Outcome Ambition	Overarching Indicator	Narrative	Measures and Rationale
Ambition 1 Securing additional years of life for people with treatable MH and physical health conditions	C1.1 Potential years of life lost to causes considered amenable to healthcare. Adults, children and young people (NHS OF 1ai & ii)	Premature deaths from circulatory disease continue to be the greatest contributor to the gap in life expectancy between Bury and the rest of England, followed by cancer and thirdly respiratory diseases. By improving the identification and management of patients with or at high risk of CVD the burden of this disease will be reduced in Bury. Health inequalities will be systematically addressed through the Better Together collaborative, driving up the quality of care and improving outcomes through the provision of quality data at practice level and support to reduce clinical variation. NHS Health Checks will be delivered by every member practice with prioritisation of those at highest risk of CVD and drive to continually improve uptake rates. Integrated services will be implemented for cardiology, diabetes and respiratory services with focus on greater uptake and completion of cardiac and pulmonary rehabilitation.	E.A.1 PYLL (Rate per 100,000 population) Baseline 2660.5 2014/15 2575.4 2015/16 2493.0 2016/17 2413.2 2017/18 2336.0 2018/19 2261.2 3.2% Year on year
Ambition 2 Improving the health related quality of life of the 15 million + people with one or more LTC including MH conditions	C 2.1 Improved health related quality of life for people with LTC	The CCG has identified a range of activities that will be operational in 2014/15 and beyond, these include: • Clinical Leadership: Bury CCG has invested in a Clinical Leadership model which provides experienced clinical leads for LTC and Mental Health with dedicated time to support developments within their respective agenda and often work closely together given many of the interdependencies. • Patient Engagement: Bury CCG is supported by a robust Patient Cabinet, which has identified leads across services areas, who link closely to clinical and managerial leads to help inform, develop and critic proposals. • LTC: Bury CCG is engaged in range of activities to support patients with LTC. The CCG is activity participating the LTC AQUA programme which sees the risk stratification of patients, the development of MDTs and the promotion of shared decision making. The CCG are also currently reviewing with PCNHSFT the impact of Care co-ordinators, Telelhealth. • Asthma: Asthma is a particular priority for the CCG in 2013/14 and beyond. 2013/14 focused on Asthma, cumulating in a training programme for all GP practice and Pharmacist on Asthma Inhaler Techniques. • Integrated Community Diabetes: Bury CCG has been working jointly with HMR CCG and	E.A.2 Average EQ-5D score for people reporting having one or more long-term condition Baseline 70.4 2014/15 71.4 2015/16 72.9 2016/17 73.1 2017/18 73.3 2018/19 73.5 Aim to achieve the England rate by 15/16 (stretch target in 2nd year) with the current England change rate of 0.2 applied each year thereafter.

		currently providers, PANHT and PCNHSFT to implement an Integrated Community Diabetes Service. The service goes live in April 2014 with a ramp up period to full delivery. The service has been designed around the 9 key care standards, see below, the need to move services closure to patients in the community, service delivery will be over 6 instead of 5 days a week, educational sessions for patients and clinicians are planned as is better communications across all parties. • Integration Agenda: With the greater access to primary care and the greater integration between stakeholders it is anticipated that LTC patients will notice the improvements and report these accordingly via the National Patient Survey. The CCG is currently developing its integration plans using its infrastructure of four sectors across the borough. Plans are well developed in the West Sector which was successful in obtaining National Demonstrator Site status. The five practices in the West Sector are already offering an enhanced primary care offer for the residents of Radcliffe, this offer includes 7 day working. • Care Homes LES: Whilst not targeting patients with LTC solely it is accepted that a large proportion of the patients covered by this arrangement do have one or more LTCs. Bury CCG is currently reviewing its Care Home LES. The LES started in 2013/14 and is set to continue for another year. Initial indications suggest a significant impact across several areas as a result of the LES. Home engaged in the LES are seeing reduced Non Elective Activity as a result of the additional support by GP practices. Longer Term the CCG is engaging a review of all community services with a view to redesign or re-procurement. In 2014/15 the CCG is establishing arrangements for an Integrated Community Respiratory Service and an Integrated Community Cardiology Service.	
	C 2.13 Estimated Diagnosis Rate for people with dementia	- Audit of GP Clinical Systems – working with the Data Quality Team and GPs to improve the recorded prevalence of dementia. - Dementia DES- Woking with Data Quality Team and GPs to search GP systems to identify patients at risk of Dementia who may not have a formal diagnosis - Dementia DES – Monitoring activity and promoting the DES with GPs. - Nursing Home LES (includes Dementia Screen) – Monitoring activity and promoting the LES with GPs - Promoting Dementia Pop Up Cafes in Bury - Support implementation of the National Dementia CQUIN (Indicator: Dementia - FIND, ASSESS, INVESTIGATE & REFER) - Membership of the Bury Dementia Action Alliance - Involvement in the discussions with Making Space re: Dementia Hub in Bury - Implementation of the Joint Dementia Strategy and Action Plan with the LA	ii) Dementia % Diagnosis 2014/15 - 0.67 2015/16 - 0.68 4. Quality Premium Local Indicator Dementia Diagnosis – Stretch Target 2014/15 0.68

	C 2.11 Recovery following talking therapies for people of all ages	- Working with IAPT service manager to promote the range of brief Cognitive Behavioural Therapy based interventions (super seminars, well being workshops) available to people of all ages, amongst GPs, pharmacist, and third sector organisations via posters, sector briefings and education. - Pharmacy pilot - IAPTS text service developed to allow people to opt into the service and to remind them about their appointment to encourage completion of treatment - Targeting of specific groups e.g. MUPS, LTC Work with LA and Public Health to develop referrals/signposting between IAPTS, Health Trainers, BEATS, Carers Centre etc Monthly meetings take place with the CCG and PCFT to monitor progress against the prevalence target and recovery target.	E.A.4 IAPT Proportion of people who receive therapies Q1 - 3.1% Q2 - 3.2% Q3 - 3.5% Q4 - 3.8% Aim to achieve the 15% target by Q4. 2015/16 - 15% E.A.S.2 IAPT Recovery 2014/15 - 45.6% 2015/16 - 50.0% Aim to achieve 50% by Q4 of 2014/15 and the full 50% in year 2015/16
Ambition 3 Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	C 3.1 Emergency admissions for acute conditions that should not usually require hospital admissions C 3.2 Emergency admissions within 30 days of discharge	The CCG has identified a range of activities that will be operational in 2014/15 and beyond, these include: • Manage the Urgent care Network. Bury CCG provide co-ordination for the NES Urgent Care Network Board. Participation in this network helps the NES CCGs to work collectively with PAHT and other stakeholders to address issues, manage and monitor the wider agenda. The co-ordination with other stakeholders such as Social Care, OHHs, NWAS, Mental Health, through this network is a key factor in helping to reduce emergency admissions. • Winter Planning: Each year the CCG develops its winter plans. Plans are mindful of the need to prioritise the co-ordination of services and ensure support for the elderly and frail and those with LTC's. Plans focus on communications to patients and the need for robust links between agencies to help facilitate safe discharge from hospital. Where pressures in the urgent care system are identified there are robust escalation procedures in place.	E.A.4 Emergency admissions composite indicator Baseline 2,931 2014/15 2,784 2015/16 2,345 2016/17 2,298 2017/18 2,252 2018/19 2,207 2013/14 projected outturn 2,173 (per 100,000) is an improvement

		• Clinical Leadership: Bury CCG has invested in a Clinical Leadership model which see experienced clinical leads for Urgent Care and Long Term Conditions. These clinical leads have dedicated time to support developments within their respective agenda and often work closely together given the obvious interdependencies. • Patient Engagement: Bury CCG is supported by a robust Patient Cabinet. The cabinet has identified leads across services areas who link closely to clinical and managerial leads to help inform, develop and critic proposals. • LTC: Bury CCG is engaged in range of activities to support patients with LTC. The CCG is activity participating the LTC AQUA programme which sees the risk stratification of patients, the development of MDTs and the promotion of shared decision making. The CCG are also currently reviewing with PCNHSFT the impact of Care co-ordinators, Telelhealth. A particular priority for the CCG in 2013/14 and beyond has been a focus on Asthma cumulating in a Training programme for all GP practice and Pharmacist on Asthma Inhaler Techniques. • Integrated Community Diabetes: Bury CCG has been working jointly with HMR CCG and currently providers, PANHT and PCNHSFT to implement an Integrated Community Diabetes Service. The service goes live in April 2014 with a ramp up period to full delivery. The service has been designed around the 9 key care standards, see below, the need to move services closure to patients in the community, service delivery will be over 6 instead of 5 days a week, educational sessions for patients and clinicians are planned as is better communications across all parties. • Integration Agenda: The CCG is currently developing its integration plans using its infrastructure of four sectors across the borough. Plans are well developed in the West Sector which was successful in obtaining National Demonstrator Site status. The five practices in the West Sector are already offering an enhanced primary care offer for the residents of Radcliffe, this offer included 7 day working. • Care Homes LES: Bury CCG is currently reviewing its Care Home LES. The LES started in 2013/14 and is set to continue for another year. Initial indications suggest a significant impact across several areas as a result of the LES. Home engaged in the LES are seeing reduced Non Elective Activity as a result of the additional support by GP practices. • Reablement: As plans are developed further with the Local Authority around the Better Care Fund, historical arrangements to support re-ablement will roll forward. These arrangements see the integration of staffing across PCNHSFT and the Local Authority	2014/15 target is a 5% reduction from baseline a reduction of 147 (5%) 2015/16 figure sees a further 15% reduction from baseline of 439 (15%) 2016 -19 set at rolling 2% reduction – work in continuing on this 4. Activity Measures A&E Attendances - all types Forecast Growth 14/15 -3% 15/16 -12% 16/17 - 2% 17/18 - 2% 18/19 - 2% 15% reduction in first 2 years in line with CCG direction and a further 2% for the years onward

		under a single management arrangement. A key component to plans is the configuration of Crisis Response services. • Crisis Response: The Crisis Response Team (CRT) is a multi-disciplinary team consisting of health & social care professionals, OT and night sitter support for Bury patients over the age of 18 (although the average age of referrals is 81) who are in crisis although medically stable. The service runs between 8.00am – 10.00pm 7 days per week. Referrals can be made by any Bury clinician. The CRT respond to the referral within 2 hours and the patient receives a comprehensive assessment and a package of care is wrapped around the patient for up to 72 hours to allow the patient to recover in their own home. If the patient requires additional support then the CR Team can place the patient into a 72 hour assessment bed, however the overall ethos of the team is to keep the patient within their own home whilst they recuperate from their illness. The service is committed to work with the reablement service around readmissions and post discharge support. Longer Term the CCG is engaging a review of all community services with a view to redesign or re-procurement. In 2014/15 the CCG is establishing arrangements for an Integrated Community Respiratory Service and an Integrated Community Cardiology Service.	
Ambition 5 Increasing the number of people who have a positive experience of hospital care. **Ambition 6** Increasing the number of people with MH and Physical conditions having a positive experience of care outside of	C 4.1 Patient experience of GP Out of Hours	The most recent data for January 2013 to September 2013 gives patient experience ratings of: Bury – 69% Greater Manchester – 71% England – 68%. The rate for Bury OOH has dropped from 72% for the 9 month period to June 2012. The Greater Manchester (GM) rate has dropped from 73% over the same period. The GM CSU have finalised a new performance & quality report for all OOH providers, which will be circulated to CCGs following internal sign-off on Friday 17th Jan. The CSU will then coordinate monthly quality and performance meetings – likely to be held jointly for both Bury and HMR CCGs. Patient experience of OOH services will be a standing agenda item with the CCGs seeking assurances around the capture patient experience data and the use of the information to inform service delivery. Pennine Acute Hospital Trust (PAHT) The most recent available data for 2011/12 shows that for PAHT the overall patient experience score is 75% versus 78% at the '80th percentile' nationally. The most significant variance was in 'access and waiting' and 'better information, more choice'.	E.A.7 The proportion of people reporting poor experience of General Practice and Out-of-Ours Services Baseline 6.2 2014/15 5.9 2015/16 5.6 2016/17 5.3 2017/18 4.0 2018/19 4.7

hospital, in General Practice and in the community	C 4.2 Patient Experience of hospital care	PAHT capture patient experience via a number of different channels including: • Ward level – 'techno huddle' data, which gives real-time patient feedback • The Friends and Family Test • Local Patient Surveys This gives patient experience feedback across the 5 key domains: • Access and Waiting • Safe, high quality, coordinated care • Better information, more choice • Building closer relationships • Clean, comfortable friendly place to be Information resulting from these channels is discussed at the monthly NE Sector Clinical Quality Leads Meetings – with CCG assurance sought around data capture, use of the information to inform service change, and future ambition. Patient experience information is also used to information the CCG's Service Walkaround Schedule. PAHT have recently refreshed their quality strategy. Pennine Care Foundation Trust (PCFT) The most recent available data for 2006/07 shows that for PCFT the overall patient experience score is 76% versus 77% at the '80th percentile' nationally. The trust captures patient experience via a number of different channels including: • By using 'Elephant kiosks', which gives information around care quality. • Feedback captured by giving email and telephone number on the reverse of appointment cards. • PALS • Complaints • CJ to add information from CQL in September The trust are in the process of completing a review to triangulate PALS, patient experience	E.A.5 The proportion of people reporting poor patient experience of inpatient care Baseline 124 2014/15 121 2015/16 118 2016/17 115 2017/18 112 2018/19 110

	C4.3 Friends and Family Test for acute inpatient care and A&E	and complaints data – looking across the breadth of patient experience information to give a broader understanding of experience by service. As above - Information resulting from these channels is discussed at the monthly NE Sector Clinical Quality Leads Meetings – with CCG assurance sought around data capture, use of the information to inform service change, and future ambition. Patient experience information is also used to information the CCG's Service Walkaround Schedule. Analysis of the first 6 months of FFT implementation is being completed nationally and due for imminent release. The GM LAT intends to schedule Workshops, following these and the release of national guidance, a trajectory can be agreed with the providers, which will be split into two measures - the response rate and the net promoter score.	E.A.6 Do you plan to meet the nationally set objective for the Friends and Family Test in 2014-15 and 2015/16? Yes
Ambition 7 Making Significant progress towards avoidable deaths in our hospitals caused by problems in care.	C5.1 Patient safety incidents	Pennine Acute Hospital Trust During 1ST October 2012 to 31st March 2013 there were 5192 reported incidents, equating to 4.8 per 100 admissions. The average number of incidents for 'large acute trusts' is in the region of 7 incidents per 1000 admissions. Bolton – 2600, 6.3 per 100 admissions. Salford – 3874, 9.4 per 100 admissions. CMFT – 11,495, 13.7 per 100 admissions. In response to their position as a relatively low reporter of incidents, Pennine Acute Trust has recently completed an incident reporting review – the results of which will be presented internally to the PAHT board in February and to the NE Sector Clinical Quality Leads in March. Catherine Jackson has requested a position statement ahead of the formal report. Serious Incidents The NE sector CCGs have established an incident review management process for PAHT and each CCG takes a lead role – Bury (community services); HMR (mental health) and Oldham (PAHT). The CCGs meet monthly to review the incidents reported on the STEIS system, discuss the root cause analysis and understand any lessons learned. Pennine Care Foundation Trust PCFT are a relatively high reporter of patient safety incidents – during October to March 2013, PCFT reported 25 incidents per 1000 bed days versus 18 for Greater Manchester West, and 8 for Manchester Mental Health. Reported incidents are analysed by the CSU and	E.A.9 Have you agreed (in conjunction with your Health and Wellbeing Board and NHS England area team) a specified increased level of reporting of medication errors from specified local providers between Q4,2013/14 and Q4, 2014/15? No To go to H&WB board for discussion on the 6th March 2014 E.A.S 5. C.Difficile infection rates set at 2013/14 rates as per direction from the LAT.

		reviewed at the monthly NE Sector Clinical Quality Review Meetings – to discuss root cause analyses and to seek assurances around lesson learned.	