Commissioning Intentions 2017/18 – 2018/19

This paper sets out the NHS Barnsley Clinical Commissioning Group commissioning intentions for 2017/18 to 2018/19.

In the interests of openness, transparency and partnership working, all NHS Barnsley CCG commissioning intentions are set out below for all providers, interested parties and the public to see.

Setting the Context

In 2017/18 and 2018/19 NHS Barnsley CCG are committed to working together to make significant steps forward in transforming health and care services in Barnsley and particularly making progress against the commitments set out in the NHS Five Year Forward View and towards our long term ambitions to move care closer to home. We will do this through delivering the Sustainability and Transformation Plan (STP) for the whole of South Yorkshire and Bassetlaw (SYB) and our local commissioning intentions are a subset of the collective commissioning intentions for SYB.

In line with STP plans, in 2017/18 and 2018/19, there will be no non recurrent support provided for the delivery of 7 day services other than that which is funded through the national tariff.

Providers are asked to consider the collective SYB commissioning intentions alongside these local intentions. Our local intentions reflect our ambition over the next two years to:

- Have a greater focus on prevention and reduction in health inequalities
- Transform the models for service delivery across health and care in Barnsley;
- Focus on self-care, by promoting universal information and advice and sign posting people earlier to a range of community based support
- Combine earlier intervention with greater use of short term / targeted interventions

Our values underpin everything we do as commissioners and this paper sets out how we intend to strengthen and improve services for our local population during 2017/18 and 2018/19. Our values are:

- Equity and fairness
- Services are designed to put people first
- They are needs led and resources are targeted according to needs
- Quality care delivered by vibrant primary and community care or in a safe and sustainable local hospital
- Excellent communication with patients

National and Local Process

The national timetable will be adhered to during contract negotiations and contracts will be agreed and signed by the deadline of 23 December 2016. A detailed timetable will be developed and agreed with providers to ensure that a contract position is agreed to achieve contract signature by the national deadline.

Commissioning Intentions

Finance and Activity

Baseline activity will be based on a 3 year average and review of 5 months of activity and forecast projections for 2016/17. Other adjustments will include but are not limited to, the impact of new models of care, new service specifications in development and delivery of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.

National tariff inflation and efficiencies will be applied to the core contract as per NHS England guidance on publication.

The contracts will remain as pre-existing block or PbR contracts, unless otherwise stated, with activity monitoring in place to support the contract review and performance process; however this is subject to review for services noted within commissioning stances.

Contract Documentation

Contracts will be issued using the National NHS Standard contract unless otherwise stated. All documentation will be reviewed and updated where appropriate.

The Core contract will be awarded for a period of two years, but will be subject to variation for any developments over the contract period as outlined within this document.

CQUIN proposals will be in line with national CQUIN guidance. Work with providers will commence to ensure agreement and delivery of CQUIN schemes.

Commissioning Stances

Accountable Care Organisation Barnsley CCG has an ambitious strategy to integrate the delivery of health and care for the people of Barnsley. This ambition is supported by our commissioning partners in Barnsley Metropolitan Borough Council and our provider partners in BHNFT and SWYPFT and by the Barnsley Healthcare Federation. The partners have come together with the CCG to form an Accountable Care Partnership Board. Our vision for the future of health and care in Barnsley is to create a simpler, more joined up health and care system; one where the people of Barnsley don't see organisational boundaries. Instead, they experience continuity of care; they see familiar faces that are clearly connected to each other regardless of

where patients are seen; be that in hospital, in the community or at home. Our goal is to dismantle boundaries at the point of delivery of care, to create a Barnsley where patient interests come first and resources are focused on improving health outcomes in areas of Barnsley where inequalities are greatest.

Although our end goal is a truly integrated Accountable Care Organisation which moves the boundaries between commissioning and provision, our first step on the journey is to see an integrated provider model up and running from 2017/18, working as a virtual **Multispecialty Community Provider** and covering the following services, where work on the new model of integrated care is already most advanced:

- Intermediate care
- Diabetes care
- Respiratory care
- Community Nursing

Our expectation is that we will enter into alliance contractual arrangements with current providers of the services. We will look to sign off care models and agree the timetable for implementation of integrated pathways and performance outcomes with providers collectively, as part of the forthcoming contracting round. As well as a shared vision for the care model, the alliance agreement is expected to cover providers commitment to managing resources together, to realising the opportunities offered for Barnsley's population in Rightcare: Commissioning for Value, as well as clear governance and gain/risk sharing arrangements to secure best value from existing resources. We would expect to have moved to the new alliance contract by September 2017.

NHS Barnsley CCG is committed to working as part of the **Commissioners Working Together Programme** to deliver regional based commissioning where there is a cohesive evidenced based case for change which identifies a need to commission services on a wider geographical footprint. Increasingly this will become part of our approach to strategic commissioning through SYB's STP. In 2017/18 progress is expected to be made with regards Hyper Acute Stroke Services (HASU) commissioning and Children's Surgical and Anaesthesia Services.

Commissioning For Value - In line with NHSE expectations the CCG will explore 100% of the opportunities identified within the RightCare Commissioning for Value packs, the CCG will take a structured approach to the analysis of the opportunities for improvements in care, outcomes and cost efficacies highlighted in the Right Care Commissioning for Value (CvF) packs, examining both the overview packs and the focus packs. This will be a key part of how the South Yorkshire and Bassetlaw Sustainability and Transformation Plan will be taken forward in Barnsley.

This will lead to the development of action plans and, where necessary service redesign, to realise improved health outcomes, decrease in unwarranted variations in care and improve cost efficiency. The analysis may result in the need to amend care pathways and current service specifications, or to re-procure services, within the contract period.

Providers will be expected to work proactively with the CCG in helping to clarify the opportunities, develop and implement the action plans and respond to the changing opportunities across the contract period.

For Barnsley CCG the data provided in the 'Where to Look Packs', published in January 2016, suggests a total saving opportunity of £23m if Barnsley performed at the efficiency of its top 10 peers.

The £23m can be broken down as follows:

Area of Opportunity	Value of Opportunity £m
Cancer and tumours	1.6
CVD (circulation problems)	3.9
Endocrine, metabolic and Nutrition problems	1.6
Gastrointestinal	3.4
Genitourinary	0.6
Mental Health Prescribing	0.9
MSK	3.7
Neurological	3.3
Respiratory	3.5
Trauma and injuries	0.5
Total Opportunities	**23**

Commissioning for Value packs currently at implementation stage include:

- Medicines management (medicines form part of all areas outlined above)
- Musculoskeletal (MSK) disease and trauma
- Respiratory Disease
- Complex patients (part of the 2016 overview pack)

The next area to be examined in depth and implementation commenced is cardiovascular disease. A staged approach to review, service redesign and implementation of all the others will begin in 2017/18 and providers are asked to be aware of the impact this will have on services and contracts over the two year planning period and to work with the CCG to secure the outcome and efficiency opportunities available. An overview of the opportunities currently being taken forward is attached at Appendix A.

The CCG will look to introduce a fast track process to take forward commissioning for value. Other commissioning for value opportunities not listed above but emerging during the 2017-19 contract period will also be subject to the fast track process.

Further detail for providers on Commissioning for Value and the opportunity for Barnsley can be found at http://www.rightcare.nhs.uk/index.php/commissioning-for-value/

To maximise the opportunity afforded to us by commissioning for value, the CCG will re-specify and re-procure **MSK services** in 2017/18.

To maximise the opportunity afforded to us by commissioning for value the CCG will review **pain management services** which may lead to re-procurement during the period of the 2017-19 contract.

Demand Management Tools - The CCG is committed to ensuring that patients who need access to specialist advice and treatment can receive high quality advice in a timely manner. Demand for elective care continues to rise and the CCG is considering how to manage that demand whilst ensuring patients receive access to treatment in line with their constitutional right. To meet national guidance on demand management the CCG has commissioned the **Map of Medicine** Referrals product and will begin roll out in October 2016 to all practices in Barnsley, with the aim of:

- Improving the quality of care to patients prior to referral, by providing standardised agreed local pathways, including prescribing information, best practice models and linkage to the most appropriate investigations and onward referral as necessary.
- Reducing the volume of inappropriate referrals to secondary care in targeted specialties/pathways where we have commissioning for value opportunity.
- Improving the appropriateness and speed of referrals and ensure patients are treated in the most appropriate environment.
- Supporting GPs by providing agreed pathways in a single location (i.e. on their clinical system).

The CCG intends to cover the following elements of the **national guidance on demand management** in our approach:

- Alternatives to outpatient appointments – transforming the way outpatient clinics are delivered, offering alternatives to traditional face to face clinics. We would expect this to be a component of the MCP model for diabetes and respiratory services
- Shared decision making - a process in which patients, when they reach a decision crossroad in their health care, can review all the treatment options available to them and participate actively with their HCP in making decisions.
- Choice – giving patients control to shape and manage their care and make meaningful choices
- Advice and guidance - To help to avoid the need for outpatient referrals, during 2017/18 the CCG will develop with BHNFT a process for the provision of consultant 'Advice and Guidance' to primary care via e-mail and / or by phone. Along with this, we will work with BHNFT to increase the provision of clinical interpretation and management advice given on the reports of clinical investigations. During 2017/18 both the provision of consultant advice and guidance and increased clinical advice on investigations will be piloted for cardiology.

Primary Care – Primary care services are the front door of the NHS but general practice is under pressure after years of relative under investment. The **General Practice Five Year Forward View** sets out a national programme to invest £2.4bn in primary care by 2020/21. Investment of approximately £23m will come from national transformation funding sources, on a SYB STP footprint, across a 5 year period and in line with national planning guidance the CCG is expected to make available from its baseline allocation indicative sums of £1.3M over the 2 year operational planning period. Investment is aimed at:

- Supporting and growing the workforce
- Improving access to general practice in and out of hours
- Transforming the way technology is deployed and infrastructure utilised
- Supporting practices to better manage workload and redesign how care is provided

NHS Barnsley CCG will be looking to support significant development of primary care services during 2017/18 and 2018/19 to ensure the local delivery of the General Practice Forward View. The CCG will be focusing on the following key priorities:

- **Clinical Practice Pharmacy development**. This is designed to integrate the role of Clinical Pharmacists into General Practice. The aim is to increase capacity of GPs and Practice Nurses, through the principle of patients being treated by the right clinician at the right time. Furthermore addition of Community Pharmacists within Practices will increase quality and safe prescribing; maximise cost effective prescribing and reduce prescribing queries.
- **Development of Primary Care training programmes.** Barnsley CCG recognises the shortage of GPs and Practice nurses. We have developed an apprenticeship training scheme encouraging administrative staff to become Health Care Assistants and for Health Care Assistants to receive further clinical skills training, to complement the existing workforce in practice. A scoping exercise will be undertaken to identify the potential for the development of a Practice Nurse and Advanced Nurse Practitioner training programme to address other workforce elements of the Primary Care Strategy.
- **First Port of Call Training** – We will look to roll out this training across all practices and develop receptionist / care navigation roles to harness the significant untapped potential within this element of the workforce.
- **GP Fellowship Scheme** – we will implement with partners, a GP Fellowship Scheme providing added value to newly qualified and new to Barnsley GPs, in a programme which will provide added value to their professional expertise and will support recruitment and retention, working in new models of care delivery.
- **Further Development of the Vocational Training Scheme** – GP recruitment and retention is a significant issue in Barnsley with only 54 GPs per 100,000 population against the national average of 65+. The number of Training Practices in Barnsley has increased only marginally over the last ten years, and expansion would improve recruitment and retention. The CCG therefore

has an ambitious aspiration to achieve training practice standards at all practices in Barnsley whilst accepting that not all practices will be trainers. Locality working and buddying systems will be explored as ways of managing training rotations across the borough.

- **Productive Primary Care** – our intention is for all practices to be engaged with the national development programme to accelerate the 10 high impact changes to release time for care
- **Primary Care at Scale** Barnsley CCG already has an at scale Federation in place, Barnsley Health Care Federation (BHF). In line with the aspiration set out in the GPFYFV the CCG will continue to support BHF to play a central part in developing new models of care, through the development of the Multispecialty Provider model outlined earlier which will integrate the provision of primary and community services. BHF are also exploring a back office function offer to practices to support them to better manage workload, harness advances in technology and capture economies of scale.
- The CCG will work with both BHF and the Local Medical Committee (LMC) to introduce a local scheme to support struggling practices. The CCG and partners are coproducing "**The Practice Doctor**" - this initiative will provide a combination of local expertise and private providers to wrap a support package around practices who are finding it difficult. In signing up to the scheme practices will be supported to develop their own plan to deliver sustainability and key outcomes for registered patients. A business case will be submitted to access the funding available through the General Practice Resilience Programme.
- **The Practice Delivery Agreement (PDA).** The PDA is designed to support the delivery of quality Primary Care Services. This work began in 2015 and will continue throughout 2017 and beyond. The PDA will be co-produced with Barnsley GP Practices and will be directly informed by patient need and known health inequalities. The role of the PDA will strengthen Primary Care services by facilitating working at scale and as a direct result deliver improved patient outcomes.
- **Developing locality models** – The CCG will be working with member practices to develop a locality alignment model. Developing the concept of "Neighbourhoods" – this model will facilitate resources to be wrapped around groups of practices and create a focus for outreaching services and delivering primary care at scale in "Neighbour Hubs", matched to the local Area Council areas. The initial development of this new model will be focussed on the Community Nursing Review, and revised resourcing, the alignment of 0-19 services and on improving the offer for patients in care homes.

In addition, in primary care:

- The **Year of Care Model** supports practices to facilitate the transformation of Long Term Condition annual reviews and to support patient centred-consultations to facilitate change in health related behaviours. A focus on the approach will continue in 2017/18 and 2018/19.
- **Reviewing and commissioning more integrated Out of Hours Urgent and Emergency Care Pathways in line with the national commissioning standards for integrated urgent care. This will include:**

    - Extended access to core Primary Medical Services - The Prime Ministers Challenge Fund (i-Heart Barnsley) service has been extended by NHSE until April 2017. From October 2016 extended GP core services will be required to be provided at a level of 30 minutes per 1,000 population funded at £6 per head of population this will require access to core services on evenings and weekends with clear criteria and KPI's to ensure national consistency.
    - Out of Hours Primary Medical Services

  The CCG will be working with all providers of out of hours services to explore how an integrated out of hours and urgent and emergency care service that aligns to national requirements can be delivered from 2017/18.
- **Cancer shared care** - Following a review of the way in which prostate and colorectal cancer follow-up appointments are delivered in Barnsley, in 2017/18 the focus will be on moving the care of stable patients for all tumour sites to primary care. This will ensure that secondary care appointments remain available for patients with greatest need and where possible patients requiring only a check-up receive the appropriate level of care closer to home. These changes will need to be reflected in both the primary and secondary care contracts.

Integrated Personalised Commissioning (IPC)/ Personal Health Budgets (PHB)- Building on the progress made by the Health and Social Care Community during 2016/17 and in the context of integrated pathways and the development of Accountable Care, IPC will be developed at pace and scale to meet the needs of the top 5% of people in Barnsley with the most complex needs in the following cohorts:

- Children and Young People
- People with Continuing Care Needs
- People with complex and enduring Mental health problems
- People with Learning Disabilities
- People with Long Term Conditions

Barnsley CCG has commissioned a new **Social Prescribing** service to facilitate access for patients to non-medical form of support within the community. During 2017/18, Barnsley CCG will work with the service provider to mobilise the service and with health care providers, the voluntary sector and other partners, patients/carers and local communities to develop referral pathways into and from the service.

Learning Disabilities Transforming Care - In line with the Barnsley, Kirklees, Calderdale and Wakefield Transforming Care Partnership and Programme, Barnsley commissioners will work with the Partnership and with the provider to: develop and re-specify the specialist LD community model in line with the national service model; develop and specify specialist LD crisis response function; monitor usage and length of stay of commissioned assessment and treatment beds; Develop an all age 'at risk of admission' register for people with LD and/or autistic spectrum disorder. Revised service specifications will be included in contract negotiations for 2017/18 and will be aligned financially to the overall contract.

The **Adult Autism and ADHD Service** has received additional non-recurrent funding in 2016 to clear the backlog of people waiting for assessment. During 2017/18 the waiting list will be cleared and a sustainable service model based on known demand will be delivered through provision of additional funding from the commissioner as per the 2016/17 agreed levels as well as improved shared care arrangements with primary care, secondary care mental health services and adult social care.

Shared Lives - The CCG will continue to work jointly with BMBC Communities Directorate to expand the offer of the current Shared Lives Scheme to support people with physical health needs from 1 June 2017. A range of support in the Shared Lives carers' home (day care, respite, recuperation, up to 6 week stays for rehabilitation and long term placements) will be available to people who:

- Have had frequent admissions to hospital
- Are frequent attenders to primary care
- Need a period of general, stroke or neuro rehabilitation but are unable to return directly home
- Need a period of recuperation following hospital admission
- Have Continuing Health Care Needs or have multiple/complex health needs giving eligibility for a personal health budget
  Require end of life support, including respite for families in their caring role

There will be a need for primary care and community services (especially therapy teams) to provide in reach support to patients residing in Shared Lives carers' home as per the support that would have been offered if they were residing in their own home.

Based upon experience during year one as to the types of patients and type of support that there is the most demand for, from 2018/19, the activity level of certain contracts (e.g. residential care based intermediate care) may need to be adjusted.

Mental Health - Having considered the implications for Mental Health Services of the 'NHS Operational Planning Guidance 2016/17 – 2018/19' a range of commissioning stances have been developed which span the breadth of mental health services. These include:

- Support continued implementation of the All-age Mental Health and Wellbeing Commissioning Strategy. This will include exploring opportunities to develop locality models in line with those described in the Primary Care section above.
- Expansion of IAPT to increase access in line with national recommendations – to incorporate Long Term Conditions.
- Support continuation of Recovery College model (no additional resources required) as there are robust links with IAPT. Commissioners will use the findings from the provider review of the Barnsley Recovery College model and costs and published evidence base to determine whether the model could deliver improved outcomes and greater accessibility in a more cost effective way to support Mental Health 5 Year Forward View priorities. This commissioner review in 2017/18 may lead to changes in 2018/19.

- Continue to support Early Intervention and Prevention (EIP) services to achieve national access and waiting time standards.
- Support the CORE 24 24/7 Psychiatric Liaison service and either:
    - Support expansion of the current service to enable access to 16+ year olds, or
    - Develop CAMHS service to provide psychiatric liaison services to 16 and 17 year olds
- Support the development of a Specialist Perinatal Mental Health Team and the continuation of the Specialist Mental Health Midwife role at BHNFT (via Specialist Development Fund application) in the first instance.
- Continue to implement the Barnsley Local Transformation Plan to improve the emotional health and wellbeing of children and young people in Barnsley.
- Support the development of a crisis café, linked to the Department of Health Place of Safety allocation process in parallel with supporting the accessing of funding to re-establish a street triage service – both elements are fully endorsed by the Barnsley Mental Health Crisis Care Concordat.
- CYP IAPT – support the ongoing delivery and developments to ensure continuation of robust service delivery, in light of reduced financial support from NHS England.
- Support the continuation of the Yorkshire and Humber Veterans Mental Health Outreach Service located in Hull.
- Work with service providers to reduce the lengthy waits for Psychological services.
- Primary care mental health – support the introduction of an increased number of mental health therapists, as nationally recommended.
- Support the Barnsley Suicide Prevention Strategy and implementation of the Suicide Prevention Action Plan, currently out to consultation

The CCG, with partners, will further develop **services for people with dementia** ensuring high quality throughout the pathway, including for patients in care homes, that reflects the priorities within the Prime Ministers Challenge on Dementia 2020

Building on the successful development of **RightCare Barnsley** further work will be undertaken to deliver the re-specified **'Intermediate Care'** (IC) offer which will include RightCare Barnsley as the broker to all out of hospital services in the borough. This will include the re-specified **Community Nursing** offer implemented in Quarter 3 of 2016/17, improved support to patients in Care Homes and consideration of how the Care Navigation Service and Falls Service resources can be utilised in a more integrated way within the IC offer. This integrated service offer will be managed by an alliance contract, assisted by locality working, and will be a key vehicle to modelling the work required in MCP development and the focus and operation of the Accountable Care Organisation described earlier. In addition, through the use of the Medworxx Tool and its role as gatekeeper to hospital care, RightCare Barnsley will maximise the best use of both hospital and out of hospital resources for the benefit of the Borough's health and social care system.

Diabetes and Respiratory Services - New service specifications for integrated care for diabetes and COPD were agreed with Providers in early 2016. Providers who

are part of the virtual MCP model (BHFNT, SWYFT and BHF) are asked to agree with the CCG their delivery model, activity levels, key performance indicators, milestones for implementation and monitoring arrangements. In addition any clarifications/amendments required to the service specifications will be agreed with Providers by the end of February 2017.

There is a close overlap between the Respiratory MCP service specification and the Respiratory Commissioning for Values priorities. Where appropriate the respiratory CvF priorities will be integrated into the respiratory MCP work. (see Appendix 1)

The agreed respiratory (COPD) service specification also notes the need for the range of conditions included in the MCP model to be expanded to cover other respiratory conditions. This will be developed with Providers during 2017/18 and 2019/18.

Diabetes is also included in the Cardiovascular Commissioning for Value pack. It is possible that once detailed analysis of the pack has been undertaken, that some additional priorities for diabetes will be identified and need to be integrated into the diabetes MCP work.

During 2017/18 we particularly wish to see, for all patients across all our practices:

- A phased move of patients with diabetes currently under secondary care outpatient follow-up who do not have complex needs back to primary care for their ongoing management.
- Commencement of a structured patient education programme for type one diabetes and more patients with type two diabetes being able to access a structured education programme
- Development and implementation of a general, and targeted, offer from respiratory and diabetic specialists to support general practices to develop their skills and confidence in managing patients with these conditions. It is anticipated that this will take the form of training, targeted support to practices, increased availability of advice and joint clinics/telehealth consultations.
- A step change in the numbers of people with COPD being referred for and receiving pulmonary rehabilitation, increasing to 400 by 2018/19.
- A clear pathway for long term oxygen assessment and follow up, and use of oxygen concordance data to inform the review and prescribing of long term oxygen.
- Increase in the proportion of patients with COPD and asthma who have had a primary care annual review within the last 12 months.
- An increase in confidence of primary care staff in the use and interpretation of spirometry; an increase in the proportion of patients whose diagnosis of COPD has been confirmed by spirometry and COPD register validation.
- Primary care proactive case management of patients with frequent hospital admissions from COPD, with support from specialist services where appropriate.

- Increase in the access to respiratory expertise within A&E and closer working between respiratory teams, A&E and RightCare Barnsley to help to avoid admissions.
- Improved discharge support for patients who have been admitted with respiratory disease.

Barnsley CCG is the lead for the STP footprint for the SY&B area for the **National Diabetes Prevention Programme NDPP**. In 2017/18 the CCG will co-produce, with primary care and diabetes specialists, pathways to enhance the early identification and management of people with non-diabetic hyperglycaemia.

Cardiovascular Disease - Building on the work undertaken in 2016/17 with the Cardiology Steering Group and following initial review of the Cardiovascular Commissioning for Value Pack, during 2017/18 and 2018/19 the CCG will:

- Support primary care practices to decrease the variation and 'raise the bar for all' in the quality of primary and secondary prevention for cardiovascular disease and diabetes in primary care
- Work with providers to implement a new referral pathway for patients with suspected heart failure
- Revise the service specification for the Community Heart Failure Service, reflecting new heart failure pathways.
- Review the provision of cardiac rehabilitation and of urgent advice for patients with chest pain, and look at ways to increase direct access to cardiac investigations and advice and guidance to enable more patients to be managed without the need for a cardiology outpatient appointment.

The CCG will work with other commissioners and providers of **Cancer Services** to deliver the National Cancer Strategy and recommendations from the Cancer Task Force. There will be a specific focus on:

- Early Diagnosis – Reviewing diagnostic capacity, increasing the focus on screening programmes.
- Improved Care Pathways to reduce waiting times across the whole pathway from Primary Care through to end of treatment. This will include supporting direct referrals form Primary Care.
- Living with and beyond cancer – Support the delivery of the living with and beyond cancer programme.

Medicines (including use of Summary Care Record/MIG information) Medicines Reconciliation. Transfer of care and discharge management are key issues identified nationally. This Medicines Optimisation commissioning intention is for the introduction of a system for medicines reconciliation to improve communication between care settings and to promote learning and analysis. For 2017/18 this includes:

- Development of medicines related communication systems when patients move from one setting to another to ensure clear information on medication is available to support patient care.

- Discharge transfer of care communication will contain a minimum dataset of information.
- Trusts to code medicines related admissions for analysis, learning and prevention.
- The GP practice information (Summary Care Record or MIG) will be used as the primary source (of the two minimum sources) of information for clinicians undertaking Medicines Reconciliation.

Medicines (High cost drugs/ Homecare) - A high cost drug and homecare service specification has been developed for contract inclusion in 2016/17. This specification defined the requirements of appropriate management of HCD and Homecare medicines. This includes:

- Homecare to be provided in line with Department of Health commissioned paper “Hackett Report”
- Provision of data in line with a minimum dataset (through the nationally commissioned Blueteq system)

Medicines Management commissioning intentions for 2017/18 to expand on the work undertaken in 2016/17 to ensure consistency in approach with NHS England Specialised Commissioning. This includes:

- Homecare delivered in line with the Hackett report (National guidance compliant):
    - Review of existing services to ensure continued benefit and effectiveness.
    - Exploring new and alternative options for homecare service provision (e.g. outsourced outpatient pharmacy)
    - Considering a scope of a procurement solution for Homecare services (as an alternative to existing SBS options).
- High cost drugs delivered in line with the service specification:
    - Development of cost improvement opportunities e.g. biosimilars, batch manufacturing, dose banding.
    - Horizon scanning to allow financial forecasting/planning
    - HCD bench marking to ensure consistency in use across regional trusts (monitored against national and local guidance/pathways)
    - Management of the transfer of commissioning responsibility from NHSE Specialised Commissioning to CCGs
- Service redesign to review existing services to ensure continued benefits for the health economy, this includes: Rheumatology, Gastroenterology and Ophthalmology services. e.g. commissioning of community based ophthalmology services, commissioning AMD services to allow the provision of Avastin through choice.

APPENDIX A

Phase 1Commissioning for Value Priorities

Medicines management	• Comprehensive medicines optimisation programme • Focus on reducing medication wastage • Introduction of clinical pharmacists in primary care
Musculoskeletal disease and trauma	• Review of MSK service • Review of use of injections for low back pain and acupuncture • Implementation of Map of Medicine pathways with hip and knee pain • Review of services for falls and osteoporosis prevention and management
Respiratory Disease	• Increasing uptake of flu / pneumococcal vaccinations • Increasing Stop Smoking service links with clinical pathways • Primary care proactive case management of patients with frequent hospital admissions from COPD – adding COPD patients who have had 3 or more admissions to ProCare Barnsley cohort. • Increase access to respiratory expertise within A&E and closer working between respiratory teams, A&E and RightCare Barnsley to improve the identification of people who could be supported in community rather than being admitted and ensure they get the appropriate community support. • Improved discharge support for patients who have been admitted with respiratory disease • Having a step change in numbers of patients receiving pulmonary rehabilitation, increasing to around 400 a year • Ensure that a clear pathway and service is in place to assess and manage patients who require Long Term Oxygen Therapy (LTOT) • Use Oxygen Supplier's concordance data and tools to inform LTOT management • An increase in confidence of primary care staff in the use and interpretation of spirometry; an increase in the proportion of patients whose diagnosis of COPD has been confirmed by spirometry and COPD register validation
Complex patients	• Roll out of Pro-care to support case management of complex patients in Primary Care
Cardiovascular disease	• Increased focus on 'Making Every Contact Count' and provision of brief advice, and onward referral to services, to support smoking

(based on initial review)	cessation, increases in physical activity, weight management and sensible use of alcohol • Support primary care practices to decrease the variation and 'raise the bar for all' in the quality of primary and secondary prevention for cardiovascular disease and diabetes in primary care • Development of the current Primary Care Health Inequalities Targeted Service (HITS) CVD related indicators including hypertension and AF case finding and management of patients at high risk of developing CVD • Development of care pathways for patients with non-diabetic hyperglycaemia, linking with the national roll out of the National Diabetes Prevention Programme. • Work with providers to implement new pathways for patients with heart failure • Review the provision of: o cardiac rehabilitation o urgent advice for patients with increasing chest pain o look at ways to increase direct access to cardiac investigations and advice and guidance to enable more patients to be managed in primary care without the need for a cardiology outpatient appointment.