning plans for implementing the outcomes and recommendations of the community bed review, which will aim to deliver more joined up care for the benefit of local people and carers. In partnership with local authorities we will implement recommendations within the National Dementia Strategy, which focuses upon early diagnosis and intervention, increased quality of care in general hospitals, living well in dementia care homes and a reduction in inappropriate use of antipsychotic drugs. Where there is joint funding of services, commissioners will come together to jointly manage performance e.g. SEPT community health services.

Care Closer to Home

You told us that today…

- There is not enough access to specialist advice from staff other than consultants e.g. specialist nurses
- That there are gaps in information and advice between the GP and hospital services and then from hospital to home
- GPs need more support and information
- ***There is a lack of capacity to support individuals in the community***
- ***There needs to be increased self-management information and advice***

That your priority is…..

- One stop clinics/services (where you are able to see a specialist e.g. consultant/specialist nurse, have your tests and receive a diagnosis and management plan in one visit) are seen to be a good way to see the right person first time

- GPs with specialist interest seeing patients in the community/surgeries
- That, where clinically appropriate, community based services, closer to people's homes, with specialist multidisciplinary staff and more convenient opening times e.g. evening and weekends is preferred to multiple hospital appointments.
- Access to talk to a suitable clinician on the phone; could be a nurse specialist
- Access to continued care through clinicians that is quick and easy

We did….

- **Commission Care Closer to Home services commencing in 2013/14**

Planned pathways of care are those where people will have planned operations or hospital appointments. In 2013 new services will commence within a range of specialties; musculoskeletal, cardiology, dermatology, vision, urology and gynecology. Services will be provided within community-based settings, closer to people's homes and at times, such as evenings or weekends, which are more convenient. These services will also focus on improved access, offering telephone advice and/or fast track appointments for people with existing long term conditions that may be deteriorating. These services will provide specialist expertise from a range of staff including Consultants, Nurses, physiotherapists etc. Where possible, one stop services will mean people can see the specialist, have tests, and receive a diagnosis and a management plan all on one visit. This means people will not need to visit hospitals for multiple appointments.

Out of Hours Service Review

You told us that today…..

- Increased out of hours support is needed to avoid inappropriate use of A&E
- Extended opening hours should be accessible in all surgeries
- ***Need to redesign the primary care platform to see GPs & Consultants working together***

We did…

We will review these services in order to:

- Examine the impact of extended opening hours of OOH services from 6pm rather than 6:30pm to respond to a peak in activity at this time at A&E as a result of GP surgery closing times.
- Examine the impact of out of hours GP services being able to perform basic diagnostics e.g. ECG and blood tests, on A&E demand.
- -Explore the options for out of hours service provision where there are opportunities to improve patient experience

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Transition from children's services to adult services

You told us that today….

- Teenagers and young people fall between services
- Schools, local authorities and health do not provide a joined up approach to supporting children and young people
- There should be a flow from childhood to adulthood without a disruption in care
- ***That there is a grey area between paediatrics and adult care due to dependence whether an individual is in education***

We did….

Will audit transition pathways for young people to test the effectiveness and implementation of the Multi Agency Transition Tool (MATT), This is a tool which will be used across all agencies (Health, social care and education) to support individual planning needs and ensure smooth transition from children to Adult services.

Key:

Patients, Carers and Public Deliberative Event feedback: Is in plain font

Health Care Provider and Charities Deliberative Event feedback: ***Is in italic font***

Bedfordshire Clinical Commissioning Group

Appendix 2

Commissioning Intentions Outline

By Domain, BCCG Vision and Local Authority

NHS Outcomes Framework Domains	*BCCG Key Area of Focus & Cross Cutting Themes*	*Central Bedfordshire Borough Council*	*Bedford Borough Council*
Preventing people from Dying Prematurely	**Care Right Now**	• *Falls Prevention* • *Out of Hours Dressings* • *Out of Hours GP services* • *Maternity Tariffs*	• *Review of walk-in centre services* • *Falls Prevention* • *Out of Hours Dressings* • *Out of Hours GP services* • *Maternity Tariffs* • *Looked After Children*
Enhancing quality of care for people with long term conditions	**Care For My Condition Into The Future**	• *Musculoskeletal Services* • *Cardiology* • *Ophthalmology* • *Dermatology* • *Gynaecology* • *Neurological disorders* • *Stroke* • *Cancer Pathways* • *Community Mental Health Teams* • *Primary Care Mental Health Services* • *Dementia* • *Multi-Agency Transition Tool* • *Children with Long Term Conditions* • *Medicines Management* • *Looked After Children*	• *Musculoskeletal Services* • *Cardiology* • *Ophthalmology* • *Dermatology* • *Neurological disorders* • *Stroke* • *Cancer Pathways* • *Community Mental Health Teams* • *Primary Care Mental Health Services* • *Dementia* • *Multi-Agency Transition Tool* • *Children with Long Term Conditions* • *Medicines Management*

Helping people recover from episodes of ill health or injury	**Care When it's Not That Simple**	• *Integrated Care* • *Personal Health Budgets* • *Liaison Psychiatry* • *Complex needs* • *Children with Special Education Needs and Disability*	• *Integrated Care* • *Personal Health Budgets* • *Liaison Psychiatry* • *Complex needs* • *Children with Special Education Needs and Disability*
Ensuring that people have a positive experience of care	**Safety & Patient Experience**	• *Review of all patient experience and engagement intelligence to ensure it is utilised to inform and influence the design of services.*	• *Review of all patient experience and engagement intelligence to ensure it is utilised to inform and influence the design of services.*
Treating and caring for people in a safe environment and protecting them from avoidable harm	**Safety & Patient Experience**	• *Patient safety & clinical quality indicators in all care provider contracts* • *Analysis of quality of quality data and information from providers to ensure early detection of quality issues* • *Review of all serious incidents, events and complaints, ensuring corrective and preventative action is taken and lessons learned are widely disseminated* • *Review Safety Alerts and published reports and consider implications to commissioned services and ensure providers implement actions within timeframes* • *Ensure that Commissioning, Quality and Innovation (CQUIN) proposals are appropriate, challenging and lead to significant improvement in quality of services and outcomes for patients*	• *Patient safety & clinical quality indicators in all care provider contracts* • *Analysis of quality of quality data and information from providers to ensure early detection of quality issues* • *Review of all serious incidents, events and complaints, ensuring corrective and preventative action is taken and lessons learned are widely disseminated* • *Review Safety Alerts and published reports and consider implications to commissioned services and ensure providers implement actions within timeframes* • *Ensure that Commissioning, Quality and Innovation (CQUIN) proposals are appropriate, challenging and lead to significant improvement in quality of services and outcomes for patients*