NHS
Bedfordshire
Clinical Commissioning Group

DRAFT Strategic Plan

Bedfordshire Health & Social Care System

2014-2019

Contents

1. Background and Context

National Context

Everyone Counts: Planning for Patients 2014/2015 to 2018/19, published on the 19th December 2013 sets out planning parameters for NHS Commissioners. For the first time commissioners are being asked to plan on a 5 year trajectory. This is to enable the NHS to:

- Make transformational changes and improvements
- Put outcomes at the heart of Commissioning Plans
- Adopt a strategic approach to the financial challenges faced by the NHS over the coming five years
- Make significant improvements to the quality of care provided to our patients

National Planning Guidance requires that individual units of planning develop a five year system strategy 2014/15 to 2018/19 with key deliverables for the first two of those years articulated via:

- A CCG Operating Plan
- A CCG Financial Plan
- A Better Care Fund Plan
- Individual Provider Plans
- An NHS England Area Team Direct Commissioning Plan

Local Context

We know that not all local services are currently coping well with patient needs. Patients and the public have told the CCGs and NHS England (in our area) repeatedly that services are difficult to navigate, are often impersonal, and people fall through the cracks between different providers. Evidence shows that today's local healthcare services are fragmented, inequitable and inefficient and do not deliver the best possible outcomes for patients.

If we do nothing, the situation will worsen: we will have old-fashioned models of care that do not attract staff to work here, services that become increasingly overstretched and potentially unsafe, and growing financial pressures that cannot be addressed. This will all result in patient care suffering.

Therefore, Bedfordshire CCG, Milton Keynes CCG (who face similar challenges) and NHS England have decided to work together to review more of the local healthcare system at the same time. This collaboration in no way implies that, at the end of the review, the same solutions or recommendations will be applied to healthcare across Bedford Borough, Central Bedfordshire and Milton Keynes. Any commissioning decisions will be made independently by each CCG on behalf of its own local population.

BCCGs dedicated website http://www.yourhealthinbedfordshire.co.uk/ maintains an up-to-date account of the significant patient, public and stakeholder engagement that is in progress as part of this review. A full account of the challenges faced by the Bedfordshire system is described within the Case for Change. The review aims to produce, by July 2014, a range of options for delivering affordable high quality healthcare now and into the future for the people of Bedford Borough, Central Bedfordshire and Milton Keynes.

Local Context

Your Health In Bedfordshire

These options will then be taken through a formal consultation process with the public and other local stakeholders to inform the CCGs' and NHS England's final decisions on the best services to buy for our patients within our available resources.

Our aims are to redesign services so that:

- People are able to take better care of themselves and lead healthier lifestyles, as well as knowing where to access the professional support and advice they need to manage their own conditions.
- Older, frailer people are supported to maintain their health, dignity and independence at home.
- People can easily access their doctor or other primary care clinician when they need urgent healthcare by phone, email and face to face consultations in local, easily accessible facilities.
- Any specialist, community and remedial services support that is needed will be arranged in a timely way and coordinated on behalf of the person who needs it.
- If people need to be admitted to hospital, it will only be when they require acute specialist care that can't be delivered in community settings. Care will be delivered in properly maintained, up-to-date facilities, seven days a week, by highly trained specialists with the relevant skills

Our aims reflect the needs of our local population. A growing and ageing population, with often multiple long term conditions, modern lifestyles creating additional health problems – e.g. obesity, smoking and alcohol misuse – which are placing an extra strain on the public sector, especially in socio-economically deprived areas and a growing level of inequality in life expectancy in deprived parts of the area create challenges which can not be resolved by simply providing more of the same types of care.

Local Background

Bedford Borough

- Population 159,200
- A lower proportion of older people (16.4% aged 65 and over) compared with the East of England (18.2%) and England (16.9%)
- Between 2001-12, the population of those aged 85 and over increased by 34%, and between 2011-21, it is expected to grow by a further 47%.
- Life expectancy for both men and women is similar to the England average, but with a gap in life expectancy for men of 14.6 years, and of 12.8 years for women, between the most and least deprived areas of the Borough
- The principle causes of differences in life expectancy between the most and least deprived are due to COPD, CHD and lung cancer – conditions closely linked to smoking
- Over past 10 years, all death rates (including premature deaths) from cancer, heart disease and stroke have fallen
- Rates of homelessness, violent crime, long term unemployment and drug misuse and the level of GCSE attainment is worse than average.

Central Bedfordshire

- Population 255,200
- A growing and ageing population, with the number of people aged 65 seeing the most increase between 2010-31(87%)
- Life expectancy for both men and women is higher than the England average, but with a gap in life expectancy for men of 7.4 years, and of 5.5 years for women, between the most and least deprived areas
- The principle causes of differences in life expectancy between the most and least deprived are due to COPD, CHD and lung cancer – conditions closely linked to smoking
- Over past 10 years, all death rates (including premature deaths) from cancer, heart disease and stroke have fallen
- The rate of road injuries and deaths is worse than the England average.

2. System Vision

Building our System Vision

In March, April and May 2014, Bedfordshire System Leaders have met to understand the collective impact of organisational operational plans upon the local health and social care economy and start to set the scene for the creation of our 5 Year Bedfordshire Health and Social Care System Plan.

Our system of planning consists of:

- Bedfordshire Clinical Commissioning Group
- Bedford Hospital Trust
- Luton and Dunstable University Hospital Foundation Trust
- South Essex Partnership Trust
- Bedford Borough Council and Central Bedfordshire Council

As a system, we are mindful that the Review of Healthcare Services in Bedfordshire and Milton Keynes is in progress, and will create a set of options for sustainable models of high quality care, however, our system vision informs our ambitions for improving outcomes for patients and service users in Bedfordshire.

The first two years of this five year vision is described in detail in the BCCG operational plan Bedfordshire Plan for Patients 2014-2016 and reflects the foundations of transformational change in three programme areas:

- Children and Younger People
- Mental Health
- Adults and Older People

As we await the outcomes of the review ,the system ambitions for years three to five are focused upon building upon this foundation to support the overarching aims of the review of healthcare services and develop supportive system-wide pathways of care around the priorities within these three strategic workstreams. Our plan on a page describes these priorities.

Purpose

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

Strategic Priorities

- **To build the relationships across organisations that enable integration of care**
- **To be recognised as a strong clinically led organisation and the local system leader**
- **To create an environment that incentivises the pace of change required for transformation**
- **Improved population health through increased patient empowerment & support**

Strategic Workstreams

Supporting mental health and wellbeing tthroughout life

- Services accessible and available alongside and integrated with physical healthcare and jointly commissioned with Local Authorities where possible
- Improving provision of mental healthcare within primary care
- Preparing for the full introduction of new Payment Systems
- Procure a Mental Health provider
- Improving care for people with complex needs and for those with dementia.

Helping adults and older people maintain a healthy life as long as possible

- Integrating the urgent care system between general practice and hospitals
- Integrating healthcare and social care for people with long term conditions (including frailty)
- Undertake a clinically led local review of hospital and community-based health care services
- Delivering specialist care (such as stroke care) through networks
- Improving End of Life Care
- Transforming Primary Care

Helping children and young people start a healthy lifetime

- Work with our two Local Authorities to jointly develop a Children's and Young People's Plan
- Maximising the wellbeing of mothers
- Developing a 21st Century model of paediatric care; as part of a wider review of local healthcare services
- Improving transition from children's services into services for adults

Integral Threads

Quality, Safety & Patient Experience | **Patient & Public Engagement** | **Prevention & Early Intervention**

Outcome Ambitions

- Securing additional years of life for the people of England with treatable mental and physical health conditions
- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions
- Reducing the amount of time people spend avoidably in hospital through better & more integrated care in the community.
- Increasing the proportion of older people living independently at home following discharge from hospital
- Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
- Increasing the number of people with mental & physical health conditions having a positive experience of care outside hospital, in general practice & in the community
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Building our System Vision

The Bedfordshire Health and Social Care Systems Leadership Group will work in partnership to continue to build, implement and monitor delivery of our 5 Year Strategic Plan. This work will be supported by underpinning priorities and principles for improving outcomes for patients and service users and developing the characteristics of a sustainable, high quality health and care system, described with the national planning guidance Everyone Counts: Planning for Patients 2014/15 to 2018/19 :

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence

System Vision

Ensuring that citizens will be fully included in all aspects of service design and change and empowered in their own care

- Individual participation – people in control of their own care
- Public participation - communities with influence and control
- Insight and feedback - understanding people's experiences

Our Vision for working with citizens is based upon transforming participation in health and social care. In 2019 people in Bedfordshire will be far more involved in their own care and personal experiences will shape all healthcare decisions.

A preventative and personalised care agenda will ensure that the Bedfordshire system proactively engages with local people before they get seriously ill or if ill already, to tailor care to reduce acute episodes. Modern technologies, such as App-driven wellness will support people in a range of activities, from counting steps, to blood glucose monitoring to nutritional information. Healthy lifestyle choices will be supported within every health and care encounter . Improved wellness will be promoted through self –care, assisted living technologies, housing adaptation and support telemedicine/telecare and remote consultations. Dedicated websites and Facebook-style web-based communities alongside shared-decision making tools will help patients, in partnership with health and care professionals, to make decisions about their care which support the goals and outcomes they want to achieve. Evidence suggests that using technology to its full effect is one of the key enablers for integrated care and integrated patient information systems e records and interoperable shared IT systems are a critical factor to joining up care journeys.

People can be supported to take better care of themselves, lead a healthier lifestyle, understand where and when they can get treatment if they have a problem, understand different treatment options, and better manage their own conditions with the support of healthcare professionals if they wish.

Commissioners and providers of health and care services will ensure that the patient, service user, carer, public and community voice is heard and central to all service design and change.

System Vision

Wider primary care, provided at scale

- The development of GP Networks or Federations offering a wide range of community care
- Primary care working closely with specialists and third-sector, private and NHS providers to deliver care in a more integrated and coordinated manner
- The foundation of excellence in the management of long term conditions

In 2019 primary care will undertake a pivotal role as part of a more integrated system of out-of-hospital care. Within general practice patients will be able to receive care from a variety of health and care staff, including GPs, practice nurses, specialist nurses, social workers, phlebotomist, physiotherapists and consultants.

General practices will be operating at greater scale through networks, federations or super-partnerships and working collaboratively with community services, hospitals, social care, voluntary/charitable organisations, community pharmacy and other partners. These primary care networks will improve patient access in each local area by working as primary care teams with 'hub practices'.

These hubs will enable General Practice to take a proactive approach in keeping people healthy; health promotion and ill-health prevention by general practice working in partnership with others is key to reducing morbidity, premature mortality, health inequalities, and the future burden of disease.

Care will be coordinated by a named GP, particularly for people with long term conditions and more complex health problems, to ensure that care is focused on people, not a care pathway or setting. To identify those individuals who would most benefit from a coordinated care package the primary care team will risk assess patients. Risk stratification using information on people's past interaction with health and social care predicts those who need more coordinated support and enables the development of an effective care plan; drawn up by the patient, professionals and carers working collaboratively to review outcomes on a regular basis.

This integrated system of care means patients are less likely to fall "between the cracks" with services coordinated jointly between co-located multidisciplinary teams; self management support is part of routine care for people with long term conditions and ill health is managed in a planned, scheduled way, closer to peoples homes.

System Vision

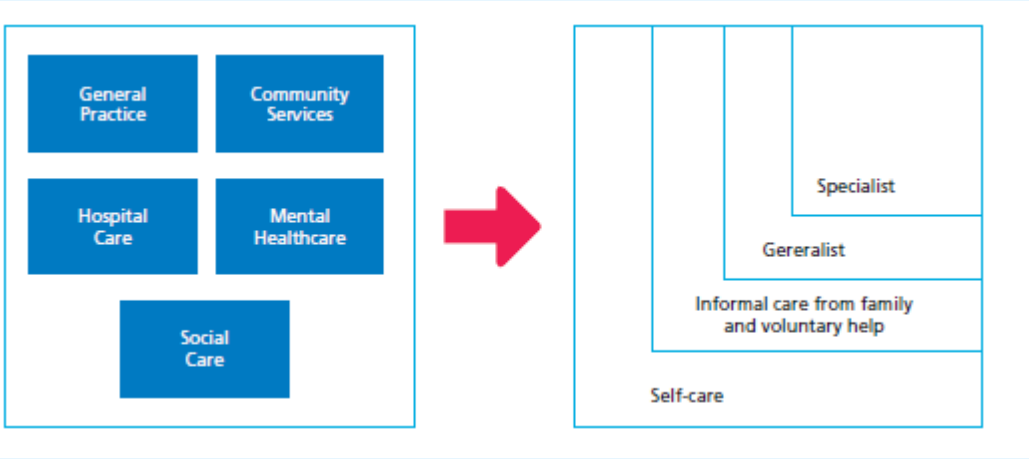
A modern model of integrated care

- Built upon Better Care Fund Plans with Bedford Borough Council and Central Bedfordshire Council
- Discrete silos of current healthcare provision are replaced with a model where the primary aim is to support patients to be self-caring and independent, with much less reliance on specialist intervention

With primary care forming the foundation of excellence in the management of long term conditions, the Bedfordshire System of integrated care is the infrastructure built upon that foundation.

The figure below depicts the essence of our vision: the discrete silos of current healthcare provision are replaced with a model where the primary aim is to support patients to be self-caring and independent, with much less reliance on specialist intervention.

By 2019, the our Better Care Fund Plans will develop further and embed the journey from silos to integration



System Vision

Access to the highest quality urgent and emergency care

- Whole system approach, which responds to immediate patient health and social care needs through stabilisation, crisis management and return to primary care coordination
- Community urgent response teams provide specialist staff, skills and expertise to support care outside of hospital

In 2019 the focus of care is on helping people to be self-caring and independent, led by primary care with specialist services to support the primary care team and the patient and their family/carers.

A whole systems approach, recognises that urgent care is an important component to managing all of an individuals care needs. The confusing and fragmented system of today's A&E departments, walk in centres, GP out of hours services and GP urgent appointments will be replaced by responsive hubs of community based urgent care response teams, led and coordinated by primary care. Urgent care will be personalised to people's care needs, provided in community hubs 24 hours a day, 7 days a week with access to diagnostics, assessment and outpatient facilities.

Our A&E departments will be central to these community hubs and part of an integrated, joined up system of urgent out of hours care, ensuring continuity of care and information sharing between all health and social care staff involved in people's care needs. Signposting and simplified information is supported by 111 services, offering a single point of access for patients, carers and clinicians to access the appropriate level of care. As a result avoidable hospital admissions will significantly reduce and where stays in hospital are required to support care needs, the duration of hospital care will be shorter.

To realise this vision the Bedfordshire Health and Social Care System will develop the local urgent and emergency care offer, to ensure that urgent and emergency care is not merely the safety net of our health and social care services, but a component within an integrated whole systems approach to health and social care needs.

System Vision

A step-change in the productivity of elective care

- Outcome-based contracts that enable different health , social , charitable and voluntary care services to collaborate to deliver shared goals and enhance productivity and efficiency to improve patient outcomes within systems of care
- Community-based models of care, with care in hospital only when clinically necessary

Changing the way health and social care providers work, so that they collaborate to deliver shared goals, is a proactive approach to ensuring that access to services is designed and managed from start to finish to remove error, maximise quality and achieve a major step-change in enhancing productivity.

Improved efficiencies , achieved through outcome-based contracts , will remove the waits, delays and duplications of care that patients currently report as they are 'ping-ponged' between organisations and health and care professionals. A care system, designed around the needs and goals of the individual means we increasingly use patient outcomes – not activity - as currency for commissioning and providing care.

Local people tell us they want joined-up , coordinated care, that is simplified and easy to understand. As our health and social care services become less about "what's the matter" and more about "what matters to you" the traditional organisational and professional barriers that seem to encumber patient pathways today, will be replaced with seamless care experiences, which as a by –product enhance productivity and efficiency.

This means changing traditional models of care, not merely by improving access to care within closer to home, community settings but also by changing how we provide care. One stop services enable patients to access assessment, diagnostics and consultant expertise in one service visit e.g. within Urology services, 7 day service provision will ensure timely access to assessment and treatment, enhanced recovery pathways will maximise evidence-based care and technologies to reduce recovery times and improve patient outcomes.

System Vision

Specialised services concentrated in centres of excellence

- Centres of excellence provide evidenced-based care for specialist treatment such as stroke thrombolysis, as part of larger clinical networks , retaining highly skilled staff , facilities and equipment and therefore improving patient outcomes
- Services integrate fully with community and primary care pathways of health and social care

International evidence demonstrates that performing some types of specialist planned surgery and specialist procedures in fewer, high volume centres provides better care for lower costs. Consolidating skilled staff and expertise, specialist equipment and facilities and consistent higher levels of treatment volumes result in better clinical and experience outcomes for patients. Local people tell us that high quality care and good experiences is a higher priority for them than possible inconveniences associated with further travel distances in order to access the right care, in the right place at the right time.

In order for specialists to maintain their skills, specialist services are increasingly being concentrated in specific locations, allowing clinicians to see a sufficiently high number of patients, effectively utilise expensive equipment and to work collaboratively with other relevant professionals. It is for this reason that patients from Bedfordshire may go to Cambridge or London for some services. Every Royal College has recommended for its specialty that this approach of centralisation is one of the key ways of improving care and outcomes for patients.

As part of our review of healthcare services in Bedfordshire we will consider the implications for sustainable, high quality services for specialised aspects of care such as stroke thrombolysis and cardiac procedures (Percutaneous Coronary Intervention). A networked approach will ensure that care is joined up with services at home and in the community, such as rehabilitation ,and well coordinated as part of the patients overall care needs. We will create resilient services that people and professionals can rely upon.

3. Improving Quality and Outcomes

Improving Quality and Outcomes

Everyone Counts: Planning for Patients 2014/2015 to 2018/19 requires CCGs to submit trajectories to support the seven outcome ambitions:

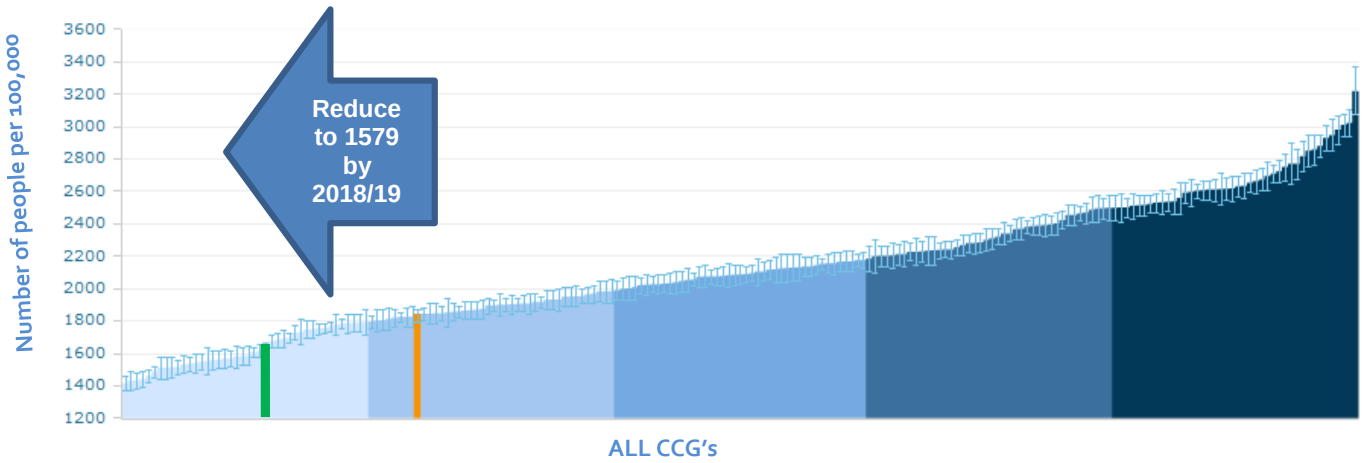
- Securing additional years of life or people with treatable mental and physical health conditions*
- Improving the quality of life of people with Long Term Conditions*
- Reduce the amount of time spent avoidably in hospital*
- Increasing the proportion of older people living independently at home following discharge from hospital
- Increasing the proportion of people with a positive experience of hospital care*
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital*
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

The CCG measures supporting each of these ambitions is described in Bedfordshire Plan for Patients 2014 – 2016. Of these seven outcome ambitions, 5 include 5 year trajectories*. These trajectories are described overleaf. Each of our improving interventions (section 5) demonstrates how these outcome ambitions will be achieved.

Improving Quality and Outcomes

Outcome Ambition 1: Securing additional years of for people with treatable mental and physical health conditions

Measure: Potential years of life lost (PYLL) from conditions considered amenable to healthcare



Bedfordshire is currently within the second top performing quintile for PYLL. By 2018/19 we aim to reach the top performing quintile.

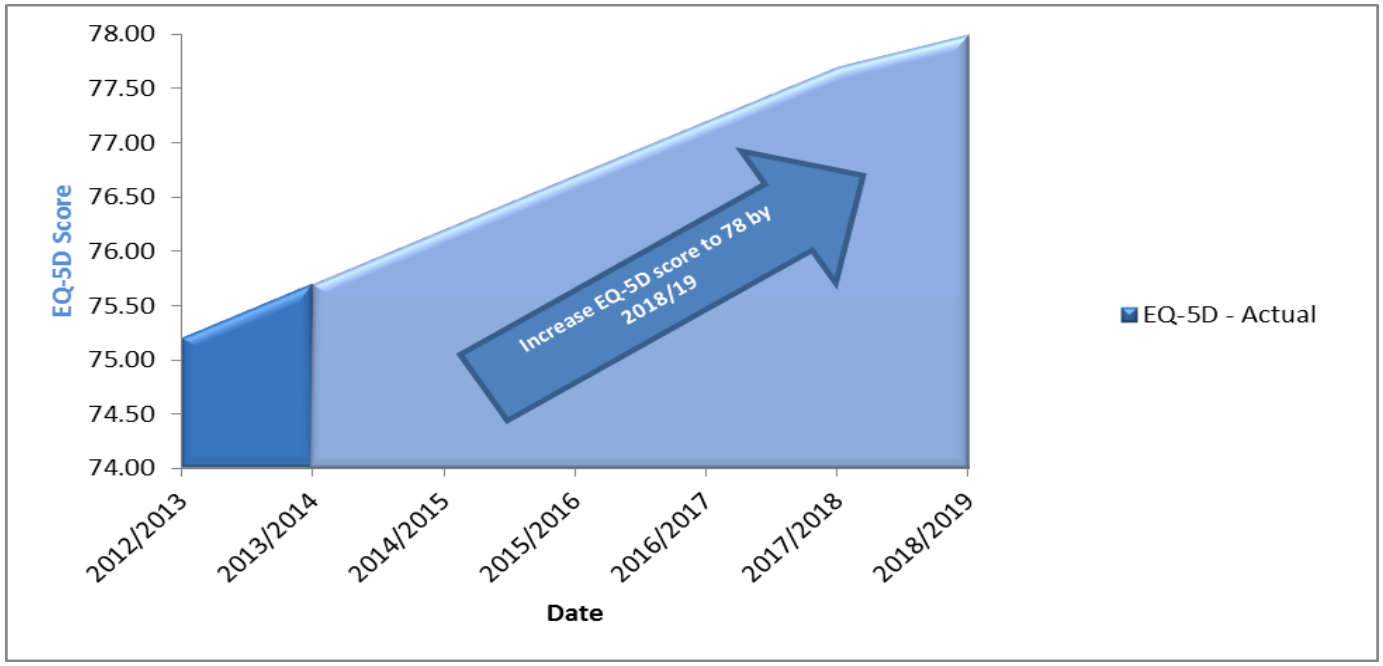
Foundations for Change

- Self care, prevention and early detection embedded with BCF plans and, out of hospital care model and review of healthcare services in Bedfordshire
- Integrated hubs of health and social care for children, young people and families or carers
- Procurement of an outcome focused stepped model of mental health
- Integration of health and social care for people with LTC incl frailty (Better Care Fund)

Improving Quality and Outcomes

Outcome Ambition 2: Improving the health related quality of life of the 15 million + people with one or more long term condition, including mental health conditions

Measure: Health related quality of life for people with long term conditions (measured using the EQ5D tool in the GP Patient Survey)



Within this measure patients with long term conditions are asked about their health in relation to mobility, self-care, usual activities, pain/discomfort and anxiety/depression. A trajectory of increasing scores will support improved quality of life outcomes for people with long term conditions

Foundations for Change

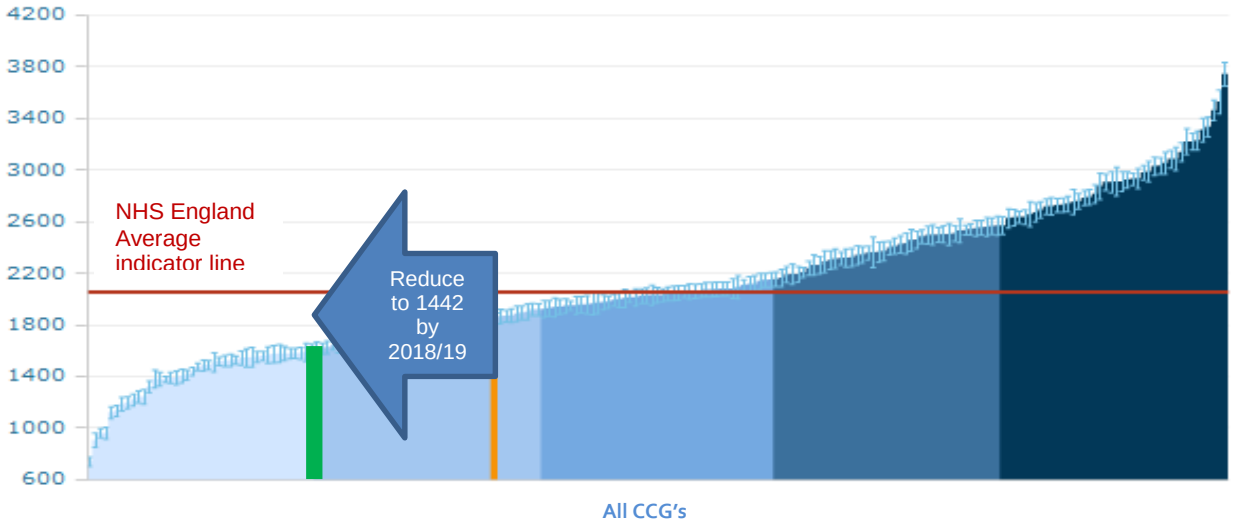
- Self care, prevention and early detection embedded with BCF plans and, out of hospital care model and review of healthcare services in Bedfordshire
- Procurement of a stepped care mental health model
- Pathway redesign with care closer to home e.g. urology, dermatology, neurology

Improving Quality and Outcomes

Outcome Ambition 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

Measure: A rate compromised of:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency admissions for children with lower respiratory tract infection



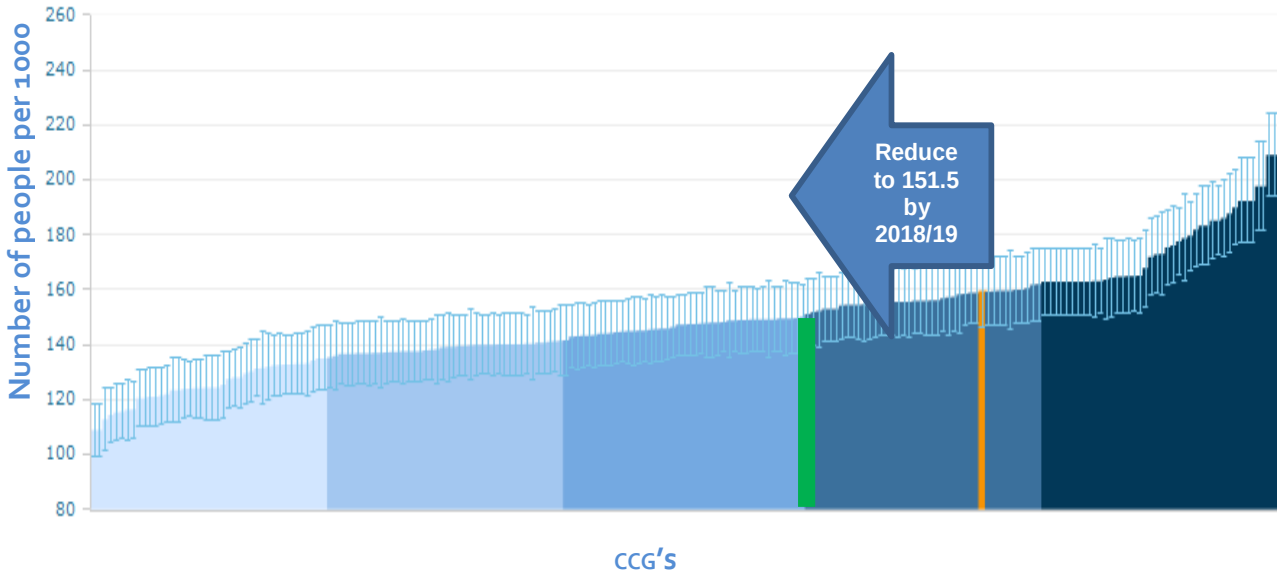
Foundations for Change

- BCF plans, out of hospital Integrated care model and review of healthcare services in Bedfordshire
- Procurement of a stepped care mental health model
- Pathway redesign with care closer to home e.g. urology, dermatology, neurology
- AEC pathways
- Excellence in Emergency care offer

Improving Quality and Outcomes

Outcome Ambition 5: Increasing the number of people having a positive experience of hospital care.

Measure: The proportion of people reporting poor patient experience of inpatient care



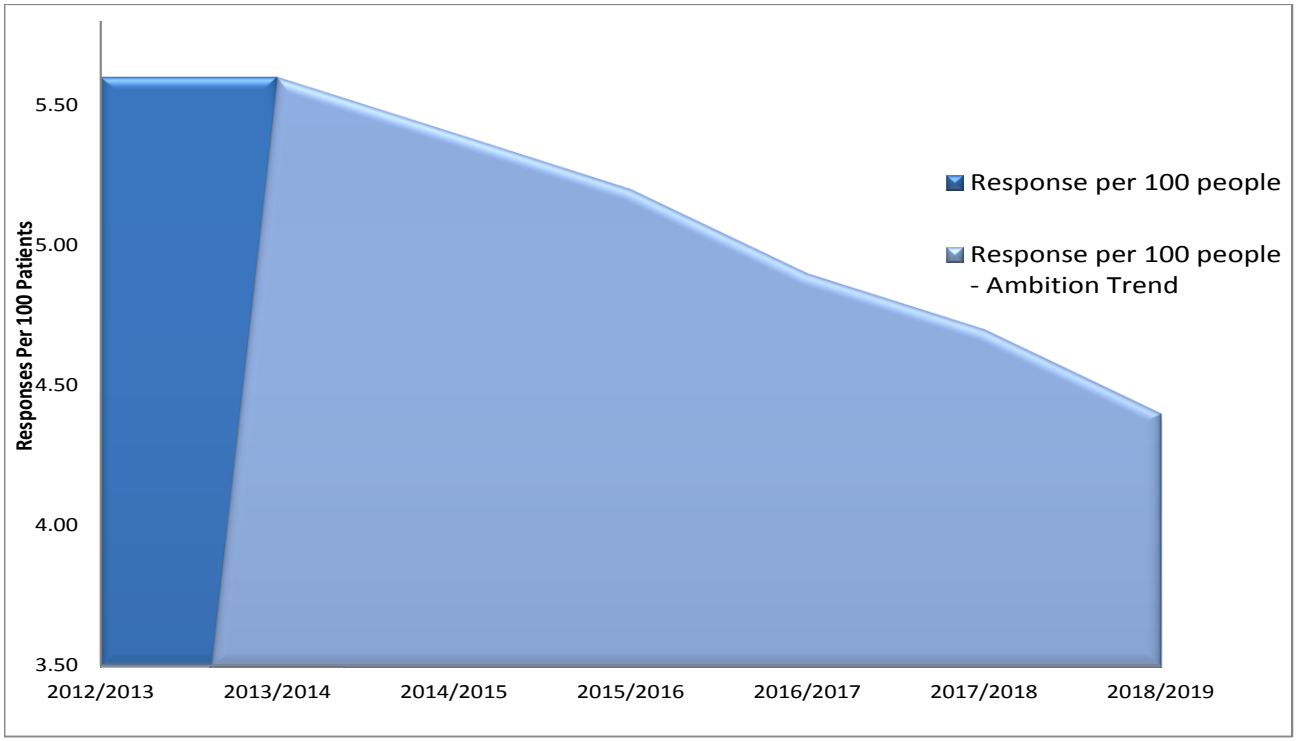
Foundations for Change

- BCF plans, and review of healthcare services in Bedfordshire
- Liaison psychiatry
- AEC pathways
- Excellence in Emergency care offer
- System vision for ensuring that citizens are fully included in all aspects of care (monitored by BCCG operational approach to patient engagement)

Improving Quality and Outcomes

Outcome Ambition 6: Increasing the number of people with mental and physical conditions having a positive experience of care outside hospital, in general practice and in the community.

Measure: The proportion of people reporting poor experience of General practice and Out of Hours Services



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Foundations for Change

- BCF plans, and review of healthcare services in Bedfordshire
- Integrated model of out of hospital care
- System vision for ensuring that citizens are fully included in all aspects of care (monitored by BCCG operational approach to patient engagement)

4. Sustainability

Review of Healthcare Services in Bedfordshire and Milton Keynes

Sustainability

The NHS belongs to the people: A Call To Action identifies future pressures on the health service. As demand for services is challenged by an ageing society, the rise of long-term conditions and increasing expectations the provision of service is also constrained by increasing costs, limited productivity gains and constrained public resource.

In Bedfordshire, while most GPs, community clinics and hospitals are meeting most basic standards of safety and there are local examples of best practice, the care they provide is inconsistent and not always of the quality expected by the public.

- The general practice "offer" to patients in Bedfordshire varies significantly, depending on where they live, the size and configuration of the practice with which they choose to register, and the nature of that locality's out of hours provider.
- There are noticeable gaps in the services available from community service teams with, for example, insufficient sub-acute care in Bedford Borough. There are also risks of duplicating community services with services provided as outreach care by hospitals, such as 'Hospital at Home'.
- In hospital care, almost all local hospitals have struggled to meet NHS Constitution waiting time targets consistently in key areas such as A&E and orthopaedic inpatient care. In addition, the two acute NHS hospitals in Bedford Borough and Milton Keynes and some units at other surrounding hospitals are relatively small scale, and their size has an impact on the quality and financial sustainability of the services they can provide.

Sustainability

Our health services are also challenged by the workforce shortages that affect the whole country. Local hospitals' particular workforce shortages include GPs (see Chart overleaf), middle grade A&E doctors, health visitors, experienced nursing staff, neonatal nurses, sonographers and Operating Department Practitioners (ODPs). With significant proportions of clinical staff nearing retirement age, there is a risk that vacancy rates will increase.

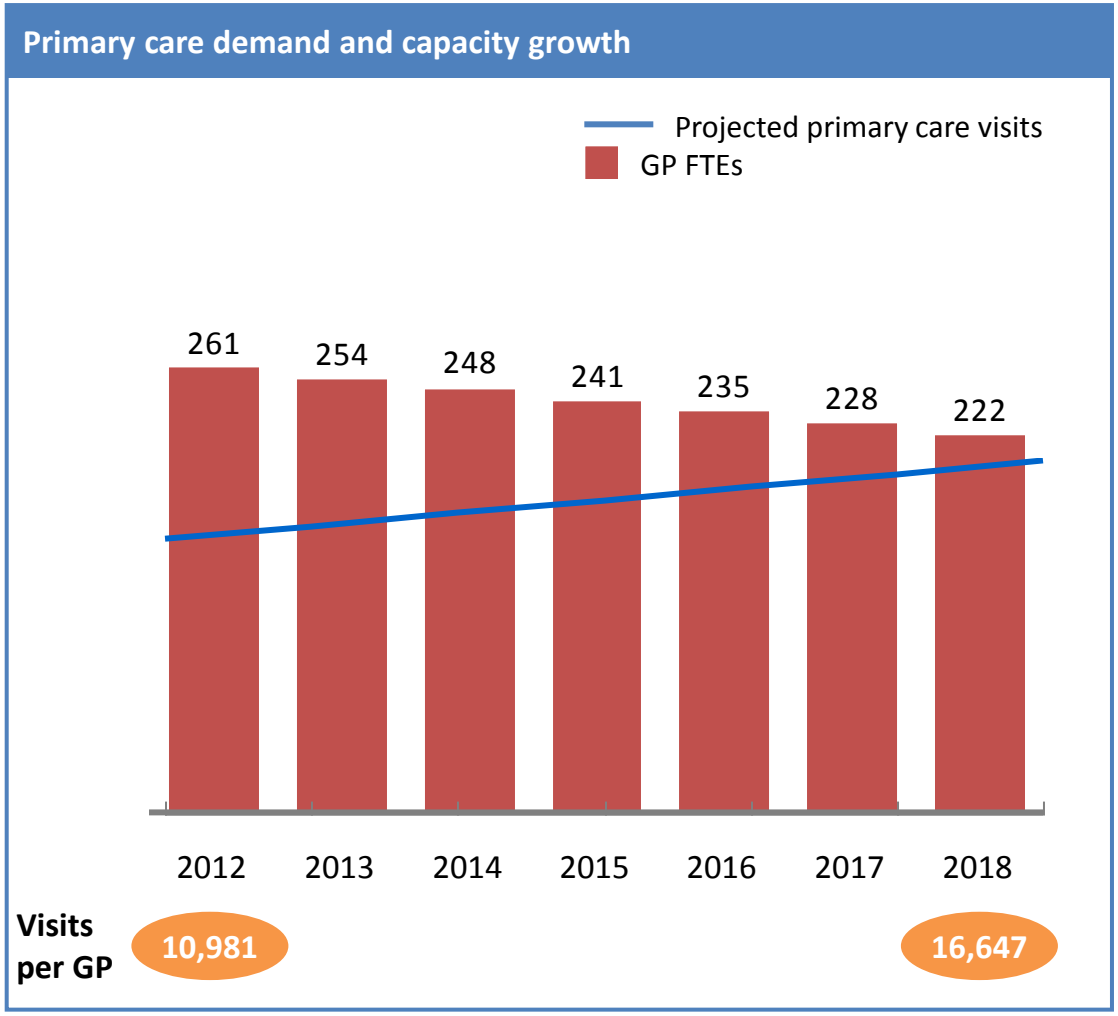
Like many other areas of the NHS, the current financial position locally is already stretched. The Bedfordshire health economy ended the 2013/14 financial year in deficit by around £9 million. This position puts at risk the ability of the local health economy to invest in sufficient new technology or staff numbers to continue to deliver safe care into the future.

Keeping up with expected demographic changes, advances in care delivery, advances in technology and financial pressures will collectively make healthcare services more difficult to provide in their current form in future. Together, the strains in today's services and the challenges of tomorrow add up to an imperative need to update and reform the pattern of healthcare provision in Bedfordshire and Milton Keynes. Existing services can neither absorb the additional population requirements nor afford to implement the models of care that deliver the best quality of care and outcomes for patients.

The people leading our local health systems share an ambition to put patients at the heart of care, to support them living independent lives at home for as long as possible, and to do so in the most cost effective way possible. The opportunities for achieving this ambition that we have so far identified are to:

- Push hard on prevention of ill-health, patient support and empowerment, and early intervention if ill-health does arise.
- Learn from innovation in clinical organisation and processes elsewhere that seem to be demonstrably improving outcomes for patients (e.g. Cornwall and Isles of Scilly pioneer project.
- Use the Better Care Fund as a catalyst to join up care, recognising that the fund is constituted from resources saved by reducing emergency admissions to hospitals, requiring both community and hospital services to be significantly redesigned.
- Reward providers for delivering better outcomes for patients, thereby incentivising collaboration rather than competition between providers.
- Promote Bedford Borough and Central Bedfordshire as the places to come and work, building on the efforts to attract business to the local area.

Chart : GP numbers are expected to decline



- Currently people see a GP ~6.24 times per year[1]
- Demographics, aging and the transfer of activity from acute to an out of hospital setting is expected to increase primary care and community care demands, most drastically for the population with long term conditions
- Assuming people with long term conditions require 15-20 visits per year to avoid hospital admissions, additional resources are required
- If GP resources decline as expected and models of care to accommodate additional primary care activity do not change, there will be a significant shortage of GPs in Bedfordshire
- Thus, a new model of care with a skill mix shift to drive more nursing led primary care is needed to create sustainable care

1 Royal College of General Practitioners Compendium of Evidence, February 2013
2 GPs over the age of 55 is 22.0%; Assumes 15% of the 22% will retire by 2018/19

Source: General Practice Tool 2013; Health Education for England; team analysis

Review of Healthcare Services

Bedfordshire CCG and NHS England have realised that, given the challenges our local healthcare systems now face (described fully within the Case for Change), we need to review our entire healthcare system, to identify the best future healthcare services for the people of Bedford Borough and Central Bedfordshire. This review is in progress and will:

- Assess the current and future predicted needs of the populations of Bedford Borough and Central Bedfordshire
- Seek out and listen to the opinions and feelings of local people about what is a priority to them from their healthcare
- Learn from examples of healthcare services in the UK and abroad that provide high quality care and good outcomes to their patients
- Work with local clinicians to understand what works and doesn't work well with existing healthcare provision in Bedford Borough and Central Bedfordshire

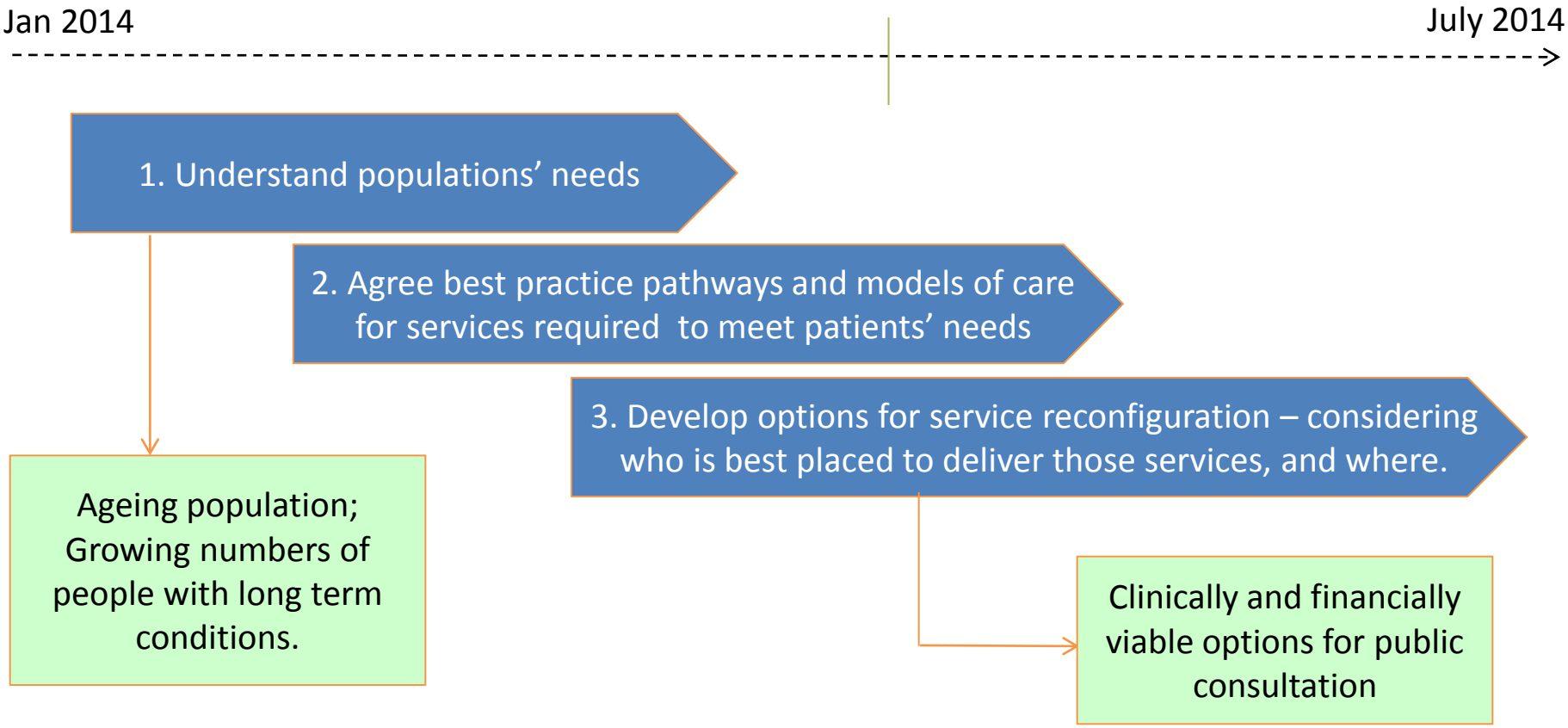
Over the past few months, we've met with hundreds of people of all ages in many locations across Bedfordshire. We've held public meetings in all five of our localities which were promoted by email to all our 600+ stakeholders and by sending 25,000 leaflets and posters to GP practices, pharmacies, opticians, dentists, libraries and children's centres. We also placed articles and adverts in the local media.

We've spoken to and surveyed local people at supermarkets and high streets around the county. We've also taken to the road on the RAVE bus Central Beds mobile community venue and the Bedford Borough library bus to spread the word in our rural communities. And we have run workshop sessions and presented to a range of groups and organisations in the area – especially our hard to reach groups.

In addition we have held events for GPs and staff at Bedford Hospital and South Essex Partnership Trust and Luton and Dunstable Hospital.

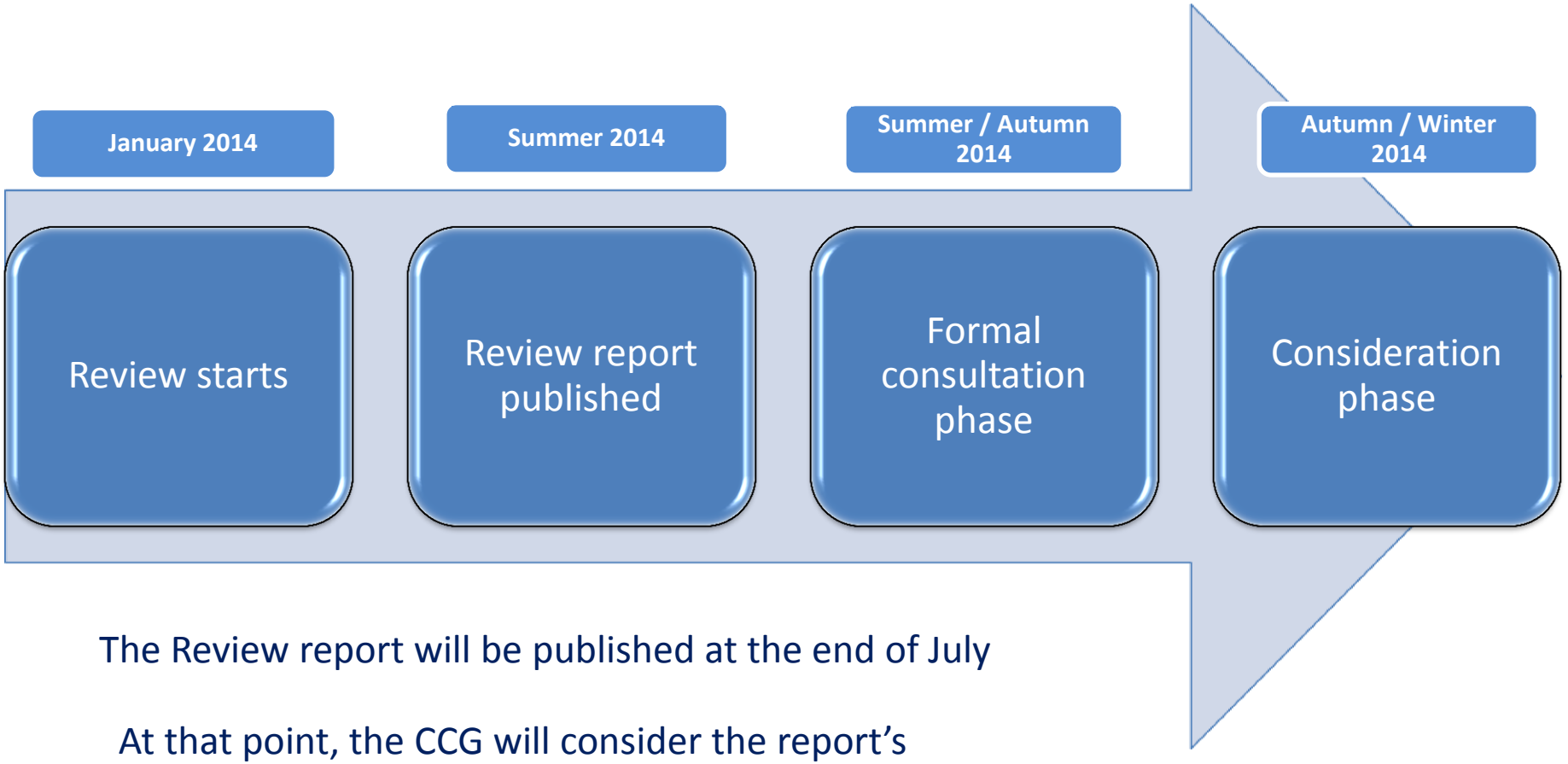
There are three key phases of the review that is running from January to July 2014

We're starting with patients' needs, and then considering what services are required to meet them, and where



We're planning to publish the results of our review over the summer, with a formal consultation taking place during the autumn of 2014

Health Review Timeline



The Review report will be published at the end of July

At that point, the CCG will consider the report's recommendations and decide whether or not to accept them, and therefore proceed to consultation, at its September 2014 governing body meeting

Financial Plan

The overriding financial strategy for Bedfordshire CCG is to ensure a long term sustainable financial position which ensures the CCGs overall objectives around patient care for our population can be achieved.

Nationally, the NHS faces an unprecedented level of future pressure driven by an ageing population, increases in long term conditions and rising costs and public expectations all within an environment of constrained resource growth.

Bedfordshire CCG has used the following planning assumptions to quantify the financial challenge it faces over the next five years:

	Confirmed		Indicative		
Assumptions:	2014/15	2015/16	2016/17	2017/18	2018/19
Resource Uplift	-3.96%	-3.62%	-3.78%	-3.75%	-3.22%
Tariff Uplift	2.30%	2.20%	3.00%	3.40%	3.40%
Tariff Efficiency	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
Prescribing Uplift	5.00%	5.00%	5.00%	5.00%	5.00%
2.5% Non-Recurrent Reserve	2.50%	0.00%	0.00%	0.00%	0.00%
Activity Growth (Demographic)	1.29%	1.27%	1.24%	1.24%	1.24%
Activity Growth (Non Demographic)	1.50%	1.50%	1.50%	1.50%	1.50%

Resource Growth

- Historically, Bedfordshire has been well below its target allocation and whilst pace of change policy previously has seen some additional growth in comparison to areas at or above target, the overall impact pace of change has been marginal. For 2014/15 NHS England have introduced a floor, which ensures all CCGs receive a minimum 2.14% growth in 2014/15 and 1.7% in 2015/16 which reduces the overall level of funding remaining for pace of change to a maximum per capita growth of 2.64%.

- For Bedfordshire CCG, the impact of NHS England's revised allocation policy sees an increase in resource of 3.96% in 2014/15 and 3.62% in 2015/16. Whilst this increase above the minimum 2.14% is welcomed, Bedfordshire remain 8.45% in 2014/15 and 7.45% in 2015/16 below their target allocation. In February 2014, NHS England published indicative allocations for the last three years of the five year plan and these suggest Bedfordshire will continue to be a net beneficiary from the continuation of the 'pace of change' policy beyond 2015/16. Resource growth for Bedfordshire CCG over the 5 year period is as follows:

Financial Impact:	£'000	£'000	£'000	£'000	£'000
Resource Uplift	(16,932)	(16,095)	(17,377)	(17,892)	(15,958)

- Despite the growth in available resource, this is insufficient to cope with the immediate financial pressures combined with the general pressures from a growing and ageing population over the 5 year planning period

Financial Challenge

The financial impact of the financial planning assumptions detailed above requires the CCG to find **£34m** of savings over the next 5 years:

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent (inclusive of full year effect)	9,512	12,350	7,229	6,188	5,291	3,357
Non-Recurrent	6,200	-	-	-	-	-
Total	15,712	12,350	7,229	6,188	5,291	3,357
% of Notified Resource	3.51%	2.69%	1.51%	1.26%	1.04%	0.64%

In addition to this 'QIPP' savings requirement, the CCG has recently identified local pressures that will require further savings to be made to maintain financial balance over the 5 year planning period.

Local pressures include higher than planned activity on acute contracts, prescribing costs and increases in demand and cost of Continuing Healthcare . These pressures increase the savings requirement in 2014/15 to **£31m** and increase the savings requirement over the 5 year period to **£54m**.

Financial Sustainability

In order to meet the financial challenge described above the CCG :

- Is Implementing its two year operational plan to deliver £12.3m of savings in 2014/15
- Has Identified a further recovery plan to close the £18.7m of further savings required including the suspension of any new investment in 2014/15.
- Continues to work with Local Health and Social Care Partners to establish the Better Care Fund to deliver better integrated services that reduce hospital admissions, freeing up resources to reinvest in improving services
- Is currently undertaking a review of both hospital and out of hospital healthcare across Bedfordshire and Milton Keynes

5. Improving Interventions

Improving Interventions

Improving interventions reflect the priorities within our Health and Wellbeing Strategies and joint strategic needs assessments with Central Bedfordshire Council and Bedford Borough Council. Key priorities are identified within the strategic workstreams for :

- Children and Younger People
- Mental Health
- Adults and Older People

The detail of what will be achieved over the next two years, the key quality, patient experience, clinical outcomes, activity changes, timescales, financial implications and higher level risks associated with these workstreams are described in Bedfordshire Plan for Patients 2014 – 2016.

Of these priorities, four initiatives will support long term, sustainable outcome improvements. These are :

- Children's and Young People's plans for health and care with Bedford Borough Council and Central Bedfordshire Council
- A stepped model of mental health, currently in procurement
- Better Care Fund plans with Bedford Borough Council and Central Bedfordshire Council
- Transforming Primary Care

These initiatives, in addition to the Review of Healthcare Services in Bedfordshire and Milton Keynes, embed transformational change beyond a 2 year operational planning period to create a 5 year system plan for sustainable outcome improvement.

What it means for children and younger people

NHS Bedfordshire Clinical Commissioning Group

Key priorities

- A single children's and young people's plan – jointly developed with our local authorities
- Improved pathways of care and transition from children's to adult services
- Improved quality of maternity services
- Improved care for LAC

Better care, better health outcomes

- Integrated hubs of health and social care for children, young people and families or carers
- 95% of LAC receive health assessment within statutory time scales
- High quality integrated pathways of care between maternity and primary care
- Reduction in waiting list times from referral to assessment and treatment

better care, better value, better health

What it means for mental health care services

NHS
Bedfordshire
Clinical Commissioning Group

Key priorities

- Accessible, integrated services jointly commissioned with LAs where possible
- Improving primary care provision, providing *local* mental health services
- Improving care for those with complex needs and dementia
- Procure mental health provider
- Prepare for new payment systems
- Support services users with physical and mental health needs

Better care, better health outcomes

- 15% of target population receive talking therapies by the end of 14/15
- 54% of those treated by IAPT moving to recovery by the end of 14/15 and 55% by the end of 15/16
- Reduce A&E crisis response to 2 hours
- Crisis support for older people
- Reduce waiting times for talking therapies
- People with a learning disability are supported to access mainstream services
- 67% people diagnosed with dementia end of 14/15 and 68% end of 15/16

better care, better value, better health

What it means for adults and older people

NHS Bedfordshire Clinical Commissioning Group

Key priorities

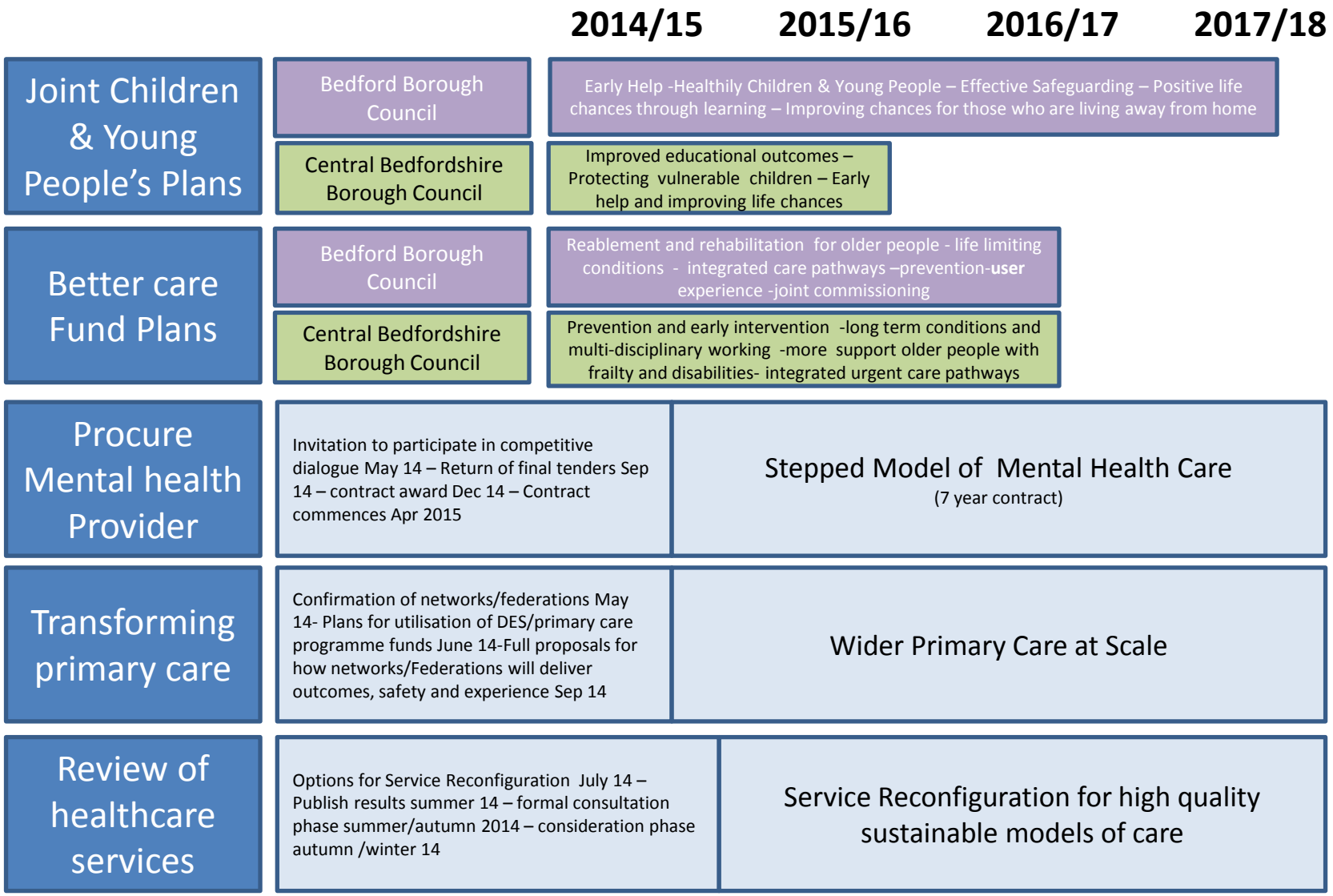
- Integration of the urgent care system
- Integration of health and social care for people with LTC incl frailty (Better Care Fund)
- Transforming Primary Care
- Delivering specialist care e.g. stroke through networks
- Improving end of life care

Better care, better health outcomes

- Improving health-related quality of life for those with LTCs
- Increase no. of high-risk patients identified and develop care plan
- Integrated care to support avoidable admissions and reduce delayed transfers of care
- 15% reduction in emergency admissions by the end of 15/16
- 15% reduction in delayed transfers of care
- 48% of palliative patients dying in their usual place of residence by the end of 14/15

better care, better value, better health

Key milestones for long term sustainability



Improving Interventions

The Everyone Counts: Planning for Patients 2014/2015 to 2018/19 milestone for completion of a system five year strategic plan is June 2014. The outcomes of the Review of Healthcare Services in Bedfordshire and Milton Keynes will not be known until the end of July 2014. The Bedfordshire Health & Social Care System will need to align its five year vision to the outcomes of this review. In the interim the system has considered where it can collaborate to build upon our priorities and develop a supporting infrastructure which will facilitate our vision for a sustainable, high quality health and care system.

These improvements are:

- Integrated Out of Hospital Care models, supported by Better Care Fund plans for Bedford Borough Council and Central Bedfordshire Council
- Excellence in emergency and urgent care offer; a simplified, productive urgent care system

Improving Interventions

Integrated Out of Hospital Care Models

Out of hospital care has been a pivotal consideration within the review of healthcare services in Bedfordshire to date. National and local challenges mean that we need to reduce the pressures on hospitals and change the way we provide out of hospital care in order to achieve this. This means transforming the traditional ways we provide primary and community care.

Our vision for primary care is supported by our plans for primary care transformation (described in Bedfordshire Plan for Patients 2014 – 2016) and is underpinned by GPs working in a federated or networked way to provide a wider range of community care . Broader policy changes support and facilitate this vision.

A variety of possible best practice out of integrated out of hospital models are being considered within the review of healthcare services in Bedfordshire and are highlighted overleaf, however, all options are subject to the outcomes of the review process and formal public consultation.

We have set out our strategic goals for out of hospital care

Access

- 7 days a week for routine care and diagnostics
- Ability to see urgent cases at short notice

Proactive care of people living with LTC and the frail elderly

- Focus on preventative care and early intervention for high risk individuals
- Delivered through a multidisciplinary team who pro-actively support patients to self-care

Supporting people in their homes

- People will be supported to live independently in their own home
- When things go wrong people will spend an appropriate time in the right setting of care before being discharged to their own homes with health and social care support plans designed to promote recovery

Consistency and quality

- Consistent standard of high quality services across the CCG, where ever and whenever people choose to access care

NHS
Bedfordshire
Clinical Commissioning Group

Out of hospital models of care – implications for primary care in Bedfordshire

General practice traditionally operates as a number of separate units, each independently providing care to their registered lists of patients. Over recent years, the practices in Bedfordshire have arranged themselves into the five localities that form the basis of the CCG's current structures. Such arrangements have supported local learning and development opportunities and provide a broad basis on which to involve local clinicians in redesign and commissioning decisions.

The relationships and trust that have built up through the locality work place our practices in strong positions to consider the future of their own sector, especially in light of the growing pressures on primary care now and into the foreseeable future articulated in the case for change. There is widespread recognition that in the future, practices will need to collaborate more closely to provide the range of services and the access requirements expected by the public. There is also a strong desire amongst our practices to (re-)establish strong multi-disciplinary working with especially community, mental health and social care colleagues, and to provide an improved urgent care response to local people.

Supported by the Local Medical Committee (and based on the locality footprints) but separate from the CCG's locality governance structures, local practices are developing provider federations and debating the locations and processes that can make such improvements happen as soon as possible.

Given the growing momentum behind such changes and with the learning from this review to call upon, NHS Bedfordshire CCG are currently seeking the views of its members in relation to expressing an interest in co-commissioning an improved model of primary care for Bedfordshire to NHS England in June 2014.

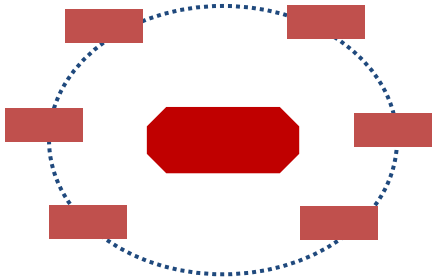
A variety of physical configurations could work

Model 1
Single site

Community facility acts as central hub

GP services located within hub

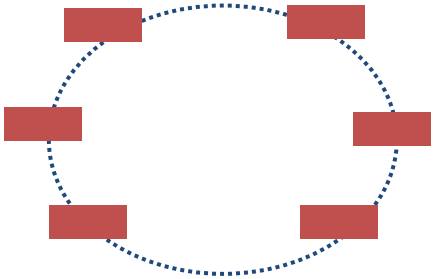
Model 2
Hub and spoke



Community facility acts as central hub

Some GP practices may be located within the central hub, others around it

Model 3
Network



Network of practices providing extended hours urgent care

Different diagnostics and services distributed across practices

A variety of physical configurations for transformed primary care could work, depending on the setting (urban/rural) and current location of general practices, all options are subject to the outcomes of the review process and formal public consultation.

Out of hospital models of care – potential configurations across Bedfordshire

At present, practices in Bedfordshire's localities are debating which option would best suit their population needs and maintain access within 'pram-pushing' distances. The most likely model is Model 2, the hub and spoke arrangement, with variation between local areas in the proportion of practices located within the hub and proportion remaining as spokes outside.

Such configurations then improve the ability of primary and community services to deliver on the strategic goals set out above. The intention is to include within the review's final report the options for new configurations of primary care in each of Bedfordshire's localities.

Our Better Care Fund Plans with Central Bedfordshire Council and Bedford Borough Council also drive changes that support integrated ways of working that reflect the differing needs of the two local populations.

Summary BCF Plan – Central Bedfordshire Council

Reshaping the model for prevention and early intervention	• Implement integrated approach to primary, secondary and tertiary prevention to stop or reduce deterioration in health • Ensure the most progressive and evidence-based prevention and early intervention are available to our population
Supporting People with long term conditions through multidisciplinary working	• Focus services around general practice in locality networks and helping people to manage their own conditions in the community • Identify and organise effective support to those with LTCs, particularly those with complex comorbidities • Provide access to multidisciplinary support and packages of care organised to maximise independence.
Expanding the range of services that support older people with frailty and disabilities	• Develop and integrate the range of housing, new technologies and mobility • Ensure availability of services which wrap around older people with specific conditions to maintain independence and remain in their own homes and communities as long as it is safe for them to do so
Restructure Integrated Care pathways for those with urgent care needs	• Ensure that these are seamless , clear and efficient to deliver the clinical shift required to move care away from acute settings, where appropriate

Local Measure

Reduction in the number of Emergency hospital admissions for injuries due to falls in people over 65 years

Summary BCF Plan – Bedford Borough Council

Reshaping or reablement and rehabilitation model for older people

- Mainstreaming the reablement approach – reviewing the existing model and planning how to increase capacity, impact and reach
- Recommissioning our community health services in line with our redesigned reablement/intermediate care model
- Reshaping our high end rehabilitation; including specialist units

Targeting our work with people with life limiting conditions

- Reviewing and redesigning the domiciliary care model to reduce reliance on more expensive alternatives by helping people to return home more quickly.
- Increasing capacity and responsiveness of 24/7 services that help keep people at home, including equipment and assisted technology
- Reviewing and redesigning end of life care to support people staying in their home at the end of their lives
- Reviewing and redesigning specialist health issues e.g. stroke, heart issues, neurology alongside mental health support needs
- Reviewing the use and scope of the community equipment service and the allocation of disabled facilities grants to ensure we maximise independence

Improving our integrated care pathways across our provision

- Reviewing the NHS to social care transfer monies and build on the successes achieved through increased hospital social work teams and reablement. Review the services within the current community contract to ensure multi-disciplinary teams and coordinated responses to patients/people. Increase housing interventions, and targeted voluntary sector support, with the aim of maximising spending and outcomes across health and social care based on evidence about what works

Local Measure

Increased attendance to leisure facilities by 5% over a 12 month period

Summary BCF Plan – Bedford Borough Council

Redesigning our prevention model

- Linking risk stratification within primary care to early preventative services available within the community across health and social care with GPs taking on the lead coordination role
- procuring a revised mental health model of care for both adults and children
- Develop the existing falls programme into a comprehensive service across BCCG, BBC and Community Services
- Our redesign will account for the changes made by, and any implications of, the Care Bill

Improving the user experience

- Developing an engagement model and approach for the development of shared outcomes and KPIs to inform redesign and commissioning;
- Creating a differentiated engagement model for clinicians, carers, and users through the use of local networks;
- Providing information and signposting to services through a single source and supporting website services,
- Effective and targeted messages and communications designed to change the culture of A&E usage and thereby divert unnecessary A&E attendances to more appropriate services (e.g. primary care, pharmacies).

Integrating our commissioning arrangements

- Creating a joint approach to the full commissioning budget, prioritising areas where joint commissioning can have the most impact; and,
- Creating a targeted resource model for task-and-finish commissioning.

Local Measure

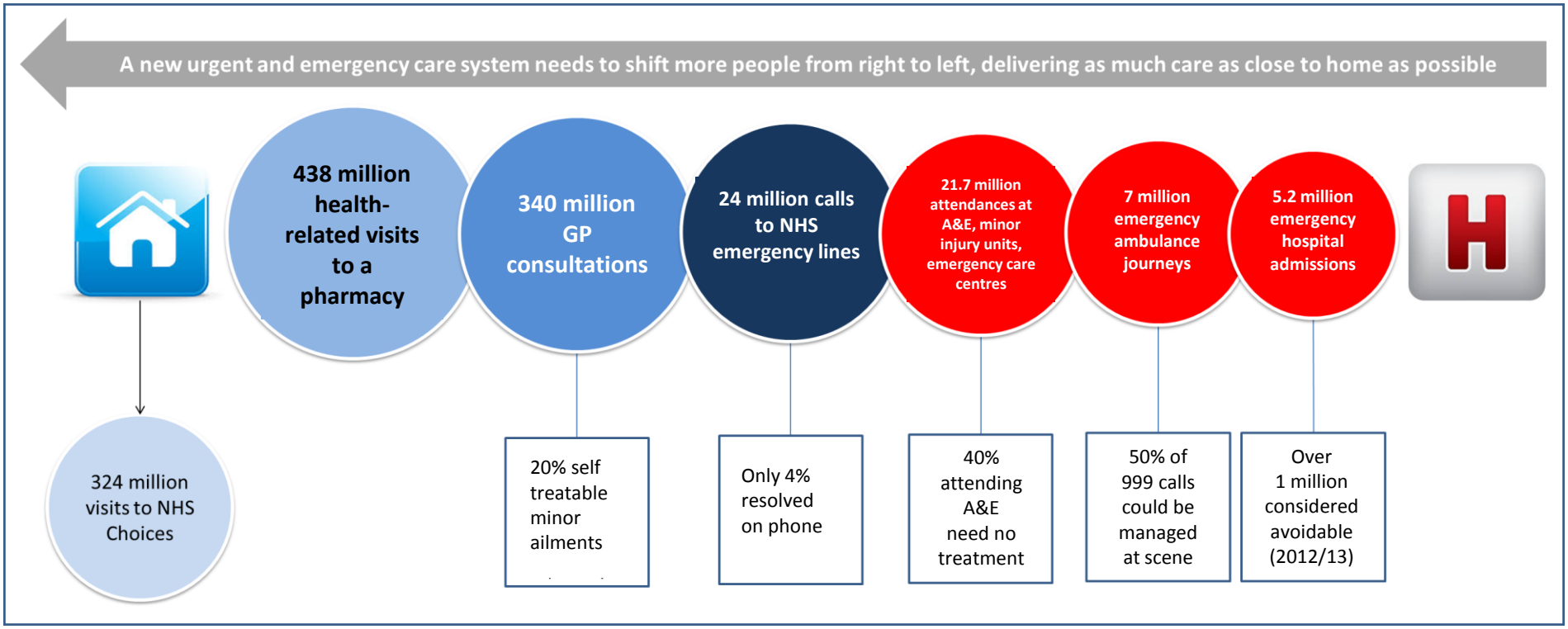
Increased attendance to leisure facilities by 5% over a 12 month period

Improving Interventions

Excellence in emergency and urgent care offer; a simplified, productive urgent care system

The creation of an emergency care offer is not separated from our Integrated Out of Hospital Care model. In fact our vision for emergency and urgent care describes a whole system approach, which responds to immediate patient health and social care needs through stabilisation, crisis management and return to primary care coordination. It establishes emergency and urgent care as an important component to managing all of an individuals care needs. Supporting care needs by delivering urgent and emergency care as close as home to possible is nationally recognised as an important element of best practice urgent and emergency care.

Vast majority of healthcare delivered through primary and community care - we should be delivering this closer to home



Source: Transforming urgent and emergency care services in England, Urgent and Emergency Care Review End of Phase 1 report, The NHS Constitution

NHS
Bedfordshire
Clinical Commissioning Group

Excellence in Emergency and Urgent care

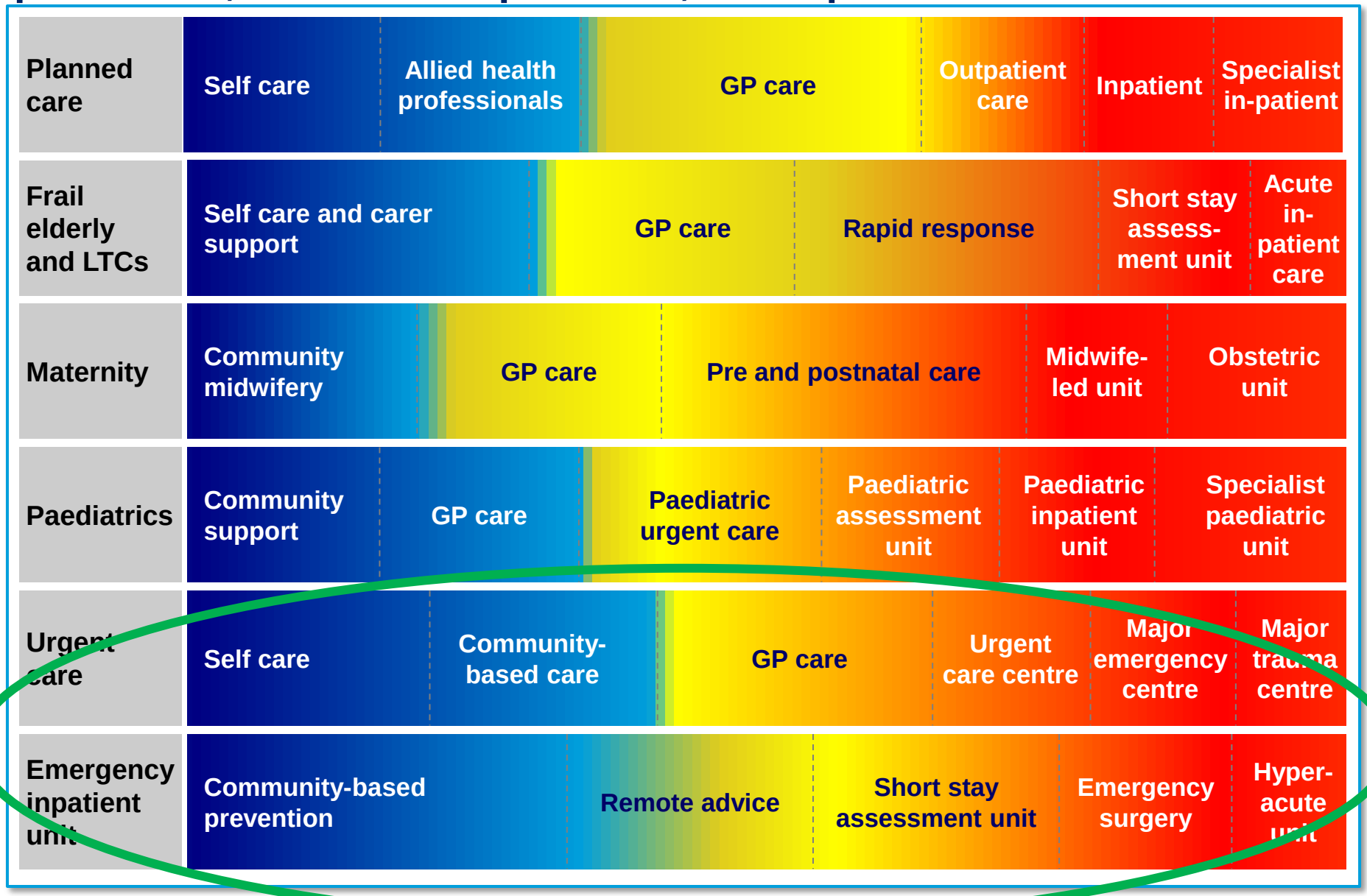
Excellence in emergency and urgent care offer; a simplified, productive urgent care system

Within the review of healthcare services clinical working groups have been considering best practice care pathways and standards for emergency and urgent care pathways. In November 2013, NHS England published the Phase 1 report of its review into urgent and emergency care (Available at: http://www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx) The vision expressed in this report is of moving such care as close to patients' homes as possible using a network of urgent and emergency care centres spanning both local (community based) urgent care services and more specialist emergency care services.

The Spectrum of Care 'heat map', shows clinicians' initial thinking on what healthcare services are needed and where. This encompasses Urgent and Emergency in-patient care. The map shows how the spectrum of care ranges from prevention and self-care on one side, through GP and community care, then on to specialist care for complex and rarer conditions at the other.

With the exception of maternity, most care that's delivered by our health services sits in the blue section on the left. It is rare for care to be needed at the top end (the right-hand side of the map), but this is where most of our money (80%) is spent. Our ultimate aim is to make the services in the blue area work more effectively and in particular prevention and self-care, so there is less need for the high-cost services in the red area. One of the most important things, if this model is to work, is to ensure that communication between each stage of the process works smoothly.

There is a service spectrum for different pathways going from prevention, to out of hospital care, to hospital based care



Excellence in Emergency and Urgent care

Excellence in emergency and urgent care offer; a simplified, productive urgent care system

Consideration of urgent and emergency care pathways, integrated with primary care and community networks provides the starting point to apply the implications of the changes in out of hospital care on the need for various types of hospital-based services.

From that point, the options for planned care, maternity and children's care, and specialist care for people with long term conditions and frail older people can be assessed and added in, depending on the availability of interdependent specialities such as diagnostics, theatre capacity, and anaesthetic cover. This should produce a set of holistic options that demonstrate the opportunities for providers to work as a healthcare system across Bedfordshire, encompassing hospital, community settings and primary care.

Possible models for hospitals to deliver the services we use most often…

	What	Services offered
Major emergency centre (type B)	• Larger units • Can assess and start treating the overwhelming majority of patients • For populations of approx 500,000-700,000	• In time a 24x7 consultant delivered A&E, emergency surgery, acute medicine • Intensive care unit • Inpatient paediatrics • Obstetrics & neonatal intensive care unit
Emergency Centre	• Can assess and start treating majority of patients • Provide inpatient care and have intensive care / high dependency units • For populations of approx 250,000-300,000	• Consultant led A&E • Acute medicine and high dependency unit • Access to surgical opinion via a network • Potentially paediatrics assessment unit and obstetrics
Integrated care hub with emergency care	• Can assessing and start treating large proportion of patients • An integrated outpatient, primary, community and social care hub • For populations of approx 100,000-250,000	• GP and A&E consultant led urgent care incorporating out of hours GP services • Step up/step down beds possibly with 48 hour assessment unit • Outpatients and diagnostics
Urgent care centre	• Provide immediate urgent care • An integrated outpatient, primary, community and social care hub • For populations of approx 50,000-100,000	• As above but no beds

The final review options are likely to be comprised of various permutations of these facility types assessed against agreed evaluation criteria covering quality and sustainability, impact on access to care, affordability and value for money, and deliverability and will be subject to formal consultation

Improving Interventions

Excellence in emergency and urgent care offer; a simplified, productive urgent care system

The outcomes of the Healthcare Services review in Bedfordshire and Milton Keynes will generate long term high quality sustainable models of care. Whilst clinically and financially viable options for public consultation are being developed the Bedfordshire Health and Social Care system will collaborate to support excellence in emergency and urgent care with the objectives to:

- Help people to look after themselves – to prevent ill health, to detect it early and to manage their own conditions when they are unwell
- Ensure that people who are vulnerable of needing urgent or emergency care have a care plan to support them to manage their condition effectively
- Work as one integrated and whole system, although involving multiple health and social care services
- Establish clear signposting; patients and the public will know how to access information and guidance in the event of needing urgent or emergency treatment
- Ensure improved quality, safety and standards
- Ensure the patient is seen at the right time, by the right person, with the right skills to manage their needs in the right place
- Support the development of out of hospital services which can respond flexibly to urgent and emergency care needs, reduce the demands on A&E departments and, when hospital admission is required, enable patients to rapidly return home for on-going care needs

6. Governance and Overview

Governance and Overview

The Bedfordshire Health and Care System leaders acknowledge that we collectively manage a complex system of care encompassing two Local Authorities, two main hospital providers (with patient pathways to multiple hospitals outside of the system) and a community and mental health service organisation in transition due to the current procurement of a new mental health provider. Each organisation has its own governance and assurance processes.

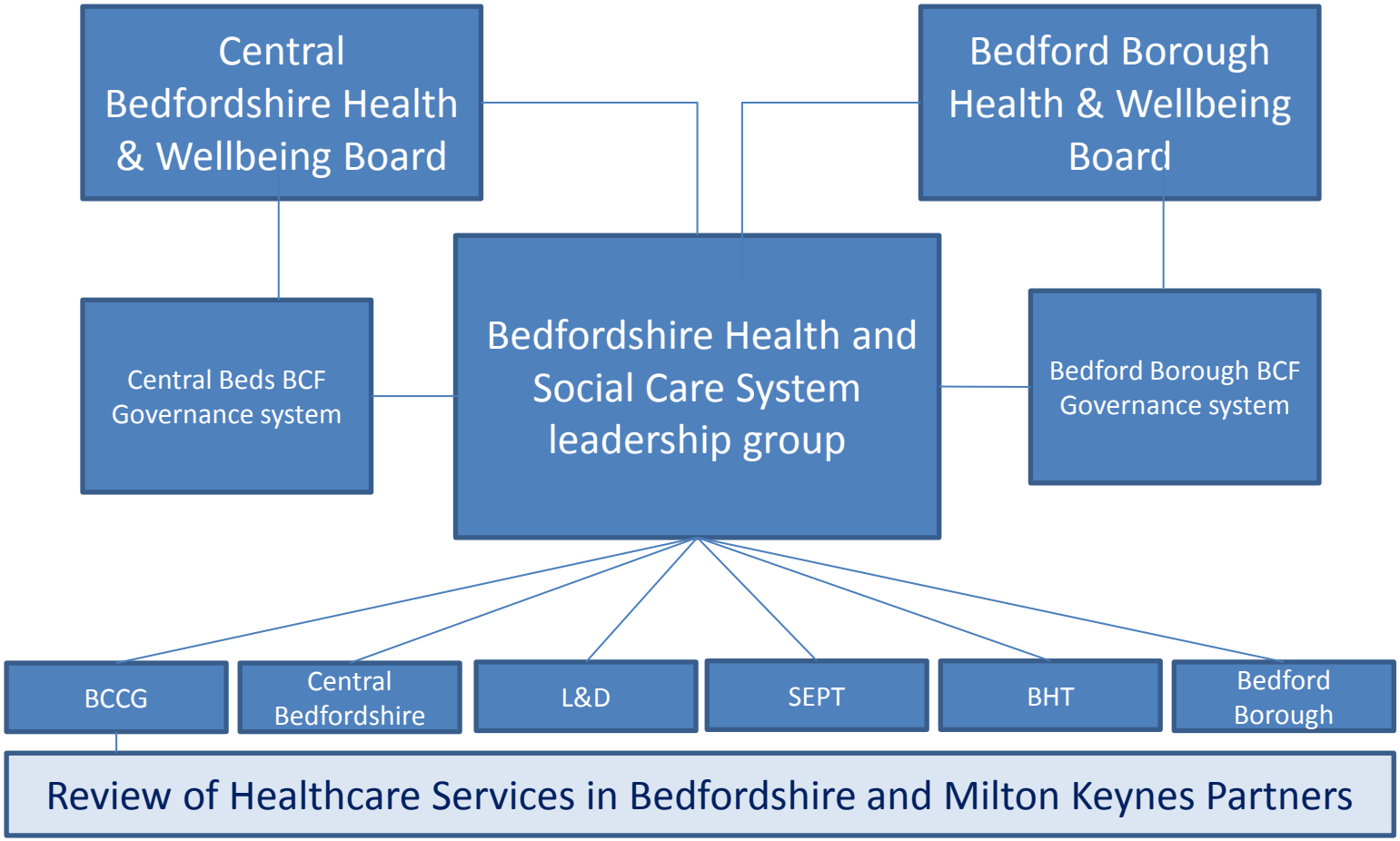
The partners supporting Bedfordshire Clinical Commissioning Group in the review of health care services; NHS England, Monitor and the Trust Development Agency have jointly developed a rigorous programme management approach to lead, monitor and assure the review process. The review governance structures are designed to achieve the programme aims within this timescale. The Programme Advisory Group is comprised of senior leaders from across the local health economy, HealthWatch, and regulators, and is supported by an Operational Group which in turn receives inputs from four sub-groups: the Clinical Advisory Group; the Operations and Finance Group; the Commissioning Intentions Groups (one for each CCG); and the Communications and Engagement Group.

The Better Care Fund plans with each Local Authority have also identified governance mechanisms to monitor and assure delivery. The Central Bedfordshire and Bedford Borough Health and Wellbeing Boards have a pivotal role in approving commissioning and joint plans; assuring delivery and collaborative working. Bedfordshire Health and Care System leaders have therefore mapped a leadership and management framework which demonstrates how we will collaborate together to monitor and support the implementation of sustainable models of care across the range of improvement initiatives identified in the Bedfordshire Health and Care System Strategic plan, this includes:

- Shared System Leadership Group
- Individual Organisations collaborating/leading on specific projects e.g. demonstration project
- Cross working across Better Care Plan Fund Initiatives

We are also extending our group membership to welcome the Local Medical Council, HealthWatch, voluntary/charitable sector representatives and Primary care representatives to advise and input into system planning.

Governance and Overview



7. System Values and Principles

System Values and Principles

The Bedfordshire Health and Social Care System leaders have identified a set of values and principles which will determine how our organisations will collaborate to transform our services over the next 5 years:

- The patient matters most; we will work collaboratively to provide patient-centred care, moving away from organisational silos to integrated care journeys
- We will create an environment that facilitates the pace and scale of change needed to create clinically and financially sustainable models of high quality care
- We will improve population health through patient/service user empowerment and support, involving families, carers and the voluntary/charitable sectors
- We will lead for the long term; applying different styles of system leadership and management that address the factors that make an integrated health system work more effectively, such as new contracting, technology, co commissioning and financial models
- We will work in an evidence-based way, using local knowledge, experiences and information, best practice and national and international evidence to innovate care, driving quality, productivity and improved experiences and outcomes

8. Risks

System Risks

System leaders have identified key risks to achieving our system vision:

Risk	Likelihood	Impact	Response
As a result of the System 5 Year Strategic Plan straddling a general election and increased national and local scrutiny on CCGs there is a risk that sustainable models of care identified within the review of healthcare services will require longer consultations and may meet greater challenge causing delay to delivery, increased costs, reduced benefits and potential wasted investment.	High	Medium	Careful and effective planning of engagement is already underway, the date of the General Election is a known milestone, (7th May 2015, with prorogation from 30th March 2015). The CCG will anticipate that no consultation exercises will be undertaken during this period. Earlier exercises (and the responses to them) will be planned in as part of good project disciplines. Currently known party plans do not propose any further reorganisation of the NHS, which will reduce the disruption to the system.
As a result of the use of patient/service user IT systems that are not interoperable between differing organisations and differing IT systems within the local health and care economy there is a risk that the lack of an integrated care record will create a barrier to the flow of patient/service user information and inhibit the feasibility of integrated care journeys.	High	High	BCCG is leading a county wide steering group to develop interoperable IT and data sharing systems that enable sharing of patient information across organisations and professional groups, governed through Better Care Fund Plan monitoring. The Steering group commences work in May 2014.
As a result of traditional workforce profiles, ways of working, an ageing and retiring workforce and local recruitment challenges there is a risk that will not have the capacity and capability within our local workforce to support sustainable models of care.	High	Medium	The review of healthcare services in Bedfordshire is undertaking workforce analysis within the development of sustainable models of care. BCCG is working with Health Education England Workforce Partnership planning processes to collaborate with provider workforce planners and identify longer term workforce strategies.
As a result of historic, fragmented approaches to assessing and managing continuing health care (CHC) needs across the local health and care economy there is a risk that inefficient, duplicated and fragmented systems result in poor patient/service user experience, quality outcomes and financial controls which inhibits the development of integrated care journeys.	High	High	BCCG is currently undertaking a review of CHC processes, spend and outcomes. Bedfordshire Health and care System Leadership group will collaborate to determine best practice cross organisational models to support integrated out of hospital care.

9. Plan on a Page

Bedfordshire Health and Social Care economy is a system compromised of partners from Bedfordshire Clinical Commissioning Group, Bedford hospital Trust, Luton & Dunstable Hospital Foundation Trust, South Essex Partnership Trust, Central Bedfordshire Council and Bedford Borough Council, who have come together to agree, refine and implement our vision for **Better Care, Better Value and Better Health**

To reduce the number of people dying prematurely from conditions amenable to healthcare by 11.2% in 5 years

To enhance the quality of life for people with long term conditions

To reduce emergency admissions to hospital by 22% in 5 years

To improve patient experience of hospital care

To improve patient experience of out of hospital care

To reduce the number of emergency hospital admissions for injuries due to falls in people over 65 years

To increase attendance to leisure facilities by 5% over a 12 month period

Delivered through our **joint children's and young people's plans** to help children and young people begin a healthy life

Delivered through our **Mental Health Procurement** which will implement a Stepped model of mental health care that will enable more patients to be seen earlier and in the community

Delivered through the **review of healthcare services** which will create a set of options for high quality, sustainable care

Delivered through our **Transforming Primary Care programme** which will develop GP networks/federations, working in an integrated way with community and specialist services to provide wider primary care at scale

Delivered through our **Better Care Fund Plans** which will bring resources together and lay the foundations for a more integrated system of health and social care

Overseen through the following **governance arrangements**

- Shared System Leadership Group
- Individual organisations collaborating/leading on specific projects
- Cross working across Better Care Plan Fund Initiatives

Measured using the following **success criteria**

- High quality, sustainable models of care
- Integrated out of hospital care
- Excellence in emergency and urgent Care; a simplified, productive urgent care system
- Achievement of system objectives

System **Values and Principles**

- The patient matters most
- A environment that facilitates pace and scale of change
- Patient/service user empowerment and support, involving families, carers and the voluntary/charitable sectors
- Leading for the long term
- Work in an evidence-based way