NHS
Wolverhampton
Clinical Commissioning Group

Meeting of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 4th April 2017
2.00 pm
Technology Centre, Wolverhampton Science Park

A G E N D A

1	Welcome and Introductions	Chair	Verbal
2	Apologies	Chair	Verbal
3	Declarations of Interest	All	Verbal
4	Minutes of the Primary Care Joint Commissioning Committee held on 7th March 2017	Chair	1 - 8
5	Matters Arising from the Minutes	All	Verbal
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7	Medicines Optimisation QiPP 2017/2018	David Birch	23 - 54
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9	Draft Minutes of the Primary Care Strategy Committee	Sarah Southall/ Steven Marshall	63 - 74
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11	Any Other Business	All	Verbal
12	Date of Next Meeting		

For further information on this agenda or about the meeting generally, or to submit apologies for absence, please contact Laura Russell on 01902 444613 or e-mail Laura.Russell4@nhs.net

NHS
Wolverhampton
Clinical Commissioning Group

MEMBERSHIP	
Wolverhampton CCG	Dr D Bush Dr D De Rosa Mrs M Garcha Dr H Hibbs Mr S Marshall Peter Price Dr Reehana Ms P Roberts Mrs C Skidmore
Patient Representatives	Sarah Gaytten Jenny Spencer
Invitees (Non-Voting)	Elizabeth Learoyd (Healthwatch) Ros Jervis (Health and Wellbeing Board)

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE JOINT COMMISSIONING COMMITTEE

Minutes of the Primary Care Joint Commissioning Committee Meeting (Public)
Held on Tuesday 7th March 2017, Commencing at 2.00 pm in the in the Stephenson Room, 1st Floor, Technology Centre, Wolverhampton Science Park

MEMBERS ~
Wolverhampton CCG ~

		Present
Pat Roberts	Chair	Yes
Dr David Bush	Governing Body Member / GP	Yes
Dr Manjit Kainth	Locality Chair / GP	No
Dr Salma Reehana	Locality Chair / GP	Yes
Steven Marshall	Director of Strategy & Transformation	Yes
Manjeet Garcha	Executive Lead Nurse	No
Peter Price	Lay Member (Vice Chair)	No

NHS England ~

Alastair McIntyre	Locality Director	Yes
Gary Lucking	Contract Manager	Yes
Bal Dhami	Contract Manager	Yes
Karen Payton	Senior Finance Manager (Primary Care)	Yes

Independent Patient Representatives ~

Jenny Spencer	Independent Patient Representative	No
Sarah Gaytten	Independent Patient Representative	No

Non-Voting Observers ~

Ros Jervis	Service Director Public Health and Wellbeing	Yes
Tracy Cresswell	Community Engagement – Wolverhampton Healthwatch	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
Jeff Blankley	Chair - Wolverhampton LPC	No

In attendance ~

Mike Hastings	Associate Director of Operations (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Jane Worton	Primary Care Liaison Manager (WCCG)	Yes
Claire Skidmore	Chief Finance and Operating Officer (WCCG)	Yes
Helen Hibbs	Chief Accountable Officer	No
Sarah Southall	Head of Primary Care	No
Laura Russell	Primary Care PMO Administrator (WCCG)	Yes

Welcome and Introductions

PCC321 Ms Roberts welcomed attendees to the meeting and introductions took place.

Apologies for absence

PCC322 Apologies were submitted on behalf of Dr Helen Hibbs, Manjeet Garcha, Sarah Gaytten, Peter Price, Gill Shelley, Anna Nicholls, Elizabeth Learoyd, Dr Kainth and Sarah Southall.

Declarations of Interest

PCC323 Dr Bush and Dr Reehana declared that, as GPs they had a standing interest in all items related to primary care.

As these declarations did not constitute a conflict of interest, all participants remained in the meeting whilst these items were discussed.

RESOLVED: That the above is noted.

Minutes of the Meeting Held on 7th February 2017

PCC324 RESOLVED:

That the minutes of the previous meeting held on 7th February 2017 were approved as an accurate record subject to the following amendment:

PCC303 NHS England Update (Page 3) - A spelling mistake it should read *'This will take affect from October 2017'.*

Matters arising from the minutes

PCC325 There were no matters arising from the minutes.

RESOLVED: That the above is noted.

Committee Action Points

PCC326 **Minute Number PCC176 – Premises Charges (Market Rent Reimbursement)** Ms Payton confirmed she had provided the contact details regarding accessing funding for NHS Property Services/Community Health Partnership Premises Charges. This information had been shared with Practices on the 2nd March 2017. Action closed.

Minute Number PCC302 – Premises Charges (Rent Reimbursement)
NHS England confirmed they are still awaiting the new cost directives and have been informed they should receive this in April 2017. This will help to provide clarity on rent reimbursement in relation to when Practices allow other service providers using their rooms such as midwives.

Minute Number PCC283 – Wolverhampton CCG Update
It was confirmed that Ms Southall will provide a joint evaluation report on the two extended opening hours scheme at the May Meeting.

Minute Number PCC304 NHS England Finance Update
The month 10 report has been provided and is on the agenda for discussion. Action closed.

Minute Number PCC305 Wolverhampton CCG Update
The General Practice Five Year Forward Plan has been provided and is an agenda item for discussion. Action closed.

Minute Number PCC307 Primary Care Operational Management Group Meeting
The full delegation agreement has been shared and is on the agenda. Action closed.

RESOLVED: That the above is noted.

NHS England Update – Primary Care Update

PCC327 Mr McIntyre advised there were no further updates from the National or Regional Team for this month.

RESOLVED: That the above is noted.

NHS England Finance Update

PCC328 Ms Payton informed the Committee the 2016/2017 GP Services allocation for the CCG at month 10 is £33.1m. The Forecast outturn is £33.1m and delivering a breakeven potion.

The Committee were advised the contingency of £34,000 availability at the last meeting has now been brought into the position following the month 10 review and has been fully utilised.

The allocation to fund GP Services for 2017/2018 will be £34.8million and the financial plans have been completed and submitted.

NHS England are still awaiting the final confirmation of the Global Sum value for 2017/2018 in order to incorporate the changes to the GP contracts.

NHS England West Midlands are still working with the CCG during April and May 2017 to ensure the CCG are fully delegated.

Ms Payton provided the details of the indicative funding in relation to the GP Forward View investments and confirmed the CCG have submitted their plans to NHS England on how they will utilise the funding.

Mr Hastings queried regarding the EFFT Cohort 2 schemes as it states they have been supported in principle and asked if this is same as the cohort 2 business cases. Ms Payton confirmed it was the cohort 2 business cases which have followed the local dual diligence process and in principle they have been agreed. The cohort 2 schemes are within the next stage of approval at National level.

Mr Hastings asked if there was any update on the ETTF cohort 3 bids, Ms Payton stated they are still awaiting advice and that is would be dependent on how the current schemes are progressing.

RESOLVED: That the above is noted.

Wolverhampton CCG Update

PCC329 Mr Hastings provided the following update on the work being progresses within Primary Care:

- Wifi is now available within all the GP practices and Juliet Bower, Director at NHS Digital will be visiting the CCG on the 21st March 2017 as the CCG are the first in the country to implement.
- New Models of Care extend hour's access scheme for Saturday opening has been extended until the end of March 2017 for practices within Primary Care 1 and 2.
- Primary Care Home 1 have been running a pilot for appointments for counselling and social prescribing and has been very well received. The findings have been shared with the CCG and this is now being rolled out across the City and expressions of interest are being sought.
- Primary Care Homes are putting together their next newsletters for patients to inform them of progress and remind them of services available such as online prescriptions access to medical records online, appointments on line agreements for text messaging.
- Patient online work is progressing with practices to support patients to sign up to patient online. This is going well and of those Practices that were less than 10% which is the target there were 23 Practices in October now down to 15 Practices who are less than 10%. A presentation has taken place at the Practices Manager Forum and a case study undertaken of Newbridge

surgery, which will be put on the website and a press release will be done to raise the profile.

- Choose and Book ERS the quality premium target at 65% the CCG's trajectory looks good and are the only CCG in the Black Country to have an increasing trajectory over the last three months.
- Advice and guidance have taken forward with Urology.

Ms Cresswell raised concerns regarding choose and book as there are issues with some Practices not giving the patient the choice and the GP is making the decision for them. Mr Hastings stated they encourage the correct use of choose and book and provide a dedicated person to provide training to Practices. Mr Hastings stated there is a possibility next year they will have to do more scientific measuring of choice and with this in mind they are looking at reintroducing the coding on the clinical system.

Discussions took place regarding GPs providing support and guidance to help the patient make an informed decision and the complexity of measuring patient choice. Mr McKenzie asked if Healthwatch could provide details in terms of numbers so they have some evidence based data they can work with and provide support to those practices, Ms Cresswell agreed to look into and report back to the CCG.

RESOLUTION: Ms Cresswell agreed to review the numbers and details regarding those areas patients feel they are not being provided with patient choice and report back to Mr McKenzie.

Primary Care Programme Board Update

PCC330 Mr Marshall presented on behalf of Ms Garcha the Primary Care Programme Board Update which has been provided for information and asked if there were any questions to take back to Ms Garcha. There were no questions raised by the Committee.

RESOLVED: That the above is noted.

Primary Care Operational Management Group Meeting

PCC331 Mr Hastings presented the Primary Care Operational Management Group report which provides an overview of the discussions that have taken place at their meeting on the 21st February 2017. The following items were highlighted to the Committee:

- Primary Care Quality discussions took place around the monitoring of quality and assurance regarding Friends and Family Test submissions and how to manage the data and fluctuation of those practices not submitting data.
- Demand Management work is on-going and progressing well.

- Extend Opening for the Christmas and New Year scheme evaluation was presented to the group. The pilot consisted of 5 GP Practices covering Primary Care Home(s) with 465 patients appointments taken of which 446 were GP appointments and 19 were nurse appointments.

Ms Roberts stated in relation to Friends and Family data NHS England currently issue breaches and queried if they will continue after full delegation. It was confirmed they would continue with this role.

RESOLVED: That the above is noted.

Primary Care Medical Services Delegation Agreement

PCC332 Mr McKenzie presented to the Committee the details of the delegation agreement between NHS England and the CCG for Primary Care Medical Services. The report has been presented for assurances purposes as the delegation agreement is the legal document which sets out how NHS England will delegate to the CCG and which powers are reserved.

The powers that will be delegated to the CCG include the day to day management of Primary Care Medical Services contracts and Practice Mergers and will have similar powers as the how the Joint Commission Committee functions. The services reserved to NHS England include management of the performance lists, capital expenditure and managing complaints.

Mr McKenzie highlighted one of the main key points set out within the agreement is the approach NHS England will take to ensure the CCG are delivering their delegated functions. The agreement sets out that the CCG will need to prepare within two months of delegation a plan setting out their approach to delivering the functions and prepare an annual report. The work is underway to the produce plan as part of the CCG's preparation for full delegation and will be submitted to the newly formed Primary Care Commissioning Committee.

Mr McKenzie advised the delegation agreement is a national mandated document and there is no scope for changes. There is however an exception schedule included for local arrangements but there are none for the CCG. The delegation agreement needs to be signed and returned by the CCG on the 8th March 2017.

The Committee noted the report's recommendations that the CCG will sign the delegation agreement in line with national guidance and that work is on-going to prepare for full delegation and developing an assurance plan.

RESOLVED: That the above is noted.

General Practice Forward View Implementation Plan

PCC333 Mr Marshall presented the General Practice Forward View Implementation Plan for 2017/2019 on behalf of Ms Southall. The report is to provide the Committee with assurance on the programme of work and provide the final version of Wolverhampton's GP Forward View Implementation Plan.

Mr Marshall presented the plan and provided an overview of each section and in particular highlighted the investment in general practice (page134) under the *CCG Recurrent Transformation Support £1.50 per head,* Mr Marshall stated this would be £3.00 per head and spread across two years.

Ms Roberts queried the Primary Care Strategy Governance chart and asked if there are any plans to merge in the future the Primary Care Commissioning Committee and the Primary Care Strategy Committee. Mr McKenzie noted that the Primary Care Commissioning Committee and Primary Care Strategy Committee would remain separate as the Primary Care Strategy is owned by the Governing Body and there are no plans to pass these responsibilities onto Primary Care Commissioning Committee. It was noted that the Primary Care Strategy Committee is still within early stages and it sits at a separate level to other Committees within the CCG.

Ms Jervis raised under investment in General Practice (page 138) under Public Health Services could the collaborative working with Public Health and the CCG is really positive and wonders if it could be more robust. Mr Marshall agreed to meet with Ms Jervis to ensure Public Health are sighted on the Primary Care programmes.

RESOLUTION: Mr Marshall agreed to meet with Ms Jervis to ensure Public Health are sighted on the Primary Care programmes.

Any Other Business

PCC308 There were no further discussion items raised by Committee.

RESOLVED: That the above is noted.

PCC309 **Date, Time & Venue of Next Committee Meeting**
Tuesday 4th April 2018 at 2.00pm in the Marston Room, 1st Floor, Technology Centre, Wolverhampton Science Park

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Primary Care Joint Commissioning Committee Actions Log

Open Items

Action No	Date of meeting	Minute Number	Item	By When	By Whom	Action Update
35b	**08.02.17**	**PCC302a**	**Premises Charges (Rent Reimbursement)**	April 2017	NHS England	08.02.17 - Awaiting the new cost directives to provide clarity on rent reimbursement in relation to when Practices allow other service providers to be use their rooms such as midwives. **07.03.17 -** NHS England confirmed they are still awaiting the new cost directives and have been informed they should receive this in April 2017. This will help to provide clarity on rent reimbursement in relation to when Practices allow other service providers using their rooms such as midwives.
~~49~~	**03.01.17**	**PCC283**	**Wolverhampton CCG Update** Ms Southall to provide Evaluation Reports on extended opening hours at the March and May Meetings.	May 2017	Sarah Southall	08.02.17 - Ms Southall confirmed an evaluation report on the two extended opening hours scheme will be provided at the March and May Committee Meetings. **07.03.17 -** It was confirmed that Ms Southall will provide a joint evaluation report on the two extended opening hours scheme at the May Meeting.
53	**07.03.17**	**PCC329**	**Wolverhampton CCG Update** Ms Cresswell agreed to review the numbers and details regarding those areas patients feel they are not being provided with patient choice and report back to Mr McKenzie.	April 2017	Tracy Cresswell	

54	**07.03.17**	**PCC333**	**General Practice Forward View Implementation Plan** Mr Marshall agreed to meet with Ms Jervis to ensure Public Health are sighted on the Primary Care programmes.	April 2017	Steven Marshall and Ros Jervis	

Closed Items

Action No	Date of meeting	Minute Number	Item	By Whom	Date Closed	Action Update
1	03.12.15	PCC04	**Proposed amendments to Committee Terms of Reference** That the 3 GP Locality Leads will attend on a rotational basis for the next 12 months. Mr McKenzie to inform Locality Leads of this arrangement.	Peter McKenzie	14 January 2016	Action complete
2	03.12.15	PCC04	**Proposed amendments to Committee Terms of Reference** That the review of the Committee Terms of Reference be in line with the two window a year permitted by NHS England for the CCG's constitution to be amended.	Peter McKenzie	14 January 2016	Action complete
3	03.12.15	PCC05	**Primary Care Commissioning Operations Management Group Terms of Reference** That the Care Quality Commission will be invited to future meetings of this Group.	Mike Hastings	14 January 2016	14.01.16 – Mike Hastings confirmed that he has spoken to the Head of Quality and Risk at the CCG to confirm local CQC Lead contact details.
4	03.12.15	PCC06	**Upcoming Issues for Provisional Work Programme** That the Showell Park Procurement be brought to a 2016 Committee meeting for decision. Ms Nicholls to confirm appropriate meeting date.	Anna Nicholls	14 January 2016	14.01.16 – Anna Nicholls confirmed that the Showell Park Procurement will be brought to the Private Session of the Primary Care Joint Commissioning Committee in March 2016. 01.03.16 - It was noted that this item is on the private Committee agenda for discussion
5	03.12.15	PCC07	**Standard Agenda item and regular reporting requirements** That the following items be included as standing items on the agenda: • NHS England Update • NHS England Finance Update • Wolverhampton CCG Update • Primary Care Delivery Board Update • Primary Care Commissioning Operations Management Group Update	Jane Worton	14 January 2016	14.01.16 – Standard items will be included from February 2016 onwards.

6	**03.12.15**	**PCC07**	**Standard Agenda item and regular reporting requirements** That Charmaine Hawker, Assistant Head of Finance - Primary Care, from NHS England Finance is invited to attend future Committee meetings.	Jane Worton	14 January 2016	14.01.16 – Confirmed that Charmaine Hawker had been invited to attend future Committee meetings.
7	**03.12.15**	**PCC08**	**Arrangements for future meetings** That the first public meeting of this Committee will take place in March 2016.	Peter McKenzie	2 February 2016	02.02.16 - It was noted the schedule of Committee dates for 2016/17 have now been diarised. Item closed.
8	**14.01.16**	**PCC17**	**Proposed Amendments to Committee Terms of Reference** That the February 2016 WCCG Governing Body Meeting and Sub Regional Team will receive an Executive Summary from this Committee.	Pat Roberts	2 February 2016	02.02.16 - It was confirmed that the executive summary is now complete and will be forwarded to David Williams at NHS England. Item closed.
9	**14.01.16**	**PCC18**	**Primary Care Commissioning Operations Management Group Terms of Reference** That the March 2016 Committee Meeting receive an update from the PCCOMG Meeting on 16 February 2016. That the risk register and Mike Hastings change in role title is reflected in the Terms of Reference.	Peter McKenzie	2 February 2016	02.02.16 - The updated Terms of Reference were discussed and the amendments agreed. Item closed.
10	**14.01.16**	**PCC19**	**Upcoming Issues for Provisional Work Programme** That the draft Primary Care Strategy is to be shared with NHS England.	Margaret Chirgwin	2 February 2016	02.02.16 - It was confirmed that Margaret Chirgwin (WCCG) had shared the Primary Care Strategy with NHS England. Item closed.
11	**14.01.16**	**PCC19**	**Upcoming Issues for Provisional Work Programme** That NHS England share the Operational Plan template with the Committee.	May 2016	NHS England	02.02.16 - It was noted that the planning return will be brought to the next Committee Meeting. 05.04.16 - It was noted that the reporting template will be brought to the May Committee meeting following the next planning deadline. 03.05,16 - It was noted that Ms Shelley would raise the reporting template query with NHS England and report back to the Committee.

						07.06.16 - Ms Shelley reported she had raised the reporting template query with NHS England and they no longer have this template. It was agreed to close the action.
12	**14.01.16**	**PCC21**	**NHS England Finance Update** That an update on financial planning will be presented to the Committee in February 2016.	Charmaine Hawker	2 February 2016	02.02.16 – The update on financial planning was provided. Item closed.
13	**14.01.16**	**PCC21**	**Capital Review Group / Strategic Estates Forum** That the Capital Review Group / Strategic Estates Forum minutes be reported to the PCCOMG Meetings.	Jane Worton	2 February 2016	02.02.16 - Item included on this meeting's agenda for discussion. Item closed.
14	**14.01.16**	**PCC21**	**WCCG Estates Strategy** That the final Estates Strategy be brought to a future Committee Meeting.	Mike Hastings	5 April 2016	05.04.16 - It was noted that this item is on the private Committee agenda for discussion.
15	**02.02.16**	**PCC38**	**West Midlands MOU for the Primary Care Hub** That the MOU be updated and signed off at the March 2016 Governing Body Meeting and Primary Care Joint Commissioning Committee.	May 2016	Mike Hastings / Gill Shelley	01.03.16 – The Committee approve the West Midlands MOU for Primary Care Hub subject to an additional quality element being added. That the MOU will be signed off at the March 2016 Public WCCG Governing Body Meeting. 05.04.16 - Ms Shelley to confirm amendments with regard to the status of WCCG commission of Primary Care as requested by the Governing Body NHS England colleagues and bring the final MOU to the May Committee meeting. 03.05.16 - Mr Hastings informed the Committee that the MOU has now been signed off by Wolverhampton CCG Governing Body and is currently being reviewed internally prior to being submitted to NHS England by 6 May 2016. 07.06.16 - Mr Hastings informed the Committee the MOU has now been signed off by Wolverhampton CCG Governing Body and has been submitted to NHS England.

						The Committee agreed to close the action.
16	**02.02.16**	**PCC42**	**Pharmacy First** That the Pharmacy First information be circulated to the Committee.	Jane Worton	1 March 2016	01.03.16 - It was noted that the information was circulated to the Committee on 11.02.16.
17	**02.02.16**	**PCC37**	**Financial Planning** A further report to be brought to the next Committee meeting.	Charmaine Hawker	1 March 2016	01.03.16 - It was noted that this report is included on the agenda for discussion.
18	**01.03.16**	**PCC53**	**Minutes of the Meeting Held on 2 February 2016** That the minutes of the previous meeting held on 14 January 2016 be approved as an accurate record subject to the following amendments. (PCC39) Spelling of Alistair McIntyre to be amended to Alastair. (PCC40) Amendment of PCCOMG Meeting to PCOMG Meeting.	Jane Worton	5 April 2016	05.04.16 – Amendments made.
19	**01.03.16**	**PCC54**	**Primary Care Models** An update report on Primary Care Home and vertical integration models will be brought to the next Committee meeting.	Mike Hastings	5 April 2016	05.04.16 - It was noted that this item is on the Committee agenda for discussion.
20	**01.03.16**	**PCC61**	**Primary Care Commissioning Operations Management Group (PCOMG) Update** That the next PCOMG update is created in the form of an overarching assurance report subject to any practice specific confidential information being discussed in private.	Mike Hastings	5 April 2016	05.04.16 - It was noted that this item is on the Committee agenda for discussion.

21	**01.03.16**	**PCC61**	**Pharmaceutical Involvement in Primary Care** That following discussion at the January 2016 Committee Meeting around the pharmaceutical involvement in primary care it was noted that Mr Blankley would attend future PCOMG meetings to drive this forward.	Mike Hastings / Jeff Blankley	5 April 2016	05.04.16 - It was noted that Mr Blankley now attends the PCOMG meetings.
22	**05.04.16**	**PCC77**	**NHS England Update** That a short report will be provided by NHSE outlining any activity throughout the month which impacts on Wolverhampton primary care.	May 2016	Alastair McIntyre / Gill Shelly	03.05.16 - The NHS England Update was included on this meeting's agenda. Item closed.
23	**05.04.16**	**PCC78**	**NHS England Finance Update** That a report will be produced for the May 2016 Committee Meeting to outline the full schedule for the 2016/17 budget.	May 2016	Charmaine Hawker	03.05.16 - The NHS England Finanxe Update was included on this meeting's agenda. Item closed.
24	**03.05.16**	**PCC100**	**GP Communication** That GP communication methods should be discussed at the next Primary Care Operational Management Group meeting.	June 2016	Mike Hastings	07.06.16 - Mr Hastings confirmed with the Committee it has been agreed until the Wolverhampton Clinical Commissioning Group (WCCG) are full delegated all correspondence will continue by NHS England.
25	**03.05.16**	**PCC101**	**PMS Premium Schemes** That the CCG Strategy and Transformation Team will provide a report to the June 2016 Committee Meeting outlining the PMS Premium schemes.	June 2016	Sharon Sidhu	07.06.16 - PMS Premium Schemes included on the Private Primary Care Joint Commissioning Committee meeting agenda.
26	**03.05.16**	**PCC103**	**Protected Learning Time for GPs** That the CCG will explore protected learning time options for GPs and update the Committee.	August 2016	Mike Hastings / Steven Marshall	07.06.016 - Mr Marshall noted further discussions need to take place to determine the details and requirements for protected learning time for GPs. It was agreed a further update would be provided for the next meeting.

						05.07.06 - Mr Marshall reported the Protected Learning Time for GPs is part of the GP Forward View and suggested this is included the full summary report update due at the next Committee meeting. August Agenda Item. 02.08.16 – Action covered within Primary Care Forward View. Item closed.
27	**07.06.16**	**PCC121**	**Terms of Reference** The Committee agreed to review the Terms of Reference in September 2016	September 2016	Peter McKenzie	05.07.16 - This agenda item is due to be presented at the September Committee Meeting. Presented at the September meeting - action closed.
28	**07.06.16**	**PC122**	**NHS England Update – Primary Care Update** Ms Shelley agreed to feedback to Ms Skidmore how the WCCG can be involved in the work around recruiting and retaining workforce.	August 2016	Gill Shelley	05.07.16 - Ms Nicholls reported they are still awaiting a response and agreed to report back at the next Committee meeting. August Update. 02.08.16 – Action covered on meeting agenda. Item closed.
29	**07.06.16**	**PC124**	**Wolverhampton CCG Update** Mr Marshall agreed to bring back to the August Meeting an update on the WWCG response to the GP Forward View. Mr Marshall agreed to develop and share a model of how the third sector organisations and other providers will link into Primary Care Services.	August 2016 July 2016	Steven Marshall Steven Marshall	05.07.16 – Mr Marshall agreed to provide a report on the WCCG response to the Primary Care Forward View at the August meeting. 02.08.16 – Item on meeting agenda and closed. 05.07.16 - Better Care Fund – Third Sector Organisations report was on the agenda. Item closed.
30	**05.07.16**	**PCC147**	**NHS England Update – Primary Care Update** Ms Nicholls agreed to clarify and report back to Dr Helen Hibbs in relation to impact of the new partner joining MGS Medical Practice (Dr Bagary) as they are involved in the vertical integration pilot.	August 2016	Anna Nicholls	02.08.16 – Ms Nicholls confirmed that the process of adding and removing partners from practices which are involved in vertical integration remained the same as the contract is held by the partnership and not RWT.
31	**02.08.16**	**PCC174**	**Wolverhampton CCG Update** Mr Hastings to respond to Wolverhampton LMC queries within 7 days.	September 2016	Mike Hastings	06.09.16 - Mr Hastings confirmed he had responded to Wolverhampton LMC queries within in the 7 day deadline. Action closed.

32	**02.08.16**	**PCC174**	**Primary Care Support England (PCSE)** Communication to go out to all practices requesting PCSE feedback.	September 2016	Jane Worton	06.09.16 - Ms Worton confirmed an e-mail went out to all Practice Managers on the 11th August requesting PCSE feedback. All the responses had been collated and sent to NHS England where the information will be discussed in a forum meeting between Capita Services and NHS England. It was confirmed any feedback would be escalated back to the CCG s this could be fed back to the GP Practices. Action closed.
33	**02.08.16**	**PCC175**	**GP Peer Review** Ms Garcha to present the GP Peer Review Terms of Reference at the September 2016 Committee meeting.	September 2016	Manjeet Garcha	06.09.16 - It was noted this item was on the meeting agenda. – Action closed.
34	**02.08.16**	**PCC176**	**Acute Discharge Process** Mr Blankley to meet with Dee Harris to review the prescribing aspect of the acute discharge process.	September 2016	Jeff Blankley	06.09.16 - Mr Blankley confirmed he had met with Dee Harris and discussions have commenced regarding prescribing within the acute discharge process. – Action closed.
35a	**02.08.16**	**PCC176**	**Premises Charges (Market Rent Reimbursement)** Ms Nicholls to look into support available to GP practices with increased premises charges and provide an update at the September 2016 Committee meeting.	February 2017	Gill Shelley / Anna Nicholls	06.09.16 - Mr Hastings agreed to chase Anna Nicholls regarding this action. 04.10.16 - Ms Shelley confirmed that details on the management of transitional funding are to be confirmed and would provide an update at the next meeting. 01.11.16 - It was advised NHSE are still awaiting the financial processes, Ms McGee agreed to take back to Charmaine Hawker as its non-recurrent funding for this financial year 2016/2017. 06.12.16 - Ms Payton informed the Committee they are still seeking further advice as NHS England have not been notified and once this is received it will be shared with the CCG. 03.01.17 - It was confirmed NHS England are still awaiting further assurance from the

						National Guidance. It was agreed as the Local Medical Committee had raised this initial concern and the CCG needed to inform them of this position. 08.02.17 - Ms Payton informed the Committee the National Team have developed local process and procedures. The application will be sent from The NHS England's Premises Team for circulation and should be returned to them once completed. 07.03.17 - Ms Payton confirmed she had provided the contact details regarding accessing funding for NHS Property Services/Community Health Partnership Premises Charges. This information had been shared with Practices on the 2nd March 2017. Action closed.
~~36~~ 38	**02.08.16**	**PCC177**	**Workforce Strategy** Ms Garcha to bring an update on the Workforce Strategy, with specific reference to GP growth, to the October 2016 meeting.	October 2016	Manjeet Garcha	06.09.16 - This item is due to be presented at the October meeting. 04.10.16 - It was noted that this item is on the agenda for discussion. Item closed.
37	**06.09.16**	**PCC186a**	**NHS England Update – Primary Care Update** Primary Care Commissioning Activity return to be shared with the Committee in October 2016.	February 2017	Mike Hastings	04.10.16 – Mr Hastings to contact the Deputy Head of Primary Care at NHS England to share a copy of the final submission with the Committee. 01.11.06 - Mr Hastings agreed to chase. 06.12.16 - Mr Hastings confirmed the CCG had made the submission to NHE England and highlighted this would not cascade back to the CCG it was agreed to share what the CCG had submitted to the Committee. 03.01.17 - Mr Hastings confirmed to send the CCG Primary Care Commissioning

						Activity return to the Committee following the meeting. shared with the Committee on the 4th January 2017.
38	**06.09.16**	**PCC186b**	**NHS England Update – Primary Care Update** Mr Hastings agreed to report back if the CCG had/or needed to make a response on the GP Resilience Programme document.	October 2016	Mike Hastings	04.10.16 - Mr Hastings informed the Committee that an details on the GP Resilience Programme was included in the Wolverhampton CCG Update on the agenda. Item closed.
39	**04.10.16**	**PCC209**	**NHS England GP Resilience Programme (GPRP)** Ms Shelley agreed to confirm the number of Wolverhampton practices that can be put forward for the GPRP programme and also any expressions of interest that they have directly received.	November 2016	Gill Shelley / Anna Nicholls	Ms Shelley will confirm the number of Wolverhampton practices that can be put forward for the GPRP programme and also any expressions of interest that they have directly received. **01.11.16 -** Ms Shelley has confirmed there is only 1 practice for Wolverhampton on the GPRP programme. Action agreed to be closed.
40	**04.10.16**	**PCC209**	**WCCG Primary Care Workforce Draft Strategy** Ms Garcha stated that there had been difficulty in confirming an NHS England lead for this work and Ms Shelley agreed to confirm details and feedback.	November 2016	Gill Shelley / Anna Nicholls	**01.11.16 -** Ms Garcha had been in touch with Jacqueline Barns regarding an NHS England Lead for Primary Care Workforce. Action agreed to be closed.
41	**04.10.16**	**PCC211**	**Vertical Integration** That the minutes from the VI assurance meeting on 3 October 2016 be shared with the Committee.	February 2017	Mike Hastings	01.11.16 - Mr Hastings confirmed the minutes from the VI assurance visit had not been received once provided they will be shared with the Committee. 06.12.16 - Mr Hastings advised the CCG are still waiting for the minutes from the VI assurance visit. It was agreed Ms Shelley would chase the relevant department at NHS England. 03.01.17 – Mr Hastings informed the Committee the CCG have received the minutes from the VI assurance visit and they

						will be circulated following the meeting. VI assurance visit minutes shared on the 4th January 2017
42	**04.10.16**	**PCC213**	**Patient Engagement** That Ms Shelly would confirm the level of patient engagement required when a practice was merging / closing.	November 2016	Gill Shelley / Anna Nicholls	**01.11.16 -** Ms Shelley advised the level of patient engagement is not in the contract as to what's relevant/appropriate to the number of patients and the changes being made within the practice. They would expect the level of engagement to be proportionate to the level of change. It was highlighted the WCCG have a policy in place for engagement and this should be followed around the proportionate of change taking place.
43	**04.10.16**	**PCC214**	**WCCG Primary Care Workforce Draft Strategy** Ms Garcha to confirm how the Wolverhampton practices involved in Vertical Integration had been recorded in the analysis.	December 2016	Manjeet Garcha	**01.11.16 -** Ms Garcha confirmed a sense check had been undertaken on the data and that 2 out of the 3 VI's had been included within the analysis. Ms Garcha had been unable to speak with the author who undertook the analysis to ask the question regarding the method of recording and confirmed to feed this back at the next meeting.
44	**04.10.16**	**PCC215**	**Social Prescribing Report** Ms Skidmore to feedback Mr McIntosh's queries to Andrea Smith.	November 2016	Claire Skidmore	**01.11.16 -** Ms Skidmore confirmed she had spoken to Andrea Smith regarding Mr McIntosh's queries. Action to be closed.
45	**01.11.16**	**PCC234b**	**Application to Close Brach Surgery** An addendum or revised business case to the December meeting on the progress of the previous business case and give further assurance on what support would be available from the practice to patients during the closure. The business case needs to state categorically that there is no expectation of patients to access services from	December 2016	Gill Shelley	

			Bilston or move to an Intrahealth practice, rather that they can exercise free patient choice.			
46	**01.11.16**	**PCC234b**	**Application to Close Brach Surgery** Further work is required to inform the patient body on the following; a) of the reason for closure i.e. CQC, failure of building and prohibited costs of renovation and the current closure due to recent maintenance event regarding infection prevention and lack of hot water etc. b) to answer the petition participants concerns and have a further public meeting if required.	December 2016	NHS England	
47	**06.12.16**	**PCC259**	**NHS England Finance Update** Ms Skidmore agreed to review, sign and return the MOU to NHS England.	January 2017	Claire Skidmore	03.01.17 - Ms Skidmore confirmed the MOU had been reviewed, signed and returned to NHS England. Closed.
48	**06.12.16**	**PCC260**	**Wolverhampton CCG Update** Ms Southall and Ms Shelley to liaise following the meeting to ensure the pharmacy rota is incorporated within the pilot for extend opening hours at Group level.	January 2017	Sarah Southall	03.01.17 - Mrs Southall advised the pilot for extended opening hours had been commenced on Christmas Eve and plans were submitted to NHS England on the 23rd December 2016. Closed.
50	**08.02.17**	**PCC304**	**NHS England Finance Update** The Month 10 position to be provided at the March Meeting.	March 2017	NHS England Finance	07.03.17 - The month 10 report has been provided and is on the agenda for discussion. Action closed.
51	**08.02.17**	**PCC305**	**Wolverhampton CCG Update** Mrs Southall to provide the General Practice Five Year Forward Plan to the March Meeting.	March 2017	Sarah Southall	07.03.17 - The General Practice Five Year Forward Plan has been provided and is an agenda item for discussion. Action closed.

52	**08.02.17**	**PCC307**	**Primary Care Operational Management Group Meeting** Mr McKenzie to provide a report to the March Meeting on the full delegation agreement as this will need formal sign off by the Committee.	March 2017	Peter McKenzie	07.03.17 - The full delegation agreement has been shared and is on the agenda. Action closed.

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Primary Care Joint commissioning committee meeting 04.04.17

Title of Report:	**Medicines Optimisation QIPP 2017/18**
Report of:	David Birch, Head of Medicines Optimisation
Contact:	David Birch, Hemant Patel
Commissioning Committee Action Required:	☒ **Decision** ☐ **Assurance**
Purpose of Report:	Approve the amendments to the Quality Prescribing Scheme for 2017/18. The changes include the increase in overall funds within the Quality Prescribing scheme. Commit additional funds to Primary Care Medicines Team for additional respiratory medication reviews. These have all been endorsed and recommended by the Modernisation and Medicines Optimisation Programme Board.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	Providing assurances medicines are being prescribed both safely and cost effectively in order to improve patient outcomes and achieve required efficiencies for the CCG.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The scheme is linked to indicators of good prescribing. Achievement of this reflects on the CCG leadership.

• **Domain 2a:** Performance – delivery of commitments and improved outcomes	The incentive scheme is designed to maintain and improve quality, and ensures better outcomes for patients.
• **Domain 2b:** Quality (Improved Outcomes)	The incentive scheme helps to achieve progress in delivering key mandated requirements around reduction of antimicrobial resistance.
• **Domain 3:** Financial Management	The incentive scheme supports the CCG in achieving good financial management of the prescribing budget.
• **Domain 4:** Planning (Long Term and Short Term)	The incentive scheme supports the medicines optimisation annual operational plans.
• **Domain 5:** Delegated Functions	

1. BACKGROUND AND CURRENT SITUATION

1.1 The CCG Medicines Optimisation Team wishes to continue to offer a prescribing incentive scheme to its GP practices for 2017/18 and seeks approval to progress.

2 MAIN BODY OF REPORT

2.1 Current Situation

The CCG has historically offered a GP Quality Incentive Scheme to support the QIPP agenda. The Medicines Optimisation Team is proposing to offer this service again. The proposed service specification for 2017/18 is attached.

2.2 Potential Payment of scheme

Payments are made based on population of 270,000. Current budget for 2016/17 is £250k. It is proposed to increase this amount to £450K to incentivise an increased number of individual components within this year's scheme. The extra funding is to be re-allocated directly from the Prescribing Budget. Successful achievement of the scheme will release savings from the prescribing budget which will fund this scheme. This approach was agreed in principle by a group consisting of the CCG chair, GP prescribing lead and locality leads in 2015/16. Payment would only be made on the respective surgery achieving the targets.

	Proposed payment per 1000 patients	100% achievement by all practices would require the following budget	Potential savings if implemented fully
PART 1: Antibiotic prescribing	**£400**	£108,000	£44,797
PART 2a: Antibiotic prescribing for UTI in primary care. Ratio of trimethoprim to nitrofurantoin prescribing	**£150**	£40,500	0
PART 2b: Antibiotic prescribing for UTI in primary care. Number of items prescribed for trimethoprim	**£150**	£40,500	0
PART 3: Hypnotics optimisation	**£125**	£33,750	£16,967
PART 4: NSAIDs	**£100**	£27,000	£44,337
Parts 1 to 4 = £249,750.			
PART 5: Low cost Blood Glucose Testing Strips	**£150**	£40,500	£127, 275
Part 6: Lower cost branded buprenorphine patches	**£125**	£33,750	£175,000
Part 7 : Diabetic pen needles	**£125**	£33,750	£39,803
Part 8: Lower cost branded tiotropium inhalers	**£200**	£54,000	£82,861
Part 9: Brand prescribing of inhalers	**£125**	£33,750	£200,000
Parts 5 to 9 = £195,750.			
Total	£1,650	£445,500	£603,766

2.3 It should be noted savings from the certain items are not accounted for, such as Quality Premium payments. The patient benefits and potential harm avoidance from lower use of hypnotics and NSAIDs as well as the long term effects on Antimicrobial resistance with appropriate use of antibiotics.

2.4 It is proposed to commit additional funds to Primary Care Medicines Team for a specialist respiratory pharmacist to provide training and guidance to primary care colleagues including PCMT to conduct respiratory medication reviews with the aim of reducing the overall cost per inhaler for inhaled corticosteroids and combinations. In addition this specialist respiratory pharmacist would be expected to undertake complex respiratory reviews.

An investment of an additional £40K (0.6FTE Band 8b) would be required to support this piece of work. Analysis of current prescribing indicates if implemented this programme of work would result in an annual saving of 220K. The work would primarily be focused on the use of cost effective inhalers and stepping down treatment where deemed clinically appropriate. Over the past few years there has been a steady increase in the number of treatments available for those with Asthma or COPD. In addition the loss of patent on standard inhaler treatments has led to the introduction of cost effective alternatives over the past 12 to 18 months. It is important cost-effectiveness of treatments is considered when prescribing for COPD or asthma. However it's vitally important to ensure that when a patient is first prescribed an inhaler they are shown how to use it, they can demonstrate that they are able to use it and ensure inhaler technique is assessed on a regular basis to ensure correct on-going technique. PCMT will raise awareness of available options for patients and stress the importance of checking Inhaler technique to support wider initiatives to reduce hospital admission.

Inhaled corticosteroids (ICS) are the first-choice regular preventer therapy for adults and children with asthma for achieving overall treatment goals. To minimise side effects from ICS in people with asthma, the BTS/SIGN guideline on the management of asthma recommends that the dose of ICS should be titrated to the lowest dose at which effective control of asthma is maintained.

3 CLINICAL VIEW

3.1. The indicators have been endorsed by the GP Prescribing lead. Each of the indicators has an aim to improve the quality of prescribing.

4. PATIENT AND PUBLIC VIEW

4.1 **Nil**

5. RISKS AND IMPLICATIONS

Key Risks

Risks relate to non-approval.

5.1 Risks of poor prescribing performance.

5.2. Risk of non-achievement of the CCG Quality premium.

5.3. Risk of non-achievement of QIPP savings plan.

5.4 Risk of poor control of prescribing budget in future years

Financial and Resource Implications

5.5 An Annual budget of £445,500 is proposed for this year for the GP Quality Prescribing Scheme and an additional budget of £40,000 is proposed for the Primary Care Medicines Team.

Quality and Safety Implications

5.6 Nil

Equality Implications

5.7 Nil

Medicines Management Implications

5.8 As per report

Legal and Policy Implications

5.9 Nil

6 RECOMMENDATIONS

- **Approve** the revised incentive specification (Quality Prescribing Scheme Service Specification).
- **Approve** the increase in budget for the Quality Prescribing Scheme Service Specification
- **Approve** the additional investment in a specialist respiratory pharmacist
- **Note** the possible impact on the CCG Quality Premium.
- Request CCG contracting team to offer the revised contract to practices alongside other enhanced services.

Name **David Birch**
Job Title **Head of medicines optimisation**
Date: **16.03.2017**

ATTACHED:

(Attached items :)

RELEVANT BACKGROUND PAPERS

(Including national/CCG policies and frameworks)

1) Proposed Service Specification - Quality Prescribing Scheme Service Specification
2) Detail Work plan document
3) Data Source reference document

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View -		
Public/ Patient View		
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team		
Medicines Management Implications discussed with Medicines Management team	**As per report**	
Equality Implications discussed with CSU Equality and Inclusion Service	**n/a**	
Information Governance implications discussed with IG Support Officer	**n/a**	
Legal/ Policy implications discussed with Corporate Operations Manager	**n/a**	
Signed off by Report Owner (Must be completed)	**David Birch**	**16.03.2017**

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SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

Service Specification No.	TBC
Service	Quality Prescribing Scheme
Commissioner Lead	David Birch
Provider Lead	Practice specific
Period	1st April 2017
Date of Review	31st March 2018

1. Population Needs

1.1 National/local context and evidence base

Participation in this Local Prescribing Incentives Services requires the practice to have a commitment to prescribing within the allocated prescribing budget, including prescribing in line with the Joint Formulary.
The practice should have a robust approach to antibiotic stewardship and prudent prescribing of antibiotics.
The practice should engage with prescribing support activities (e.g. evidence of timely participation in agreed cost-efficiency programmes, minutes from practice meetings demonstrating engagement with the Primary Care Medicines Team and completion of agreed actions).

In addition the practice can demonstrate that:

- ScriptSwitch is utilised by all prescribers
- Eclipse Live must be activated at the practice for use by the Primary Care Medicines Team

PART 1: Antibiotic prescribing (£400 per 1000 patients)
Aim
Review and, if appropriate, revise current prescribing practice and use implementation techniques to ensure prescribing is in line with Public Health England guidance this includes control of the total volume of antibiotic prescribing. Implementing the above will also help Wolverhampton CCG achieve its Quality Premium. Practices will need to access and use the guidance available at https://www.prescqipp.info/projects/antimicrobial-stewardship#target-antibiotics and where necessary have ensured the practice has undertaken training in antibiotic stewardship.

Background information
Antibiotic resistance continues to be a public health issue. The consequences of antimicrobial resistance (AMR) include increasing treatment failure for the most commonplace infections for example, urinary tract infections and decreasing the treatment options available where antibiotics are vital. Antibiotic prescribing and antibiotic resistance are inextricably linked.

Overuse and incorrect use of antibiotics are major drivers of resistance.

To help prevent the development of resistance it is important to only prescribe antibiotics when they are necessary, and not for self-limiting mild infections such as colds and most coughs, sinusitis, earache and sore throats. This year NHS England has introduced a mandatory quality premium to improving antibiotic prescribing in primary and secondary care. The aim of the quality premium is to reduce over use and inappropriate use of antibiotics in order to reduce the spread of antimicrobial resistance.

Wolverhampton CCG will be measured on the full 2017-18 financial year prescribing data set published by the NHS BSA in June 2018 against prescribing rates based on the financial year 2013-14 NHS BSA prescription services data set. The Quality premium will only be achieved if the CCG can demonstrate a performance equal to (or below) the England 2013/14 mean performance of 1.161 items per STAR-PU. In addition the number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of selected antibiotics prescribed in primary care to be equal to or lower than 10%.

Public Health England (PHE) guidance recommends that simple generic antibiotics should be used if possible when antibiotics are necessary. The PHE website also has more information on antibiotic resistance, and resources to help reduce inappropriate antibiotic prescribing.
The local formulary primary care guidance is available at:
http://www.wolverhamptonformulary.nhs.uk/formulary/BNF/Section%205%20Infections/bnf5.asp

Useful Resources:
NPC's e-learning resource on antibiotics:
http://www.npc.nhs.uk/qipp/qipp_elearning/antibiotics_elearning.php

RCGP TARGET 'Antibiotic Resistance in Primary Care' e-learning module
http://www.rcgp.org.uk/clinical-and-research/target-antibiotics-toolkit.aspx

PART 2a: Antibiotic prescribing for UTI in primary care (£150 per 1,000 patients)

Aim
To reduce or maintain prescribing below a specific ratio of trimethoprim to nitrofurantoin prescribing for UTI in primary care.

The required performance in 2017/18 - the ratio of trimethoprim to nitrofurantoin prescribing to be below 1.580 (based on CCG baseline data (June15-May16) for 2017/18.

PART 2b: Antibiotic prescribing for UTI in primary care (£150 per 1,000 patients)

Aim
To reduce or maintain the number of items prescribed for trimethoprim in primary care.

The required performance in 2017/18 - a 10% reduction (or greater) in the number of trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June15-May16) for 2017/18

PART 3: Hypnotics optimisation (£125 per 1000 patients)
Aim
The risks associated with hypnotics, such as falls, cognitive impairment, dependence and withdrawal symptoms, are well recognised. Hypnotics should be used only if insomnia is severe, using the lowest dose that controls symptoms for short periods of time. Review and, if appropriate, revise prescribing of hypnotics to ensure that it is in line with national guidance.

Background information
Risks associated with the long-term use of hypnotic drugs include falls, accidents (including motor accidents, cognitive impairment, dependence, withdrawal symptoms and increased risk

of death).

The NICE technology appraisal guidance on zaleplon, zolpidem and zopiclone recommends that when, after due consideration of the use of non-pharmacological measures, hypnotic drug therapy is considered appropriate for the management of severe insomnia interfering with normal daily life, hypnotics should be prescribed for short periods of time only, in strict accordance with their licensed indications. The NICE technology appraisal guidance states that there is no compelling evidence of a clinically useful difference between the 'Z drugs' and shorter acting benzodiazepine hypnotics from the point of view of their effectiveness, adverse effects, or potential for dependence or abuse. There is no evidence to suggest that if people do not respond to one of these hypnotic drugs, they are likely to respond to another.

PART 4: NSAIDs (£100 per 1000 patients)

Aim
To encourage the review of the appropriateness of non-steroidal anti-inflammatory drug (NSAID) on a routine basis, especially in people who are at higher risk of gastrointestinal, renal and cardiovascular morbidity and mortality (for example, older people).
If an NSAID is needed, ibuprofen (1200 mg a day or less) or naproxen (1000 mg a day or less) should be used.
Prescribing should be the lowest effective dose for the shortest duration of treatment necessary to control symptoms. Co-prescribe a proton pump inhibitor with NSAIDs in line with NICE guidance.

Background information
There are long-standing and well-recognised gastrointestinal and renal safety concerns with all NSAIDs. There is also substantial evidence confirming an increased risk of cardiovascular events with many NSAIDs, including COX-2 inhibitors and some traditional NSAIDs such as diclofenac and high-dose ibuprofen.

PART 5: Low cost Blood Glucose Testing Strips(BGTS) (£150 per 1000 patients)

Aim
The cost of prescribing blood glucose testing strips is growing rapidly and there are significant savings to be made by rationalising prescribing.
Self-monitoring of blood glucose in type 2 diabetes is only beneficial for a selective group of patients and this practice should be restricted in line with NICE guidelines, see link to guidance below,
https://www.nice.org.uk/guidance/ng28/chapter/1-Recommendations#self-monitoring-of-blood-glucose

Prescribing of BGTS should be based on a patient's individual needs and patients should receive a product from the preferred list of blood glucose testing strips and meters to be used locally.

BGTS with an acquisition price under £10 are deemed to be cost-effective and a target has been set to reflect this.

Background information
Self-monitoring of blood glucose (SMBG) is essential for people with diabetes on insulin therapy and can be beneficial for some people on other hypoglycaemic agents. Where SMBG is not serving a specific purpose in the management of the condition however, it is a waste of resources and can cause unnecessary pain to the patient. NICE recommends that SMBG should be used only if it is going to be an integral part of the patient's self-management education, and the continued benefit of self-monitoring should be assessed in a structured way each year.

Part 6: Lower cost branded buprenorphine patches (£125 per 1000 patients)

Aim Substantial savings could be achieved if buprenorphine 5 mcg, 10 mcg and 20 mcg transdermal patches are prescribed as Butec® or Sevodyne® 5 mcg, 10 mcg and 20 mcg patches respectively. These brands are currently 55% less expensive than generic buprenorphine patches and Butrans® patches (based on MIMS/Drug Tariff Jan-17 prices).

Background information
If strong opioids are required, oral morphine should be the first choice for most patients and is a cost effective choice compared with other stronger opioids, such as fentanyl, buprenorphine and oxycodone, which are considerably more expensive.

Part 7 : Diabetic pen needles (£125 per 1000 patients)

Aim

Prescribing data show that 7% of the total cost of prescribing for diabetes is spent on hypodermic devices. Significant savings can be made by reviewing and switching patients to a more cost-effective pen needle within the range of prescribable needles for pre-filled and reusable pen Injectors. Pen needles with an acquisition price under £6 per 100 needles are deemed to be cost-effective and a target has been set to reflect this. The target of 60% has been set a level to support the fact that some patients will require a safer sharps pen needle therefore the needs of patients, carers and health professionals who administer the medication should be considered before any change

Part 8: Lower cost branded tiotropium inhalers (£200 per 1000 patients)

Aim

Substantial savings could be achieved if a breath actuated tiotropium inhaler is prescribed as branded Braltus® instead of prescribing generically or as branded Spiriva Handihaler®. In addition Spiriva Respimat which is licensed for asthma and COPD is a cost effective choice. There have been several developments with tiotropium inhalers recently. Following the expiry of tiotropium's UK patent, the first lower cost 'equivalent' to Spiriva Handihaler® was launched by Teva under the brand name Braltus®. Also, the price of Spiriva Respimat® (tiotropium aqueous solution for inhalation) dropped substantially in the last year.

It is important to note that Braltus® has been named according to the dose of tiotropium that is 'delivered' (i.e. the dose that leaves the mouthpiece), whereas the reference product Spiriva Handihaler® (tiotropium 18 microgram powder for inhalation capsules) is named according to the 'pre-metered' dose of tiotropium. The pre-metered dose for Braltus® is 13 micrograms. However, both products provide the same 'delivered' 10 microgram dose of tiotropium.

Dosing regimens are the same for both products (inhalation of the contents of one capsule, once daily), using the products' respective delivery devices, which, in the case of Braltus®, is the Zonda® device.

The therapeutic indications for Braltus and Spiriva Handihaler are identical, with both licensed as maintenance bronchodilator treatment to relieve symptoms of patients with chronic obstructive pulmonary disease (COPD). (Note - tiotropium is also indicated as an add-on maintenance treatment in asthma, however, this applies only to the Spiriva Respimat® aerosol inhaler – neither Spiriva Handihaler® or Braltus® are licensed for use in asthma.)

Part 9: Brand prescribing of Inhaled corticosteroid, long acting muscarinic antagonists and combinations with long-acting beta agonists inhalers (£125 per 1000 patients)

Aim

Over the past few years there have been a vast increase in the number of inhalers available within the UK market. As a result it is recommended that all inhalers are prescribed by brand name to ensure the patient receives the same device. This is especially important for steroid

based inhalers which are not interchangeable.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

- To reduce the overall rate of antibiotic prescribing in line with national guidance. This will slow the development of antibiotic resistance.
- To reduce hypnotic prescribing in line with national trends to minimise risk and provide better outcomes for patients
- To reduce the cost of blood glucose monitoring whilst maintaining benefit in those patients who need to test
- To reduce NSAID prescribing in line with national trends to minimise risk and provide better outcomes for patients

3. Scope

3.1 Aims and objectives of service

- Good antibiotic prescribing is a well-established indicator of quality prescribing. To maintain the control of antibiotic prescribing in line with national guidance. This will slow the development of antibiotic resistance and ensure clinical appropriateness and benefits to the patient
- Achieve the Quality Premium requirements for the CCG.
- Support for QIPP

3.2 Service description/care pathway

Prescribing incentive scheme

Scheme Details for Part 1 - Antibiotic prescribing

Practices are required to reduce or maintain antibacterial prescribing as per national guidance. The items per STAR-PU must be equal to or below England 2013/14 mean performance value of 1.161 items per STAR-PU and the number of co-amoxiclav, cephalopsorins and quinolones as a proportion of the total number of selected antibiotics must be equal to or lower than 10% (April 2017 to March 2018).

Monitoring and Payment

PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available. Payment is not conditional on Wolverhampton CCG achieving the Quality Premium.

Scheme details for Part 2a - antibiotic prescribing for UTI in primary care.

Practices are required to reduce or maintain antibacterial prescribing below a specific ratio of trimethoprim to nitrofurantoin prescribing for UTI in primary care.
The ratio of trimethoprim to nitrofurantoin prescribing must be below 1.580 (based on CCG baseline data (June15-May16) for 2017/18.

Scheme details for Part 2b - antibiotic prescribing for UTI in primary care.
Practices are required to reduce antibacterial prescribing trimethoprim items prescribed to patients aged 70 years by 10% or greater on baseline data (June15-May16) for 2017/18.

The specific number of items will be based on the practices current prescribing rate (June 2015 to May 2016), thus each practice will be set a specific target which will cover their prescribing data for the period April 2017 to March 2018 as indicated in the scheme details.

Scheme Details for Part 3 - Hypnotics
The prescribing of benzodiazepine hypnotic items in January 2018 to March 2018 will be analysed via epact searches to determine each practices position. Practices at or below 0.24 ADQ/STARPU (national average) will need to remain below that target. Practices with prescribing rates above that will need to reduce to that level or by 10%.
For this scheme where practice believe they have been unable to achieving the target as a result of recommendations from mental health consultants that are beyond their control they should provide audit data to allow for an adjustment to be made to their data.

Monitoring and Payment
PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

Scheme Details for Part 4 - NSAIDs
The prescribing of NSAID items in January 2018 to March 2018 will be analysed via epact searches to determine each practices position. Practices at or below (1.280) ADQ/STARPU will need to remain below that target. Practices with prescribing rates above that will need to reduce to that level or by 10%.

Monitoring and Payment
PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

Scheme Details for Part 5 - Low cost glucose testing strips
The practice prescribing of low cost BGTS (less than £10 per pack) as a % of all strips will be assessed based on March 2018 data. The target for all practices is to achieve a prescribing rate above 60%.

Monitoring and Payment
PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

Scheme Details for Part 6 - Branded buprenorphine patches & morphine as a % of all opioid prescribing.

The practice prescribing of low cost once weekly buprenorphine 5, 10 & 20mcgs patches as a % of all buprenorphine 5, 10 & 20mcgs patches will be assessed based on March 2018 data. The target for all practices is to achieve a prescribing rate above 75%.

The percentage of oral morphine prescribing as a percentage of strong opioid prescribing must

be above 40%. Both elements must be achieved to qualify for payment.
For this scheme where practice believe they have been unable to achieving the target as a result of recommendations from secondary care / other care sectors e.g. hospice that are beyond their control they should provide audit data to allow for an adjustment to be made to their data.

Monitoring and Payment

PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

Scheme Details for Part 7 – Diabetic Pen needles

The practice prescribing of low cost hypodermic needles (less than £6 per pack) as a % of all hypodermic needles will be assessed based on March 2018 data. The target for all practices is to achieve a prescribing rate above 60%.

Monitoring and Payment
PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

Scheme Details for Part 8 - Lower cost branded tiotropium inhalers

The practice prescribing of low cost branded tiotropium (Braltus® & Spiriva Respimat®) as a % of all tiotropium prescribing will be assessed based on March 2018 data. The target for all practices is to achieve a prescribing rate above 50%.

Monitoring and Payment
PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

Scheme Details for Part 9: Brand prescribing of Inhaled corticosteroid, long acting muscarinic antagonists and combinations with long-acting beta agonists inhalers (£125 per 1000 patients)

The practice prescribing of branded inhalers as a % of all inhaler prescribing will be assessed based on March 2018 data. The target for all practices is to achieve a prescribing rate above 95%.

Monitoring and Payment
PACT data will be used to monitor the prescribing and practices will receive feedback throughout the contractual period to enable them to check their progress.
Payment will be made once prescribing data becomes available.

3.3 Population covered
For GP practices in Wolverhampton

3.4 Any acceptance and exclusion criteria and thresholds
None

3.5 Interdependence with other services/providers

None

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)
NICE guidance will be implemented.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)
None

4.3 Applicable local standards
None

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)
None

5.2 Applicable CQUIN goals (See Schedule 4D)

None

6. Location of Provider Premises

The Provider's Premises are located at:
As per the contract

7. Individual Service User Placement

None

NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton CCG Medicines Optimisation Work plan 2017/18

Contents

Wolverhampton CCG Medicines Optimisation Work plan 2017/18

Overall Outcomes

Through our medicines optimisation work programme we aim to:

- Improve patient safety
- Improve cost-effective prescribing
- Support patients to get maximum benefit from their medicines

Patient Safety

Eclipse

The CCG will continue to pay the license for Eclipse Live. Eclipse Live improves patient safety by analysing prescribing and patient data to:

- Identify patients at risk from their medicines
- Assist in the management of chronic disease

The tool will be used by GP practices and the Primary care Medicines Team (PCMT)

Drug Alerts

The PCMT will continue to support practices where action is required in the event of a MHRA Drug Alerts. The CCG will explore the use of new functionality within GP clinical systems to further support practices.

Antibiotic Use

Antibiotic resistance poses a significant threat to public health, especially because antibiotics underpin routine medical practice. To help prevent the development of resistance, it is important to only prescribe antibiotics when they are necessary; not for self-limiting, mild infections such as colds and most coughs, sinusitis, earache and sore throats.
Public Health England (PHE) guidance recommends that simple generic antibiotics should be used if possible when antibiotics are necessary. Broad-spectrum antibiotics (for example, co-amoxiclav, quinolones and cephalosporins) should be avoided when narrow spectrum antibiotics remain effective because they increase the risk of methicillin resistant Staphylococcus aureus (MRSA), Clostridium difficile and resistant urinary tract infections.

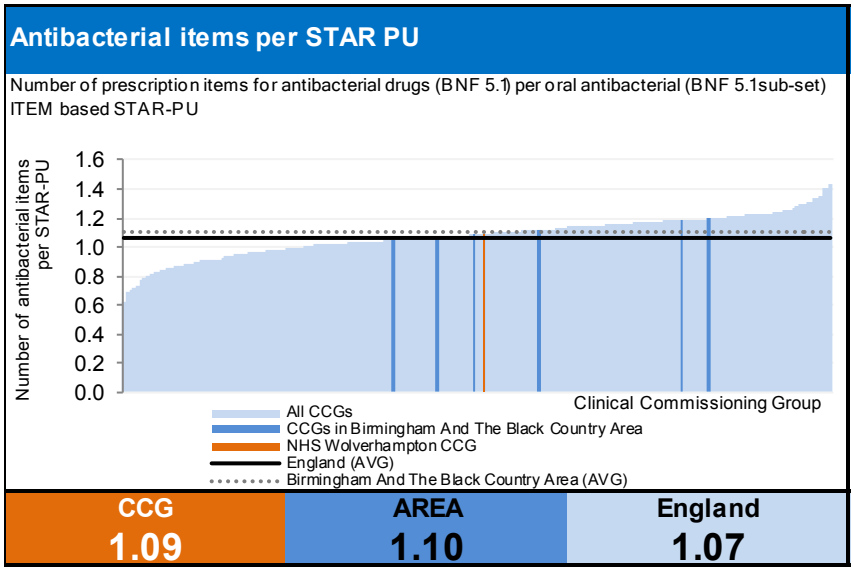
This year's Quality premium includes the requirement to reduce or maintain the number of items prescribed for trimethoprim in primary care. The CCG will need to reduce the number of trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June15-May16) for 2017/18 by 10%. In addition the CCG will need to reduce or maintain prescribing below a specific ratio of trimethoprim to nitrofurantoin prescribing for UTI in primary care.

The required performance in 2017/18 - the ratio of trimethoprim to nitrofurantoin prescribing to be below 1.580 (based on CCG baseline data (June15-May16) for 2017/18

Therefore the team will continue to:

- Review and audit, if appropriate, revise current prescribing practice and use implementation techniques to ensure prescribing is in line with PHE guidance.
- Review the total volume of antibiotic prescribing against local and national data.

Current position (NHSE MO Dashboard)



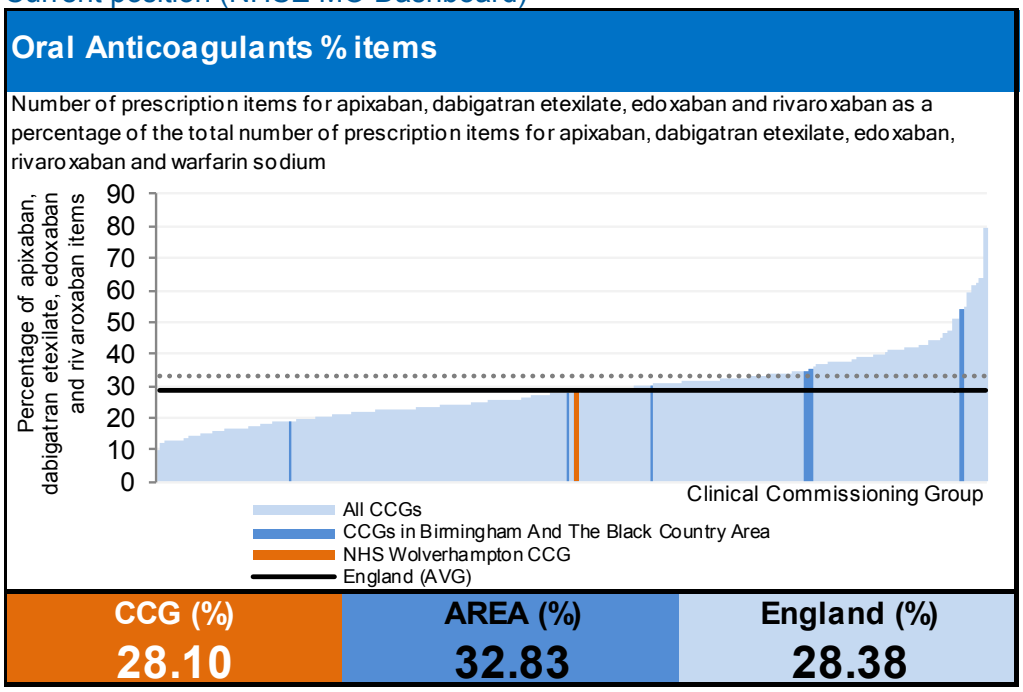
Medicines Commissioning

Primary Care Prescribing

Through the actions of the CCG Formulary Subgroup the Medicines Optimisation team will continue to:

- Review, discuss and action formulary decisions on behalf of local commissioners.
- Identify patient safety with regard to medicines and recommend action to address risks.
- Seek to harmonise with other local health economy formularies
- Seek to make best use of medicines within the available budget e.g. New Oral Anticoagulants

Current position (NHSE MO Dashboard)



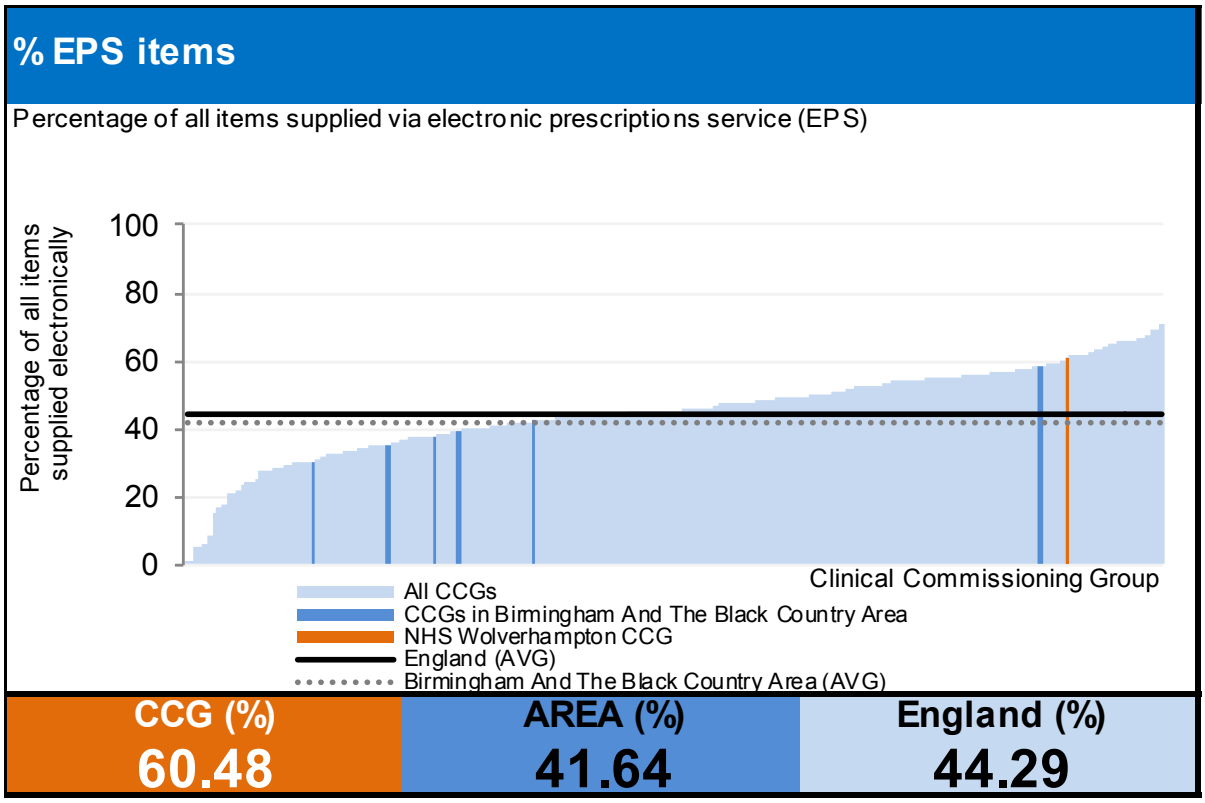
Secondary Care Prescribing

Through close working with the CCG Contracting and Finance Teams the Medicines Optimisation Team will continue to review Royal Wolverhampton Trust (RWT) business cases and NICE implementation plans and advise accordingly.
Use of the Quality Matters reporting system will allow monitoring of adherence to the commissioning for medicines quality aspects of the RWT and Black Country Partnership (BCP) contracts.

The PCMT will use an audit approach to improve the quality in transfer of information at admission and discharge from secondary care to ensure all communication is prompt and understandable to all.

EPS

The PCMT will seek to support full implementation of electronic transfer of prescriptions allowing improved patient access to their treatments.
Current position (NHSE MO Dashboard)



Medicines Governance

There will be a continuation of the process to incorporate of medicines optimisation within service specification requirements within contracts issued to NHS, Private and Independent health and care providers, including clear lines of accountability for the governance of medicines through the update of robust terms and schedules. In addition the Medicines Optimisation Team will continue to provide oversight of service provider protocols and sign off accordingly.

QIPP (Savings are reported via monthly reporting process)

The savings will be reported on a single line however the work streams are as shown below and will be expanded upon in this document:-

Work Stream	QIPP target 2017/18
Rebates -	£150,000
Script Switch	£350,000
Nutrition Support Service	£150,000
PCMT Work plan	£1,180,000 (plus an additional 220k dependent upon additional investment)
Total	£1,830,000 (increases to £2,050,000 with additional investment)

The PCMT will be working extensively to reduce the cost of prescribing in the following areas:

Area of work	QIPP savings in plan (,000)
Polypharmacy Reviews	662
Blood glucose testing strips- formulary products	2
Diabetes needles- formulary products	2
Gluten Free prescribing- staple foods	11
Oxycodone- lower cost branded products	25
Emollients- cost effective products	5
Lipid modifying drugs (exc statins)	10
Infant formula milks- formulary products	2
Inhalers- Inhaled Corticosteroids (cost effectiveness & Step down) *	220
Inhalers- cost effective tiotropium	80
Buprenorphine patches- cost effective brands	120
Antibiotics (azithromycin, fosfomycin)	5
Branded generics (including NP8)	50
Ocular lubricants- cost effective products	5
Proton pump inhibitor step down	1
Quetiapine -cost effective MR brands	10
Pharmaceutical specials- appropriate prescribing	90
Care home reviews	100
TOTAL	**1400**

*Additional investment required

Polypharmacy Reviews

Polypharmacy is a term that refers to either the prescribing or taking of many medicines. Concerns about the risks of polypharmacy are growing, supported by evidence which associates polypharmacy with increased adverse drug events, hospital admissions, increased healthcare costs and non-adherence. Polypharmacy reviews will be undertaken

using a patient-centred approach which combines both clinical and patient perspective in order to reduce polypharmacy and undertake deprescribing safely.

The NICE guideline on medicines optimisation recognises that optimising a person's medicines can support the management of long-term health conditions, multimorbidity and polypharmacy. Deprescribing is the complex process needed to ensure the safe and effective withdrawal of inappropriate medicines. Resources have been developed to support healthcare professionals who are reviewing people with polypharmacy to help guide decision-making about the appropriateness of prescribing and deprescribing including STOPP/START and NO TEARS tools.

Blood glucose testing

Wolverhampton has a new Blood Glucose Meter Formulary agreed across primary and secondary care. There are three main meters all have strips costing less than £10 per pot of 50. The PCMT will raise awareness of the updated formulary and encourage practices to adopt these meters for patients requiring a new or replacement meter.

Diabetic needles

Cost effective use of diabetic needles and lancets will be considered which will help offset the higher cost of prescribing under the safer sharps initiative where more costly retractable needles will be prescribed.

Gluten Free Prescribing

Assist patients to adopt a healthy diet by promoting healthier gluten free foods as opposed to luxury items such as chocolate biscuits, cakes, pies and puddings. In addition to this work would continue on recommending the number of units of GF products in line with Coeliac Society recommendations.

Oxycodone

Substantial savings could be achieved if Oxycodone Slow release tablets are prescribed as Longtec® tablets. This brand is currently half the price than the originator brand or if prescribed generically (based on MIMS/Drug Tariff Feb-17 prices).
If strong opioids are required, oral morphine should be the first choice for most patients and is a cost effective choice compared with other stronger opioids, such as fentanyl, buprenorphine and oxycodone, which are considerably more expensive.

Emollients

Evidence from controlled trials for the effectiveness of emollients in treating skin conditions such as eczema is limited, as is evidence comparing efficacy of different emollients. However, there is general agreement amongst clinicians that emollients have a key role in treating dry skin conditions, including eczema and psoriasis. Recommending patients are prescribed cost effective emollients in line with the formulary is a starting point for prescribing. Choice of an emollient needs to be made after discussion with the patient in order to match choice to patient lifestyle and increase compliance. Recommending the first prescription is for a small quantity amount of emollient on an acute prescription to gauge suitability to patient.

Lipid Modifying Drugs

The NICE guideline on lipid modification recommends that bile acid sequestrants, nicotinic acid, fibrates and omega-3 fatty acid compounds should not generally be offered (see the guideline for details). It may be appropriate to use bile acid sequestrants, nicotinic acid or fibrates to treat familial hypercholesterolemia in some circumstances.

The PCMT will review and, if appropriate, optimise prescribing of lipid-modifying drugs including statins, ezetimibe, bile acid sequestrants, fibrates, nicotinic acid, omega-3 fatty acid compounds to ensure it is in line with NICE guidance.

Infant formula

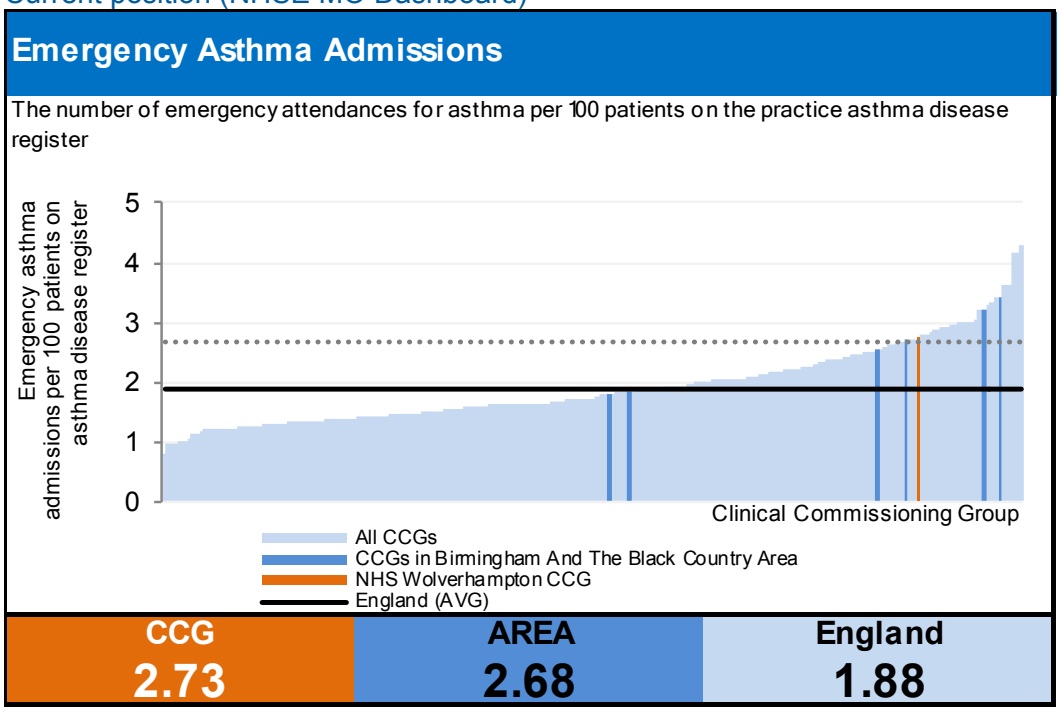
The APC has produced guidance around infant formula milks. Reviews will take place of existing prescribing against the guidance and following a discussion with the patient's parents/carers, inappropriate prescribing of these formulas will cease.

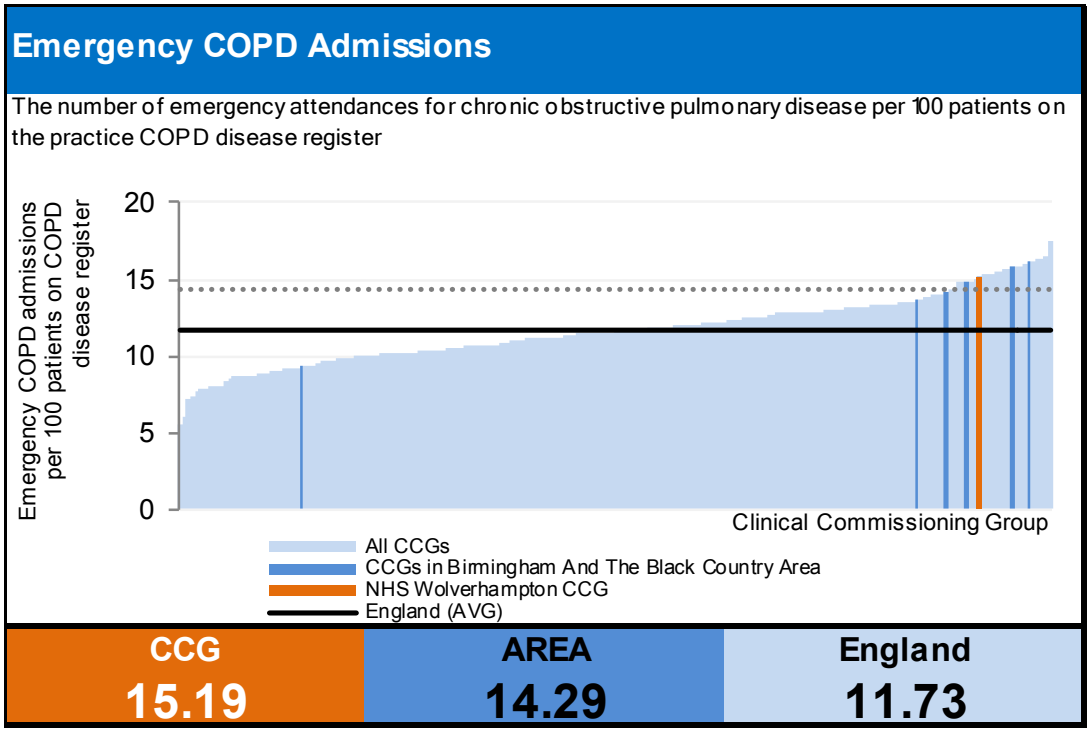
Cost effective inhalers & Step Down

Over the past few years there has been a steady increase in the number of treatments available for those with Asthma or COPD. In addition the loss of patent on standard inhaler treatments has led to the introduction of cost effective alternatives over the past 12 to 18 months. It is important cost-effectiveness of treatments is considered when prescribing for COPD or asthma. However it's vitally important to ensure that when a patient is first prescribed an inhaler they are shown how to use it, they can demonstrate that they are able to use it and ensure inhaler technique is assessed on a regular basis to ensure correct on-going technique. PCMT will raise awareness of available options for patients and stress the importance of checking Inhaler technique to support wider initiatives to reduce hospital admission.

Inhaled corticosteroids (ICS) are the first-choice regular preventer therapy for adults and children with asthma for achieving overall treatment goals. To minimise side effects from ICS in people with asthma, the BTS/SIGN guideline on the management of asthma recommends that the dose of ICS should be titrated to the lowest dose at which effective control of asthma is maintained. To achieve the QIPP savings target in this area will require additional investment in the PCMT to employ a specialist respiratory pharmacist.

Current position (NHSE MO Dashboard)





Buprenorphine patches

Substantial savings could be achieved if buprenorphine 5 mcg, 10 mcg and 20 mcg transdermal patches are prescribed as Butec® or Sevodyne® 5 mcg, 10 mcg and 20 mcg patches respectively. These brands are currently 55% less expensive than generic buprenorphine patches and Butrans® patches (based on MIMS/Drug Tariff Feb-17 prices). If strong opioids are required, oral morphine should be the first choice for most patients and is a cost effective choice compared with other stronger opioids, such as fentanyl, buprenorphine and oxycodone, which are considerably more expensive.

Branded generics (including NP8)

These are generic drugs which are not in section 8 of the Drug Tariff e.g. sodium valproate MR 300mg tablets. Community pharmacies will be reimbursed for the invoice price by the NHSBSA. Historically, there have been some instances where some companies have inflated prices of non-drug tariff products. Regulations do not currently preclude this practice. Attention should be given to prescribing preparations that are included in the part 8 of the drug tariff to ensure cost effectiveness for the NHS. In addition a list of preferred brands for prescribing has been agreed to provide a means of cost control for these products.

Ocular Lubricants

There are many products available for the treatment of dry eyes. Manufacturers of pharmaceutical products have expanded their range of ocular products to include relatively expensive unit dose products. There is a lack of evidence showing that any one product is better than another, so practices should choose to prescribe those with the lowest acquisition cost. Prescribing appropriately in line with the formulary should help for new and existing patients will help maximise efficiencies.

PPI step down

When reviewing a person's treatment, prescribers should consider that whilst generally well-tolerated, there is evidence to suggest that long-term PPI use is associated with an

increased risk of fracture, hypomagnesaemia and possible increased risk of *Clostridium difficile* infection.

Branded MR Quetiapine

Several modified release brands of quetiapine are now available and many are much less expensive than generic quetiapine MR tablets. The CCG has been working to ensure that patients are prescribed a cost effective brand for 2016/17(73% of prescribing). This will continue in 2017/18.

Pharmaceutical Specials

On occasion there are times when a patient is unable to use a licensed formulation of a medicinal product, either due to the correct strength being unavailable, or being unable to take a solid dosage form. In these circumstances an unlicensed medicine (special) is prescribed for which the prescriber takes full responsibility. These are usually obtained from specials manufacturers and are costly. Pharmaceutical specials are a necessity for some patients; however long term there may be other options available or a special may be being prescribed on repeat when it is no longer required. Patients receiving a special should be reviewed to ensure it is still required and that there aren't other more suitable medications available.

Care Home Reviews

The older population are at higher risk from medication errors as this population have a higher level of morbidity and are frequently prescribed more medication as a result. NICE guidance SC1: Managing Medicines in Care Homes, published March 2014, was developed to provide recommendations for good practice on the systems and processes for managing medicines in care homes.

The guidance recommends that GPs should ensure that arrangements have been made for their patients who are residents to have medications reviews. All medication reviews should be linked to the patient's care plan.

Wolverhampton CCG has a commissioned a service from the Primary Care medicines Team that is supported by a local geriatrician to ensure that deprescribing i.e. withdrawal of inappropriate medication is done safely and effectively.

Rebates

Primary Care Rebate Schemes are contractual arrangements initiated by pharmaceutical companies which offer financial rebates on particular branded medicines. Rebate Schemes offer CCGs entry into a retrospective discount agreement with a pharmaceutical manufacturer in order to reduce the expense of prescribing high-cost, branded drugs and also contribute to established NHS efficiency. The CSU manages rebates and provides the governance on behalf of the CCG. QIPP target is £150,000

Scriptswitch (reported quarterly by system supplier)

This is a prescribing decision support tool that works in conjunction with the GP clinical systems to offer tailored medicines optimisation recommendations in accordance with the profile managed by the CSU on behalf of the CCG. It offers the ability to make changes to medication as well as providing patients safety messages at the point of prescribing

Annual cost of license is £80,000 (VAT exempt)

QIPP target for 2017/18 is £350,000

Areas of cost control in addition to QIPP

GP Prescribing Incentive Scheme (Reported via quarterly Quality and Safety Committee reports)

By setting an annual incentive scheme for GPs which as a primary focus of improving quality in prescribing there will be an associated control of costs. The following areas are proposed as an incentive for 2017/18 where the GP practices are asked to maintain or reduce the prescribing in the following areas:

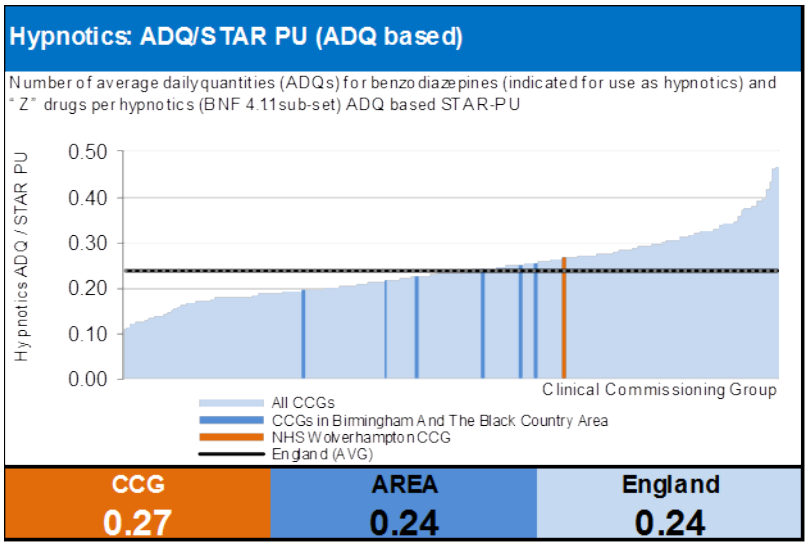
- Antibiotic prescribing rates
- Antibiotic prescribing for UTI in primary care.
- Hypnotic prescribing rates
- NSAID prescribing rate
- Increase the proportion of low cost blood glucose testing strips prescribed
- Lower cost branded buprenorphine patches
- Diabetic pen needles
- Lower cost branded tiotropium inhalers
- Brand prescribing of inhalers except short acting beta agonists

Also GP practices use of Scriptswitch will need to be demonstrated. Awareness of the system benefits will be promoted.

Hypnotic Prescribing Rates

Risks associated with the long-term use of hypnotic drugs have been well recognised for many years. These include falls, accidents, cognitive impairment, dependence and withdrawal symptoms. Benzodiazepine hypnotics should be used only if insomnia is severe, disabling or causing the person extreme distress. The lowest dose that controls symptoms should be used, for a maximum of 4 weeks and intermittently if possible. Prescribing of hypnotics should be reviewed, and if appropriate, revised, to ensure that it is in line with national guidance.

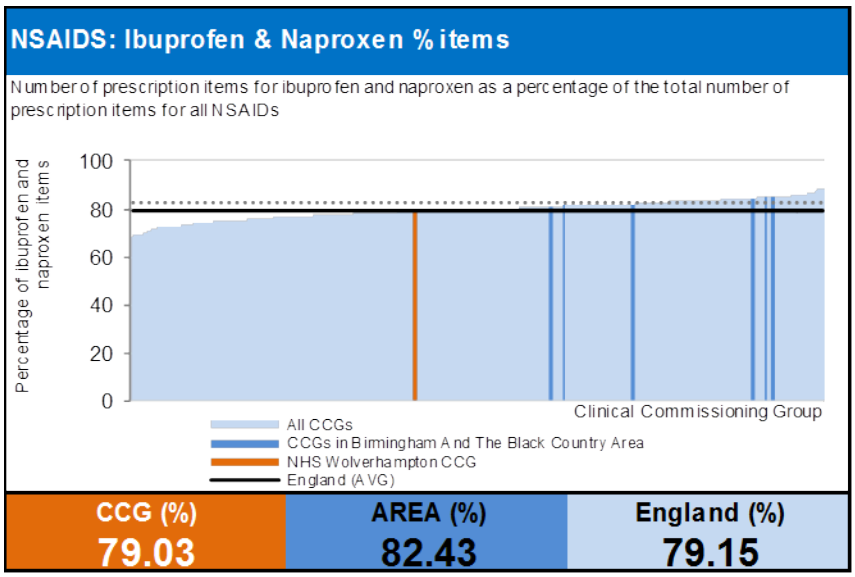
Current position for hypnotics (NHSE MO Dashboard)



NSAIDs

There are long-standing and well-recognised gastrointestinal and renal safety concerns with all NSAIDs. There is also an increased risk of cardiovascular events with many NSAIDs, including COX-2 inhibitors and some traditional NSAIDs. The MHRA recommend that the

lowest effective dose of NSAID should be prescribed for the shortest time necessary for control of symptoms. Prescribing of NSAIDS will be reviewed against the guidance. Where NSAIDs are used ibuprofen and naproxen are considered to have the best safety profile. Current position (NHSE MO Dashboard)



Low cost blood glucose testing strips
Current position for proportion of low cost blood glucose testing strips prescribed is 49%

Lower cost branded buprenorphine patches
Current position for proportion of higher cost patches is 82%

Diabetic pen needles
Current position – Our use of the least costly insulin (less than £6 per 100) disposable needles stands at 30% of all insulin disposable needles.

Lower cost branded tiotropium inhalers
Following the expiry of tiotropium's UK patent, the first lower cost 'equivalent' to Spiriva Handihaler® was launched by Teva under the brand name Braltus®. Also, the price of Spiriva Respimat® (tiotropium aqueous solution for inhalation) dropped substantially in the last year. The target for all practices is to achieve a prescribing rate above 50%.

Oversight of High Cost Drug Prescribing
The CCG has a process for managed introduction of new drugs and operate a joint formulary. High Cost Drugs (HCDs) are substantial parts of CCG spend. The CCGs uses the BlueTeq system for HCDs charged to the CCG. During the first 8 months of 2016/17, 355 individual charges have been queried as these haven't matched against the BlueTeq request or they should have been passed to other commissioners. The CCG will continue to use BlueTeq in 2017/18
The CCG will continue to challenge RWT to provide a rationale for those patients that are overdue a review.

Nutrition (reported via annual report produced by provider)
It is recognised that many patients are prescribed sip feeds inappropriately and require review. NICE have issued guidance around nutrition support in adults (CG32); this should be followed to ensure that patients do not receive oral nutrition inappropriately, and also so that

those patients that do require it receive it. Screening for malnutrition, or the risk of malnutrition, should be carried out by healthcare professionals with appropriate skills and training. The CCG commission a service from RWT that provides the input as outlined above.

QIPP target is £150,000

Timescales

Area of Work	Quarter 1	Quarter 2	Quarter 3	Quarter 4
GP Incentive scheme	Work undertaken by GP practices	Work undertaken by GP practices	Work undertaken by GP practices	Work undertaken by GP practices
Eclipse	Red and amber alerts	On going	On going	On going
Drug Alerts	As published	As published	As published	As published
Polypharmacy review	On going	On going	On going	On going
Care Home reviews	On going	On going	On going	On going
Buprenorphine patches	Work to support GP incentive scheme	Work to support GP incentive scheme		
Ocular lubricants	Ensure compliance with formulary	On going	On going	On going
Non drug tariff products(NP8)	On going	On going	On going	On going
Specials	On going	On going	On going	On going
Infant formula	Practice audits and advice on appropriate products	On going	On going	On going
NSAIDs	Work to support GP incentive scheme	Work to support GP incentive scheme	Work to support GP incentive scheme	Work to support GP incentive scheme
Lipid lowering drugs	Practice audits to check on compliance	Practice audits to check on compliance		
Emollients	Promotion of Zero range of products to improve ScriptSwitch acceptance rates	Promotion of Zero range of products to improve ScriptSwitch acceptance rates	Technician work plan.	Technician work plan.
Blood glucose testing strips(supports GP incentive scheme)	Patients not on insulin are using locally approved products	On going	On going	On going
Diabetic needles	Work to support	Work to		

	GP incentive scheme	support GP incentive scheme		
Cost effective inhalers	On-going as patients receive annual asthma/COPD review	On-going as patients receive annual asthma/COPD review	On-going as patients receive annual asthma/COPD review	On-going as patients receive annual asthma/COPD review
PPI step down (links to antimicrobial and NSAID work- supports GP incentive scheme)			Work to support GP incentive scheme	Work to support GP incentive scheme
Branded MR quetiapine	Continuing work from last year monitoring new patients initiated	On going	On going	On going
Pharmaceutical Rebates	Finance re-charge based on CSU analysis. CSU actively reviewing industry proposals	On going	On going	On going
Scriptswitch(Actual cost benefit)	Monthly system report	Monthly system report	Monthly system report	Monthly system report
Dieticians reviews	On going	On going	On going	On going

Data Source Reference Document
Quality Prescribing Scheme Data
Based on Population of 270K. Current 250k BUDGET = Payment of £925 per 1000 patients

	Proposed payment per 1000 patients	100% achievement by all practices would require the following budget	Potential savings if implemented fully	Comments	Source
PART 1: Antibiotic prescribing	**£400**	£108,000	44,797	Linked to Quality Premium	from Mids and Lancs CSU QIPP document
PART 2a: Antibiotic prescribing for UTI in primary care. Ratio of trimethoprim to nitrofurantoin prescribing	**£150**	£40,500	0	Linked to Quality Premium	
PART 2b: Antibiotic prescribing for UTI in primary care. Number of items prescribed for trimethoprim	**£150**	£40,500	0	Linked to Quality Premium	
PART 3: Hypnotics optimisation	**£125**	£33,750	16,967		from Mids & lancs CSU QIPP document
PART 4: NSAIDs	**£100**	£27,000	44,337		from Mids & lancs CSU QIPP document
Parts 1 to 4 = £249,750.					
PART 5: Low cost Blood Glucose Testing Strips	**£150**	£40,500	127, 275		extracted from diabetes dashboard
Part 6: Lower cost branded buprenorphine patches	**£125**	£33,750	175,000	Assumes 75% uptake of brand prescribing	epact data
Part 7 : Diabetic pen needles	**£125**	£33,750	39,803	Increase in lower cost needles from 30% to 60%	PresQipp data
Part 8: Lower cost branded tiotropium inhalers	**£200**	£54,000	82,861	increase to 50% uptake of preferred brand prescribing	epact data
Part 9: Brand prescribing of inhalers	**£125**	£33,750	200,000	Increase from 48.7% to 85%	epact data
Parts 5 to 9 = £195,750.					
Total	£1,650	£445,500	603,766		

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NHS Wolverhampton Clinical Commissioning Group Constitution Appendix H6

The Primary Care Commissioning Committee Terms of Reference

1. Introduction

1.1 Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England and CCGs would delegate the exercise of certain specified primary care commissioning functions to a CCG.

1.2 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to Wolverhampton CCG. The delegation is set out in Schedule 1.

1.3 The CCG has established the Wolverhampton CCG Primary Care Commissioning Committee ("the Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of these delegated powers for commissioning primary medical services for the people of Wolverhampton.

2. Statutory Framework

2.1 NHS England has delegated authority to the CCG to exercise the commissioning functions set out in Schedule 2 in accordance with Section 13Z of The National Health Service Act 2006 (as amended) ("NHS Act").

2.2 Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

2.3 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);
b) Duty to promote the NHS Constitution (section 14P);
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
d) Duty as to improvement in quality of services (section 14R);
e) Duty in relation to quality of primary medical services (section 14S);
f) Duties as to reducing inequalities (section 14T);
g) Duty to promote the involvement of each patient (section 14U);
h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2).

2.4 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those functions set out below:-

- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

2.5 The Committee is established as a committee of the Governing Body of the CCG in accordance with Schedule 1A of the NHS Act.

2.6 The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3. Role of the Committee

3.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Wolverhampton, under delegated authority from NHS England.

3.2 The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

3.3 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act

except those relating to individual GP performance management, which have been reserved to NHS England. This includes the following activities:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

3.4 The Committee will also be responsible for maintaining an overview of the CCG's other activities in relation to the delegated functions related to Primary Care and ensuring that they are aligned with the CCG's Primary Care strategy. These activities include:-

- Planning for sustainable primary medical care services in Wolverhampton;
- Reviewing primary medical care services in Wolverhampton with the aim of further improving the care provided to patients
- Co-ordinating the approach to the commissioning of primary care services generally;
- Managing the budget for commissioning of primary medical care services in Wolverhampton.

3.3 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Wolverhampton CCG, which will sit alongside the delegation and terms of reference.

4. Geographical coverage

4.1 The Committee will comprise the Wolverhampton CCG (The CCG). It will undertake the function of jointly commissioning primary medical services for Wolverhampton.

5. Membership

5.1 The Membership of the Committee shall consist of:-

- The Deputy Chair of the CCG's Governing Body

- The CCG Governing Body Lay Member for Finance and Performance
- Two Executive Members of the CCG's Governing Body (currently the Director of Strategy and Transformation and the Executive Director of Nursing and Quality)
- The Three GPs elected to the CCG Governing Body as Locality Leads (Non-Voting)
- Two Patient Representatives

5.2 The Chair of the Committee shall be the Deputy Chair of the CCG's Governing Body

5.3 The Vice Chair of the Committee shall be the CCG Governing Body Lay Member for Finance and Performance.

5.4 Any member of the committee may nominate a substitute to attend a meeting on their behalf, provided that they notify the Chair 24 hours before the meeting.

6. Invited Attendees

6.1 Both a representative of Healthwatch Wolverhampton and a representative of the Wolverhampton Health and Wellbeing Board (who must represent Wolverhampton City Council on the Board) shall be invited to attend meetings of the Committee as a non-voting observer.

6.2 The observers shall be invited to provide assurance that the provisions for managing conflicts of interest are being correctly applied and shall be entitled to attend private sessions of the Committee.

6.3 The Committee may also call additional experts to attend meetings on an ad hoc basis to inform discussions.

7. Meetings and Voting

7.1 The Committee will operate in line with the CCG's Standing Orders and Policy for Declaring and Managing Interests. The agenda and supporting papers will be circulated to all members at least five working days before the date the meeting will take place unless a shorter time period for circulation of papers is necessary due to a meeting being re-scheduled at short notice.

7.3 Decisions of the Committee should be reached by consensus where possible. Where this is not possible, a vote will be taken with a simple majority of the votes cast being required to reach a decision with the Chair having a second and casting vote in the event of a tie.
N.B. In line with national statutory guidance, the GP representatives on the Committee shall not be entitled to vote.

7.3 Meetings of the Committee shall be held in public, unless the Committee resolves to exclude the public from either the whole or part of the proceedings whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

7.4 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7.5 Members of the Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the committee in which event these shall be observed.

8. Quorum

8.1 Meetings of the Committee shall be quorate when over 50% of its members, including the Chair or Vice Chair and at least one Executive Governing Body member is present and overall make up of those present is such that there is a majority of non-clinical members.

9. Frequency of Meetings

9.1 The Committee shall agree a regular programme of meetings each year. In addition, the Chair may call additional meetings if they are required in line with the provisions for notice of meetings set out above.

10. Secretary

10.1 A named individual (or his/her nominee) shall be responsible for supporting the Chair in the management of the Committee's business and for drawing

members' attention to best practice, national guidance and other relevant documents as appropriate.

10.2 The Secretary will circulate the minutes and action notes of the committee with 3 working days of the meeting to all members and present the minutes and action notes to NHS West Midlands and the governing body of the CCG.

10.3 The Secretary will also provide an executive summary report which will presented to NHS West Midlands and the governing body of the CCG each month for information.

11. Accountability of the Committee

11.1 The Committee will be directly accountable for the commitment of the resources / budget delegated to the CCG by NHS England for the purpose of commissioning primary care medical services. This includes accountability for determining appropriate arrangements for the assessment and procurement of primary care medical services, and ensuring that the CCG's responsibilities for consulting with its GP members and the public are properly accounted for as part of the established commissioning arrangements.

11.2 For the avoidance of doubt, the CCG's Scheme of Reservation & Delegation, Standing Orders and Prime Financial Policies will prevail in the event of any conflict between these terms of reference and the aforementioned documents.

11.3 The Committee is accountable to the governing body to ensure that it is effectively discharging its functions.

12. Procurement of Agreed Services

12.1 The procurement arrangements will be set out in the delegation agreement (Schedule 1 and 2 to this Terms of Reference between NHS Wolverhampton CCG and NHS England).

13. Decisions

13.1 The Committee will make decisions within the bounds of its remit set out in paragraph 3 above. The decisions of the Committee shall be binding on NHS England and NHS Wolverhampton CCG and will be published by both parties.

14. Review of Terms of Reference

14.1 These terms of reference will be formally reviewed by the Committee in April of each year, following the year in which the committee is created and any recommendations for changes will be made to the Governing Body.

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Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
Minutes of the Primary Care Strategy Committee
Held on Thursday 16th March 2017
Commencing at 1pm in the CCG Main Meeting Room, Wolverhampton Science Park, Glaisher Drive, Wolverhampton

Present:

Sarah Southall	Head of Primary Care, WCCG (Vice Chair)
Dr DeRosa	Chair of Governing Body, WCCG
Claire Skidmore	Chief Finance & Operating Officer, WCCG
Mike Hastings	Associate Director of Operations, WCCG
Vic Middlemiss	Head of Contracting & Procurement, WCCG
Jane Worton	Primary Care Liaison Manager, WCCG
Tally Kalea	Commissioning Operations Manager, WCCG
Dr Kainth	Locality Lead/New Models of Care Representative, WCCG
Dr Mehta	LMC Chair
Stephen Cook	Senior IM&T Project Manager, WCCG
Dr Reehana	Locality Lead/New Models of Care Representative, WCCG
Ranjit Khular	Primary Care Transformation Manager, WCCG
Barry White	New Models of Care Project Manager, WCCG
Jason Nash	New Models of Care Project Manager, WCCG
Laura Russell	Primary Care PMO Administrator, WCCG
Liz Hull	Administrative Officer, WCCG

Declarations of Interest

PCSC104 Dr DeRosa, Dr Kainth, Dr Mehta and Dr Reehana declared their interest, as GP's in all items related to primary care. However, as declarations did not constitute a conflict of interest, they all remained in the meeting whilst these items were discussed.

Apologies for absence

PCSC105 Apologies were submitted on behalf of Dr Helen Hibbs, Steven Marshall, Andrea Smith, David Birch and Sharon Sidhu.

Minutes and Actions

PCSC106 The minutes of the previous meeting held on 8th February 2017 were approved as an accurate record.

The action log was discussed and an updated version will be circulated with the minutes.

RESOLVED: **That the above was noted.**

Matters Arising

PCSC107 Outcomes of Discussions – Report to Governing Body of the Primary Care Strategy Committee:

The Committee was informed that the report was accepted at the Governing Body Meeting on Tuesday 14th March 2017.

RESOLVED: **That the above was noted.**

Risk Register

PCSC108 Risk Register Report Datix:

Mrs Southall presented the Risk Register and reported that there were no red risks to escalate to the Committee.

Summary of Risk Logs:

Risk logs for the following Task and Finish Groups were reviewed by the Committee:

- Capital Review Group / Strategic Estates Forum
- Primary Care Project Management
- Localities as Commissioners
- Clinical Pharmacist in Primary Care
- Workforce Development – concerns were raised in relation to the lack of risks included.

RESOLUTION: **All Task and Finish Groups to ensure that risk log colour coding is correct.**

Performance

PCSC109 **Strategy Implementation Plan**

Ms Russell provided the Committee with an update in relation to the Strategy Implementation Plan and the following key points were noted:

- Exception reports to be tabled for New Models of Care, Workforce Development, Primary Care Contract Management and Estates Development.
- New Models of Care – most of the key objectives will be delivered in 2017/18.

- Practices as Providers – a number of objectives are on schedule to be complete by the end of March, with the remaining objectives being carried forward for completion into 2017/18.
- Localities as commissioners – objectives to be carried forward into 2017/18.
- Workforce Development – Slippage has been identified in the low level plan and this will be monitored, exception report available.
- Clinical Pharmacists in Primary Care – the plan is on target and objectives to be achieved in 2017/18.
- Primary Care Contract Management – a number of objectives are scheduled to be complete by the end of March and a review will be undertaken with the Group leads to look at objectives going forward.
- Estates Development – There has been some slippage for 2016/17. Larger pieces of work will be carried forward into 2017/18.
- IM&T Business Intelligence – Progressing into 2017/18.
- GP 5 Year Forward View – a separate programme of work is being compiled, activities are underway and objectives will be mapped to the Primary Care Strategy Programme of Work for consideration at a future meeting.

RESOLVED: That the above was noted.

Task & Finish Groups

PCSC110 **Practice as Providers Task & Finish Group**

Mr Khular provided the Committee with a summary of discussions that took place at the Task and Finish Group on 14th February 2017. Key points were noted as follows:

- Improved access to Primary Care – An overview plan has been developed to confirm how the 10 High Impact actions will be delivered and a Local Enhanced Service has also been prepared to further define this. Discussions have established that some of the good practice that underpins the High Impact Actions is already taking place. Therefore, the first phase will involve setting a baseline.

- Non-Clinical Support Functions – Work is being undertaken with the Primary Care Home and Medical Chambers Groups to identify their preferred options for provision of each function, which are:
    - Legal Services
    - Human Resources
    - Mandatory Training
    - Payroll
    - Standardised Policies and Procedures
    - Business Intelligence and Data
    - Medicine Optimisation and Prescribing Support
    - Contract Management
    - Procurement of Goods and Services

A more in depth update to be provided at the next meeting.

- GP Peer Review – A discussion has taken place with BI with regards to the presentation of data on GP referrals for the specialities with the greatest volume of activity and variance across the following 4 quadrants:
    - Quadrant 1 – low referrals / low conversion
    - Quadrant 2 – low referrals / high conversion
    - Quadrant 3 – high referrals / high conversion
    - Quadrant 4 – high referrals / high conversion

  This data will form the basis of Peer Review discussions in 2017/18 and the Committee was advised that a paper was presented to the Clinical Reference Group to propose a way forward. Practice groupings are considering forming sub groups at which Peer Reviews can be completed.

- Asthma / COPD Enhance Review – The Committee was informed that coding issues have been identified. However, positive feedback has also been received which can be utilised going forward.

- Aristotle / Risk Stratification – A stakeholder meeting is in the process of being arranged to consider progress made with Risk Stratification to date and to agree next steps to embed in practices. The meeting will include PCH1, PCH2, Unity, RWT and Social Care. The Committee will be provided with feedback at the next meeting.

- New Consultation Types – An options appraisal is expected at the IM&T Task and Finish Group.

RESOLUTION: Mr Khular to provide a more in-depth update, at the next meeting, in relation to the Non-Clinical Support Functions.

PCSC111 **New Models of Care (Primary Care Home) Task & Finish Group**

Mr White presented an update to the Committee as follows:

- Work continues on the Gap Analysis of the work required to enable the formation, implementation and operation of Primary Care Homes within Wolverhampton CCG.
- Engagement with task and finish groups is on-going.
- Primary Care Home 1 and 2 meetings have taken place.
- Patient engagement and self-health care development – a presentation was delivered by the 'Sound Doctor' who provided information on what can be provided in the form of a suite of patient advice, awareness and engagement videos. A business case has been drafted.
- Clinical Pharmacists for PCH1 and PCH2 – submissions were made on 10th February and a decision is still awaited.
- Individual electronic folders for the PCH groups are up and running on the W drive.

- Extended hours covering Christmas / New Year and Saturday - An extension has been provided until the end of March. This includes an additional extended service in each locality (1 site per locality) which would provide 72 additional appointments across 3 sites on Saturday mornings.
- Service and pathway development meetings have taken place to agree progress requirements for Mental Health, Frailty and Clinical Pharmacist.
- The PCH2 Practice Managers Meeting is due to take place on 23rd March. Work continues to develop:
    - Resource lists for PCH1 and PCH2
    - IM&T requirements
    - Administration governance
    - Meetings and operational control
    - Practice Manager and staff engagement and understanding
    - Patient engagement and involvement
    - 10 point High Impact Action Plan
    - Back office support functions requirements
    - Use of Community Matrons
- EMIS sharing requirements:
    - Costs will be validated by IM&T colleagues.
    - A workshop took place on 27th January 2017 and the outputs will be communicated to Practice Managers.
    - The logistics of training days are yet to be identified.
    - Policies, procedures and management documentation – a suite of documentation to meet PCH requirements. Currently, the following documents have been produced for validation by PCH's:
        - Members agreement
        - Company accounts spreadsheet
        - Invoicing template
        - Expenses template
        - Purchasing/revenue spend application process and documents
        - Templates for costing and service evaluation
- Work is taking place with Practice Managers from PCH1 and PCH2 to develop and plan requirements and deliverables.
- Newsletters for PCH1 and PCH2 which will also be shared with CCG employees

RESOLUTION: Mr White to ensure that a copy of the newsletter is circulated with the minutes.

PCSC112 **New Models of Care (Unity) Task & Finish Group**

Mr Nash referred the Committee to a highlight report and key points were noted as follows:

- Unity Meeting – the second meeting took place on 2nd March 2017 and focused federated working / MCP contracts, hub working and social prescribing. Updates were also provided at the meeting with regards to Admin

/ Reception training, a Peer Review proposal and Risk Stratification & Community Neighbourhood Teams.

- PCC Opportunity – A workshop will take place on 27th April 2017 to help Unity develop a cohesive vision and clarify how they can play a part in the development of the MCP model.
- Peer Review Proposal – A paper was submitted to the Clinical Reference Group following a review of the peer review process. The proposal seeks to agree a number of specialities for review during 2017/18.
- Clinical Pharmacist – Intrahealth submitted a bid on behalf of the group. If successful, Intrahealth will be the employing organisation and hold an SLA with each participating practice. The bid seeks to establish 5 clinical pharmacists to become integral parts within general practice, covering a registered population of 59, 800 patients. The outcome is still awaited.
- Extended Opening – To support the implementation of extended opening across all Unity practices, a proposal has been distributed to the group that suggests splitting into 3 geographical hubs that will seek to deliver care close to the patient's home. Concerns were expressed by members of the Committee because it is the view of NHS England that practices with half day closing are unable to participate in extended opening. It was therefore agreed to build contractual changes in schemes and recognise as a risk (Action: RK).
- Remote Consultations – A demonstration had been arranged directly with EMIS for 5th April 2017 and invites have been sent to practices. MH reiterated the importance of working in close collaboration with the IT Team at the CCG.
- Winter Pressures Increased Access – Extended for a number of practices until the end of March.
- Simple Dressings / Wound Care – The group have been asked to consider delivering group wide wound care to resolve difficulties with waiting times and RWT being unable to refer patients for follow up treatment to Vocare post discharge. Initial feedback is concern over the increasing expectations on general practice. Dr Bush has agreed to look at confirming further capacity and a number of other practices have similarly indicated.
- End of Life Identification (EOI) – A meeting took place recently between Karen Evans and Dr Kam Ahmed who had highlighted concerns in relation to this. Feedback from that meeting will be obtained.

RESOLUTION: **Mr Nash to ensure that the Risk Log is updated to recognise contractual changes as a risk.**

Ms Southall to send Dr Mehta the national guidance in relation to appointment times, contained within the 5 Year Forward View Plan.

Mr Cook to attend the next Unity Meeting.

PCSC113 **New Models of Care (Unity) Exception Report**

Mr Nash presented the Committee with an exception report in relation to slippage for the following areas of the implementation plan:

- Confirmation of leadership roles / organisation structure
- Evaluation of data from participating practices once extended access scheme has been completed
- Audit of DNA rates
- Update / presentation on Active Signposting / Staff training at Penn Manor
- Case reviews of Paramedics supporting Primary Care

RESOLUTION: The Committee approved the proposed revised timelines with the caveat that this should be re-considered if the need arises.

PCSC114 **Localities as Commissioners Task & Finish Group**

Mr Khular provided the Committee with an update and highlights were noted as follows:

- 7 Day Working
  - A patient engagement event was due to be held by the trust and a presentation will be delivered to GPs at the next Team W event on 22nd March 2017.
- Practice Level Dashboards:
  - A demonstration of the practice level view of Aristotle was delivered by Midlands and Lancashire CSU BI Team.
  - Reports that can be generated at practice and group level on the various domains within Aristotle include Contract Monitoring, Performance, High Intensity User Dashboard, Ambulatory Care Sensitive Conditions and Risk Stratification
  - Data in relation to prescribing is held by the Medicines Optimisation Team, which can also be included in the dashboards.
- Local QOF
  - The Steering Group has met and meetings will be held at monthly intervals.
  - A Terms of Reference has been considered.
  - A review of national indicators is currently taking place.
  - Dudley CCG's approach to implementing a local QOF has been reviewed. Their process took 2 years to agree, with input from NHS England and the CQC. All indicators are reported against a specific function within EMIS.
  - NHS England (Contracting) will be part of the group, along with Dr Ahmed from Medical Chambers.
  - The intention is to develop a QOF+ rather than suspend the national QOF fully. Additional indicators are being identified & will be shortlisted in the coming months with a view to implementation thereafter.

- Risk Stratification
  - A stakeholder meeting has been arranged to consider progress made to date and to agree next steps to ensure that risk stratification is embedded in practices. The meeting will involve representation from PCH1 and 2, Unity, RWT and Social Care and colleagues responsible for the Community Matron Service.

RESOLUTION: **Mr Khular agreed to liaise with the LMC to ensure that they are included in the Local QOF Steering Group.**

PCSC115 **Workforce Development Task & Finish Group**

In Ms Garcha's absence, the Committee reviewed the report submitted by Ms Garcha and the following queries were noted:

- Why is there no mention of GP recruitment?
- When is the recruitment fayre taking place?
- Is there a compelling vision about what is to be achieved?

RESOLUTION: **Ms Garcha is required to provide a more in-depth report to include a stronger focus on what the fayre is going to include, how it will be delivered and when.**

Ms Garcha to ensure that the Risk Log is accurate.

Ms Southall to attend the next Task & Finish Group.

Ms Hull to circulate information from the Advisory Board with the minutes.

PCSC116 **Clinical Pharmacist in Primary Care Task & Finish Group**

Mr Birch had sent apologies, therefore the Committee reviewed the report in his absence. It was noted that:

- A bid has been submitted for funding by PCH1 and 2, VI and Intrahealth (on behalf of Unity).
- A KPI data collection form is still in the process of being developed.
- The Gap Analysis database is being kept up to date.

RESOLUTION: **The Committee accepted the report in principle and Ms Skidmore and Ms Southall agreed to explore, outside of the meeting whether this T&FG should remain separate to the Workforce T&FG.**

PCSC117 **Primary Care Contracting Task & Finish Group**

Mr Middlemiss summarised the Primary Care Contracting Task and Finish Group highlight report as follows:

- Implementation Plan:
  - There is slippage for 3 areas and other areas are complete or in progress.
  - Discussions have focused on Primary Care Contracting update, development of new models of care, contracting support via the PC Hub / progression to full delegation, and risks / issues.
- Primary Care Contracting Update - The CCG have circulated expression of interest opportunities in relation to:
  - Zero Tolerance Scheme for violent patients
  - Primary Care Counselling
  - End of Life
- Development of Models of Care:
  - Members of the CCG recently attended a conference, hosted by the King's Fund. Feedback from this is that an options appraisal is recommended to determine the best MCP contracting model for the service model being commissioned. It is also recognized that VAT implications are a key issue for Primary Care Groupings with regards to VAT liability facing non-NHS bodies. A review is taking place by the Treasury in relation to this.
  - Medical Chambers Group is holding an Away Day in April, hosted by Primary Care Commissioning and it is hoped that this will provide an opportunity for shared learning.
- Preparing for Full Delegation:
  - The CCG is still awaiting release of the latest iteration of the Primary Care Hub MoU.
  - The CCG has approved a new post – Primary Care Contracts Manager, which will lead on the responsibility associated with delegation of Primary Medical Services commissioning.
- Task & Finish Group Actions:
  - A meeting will take place to explore joint procurement options between the CCG and Wolverhampton City Council.
  - Mr Middlemiss will review the Kings Fund Conference presentations to determine if some of the slides can be shared with the Task and Finish Group.
  - Additional risks to be included on the Risk Register.

RESOLVED: The Committee noted the update provided.

PCSC118 **Primary Care Contracting Exception Reports**

Mr Middlemiss referred to 2 exception reports as follows:

- Exception Report 1 Delay in the release of the updated Primary Care Hub MoU – a number of mitigating controls have been put in place to ensure that the CCG is as fully prepared as possible for full delegation in the absence of a MoU.

- Exception Report 2 Delay associated with the implementation of MCP/PACs emerging care model and contract framework, working in conjunction with NHS England – specific areas of the delay are:
    - Preparation of a contract plan for Primary Care in response to practice groupings.
    - Preparedness of practice groups to sub contract services where necessary.

RESOLUTION: **The Committee noted both exception reports and requested that a milestone review should take place in May 2017.**

Mr Middlemiss should include the Maturity Model (Self Assessments) as an agenda item for the Task and Finish Group Meeting.

Mr Middlemiss to note that the next meeting of this group overlaps with the meeting for Practices as Providers.

PCSC119 **Estates Development Task & Finish Group**

Mr Kalea updated the Committee with highlights from the Estates Development Task and Finish Group:

- Locality Hubs:
    - North East - A piece of work is being undertaken to identify land.
    - South West – RWT have advised that West Park will be an interim hub.
    - South East – Issues with a plot of land and information is still awaited and other options exist.
- Cohort 1 Schemes:
    - The three Cohort 1 practices that were successful with ETTF bids should have had completed builds by 1st April 2017. The delay in funding allocation from NHS England and lease agreements from NHS Property Services not being created has led to the programmes of work for each practice slipping beyond the original completion date.
    - Meetings are taking place with practices so that the lease agreements can be completed with CCG support.
    - Further meetings with NHS Property Services are in place to ensure practices are kept up to date on progress in relation to sign off of the agreements and planned start dates for building works.
    - Mr Kalea confirmed that the CCG has been provided with confirmation that money for Cohort 1 Schemes is protected

RESOLUTION: **The update was noted by the Committee.**

Mr Kalea to obtain confirmation from Property Services by the end of the month.

PCSC120 **IM&T Business Intelligence Task & Finish Group**

Mr Cook joined the meeting to share highlights of the IM&T Business Intelligence Task and Finish Group with the Committee:

- Wolverhampton LDR Enablement group has finalised the MoU and ToR, which is now being shared with the Boards of member organisations and it is planned to be a single document going forward.
- Wi-fi is now live.
- The NHS digital visit has been delayed until May.
- EMIS remote consult projects are in progress for all of the GP groups.
- The ETTIF JAYEX (auto arrival solution) project has started and the replacement of equipment has started.
- ETTF Bid for 2017/18 has been submitted. The bid is developed in collaboration with Walsall CCG and would look to expand on the existing Shared Care Record. We are currently waiting to see if this has been agreed.

RESOLVED: The Committee noted the update provided.

PCSC121 **General Practice Forward View Implementation Plan 2017-19**

Ms Southall presented an update report to the Committee and it was noted that:

- Further guidance issued by NHS England identifies Primary Care as a must do area for local operational plans 2017-19. In December 2016 the CCG submitted an outline delivery plan to NHS England for consideration.
- Wolverhampton's General Practice Forward View is being shared with a range of other forums, including:
    - Primary Care Operational Management Group
    - Senior Management Team
    - Governing Body
- Regular assurance reports on the programme of work will be overseen by the Primary Care Strategy Committee from April 2017 and shared periodically with the above forums as well.

RESOLUTION: Ms Southall agreed to send the General Practice Forward View Implementation Plan to each practice with a covering email.
Ms Southall to raise the issue of bulletins not being updated on the Intranet with the Comms Team.

PCSC122 **Discussion Items**

Zero Tolerance & Commissioning Intentions

Ms Southall presented to the Committee a report that summarised progress made in relation to the Zero Tolerance Service Specification, current provider performance and policy development.

The Service specification was approved at the Joint Commissioning Committee in February 2017 following prior consultation with members of the Primary Care

Operational Management Group. It has been shared with Wolverhampton member practices for expressions of interest to provide the service from April 2017.

The current service provider's contract is due to end on 31st March 2017 as per commissioning arrangements with NHS England, although agreement has been confirmed to continue until a suitable alternative provider is identified. A service review was undertaken during February, with the current contract holder, the CCG and NHS England. There are currently 12 patients registered with the service, all receiving care from the provider in line with the existing contract with NHS England. There were no major concerns identified during the service review.

A new Zero Tolerance CCG policy has been prepared based on guidance available from NHS England to enable the new service to be managed effectively by commissioner and provider. The Committee was asked to note the processes defined within the policy that are being used locally in the absence of any previous iterations of a CCG policy. The processes enable stakeholders to manage appeals, complaints and operational difficulties that may have arisen.

The Committee was informed that the Service Specification and Policy have both been agreed in principle.

RESOLVED: The Committee noted the contents of the report.

PCSC123 **Any Other Business**

Dr DeRosa's – Ms Southall advised the Committee that this would be Dr DeRosa's last meeting and thanked him for all the input that he has made. Dr DeRosa was also wished well for the future.

RESOLVED: That the above is noted.

Primary Care Strategy Communications Plan – It was agreed that the Communications Plan should be included on the agenda at the next Committee and should also be included on the agenda for the next Members Meeting.

RESOLUTION: Ms Southall to liaise with the Helen Cook / Charlotte Hibbs.

Date of next meeting

Thursday 20th April 2017 at 1.00pm – 3.00pm in the CCG Main Meeting Room, Wolverhampton Science Park

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

PRIMARY CARE COMMISSIONING COMMITTEE
Tuesday 4th April 2017

TITLE OF REPORT:	Primary Care Operational Management Group Update
AUTHOR(s) OF REPORT:	Mike Hastings, Associate Director of Operations
MANAGEMENT LEAD:	Mike Hastings, Associate Director of Operations
PURPOSE OF REPORT:	To provide the Committee with an update on the Primary Care Operational Management Group.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• Full Delegation - The Primary Care Medical Services Delegation Agreement has now been signed which outlines how NHS England will delegate to the CCG and which powers will be reserved. • CQC Primary Care Update - The inspection programme for 2016/2017 has been completed • Primary Care Quality Update - The infection prevention rates for the month of January have improved. There were seven Practices who have not submitted Friends and Family Data for the month of January.
RECOMMENDATION:	The committee are asked to note the progress made by the Primary Care Operational Management Group.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	The Primary Care Operational Management Group monitors the quality and safety of General Practice.

2. Reducing Health Inequalities in Wolverhampton	The Primary Care Operational Management Group work with clinical groups within Primary Care to transform delivery.
3. System effectiveness delivered within our financial envelope	Operational issues are managed to enable Primary Care Strategy delivery.

1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Operational Management Group met on Tuesday 20th March 2017 and this report is a summary of the discussions which took place.

2. MAIN BODY OF THE REPORT

2.1. Primary Care Quality Update

A review of the Quality Matters process is being undertaken and this will include the process of how closed matters are handled due to issues raised by the GPs.

The infection prevention rates were received from the Practices visits that have been undertaken for January and there has been an overall improvement.

Friends and Family submission data for the month of January 2017 was shared with the Group, there were seven Practices who did not submit data. It was highlighted there had been issues with the CQRS not showing data as submitted although the Practices have submitted data and this issue is being investigated.

2.2. Contract Visit Programme

The collaborative joint contract review pilot visits are due to be completed by the end of March 2017. The programme for the next six months is currently being arranged and an update will be provided at the next meeting.

2.3. Online Access Update

The practices online access programme continues which provides support to patients to sign up to patient online. There are different methods being introduced to support those Practices who are struggling to meet the 10% target.

2.4 **Full Delegation**

The CCG are expected to receive the final Memorandum of Understanding by the end of March 2017. The Task and Finish Group continues to meet to discuss the impact and plans for contractual changes across the CCG. The Primary Care Medical Services Delegation Agreement has now been signed which outlines how NHS England will delegate to the CCG and which powers will be reserved.

2.4. **Zero Tolerance Scheme**

It was reported the policy will come into effect from the 3rd April 2017 and they are currently out for expressions of interest for the service provider.

2.5. **CQC Primary Care Update**

The inspection programme for 2016/2017 has been completed and there were similar trends across the visits which have been identified and were discussed. The plan for quarter one and two of the 2017/2018 visit programme will be dedicated to following up visits either by desk top or telephone.

2.6. **General Practice Forward View Implementation Plan update**

An overview of the live projects from the GP Five Year Forward View was presented to the Group. This provided detailed on the progress and status of each project and going forward a programme of work will be developed and monitored which will link in with the Primary Care Strategy programme of work.

3. CLINICAL VIEW

3.1 A clinical representative from LMC attends the meetings and gives views on all discussions.

4. PATIENT AND PUBLIC VIEW

4.1. Patient and public views are sought as required.

5. KEY RISKS AND MITIGATIONS

5.1. Project risks are reviewed as escalated from the programme.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. The group has no authority to make decisions regarding Finance.

Quality and Safety Implications

6.2. A quality representative is a member of the Group.

Equality Implications

6.3. Equality and Inclusion views are sought as required.

Legal and Policy Implications

6.4. Governance views are sought as required.

Other Implications

6.5. Medicines Management, Estates, HR and IM&T views are sought as required.

Name: Mike Hastings
Job Title: Associate Director of Operations
Date: 27th March 2017

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)	**Mike Hastings**	**27.03.17**

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