NHS
Bedfordshire
Clinical Commissioning Group

Commissioning for the future

Commissioning intentions 2018 - 19

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Version 12

better care, better value, better health

Version Control		
July 2017	Document refreshed to include - update on plans for 2018/19 - updated finance section - updated QIPP	Anne Elgeti Assistant Director/ Strategy and Transformation
August 2017	Document refreshed to include - update financial plans - update on contracting/procurement/quality intentions - update on commissioning intentions	Samina Arshad Assistant Director for out of hospital Integration
September 2017	Document refreshed to include feedback from various committees/socialisation events. All feedback is documented in the feedback Log. - update on financial context/QIPP pipeline/contractual forms	Samina Arshad Assistant Director for out of hospital Integration

Contents

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.

This document has been refreshed through the summer, to provide further detailed plans for 2018-19 and building on our achievements in 2016-17 and on our ambitious plans for 2017-18.

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: 169,000 in Bedford Borough and 279,000 in Central Bedfordshire. The population of Bedford Borough is set to rise to approximately 182,000 by 2023 – an overall increase of 8%. The number of older people is expected to increase at a faster rate and over the same period the number of people aged 65 and over is set to rise by 17% (from 29,208 to 34,110); the number aged 85 and over is set to rise by 27% (from 4,197 to 5,312).

In Central Bedfordshire the population in 2016 was 278,900 (ONS 2016 mid-year estimate) and is projected to rise to 297,700 by 2021, with the fastest rise in adults aged 65 and over. The population is aging as well as growing, between 2015 and 2021.

The number of people aged 65 and over is forecast to increase from 47,100 to 74,400, a 58% increase. 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 52 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 • Wider determinants of health such as housing, schooling and employment are the key to deliver the transformation needed in mental health services and care.	• 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. This 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.

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.

This CCG forms part of the Bedfordshire, Milton Keynes and Luton STP (BLMK STP) area. In June 2017, Simon Stevens, CEO of NHS England, announced at the NHS Confederation that BLMK STP is one of eight areas that has been successful in its application to become one of the lead Accountable Care Systems (ACS) in the first wave of development.

This is an excellent opportunity for us to reshape our health and social care system so that it's easier for us to work together to deliver better health and wellbeing outcomes for our population.

The STP has identified five priority work streams as:-

Priority 1:	Enabling people to stay healthy and well by promoting prevention, early intervention and self-care
Priority 2*:	Achieving high quality, scaled and resilient primary, community and social care services across BLMK
Priority 3*:	Developing sustainable secondary care services across the footprint.
Priority 4:	Forging footprint-wide collective leadership, and designing a BLMK digital programme

Priority 5: Development of an Accountable Care System: Re-engineering health and social provision to meet the variable needs of residents

**Priority two includes achieving high quality integrated Mental Health services across primary, community and social care across BLMK.*

Bedfordshire, Luton and Milton Keynes health and care partners will work together to help individuals and communities to build resilience, and to support people with mental health problems and their families to access good quality person-centred services that support them to achieve their health and life goals. To do so, we will ensure that mental health is at the heart of the development of our accountable care system, with sustainable mental health providers working together with primary, secondary and social care partners to develop integrated whole person services and deliver the Five Year Forward Views for Mental Health and General Practice.

**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.*

Bedfordshire CCG have identified six 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
- Mental Health and Learning Disability

In addition, we have identified, using Right Care data and information on our current services, six clinical priorities for 2017/18 building on the work undertaken in 2017/18.

They are:

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

Our commissioning intentions for 2017-19 were developed to reflect the changes required across each of these strategy areas and clinical priorities. We will continue this work in 2018/19.

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

In recent years the CCG has endured a turbulent financial environment after posting a deficit £43.2m in 2014/15, making a significant recovery in the following year to post a greatly reduced deficit of £19.9m before returning to a positive position in 2016/17 by declaring a surplus of £14.4m.

Although the headline numbers are impressive the 2016/17 surplus was improved by a number of one-off benefits which, although they inflated the overall position, by their very nature were not part of the underlying or ‘recurrent’ surplus which still remained weak.

The fragile recurrent platform which was carried forward into 2017/18 was then undermined by several additional factors:

- The acute activity position showed a significant increase in the first quarter of 2017/18 which was not captured in the acute contract plans for 2017/18. These contracts were nationally mandated by NHS England to be signed by December 2016, before the trend was fully identified. This resulted in an immediate cost pressure in 2017/18.
- Acute activity has continued to accelerate from this inflated base creating further in year cost pressure.

- Not all of the 2016/17 acute costs were captured in that year due to the steep increase in activity which resulted in a legacy cost carried forward in to 2017/18.

The combination of these factors has put the CCG under significant financial pressure in 2017/18 and, from a Commissioning Intentions viewpoint, has undermined the draft baseline plan position for 2018/19 by inflating the historic recurrent cost base.

The table below which outlines the overall financial spend envelopes must therefore be considered as draft and subject to an affordability review and potential amendment.

The acute providers who hold contracts for services with Bedfordshire CCG need to be aware that any contractual uplift in 2018/19 will be solely on the basis of financial affordability envelopes set by Bedfordshire CCG and no other methodology. This is to ensure that the CCG stays within its allocated resources and, in some cases this may mean that there is no uplift.

	2016/17 (actual)		2017/18 (forecast)		2018/19 (plan)	
	Gross £m	%	Gross £m	%	Gross £m	%
Acute Commissioning	294.3	55.3%	302.2	54.7%	298.6	53.0%
Mental Health	59.2		62.1		66.4	
Out of Hospital	61.9		63.5		68.5	
CHC	24.7		25.1		26.0	
Medicines Management	59.8		59.1		60.0	
Other	23.4		30.7		33.7	
Non-Acute Commissioning	229.0	43.0%	240.5	43.5%	254.6	45.2%
Running Costs	9.1	1.7%	9.8	1.8%	9.9	1.8%
Total	**532.4**	**100.0%**	**552.5**	**100.0%**	**563.1**	**100.0%**
QiPP	**15.8**		**25.3**		**27.5**	

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 (estimated to be 2.5% per year).

Currently, 55% 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.

QIPP 2018/19

Table One: Indicative Impact of Identified QIPP Projects on Provider Streams

Provider Stream	Value £000's	Percentage
Acute	11,690	39
Community	1,956	7
Other	3,725	12

To be determined	12,630	42
Indicative Programme	**30,000**	**100**

Table Two: Indicative Impact of Identified QIPP Projects by Programme Stream

Programme Stream	£000's	Percentage
CHC	300	1
Children and Young People	285	1
Medicines Management	3,725	12
Finance and Contracting	5,854	20
Primary Care	200	1
Mental Health and Learning Disability	790	3
Planned Care	2,338	8
Right Care	2,507	8
Unplanned Care	3,163	11
To be determined	10,838	36
Indicative Programme	**30,000**	**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	17/18 Programmes
Reducing emergency admissions	Hospital at Home services, Clinical Navigation, Community based rapid intervention service, Out of hours services, End of life pathways, 7 day CAMHS Crisis service, specialist eating disorders pathways for CYP, Perinatal MH 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, review of Children's continuing care provision and development of an AQP.

1.5 The commissioning landscape

QIPP is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS.

BCCG seeks to achieve £30m of QIPP programme savings in 2017/18 which equates to 4.6% of the organisations total financial allocation. This level of ambition to seek efficiencies, value for money and improved health outcomes will continue into 2018/19 in our revised QIPP Programme.

The QIPP Programme for 2018/19 contains a number of projects and schemes, some transactional (for example reduced corporate spend, contract efficiencies) and some transformational (for example commissioning new services, enhancing services or decommissioning services). These projects and schemes are grouped into logical areas of commissioning called sub-programmes. An outline of the QIPP Programme 2018/19 is shown below:

QIPP Programme 2018/19			
Sub-Programme	**Category**	**Example Projects / Schemes**	**Objectives**
Continuing Healthcare (CHC)	Transactional &Transformational	CHC Optimisation	Continue driving though efficiencies in CHC packages
Children, Young People & Maternity	Transformational	Children's Continuing Care	Continue commissioning bespoke packages of care for individual children with Continuing Care needs based on an agreed pricing structure. Community based Pediatrics Liaison service. Improving access and waiting times for CAMHS Reduction of 1:1 agency MH support to the acute trusts through Increase of ELFT crisis services.
Medicines Management	Transactional &Transformational	Medicines Optimisation Waste Reduction Care Home Pharmacy	Continue driving through efficiencies in medicines management including Gluten Free Foods (GFF), Over the Counter (OTC) medicines, reducing waste. It also includes introducing more pharmacists in care homes.
Finance & Contracting	Transactional	Reduced Corporate Spend	Continue identifying and exploiting efficiencies in corporate spend.

Primary Care	Transformational	Anticoagulation Services Minor Eye Conditions	Continue strengthening anticoagulation services and supporting patients with minor eye conditions in the community.
Mental Health & Learning Disability	Transactional &Transformational	Street Triage Service Liaison Psychiatry Improving Access to Psychological Therapies (IAPT) Crisis Care	Continue commissioning a Street Triage service and enhancing liaison psychiatry, IAPT and crisis care services for patients.
Planned Care	Transformational	Value Based Elective Commissioning (VBEC) Advice and Guidance End of Life Pathway (EOL)	Continuing to ensure procedures are only conducted on patients when clinical evidence indicates that they will optimally benefit from that procedure at that time. To continue offering advice and guidance to GPs and strengthen our EOL pathways.
RightCare	Transactional &Transformational	Respiratory Cardiovascular Disease Cancer Gastro-Intestinal Genito-Urinary Diabetes	Continue ensuring that our commissioning plans are focused on the opportunities that have the potential to provide the biggest improvements in health outcomes, resource allocation and reducing inequalities
Unplanned Care	Transactional &Transformational	A&E Front Door Model Falls Pathway Fracture Liaison Service Ambulance Hear & Treat Enhancement GP Referral Pathway Managing Transfers of Care between Hospital and Home and Supporting Care outside of Hospital	Continue enhancing secondary care by strengthening existing services and introducing new pathways and services, for example the introduction of streaming patients to either Primary Urgent Care or Emergency Care depending on the patient's condition. To continue supporting a reduction in unnecessary non-elective attendances and admissions, reduce delayed transfers of care and for reducing length of stay and excess beds days by improved proactive case management for adults and children with more complex needs.
Sustainability Transformation Plan (STP) Efficiencies	Transformational	Complexity of Care Transitions of Care Paediatric Non-Elective	Continue identifying and exploiting efficiencies across the STP foot print.

QIPP will continue to be a significant focus for us in for the remainder of 2017/18 and into 2018/19. In addition, there are a number of procurements taking place or planned in 2017-19.

1.6 QIPP Pipeline 2018/19

Until QIPP opportunities are thoroughly scoped and tested they reside in a Pipeline, and are not included in our QIPP programme. Following scoping and testing a proportion of these opportunities will be deemed viable and desirable, and will therefore be transferred into the QIPP programme. The remaining unviable and undesirable QIPP opportunities will not be pursued.

The following table shows the full Pipeline of QIPP opportunities being considered in 2018/19:

Pipeline Opportunity
Online Pre-Operative Assessments
Virtual Follow-Ups
Domiciliary Pharmacy
Direct Access MRI
Ear, Nose and Throat Pathways
Review of Elective Procedures with no complications
Review of BADS / Day Case
Review of First to Follow-Up Ratios
Review of Appliance Management
Use of Alternatives to GP Appointments
Additional PoLCV policies
Strengthening the avoidance of admissions from Care Homes
Review of 18 Week Waits
Digitalisation across Health & Social Care
Ambulatory Care
Frailty Unit
Development of Enhanced Services
Stroke Rehabilitation outside of Acute Trusts
Review of Frequent Acute Attenders
Estates Cost Optimisation
Review of Dementia Services
Review of Stable Glaucoma
Review of Oral Micro-suction
Review of the Perinatal Mental Health Pathway
Review of Out of Hospital placements for complex children

2. Our 2018/19 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 is a year of transition, and this will continue in 2018/19, in line with the development of the local place based needs and wider BLMK STP development of an Accountable Care System.

A number of changes planned for 2017/18 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 2017-19 to drive some of this change and continue the process into any renegotiations for 2018/19, for example, targeted CQUINS to demonstrate improvements in outcomes for patients.

2.1 Planning guidance and nine 'must do's'

NHS England has issued planning guidance that includes nine 'must do's' for 2017/18 and 2018/19. We have a statutory duty to tackle health inequalities therefore must make sure that our commissioning strategy aligns with local Health and Well-being strategies. The nine 'must do's' in the planning guidance for 2017/18 and 2018/19.

1.	Sustainability Transformation Plan	Deliver and implement agreed Sustainability Transformation Plan milestones and achieve agreed trajectories for key measures of success.
2.	Finance	Deliver financial control totals, moderate demand and increase provider efficiency.
3.	Primary Care	Ensure the sustainability of General Practice, extend access and support General Practice at scale.
4.	Urgent and emergency care	Deliver the four A&E standard including the seven elements of the A&E improvement plan, eight high impact changes and priority standards for seven day hospital services; reduce ambulance conveyances, to meet the 15 minute Ambulance handover.
5.	Referral to treatment times and elective care	Deliver the constitutional standard for referral to treatment times, streamline elective care pathways, including outpatient redesign, 100 per cent use of e-referrals, and deliver the national maternity services review, Better Births, through local maternity systems.
6.	Cancer	Deliver cancer standards, implement the national cancer task force report, improve one year survival rates, roll out follow up pathways starting with breast cancer
7.	Mental Health (IAPT/Dementia standards)	Deliver the implementation plan for the Mental Health Forward View, ensure delivery of the mental health access and quality standards, increase baseline spend on mental health, maintain a dementia diagnosis rate of at least two thirds; eliminate out of area placements for non- specialist acute care.
8.	People with learning disabilities	Deliver Transforming Care Partnership plans, reduce in-patient bed capacity for people with learning difficulties, improve access to healthcare for people with learning disabilities and reduce premature mortality.
9.	Improving quality in organisations	Implement plans to improve quality of care.

We engaged with a range of stakeholders to develop our intentions in 2016 and further engagement was undertaken in July/August 2017 to ensure the CCG ambitions are correctly aligned with our population needs and take their views into account. These ambitions are captured below:- .

The following table outlines the key commissioning intentions:

Programme Area	Service Area	Commissioning Intent	Impact Area/Main Providers Impacted	Timescales
Urgent & Emergency Care	**Integrated Urgent Care**	We will be further developing our Integrated Urgent Care service throughout 2018/19 and will be re-procuring this service in line with the recently published National service Specification for Integrated Urgent Care Services to commence 1/4/19.	Primary Community Acute Herts Integrated Urgent Care	Q1/2018
	Urgent Treatment Centre	In April 2018, there will be a GP led Urgent Treatment Centre (UTC) open 7 days a week offering direct booking from NHS 111, GPs and the Ambulance Service including access to simple diagnostics and x-ray facilities. Bedford Hospital Trust (BHT) will be required to work with the provider of the Urgent treatment Centre to support the pathways for accessing diagnostics; x-rays. The Integrated Urgent Care provider will be expected to work up the pathway on the Directory of Services, to triage and stream patients. This will be accessible through NHS Pathways for a clinical disposition of referring the patient directly into the Urgent Treatment Centre where appropriate, rather than directing patients to A&E or to the ambulance service. Ambulance colleagues will be expected to refer directly into the Urgent treatment Centre where appropriate, rather than take/direct patients to A&E. Providers would be expected to work with commissioners to develop dedicated pathways for mothers and children.	 BHT EEAST HUC EEAST/BHT/HUC	Q4/2018 2018/19
	Frail and elderly	We will require BHT and L&D to continue to roll out of community delivered geriatric hot clinics 7 days a week during 2018/19. This will form part of a contract variation.	BHT L&D	1st April 2018
Elective Care	**Out of hospital care**	Building upon the service developments in 2017/18, we will work with local providers to enhance the model and specification for multi-specialty community hubs, enabling care to be provided closer to home with a reduction in cost due to local tariff arrangements. The model will include GPs with Specialist Interest and other community clinicians as appropriate. The initial scope to include: ▪ Community Urology Outpatient and Minor Surgery	**Acute and Community** BHT L&D MK Cambridge Bucks Lister	Service model and specification to be agreed by March 2018 Implementation from June 2018 for two specialty areas Implementation from April 2018

		▪ Community ENT Outpatient and Minor Surgery ▪ Community Ophthalmology Outpatient and Minor Surgery ▪ Community Gynecology Outpatient and Minor Surgery ▪ Community Dermatology Outpatient and Minor Surgery ▪ Direct Access Diagnostics - MRI, Ultrasound, ECG ▪ Community Peadiatric hub to look after children, closer to home to be developed. The proposed services will be commissioned via contract variation or through procurement. Payment model to be agreed but would either be based on a gain share model with limited risk of over-performance or based on a % reduction of PBR at a minimum of 70% of PBR tariff.		
	Virtual Follow-up	We will work with local providers to expand the roll-out of virtual follow-ups across additional specialties following initial launch in 2017/18. The tariff arrangements will be reviewed alongside a service specification with key performance indicators. Subject to contract negotiation.	**Acute** BHT L&D MK	1st April 2018
	Online pre-operative assessment	Following the 2017/18 pilot for online pre-operative assessments, we will work with providers to implement across a range of eligible procedures and patients. This will require the ongoing design of an online health questionnaire and specified pathology tests to be carried out in primary care. We will review the local tariff for online pre-operative assessments where the pathway authorises separate pre-operative assessment tariff payments. We will not fund any pre-operative assessments that are included in the procedure Health Care Resource Group (HRG) tariff and are currently not separately charged.	**Acute** BHT L&D MK	1st April 2018
	Integrated MSK Service	We will undertake a clinical and financial review of the MSK service model, outcomes and variation, leading to: ▪ Implementation of key changes within the remaining contractual years 2018/19 and 2019/20 via contract variation ▪ Governing Body decision regarding contracting arrangements in 2020/21 i.e. contract extension and/or re-procurement of the service.	**Community** Circle MSK	Clinical review by end of Q1 2018/19
	Community Dermatology Service	Following enhancement of the Bedfordshire Community Dermatology Service, we will work with BHT as lead provider for the Bedfordshire Community Dermatology Service to develop the future model and specification with an emphasis on demand management.	Provider impacted: BHT, indirect impact to our other main Acutes.	Q1 2018/19

		Teledermatology will be a core component of the service, providing timely access to a consultant review and resulting in patients being managed in primary care, with support where required. The service will be implemented during Q3 2017/18 as per agreed Heads of terms and will be commissioned on an incentive / risk share basis. This will continue into 2018/19 and we will work jointly to identify further opportunities for model development. This will be subject to contract negotiation and implementation by variation.		
	Direct Access MRI	We are reviewing direct access MRI pathways and seek to negotiate changes with key providers, subject to negotiation. This may include de-commissioning direct access MRIs for MSK related conditions.	**Community** Circle MSK **Acute** BHT/L&D **Primary Care**	1st April 2018
	Referral Management Services	Following implementation of a Referral Management Service (RMS) in 2017/18 providing clinical triage of all consultant to consultant referrals with the exception of specified exclusions, we intend to expand the service to other referral sources during 2018/19. Referrals that are sent outside of the RMS that do not meet the specified exclusions will be contractually challenged and not funded. This will be subject to contract negotiation.	Acute Providers Primary Care GP Practices	1st April 2018 Q1
	Consultant-led advice & guidance	We will continue to implement E-Referral Advice & Guidance across a wider number of specialties, including children's, enabling primary care to seek clinical advice in line with the 2017/19 CQUIN requirements. A local specification building on the requirements of the CQUIN will has been implemented in 2017/18 and will be reviewed in line with learning and developments. In addition to CQUIN, through the Service Development Improvement Plan (SDIP) we require the mobilisation of three specialties per quarter from Q2 2017/18 until 80% of services are available for Advice & Guidance, this must at least equate to 35% of eligible specialties in 2017/18 and 75% of eligible specialties in 2018/19. We will work collaboratively with the lead commissioners for the remaining five main acute providers to ensure the standards are also implemented. Providers to be compliant from 1st April 2018.	BHT L&D Lister	1st April 2018
	Diabetes	Following development of the Diabetes care pathway in 2017/18 we will work with our main providers, including all General Practices, to: • Optimise all levels of the pathway for people with both pre-diabetes (including NHS Diabetes	Public health All general practices ICDS – BHT & LDH Acute providers Community Services provider (EPUT)	Q2 2018/19

		Prevention Programme) and those with diabetes • Promote self-care / self-management delivered through access to health and wellbeing services e.g. weight management, smoking cessation • Further improve the uptake of the nine recommended care processes and the 3 NICE recommended Treatment Targets • Embed individualised care planning across all practices as part of the diabetes annual review • Further expand capacity and uptake of Structured Education for patients with diabetes at accessible times and venues • Fully roll out implementation of an improved diabetic foot care pathway including specialist podiatry and Consultant specialists (diabetology, vascular surgery, orthopaedics and radiology) • Further develop a practice-based dashboard/audit tool linked with SystmOne to monitor and measure performance • Reduce avoidable admissions and length of stay; reduce number of foot amputations • Improve diagnosis of diabetes by offering all general practices access to HbA1c, in addition to FPG, as a diagnostic test where appropriate. • Improve management of patients with ketoacidosis, particularly in children, by promoting closer working between Primary Care and the Paediatric Diabetes services, including advice, guidance and education of primary care practitioners. • Use recommendations from National Pregnancy in Diabetes Audit to improve outcomes for mothers. We will work with key stakeholders to enable record sharing that complies with information governance, particularly the interface between Primary Care and the Integrated Community Diabetes Service. Services changes will be negotiated with providers and monitored via the service development improvement plan.		Ongoing - quarterly monitoring Q4 2018/19 Ongoing – quarterly monitoring Q2 2018/19 Q2 2018/19 Quarterly monitoring Q1 2018/19 Q2 2018/19 Q2 2018/19
	Respiratory	Due to high levels of Elective and Non-Elective variation in comparison to CCG Peer Group, we will undertake a review of the existing service provision for Respiratory across the primary, community and secondary care pathway,	**Acute** BHT L&D ICOPD Services (provided by BHT/L&D)	Q1 2018/19

		including both adult and children's services. The service review will lead to revised scope, model and service specification for the Integrated COPD Service to enable an improved interface with primary care in preventing unnecessary hospital admissions at both BHT and L&D. The service changes will be implemented via contract variation.		
	Gastroenterology	Following implementation of the Gastroenterology Service Model during 2017/18, we will work with our main providers to widen the implementation of Gastroenterology service changes that will reduce the number of referrals and subsequent elective endoscopies. The service changes are as follows: ▪ Condition specific primary care pathways based on main presenting complaints – we will work with both primary care and secondary care leads to develop and approve ▪ Increase the rate of Faecal Calprotectin (FCP) tests initiated in primary care leading to increased detection of patients with IBS and reduction in endoscopies ▪ Implementation of a Bedfordshire Clinical Assessment Service (CAS) providing consultant-led triage of all Gastroenterology referrals (GP, Consultant and Other), where referrals are redirected to primary care with a management plan. We intend to appoint a lead provider to deliver this service across Bedfordshire. The above services will be implemented via contract variation and provided within as part of a gain share model to be negotiated locally. We will also undertake a Non-Elective audit with both BHT and L&D to understand the key drivers and prevention opportunities for short-stay Gastroenterology emergency admissions. Findings and service changes will be agreed and implemented by contract variation.	**Primary Care and Acute** BHT L&D MK Cambridge Bucks Lister	Q1 2018/19
	Genito-Urinary	Following implementation of the Genito-Urinary initiatives during 2017/18 and identification of further service developments, we will work with local providers to reduce the elective demand and of emergency presentations of UTIs,	**Primary Care, Community and Acute** EPUT BHT L&D	Q1 2018/19

		based on level of variation compared to CCG Peer Group. Service changes and tariff arrangements will be implemented through contract variation.		
	Cancer	In line with the national 'Achieving World Class Cancer Care' programme, we will: • Commission a Cancer and Palliative Care psychological support service across Bedfordshire • Commission national timed pathways for lung, colorectal and prostate cancer • Undertake a clinical review of patient pathways identified as priorities in 2017/18. Breast, Gynaecology, Lung and Colorectal. Subject to intentions within the East of England Alliance, we will work with clinicians to deliver the following redesign projects – Prostate pathway redesign, FIT Testing in Primary Care, Risk Stratification and Recovery Package.		Q1 2018/19 Q1 2018/19 Q2 2018/19 Q4 2018/19
	Integrated Cardiology Community Service	Due to high levels of Elective and Non-Elective variation in comparison to our CCG Peer Group, we will commission the following service developments to deliver: • Bedfordshire-wide Community Heart Failure Service (EPUT) to include Bedford Borough and BHT – providing in-reach into acute and support to primary care • Comprehensive cardiac rehabilitation services within the available resources ensuring adherence with NICE guidelines. • Increasing Cardiology and Heart Failure Specialist Nurses to provide specialist services, Multi-disciplinary management, care planning and diagnostics • Consultant-led elective outpatient services The service model and specification will be developed in partnership with key providers and patient representatives, implemented via contract variation following contract negotiations.	**Primary Care, Community and Acute** BHT L&D EPUT	Q1 2018/19
	Stroke Pathway Redesign	BCCG will seek to improve pathways for acute stroke, community rehabilitation and services to support improving independence for stroke survivors. • We will continue to develop Stroke Early Supported Discharge during 2018/19 by improving links to psychology, dietetics and social care • We will continue redesign of Hyper-Acute Stroke services. Providers within hub and spoke model will be expected to	**Community** EPUT **Acute** BHT L&D	Q4 2018/19 Q2 2018/19 Q1 2018/19

		operate a single tariff for acute stroke admissions across hub and spoke. • We will work with local authority leads to strengthen joint commissioning of stroke recovery services such as Headway contract Service changes will be implemented via contract variation.		Q1 2018/19
	Procedures of Limited Clinical Value	We will review the Individual Funding Request (IFR)/Prior approval also known as Procedures of Limited Clinical Value (POLCV) .Specific deliverables can be found in: Restricted procedures, treatments and interventions 2017/18. Across the STP commissioners will seek to negotiate different standardised procedures/contract terms with the aim of improving unwarranted clinical variation with providers for 2018/19. This will include the introduction of further prior approval.	All providers	2018/19
	Direct Access Pathology	We will undertake a review of the service provision for Direct Access Pathology within Bedfordshire to implement: • Single tariff arrangement for D/A Pathology services • Implementation of demand management initiatives, including pre-set checklists for routine investigations i.e. annual diabetes review Changes will be implemented subject to contract negotiation.	BHT L&D MK	Q3 2018/19
	Direct Access Diagnostics	We will undertake a review of the service provision for Direct Access Diagnostics within Bedfordshire to implement: • Single tariff arrangement for D/A Diagnostic services • Implementation of demand management initiatives • Expansion of community based diagnostic services Changes will be implemented subject to contract negotiation.	BHT L&D MK AQP Ultrasound and MRI providers	Q3 2018/19
Primary Care	**GP Access**	In 2018 we will pilot an Extended Access model with clusters with the view to procuring a service by March 2019. Local patients will have access to routine appointments during the evening and at weekends. This will include specific dedicated pathways for mothers and children, people with Learning disability, Mental Health and other vulnerable groups.	GP Practices	2018/19

	New ways of working	As part of the delivery of the GP five year forward view plan, we will support cluster to introduce new roles to develop the wider primary care team e.g. clinical pharmacists, clinical administrators, mental health therapists and care navigators, and to support the recruitment and development of the primary care workforce. Also we will explore digital technology to introduce new ways of accessing support and advice from primary care clinicians, including electronic Patient consultations.	General Practice	2018/19
	Collaborative Commissioning	In line with the Practice cluster footprints and using the three pound per head transformation funding, we will continue to develop collaborative commissioning at scale across primary care to deliver out of hospital services e.g. frail and elderly pathway to reduce admissions, diabetes care, anticoagulation, referral co-ordination / facilitation services. These areas have been highlighted as Priority service areas in Year Two of the Locality Development Plans.	Cluster of GP Practices Primary Care Home Model	March 2019
	Sustainable estate for delivering primary care services	We will work in partnership with both Local Authorities and GP providers to secure new/improved premises for the delivery of care, including to address the needs associated arising from housing growth. The priority areas of focus will include Cranfield/Marston Moretaine. We will continue to work with wider partners to develop integrated hubs to support the delivery of primary care at scale, and more integrated working across health and care services. A number of place based integrated hubs will be developed working in partnership with providers and wider key stakeholders. Each hub will provide local access to a range of health and social care services improving patient outcomes through a multidisciplinary approach. The Business Cases for the first three hubs in Bedfordshire will be agreed with partners during 2018/19.	GP Practices Community Health Services Provider ELFT	2018/19
Children's	**Community based rapid intervention service**	We aim to reduce Hospital admissions by developing Community based rapid intervention service as part of the new Community Services contract. Work will be done during 2017/18 Q2 – Q4 to evaluate and quantify the impact to Acute providers.	Community Services Primary care Acute Hospitals	2017/18 Q2 - Q4
	Personalised Asthma Plans	BCCG has a high Asthma mortality rate in children. We are undertaking a review of the Children's Asthma Pathway implemented in 2016/17, and we will be looking to continue to implement the resulting recommendations in 2017/18.	Acute Hospitals Community services Primary Care	2017/18 Q2 - Q4

		We will expect primary care to develop personalised Asthma Plans to empower patients to better manage their condition by continuing the work started in 2016/17 working with the NHSE respiratory nurses.		
	Continuing Care/ Any Qualified Provider (AQP)	Children's continuing care provision will be managed through development of an Any Qualified Provider approach to service delivery across the STP footprint. The procurement will commence in November 2017 and go Live April 2018. This will have an impact on the Community Service Provider who currently provide a small number of these packages of care.	Community services	2017/18 Q3 - Q4
	Repatriation of Complex out of area children in Placements out of county	Working in partnership with local providers and both Local authorities to secure specialist placements in area linked to local provision to deliver care closer to home.	Community services/ELFT/ Local Authorities	2018/19
	Special Education Needs & Disability (SEND)	We will be ensuring that the requirement to undertake Special Education & Disability (SEND) clinical assessments in partnership with the local authority in a meaningful, timely and patient centered focus will be included in the Community Services contract for 2018/19.	Community Services Primary Care	2017/18 Q1
	Integrated Therapy Services	Scoping and developing new models of care to improve access to therapy services: • Redesign speech, language and communication pathways. • Redesign Occupational therapy pathways. • Redesign Physiotherapy pathways.	Community Services Acute trusts BHT L&D	2018/19 Q1/Q2
	Paediatric Pathways	We will develop paediatric pathways with new models of care to build resilience and treat children closer to home including addressing the increase in demand for neurodevelopmental cases and SEND requirements. Opportunities will be considered across the STP footprint.	Community Services	2017/18 Q3
	Palliative Care/EOL	Scoping and review of provision at Keech hospice for respite care and palliative care will lead to revised service specification which will be contractually negotiated.	Keech/Local Authorities Community Provider	2017/18 Q4
	Learning Disability and Autistic Spectrum Disorder	Commissioners will work with providers to increase capacity to meet national guidance requirements to complete CETR for children with LD/ASD who are at risk of admission or placement breakdown.	Community Provider	2018/19
Maternity and Children's	**Maternity services**	We will continue to work with all stakeholders represented within the Bedfordshire, Luton and Milton Keynes Local maternity system to commission safe and sustainable services for our mothers and their families. We will work in close partnership with maternity voices partnerships so that the services we commission matter most to our mothers and their families. Our commissioning plans are around implementing the recommendations from the five year forward view as documented in the Better	Acute and Community Midwifery services Community Health Visiting Services	The requirements and outcomes will be included in the Acute and Community services Contracts in order to deliver the BLMK Local Maternity Services plan in 2017/18.

		Births report from 2015. We will make sure through our commissioning of maternity services that all women get: **1.** Personalised care – women should have a personalised care plan. **2.** Continuity of care - every woman should have a named clinicians who support their care throughout their pregnancy. **3.** Safer care – each hospital board providing maternity care have a champion for maternity services and teams should routinely collect data on the quality and outcomes of their services. **4.** Better postnatal and perinatal mental health care – work across existing mental health services so that mothers get support for perinatal and postnatal mental health presentations . **5.** Experience Multi-professional working - multi-professional learning and close working across midwives and obstetricians will be key. **6.** Receive care from one stop community settings - We will work with BLMK STP steering group and developments around new models of care in community and primary care to see where possible community hubs can be established creating a one-stop shop for women receiving maternity care. **7.** A high quality care is available for all women that is delivered by an efficient payment system for maternity services which fairly and adequately compensates providers.		
Mental Health	**Crisis Care Review**	Building on the crisis care review work and engagement we will work with partners to enhance and develop the crisis care model and specification in line with the crisis care review findings through contract variations and procurement.	ELFT/Voluntary sector providers	July 2018
	Psychiatric Liaison	Using the national transformation bid funding we will continue to work with ELFT to enhance the mental health support offered in secondary care to 'core 24' standards through development of a specification and contract variation.	ELFT/BHT	March 2019
	Suicide Prevention	We will require all providers including their estate departments to include suicide prevention and self-harm risk assessments as part of their clinical practice and estate management. This will be added to all quality schedules.	ELFT/BHT/L&D/ Community provider/ Voluntary sector providers	March 2019
	Psychological Therapies	We will continue to ensure delivery for our investment in psychological therapies to meet the national IAPT targets in access (19%), and sustaining recovery (50%) and	ELFT	March 2018

		wait (95%) rates for 2017/18 with contract variation with ELFT.		
	Memory assessment service	We will continue to work with ELFT to review capacity within the service and system to support achievement and sustainment of the national dementia diagnostic rates (at least two thirds of estimated local prevalence) through a local primary care shared care protocol agreed with GP practices.	ELFT/GPs	March 2019
	Specialist dementia care provision	We will work with the successful provider of the specialist dementia intensive support team to implement the new model and specification through contract award and mobilisation.	Care home providers/ELFT/CBC/BBC	June 2018
	Provision of specialist placements for patients with severe mental health issues	BCCG and ELFT will review the needs of specialist placements with the view to sourcing a local solution and business case reducing the number of spot purchased placements for specialist care. This will be delivered via a contract variation.	BCCG/ELFT	March 2019
	Early intervention psychosis (EIP)	We will continue to continue to work with ELFT to enhance the all age EIP service in line with national targets (treatment within 2 weeks for more than 50% of people experiencing a first episode of psychosis) thorough service development and contract variation.	BCCG/ELFT	March 2019
	Individual Placement Support (IPS) employment	We will continue to work with ELFT, via contract variation to expand pathways to ensure access for more people to IPS employment support for those individuals with severe mental illness in line with national NHS England transformation funds.	BCCG/ELFT	April 2019
	Perinatal Mental Health provision	BCCG will implement the roll out of specialist and community based Perinatal Mental Health services.	BCCG/ELFT	March 2019
Children's Adolescent Mental Health Service **(CAMHS)**	**Children and young people services**	The key priorities identified in the Local transformation plan based on Future in Minds guidance (NHSE 2015) will continue to be delivered and developed further based on National requirements, This will be included in the contract for 2018/19 : • Improvement in access and waiting times to CAMHS through developing crisis and community services. • Development of crisis services to offer extended hours in addition to a 7 day service and 1.1 support for the acute trusts when CYP admitted for medical stabilization. • Develop CYP - IAPT (Improved access to psychological therapies). • Further development of Early Intervention and schools support. • Development of Perinatal Mental Health services following outcomes of national bidding process.	ELFT	Q1 2018-2020 Q3/Q4 Q1 Q3/Q4

		• Development of pathways for Vulnerable groups i.e. Autistic spectrum disorder /challenging behaviour / complex care/ Looked After Children (LAC). • Development of collaborative commissioning plans with Specialist Commissioning (NHS England) for Tier 4 beds in-patient beds and forensic pathways locally.	NHS England/ELFT	Q2/Q3 Q3/Q4
Learning Disability	**Learning Disabilities Mortality Review (LeDeR) Programme**	BCCG will support the roll out of the local system and response to the LeDeR programme ensuring all reviews are completed and identified learning and recommendation from the review feedback into he the local system. Providers will expected to be compliant with requirement as specified in the contract.	BCCG/ELFT/BHT/L &D/BBC/CBC	October 2018
	Adult Specialist Learning Disability provision	BCCG to work with ELFT to review the adult Specialist Learning Disability provision to ensure effective response to local needs and alignment with the TCP plan.	BCCG/ELFT	March 2018
Personal Health Budgets	**Roll out of Personal Health Budgets**	In 2018/19, the areas of focus for PHBs and person-centred commissioning are: • **Adult Continuing Healthcare**: Care Providers to deliver individual packages of care, funded through a PHB held with the service user, a third party, or BCCG. • **Children Continuing Care**: Care Providers to deliver individual packages of care, funded through a PHB held with the service user, a third party, or BCCG. • **Wheelchair Services**: Wheelchair provider to develop, offer and manage Personal Wheelchair Budgets for all wheelchair service users. The new Community Health service provider will be required to continue to embed this requirement through service delivery. • **Mental Health Services:** Providers to work jointly with the CCG and Local Authorities to develop and deliver S117 aftercare packages that can be funded through a PHB. • **Services for children and adults with a learning disability or autism**: Providers to work jointly with the CCG and Local Authorities to develop and deliver Services specifically for these individuals that can be funded through a PHB. • **Children and Young People with an Education, Health and Care Plan**: Providers to work jointly with the CCG and Local Authorities to develop and deliver Services specifically for these individuals that can be funded through a PHB. • Changes would be agreed with Providers through the SDIP and specified into contracts. Providers	BCCG/ELFT/EPUT/ Care Providers / Voluntary Sectors	April 2018

		would be expected to be compliant from 1st April 2018. This will be subject to contract variation.		
Prevention and Detection	**Excess weight provision**	We will undertake a review of tier 3 and 4 provision for excess weight and commission appropriate services following service review. These changes may result in variation to existing provider services or the commissioning via variation or procurement of new services.	Local authority Community Health Services provider BHT / L&D	2018/19
Integrated/ Out of Hospital Care	**Community Health Services procurement**	In 2016 we launched a joint procurement of Community Health Services with Bedford Borough Council and Central Bedfordshire Council. Services under the new contract will commence in April 2018. During 2018/19 we will work with the new Community provider to mobilise services in line with our out of hospital strategies. In the meantime we will continue to work 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.	Community Health Services provider Local authority	2018/19
	Discharge to Assess/Community Beds	We will build on the work already undertaken in 2017/18 related to community bed provision to ensure appropriate out of hospital capacity to meet the needs of the population and ensure there are clear pathways to support patient flow out of hospital as part of the discharge to assess process and introduce three clear pathways to ensure capacity for CHC DST assessments to be completed outside of hospital. The three pathways we will focus on will be • Enabling patient to go home – with or without support depending on their needs – pathway 1 • Providing active rehabilitation to patients with rehab and reablement needs in commissioned community beds (Inc. DST) – pathway 2 • Enabling patients to be assessed for their long term needs in a more suitable setting outside the	Local authority Community Health Services provider Acute Providers BHT / L&D	2018/19

		hospital (fund without prejudice)– pathway 3 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.		
	Community Rehabilitation Ward 5/Ward 19	The CCG does not expect rehabilitation element of pathways to be delivered in acute setting. The CCG will therefore work with the acute trusts to agree Pathway changes into community services.	L&D	2018/19
	Domiciliary Phlebotomy and Community Warfarin services	Commissioners will work with the new community services provider to undertake a comprehensive clinical service review to inform future commissioning model of care.	New Community Services provider BHT Primary Care/GP Clusters	Q3/Q4

3. Contracting Intentions

3.1 Contracting Principles

1. The NHS Five Year Forward View and the Next Steps update published in March 2017 described a movement towards integrated care, delivered through collaboration across health and care systems.

2. Sustainability and Transformation Partnerships (STPs) have been established across England. These partnerships are pragmatic vehicles for health and care organisations to chart their own course for keeping people healthier, improving care and managing taxpayer money in the most optimal way. STPs are a means to an end – a way of facilitating collaboration amongst local leaders and clinicians to improve services and to make the most of every pound of public spending.

3. Some areas are ready to go further and more fully integrate their services and funding. The national bodies have designated eight emerging 'Accountable Care Systems' (ACSs), along with two devolution areas (Surrey Heartlands and Greater Manchester), that will lead the way in implementing the priorities set out in Next Steps. An ACS is an evolved version of an STP, potentially covering a sub–set of an STP's geography, in which commissioners and providers, in partnership with Local Authorities, take explicit collective responsibility for resources and population health. In return, they will gain greater freedom and control over the operation of their local health system and how funding is deployed. Bedfordshire Clinical Commissioning Group has been designated one of the eight ACSs.

4. Some areas also wish to establish Accountable Care Organisations (ACOs). ACOs and ACSs have the same objective of integrating care and having a single, systematic approach to using the resources for a local population to improve quality and health outcomes. They are different in that an ACO is where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health. ACO procurements are lengthy and complex, and the development of ACOs relies on a strong underlying approach to care design, engagement and collaboration. For these reasons, we need to establish ourselves as an ACS before considering whether to introduce the ACO model.

   The 2018/19 contracts 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. These changes will be implemented by Contract Variations where necessary.

3.2. Planning Principles

The planning principles are based on the outcome of the Joint Chief Executive Committee and are as follows:

- Agree and work to a common set of planning assumptions that will form the basis of their 18/19 institutional plans submitted to regulators across the system (subject to compliance with the national planning guidance for NHS organisations due to be issued in September 2017).
- Develop a mechanism than enables a system control total to operate during 2018/19. This will include:

- a means of sharing/managing risk that surfaces in the system from STP partners implementing agreed transformation measures; and

- a review of how all contracts will operate in the context of operating a BLMK system control total. This is likely to include consideration of alternative funding mechanisms to PBR, block contracts and quality reward measures. Any changes to funding/payment mechanisms are expected to require a period of shadow testing and will be aimed at achieving more effective risk management rather than simply 'risk transfer'.

- Develop an investment framework by which STF funding will be prioritised and applied to the achievement of BLMK STP goals.

- Work in an aligned way to commission and contract for services in 18/19, as far as is practical. Commissioners will jointly assess any national guidance/mandates (when published) and ensure fit with STP and place-based plans.

- Align their 18/19 institutional plans with the current BLMK STP direction of travel.

- Perform joint oversight of the goals/targets required and the actions to deliver these as set out in a BLMK STP wide plan.

3.3 Contractual form

The CCG intends to pursue the application of different contractual forms with providers for the 2018/19 financial year. We currently operate with the majority of contracts based on tariff/PbR or block funding models, with some further inclusion of prime provider models. We recognise that the current tariff model generates an unsustainable level of financial risk within the healthcare system and diverts resources away from improvement to healthcare delivery. As such, we will engage with providers to explore other contract forms as appropriate for different services, within the standard NHS contract parameters, including:

- Capitated contracts (contract values determined per patient being treated, rather than per treatment; better suited to longer term care pathways and used to incentivise fewer, high quality contacts rather than overall higher numbers of contacts)
- Minimum Income Guarantee contracts (to reduce financial volatility)
- Marginal Rate – above an agreed threshold the activity is paid for at an agreed rate.
- Block contract, with or without a cap and collar arrangement (cap and collar allows limited variation from the block value, with the cap representing the upper limit and the collar representing the lower limit)
- Aligned Incentive contract (fixed income, possibly with cap/collar; agreed activity plan including joint measures to reduce activity; agreed approach to risk share for specific costs; cost risk reserve)
- Risk share/gain share (specifically related to savings opportunities, the ability to include within contracts provision for joint ownership and risk/benefit for key schemes to incentivise collaboration)

3.4 Contracting Timetable

For the Acute contracts we have signed two year contracts, ending 31 March 2019. Some items, such as the National Tariff and CQUIN have been defined for the second year of the contract. However, a number of areas such the Indicative Activity Plan, will require to be renegotiated and adjusted in the contract via Contract Variations.
The above and other adjustments are likely to require completion, set to a national timetable. At the timing of writing it has not been published but is likely to be as follows:

- 21 Sep 17 - Planning/Technical Guidance
- 31 Oct 17 - CQUIN Guidance
- 03 Nov 17 - Commissioners to propose changes to Year 2 of the contract
- 10 Nov 17 - Providers to respond
- 04 Dec 17 - If no agreement, consider mediation
- 22 Dec 17 - Agreement on second year of the contract

3.5 Rehabilitation Services

Rehabilitation Services will not be commissioned from Acute Providers as the most appropriate place for rehabilitation is in a community setting. In particular, decommissioning of the rehabilitation service in ward 19A of the Luton and Dunstable University Hospital will be completed by December 2017, in parallel with the procurement of compensating community beds.

3.5 CQUIN

The 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 has made two changes to the scheme:
First, as in previous 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.

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.

3.6 E-Referrals

We will adhere to the National mandated targets with acute providers, in line with the National CQUIN requirements, to ensure that 100% of eligible referrals are sent by GP Practices to NHS E-Referral.

We require our main acute providers to ensure all consultant-led acute services are published on NHS E-Referral and Appointment Slot Issues (ASIs) are maintained within the national target of 4%.

3.7 Clinical Audit

All providers in the STP area contribute to the creation of clinical policies for the Hertfordshire and Bedfordshire Priorities Forum. The Forum advices on which policies and interventions should be given high or low priority and advises on thresholds. We therefore, expect all providers to adhere to these policies. The CCG shall gain assurance of adherence to these policies through a clinical audit process, irrespective of whether or not the CCG has a formal Prior Approval System (PAS) in place with that provider. Where there is no formal PAS in place, the CCG shall rely upon the audit provisions within the Service Conditions of the NHS Standard Contract. The audits will be carried out to an agreed annual timetable with nominated clinical specialties and audit sample sizes. The audits will be performed quarterly. The results of which will be extrapolated retrospectively, for each quarter, and any non-compliance will result in a proportionate financial deduction.

3.8 POLCV (Procedures of Limited Clinical Value)

The CCG works with a range of POLCV definitions and thresholds across its portfolio of contracts and intends to harmonise these, particularly with local STP partners, to ensure consistency of access to care for all Bedfordshire residents. All partners in the STP will work to increase consistency in clinical policies and to agree consistent approaches with hospitals and other providers.

3.9 Referral Rates

A consultant to consultant policy will be agreed within contracts for agreed levels of consultant to consultant referral and conversion of first outpatient appointments to follow up appointments, to ensure that all referrals and conversions are genuinely medically required and support high quality care. Transparency around reporting of activity levels, and provision for flexibility for specific pathways (e.g. Cancer) where tight ratios may be counterproductive. Penalties will apply where agreed metrics are breached.

3.10 Addressing unwarranted variation

We will address areas of unwarranted variation which may result in:

- Contractual coding and counting challenges
- Service variations
- New service opportunities
- Decommissioning

Unwarranted variation will be identified using key comparator tools such as RightCare Commissioning for Value, Getting It Right First Time (GIRFT), Atlas of Variation and other benchmarking tools as applicable.

3.11 Out of area activity

We will work with STP Partners to ensure local good quality services meet the needs of our population and reduce the need for request to travel long distances.

3.12 Procurements

Procurement activity in view for 2018/19 include mobilisation of the new community health services contract and a new patient transport services contract from 1st April 2018; and ongoing review of the out of hours/111 service with potential to re-procure.

3.13 Commissioning for Quality

During a time of increasingly constrained resources and the need to achieve value for money, it is essential that we maintain focus on ensuring that the quality (safety, experience and effectiveness) of the services we commission is not compromised and that unwarranted variation in care is minimised.

We will work with providers to:

Place the NHS constitution at the heart of our work ensuring we monitor and make improvements to the quality and equality of healthcare we commission.

Further develop and refine the local quality schedule within contracts to supplement the requirements of the standard national contract ensuring best practice to deliver better outcomes with a robust quality assurance process to measure success.

Implement national CQUINs as per guidance and to ensure the CQUIN goals are sustained after the CQUIN scheme has ended.

Build on the work already implemented and in progress to deliver improvements in the NHS England assurance framework individual indicators for the six clinical priorities of cancer, dementia, diabetes, learning disabilities, maternity and mental health.

Respond to requirements from regulatory reviews, embed learning from serious incidents, coroners inquests, safeguarding, complaints and clinical reviews in to contractual processes and review assurances methodology to include triangulating data, targeted site visits and working with providers.

Strengthen keeping patient and staff experience central to supporting openness, transparency and candour throughout the system.

Support self-management for people diagnosed with long term conditions with measurable prevention initiatives ‘making every contact count’.

Sustain scrutiny on mortality to reduce avoidable mortality.

Develop enhanced quality assurance in care homes and domiciliary care with the local authority.

Focus on access to services for looked after children and care leavers including looked after children placed into Bedfordshire.

Focus on the early identification and treatment of sepsis of any person in any clinical environment.

Providers must respond to national and local emerging safeguarding requirements