Overview of Place Based Plan

Place based plan in response to BLMK ICS priorities and challenges including:

• to drive better care delivery
• improve health outcomes
• reduce inequalities
• better integrated care
• make progress in ensuring a sustainable health and care system

To ensure patients and residents:

» Experience **seamless access** to a timely, coordinated offer of health and care support
» Can access a wide range of support to **prevent ill-health** with increasing emphasis on early interventions through the support of voluntary, community and long term condition groups
» Are supported to **remain independent** through integrated GP and multi-disciplinary teams delivering the care within their own home, wherever possible
» Have access to a wider range of health and care **services in the community** that will help to avoid unnecessary hospital admission and, following any necessary admission, will enable discharge to home care as soon as it is safe to do so;
» Have access to **mental health services that are integrated with physical health and social care services**, through acute, primary, community and specialist teams and aligned to Integrated Health and Care Hubs.
» Have access to **integrated rehabilitation and reablement** services that will avoid or minimise the need to enter into residential or nursing home care;
» Experience **reduced variations** in care with improved outcomes;
» Have **support for carers** that is timely and person centred with an integrated response underpinned with joint planning and assessment, as appropriate;
» Experience services that are **person-centred**, highly responsive and flexible, designed to deliver the outcomes important to the individual; and
» Benefit from stream-lined and integrated working with **joint information systems**.
Our Local Vision

Our local vision is for the people of Central Bedfordshire to have access to good quality, safe, local health and social care across its towns and rural areas.

This will be centred on the integration of health and social care through a whole system and seamless approach to improving physical and mental health, so that people can experience care ‘better care, locally without organisational boundaries’. Integrated Health and Care Hubs will act as focal points for joining up health and social care and provide facilitate the Primary Care Home model and the ambitions of the GP Five Year Forward View.

We want care to be coordinated around an individual’s needs with prevention and support for maintaining and maximising independence at its core and underpinned by the following principles:
• Care coordinated around the individual
• Decisions made with, and as close to, the individual as possible
• Care should be provided in the most appropriate setting; and
• Funding flowing to where it is needed.

This will ensure our populations are provided with the opportunities to realise their full potential and have the support they require to lead healthy and independent lives; that they receive timely access to high quality services such as health and care when they need it.
Summary of Progress Q1 and Q2 2018/19

Good progress has been made across all priority areas across Central Bedfordshire including:

• **Priority 1 Prevention**: launch of the social prescribing service
• **Priority 2 Primary, Community and Social Care**: 100% population coverage for extended access in primary care, launch of Urgent Treatment Centre, MDA roll out across all clusters, Programme for development of Integrated Health and Care Hubs progressing; implementation of Enhanced Health in Care Homes framework, a range of improvements in children’s services including CAMHS crisis service and in respiratory and diabetes services
• **Priority 3 Acute sector**: Improvements in Maternity care
• **Priority 4 Digitisation**: Increased record sharing between practices and improving digitisation in care homes;
• **Priority 5**: Provider Alliance established; transfer of community services contract to ELFT; Strategic Commissioning Board for Central Bedfordshire established and will have its first meeting in November.

There have been notable challenges for example roll out of flu vaccinations to the elderly due to a national problem with distribution of vaccines and the delay in plans to merge BHT and L&D.

Key area of focus for Q3 anQ4 will include continued development of primary care home; agreeing an equitable clinical support model for care homes; further roll out of SystmOne, including access to multidisciplinary and care home modules and development of strategic digital solutions.

Detailed updates are provided in the remainder of the report.
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<tr>
<td>Reduce non medical demand on primary care</td>
<td>Implement social prescribing, social support, health coaching and navigation, wellbeing champions, Village Care, Good Neighbour schemes, information and guidance, digital solutions</td>
<td>Central Bedfordshire Community Wellbeing Champions have been appointed across the 4 localities and a Social Prescribing Service was launched in October. Asset mapping for community resources is underway. Inaugural BCCG self care group meeting in Nov and agreement to develop a BLMK self care / management network.</td>
<td>The social prescribing service is also an integral part of a multidisciplinary approach within localities and will support initiatives targeted at High Intensity Users. External evaluation is planned.</td>
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<td>Reduce levels of smoking and harmful alcohol and substance misuse</td>
<td>Stop smoking re-design to improve access to services Effective delivery of prevention and treatment services for drugs and alcohol Implementation of risky behaviours CQINN in acute and community providers</td>
<td>Re-design at consultation phase with implementation of quit-line service and targeted interventions for vulnerable groups in April 2019 Health Needs Assessment complete with recommendations for further improved outcomes</td>
<td>Smoking quitters 72% of target in July 2017 Outcomes for successful completions of drug and alcohol treatment in top quartile in all categories</td>
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<td>Reduce flu in vulnerable groups</td>
<td>Seasonal flu vaccinations to be completed by Dec 18</td>
<td>There have been delays in some practices receiving their flu vaccine orders. This has been mostly resolved and the programme is underway.</td>
<td>Admissions to hospital due to flu for vulnerable groups including older people will be monitored and evaluated in Spring 2018</td>
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<td>Reduce incidence of cardiovascular disease (CVD)</td>
<td>Review of the CVD Rightcare pack revealed considerable variation in practice and outcomes. Promotion of HeartAge Tool</td>
<td>The pilot of opportunistic screening for AF/HT has had limited take up by community pharmacies, limiting evaluation Proposals to address variation will be taken to the Clinical Executive Group to review and address these</td>
<td>The second phase of the AF/HT pilot is being scoped including further evaluation</td>
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<td>Ensuring that growth delivers improvements in health and wellbeing for current and future residents</td>
<td>Improve understanding of people’s experiences of recent local growth. Use this and evidence from elsewhere in the country, to identify specific changes or interventions to create ‘healthy places’</td>
<td>Commissioned customer insight for delivery in Q3 2018</td>
<td>The outputs of the survey will be available in Q4 2018/19</td>
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**Lead:** CBC Public Health
## Priority 2 – Delivering high quality and resilient primary, community and social care services

**Lead and partners** (who). GP Clusters; ELFT / CBC, BCCG and Community and Voluntary sector

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<td><strong>Primary Care Home</strong>&lt;br&gt;To support and accelerate the development of primary care networks with a focus on population health management.</td>
<td>Clusters to:&lt;br&gt;• demonstrate Level 1 of NHS E ICS Primary Care maturity matrix by end of 18/19&lt;br&gt;• make best use of shared assets and workforce;&lt;br&gt;• uniformly deliver care through integrated teams to high risk groups;&lt;br&gt;• make use of data to understand their populations, have developed transformation project and development plan to work collaboratively&lt;br&gt;• PMS scheme for 18/19 to expand multidisciplinary approach&lt;br&gt;• continue delivery of GPFV commitments and primary care home model&lt;br&gt;• align local investment opportunities.</td>
<td>Six clusters of GP Practices are signed up to NAPC Programme. Current cluster maturity assessment:&lt;br&gt;West Mid Beds F&lt;br&gt;Leighton Buzzard F&lt;br&gt;Ivel Valley North F&lt;br&gt;Ivel Valley South F&lt;br&gt;Chiltern Vale F&lt;br&gt;Increased the number of clinical pharmacists, Emergency care practitioners and AHP roles in primary care&lt;br&gt;Next steps are to:&lt;br&gt;• develop Population Segments to identify priority groups and update cluster development plans&lt;br&gt;• Continue to develop multidisciplinary team working to support complex patients and High Intensity Users of services&lt;br&gt;• Evaluate the benefits of the cluster transformation schemes</td>
<td>Improved access to primary care appointments via Extended Access services introduced in Sept 18 Clusters transformation schemes now benefiting patients and the system: Joint Frailty nurse in WMB cluster providing support to patients in their own homes to reduce possible risks of admission to hospital Ivel Valley complex care team approach with nurse and pharmacist input have supported patients to potentially avoid 37 admissions Chiltern Vale have recently appointed a Frailty nurse to provide on the day home visits LB practices are collaborating to use technology via Footfall website to provide more timely information to patients and reduce need to face to face appointments</td>
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Priority 2 – Delivering high quality and resilient primary, community and social care services -

**Lead and partners** (who): GP Clusters; ELFT/CBC, BCCG and Community and Voluntary sector

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<td>To develop 5 <strong>Integrated Health and Care Hubs</strong> as focal points for Primary Care Home model</td>
<td>Development of Business Cases for Integrated Health and Care Hubs. OBC/FBC for Dunstable and Biggleswade Hubs. Development of Strategic case for remaining Hubs – WMBs, LB and HR</td>
<td>Programme plan to develop OBCs for Dunstable and Ivel Valley Hubs on track – expected completion February 2019. SOCs for West Mid Beds, Leighton Buzzard and Houghton Regis Hubs being finalised – completion November 2018.</td>
<td>Integrated Health and Care Hubs as a focal point for access and delivery of primary care and out of hospital services. <strong>Planned:</strong> Improved access to sustainable primary and community care and securing integrated outcomes residents. Reduced demand for planned and urgent secondary care services</td>
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<td>To proactively support complex care patients</td>
<td>Residents with complex needs and those at high risk of deterioration are identified and supported within a multidisciplinary framework. - Multi-disciplinary approaches implemented across all localities - Implementation of CHS transformation</td>
<td>MDTs rolled out across all clusters from July 18 Proactive case management including social prescribing for High Intensity Users starting Nov 18 CHS Transformation Plan to be agreed at Nov contract meeting CHS Single Point of Contact implemented 1st Oct</td>
<td><strong>Planned:</strong> Prevent rising health care risks, Improve primary care access for patients Reduce inappropriate or preventable crisis demand on the acute sector.</td>
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<td>To improve outcomes for frail older people and better complex care management in the community</td>
<td>Delivering <strong>enhanced health in care homes (EHICH)</strong> and implementation of a frailty index</td>
<td>EHICH Framework in place. Red Bag scheme, Trusted Assessor, Training, *6 111 scheme, WHZAN remote baseline monitoring pilot underway Implementation of tele-monitoring support to Care Homes. Complex Care Team support to Care Homes in Ivel Valley; WMB Frailty nurse Clusters starting to use frailty scores</td>
<td><strong>Planned</strong> Reduced admissions for complex patients including from care homes. Alignment of GP support to care homes. MDT and Geriatrician support to Care Homes.</td>
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Priority 2 – Delivering high quality and resilient primary, community and social care services

Lead and partners: GP Clusters; ELFT/CBC, BCCG and Community and Voluntary sector

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<td>To improve access to urgent care and primary care services to avoid unnecessary A&amp;E and inpatient admissions.</td>
<td>• Extended Access to Primary Care</td>
<td>Integrated discharge team at L&amp;D</td>
<td>Reduce A&amp;E attendances and non elective admissions</td>
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<td></td>
<td>• Urgent Treatment Centre (UTC)</td>
<td>Extended access started 1st Sept 18.</td>
<td>Extended access delivering c 410 appointments per week in CBC</td>
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<td>100% population coverage</td>
<td>The UTC has seen 715 patients since going live on the 1st October 2018, of which 221 were via 111 into a pre-agreed booked appointment</td>
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<td>UTC opened 1st Oct 18</td>
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<td>Reduce non electives for Children and Young people</td>
<td>• Transformation of CAMHS</td>
<td>CAMHS; 7 day CAMHS crisis service embedded / community specialist eating disorders services fully recruited /schools- CAMHS link workers covering all secondary schools across Bedfordshire .</td>
<td>Reduction in admissions</td>
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<td>• Roll out of additional 6 high volume pathways across primary care;</td>
<td>New models of care business case for reducing in patient admissions to tier 4 beds in progress .</td>
<td>Reduction in LOS</td>
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<td>• Formalisation of urgent A&amp;G;</td>
<td>Community: Bronchiolitis training rolled out to primary care / oxygen saturation monitors purchased and provided</td>
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<td>• Front door triage;</td>
<td>to primary care and community nursing teams .</td>
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<td>• Community Nursing for children with acute s/t illness;</td>
<td>Rapid response team being developed in community model</td>
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<td>• Implementation of Local Transformation Plan including further</td>
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<td>development of Specialist Eating disorders community service (across STP);</td>
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<td></td>
<td>• 7 day crisis service;</td>
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<td></td>
<td>• Early intervention and schools support;</td>
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<td>• Roll out of CYP IAPT; Development of seamless pathways for</td>
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<td>inpatient admission with specialist commissioning.</td>
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Priority 2 – Delivering high quality and resilient primary, community and social care services

**Lead and partners (who):** GP Clusters; ELFT/CBC, BCCG and Community and Voluntary sector

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| FYFV aim to improve mental health outcomes including parity of esteem for MH | • Implementing early intervention programmes;  
• Continue to develop dementia services with support to care homes;  
• Work with ELFT to embed mental health in multidisciplinary working across clusters;  
• Housing Officers support to mental health patients;  
• Scope the potential for achieving economies of scale and improving specialist mental health pathways through provision across the STP footprint. | Mental Health Social Worker now contributing to Multidisciplinary team meetings.  
Four Housing Officers appointed to support mental health patients | Update: the development of a Dementia Intensive Support Service (DISS) has been approved. Awaiting business case from MH provider with launch date to be confirmed but anticipated to be January 2019. |
### Priority 2 – Delivering high quality and resilient primary, community and social care services

**Lead and partners:** (who) GP Clusters; L&D/BHT ICOPD Service, ELFT / CBC, BCCG and Community and Voluntary sector

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| To improve health outcomes and reduce unplanned episodes of care for people with **Respiratory Conditions** Rapid response service/ early supported discharge. Community Epilepsy pathways. Community respiratory pathways. Long term conditions management in the community/ complex case management. Therapies remodelling – SCLN / Physio / OT sensory. | • Improved service provision and management of bronchitis pathway  
• Saturation monitors to be distributed during May / June 2018.  
• CAKES training for assessing children with acute short term illness and train the trainer sessions to be provided to Practice Nurses.  
• Joint initiative with NSHI delivering paediatric asthma management guidelines targeting high referring GP practices rolling into Yr2 delivery.  
• Provision of Paediatric Community Nursing support, in line with what is already available in Luton and MK  
**Adults:**  
• Structured preventative care in primary care  
• Proactive recall of patients at risk of COPD for spirometry  
• Enhance delivery of community based services.  
**Children:**  
Bronchiolitis pathway developed and use Pulse Oximeters  
CAKES training being rolled out. NSHI nurses – Asthma mentoring for age 5 and above – guidelines being developed  
Paediatric community nursing services supports complex needs and acute care in community  
**Adults:**  
• Training of workforce to make accurate diagnosis of respiratory symptoms (Protected Learning Time events)  
• British Lung Foundation ‘Information Event’ - October  
• Promote use of Bedfordshire Community Health Services ‘Rapid Intervention Service’  
• Breathlessness symptom pathway to inform accurate diagnosis  
• Adult asthma – one page guide to management of mild/moderate problems in primary care  
• One page pathway for COPD  
• Specialist psychologies for respiratory commenced October | Providing access to timely treatment and support significantly impact on patients quality of life, psychological issues associated with chronic conditions and co-morbidities such as obesity, social isolation and mortality, which create pressures on other areas of the system  
**Children:**  
CAKES training – KPIs and outcomes developed for reporting form Q3 2018/19  
Promote clinical guidelines – bronchiolitis, asthma  
Plan to:  
Reduce non-elective hospital admissions for children aged 0-4 with bronchiolitis / Viral Induced Wheeze (VIW) by providing safe care closer to home  
**Adults:**  
1) Reduce A&E attendance and non-elective admission for adults with respiratory disease mainly COPD, Asthma and influenza/pneumonia  
2) Increase the capability and confidence of Primary and Community Care to manage respiratory conditions in very young children  
3) Empower patients and families to self-manage conditions at home  
4) Standardising patient pathway |
### Priority 2 – Delivering high quality and resilient primary, community and social care services

**Lead and partners**(who): GP Clusters; ELFT / CBC, BCCG and Community and Voluntary sector

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| Cont.. | Cont.. | • Shared Decision Making - CCG is part of a collaborative. CCG has used the national framework and a logic model to help inform the work. Continue work to help embed into business as usual.  
• Respiratory: Introduction of GOLD Guidelines - Launched guidelines back April 2018. Secured funding for two respiratory nurses for two years. Start in January 2019. Review patients at practice level, auditing, inviting patient in to have discussions ensure patients are on correct drug therapy, which will help to avoid admissions.  
• Community-based case finding with quality assured spirometry  
• FeNO – equipment and training in primary care. Plan for scoping.  
• Flu and pneumonia vaccinations -  
• Promotion and awareness with at risk group – Green book reminder of eligible patients  
• Timely access to pulmonary rehabilitation  
• Access to specialised Services – Development LTC IAPT programme and operationalise the offer and recent introduction of 2 x Clinical Phycologists. (Prioritised COPD and Diabetes). |
Priority 2 – Delivering high quality and resilient primary, community and social care services - tick

Lead and partners (who). GP Clusters; ELFT /CBC, BCCG, BHT & LDH community diabetes services (ICDS), and Community and Voluntary sector

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| To improve health outcomes and reduce unplanned episodes of care for people with Diabetes | **NHS Diabetes Prevention Programme (NDPP) – commenced June 2017**  
- Two-year Programme providing education and support for people at risk of diabetes to help prevent or delay onset  
- Patient participation in care planning as part of annual review including jointly agreed care plan  
- Improved access to services including health and well-being services and structured education, provided by Integrated Diabetes Service  
- Early identification of foot problems and referral to specialist MDFT services,  
- Investment for Integrated Community Diabetes Service (ICDS) to support patients who are struggling to optimise control of their diabetes and tailored support to practices where indicated by current outcomes and performance. | **NDPP – to date**  
- 4087 patients referred to programme (across BCCG)  
- 33% referred attended Initial Assessment (IA)  
- Re-procurement underway for further 3 year programme from August 2019  
- **Diabetes Treatment & Care Programme**  
  - 47/48 practices signed up to local incentive scheme for care planning as part of diabetes annual review – attended personalised care planning training  
  - Expansion in structured education (SE) capacity in choice of local venues and flexible days including Saturdays  
  - Promotion of access to well-being services (weight management, IAPT, smoking cessation)  
  - Podiatrist training for practice staff to undertake footchecks  
  - Community Foot Protection Service and hospital Multi-Disciplinary Footcare Team implemented  
  - Additional posts in ICDS to support practices including use of new IT tool to identify individual patients not achieving treatment targets (HbA1c, cholesterol & blood pressure)  
  - Webinars for practices – SE, use of purpose designed IT template | **NDPP – to date**  
- Reduction in mean weight of patients after 6 months on programme – 3.9 kgs (178 patients to date)  
- Ongoing monitoring of impact of programme  
**Diabetes Treatment & Care Programme April-September 2018**  
- 3000+ personalised care plans  
- 10,000 + foot checks in practices  
- 280 additional SE places compared to same period 2017/18  
- 944 referrals to structured education (35% attendance)  
- 165 Diabetes referrals to IAPT 2018/19 Year-end targets  
  - 10,000 care plans delivered  
  - 20,000 foot checks delivered  
  - 1800 referrals to SE and increase attendance rate  
  - All practices referring diabetes patients for weight management and/or SE  
  - Reduction of 12 major foot amputations (75%)  
  - Reduction of 14 minor foot amputations (53%)  
  - Note: Information provided is for all BCCG patients |
## Priority 2 – Impact

**Impact**

- 100% coverage of self-identified primary care networks, mitigating primary care workforce recruitment and retention issues
- Access to fully integrated teams in primary care
- Improved and extended access to integrated services in the community including delivery of primary care at scale
- Reduced A&E attendances and hospital outpatient appointments
- Avoid unplanned hospital admissions across all ages
- Reduce length of stay in hospital
- People are supported to better understand their condition and improve self-management
- People with long term conditions, including dementia have person-centred care plans in place
- Improved outcomes for adults and children with mental health issues.
- Complex care support to Care homes residents and equitable access to health and care services
- Increased access to mental health support for children and young people,
- improved access to psychological therapies for people with common mental health problems
- Increased the number of people being diagnosed with dementia and receiving post diagnostic care
- Improved physical health care for people with severe mental illness (SMI)
- Increased access to perinatal mental health support.
- To reduce hospital admissions for people with diabetes, reduced length of stay and reduction in foot amputations
## Priority 3 – Sustainable Secondary Care

**Lead and partners** (who) Acute Trusts; ICS PMO

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<td>To deliver high quality and sustainable secondary (hospital) care services.</td>
<td>To support merger of the L&amp;D and BHT Working with Acute hospitals to support delivery of out of hospital services in Integrated Health and Care Hubs.</td>
<td>Ongoing</td>
<td>Through the integration of clinical services and teams, it is anticipated the merged Trust will deliver high standards of inpatient care that is safe, timely, effective, efficient and patient focused, and can be used to drive a system-wide approach to the delivery of streamlined integrated care</td>
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**Cancer**

BCCG as lead STP CCG for Cancer continue to work with the Cancer Alliance to develop the EoE Cancer ambitions focusing on performance, improving 1 year survival, implementing national best practice pathways for Breast, Lung, Colorectal and Urology services and developing a strategy for Cancer as a long term condition.

The STP Cancer Delivery Plan and NHSE Cancer Transformation Funding will support delivery against the plans, which cover Early Diagnosis and Living with and Beyond Cancer

The Transformation team have successfully rolled out a new primary care test to detect Colorectal Cancers earlier. The Faecal immunochemical test (FIT) was launched early October across the STP. Each project has a pan STP working group

There are 9 projects included in the Transformation Plan focusing on Early Diagnosis and Living With and Beyond Cancer. 7 of the 9 projects are well established as part of the year 1 programme with work underway to scope the 2 new 18/19 projects.

BCCG has retained Patient Experience score of 8.7/10 in the annual National cancer Patient Experience Survey

BCCG has retained Good rating in the annual NHSE Improvement and Assessment Framework.

Year 2 funding to support the programme for 18/19 has been approved by NHS England.
## Priority 3 – Sustainable Secondary Care

**Lead and partners (who)**: Acute Trusts; ICS PMO

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<td>To deliver high quality and sustainable secondary (hospital) care services.</td>
<td><strong>Maternity</strong>    Delivery of Local Maternity Services Plan   priorities including Improve the safety of maternity services; Create a joined-up approach to workforce planning; Develop and implement standardised pathways; Improve choice and personalisation of maternity services.     Place based workstreams are focussed on effective service user co-production and the establishment of independent, formal, multidisciplinary &quot;Maternity Voice Partnerships&quot; to influence and share decision making.     Alignment of Local Maternity Services in Integrated Health and Care Hubs.</td>
<td>A newly developed Maternity dashboard to monitor progress against Better Births Standards has been added to BHT contract this year.</td>
<td>by 2020/21 BLMK maternity services have made significant progress towards the &quot;halve it&quot; ambition to reduce still births and neonatal deaths, maternal death and brain injuries during birth by 50% by 2030.</td>
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# System Enablers – Priority 4 Digitisation

**Lead and partners:** P4 Board and ICS PMO

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| Place based implementation in conjunction with Digital Transformation workstreams | **Shared Health and Care Record:** Continued N3 replacement across STP; Continued Wi-Fi roll out in Practices and Care Homes; EHR Core mobilisation at BHT (Q1), rollout of S1 to ELFT PC link workers, Clinical System Reviews and template alignment for BCCG member practices; Data sharing agreements and IG agreements between Practices and with STP Providers supporting development of shared care records across clusters and place. Care Homes undertaking IG toolkit readiness and assessment to expand on the LGA funded pilot. Social care workforce primed for agile working. **Technology:** SMS messaging in practices rolled out across STP; Development and procurements for online consultations; Telehealth monitoring pilots begin in Care Homes. Whole population health analytics: Tactical Business Intelligence solutions being explored. Central Bedfordshire commissioning case management system (SWIFT replacement) Whole population health analytics Continue to commission Civica SLAM **Information Governance:** BLMK information sharing agreements reconfirmation in Q1; Data-sharing model to continue to be developed; Assurance of compliance with GDPR across STP. | **Progress to date:**  - Monitoring the improvement against Universal capabilities and Interoperability across providers  - Procurement of replacement N3 services via a BLMK / Herts STP procurement supported by HSCN  - Increased rollout of SystmOne as tactical shared record solution across BLMK  - Project established and well underway to roll out robust WiFi, NHSMail, IG training and SystmOne access to all BLMK Care Homes  - Procurement of online consultation solution  - Remote monitoring pilots mobilised in each CCG area  - GP Collaborative Working Toolkit produced and disseminated  - Clinical Systems Reviews at BLMK practices to ensure consistency, template alignment work is ongoing  - BLMK IG model developed and overarching ISA’s signed  - Extended access technical solution developed for all BLMK CCG areas  - Options appraisal and Outline Business Case for strategic Interoperability Architecture solution completed  - Engagement events held to support this strategic programme  - HSLI Bid submitted for funding of the Interoperability Architecture  - BLMK Maternity Programme provided with Digital Transformation Support | Strategic solution developed  
Increased record sharing via SystmOne  
Increasing enablement of collaborative working |
## System Enablers – Priority 5 System Redesign

### Lead and partners
(who) P5 Board and ICS PMO

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| During 2018/19, continue the work to design the place based framework for Central Bedfordshire and support key transitional steps to progress the journey towards an ICS. | • Implementation of new CCG Leadership arrangements that support greater integration of commissioning at scale and at place  
• Build ICS infrastructure  
• Consolidate the Provider alliances/partnerships and networks to progress greater integration between health and social care  
• Establish an understanding of the collective resource for Central Bedfordshire as part of the maturing collective financial management arrangements across BLMK, including managing and delivering the BLMK system control totals  
• Implement whole population health management capability as a key enabler to the ICS becoming operational;  
• Develop potential risk/gain share mechanism related to the management of non-elective activity in the Bedfordshire system. | Joint CCG Accountable Officer and CFO take up posts in November  
Transformation Board established in Central Bedfordshire and is subgroup of the Health and Wellbeing Board.  
Transfer of adult and children’s community health services to East London Foundation Trust completed and transformation in progress.  
Central Bedfordshire has established a Provider Alliance, which includes the PVI sector.  
A Strategic Commissioning Board for Central Bedfordshire has been established and will have its first meeting in November. | Planned |