NHS
South Yorkshire
Integrated Care Board

Practice Delivery Agreement 2025/26

Barnsley Practice Delivery Agreement

Purpose

The aim of the PDA is to invest in the capacity needed to deliver a consistently high standard of General Practice across Barnsley. The PDA is reviewed and refreshed annually with consideration to the challenges for Primary Care and alignment with Barnsley place priorities.

The PDA has been established since 2014/15 changing each financial year to address variation and prioritise.

PDA 2024/2025 Achievement

PDA breakdown 2024/25 -

- PDA Core - £1,691,206
- MMT - £1,518,429
- Eclipse - £68,135
- Shared Care - £357,698
- Anticoag - £218,079
- **Total £3,853,54**

Achievement	No of practices
100%	15
95% or more	11
87%	1
59 – 63%	3
19%	1

High Level Outcomes

1564 Patients had been reviewed for potential undiagnosed COPD & Asthma. From this **460** patients were diagnosed with Asthma, **162** with COPD, **10** patients with COPD & Asthma. **165** patients have been referred for onward investigation.

672 Patients with COPD at high risk of admission have received a proactive review from their GP practice aimed to put proactive measures in place to avoid admission.

972 COPD patients who had previously not received the PPV vaccine have been vaccinated as a preventative measure.

1646 Aging well assessments were delivered

High Level Outcomes

551 new patients diagnosed with hypertension

1951 patients had a review of their lipids and medication and were optimised as per NICE guidelines.

1359 patients were screened for diabetes – **158** patients were diagnosed as having diabetes and **786** patients coded as pre-diabetes.

78 Women with Gestational Diabetes who didn't have a HbA1c in 12 months now have a HbA1c completed - **10** women diagnosed with diabetes

2025/2026

- Scheme ideas were invited from all partners across the system on the key initiatives that could be undertaken in primary care to improve the health of Barnsley people.
- A PDA Working Group of GPs, Public Health and the ICB reviewed schemes and proposed 16 schemes to Barnsley SMT for approval.
- 16 Schemes in total were agreed, a breakdown is on each table.
- All approved schemes were sent out 01 April 2025.
- Since this time we have been working with ARDENS to develop the pathways in ARDENS Manager – practices now only need to add READ Codes into patients records which will automatically update ARDENS Manager on PDA progress.
- This work is complete and all practices can commence the 25/26 PDA work.

2025/26 Schemes

Respiratory

Scheme 1: Reduction of patients on 6 or more SABA inhalers with a diagnosis of Asthma.

Scheme 2: Review of all patients on 5 or more SABA with no diagnosis of COPD & Asthma.

Scheme 3: Achieve a reduction of Asthma Patients on SABA only and no ICS ever or within last 12 months

Scheme 4: Review of COPD & Asthma high risk patients to ensure that they are fully optimised to avoid the need for emergency care and offer an early intervention. All high risk COPD patients should be referred to BREATHE.

Scheme 5: Ensure that all newly diagnosed COPD & Asthma Patients are reviewed in practice within the first 3 months of diagnosis and have had their inhaler technique assessed and self-management plan completed.

2025/26 Schemes

CVD

Scheme 6: Hypertension case-finding: All patients with latest systolic BP > 160 and on anti-hypertension medication and no code of hypertension in deciles 1 & 2 and under 60.

Scheme 7: Increase the % of patients diagnosed with Hypertension treated to NICE guidelines

Scheme 8: Lipid Optimisation for patients with a QRISK over 20%, under 60 years, not on high intensity lipid lowering therapy.

Scheme 9: Heart Failure - Ensure every patient newly coded from 01 May 2025 with Health Failure has a review within 6-months.

2025/26 Schemes

DIABETES

Scheme 10: Ensure all patients coded Gestational Diabetes Meliltus (GDM) have annual bloods and referral to NDPP.

Scheme 11: Early onset diabetes - Increasing the completion of all the 8 key care processes through targeted intervention for each person with Early Onset Type 2 Diabetes age 18-39.

Scheme 12: Non-Diabetic Hyperglycaemia - Patients with HbA1c 42-47 who have not been coded as NDH to have a review.

Scheme 13: Diabetes Case Finding - Case finding potentially undiagnosed diabetes. ARDENS search for 2 or more HbA1c >=48mmol/mol in the last 12 months.

Scheme 14: Renal UACR – Practice to increase % diabetics and CkDG3a+ who have UACR done.

2025/26 Schemes

Scheme 15: Embed a direct referral process to Yorkshire Smokefree / Accurate recording of QUITS
(for practices delivering the service in house the scheme aims to ensure that the number of QUITs are accurately recorded, for practice who use Yorkshire Smokefree they must embed a direct referral process rather than patient self referral).

Scheme 16: Phlebotomy Provision

- New Scheme to provide funding and consistent service specification for phlebotomy delivered in General Practice
- This scheme only covers phlebotomy generated by the practice and excludes phlebotomy requested externally
- The specification requires all practices to provide an urgent phlebotomy service to their registered patients within 5 days of need.
- Routine phlebotomy can be delivered within the practice or via the CDC

2025/26 PDA

SCHEME	VALUE
Respiratory	£270k
CVD	£378k
Diabetes	£378K
Smoking	£55k
Phlebotomy	£650k
Total	£1.7m

2026/2027

We are starting to work through a process for the developing the 26/27 PDA.

We need to reconigse early that the 26/27 PDA **may** look different as we start to move towards more neighbourhood health models and also as we work through a South Yorkshire review of locally commissioned services from Primary Care to get alignment across South Yorkshire.

If anyone would like to be involved in the 2026/27 PDA development please contact Dr Guntamukkala.