Barnsley Clinical Commissioning Group

NHS Barnsley Clinical Commissioning Group

Working Together

A commissioning plan 2013-14 and beyond that puts the people of Barnsley first

Version 6

Executive Summary

Barnsley Clinical Commissioning Group (CCG) is the new NHS commissioning organisation serving the borough of Barnsley. The CCG will commission effective and efficient high quality and sustainable NHS services for our patients, with prioritised use of resources, improved patient outcomes and greater financial stability.

This document sets out the changes and improvements that Barnsley CCG seeks to make in 2013/14 and beyond through commissioning (planning and buying).

The plan builds on the collaborative work we have undertaken with our partners in health and social care to introduce new and innovative ways of working which will improve the health of the local population; reduce inequalities and improve productivity. This is to support the delivery of the five outcome challenges set for the NHS:

- To prevent people from dying prematurely
- To enhance the quality of life for people with long term conditions
- To help people recover from episodes of ill health or following injury
- To ensure that people have a positive experience of care
- To treat and care for people in a safe environment and protect them from avoidable harm

In order to identify the changes we want to make we have reviewed the health needs of our population from the Joint Strategic Needs Assessment. We have found:

- Growing and increasingly elderly population
- Widening health inequalities across Barnsley and between Barnsley and the rest of England (life expectancy)
- High levels of deprivation
- High levels of hospitalisation
- High level of premature deaths from cancer and cardiovascular disease
- Variation in practice and performance.

From this we have identified a number of opportunities for change that will help to improve patient outcomes.

The CCG has identified 7 priority areas it intends to focus on during the period 2013-14 and beyond. These priority areas are aligned to the key priorities included in the Joint Health and Wellbeing Strategy. Underpinning each of the priority areas are key programmes of work / actions that are planned for 2013/14, these are identified in Section 4 – Improving Outcomes, Reducing Inequalities of the plan.

The priority areas for Barnsley CCG which are detailed in Section 4 are:

Priority		Key Actions
1	Cancer	• Targeted work with public health to promote healthy lifestyles • Targeted activities in deprived communities to improve symptom awareness and improve uptake

		in screening programmes • Continue to develop primary, secondary and tertiary care pathways • Implement the MacMillan Cancer survivorship programme • Monitor impact of end of life care pathway
2	Cardiovascular Disease	• Targeted work with public health to promote healthy lifestyles • Targeted activities in deprived communities to improve symptom awareness • Maximise care planning in primary care • Treat all patients over 65 with a diagnosis of atrial fibrillation with appropriate anti-coagulants • Develop cardiology care commissioning standards • Ensuring that the End of Life pathway is embedded as part of Cardiovascular Care
3	Long Term Conditions	• Implement the recommendations of the intermediate care review • Undertake risk stratification of patients who are high intensity users of services, are at risk of readmission or who have modifiable risk factors • GP led case review and integrated care planning • Develop and refine pathways to ensure maximum access to telehealth support • Promote dementia friendly community target schools and education centres • Implement the recommendations of the memory service review • Evaluate dementia assessment process and effectiveness of post dementia diagnosis support
4	Mental Health	• Review the improving access to psychological therapies service • Review In patient provision and the service model for community rehabilitation • Review and implement pathways and packages of care • Develop and implement eating disorder pathway • Monitor and evaluate the Autistic spectrum disorder and Attention deficit-hyperactivity disorder pathways • Commission the Black Minority Ethnic liaison service • Review service model for Community rehabilitation
5	Unplanned Care	• Develop mechanisms to establish care navigation and negotiation • Develop pathways for emergency ambulatory care conditions • Review pathway for frail elderly people to facilitate

		rapid assessment, care planning and early supported discharge • Implement the recommendations of the intermediate care review • Evaluate the local NHS111 pathway in respect of patient flow and access to the right care first time • Develop and agree an urgent care local enhanced service
6	Planned Care	• Ensure that demand management initiatives are underpinned by educational support and peer review • Continue to work to reduce outpatient first to follow-up rates and improve day case rates • Pilot virtual clinics to reduce face to face consultations in hospital • Review the referral criteria list for procedures of limited clinical value • Support more choice for patients through the further use of any qualified provider contracts • Review clinical pathways including the ophthalmology and the clinical assessment service
7	Maternity / Children	• Action all relevant recommendations identified in the OFSTED / Care Quality Commission inspection particularly in relation to looked after children and safeguarding • Develop a teenage health strategy, to review teenage pregnancy, lifestyle factors such as alcohol, diet and smoking • Review commissioner and provider arrangements, arrangements for children with long term conditions and children's continuing healthcare arrangements • Continue to evaluate the stronger families approach with a view to rolling out across the borough

Governing Body members have been appointed to provide clinical leadership across the seven priority areas. Each member will be responsible for setting the direction of and overseeing the delivery of the planned work in relation to the key actions.

In addition we have identified a number of enablers which will help support the delivery of the priorities these are identified in Section 5 of the plan and are summarised as follows:

- Patient and Public Engagement
- Organisational Development
- Partnership Working
- Medicines Optimisation
- Innovation and Technology

We will continue to develop an approach of innovation, challenge and assurance to drive quality improvement in the services we commission. In particular a priority for the CCG is to ensure that providers cost improvement programmes can be delivered without reducing quality and safety.

Ensuring the delivery of the rights and pledges, which are included in the NHS Constitution, along with a range of outcomes from the national outcomes framework will continue to be of importance to the CCG. We will report to our Governing Body and Membership Council progress against these outcomes.

Section 8 of the plan identifies how we intend to deliver the 5 offers identified in the Everyone Counts planning guidance, these being:

1. NHS services, seven days per week
2. More transparency, more choice
3. Listening to patients and increasing their participation
4. Better data, informed commissioning, driving improved outcomes
5. Higher standards, safer care.

The CCG has accountability for the healthcare commissioning budget of Barnsley borough from 01 April 2013. For 2013/14, the CCG has £367,124m resources available. This strategy aims to optimally utilise this resource for the Barnsley population.

A high level summary of our plan, our plan on a page, can be found on page 11.

Section 1 - Introduction

This plan will describe how the Clinical Commissioning Group (CCG) will deliver the NHS outcomes framework for its population in conjunction with a range of stakeholders from across the borough through the delivery of system reform, quality, performance and financial metrics as defined in:

- The NHS Constitution - rights of and pledges to patients to be upheld.
- The Mandate for the NHS in England - the strategic framework for the discharge of NHS responsibilities, requiring the NHS to deliver improvements against the NHS Outcomes Framework.
- The NHS Outcomes Framework - the standards for the NHS to achieve to secure better outcomes.

Through the delivery of the mandate, the NHS Constitution and the NHS Outcomes Framework, NHS Barnsley CCG will place the people of Barnsley first; no community will be disadvantaged; we will focus on reducing health inequalities and improving service quality to improve outcomes for patients.

We aim to treat patients as individuals; to support them to take control and make informed choices.

In order to develop this plan a number of partners within Barnsley and across a wider conurbation were consulted in order to confirm the results of our planning processes.

Section 2 - Barnsley

NHS Barnsley CCG will be formed in April 2013 as a group of general practices serving the residents of the Barnsley Borough. The combined registered population of Barnsley's 38 general practices is 250,264. The CCG will be coterminous with Barnsley Metropolitan Borough Council.

This plan sets out the CCG's vision, values and priorities for 2013/14 onwards. Its purpose is to allow us to see how our performance, finance, quality, efficiency, workforce and information technology plans are aligned with the requirements of the NHS Outcomes Framework, the Commissioning Board Mandate, the NHS Constitution and the NHS Everyone Counts Planning Guidance. The plan also incorporates our strategic goals and our commissioning intentions and gives a clear and credible plan for the commissioning and delivery of health services in Barnsley.

Vision, Values, Principles and Goals

The CCG has set out our vision for the Barnsley population which is underpinned by our values and principles. These will underpin our work, along with the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.

The vision for NHS Barnsley CCG is:

"We are a clinically led commissioning organisation that is accountable to the people of Barnsley. We are committed to ensuring high quality and sustainable health care by putting the people of Barnsley first."

Services will be commissioned so that they have at their heart the following values:

- Equity and Fairness
- Services are designed to put people first – helping them to have control and be empowered to maximise their own health and well-being.
- They are needs led.
- Quality care delivered by vibrant primary and community care or in a safe and sustainable local hospital.
- Excellent communication with patients.

We will use allocated resources to commission the highest quality of care possible:

- There will be no compromise on the safety of care.
- Decisions will result from listening to patients and the public as well as to members.
- All decision making is clear and transparent – all written communications and documents for the public will be jargon and acronym free.
- We will work together with providers and other commissioners to develop integrated care for patients across all pathways.
- The Governing Body and staff are accountable to the public and to members.
- Protecting and using well the resources we have - Making the best most effective use of the Barnsley £.

- There will be excellent communication with all of our stakeholders.

Our Goals are:

- To have the highest quality of governance and processes to support our business
- To commission high quality health care that meets the needs of individuals and groups
- Wherever it makes safe clinical sense to bring care closer to home
- To support safe and sustainable local hospital services, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley
- To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £. These partnerships will be with:

    - Patients
    - The public
    - Providers
    - Barnsley Metropolitan Borough Council
    - The local voluntary sector
    - And other stakeholders as required.

NHS Barnsley CCG has ambitious plans to make Barnsley a healthier place to live and to ensure that wherever possible we diagnose and prevent risks to health before they materialise. To provide fair, personal, effective and safe treatment and care we know everybody wants and to ensure these services are provided in the most cost effective way.

The CCG places the greatest emphasis on quality and patient outcomes from the services it commissions, and expects all our providers including primary care to play their part in ensuring that wherever patients receive care it is of the highest quality possible, and that it delivers the best outcomes.

Patient and Public Engagement is central to the work we do and having a strategy and framework that ensures it is built into every aspect of our work will enable the essential dialogue about the challenges and solutions to take place.

Our programmes of work will be underpinned by promoting integrated ways of working that support the patient, their families and carers to take more responsibility for their own health both in terms of staying healthy and in accessing the right care in the right place at the right time.

By encouraging the people of Barnsley to demand the best and our local providers of health care to deliver safe, high quality services we will reduce unacceptable variation in performance and ensure the right care is delivered to meet the needs of patients. In our determination to maintain financial stability we will promote clinical leadership and stronger partnerships within our local community; we will also

champion innovation and prevention strategies that deliver improved outcomes for the people of Barnsley.

There is nothing of any significance that we can achieve in isolation. We must work closely with our local partners, in particular Barnsley Metropolitan Borough Council, the local Children's Trust, Barnsley Hospital NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust and Primary Care providers on issues across Barnsley and with other CCGs on matters that cross CCG boundaries.

Joint work with other clinical commissioners will be particularly important when considering the future shape of acute services.

We are playing our part in the continued development of the Health and Wellbeing Board. We have participated in the development of the Joint Health and Wellbeing Strategy which represents our longer term strategy.

We have a Memorandum of Understanding in place for public health support and we can draw on public health skills to inform our commissioning plans including service redesign, and pathway development especially those that will help reduce inequalities.

NHS Barnsley CCG has identified seven high level priorities which it intends to focus on during 2013/14; these priorities are underpinned by a number of actions. The following provides a plan on a page summary of the detailed narrative included within this plan.

NHS Barnsley Clinical Commissioning Group Plan 2013 -14 & beyond

This is Barnsley	Vision	System Perspective	Desired Outcomes	Improvement Programmes and QIPP Programmes (Opportunities for Change)		Enablers
1. Growing and increasingly elderly population **2.** Widening health inequalities between Barnsley and the rest of England (life expectancy) **3.** High levels of deprivation **4.** Significant financial challenge – low £ growth **5.** High levels of hospitalisation **6.** High level of premature deaths from cancer and cardiovascular disease **7.** Variation in practice and performance	Sustainable Healthcare Putting people first High Quality Healthcare	Making the best use of the Barnsley £ Effective Partnership Working (transformation) Excellent Communication with Patients	• Reduced <75 mortality in Cardiovascular disease and Cancer • Improved 1 year and 5 year cancer survival rates • Reduced emergency admissions • Reduced emergency readmissions within 30 days of discharge from hospital • Improved patient experience • Proportion of deaths in usual home • Reduced incidence of avoidable harm in hospitals • Financial Balance • Better quality of life for those with long term conditions • Reduced inequalities	**Cancer**	• Preventing – Targeted work with public health to promote healthy lifestyles • Diagnosing – Targeted activities in deprived communities to improve symptom awareness and improve uptake in screening programmes • Treating – Continue to develop primary, secondary and tertiary care pathways • Support - Implement the MacMillan Cancer survivorship programme • End of life - Monitor impact of end of life care pathway	Innovation & Technology Medicines Optimisation Patient and Public Engagement Effective Partnerships / Integrated Team Working Organisational Development
				Cardiovascular Disease	• Preventing – Targeted work with public health to promote healthy lifestyles • Diagnosing – Targeted activities in deprived communities to improve symptom awareness • Treating – Maximise care planning in primary care • Treat all patients over 65 with a diagnosis of atrial fibrillation with appropriate anti-coagulants • Develop cardiology care commissioning standards • End of life - Ensuring that the End of Life pathway is embedded as part of Cardiovascular Care	
				Long Term Conditions	• Implement the recommendations of the intermediate care review • Undertake risk stratification of patients who are high intensity users of services, are at risk of readmission or who have modifiable risk factors • GP led case review and integrated care planning • Develop and refine pathways to ensure maximum access to telehealth support • Promote dementia friendly community target schools and education centres • Implement the recommendations of the memory service review • Evaluate dementia assessment process and effectiveness of post dementia diagnosis support	
				Mental Health	• Review the improving access to psychological therapies service • Review In patient provision and the service model for community rehabilitation • Review and implement pathways and packages of care • Develop and implement eating disorder pathway • Monitor and evaluate the Autistic spectrum disorder and Attention deficit-hyperactivity disorder pathways • Commission the Black Minority Ethnic liaison service	
				Unplanned Care	• Develop mechanisms to establish care navigation and negotiation • Commission a virtual ward to support patients who are at very high risk of re-admission to hospital • Review the efficacy of the pathway for frail elderly people to facilitate rapid assessment, care planning and early supported discharge • Implement the recommendations of the intermediate care review • Evaluate the local NHS111 pathway in respect of patient flow and access to the right care first time • Develop and agree an urgent care local enhanced service	
				Planned Care	• Ensure that demand management initiatives are underpinned by educational support and peer review • Continue to work to reduce outpatient first to follow-up rates and improve day case rates • Pilot virtual clinics to reduce face to face consultations in hospital • Review the referral criteria list for procedures of limited clinical value • Support more choice for patients through the further use of any qualified provider contracts • Review clinical pathways including the ophthalmology and the clinical assessment service	
				Maternity / Children	• Action all relevant recommendations identified in the OFSTED / Care Quality Commission inspection particularly in relation to looked after children and safeguarding • Develop a teenage health strategy, to review teenage pregnancy, lifestyle factors such as alcohol, diet, smoking • Review commissioner and provider arrangements, arrangements for children with long term conditions and children's continuing healthcare arrangements • Continue to evaluate the stronger families approach with a view to rolling out across the borough	
	Clinical leadership and continuous improvement in quality, outcomes and excellence					
Key Risks	• Healthcare Acquired Infections - Clostridium Difficile and MRSA – the targets for 2013/14 are challenging but plans are in place to actively review and monitor performance • Accident and Emergency – 4 hour wait target - a remedial action plan has been developed and progress against this will be actively monitored • Looked After Children – the recent Ofsted report identified a number of recommendations, an action plan has been developed and actions are being implemented in response to this					
Performance Measures	NHS Barnsley Clinical Commissioning Group is committed to ensuring that the national requirements in respect of performance measures included in the NHS Constitution, the NHS Outcomes Framework and the Mandate are achieved.					

Section 3 - Barnsley People and their Needs

Population Demographics

The age distribution of Barnsley's 232,000 people (resident population) is similar to that seen nationally, except for a slightly lower proportion of young people aged 25 to 39 years. 19% of the population is aged under 16, with 17% aged 65 years or older. In 2011, there were 2,991 live births in Barnsley and 2,274 deaths.

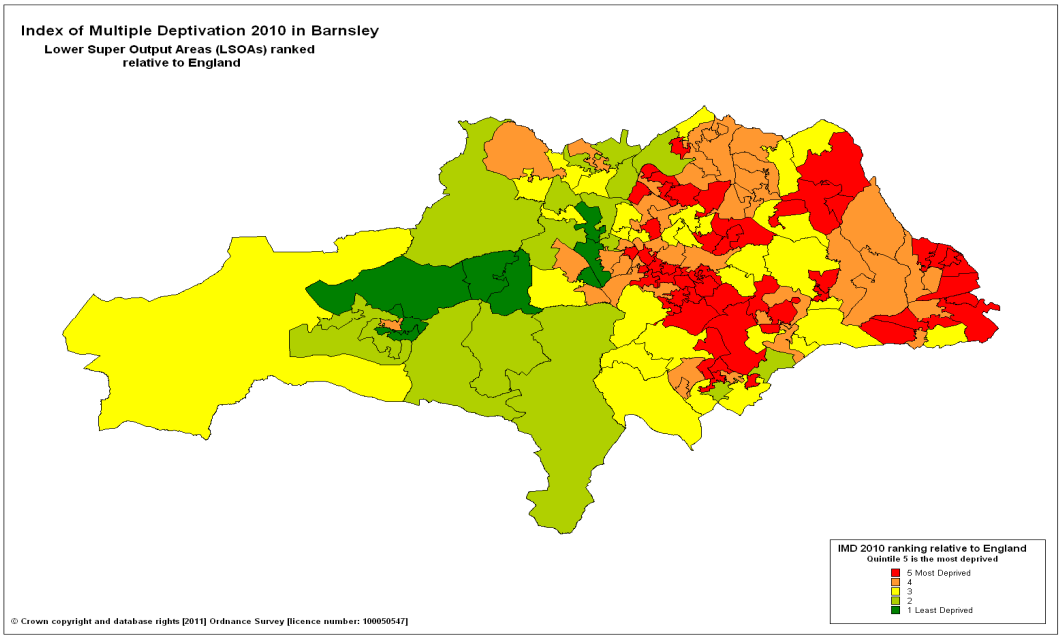
The total population of Barnsley is projected to rise by 7.2% by 2021.

Deprivation

Barnsley is ranked as the 47th most deprived borough of 326 English boroughs, with 32% of the population living in the 20% most deprived areas in the country. The deprivation is concentrated in the east of the borough (Figure 1). 23.8% of children in Barnsley currently live in poverty.

There are substantial and persistent inequalities in the health needs and outcomes of local people compared to the rest of the country as a whole. For example, the percentage of Barnsley residents with a long-term illness or disability is 24.6%, higher than the national average of 17.3%.

Figure 1: Index of Multiple Deprivation 2010 in Barnsley



Health Needs

Taking the JSNA, combined with the analysis of the 2011 Director of Public Health's Annual Report, the health and wellbeing needs of the Barnsley community are summarised as follows:

Life Expectancy

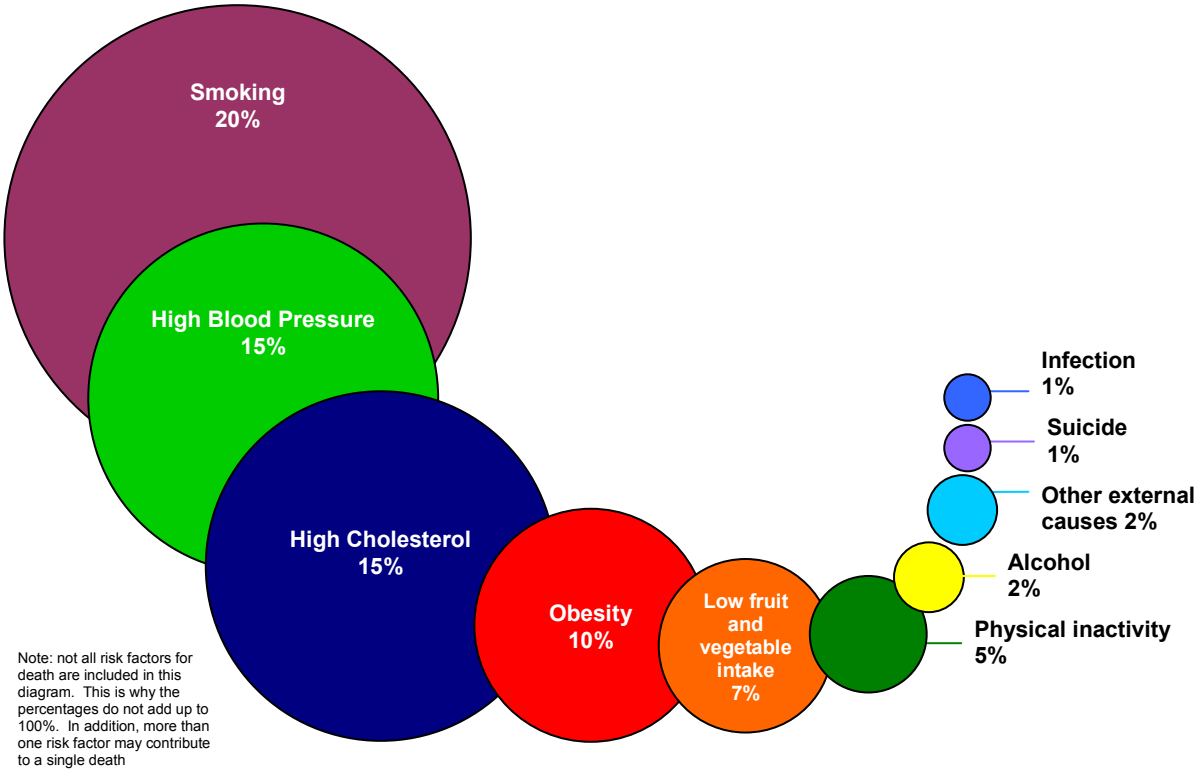
Life expectancy at birth in Barnsley is increasing. Unfortunately, the rate of improvement is not as fast as the national average, with the gap in life expectancy widening both within the borough and between Barnsley and the national average, particularly for men.

The main contributors to the gap in life expectancy between Barnsley and the rest of the country are:

- Cancer
- Cardiovascular disease
- Respiratory disease

Risk Factors

A large proportion of deaths in Barnsley can be attributed to modifiable lifestyle factors, as detailed below:



The substantial contribution of smoking to deaths in Barnsley reflects the high prevalence of smoking within the borough. After smoking, high blood pressure and high cholesterol together contributed to 30% of deaths in Barnsley over the 2008-10 period.

The prevalence of risk factors in Barnsley is derived from modelled estimates and should be interpreted with some caution. Estimates suggest that locally:

- 26% of adults smoke cigarettes
- 16% of adults have high blood pressure
- 7% have diabetes

- 28% of adults are obese.
- 80% do not eat healthily, as measured by eating five portions of fruit and vegetables a day
- 12% of adults comply with recommended physical activity levels
- 22% drink excessive amounts of alcohol

Health and Wellbeing

Cancer

Cancer is the leading cause of premature death in Barnsley, and the second leading cause of death overall. Although premature mortality from cancer is falling, the gap in cancer mortality between Barnsley and England is widening.

Cardiovascular Disease (CVD)

Cardiovascular disease is the leading cause of death in Barnsley, and the second leading cause of death in those aged under 75 years. Whilst improvements are being made locally, Barnsley has a significantly higher premature CVD mortality rate compared to the national average.

Respiratory Disease

Respiratory disease is the third most common cause of death in Barnsley. The largest number of deaths from respiratory disease is from pneumonia, with Barnsley having the highest mortality rate for women and the second highest for men from pneumonia in the Yorkshire and Humber region. Pneumonia also accounts for a large proportion of hospital admissions.

Long Term Disease and Disability

There are an estimated 23,600 people over the age of 65 years with a limiting long term illness, this is projected to rise year on year up to 2015 when the estimate will be at 25,200, this alongside the general elderly population growth rate at 3% year on year will have a significant burden on both health and social care services.

There are an estimated 4,300 adults with learning disabilities in Barnsley. Of these 900 have moderate or severe learning disabilities.

Ageing Population

There are approximately 232,000 people (resident population) living in Barnsley. This is projected to increase to 238,500 by 2015 and to 248,600 by 2021. Interim projections show that the largest projected increase is likely to be those aged over 65 (increasing by 20.9% in 2021). 20% of the total population will be aged over 65 in 2021.

Alcohol Misuse

Barnsley's rate of binge drinking is significantly higher than the England average. The rate of alcohol related hospital admissions are rising (a year on year increase since 2007-08) with men having significantly higher alcohol specific hospital

admissions than the England average. During the period 2008/09 – 2010/11 Barnsley had a significantly higher rate of under 18s alcohol specific hospital admissions when compared to the England average.

Children, Young People and Maternity

The infant mortality rate in Barnsley is lower than the England average. Deaths in infancy are concentrated in areas of higher deprivation locally. 23% of women are recorded as smoking at the time of delivery.

Childhood obesity remains a problem in Barnsley; especially amongst Year 6 children. Obesity is a significant risk factor for poor health in later life.

The under 18 conception rate in 2010 was 55.2 per 1000 girls aged 15-17, representing an unwelcome increase; the rate is now the highest in South Yorkshire.

Section 4 - Improving Outcomes, Reducing Inequalities

From 2013/14 the CCG will be monitored against the outcomes measures included in the NHS Outcomes Framework which identifies five domains. The five domain areas are:

- Preventing People from Dying Prematurely
- Enhancing Quality of Life for People with Long-term Conditions
- Helping People to Recover from Episodes of Ill Health or Following Injury
- Ensuring that People have a Positive Experience of Care
- Treating and Caring for People in a Safe Environment and Protecting them from Avoidable Harm.

As a result we have ensured that our plan and the work that we do is aligned to the requirements of the Outcomes Framework along with the requirements of the recently published NHS Mandate and NHS Constitution.

During 2012/13, progress against the measures included in the outcomes framework was monitored; this monitoring also identified those areas that Barnsley was benchmarked as being below average. This information was used to help shape and identify the key priority areas for the CCG for 2013/14 and beyond.

We are setting out a proposal for a systematic approach to commissioning, set within a programme management approach which we are planning to develop with our local partners in Barnsley.

The following identifies the priority work areas that we have agreed to progress from 2013/14 onwards.

Domain 1 - Preventing people from dying prematurely

The CCG is committed to working with partner organisations including the NHS Commissioning Board, Public Health England, the Health and Wellbeing Board and Barnsley Metropolitan Borough Council to:

- Provide integrated health and social care approaches through targeted use of health checks to ensure earlier diagnosis;
- To improve early management in community settings;
- To improve acute services and treatment and
- Prevent recurrence after an acute event.

Using the recently published CCG Outcomes Benchmarking Support Pack published by the Department of Health in December 2012 and local intelligence the following specific priorities and programme areas of work have been identified in relation to this domain:

Priority 1 – Cancer

What is the rationale for this priority?
Cancer is the leading cause of premature death in Barnsley, and the second leading cause of death overall. Although premature mortality from cancer is falling, the rate of this fall is not as fast as that seen across the rest of the country and therefore the gap in cancer mortality between Barnsley and England is widening. The largest single cause of cancer deaths in Barnsley is lung cancer, followed by bowel, prostate and breast. Five year survival rates for prostate, bowel and breast cancer are significantly lower in Barnsley compared to the rest of the country. Over half of all cancers could be prevented by lifestyle changes, predominantly stopping smoking. Barnsley health community compares unfavourably to the England median and similar CCGs in the under 75 mortality rate from cancer and potential years of life lost from causes amenable to healthcare.
What are the key actions?
A systematic and proactive approach to prevention, early detection and treatment is required to reduce avoidable cancer deaths in Barnsley. The table below identifies the key actions that will be undertaken:

Barnsley Cancer Strategy		**Key Actions**
Goal 1 – Knowing our population	1.1	Implement significant event audits
Goal 2 – Develop a systematic approach to cancer prevention	1.2	Needs led work with public health to promote healthy lifestyles, specifically, public health campaigns focussed on smoking, diet, alcohol, weight and physical activity
	1.3	Targeted programme across the borough for 'Healthwise' mobile cancer information unit
Goal 3 – Promote early detection, screening and diagnosis	1.4	Targeted activities to improve symptom awareness in deprived communities to increase early presentation of lung cancer
	1.5	Targeted activities to improve uptake rate on national screening programmes, focussing specifically on those communities where screening uptake is low
	1.6	Work with Public Health to increase the number of smoking quitters and reduce harmful alcohol consumption
	1.7	Promote effective use of GP cancer risk assessment toolkit
Goal 4 – Implement effective treatment pathways with fast access to surgery, chemotherapy,	1.8	Continue to develop primary, secondary and tertiary care pathways to improve compliance against the Improving Outcomes Guidance to include the National Peer Review Programme and Multi-Disciplinary Team measures and the Cancer Winning Principles and to provide better access for patients to see medical professionals earlier
	1.9	Development of individual care plans for these patients

radiotherapy and drug treatments	1.10 1.11	Improve staging data for all cancers to inform detection and screening work plan Improve communication with all medical professionals
Goal 5 – Support and empower patients living with and beyond cancer	1.12 1.13	Implement the MacMillan Cancer survivorship programme for people with colorectal cancer Pilot self-care support through telehealth interventions for patients flowing treatment for colorectal cancer
Goal 6 – Improve quality and choice for people approaching the end of life	1.14 1.15	Monitor impact of end of life Liverpool care pathway Ensure the End of Life pathway is embedded as part of cancer care
Patient and Public Engagement	1.16	Work in partnership with public/patients of Barnsley

What are the outcomes we expect to achieve?

- Reduce the Cancer mortality rates from the current baseline rate in 2011 of 133.2 per 100,000 population

- Reduce variation above or below the England average for age standardised 2 week wait cancer referrals by 33%

- Cancer screening coverage rates:
  Improve Breast screening coverage for persons aged 50 – 70 from 79%
  Improve Cervical screening coverage for women aged 25 – 64 years from 82.19%
  Improve cervical screening coverage for women aged 25 – 49 years from 78.2%
  Improve cervical screening coverage for women aged 50 – 64 years from 79.9%

- Improve Cancer survival rates for 1 year and 5 years from:

	1 year (baseline 05/08)	5 years (baseline 01/04)
Colorectal	70.8	43.3
Breast	94.1	82.5
Lung	25.3	6.6

What will the benefits be?

- Improved cancer mortality rates for the Barnsley community
- Reduced variation in mortality and screening uptake across the borough
- Improved symptom awareness
- Increased life expectancy
- Reduced health inequalities

Is the priority aligned to the Health and Wellbeing Strategy?

Cancer is identified as one of the priority areas in the Health and Wellbeing Strategy. Actions and outcomes identified in this plan are aligned with those included in the health and Wellbeing Strategy.

Will the actions reduce health inequalities?

By reviewing variation in performance across providers and undertaking targeted activities health inequalities should be reduced.

Priority 2 – Cardiovascular Disease

What is the rationale for this priority?
Cardiovascular disease has been selected as a priority for the CCG. The Joint Strategic Needs Assessment identified Cardiovascular disease as the leading cause of death in Barnsley, and the second leading cause of death in those aged under 75 years. The majority of these deaths from coronary heart disease and stroke. Whilst improvements are being made locally, Barnsley has a significantly higher premature CVD mortality rate compared to the national average. Barnsley health community compares unfavourably to the England median and similar CCGs in the under 75 mortality rate from cardiovascular disease and potential years of life lost from causes amenable to healthcare.
What are the key actions?

		Key Actions
Preventing	2.1	Targeted work with public health to promote healthy lifestyles
	2.2	Review the practice variation of the implementation of the NHS health checks programme ensuring that people at high risk of, or with previously undiagnosed cardiovascular disease are identified and work is taken to address. (This will be in conjunction with the Local Authority who will be responsible for commissioning NHS health checks from April 2013)
	2.3	In conjunction with public health, carry out a cardiovascular mortality audit to help deliver a more systematic secondary prevention of cardiovascular disease
	2.4	Develop and agree an atrial fibrillation local enhanced service
	2.5	Re-run the GRASP AF tool and review patients who are not on warfarin or appropriate anticoagulation treatment to ensure optimal medication to reduce the risk of stroke.
Diagnosing	2.6	Targeted activities in deprived communities to improve symptom awareness
Treating	2.7	Ensure all patients with a previous cardiovascular disease event are treated appropriately with a beta blocker, aspirin, an ACE inhibitor, and statins where clinically indicated
	2.8	Undertake a health equity audit of critical cardiovascular disease services such as primary angioplasty to ensure that all patients have equitable access to treatment
	2.9	Maximise appropriate treatment for those with diagnosed hypertension
	2.10	Treat all patients aged over 65 and with a diagnosis of atrial fibrillation with appropriate anticoagulants according to CHAD score or newer agents
	2.11	Take action to reduce HbA1c by one unit in all diabetic patients with an HbA1c greater than 7.5
Pathway Development	2.12	Develop Cardiology Care commissioning standards for emergency and non-urgent admissions
	2.13	Increase the numbers of patients completing the cardiac rehabilitation programmes

End of life	2.14	To ensure the End of Life pathway is embedded as part of Cardiovascular Care
Patient and Public Engagement	2.15	Work in partnership with public/patients of Barnsley

What are the outcomes that we expect to achieve?

- Reduce the under 75 Mortality rate from cardiovascular disease from the 2011 baseline rate of 89.6 per 100,000 population
- Increase % of patients aged over 65 and with a diagnosis of atrial fibrillation with appropriate anti-coagulants according to CHAD score or newer agents to 66%
- Increase the number of people who have had a stroke who are admitted to an acute stroke unit within four hours of arrival to hospital from the quarter 3 2012/13 baseline of 68.6% to the target of 90%
- Increase the number of people who have had a stroke who receive thrombolysis following an acute stroke, baseline to be identified in 2013/14
- Maintain the number of people who have had a stroke who are discharged from hospital with a joint health and social care plan of 100%, ensuring that the target of 85% continues to be achieved
- Maintain current performance levels of 100% of people who have had a stroke who receive a follow up assessment between 4 – 8 months after initial admission
- Increase the % of people who are offered and receive health checks ensuring that at least 20% of eligible people are offered checks and 12% of eligible people receive checks during 2013/14

What will the benefits be?

- Reduced cardiovascular disease mortality rates
- Reduced health inequalities
- Increased life expectancy
- Increased symptom awareness

Is the priority aligned to the Health and Wellbeing Strategy?

Cardiovascular disease is identified as one of the priority areas in the Health and Wellbeing Strategy.

Actions and outcomes are aligned with the Health and Wellbeing Strategy.

Will the actions reduce health inequalities?

By reviewing variation in performance across providers and undertaking targeted activities health inequalities should be reduced.

Domain 2 - Enhancing the quality of life for people with long-term conditions

NHS Barnsley CCG will work through the Health and Wellbeing Board to:

- Provide person-centred integrated care for people with long-term conditions through improvements in primary care;
- Put patients in charge and having ownership of their care through personalised care plans and budgets and ensure coordination and continuity of their care.

Using the information included in the Outcomes Benchmarking support pack along with local intelligence the following priorities and actions have been identified in relation to this domain:

Priority 3 - Long Term Conditions

What is the rationale for this priority?

The Joint Strategic Needs Assessment identifies that there is a growing and increasingly elderly population. There are approximately 231,900 people living in Barnsley. This is projected to increase to 238,500 by 2015 and to 248,600 by 2021. Interim projections show that the largest projected increase is likely to be those aged over 65 (increasing by 20.9% in 2021). 20% of the total population will be aged over 65 in 2021.

There are an estimated 23,611 people over the age of 65 years with a limiting long term illness, this is projected to rise year on year up to 2015 when the estimate will be at 25,237, this alongside the general elderly population growth rate at 3% year on year will have a significant burden on both health and social care services.

The NHS mandate identifies dementia as a key priority area for organisations.

Long term conditions have been identified as one of the Quality, Innovation, Productivity and Prevention transformational programmes for the CCG.

When compared to the England median and similar CCGs, Barnsley performs badly against the following measures:

- Proportion of people feeling supported to manage their condition
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)

What are the key actions?

Long Term Conditions		Key Actions
Risk profiling	3.1	Risk stratify patients who are high intensity users of services, at risk of readmission or who have modifiable risk factors and ensure patients are referred to the most appropriate service to meet their needs as close to home as possible.
	3.2	Review risk profiling tools that amalgamate hospital, community and primary care data and procure for use in 2013/14.

Integrated teams	3.3 3.4	Develop, agree and implement a model for integrated teams that reflect the map of services accessed by high intensity users of services and supports better alignment with primary care. Develop and agree a primary care local enhanced service to ensure GP leadership of the case review and integrated care planning to ensure resources are optimally deployed.
Self-care / Shared Decision Making (including telehealth)	3.5 3.6 3.7	Continue to develop and refine pathways to ensure maximum access to telehealth support (telehealth monitoring, health coaching, care navigation and post crisis support) to ensure that patients are supported to self-care as close to home as possible and avoid the need for an unplanned admission in line with the Department of Health's 3 million lives programme. Continue to develop and refine pathways for ambulatory care sensitive conditions where we are an outlier in respect of the number of emergency admissions to hospital Develop proactive care home case management
Older People – Intermediate Tier	3.8	Implement the recommendations of the intermediate tier review
Dementia		
Information & Advice	3.9 3.10 3.11 3.12	Promote Dementia Friendly Community agenda Increase the uptake of information and advice numbers Target specific sessions to schools and education centres to be delivered through workforce development and Dementia champions Increase the number of befriending volunteers (by 20%) for users with dementia
Memory service (Assessment & Diagnosis)	3.13 3.14 3.15	Implement the recommendations of the memory service review Increase the diagnosis rate for dementia to reflect national and regional trends Undertake a comprehensive customer journey mapping exercise as well as service pathway mapping exercise to inform short term adjustments and long term reconfiguration plan
Assessment support	3.16 3.17	Evaluate the assessment process and effectiveness with carers and customers with a view to identify efficiencies within current system. Evaluate the effectiveness of link with social care for users undergoing assessment process.
Post Diagnosis support	3.18	Target and evaluate the effectiveness of post diagnosis support for users and their carers working with all commissioned services.
End Of life (Dementia)	3.19 3.20	Evaluate the current impact of the End of Life pathway on Dementia sufferers. Identify gaps and opportunities with a view to re-align intervention to reflect the needs of patients with

		Dementia as well as their carers.
Research and development	3.21	Respond to carers feedback during 2013/14 by developing strategies to provide support to existing carers and hard to reach carers to maximise opportunities
Older People – End of Life Care	3.22	Implement the national strategy 'Living and Dying Well' across Barnsley focussing on the 8 key actions for Primary and Community Care
Older People – Falls	3.23	Revise and realign the current falls strategy to reflect demand and inform any need for reconfiguration
Patient and Public Engagement	3.24	Work in partnership with public/patients of Barnsley

What are the outcomes we expect to achieve?

- Increase the proportion of people feeling supported to manage their condition from the 11/12 baseline of 54.6%
- Reduce the rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) from the 2011/12 baseline of 1268 per 100,000 population
- Improve the dementia diagnosis rates from 46.68% to 60.6% in 2013/14.

QIPP Programme	**High Level Key Performance Indicators**	
	2013/14	**2014/15**
Long Term Conditions	£ - included in unplanned care 2% reduction in ASC non-elective admissions compared to 09/10 baseline 250 staff trained in behaviour changing methodologies 25 'trainers' trained in behaviour change methodologies 9000 people supported to self care Improved patient satisfaction	£ - included in unplanned care 2.5% reduction in ASC non-elective admissions compared to 09/10 baseline 250 staff trained in behaviour changing methodologies 25 'trainers' trained in behaviour change methodologies 9000 people supported to self care Improved patient satisfaction

What will the benefits be?

- Reduced delayed discharges
- Reduced inappropriate admissions to hospital
- Increased timely access to rehabilitation services and Intermediate care beds
- Increased timely access to sub acute longer term beds
- Increased timely uptake of re-enablement service
- Integrated team working across the community
- Improved patient experience

Is the priority aligned to the Health and Wellbeing Strategy?

Older people has been identified as a priority area in the Health and Wellbeing Strategy.

Will the actions reduce health inequalities?

By reviewing variation in performance across providers and undertaking targeted activities health inequalities should be reduced.

Priority 4 - Mental Health

What is the rationale for this priority?
Performance relating to the improving access to psychological therapies measures has been a challenge during 2012/13. The measures continue to be of significant focus nationally during 2013/14 with the requirement for trajectories to be achieved. The outcomes framework and the Mandate identify the requirement for progress to be made in respect of mental health, in particular, in supporting people with mental health. The Joint Strategic Needs Assessment estimates that 29,200 adults aged 16-74 years in Barnsley have a neurotic disorder. 29,100 adults had a diagnosis of depression in Barnsley (15%); this is higher than the average for England (11.2%).

What are the key actions?

		Key Actions
Improving access to psychological therapies	4.1	Continue to implement and monitor the recovery plan to ensure improvement against performance
	4.2	Extend provision to those with physical conditions
	4.3	Review service and revise service specification
In patient provision	4.4	Review inpatient provision to ensure local provision meets local need
	4.5	Review of liaison and Home Based Treatment services
Pathways and packages of care	4.6	Agree new specifications for clusters of care
	4.7	Agree service configuration with provider
Eating disorder pathway	4.8	Children's services – transition to adult services to be considered as part of the pathway work. Children and young people should also be considered in the promotion, awareness and prevention
	4.9	Develop peer support group
	4.10	Assessment of risk and need – define the three categories of risk and need identified in the service user journey.
Autistic spectrum disorder and Attention deficit-hyperactivity disorder (ADHD) pathway implementation	4.11	Monitor and evaluate the introduction of the pilot service by South West Yorkshire Partnership NHS Foundation Trust
Commission the Black Minority Ethnic (BME) liaison service	4.12	Promote mental health and well-being within local BME communities.
Accommodation pathway work - review of service	4.13	Address concerns in relation to utilisation of provision
	4.14	Agree alternative models with provider(s)

model for community rehabilitation	4.15	Review the pathway model and consider capacity for community accommodation and rehabilitation to ensure that local provision meets local need
Patient and Public Engagement	4.16	Work in partnership with public/patients of Barnsley

What are the outcomes we expect to achieve?

- Increase the Improving access to psychological therapies recovery rate to 50% during 2013/14
- Increase the proportion of people who receive psychological therapies to 12.38% during 2013/14
- Reduced waiting times for access to the improving access to psychological therapy service

What will the benefits be if the priority is achieved?

- Improved access to psychological therapies across the borough
- Improved recovery rates from psychological therapies
- Improved patient experience
- Improved care pathway
- Improved access to mental health services for the Black Minority Ethnic community

Is the priority aligned to the Health and Wellbeing Strategy?

Although there is no specific priority relating to mental health in the Health and Wellbeing Strategy, a number of actions identified in this section will contribute to the delivery of health and wellbeing priorities.

Will the actions reduce health inequalities?

Reduced variation in access of psychological therapies which will reduce health inequalities. Improved access to mental health services for the Black Minority Ethnic community.

Domain 3: Helping people to recover from episodes of ill health or following injury

NHS Barnsley CCG will work to:

- Reduce avoidable admissions to hospitals;
- Keep people out of hospitals if better care can be delivered in a different setting;
- Ensure effective joined-up working between primary and secondary care;
- Deliver high quality and efficient hospital care and coordinate care and support post discharge
- Work with providers to invest savings in better re-ablement and post-discharge support.

Specifically, NHS Barnsley CCG has identified the following priorities and actions:

Priority 5 - Unplanned Care

What is the rationale for this priority?

There are high levels of emergency admissions and hospitalisation in the area.

Performance against the four hour waiting target in Accident and Emergency has not been at the standard specified in the NHS Constitution.

When compared to the England median and similar CCGs, Barnsley compares unfavourably against the following measures:

- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency readmissions within 30 days of discharge from hospitalisation

Unplanned care has been identified as a Quality, Innovation, Productivity and Prevention transformational programme

What are the key actions?

Key Actions	
5.1	Develop mechanisms to establish care navigation and negotiation
5.2	Develop and agree a primary care urgent care local enhanced service
5.3	Review and implement pathways for the primary care stream within A&E following the completion of the capital changes in July 2013
5.4	Review the GP out of hours contract and the location from where it is provided
5.5	Evaluate commissioning additional bookable same day appointment slots which are directly bookable from A&E
5.6	Commission a virtual ward to support patients who are at very high risk of re-admission to hospital within 30 days of discharge
5.7	Implement phase two of the Barnsley Urgent Care Centre to encompass the development of pathways for emergency ambulatory care conditions to be managed on the observation ward in the emergency department
5.8	Review the efficacy of the local pathway for frail elderly people to facilitate rapid assessment, care planning and early supported discharge

5.9	Implement the recommendations of the intermediate tier review
5.10	Evaluate the local NHS111 pathway in respect of patient flow and access to the right care first time
5.11	Further integrate the Home Assessment and Reablement service with the Hospital at Home service.
5.12	Work in partnership with public/patients of Barnsley

QIPP Programme	**High Level Key Performance Indicators**	
	2013/14	**2014/15**
Urgent Care	£1.0 m (linked to long term conditions also) Non-elective FFCEs 31,040 Patient satisfaction – Friends and Family baseline	£0.09 m(linked to long term conditions also) Non-elective FFCEs TBC Patient satisfaction – Friends and Family 2% improvement on baseline TBC

What are the outcomes we expect to achieve?

- Reduce the emergency admissions rate for acute conditions that should not usually require hospital admission from the 2011/12 baseline of 1270 per 100,000 population
- Reduce the percentage of Emergency readmissions within 30 days of discharge from hospitalisation from the 2010/11 baseline of 12.3%
- Reduce the non-elective admission rate from the 2011 baseline of 148 per 1000 population

What will the benefits be?

- Reduced emergency admissions and readmissions to hospital
- Reduced A&E attendances
- Reduced non-elective admission rates
- Reduced practice variation in relation to A&E attendances
- Joined up working between primary and secondary care providers
- Improved patient experience

Is the priority aligned to the Health and Wellbeing Strategy?

A number of the actions identified are linked to the older people's priority included in the Health and Wellbeing Strategy.

Will the actions reduce health inequalities?

By reviewing variation in performance across providers health inequalities will be addressed. In addition, the redesign of care pathways will improve patient flow through the system.

Priority 6 - Planned Care

What is the rationale for this priority?

NHS Barnsley CCG compares unfavourably to similar CCGs in relation to outpatient activity, planned procedures, and Patient Reported Outcomes Measures, specifically the total health gain assessed by patients for hip replacements, knee replacements.

Planned care has been identified as a Quality, Innovation, Productivity and Prevention programme.

What are the key actions?

	Key Actions
6.1	Ensure that demand management initiatives are underpinned by educational support and peer review to reduce first outpatient appointments and subsequent treatment
6.2	Continue work to reduce outpatient first to follow-up rates and improve day case rates by converting elective activity to day cases and day cases to outpatient appointments
6.3	Pilot virtual clinics to reduce face to face consultations in hospital
6.4	Review the referral criteria list for procedures of limited clinical value
6.4	Support more choice for patients through the further use of any qualified provider contracts
6.5	Review clinical pathways including ophthalmology and the clinical assessment service (CAS)
6.6	Work in partnership with public/patients of Barnsley

What are the outcomes we expect to achieve?

Improve the total health gains assessed by patients for hip replacements from the 2010/11 – 2011/12 baseline of 0.37
Improve the total health gains assessed by patients for knee replacements from the 2010/11 – 2011/12 baseline of 0.30
Improve the total health gains assessed by patients for groin hernias from the 2010/11 – 2011/12 baseline of 0.10
Reduce the elective admission rate from the 2011 baseline of 149 per 1000 population

QIPP	High Level Key Performance Indicators	
	2013/14	**2014/15**
Planned Care	£1.97 m First out-patient attendances 95,585 Outpatient day cases TBC	£2.07 m First out-patient attendances TBC Outpatient day cases TBC

What will the benefits be?

- Reduced elective admissions
- Reduced first outpatient attendances
- Reduced outpatient follow up ratios
- Improved patient experience

Is the priority aligned to the Health and Wellbeing Strategy?

Will the actions reduce health inequalities?

By reviewing referral patterns and reducing variation in performance across providers, health inequalities will be addressed.

The remaining priority that the CCG has identified is in relation to maternity / children. Although this doesn't sit specifically within any of the 3 outcomes

framework domains identified above, the actions identified in relation to teenage health may impact on all 3 domains.

Priority 7 - Maternity/Children

NHS Barnsley CCG will work closely with Barnsley Metropolitan Borough Council and providers of commissioned services to improve the health outcomes of children.

What is the rationale for the priority?

In terms of young people, 29.9% of males and 30.1% of females in Year 10 reporting drinking alcohol often or daily; this shows a slight decrease from the 2008 data when 32.6% of males and 39% of females were drinking alcohol often or daily. Furthermore, during the period 2008/09 – 2010/11 Barnsley had a significantly higher rate of under 18s alcohol specific hospital admissions when compared to the England average.

Childhood obesity remains a problem in Barnsley; especially amongst Year 6 children. Obesity is a significant risk factor for poor health in later life.

The under 18 conception rate in 2010 was 55.2 per 1000 girls aged 15-17, representing an unwelcome increase; the rate is now the highest in South Yorkshire. Although Barnsley's annual rate has fallen since 1998, it remains higher than the regional and England averages. The most recent figures for 2008-10 (three year rolling average) show that the rates in Barnsley have increased slightly; now at 53.2 per 1000 15-17 year old girls. The annual rates roughly equate to approximately 220 conceptions to women under the age of 18 in Barnsley every year.

What are the key actions?

	Key Actions
7.1	Action all relevant recommendations identified in the OFSTED / Care Quality Commission action plan, particularly in relation to looked after children and safeguarding
7.2	Update the teenage health strategy particularly in relation to teenage pregnancy, lifestyle factors such as alcohol, diet and smoking to identify any actions that can be taken to improve the current outcome measures
7.3	Review commissioner and provider arrangements for children's services
7.4	Review arrangements of children with long term conditions and access to psychological support
7.5	Continue to evaluate the stronger families approach with a view, subject to evaluation, to rolling out stronger families across the borough
7.6	Consider the recommendations in the special educational needs green paper in relation to the integrated children's disability service
7.7	Review children's continuing health care arrangements
7.8	Work in partnership with public/patients of Barnsley

What are the outcomes we expect to achieve?

- Improvement in the under 18 conception rate from the 2010 baseline of 55.2 per 1000 female population aged 15 – 17 years
- Reduce excess weight in 4-5 year olds from the 2010/11 baseline of 21.35% and in 10-11 year olds from the 2010/11 baseline of 33.93%

- Reduce the Smoking prevalence in under 15 year olds from the 2011 baseline of 8.5%
- Reduce the rate of hospital admissions from alcohol for under 18s from the 2010/11 baseline of 87.7 per 100,000
- Reduce the rate of hospital admissions (alcohol specific) per 100,000 population from the 2010/11 baseline of 217.07 for females and 546.52 for males
- Reduce the rate of hospital admissions (alcohol attributable) per 100,000 population from the 2010/11 baseline of 972.46 for females and 1847.47 for males
- Reduce the rate of unplanned hospitalisation for asthma, diabetes and epilepsy in under 19's from 383 per 100,000 population
- Reduce the Emergency admissions rate for children with Lower Respiratory Tract Infections (LRTI) from the 2011/12 baseline of 502

What will the benefits be?

- Reduced teenage conception rate
- Reduced smoking prevalence in under 15s
- Improved childhood obesity levels
- Reduced hospital admissions for under 18s

Is the priority aligned to the Health and Wellbeing Strategy?

Children's health has been identified as an area of focus in 2013/14 in the Health and Wellbeing Strategy, particularly targeting the health and wellbeing of young people (aged 13 to 19) sexual health and relationships, addressing risky behaviours (misuse of alcohol and other substances) and ensuring that the health needs of children in care are met effectively.

Actions identified by the CCG are fully aligned with the Health and Wellbeing Strategy.

Will the actions reduce health inequalities?

Through close partnership working we can reduce health inequalities. Through working with Barnsley Metropolitan Borough Council, and our provider colleagues we can:

Reduce childhood obesity
Reduce teenage pregnancy
Reduce smoking prevalence

Domain 4 - Ensuring people have a positive experience of care

NHS Barnsley CCG will:

- deliver rapid comparable feedback on the experience of patients and carers;
- build capacity and capability in providers and commissioners to act on patient feedback;
- assess the experience of people who receive care and treatment from a range of providers in a coordinated package.

The CCG Outcomes Benchmarking Support Pack identified the following outcome measures relating to this domain:

- Patient experience of primary care – GP services and GP Out of Hours services
- Patient experience of hospital care.

NHS Barnsley CCG scores well when compared to the England median and similar CCGs against all three measures.

Through the review of existing sources of feedback (including the Friends and Family Test) a business intelligence approach will be adopted to effectively collate and triangulate the data to ensure it is shared in an easily accessible format and timely manner. Where necessary duplication of feedback collection will be challenged and new methods adopted, most importantly the focus will be on ensuring that the feedback is appropriately acted upon – to praise as well as remediate – and that such actions are also publicised to give the public confidence in the efficacy and integrity of the process.

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

The CCG Outcomes Benchmarking Support Pack identified the following outcome measures relating to this domain:

- Incidence of healthcare associated infection (HCAI) – MRSA and C-Difficile.

NHS Barnsley CCG compares unfavourably to the England median and similar Clinical Commissioning Groups against both measures.

The CCG will aim to reduce the incidence of clostridium difficile in all providers in the health economy and will aim to deliver zero tolerance to MRSA infection.

As part of its Patient Safety Governance, the CCG already has an established Root Cause Analysis process. This will be reviewed to ensure it is effective to enable timely and robust actions to be taken to address root causes. In addition work will be undertaken to preventatively and routinely review care delivery to ensure that best practice is embedded.

The NHS Commissioning Board has developed, in conjunction with other commissioners, a quality assurance dashboard which will be scrutinised by the Quality and Patient Safety Committee of the CCG and will provide assurance in relation to commissioned services to identify potential safety failures in providers.

The 3 Local Priorities

In 2014 CCGs will be eligible for a quality premium payment based on performance in 2013. To qualify for the payment, CCGs should have no significant in-year quality failures, should meet the NHS constitution rights and pledges and should not overspend its resource limit. In addition CCGs are required to demonstrate improvement or achievement of high standards against seven measures, four of which are nationally mandated and three which should be locally determined by CCGs.

The four nationally mandated measures are:

- Potential years of life lost from causes considered amenable to healthcare
- Avoidable emergency admissions
- The Friends and Family Test
- Incidence of Health Care Acquired Infections (MRSA and Clostridium Difficile)

The three measures identified by NHS Barnsley CCG are:

Locally Identified Measure	**Required Improvement**	**Rationale for Selection**
Increasing % of patients aged over 65 and with a diagnosis of atrial fibrillation with appropriate anti-coagulants according to CHAD score or newer agents	The rate identified to be delivered in 2013/14 is 66%.	Needs assessment information shows that cardiovascular disease is the leading cause of death in Barnsley This is a priority area identified by the CCG This is also a priority area for the Health and Wellbeing Board
Reducing variation above or below the England average for age standardised 2 week wait cancer referrals	The reduction in variation rate identified to be delivered in 2013/14 is 33%.	Needs assessment information shows that is the second leading cause of death in Barnsley This is a priority area identified by the CCG
Improving dementia diagnosis rate	The rate identified to be delivered in 2013/14 is 60.6.	Benchmarking information shows that Barnsley has a lower dementia diagnosis rate when compared to other CCGs This is a priority area identified

		by the Health and Wellbeing Board

If improvement is realised against the above measures this will go some way to addressing a number of local issues that have been identified both by the CCG and the Health and Wellbeing Board. The measures selected are where the performance against these outcomes compares unfavourably to others and if improvement is made this in turn will contribute to reduced health inequalities.

In relation to the local priority measures that have been identified as annual (the mortality measures), NHS Barnsley CCG is working with public health colleagues to identify proxy measures that can be measured in year. This will provide the CCG with the assurance that improvements are being made against the identified measures prior to the annual data being published.

Section 5 - NHS Barnsley Clinical Commissioning Group Enablers

The CCG has identified a number of enablers which are fundamental to the success of the organisation and to the priorities being achieved.

Patient and Public Engagement

What is the rationale for this priority?
Patient and public engagement and excellent communication lies at the heart of the CCG's vision and values. The CCG has made a commitment to be an exemplar in patient and public engagement. As a new organisation this gives the CCG an opportunity to translate that intention into a meaningful set of actions and outcomes.
What are the key actions?
Develop the OPEN brand Develop the OPEN brand to be transparent, inclusive and to encourage empowerment. For 13/14 the aim is to grow this network in partnership. Specifically the focus for this year will be on shaping how OPEN works across the Barnsley community, embedding it throughout CCG workstreams and growing patient and public involvement in by recruiting patients and the public to levels one, two and three. Level one being a receiver of information through to level three where patients are directly involved in service redesign for example. **Work with local commissioners and providers to develop a joint approach** Developing OPEN in partnership with local commissioners and providers builds mutual trust and brings benefits to the people of Barnsley. As part of the partnership approach of OPEN the CCG will look at how GP practice patient reference groups can contribute to that. HealthWatch will be central to developing patient and public engagement in CCG commissioned services. 13/14 will be its first year in existence, building on the previous work of LINKs **Review current health engagement tools** Recognising that shared decision making leads to better patient outcomes, there are number of areas where this work can be progressed in 13/14. One of those will be to promote shared decision making through the delivery of a primary care education session. In addition, there are a number of products both on the market and in development that facilitate and encourage a move to self-care, where clinically appropriate and where there is an appetite form patients and carers. This piece of work will investigate digital technologies which can deliver an improved experience for patients and carers.

Aligned to this will be the development of a set of metrics and innovative ways of measuring engagement activity, whether that is an individual's role in their own health decisions through to the wider role of public consultation.

Develop a digital media strategy
Development of a digital media strategy will include both the CCG's use of web and mobile based applications and methods to communicate and engage. Included in this will be the use of social media to promote long term condition management campaigns.

As part of the development work the CCG will investigate the benefits of working closely with both our commissioning and provider partners.

Develop channels for real time communication with patients
Real time communication with patients has the potential to offer benefits to both patients in terms of an improved experience and to the CCG in terms of self care, gathering insights and improving engagement.

What are the outcomes we expect to achieve?

- Achievement of CCG objectives

What will the benefits be?

- Improved reputation of the CCG with patients, public, members, staff and partners
- Improved patient and public involvement in the designing, developing and decision making of CCG commissioned services, leading to a better patient experience and health outcomes

Is the priority aligned to the Health and Wellbeing Strategy?

The Health and Wellbeing strategy is reliant for implementation on the effectiveness of individual members. By increasing the role of patients and public in our decision making process we will become more effective partners.

Will the actions reduce health inequalities?

Becoming a highly effective commissioning organisation will allow us to make progress on a range of organisational priorities including reducing health inequalities

Organisational Development

What is the rationale for this?
Particularly as a new organisation, Organisational Development is rightly recognised as an important area. Everybody who works for the CCG is in a new role and is operating in a different sort of organisation. The CCG can only be as effective as the ambition effort skills and experience of its leaders and staff. Organisations with effective Human Resource processes and a high skilled and motivated workforce are shown to have high levels of organisational performance/better outcomes.

What are the key actions?

	Structure	Strategy	Style	Staff	Skills	Systems	Shared Values
• Develop and implement a high quality protected learning time programme for 2013/14 aligned to CCG priorities.					✓		
• Ensure that CCG staff are fully compliant with mandatory training requirements.				✓	✓		
• Maximise the opportunities for training funded by the Yorkshire and Humber Local Education and Training Board				✓	✓		
• Maximise the opportunities for professional development including those available via local universities				✓	✓		
• Developing our members as commissioners and providers by offering a range of Organisational Development diagnostic tools and then supporting an appropriate range of Organisational Development interventions. Practice Managers should be a particular focus of our efforts recognising the pivotal role they play in the delivery of high quality primary medical services.					✓		✓
• All staff and governing body members to have agreed personal objectives and a supporting personal development plan for 2013/14.				✓	✓		
• Progress to be monitored through a series of not less than six monthly review meetings.				✓	✓		

• Implement a robust programme and project management approach to assure delivery of the CCG's objectives within the context of the wider needs of the Barnsley health and social care economy / landscape.				✓	✓	✓	
• Clarity over strategic direction to influence health and wellbeing strategy	✓						✓
• Review organisation structure to ensure fitness for purpose.	✓	✓	✓	✓	✓	✓	✓
• Highly participative staff engagement programme.		✓	✓				

What are the outcomes we expect to achieve?

- Achievement of CCG objectives

What will the benefits be?

- Clarity of ways of working including respective roles, consistency of approach.

Is the priority aligned to the Health and Wellbeing Strategy?

The Health and Wellbeing strategy is reliant for implementation on the effectiveness of individual members. By developing our capability to deliver we will become more effective partners.

Will the actions reduce health inequalities?

Becoming a highly effective commissioning organisation will allow us to make progress on a range of organisational priorities including reducing health inequalities.

Partnership Working

What is the rationale for this priority?

There is nothing of any significance that the CCG can achieve working in isolation. Developing robust and effective relationships with a wide range of health, public, private, and voluntary sector partners is an important priority especially in our first year. It represents one of the necessary foundation blocks upon which many other activities can then be built.

What are the key actions?

Health and Wellbeing Board

- Develop a strategy for Health and Wellbeing in Barnsley which is consistent with CCG views, reflective of the wishes of the people of Barnsley and provides a framework for the delivery of integrated services.
- Understand partner plans and priorities to ensure maximum alignment and that individual organisation level decisions are made in full knowledge of the impact on all partners.
- As a member of the Home Truths programme, work with the Board and other local authority participants to strengthen joint working between general practice and the Council.

Barnsley Hospital NHS Foundation Trust (BHNFT)

- Through collaboration and a developing understanding of secondary care, assure ourselves of BHNFT cost improvement measures.
- Working with commissioners and providers across South Yorkshire and Bassetlaw explore the most appropriate disposition of hospital services to ensure safe sustainable and local hospital services are maintained and developed.
- Support BHNFT transformation by ensuring that projects that span across hospital boundaries are successful.

Primary / Community Care Providers

- Working with South West Yorkshire Partnership Foundation Trust and other partners, establish and develop high performing teams delivering effective primary health and social care services.
- Supporting the NHS Commissioning Board to assure a smooth transition from Primary Care Trusts to the NHS Commissioning Board. Thereafter use data and intelligence to drive improved outcomes and consistency
- Support the co-production of a primary care strategy for South Yorkshire and Bassetlaw.

Voluntary Sector

- Develop an action plan to work with the voluntary sector to include capacity building, promoting self-care and a commitment to broaden the role of the voluntary sector in delivering commissioned services.
- Support Carers.

What are the outcomes we expect to achieve?

- Reduction in the rate of premature and avoidable death in part by encouraging consistency.
- Promoting self-care leading to more resilient communities
- Reducing health inequalities across Barnsley and preventing the gap between Barnsley and the rest of England from widening.

What will the benefits be?

- Maximising the use of the Barnsley pound by ensuring it is spent collectively against agreed priorities, and not wasted through duplication of effort.
- Increasing the effectiveness of our direct efforts by harnessing the commitment / resources of others.
- Shaping our own plans so that they are genuinely innovative - most innovation comes from providers.

Is the priority aligned to the Health and Wellbeing Strategy?

The strategy seeks to align the efforts of organisations across Barnsley. Effective relationships / robust challenge / mutual accountability is the only route to success.

Will the actions reduce health inequalities?

Many of the causes of and solutions to health inequalities lie outside the direct control of the CCG. Working in partnership particularly with Barnsley Metropolitan Borough Council via the Health and Wellbeing Board and the voluntary sector in Barnsley is the principal way in which health inequalities can be addressed.

Medicines Optimisation

What is the rationale for this priority?

Medicines optimisation has been identified as a Quality, Innovation, Productivity and Prevention programme. Activities identified are in line with the National Medicines Management and procurement Quality, Innovation, Productivity and Prevention strategy

The outcomes benchmarking support pack identifies the CCG to have a high prescribing spend rate when compared to similar CCGs and the national average for:

- Circulation
- Respiratory
- Endocrinology
- Mental Health

What are the key actions?

Therapeutic Area		Key Actions
Gastrointestinal	10.1 10.2	PPI reviews - increasing use of low cost PPIs (choice of drug and formulation) and step down. Additionally changes from Gaviscon® Advance to Peptac®, Movicol® to Laxido® and laxative reviews
Cardiovascular	10.3 10.4 10.5 10.6 10.7 10.8 10.9	Managed implementation of new anticoagulants e.g. Rivaroxaban in line with NICE guidance and local shared care guidance and Grasp AF audit. Statin reviews/switches including Ezetimibe Omacor® review ACE1 A2RA review/switches – use of low cost A2RAs or ACEIs first line. Additionally Reviews of Aliskiren, Clopidogrel/Prasugrel, Ticagrelor, ISMN MR and Doxazosin MR.
Respiratory	10.10	Inhaler devices reviews and high dose inhaled corticosteroid review/step down including use of Incheck training devices
Central Nervous System	10.11 10.12 10.13 10.14	Review of analgesics, particularly opioid prescribing i.e. transdermal buprenorphine and fentanyl patches, but also Pregabalin and soluble formulations and analgesic line in therapy. Antidepressant reviews (NICE/MHRA) (Venlafaxine MR capsules, citalopram/escitalopram) Review of antipsychotics in dementia Additionally reviews of Benzodiazepine/Z Drugs, Orlistat, Olanzapine, Triptans and Domperidone.
Infections	10.15 10.16	Review of antibiotic prescribing against formulary – choice and duration, particularly Minocycline Flucloxacillin 250mg/5ml usage and Quinolone.
Endocrinology	10.17	Review of test strip use in T2DM

	10.18 10.19	Managed introduction of newer hypoglycaemics and insulin analogues in line with national guidance. Additionally reviews of Bisphosphonates, Prednisolone e/c, erectile dysfunction drugs and Metformin solution.
Obstetrics, gynaecology and urinary tract disorders	10.20 10.21	Prescribing cost effective brands of oral contraceptives Additionally review of Tamsulosin tablets vs capsules
Nutrition and blood	10.22 10.23 10.24	Sip feed review Gluten free prescribing review Additionally reviews of Ferrous sulphate and dispersible calcium and vit D preps.
Musculoskeletal	10.25 10.26	Review of NSAIDs including topical preparations Additionally glucosamine review
Other areas	10.27 10.28 10.29 10.30 10.31 10.32 10.33 10.34	Waste Campaign, including implementation of Community Pharmacy Waste pilot Nursing home review pilot Review of dressings against wound care formulary, particularly silver dressings and vacuum dressings. Central purchase of vacuum dressings and first line dressing products. Review of medicines prescribed in primary care against national and local guidance, i.e. Red and Grey list drugs. Review use of unlicensed specials (in line with local specials guidance and Drug Tariff Generic versus brand prescribing; Potential generic savings (including brand to generic switches for recent and forthcoming patent expiries) and Generic to brand prescribing for drugs which should be prescribed by brand (e.g. lithium, ciclosporin, tacrolimus etc) Maximising use of ScriptSwitch software Use of Eclipse live software

What are the outcomes we expect to achieve?

- Quality, Innovation, Productivity and Prevention savings, 2013/14 - £1.35m, 2014/15 - £1.35m
- Improved prescribing spend rates from the 2011 baseline of an average of £100 per person

What will the benefits be?

- Maintaining or improving quality of prescribing whilst at same time increasing efficiency and delivering savings

Is the priority aligned to the Health and Wellbeing Strategy?

A number of the medicines optimisation key actions are linked to the Health and Wellbeing Strategy key priorities, for example, cardiovascular disease.

Will the actions reduce health inequalities?

By undertaking the activities identified above, variation will be reduced in prescribing across the patient pathways.

Innovation &Technology

What is the rationale for the priority being selected?
I M & T will enable many of the CCG's proposed developments to be delivered.
What are the key actions that will be undertaken?
Information Management and Technology IM & T is a crucial element of the CCG's plans going forward. The CCG recognises that a plan encompassing all the required developments will need to be in place early in 2013/14. In developing the plan the CCG recognises the need to ensure that patient expectations are met, and the NHS Information Strategy 'The Power of Information' has set out a number of national developments related to this, such as the development of electronic care records shared between practitioners and accessible by the patient. The development of broader technological mechanisms such as telehealth and telecare will be reviewed and new developments included within the plan. The Governments ambition to provide a single comprehensive online 'portal' to enable health, care, support and public health information to be shared, has the potential to support greater and closer joint working across Barnsley. This is likely to be a key strand of the plan for 2013/14. In the short term it will be crucial to ensure that the existing systems and hardware continue to effectively support the health community through the transition into new organisations. A review of mobile working technology will take place early in 2013/14 in order to provide adequate support to CCG staff and GP's. Below are some specific developments where implementation will continue into 2013/14. • Electronic prescription service – The roll out of this commenced, February 2013. Pairing of pharmacies and GP practices has commenced and will be included in the first tranche of the development. • Migration of GP practices to IT systems providing a summary case record. Currently Barnsley has 48% of the population coverage for summary case record. Discussions with GP practices are ongoing to enable practices using EMIS web to upload SCR during 2013/14.
What are the outcomes we are hoping to achieve?
• Patients able to access telehealth and telecare to prevent admissions to hospital and enable earlier detection of issues. • Sharing of information between clinicians and social care to enable more informed diagnosis and treatment.
What will the benefits be if the priority is achieved?
• More efficient and effective health services
How is the priority aligned to the Health and Wellbeing Strategy?
I M & T supports the Health and Wellbeing Strategy to be delivered effectively.
How will the actions reduce health inequalities?

Section 6 - The Basics of Care

Patient experience, patient safety and clinical effectiveness is of the highest importance for the CCG. Whilst the catalyst for driving quality improvement is framed by the NHS Outcomes Framework and the Francis Report, the CCG will continue to develop, in conjunction with its partners, an approach of innovation, challenge and assurance.

Our approach in 2013/14 will be to continue to ensure that robust systems are in place to provide high quality seamless health and social care services across Barnsley, much of this will be achieved through our various commissioning arrangements. These include our joint commissioning arrangements with the Local Authority, the Children's and Young People's Trust and Specialised Commissioning arrangements.

Cost Improvement Programmes

As part of our contracts with providers the CCG will require any cost improvement programmes to have explicit sign off by the relevant Medical and Nursing Directors and evidence of this provided to demonstrate services are safe for patients with no reduction in quality and do not contravene NICE guidance. In addition work will be undertaken to prophylactically and routinely review care delivery to ensure that best practice is embedded.

Reporting Arrangements

NHS Barnsley CCG has robust arrangements for assuring patient safety, patient experience and clinical effectiveness.

The CCG has established a committee reporting to the Governing Body known as the Quality and Patient Safety Committee. The Committee is responsible for establishing and maintaining effective systems to monitor Quality and Patient Safety for the services the CCG commissions.

The Committee will receive regular reports in respect of patient safety, experience and clinical effectiveness. The Committee will also ensure that mechanisms for concerns about quality and safety issues, patient feedback and underperformance are in place and working and that action is taken to ensure that any concerns are addressed to ensure that high quality of care are delivered.

Where it is felt that quality of care is being compromised, this will be escalated to the Governing Body and through the Quality Assurance Framework.

Monitoring of Providers
(Including NHS independent and voluntary sector)

NHS Barnsley CCG has a range of mechanisms for gaining quality assurance and to drive quality improvement in the delivery of care through its own governance processes.

Contract/Clinical Quality Performance Review Meetings

Each of the main NHS provider contracts held by the CCG for provision of health services has a robust contract monitoring mechanism to support it. The following areas are reviewed on a regular basis:

- Performance against national targets
- Use of professional evidence based practice such as NICE guidance
- Levels of patient satisfaction/experience including complaints and other data
- Compliance with Care Quality Commission essential data standards of quality and safety
- Mechanisms to manage risk
- Results from staff engagement surveys
- Patient Safety Thermometer data
- Patient safety measures

The quality reporting schedules, which are included in the provider contracts, have been developed for 2013/14 ensuring that significant areas in relation to the quality agenda have been included. These schedules have also included the requirement for providers to identify how they have considered the Francis report recommendations.

Quality Assurance Framework

The CCG has robust quality assurance processes in place to ensure people have a positive experience of care and that they are treated and cared for in a safe environment that protects them from avoidable harm.

The quality assurance framework describes our approach to assuring quality in all our commissioned services and it specifically applies to all commissioned NHS and Independent Providers. Patient safety, clinical effectiveness and patient experience will be monitored through routine internal contractual processes and clinical governance structures and external sources such as Care Quality Commission, MONITOR, peer reviews, national surveys etc.

Where serious concerns are identified a structured and purposeful Quality Assurance Visit (Appreciative Enquiry) to the Trust may be required to enable further scrutiny to take place.

Section 7 - Patients' Rights: The NHS Constitution

The table below contains detailed information on how the CCG plans to deliver the rights and pledges identified in the NHS Constitution 2013/14.

Measure	2012/13 Performance	2013/14 Plans
⅄ 90% of admitted patients to start treatment within a max of 18 weeks from referral ⅄ 95% of non-admitted patients to start treatment within a max of 18 weeks from referral ⅄ 92% of patients on an incomplete non-emergency pathway (yet to start treatment) should have been waiting no more than 18 weeks from referral	During 2012/13 performance against the above referral to treatment waiting times for non-urgent consultant-led treatment measures exceeded the trajectory.	The measures have been included in the quality schedule of the contract and if the provider fails to deliver the targets contractual penalties will be enforced. A monitoring process to identify any potential long waits in the system has been implemented. However, in the event that a patient for any referral to treatment waits more than 52 weeks, a zero tolerance approach will be adopted and will apply contractual penalties against the relevant provider.
⅄ 99% of patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral.	Performance against the above diagnostic waiting times measure exceeded the trajectory.	The measure has been included in the quality schedule of the contract and if the provider fails to deliver the target contractual penalties will be enforced.
⅄ 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department.	Performance against this target proved challenging at Barnsley Hospital NHS Foundation Trust particularly from quarter 3 onwards. A remedial action plan was produced by the Trust to remedy the situation.	An extensive capital build is underway focussed around the Emergency Department to improve the flow of patients through the system of which the benefits of this redevelopment will not be realised until early in 2013/14. The measure has been included in the quality schedule of the contract and if the provider fails to deliver the target contractual penalties will be enforced.
⅄ No patient to wait on a trolley for longer than 12 hours.	In relation to Barnsley registered patients during 2012/13 no patient waited on a trolley longer than 12 hours	The CCG will enforce contractual penalties on the provider if a patient waits longer than 12 hours on a trolley in 2013/14.
⅄ 75% Cat A calls resulting in an emergency response arrive within 8 minutes (met for red 1 and red 2 calls separately) ⅄ 95% Cat A calls resulting in an ambulance arriving at the scene within 19 minutes	Performance against the ambulance measures exceeded the trajectories.	To ensure that these targets continue to be met in 2013/14 it is planned to commission additional service capacity.
⅄ All handovers between an ambulance and an A&E department to take place within 15 minutes and crews ready to accept new calls within further 15 minutes	Not applicable for 2012/13	The measures are new for 2013/14 and will be monitored via the relevant contracts. Penalties will be implemented for all delays with the appropriate provider.
⅄ 93% max 2 week wait for first outpatient for patients referred urgently with suspected cancer by a GP ⅄ 93% max 2 week wait for first outpatient for	Performance against the cancer waits - 2 week wait measures exceeded the trajectories	Additional capacity at Barnsley Hospital NHS Foundation Trust has been introduced to ensure continued achievement against this indicator. The measures are included in the quality schedule of the contract and if the

patients referred urgently with breast symptoms (where cancer was not initially suspected)		provider fails to deliver the targets contractual penalties will be enforced.
• 96% max one month (31-day) wait from diagnosis to First Definitive Treatment for all cancers • 94% max 31 day wait for subsequent treatment where that treatment is surgery • 98% 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen • 94% max 31 day wait for subsequent treatment where that treatment is a course of radiotherapy	Performance against the cancer waits – 31 days measures exceeded the trajectories	A system of Performance Management is in place to assess individual breaches against this indicator. Root Cause Analysis is undertaken for each breach and mitigating actions put in place to prevent future cases. The penalties within the contract will be applied where performance is not in line with national targets.
• 85% max 2 month (62-day) wait from urgent GP referral for First Definitive Treatment for cancer • 95% max 62 day wait from referral from an NHS Screening service for First Definitive Treatment for all cancers • Max 62 day wait for First Definitive Treatment following a consultant's decision to upgrade the priority of the patient (all cancers) - no operational standard.	Performance against the cancer waits – 62 days measures exceeded the trajectories.	A system of Performance Management is in place to assess individual breaches against this indicator. Root Cause Analysis is undertaken for each breach and mitigating actions put in place to prevent future cases. The penalties within the contract will be applied where performance is not in line with national targets.
Minimal mixed sex accommodation breaches	Performance during 2012/13 showed that the target of 0 was not achieved as a result of out of area mixed sex accommodation breaches. The organisation worked through the relevant primary care organisations to ensure no compromise to high standards continued to be achieved.	The CCG will ensure that all provider organisations it commissions services from have an Elimination of Mixed Sex Improvement plan. NHS Barnsley CCG will continue to actively monitor providers against the eliminating mixed sex accommodation guidance / plan ensuring that minimal clinically unjustified breaches are reported. The requirement to eliminate mixed sex accommodation breaches is included in the quality schedules; penalties for any occasion when breaches occur will also be included and will be enforced should there be a breach. If a breach occurs locally, this will be discussed in the root cause analysis group to determine the reasons for the breach along with identifying any actions to ensure that this does not occur again. Any occurrence of a clinically unjustified mixed sex accommodation breach

		for a Barnsley registered patient outside the Barnsley community where the NHS Barnsley CCG is not the lead commissioner will also incur a withholding of funds as per the standard contract financial penalty.
⅄ All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patients choice. ⅄ No patient to tolerate an urgent operation being cancelled for the second time.		The CCG will enforce financial penalties included in the contract if the provider fails to meet the 2 indicators.
⅄ Care Programme Approach (CPA): 95% of the proportion of people under adult mental health specialities of CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.	During 2012/13 performance against the above care programme approach measure exceeded the trajectory.	During 2013/14, providers will at least maintain the performance achieved in 2012/13. The CCG has included this target in the quality schedule of the contract and if the provider fails to deliver this target contractual penalties will be enforced.
⅄ Clinical Commissioning Groups to commission and complete full roll out of access to psychological therapies programme by 2014/15 and reach a 50% recovery rate.	The improving access to psychological therapies programme and has been commissioned and rolled out in Barnsley. Performance in 2012/13 was a challenge in relation to the recovery rate indicator. A recovery plan was developed to improve performance.	We will work with the provider to ensure that the recovery plan continues to be implemented. The following actions will be incorporated into the recovery plan for 2013/14 to help improve the recovery rate ensuring the 50% target is achieved: ▪ Develop new work streams related to NICE mapping, specifically aligning services to the national guidance on organising services for the management and treatment of mild to moderate mental health problems (CG123) ▪ Review criteria for eligibility and inclusion into service ▪ Review service opening hours, with a view to implementing an 8-8 service model through a phased approach ▪ Refreshing training strategy ▪ The development of the current counselling resource to meet the national IAPT clinical competencies for counselling The CCG will continue to seek performance improvement through regular performance monitoring with the Provider.

Keeping Our Promises: Choice and the information to exercise it

The CCG expects all providers to; publish and actively maintain current waiting times; communicate with patients regarding progress along the pathway offering choice as appropriate; communicate with commissioners; maintain directory of services; and ongoing maintenance of waiting lists.

Keeping Our Promises: Dementia/Improving Access to Psychological Therapies

The NHS constitution also identifies the requirement for CCGs to improve dementia diagnosis rates and to improve access to psychological therapies. The Improving Outcomes, Reducing Inequalities section identifies the actions that will be undertaken during 2013/14 along with the proposed trajectories for 2013/14.

Performance Monitoring Arrangements

The CCG has developed a systematic approach to monitoring progress against all indicators for which they are responsible. During 2013/14, the Governing Body and the Finance and Performance Committee of the CCG will continue to review progress against all measures identified in the national frameworks along with the quality premium measures, on a monthly basis through the Barnsley CCG Integrated Performance Report.

Where it is identified that an indicator is behind expectation, remedial / action plans will be requested from the identified lead and monitored until performance is achieving expected levels. The CCG Governing Body will receive reports highlighting areas that are challenged.

In addition the CCG Membership Council will also receive the Integrated Performance Report at each meeting.

Risks and Mitigation

NHS Barnsley CCG is committed to actively managing risks, this includes minimising risks to our patients, staff, members of the public and other stakeholders. The CCG is establishing an organisational culture to ensure that risk management is an integral part of everything we do.

Risk management is a proactive systematic process of risk identification, analysis, treatment and evaluation of potential and actual risks. The CCG has developed an assurance framework which contains high level strategic risks that pose a risk to the objectives of the organisation; it is underpinned by a risk register.

The risk register only contains the current risks facing the organisation including the risks in the Assurance Framework for which there are gaps in control or assurance, this also includes any risks identified in the delivery of the Quality, Innovation, Productivity and Prevention programmes.

The Audit Committee of the CCG, as part of the assurance it provides to the Governing Body, oversees the risk management function and ensures that systems of internal control exist and are functioning correctly. The Quality and Patient Safety Committee, in addition to the Audit Committee, is also responsible for reviewing and managing the risk register.

There is potential for significant risks within the system as we go through transition, however the robust system of risk management and governance gives confidence that any emerging risks will be identified at an early stage and mitigation plans will be implemented. The following risks have been included on the CCG risk register for 2013/14:

The trajectories for the healthcare acquired infections performance measures will continue to be challenging during 2013/14. A whole systems approach will continue to be applied, which includes acute, community, primary care, social care, public health and the Health Protection Agency to assess each case via our Root Cause analysis processes in order to identify learning and further preventative actions.

The Accident and Emergency 4 hour wait standard will continue to be a challenge to sustain 95% in 2013/14, as identified earlier in the section. The impact of the measures implemented during 2012/13 will be reviewed to identify if these are required to be continued in 2013/14.

The recent OFSTED Inspection identified a number of recommendations in relation to Looked after Children and Safeguarding, an action plan has been developed in response to the recommendations and actions are currently in the process of being implemented.

Section 8 - Patient Centred, Customer Focussed

The following section identifies how NHS Barnsley CCG intends to work with stakeholders to reform the health and social care system to deliver the five offers of the National Commissioning Board:

The CCG will be considering the implications of the Medical Director's work on NHS services across seven days each week and will actively work across the health community to deliver this transformational change.

NHS Barnsley CCG plans to engage with providers during 2013/14 to ensure that for the services it commissions, information is published on the following specialties on provider websites in the healthcare quality improvement partnership format:

- Adult cardiac surgery
- Interventional cardiology
- Vascular surgery
- Upper gastro-intestinal surgery
- Colorectal surgery
- Orthopaedic surgery
- Bariatric surgery
- Urological surgery
- Head and neck surgery
- Thyroid and endocrine surgery

NHS Barnsley CCG will explore suitable opportunities for extending its market environment during 2013/14 which will be pursued via the Any Qualified Provider process.

Listening to Patients and Increasing Their Participation

NHS Barnsley CCG adopts the need for good systematic engagement with the public, patients and staff and stakeholders which is essential so that service delivery and change is taken forward with the involvement of local people.

It is essential that there is a clear line of sight between the patient choice, shared decision making and patient experience. This has been reflected in the terms of reference across the CCG committees to ensure this practice is embedded, allowing strategic influence on the decisions made.

The CCG has developed OPEN, which stands for Our Public Engagement Network to both engage and communicate with patients and the public. This membership scheme will be refined over time to ensure the CCG is tailoring content to the requests of the members.

Joint working with key providers and their membership schemes and networks means access to a wider range of people and allows the CCG investment in areas where health inequalities will be greater or where improved engagement methods

are required.

The CCG will ensure that there is timely and effective use of the Friends and Family Test results in hospitals and that the results and the actions are made available to the public in a variety of ways.

The CCG will be making an in depth consideration of the Francis Report recommendations and will be pursuing a greater insight into the narrative of complaints about providers to add to our intelligence gathering.

Acting on Feedback

Friends and Family test feedback and any actions taken as a result will be made available to the public through a variety of channels for information. However, the intention is to use this data as part of a much wider set of insights, which will be used and analysed as part the OPEN scheme. Feedback will go to local patient reference groups, patient council and interest groups to form part of the discussion of commissioning plans. Any proposals will be fed back through the decision making process which involves the patient and public engagement committee and ultimately the Membership Council and Governing Body.

The CCG has been working with the emerging HealthWatch in Barnsley. It will continue this work with the development of the role of GP practice patient reference groups for example.

Measuring the return on investment and the impacts of patient and public involvement activities is both challenging and an opportunity. The CCG is developing an insight database which will contribute to a performance, quality, safety and outcome dashboard. New ways of measuring the conversation in social media are emerging, and it will be these areas of innovation that we will include in our approach.

Informing Patients

The CCG has been working with the emerging HealthWatch in Barnsley, building on the strong relationship with LINks. Aiming to build a credible relationship built on respect and trust. Working alongside the Health and Wellbeing Board the CCG will be keen to test the understanding of the community to make sure it has not missed anything.

Better Data, Informed Commissioning, Driving Improved Outcomes

The CCG will deliver the universal adoption of the NHS number as the primary identifier by all providers in 2013/14 by continuing to include this requirement within the Standard contract, utilising the data quality improvement plan.

If the CCG is not satisfied with the completeness and quality of provider data on Secondary Uses Service in 2013/14 we will enforce the NHS standard contract sanctions via the contract management process.

The CCG will require its secondary care providers to provide quarterly updates on its Quality Account and work towards universal electronic record keeping utilising robust governance processes that involve external scrutiny.

In 2013/14 the CCG plans to introduce a monitoring process to ensure that secondary care providers comply with data collections based on Information Standards Board and National Commissioning Board advice.

From a secondary care perspective the CCG envisages a health community engagement for the maintenance and improvement of the Choose and Book system to ensure the easy access to appointments.

NHS Barnsley CCG is commissioning services from South Yorkshire and Bassetlaw Commissioning Support Unit to support and develop appropriate GP information services to provide clinical assurance and safety.

Higher Standards, Safer Care

The CCG and its partner organisations will ensure that following the required stock take, the Transforming Care: A national response to Winterbourne View Hospital and the Francis report recommendations are implemented. Significant work is underway regarding specialist and out of area placements.

In addition, the CCG will require all of its providers to demonstrate the effective upholding of standards of care on a proactive basis that will ensure compliance with external scrutiny and most importantly be shared with the public the providers serve to give them the confidence and trust they deserve.

The CCG will provide leadership to all providers about how best to embed Compassion in Practice standards and undertake work with them to articulate evidence of the upholding of these vital standards and principles so that both assurance and learning can be shared.

The CCG will ensure that assurance reviews of our appraisal and clinical governance is part of our annual workplan and we will work closely with the Area Team to support their Responsible Officer role in revalidation.

NHS Barnsley CCG will ensure that the provider organisations it commissions services with, where it is lead provider, will demonstrate a commitment to implementation of the Comply or Explain regime ensuring compliance through the NHS standard contract.

Innovation

As part of their contracts, providers must demonstrate compliance with National Institute of Clinical Excellence (NICE) technology appraisals and the CCG has a member of staff who is registered as a NICE stakeholder.

Through the Area Prescribing Committee (APC) the CCG will ensure that there are systems in place to ensure that local formularies fulfil requirements to enable

effective tracking of the adoption of NICE technology appraisals that encourage proactive and innovative practice.

From 2013/14 the NHS Barnsley CCG Medicines Optimisation strategy and workplan includes; Effective uptake of NICE approved medicines will be demonstrated by performance metrics; approved medicines within the prescribing formulary and treatment pathways and disinvestment in medicines determined to be of low priority, ensuring that the Barnsley formulary is up to date and publicised in line with the NICE and Department of Health direction.

The strategy recognises that there is an ongoing challenge to achieve consistent implementation of NICE technology appraisals and clinical guidelines across Barnsley. Safety and quality will be improved by ensuring medicines management resources work to achieve consistent implementation with regard to medicines optimisation across the whole patient pathway.

From February 2013 the Barnsley Area Prescribing Committee will receive a summary of medicines related NICE guidance and action changes to the local formulary and Innovation Scorecard on a monthly basis. A joint Barnsley locality formulary exists and this is currently being reviewed to ensure that it includes links to related NICE guidance. It has been agreed that from the 1st April 2013 the formulary and innovation scorecard will be collaboratively hosted on the Barnsley Hospital NHS Foundation Trust public website and will be updated on a monthly basis. Changes to the formulary and innovation scorecard will be publicised and communicated across the Barnsley locality.

The CCG confirms its membership of the Academic Health Science Network (AHSN) and commitment to actively utilise this to spread innovation.

The CCG has already affirmed its commissioning intentions for 2013/14 and beyond to build on the nationally acclaimed piloting of telehealth in Barnsley to maximise sound developments to positively benefit patients and will actively seek other opportunities with regards to other technologies to improve outcomes.

Section 9 - Joined up Local Planning

A significant amount of multi-agency work has been undertaken to identify the parents of children with special educational needs or disabilities who could benefit from a personal budget based on a single assessment across health, social care and education. Strategic arrangements are in place which include the Disabled Children's Programme Board, Transitions Board, Disabled Children's Parents Care Forum and there has been joint work the Adult services.

Work is taking place to develop the core offer to:

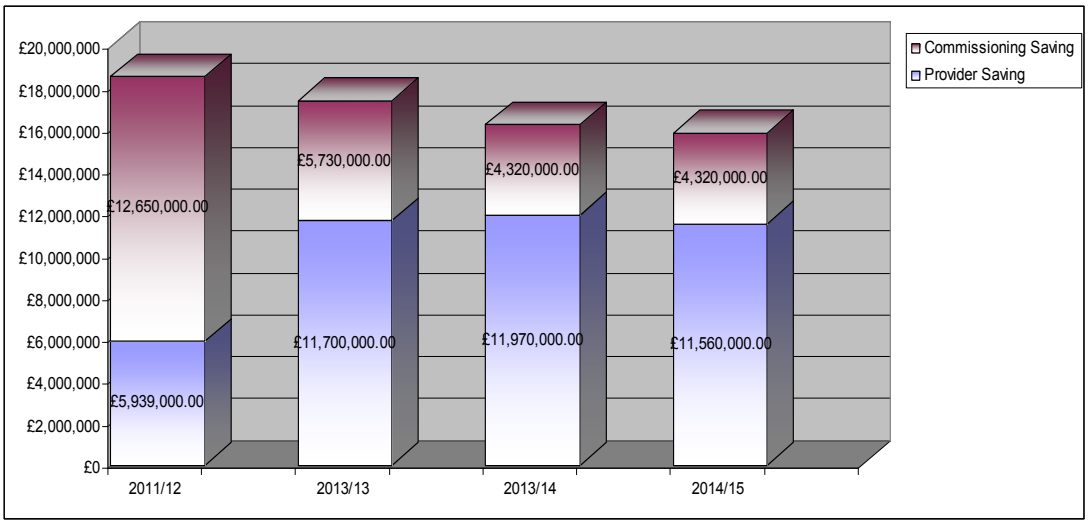
- Create a meaningful approach to parental choice
- Developing a pathway for early support
- Working together to develop a health, education, social care plan (waiting for pilot authorities to report)
- Planning for personal budgets
- Creating the cultural changes we need to make to get people (professionals) on board with personal budgets

Work will continue to take place during 2013/14 to progress the above areas of work.

QIPP 2013/14

The QIPP Challenge

The bar chart below shows the planned commissioner and provider savings for the period 2011/12 to 2014/15. It should be noted that the CCG'ssavings for 2013/14 and 2014/15 is a proportion of the PCT savings identified in previous plans.



The Quality, Innovation, Productivity and Prevention programme is central to our plans and underpins our commissioning intentions. All of the work we are undertaking and planning to undertake plays its part in ensuring the quality and financial sustainability of the services we commission, so the appropriate level of

care is centred on patients' needs and provided as safely, efficiently and effectively as possible.

The CCG will work with local clinical leaders to improve quality as well as increase productivity and efficiency. Clinical quality incentives (CQUINS) continue to be an important mechanism to drive improvements in the quality of services.

Through the review of our existing quality assurance mechanisms against the Francis recommendations, the CCG will ensure that all our Quality, Innovation, Productivity and Prevention programme work is appropriately risk managed and monitored and delivers the required improvements in the quality of process and outcomes of care.

We will be honest with the public and our partners about our need to drive up quality and increase the effective use of financial resources.

Transformation Programmes

The CCG recognises the challenge in the requirement to deliver transformational change through clinical redesign. For 2013/14 we will build on the considerable progress in delivering the efficiency and quality challenge within the Barnsley health and social care system and through re-investment of efficiency savings continue to drive the delivery of transformational change across pathways, services and systems. Our plans are ambitious given the demographic profile of our population, particularly the disproportionate growth in the elderly population and the predicted growth in people over 65 years with long term conditions. For this reason our plan assumes that there will be growth in all aspects of services and that this growth will be mitigated by large scale transformational change in at least the following key areas, to stem the tide on some of the pressures on services and in particular expensive hospital based care:

- Transforming urgent care
- Supporting long term conditions
- High quality planned care
- Medicines optimisation

The key initiatives to support delivery in 2013/14 of the above areas programmes are included in the Improving Outcomes, Reducing Inequalities section.

Rigorous performance management of key milestones and quality, activity and finance indicators for 2012/13 indicates that we are on target to deliver planned improvements including:

- Reduced non elective admissions to a medical specialty
- Reduced ambulatory care sensitive non elective admissions
- Increased the number of people supported to self care
- Increased the number of front line staff trained in behaviour change methodologies
- Reduced the number of first outpatient appointments compared to the 09/10 baseline
- Enhanced safe and effective prescribing
- Target efficiency savings across all programme

As well as working on the Quality, Innovation, Productivity and Prevention agenda locally the CCG recognises it will have to play its part in Quality, Innovation, Productivity and Prevention plans set out by the NHS Commissioning Board Area Team that include Barnsley or services accessed by Barnsley people in their scope. We will also be actively involved in the development and implementation of collaborative plans agreed by Clinical Networks and the Specialised Commissioning Group (SCG). They will need to be part of the debate with other commissioners across the South Yorkshire and Bassetlaw patch.

QIPP Governance and Performance Monitoring

We will continue to lead 'Whole System' approach to the Quality, Innovation, Productivity and Prevention agenda, to ensure the delivery of transformational change across the local health and social care community, realise maximum benefits to our population and support partners to maintain financial balance.

Our Quality, Innovation, Productivity and Prevention programmes have been developed with the involvement of all our key partners through the whole system forum. Robust programme and project arrangements will be put in place to ensure that the developmental work required is delivered across a variety of projects and task groups working in a matrix fashion. This will maximise engagement, alignment and co-working on solutions which support the CCG's objectives against the wider background of the needs of the Barnsley health and social care economy.

Each Quality, Innovation, Productivity and Prevention programme is embedded within our core business and the accountable manager and clinical lead identified. Our programme management structure identifies the resources and requirements to support the delivery of projects. This includes the identification of risks to delivery, evaluation of the nature and extent of identified risks and the effective management of any risk in line with the CCGs risk management framework.

Progress on the delivery of our Quality, Innovation, Productivity and Prevention programmes is reported as part of the Integrated Performance Management Report. Progress in respect of the delivery of key milestones, key performance indicators and risk is also reported to the South Yorkshire and Bassetlaw Area Team in line with Department of Health reporting arrangements.

The Finance and Performance Committee of the CCG provides a forum for a detailed review of progress, risks and mitigating actions in respect of all programmes and projects.

Section 10 - Financial Planning

Financial Control

The planned level of resource and application based upon allocations received from DH is shown below for 2013/14 to 2015/16. This is based upon current assumptions as at March 2013, and may be subject to change. It is proposed non recurrent funding will be used as pump priming to deliver future efficiencies across a number of commissioned services.

The planned in year surplus is 2% for 2013/14 on the basis of South Yorkshire and Bassetlaw Area Team advice. This will have the effect of additional resource being allocated in 2014/15.

Overall Plan for 2013/14

For 2013/14, the CCG has the following level of planned resource and expenditure:

	2013/14 £000	2014/15 £000	2015/16 £000
Resources Available:			
Recurrent	358,462	365,334	372,344
Non-recurrent	8,662	8,971	6,681
Total	367,124	374,305	379,025
Application			
Recurrent	347,034	357,304	361,929
Non-recurrent	13,447	13,447	13,447
	360,481	370,751	375,376
Planned Surplus	6,643	3,554	3,649

Surplus Policy

NHS Barnsley CCG is planning to deliver at least a 2% recurrent surplus with an in-year surplus of a minimum 1%. The CCG is confident of delivery, with a number of recurrent reserves identified to support the spending plan identified. These reserves cover adjustments to recurrent budgets for movements to 2012/13 forecast outturn, additional activity growth beyond this level, any unintended consequences of tariff implementation and the potential impact of the widening of specialised services on non-specialised services.

In addition, NHS Barnsley CCG will utilise the return of 2012/13 surplus to support non-recurrent schemes in line with its Commissioning Intentions and deliver further quality and efficiencies.

Managing Risk

NHS Barnsley CCG, as outlined above, has set aside a number of risk reserves to support its recurrent and in-year plan for surplus. In addition, a 0.5% non-recurrent contingency has been set aside for further risk.

The CCG will also work with fellow CCGs within the South Yorkshire and Bassetlaw area to collaboratively commission certain services to adequately share risk. Throughout 2013/14, the CCG will work closely with providers to ensure that any deterioration in the financial position is assessed and mitigated against through a joint recovery plan.

The CCG has set aside 2% of its recurrent resource to be invested non-recurrently in 2013/14. Work is currently ongoing to identify schemes, through working with providers, to ensure that the utilisation of this reserve effectively supports clinical commissioning intentions and assists in the delivery of ongoing recurrent surpluses in line with national planning guidance. These plans will be formalised by the end of March 2013.

In relation to the potential risk arising from new Commissioning arrangements, particularly with reference to Specialised Services, the CCG in conjunction with all other CCGs within Yorkshire and the Humber and the NHS Commissioning Board is currently seeking to develop a risk sharing mechanism. This is expected to be finalised by contract sign-off.

Any further risks identified through the year will be mitigated by the extension and development of further QIPP schemes where felt appropriate.

Planning Assumptions

NHS Barnsley CCG has utilised the following high-level assumptions to underpin the financial and single integrated plan.

These are as follows:

- The CCG will receive an annual budget of £344m and a separate running cost allowance of £6.1m
- A minimum of 1% in-year and 2% recurrent surplus will be delivered
- Tariff rules and efficiency will be applied to contracts as detailed below
- Reserves have been set aside for movement of recurrent budgets to forecast outturn and for other activity changes relating to demographic or non-demographic changes. The forecasting of such demographic and non-demographic changes is currently underway with providers and expected to be fully reflected in financial plans by the end of March 2013 as contracts are agreed. However, the CCG is confident that any such changes will be effectively managed within the reserves currently identified.

Tariff

NHS Barnsley CCG has planned on the basis of delivering 4% efficiency on tariff and non-tariff expenditure with the exception of Continuing Healthcare and Primary Care budgets (0%) and Prescribing (3%).

Inflation for tariff services is forecast at 2.9%, allowing for 0.2% embedded efficiency in the tariff (a net reduction of 1.1%) and for non-tariff prices at 2.7% (a net reduction of 1.3%). Primary care inflation is assessed at 0.5% in line with previous years and Prescribing at 5% to take account of price rises outside of the control of the CCG.

The CCG is planning to continue with the application of the 30% marginal rate for non-elective admissions. The plan is predicated on paying 100% but with 70% withdrawn from allocations. Furthermore the CCG is planning on the continued application of the readmissions reduction policy. Any savings generated from this policy are intended to be reinvested in improving services and the readmission rate.

Integrated Care Plans

NHS Barnsley CCG will work closely with Barnsley Metropolitan Borough Council to develop plans for the administration of reablement monies and link these to benefits for the local population.

Details are expected to be finalised through February 2013 and at present are included as committed within the CCG financial plan.

Contracting for Quality

For those providers where the CCG is the lead commissioner the NHS Standard contract will be used.

Commissioning for Quality Innovation (CQUIN)

NHS Barnsley CCG has approved an evidence-based process for agreeing and implementing local CQUIN schemes for 2013/14, which takes into account the NHS Commissioning Board Guidance on CQUINS 2013/14.

In relation to the high impact innovations, discussions are underway with local provider organisations to agree which of the five schemes that will apply to them they will be focusing on. The providers are currently considering which three schemes (50% of the high impact innovations) they will work up their trajectories for, in liaison with the commissioner. Discussions are planned with local providers where NHS Barnsley CCG is the lead commissioner. Where we are an associate to other contracts it is planned to link into discussions with the lead commissioner. The CCG will ensure that CQUINs will only be paid where providers meet the minimum requirements of high impact innovations.

The four national schemes identified for 2013/14 are:

- Friends and Family test
- Improvement against the NHS safety Thermometer (excluding VTE)
- Improving dementia care (FAIR)
- Venous Thromboembolism (VTE) – 95% patients being risk assessed and achieve locally agreed goal for no. of VTE admissions that are reviewed through RCA.

Of the above national schemes, all four apply to Barnsley Hospital NHS Foundation Trust and one applies to South West Yorkshire Partnership NHS Foundation Trust (NHS safety thermometer).

In relation to local schemes, the CCG will target schemes at a range of tangible, high impact service and patient quality improvements. The areas for improvement will be evidence based and will require information to be gathered and submitted from the start to strict timescales in order to demonstrate effective progress towards delivering better outcomes for the local population.

Local CQUIN schemes from 2012/13 that have been achieved will become part of the contracted performance requirements for 2013/14. Any previous CQUINS, which become part of the contract, will be supported by financial penalties to ensure that previous investment is protected and continued performance is maintained.

The CCG CQUIN Eligibility Criteria will consider proposals, which meet any of the following:

- Service quality improvements
- Existing schemes that continue to have potential for improvement
- Stretch targets
- Evidence based schemes
- Schemes that are able to be monitored from Quarter 1 to ensure real progress can be made
- CQUINS that are monitored quarterly
- New pathway development

The CCG Membership Council and the Governing Body, using local priorities (CCG Commissioning Intentions) and national priorities, have identified potential themes for local CQUINS.

The proposed local schemes for Barnsley Hospital NHS Foundation Trust are:

- Quality and timeliness of communications – outpatient letters and discharge communications
- Patient experience
- Respiratory – care bundle for COPD
- Medication care planning

The proposed local schemes for South West Yorkshire Partnerships Foundation Trust are:

- Quality and timeliness of communications – outpatient letters and discharge communications

- Increasing the number of people in secondary MHS in employment
- Improving health outcomes for people on Care Programme Approach (focusing on smoking, Body Mass Index and exercise)
- Assurance of safety and quality of high risk individual placements
- Integrated team working
- Mental Health Payment by Results – data systems and recording quality
- Learning Disability health equalities framework

The CCG will monitor progress against the high impact innovation schemes which are relevant to the providers along with the national and local CQUINs on a quarterly basis.

Key Performance Indicators

NHS Barnsley CCG has incorporated all relevant key performance indicators in the quality schedules for those providers where it is lead commissioner.

As indicated earlier in the plan, a robust system of performance monitoring has been developed to monitor provider progress against the key performance indicators. Where providers fail to meet the identified standard/threshold the CCG will enforce the terms of the standard contract.

Glossary

A&E	Accident & Emergency
ACE	Angiotensin Converting Enzyme
ACEI	Angiotensin Converting Enzyme Inhibitor
ADHD	Attention Deficit Hyperactivity Disorder
AF	Atrial Fibrillation
AHSN	Academic Health Science Network
APC	Area Prescribing Committee
AQP	Any Qualified Provider
ASC	Ambulatory Sensitive Conditions
A2RAs	Angiotensin II Receptor Antagonist
BHNFT	Barnsley Hospital NHS Foundation Trust
BMBC	Barnsley Metropolitan Borough Council
BME	Black Minority Ethnic
CAS	Clinical Assessment Service
CCG	Clinical Commissioning Group
C-Diff	Clostridium Difficile
CHAD	Congestive heart failure, Hypertension, Age 75 years or over, Diabetes mellitus
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CVD	Cardiovascular Disease
FAIR	Find, Assess, Investigate, Refer
FFCE	First Finished Consultant Episode
GRASP	Guidance on Risk Assessment and Stroke Prevention
HCAI	Healthcare Acquired Infections
IAPT	Improving Access to Psychological Therapies
IM&T	Information Management and Technology
ISMN	Isosorbide Mononitrate
IT	Information Technology
JSNA	Joint Strategic Needs Assessment
LINks	Local Intelligence Networks
LRTI	Lower Respiratory Tract Infection
LTC	Long Term Conditions
MHRA	Medicines and Healthcare products Regulatory Agency
MHS	Mental Health Service
MR	Medicines Review
MRSA	Methicillin-resistant Staphylococcus aureus
NICE	National Institute of Clinical Excellence
NSAIDs	Nonsteroidal anti-inflammatory drugs
OPEN	Our Public Engagement Network
OFSTED	Office for Standards in Education
PCT	Primary Care Trust
PPI	Proton Pump Inhibitors
QIPP	Quality, Innovation, Productivity and Prevention
SCG	Specialised Commissioning Group
SWYPFT	South West Yorkshire Partnerships NHS Foundation Trust
T2DM	Type 2 Diabetes Mellitus
VTE	Venous Thromboembolism