NHS
Bedfordshire
Clinical Commissioning Group

Commissioning for the future

Commissioning intentions 2017 - 18

September 2016

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better care, better value, better health

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1. Introduction

These commissioning intentions provide the context for constructive engagement with providers and partners, with a view to achieving the shared goal of improved patient outcomes and service improvement within the fixed resources available, building on the work already undertaken in 2016/17.

These commissioning intentions should be read alongside NHS England technical planning guidance which was published on 22 September and subsequently updated on 27 September 2016.

1.1 Our population

There are around 450,000 people living in the Bedfordshire CCG area, the number of older people is expected to increase dramatically in the next few years. The number of children aged 0-15 years is approximately 84,000 which is set to rise to 94,000 by 2021. This increase is as a result of rising birth rates and inward migration driven by housing growth, particularly in Central Bedfordshire.

The CCG is made up of five localities: Bedford, Chiltern Vale, Leighton Buzzard, Ivel Valley and West Mid Bedfordshire. Bedford locality is almost co-terminous with Bedford Borough Council, the remaining localities form the area covered by Central Bedfordshire. There are 55 GP Practices spread across the localities. The main hospitals used by Bedfordshire patients are located in Bedford and Luton. The main causes of death for people under 75 are Cancer, Coronary Heart Disease, Stroke, Chronic Obstructive Pulmonary Disease and Diabetes.

1.2 Strategic context – the national direction of travel

The Five Year Forward View set out the need to create “A sustainable NHS that continues to be tax-funded, free at the point of use and that is fully equipped to meet the evolving needs of its patients, now and in the future”. It highlighted three gaps that need to be addressed to deliver this vision:

The health and wellbeing gap	The care and quality gap	The funding and efficiency gap
•The majority of illnesses the NHS treats are caused by obesity, smoking or alcohol •Many of these illnesses, such as heart disease or diabetes, are preventable	•People are living longer and need a wider range of health services over a longer period of time •Care is disjointed across different organisations	•The way the NHS currently delivers care isn't cost effective •There will be a gap between patient needs and NHS resources of £30 billion a year by 2020/21

The country has been split in to 44 footprints to develop Sustainability and Transformation Plans (STPs) which describe how we, as a system, will go about closing the three gaps identified. The CCG is part of the Bedfordshire, Luton and Milton Keynes (BLMK) footprint, and is working with the other CCGs, hospital providers, community services providers, mental health providers and local authorities to develop a system-wide plan.

The first iteration of the STP has identified five priorities. They are:

1. Impactful health improvement and illness prevention and empowering self-management and social capacity
2. High quality, scaled and resilient primary, community and social care services across BLMK
3. Sustainable secondary care services across footprint
4. Forge footprint-wide collective leadership, charged with designing a BLMK digital programme
5. Re-engineer the system of demand management, commissioning and health social provision

Priority three includes the need for secondary care to network services across the footprint and as part of this will need to identify and address those service areas that are currently unsustainable, for example, because of workforce and capacity issues.

1.3 Local strategic context

The CCG has developed an approach to localising the strategic direction emerging from the STP work, whilst ensuring that we are addressing the particular needs of our population. We have identified five key strategy areas which are 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, using Right Care data and information on our current services, five clinical priorities for 2017/18. They are:

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

Our commissioning intentions have been developed to reflect the changes required in 2017/18 across each of these strategy areas and clinical priorities. Each of the strategic areas and clinical priorities have a number of cross-cutting themes and need to consider specific population needs. These commissioning intentions should be read within this context.

Cross cutting themes	Population considerations	Enablers
• 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	• 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	• Digitisation and shared records • Seven day services • Workforce • Patient education and self-management • Estates • Integration of both commissioning and delivery

Subject to available resources, the CCG will endeavor to deliver increased funding under parity of esteem for patients with mental health conditions and deliver the key priority areas e.g. early intervention in psychosis. Similarly, the CCG is committed to supporting people with learning disabilities through the Transforming Care programme which is an STP-wide initiative.

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 in order to make improvements. The scope of these reviews will include:

1.4 Financial context

The CCG has delivered a significant financial turnaround in the years 2014/15 to 2016/17, moving from a 6% uncontrolled overspend to a controlled ‘stretch’ surplus of 2.3%. However, the financial outlook continues to be challenging, with any growth monies received needing to meet demographic and tariff growth. Therefore, the key financial messages for 2017/18 are:

- Business as usual is not sustainable, operationally or financially
- Significant change is required at scale – we need focused commissioning intentions and transformation of service delivery

The anticipated level of allocation growth for the CCG in to 2017/18 is 3.4% with 3.5% increase in to 2018/19. It is currently anticipated that this will barely offset underlying demographic growth (1.2% per year) plus the cash impact of tariff growth (thought to be circa 2.5% per year).

Currently, around 56% of the CCG’s spend funds hospital trust activity, with a significantly smaller proportion being spent in community services and mental health services. There is a need, particularly if we are to deliver the prevention and joined-up care agenda, to look at how we can redistribute NHS funding differently in the future.

The indicative growth assumptions that we are working with for planning purposes are set out below:

	2016/17 (plan)		2017/18 (estimate)		2018/19 (estimate)	
	Gross £m	%	Gross £m	%	Gross £m	%
Acute Commissioning	298.4	56%	303.1	55%	307.0	54%
Mental Health	*56.4*					
Out of Hospital	*63.9*					
Continuing Healthcare	*25.2*					
Medicines Management	*62.9*					
Other	*18.9*					
Non-Acute Commissioning	227.3	42%	237.5	43%	247.3	44%
Running Costs	9.8	2%	9.9	2%	9.6	2%
Total	**535.5**	100%	**550.5**	100%	**563.9**	100%

In summary, there is marginal growth in non-acute services with a proportional decline in the amount invested in acute commissioning, despite a cash increase. Any growth in funding is likely to be offset by system pressures. This is further evidence that the current configuration of services is not sustainable.

Aside from core investment in acute and non-acute services, the CCG will also be reviewing investments badged under guidance for marginal rates emergency threshold (MRET), 30 day re-admission and winter pressures monies to ensure value for money and appropriate impact within the local health system.

Based on 16/17 plans BCCG will focus investment in the following areas with the intention of:

- Reducing emergency admissions
- Improving a patient's recovery through earlier discharge
- Enhanced community-based rehabilitation and reablement to prevent inappropriate readmissions

Marginal Rate Target	16/17 Programmes
Reducing emergency admissions	Hospital at Home services, Clinical Navigation, Community based rapid intervention service, Out of hours services, End of life pathways,
Improving a patient's recovery through earlier discharge	Community reablement services, Community bed provision
Enhanced community-based rehabilitation and reablement to prevent inappropriate readmissions	Early support discharge for stroke, Community reablement services,

1.5 The commissioning landscape

The QIPP programme (Quality, Innovation, Productivity and Prevention) continues to be a key focus for us in 2017/18. We will need to work with partners to deliver a challenging QIPP target, ensuring that opportunities to improve services are maximised through the use of new technologies and simplified care pathways.

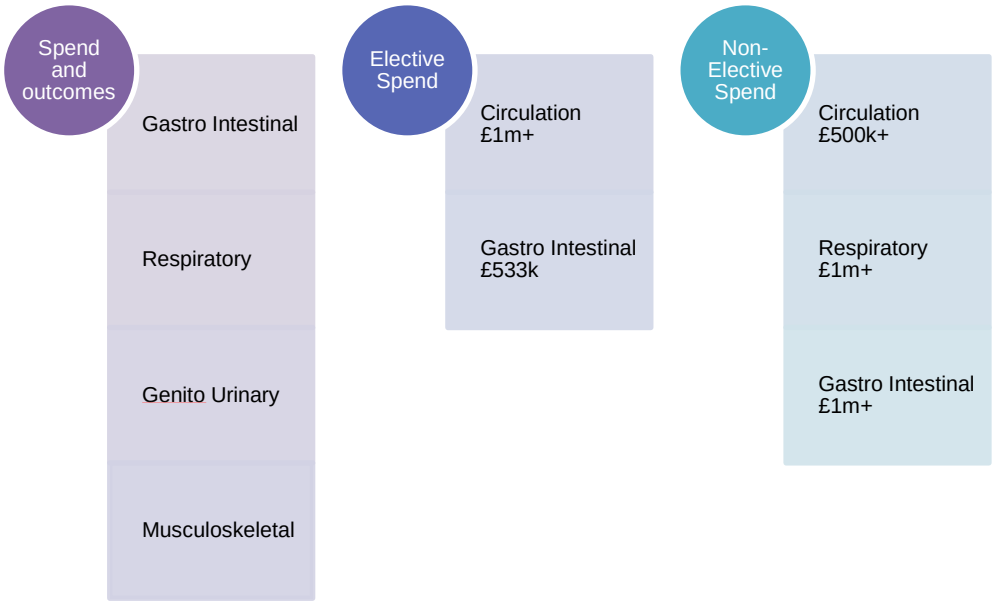
In addition to QIPP, as in every year, we will be expected to deliver our constitutional standards including:

- Cancer waiting times
- Ambulance response
- Referral to treatment
- 52 week wait
- Diagnostics
- Improving access to psychological therapies
- MRSA and C.Difficile incidents
- Dementia diagnosis
- A&E wait

There are currently a number of “hot spots” in the system are experiencing challenges with activity volume and performance against their standards. These include, in 2016/17, trauma and orthopaedics, plastic surgery, general surgery and urology. In addition, Community Paediatrics is experiencing increase in demand particularly driven by Special Educational Needs and increasing diagnosis and prevalence of Autism. We will work with providers to understand the pressures on these services, and will expect to see improvements in these areas throughout 2017/18.

Through the conversations informing the development of the STP, it is clear that hospital providers are keen to play a more significant role in the delivery of services outside of hospital, in both community and primary care settings. We will work with partners through 2017/18 to explore the opportunities for integration including hospital services to ensure we are developing services that meet the local needs of our population.

Right Care data is a national dataset that brings together the population need, activity provided and performance levels against standards, and matches the CCG to similar CCGs to provide benchmarking. There are a number of areas for which Bedfordshire CCG is an outlier, and we have used this information to target areas for further investigation in 2016/17, and will continue this work in to 2017/18.



The CCG has a newly commissioned musculoskeletal service which is making progress in addressing spend and outcomes gaps in this area.

In summary, the CCG has a challenging commissioning year ahead in 2017/18 to balance the delivery of QIPP targets, tacking the service “hot spots” and closing the Right Care gaps. QIPP will continue to be a significant focus for us in 2017/18. There are a number of procurements taking place or planned in 2017/18

2. Our 2017/18 commissioning intentions

In forming our commissioning intentions, we looked at a range of information including:

- The strategies we need to deliver
- The views of clinicians
- The financial picture
- Feedback from patients and the public
- Contract performance and commissioning gaps

2017/18 will be a year of transition, building towards transformation from 2018/19 on, in line with the development of the STP. There are a number of changes that need to take place throughout 2017/18 which will act as enablers to delivery of future models of care, which includes the level of collaborative working between providers. We will therefore use the contractual levers available to us in 2017/18 to drive some of this change, for example, targeted CQUINS to demonstrate improvements in outcomes for patients.

We engaged with a range of stakeholders to develop our intentions, which are captured below.

2.1 Urgent and Emergency Care

Urgent and emergency care remains a key focus for the CCG in 2017/18, and there are a number of national and local strategies in place to streamline and simplify services, implement new models of care including primary care at the front door of A&E and ensuring appropriate responses to particular patients, e.g. the Crisis Care Concordat.

As noted in the finance section above, non-core investments designed to reduce demand in acute and emergency care will continue to be reviewed for effectiveness and new investments made in line with emerging best practice.

There is a view from clinicians that stronger networking is needed between hospitals to ensure that patients get the best care, and this is being taken forward through the STP. However, patients are concerned about the possible loss of core services from their local hospitals.

All of our “top six” local hospitals are experiencing challenges in delivering the A&E 4 hour wait standard. Many patients are presenting at A&E with issues that might best be dealt with by primary care, and this is putting increased pressure on the urgent and emergency care system. We currently have high rates emergency admissions for under 5 year old children and this is increasing, although we have a slightly lower A&E attendance rate for this patient group. Both activity and cost is over the contracted levels at Bedford Hospital, Luton & Dunstable Foundation Trust and East and North Hertfordshire

We are procuring a new combined NHS 111 and GP Out of Hours service in 2016/17, for the new service to commence in April 2017, and as part of this we will look to address the current issues with sharing patient records – something that in a primary care setting out of hours adds considerable value.

Commissioning intentions:

- We will work with providers to implement a system-wide solution to urgent and emergency care reflective of the A&E improvement plan, with particular emphasis on the five nationally mandated interventions
- 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 improve hospice support
- We will continue shifting settings of mental health care – moving to primary care delivered intervention, assessment and recovery services, reducing inpatient admissions and building crisis care that can respond in an hour supporting new models of care in A&E
- We will develop rapid intervention services able to respond to patients within an hour building on the success of Street Triage and Community Services models to ensure a robust urgent care response and explore models for paediatric rapid intervention
- We will look to implement a fracture liaison service, assuming that resources are available for its development (subject to the funding strategy for 2017/18)
- We will undertake clinical reviews on the following areas of unscheduled care:
    1. Paediatrics
    2. Frail Elderly
    3. End of Life Care

2.2 Planned Care

There is very much a national drive for CCGs to work with providers to establish new models of care to deliver more care to patients in a community setting rather than in hospital. There is also a recognition that specialist care is best delivered in centres of excellence, meaning that stronger networking between hospitals is needed. Patient support for networked services is strong, with patients saying that they would be happy to travel further to get the best specialist care possible for them and their families. However, there is a level of anxiety in relation to the loss of local services, particularly emergency services.

Our current hospital spend is unsustainable, with contracts routinely over-performing against plan. There is considerable challenge locally in delivering the 18 week referral to treatment standard, and there are further disease-specific challenges especially around the national Cancer standards.

We need to focus our efforts on understanding the reason for over-performance, and at the same time we need to establish how much activity we can move out of the hospital setting.

We currently have referral hubs in place for Musculo-Skeletal, Dermatology and Individual Funding Requests, and we will expect more referrals to go through the appropriate referral hub. We will also explore referral management systems more generally to look for improvements in relation to their ease of use, and may look to increase the scope of the current hubs. We will increase access to patient management advice from consultants without the need for patient referral.

Commissioning intentions:

- We will undertake a clinical review including the patient pathway and delivery mode for the following clinical areas:
    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. urology services
- We will expect providers to engage with these clinical reviews and the development of solutions to facilitate an appropriate shift to care closer to home
- We will expect a greater proportion of referrals to go through an appropriate referral hub, which requires engagement with primary care and hospital consultants
- We will review consultant to consultant referral policies, and ensure that these policies are being implemented and followed
- We will expect acute provider involvement in facilitating a shift of activity to 'closer to home' community settings, particularly for those services where a community-based triage and treatment model would lead to lower secondary care referrals
- 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 be fitter for surgery and with reduced health risks, and also treatments that have a low evidence base for effectiveness (whether new or existing treatments)
- We will develop a single point of access for all services in the community and will require providers to work together on this development

2.3 Prevention and Detection

There is a national drive to improve both primary and secondary prevention and broader public health to reduce the demand on NHS services. The secondary prevention agenda, preventing further conditions and early management of exacerbations is key to helping reduce demand on services by the older population with one or more long term condition. Patients are keen for a new approach to be developed to prevention, focusing on individuals, their families and the local communities, and the role that they all have on influencing this agenda. There are also roles for community pharmacies and voluntary organisations in advising and treating people, and this additional resource should be factored in to solutions.

Primary prevention services are currently commissioned by NHS England, and identifying investment for prevention is challenging, especially given the financial pressures on other areas of the system, for example urgent and emergency care. In Bedfordshire, flu vaccinations are low at less than 50% for target groups and there are currently no vaccination schemes directly commissioned by the CCG. In addition, only just over 50% of patients with diabetes are receiving structured education on their condition, and this is a high prevalence condition in Bedfordshire. Dementia diagnosis rates are below target.

Our discussions with patients and the public in developing our commissioning intentions has identified prevention and detection as a priority, particularly around helping the public to make the right choices through making information available to them. New technologies offer a particular opportunity to engage with working age and young adults in this regard.

Commissioning intentions:

- 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, learning disability (including SEND) and children
- We will implement supported self-management and structured education through an evidence-based approach, maximising the opportunities that new technologies and apps gives us to help patients manage their condition (e.g. diabetes management, see section 2.6)

2.4 Out of Hospital Care

The CCG is currently developing its vision and strategy around out of hospital care, or care closer to home. We need to reflect the national strategy to increase care provided in community settings rather than in hospitals, and we need to look towards new models of care to deliver services in the future, ensuring appropriate integration across hospital, community, primary and social care. Patients are supportive of having care delivered closer to home – this is particularly the case in the more rural areas of Bedfordshire.

During 2016/17 we will commence the procurement of our community services in partnership with local authorities, and the new contract will commence in April 2018. During 2017/18 we will be working with existing providers to address a number of issues including:

- Improving coordination between settings of care
- Improving access routes and availability of services to minimise unnecessary A&E attendances / hospital admissions
- Easing the pressure on waiting times for community services
- Improving the data available to commissioners to inform future service design

Commissioning intentions:

- We will continue to strengthen the visibility of available services through the inclusion of services on the Directory of Services (DoS) to support NHS 111 and other signposting services
- Acute, primary and community providers will be expected to work together on workforce, risk profiling and care planning
- We will form an alliance, including Adult Social Care, to facilitate the provision of an integrated step up / step down community bed service linked to appropriate therapy and rehabilitation pathways and based on the principle that services will support people at home wherever possible

- We will establish a shared approach to commissioning, service development and delivery of health and social care through the Better Care Fund with an emphasis on building community resilience
- 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 to home including addressing the increase in demand for neurodevelopmental cases
- We will ensure psychological therapies are integrated within pathways for pain management, chronic condition management and supporting self-management education programmes
- Acute and community providers will be expected to work closely with Adult Social Care to support effective and safe discharge from hospital (linked to the A&E Delivery Board plan)
- 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 management for frail and elderly, keyworker or named consultant for long term / chronic conditions, implementing care planning across primary care, community care, social care, acute care and mental health
- We will look to implement a falls group for residents in Central Bedfordshire building on the work already undertaken in Bedford Borough which helps people that have fallen or are worried about falling, providing strength and balance training, education and confidence building
- We will build on the work already undertaken in 2016/17 related to community bed provision to ensure appropriate out of hospital capacity to meet the needs of the population

2.5 Primary Care

The responsibility for commissioning primary care is transferring during 2016/17 from NHS England to the CCG through a stepped process of co-commissioning and delegated commissioning.

Primary care is facing a significant challenge, both nationally and locally. There is a national drive to make primary care services available seven days a week, as well as look at new models for the way in which it is both commissioned and provided, such as Primary and Acute Care Systems and integrated Multi-Specialty Community Providers. GP practices are needing to form federations and partnerships to share infrastructure costs, and make services available seven days a week, as there are issues around recruitment, retention and training of workforce, both GPs and practice staff.

Locally, practices are working together to develop federations, but there are considerable issues around practice sustainability in the short to medium term. There is variable performance practice to practice across the CCG. Patients have said that access to GPs is variable, and that they would like simplified access to primary care services 24/7. There is also a level of frustration around the lack of joined up care, for example, including the GP in planning for when a patient is discharged from hospital.

Commissioning intentions:

- We will continue to move to collaborative commissioning at scale across primary care e.g. anticoagulation, referral co-ordination / facilitation, Locally Enhanced Services and direct access to diagnostics. Priority will be given to those service areas highlighted in Locality Two Year Development Plans.

- 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

2.6 Diabetes

The prevalence of diabetes across the country is growing, linked to the growing rates of obesity. There are a number of national diabetes programmes including the NHS Diabetes Prevention Programme – The Healthier You, that are looking to identify individuals at risk and refer them to a behaviour change programme.

Care for patients diagnosed with both type 1 and type 2 diabetes is inconsistent, with 54.5% of patients attending structured education, insufficient uptake of the eight recommended care processes in primary care, gaps in treatment targets and a significantly higher medicines spend than comparator CCGs. There is not currently an effective foot care pathway for diabetics, and local clinicians believe this is linked to unnecessary admissions. Once admitted, there is a lack of specialist management of in-patient diabetics which can lead to complications, particularly if the diabetes is not linked to the initial reason for the hospital admission.

Patients would like better information once diagnosed with diabetes as they appreciate that there are ways in which self-management could help them. The patient representatives attending our commissioning intentions workshop felt that there was much that could be achieved with minimal investment if we worked with Diabetes UK and other organisations to improve the opportunities for better self-management.

Commissioning intentions:

- We will work with primary, community and acute care to improve the uptake of the eight recommended care processes as part of setting individual treatment targets with patients
- 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 help with developing an understanding of the condition and how best to manage it

2.7 Respiratory

Compared to other CCGs, we have a high non-elective spend on this clinical area, for acute and chronic lower respiratory tract infections as well as pneumonia and influenza. We currently have a Chronic Obstructive Pulmonary Disease (COPD) service which clinical leads feel could be expanded to include other conditions such as

Bronchitis, Asthma and respiratory infections, although we also have high rates of elective and non-elective spend for COPD.

The CCG has a high Asthma mortality rate in children and adults, and it is essential that we improve prevention including smoking cessation services. We are undertaking a review of the Children's Asthma Pathway in 2016/17, and we will be looking to continue to implement the resulting recommendations in 2017/18.

Commissioning intentions:

- We will undertake a comprehensive clinical review for both Asthma and COPD including the patient pathway and the delivery mode to prevent A&E attendances and admissions
- 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 condition

2.8 Cancer

Cancer has been a long standing priority for the CCG as we have increasing prevalence, low screening uptake and there are issues with meeting the constitutional standards for treatment within 62 days. There are currently high rates of non-elective hospital spend for breast, lower GI and skin cancers suggesting that there has been a delay to the detection of the cancer leading to an unplanned hospital episode and we are in the process of identifying the root causes. Early diagnosis is key to improving outcomes, and so we need to understand how to improve the one year survival rates.

Nationally there is a programme called Achieving World Class Cancer Care, which looks to deliver:

- Upgrade in prevention and public health
- National ambition to achieve earlier diagnosis
- Patient experience on par with clinical effectiveness and safety
- Support people living with and beyond cancer
- High quality modern services
- Commissioning, provision and accountability processes.

We are working on implementing key elements of this programme, and need to explore commissioning pathways for lung, colorectal and prostate cancers which include straight to test and fast tracking patients suitable for surgery. We also need to define the future community follow up model, and the role that general practice plays in supporting patients during and after a cancer diagnosis. Currently, 59% of Bedfordshire patients said that they thought general practices did everything they could to support them whilst they were having cancer treatment, so there is room for improvement.

Commissioning intentions:

- 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 identified as priorities in 2016/17
- Subject to funding availability, we will work with clinicians to improve direct access to diagnostics

2.9 Gastro Intestinal

Bedfordshire has a high level of alcohol related admissions, and a higher mortality rate from liver disease in people under 75 years than the five best comparator CCGs. Elective and non-elective colorectal surgery and gastroenterology spend both exceeded plan in 2015/16, and year to date in 2016/17. The CCG has higher mortality from gastro intestinal issues in people under 75 years than the best five comparator CCGs, and there are increasing rates of young teenagers drinking alcohol. There is also a high admission rate in patients under one year of age for gastroenteritis.

We need to spend some time in 2016/17 exploring the drivers for this high level of activity and cost, and putting in place a comprehensive prevention strategy and appropriate pathways, ensuring that the use of diagnostics is targeted towards at risk groups.

Commissioning intentions:

- 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

2.10 Cardiovascular Disease

Bedfordshire has a significantly higher premature mortality rate from Coronary Heart Disease and Myocardial Infarction than comparator CCGs. Elective and non-elective spend on Cardiovascular Disease is high, and we spend significantly more on anti-anginal and anti-heart failure medications, and Cardiovascular Disease as a whole. Cardiac surgery and primary cardiac conditions spend is currently over plan.

It is crucial, to turn some of these trends, that we look at prevention and risk stratification to take proactive steps to reduce the risk of individuals developing Cardiovascular Disease. Whilst the CCG does commission some cardiac rehab provision, and some Heart Failure Specialist Nurses, access is variable. There is no Cardiology Centre of Excellence within the CCG's footprint, and we need to explore whether the higher mortality rates are because of late detection / poor treatment pathways.

Commissioning intentions:

- We will commission comprehensive cardiac rehabilitation services within the available resources
- 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 and nursing homes, and the patient's own home

3. Contracting Intentions

3.1 Contracting Principles

Following the publication of 'Strengthening Financial Performance & Accountability in 2016/17' (NHS Improvement and NHS England, 21 July 2016), the contracting round for the next two financial years, commencing 1 April 2017, is due to start in September 2016 with contracts and operating plans agreed by the end of December 2016.

3.2 Contract Terms 2017-19

It is our intention to sign the national standard contract for 2017/18, which will include all nationally mandated contract terms and conditions. There will also be areas for local discussion that we will seek to agree over and above these nationally mandated terms and conditions, covering both requirements to support the implementation of agreed STP, CCG and provider priorities and also any local standards and requirements related to key contract schedules such as quality.

Given the complexity of the contract documentation and supporting schedules and the shortened negotiating timeframe our overall objective for 2017-19 is to keep to a minimum the re-negotiation of contract terms and schedules, noting that a number of key areas – CQUIN, KPIs, quality indicators, information requirements, SDIP and DQIP plans will require a review and likely re-negotiation of targets and indicators in light of national guidance, STP requirements and performance trajectories agreed as part of the Sustainability and Transformation funding.

3.3 National Priorities for 2017-19

The priorities set out in the Five Year Forward View continue to apply, as do those in the Strengthening Financial Performance and Accountability framework. The prime focus will be on recovery and sustainability across finance, productivity and efficiency and performance alongside improvement in the quality of patient care. It would be our intention to reflect priorities and feedback on the STPs and Operating Plans once they are known in October 2016.

3.4 CQUIN

The current CQUIN scheme enables providers to earn up to 2.5% of annual contract value if they deliver objectives set out in the scheme. For 2017/18 and 2018/19, the full 2.5% will continue to be available to providers. NHS England is intending to make 2 changes to the scheme.

First, continuing the arrangements of the current year, 1.5% of the 2.5% will be linked to delivery of nationally identified indicators. The indicator set has been streamlined, and with different indicator sets for different provider types. NHS England will seek views over the next month on the measures and thresholds proposed for each indicator, through a new engagement exercise.

Secondly, the remaining 1% will be assigned to support providers locally. 0.5% will be available subject to full provider engagement and commitment to the STP process. In effect, this will be a cost free indicator for providers with clear scope for earning the full amount. The remaining 0.5% is paid at the beginning of 2017/18 if they meet their 2016/17 control total.

In reviewing CQUIN proposals we will need to jointly identify those CQUIN targets that should appropriately move from being incentivised through CQUIN to core standards as part of the 2017-19 contract, as well as new priorities for CQUIN development for 2017-19.

3.5 National Tariff Payment System (NTPS) guidance 2017-19

Publication of the final national tariff guidance and prices is not expected until early December 2017. In this context we will need to consider how we progress the negotiations on the basis of draft tariffs as timeframes for agreement will preclude us waiting for final tariffs to be available.

3.6 Local Sustainability and Transformation Plans (STPs) and Commissioning Intentions (CIs) for 2017-19

Refreshed STP Delivery Plans are to be submitted by October 2016 setting out the overall STP footprint five year transformation and sustainability plan, underpinned by a series of organisational and provider specific assumptions and deliverables. The 2017 to 19 contract will need to reflect agreed STP commitments and priorities including any agreed service and care pathway redesign chances, quality standards and outcomes, financial and performance commitments and productivity and efficiency improvements as set out in years two and three of the STP plans. A key component of our contract negotiation will therefore require a mutual understanding of the STP commitments and the respective contributions of CCGs, providers and other stakeholders to the delivery of these plans.

3.7 Better Care Fund

The Better Care Fund (BCF) will continue to be of relevance to the acute contracts for 2017-19 and we will need a joint understanding of national requirements and local health economy BCF submissions and agreements to ensure these are appropriately reflected in acute contracts for 2017-19 and are consistent with local STPs.

3.8 Productivity and efficiency - Trust wide Key Performance Indicators (KPIs)

Commissioners will expect to include in 2017-19 signed contracts a range of KPIs aimed at improving productivity and efficiency performance. Associated payment thresholds related to non-delivery of agreed KPI targets will be in place and will represent a stretch improvement from performance standards agreed for 2016/17.

As in 2016/17 these KPIs will be set and assessed on a provider-wide basis, with any financial adjustments pro-rated for the relevant KPI across commissioners. KPIs will be measured at specialty not aggregate level, e.g. first to follow up ratios, and where available benchmarking data will be used.

3.9 Process for developing contract proposals for 2017-19

Commissioners will wish to agree with providers the methodology to be applied in developing their contract proposals for 2017-19, taking due account of national operating plan expectations and requirements, STP planning assumptions and CCG/provider assessments where relevant, recognising the need to ensure a degree of consistency and an ability to reconcile across these differing assumptions will be required.

We envisage taking forward this work through the stages summarised below, with the objective of securing a position where we have an early, agreed view of activity planning

assumptions, recognising that final tariff is not due for publication until December 2016 so draft tariffs or a set of agreed tariff assumptions will be required to assess affordability.

- The agreement of recurrent baselines for 2017/18 alongside an agreement of approaches to planning assumptions for 2018/19. We would seek to reach agreement on this recurrent baseline with providers, prior to the issuing of CCG acute envelopes or provider costed proposals for the year.

- Agreement on the methodology to be used to frame Trust costed proposals. We would wish to agree the basis of each provider's activity proposal for the forthcoming year, taking due account of the following: 2016/17 plan, an agreed view of likely 2016/17 outturn, recognising that the earlier contracting round means we will need to base this outturn assessment on a short period of 2016/17 actual data and an assessment as to rest of year likely actuals, expected growth and backlog clearance adjustments, where required, for planned care.

- Activity and finance using SUS SEM, SUS PbR and SLAM to ensure alignment with operating plan requirements.

3.10 Pricing Issues

We would expect 2017-19 contracts to be set on the basis of national tariffs for nationally priced services (tariff), and on the basis of locally agreed tariffs for all locally priced (non-tariff) services. We would expect national efficiency expectations to be delivered at a minimum across both national tariff and non-tariff services.

We would also wish to work jointly on key areas of tariff change to secure a mutual understanding interpretation and application for 2017-19. Based on the recent National Tariff Payment System (NTPS) proposals for 2017-19, key issues are likely to be the introduction of a two year tariff, HRG4+ phase 3 (1200 more HRGs due to improved granularity), four new national tariffs, the blocking of follow-up outpatient activity, changes to antenatal maternity tariffs, the recurrent impact of 2016/17 and other 2017-19 tariff changes (e.g. impact of new best practice tariffs).

In overall terms commissioners will be seeking as much tariff stability as possible for 2017-19 outside of any required national tariff changes or known tariff issues identified in 2016/17 that need to be addressed for 2017-19 contracts.

3.11 Medicines Management

We would expect to include any new drug service development proposals as part of the above process, but will operate alongside this process for new drugs or treatment regimens proposed by providers a process by which any new NICE guidance, Prescribing Committee recommendations or new indications policies are reviewed and agreed by CCG commissioners and revised contracting policies included in the Medicine Management and drugs claims protocols for 2017-19 contracts.

3.12 Timetable and process for 2017-19

Contracts are to be agreed by 31 December 2016 and operational planning guidance is due to be published in September to assist this. The national timetable is summarised below and we will need to work to a local timetable that reflects these milestones and makes provision for other requirements opt ensure the end of December deadline to be met, noting that mediation processes may need to take place during December to support end December agreement**.** We will issue a detailed proposed timetable for

discussion and agreement following publication of the operational guidance in September 2016. Key national milestones, as currently understood are summarised below:

National Timetable

16 September 2016:	STF finance and productivity template submitted
30 September 2016:	Operational Planning Guidance to be published Launch of Standard Contract consultation CQUIN and QP to be published
31 October 2016:	Submission of refreshed STPs
November 2016:	Publication of final version of Standard Contract Commissioners and providers submit first draft of operational plans (mid-November)
December 2016:	Publish final tariff (early December) Commissioners and providers submit second draft of operational plans (mid-December)

Appendix 1 – Summary of the 2017/18 Commissioning Intentions

Urgent and Emergency Care	- We will work with providers to implement a system-wide solution to urgent and emergency care reflective of the A&E improvement plan, with particular emphasis on the five nationally mandated interventions - 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 improve hospice support - We will continue shifting settings of mental health care – moving to primary care delivered intervention, assessment and recovery services, reducing inpatient admissions and building crisis care that can respond in an hour supporting new models of care in A&E - We will develop rapid intervention services able to respond to patients within an hour building on the success of Street Triage and Community Services models to ensure a robust urgent care response and explore models for paediatric rapid intervention - We will look to implement a fracture liaison service, assuming that resources are available for its development (subject to the funding strategy for 2017/18) - 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 clinical areas: 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. urology services - We will expect providers to engage with these clinical reviews and the development of solutions to facilitate an appropriate shift to care closer to home - We will expect a greater proportion of referrals to go through an appropriate referral hub, which requires engagement with primary care and hospital consultants - We will review consultant to consultant referral policies, and ensure that these policies are being implemented and followed - We will expect acute provider involvement in facilitating a shift of activity to 'closer to home' community settings, particularly for those services where a community-based triage and treatment model would lead to lower secondary care referrals - 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 be fitter for surgery and with reduced health risks, and also treatments that have a low evidence base for effectiveness (whether new or existing treatments) - We will develop a single point of access for all services in the community and will require providers to work together on this development
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, learning disability (including SEND) and children - We will implement supported self-management and structured education through an evidence-based approach, maximising the opportunities that new technologies and apps gives us to help patients manage their condition (e.g. diabetes management, see section 2.6)
Out of Hospital Care	- We will continue to strengthen the visibility of available services through the inclusion of services on the Directory of Services (DoS) to support NHS 111 and other signposting services - Acute, primary and community providers will be expected to work together on workforce, risk profiling and care planning - We will form an alliance, including Adult Social Care, to facilitate the provision of an integrated step up / step down community bed service linked to appropriate therapy and rehabilitation pathways and based on the principle that services will support people at home wherever possible - We will establish a shared approach to commissioning, service development and delivery of health and social care through the Better Care Fund with an emphasis on building community resilience - 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 to home including addressing the increase in demand for neurodevelopmental cases - We will ensure psychological therapies are integrated within pathways for pain management, chronic condition management and supporting self-management education programmes

	- Acute and community providers will be expected to work closely with Adult Social Care to support effective and safe discharge from hospital (linked to the A&E Delivery Board plan) - 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 management for frail and elderly, keyworker or named consultant for long term / chronic conditions, implementing care planning across primary care, community care, social care, acute care and mental health - We will look to implement a falls group for residents in Central Bedfordshire building on the work already undertaken in Bedford Borough which helps people that have fallen or are worried about falling, providing strength and balance training, education and confidence building - We will build on the work already undertaken in 2016/17 related to community bed provision to ensure appropriate out of hospital capacity to meet the needs of the population
Primary Care	- We will continue to move to collaborative commissioning at scale across primary care e.g. anticoagulation, referral co-ordination / facilitation, Locally Enhanced Services and direct access to diagnostics. Priority will be given to those service areas highlighted in Locality Two Year Development Plans. - 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 processes as part of setting individual treatment targets with patients - 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 help with developing an understanding of the condition and how best to manage it
Respiratory	- We will undertake a comprehensive clinical review for both Asthma and COPD including the patient pathway

	and the delivery mode to prevent A&E attendances and admissions - 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 condition
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 identified as priorities in 2016/17 - 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 resources - 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 and nursing homes, and the patient's own home