AGENDA ITEM: Pages –

Meeting	Health and Well-Being Board
Date	25 April 2013
Subject	**Barnet Clinical Commissioning Group Integrated Strategic and Operational Plan 2013 - 2015**
Report of	Chief Officer, Barnet Clinical Commissioning Group
Summary of item and decision being sought	This paper sets out the Barnet CCG Integrated Strategic and Operating Plan 2013 – 2015. This includes the CCG vision, case for change, strategic objectives, a summary of the projects and planned outcomes in each of the Clinical Commissioning Programmes and the supporting work programmes. The Health and Well Being Board is asked to approve the Integrated Strategic and Operational Plan 2013 – 2015 for Barnet CCG.

Officer Contributors	John Morton, Chief Officer, Barnet CCG Helen Boswell, Senior Commissioning Support Manager (Barnet CCG)
Reason for Report	Barnet Clinical Commissioning Group shared the Clinical Commissioning Group Vision and Strategic Objectives with the Health and Well Being Board at a workshop on 29 November 2012. The plan has been further developed and was approved by the Barnet Clinical Commissioning Group on 4 April 2013. The Health and Well Being Board are asked to note the plan and assure it that the plan supports the delivery of the Health and Wellbeing Strategy and agree the local priorities and measures.
Partnership flexibility being exercised	None
Wards Affected	All

Contact for further information

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1. RECOMMENDATION

1.1.1 The Health and Wellbeing Board is asked to assure itself that the Barnet CCG Integrated Strategic and Operating Plan 2013 – 2015 supports delivery of the Health and Wellbeing Strategy.

1.1.2 The Health and Well-being Board is asked to note and agree the local priorities and measures. These will be submitted to NHS England as part of the 2013/14 Operating Plan.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Barnet CCG Board meeting held on 4 April 2013.

2.2 Health and Being Board Workshop held on 29 November 2012.

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY STRATEGY; COMMISSIONING STRATEGIES)

3.1 The plan sets out the Barnet Clinical Commissioning Group vision, strategic objectives and clinical commissioning programmes and explains how these reflect the key themes from the Barnet Joint Strategic Needs Assessment. It confirms how these will support the implementation of the Health and Well Being Strategy and the achievement of the NHS Mandate and NHS Constitution standards.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The plan identifies the main themes from the Barnet Joint Strategic Needs Assessment and how these will be managed in each Clinical Commissioning Programme. There has been no equality impact assessment of the plan as a whole but each of the Quality Improvement Prevention and Productivity projects will have been equality impact assessed as part of the project development process.

5. RISK MANAGEMENT

5.1 Risks identified within the plan will be managed through the Barnet Clinical Commissioning Group Board Assurance Framework and Risk Register.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 The financial position of Barnet Clinical Commissioning Group is a significant component of the plan.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The plan on a page summary and clinical commissioning programmes have been shared and discussed with user representatives and stakeholders at Partnership Boards, CCG Locality Boards, meetings with voluntary sector providers and public engagement events. Further work will be undertaken to produce a publicly accessible version of the plan.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 The Quality, Improvement, Prevention and Production (QIPP) projects in each clinical programme have been developed through engagement with provider organisations.

10. DETAILS

10.1.1 Draft planning guidance for Clinical Commissioning Groups published in November 2012 emphasised the principle that planning and contracting is managed locally by Clinical Commissioning Groups in partnership with Health and Wellbeing Boards. It states that 'all NHS commissioners are required to have clear and credible commissioning intentions that best meet the needs of their local populations within the resources available to them.' The plan needs to reflect the health needs identified in the Barnet Joint Strategic Needs Assessment and the plans and outcomes described in Keeping Well, Keeping Independent, the Barnet Health and Well Being Strategy.

10.2 The Mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015 (The Mandate) will act as the main formal accountability mechanism for the NHS Commissioning Board (NHSCB) and Clinical Commissioning Groups are asked to outline their plans to meet its requirements in relation to the key priority areas:

Domain 1: Preventing people from dying prematurely
Domain 2: Enhancing the quality of life for people with long term conditions
Domain 3: Helping people to recover from episodes of ill health or following injury
Domain 4: Ensuring the people have a positive experience of care
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

Clinical Commissioning Groups are also asked to take account of and outline their intentions against the national planning framework *Everyone Counts: Planning for Patients 2013/4* summarised in five offers.

Offer 1: NHS services, 7 days a week
Offer 2: More Transparency, More Choice
Offer 3: Listening to Patients and Increasing their Participation
Offer 4: Better data, informed commissioning driving improved outcomes
Offer 5: Higher standards, safer care

10.3 Barnet Clinical Commissioning Group is required to submit as part of the 2013/14 Operating Plan proposals for three local outcome measures to be used in conjunction with national outcome measures as part of the Quality Premium. These measures should be agreed with NHS England after consideration with Health and Wellbeing Boards and key stakeholders, especially patients and local community representatives.

These measures should focus on local issues and priorities, especially where the outcomes are poor compared to others and where improvement in these areas will contribute to reducing health inequalities. Each measure should be based on robust data and the improvement needed to trigger the reward should be expressly agreed between the Clinical Commissioning Group and the NHS England (London Region) Team.

The 'quality premium' is intended to reward clinical commissioning groups for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. The quality premium paid to Clinical Commissioning Groups in 2014/15 – to reflect the quality of the health services commissioned by them in 2013/14 – will be based on four national measures and three local measures.

The national measures, all of which are based on measures in the NHS Outcomes Framework, will be:

• Reducing potential years of lives lost through amenable mortality (12.5% of quality premium): the overarching objective for Domain 1 of the NHS Outcomes Framework;

• Reducing avoidable emergency admissions (25% of quality premium): a composite measure drawn from four measures in Domains 2 and 3 of the NHS Outcomes Framework;

• Ensuring roll-out of the Friends and Family Test and improving patient experience of hospital services (12.5% of quality premium), based on one of the overarching objectives for Domain 4 of the NHS Outcomes Framework;

• Preventing healthcare associated infections (12.5% of quality premium), based on one of the objectives for Domain 5 of the NHS Outcomes Framework.

Barnet Clinical Commissioning Group proposes the following local priorities and measures.

Dementia Services

The GPs felt that Dementia services were a priority because of the increasing numbers of older people and the increasing prevalence of Dementia. There is a work programme already developed for this service and Barnet Clinical Commissioning Groups; in conjunction with local authority colleagues has already set targets for increasing the number of people diagnosed with Dementia on GP registers.

The numerator is the number of people on the dementia register for England in the Quality and Outcomes Framework (QOF). This figure is published by the Health and Social Care Information Centre as the QOF DEM1 indicator. The Denominator is prevalence. This is based upon the Dementia prevalence rates published in Dementia UK report (2007), adjusted for general practice register patient numbers, and numbers of general practice patients in care homes (Adjusted National Dementia Prevalence, NHS Commissioning Board Dementia Prevalence Calculator, 2012). The target for 2013/14 is 59% and 61% for 2014/15.

End of Life Care
Barnet Clinical Commissioning Group would like to focus upon Increasing the number of people who are receiving end of life care that are supported to die outside of hospital. The numerator is the total number of Barnet patients dying in hospital. The denominator is the crude total deaths in Barnet. This data is sourced from Office for National Statistics (ONS) population dataset and Office for National Statistics (ONS) Public Health Annual Mortality.

The End of Life Care profiles 2012/13 (2008 – 2010 average) indicate that 59.3% patients died in hospital compared with a national average of 54.5%. The Clinical Commissioning Group would like to have a target of 58.5% in 2013/14.

Stroke Services
The Joint Strategic Needs Assessment identifies CVD and Stroke as a major cause of death in Barnet. The GPs would like to improve the number of atrial fibrillation patients identified and treated across Barnet. Quality Management and Analysis System (QMAS) data is showing a cross prevalence of patients on the CVD register in Barnet ranging from 2.11% - 0.13% with an average of 1.1%. The NCL prevalence is currently 0.88%. As part of developing the business case for Barnet the London stroke team have done some modelling work based on the following assumptions:

Barnet Population 370,335
Current number of atrial fibrillation cases 4,168
Atrial Fibrillation patients with stroke risk factors 2501
Current strokes prevented 54

If the target prevalence for Barnet was 1.3% there would be a total 4814 patients, an extra 646 patients, with 116 new numbers of strokes prevented based on adjusted prevalence. 29 practices out of the 68 practices in Barnet are achieving the 1.3% adjusted prevalence rate; the proposal is for the reminder of the practices to work to achieve this prevalence rate.

11 BACKGROUND PAPERS

11.1 None