Paper 11.0 (a)

Governing Body Meeting in Public
26th January 2017

Title: Bedfordshire CCG: Operational Plan 2017-19	**Agenda Item:** 11.0 (a)
Presented by: Clare Steward, Director of Strategy & Transformation (Interim)	
Author: Liz Eckert, Interim Assistant Director of STP and Programme Oversight	
Responsible Executive Director: Clare Steward, Director of Strategy & Transformation (Interim)	
Has this paper been signed off by the Responsible Executive Director? Yes	

Actions/ Recommendations required by the Governing Body:

To receive and note the Operational Plan submitted to NHS England on 23rd December 2016.

Purpose of Paper:

To provide the Executive with the final draft of the 2017-19 Operational Plan* submitted to NHS England on 23rd December 2016.

*NHS England required each CCG to develop a two year operational plan to span 2017-19, detailing the commissioning and contracting implications of implementing the Sustainability and Transformation Plan (STP), as well as other activities that the CCG is responsible for.

Background:

Operational Plan development is a core step in our annual planning process, although this year the CCG was asked to develop a plan spanning two years, aligned to the system-wide changes planned through the developing Sustainability and Transformation Plans (STP). The operational plan also aligns to local initiatives, particularly how we plan to take forward our commissioning intentions and how we intend to proceed with place-based planning in parallel with the STP activities.

A draft plan was submitted to NHS England on 24th November, further to which positive feedback was received by the CCG on 16th December, requiring a few minor additional amendments.

All of the points raised in that feedback have been responded to within the revised plan which was approved by the CCG Executive Committee on 22nd December, acting on the delegated authority of the CCG Governing Body.

The final plan was submitted to NHS England on 23rd December and we await further comment.

Audit Trail:

22.12.2016: Approved by Bedfordshire CCG Executive Team under delegated authority from the CCG Governing Body.

Strategy Implications:

The Operating Plan is directly aligned to the STP, Commissioning intentions, QIPP and organisational priorities.

There are interdependencies between this and the following strategic areas:

- Primary care
- Out of Hospital strategy
- Urgent and Emergency Care
- Planned Care

Financial Implications: None

Risks: None

Legal: None

Has appropriate engagement and consultation taken place? N/A

Has an appropriate equality and diversity assessment taken place? N/A

Executive Summary:

The requirements of the contracting round in relation to operational planning changed this year, with CCGs being asked to complete negotiation on two year contracts, create finance, activity and narrative plans and respond to the General Practice Five Year Forward View by the 23 December 2016. NHS England set out clear requirements in their planning guidance

The timeframe for development and sign off was shorter than in previous years, and the Governing Body delegated responsibility to the CCG Executive Committee for signing off the draft and final versions in readiness for submission to NHS England by the prescribed deadlines.

A draft Operational Plan was submitted to NHS England on 24th November 2016, further to which positive feedback was received by the CCG on 16th December, requiring a few minor additional amendments.

All of the points raised in that feedback have been responded to within the revised plan which was approved by the CCG Executive Committee on 22nd December, acting on the delegated authority of the CCG Governing Body.

The final plan was submitted to NHS England on 23rd December and is attached for the Governing Body to endorse.

Requirements from NHS England

In September 2016, NHS England and NHS Improvement published *NHS Operational Planning and Contracting Guidance 2017-19*. In this guidance, NHSE set out an expectation that the 2017-19 operational planning and contracting round will be built out from Sustainability and Transformation Plans (STPs), which includes finance and activity planning, narrative plans and contracts with providers.

The guidance asked for the planning process to be completed earlier than usual within the cycle, with all contracts with providers to be signed by 23 December 2016 to cover the two years 2017-19, and finance and activity plans and associated narrative to be submitted to NHS England on the same date.

There was also a requirement to respond to the GP Five Year Forward View (GP FYFV) which was published in April 2016. Submissions needed to reflect local circumstances and also detail how CCGs intend to:-

- Improve access to general practice
- Create and deploy the funds for practice transformational support which is required in the GP FYFV.
- Ring-fence and deploy funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations

This is included in a separate paper for the Board to endorse also

Developing the Two Year Operational Plan for 2017-19

The Two Year Operational Plan narrative was different to the requirement in previous years, where CCGs were historically asked to develop quite long, detailed plans that have resulted in the annual Plan for Patients. This year, NHS England asked for a shorter, more concise document which focussed on how the CCG will deliver national standards, business rules and the nine ‘must do’s’ set out in the planning guidance.

The narrative plan focuses on the areas set out below that have provided in a template by NHS England Midlands and East region:

1. Relationship to the STP
- Clear statement how the plan supports the delivery of the STP and the schemes within it to deliver the Five Year Forward View, GP Forward view and the Mental Health Forward View over the two year period
- Any reasons for non-alignment to STP at a local level
- Risks and issues that affect delivery of the STP

2. Challenges
- Briefly state the key challenges that the CCG faces

3. Delivery of plan priorities
- Key actions the CCG will take to deliver the nine must do's, STP priorities and local priorities
- How success will be measured and planning trajectories
- Relationships to national programmes e.g. RightCare

4. Supporting narrative to plan templates
- Explanation of the data submitted for finance and activity
- Planning assumptions used
- QIPP plans and how they're reflected in contracts
- Provider capacity to deliver required activity
- Alignment between finance and activity plans and delivery of constitutional standards

5. Quality
- Priorities for quality improvement
- Arrangements for quality assurance and how this triangulates with financial and activity planning

6. Engagement
- Plans for engagement around the transformational aspects of the plan

7. Workforce
- Impact of the plan on workforce e.g. new roles, recruitment and retention
- Engagement with Health Education England
- Relationship between finance and activity plans and workforce

8. Risks
- Major risks in relation to delivery of the plan and mitigations in place
- Assurance structure for risk management and escalation linked to the Board Assurance Framework

In agreement with other CCGs in our STP footprint (Luton and Milton Keynes) the CCG successfully developed consistent narrative content around the STP level activities and those priorities that are common across the CCGs, but are not part of the STP itself.

However, in relation to local 'Place-based' differences for each CCG, these have been clearly been identified and addressed through the individual CCG plans.

The timescales and process undertaken for developing the response to the Operating Plan and GP Five Year Forward View (GPFYFV) prior to presentation to the Governing Body

Detailed guidance on each of the submissions was contained within an annexe of the *NHS Operational Planning and Contracting Guidance 2017-19* guidance.

Timescales

17 November 2016 First draft of narrative plan approved by Executive for submission to NHS England
24 November 2016 First draft of narrative plan submitted to NHS England
22 December 2016 Final draft of narrative plan approved by Executive Final draft of GP FYFV response approved by Executive
23 December 2016 Submission to NHS England of final narrative plan. Submission to NHS England of GP FYFV
26 January 2017 Plans shared with Governing Body for information

Final plans were submitted to NHS England on 23rd December following approval from the CCG Executive Team acting on the delegated authority of the Governing Body. These plans are presented today for information and endorsing.

NHS
Bedfordshire
Clinical Commissioning Group

Bedfordshire CCG Operating Plan 2017-2019

Narrative Plan

December 2016

1 Foreword

Our Operational Plan for 2017-19 sets out how we intend to deliver our statutory responsibilities and our vision for healthcare services in Bedfordshire over the next two years.

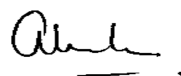
The Plan outlines our strategy for local services, within the framework of the Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP). It is also written in the context of the Five Year Forward View, which emphases that CCGs should move away from arrangements with multiple providers of healthcare with competing interests to more efficient place-based systems where providers work together to improve health and care for the populations they serve.

In future, multiple health and social entities will work together within and across organisational boundaries in the BLMK STP 'footprint' to advance the effective delivery of healthcare for our residents. We know, for instance, that people with long-term conditions, many of whom are older people, are now account for 70% of the total health and care budget. Often these patients interact with health services in a series of hospital episodes. We will need to establish a clear framework for how services fit within the wider system of referral pathways to support these patients through the life of their condition. In other words, treating the person, not just the condition.

Our Operating Plan outlines our local and shared priorities alongside the STP, including key strategic clinical areas, the clinical priorities from RightCare data, and our commissioning intentions. The CCG's financial outlook, projected spend, and estimated QIPP savings, as well as our assessment of financial risk, is also summarised. The plan sets out how we will aim to deliver the national 'must dos' for urgent and emergency care, referral to treatment, cancer, mental health, learning disability, quality and engagement.

However, there are many challenges facing us, not least our uncertain financial position and the amount of funds we will have available for further investment. There are additional challenges with many in our workforce who are approaching retirement, a resident population that is ageing, and an increasing number of people in Bedfordshire who have co-morbidities.

We are confident, however, that with sufficient financial investment and collaboration with our local partners, we can build on our success so far to deliver our ambitions for better, more integrated, and cost effective services over the next two years.



Mathew Tait
Accountable Officer, Bedfordshire CCG

Dr Alvin Low
Clinical Chair, Bedfordshire CCG

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2 Our overall strategy and ambition

This document sets out Bedfordshire CCG's Operating Plan for 2017-19. It outlines the activities that the CCG will undertake to address its challenges, deliver the Five Year Forward View, and implement the solutions set out within the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan (STP). It also sets out our local work on specific areas of the nine 'must dos' of the NHS planning guidance 2016/17-2020/21, and milestones for meeting our objectives.

There are 450,000 people residing in Bedfordshire and, as elsewhere in the country, the population's health needs are increasingly complex. As these needs have become more complex so too have the health and social services designed to meet them. Currently, most of the CCG funding is spent is on acute hospital services, with a significantly smaller proportion on community and mental health services. This is unsustainable and we now have a double challenge:

1. To meet the variety of real time needs of patients in their own particular life situations and,
2. To do so in such a way that is economically sustainable and cost effective.

As a CCG our key ambitions are:

1. Securing additional years of life for people with treatable mental and physical health conditions through self-care, prevention and early detection;
2. Improving the health-related quality of life of our residents with one or more long term condition, including mental health conditions;
3. Reducing the amount of time people spend avoidably in hospital through better and more cohesive care in the community, outside of hospital;
4. Increasing the number of people having a positive experience of hospital care;
5. 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.

Early intervention to secure long-term benefits is essential to these ambitions; it will keep people more independent and creates the potential to make savings to the system through avoided hospital admissions. But early intervention requires coordinating more complex responses in the community to tackle the social as well as the health issues that contribute to hospital admissions and delayed discharges.

In addition, it means combining resources and know-how between local partners in health and social care to align and synchronise traditionally separate organisations and ways of working which will help us meet the needs of patients, particularly where multiple agencies are involved.

Our plans demonstrate a shift from commissioning providers with competing interests to facilitating collaboration and cooperation within a place-based framework. We will establish economies of governance in the way resources are brought together and economies of alignment in the way services are combined to deliver timed interventions; and develop resilience in our services to cope with the diversity of our population's needs.

3 Delivering the Five Year Forward View

The NHS Five Year Forward View, published in 2014, sets out a shared view on how services need to change and new models of care that will be required in the future. It states that prevention and public health should be at the forefront of healthcare strategy, with patients having far greater control of their own care.

Traditionally, providers have added on services to meet growing demand, organising around treatments rather than outcomes. Personalised and coordinated health services to patient need can only be achieved through interoperating care networks; thus breaking down the traditional boundaries between disparate services is essential to achieving our goals. Our STP will build the structure for a network of collaborating agencies working within a ‘place-based’ system. This will help drive down waste and duplication as well as bringing combinations of services into alignment to the specific needs of the whole population residing within the footprint. Our STP means developing ‘leaner’ services, therefore, that deliver more co-ordinated responses to our patients and at less cost to the local healthcare system.

The Forward View outlines a range of care models that may be adapted in different areas to put in place services fit for the needs of local populations. Whilst we are considering which of these new models of care fit best for our local populations, we have worked with health and social care partners to develop a system-wide plan.

The key priorities of the Bedford, Luton and Milton Keynes (BLMK) STP combine user-facing initiatives, in prevention, primary, community and social care and hospital services, with enabling tools such as digital care records, combined data platforms, and structural incentives to support the transformation process.

The STP plan aims to hold cross boundary working and facilitate whole pathway management through an Accountable Care Organisation. It will inject more flexibility and agility into the system, creating better access to community and hospital services, more joined up services, technology to support self-care, better opportunities for prevention, and access to health care closer to home.

For councils, the STP plan will support public health directives, boost investment in community infrastructures, and build greater interoperability between health and social services. It will help build sustainability and resilience in primary care, encourage the development of specialist skills, facilitate working between GPs and hospital clinicians, and improve care management.

3.1 STP overview

The STP has set out five priority areas of work which are being implemented through a multi-agency programme. They are:

STP priority 1: Encouraging self-management and social capacity to impact on health improvement and illness prevention

System-wide prevention plans are being developed with STP partners and communities and the prevention aspect of the STP is focused on six areas (best start for children, lifestyle behaviours, screening and immunisations, mental health and well-being, healthy workforce, and empowerment). Improved technology to support self-management will help in the development of models of co-managed care with patients.

Locally, we are undertaking a range of enterprises to support self-care and management: targeting people at high risk of a hospital admission to help them to manage their conditions better, raising awareness of cancer symptoms in the community to increase the number of diagnoses made early, applying our suicide prevention strategy, and increasing awareness of mental health issues in children and young people to encourage early intervention.

STP priority 2: Achieving high quality, scaled and resilient primary, community and social care services across BLMK

Our BLMK STP aims to strengthen primary care services and shift activity away from hospitals to the community.

The key goals of the workstream are to:

- Strengthen primary care services to ensure sustainability and enable transformation;
- Increase the health of the population by maximising prevention and self-care
- Shift activity away from acute services to out of hospital care, closer to the patient;
- Ensure that people are able to access appropriate urgent care services, reducing reliance on A&E and reducing avoidable unplanned admissions;
- Improve services for people with learning disabilities; and combine physical and mental health care;
- Improve interoperability and capabilities for alignment in relation to the particular needs of patients between health and social care services.

It is essential that the primary care record should provide the data platform and reference point for all relevant agencies.

We will build care management teams around GPs to help them manage registered patient lists more effectively, including the identification of patients at high risk of hospital admission using stratification tools applied to the analysis of referral pathways. Primary Care Home will enhance the cohesion of interoperating services and we will support GPs to focus on patients with multiple chronic conditions to improve care outside of the hospital setting. Within this context, we will develop a framework for aligning multiple health and social services to particular patient's needs, creating the potential for economies of alignment in primary and community care.

STP priority 3: Developing sustainable secondary care services across the footprint

From July 2016, BLMK will adopt a tri-hospital campus and service delivery approach working together with all three providers and centralising leadership, management, and operational in accord with the BLMK STP vision. This will establish the economies of governance needed to rationalise services and make better use of resources within the footprint

STP priority 4: Forging footprint-wide collective leadership, and designing a BLMK digital programme

Our plans for a digital programme will revolutionise our capability to communicate between people, patients and clinicians, through shared digital records. Data on composite targets in contractual agreements will not be sufficient for effective palce-based commissioning. The digital programme will create a mechanism to track individual patients along the referral pathways in order to identify multiple diagnoses and co-morbidities, enabling us to proactively manage and review those with complex needs, and review patients more easily across a range of health and social locations. For example, we will need to understand patterns of comorbidity and the nature of multi-condition management. Shared records will enable us to hold the balance between health and social contexts more successfully.

New dynamic data platforms will be used to analyse case mix and patient demand, how new pathways affect key clinical groups (and services), support clinicians and service development, provide operational information on quality and demand, and produce better data aggregation to monitor our performance against strategic objectives.

The key activities for this priority are:

- Converge and unify primary and secondary systems making intelligence easily accessible across the footprint; and maximise the use of primary care systems such as System One. Locally, we are using the Estates & Technology Transformation Fund (ETTF) and additional dedicated funding from NHS England, to provide the technical infrastructure for single point of access between practices, new forms of e-consultation; and digital solutions to support self-care and self-management.
- Develop the capability for proactive patient care through risk stratification derived from analysis of referral pathways and predictive analytics; and we aim to deliver better data and support tools for clinicians to understand the needs of their registered populations;
- Supply patients with intelligence and technology so that they can expect a more dynamic interaction between health and social services and their personal situation, and have the tools to self-care and manage their condition. This will be underpinned with a robust information governance framework.
- Enable system-wide view of capacity and demand across all care settings in the footprint (e.g. home care, care home to intensive care unit.)

STP priority 5: Re-engineering health and social provision to meet the variable needs of residents

Traditionally, many health and social services have restricted their criteria to provide a one-sided response to patient's needs with predetermined pathways based on contractual commissioner-provider relationships. BLMK aims to adopt a whole system model that focuses on value – both for us as commissioners in purchasing needed services, to providers in understanding their part within an interoperating network; and direct and indirect benefits to patients in that the costs of alignment will be inherent in the new model, not externalised to them. In other words, getting the right care at the right time.

All relevant parties (i.e. both commissioners and providers) across BLMK have expressed an appetite for adopting an accountable care approach to commissioning

and delivering NHS services. Such an approach will continue to see care designed and delivered at the locality level (typically 30,000 to 50,000 population), sensitised to the needs of different resident populations, and whereby list-based general practice remains front and centre. Some functions will operate in patches co-terminus with local Council boundaries, while others, such as health analytics, information and communications systems, technology and administration will operate across the BLMK footprint.

3.2 STP challenges

Our BLMK health economy has overspent its NHS allocation in recent years, and its combined recurrent shortfall will rise to £203m per annum by 2010/21, resulting in a consolidated BLMK debit in 2020/21 of £311m. This presents a considerable challenge to the plan. Moreover, the detail of how STPs can access STF funding to invest in STP initiatives has not been yet confirmed. Until the timeline and process for this is known, activity assumptions have not been included in the CCG plan.

Current contract offer exchanges between commissioners and providers indicate that for 2017/18-18/19 there is still considerable dialogue required between the parties to move towards an approach that is more aligned with the STP vision of achieving a BLMK system-wide control total.

4 How this Operating Plan supports the BLMK STP

4.1 Key priorities

In a relatively short timescale, the STP has made significant steps towards developing a future vision for the whole health and social care system in Bedfordshire, Luton and Milton Keynes. However, the detailed plans and timescales for change are yet to be fully developed. We have, therefore, aligned our Operating Plan priorities, commissioning intentions and QIPP to the emerging STP, focussing on developing strength, sustainability and capacity within the health and social care system as enabler for the changes to come.

The following matrix demonstrates how the plan, commissioning intentions and QIPP contribute to the delivery of the STP.

STP priority	Area	Operational Plan 2017/19	Commissioning Intentions	QIPP 2017/19	Mandate 2020 goals
Prevention	Obesity	●	●		●
	TB		●		
	Vaccination in care homes		●		
	Health Coaching		●		●
	Increased use of technologies for self care and management	●	●		●
	Place-based population strategies,		●		●
	Risk profiling and care planning.	●	●		
	Step up/Step down integrated service		●		●
	Frail Elderly pathway		●		
	Psychological therapies	●	●	●	●
	Safe discharge from hospital	●	●	●	
Clinical priorities	Diabetes	●	●	●	●
	Respiratory	●	●	●	●
	Cancer	●	●	●	●
	Gastro-intestinal	●	●	●	●
	Cardiovascular	●	●	●	●
Primary, Community and Social Care	Extended access	●			●
	E-consultations	●			●
	Information quality	●			
	Co-location of primary and acute care	●			●
	Referral hub activity	●			●
	A&E streaming	●		●	●
Secondary Care	NHS 111 and signposting	●	●	●	●
	Ambulance services	●	●	●	●
	Improved flow	●	●	●	●
	Safe discharge	●	●	●	●
	Fracture liaison	●	●	●	●
	End of life pathway	●	●	●	●
	Crisis care for mental health	●	●	●	●
	Street Triage, rapid access	●	●	●	●
	Clinical reviews	●	●		●
	Self management in Asthma, COPD, Diabetes.	●	●		●
Digitisation	Access to primary care services	●			●
	Self care	●			●
	Analytics and risk profiling	●	●		
New models of care	Out of hospital care	●		●	●
	Street Triage	●		●	●
	Community services	●		●	●
	Fracture liaison	●		●	●
	Paediatric and maternity pathways	●	●		●

We envisage that the changes to the system needed to facilitate a shift from acute care to out of hospital services will start in 2017/18, although the system is unlikely to see significant impact until 2018/19, and this is reflected in our finance and activity planning assumptions.

4.2 CCG shared priorities

In addition to the activities outlined in the STP, there are a number of priorities that are shared by the three CCGs in the STP footprint, and the partnership working fostered by the STP is seen as an opportunity to address these collectively.

The CCGs are in the process of securing support to deliver a Collaborative Savings Programme which will pull together individual QIPP and transformation plans in to a single set of consolidated plans which need to be delivered in order to meet the combined control total. The CCGs are already collaborating on a number of STP-wide STF bids including:

- Cancer
- Diabetes
- Mental Health

The Collaborative Savings Programme will be one of the strands of work that will be overseen by the Joint Commissioning Executive, which will be in place from January 2017, bringing together the Accountable Officers, Chairs and other senior membership of the three CCGs. In addition to the Collaborative Savings Programme, the Joint Executive Committee will be:

- Overseeing development of the STP-wide bids
- Sharing learning, particularly around areas such as procedures of limited clinical value
- Considering the impact of the secondary care workstream of the STP on commissioning priorities e.g. maternity and paediatrics services
- Considering future commissioning arrangements, looking at short and long term arrangements around lead commissioner arrangements, back office functions, primary care commissioning and the move to full delegation

4.3 Local strategy

The CCG has developed an approach to localising the strategic direction emerging from the STP work, whilst ensuring that we are addressing the specific needs of our population. We have identified five key strategy areas aligned to the STP priorities. They are:

- Urgent and Emergency Care
- Planned Care
- Prevention and Detection
- Out of Hospital Care
- Primary Care

In addition, we have identified five clinical priorities for 2017/18, using Right Care data and information on our current services. They are:

- Diabetes
- Respiratory
- Cancer
- Gastro Intestinal
- Cardiovascular Disease

Our commissioning intentions have also been developed to reflect the changes required in 2017/18 across clinical priorities. Each of these areas have cross-cutting themes and need to consider specific population needs.

Cross cutting themes

- Parity of esteem and integrating physical and mental health
- Finanical sustainability
- Quality
- New models of care / ways of working
- Changing settings of care
- Maximising community input / voluntary sector value

Population considerations

- Children and young people
- Older people
- Working age adults
- Parents and guardians of children
- Hard to reach communities
- Deprived populations
- Carers
- Learning disabilities
- Mental Health

Enablers

- Digitisation and shared records
- Seven day services
- Workforce
- Patient education and self-management
- Estates
- Integration of both commissioning and delivery

For some of the clinical priority areas, the commissioning intentions point to an end to end pathway and mode of delivery review. This is to ensure that we work with partner organisations to establish the issues with specific clinical areas, and identify the changes needed to make improvements. The scope of these reviews will include:

In addition, it is often the case that patients have more than one long-term condition. For example, Right Care has identified 2% of patients in Bedfordshire who account for 16% of spend, and additional analysis of NHSE data below shows the proportion with a higher than average likelihood of a comorbidity with the condition for which they were admitted. So, for instance, 30% of those admitted for circulation problems also had respiratory diagnosis; 29% had neurological problems, and so on. There will be many more patients over and above this 2% who have multi-morbidity profiles, and our STP (Priority 2) and Operating Plan programmes will aim to understand these patients better, and amalgamate their needed interventions through person-centred coordinated care packages.

No. pts		Gastrointestinal	Neurological	Cancer	Circulation	Respiratory	Genitourinary
380	Gastrointestinal		26%	26%	28%	27%	0%
346	Neurological	32%		25%	33%	31%	30%
319	Cancer	31%	27%		18%	27%	22%
410	Circulation	24%	28%	14%		30%	17%
367	Respiratory	31%	29%	23%	34%		22%
							Average = 25%

Figure 1: Source = 2% of population identified by NHSE with comorbidities (data reworked)

A summary of our commissioning intentions is in appendix 3.

5 The General Practice Forward View

Building upon successful working arrangements throughout 2016/17, we have developed a robust plan to ensure implementation of the *General Practice Forward View* (GPFV) within Bedfordshire throughout 2017-19 and beyond. The GPFV will sit alongside our STP vision to provide more care closer to home in the community, provided by interoperating services and pathways.

The priorities highlighted in our GPFV plan include:

- Strengthening primary care services;
- Maximising prevention and self-care;
- Shifting activity away from acute services to the community;
- Clearly defining urgent care services according to need, reducing reliance on A&E and avoidable unplanned admissions;
- Integrating health and social care pathways by developing care networks;
- Helping to integrate physical and mental health services.

There are significant primary care sustainability issues within Bedfordshire (as there are across many areas of the country), and targeted support is being provided to vulnerable practices. Alongside this, practices are being supported to develop longer-term primary care solutions at locality level, and significant work is underway to develop the key enablers to underpin the delivery of more sustainable models of primary care: helping to create a workforce, primary care estate and IM&T infrastructure that are fit for the future.

The plan describes that the principal focus during the next two years is to work closely with member practices and our relevant partners to deliver at-scale sustainable primary care solutions through locality based primary care development plans, whilst maximising the focus on developing the key enablers, infrastructure and partnerships that will enable us to deliver new models of working fit for the future.

Our plan also includes:

- How access to general practice will be improved
- How funds for Practice Transformational Support will be created and deployed to support general practice
- How ring-fenced funding being devolved to CCGs to support training and stimulate the use of online consultations will be deployed.

6 Local challenges

The increasingly complex and variable health and care needs of our local population sit within a challenged health care economy in Bedfordshire, and across BLMK. We have a growing population due to increasing life expectancy, an increase in those with a long-term condition, a rising birth rate and inward migration.

6.1 Health and wellbeing

Life expectancy is better than the national average in Bedford Borough and Central Bedfordshire, but there are large inequalities depending on where people live. Obesity, smoking and alcohol remain significant issues; while mental health problems are rising. The four main causes of early death are diabetes, cardiovascular disease, cancer and chronic obstructive pulmonary disease (COPD).
The 85+ age group is predicted to grow faster than the rest of the population in the next 20 years.

6.2 Care and quality

The CCG has performed well against external assessment such as CQC, but we have certain service areas that need improvement, particularly in cancer, dementia, diabetes, learning disabilities, and maternity. In addition, we have some fragile services, which require stabilisation.

GP practices in Bedfordshire have more registered patients per GP than the national average; at the same time, a significant proportion of our workforce is approaching retirement, and we face challenges recruiting health professionals in primary, community and social care.

At present, our hospitals and ambulance services are struggling to meet demand while maintaining national standards.

6.3 Funding and finance

More than half of our budget currently goes on hospital services and specialist care, with a significantly lesser proportion spent on community care. In addition, our main hospital trust is in deficit.

6.4 STP planning challenge

The twelve NHS organisations and four local authorities that comprise the BLMK STP submitted their final STP in October but there is considerable further detailed work to do in developing the implementation plans that will deliver the STP vision. Once detailed STP plans are agreed, the impact on activity and spend will be more accurately reflected in CCG plans. Working within the confines of the STP and its influence on our organisational planning introduces an additional level of complexity.

6.5 The STP/local plans alignment challenge

The CCG has a number of competing priorities in terms of the delivery of its statutory functions, the delivery of QIPP and achieving the financial control total, improving the services it commissions as well as implementing the changes required from the

developing STP. As the STP develops it is therefore essential that we continually review the CCG plans to ensure alignment and focus resource on the solutions that address a number of the challenges at the same time.

6.6 The capacity challenge

There are significant pressures in our system on acute, primary care and social care. Our challenge within the overall model of the STP and our own commissioning intentions and Operating Plan will be to understand the specific needs of different patient cohorts, and set up more agile and flexible services to support them. In other words, how to organise more efficiently different components of services into tailored care pathways for individual patients.

7 Delivery of plan priorities

This section provides an overview of our plan priorities while the details each local delivery plan for the nine 'must do's can be found in the templates attached. The templates are organised into worksheets for each 'must do' area, and reflect the NHSE guidance layout.

7.1 Sustainability and Transformation

Appendix 5 captures the overall STP milestones and how the CCG will be contributing to their delivery.

7.2 Finance

7.2.1 Current financial performance

The 2016/17 financial period has been shaped by a stretching surplus control total, meaning that the CCG was required to generate a £12m surplus, which will be used to 'pay off' part of the accumulated deficit arising from overspending in 2013-15 (the value of which was £63m at April 2016). This has proved to be a challenging target, requiring significant reductions in planned investments and a higher QIPP (savings) target.

The operating context is made more challenging through the control totals set for local providers, which has led to a more competitive approach to financial management within the local health economy: the healthcare resources of Bedfordshire are being spread more thinly as the CCG seeks both to repay the accumulated deficit and to fund ongoing increases in acute hospital care, without having the available resources to invest in alternatives to acute care (which could help reduce overall costs).

7.2.2 Financial outlook

This cycle is set to repeat in the next two years, with ongoing tension between providers and commissioners to secure their own control totals, ongoing demand increases for acute care, pressure to secure parity of esteem in mental health services, to expand community and out of hospital provision, and to support primary care, as well as to service debt repayments. Significant investment in out of hospital care at scale to create viable alternatives to acute care is less likely in the current environment. Internally, scope for change will rest with our ability to generate additional QIPP spending reductions that may then fund investment in alternatives to acute care. This will take time to mobilise at scale, and may still be insufficient in the face of ongoing population, tariff and acute demand growth.

This financial plan is significantly stretched, and it is not completely clear whether the combination of a significant QIPP target, plus deficit repayment, plus STP investment and transformation, all in the context of ongoing local provider efficiency pressures, is genuinely achievable within the year. This is under review.

7.2.3 Activity forecast

The forecast activity growth informing the plan is set out below. The projection is based upon HRG level analysis of 2016/17 year to date trends adjusted for

seasonality to reflect a full year and compared with the last three years' full year data. There are no significant changes to activity patterns through providers expected at this time that have been included in the baseline trend.

The 'do something' analysis of future years is based upon projection of the planned impact of QIPP schemes analysed to POD level, based on expected HRG level impacts. This is captured at PID (Project Initiation Document) level for each of the QIPP schemes and reflected in Unify submissions.

Investment required to deliver these schemes has been analysed at a high level and is being cross-referred to operating budgets. Current investment requirements have been kept to a minimum and, where required, are funded through application of MRET, Readmissions and winter funds. This is the subject of ongoing discussion with providers as part of the contract round.

This level of growth is fully aligned to the growth assumptions underpinning the provider offers. Many of the counter offers include similar levels of growth on aligned baselines. Key points of difference are, therefore, focused around specific changes arising from QIPP schemes, and counting and coding changes.

The CCG is also working through the A&E emergency Board to reduce spend on admissions, readmissions and winter pressures; and will be one way in which resources can be stretched to meet increasing demand.

	A&E Attendances excluding follow ups	GP Referrals (G&A)	Other Referrals (G&A)	Total Referals (G&A)	All 1st OP - Consultant led	Follow-up OP - consultant led	Total Elective spells (IP+DC)	Non-elective spells complete
2016/17	127,338	82,623	61,269	143,892	119,946	225,322	49,999	43,471
2017/18 (do nothing)	133,574	82,953	65,143	157,378	120,879	233,373	50,659	45,310
growth unmitigated	4.9%	0.4%	6.3%	9.4%	0.8%	3.6%	1.3%	4.2%
mitigations	- 3,681	-	- 4,500	- 4,500	- 4,500	- 7,503	- 1,179	- 2,062
2017/18 (do something)	129,893	82,953	60,643	152,878	116,379	225,870	49,480	43,248
growth mitigated	2.0%	0.4%	-1.0%	6.2%	-3.0%	0.2%	-1.0%	-0.5%
2018/19 (do nothing)	136,254	83,285	64,478	162,136	117,285	233,940	50,133	45,077
growth unmitigated	4.9%	0.4%	6.3%	6.1%	0.8%	3.6%	1.3%	4.2%
mitigations	- 3,500	-	- 4,500	- 4,500	- 4,500	- 7,000	- 1,200	- 2,000
2018/19 (do something)	132,754	83,285	59,978	157,636	112,785	226,940	48,933	43,077
growth mitigated	2.2%	0.4%	-1.1%	3.1%	-3.1%	0.5%	-1.1%	-0.4%

2017/18 mitigations are predominantly achieved through QIPP schemes, although there is also an adjustment for consultant to consultant (medical oncology) referrals. QIPP mitigations are targeted at non-elective and A&E activity, especially through A&E streaming, better signposting for self-referrals, and other interventions. Elective spells are also being targeted via ongoing work to ensure that all spells are 'value-adding' and limitation on less effective activity.

QIPP schemes being developed for 2018/19 are under review to establish their effect on each of the points of delivery.

7.2.4 Financial planning assumptions

- Month 7 2016/17 forecast outturn for run-rates, and latest 2016/17 recurrent exit position.
- A net tariff inflator of 0.1% and CNST allowance of 0.7% have been applied; and the HRG 4+ and IR allocation adjustments are cost neutral (HRG4+ impact has been reviewed for our main provider, BHT, and found to have a cost implication of 1.1%, which is largely covered by the adjustment to the baseline allocation)
- Overall growth is forecast at 3.3%. Growth for Continuing Healthcare Services (price & volume) has been set at 6%, whilst the inflation for prescribing (price & volume) has been set at 7%. These growth assumptions correlate to the activity growth, discussed above, and assume that underlying activity growth of 5%+ has a 3.3% cost impact, which can then be mitigated via QIPP schemes. This is consistent with the current year, in which overall growth translates by c 60% into cost growth.
- It is anticipated that there will be significant cost pressures with several providers including:
    - Patient Transport Services – review of current contract for activity growth and additional provider cost pressures
    - Ambulance services – arising from the East of England AS Remedial Action Plan
    - East and North Herts Hospitals – arising from changes to counting and coding
- It is also assumed that MRET and readmissions funding is retained by the CCG.

The following business rules have been applied:

- 0.5% Contingency Reserve
- 1.0% Non-recurrent Reserve (50% uncommitted)
- 1.0% surplus (used to fund deficit recovery, as also below)
- 1.3% deficit recovery payment

- The £3 per head Primary Care investment to be made over the course of this plan is covered by the uncommitted element of Non-Recurrent Reserve (above).
- Our £25.5m QIPP target is 4.6% of total recurrent allocation, and a summary of schemes by programme area is below.
- A surplus of £11.0m is planned for 2017/18 in line with the control total allocated.

7.2.5 Summary of Spend

	2016/17 (Month 7 FOT)			2017/18			2018/19		
	Plan £m	FOT £m	Variance £m	Plan £m	Yr on Yr Movement £m	%	Plan £m	Yr on Yr Movement £m	%
Acute	297.27	302.46	-5.19	299.80	-2.66	-0.9%	301.60	1.80	0.6%
Mental Health Services	62.55	62.24	0.31	65.20	2.96	4.8%	70.00	4.80	7.4%
Community Health Services	35.63	36.72	-1.09	39.30	2.58	7.0%	42.60	3.30	8.4%
Continuing Care Services	26.08	26.80	-0.72	29.30	2.50	9.3%	32.70	3.40	11.6%
Primary Care Services	7.72	9.42	-1.70	10.60	1.18	12.5%	11.40	0.80	7.5%
Medicines Management	61.90	59.43	2.47	62.90	3.47	5.8%	66.40	3.50	5.6%
Running Costs	9.06	9.12	-0.06	9.60	0.48	5.3%	9.70	0.10	1.0%
Other Expenditure	28.68	25.60	3.08	28.10	2.50	9.8%	29.10	1.00	3.6%
Total Expenditure	**528.89**	**531.79**	**-2.90**	**544.80**	**13.01**	**2.5%**	**563.50**	**18.70**	**3.4%**

The table above sets out the overall view of the plan for 2017-19 compared to the current year. The above summary is based on the month seven (October) forecast outturn showing a £12m surplus reported to NHSE with the exit rate adjusted to an anticipated forecast outturn of £9.1m. Deficit repayments are shown as an in-year surplus. The strategic direction of travel away from acute setting to out of hospital services is reflected in the planned expenditure for 2017/18.

7.2.6 Planned investment

The CCG has been through a prioritisation process to determine where it should focus investment in 2017-19, based on strategic priorities and contracting pressures. The following is a summary of investment for 2017/18:

Delivery area	£000's
Investments to deliver QIPP plan	2,932
Investments to deliver Commissioning Intentions	3,980
Transformational costs	2,742
TOTAL	9,654

7.2.7 Risks relating to the financial plan

The plan includes a number of significant risks, including:

- Ability to conclude affordable provider contracts within planned envelopes;
- Adequacy of assessment of demographic growth and the impact on hospital attendances is not understated;
- Ability to deliver the QIPP schemes at sufficient scale;
- Likelihood that the current planned level of QIPP will not be adequate, and that a higher level of QIPP will be required to be found; identifying and delivering those additional schemes effectively in the context of a financial challenged STP (approximately 2/3 of all QIPP will need to impact on acute activity).
- Implications for Mental Health Parity of Esteem if contract negotiations lead to a higher level of acute contract spend.

7.2.8 Summary of QIPP Schemes 2017/18

This section outlines details of our QIPP plan for 2017-18, and identifies the financial challenge that needs to be addressed. Summarised below, by workstream, are details of the proposed QIPP initiatives for dealing with this challenge over the two years covered by this plan and for driving improved health outcomes for our patients.

The QIPP target for 2017/18 is £25.531m. To achieve this target, the CCG plans to deliver a £19.235m QIPP Programme, supported by a £2.750m stretch target. In addition there is a £3.546m unidentified QIPP value, and the schemes to deliver this are currently being scoped. The financial values are summarised in the table below:

2017/18 areas	Financial Impact (£'000)	Stretch Target (£'000)	Unidentified QIPP (£'000)
CHC	399		
Children, Young People & Maternity	506		
Medicines Management	1,848	250	
Finance & Contracting	3,915	350	
Primary Care	1,003		
Community Services	400		
Mental Health & Learning Disability	1,146		
Planned Care	8,601	2000	
Unplanned Care	1,417	150	
Unidentified QIPP	0	0	3,546
Sub Total	**19,235**	**2,750**	**3,546**
Grand Total			**25,531**

More detail on each QIPP scheme is presented in Appendix 4.

So far for 2018/19, £6.35 million of QIPP savings has been identified, with a further £5.19 million to be identified. The impact of these initiatives on each point of delivery is currently being scoped.

7.3 Primary care

To enable the realisation of the GP Forward View and STP vision within Bedfordshire, there is an immediate priority for us to address significant sustainability issues within general practice and to continue to work with practices to improve the quality of care, to provide a strong platform and support the delivery of longer term goals.

The principal focus on primary care during 2017-19, is to work closely with member practices and our relevant partners to deliver at scale sustainable primary care solutions through joint locality based primary care development plans, whilst maximising the focus on developing the key enablers, infrastructure and partnerships that will enable us to deliver new models of working fit for the future. This will include the development of hubs and primary care capacity at scale to enable broader out of hospital services to develop.

7.3.1 Specific deliverables for 2017-19

We will continue to provide evidence-based and practical support for practices around workforce development and new models of service delivery; and through a *Time for Care* programme. Subject to engagement with our member practices, we will:

- Make available £1.50 per head of population in 2017/18 and a further £1.50 per head in 18/19 (£3 per head in total) as Practice Transformational Funding:
    - To enable practices to deliver on their locality development plans working at scale;
    - to support practices to implement the ten high impact changes as per the priorities identified in our locality primary care development plans, including pump-priming new workforce models, such as practice-employed paramedics, an expansion of the minor illness nurse workforce, and expansion of the Clinical Pharmacist model
    - to deliver targeted workforce diagnostic assessment and facilitated change management across groups of practices
    - to fund dedicated administration and clinical leadership capacity to support new models of integrated mutli-disciplinary working with community services and social care
    - to ensure additional project capacity to support the *Time for Care* programme and to support primary care estates development.
- Establish clinical administrators working in 11 GP practices by April 2016, and within all Bedfordshire practices by 2020/21 (using dedicated funding from NHS England);
- Continue the recruitment and retention of GPs locally through GP fellowship and GP leader programmes, and supporting practices to create more flexible career structures for GPs;
- Develop a Practice Manager Leadership and Innovation Group, which will co-design and drive change;
- Support multi-professional development, mentorship and career opportunities;
- Employ funding from NHS England (£3.34 per head of population in 2018/19) to make progress towards commissioning 100% coverage of extended access by Quarter 3 of 2018/19, to build upon the extended access already provided by many Bedfordshire practices under the NHS England-commissioned DES.
- Use funding via the Estates & Technology Transformation Fund (ETTF) and from NHS England, to improve the technical infrastructure for a single point of access model between practices; as well as new forms of electronic consultation such as e-consultations, shared telephone triage between practices, and Skype consultations; and digital solutions to support self-care and self-management.
- We will consider developing an IM&T Innovation Local Enhanced Service to support and encourage practices with implementing these new modes of working, and to increase uptake of e-referrals and to increase the number of patients who have provided consent to share records between health and care professionals, to help enable primary care at scale and multi-disciplinary working.
- The ambition is for an integrated Health and Care Record, with appropriate governance to facilitate the sharing of relevant information, across the Bedfordshire system, and would be keen to see this reflected at STP level.

The CCG will provide project and change management support within each locality to help reduce GP workload and increase productivity. We will work with NHS England in our joint commissioning role to facilitate the re-procurement of APMS contracts to combine small contracts into new, larger surgeries where possible. In particular, to develop an enhanced primary care centre on the Bedford Hospital site in 2017, with

the potential to re-locate the Walk-in Centre and out of hours provider into the same facility by 2018 (subject to patient consultation); and to provide a 24 hour Primary Care Access Hub.

ETTF funding will enable Full Business Cases to be produced for a further three hubs (in Dunstable, Biggleswade and Bedford) in 2017/18, and the specialist work associated with achieving planning permission to be undertaken, with a view to commencing construction of these facilities in 2018/19.

The CCG will work with member practices will seek to gear up for fully Delegated Commissioning in order to realise benefits over and above Joint Commissioning status already achieved, and ensure a safe transfer of the associated functions from NHS England, at the appropriate stage.

Appendix 6 provides more detail.

7.3.2 Out of Hospital care

To improve the strength and resilience of services across health and social care, we need to create a model of care closer to home which is fit for the future both in terms of operational and financial sustainability. This will require significant planning and investment (both recurrent and non-recurrent) and the development of more innovative and integrated modes of delivery.

The CCG and its local partners are keen to explore the possibilities for organisational integration and co-working and maximise the benefits for patients of a multi-specialty delivery model. This will need to be underpinned by contractual arrangements that incentivise organisations and teams to work collaboratively, simplifying and improving services delivered outside hospital settings, spanning primary, community and social care. There is an appetite to explore broader opportunities for co-working beyond health and social care boundaries to housing, education and welfare, which would create an opportunity to develop holistic approaches to supporting the wellbeing of the population. Evidence elsewhere suggests that the introduction of Local Area Coordinators working with individuals to facilitate access to local and community support reduces the demand on GPs and hospitals.

The CCG will be refining plans for health and social care hubs, in partnership with local authorities and out of hospital providers, to deliver a range of services for patients and the population. This work includes:

- Multidisciplinary Team Working arranged around locality hubs;
- Developing community clinics for the five clinical priority areas
- Discharge to assess;
- Specialist services e.g. early supported discharge for stroke and brain injury patients.

These developments will parallel the procurement of community services provision in 2017/18 and are being led by the CCG on behalf of the two local authorities. The design of out of hospital services procured for children and adults services will build on the work of the Better Care Fund, and the emerging direction of travel from the STP.

To ensure the out of hospital provision is reflective of the needs of the local population, place-based transformation boards have been put in place with each of

the local authorities. These boards will provide a strategic link between the STP and the local context, and drive forward initiatives that are specifically designed for local residents; including the design of new models of care within the emerging accountable care framework.

7.4 Urgent and emergency care

The CCG's overall aim is to help our residents manage their health needs where possible and get to the right care at the right time when needed. As well as providing effective information on self-care and signposting, alternative to A&E we are targeting people at risk in the community of an emergency attendance or admission.

The CCG works through the Bedfordshire A&E Delivery Board that was set up on 1 September 2016 in line with the national directive, to focus solely on Urgent and Emergency Care and to support the improvement of A&E delivery and recovery of performance in conjunction with the STF by the end of 2016/17.

Key deliverables of the A&E Board include:

- Coordination and oversight of the five mandated interventions by reproducing best practice from the best systems already in place, and focusing on outcomes;
- To develop plans for winter resilience and ensuring effective system wide surge and escalation processes exist;
- Support of whole-system planning and operations for local ambulance services;
- To work within the STP footprint and with the UEC Network to deliver the UEC strategy locally with specific focus to be given to expanded access to primary care.

Building on the Keogh Report for Urgent and Emergency Care, the national direction is for an Integrated Urgent Care service to combine NHS 111 and Out of Hours services primary care services. The current contracts for Bedfordshire NHS 111 and Out of Hours services were due to end on 31 March 2017, and a procurement exercise was therefore launched to deliver a new service as of 1 April 2017. Bedfordshire and Luton CCGs took this as an opportunity to integrate their NHS 111 and Out of Hours services across Bedfordshire and Luton enhanced by a Multi-Disciplinary Clinical Advisory Service, in order to provide a more cohesive and seamless service for our patients. The new Integrated Urgent Care service will ensure consistent and clear pathways between NHS 111, Out of Hours and Primary Care, providing a truly 24/7 urgent primary care service. This is expected to demonstrate improved value for money and ensure that the patient receives care at the right care at the right time in the right place.

Some of the key changes to the current service provision included in the procurement are:

1. To allow immediate conversation with a primary care clinician (DX11) when the disposition results in "urgent speak to within 1 and 2 hours";
2. To allow for pre-bookable appointments when the disposition (DX05) results in "urgent contact a primary care clinician within 2 hours";
3. NHS 111 will incorporate a large proportion of the 'telephone advice' currently provided in Out of Hours;
4. Face to face consultations will continue to be provided and will be pre-bookable by NHS 111 when the disposition results in this requirement;

5. To allow immediate conversation with a primary care clinician (DX11) when the disposition results in "green ambulance and refer to A&E disposition".

7.5 Referral to treatment

Further information on referral to treatment is contained within appendix 7.

7.5.1 18 weeks referral to treatment

The CCG is committed to achieve aggregate performance for RTT and Bedford Hospital has a stretch target of 94.61%, with a joint agreement that the STF fund will be delivered on compliance of the national 92% standard. To promote achievement the CCG will commission Advice and Guidance for GP's to access to try to achieve most appropriate utilisation of acute care.

7.5.2 Patient choice

Overall, patient choice will be improved in Bedfordshire through creating better access to community and hospital services, more joined up services, technology to support self-care, better opportunities for prevention, and access to health care closer to home.

More specifically, patients will have more choice via our plans to increase e-consultations (via telephone, Skype, etc.); provide more seven-day opening hours in primary care, and create a 24 hour Access Hub with a view to constructing three more Hubs by 2019/20.

7.5.3 Elective care pathways

The CCG is working on five areas as part of the RightCare Programme, and these are: Cardiology, Cancer, Diabetes, Gastro-Intestinal and Respiratory conditions. The '*Commissioning for Value – where to look pack'* for October 2016 highlighted these areas. The aim is to commission whole pathways. The RightCare Transformation Board will provide leadership on the overall programme; while each clinical area will be steered by an Implementation Group. These Groups will be responsible for innovating services to ensure better outcomes for patients and improved efficiency, which will include Primary Care through to acute and Specialist Care

This programme will support work across the three CCGs within the STP, highlighting QIPP and Quality programme opportunities for 2017/18 and beyond, with a specific focus on prevention.

7.5.4 Better births

During 2017/18 and 2018/19, our maternity specifications and contracts will emphasise the recommendations of the Better Births review, and we will work closely with local maternity services and support them in implementing the action plans from the review. We will work with the East of England strategic clinical network for maternity to learn from national best practice and use the support offered to improve outcomes locally.

In addition, included in the STP footprint are plans to set up a steering group with commissioners from Bedfordshire, Luton and Milton Keynes to develop maternity systems and improve outcomes for our local mothers.

7.6 Cancer

The CCG has developed an action plan based on the main recommendations of the Cancer Strategy for England 2015-2020 which was published by the Cancer Taskforce.

The CCG's cancer strategy is to:

- Improve early diagnosis of cancer by increasing awareness among the population of Bedfordshire
- Improve cancer outcomes – particularly one-year survival rates
- Improve the experience of care for cancer patients and for their carers
- Improve the quality of life for those people living with and beyond cancer diagnosis

Through its Cancer Improvement Group, the CCG will ensure that people with cancer are diagnosed promptly, treatment is compliant with Improving Outcomes Guidance, and individual patients receive care in the most appropriate setting.

More details can be found in Appendix 9.

In Q4 2016/17 we will be establishing a pan-STP Cancer Leadership Group which will bring together those challenges for which an STP-wide approach would be useful, particularly around delivery of the NHS constitutional standards relating to Cancer.

7.6.1 Cancer Taskforce Report

A Cancer Alliance Board is now in place for the East of England, and the CCG is represented via the STP link. Recommendations made by the Cancer Alliance will be ratified by the CCG Governing Body. The CCG has identified the responsibilities for the delivery of the 96 recommendations. A Bedfordshire Cancer Improvement Group is established with both commissioner and provider representation, and this group is responsible for taking forward those areas that require local leadership. These include:

- Early diagnosis – improving screening, access to diagnostics, quality of referrals
- Improving survival – reducing the number of people that wait longer than 100 days for complete treatment, reducing variance in treatment pathways, access to the right treatment e.g. radiotherapy
- Improving experience of care, treatment and support – improvements to patient experience scores, access to psychological support
- Improving quality of life after treatment – community rehab and nursing services including physical therapies

All of these areas will be explored further in our local Cancer Strategy, which will be completed by the end of Q4 2016/17.

7.6.2 62-day cancer standard

Performance against this standard has been a challenge for the CCG. However, with an improvement plan in place with providers, our aim is to recover performance as quickly as possible. Current performance is at 81.23%, and the target is to reach 85% by the start of Quarter 1 2017/18, and then to maintain this through the course

of the plan. Delivery of the improvement plan is monitored through the Cancer Improvement Group which includes representation from commissioners and providers.

There is a clear link between the meeting the 62-day standard and the quality of the initial referral, and so the work underway to improve this will be instrumental in enabling delivery of the target by Q1 2017/18. We are also in the process of developing a bid to the STF to provide additional capacity to being the target down to 28 days rather than 62 as per the ambition set out in the Cancer Taskforce Report. We will also focus on ensuring that the tertiary pathways meet the 62-day standard.

7.6.3 Improving one-year survival rates

We need to ensure more people survive one-year post diagnosis, particularly where the CCG is doing less well in breast, lung and colorectal cancer. We will do this by making improvements across several areas:

What	How	When
Improving quality of two-week wait referrals working in partnership with Cancer Research UK	Cancer Research UK facilitator working in Bedfordshire with Macmillan GP lead to identify and provide support to practices where improvement is required	Q4 2016/17 and Q1 2017/18
Understanding variance in treatment pathways and agreeing key actions to improve	The Cancer Improvement Group is inputting in to the NHS England Radiotherapy Review to drive up the access to radiotherapy and chemotherapy provision for Bedfordshire residents, as it is currently lower than comparator CCGs. The Cancer Improvement Group is also reviewing individual pathways with providers starting with the breast cancer pathways to identify gaps and make improvements	Q3 2016/17 to Q2 2017/18
Reduce the number of people waiting for longer than 100 days for treatment	Root cause analysis for each breach and remedial actions being tracked through the Cancer Improvement Group	Q3 2016/17 to Q2 2017/18

We also proactively monitor all cases where patients wait 104+ days to ensure that no harm has been caused by the delay in care. Lessons learned are circulated to providers.

7.6.4 Risk stratified pathways

This initiative focuses on redesigning follow-up care pathways for people with cancer. It includes the development of supported self-management pathways for patients who have received treatment with curative intent, and those whose treatment has been completed and for whom the acute effects of treatment have subsided. Providers have follow-up care pathways in place for Breast Cancer and there are plans to introduce this in other key specialities such as colorectal and prostate cancer.

7.6.5 Commission the full Recovery Package

The recovery package is a composite of key, timed interventions which together can greatly improve outcomes for people living with and beyond cancer diagnosis. The CCG has already commissioned some elements of the recovery package and plans to introduce a redesigned process for undertaking Holistic Needs Assessments, and increased access to psychological support for cancer patients, and patients at the end of their life, during 17/18.

7.7 Mental health

The 'Five Year Forward View for Mental Health' focuses primarily on the role of the NHS in delivering its commitments and is directed at commissioners and providers to support and influence local plans.

A common theme across many objectives of the plan is building capacity within community based services to reduce demand and reliance on the acute sector and inpatient beds, whilst in parallel moving towards a 'place based' approach. The national roadmap prioritises objectives for delivery by 2020/21. As part of the Five Year Forward View, the CCG's commissioning priorities will be on the following areas:

- Re-provision of inpatient facilities;
- Reduction of admissions in non-specialist adult acute mental health inpatient provision;
- Transformation of Mental Health crisis care which will include a focus on A&E attendances, care pathways and the provision of liaison services to include evaluation of the Street Triage Model.
- Continue to develop maternal and perinatal mental health services;
- Expand primary care mental health provision to improve access to IAPT for individuals with long-term conditions;
- Increase access to recovery based services, including employment and housing;
- Improvement in dementia diagnosis rates through primary care development supported by the dementia assessment services;
- Development of suicide prevention;
- Full implementation of the early intervention in psychosis pathways for patients of all ages.

Further details are contained within Appendix 10.

7.7.1 Psychological therapies

The development of Health Psychology in pathways for treatment and management of Long Term Conditions will continue. The CCG will also continue to improve the performance and access to IAPT (Improving Access to Psychology Therapies) and support access in primary care for individuals with long-term conditions patients needing support with diabetes or pain management.

IAPT services for children and young people are being developed through the 'Future in Minds Local Transformation Plan for 2016-2020. These are detailed in the templates attached.

7.7.2 Early intervention in psychosis treatment

The expansion of the early intervention in psychosis provision so that more individuals can access timely and effective treatment across Bedfordshire. This will be an all age service and will include pathway development with children and young people services.

There will be continued focus on recruitment and workforce development opportunities, including agreeing clinical capacity with appropriate competencies according to local need - as defined by PsyMaptic and workforce calculator for those aged 14-65 with a first episode of psychosis. There will also be a drive on date collection systems to guarantee robust and accurate recording.

7.7.3 Placement support

To support the expansion of the individual placement and support opportunity for those individuals with severe mental health, with development of this provision to support those in secondary care to be able to gain training and sustainable employment to support their recovery.

7.7.4 Mental health access and quality standards

We are evaluating current provision and scoping a future model for Bedfordshire for people in mental health crisis. This will include access and quality standards for 24/7 community crisis resolution teams and liaison psychiatry, and evaluating the impact on A&E attendances and wider care pathways of individuals with mental health needs in Bedfordshire.

During 2017-19 we will be working on increasing access for people with severe mental illness in acute settings. There are a number of actions that will take place in the remainder of 2016/17 to facilitate this. These include:

What	When
Complete a baseline exercise to determine use of Individual Placement Support for those with severe mental illness	Q3 and Q4 2016/17
Improvements to data reporting	Q4 2016/17
Set performance targets within new contract	Q4 2016/17

7.7.5 Mental health investment

We are increasing our investment in Mental Health in line with the parity of esteem national guidance and our local commissioning intentions. In the 2017-19 contract round this means an increase of £1m. This investment will be focused on:

- Developing crisis care with a focus on Street Triage and A&E Liaison initially
- Investing in primary mental health care supporting improve access and reducing physical and mental health inequalities
- Increasing capacity in IAPT to enable greater numbers of people with common mental health problems to receive treatment

7.7.6 Dementia diagnosis

The CCG has worked hard to improve diagnosis of dementia in its population. It will continue to work collaboratively with GPs to support referral pathways, by providing diagnostic tools and codes, supporting practices to help people with dementia post diagnosis, identifying dementia champions and establishing clinical and strategic networks.

To ensure delivery of the 66.7% target by April 2017, the following actions are being undertaken:

What	When
Development of new clinical network	Q4 2016/17
Establish the number of GP practices taking part in a pilot to screen at risk patients	Q4 2016/17
Continue to identify Dementia Champions within GP practices	Q4 2016/17
Roll out of a series of educational events to patients and carers to cover: • Worried about your memory and what to expect at the memory assessment service • Living well with Dementia and post diagnosis support	Q4 2016/17
Referral analysis and targeted intervention at practices that have a lower than expected referral rate	Q4 2016/17

7.7.7 Out of area placements

The CCG has largely achieved this with exception of people on Section 117; its plan, therefore, is to maintain this position, invest in crisis care and community care, and reduce acute care – all of which comes under the CCG's STP strategy to shift more activity from acute settings to the community. There is further work and aspiration to transform the specialist personality disorder and ADHA model of care for individuals in Bedfordshire.

7.7.8 Children and young people

The Bedfordshire 'Future Minds Local Transformation Plan for 2016-2020 for Children and Young People' (LTP) will create more high quality services for children and young people. For example, creating better links between schools in Bedfordshire and health services, and providing specialist mental health services to parents of children. In addition, the CCG will work to differentiate the provision of services for people with common mental health disorders in accordance with the most effective interventions.

We have started the Mental Health Crisis Care Concordat to ensure that local health, social, statutory and voluntary organisations will collaborate to guarantee that children and adolescents in mental health crisis get quick and personalised help. Our local transformation plan has been completed jointly between Bedfordshire and Luton CCGs to drive efficiencies in costs across specialist services.

The LTP identifies the outcomes and key performance indicators signed off through the CCG Executive team and both Health and Wellbeing Boards against four priority areas:

- Eating disorders community service;
- Perinatal mental health;
- Early Intervention / crisis prevention;
- Addressing the needs of vulnerable groups and embedding CYP- IAPT (improved access to psychological therapy) principles.

The Bedfordshire and Luton Future in Minds Steering Group is attended by key stakeholders; the group will monitor the progress of the LTP and report back through appropriate governance structures in Bedford Borough Council, Central Bedfordshire and Bedfordshire CCG.

In addition, Bedfordshire CCG has a non-recurrent fund of £50,000 to become part of a Schools/ CAMHS training pilot, which started in November 2015. This will reinforce KPI's aimed at improving early identification and early intervention in children's mental health and wellbeing.

Bedfordshire CCG's strategy for children's services is based on a collaborative effort with partners from all community services with the aim of creating better interoperation and alignment of otherwise disparate services to the needs of individual children. All secondary and community children's services are being reviewed, with the aim of creating better integration and alignment of services. The CAMH Service model was developed to ensure there is a strategic fit within this vision. East London Foundation Trust (ELFT) has taken over as the provider of mental health services for Bedfordshire and Luton and designed a new model for managing CAMH services in April 2016.

The CAMHS Clinical Service Model will:

- Increase the capacity of the service, and shift capacity from Tier 3 (specialist) to Tier 2 (targeted), with an increased focus on early intervention and preventative work;
- Provide services to children with the greatest need, most likely to benefit from service uptake, and as close to their home as possible;

There will be improvements to:

- Referrals and access (e.g. single point of entry, same day screening);
- Assessment (all referred CYP receive an assessment using a standardised CAMHS and Risk Assessment, or are redirected to an appropriate partner agency for further intervention);
- Treatment and interventions (integrating clinical pathways of Tier 2 and 3 services, with stepped care model, shared care protocols with GPs, and training partner agencies).

Services will be provided within designated teams, and case-management provided by clinical leads.

Our plans outline that we will improve access rates for Children and Young People to 80% by the end of 2017/18 and 90% by the end of 2018/19. This will be delivered through a number of initiatives, including:

What	When
Embed specialised community eating disorder service	Q3 and Q4 2016/17
Embed early intervention workers and schools link workers	Q3 and Q4 2016/17
Continuation of seven day access to crisis service	Q3 and Q4 2016/17
Additional funding for agency staff to support access and waiting standards	From Nov 2016
Improvements to data reporting	Q4 2016/17
Set performance targets within new contract	Q4 2016/17
Workforce development – recruit Psychological Wellbeing Practitioners to provide additional capacity through CHUMS and Early Intervention services	Q4 2016/17
Training for Health Visitors and Midwives on perinatal mental health awareness to improve identification and early intervention of perinatal mental health illness	Q4 2016/17

7.7.9 Eating disorders

A dedicated specialist community eating disorder service for children and young people has been established across Bedfordshire and Luton. The Provider's (ELFT) CAMHS teams are developing the workforce required to identify and support young people who have an eating disorder, particularly those with Anorexia Nervosa and/or Bulimia Nervosa. Most young people, who have an eating disorder as their primary presenting problem, will now have access to this new service.

Across the two CCG areas, we anticipate that around fifty patients each year will be referred to specialist Eating Disorder services. The service will support patients within the wider CAMHS and/or paediatric services in Bedfordshire and Luton who have mild-to-moderate disorders, including where it is a secondary diagnosis. We are monitoring the numbers of children who are currently accessing the service.
In addition, the team will also raise awareness and skills with partners across health care, social care, and education. We are keen to identify quickly individual young who in need of help, get them appropriate services, and help prevent a clinical and personal crisis. Bedfordshire has invested £227k recurrently in eating disorder services; Luton has invested £113k.

7.7.10 Suicide prevention

The national guidance on suicide prevention is focused on reducing the risk in high risk groups and improving the mental health of people in specific groups such as those in difficult economic or domestic circumstances; pregnant women, children and young people.

Within Bedfordshire and Luton, the following projects are being worked through; each will be managed as a sub-project, reporting into the Steering Group:

Reduce the risk of suicide in key high-risk groups	Project 1: People in contact with the criminal justice system e.g. Bedford Prison. Project 2: Mental Health Street Triage.
Tailor approaches to improve mental health in specific groups	Project 3: Self-harm in young people (0-25).
Reduce access to the means of suicide	Project 4: Guidance for NHS employees.

Provide better information and support to those bereaved or affected by suicide	Project 5: "Postvention".
Support the media in delivering sensitive approaches to suicide and suicidal behaviour	Project 6: Disseminate media guidelines.
Support research, data collection and monitoring	Project 7: Improve real time reporting of suicides / unexplained deaths.
Overarching Themes	Project 8: Bedfordshire Suicide Prevention Conference / Stakeholder Event. Project 9: Communications Strategy.

7.8 Learning disability

The Bedfordshire, Luton and Milton Keynes (BLMK) Transforming Care Partnership (TCP) is a newly formed arrangement set up to transform care for people with a learning disability and/or autism across four local authorities and three CCGs in central eastern England. The plan covers the period 2016 - 2019, and work is now beginning on mobilisation. Further details are contained within appendix 11.

Across the partnership, all three CCG areas have patients placed in secure inpatient settings that are either funded by the commissioners or NHS England specialist commissioning. In addition, there are a range of independent, voluntary and statutory sector providers that provide community support, supported living, residential care and education to people with a learning disability and /or autism. Much of this care and support is spot purchased or provided through small block contacts by the individual CCG's and councils across the partnership area and more widely across the country when need cannot be met locally.

The aim of the TCP is to:

- Reduce the numbers of in-patient admissions required for people with a learning disability and/or autism;
- Manage effective discharge and transition for people in hospital;
- Build resilient community services to support people to live as independently as possible in the most appropriate community setting.

Those affected will be individuals currently living in the community and individuals residing in in-patient and residential placements out of the area, who can be brought back into the community. These people will need supporting through new or strengthened provision in health and social care, prevention, advocacy, support for their carers, welfare, education and training. The TCP has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers.

The TCP has a governance framework to see through the changes, headed by a BLMK Transformation Board, which had its first meeting in January 2016, and meets every month.

In line with the TCP agenda, we will be focusing on reducing premature mortality for people with learning disabilities by improving access to health services, ensuring individuals register with a GP and receive an annual health check, and ensuring necessary reasonable adjustments are made.

The CCG will also make sure that findings of case reviews from the new National Learning Disability Mortality Review Programme are progressed and that education and training needs of staff working with those with learning disabilities are met.

The CCG has a number of organisation-specific tasks in relation to delivery of the TCP agenda. These include:

What	When
Local CQUIN set	Q4 2016/17
Review and refresh LD projected needs analysis	Q1 2017/18
Review of current local provision with possible redesign in conjunction with need analysis and MPS findings and recommendations.	Q1 2017/18
Review effectiveness and use of Blue Light CTRs and review CTRs.	Q1 2017/18
Audit of individuals with LD GP registration and health check. Identification of gaps and develop next steps to ensure an increase in registration and annual health checks.	Q1 2017/18
Ensure suitable step down placements are sourced to ensure transition of out of area NHS E commissioned placements and individuals can return to Bedfordshire.	Q1 2017/18
Developed robust transition processes to ensure preventative work with individuals transition from Children's & YP services to adults.	Q2 2017/18
Completion of Market Position Statement (MPS) for Health in conjunction with social care to determine unmet and future needs for Bedfordshire.	Q2 2017/18
Improvements to activity reporting	Q2 2017/18
Bid submission and development of positive behavioural support provision for both adults and Children and Young people with LD needs.	Q3 2017/18
Training needs assessment to be completed and commission training needs across professional and services in Bedfordshire.	Q3 2017/18
Explore a forensic supported living model to assist support for those individuals within the Criminal Justice system and/or at risk of offending. This will assist placing individuals back to Bedfordshire and stop out of area placements.	Q3 and Q4 2017/18

7.9 Improving quality

The CCG is committed to services provided across Bedfordshire that are safe, effective and deliver an excellent patient experience, with a robust process of assurance. Our quality framework is designed to identify risks early, with protocols in place to mitigate against potential risk. We rely on continuous feedback from our patients on their experience of health care in Bedfordshire.

7.9.1 Assurance processes

The CCG Quality directorate uses a set of comprehensive data and information, submitted by providers through contract monitoring, as an initial baseline of quality. This information is triangulated with local intelligence provided by GPs, Health Watch

and with feedback from patient engagement, external data sources and local stakeholders. This information is then worked through with providers, to develop plans to address any issues identified. As part of the local out of hospital programme, we will explore setting up an accreditation process for all staff working in out of hospital settings providing services that are not consultant-led.

7.9.2 Priorities

The information we receive as part of our quality surveillance must be seen within a broader context to identify potential risks and the need for intervention. Through close working with our performance and commissioning team, therefore, we combine intelligence to understand where priorities for action and continuous improvement are needed. At present these are:

- A greater focus on improving early cancer diagnosis and improving one-year survival outcomes;
- Improvement in education and proactive management of Diabetes pathway;
- Ensuring delivery of the Transforming Care Plan;
- Improvement in Maternity services in relation to the National Survey;
- Delivery of the Future in Minds programme, guaranteeing early intervention for children in crisis, and improved eating disorder and perinatal mental health services;
- Delivery of the SEND improvement plan that all children with Educational and Disability have early support and a plan to enable them to achieve their optimum level of well-being;
- We will continue to develop our relationship with NHS England to oversee quality improvement within our primary care services.

In addition, the CCG is focusing on specific clinical areas for quality improvement, including cancer, dementia, diabetes, learning disabilities and maternity services.

7.9.3 Quality Impact Assessment

The CCG has in place a Quality Impact Assessment (QIA) process, which underpins our commissioning decisions to either make potential changes to services, or decommissioning service elements. The impact for individual patient’s experience and health outcomes is assessed, and steps to mitigate any possible negative effects are taken as appropriate.

7.9.4 Governance

An Integrated Commissioning and Quality Committee (ICQC) has been set up at the CCG, and through which the internal directorates must provide assurance that patient care and patient’s experience of healthcare services are not compromised by current strategic planning and development. The ICQC is a subcommittee of the Governing Body. It is attended by two lay members who can challenge CCG decision making. The ICQC reports back to the Governing Body.

7.9.5 Safeguarding

The Safeguarding team for adults and children is active within the Local Authorities and the Local Safeguarding Children’s Board. The Children’s Safeguarding Boards for Bedford Borough and Central Bedfordshire have key priorities orientated to local

need. These include:

- A focus on the efficiency and effectiveness of the board and its work streams to protect local individual children's welfare;
- Ensure that there are mechanisms for individual children to raise issues;
- Evaluate the impact of work undertaken on domestic abuse;
- Ensure that there are quick and effective responses to concerns and reports about sexual abuse of children through exploitation.

The Adult Safeguarding Board has six broad strategic aims, which drive safeguarding practice in Bedford Borough and Central Bedfordshire:

- Preventing abuse and neglect; and raising awareness;
- Workforce development and accountability;
- Partnership working;
- Quality assurance and protection;
- Involving people and empowerment;
- Outcomes and proportionality.

7.9.6 Inspection

The CCG proactively monitors any provider that is required to improve following a CQC inspection. All providers produce a workforce report, which is reviewed and discussed in relation to gaps, hot spot areas and any risk to sustaining on-going services. The National Quality Board guidance acts as a helpful source to the CCG to highlight gaps against standards and benchmark data for all organisations involved.

Mortality is a key performance indicator that is reviewed regularly to understand where further review may be needed of clinical and referral pathways. This information is triangulated with other quality data to get a whole system perspective on the impact of poor outcomes. The Acute hospitals have mortality governance boards in place to focus on this work.

Additionally, the CCG is fully involved in the Child Death Overview Panel and that any recommendations made are fed into commissioning processes and inform the redesign of services.

7.9.7 Annual publication of findings from patient death

Bedford Hospital has a well-established Mortality Board and we are strengthening GP involvement as this work progresses. The CCG's Clinical Chair is liaising to see how primary care can engage, as there is recognition that some of the learning will be system-wide rather than just within the hospital. The CCG Acute Quality Lead is a member of the Mortality Board so that learning is shared and considerations for commissioning of services and contractual management can be made. The Mortality Board will be responsible for the preparation and sharing of the Annual Publication of Findings From Patient Death, and as we have both primary care and CCG representation on this group, the CCG is well placed to influence the process and output of this, as well as how learning can be shared system-wide.

Avoidable mortality is also a standing item at the quarterly contract Quality Meetings with providers, to enable the monitoring of actions and ensure any learning can be implemented.

To further strengthen arrangements, following the National Mortality Case Record Review pilot, Bedford Hospital has applied to the Royal College of Physicians to become an early adopter site.

7.10 Workforce

Delivering the STP's ambitious vision will require a system-wide transformation of the workforce. In partnership with Health Education England (HEE) and our providers we will work to enhance and advance the skills and competencies of the existing workforce to enable a shift in where care is provided, and we will design models of education and training to develop the workforce of the future.

Our plans will require us to ensure there is both a supply of appropriately trained staff to meet the needs of the population, and that there is sufficient leadership to take forward the transformation and organisational development required to deliver the STP over the next few years.

The developing STP has given us an indication of the roles that we need to invest in to deliver the future model, however the detailed plans and timelines for the implementation of changes are yet to be developed, and the pace at which we move to new models will have a significant impact on workforce planning. As a new footprint area, the STP is yet to develop a solid, combined picture of the current workforce and service delivery models to determine the level of redeployment available to maximise the resource already available to us and minimise the need for inefficient investment. Whilst this picture develops, we will continue to work with HEE so that we can respond appropriately to what this means within the local workforce across health and social care.

Further details on the workforce plan can be found in Appendix 12.

7.10.1 The STP Plan and development of the workforce

Representatives of our local health economy and Health Education England (HEE), have identified key actions to deliver our vision for workforce, co-designed with the STP workforce project stream. Engaging closely with our main stakeholders, including Higher Education Institutions and Trade Unions, this work will cover five broad areas:

- Leadership and Organisational Development
- Workforce Planning and Design
- Training and Development
- HR processes, Temporary Staffing and Partnerships
- Communication and engagement – staff and unions

We already have good examples in place to increase the workforce and to support the STP. We have reduced the level of attrition from courses, developed new routes to qualification and increased the number of staff on apprenticeships. We have also decreased turnover. In addition, we have developed new roles: for example, clinical pharmacy in general practice; and have implemented new ways of working, such as through our Caring Together pilot.

7.10.2 Local workforce context

Like many other areas nationally, the demand for an appropriately trained workforce is increasing. There are hotspots of hard to recruit to posts, and the number of vacancies is rising. GP and practice staff roles are particularly difficult to fill, as well as allied health professionals and nurses. This has made us over-reliant on agency and interim specialist staff.

The STP plan will see a reduction in acute activity and shift in care to out-of hospital settings. The out-of-hospital model will also need to reflect the focus on supporting prevention (self-care) rather than traditional interventional responses. This will inevitably mean a reduction in acute personnel, an increase in the community workforce; and a decrease in back office staff of all CCGs and providers.

The main implications for the workforce relate to:

- Enhancing and advancing the skills and competencies of the acute workforce;
- Developing the out-of-hospital workforce:
- Developing Leadership capability and capacity across the system as set out in the NIPSF;
- Organisational Development;
- Enhancing the supply pipeline and reducing turnover;
- Creating opportunities and conditions for collaborative working;
- Developing new ways of working and enhancing primary care;
- Supporting the workforce to develop the skills to work flexibly – across care settings.

We will model the changes in investment and activity – where and how services will be delivered – and bring plans for workforce development and investment into line – while maintaining a clear link between finance, activity and workforce. We will also make sure that staff have the knowledge and skills to work to quality and outcomes for individual patients. At present, we meet every six months with providers as part of the CIP review process to review these controls, and will consider the feasibility of moving these to a governance appraisal within the whole system. The CCG will also develop plans with providers to test new and hybrid roles.

The workforce programme will focus on a smaller number of high impact areas, actions and enablers rather than attempting to address workforce transformation on all fronts. It will build on the work already done by the Bedfordshire and Hertfordshire workforce partnership executive Group (WPEG), and will include:

- Reducing agency spend and usage;
- Reducing attrition of our trainees from courses;
- Attracting new staff to careers in health & social care to the footprint;
- Reducing turnover of our existing qualified and skilled staff;
- Supporting the integrated development of skills for our workforce to work and provide patient focused care across care settings.

7.11 Engagement

The NHS Constitution and Five Year Forward View have set out a clear message that the NHS should put patients and the public at the heart of everything it does. Meaningful involvement is essential for effective commissioning.

This Operating Plan seeks to deliver the best value possible for each taxpayer in the current context, and we will also make informed, considered decisions involving local people, clinicians and other interested stakeholders about how best to use the money available to the CCG. To do this successfully, and to provide maximum insight and information to the BLMK STP process, throughout December 2016 and January 2017, we will:

- Review our activity to understand fully the engagement and consultation requirements that overlap between the Operating Plan and the STP and;
- Continue to develop and test our commissioning priorities by involving patients, the public, clinicians and stakeholders in meaningful engagement and discussions about our plans for the health needs of the locality.

To deliver this Operational Plan and QIPP initiatives, the CCG will consider the whether the proposed changes to service delivery constitute significant change, and require formal "consultation". Where this is not the case, the CCG will "engage" with stakeholders and partners to ensure involvement. The CCG will also take forward any consultation required from the STP's communications and engagement plans from April 2017 onwards; and the CCG will lead on engagement related to specific initiatives from the STP that affect Bedfordshire residents.

Our approach will adopt the general principles of good practice engagement and subsequent consultation using the Gunning Principles:

- Engagement and/or consultation will occur when proposals are at a formative stage;
- Engagement and/or consultation will give sufficient reasons for any proposals to permit intelligent consideration;
- Engagement and/or consultation will allow adequate time for consideration and response; and
- The product of all engagement and/or consultation will be conscientiously considered in decision-making.

Patient, public and clinical engagement has underpinned all activities throughout the commissioning cycle to date. This Operating Plan is mindful of the STP priority areas and where any change to services is a possibility, then a full public consultation exercise will be undertaken to ensure the CCG complies with its statutory obligations to:

- Involve patients and the public in the development and consideration of change proposals;
- Consider legitimate expectation in all option development work;
- Consultation will take place whilst proposals are at a formative stage;
- Provide sufficient information to enable consultees to give proposals intelligent consideration;
- Develop commissioning intentions by making: criteria used, weightings accorded to them and who is involved, fully transparent.

8 Risks

8.1 Financial risks

As noted above, the CCG's debt repayment obligations will affect plans for service development and investment significantly, and outlay on out of hospital care to create viable alternatives is less likely in the current environment. Internally, it will take time to mobilise effective QIPP programmes at the required scale to release investment required. This may still be insufficient in the face of ongoing population, tariff (including HRG4+) and acute demand growth. In addition, the CCG is consistently funded below target funding levels, which further adds to the risk.

This financial plan is significantly stretched, and it is not completely clear whether the combination of a significant QIPP target (including a level of unidentified schemes), deficit repayment, STP investment and transformation, is genuinely achievable within the year.

8.2 Workforce related risks

A significant proportion of our workforce is approaching retirement, and we face challenges recruiting health professionals in primary, community and social care. There is a national shortage of senior clinical staff, and so we will be exploring the opportunities that new delivery models can offer in relation to developing new roles and competency levels.

There are challenges around the level to which health and social care professionals can integrate whilst retaining separate and quite different terms and conditions of employment, with a significant financial impact of moving staff to NHS terms and conditions.

8.3 CCG capacity

Following several challenging financial years, the CCG's capacity has been rationalised to contribute to savings. We are now in a position whereby in order to deliver the level of change required by the STP, QIPP, service development and other local initiatives, we will need to invest in securing the required workforce. This is a risk to the delivery of multiple elements of the Operating Plan.

8.4 Changing complexity of contracting

While the CCG has commenced work to strengthen its performance and contract management systems for commissioned services, additional complexity introduced by the scale of change expected to deliver the Operating Plan and STP puts pressure on our contracting function. We will need to explore opportunities offered through new contracting models, provider alliance arrangements and partnership working with local providers to simplify mechanisms so far as is possible.

8.5 How we manage risk

The CCG maintains a robust Risk Management and Policy for Assurance Framework for assessment, response and management of risk. This ensures that any current and emerging risks can be mitigated and minimised. The Framework is based on the Management of Risk (MoR)® methodology and complies with the International

Organisation for Standardisation (IOS) 3000, a universally recognised benchmarking system.

The CCG maintains risk registers at all levels of the organisation, and assessments of risk maturity are undertaken regularly by the Governance and Risk Manager. Parts of the business engaged in project and programme work undertake regularly reviews of risk facilitated by the Programme Management Office.

A monthly Risk Group is held, which reviews all risk registers and prepares for the annual internal audit. Risks are assessed in terms of cause and potential effect, and tolerance levels are agreed at the Governing Body.

8.6 Risk Management of QIPP Schemes

QIPP schemes are managed as projects, which are inherently riskier than businesses-as-usual because they are introducing change to business operations and, therefore, an element of uncertainty. In addition, projects are unique, often complex, cross divisional and are constrained by finite conditions.

All project risks are described and scored in Risk Registers. If a risk reaches an overall residual score of 15, or above, it is automatically escalated to the QIPP and Priorities Portfolio Board via the Senior Responsible Owner (SRO). Escalated risks are then discussed at the QIPP and Priorities Portfolio Board, to agree the severity of the risk and the current mitigations. If the current mitigations are deemed insufficient to reduce the risk to an acceptable level, i.e. below an overall score of 15, the Board will agree additional support for the risk owner.

9 Appendices

In the templates attached are details of timelines and milestones for delivery of specific elements of our Operating Plan. Where appropriate, we have indicated relationships to other programmes such as RightCare.

1. Constitutional dashboard
2. Key priorities
3. Commissioning intentions
4. Summary of QIPP schemes for 2017/18
5. STP
6. Primary care
7. Urgent and emergency care
8. Referral to treatment
9. Cancer
10. Mental health
11. Learning disability
12. Workforce

Appendices

Appendix 1	Constitutional dashboard
Appendix 2	Key priorities
Appendix 3	Commissioning intentions
Appendix 4	Summary of QIPP schemes for 2017/18
Appendix 5	STP
Appendix 6	Primary Care
Appendix 7	Urgent and emergency care
Appendix 8	Referral to treatment (RTT)
Appendix 9	Cancer
Appendix 10	Mental health
Appendix 11	Learning disability
Appendix 12	Workforce

Appendix 1: Constitutional dashboard

Performance Against NHS Constitutional Pledges																
KPI Code	BCCG Indicator Level	Plan	Latest Data	Reporting Period	YTD	Trend	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
E.B.6	Cancer 2 week waits following urgent GP referral for suspected cancer	93%	95.00%	Q2 16/17	94.58%	*↑								
E.B.7	Cancer 2 week waits - Breast Symptomatic where cancer not initially suspected	93%	94.74%	Q2 16/17	93.78%	*↑								
E.B.8	Cancer 31 day - 1st definitive treatment from diagnosis	96%	97.95%	Q2 16/17	97.64%	*↑								
E.B.9	Cancer 31 day - Subsequent treatment for cancer - Surgery	94%	96.80%	Q2 16/17	96.15%	*↑								
E.B.10	Cancer 31 day - Subsequent treatment for cancer - Drugs	98%	99.03%	Q2 16/17	99.56%	*↓								
E.B.11	Cancer 31 day - Subsequent treatment - Radiotherapy	94%	94.09%	Q2 16/17	95.00%	*↓								
E.B.12	Cancer 62 days - 1st treatment following an urgent GP referral	85%	81.23%	Q2 16/17	82.43%	*↓								
E.B.13	Cancer 62 days - 1st treatment following referral from Screening Service	90%	94.29%	Q2 16/17	88.70%	*↑								
E.B.14	Cancer 62 days - 1st treatment following consultants decision to upgrade		100.00%	Q2 16/17	91.43%	*↑								
E.B.15.i	Ambulance Category A - Red 1 (immediate life threatening and most time critical) response arriving within 8 mins - commissioner	75%	78.07%	Sep-16	77.09%	↓								
E.B.15.ii	Ambulance Category A - Red 2 (life threatening and less time critical than Red 1) response arriving within 8 mins - commissioner	75%	71.22%	Sep-16	68.13%	↑								
E.B.16	Ambulance Category A ambulance arrival within 19 mins - commissioner	75%	96.34%	Sep-16	95.08%	↓								
E.B.S.3	CPA follow up within 7 days of discharge from psychiatric in-patient care	95%	95.49%	Q2 16/17	95.40%	↑								
E.B.1	18 week Referral to Treatment for completed admitted patients	90%	83.00%	Sep-16	83.86%	↓								
E.B.2	18 week Referral to Treatment for completed non admitted patients	95%	91.16%	Sep-16	93.11%	↓								
E.B.3	18 week Referral to Treatment - Incomplete pathway	92%	92.32%	Sep-16	92.98%	↑								
E.B.S.4.i	52 week referral for completed admitted pathways	0	2	Sep-16	7	↓								
E.B.S.4.ii	52 week referral for completed non-admitted pathways	0	1	Sep-16	13	↑								
E.B.S.4.iii	52 week referral for incomplete pathways	0	3	Sep-16	8	↓								
E.B.4	Diagnostic tests - % of patients waiting 6 wks or more	99%	99.42%	Sep-16	99.15%	↑								
E.B.5	A&E 4 hour wait (7 Providers)	95%	92.48%	Sep-16	93.12%	↓								
E.B.S.1	Mixed-sex accommodation breaches	0	0	Sep-16	0	↔								
E.B.S.2	Cancelled operations on or after day of admission and not offered another date within 28 days	0	2	Q1 16/17	2	↑								
E.B.S.6	Urgent Operations cancelled for a second time	0	0	Sep-16	0	↔								
E.A.S.4	Number of MRSA incidents	0	0	Sep-16	0	↔								
E.A.S.5	Number of C-Difficile incidents	73	9	Sep-16	36	↓								

Appendix 2: Key Priorities

STP priority	Area	Operational Plan 2017/19	Commissioning Intentions	QIPP 2017/19	Mandate 2020 goals
Prevention	Obesity	●	●		●
	TB		●		
	Vaccination in care homes		●		
	Health Coaching		●		●
	Increased use of technologies for self care and management	●	●		●
	Place-based population strategies,		●		●
	Risk profiling and care planning.	●	●		
	Step up/Step down integrated service		●		●
	Frail Elderly pathway		●		
	Psychological therapies	●	●	●	●
	Safe discharge from hospital	●	●	●	
Clinical priorities	Diabetes	●	●	●	●
	Respiratory	●	●	●	●
	Cancer	●	●	●	●
	Gastro-intestinal	●	●	●	●
	Cardiovascular	●	●	●	●
Primary, Community and Social Care	Extended access	●			●
	E-consultations	●			●
	Information quality	●			
	Co-location of primary and acute care	●			●
	Referral hub activity	●			●
	A&E streaming	●		●	●
Secondary Care	NHS 111 and signposting	●	●	●	●
	Ambulance services	●	●	●	●
	Improved flow	●	●	●	●
	Safe discharge	●	●	●	●
	Fracture liaison	●	●	●	●
	End of life pathway	●	●	●	●
	Crisis care for mental health	●	●	●	●
	Street Triage, rapid access	●	●	●	●
	Clinical reviews	●	●		●
	Self management in Asthma, COPD, Diabetes.	●	●		●

Appendix 2: Key Priorities

Digitisation	Access to primary care services	●			●
	Self care	●			●
	Analytics and risk profiling	●	●		
New models of care	Out of hospital care	●		●	●
	Street Triage	●		●	●
	Community services	●		●	●
	Fracture liaison	●		●	●
	Paediatric and maternity pathways	●	●		●

Appendix 3: Commissioning intentions

Urgent and Emergency Care - We will work with providers to implement a system-wide solution to urgent and emergenc
- We will fully implement a new Stroke pathway for the residents of Bedfordshire
- We will be working to improve the end of life pathway to appropriate settings including for patients with dementia to ir
- We will continue shifting settings of mental health care – moving to primary care delivered intervention, assessment an
- We will develop rapid intervention services able to respond to patients within an hour building on the success of Street
- We will look to implement a fracture liaison service, assuming that resources are available for its development (subject
- We will undertake clinical reviews on the following areas of unscheduled care:
1. Paediatrics
2. Frail Elderly
3. End of Life Care

Planned Care: - We will undertake a clinical review including the patient pathway and delivery mode for the following clir
1. Diabetes
2. Respiratory
3. Cancer
4. Cardiovascular Disease
5. Gastro Intestinal
- We will also review the clinical pathways for those service areas over-performing against contract in 2016/17 e.g. urolo
- We will expect providers to engage with these clinical reviews and the development of solutions to facilitate an appropr
- We will expect a greater proportion of referrals to go through an appropriate referral hub, which requires engagement
- We will review consultant to consultant referral policies, and ensure that these policies are being implemented and foll
- We will expect acute provider involvement in facilitating a shift of activity to 'closer to home' community settings, parti
- We will review the role, function and criteria for the Archer Unit
- We will expect all providers to meet their 18 week referral to treatment target across specialisms
- We will continue to develop and review our policy for supporting patients being referred for elective surgical opinion to
- We will develop a single point of access for all services in the community and will require providers to work together on

Prevention and Detection: - We will undertake a review of tier 3 and 4 provision for excess weight
- We will undertake a review of TB detection and management
- We will develop a healthy weight strategy that includes malnutrition and underweight services
- We will explore the value of vaccination in care homes and commission a service to meet the gaps
- We will review and explore options around Health Coaching, building on best practice
- We will work with Local Authorities to deliver place based population strategies on all age mental health, older people,
- We will implement supported self-management and structured education through an evidence-based approach, maxim

Out of Hospital Care: - We will continue to strengthen the visibility of available services through the inclusion of services
- Acute, primary and community providers will be expected to work together on workforce, risk profiling and care plannir
- We will form an alliance, including Adult Social Care, to facilitate the provision of an integrated step up / step down com
- We will establish a shared approach to commissioning, service development and delivery of health and social care throu
- We will deliver a Frail Elderly pathway from primary through to acute care
- We will develop paediatric and maternity pathways with new models of care to build resilience and treat children closer
- We will ensure psychological therapies are integrated within pathways for pain management, chronic condition manage
- Acute and community providers will be expected to work closely with Adult Social Care to support effective and safe dis
- We will explore the health and social care integration agenda in 2017/18
- We will work with our Local Authorities to develop care planning and personalised care – personal health budgets, case

- We will work with our Local Authorities to develop care planning and personalised care – personal health budgets, case
- We will look to implement a falls group for residents in Central Bedfordshire building on the work already undertaken ir
- We will build on the work already undertaken in 2016/17 related to community bed provision to ensure appropriate ou

Primary Care: - We will continue to move to collaborative commissioning at scale across primary care e.g. anticoagulatio
- We will improve the quality of information to primary care to help inform pathway changes
- We will explore the benefits of the co-location of primary and acute care, building on the work in 2016/17
- We will continue to work with wider partners to develop primary care health and social care hubs
- We will expect a greater proportion of planned care referrals to go through an appropriate referral hub
- As part of our co-commissioning role, we will collectively assure the quality of primary care services

Diabetes: - We will work with primary, community and acute care to improve the uptake of the eight recommended care
- We will review the roles of primary, community and acute care in the delivery of diabetes care
- We will continue to implement the diabetic foot care pathway, ensuring timely access to appropriate podiatry services
- We will maximise opportunities to improve self-care / self-management through our work with partners and patients
- We will put in place an enhanced education programme for both non-specialised health professionals and patients to he

Respiratory: - We will undertake a comprehensive clinical review for both Asthma and COPD including the patient pathw
- We will implement the recommendations of the Children's Asthma Pathway Review taking place in 2016/17
- We will expect primary care to develop personalised Asthma Plans to empower patients to better manage their conditio

Cancer: - We will commission a psychological support service
- We will commission national timed pathways for lung, colorectal and prostate cancer
- We will undertake a clinical review including the patient pathway and delivery mode for those cancer pathways identifie
- Subject to funding availability, we will work with clinicians to improve direct access to diagnostics

Gastro Intestinal: - We will undertake a comprehensive clinical review including the patient pathway and delivery mode
- We will explore ways to maximise the efficiency and targeted use of endoscopy services
- We will reduce alcohol related harm and improve poor outcomes from Liver Disease

Cardiovascular Disease: - We will commission comprehensive cardiac rehabilitation services within the available resourc
- We will undertake a clinical review resulting in an action plan related to clinical pathways
- We will continue to implement Early Supported Discharge during 2017/18 for patients following a stroke in residential a

Appendix 4: Summary of QIPP Schemes 2017/19

This section outlines details of our QIPP plan for 2017-18, and identifies the financial challenge that needs to be addressed. Summarised below, by work stream, are details of the proposed QIPP initiatives for dealing with this challenge over the two years covered by this plan and for driving improved health outcomes for our patients. The QIPP target for 2017/18 will be £25.531m. To achieve this target BCCG plans to deliver a £19.235m QIPP Programme, supported by a £2.750m stretch target attributed to the existing QIPP Programme. In addition there is a £3.546m unidentified QIPP value, where schemes have not been identified yet. The financial values are summarised in the table below:

2017/18 areas	Financial Impact (£'000)	Stretch Target (£'000)	Unidentified QIPP (£'000)
CHC	399		
Children, Young People & M	506		
Medicines Management	1,848	250	
Finance & Contracting	3,915	350	
Primary Care	1,003		
Community Services	400		
Mental Health & Learning D	1,146		
Planned Care	8,601	2000	
Unplanned Care	1,417	150	
Unidentified QIPP	0	0	3,546
Sub Total	**19,235**	**2,750**	**3,546**
Grand Total			**25,531**

2018/19 areas	Financial Impact (£'000)
Unidentified QIPP	5,195
Identified QIPP	6,349
Grand Total	**11,544**

Programme	QIPP Project	17/18 FOT (£'000)	17/18 Stretch Target (£'000)	Current Stage	Description of QIPP Project	Health Benefits	Finance and Activity
CHC	CHC Optimisation	399		Delivery	Continuing the funding assessment process and driving through efficiencies aligned with Operational Policy, reducing spot purchasing and improving rehabilitation packages. To agree standards and prices for CHC packages of care.	More appropriate packages of care and better quality of services and CHC packages of care.	Savings will be achieved via reduced spend in CHC and reduced spend in CHC equipment.
Children, Young People & Maternity	Children's AQP	378		Pre-Project	Addressing the provision of commissioning bespoke packages of care for individual children with Continuing Care needs, that cannot be met by existing and specialist services alone.	Bespoke packages of care for individual children with Continuing Care needs	Savings will be achieved via efficiencies in more bespoke packages of care
Children, Young People & Maternity	Home Enternal Feeding	60		Pre-Project	Aims to address patients who have not received timely reviews from a dietetics service.	Improved patient outcomes as a result of more timely reviews of dietetics.	Savings will be achieved via a reduction in length of stay in hospital
Children, Young People & Maternity	Dietetics - Prescriptions Infant Feeds	50		Pre-Project	Review expenditure and cost per item for Sip feeds (Oral Nutritional Supplements – ONS) and Enteral Feeds by scoping alternative service specifications and re-procurement of contract. Feeds are currently paid through FP10 prescriptions. Opportunity to change to a central store approach and other models nationally have demonstrated savings by moving prescribing responsibility to dietician prescribing responsibility to dieticians.	The efficiencies identified will enable BCCG to focus more resources on enhancing patient outcomes in other areas of commissioning.	Savings will be achieved from the medicines management budget
Children, Young People & Maternity	CAMHS 1:1 Support into the acute trust	18		Pre-Project	This proposal aims to support a 1:1 CAMHS service in the acute trust to ensure patients receive the greatest level of care.	Improved patient outcomes as a result of 1:1 CAMHS support	Savings will be achieved via reduced average length of stay in the system as patients progress through the system appropriately and in a timely way.
Medicines Management	Medicines Optimisation	1,400	250	Delivery	The identification, review and implementation of efficiencies in Medicines Management including switching to branded-generics, exploiting license extensions and patent expiration, adherence to NICE guidelines and price controls through Pharmaceutical Price Regulation Scheme (PPRS) and category M drugs.	Improved patient outcomes and experience as a result of maximising prescribing resources and knowledge.	Medicines management efficiencies
Medicines Management	Biosimilars: Infliximab & Etanercept	132		Delivery	Agree with acute providers gain-sharing arrangements for High Cost Drug.	BCCG will become more efficient and allow more resources to be used to enhance patient outcomes in other areas of commissioning.	Medicines management efficiencies
Medicines Management	Drugs Expenditure	116		Pre-Project	To call patients and ask about their medication, to identify patients who are regularly ordering items on repeat and check if they are taking the medication. If medication is not being taken then actions are taken to review their medication to prevent unused medications being stored in homes.	Improved patient outcomes and experience as a result of maximising prescribing resources and knowledge.	Medicines management efficiencies
Medicines Management	Urology Equipment Formulary Switches	108		Implementation	Urology equipment purchased at a reduced price.	Patients offered choice of product	Medicines management efficiencies
Medicines Management	Care Home Pharmacy	74		Implementation	Care home pharmacist to review medicines of most vulnerable patients residing in nursing, residential and care homes. Working closely with other clinicians to optimise prescribing which may result in reduced waste and prescribing.	Improve prescribing in nursing, residential and care homes and reduction in drug interactions from poly pharmacy and improved compliance to prescriptions.	Medicines management efficiencies and reduction in non-elective admissions.
Medicines Management	Script Switch Contract Efficiency	18		Delivery	Use of prescribing tools to support cost effective options e.g. Scriptswitch. Continued input from Medicine Management Team to optimise Primary Care prescribing.	BCCG will become more efficient and allow more resources to be used to enhance patient outcomes in other areas of commissioning.	Medicines management efficiencies

Finance & Contracting	VBEC 1 (Declined, & Admin Closures - tougher procedures/reduce leakage)	1,536	250	Delivery	More rigorous processes are being applied to secure prior approval for an identified list of low value clinical procedures. In addition, we are ensuring that individual funding requests are made via the Individual Funding Request Panel. The policies will be extended further for April 2017 in line with guidance from Academy of Royal Colleges and across multiple providers within the STP.	More patient procedures will be undertaken in a time that is most clinically beneficial.	Savings will be achieve via reductions in procedures with limited clinical value in an agreed basket of procedures.
Finance & Contracting	EEAST Contract Rebase - 3rd year	675		Delivery	Review of the placement of Paramedics and Ambulance staff in order to best utilise skills and services provided; by placing improving MDT working, hear and treat and see and treat and through service working together to drive MDT working.	Patients will receive more rapid care in their own home and where possible be cared for by known professionals. Quality of care for those in need of emergency treatment will be improved and waiting times for both A&E and Ambulance conveyancing will be improved.	Reduce A&E Attendance and improved level of conveyancing
Finance & Contracting	VBEC 1 (Contracting Challenges - CSU)	554		Delivery	To challenge the acute providers where procedures should have not been carried out as per out policies.	The efficiencies identified will enable BCCG to focus more resources on enhancing patient outcomes in other areas of commissioning.	Challenges
Finance & Contracting	High Cost Drugs	450		Implementation	This is a contract challenge to ensure that BCCG is only paying for high cost drugs for our patient population and ensure specialist commissioning is appropriately cost charged. Bedford CCG commissioned drugs are NICE approved or local policy approved. Prior approval required using Proforma or Blueteq for drugs not directly commissioned by the CCG.	Patients will only be in receipt of Drugs which match their condition. Better control of patient's treatment as they will only consume BCCG prescribed drugs.	Savings will be made in the high cost drugs expenditure.
Finance & Contracting	Challenges (Contracting & CSU)	388		Delivery	Contract challenges in line with SLAM and SUS reconciliation.	CCG policies adhered too, which are designed to optimise patient care.	Acute sector expenditure
Finance & Contracting	Vacancy Factor	120		Pre-Project	Reduce the use of interims and temporary staffing and hold vacancies for permanent roles.	BCCG will become more efficient and allow more resources to be used to enhance patient outcomes in other areas of commissioning.	Reduction in CCG running costs across STP
Finance & Contracting	STP System efficiencies	120		Pre-Project	Through working across the new STP footprint we will work with system partners to share programme resources and back office functions where there is opportunities to do so.	BCCG will become more efficient and allow more resources to be used to enhance patient outcomes in other areas of commissioning.	Reduction in CCG running costs across STP
Finance & Contracting	High Cost Devices	48	100	Pre-Project	This is a contract challenge to ensure that BCCG is only paying for high cost devices for our patient population.	Patients will receive devices in line with our CCG clinical standards.	Savings will be made in the high cost devices expenditure.
Finance & Contracting	External Audit	24		Implementation	Re-procured an external auditor across the STP footprint and made contract efficiencies through economies of scale.	CCG improved efficiency which supports future investment into patient care.	Procurement overall cost efficiency.
Primary Care	General Practice Quality and Performance & Stretch	453		Delivery	Localities supporting GP practices to reduce non-elective attendances and admissions and to use MDT methodology and risk stratification to target patients at greatest risk and share care plans with out of hospital/community providers to reduce unnecessary attendances and reduce unwarranted variation across General Practice. This will be supported by an enhanced service which will support the development of a sustainable workforce at locality level and support extended access to primary care.	Better care for patients as a result consistent adoption of best practice by GPs and enhanced out of hospital workforce in primary care.	Savings will be achieved via a reduction non-elective admissions and attendances.
Primary Care	Building Capacity in Anticoagulation Services	444		Implementation	To increase capacity for community anticoagulation services for the patients of Bedfordshire, with the aim of reducing the risk of a Stroke and offering more patients an alternative to Novel Oral Anticoagulants (NOACs) prescribing.	Improving patient safety and reducing stroke risk are at the heart of this project. Quality drivers include improving access by developing more services that are closer to home and at more convenient times to patients.	Savings will be achieved via a reduction in spend on Stroke admissions and Novel Oral Anticoagulants (NOACs)
Primary Care	Advice and Guidance/e-referral	106		Implementation	Provide advice and guidance to GPs for patients within a 48-hour time window via email to support improved clinical decision making between primary and secondary care. This service will be supported by a new CQUIN for 17-19 and will commence with cardiology, gastroenterology and urology but will expand to cover the core specialities with 17/18.	Better care for patient's as a result consistent adoption of best practice by GPs through closer working with secondary care. This will result in more care being delivered out of hospital and closer to home.	Savings will be achieved through a reduction in outpatient referrals and follow up outpatients.
Community Services	CV for community beds - Biggleswade out and flex criteria for Archer/DTA home	250		Pre-Project	To improve the utilisation of the community hospital facility to support earlier discharge and maximise the bed base.	Patients will receive care closer to home and the right care in the right location supported by appropriate therapy and rehabilitation services to enable re-aliment.	Savings will be achieved via reduced spend in excess bed days and reduced length of stay and reduced cost of spot purchasing.
Community Services	SEPT and One Call - Re-commissioning of one call	100		Pre-Project	Provide a single point of access for all services in the community and will require providers to work together on this development thereby enabling a more cost effective service model to be developed.	Provide a single service model to reduce fragmentation and improve care planning.	Standardised commissioning model.
Community Services	Integration with PEPS for end of life pathway	50		Pre-Project	This proposal aims to review the potential integration with PEPS for end of life pathway	Improve and integrate care for patients at end of life.	Reduced non-elective care and efficiencies from new service model.
Mental Health & Learning Disability	ELFT Contract - Mental Health Stepped Care Model - Year 3	591		Delivery	The Mental Health services in Bedfordshire were remodelled in the last financial year. Following a procurement exercise the provider chosen to deliver the services ELFT. The contract commenced on 01/04/2015. This is the third year of the contract.	The ELFT service is improving the outcomes and experience of patients with a Mental Health or Learning Disability condition and support the delivery of parity of esteem.	The savings will be achieved via the ELFT contract (applying a Tariff Deflator @ 1.8% to the 2014/2015 tariff)
Mental Health & Learning Disability	Street Triage (year 2 investment)	555		Delivery	Working in partnership with GP's, Acute Hospitals, Ambulance Trusts, Local Authorities and the Police to provide a service which can rapidly respond to people experiencing a mental health crisis delivering rapid treatment and intervention and ensuring any ongoing needs or support takes place in the most appropriate environment.	A&E will not be the default option for dealing with people in crisis, they will be seen in the most appropriate setting. Any crisis situation responded to will be handled promptly and effectively by the right professional.	The savings will be achieved via a reduction in non-elective admissions to hospital.
Planned Care	Discharge to assess - reducing excess bed days expenditure - requires significant investment	1506	500	Pre-Project	Implementation of Discharge to Assess BCCG will implement a home first, Discharge to assess pathway which will be in operation across all appropriate hospital wards. This will provide a single trusted assessor arrangements across the NHS, Social Care and Independent Care Sector providers and support and facilitate patients being discharge appropriately from hospital.	This programme will support a reduction of people delayed or stranded in an acute sector and support the CCG to achieve its 2.5% DTOC target too ensure that people are assessed in the most appropriate environment for their long-term care needs. This should almost always be outside of an acute setting in order to maintain people's maximum independence at home for as long as possible.	Improvement in the number of care assessments carried out in acute beds, reduction in length of stay for Frail Elderly (>75s), reduction in interim care package and placement costs across health, social care and CHC and a reduction in excess bed day spend.
Planned Care	Circle contract extension for MSK services	996		Pre-Project	Maximising efficiencies by capping inflation and reducing the penalty costs when referrals do not go through the Circle Triage Hub and reducing bypassing of the hub through the further extension of the Circle contract.	The efficiencies identified will enable BCCG to focus more resources on enhancing patient outcomes in other areas of commissioning.	Savings will be achieve via the efficiencies in the Circle Contract.
Planned Care	Community Beds - Rehabilitation	767		Delivery	Reduction of spot purchasing and procurement of community beds for acquired brain injury patients to support, Reablement and early supported discharge.	Patients will receive care closer to home and the right care in the right location supported by appropriate therapy and rehabilitation services to enable re-aliment.	Savings will be achieved via reduced spend in excess bed days and reduced length of stay and reduced cost of spot purchasing.
Planned Care	VBEC 2: Gluten, prescription over counter and IVF	558		Initiation	Consulting with the public on options to divest in a small number of interventions.	More patient procedures will be undertaken at a time that is most clinically beneficial to the patient.	Savings will be achieved through divestment in a small number of interventions.

Planned Care	End of life pathway redesign	492		Pre-Project	EoL services are currently fragmented and difficult to navigate. A lead provider would be responsible for the creation of an integrated system of EoL care and development of a new service model. They would monitor capacity across the community EoL system and ensure patients are seen by the right person, at the right time, in the right place.	Improve and integrate care for patients at end of life.	Reduced non-elective care and efficiencies from new service model.
Planned Care	Re-commissioning specialist dementia	492		Pre-Project	Re-provision of specialist dementia services for the BCCG population to support the achievement of improved care dementias pathways and achievement of national dementia targets.	Improved outcomes for patients with dementia.	Reduction in non-elective admissions and A&E attendances for patients with dementia and improved contract efficiencies.
Planned Care	RightCare Programme for diabetes	400	300	Pre-Project	The RightCare programme for diabetes outlines significant opportunities to improve both patient outcomes and spend in non-elective admissions and prescribing and to ensure education programmes for diabetic patients are utilised and they are receiving all three of the target treatment and support improve patient level monitoring.	Improved outcomes for patients with diabetes.	Reduction in non-elective admissions and A&E attendances.
Planned Care	RightCare Programme for Respiratory System Problems	403	300	Pre-Project	The RightCare programme for respiratory system problems outlines significant opportunities to improve both patient outcomes and spend in non-elective admissions, elective and day case procedures and primary care prescribing. Reported prevalence levels in primary care will be improved and pathways of care improved for children with asthma emergency admissions.	Improve care for patients with COPD and for children with asthma.	Reduction in elective and day case admissions and reduction in non-elective and prescribing.
Planned Care	RightCare Programme for Cancer and Tumours	414	300	Pre-Project	The RightCare programme for cancer and tumours outlines significant opportunities to improve both patient outcomes and spend in elective, day case and primary care prescribing as well as improvements in breast and bowel screening.	Improve care for patients with cancer and tumours and improvements in screening for breast and bowel cancer to support earlier detection and treatment.	Reduction in elective and day case admissions and reduction in non-elective and prescribing.
Planned Care	RightCare Programme for Gastro Intestinal	300	300	Pre-Project	The RightCare programme for gastro-intestinal outlines significant opportunities to improve both patient outcomes and spend in elective, day case and primary care prescribing as well as rate of emergency gastroscopies and colonoscopies and emergency admissions for gastroenteritis for children.	Improve care for patients with gastrointestinal problems and reduction in the rate of emergency admissions and emergency diagnostic procedures.	Reduction in elective and day case admissions and reduction in non-elective, prescribing and emergency diagnostics.
Planned Care	RightCare Programme for Circulation problems (CVD)	450	300	Pre-Project	The RightCare programme for circulation problems outlines significant opportunities to improve both patient outcomes and spend in elective, day case and non-elective spend to drive improvements in HF, estimated prevalence of AF and anti-coagulation therapy for high risk patients and estimated prevalence of hypertension.	Improved mortality rates for patients with circulatory diseases and improvements in specialist nursing and primary care to support patient care out of hospital.	Reduction in elective, day case admissions and reduction in non-elective.
Planned Care	Minor Eye Conditions - LOCSU	575		Implementation	We will redesign the current pathway for common, acute eye conditions, with a view to commissioning an "Optometry-First" Minor Eye Conditions Service (MECS), from the network of local optical practices in Bedfordshire CCG. Patients with minor eye conditions would be able to refer to a participating optometrist practice from a range of sources – GP, OOH / 111, other optometrist, self, A&E, pharmacies. Participating optometrists are expected to keep one or two slots available every day to see referrals. Participating optometrists triage and either advice, treat or refer on to secondary care according to need.	Patients will benefit from improved access to high quality eye health care in the community for the management of minor eye conditions and reduction in GP attendances for minor eye conditions through the development of increased capacity of primary care ophthalmology services to manage minor eye conditions within the community.	Reduction in tariff of outpatient for minor eye conditions.
Planned Care	Gastroenterology (Faecal Calprotectin)	360		Implementation	BCCG will use of faecal Calprotectin (FCP) via a stool sample as a biological marker for inflammatory bowel disease (IBD). It is inexpensive compared to invasive procedures and has been demonstrated to be sensitive and specific enough to be utilised for this purpose. The introduction of faecal Calprotectin as a test within primary care should reduce the need for first outpatient appointment to gastroenterology & subsequent invasive colonoscopy and Sigmoidoscopy.	Through the development of clear pathways for IBS/IBD patient care for IBS can be shifted to primary care through a simple test and this means less invasive procedures for patients.	Reduction in the cost of outpatients, follow-ups and scoping for patients identified with IBS.
Planned Care	Psychology Integration with MSK	262		Initiation	Integrating Psychology into the MSK service enabling better treatment of patients needing access psychology service, more patients to have access to the psychological aspects of pain management and patients with complex psychological needs to be diverted into psychology services rapidly, thus supporting the proactive management of patients developing psychological issues associated with pain.	To help patients to understand their pain and to minimise the impact of pain on daily living and to improve overall patient quality of life in spite of pain.	Savings will be achieved via reduction in outpatient referrals and follow ups for pain via acute providers.
Planned Care	Stroke - Early Supported Discharge	180		Delivery	Reduction of spot purchasing and procurement of community beds for stroke patients to support, Reablement and early supported discharge.		
Planned Care	Improvement of diabetic footcare pathway	156		Implementation	Improved access to podiatrist to support improvement in footcare management for diabetic patients and thereby reduce amputations for patients at risk.	Improved footcare management leading to a reductions in amputations.	Reduced non-elective care and efficiencies from new service model.
Planned Care	Ear, Nose and Throat pathways	235		Implementation	Review of ENT pathways and care models in other CCG areas where the productivity gain is small and they have services in place that are managing to divert a large proportion of referrals from secondary care.	New pathways should be more efficient for patients to access, and with low need for an onward referral to secondary care.	Savings will be achieved via a reduction in GP generated first outpatient attendances.
Planned Care	Integrated COPD Service	42		Delivery	Improving outcomes for people living with respiratory disease by enhancing the Acute Respiratory Assessment Service (ARAS) and Early Supported Discharge (ESD) for people with COPD.	Clinical effectiveness will improve as the service reaches more people and focuses on achievement of outcomes. Outcomes will include symptom control, quality of life, frequency of exacerbations and unplanned admissions.	Savings will be achieved via reductions in non-elective admissions to hospital.
Planned Care	Nerve Conduction Studies carried out at the MSK Bedfordshire Hub	14		Delivery	NCS have historically been carried out in Bedfordshire at the Luton and Dunstable University Hospital Foundation Trust (L&D). Bedfordshire MSK (Circle) routinely and solely send patients to the L&D for NCDs so these particular diagnostics can be carried out. Some of the common disorders that can be diagnosed by NCS are: Carpal tunnel syndrome, Cubital Tunnel Syndrome, Guillain-Barré syndrome, Guyon's canal syndrome, Peripheral neuropathy, Peroneal neuropathy, Tarsal Tunnel Syndrome, Ulnar neuropathy.	This ensures MSK Circle Contract can provide a one-stop shop for patients requiring nerve conduction studies and reduces fragmentation across service providers.	Savings will be achieved from a reduction in first outpatients and reduction in diagnostic cost.
Unplanned Care	111 / Out of Hours Procurement	500		Implementation	The aim of this project is for Luton and Bedfordshire CCGs to work jointly to progress Phase 1 of the Urgent Care Strategy focusing on the re-procurement of 111 and Out of Hours as an integrated service.	The future will make it easier for the public to access urgent health advice and care. This will increasingly be in a way that offers a personalised and convenient service that is responsive to people's health care needs.	Savings will be achieved through a reduction in A&E admissions, attendances and ambulance conveyances.

Unplanned Care	Urgent Care Advise and Guidance	288		Initiation	Urgent Connect is based on the implementation of a telecom solution which enables GPs to have direct and immediate telephone contact with Acute hospital staff prior to sending a patient to A&E. Urgent Connect is a fully supported software platform that allows GPs to access an immediate telephone navigation advice & guidance service. Using the platform, a GP waits on average less than a minute to get through and the conversation lasts an average of 4 minutes. Call data and outcomes are tracked and stored on a secure server, together with a recording of the call. The immediate availability of Advice & Guidance means that GPs can choose to access the service whilst the patient is still with them.	Patients benefit by getting the right care in right place and this supports streaming of patients into different care pathways which then frees up capacity for patients with highest level of acuity whilst also up-skills primary care and improving collaborative working across primary and secondary care. This also supports delivery of national targets and addresses immediate need to stem pressures in A&E.	Savings will be achieved via reductions in non-elective admissions to hospital.
Unplanned Care	Integrated Care Centre front door model	217		Initiation	The need for an integrated A&E front door model is imperative for both adult and paediatric attendances. This proposal aims to provide a single point of clinical triage as the patient enters the front door of A&E, with the clinician 'eye balling' and using an agreed set of clinical streaming protocols to establish whether the patient should be directed to Primary Urgent Care or Emergency Care, which will include a Frailty Pathway and Ambulatory Emergency Care. This will be dependent on the relocation of primary care contracts onto the Bedford Hospital site	Patients benefit by getting the right care in right place and this supports streaming of patients into different care pathways which then frees up capacity for patients with highest level of acuity whilst also up-skills primary care and improving collaborative working across primary and secondary care. This also supports delivery of national targets and addresses immediate need to stem pressures in A&E.	Savings will be achieved via reductions in non-elective admissions to hospital.
Unplanned Care	Consultant to Consultant Referrals (C2C/Other) - RMS solution	123	100	Pre-Project	This scheme aims to review the potential of a Referral Management System for C2C referrals	Better care for patients as a result consistent adoption of best practice	Reduction in consultant and non-consultant led outpatients and follow ups.
Unplanned Care	Consultant to Consultant Referrals (C2C/Other) - contract challenges	96	50	Pre-Project	GPs remain the gatekeeper for all referrals to secondary care apart from 2week waits for cancer where consultants can refer directly. This is a contract challenges schemes to ensure acute providers adhere to the protocols set down by the CCG.	Better care for patients as a result consistent adoption of best practice	Reduction in consultant and non-consultant led outpatients and follow ups.
Unplanned Care	Urgent connect - L&D	60		Delivery	Urgent Connect is based on the implementation of a telecom solution which enables GPs to have direct and immediate telephone contact with Acute hospital staff prior to sending a patient to A&E. This scheme aims to exploit the savings from the Urgent Connect system already implemented in the L&D	Patients benefit by getting the right care in right place	Savings will be achieved via reductions in non-elective admissions to hospital.
Unplanned Care	Ambulance- Hear and Treat/See and Treat	60		Initiation	The proposal is to increase the use of clinical advice offered to 999 ambulance callers so that a lower proportion of these calls result in the attendance of an ambulance clinical resource. Or where an ambulance is dispatched, for the ambulance service to treat at home or refer into an Alternative Clinical Pathway, where appropriate in order to support the delivery of national targets for ambulance conveyancing.	Improved response times for ambulance conveyancing for red 1 and 2 and improved, responsive patient care.	Savings will be achieved through a reduction in A&E admissions, attendances and ambulance conveyances.
Unplanned Care	Fracture Liaison Service	55		Initiation	Preventing falls through earlier and more effective coordinated interventions will both improve the quality of life of individuals and families and reduce demand on health and social care services.	Prevent falls and reduce the harm caused by falls for residents in Care Homes and Sheltered Accommodation	Savings will be achieved via reductions in non-elective admissions to hospital.
Unplanned Care	NCA Ambulances	18		Initiation	The proposed intention of this project is to develop a robust data interrogation system which will identify EEAST non-contracted inter-hospital transfers monthly allowing the CCG to challenge EEAST and Bedford Hospital and withhold funding where appropriate.	The efficiencies identified will enable BCCG to focus more resources on enhancing patient outcomes in other areas of commissioning.	Savings will be achieved through a reduction in NCA Ambulance expenditure
	Total	19,235	2,750				

Appendix 5: Sustainability and Transformation Plan

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STP scheme	Dey deliverables	Baseline position	2017/18 actions/milestones (steps to delivery)	2018/19 actions/milestones (steps to delivery)	Impact	KPIs/plan trajectory	Relationship to other plans, e.g. RightCare UECN
STP priority 0 - Programme Structure and Management	Create resourcing and governance , delivering against priority plans (Steering Group, STP CEO Group, Prevention Steering Group, Care Closer to Home Board, Secondary Care Transformation Board, Digitisation Board, Accountable Care System Activation Board); Communication and engagement strategy developed and activated.	Resourcing and governance established in 2016/17.	Q1: P0 governance structure continues with planning in place to transfer arrangements to P5 post 2017/18 Q2: Q3: Q4:	Q1: P5 arrangements will include Q2: Q3: Q4:			
STP priority 1- Prevention	Implementation of Fracture Liaison Service; Implementation of Social Prescribing Hub; Development of communication strategy	Prevention Group and Champions established; Organisation Prevention plans drafted and agreed; Business case for Fracture Liaison Service and Social Prescribing Hub written. BLMK prevention priorities are integrated into joint Health and Wellbeing strategies.	Q1: Organisation Prevention Plans implemented; implement communication plan Q2: Implement business cases for FLS and SPH into services Q3: Q4:	Q1: Implementation of communication strategy Q2: On-going engagement with Health and Well -Being Boards Q3: Q4:		Number of pregnant women who smoke; Number of women breastfeeding; Referrals to weight mangement for children and pregnant women; Hospital admissions for asthma; flu immunisation uptake; Cervical screening coverage; Bowel screening coverage; Diagnosis of HIV; Detection and treatment of chlamydia; Alcohol related admissions; Uptake of preventative programmes; Perinatal mental health (KPI tbc); Emotional wellbeing of young people (KPI tbc); Diagnosis of dementia; Physical health and life expectancy of people with mental health issues; Admissions for falls; Diabetics attending education course; Diabetes treatment targets; Score of patients on anticoagulation; Pharmacies achieving Healthy Living accreditation.	
STP priority 2 - Primary, Community and Social Care	Project plans for solutions developed ('Better Care Closer' change programme; Single Point of Access and Clinical Hub) Delivery of Primary Care Home work package(establishing GP clusters and community and social care teams) and developing transfer protocols.	Transfer protocols; Planning for Primary Care Home work package.	Q1: Delivery of Better Care, Closer solutions and SPOA Q2: Delivery of Primary Care Home and developing transfer protocols Q3: Q4: Delivery of projects: enhanced primary care, complex care management, acute based care delivery, referrals management, medicine optimisation, community based outreach.	Q1: Q2: Q3: Q4: Delivery of projects: enhanced primary care, complex care management, acute based care delivery, referrals management, medicine optimisation, community based outreach.	People feel beetter supported in their communities; Reduced dependency on acute and non-elective care; Population health is improved; Population funding is in place and linked to outome based contracts.	Enhanced primary care activity shift: 64,362 episodes; Complex care management activity shift: tbc; Acute based care management activity shift: tbc Referrals management activity shift: tbc Medicine optimisation activity shift: tbc Community based outreach:tbc	STP Headline Opportunities from October 2016 and in relation to RightCare priorities: - Gastro-intestinal - Endocrine - Circulation - Respiratory - Genito-urinary - Complex patient
STP priority 3 - Secondary Care Transformation)	Clinical service model for stroke established; All hospital clinical services examined and target leadership; managment and operational models determined, including any recommended service change. Public consultation requirements assoicated with any recommended clinical service change considered and early planning commences. Non-medical clinical workforce model implemented ; Investment case development and delivery.	Clinical service model for stroke developed, agreed and implemented across BLMK; Clinical service model for wave 1-3 specialties developed and implemented; Clinical reconfiguration investment cases completed; non-medical clinical workforce model (NIMCWM) - investigated and defined; NIMCWM implementation; costed solutions for fully integrated back office services for non-clinical support; implementation of agreed solutions for non-clinical support; integrated clinical support service plan agreed.	Q1&Q2: Assurance check on investment cases by NHSE/I and Public Consultation. Integrated clinical support service plan agreed. Q3 &Q4: Implementation of secondary care reconfiguration for services to new models.	Q1 &Q2: Implementation of secondary care reconfiguration for services to new models. Q3: Q4:		Cost for care hours Use of agency staff Rotation and sharing of staff across points of delivery £25m savings in specialty clinical services	
STP priority 4- Digitisation	Health information exchange solution designed; Network connectivity for system designed and procured; Pilot citizen facing architecture in primary care; Shared infrastructure and interoperability.	Intermediate solution for shared health and care citizen record made available to the clinical hub to support care co-ordination	Q1:Health information exchange solution designed; Network selection procured. Q2: Full citizen access designed and implementation. Q3:Citizen facing techonology enabled focusing on LTCs Q4: Network connectivity solution procured. Procurement of platform for data management and risk stratification.	Q1:Risk stratification and care co-ordination goes live Q2: Q3: New citizen facing record go live. Q4: Shared care record optimal solution implemented.	LDR universal capability Shared health and care citizen record integrated and communicable across all organisations Patients have access to own health and care record Technology to support self management Analytics to support risk stratification and operational intelligence Development of digital skills in workforce System wide leadership		
STP priority 5- System Re-engineering	Preferred Accountable Care System determined and solution signed off by relevant statutory bodies; Detailed design and development work on ACS completed;Procurement planning work completed	Plan as per STP	Q1: Q2: NHSE/1 new care models assurance process completed Q3: Public consultation on new models completed Q4: Agreed ACS solution ACO established; Procurement of integrated support	Q1: Q2: ACO supply chain procured Q3: ACO contract awarded by commissioner Q4: Mobilisation and delivery of accountable care system, system integration activity and channel shift measures			

Appendix 6: Primary care

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	Dey deliverables	Baseline position	2017/18 actions/milestones (steps to delivery)	2018/19 actions/milestones (steps to delivery)	Impact	KPIs/plan trajectory	Relationship to other plans, e.g. RightCare UECN
Local priority 1: Extended Access	100% of practices offer full extended access by April 2019	38 practices are currently participating in extended access DES, none currently meet the extended access requirements outlined in the GPFV.	Q1: Identify/recruit project manager for combined extended access, e-consultations & digital self-care project, and establishment of Steering Group & project plan. Engagement with practices and other stakeholders. Establish buddy relationship with a more advanced CCG (one of PM's Challenge sites). Scoping of demand for appointments during extended hours. Implementation through delivery of locality development plans, with pump priming funding for Practice Transformational support and dedicated project support resources. Support/incentivise practices to increase number of patients with explicit consent to share information.	Q1: Go-live of pilot/early adopter practices within Bedfordshire - 100% of patients offered full extended access by Q3, 2018/19	Achievement of national Extended Access target - 100% of Bedfordshire patients able to book routine and urgent appointments in the evening and on weekends by 2020. Enabler for collaborative working between practices. Reduced innapropriate non-elective admissions. Lower levels of readmission, shorter length of stay, improved patient experience. effective use of workforce and increased productivity.	Baseline position, 38 practices offering extended hours under terms of Extended Access DES. 100% of patients offered full extended access by Q3, 2018/19	
			Q2: Implementation of combined extended access, e-consultation & digital self-care project plan. Support delivery through implementation of locality development plans. Provide technical solutions to enable inter-operability of IM&T between practices, via implementation of Local Digital Roadmap.	Q2: Go-live of next wave of practices		.	
			Q3: Implementation of combined extended access, e-consultation & digital self-care project plan. Implementation through delivery of locality development plans. Identify pilot/early adopter practices.	Q3: Go-live of further wave of practices			
			Q4: Implementation of combined extended access, e-consultation & digital self-care project plan.	Q4: 100% coverage of extended access			
Local priority 2: E-consultations	Provide the technical infrastructure for collaborative working and towards a single point of access model between practices; as well as new forms of electronic consultation such as e-consultations, shared telephone triage between practices, and Skype consultations; and digital solutions to support self-care and self-management.		Q1: Identify/recruit project manager for combined extended access, e-consultations & digital self-care project, and establishment of Steering Group & project plan. Engagement with practices and other stakeholders. Develop suite of technical options to offer practices to enable e-consultations, e.g. Skype, through practice websites, Systm1 online messaging (funding secured via ETTF). Provide Information Governance assurance around the technical options. Implementation through delivery of locality development plans. Commence planning for development/commissioning of local health app.	Q1: Minimum of 40% patients offered some form of e-consultation	Achievement of national online consultations target. Improved patient access and satisfaction. Increased GP productivity Reduced innapropriate non-elective admissions. Lower levels of readmission, shorter length of stay, improved patient experience. effective use of workforce and increased productivity.	E-consultations offered to 40% of patients by end of Q1, 2018/19; 75% of practices offering online consultations by Q2 2018/19; E-consultations offered to 95% of patients by end of Q4, 2019/20.	
			Q2: Implementation of combined extended access, e-consultation & digital self-care project plan. Implementation through delivery of locality development plans.	Q2: 75% of practices offering online consultations			
			Q3: Implementation of combined extended access, e-consultation & digital self-care project plan. Implementation through delivery of locality development plans.	Q3: Ongoing implementation of project, including sharing of successes of early adopter practices.			Bedfordshire CCG clinical leads, providers and commissioners have agreed to work together with HealthWatch to realise opportunities identified by RightCare Programme. The five clinical areas the CCG is focusing on are: Cardiology, Cancer, Diabetes, Gastro-Intestinal and Respiratory. The programme will review provider spend, activity and performance, prevention, early diagnosis and out of hospital spend. In particular, we want to improve outcomes for patients with these conditions and at less cost to the local health system.

			Q4: Implementation of combined extended access, e-consultation & digital self-care project plan. Implementation through delivery of locality development plans.	Q4: Online consulations available to 95% of patients			Primary Care is also part of our co-commissioning intentions, and underpins our GP Forward View and the BLMK STP workstreams (2 & 5). The operational plan priorities will support GPs in complex care management, enhanced services, effective use of thier workforce and facilitating patients in self care and management of their conditions. The Digital Road Map will support shifts of activity to primary care through shared records and health intelligence.
Local priority 3: Local Time for Care Programme	• To implement ten high impact changes within the priorities of our locality primary care development plans; • To have clinical administrators working in eleven GP practices by April 2016, and within all Bedfordshire practices by 2020/21; • To provide £800k investment across 2017-19 to pump-prime new workforce models, including practice-employed paramedics, an expansion of the minor illness nurse workforce, and roll-out of the Clinical Pharmacist model. • To invest a further £590k in Practice Transformational support across the two years, including the delivery of targeted workforce diagnostic assessment and facilitated change management support across groups of practices, and additional project capacity to support the Time for Care programme; • To continue the recruitment and retention of GPs locally through GP fellowship and GP leader programmes, and supporting practices to create more flexible career structures for GPs; • To develop a Practice Manager Leadership and Innovation group which will co-design and drive change; • To support multi-professional development, mentorship and career opportunitiesTo work towards commissioning 100% coverage of extended access by Quarter 3 of 2018/19, to build upon the extended access already provided by many Bedfordshire practices under the NHS England-commissioned DES.		.Q1: Consolidation of existing workforce development and service change initiatives into robust Time for Care programme, with additional project support. Implementation of High Impact Actions, as prioritised within Locality Development Plans. Second phase of clinical administrator training - to achieve 50% coverage across Bedfordshire practices. Support practices/ localities to recruit paramedics and pharmacists (utilising Practice Transformational Funding and second wave of NHSE scheme). Establishment of Practice Manager Leadership and Innovation Group to co-design and drive change. Continuation of support for recruitment, retention, training and mentorship expansion through CEPN (Community Education Provider Network). Q2: First wave of specialist workforce diagnostic and change management support across groups of practices (utilising Practice Transformational Funding). .Q3: Continuation of workforce diagnostic and change management support. .Q4: Continuation of workforce diagnostic and change management support.	Q1: Third phase of clinical administrator training - to achieve 75% coverage across Bedfordshire practices. . .	Effective use of workforce and increased productivity. Implementation of High Impact Actions Increased skillmix within general practice Reduction in workload for GPs Improved recruitment and retention of GPs and nurses Increased sustainability of primary care	50% of practices to have a trained clinical administrator by end of Q2, 2017/18	
Local priority 4: MDT working and enhanced support for care homes	As part of our STP, we will be developing building care management teams around GPs. Key delivables will include: 1. Primare care home/enhanced primary care 2. Complex care managment 3. Acute based care management 4. Referrals management 5. Medicines optimisation 6. Community based outreach 7. Single point of access and the clinical hub	Set up of governance and project planning for enhanced primary care, complex care management, improved discharge management, improved referrals management, medicines optimisation, community outreach, standardised approach to care coordination, and clinical hub.	Q1: Support implementation of locality development plans through pump priming Practice Transformational support and dedicated project support resources. Re-procurement of three APMS contracts under one contract in Bedford. Facilitation of partnership working between practices and new OOH/111 provider, including pilot of 111 triaging and directly booking appointments for four practices. Estates programme to develop first three hubs in Bedfordshire (ETTF funding secured), and scoping for further four hubs (subject to One Public Estate funding being available). Programme to implement Local Digital Roadmap (ETTF funding secured) to provide technical infrastructure to enable primary care at scale. BLMK standardised approach: appoint leads, operating procedures, define GP clusters. Care management teams, phase 1 activities: primary care home; Complex care management activities: risk stratification, MDT working, mental health. Discharge management: shared records, specialist outreach, specialist support. Community outreach: development of coordination team. Q2-Q4: BLMK standardised approach - establish MDT teams, tools and processes. Deliver proactive care. Referrals management: review pathways, benchmarking, practice plans, virtual consultations. Medicines optimisation: MDT links, compliance monitoring. Community outreach: collation of available services.	Q1: Implementation through delivery of locality development plans. Ongoing implementation of Estates and IM&T programmes.	Reduced innapropriate non-elective admissions. Lower levels of readmission, shorter length of stay, improved patient experience. effective use of workforce and increased productivity. GPs are able to focus on patients with multiple chronic conditions. Core general practice provides better access and wellbeing services. appropriate referrals and use of specialist services. Improved pathways and access. GP	2% of complex needs population 18% high healthcare needs population 80% generally healthy population A&E and inpatient elective and non-elective activity and spend Patients with specialist referrals Patients in 2% and 18% pops using prescription medications	

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Appendix 7: Urgent and emergency care

	Dey deliverables	Baseline position	2017/18 actions/milestones (steps to delivery)	2018/19 actions/milestones (steps to delivery)	Impact	KPIs/plan trajectory	Relationship to other plans, e.g. RightCare UECN
Local priority 1: A&E streaming	Streaming at the front door – to ambulatory and primary care. To reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.	AEC unit fully operational from 26th September 2016. Community pathway and 2-hour response for intermediate care services established. GP access to specialty consultant advice started. Five additional 'majors' cubicles in A&E. Caudwell Road GP Practice on BHT site with effect from October 2016. Streaming for mental health established. Frailty unit established.	Q1-Q4 AEC to move to 7 day working. Establish robust ENP led See and Treat service. All major specialties to have a consultant available to provide advice to GPs by phone. Increase in awareness of Alternative Clinical Pathways (ACPs) to which ambulance crews can convey and/or signpost patients. AEC and pimary care streaming to manage at least 25% of the emergency take Q1: '111': 30% of calls transferred to a clinical advisor Improved A&E performance to 96.57%	Further milestones need to be agreed by A&E delivery board.	To reduce waits and improve flow through emergency departments. Improved A&E performance. Less spend on secondary care by 2021 across BLMK.	AEC and pimary care streaming to manage at least 25% of the emergency take '111': 30% of calls transferred to a clinical advisor Improved A&E performance to 96.57% by Q1 2017.	
Local priority 2: NHS 111	NHS 111 – increasing clinical call handler capacity in advance of winter. To decrease call transfers to ambulance services and reduce A&E attendances.	Clinical expertise planned according to demand. A&E delivery board monitors 111 service and OOH. DOS service reviewed and system in place for updates. Alternative services to A&E are established and monitored. A&E delivery board kept informed of demographics through modelling work and audits undertaken in 2016.	Re-procurement of an Integrated Urgent Care (IUC) service, bringing together 111 and OOH across Bedfordshire and Luton, in conjunction with a clinical advisory service to commence 1/4/17. Q1: 30% calls transferred to clinical advisor; increase in number of 111 calls closed to 15%; reduction in number of ambulance dispatches from 111 to 6%; reduction in A&E attendances sent via 111 to 6%.	Re-procurement of an Integrated Urgent Care (IUC) service, bringing together 111 and OOH across Bedfordshire and Luton, in conjunction with a clinical advisory service to commence 1/4/17.	To reduce waits and improve flow through emergency departments. Improved A&E performance. Less spend on secondary care by 2021 across BLMK.	30% calls transferred to clinical advisor by Q1 2017. Increase in number of 111 calls closed to 15% by Q1 2017. Reduction in number of ambulance dispatches from 111 to 6% Q1 2017. Reduction in A&E attendances sent via 111 to 6% in Q1 2017.	
Local priority 3: Ambulance services	Ambulances – DoD (Disposition on Dispatch) and code review pilots; HEE increasing workforce. To help the system move towards the best model to enhance patient outcomes by ensuring all those who contact the ambulance service receive appropriate and timely clinician and transport response. Decrease in conveyance and an increase In 'Hear and treat' and 'See and treat' to divert patients away from the ED.	Ambulance executive on A&E delivery board. Working definitions of See and Treat agreed across the local health economy. Alternative services able to accept ambulance dispositions. Local mechanism for increasing clinical input into green dispositions established. Agreed workforce and service plans to deliver increase in See and Treat.	Q1: Reduction in ambulance conveyances. Increase in Hear and Treat to 9%.	Further milestones need to be agreed by A&E delivery board.	Reduction in ambulance conveyances	Reduction in ambulance conveyances. Increase in Hear and Treat to 9%.	Bedfordshire CCG clinical leads, providers and commissioners have agreed to work together with HealthWatch to realise opportunities identified by RightCare Programme. The five clinical areas the CCG is focusing on are: Cardiology, Cancer, Diabetes, Gastro-Intestinal and Respiratory. The programme will review provider spend, activity and performance, prevention, early diagnosis and out of hospital spend. In particular, we want to improve outcomes for patients with these conditions at less cost to the local health system. Secondary acute care will be a key element of our focus as we examine non-elective attendances diagnostics and admissions; review inpatient LOS and excess beds days; and diagnostics spend for outpatients, inpatients , and per 1000 population. Our overall aim within STP and QIPP savings is to streamline pathways to acute care, ensuring better alignment between patient need and the appropriate level of acute response; while developing more out of hospital services. Prevention will also be a key feature of the CCG's work on clinical conditions. Our STP programme will underpin local initiatives with a framework for bolstering primary care capacity and capability, and opportunities for patients to manage their conditions with the close support of MDTs in the community.
Local priority 4: Improved flow	Improved flow – To reduce inpatient bed occupancy, reduce length of stay, and implementation of the SAFER bundle.	Hospital discharge process established with pathways, clinical criteria, and full roll out of SAFER bundle by end of 16/17. Palliative care pathway reviewed and changes agreed. Frequent attenders identified, agreed process for record sharing, and MDT working. Data sharing agreed. TTA's and transport model implemented.	Q1: 100% roll out of SAFER bundle; reduction on in DTOCs by 3.5%; increase in number of discharges before midday to 33%.	Further milestones need to be agreed by A&E delivery board.	Increase in safe discharges. Reduction in DTOCs. Elimination of variation in KPIs related to LoS, mortality, patient experience, SUIs, etc	100% roll out of SAFER bundle by Q1 2017. Reduction in DTOCs by 3.5% by Q1 2017. Increase in number of discharges before midday to 33% by Q1 2017.	
Local priority 5: Discharge	Discharge – mandating 'Discharge to Assess' and 'trusted assessor' type models. All systems moving to a 'Discharge to Assess' model to reduce delays in discharging, points to home as the first port of call if clinically appropriate. This will require close working with local authorities on social care to ensure successful implementation for the whole health and care system.	Whole system agreement to DTOC process. Home first pathway in place. CHC screenings and assessments conducted outside of acute setting. SOP for patient choice. Review system for stays that exceed 6 and 30 days. DTOC director in place and named senior personnel in every CCG and SD.	Q1: Falls Training in Care Homes. Community hubs to be in place. Reduction in DTOC stays that exceed 6 and 30 days; elimination of variation in KPIs related to LoS, mortality, patient experience, and SUIs.	Further milestones need to be agreed by A&E delivery board.	Reduce delays to discharge and ensure that patients are able to go home with appropriate support within optimum period of time.	DTOC stays that exceed 6 and 30 days Elimination of variation in KPIs related to LoS, mortality, patient experience, SUIs, etc	

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Appendix 8: Referral to Treatment

Must do' Scheme	Dey deliverables	Baseline position	2017/18 actions/milestones (steps to delivery)	2018/19 actions/milestones (steps to delivery)	Impact	KPIs/plan trajectory	Relationship to other plans, e.g. RightCare UECN
Local priority 1: NHS constitution standard	Achievement of national standard for RTT Incomplete Pathway	92%	Q1: 92% Q2: 92% Q3: 92% Q4: 92%	Q1: 92% Q2: 92% Q3: 92% Q4: 92%		Achievement of aggregate performance in line with national standard. This is an STF indicator and Bedford Hospital has a stretch target of 94.61% with agreement that the fund would be delivered on compliance of national 92% standard.	
Local priority 2: increase E-referral uptake		36.60%	Q1: Commission Local Enhanced Service to incentivise practices to increase uptake (subject to financial prioritisation), and continue to work with secondary care providers to improve slot availability. Identify project lead to support practices to utilise and improve local systems. Q2: Performance monitoring and close liaison with secondary care providers and practices Q3: 80% utilisation Q4: Performance monitoring and close liaison with secondary care providers and practices	Q1: Performance monitoring and close liaison with secondary care providers and practices. .Q2: Performance monitoring and close liaison with secondary care providers and practices. .Q3: 100% utlisation Q4: Ongoing performance monitoring and close liaison with secondary care providers and practices.	Achievement of national utilisation targets for e-referrals Improved information sharing and patient flows between primary and secondary care	80% use of e-referrals by September 2017 100% use of e-referrals by April 2018	
Local priority 3: Elective care pathways	Currently the five pathways the CCG is working on as part of the RightCare Programme are: Cardiology, Cancer, Diabetes, Gastro-Intestinal and Respiratory. Additional areas for us address in terms of spend and outcomes are: circulation, genito-urinary and mental health.						
Local priority 4: Better Births	Working closely with local maternity services and support them in implementing the action plans, based on the recommendations of the review for Better Births. Secure safety and choice of all expectant mothers across Bedfordshire. Work across the STP footprint to set up a steering group with commissioners from Bedfordshire, Luton and Milton Keynes to develop maternity systems and improve outcomes for our mothers.						

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Appendix 9: Cancer

Must do' Scheme	Dey deliverables	Baseline position	2017/18 actions/milestones (steps to delivery)	2018/19 actions/milestones (steps to delivery)	Impact	KPIs/plan trajectory	Relationship to other plans, e.g. RightCare UECN
Local piority 1: Improving outcomes in 1 year survival	Undertake Root Cause Analysis to understand link between detection rates and outcomes	68.90%	Q1: Reduce number of people waiting longer than 100 days for treatment. GP education events delivered by Acute Trusts to raise awareness of 2ww pathway Q2: Work with partners (Acute Trusts, primary care, Cancer Research UK and Macmillan Charities) to develop a programme of work to understand variance in treatment pathways that could affect outcomes. Increase uptake of screening for Bowel, Breast and Cervical cancer Q3: Q4: Work with NHSE and Local Authority Public Health teams to identify barriers to uptake in cancer screening programmes	Q1: Q2: Q3: Q4:			
Local piority 2: Improve and maintain 62 day	Pathway redesign to reduce diagnostic delays by implementing national treatment pathways	Q2 16/17 81.23%	Q1: 85% Undertake GP audit of 2ww referrals – appropriateness and quality Q2: 85% Q3: 85% Implement best practice treatment pathways for Breast, Urology, Colorectal and Lung cancer pathways which includes offer of 1st appointment with 7 days and straight to test which reduces delays to diagnostics Q4: 85% Review capacity within cancer services to ensure providers have planned for appropriate levels of activity with diagnostics, outpatient services and surgery	Q1: 85% Q2: 85% Q3: 85% Q4: 85%		85%	Current STP Commissioning intention from September 2016: - includes cancer as a priority area. There will be a Cancer Implementation Group, Chaired by Dr Kay Elliott, which reports to the RightCare Transformation Board.
Local piority 3: Risk stratified pathways	Phased roll-out to continue to include Colorectal and Urology (prostate)	Risk Stratified Pathways in place already for Breast, Head and Neck and Renal (urology) Cancers	The Cancer Improvement Group will monitor the roll-out plan for the remaining specialities. By Q4 17/18 we expect to have these pathways in place	Review effectiveness of new pathways			
Local piority 4: Formalise commissioning of recovery package	Pick up funding agreed for macmillan psychological support service as part of peer review measures Embed HNAs and care planning formally	HNAs and End of treatment summaries are part of 16/17 CQUIN with acute providers. Need to ensure this is rolled over into 17/18 Standard Acute Contract.	The Cancer Improvement Group will monitor the implementation of the services that contribute to the recovery package Q1: Embed Macmillan Psychological Support service in SEPT Community contract for 2017/18 BHT to submit bid to Macmillan for support tools for CNS's to enhance HNAs Ensure End of Treatment summaries CQUIN is rolled into main contract	Review effectiveness of new pathways			
Local priority 5: CCG Right Care Programme	Understand cancer spend in order to strategically align resources	High spend in some areas of cancer diagnostics and treatment compared to similar CCGs (QIPP)	Redesign of pathways identified in 16/17 as priority areas for Cancer Rightcare programme Review TOR for Cancer Improvement Group to reflect Right Care approach	Review effectiveness of new pathways			

similar CCGs (QIPP)

Analysis of cancer spend

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Appendix 10: Mental health

STP scheme	Dey deliverables	Baseline position	2017/18 actions/milestones (steps to delivery)	2018/19 actions/milestones (steps to delivery)	Impact	KPIs/plan trajectory	Relationship to other plans, e.g. RightCare UECN
Local priority 1 : psychological therapies	Additonal pschological therapies for people with anxiety and depression. To be integrated with physical care. IAPT – improved access target 2017/18. • Upskill/ develop workforce in CYP IAPT interventions • Improved outcomes monitoring and measurement • Increased access to NHS funded community health services for children and young people (CYPs).	15%	Q4: access rates to be increased to 16.8%; 25%	Q4: access rates to be increased to 19%; 30%	• Improved outcomes monitoring and measurement • Increased access to NHS funded community health services for Children and young people	Increase in access rates to 16.8% in Q4 17/18 and to 19% 18/19 Psychiatric Liaison service established in Bedford Hospital No. CYPs with a diagnosable MH condition receive treatment from Community MH services; CYPs receiving treatment from NHS funded community services in the reporting periods; total individual CYPs receiving treatment by NHS funded community services.	
Local priority 2: Children and young people	Improve access and waiting times to services for children and young people. Provide a crisis service for CYPs in Bedordshire and Luton. EIP for CYPs.		**Access:** 30% access rates, 80% to get assessment within one week or less, 30% reduction in CYP admitted to acute trusts, 50% reduction in CYPs admitted to 4 tier bed, 85% of CYPs with discharge plan in place on admission, 85% accessing NICE compliant interventions. **Crisis services**: CYPs seen out of office hours; 25% reduction in repeat presentations; 75% MH patients seen and assessed within 2 hours of presentation at A+E; Length of waiting times; Numbers attending A+E; 75% reduction in numbers admitted to inpatient beds; 75% reduction in umbers admitted to Tier 4; reason for admission; 85% with discharge plan in place; length of stay. **Psychological therapies for children:** CYPs with a diagnosable MH condition receive treatment from Community MH services; 26 CYPs receiving treatment from NHS funded community services in the reporting periods; 1414 total individual CYPs receiving treatment by NHS funded community services. **Eating disorder:** Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases.	Q4: 30% access rates, 90% to get assessment within one week or less, 60% reduction in CYP admitted to acute trusts, 80% reduction in CYPs admitted to 4 tier bed, 90% of CYPs with discharge plan in place on admission, 90% accessing NICE compliant interventions. **Crisis services:** CYP seen out of office hours; 50% reduction in repeat presentations; 85% MH patients seen and assessed within 2 hours of presentation at A+E; Length of waiting times; Numbers attending A+E; 85% reduction in numbers admitted to inpatient beds; 85% reduction in umbers admitted to Tier 4; reason for admission ; 95% with discharge plan in place; length of stay. **Psychological therapies for children:** CYPs with a diagnosable MH condition receive treatment from Community MH services; 35 CYPs receiving treatment from NHS funded community services in the reporting periods; 1696 total individual CYPs receiving treatment by NHS funded community services. **Eating disorder**: Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases.	• Rapid Access to specialist support • Improved patient experience • Reduced hospital admissions for Eating disorders • Increased awareness of the presentation and prevalence of eating disorders. • Joining up services locally • Improve the quality and effectiveness of all aspects of the service.	Access rates, length of time to assessment, numbers admitted to acute trusts and numbers in tier 4 beds, length of stay, discharge plans in place at admission, numbers accessing NICE compliant interventions.	
Local priority 3: EIP	CAMHS: More than 50% of people with first episode of psychosis are treated with a NICE approved package of care within two weeks of referral. Specialist EIP service in line with NICE recommendations. 35% receiving early treatment are in employment compared with 12% in traditional care. Reduced likelihood of an individual receiving compulsory treatment from 44% to 23% during first two months of psychosis. Reduced suicide risk from 15% to 1%. Reduced numbers detained under MHA. Referral to treatment times.	50%	Q1: 52.6% Q2: 52.6% Q3: 52.6% Q4: 52.6%	Q1: 55% Q2: 55% Q3: 55% Q4: 55%		53% /56% of people experiencing a first episode of psychosis begin treatment withiin two weeks of referral	
Local priority 4: Severe mental illness	Increase access to individual placement for people with severe MH in secondary care services.		Q1 Q2 Q3: Complete a baseline exercise to determine use of Individual Placement Support for those with severe mental illness Develop key links with the Recovery academy and services Identify Employment champions across all services Develop key links with stakeholders in the local authorities and other partners. Q4: Improvements to data reporting Set performance targets within new contract	Q1: increase access by 25% Q2 Q3 Q4:		increase access by 25% by April 2019	The CAMHS deliverables form part of the Future in Minds Local Transformation Plan - 2016-2020 - with Bedford borough Council and Luton CCG. Mental Health is part of our RightCare strategy and there will be a Mental Health Implementation Group Chaired by Dr Norah Chidote, reporting to the RightCare Transformation Board.
	Reduce suicide rates. 1. Reduce the risk of suicide in key high-risk groups: 2. Tailor approaches to improve mental health in specific groups 3. Reduce access to the means of suicide	There were 8 suicides/open verdicts in Central Bedfordshire in 2015-2016 (7 male, 1 female). There were 6 suicides/open verdicts in Bedford	Project 1: People in contact with the criminal justice system e.g. Bedford Prison. Project 2: Mental Health Street Triage. Project 3: Self-harm in young people (0-25). Project 4: Guidance for NHS employees.			10% reduction against 2017/18 baselines	

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Local priority 5: Suicide prevention	4. Provide better information and support to those bereaved or affected by suicide 5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour 6. Support research, data collection and monitoring 7. Overarching Themes	Borough in 2015-2016 (3 male, 3 female). Bedfordshire has low suicide rates relative to the rest of England.	Project 5: "Postvention". Project 6: Disseminate media guidelines. Project 7: Improve real time reporting of suicides / unexplained deaths. Project 8: Bedfordshire Suicide Prevention Conference / Stakeholder Event. Project 9: Communications Strategy.		
Local priority 6: Mental health investment standard	Increase baseline spend on MH to deliver MH investment standard		Please refer to finance submission	Please refer to finance submission	
Local priority 7: perinatal mental health	• Reduction in attachment difficulties • Avoidance of early trauma • Parents feeling better supported • Reduction in mental health crisis • Effectiveness of interventions monitored through use of outcome monitoring. • Sustain model of learning over the next years through the use of the champions facilitating training thereafter. All current and future staff to attend training to ensure competence and confidence .	Trained health visitors: 12 Trained midwives: 4	Trained health visitors: 300 (tbc) Trained midwives: 100 (tbc) Further trajectories to be established.	Trained health visitors: 600 (tbc) Trained midwives: 200 (tbc) Further trajectories to be established.	Numbers of health visitors trained Number of midwifes trained. Numbers referred for perinatal interventions. Numbers of pregnant mothers receiving rapid access to adult IAPT services. Numbers of fathers with mental health problems receiving rapid access to IAPT. Number of mothers assessed and number of babies/children assessed. Number of early interventions and attendance at these within the HV service for mothers with identified depression.
Local priority 8: Dementia	Improve diagnosis of dementia • Engage with local people to determine what support should be developed. • Local refresh and Implementation of the National Dementia Strategy. • Impact Assessment; Carers and people whose needs are not currently being met.	66.70%	Q1 • Recruitment of Dementia champions with support of CCG clinical lead • Establishing clinical and strategic networks Q2 Q3 • Development and implantation of a dementia screening tool • Patient education event Q4:	Q1: Q2 Q3 Q4:	At least two thirds of estimated prevalence due regard to post diagnostic cre
Mental Health Five Year Forward View	**Additional acitivities as part of MHFYFV:** • Re-provision of Weller Wing • Reduction of admissions in non-specialist adult acute mental health inpatient provision • QIPP project – Liaison Psychiatry in Bedford Hospital • Adult mental health community, acute and crisis care • Perinatal mental health • Integration agenda / STP / Hubs • Recovery Service • Children and young people's mental health – Five year forward view for mental health • SPLD Review • Transforming care o The Coppice (BLMK) o LD Assessment and Treatment beds o Forensic / at risk of offending (community) o IFR - Complex Case Panel • Spot purchase placements • Single Point of Contact (SPOC) – Commissioned model of service		Q1 Q2 Q3 Q4:	Q1: Q2 Q3 Q4:	

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Appendix 11: Learning disability

STP scheme	Dey deliverables	Baseline position	2017/18 actions/milestones (steps to delivery)	2018/19 actions/milestones (steps to delivery)	Impact	KPIs/plan trajectory	Relationship to other plans, e.g. RightCare UECN
Local priority 1 : TCP	Deliver Transforming Care Partnership, enhancing community provision for people with learning disabilities and/or autism. Reduce inpatient bed capacity. Reduce mortality through improved access to healthcare for people with LD: more people registered with GPs and with an annual review, more people with a person-centred care and access to direct payments.prim We will also make reasonable adjustments to support access to health services; and will improve education and training to LD staff, primary care, and we will look at other services to review any gaps.	No. people on learning disability register in BLMK: 3,715. The BLMK partnership area has low usage of inpatient beds, compared to many other areas in Eastern and Central England. As of 31st January 2016 the partnership was reporting on 19 adults in inpatient settings. It has been projected that by April 2017 12 of these patients will have been discharged or have a confirmed discharge date. At March 2016: **CCG Commissioned Inpatient Care**= 17 **NHS England Specialised Commissioning** =14 7 crisis beds commissioned within footprint 0 locked rehab commissioned within footprint 18 beds outside of footprint currently in use by TCP	Q1: • Complete a LD projected needs analysis • Improvements to activity reporting • Ensure suitable step down placements are sourced to ensure transition of out of area NHS E commissioned placements and individuals can return to Bedfordshire • Review effectiveness and use of Blue Light CTRs and review CTRs • Review of current local provision with possible redesign in conjunction with need analysis and MPS findings and recommendations	Q1: • Review of current local provision with possible redesign in conjunction with need analysis and MPS findings and recommendations • Ensure suitable step down placements are sourced to ensure transition of out of area NHS E commissioned placements and individuals can return to Bedfordshire • Audit of individuals with LD GP registration and health check. Identification of gaps and develop next steps to ensure an increase in registration and annual health checks	Improve access to healthcare for people with LD	By Q4 2018/19: 0 secure beds within footprint to be commissioned by TCP; 7 crisis beds within footprint to be commissioned by TCP; 5-7 CCG commmissioned beds per for the Bedfordshire population.	This joint transformation plan will link closely with the following existing strategies and plans and across the partnership area: - • Local Transformation Plans for Children and Young People's Health and Wellbeing • Local action plans under the Mental Health Crisis Concordat • The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care) • Local Autism Strategies (Bedfordshire, Luton and Milton Keynes) • The roll out of education, health and care plans • CAMHS Mental Health and Wellbeing strategies for Bedford Borough and Central Bedfordshire The joint Transforming Care plan supports the Joint Health and Wellbeing Strategies for all of the partners, e.g. the Milton Keynes Joint Health and Wellbeing strategy 2015-18, and in particular 'starting well: giving every child the best chance in life' and 'living well: working with communities to live longer and healthier lives'. This joint transformation plan references and supports the: • Local Children and Young Peoples Mental health and Wellbeing Pathway. • The Local action plans under the Mental Health Crisis Concordat • The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)
			Q2: • Completion of Market Position Statement (MPS)for Health in conjunction with social care to determine unmet and future needs for Bedfordshire • Developed robust transition processes to ensure preventative work with individuals transition from Children's & YP services to adults	Q2: • Developed robust transition processes to ensure preventative work with individuals transition from Children's & YP services to adults			
			Q3: • Explore a forensic supported living model to assist support for those individuals within the CJ system and/or at risk of offending. This will assist placing individuals back to Bedfordshire and stop out of area placements. • Bid submission and development of positive behavioural support provision for both adults and Children and Young people with LD needs. • Training needs assessment to be completed and commission training needs across professional and services in Bedfordshire	Q3: • Training needs assessment to be completed and commission training needs across professional and services in Bedfordshire		Further KPIS: Proportion of inpatient population with learning a disability or autism who have a person-centred care plan, updated in the last 12 months, and local care co-ordinator; Proportion of people receiving social care primarily because of a learning disability who receive direct payments (fully or in part) or a personal managed budget; Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital; Proportion of people with a learning disability receiving an annual health check; Waiting times for new psychiatric referral for people with a learning disability or autism; Proportion of looked after people with learning disability or autism for whom there is a crisis plan. By 2020 75% of people with LD on GP register are receiving annual health care	
			Q4: • Audit of individuals with LD GP registration and health check. Identification of gaps and develop next steps to ensure an increase in registration and annual health checks.	Q4:			

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Appendix 12: Workforce

STP scheme	Dey deliverables	Baseline position	2017/18 actions/milestones (steps to delivery)	2018/19 actions/milestones (steps to delivery)	Impact	KPIs/plan trajectory	Relationship to other plans, e.g. RightCare UECN
Local priority 1 : TCP	**Delivery of the STP Plan re Workforce:** • Leadership and Organisational Development • Workforce Planning and Design • Training and Development • HR processes, Temporary Staffing and Partnerships • Communication and engagement – staff and unions **Specifically:** • Reducing agency spend and usage; • Reducing attrition of our trainees from courses; • Attracting new staff to careers in health & social care to the footprint; • Reducing turnover of our existing qualified and skilled staff; • Supporting integration of our workforce and provide patient focused delivery, across care settings.		**Workforce transformation across health and social care to support integrated working** • Build on the work already commenced by the CEPN around strategies to improve primary care recruitment and retention, expanding training and mentorship capacity and develop attractive portfolio career pathways for all professions • Test and embed new roles such as paramedics, clinical administrators, care navigators and physician's associates. We will continue to support clinical pharmacist pilots and bid again to pilot nurse associates in wave 2. • Support the safe and effective development of further hybrid roles related to our identified STP needs. • Encourage the pooling of training resources, where appropriate and train jointly in key delivery areas utilising our CEPN as a means to further support integrated training and development and support staff through change. **Improving Recruitment and Retention** • Work collaboratively to develop a whole system offer with skills exchange opportunities, across the system including primary care. • Reduce attrition from our HEIs by holding them to account and ensuring that offers are made to students in year one. • Hold an interactive "Careers Expo" across the CCG areas in the STP, aimed at young people 15 and above to consider a career in health and social care • Support various recruitment drives, celebrating successes ('good care week) and continuing to support the development of the role of the care practitioner. • Support organisations to develop bank arrangements across the system, to drive down agency use and continue with the whole system agency agreements that we have in place, encourage part time staff to increase their hours and provide flexible opportunities to encourage retirees to return. • Lobby for increased key worker housing and encourage international recruitment collaboration amongst our providers. • Continue to promote careers in primary care by continuing with the GP Development programmes, provide additional student training opportunities so as to promote primary care as a career of choice and continue to support the network for practice nurses and GPs that we have established. **Leadership and Organisational Development to support future services** • As an STP, we will continue to pool resources on talent management and leadership opportunities and develop a collective talent management strategy. This will build on our local leadership programme which has been developed in conjunction with Ashridge Business School across Bedfordshire and Hertfordshire. • Support and encourage wellbeing initiatives, utilising the national CQUIN to achieve this. • Support the training needs of managers within primary care in order to optimise GP time and develop management capacity to deliver wider GP networks. • Continue to work with the local authorities to support staff in the care home sector to access relevant training and develop key competencies				