NHS
Bedfordshire
Clinical Commissioning Group

# Bedfordshire Plan for Patients

## Executive Summary:
## Background and context:

This document, the Bedfordshire Plan for Patients, is a technical commissioning document that takes our strategic starting point and applies it to the Bedfordshire health economy in the 2013-14 financial year, with indications of intent in 2014-15 and 2015-16. It sets out the projects and changes that will occur during the year to improve the quality and safety of care within the financial envelope available. It also sets out the ensuing implications on clinical pathways, activity in the main categories of healthcare provision, and expected shifts in workforce patterns. As well as the intentions of us as commissioners, it takes into account the plans of the major providers serving the Bedfordshire population. It is therefore a tool that can be used to monitor progress and delivery across the health and social care system of Bedfordshire during and after 2013-14.

Bedfordshire Clinical Commissioning Group's (BCCG) total population of 441,766 is split between the two unitary authorities with 165,270 residents in Bedford Borough and 276,496 in Central Bedfordshire. As in many parts of England, significant increases in the numbers of older people are expected over the next five to ten years. Around 3,300 deaths happen each year, of which one third are of people aged under 75, i.e. premature deaths. The 'big killers' of circulatory diseases, cancers and respiratory diseases are significant contributors to the life expectancy gap, as they are to overall life expectancy. In particular, cardiovascular disease is the single biggest driver of the life expectancy gap between the most deprived and least deprived.

During 2012/13 the shadow CCG began to operate in full shadow form. It took on formal delegated budgets from the Cluster PCT, built on its existing leadership of the 2011/12 QIPP Programme, led the main provider contracts and developed its joint work programmes with Local Authorities. BCCG used 2012/13 to invest in the infrastructure to support an effective quality and safety function. BCCG's overall strategic approach includes a focus on delivery of improved patient outcomes, with the recognition that this will require development of new ways of commissioning and contracting. As a result, during 2012/13, BCCG has been at the forefront of innovations in commissioning approaches, with its procurement of a system of musculoskeletal care which incentivises providers to collaborate to deliver improved outcomes for patients within an agreed overall budget.

BCCG is 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. In addition to strengthening these existing

relationships, we will be building new commissioning relationships with both public health and the NHS England's Local Area Team (LAT). In 2013-14, we will also 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 place where all health and social care commissioning– CCG, social care, public health and NHS England – 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. 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. Both Health & Wellbeing Boards have developed their strategies and set out strategic priorities and this Plan for Patients plays a significant part in delivering against both sets of priority measures.

BCCG is already laying a strong foundation to build upon in its approach to working in partnership with patients, carers and the public. Understanding and listening to patient, carer and community views is critical to delivering health care improvement. BCCG's involvement of LINks and other public and patient groups can be seen in 2012/13 with the patient and public deliberative event that informed BCCG's commissioning intentions, in the involvement of LINk representatives in unannounced visits to community units, and in its support of a variety of partnership boards that bring together service user and carer representatives.

During 2012/13, BCCG has also established systematic ways to routinely and methodically capture the views and experiences of patients/service users, carers and the public. These will become embedded during 2013/14 and increasingly used as sources of 'intelligence' to complement hard data on health need, benchmarking and evidence of best practice.

Information on clinical quality comes from routinely reported data sets, regulator reviews, and the work of BCCG's Quality and Safety team. Together, these sources provide rich evidence on the state of care experienced by patients. The quality monitoring process in relation to all our large provider contracts includes a quarterly face to face review. This review is based on intelligence provided by the provider (in the case of largest contracts, usually a hospital) in relation to the CQC outcomes framework. There is a detailed review of incidents, complaints and intelligence in relation to patient experience that may come from external bodies including LINks/HealthWatch or GP practices. The other important source of intelligence in relation to provider quality and patient experience are the safeguarding alerts and investigations.

In 2013-14, Bedfordshire CCG will invest its resources in a range of NHS, private and voluntary agencies. Bedfordshire contains one local hospital (Bedford Hospital NHS Trust, 2012-13 contract size £119 million). The Bedfordshire population also routinely use the services of five other hospital sites in surrounding areas.

Despite good clinical performance, Bedford Hospital's Trust Board has recognised that the Trust will not be either clinical or financially viable or sustainable in the long term. This means it would not be able to reach Foundation Trust status as a standalone organisation. In October 2012, Bedford Hospital developed an Outline Business Case on a merger partnership with Milton Keynes NHS Foundation Trust. This will be further explored with the NHS Trust Development Agency and Monitor in the early part of 2013/14. Bedford Hospital required financial support to break even in 2012/13 and faces another significant financial challenge in 2013/14.

Most adult and children's community services in Bedfordshire are provided by South Essex Partnership NHS Foundation Trust (SEPT), with a 2012-13 contract valued around £36 million per annum and running until August 2014. SEPT runs community bedded units at the Archer Unit (Bedford), Biggleswade Community Hospital, and provides therapist input to specifically commissioned beds within two nursing homes (the Taymer and the Knolls, both in Central Bedfordshire). Their strategic direction is to move to greater, potentially universal, use of virtual wards with patients cared for within their own homes.

SEPT is the largest provider of mental health and learning disability healthcare in Bedfordshire. Their service covers in-patient and community mental health teams, learning disability in-patient and specialist teams, a memory and dementia service for the over-65s, and a crisis team.

In 2011, the NHS in Bedfordshire, Luton, Milton Keynes and Northamptonshire formed 'Healthier Together', a programme to review the way our hospital services are delivered.Six Clinical Working Groups (CWGs) were created with the mandate to consider how we improve the quality and outcomes of services for the population while ensuring that each of the five hospitals retains A&E and maternity service as well as outpatient appointments and many other routine services. The reports were completed in late 2012 and will form the basis for discussions with the local clinical workforce and the local populations to make recommendations for the future. As a result of a number of factors, the Healthier Together programme board made the decision to close the programme in its current form at the end of March 2013. However, the important work of the programme (including the Clinical Working Groups' reports) will not be lost and will be taken forward by the CCGs in more local programmes.

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%. Programme budgeting information suggests that one third of the CCG's total

available budget is spent on just three clinical areas: mental health disorders, circulatory problems and cancers.

The challenge for the CCG is the difference between its anticipated resource growth and the pressures it faces from pay and price pressures (i.e. increasing costs of drugs and devices), demand and quality pressures (growing and ageing population) and local underlying pressures arising from known differences between actual current expenditure and the allocation of resources through the exercise undertaken to establish CCG baselines (e.g. Continuing Healthcare), less the benefit it receives from providers from the nationally agreed 1.3% reduction in tariff. In 2013/14, the CCG's financial challenge has been calculated as £15.7 million.

The financial plan allows for 2% of the overall commissioning budget to be set aside to fund transformation within the local health economy.

The main operational areas of risk to the overall Bedfordshire position for 2013/14 relate predominantly to continuing care retrospective claims and secondary care commissioning both in terms of activity growth exceeding the levels assumed within plans/contracts and non-delivery of planned change programme savings. Other risks include Specialist Commissioning Group (SCG) take versus actual SCG spend currently within contracts, unplanned costs arising from the Pathology redesign and a local provider that is currently financially unsustainable.

In response to these risks the CCG will:

- robustly manage acute contracts including sharing contract forecasts, monitor, validate and challenge activity/finance with providers
- review expenditure to ensure that it is consistent with the basis on which CCG allocations were made, identify areas where this is not the case and correct any errors (e.g. SCG/Enhanced Services)
- work to ensure pathology implementation delivers potential benefits
- review continuing care to minimise procurement costs and fully understand the potential impact of retrospective CHC claims,
- deliver the required level of savings to ensure maintenance of financial balance through rigorous programme management approach to our change programme

In addition to the mitigating actions detailed above the CCG has also increased its contingency reserve from 0.5% to 1% to manage any higher than planned variations in activity.

## Objectives of the Bedfordshire Plan for Patients 2013/14

Our vision considers all aspects of health and social care in Bedfordshire. It is clear that traditional concepts of secondary care, community care and mental health are no longer suitable to describe the integrated system of care required in the 21st Century. The discrete silos of current healthcare provision are replaced with a model more suited to the predominance of long term conditions experienced by our population. In our model, the primary aim is to support patients to be self-caring and independent, with much less reliance on specialist intervention.

The specific objectives of this operational plan are set out in the three strategic areas of focus described in BCCG's strategic commissioning plan. In each area, BCCG has established a strategic aim, a longer term strategic outcome measure (linked directly to the 2013/14 NHS Outcomes Framework) and an annual priority measure (which may be a process measure designed to ensure delivery towards the relevant overall outcome). The plan's strategic approach and objectives tie in completely with the 2013-14 NHS Outcomes Framework and our two local Health & Wellbeing strategies, as set out in the table. In addition, they also support work to reduce inequalities in health as identified in the November 2012 reports for each local authority by the Director of Public Health.

### *Care right now*

The existing system of urgent care can be confusing and duplicative, resulting in a less than optimal patient experience and inefficient use of resources. We will review and improve patients' access to "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.

***Locally identified priority measure: Improving patient experience of general practice services, measured using the Friends & Family (net promoter) test, such that the net promoter score is 5% better in Quarter 4 (Jan-March 2014) than in Quarter 1 (April-June 2013)***

### *Care for my condition into the future*

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.

***Locally identified priority measure: In the 20% most deprived population of Bedfordshire, increase the number of smokers who have quit for 4 weeks by 15% more than the 2012/13 target***

***Care when it's not that simple***

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.

***Locally identified priority measure: Increase to 47%, the proportion of people able to die at their usual place of residence***

## Activities to be delivered

1. Improving quality in primary care

We have predominantly high performing GP practices that are committed as providers and commissioners to improving healthcare for their local community. Our practices are relatively low referrers to hospital and have reduced variation in their prescribing to an extent that, nationally, they are among the highest quality prescribers of antibiotics.

However variation in quality, access, productivity and outcomes between our practices is still too great. We recognise that general practice is subject to its own demand and quality challenges coupled with recruitment and retention problems. Primary care clinicians and practice managers have developed a new primary care quality framework for 2013/14. Our practices and localities already hold each other to account for the quality of services that they provide and will continue to support and help each other through the changes ahead.

2. Better value through effective contract management

Effective contract management will be delivered through a combination of continual review and challenge of coding and counting with its providers as well as driving improvements in patient care with initiatives such as reducing variation between providers in excess bed days and eliminating unnecessary follow up outpatient appointments. The CCG has established a revised consultant to consultant referral protocol and will audit these referrals closely to ensure that providers are remunerated for only those that are necessary and within the parameters of the protocol.

The planned total productivity opportunity from effective contract management will be £5.518 million.

3. Programme delivery:

*(a) Urgent care & integrated care (total productivity opportunity = £1.7million)*

In 2013/14 we aim to achieve:

1. provision of proactive rather than solely reactive care
2. development of 'people-' rather than 'organisation-' focussed care pathways
3. Improvement in experience and outcomes for patients and carers
4. the system coming together to deliver care pathways in a more integrated way
5. the whole system coping better with urgent need
6. support for providers to reduce capacity in acute facilities

This will require a different approach to commissioning healthcare locally. We would see the establishment of provider partnership groups, incentivised in the right way, to collectively own the challenges we face and collectively own the solutions in a cost effective and clinically effective way. This innovative and partnership model is driven by the following principles:

1. provide services that work together to help people stay well and supported in their own home
2. improve quality and patient experience and outcomes
3. care is evidence-based and safe
4. the overall pathway us financially affordable and sustainable

This will require a shift away from hospital focussed, to community-focussed care.

Financially, providers will asked to come together to operate integrated care within indicative budgets and an ability to draw on transformational funds to accelerate the required transformational change and improvement in patient pathways and patient outcomes.

In urgent care, the work programme includes reviews of walk-in centre services and out of hours GP services.

*(b) Maternity and children (total productivity opportunity = £0.16 million)*

We will prepare for new maternity tariffs to look at financial implications for local acute trust maternity services, and examine in detail differences in admission rates for local maternity units, developing plans to address any inconsistencies in line with best practice.

We will be working with local acute and community providers to develop local pathways to support an effective treatment for children and young people with long term conditions, in particular Asthma, Epilepsy and Diabetes.

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 findings of the Healthier Together programme to commission an up to date model of care.

*(c) Planned Care (total productivity opportunity = £1.3m)*

A well-defined list of specialties are, in most cases, in the latter stages of redesign and will go live within 2013/14. These include an integrated musculoskeletal system of care, cardiology, ophthalmology, dermatology, neurology and stroke care.

*(d) Mental health and learning disabilities (total productivity opportunity = £0)*

Much of the work in this programme will be in determining the value of services currently provided and deciding strategic priorities for the future re-procurement of mental health services within the existing budgets assigned to mental health. However, particular focus in 2013/14 will be placed on the expansion of community mental health teams and primary care mental health services, as well as improved diagnosis and early intervention for people with dementia, and improved access to psychological therapies.

*(e) Quality and productivity of primary care (total productivity opportunity = £6.97m)*

Building on the need to improve quality in primary care, this programme incorporates both the medicines management plans (based around optimisation of patients' medications) and plans to reduce unwarranted variation in referral rates and utilisation of services outside primary care. This work will predominately take place at locality level.

## Quality impact assurance of provider cost improvement plans

In order to gain assurance of quality and safety, BCCG are checking that providers have focused on the impact on quality of their identified CIPs and that a quality impact assessment has been completed and approved by the provider's board. The principles within the 'Star chamber' approach have been adopted as part of the quality review and Integrated Performance meetings. Sign-off of all provider cost improvement plans will be completed during April 2013.

## Activity and workforce

Activity levels across each main form of acute activity (A&E attendances, elective and non-elective admissions, and outpatient attendances) are expected to shift out of hospital and fall compared with 2012/13 planned rates.

For Bedfordshire, workforce figures show an overall decrease in staff in post and an increase in pay-bill due to staffing costs increasing in line with annual increments. In community and mental health services, there is little predicted change over the whole workforce but this is net result of changes to different workforce groups. These changes include a growth in nursing, a reduction in clinical support and small reduction in infrastructure support. The medical and scientific workforce are predicted to remain constant.

In Bedford and L&D hospitals, numbers of staff in post are predicted to fall over the next five years. This reduction is applied broadly across all workforce groups with the largest change occurring in the administrative staff group.

## Delivery and assurance

BCCG has established a Patient Safety and Quality Committee (PSQC) as a sub-Committee of the BCCG Governing Body. The Committee will provide the BCCG Governing Body with assurance that appropriate processes are in place to demonstrate effective delivery of the organisation's priorities and objectives in the context of patient safety, clinical effectiveness and patient experience. Quality risks will be managed in line with BCCG's Risk Management Framework. BCCG, with support from the Commissioning Support Unit (CSU), will deliver the development, negotiation and monitoring of quality outcome measures within annual contracts with providers.

Bedfordshire Clinical Commissioning Group has noted the recommendation within the Francis report that GPs will need to undertake a monitoring role of behalf of their patients in relation to acute care and other services. There is recognition that "the GP role does not end with the referral". We already have good examples of GP involvement of monitoring the pathways in relation to Stroke pathways in both main Acute Trusts; this principle will continue.

In order for any plan to be successful and deliver it requires a solid framework within which to work. The local system utilizes a framework based on sound, internationally recognised methodologies. The schemes for change are grouped into Programmes each of which is governed by a clinical Senior Responsible Owner (SRO). This methodology ensures that work is both clinically led and assured, and that clinical, ethical and financial commitments can be owned accountably and effectively within the Group. Teams of service redesign managers and project managers manage the grassroots delivery of change; specialist support within these projects is provided by our commissioning support service.

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

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

Locality representation is embedded in the process through input into the planning of the contracts required by locality teams and also their engagement with programmes led by the service redesign team.

The use of programme boards to oversee the development and implementation of projects and delivery of programme objectives ensures regular and consistent input from CCG localities, local authority commissioning partners, health and social care providers, patients and carers, and patient/public representatives such as HealthWatch and service user groups. Community engagement and consultation is a significant and important aspect of any organisation or service if that organisation is to plan and deliver services that meet the needs of individuals in local communities. Whilst any methods of consultation and engagement used are generally suitable for all communities, there are certain aspects and issues that need additional consideration for minority groups. BCCG will ensure they consult their local diverse population as appropriate and that Equality Impact Analysis is undertaken on all projects and proposals to engage and involve stakeholders and reflect the importance of inclusivity and the demographics of Bedfordshire.

The full Bedfordshire Plan for Patients document can be found here .