

**A meeting of the Wolverhampton Clinical Commissioning Group Governing Body**

**will take place on Tuesday 13th February 2018 commencing at 1.00 pm**

**at Wolverhampton Science Park, Stephenson Room**

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		<b>Date and time of next meeting ~</b> Tuesday 10 April 2018 – Governing Body Board Meeting		



**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY**

Minutes of the Governing Body Meeting held on Tuesday 12 December 2017  
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

**Attendees ~**

Dr S Reehana

Chair

**Clinical**

Dr D Bush  
Dr R Gulati  
Dr M Kainth  
Dr J Parkes  
Dr R Rajcholan

Board Member  
Board Member  
Board Member  
Board Member  
Board Member

**Management**

Mr T Gallagher  
Mr M Hastings  
Dr H Hibbs  
Mr S Marshall

Chief Finance Officer – Walsall/Wolverhampton  
Director of Operations  
Chief Officer  
Director of Strategy and Transformation

**Lay Members/Consultant**

Ms S McKie  
Mr L Trigg

Lay Member  
Lay Member

**In Attendance**

Ms H Cook  
Ms T Cresswell  
Mr J Denley  
Mr S Forsyth  
Ms K Garbutt  
Mr M Hartland

Engagement, Communications and Marketing Manager (part)  
Health Watch representative  
Director of Public Health  
Head of Quality and Safety  
Administrative Officer  
Chief Finance Officer – Dudley CCG (Strategic Financial Adviser)

Mr P McKenzie  
Mr S Parvez  
Ms S Southall

Corporate Operations Manager  
Patient Safety Manager  
Head of Primary Care (part)

## **Apologies for absence**

Apologies were received from Mr J Oatridge, Mr P Price, Ms H Ryan, Ms T Cresswell, Mr A Chandock, Mr M Hartland and Dr M Asghar.

## **Declarations of Interest**

WCCG.2002 Dr J Parkes declared he is an employee of The Royal Wolverhampton Trust (RWT).

RESOLVED: That the above is noted.

## **Patient Story**

WCCG.2003 Mr P McKenzie presented a patient story from a patient who described how a neighbour who worked at a hospital trust accessed her confidential medical records over a period of time. The case resulted in a fine being applied in the Magistrate's court.

Dr Kainth arrived

Unfortunately this is not an isolated incident. Mr McKenzie highlighted several other cases up and down the country of individuals accessing patient records inappropriately. Mr M Hastings added we have a number of projects we are working on about training staff so they are aware of their responsibilities when sharing information. Ms S McKie felt it would be a good idea to include clinicians in the training and possibly this could be shared in a Team W meeting.

RESOLVED: That the above is noted

## **Minutes**

WCCG.2004 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 14 November 2017 be approved as a correct record.

## **Matters arising from the Minutes**

WCCG.2005 There were no matters arising.

RESOLVED: That the above is noted.

## **Committee Action Points**

### **WCCG.2006 Minutes WCCG.1970 Board Assurance Framework**

Mr McKenzie confirmed a summary will be provided on a regular basis in order to monitor risks.

RESOLVED: That the progress report against actions requested at previous Board meetings be noted.

## **Chief Officer Report**

WCCG.2007 Dr Hibbs presented the report. She highlighted Accountable Care Systems. Work continues in Wolverhampton to develop a local place based health and care system which will relate to the overarching system developing at Sustainability Transformation Plan (STP) level.

She pointed out that we have presented our annual assessment of Emergency Planning, Resilience and Response (EPRR) to NHS England. She added that we are pleased to confirm that Les Trigg has been named as the Lay Member of the Governing Body charged with ensuring that the Operations directorate is managing our EPRR readiness appropriately.

RESOLVED: That the above is noted

## **Commissioning Committee**

WCCG.2008 Dr M Kainth gave an overview of the report. He highlighted the Sepsis Counting and Coding change which is being challenged. The Committee was advised last month that a national counting and coding change has been implemented regarding sepsis.

Dr Kainth pointed out the cancer activity transfer from City/Sandwell. The Royal Wolverhampton Trust (RWT) has confirmed there is going to be a 70/30 split of the Oncology and Gynecology Oncology work from City/Sandwell Hospital. RWT is anticipating that this will adversely impact on the Cancer 62 day standard. However the full impact on performance cannot be predicted at present. Dr Hibbs added that several meetings have taken place with RWT regarding recovery of the 62 day cancer standard and they are currently rewriting their recovery plan to include the concerns around the transfer of patients.

RESOLVED: That the above is noted.

## **Quality and Safety Committee**

WCCG.2009 Dr R Rajcholan gave an overview of the report. She pointed out the key areas of concern. The Care Quality Commission (CQC) rating is inadequate following the visit which took place at Vocare in March 2017. A follow up announced visit took place on the 26 October 2017 to look at particular concerns which provided assurance of some improvements. She referred to the maternity performance issues. There were two serious incidents reported for the maternity services for November 2017 and in total eight have been reported for maternity services since June 2017.

Ms S Southall arrived

Mr J Denley pointed out that Public Health will soon be entering into a full public consultation around some of the services they currently provide. Public Health along with partners need to look at different ways of working. Dr Reehana added finding an alternative rather than stopping services in many areas is a good idea.

RESOLVED: That the above is noted.

## **Finance and Performance Committee**

WCCG.2010 Mr T Gallagher presented the report. No additional Quality, Innovation, Productivity and Prevention (QIPP) has been identified in month 7. The CCG is reporting achieving its QIPP target as shortfall is being covered by reserves and other under spends. Following a review of the financial position at month 7 the level of risks has been adjusted to reflect those risks now incorporate into the forecast out turn and the Clinical Commissioning Group (CCG) is maintaining a nil net risk as mitigations match identified risks.

There has been an increase in prescribing spend. This mainly relates to no cheaper stock being available and is a national cost pressure. He also pointed out the performance measures on page 15 of the report.

Helen Cook arrived

Dr Hibbs added that measures are increasingly being looked at on a STP footprint as well as a Wolverhampton footprint.

Dr D Bush asked how patients choice will fit in with new ways of working. Dr Hibbs replied that the view is that systems need to be of a high enough quality to ensure patients wish to remain within them.

RESOLVED: That the above is noted

### **Audit and Governance Committee**

WCCG.2011 Mr Gallagher stated the report is for information.

RESOLVED: That the above is noted.

### **Primary Care Commissioning Committee**

WCCG.2012 Ms McKie gave a brief overview of the report. She pointed out that overall the practices with no submission for Friends and Family Test has reduced.

RESOLVED: That the above is noted

### **Primary Care Programme Milestone Review**

WCCG.2013 Mr Marshall introduced the report. The draft Primary Care Workforce Strategy was tabled at the meeting. Ms S Southall stated this strategy is a refresh and apologised for the late paper. She pointed out the Five Year Forward View on page 6 of the report.

Dr Gulati arrived

Our shared vision with recommendations from the General Practice Forward View is to develop and sustain a workforce, built around the needs of our population, which has the skills, knowledge and values to transform at scale and deliver high quality care within Wolverhampton. Dr J Parkes pointed out on page 9 of the report the STP level of retirements and GP work load. He pointed out this is not a description of demographics of staff within Wolverhampton. Ms Southall confirmed the local information is available and can be included within the strategy.

A discussion took place regarding the future staffing model example on page 11 of the strategy. A programme of work will be carried out.

Mr Trigg arrived, Ms Southall and Mr Parvez left

RESOLVED: That the above is noted.

### **Communication and Engagement update**

WCCG.2014 Ms H Cook presented the report. She pointed out that the Minor Eye Conditions Service (MECS) has continued its web and social media presence following its launch in September. In November 2017 a public

event took place at Bentley Bridge, Sainsbury. More than 300 people attended and the vast majority were really interested in the service.

She highlighted the extended opening in Primary Care. We are working with our colleagues in Primary Care and Pharmacy to promote their extended opening hours, particularly for cover over the Christmas and New Year holidays.

Ms McKie stated she attended her first Patient Participation Group (PPG) meeting. She pointed out that a number of presentations took place and the agenda requires re-organising going forward.

A discussion took place regarding the Stay Well campaign regarding reducing attendance at A&E when other alternative may be more appropriate. Ms Cook confirmed there is a massive drive to push the 111 service. Dr R Gulati felt this is moving forward as patients state they have used the 111 service. Dr Reehana stated use of this service seems embedded within families. Ms McKie added that with some patients English is not their first language and cultures are not the same which can cause difficulties for access to services. Ms Cook added there are outreach events in the New Year which may help.

Mr M Hastings pointed out that there was a big challenge over the weekend due to the bad weather regarding staffing at RWT. With Ms Cook's help the necessary communications were put through the internet in order to enable staff to get to work. He thanked her for her help.

RESOLVED: That the above is noted.

### **Minutes of the Quality and Safety Committee**

WCCG.2015      RESOLVED: That the minutes are noted.

### **Minutes of the Finance and Performance Committee**

WCCG.2016      RESOLVED: That the minutes are noted.

### **Minutes of the Primary Care Commissioning Committee**

WCCG.2017      RESOLVED: That the minutes are noted.

### **Minutes of the Audit and Governance Committee**

WCCG.2018      RESOLVED: That the minutes are noted.

**Minutes of the Commissioning Committee**

WCCG.2019        RESOLVED: That the minutes are noted.

**Black Country and West Birmingham Commissioning Board Minutes**

WCCG.2020        RESOLVED: That the minutes are noted.

**Minutes of the Health and Wellbeing Board**

WCCG.2021        RESOLVED: That the minutes are noted.

**Any Other Business**

WCCG.2022        RESOLVED: That the above is noted.

**Members of the Public/Press to address any questions to the Governing Board**

WCCG.2023        RESOLVED: That the above is noted.

**Date of Next Meeting**

WCCG.2024        The Board noted that the next meeting was due to be held on **Tuesday 13 February 2018** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 2.30 pm

Chair.....

Date .....

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**Wolverhampton Clinical Commissioning Group Governing Body**

**13 February 2018**

<b>Date of meeting</b>	<b>Minute Number</b>	<b>Action</b>	<b>By When</b>	<b>By Whom</b>	<b>Status</b>
14.11.17	WCCG.1969	Chief Officer Report ~ data sharing relating to care records being shared to be raised at the next Audit and Governance Committee	February 2018	Peter Price	

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**WOLVERHAMPTON CCG**  
**GOVERNING BODY**  
**13 FEBRUARY 2018**

**Agenda item 6**

<b>TITLE OF REPORT:</b>	Chief Officer Report
<b>AUTHOR(S) OF REPORT:</b>	Dr Helen Hibbs – Chief Officer
<b>MANAGEMENT LEAD:</b>	Dr Helen Hibbs – Chief Officer
<b>PURPOSE OF REPORT:</b>	To update the Governing Body on matters relating to the overall running of Wolverhampton Clinical Commissioning Group.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain.
<b>KEY POINTS:</b>	<p>Integrated Care Systems (ICS) across the Sustainability and Transformation Plan (STP )</p> <p>The West Midlands Director of Commissioning Operations Team are leading a piece of work in conjunction with the national team to look at how the various STP systems can evolve to become integrated care systems. The Black Country STP are part of this although within the Black Country STP the development of the four placed based solutions is fundamental.</p> <ul style="list-style-type: none"> <li>STP Joint Commissioning A review is currently being undertaken of the governance arrangements for the Black Country STP and a recommendation for the appointment of an independent Chair is being worked on.</li> </ul>
<b>RECOMMENDATION:</b>	That the Governing Body note the content of the report.
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	
1. Improving the quality and safety of the services we commission	This report provides assurance to the Governing Body of robust leadership across the CCG in delivery of its statutory duties.
2. Reducing Health	By its nature, this briefing includes matters relating to all domains contained within the BAF.

Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	



## **1. BACKGROUND AND CURRENT SITUATION**

- 1.1. To update the Governing Body Members on matters relating to all the overall running of Wolverhampton Clinical Commissioning Group (CCG).

## **2. CHIEF OFFICER REPORT**

### **2.1 IAF Framework Outcomes**

- 2.1.1 The CCG has had an initial moderated rating of Good (Green) by NHS England (NHSE). This has been reached following a self-assessment and a face to face 'review and challenge' exercise with every CCG to test the content of the self-assessments. A standard set of Key Lines of Enquiry (KLOEs) were used in the 'review and challenge' meetings, constructed to deep dive into local leadership examples. The Wolverhampton CCG meeting took place on 30 October 2017. The combination of these two exercises provides a consistent indicative assurance baseline for each CCG. The West Midlands NHSE Executive Team moderation and decision making took place in December 2017. Indications are that if we continue to closely manage provider activity performance, maintain financial performance, fully implement our new Performance Development Review (PDR) process and continue to provide strong support to the Sustainability and Transformation Plan (STP) then we may have the opportunity to improve this rating. We need all staff members to continue their hard work and which will earn the recognition we deserve.

### **2.2 Accountable Care Alliance Development Locally**

- 2.2.1 Work continues with GP leads, Provider organisations, the Local Authority and Public Health to develop a new way of working together in Wolverhampton. Initial work is looking to inform the Clinical Strategy and determine the first areas of focus.
- 2.2.2 A visit from the CQC and a representative from the Department of Health was hosted at Rwt and feedback on the local work that we are doing was excellent.

### **2.3 Integrated Care Systems (ICS) across the STP**

- 2.3.1 The West Midlands Director of Commissioning Operations Team are leading a piece of work in conjunction with the national team to look at how the various STP systems can evolve to become integrated care systems. The Black Country STP are part of this although within the Black Country STP the development of the four placed based solutions is fundamental.

### **2.4 STP Joint Commissioning**

- 2.4.1 A review is currently being undertaken of the governance arrangements for the Black Country STP and a recommendation for the appointment of an independent Chair is being worked on.

## 2.5 Safer Provision and Caring Excellence (SPACE)

2.5.1 The SPACE programme is a 2 year quality improvement initiative funded by The West Midlands Patient Safety Collaborative (WMPSC) targeted at care homes across Wolverhampton and Walsall.

2.5.2 The programme which commenced in November 2016 is led by quality improvement facilitators employed by the respective CCGs. Eighteen care homes with a total bed capacity of 959 beds are currently participating in the Wolverhampton programme.

2.5.3 The overall aim of the programme is to up-skill care homes staff through facilitation and training in basic quality improvement techniques and methodologies with the intention of:

- Improving the quality and safety of care delivered to residents in care homes
- Reducing the incidence of preventable harms
- Reducing avoidable hospital admissions.

2.5.4 To date training has been delivered in various forms to over 250 care home staff in collaboration with specialist professionals from the Falls Prevention Service, Tissue Viability and End of Life Care and the RiTs (Rapid intervention Team).

2.5.5 Demonstrable successes in the first year have been celebrated which include:

- Reduction in falls by more than 50% in a home with a high incidence of falls.
- No avoidable stage 3 or 4 pressure injuries for 15 months in one home.
- Improved hydration and nutrition of residents in several homes.
- Admission avoidance for UTI (urinary tract infections) due to prevention and early recognition.
- Improvements in the environment for residents with dementia to promote orientation and falls prevention.
- The rise of transformational leaders due to the Care Home Manager Development Programme and support networks.

2.5.6 The SPACE programme has gained recognition locally and nationally and has been presented to NHS England, the Enabling Research in Care Homes (ENRICH) event and at the Patient Safety First Conference.

2.5.7 A sustainability plan is being developed in conjunction with the Local Authority to support continuation of the programme beyond December 2018.

## 2.6 Empowerment of Hard to Reach Communities in the Prevention of Violence Against Women and Girls

2.6.1 Empowerment of Hard to Reach Communities in the Prevention of Violence Against Women and Girls launched in November 2017. Annette Lawrence, Designated Adult Safeguarding Lead, has been successful in securing funding from NHS England to support this project. It is a collaborative project with the Refugee and Migrant Centre and the Wolverhampton Domestic Violence Forum. A poster detailing the project has been presented at the Chief

Nursing Officer Summit Conference in December, and will be presented at the Leading Change Adding Value Conference in February.

2.6.2 This project will equip members of hard to reach communities specifically new arrivals, Black, Asian, and Minority Ethnic communities with:

- Increased confidence in reporting domestic abuse, female genital mutilation and modern day slavery/trafficking
- Facilitated reporting pathways
- Access to appropriate projects/services
- Resilience to becoming victims, preventing serious harm and associated effects on health and well being
- Sustainable legacy of well-informed community members/networks raising awareness across communities

## 2.7 **GP Domestic Violence Training and Support Project**

2.7.1 GP Domestic Violence Training and Support Project is a collaborative project with Safer Wolverhampton Partnership and Wolverhampton Domestic Violence Forum, co-ordinated by WCCG. This project provides free training (which can be used towards Safeguarding level 3 training), free resources, a domestic violence pathway for primary care, identification of champions within each practice, allows identification of people at risk of Domestic Violence at an early stage, provides a clear process for assessment and onward referral of individual, access to twice weekly drop in sessions, has clear cost savings, saves lives and thus reduces the need for Domestic Homicide Reviews. This project is about to launch in February 2018.

## 3. **CLINICAL View**

3.1 Not applicable to this report.

## 4. **PATIENT AND PUBLIC VIEW**

4.1. Not applicable to this report.

## 5. **KEY RISKS AND MITIGATIONS**

5.1. Not applicable to this report.

## 6. **IMPACT ASSESSMENT**

### ***Financial and Resource Implications***

6.1. Not applicable to this report.

### ***Quality and Safety Implications***

6.2. Not applicable to this report.

***Equality Implications***

6.3. Not applicable to this report.

***Legal and Policy Implications***

6.4. Not applicable to this report.

***Other Implications***

6.5. Not applicable to this report.

<b>Name</b>	<b>Dr Helen Hibbs</b>
<b>Job Title</b>	<b>Chief Officer</b>
<b>Date:</b>	<b>31 January 2018</b>



**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.

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	<b>N/A</b>	
Public/ Patient View	<b>N/A</b>	
Finance Implications discussed with Finance Team	<b>N/A</b>	
Quality Implications discussed with Quality and Risk Team	<b>N/A</b>	
Equality Implications discussed with CSU Equality and Inclusion Service	<b>N/A</b>	
Information Governance implications discussed with IG Support Officer	<b>N/A</b>	
Legal/ Policy implications discussed with Corporate Operations Manager	<b>N/A</b>	
Other Implications (Medicines management, estates, HR, IM&T etc.)	<b>N/A</b>	
Any relevant data requirements discussed with CSU Business Intelligence	<b>N/A</b>	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Dr Helen Hibbs</b>	<b>31/01/18</b>



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**WOLVERHAMPTON CCG**
**GOVERNING BODY**  
**13 FEBRUARY 2018**
**Agenda item 7**

<b>TITLE OF REPORT:</b>	<b>NHS England Consultation on conditions for which over the counter items should not routinely be prescribed in primary care: A Consultation on guidance for CCGs.</b>
<b>AUTHOR(s) OF REPORT:</b>	Hemant Patel, Head of Medicines Optimisation
<b>MANAGEMENT LEAD:</b>	Hemant Patel, Head of Medicines Optimisation
<b>PURPOSE OF REPORT:</b>	<p>This report advises Governing Body that NHS England have begun a consultation on conditions for which over the counter items should not routinely be prescribed in primary care: A Consultation on guidance for CCGs.</p> <p>The report seeks Governing Body views on what response the CCG should provide to the consultation.</p>
<b>ACTION REQUIRED:</b>	<input checked="" type="checkbox"/> <b>Decision</b> <input type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	Public. The outcome will be uploaded to the consultation website.
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>NHS England have begun a consultation exercise on conditions for which over the counter items should not routinely be prescribed in primary care:</li> <li>The guidance aims to reduce unwarranted variation by providing clear guidance to CCGs on items that should not be prescribed to ensure that best value is obtained from prescribing budgets.</li> </ul>
<b>RECOMMENDATION:</b>	<p>That the Governing Body</p> <ol style="list-style-type: none"> <li>1) give their views on the CCG response to the consultation on conditions for which over the counter items should not routinely be prescribed in primary care.</li> <li>2) Note that the responses received from GP members at members meeting (attached) regards to their obligations to patients, their contract and GMC. Dealing with patient complaints, support from CCG. Local public consultation and campaign and possible widening health inequalities.</li> </ol>
<b>LINK TO BOARD</b>	

<b>ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	
1. Improving the quality and safety of the services we commission	The report seeks to gain Governing Body views on potential patient engagement on the consultation response to ensure they are effectively taken into account.
2. Reducing Health Inequalities in Wolverhampton	[INSERT TEXT/ DELETE AS RELEVANT]
3. System effectiveness delivered within our financial envelope	The consultation will result in guidance to the CCG on prescribing which will aim to support the management of the prescribing budget and support the self-care agenda.

## 1. BACKGROUND AND CURRENT SITUATION

- 1.1. NHS England have begun their second national consultation on conditions for which over the counter items should not routinely be prescribed in primary care: A Consultation on guidance for CCGs.
- 1.2. The consultation is taking place for twelve weeks from 20th December 2017 until 14th March 2018 and is available on the NHS England website <https://www.engage.england.nhs.uk/consultation/over-the-counter-items-not-routinely-prescribed/>

## 2. CCG RESPONSE

- 2.1. The consultation is being brought to the attention of the Governing Body to support the development of a CCG response, which will ultimately be owned and signed off by the Governing Body.
- 2.2. The consultation is being signposted on the CCG's own website
- 2.3. The draft response is written as follow:

**In what capacity are you responding?**  
Clinical Commissioning Group

**Name** Wolverhampton CCG

**Have you read the document: Conditions for which over the counter items should not routinely be prescribed in primary care: A Consultation on guidance for CCGs. Yes**

### **Equality and Health Inequalities**

NHS England has legal duties which require giving due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as defined under the Equality Act 2010) and those who do not share it. NHS England must have regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities. An initial Equality and Health Inequalities Assessment (EHIA) has been carried out on these proposals and this can be read here. <https://www.engage.england.nhs.uk/consultation/over-the-counter-items-notroutinely-prescribed> . Further information on our duties can be read at <https://www.england.nhs.uk/about/equality/>

**Do you feel there are any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?**

Yes (please tick all that apply)

**Age** – yes – previously those under 16 or under 19 in full time education or over 60 would have recourse to receiving these items for the conditions mentioned below without charge

**Disability** - yes - a patient with a continuing physical disability which means you cannot go out without the help of another person would currently have the treatment s mentioned in this consultation funded.

**Gender** – no

**reassignment/race/religion** – no

**belief/sex/sexual orientation/marriage and civil partnership** – no

**pregnancy and maternity** – yes - would have recourse to receiving these items for the conditions mentioned in this consultation without charge

**Do you feel there is any further evidence we should consider in our proposals on the potential impact on health inequalities experienced by certain groups?**

Yes – Wolverhampton is the 21<sup>st</sup> most deprived place in the country. The national averages don't take this into consideration. Purchasing OTC products may not be an option for some.

### **Proposals for CCG commissioning guidance**

**Do you agree with the three proposed categories for [items] or [conditions] as below:**

- **An item of low clinical effectiveness, where there is a lack of robust evidence for clinical effectiveness; - Agree**
- **A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own; or – Agree**
- **A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy – disagree - this could potentially lead to some patients not managing a treatment which then develops into a more sinister condition due to the patients inability to fund treatment. Or the patient may seek treatment from a differing source e.g. out of hours services.**

**Do you agree with the general exceptions proposed? Agree/Neither agree or disagree/Disagree/Unsure (for each exception)**

- **Circumstances where the product licence doesn't allow the product to be sold over the counter to certain groups of patients. Agree**
- **Patients with a minor condition suitable for self-care that has not responded sufficiently to treatment with an OTC product. -Agree**
- **Patients where the clinician considers that the presenting symptom is due to a condition that would not be considered a minor ailment. – Agree**
- **Circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care. – agree**

- **Patients where the clinician considers that their ability to self-manage is compromised as a consequence of social, medical or mental health vulnerability to the extent that their health and/or wellbeing could be adversely affected if left to self-care. - Agree**

**Should we include any other patient groups in the general exceptions?**

Care home residents, vulnerable adults and children

**Section 1: Drugs with limited evidence of clinical effectiveness Do you agree with the recommendation to: Advise CCGs to support prescribers in advising patients that [item] should not be routinely prescribed in primary care due to limited evidence of clinical effectiveness?**

**Agree/Neither agree or disagree/Disagree/Unsure (for each item)**

**Probiotics - Agree – where no evidence exists**

**Vitamins and minerals – Agree where no evidence exists**

**Section 2: Self-Limiting Conditions Do you agree with the recommendation to: Advise CCGs to support prescribers in advising patients that a prescription for treatment of [condition] should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without the need for treatment?**

- **Acute Sore Throat - agree with caveats on Social / economic grounds**
- **Cold Sores – agree with caveats on Social / economic grounds**
- **Conjunctivitis - agree with caveat on Social economic grounds, children under 1 and if Pharmacy could refer to MECS**
- **Coughs and colds and nasal congestion - agree with caveat on Social economic grounds**
- **Cradle Cap (Seborrhoeic dermatitis – infants) - agree**
- **Haemorrhoids - disagree**
- **Infant Colic - agree with caveat on Social economic grounds**
- **Mild Cystitis - disagree**

**Section 3: Minor Ailments Suitable for Self- Care Do you agree with the recommendation to: Advise CCGs to support prescribers in advising patients that a prescription for treatment of [condition] should not routinely be offered in primary care as the condition is appropriate for self-care? Agree/Neither agree or disagree/Disagree/Unsure (for each condition)**

- **Contact Dermatitis** - disagree
- **Dandruff** - agree
- **Diarrhoea (Adults)** – agree only if this was self-limiting and acute
- **Dry Eyes/Sore (tired) Eyes** – agree – if MECS service continues
- **Earwax** - agree
- **Excessive sweating (Hyperhidrosis)** – disagree
- **Head Lice** - agree
- **Indigestion and Heartburn** – disagree as it may mask more sinister ailment, a ban on prescribing may discourage patients from having this reviewed.
- **Infrequent Constipation** - agree
- **Infrequent Migraine** – agree – depending on severity
- **Insect bites and stings** - agree
- **Mild Acne** – agree except for those prescribed antibiotics as require co prescription of OTC product
- **Mild Dry Skin/Sunburn** - disagree – adults ok but children should be excluded- may be infected? Potential safeguarding opportunity missed.
- **Mild to Moderate Hay fever/Seasonal Rhinitis** - agree
- **Minor burns and scalds** - disagree - – may be infected? Excluding children - Potential safeguarding opportunity missed.
- **Minor conditions associated with pain, discomfort and/fever. (e.g. aches and sprains, headache, period pain, back pain)** – agree –although difficult to implement and could mask more sinister ailments
- **Mouth ulcers** – agree
- **Nappy Rash** - disagree - may be infected? Potential safeguarding opportunity missed.
- **Oral Thrush** - agree –excluding elderly and children
- **Prevention of dental caries** – Agree
- **Ringworm/Athletes foot** - disagree – may not be a minor issue
- **Teething/Mild toothache** - agree
- **Threadworms** - disagree – expensive to purchase
- **Travel Sickness** - agree
- **Warts and Verrucae** agree

**Are there any item or condition specific exceptions you feel should be included, in addition to those already proposed and the general exceptions covered earlier?**

This CCG supports access to treatment of self-limiting conditions for patients on low income via a national community pharmacy minor ailments scheme. Community pharmacists are well placed to help reduce primary care workload and educate patients on self-care. The Department of Health should do all their power to make sure that the NHS does not pay any more for these medicines than a patient would pay over the counter. It should also seek to remove the VAT on medicines supplied under a national minor ailments scheme. This CCG firmly believes that a commissioning policy is not the correct means of restricting access to over the counter products. If NHSE wishes to proceed on this basis they should add these OTC products to Part XVIII A Drugs, medicines and other substances not to be ordered under a GMS contract. This would put the restrictions on a firm legal basis. This CCG does not wish to see itself exposed to a legal challenge for restricting access to these medicines. The CCG can only guide and seek to persuade GPs to re-educate patients on self-care and transfer this type of work to community pharmacy.

In addition this CCG does not want to see our GPs members being placed at clinical or legal risk for not prescribing the items included in the scope of this consultation where the exceptional use criteria are not in place.

Any savings as a result of an NHS blacklist approach should be available for use locally and not retained centrally.

This CCG also has concerns about the unintended consequence of increasing the use of prescribing more expensive treatments. Restricting access to OTC treatments may not reduce workload as patients may still seek a GP diagnosis rather than going to a community pharmacy first. This may lead to the prescribing of more potent prescription only medicines such as pain killers that are available on the NHS.

### **3. CLINICAL VIEW**

- 3.1. The views of the Clinical Members of the Governing Body are being sought through discussion of this paper and they will contribute to the final response.
- 3.2. GP members have shared their views (see attachment)

### **PATIENT AND PUBLIC VIEW**

- 3.3. The consultation is seeking public and patient views on this matter and the Governing Body are being asked for their views to help shape a CCG response.

### **4. KEY RISKS AND MITIGATIONS**

- 4.1. The exact risks and impact of any guidance on items which should not be prescribed will not be known until it is published and assessed. There is the potential for damage to the CCGs reputation should guidance and subsequent CCG decisions lead to conditions for which over the counter items are not routinely prescribed in primary care. There may also be a risk that alternative, more expensive items are prescribed as a result or that more sinister ailments develop or are missed as a result of not managing these conditions in the current method.
- 4.2. The potential risks, particularly to the CCG's reputation could be mitigated by the CCG responding to the consultation with a robust reasoned response.

## **5. IMPACT ASSESSMENT**

### ***Financial and Resource Implications***

- 5.1. There is no immediate impact of the consultation, there may be a financial impact from any guidance published as a result.

### ***Quality and Safety Implications***

- 5.2. There are no Quality and Safety implications arising from this report.

### ***Equality Implications***

- 5.3. There may be equality implications arising from the impact of the guidance when it is published. NHS England will be required to consider this as the guidance is developed.

### ***Legal and Policy Implications***

- 5.4. The consultation will support the drafting of NHS England Commissioning guidance for the CCG, which the CCG will need to have regard to in developing it's own policies and commissioning decisions.

### ***Other Implications***

- 5.5. The guidance will impact on Medicines Management and the prescribing budget, details of which will not be available until the guidance is published.

**Name** Hemant Patel  
**Job Title** Head of Medicines Optimisation  
**Date:** 02.02.2018

**ATTACHED:**

NHS England Consultation Document Items which should not routinely be prescribed in primary care: A Consultation on guidance for CCGs

GP member's views obtained at members meeting on 31<sup>st</sup> January 2018.

**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.**

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	GP members & sought via paper	31.01.18 & 13/02/2018
Public/ Patient View	Sought via Paper	13/02/2018
Finance Implications discussed with Finance Team	N/a at this stage	
Quality Implications discussed with Quality and Risk Team	N/a at this stage	
Equality Implications discussed with CSU Equality and Inclusion Service	N/a at this stage	
Information Governance implications discussed with IG Support Officer	N/a at this stage	
Legal/ Policy implications discussed with Corporate Operations Manager	N/a at this stage	
Other Implications (Medicines management, estates, HR, IM&T etc.)	N/a at this stage	
Any relevant data requirements discussed with CSU Business Intelligence	N/a at this stage	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Hemant Patel</b>	<b>01/02/2018</b>



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**Feedback from members meeting 31/1/18**

**23 GPs in attendance and 2 GPs provided comments via email.**

**General exceptions that could apply to the recommendation to self-care**

	<b><u>Agree y/n ( provide comments if no )</u></b>
1. Clinicians should continue to prescribe for the treatment of long term conditions	Y
2. for the treatment of more complex forms of minor illnesses (e.g. severe migraines that are unresponsive to over the counter medicines)	Y
3. for those patients that have symptoms that suggest the condition is not minor (i.e. those with red flag symptoms such as cough lasting longer than three weeks.)	Y
4. Treatment for complex patients (e.g. immunosuppressed patients) and patients on treatments that are only available on prescription	Y
5. Patients prescribed OTC products to treat an adverse effect or symptom of a more complex illness and/or prescription only medications	Y
<u>Prescriptions for the conditions listed in this guidance should also continue to be issued on the NHS for:</u>	Y
6. Circumstances where the product licence doesn't allow the product to be sold over the counter to certain groups of patients.	Y
7. Patients with a minor condition suitable for self-care that has not responded sufficiently to treatment with an OTC product.	Y – only if all OTC products have been exhausted.
8. Patients where the clinician considers that the presenting symptom is due to a condition that would not be considered a minor ailment.	Y -
9. Circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care.	75% yes 25% no (those that said no, thought this clause would make it harder to implement the policy)
10. Patients where the clinician considers that their ability to self-manage is compromised as a consequence of social, medical or mental health vulnerability to the extent that their health and/or wellbeing could be adversely affected if left to self-care.	Y

**Question – Which of the following conditions would you support in terms of no longer providing NHS treatment, with or without caveats? (Please note this does not mean you would refuse to see a patient)**

No.	Condition	Agree - complete	Agree – with	Disagree and reasons	Comments e.g. How implementation could be made easier?

		ly	caveats	why	
1	Infant Colic	15	6	4	Those that disagreed thought this was distressing to parents as well as the child and expensive  Caveats = Social/economic grounds
2	Acute Sore Throat -	<b>15</b>	10		Caveats = Social/economic grounds
3	Cold Sores	<b>15</b>	10		Caveats = Social/economic grounds-
4	Conjunctivitis	<b>15</b>	10		Caveats = Social/economic grounds/ children under 1  If Pharmacy could refer to MECS
5	Coughs and colds and nasal congestion	<b>15</b>	10		Caveats = Social/economic grounds
6	Cradle Cap (Seborrhoeic dermatitis – infants)	<b>21</b>	4		Caveats = Social/economic grounds Thought it could be severe in some and require treatment.
7	Haemorrhoids	<b>7</b>	8	10	Caveats – children  Disagree – concern it would mask more sinister disease.
8	Mild Cystitis	<b>10</b>		15	Difficult to implement – what would constitute as mild
9	Mild Dry Skin/Sunburn -	<b>21</b>	4		Caveats = children (safeguarding)
10	Minor burns and scalds -	12	13		Caveats = children (safeguarding)
11	Nappy Rash -	2	12	13	Caveat- severity  Disagree – often need to see whether it is fungal
12	Teething/Mild toothache	19	6		Caveats = children, do they have access to a dentist

13	Threadworms	7		18	Expensive to purchase
14	Ringworm/ Athletes foot	7	8	10	Caveat – may need to check whether fungal infection.  Disagree – may not be a minor issue
15	Contact Dermatitis	2		23	Wouldn't want to discourage patients from having this diagnosed and treated.
16	Dandruff	16	9		Caveat – this can be severe in some patients
17	Diarrhoea (Adults)	2	20		Caveat - Wouldn't want to discourage patients from having this diagnosed and treated as it may well be more severe, C.Diff, IBS, change in bowel habit.
18	Dry Eyes/Sore (tired) Eyes	2	20		Would require access to MECs
19	Earwax	25			
20	Excessive sweating (Hyperhidrosis)	2	17	8	Wouldn't want to discourage patients from having this diagnosed and treated.  Patients have usually tried all OTC products and may need referral
21	Head Lice	21	4		Caveats = Social/economic grounds
22	Indigestion and Heartburn	2	19	4	Caveats = people have often tried otc products so wouldn't want to discourage patients from having this diagnosed and treated.
23	Infrequent Constipation	21	4		Caveats = Social/economic grounds
24	Infrequent Migraine	7	18		Caveat – Dependent on severity, may need a referral
25	Insect bites and stings	16	9		Caveat – unless it was infected
26	Mild Acne	12	13		Caveat = if prescribed an antibiotic, as will need OTC product to help with treatment. Many may otherwise choose not to purchase OTC products this lessening the effectiveness of the antibiotic.

27	Mild to Moderate Hay fever/ Seasonal Rhinitis	21	4		Caveats – based on severity
28	Minor conditions associated with pain, discomfort and/fever. (e.g. aches and sprains, headache, period pain, back pain)	12	13		Caveat – difficult to assess without reviewing – might discourage some from coming to GP.
29	Mouth ulcers	21	4		Caveats = Social/economic grounds
30	Oral Thrush	7	14	4	Caveats= elderly and children. Severity Disagree – no comment
31	Prevention of dental caries	25			Oncology patients require high fluoride toothpaste so would be excluded from this.
32	Travel Sickness	16	9		Caveat- children
33	Warts and Verrucae	15	10		Caveats – based on severity

### **Statements and Questions raised**

The policy should exclude children, care home residents & vulnerable adults

Concerns were raised about those unable to afford even the cheapest OTC medicines.

Concerns about complaints to GMC, NHSE

Is it ethical?

Would the GP be in breach of their contract?

Can we clarify the definition of prescribing from a contractual perspective and GMC perspective?

What if a patient demands a prescription even after being advised to purchase OTC, what are the obligations on a GP?

Patient rep needs to be included

Public consultation

### **Support required**

Clarity is required on the process of commissioning / decommissioning certain medicines

Wonderful idea however easier said than done. Implementation is going to be very difficult. Patient's expectations need to change. We need to be VERY supported by GMC, NHSE and Dept. of Health

GMC advise must be included

GP contract clarification must be included and NHSE must put clear statement that it is not a breach if CCG guidelines seem to go against the contract

GPs should have more support from the CCG when patients complain about the changes

### **Black list – take decision out of clinician's hands**

Difficult discussion - either government decide a blanket ban - otherwise it is impossible to manage with poor social economic conditions.

Medications should be blacklisted

Choice to stop should be made from the top and not pass the buck to the individual GP's and practices

Caveats lay GPs open to charges of discrimination

Not down to the individual clinician or CCG

Feel the drugs should be blacklisted by the government - would be more widely accepted by the public and reduce complaints to the GPs

### **Widening health inequalities**

A lot of caveats must be considered

What about those that cannot afford over the counter medication?

If not done correctly, there will be considerable variation between practices, GPs and demographics

This is going to lead to postcode prescribing

Inappropriate restrictions and exceptions for patients who may not be able to afford the drugs

Need to have specific directions as too much risk of variation or individual interpretation

Need POLCV type approach.

### **Implementation**

Appraisal team must also ok the action

It will be difficult to manage in 10 mins consultations

Vital exercise - Made you think about your own practice and how it might affect patient demand for appointments

Doctors worried about not being able to prescribe self care medication when these are often prescribed as an alternative to antibiotics

“This is interesting. It would cause uproar with patients but would ease our workload massively. If it is watered down it will be more difficult to manage, I would go the whole hog!!”

“I'm strongly in favour of the proposed lists of medications and minor conditions produced by NHSCC and NHSE to guide prescribers towards restricting NHS prescription issuance. Reform is overdue. If we can discourage people attending for minor things there are likely to be savings beyond the cost of the listed prescriptions and clinician time. Inevitably some patients will raise other minor matters. If, however, there are problems important to the patients they would not (and should not) be dissuaded from making appointments merely by the prospect of a having free prescription”

# **Conditions for which over the counter items should not routinely be prescribed in primary care: A Consultation on guidance for CCGs.**

## **Conditions for which over the counter items should not routinely be prescribed in primary care: A Consultation on guidance for CCGs**

Version number: 1

First published: 20 Dec 2017

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact NHS England on [england.medicines@nhs.net](mailto:england.medicines@nhs.net)

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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## 1 Background

### 1.1 What is the issue we are trying to tackle?

In the year prior to June 2017, the NHS spent approximately £569 million<sup>1</sup> on prescriptions for medicines for minor conditions, which could otherwise be purchased over the counter (OTC) from a pharmacy and/or other outlets such as petrol stations or supermarkets.

These prescriptions include items for a condition:

- That is considered to be self-limiting and so does not need treatment as it will heal or be cured of its own accord;
- Which lends itself to self-care, i.e. that the person suffering does not normally need to seek medical advice and can manage the condition by purchasing OTC items.

Or items:

- That can be purchased over the counter, sometimes at a lower cost than that which would be incurred by the NHS;
- For which there is little evidence of clinical effectiveness.

By reducing spend on treating conditions that are self-limiting or which lend themselves to self-care, these resources can be used for other higher priority areas that have a greater impact for patients, support improvements in services and deliver transformation that will ensure the long-term sustainability of the NHS.

The costs to the NHS for many of the items used to treat minor conditions are often higher than the prices for which they can be purchased over the counter as there are hidden costs. For example, a pack of 12 anti-sickness tablets can be purchased for £2.18<sup>2</sup> from a pharmacy whereas the cost to the NHS is over £3.00<sup>3</sup> after including dispensing fees. The actual total cost for the NHS is over £35 when you include GP consultation and other administration costs.

A wide range of information is available to the public on the subjects of health promotion and the management of minor self-treatable illnesses. Advice from organisations such as the [Self Care Forum](#) and [NHS Choices](#) is readily available on the internet. Many community pharmacies are also open extended hours including weekends and are ideally placed to offer advice on the management of minor ailments and lifestyle interventions. [The Royal Pharmaceutical Society](#) offers advice on over the counter products that should be kept in a medicine cabinet at home to help patients treat a range of self-treatable illnesses.

Research<sup>4</sup> shows that in many cases, people can take care of their minor conditions if they are provided with the right information; thereby releasing health care

<sup>1</sup> Refined BSA data to June 2017

<sup>2</sup> Online pharmacy checked December 2017

<sup>3</sup> [Drug Tariff online](#)

<sup>4</sup> Self-care of minor ailments: A survey of consumer and healthcare professional beliefs and behaviour, Ian Banks, Self-Care Journal

professionals to focus on patients with more complex and/or serious health concerns. Past experience with self-care builds confidence in patients, with 84 per cent choosing to self-care for new episodes.

More cost-effective use of stretched NHS resources allows money to be spent where it is most needed, whilst improving patient outcomes. As an example, every £1m saved on prescriptions for over the counter treatments could fund (approx.)<sup>5</sup>:

- 39 more community nurses; or
- 270 more hip replacements; or
- 66 more drug treatment courses for breast cancer; or
- 1000 more drug treatment courses for Alzheimer's; or
- 1040 more cataract operations<sup>6</sup>.

Clinical Commissioning Groups (CCGs) asked for a nationally co-ordinated approach to the development of commissioning guidance to ensure consistency and to address unwarranted variation. NHS England has therefore partnered with NHS Clinical Commissioners (NHSCC) to support CCGs in ensuring that they use their prescribing resources effectively and deliver the best patient outcomes from the medicines that their local population uses. To lead the work, NHS England and NHSCC established a joint clinical working group with prescriber and pharmacy representatives from relevant national stakeholders including the Royal College of General Practitioners, the Royal Pharmaceutical Society, the British Medical Association, the National Institute for Health and Care Excellence (NICE), the Medicines and Healthcare Products Regulatory Agency, the Department of Health, PrescQIPP and CCG representatives.

As a result of our work, NHS England and NHSCC have identified a number of items and conditions which fall under one or more of the criteria listed above.

## 1.2 What is the objective of this work and what are we doing now?

This document sets out proposals for national guidance for CCGs on the prescribing of 'over the counter (OTC) products' for **35 minor and/or self-limiting conditions**. This guidance is intended to encourage people to self-care for minor self-treatable and/or self-limiting conditions only. It is being sent out for consultation nationally. We strongly encourage CCGs in particular to take part in this consultation, determine the impact of it on their local populations and engage with their communities and local professionals. Further information and guidance on how to engage in the consultation can be found in section 1.7 and chapter 5.

The objective of this work is to support CCGs in their decision-making when formulating local prescribing policies, to address unwarranted variation, and to provide clear national guidance on local prescribing practices for the conditions identified. The aim is that this will lead to a more equitable process for making decisions about CCG's policies on prescribing medicines; CCGs will need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reduce health inequalities.

<sup>5</sup><https://improvement.nhs.uk/resources/national-tariff-1719/>

<sup>6</sup> [Drug Tariff online](#)

CCGs need to make increasingly difficult decisions about how to spend the NHS budget and this means prioritising those things that will give patients the best clinical outcomes. Any savings from implementing the proposals could be reinvested in improving patient care.

### 1.3 Who will the commissioning guidance be addressed to?

This guidance is addressed to CCGs to support them to fulfil their duties around appropriate use of their resources. We would expect CCGs to take the proposed guidance into account in formulating local policies, unless they can articulate a reason to do otherwise, and for prescribers to reflect local policies in their prescribing practice. The guidance would not remove the clinical discretion of the prescriber in accordance with their professional duties.

This guidance is issued as general guidance under s14Z10 and S2 of the NHS Act 2006 and is addressed to CCGs to support them to fulfil their duties around appropriate use of prescribing resources. The objective of this guidance is to support CCGs in their decision-making, to address unwarranted variation, and to provide clear national advice to make local prescribing practices more effective.

### 1.4 How have these proposals been developed?

NHS England has previously consulted on *items which should not be routinely prescribed in primary care* (21<sup>st</sup> July – 21<sup>st</sup> October 2017). That initial consultation sought views generally on the principle of restricting the prescribing of medicines which are readily available over the counter. We set out an initial list of 26 minor or self-limiting conditions where prescribing restrictions could be considered.

Some responses from the initial consultation have been shared below:

- The Proprietary Association of Great Britain (PAGB) responded that *'it is vital to promote and empower more people to self-care, rather than use GP and A&E services for conditions which could be self-treated at home or with advice from a pharmacist.; taking a system-wide approach to self-care has the potential to release greater efficiency savings (> £2bn) than those outlined in the consultation document'*
- A Health Watch survey carried out stated *'that many respondents said they would buy over the counter where possible to save the NHS money and/or because it is often less than the prescription charge. Concerns were raised about people on lower incomes or benefits who would not be able to afford to manage their condition if their medications were not available on prescription'*
- A survey by the National Association of Patient Participation (NAPP) also asked respondents whether they agree with the principle of CCGs not allowing the prescribing of medicines that are cheaply available over the counter. Of the 464 who responded, 71% agreed.

However, whilst there is general support for consulting on this topic (65% agreed with our proposed criteria to assess items for potential restriction), feedback from patients and patient organisations has highlighted that considerations must be made for those

with long-term conditions who require a large supply of over the counter medicine and that the de-prescription of these items could result in patient compliance and clinician monitoring issues.

We are also aware of a range of concerns from professional and patient groups relating to access to over the counter medicines and we will be engaging further on these specific issues; indeed this consultation specifically asks respondents to share their views on our proposals and the exceptions to them. Comments were received which asked us to consider the impact on vulnerable groups amid concerns that some patients may not be able to afford treatments.

*“I agree that the NHS needs to save money but the whole consultation and any resulting alteration of the guidelines needs to be done fairly, taking each patient’s needs into consideration.”* (Voluntary organisation)

We intend to address these issues through the consultation and by engaging further with patient groups that may be affected. Indeed, following initial consultation with patient groups and our clinical working group, we have refined our proposed exceptions to this guidance and included a specific exception for vulnerable patients.

We consulted our clinical working group on our proposed approach and, based on their guidance, mapped OTC items to the minor conditions for which they are typically prescribed. **We refined our approach to propose prescribing restrictions based on condition rather than item name or formulation** as the volume of OTC products prescribed in the NHS (c. 3,200), and the fact that product names change over time, could make it difficult to apply any restrictions based on product name or formulation. Nevertheless, many of the criteria that would normally be used to assess products (e.g. efficacy, safety, cost) are still relevant to condition-based restrictions and have been incorporated into our thinking.

The OTC items prescribed by the NHS were analysed using data from the NHS Business Services Authority (year prior to June 2017 data) which showed that approximately £569m was spent on OTC medicines. We analysed the medicines falling within the top 90% of OTC spend, to identify how the medicines could be classified according to the conditions for which they might be prescribed (as per their licensed indications). Information on the conditions for which the item was prescribed in individual cases (otherwise known as indication) is not available to us and therefore all spend figures quoted are only approximations.

**We estimated that restricting prescribing for ‘minor’ conditions may save up to £136m once all discounts and clawbacks have been accounted for.**

Following our mapping exercise, additional minor conditions were identified which we also deemed appropriate for inclusion in this guidance. Vitamins and minerals, and probiotics have been included as standalone categories given they have been identified as high cost in terms of OTC spend, although their use cannot be mapped to one single condition. A full list of the conditions under consideration in this proposed guidance is attached at appendix 1. A list of example products that could be prescribed for each of the listed conditions is attached at appendix 2 however it is important to note that this guidance focuses on restricting prescribing for the conditions outlined, not on the restriction of prescribing for individual items.

We then identified the following categories, within which we propose we could group each condition:

- A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own; and/or
- A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.

And in the case of vitamins, minerals and probiotics, we have classified these as:

- Items of low clinical effectiveness, where there is a lack of robust evidence for clinical effectiveness.

NHS England now proposes to make one of the following three recommendations for each condition (or item):

- Advise CCGs to support prescribers in advising patients that **[item]** should not be routinely prescribed in primary care due to **limited evidence of clinical effectiveness**.
- Advise CCGs to support prescribers in advising patients that a prescription for treatment of **[condition]** should not routinely be offered in primary care as the condition is **self-limiting and will clear up on its own** without the need for treatment.
- Advise CCGs to support prescribers in advising patients that a prescription for treatment of **[condition]** should not routinely be offered in primary care as the condition is **appropriate for self-care**.

## 1.5 General exceptions that could apply to the recommendation to self-care

For the category of conditions identified as being appropriate for self-care, this guidance is intended to encourage people to self-care for minor illnesses as the first stage of treatment.

Clinicians should continue to prescribe taking account of NICE guidance as appropriate for the treatment of long term conditions (e.g. regular pain relief for chronic arthritis or treatments for inflammatory bowel disease), for the treatment of more complex forms of minor illnesses (e.g. severe migraines that are unresponsive to over the counter medicines) and for those patients that have symptoms that suggest the condition is not minor (i.e. those with red flag symptoms such as cough lasting longer than three weeks.)

Treatment for complex patients (e.g. immunosuppressed patients) and patients on treatments that are only available on prescription should continue to have these products prescribed on the NHS.

Patients prescribed OTC products to treat an adverse effect or symptom of a more complex illness and/or prescription only medications should continue to have these products prescribed on the NHS.

CCGs should ensure that community pharmacists are reminded of 'red flag' symptoms for patients presenting with symptoms related to the conditions covered by this consultation. GPs and/or pharmacists should refer patients to NHS Choices, the Self Care Forum or NHS 111 for further advice on when they should seek GP Care.

Prescriptions for the conditions listed in this guidance should also continue to be issued on the NHS for:

- Circumstances where the product licence doesn't allow the product to be sold over the counter to certain groups of patients. This may vary by medicine, but could include babies, children and/or women who are pregnant or breast-feeding. Community Pharmacists will be aware of what these are and can advise accordingly.
- Patients with a minor condition suitable for self-care that has not responded sufficiently to treatment with an OTC product.
- Patients where the clinician considers that the presenting symptom is due to a condition that would not be considered a minor ailment.
- Circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care.
- Patients where the clinician considers that their ability to self-manage is compromised as a consequence of social, medical or mental health vulnerability to the extent that their health and/or wellbeing could be adversely affected if left to self-care.

## **1.6 Who has been involved in developing the proposal in this consultation?**

This draft guidance builds on the feedback from the initial consultation on *items which should not be routinely prescribed in primary care* (21st July – 21st October 2017). That consultation sought views generally on the principles of restricting the prescribing of medicines which are readily available over the counter, and indicated an initial list of 26 minor acute/self-limiting conditions where this approach could be considered.

Following the initial consultation, NHS England and NHS Clinical Commissioners have further engaged our joint clinical working group and patient groups in developing and refining these draft recommendations, and in particular, the exceptions which may apply to our guidance. We held a stakeholder event which was attended by groups including the Patient Association, National Voices and Health Watch England, to test out and further shape and refine the draft proposals.

## **1.7 What evidence has been used in developing these proposals?**

The joint clinical working group considered the information and evidence set out in section 4 from the following sources and organisations:

- [NICE CKS](#)
- [NHS Choices](#)
- [BNF](#)
- [NICE Clinical Guidelines](#)
- [Public Health England](#)
- [PrescQIPP CIC](#)

## 1.8 Who are we consulting and how can they respond?

This consultation is addressed to all CCGs, the public and patients, and any relevant interest group or body. It will be open for twelve weeks from 20th December 2017 until 14<sup>th</sup> March 2018.

Please see Chapter 5: Consultation Format for details on how to submit responses.

During the national consultation phase, an individual CCG can provide a response to the national consultation on the commissioning guidance, based on their own local consultation and engagement activities. This could include but is not limited to:

- the CCG's own perspective on the guidance;
- the outcome of any relevant local consultations; and/or
- feedback from local engagement with patient participation groups, local community groups representing people with protected characteristics, Healthwatch and/or discussion with the local overview and scrutiny committee of the Local Authority

The potential equality impact of these proposals has been considered and is outlined in the Equality and Health Inequalities Impact Assessment document published alongside this consultation. We believe that the proposals are likely to have a neutral impact on the health of individuals with protected characteristics. If you do not agree, and/or if you think there will be direct or indirect negative impact on people with protected characteristics, you can let us know by providing your views to the relevant consultation questions.

## 1.9 Confidentiality

It is our intention to publish a summary of the responses we receive to this consultation on the NHS England website in due course. You can respond with your name and/or organisation, you can remain anonymous or ask that your details are kept confidential and excluded from the published summary of responses. If you would like any part of the content of your response (instead of or as well as your identity) to be kept confidential, please let us know and make it obvious by marking in your response which parts we should keep confidential.

Please also be aware that the summary may include details taken from any area of the consultation response, and so please bear this in mind when providing your comments. If you would prefer any particular comments are kept confidential (i.e. not published) please make this clear.

If you provide us with any personal information (i.e. name or email address) we will process, hold and store this in accordance with the Data Protection Act 1998. Your details will be kept for the minimum time necessary.

## 2 Definitions and scope

### 2.1 Glossary

**ACBS:** The Advisory Committee for Borderline Substances is responsible for advising the NHS on the prescribing of foodstuffs and toiletries which are specially formulated for use by people with medical conditions. Borderline substances are mainly foodstuffs, such as enteral feeds and foods but also include some toiletries, such as sun blocks for use by people with conditions such as photodermatosis.

**Annual Spend:** Unless otherwise indicated this is the total value from NHS Prescription Services at the NHS Business Services Authority. This is an approximate spend to the nearest £100,000. The figure quoted is the net ingredient cost which refers to the cost of the drug before discounts and does not include any dispensing costs or fees. It does not include any adjustment for income obtained where a prescription charge is paid at the time the prescription is dispensed or where the patient has purchased a prepayment certificate.

**Item:** An item is anything which can be prescribed on an NHS prescription. More information on what is prescribed on an NHS prescription is available in the [Drug Tariff](#).

**MHRA:** Medicines and Healthcare products Regulatory Agency. MRHA regulates medicines, medical devices and blood components for transfusion in the UK.

**NHS Clinical Commissioners:** NHSCC are the independent membership organisation for CCGs, providing their collective voice, facilitating shared learning and delivering networking opportunities for CCG members.

**NICE:** The National Institute for Health and Care Excellence. NICE provides the NHS with clinical guidance on how to improve healthcare.

**Over the counter (OTC) item:** items which can be purchased from a pharmacy or in a supermarket or other convenience store without the need for a prescription. Such items may also be available at other outlets such as supermarkets, petrol stations or convenience stores.

**PHE:** Public Health England. PHE protects and improves the nation's health and wellbeing, and reduces health inequalities.

**PrescQIPP CIC:** PrescQIPP CIC (Community Interest Company): PrescQIPP is an NHS funded not for-profit organisation that supports quality, optimised prescribing for patients. PrescQIPP produces evidence-based resources and tools for primary care commissioners, and provide a platform to share innovation across the NHS.

## 2.2 Scope

The following chapter sets out the process for how NHS England and NHS Clinical Commissioners will conduct the process to review and update the guidance to CCGs as appropriate. Chapter 4 sets out draft guidance to CCGs on prescribing in 35 conditions that have been identified as being suitable for self-care based on the latest available evidence and the clinical consensus that has been reached by our joint clinical working group. The consultation seeks views on whether this guidance can be implemented and is clinically sound. Full details of the questions can be seen on the online consultation form and in Appendix 4.

## 3 How will the guidance be updated and reviewed?

The NHS England and NHS Clinical Commissioners joint clinical working group will continue to meet during and after the consultation, and update the proposals as a result of the consultation.

In future, the joint clinical working group will review the guidance to identify potential conditions to be retained, retired or added to the current guidance. There will be three stages:

### Stage 1: Condition identification

The organisations represented on the joint clinical working group will, taking into account previous feedback, identify conditions and subsequent items prescribed from the wide range of items that can be prescribed on NHS prescription in primary care that they consider could fall within the categories defined in section 1.4.

### Stage 2: Condition prioritisation

The joint clinical working group will prioritise the identified items based on the following criteria:

- Safety Issue
- Evidence of efficacy
- Degree of variation in prescribing
- Cost to the NHS
- Strong clinician or patient feedback

A draft list of conditions will be made available online through the NHS England website for a four week period when comments will be sought from interested parties. Feedback will be collated and then published on the NHS England website.

### Stage 3: Condition selection for inclusion or removal from the guidance

The joint clinical working group will consider the feedback and produce a final list of recommendations for consideration by NHS England and NHS Clinical Commissioners to update the proposed commissioning guidance *Conditions for which over the counter items should not routinely be prescribed in primary care*.

## 4 Our proposals for CCG commissioning guidance

### 4.1 Items of low clinical effectiveness

#### 4.1.1 Probiotics

Category	An Item of low clinical effectiveness, where there is a lack of robust evidence for clinical effectiveness.
Annual Spend	c. £1,100,000
Rationale for recommendation	<p>There is currently insufficient clinical evidence to support prescribing of probiotics within the NHS for the treatment or prevention of diarrhoea of any cause.</p> <p>Both the <a href="#">Public Health England C.difficile guidance</a> and <a href="#">NICE CG 84</a> recommend that probiotics cannot be recommended currently and that “Good quality randomised controlled trials should be conducted in the UK to evaluate the effectiveness and safety of a specific probiotic using clearly defined treatment regimens and outcome measures before they are routinely prescribed.”</p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">Public Health England C.difficile guidance</a></li> <li>2. <a href="#">NICE CG 84:Diarrhoea and vomiting caused by gastroenteritis in under 5s: diagnosis and management</a></li> <li>3. <a href="#">PrescQIPP CIC: Probiotics</a></li> </ol>
Recommendation	Advise CCGs to support prescribers that probiotics should not be routinely prescribed in primary care due to limited evidence of clinical effectiveness.
Exceptions	ACBS <sup>7</sup> approved indication or as per local policy.

#### 4.1.2 Vitamins and minerals

Category	An Item of low clinical effectiveness, where there is a lack of robust evidence for clinical effectiveness.
Annual Spend	c. £ 48,100,000
Rationale for recommendation	<p>There is insufficient high quality evidence to demonstrate the clinical effectiveness of vitamins and minerals.</p> <p>Vitamins and minerals are essential nutrients which most people can and should get from eating a healthy, varied and balanced diet. In most cases, dietary supplementation is unnecessary.</p> <p>Many vitamin and mineral supplements are classified as foods and not medicines; they therefore do not have to go through the strict criteria laid down by the Medicines and Health Regulatory</p>

<sup>7</sup> The ACBS recommends some foods and toilet preparations which may be regarded as drugs for the treatment of specified conditions. If a doctor is satisfied that the product can be safely prescribed, that patients will be adequately monitored and have access to hospital supervision if needed, they can prescribe these products on a prescription endorsed with “ACBS”.

	<p>Authority (MHRA) to confirm their quality, safety and efficacy before reaching the market. It is therefore not deemed appropriate for such preparations to be routinely funded on the NHS.</p> <p>Any prescribing not in-line with listed exceptions should be discontinued.</p> <p><i>This guidance does not apply to Healthy Start Vitamins but these are not currently prescribed on NHS prescription.</i></p>
References	<ol style="list-style-type: none"> <li>1) <a href="#">PrescQIPP bulletin 107, August 2015; the prescribing of vitamins and minerals including vitamin B preparations (DROP-list)</a></li> <li>2) NHS Choices: Supplements, Who Needs Them? <a href="#">A behind the Headlines Report</a>, June 2011</li> <li>3) <a href="#">NHS Choices: Do I need vitamin Supplements?</a> Accessed October 2017</li> <li>4) <a href="#">Healthy Start Vitamins</a></li> </ol>
Recommendation	<p>Advise CCGs to support prescribers that vitamins and minerals should not be routinely prescribed in primary care due to limited evidence of clinical effectiveness.</p>
Exceptions	<p>Iron deficiency anaemia.          Demonstrated vitamin D deficiency (NB not maintenance)          Calcium and vitamin D for osteoporosis          Malnutrition including alcoholism (see <a href="#">NICE guidance</a>)</p> <p><i>Patients suitable to receive Healthy start vitamins for pregnancy or children between the ages 6 months to their fourth birthday. (NB this is not on prescription but commissioned separately)</i></p>

## 4.2 Self-Limiting Conditions

### 4.2.1 Acute Sore Throat

Category	A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own.
Annual Spend	c. < £100,000
Rationale for recommendation	<p>A sore throat due to a viral or bacterial cause is a self-limiting condition. Symptoms resolve within 3 days in 40% of people, and within 1 week in 85% of people, irrespective of whether or not the sore throat is due to a streptococcal infection.</p> <p>There is little evidence to suggest that treatments such as lozenges or throat sprays help to treat the cause of sore throat and patients should be advised to take simple painkillers and implement some self-care measures such as gargling with warm salty water instead.</p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Sore Throat- accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Sore Throat - Acute accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of acute sore throat should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without the need for treatment.
Exceptions	No exceptions have been identified.

### 4.2.2 Cold Sores

Category	A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own.
Annual Spend	c. < £100,000
Rationale for recommendation	<p>Cold sores caused by the herpes simplex virus usually clear up without treatment within 7 to 10 days.</p> <p>Antiviral creams are available over the counter from pharmacies without a prescription and if used correctly, these can help ease symptoms and speed up the healing time.</p> <p>To be effective, these treatments should be applied as soon as the first signs of a cold sore appear. Using an antiviral cream after this initial period is unlikely to have much of an effect.</p> <p>This guidance does not apply to complex patients (i.e. immunocompromised patients).</p>
References	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Cold sore (herpes simplex virus) accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Herpes Simplex Oral accessed October 2017</a></li> </ol>

Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of cold sores should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without the need for treatment.
Exceptions	No exceptions have been identified.

### 4.2.3 Conjunctivitis

Category	A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own.
Annual Spend	c. £500,000
Rationale for recommendation	<p>Treatment isn't usually needed for conjunctivitis as the symptoms usually clear within a week. There are several self-care measures that may help with symptoms.</p> <p>If treatment is needed, then treatment is dependent on the cause:</p> <ul style="list-style-type: none"> <li>• In severe bacterial cases, antibiotic eye drops and eye ointments can be used to clear the infection.</li> <li>• Irritant conjunctivitis will clear up as soon as whatever is causing it is removed.</li> <li>• Allergic conjunctivitis can usually be treated with anti-allergy medications such as antihistamines. The substance that caused the allergy should be avoided.</li> </ul> <p>Treatments for conjunctivitis can be purchased over the counter however almost half of all simple cases of conjunctivitis clear up within ten days without any treatment.</p>
References	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Conjunctivitis accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Conjunctivitis - Infective accessed October 2017</a></li> <li>3. <a href="#">PHE Advice for schools: September 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of conjunctivitis should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without the need for treatment.
Exceptions	No exceptions have been identified.

### 4.2.4 Coughs and colds and nasal congestion

Category	A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own.
Annual Spend	c. £1,300,000
Rationale for recommendation	Most colds start to improve in 7 to 10 days. Most coughs clear up within two to three weeks. Both conditions can

	cause nasal congestion. Neither condition requires any treatment.
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Common Cold accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Common Cold accessed October 2017</a></li> <li>3. <a href="#">PrescQIPP: Coughs and Colds.</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of coughs, colds and nasal congestion should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without the need for treatment.
Exceptions	No exceptions have been identified.

#### 4.2.5 Cradle Cap (Seborrhoeic dermatitis – infants)

Category	A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own.
Annual Spend	c. £4,500,000
Rationale for recommendation	Cradle cap is harmless and doesn't usually itch or cause discomfort. It usually appears in babies in the first two months of their lives, and clears up without treatment within weeks to a few months.
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Cradle Cap accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Seborrheic dermatitis accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of cradle cap should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without the need for treatment.
Exceptions	No exceptions have been identified.

#### 4.2.6 Haemorrhoids

Category	A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own.
Annual Spend	c. £500,000
Rationale for recommendation	<p>In many cases, haemorrhoids don't cause symptoms and some people don't even realise they have them. Haemorrhoids often clear up by themselves after a few days. Making simple dietary changes and not straining on the toilet are often recommended first.</p> <p>However, there are many treatments (creams, ointments and suppositories) that can reduce itching and discomfort and these are available over the counter for purchase.</p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Haemorrhoids accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Haemorrhoids accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a

	prescription for treatment of haemorrhoids should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without the need for treatment.
Exceptions	No exceptions have been identified.

#### 4.2.7 Infant Colic

Category	A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own.
Annual Spend	c.<£100,000
Rationale for recommendation	As colic eventually improves on its own, medical treatment isn't usually recommended.  There are some over-the-counter treatments available that could be tried however; there is limited evidence for the effectiveness of these treatments.
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Colic accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Colic Infantile accessed October 2017</a></li> <li>3. <a href="#">PrescQIPP: Infant Colic</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of infant colic should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without the need for treatment.
Exceptions	No exceptions have been identified.

#### 4.2.8 Mild Cystitis

Category	A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own.
Annual Spend	c. £300,000
Rationale for recommendation	Mild cystitis is a common type of urinary tract inflammation, normally caused by an infection; however it is usually more of a nuisance than a cause for serious concern. Mild cases can be defined as those that are responsive to symptomatic treatment but will also clear up on their own. If symptoms don't improve in 3 days, despite self-care measures, then the patient should be advised to see their GP. Symptomatic treatment using products that reduce the acidity of the urine to reduce symptoms are available, but there's a lack of evidence to suggest they're effective.
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Cystitis accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Urinary tract infection (lower) - women accessed October 2017.</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of mild cystitis should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without the need for treatment.
Exceptions	No exceptions have been identified.

### 4.3 Minor Ailments Suitable for Self-Care

#### 4.3.1 Contact Dermatitis

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £14,500,000
Rationale for recommendation	<p>Contact dermatitis is a type of eczema triggered by contact with a particular substance. Once treated most people can expect their symptoms to improve and/or clear up completely if the irritant or allergen can be identified and removed or avoided</p> <p>It is most commonly caused by irritants such as soaps, washing powders, detergents, solvents or regular contact with water. Treatment normally involves avoiding the allergen or irritant and treating symptoms with over the counter emollients and topical corticosteroids.</p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Contact Dermatitis accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Dermatitis - contact accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of contact dermatitis should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.2 Dandruff

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £4,500,000
Rationale for recommendation	<p>Dandruff is a common skin condition; it isn't contagious or harmful and can be easily treated with over the counter anti-fungal shampoos.</p> <p>A GP appointment is unnecessary.</p>
References	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Dandruff accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Scenario: Seborrhoeic dermatitis - scalp and beard accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment for dandruff should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

### 4.3.3 Diarrhoea (Adults)

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £2,800,000
Rationale for recommendation	<p>Diarrhoea normally affects most people from time to time and is usually nothing to worry about. However it can take a few days to a week to clear up.</p> <p>Acute diarrhoea is usually caused by a bacterial or viral infection and other causes include drugs, anxiety or a food allergy.</p> <p>OTC treatments can help replace lost fluids or reduce bowel motions. This recommendation does not apply to children.</p>
References	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Diarrhoea accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Diarrhoea - adult's assessment accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment for acute diarrhoea will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

### 4.3.4 Dry Eyes/Sore tired Eyes

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £14,800,000
Rationale for recommendation	<p>Dry eye syndrome, or dry eye disease, is a common condition that occurs when the eyes don't make enough tears, or the tears evaporate too quickly.</p> <p>Most cases of sore tired eyes resolve themselves.</p> <p>Patients should be encouraged to manage both dry eyes and sore eyes by implementing some self-care measures such as good eyelid hygiene and avoidance of environmental factors alongside treatment</p> <p>Mild to moderate cases of dry eye syndrome or sore tired eyes can usually be treated using lubricant eye treatments that consist of a range of drops, gels and ointments that can be easily be purchased over the counter.</p>

References	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Dry eye syndrome accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Dry eye syndrome accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of dry or sore eyes should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.5 Earwax

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £300,000
Rationale for recommendation	<p>Earwax is produced inside ears to keep them clean and free of germs. It usually passes out of the ears harmlessly, but sometimes too much can build up and block the ears.</p> <p>A build-up of earwax is a common problem that can often be treated using eardrops bought from a pharmacy. These can help soften the earwax so that it falls out naturally.</p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Earwax build-up accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Earwax Summary accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for the removal of earwax should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.6 Excessive sweating (Hyperhidrosis)

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £200,000
Rationale for recommendation	<p>Hyperhidrosis is a common condition in which a person sweats excessively.</p> <p>First line treatment involves simple lifestyle changes. It can also</p>

	<p>be treated with over the counter high strength antiperspirants.</p> <p>An antiperspirant containing aluminium chloride is usually the first line of treatment and is sold in most pharmacies.</p>
References	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Hyperhidrosis accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Hyperhidrosis accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for high strength antiperspirants for the treatment of mild to moderate hyperhidrosis should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.7 Head Lice

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £600,000
Rationale for recommendation	<p>Head lice are a common problem, particularly in school children aged 4-11. They're largely harmless, but can live in the hair for a long time if not treated and can be irritating and frustrating to deal with.</p> <p>Head lice can easily be treated with wet combing or over the counter medicines that can be purchased from a pharmacy. Everyone in the household needs to be treated at the same time - even if they don't have symptoms.; Further information on how to treat head lice without medication can be found on NHS Choices.</p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Head Lice and nits accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Head Lice accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of head lice will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.8 Indigestion and Heartburn

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	£7,500,000
Rationale for recommendation	Most people have indigestion at some point. Usually, it's not a sign of anything more serious and can be treated at home without the need for medical advice, as it's often mild and infrequent and specialist treatment isn't required.

	<p>Most people are able to manage their indigestion by making simple diet and lifestyle changes, or taking medication such as antacids.</p> <p>Most people can ease symptoms by simple changes to diet and lifestyle and avoiding foods that make indigestion worse. (e.g. rich spicy or fatty foods, caffeinated drinks).</p>
References	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Indigestion accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Dyspepsia - proven functional accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of Indigestion and heartburn will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.9 Infrequent Constipation

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £22,800,000
Rationale for recommendation	<p>Constipation can affect people of all ages and can be just for a short period of time.</p> <p>It can be effectively managed with a change in diet or lifestyle and short term use of over the counter laxatives.</p>
References	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Constipation accessed October 2017.</a></li> <li>2. <a href="#">NICE CKS: Constipation accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of simple constipation will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.10 Infrequent Migraine

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £700,000
Rationale for recommendation	Migraine is a common health condition, affecting around one in every five women and around one in every 15 men. Mild infrequent migraines can be adequately treated with over the counter pain killers and a number of combination medicines for

	<p>migraine are available that contain both painkillers and anti-sickness medicines.</p> <p>Those with severe or recurrent migraines should continue to seek advice from their GP.</p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Migraine accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Migraine accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for the treatment of mild migraine should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.11 Insect bites and stings

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £5,300,000
Rationale for recommendation	<p>Most insect bites and stings are not serious and will get better within a few hours or days.</p> <p>Over-the-counter treatments can help ease symptoms, such as painkillers, creams for itching and antihistamines.</p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Insect bites and stings accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Insect bites and stings accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment for insect bites and stings will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.12 Mild Acne

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £800,000
Rationale for recommendation	<p>Acne is a common skin condition that affects most people at some point. Although acne can't be cured, it can be controlled with treatment.</p> <p>Several creams, lotions and gels for treating acne are available at pharmacies. Treatments can take up to three months to work.</p>

References:	1. <a href="#">NHS Choices: Acne accessed October 2017</a> 2. <a href="#">NICE CKS: Acne Vulgaris accessed October 2017</a>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of mild acne will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.13 Mild Dry Skin/Sunburn

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £100,000
Rationale for recommendation	Most people manage dry skin or sun burn symptoms themselves or prevent symptoms developing, using sun protection, by using products that can easily be bought in a pharmacy or supermarket.  Emollients are often used to help manage dry, itchy or scaly skin conditions.
References:	1. <a href="#">NHS Choices: Emollients accessed October 2017</a> 2. <a href="#">NICE CKS: Eczema - atopic accessed October 2017.</a> 3. <a href="#">PrescQIPP: sunscreens</a>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of dry skin, sunburn or sun protection should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	ACBS approved indication of photodermatoses (skin protection in) See earlier for general exceptions.

#### 4.3.14 Mild to Moderate Hay fever/Seasonal Rhinitis

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £1,100,000
Rationale for recommendation	Hay fever is a common allergic condition that affects up to one in five people. There's currently no cure for hay fever, but most people with mild to moderate symptoms are able to relieve symptoms with OTC treatments recommended by a pharmacist.
References:	1. <a href="#">NHS Choices: Hay fever accessed October 2017</a> 2. <a href="#">NICE CKS: Allergic rhinitis - Summary accessed October 2017</a> 3. <a href="#">PrescQIPP: Hay fever</a>

Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of mild to moderate hay fever will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.15 Minor burns and scalds

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £200,000
Rationale for recommendation	Burns and scalds are damage to the skin caused by heat. Both are treated in the same way.  Depending on how serious a burn is, it is possible to treat burns at home.  Antiseptic creams and treatments for burns should be included in any products kept in a medicine cabinet at home.
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Burns and Scalds accessed October 2017.</a></li> <li>2. <a href="#">NICE CKS: Burns and scalds accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for minor burns and scalds should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	See earlier for general exceptions. No routine exceptions have been identified. However more serious burns always require professional medical attention. Burns requiring hospital A&E treatment include but are not limited to: <ul style="list-style-type: none"> <li>• all chemical and electrical burns;</li> <li>• large or deep burns;</li> <li>• burns that cause white or charred skin;</li> <li>• burns on the face, hands, arms, feet, legs or genitals that cause blisters.</li> </ul>

#### 4.3.16 Minor conditions associated with pain, discomfort and/fever. (e.g. aches and sprains, headache, period pain, back pain)

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £38,200,000
Rationale for recommendation	In most cases, headaches, period pain, mild fever and back pain can be treated at home with over-the-counter painkillers and

	<p>lifestyle changes, such as getting more rest and drinking enough fluids.</p> <p>Patients should be encouraged to keep a small supply of OTC analgesics in their medicines cabinets at home so they are able to manage minor ailments at home without the need for a GP appointment.</p> <p><i>Examples of conditions where patients should be encouraged to self – care include: Headache, colds, fever, earache, teething, period pain, cuts, self-limiting musculoskeletal pain, sprains and strains, bruising, toothache, sinusitis/nasal congestion, recovery after a simple medical procedure, aches and pains and sore throat.</i></p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Living with Pain accessed October 2017.</a></li> <li>2. <a href="#">NHS Choices: Your medicine cabinet</a></li> <li>3. <a href="#">NICE CKS:Mild to Moderate Pain accessed October 2017</a></li> <li>4. <a href="#">PrescQIPP: analgesia resources</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of conditions associated with pain, discomfort and mild fever will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.17 Mouth ulcers

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £5,500,000
Rationale for recommendation	Mouth ulcers are usually harmless and do not need to be treated because most clear up by themselves within a week or two. Mouth ulcers are common and can usually be managed at home, without seeing your dentist or GP. However, OTC treatment can help to reduce swelling and ease any discomfort.
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Mouth ulcers accessed October 2017.</a></li> <li>2. <a href="#">NICE CKS: Aphthous ulcer accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of mouth ulcers will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

**4.3.18 Nappy Rash**

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £500,000
Rationale for recommendation	Up to a third of babies and toddlers in nappies have nappy rash at any one time. Nappy rash can usually be treated at home using barrier creams purchased at the supermarket or pharmacy.  Nappy rash usually clears up after about three days if recommended hygiene tips are followed.
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Pregnancy and baby - Nappy Rash accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Nappy rash accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment for nappy rash will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

**4.3.19 Oral Thrush**

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £4,500,000
Rationale for recommendation	Oral Thrush is a minor condition that can be treated without the need for a GP consultation or prescription in the first instance.  It is common in babies and older people with dentures or those using steroid inhalers.  It can easily be treated with over the counter gel.
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Oral Thrush (adults) accessed October 2017</a></li> <li>2. <a href="#">NHS Choices: Oral Thrush (babies) accessed October 2017</a></li> <li>3. <a href="#">NICE CKS: Candida Oral accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment for oral thrush will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.20 Prevention of dental caries

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c.< £100, 000
Rationale for recommendation	The dentist may advise on using higher-strength fluoride toothpaste if you are particularly at risk of tooth decay. Higher fluoride toothpastes and mouthwashes can be purchased over the counter.
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Tooth Decay accessed October 2017.</a></li> <li>2. <a href="#">PrescQIPP: Dental products</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for high fluoride OTC toothpaste should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.21 Ringworm/Athletes foot

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £3,000,000
Rationale for recommendation	<p>Ringworm is a common fungal infection that can cause a red or silvery ring-like rash on the skin. Despite its name, ringworm doesn't have anything to do with worms.</p> <p>Athlete's foot is a rash caused by a fungus that usually appears between the toes. These fungal infections, medically known as "tinea", are not serious and are usually easily treated with over the counter treatments. However, they are contagious and easily spread so it is important to practice good foot hygiene.</p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Athletes Foot accessed October 2017.</a></li> <li>2. <a href="#">NHS Choices: Ring Worm accessed October 2017</a></li> <li>3. <a href="#">NICE CKS:Fungal Skin Infection - Foot accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of ringworm or athletes foot will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

**4.3.22 Teething/Mild toothache**

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £5,500,000
Rationale for recommendation	<p>Teething can be distressing for some babies, but there are ways to make it easier for them.</p> <p>Teething gels often contain a mild local anaesthetic, which helps to numb any pain or discomfort caused by teething and these can be purchased from a pharmacy.</p> <p>If baby is in pain or has a mild raised temperature (less than 38C) then paracetamol or ibuprofen suspension can be given.</p> <p>Toothache can come and go or be constant. Eating or drinking can make the pain worse, particularly if the food or drink is hot or cold. Mild toothache in adults can also be treated with over the counter painkillers.</p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Toothache accessed October 2017.</a></li> <li>2. <a href="#">NICE CKS: Teething accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for teething in babies or toothache in children and adults will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

**4.3.23 Threadworms**

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £200,000
Rationale for recommendation	<p>Threadworms (pinworms) are tiny worms in your stools. They are common in children and can be spread easily. They can be effectively treated without the need to visit the GP.</p> <p>Treatment for threadworms can easily be bought from pharmacies. This is usually a chewable tablet or liquid you swallow. Strict hygiene measures can also help clear up a threadworm infection and reduce the likelihood of reinfection</p> <p>Everyone in the household will require treatment, even if they don't have symptoms.</p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Threadworms accessed October 2017</a></li> <li>2. <a href="#">NICE CKS: Threadworm accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a

	prescription for treatment of threadworm should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.24 Travel Sickness

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £4,500,000
Rationale for recommendation	Mild motion sickness can be treated by various self-care measures (e.g. stare at a fixed object, fresh air, listen to music etc.); more severe motion sickness can be treated with over the counter medicines.
References	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Travel Sickness accessed October 2017.</a></li> <li>2. <a href="#">Patient info: Travel Sickness accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment for motion sickness will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

#### 4.3.25 Warts and Verrucae

Category	A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.
Annual Spend	c. £900,000
Rationale for recommendation	<p>Most people will have warts at some point in their life. They are generally harmless and tend to go away on their own eventually.</p> <p>Several treatments can be purchased from a pharmacy to get rid of warts and verrucae more quickly if patients require treatment.</p>
References:	<ol style="list-style-type: none"> <li>1. <a href="#">NHS Choices: Warts and Verruca's accessed October 2017.</a></li> <li>2. <a href="#">NICE CKS: Warts and Verrucae References accessed October 2017</a></li> </ol>
Recommendation	Advise CCGs to support prescribers in advising patients that a prescription for treatment of warts and verrucae will not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	No routine exceptions have been identified. See earlier for general exceptions.

## 5. Consultation Format

NHS England and NHS Clinical Commissioners are grateful to individuals and organisations who take the time to respond to this consultation. During the 3 month consultation period, we will work with patient representative bodies, charities, Royal Colleges and industry to gather views across the range of stakeholders. We will also be asking CCGs to respond and to undertake their own local engagement activities.

If you would like to respond to this consultation you can do so by:

- Using the online web-form:  
<https://www.engage.england.nhs.uk/consultation/over-the-counter-items-not-routinely-prescribed>.  
Questions from the online form are listed in appendix 4. Individuals may also want to contact their local CCG to inform a local response. You can find contact details for your local CCG on [NHS Choices](#).
- Written enquiries can be submitted to [england.medicines@nhs.net](mailto:england.medicines@nhs.net) Please note that NHS England and NHS Clinical Commissioners will not be able to respond to every response individually.

Following the close of the consultation period, NHS England and NHS Clinical Commissioners, via the joint clinical working group, will review, analyse and consider all responses received. A summary of the responses will be published on the NHS England and NHS Clinical Commissioners websites to provide an opportunity to reflect on what has been heard.

The joint clinical working group, will develop finalised commissioning guidance. The finalised commissioning guidance will then be published with the expectation that CCGs should 'have regard to' it, in accordance with the Health and Social Care Act.

Each CCG will then need to make a local decision on whether to implement the national commissioning guidance, with due regard to both local circumstances and their own impact assessments.

## **Appendix 1 - Conditions for which prescribing could be restricted**

1. Probiotics
2. Vitamins and minerals
3. Acute Sore Throat
4. Cold Sores
5. Conjunctivitis
6. Coughs and colds and nasal congestion
7. Cradle Cap (Seborrhoeic dermatitis – infants)
8. Haemorrhoids
9. Infant Colic
10. Mild Cystitis
11. Contact Dermatitis
12. Dandruff
13. Diarrhoea (Adults)
14. Dry Eyes/Sore (tired) Eyes
15. Earwax
16. Excessive sweating (Hyperhidrosis)
17. Head Lice
18. Indigestion and Heartburn
19. Infrequent Constipation
20. Infrequent Migraine
21. Insect bites and stings
22. Mild Acne
23. Mild Dry Skin/Sunburn
24. Mild to Moderate Hay fever/Seasonal Rhinitis
25. Minor burns and scalds
26. Minor conditions associated with pain, discomfort and/fever. (e.g. aches and sprains, headache, period pain, back pain)
27. Mouth ulcers
28. Nappy Rash
29. Oral Thrush
30. Prevention of dental caries
31. Ringworm/Athletes foot
32. Teething/Mild toothache
33. Threadworms
34. Travel Sickness
35. Warts and Verrucae

## Appendix 2– Example products for conditions or over the counter items that could be restricted.

NB the products highlighted below are included for illustration purposes only. This guidance focuses on prescribing restrictions for the conditions identified.

Condition/Item	Example products
Probiotics	Probiotic sachets
Vitamins and Minerals	Vitamin B compound tablets, Vitamin C effervescent 1g tablets, Multivitamin preparations.
Acute Sore Throat	Lozenges or throat sprays
Cold Sores	Antiviral cold sore cream
Conjunctivitis	Antimicrobial eye drops and eye ointment.
Coughs and Colds and Nasal Congestion	Cough mixtures or linctus, Saline nose drops, Menthol vapour rubs, Cold and flu capsules or sachets.
Cradle Cap	Emulsifying ointment, Shampoos
Haemorrhoids	Haemorrhoid creams, ointments and suppositories.
Infant Colic	Simethicone suspensions lactase drops
Mild Cystitis	Sodium bicarbonate or potassium citrate granules
Contact Dermatitis	Emollients, Steroid creams.
Dandruff	Antidandruff shampoos Antifungal shampoos
Diarrhoea (Adults)	Loperamide 2mg capsules Rehydration sachets,
Dry Eyes/Sore(tired) eyes	Eye drops for sore tired eyes Hypromellose 0.3% eye drops
Earwax	Drops containing sodium bicarbonate, hydrogen peroxide, olive oil or almond oil.
Excessive sweating (mild – moderate hyperhidrosis)	Aluminium chloride sprays, roll-ons, solutions.
Head Lice	Creams or lotions for head lice
Indigestion and Heartburn	Antacid tablets or liquids Ranitidine 150mg Tablets OTC proton pump inhibitors e.g. omeprazole 10mg capsules. Sodium alginate, calcium carbonate or sodium bicarbonate liquids.
Infrequent Constipation	Bisacodyl tablets 5mg Ispaghula Husk granules

	Lactulose solution
Infrequent Migraines	Migraine tablets Painkillers Anti-sickness tablets
Insect bites and stings	Steroid creams or creams for itching.
Mild Acne	Benzoyl peroxide products Salicylic acid products
Mild Dry Skin/Sunburn	Emollient creams, ointments and lotions After sun cream Sun creams
Mild to Moderate Hay fever/Seasonal Rhinitis	Antihistamine tablets or liquids. Steroid nasal sprays Sodium cromoglicate eye drops
Minor Burns and Scalds	Antiseptic Burns Cream, Cooling burn gel.
Minor conditions associated with pain, discomfort and/fever. (e.g. aches and sprains, headache, period pain, back pain)	Paracetamol 500mg tablets, Ibuprofen 400mg tablets, NSAID topical creams or gels Paracetamol Suspension
Mouth Ulcers	Antimicrobial mouthwash
Nappy Rash	Nappy rash creams
Prevention of dental caries	Fluoride toothpastes Mouthwashes
Ringworm/Athletes foot	Athlete's Foot Cream Antifungal creams or sprays
Teething/Mild Toothache	Antiseptic pain relieving gel Clove Oil Painkillers
Threadworms	Mebendazole 100mg tablets
Travel Sickness Tablets	Travel sickness tablets
Warts and Verrucae	Creams, gels, skin paints and medicated plasters containing salicylic acid dimethyl ether propane cold spray

## Appendix 3 - Unintended Consequences

We considered the potential unintended consequences of Section 4: Our Proposals for CCG commissioning guidance. These are set out in the table below. Please consider unintended consequences when submitting responses to the consultation.

Potential Unintended Consequences of issuing the proposed guidance	Potential solution
Increased patient interactions with secondary care and consequent costs	Joint local guidance with A&E secondary care providers may be appropriate. CCGs may wish to monitor A&E attendance for any of the minor conditions within the guidance.
Prescribers may decide to prescribe alternative treatments, with increased cost implications.	There may be cases where GP's prescribe more expensive or prescription only products to treat some of the conditions outlined within this guidance, however the recommendation is that, subject to the exceptions listed, no items should be prescribed for these conditions and GP's will need to take account of this guidance and take professional responsibility for any prescribing decisions made.
This guidance undermines individual prescribers' decision making.	Prescribers must recognise and work within the limits of their competence, as recommended by the GMC and other professional regulators/bodies. Nationally accessible resources (e.g. patient information leaflets) and local professional support should be provided to prescribers. The proposed guidance does not remove the clinical discretion of the prescriber in deciding what is in accordance with their professional duties.
Increased complaints about general practice and associated administration time	There is a potential for numbers of complaints to rise and the impact this would have on general practice workload and parts of the NHS needs to be considered. Therefore to support communication of the changes proposed in the guidance, educational aids will be produced. Stakeholder events have been arranged.
Effect on medicines supply	It is recognised that by proposing guidance on restricting the supply of over the counter medicines on prescription and encouraging people to purchase some of these items, an increased demand for OTC medicines from pharmacies needs to be considered. NHS England will work

	<p>with Department of Health colleagues to ensure that pharmaceutical companies (PAGB, BGMA) are aware of the proposed guidance and potential need for increased supply in some other products.</p>
<p>Risk of patients not self-treating for conditions.</p>	<p>Provided that patients are seeking help for red flag symptoms i.e. when the condition is not minor, for most of the conditions contained within the list there is a very low risk if these conditions are not treated, as most of these illnesses will clear up on their own. The following conditions may have some additional risks associated with not treating:</p> <p>Hay fever/allergic rhinitis – there may be an unintended consequence of an increase in steroid and or prescription antihistamine prescribing.</p> <p>There is also a minor risk of spread of infection with the following conditions:</p> <ul style="list-style-type: none"> <li>• Ringworm</li> <li>• Head lice.</li> <li>• Threadworms</li> </ul>
<p>Risk of patient not presenting to a GP with a red flag symptom</p>	<p>Patients should be encouraged to access health information via NHS choices, the Self-Care forum NHS 111 and their local community pharmacy. Patient information leaflets will be produced to highlight these resources to patients. In addition if patients present in a community pharmacy, pharmacists are trained healthcare professionals who will be able to refer patients to the GP when appropriate.</p>
<p>Patients in Care Homes</p>	<p>There is a risk that some care homes will still request prescriptions from GP's on the basis that they can't practically administer the medicine to residents without a prescription. However, all care homes should be encouraged to adopt a Homely Remedies Policy which includes the purchase and administering of a range of OTC medicines to residents. Some homes may be resistant to this due to the financial implications to the care home, however, the conditions within our guidance require treatments or items that the patient would normally be expected to buy so would not fall under the provision</p>

	of the care home.
Misinterpretation of the guidance	Some prescribers may misinterpret the guidance and stop prescribing for long term conditions or fail to apply an exception. Implementation tools will make it clear that all restrictions apply to minor, self-treatable illnesses only and that prescribers remain responsible for their decisions.

## Appendix 4 - Consultation Questions

To view the questionnaire in its intended format and submit responses please visit <https://www.engage.england.nhs.uk/consultation/over-the-counter-items-not-routinely-prescribed>

### **Introduction**

#### **In what capacity are you responding?**

Patient/Family member, friend or carer of patient/Member of the public/Patient representative organisation/Voluntary organisation or charity/Clinician/Clinical Commissioning Group/NHS Provider organisation/Industry/Other NHS Organisation/Other Healthcare Organisation/Professional Representative Body/Regulator/Other (please specify)

**Name or organisation** (optional)

**Email address** (optional)

Have you read the document:

***Conditions for which over the counter items should not routinely be prescribed in primary care: A Consultation on guidance for CCGs.***

- Yes
- No

### **Equality and Health Inequalities**

NHS England has legal duties which require giving due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as defined under the Equality Act 2010) and those who do not share it. NHS England must have regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities. An initial Equality and Health Inequalities Assessment (EHIA) has been carried out on these proposals and this can be read here.

<https://www.engage.england.nhs.uk/consultation/over-the-counter-items-not-routinely-prescribed>. Further information on our duties can be read at <https://www.england.nhs.uk/about/equality/>

**Do you feel there are any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?**

Yes (please tick all that apply)/No/Unsure

Age/disability/gender reassignment/race/religion or belief/sex/sexual orientation/marriage and civil partnership/pregnancy and maternity

Please provide further information on why you think this might be the case.

**Do you feel there is any further evidence we should consider in our proposals on the potential impact on health inequalities experienced by certain groups?**

Yes/No/Unsure

Please provide further information on why you think this might be the case

**Proposals for CCG commissioning guidance**

**Do you agree with the three proposed categories for [items] or [conditions] as below:**

- An item of low clinical effectiveness, where there is a lack of robust evidence for clinical effectiveness;
- A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own; or
- A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy

Agree/Neither agree or disagree/Disagree/Unsure (for each category)

Please provide further information.

**Do you agree with the general exceptions proposed?**

Agree/Neither agree or disagree/Disagree/Unsure (for each exception)

Please provide further information.

**Should we include any other patient groups in the general exceptions?**

Yes/No/Unsure

Please provide further information.

**Section 1: Drugs with limited evidence of clinical effectiveness**

Do you agree with the recommendation to: Advise CCGs to support prescribers in advising patients that **[item]** should not be routinely prescribed in primary care due to limited evidence of clinical effectiveness?

Agree/Neither agree or disagree/Disagree/Unsure (for each item)

- Probiotics
- Vitamins and minerals

Please provide further information.

**Section 2: Self-Limiting Conditions**

Do you agree with the recommendation to: Advise CCGs to support prescribers in advising patients that a prescription for treatment of **[condition]** should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without the need for treatment?

Agree/Neither agree or disagree/Disagree/Unsure (for each condition)

- Acute Sore Throat
- Cold Sores
- Conjunctivitis
- Coughs and colds and nasal congestion
- Cradle Cap (Seborrhoeic dermatitis – infants)
- Haemorrhoids
- Infant Colic
- Mild Cystitis

Please provide further information.

**Section 3: Minor Ailments Suitable for Self- Care**

Do you agree with the recommendation to: Advise CCGs to support prescribers in advising patients that a prescription for treatment of **[condition]** should not routinely be offered in primary care as the condition is appropriate for self-care?

Agree/Neither agree or disagree/Disagree/Unsure (for each condition)

- Contact Dermatitis
- Dandruff
- Diarrhoea (Adults)
- Dry Eyes/Sore (tired) Eyes
- Earwax
- Excessive sweating (Hyperhidrosis)
- Head Lice
- Indigestion and Heartburn
- Infrequent Constipation
- Infrequent Migraine
- Insect bites and stings
- Mild Acne
- Mild Dry Skin/Sunburn
- Mild to Moderate Hay fever/Seasonal Rhinitis
- Minor burns and scalds
- Minor conditions associated with pain, discomfort and/fever. (e.g. aches and sprains, headache, period pain, back pain)
- Mouth ulcers
- Nappy Rash
- Oral Thrush
- Prevention of dental caries
- Ringworm/Athletes foot
- Teething/Mild toothache
- Threadworms
- Travel Sickness
- Warts and Verrucae

Please provide further information.

**Are there any item or condition specific exceptions you feel should be included, in addition to those already proposed and the general exceptions covered earlier?**

If needed, please provide further information.

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**WOLVERHAMPTON CCG**
**GOVERNING BODY**  
**13 February 2018**
**Agenda item 8**

<b>TITLE OF REPORT:</b>	<b>NHS England Consultation on Items which should not routinely be prescribed in Primary Care</b>
<b>AUTHOR(s) OF REPORT:</b>	Hemant Patel, Head of Medicines Optimisation
<b>MANAGEMENT LEAD:</b>	Hemant Patel, Head of Medicines Optimisation
<b>PURPOSE OF REPORT:</b>	This report requests the Governing Body support the principle outcome of the NHS England consultation on items which should not routinely be prescribed in Primary Care. To support the GP members views with respect to implementation.
<b>ACTION REQUIRED:</b>	<input checked="" type="checkbox"/> <b>Decision</b> <input type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	Public. The outcome will be upload to the consultation website
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>• NHS England have completed a consultation exercise on developing guidance for CCGs on items that should not be routinely prescribed in Primary Care</li> <li>• The guidance aims to reduce unwarranted variation by providing clear guidance to CCGs on items that should not be prescribed to ensure that best value is obtained from prescribing budgets.</li> <li>• The CCG will need to make a decision whether it will support the recommendations made or not.</li> <li>• GP members view was to support the majority of this consultation with certain caveats (see attachment 1)</li> <li>• GP members felt it was important for a patient and public engagement process to be run by the CCG to support this.</li> </ul>
<b>RECOMMENDATION:</b>	<p>That the Governing Body</p> <p>1) This report requests the Governing Body support the principle outcome of the NHS England consultation on items which should not routinely be prescribed in Primary Care. To support the GP members views with respect to implementation.</p>

<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	
1. Improving the quality and safety of the services we commission	The report seeks to gain Governing Body support for the outcome of the NHS England consultation in order for the CCG to begin working to align prescribing with NHS England recommendations
2. Reducing Health Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	Working to support the recommendations in the guidance from NHS England on prescribing will aim to support the management of the prescribing budget.

## 1. BACKGROUND AND CURRENT SITUATION

- 1.1. NHS England has undertaken a national consultation on the development of guidance for CCGs on items which should not be routinely prescribed in primary care.
- 1.2. The consultation ran from the July to October 2017 and the outcome was published on 30<sup>th</sup> November is available on the NHS England website <https://www.engage.england.nhs.uk/consultation/items-routinely-prescribed/>
- 1.3. GP members were asked for their opinions at the members meeting on 31<sup>st</sup> January 2018

## 2. NHS England Consultation outcome

- 2.1. NHS England has agreed plans to save money each year by recommending low value treatments, including fish oil, herbal remedies and homeopathy no longer be provided on the NHS.

NHS England has published guidance for GPs and CCGs to remove 18 ineffective, unsafe and low clinical value treatments, such as some dietary supplements herbal treatments and homeopathy.

2.2. NHS England Board has agreed these treatments should no longer be routinely prescribed and in addition recommended that seven products be referred to the Department of Health to be formally considered for the blacklist:

- Homeopathy – no clear or robust evidence to support its use.
- Herbal treatments – no clear or robust evidence to support its use.
- Omega-3 Fatty Acid Compounds (fish oil) – essential fatty acids which can be obtained through diet, low clinical effectiveness.
- Co-proxamol – pain killer which has had its marketing authorisation withdrawn due to safety concerns.
- Rubefacients (excluding topical NSAIDs) – warming muscle rub products, limited evidence.
- Lutein and Antioxidants – used to treat the eye condition age related macular degeneration , low clinical effectiveness.
- Glucosamine and Chondroitin – used for joint pain, low clinical effectiveness.

### 2.3. **NHS England Consultation Guidance**

The following recommendations have been made for each of the medicines:-

#### 1) **Co-proxamol**

- Advise CCGs that prescribers in primary care should not initiate co-proxamol for any new patient.
- Advise CCGs to support prescribers in deprescribing co-proxamol in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change

#### 2) **Dosulepin**

- Advise CCGs that prescribers in primary care should not initiate dosulepin for any new patient.
- Advise CCGs to support prescribers in deprescribing dosulepin in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
- Advise CCGs that if, in exceptional circumstances, there is a clinical need for dosulepin to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.

#### 3) **Prolonged-release Doxazosin (also known as Doxazosin Modified Release)**

- Advise CCGs that prescribers in primary care should not initiate prolonged-release doxazosin for any new patient.
- Advise CCGs to support prescribers in deprescribing Prolonged-release doxazosin in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

#### **4) Glucosamine and Chondroitin**

- Advise CCGs that prescribers in primary care should not initiate Glucosamine and Chondroitin for any new patient.
- Advise CCGs to support prescribers in deprescribing glucosamine and chondroitin in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

#### **5) Herbal Treatments**

- Advise CCGs that prescribers in primary care should not initiate herbal items for any new patient
- Advise CCGs to support prescribers in deprescribing herbal items in all patients and where appropriate, ensure the availability of relevant services to facilitate this change

#### **6) Homeopathy**

- Advise CCGs that prescribers in primary care should not initiate homeopathic items for any new patient
- Advise CCGs to support prescribers in deprescribing homeopathic items in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

#### **7) Lidocaine Plasters**

- Advise CCGs that prescribers in primary care should not initiate lidocaine plasters for any new patient (apart from exceptions below)
- Advise CCGs to support prescribers in deprescribing lidocaine plasters in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
- Advise CCGs that if, in exceptional circumstances, there is a clinical need for lidocaine plasters to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.

#### **8) Lutein and Antioxidants**

- Advise CCGs that prescribers in primary care should not initiate lutein and antioxidants for any new patient
- Advise CCGs to support prescribers in deprescribing lutein and antioxidants in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

### **9) Omega-3 Fatty Acid Compounds**

- Advise CCGs that prescribers in primary care should not initiate omega-3 Fatty Acids for any new patient.
- Advise CCGs to support prescribers in deprescribing omega3 Fatty acids in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

### **10) Oxycodone and Naloxone Combination Product**

- Advise CCGs that prescribers in primary care should not initiate oxycodone and naloxone combination product for any new patient.
- Advise CCGs to support prescribers in deprescribing oxycodone and naloxone combination product in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
- Advise CCGs that if, in exceptional circumstances, there is a clinical need for oxycodone and naloxone combination product to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multidisciplinary team and/or other healthcare professional.

### **11) Paracetamol and Tramadol Combination Product**

- Advise CCGs that prescribers in primary care should not initiate paracetamol and tramadol combination product for any new patient.
- Advise CCGs to support prescribers in deprescribing paracetamol and tramadol combination product in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

### **12) Perindopril Arginine**

- Advise CCGs that prescribers in primary care should not initiate perindopril arginine for any new patient.
- Advise CCGs to support prescribers in deprescribing perindopril arginine in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

### **13) Rubefacients (excluding topical NSAIDs)**

- Advise CCGs that prescribers in primary care should not initiate rubefaciants (excluding topical NSAIDs) for any new patient.
- Advise CCGs to support prescribers in deprescribing rubefaciants (excluding topical NSAIDs) in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

#### **14) Once Daily Tadalafil**

- Advise CCGs that prescribers in primary care should not initiate once daily tadalafil for any new patient
- Advise CCGs to support prescribers in deprescribing once daily tadalafil in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

#### **15) Trimipramine**

- Advise CCGs that prescribers in primary care should not initiate trimipramine for any new patient.
- Advise CCGs to support prescribers in deprescribing trimipramine in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

#### **Guidance with exceptions**

#### **16) Immediate Release Fentanyl**

- Advise CCGs that prescribers in primary care should not initiate immediate release fentanyl for any new patient.
- Advise CCGs to support prescribers in deprescribing immediate release fentanyl in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
- Advise CCGs that if, in exceptional circumstances, there is a clinical need for immediate release fentanyl to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.

#### **Exceptions and further recommendations**

These recommendations do not apply to patients undergoing palliative care treatment and where the recommendation to use immediate release fentanyl in line with NICE guidance (see below), has been made by a multidisciplinary team and/or other healthcare professional with a recognised specialism in palliative care.

**17) Liothyronine** (including Armour Thyroid and liothyronine combination products)

- Advise CCGs that prescribers in primary care should not initiate liothyronine for any new patient
- Advise CCGs that individuals currently prescribed liothyronine should be reviewed by a consultant NHS endocrinologist with consideration given to switching to levothyroxine where clinically appropriate.
- Advise CCGs that a local decision, involving the Area Prescribing Committee (or equivalent) informed by National guidance (e.g. from NICE or the Regional Medicines Optimisation Committee), should be made regarding arrangements for on-going prescribing of liothyronine. This should be for individuals who, in exceptional circumstances, have an on-going need for liothyronine as confirmed by a consultant NHS endocrinologist.

**Exceptions and further recommendations**

The British Thyroid Association (BTA) advise that a small proportion of patients treated with levothyroxine continue to suffer with symptoms despite adequate biochemical correction.

In these circumstances, where levothyroxine has failed and in line with BTA guidance, endocrinologists providing NHS services may recommend liothyronine for individual patients after a carefully audited trial of at least 3 months duration of liothyronine.

Liothyronine is used for patients with thyroid cancer, in preparation for radioiodine ablation, iodine scanning, or stimulated thyroglobulin test. In these situations it is appropriate for patients to obtain their prescriptions from the centre undertaking the treatment and not be routinely obtained from primary care prescribers.

**18) Travel Vaccines** (vaccines administered exclusively for the purposes of travel)

- Advise CCGs that prescribers in primary care should not initiate the stated vaccines exclusively for the purposes of travel for any new patient.
- This is a restatement of existing regulations and no changes have been made as a result of this guidance.

**Exceptions and further recommendations**

To note the following vaccines may still be administered on the NHS exclusively for the purposes of travel, if clinically appropriate, pending any future review:

- Cholera
- Diphtheria/Tetanus/Polio
- Hepatitis A
- Typhoid



This guidance covers the following vaccinations which should not be prescribed on the NHS exclusively for the purposes of travel:

- Hepatitis B
- Japanese Encephalitis
- Meningitis ACWY
- Yellow Fever
- Tick-borne encephalitis
- Rabies
- BCG

These vaccines should continue to be recommended for travel but the individual traveller will need to bear the cost of the vaccination.

NHS England and NHS Clinical Commissioners recognise that the availability of vaccinations on the NHS for the purposes of travel can be confusing for prescribers and the public. The working group has recommended that Public Health England and Department of Health, working collaboratively with NHS England and NHS Clinical Commissioners, conduct a review of travel vaccination and publish the findings in Spring 2018.

#### 2.4. **Equality and Health Inequalities**

NHS England has legal duties which require giving due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and having regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities. An initial Equality and Health Inequalities Assessment (EHIA) has been carried out on these proposals and this can be read here. Further information on our duties can be read at <https://www.england.nhs.uk/about/equality/>

### 3. **CLINICAL VIEW**

- 3.1. The views of the Clinical Members of the Governing Body are being sought to support the recommendations of the consultation.
- 3.2. The views of GP members were requested at the members meeting held on 31<sup>st</sup> January 2018. The findings from that meeting are attached with this document.

## **PATIENT AND PUBLIC VIEW**

- 3.3. The consultation received over 5.5K responses seeking public and patient views on this matter and the CCG had made the link to the consultation available on its website.

## **4. KEY RISKS AND MITIGATIONS**

- 4.1. The exact risks and impact of this guidance on items which should not be prescribed will not be known until discussion with specific patients begins.
- 4.2. There is the potential a risk of increasing demand on consultations with patients affected by this guidance.
- 4.3. Any potential savings need to be weighed against the cost of alternative treatments being prescribed
- 4.4. The demand would be mitigated with recommendations being highlighted at the point of prescribing via our commissioned decision support software (Script Switch). This would be complemented by support from members of the Primary Care Medicines Team.

## **5. IMPACT ASSESSMENT**

### ***Financial and Resource Implications***

- 5.1. There is no immediate impact of the consultation; there may be a financial impact from any guidance published as a result.

### ***Quality and Safety Implications***

- 5.2. There are no quality and safety implications arising from this report.

### ***Equality Implications***

- 5.3. There are no equality implications arising from the impact of the published guidance

### ***Legal and Policy Implications***

- 5.4. The NHS England Commissioning guidance for the CCG provides clear rationales and guidance for the CCG to adopt.

### ***Other Implications***

- 5.5. The guidance will impact on Medicines Optimisation and the prescribing budget, details of which will not be available until the guidance is published.

**Name** Hemant Patel  
**Job Title** Head of Medicines Optimisation  
**Date:** 1 February 2018

**ATTACHED:**

NHS England Consultation Document Items which should not routinely be prescribed in primary care: A Consultation on guidance for CCGs

Feedback from GPs at Members Meeting 31.01.18

**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.**

	<b>Details/ Name</b>	<b>Date</b>
Clinical View & GP member group	GP Members	31/01/2018
Public/ Patient View	Provided via consultation	13/02/2018
Finance Implications discussed with Finance Team	N/a at this stage	
Quality Implications discussed with Quality and Risk Team	N/a at this stage	
Equality Implications discussed with CSU Equality and Inclusion Service	N/a at this stage	
Information Governance implications discussed with IG Support Officer	N/a at this stage	
Legal/ Policy implications discussed with Corporate Operations Manager	N/a at this stage	
Other Implications (Medicines management, estates, HR, IM&T etc.)	N/a at this stage	
Any relevant data requirements discussed with CSU Business Intelligence	N/a at this stage	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Hemant Patel</b>	<b>01/02/2017</b>



**Feedback from Members meeting regarding NHSE consultation one - 31.1.18**

**Based on 23 GPs that attended Members meeting and 2 providing comments via email**

<b>No</b>	<b>Medicine</b>	<b>Do you support the recommendation Y/N</b>	<b>If yes, how easy do you think it will be to implement. Grade 1 to 10. (1 being very easy)</b>	<b>If you do not support the recommendation provide comment/s why</b>	<b>Additional Comments. E.g. How could implementation be made easier?</b>
1	Oxycodone and Naloxone prolonged release	Y	4		Require support from secondary care colleagues
2	Lidocaine plasters	y	2		Require support from secondary care colleagues
3	Dosulepin	y	4		
4	Fentanyl (immediate release)	y	3		Require support from secondary care colleagues
5	Liothyronine in primary Hypothyroidism	y	1		
6	Tadalafil once daily	y	1		If started by secondary care, the recommendation to stop should come from secondary care.
7	Paracetamol and Tramadol combination product	y	2		
8	Trimpramine	y	1		Do not initiate for new patients, where it has been initiated by secondary care. This will require support and recommendations for alternative treatment.
9	Doxazosin (MR)	y	1		
10	Perindopril	y	1		
11	Homeopathy	y	1		
12	Herbal treatments	y	1		
13	Omega-3 Fatty Acid	Y	1		If initiated by secondary care, it

	Compounds (fish oil)				should be discontinued on the advice if a secondary care clinician
14	Co-proxamol	y	1		
15	Rubefacients (excluding topical NSAIDS)	n		y- Couldn't understand rationale if patients were happy. Consider for new patients only	
16	Lutein and Antioxidants –	y	1		
17	Glucosamine and Chondroitin –	y	1		
18	Travel Vaccines	y	1		

### Comments made by GPs regarding this consultation

Patient rep needs to be included

Public consultation

### Support required

Clarity is required on the process of commissioning / decommissioning certain medicines

Wonderful idea however easier said than done. Implementation is going to be very difficult. Patient's expectations need to change. We need to be VERY supported by GMC, NHSE and Dept. of Health

GMC advise must be included

GP contract clarification must be included and NHSE must put clear statement that it is not a breach if CCG guidelines seem to go against the contract

GPs should have more support from the CCG when patients complain about the changes

### Black list – take decision out of clinician's hands

Difficult discussion - either government decide a blanket ban - otherwise it is impossible to manage with poor social economic conditions.

Medications should be blacklisted

Choice to stop should be made from the top and not pass the buck to the individual GP's and practices

Caveats lay GPs open to charges of discrimination

Not down to the individual clinician or CCG

Feel the drugs should be blacklisted by the government - would be more widely accepted by the public and reduce complaints to the GPs

### **Widening health inequalities**

A lot of caveats must be considered

What about those that cannot afford over the counter medication?

If not done correctly, there will be considerable variation between practices, GPs and demographics

This is going to lead to postcode prescribing

Inappropriate restrictions and exceptions for patients who may not be able to afford the drugs

Need to have specific directions as too much risk of variation or individual interpretation

Need POLCV type approach?

### **Implementation**

Appraisal team must also ok the action

It will be difficult to manage in 10 mins consultations

Vital exercise - Made you think about your own practice and how it might affect patient demand for appointments

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# **Items which should not routinely be prescribed in primary care: Guidance for CCGs**

## NHS England Gateway Publication 07448

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the recommendations set out in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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## 1 Background

### 1.1 Who is this guidance for?

This guidance is addressed to CCGs to support them to fulfil their duties around appropriate use of their resources. We expect CCGs to take the proposed guidance into account in formulating local policies, and for prescribers to reflect local policies in their prescribing practice. The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties.

This guidance is issued as general guidance under s14Z10 and S2 of the NHS Act 2006 and is addressed to CCGs to support them to fulfil their duties around appropriate use of prescribing resources. The objective of this guidance is to support CCGs in their decision-making, to address unwarranted variation, and to provide clear national advice to make local prescribing practices more effective.

### 1.2 Why have we developed this guidance?

Last year 1.1 billion prescription items<sup>1</sup> were dispensed in primary care at a cost of £9.2billion<sup>2</sup>. This growing cost coupled with finite resources means it is important that the NHS achieves the greatest value from the money that it spends. We know that across England there is significant variation in what is being prescribed and to whom. Some patients are receiving medicines which have been proven to be relatively ineffective or in some cases potentially harmful, and/or for which there are other more effective, safer and/or cheaper alternatives; there are also products which are no longer appropriate to be prescribed on the NHS.

NHS England has partnered with NHS Clinical Commissioners to support Clinical Commissioning Groups (CCGs) in ensuring that they can use their prescribing resources effectively and deliver best patient outcomes from the medicines that their local population uses. CCGs asked for a nationally co-ordinated approach to the creation of commissioning guidance, developed with and by CCGs. The aim was a more equitable basis on which CCGs can take an individual and local implementation decisions. CCGs will still need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reducing health inequalities.

### 1.3 How have the recommendations in this guidance been developed?

In response to calls from GPs and Clinical Commissioning Groups (CCGs) who were having to take individual decisions about their local formularies, NHS Clinical Commissioners (NHSCC), the national representative organisation for CCGs, surveyed their members during February and March 2017 to assess views as to

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<sup>1</sup> An item is anything which can be prescribed on an NHS prescription. More information on what is prescribed on an NHS prescription is available in the [Drug Tariff](#).

<sup>2</sup> [NHS Digital Prescription Cost Analysis 2016](#)

whether a range of medicines and other products should be routinely available for prescription on the NHS.

NHS Clinical Commissioners asked NHS England to work with them to produce commissioning guidance to support their member organisations in taking decisions about prescribing of these products in primary care.

Together, NHS England and NHSCC established a clinical working group, chaired by representatives of these two organisations, with membership including GPs and pharmacists, CCGs, Royal College of General Practitioners, National Institute for Health and Care Excellence (NICE), Department of Health, the Royal Pharmaceutical Society and others (full membership listed at appendix A). This clinical working group was tasked with identifying which products should no longer be routinely prescribed in primary care.

Work focused on developing guidelines for an initial list of eighteen products which fall into one or more of the following categories:

- Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns;
- Products which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation; or
- Products which are clinically effective but, due to the nature of the product, are deemed a low priority for NHS funding.

The group assigned one or more of the following recommendations to products considered:

- Advise CCGs that prescribers in primary care should not initiate {item} for any new patient;
- Advise CCGs to support prescribers in deprescribing {item} in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change;
- Advise CCGs that if, in exceptional<sup>3</sup> circumstances, there is a clinical need for the item to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional;
- Advise CCGs that all prescribing should be carried out by a specialist; and/or
- Advise CCGs that this item should not be routinely prescribed in primary care but may be prescribed in named circumstances such as {item}.

In reaching its recommendations for the 18 products listed in this guidance document, the group considered recommendations from NICE, where relevant, in

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<sup>3</sup> In this context, “exceptional circumstances” should be interpreted as: Where the prescribing clinician considers no other medicine or intervention is clinically appropriate and available for the individual

order to support CCGs in implementing NICE guidance across the country; in particular it identified items which NICE consider to be “Do not do’s<sup>4</sup>”.

Where NICE guidance was not available the group considered evidence from a range of sources, for example; the Medicines and Healthcare products Regulatory Agency (MHRA), the British National Formulary, the Specialist Pharmacist Service and PrescQIPP Community Interest Company (CIC) evidence reviews.

The group reviewed each product against the following criteria:

- **Legal Status** i.e. is it prescription only, or is it available over the counter in pharmacies and/or any retail outlet?
- **Indication** i.e. what condition is it used to treat?
- **Background** i.e. a general narrative on the drug including. pack size, tablet size, whether administered orally etc.
- **Patent Protection** i.e. is the drug still subject to a patent?
- **Efficacy** i.e. is it clinically effective?
- **Safety** i.e. is the drug safe?
- **Alternative treatments and exceptionality for individuals** i.e. do alternatives exist and if so, who would they be used for?
- **Equalities and Health Inequalities** i.e. are there groups of people who would be disproportionately affected?
- **Financial implications, comprising:**
  - **Commissioning/funding pathway** i.e. how does the NHS pay for the drug?
  - **Medicine Cost** i.e. how much does the drug cost per item?
  - **Healthcare Resource Utilisation** i.e. what NHS resources would be required to implement a change?
  - **Annual Spend** i.e. what is the annual spend of the NHS on this item?
- **Unintended consequences**

The group’s recommendations on the 18 items within this guidance were publicly consulted on for a period of 3 months, from 21<sup>st</sup> July – 21<sup>st</sup> October 2017. During the consultation we heard from members of the public, patients and their representative groups, NHS staff, various Royal Colleges and the pharmaceutical industry, amongst others. Section 1.4 details the main findings from the consultation and the changes that have been made as a result of what we have heard. A more detailed report on the consultation can be found in *Items which should not routinely be prescribed in primary care: consultation report of findings* published alongside this guidance. The final recommendations set out in this guidance document reflect the outcome of the consultation. The potential equality impact of these recommendations has also been considered and is outlined in the Equality and Health Inequalities Impact Assessment document published alongside this guidance.

## 1.4 How have the recommendations in this guidance been developed following the results of the consultation?

We listened to what our stakeholders told us through the consultation and refined our draft guidance in light of the responses, discussion through webinars and the

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<sup>4</sup> Practices NICE recommend should be discontinued completely or should not be used routinely

engagement exercises, as well as recommendations from the joint clinical working group which considered the feedback in detail.

Whilst overall the final guidance remains largely unchanged from the draft guidance published in July 2017, there have been some important refinements and clarifications made in respect of a number of products. Details of each product are as follows:

**Co-proxamol** – We received a significant number of responses during the consultation around co-proxamol and the safety of continuing to prescribe this treatment emerged as the main theme. As a result of what we heard, the joint clinical working group recommended that we keep our original recommendations.

**Dosulepin** – As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for dosulepin.

**Prolonged-release Doxazosin** - As a result of what we heard the joint clinical working group did not feel it necessary to amend the proposed recommendations on deprescribing for prolonged-release doxazosin; however the group felt that there would not be cases of exceptionality that would warrant referral to a multidisciplinary team so removed that recommendation.

**Immediate release Fentanyl** – During the consultation we heard from patients, healthcare professionals and others that it is important that immediate-release fentanyl is available for use in palliative care. The joint clinical working group therefore decided that the three original proposed recommendations should remain but that a defined exemption and clarification should be provided for use as outlined in NICE guidance for palliative care.

**Glucosamine and Chondroitin** - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for glucosamine and chondroitin.

**Herbal Treatments** - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for Herbal treatments.

**Homeopathy** – During the consultation we heard a range of views both agreeing and disagreeing with our proposals on homeopathy. Due to the volume of evidence submitted a further review of the evidence was commissioned from the Specialist Pharmacy Service (SPS) by NHS England. The SPS review found that there was no clear or robust evidence base to support the use of homeopathy in the NHS and therefore, also taking into account responses received from medical and scientific bodies, the joint clinical working group did not feel it necessary to amend the proposed recommendations for homeopathy.

**Lidocaine Plasters** - During the consultation we heard from patients, healthcare professionals and others that there may be some specialist uses for this item which may be outside the terms of its license. We also received further submissions of evidence and a review of this evidence was commissioned from the Specialist Pharmacy Service (SPS) by NHS England. The joint clinical working group

considered the consultation feedback and the SPS evidence review and decided that the three recommendations should remain, but that a defined exemption and clarification should be provided for the use of lidocaine plasters in Post Herpetic Neuralgia (PHN) only, for which it is licensed in adults and for which there is some evidence of efficacy.

**Liothyronine** - We received a significant number of responses during the consultation around liothyronine. The main recurring theme – particularly from patients and organisational bodies - is that liothyronine is an effective treatment which is invaluable to patient wellbeing, quality of life and condition management. We also heard that a small proportion of patients treated with levothyroxine continue to suffer with symptoms despite adequate biochemical correction. The joint clinical working group considered the consultation feedback and therefore decided that liothyronine should still be prescribed for a small cohort of patients. The joint clinical working group changed the recommendations so that initiation of prescribing of liothyronine in appropriate patients should be initiated by a consultant endocrinologist in the NHS, and that deprescribing in ‘all’ patients is not appropriate as there are recognised exceptions.

**Lutein and Antioxidants** – As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for lutein and antioxidants.

**Omega-3 Fatty Acid Compounds** - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for omega-3 fatty acid compounds.

**Oxycodone and Naloxone combination product** - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for oxycodone and naloxone combination product.

**Paracetamol and Tramadol combination product** - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for paracetamol and tramadol Combination Product.

**Perindopril Arginine** - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for perindopril arginine.

**Rubefacients** (excluding topical NSAIDs) - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for rubefacients (excluding topical NSAIDs).

**Once daily Tadalafil** - As a result of what we heard the joint clinical working group did not feel it necessary to amend the proposed recommendations for once daily tadalafil.

**Vaccines administered exclusively for the purposes of travel** - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for vaccines administered *exclusively for the purposes of*

*travel*. However we did hear that confusion persists around travel vaccines and we have amended the wording of our guidance to reduce confusion.

**Trimipramine** - As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for deprescribing trimipramine however the group felt that there would not be cases of exceptionality that would warrant referral to a multidisciplinary team so removed that recommendation.

Whilst not a part of our consultation, the Department of Health recently consulted on the availability of Gluten free foods in primary care. The Department of Health will make recommendations in due course and we have removed references to Gluten free foods from this commissioning guidance.

## 2 How will this guidance be updated and reviewed?

To ensure that the NHS continues to allocate its resources effectively, the joint clinical working group will review the guidance at least annually (or more frequently if required) to identify potential items to be retained, retired or added to the current guidance. There will be three stages:

### Item identification

Organisations represented on the joint clinical working group will, taking into account previous feedback, identify items from the wide range of items that can be prescribed on NHS prescription in primary care in the categories defined in section 1.3.

### Item prioritisation

The joint clinical working group will prioritise items based on the following criteria:

- Safety Issue
- Evidence of efficacy
- Degree of variation in prescribing
- Cost to the NHS
- Clinician or patient feedback

In order to seek initial views from interested parties, a draft list of items will be made available online through the NHS England website for a four week period, when comments will be sought. Organisations detailed in Appendix 1 and others where appropriate may be sent an invitation to comment. Feedback will then be collated and published on the NHS England website.

### Item selection for inclusion or removal from the guidance

The joint clinical working group will consider the feedback and produce a final list of recommendations for consideration by NHS England and NHS Clinical Commissioners to update the proposed commissioning guidance for items which should not be routinely prescribed in primary care. It is envisaged that we will now consult formally on these recommendations as has been done for the products included in this guidance.

### 3 Definitions

**Annual Spend:** Unless otherwise indicated this is the total value from NHS Prescription Services at the NHS Business Services Authority. Prescriptions written by General Medical Practitioners and non-medical prescribers (nurses, pharmacists etc.) in England represent the vast majority of prescriptions included. Prescriptions written by dentists and hospital doctors are also included provided that they were dispensed in the community. Also included are prescriptions written in Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England. Prescriptions written in England but dispensed outside England are not included. The figure quoted is the net ingredient cost which refers to the cost of the drug before discounts and does not include any dispensing costs or fees. It does not include any adjustment for income obtained where a prescription charge is paid at the time the prescription is dispensed or where the patient has purchased a prepayment certificate.

**BNF:** British National Formulary provides healthcare professionals with authoritative and practical information on the selection and clinical use of medicines.

**Exceptional Circumstances:** In the context of this guidance, “exceptional circumstances” should be interpreted as: Where the prescribing clinician considers no other medicine or intervention is clinically appropriate and available for the individual

**Item:** An item is anything which can be prescribed on an NHS prescription. More information on what is prescribed on an NHS prescription is available in the [Drug Tariff](#).

**New patient:** This refers to any patient newly initiated on an item listed in the guidance.

**NICE:** The National Institute for Health and Care Excellence. They provide the NHS with clinical guidance on how to improve healthcare.

**MHRA:** Medicines and Healthcare products Regulatory Agency. They regulate medicines, medical devices and blood components for transfusion in the UK.

**NHS Clinical Commissioners:** NHSCC are the independent membership organisation for CCGs, providing their collective voice, facilitating shared learning and delivering networking opportunities for CCG members.

**PHE:** Public Health England. They protect and improve the nation's health and wellbeing, and reduce health inequalities.

**PrescQIPP CIC (Community Interest Company):** PrescQIPP are an NHS funded not-for-profit organisation that supports quality, optimised prescribing for patients. They produce [evidence-based resources](#) and tools for primary care commissioners, and provide a platform to share [innovation](#) across the NHS.

## 4 Recommendations

Our final recommendations by product are listed below.

### 4.1 Co-proxamol

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate co-proxamol for any new patient.</li> <li>Advise CCGs to support prescribers in deprescribing co-proxamol in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£9,002,824 ( <a href="#">NHS Digital</a> )
Background and Rationale	<p>Co-proxamol was a pain-killer which was previously licensed in the UK until being fully withdrawn from the market in 2007 due to safety concerns. All use in the UK is now on an unlicensed basis. Since 1985 advice aimed at the reduction of co-proxamol toxicity and fatal overdose has been provided, but this was not effective and resulted in withdrawal of co-proxamol by the MHRA. Since the withdrawal, further safety concerns have been raised which have resulted in co-proxamol being withdrawn in other countries.</p> <p>Due to the significant safety concerns, the joint clinical working group considered co-proxamol suitable for inclusion in this guidance.</p>
Further Resources and Guidance for CCGs	<p>MHRA Drug Safety Update: <a href="#">November 2007</a>, <a href="#">January 2011</a></p> <p><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Co-proxamol</a></p> <p>Patient information leaflets:  <a href="https://www.prescgipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescgipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>

## 4.2 Dosulepin

Recommendation	<ul style="list-style-type: none"> <li>• Advise CCGs that prescribers in primary care should not initiate dosulepin for any new patient.</li> <li>• Advise CCGs to support prescribers in deprescribing dosulepin in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> <li>• Advise CCGs that if, in exceptional circumstances, there is a clinical need for dosulepin to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£2,651,544 ( <a href="#">NHS Digital</a> )
Background and Rationale	<p>Dosulepin, formerly known as dothiepin, is a tricyclic antidepressant. <a href="#">NICE CG90: Depression in Adults</a> has a “do not do” recommendation: <i>“Do not switch to, or start, dosulepin because evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose.”</i></p> <p>Due to the significant safety concerns advised by NICE, the joint clinical working group considered dosulepin suitable for inclusion in this guidance.</p>
Further Resources and Guidance for CCGs	<p><a href="#">NICE CG90: Depression in Adults</a></p> <p><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Dosulepin</a></p> <p>Patient information leaflets:  <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>

### 4.3 Prolonged-release Doxazosin (also known as Doxazosin Modified Release)

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate prolonged-release doxazosin for any new patient.</li> <li>Advise CCGs to support prescribers in deprescribing Prolonged-release doxazosin in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	£7,769,931 ( <a href="#">NHS Digital</a> )
Background and Rationale	<p>Doxazosin is an alpha-adrenoceptor blocking drug that can be used to treat hypertension and benign prostatic hyperplasia. There are two oral forms of the medication (immediate release and prolonged-release) and both are taken once daily.</p> <p>Prolonged-release Doxazosin is approximately six times the cost of doxazosin immediate release (<a href="#">NHS Drug Tariff</a>).</p> <p><a href="#">NICE CG127 Hypertension in adults: diagnosis and management</a> recognises that doxazosin should be used in treatment but does not identify benefits of prolonged-release above immediate release.</p> <p><a href="#">NICE CG97 Lower urinary tract symptoms in men</a>: management recommends Doxazosin as an option in men with moderate to severe lower urinary tract symptoms. It does not identify benefits of Prolonged-release above immediate release.</p> <p>Due to the significant extra cost of prolonged-release doxazosin and the availability of once daily immediate release doxazosin, the joint clinical working group considered prolonged-release doxazosin suitable for inclusion in this guidance.</p>
Further Resources and Guidance for CCGs	<p><a href="#">NICE CG127 Hypertension in adults: diagnosis and management</a></p> <p><a href="#">NICE CG97 Lower urinary tract symptoms in men</a></p> <p><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Prolonged Release Doxazosin</a></p> <p><a href="#">BNF - Doxazosin</a></p>

	<p>Patient information leaflets:  <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>
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#### 4.4 Immediate Release Fentanyl

<p>Recommendation</p>	<ul style="list-style-type: none"> <li>• Advise CCGs that prescribers in primary care should not initiate immediate release fentanyl for any new patient.</li> <li>• Advise CCGs to support prescribers in deprescribing immediate release fentanyl in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> <li>• Advise CCGs that if, in exceptional circumstances, there is a clinical need for immediate release fentanyl to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.</li> </ul>
<p>Exceptions and further recommendations</p>	<p><b>These recommendations do not apply to patients undergoing palliative care treatment</b> and where the recommendation to use immediate release fentanyl in line with NICE guidance (see below), has been made by a multi-disciplinary team and/or other healthcare professional with a recognised specialism in palliative care.</p>
<p>Category</p>	<p>Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.</p>
<p>Annual Spend</p>	<p>£10, 952,130 (<a href="#">NHS Digital</a>)</p>
<p>Background and Rationale</p>	<p>Fentanyl is a strong opioid analgesic. It is available as an immediate release substance in various dosage forms; tablets, lozenges, films and nasal spray. Immediate release fentanyl is licensed for the treatment of breakthrough pain in adults with cancer who are already receiving at least 60mg oral morphine daily or equivalent. <a href="#">NICE CG140 Opioids in Palliative Care</a> states <i>Do not offer fast-acting fentanyl as first-line rescue medication.</i></p> <p>This recommendation does not apply to longer sustained release versions of fentanyl which come in patch form.</p> <p>Due to the recommendations from NICE and immediate release fentanyl being only licensed for use in cancer, the joint clinical working group considered immediate release fentanyl was suitable for inclusion in this guidance with specific exceptions for people receiving palliative care reflecting NICE and the terms of the product licence.</p>

Further Resources and Guidance for CCGs	<p><a href="#">Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain</a></p> <p><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Immediate Release Fentanyl</a></p> <p><a href="#">Faye's story: good practice when prescribing opioids for chronic pain</a></p> <p>Patient information leaflets:  <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>
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#### 4.5 Glucosamine and Chondroitin

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate Glucosamine and Chondroitin for any new patient.</li> <li>Advise CCGs to support prescribers in deprescribing glucosamine and chondroitin in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£444,535 ( <a href="#">NHS Digital</a> )
Background and Rationale	<p>Glucosamine and Chondroitin are nutraceuticals which used to improve pain associated with osteoarthritis. The <a href="#">BNF</a> states the following about glucosamine, <i>The mechanism of action is not understood and there is limited evidence to show it is effective.</i></p> <p><a href="#">NICE CG177: Osteoarthritis care and management</a> has the following “do not do” recommendation:</p> <p><i>Do not offer glucosamine or chondroitin products for the management of osteoarthritis</i></p> <p>Due to the recommendation from NICE and due to the lack of evidence as advised by the BNF, the joint clinical working group considered glucosamine and chondroitin suitable for inclusion in this guidance</p>
Further	<a href="#">BNF</a>

Resources and Guidance for CCGs and prescribers	<p><a href="#">NICE CG177: Osteoarthritis care and management</a></p> <p><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Glucosamine</a></p> <p>Patient information leaflets:  <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>
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## 4.6 Herbal Treatments

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate herbal items for any new patient</li> <li>Advise CCGs to support prescribers in deprescribing herbal items in all patients and where appropriate, ensure the availability of relevant services to facilitate this change.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£100,009 (Source: NHS Business Services Authority)
Background and Rationale	<p>Under a Traditional Herbal Registration there is no requirement to prove scientifically that a product works, the registration is based on longstanding use of the product as a traditional medicine.</p> <p>Due to the lack of scientific evidence required to register these products with the MHRA, the joint clinical working group felt that they were suitable for inclusion in this guidance.</p>
Further Resources and Guidance for CCGs and prescribers	<p><a href="#">GOV.UK Traditional herbal medicines: registration form and guidance</a></p> <p><a href="#">GOV.UK Herbal medicines granted a traditional herbal registration (THR)</a></p> <p>Patient information leaflets:  <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>

## 4.7 Homeopathy

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate homeopathic items for any new patient</li> <li>Advise CCGs to support prescribers in deprescribing homeopathic items in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£92,412 ( <a href="#">NHS Digital</a> )
Background and Rationale	<p>Homeopathy seeks to treat patients with highly diluted substances that are administered orally.</p> <p>During the consultation we received a range of submissions pertaining to homeopathy and it was deemed necessary to have a further, up to date review of the evidence which was conducted by the Specialist Pharmacy Service. The review found that there was no clear or robust evidence to support the use of homeopathy on the NHS.</p>
Further Resources and Guidance for CCGs and prescribers	<p>Specialist Pharmacy Service homeopathy evidence review: <a href="https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/">https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/</a></p> <p><a href="#">GOV.UK Register a homeopathic medicine or remedy</a></p> <p>Patient information leaflets: <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>

## 4.8 Lidocaine Plasters

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate lidocaine plasters for any new patient (apart from exceptions below)</li> <li>Advise CCGs to support prescribers in deprescribing lidocaine plasters in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> <li>Advise CCGs that if, in exceptional circumstances, there is a clinical need for lidocaine plasters to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.</li> </ul>
Exceptions and further recommendations	<p>These recommendations do not apply to patients who have been treated in line with <a href="#">NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings</a> but are still experiencing neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia).</p>
Category	<p>Item of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns</p>
Annual Spend	<p>£19,295,030 (<a href="#">NHS Digital</a>)</p>
Background and Rationale	<p>Lidocaine plasters can be applied for pain relief and are licensed for symptomatic relief of neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia, PHN) in adults.</p> <p><a href="#">NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings</a> does not recommend lidocaine plasters for treating neuropathic pain.</p> <p>The joint clinical working group also considered a <a href="#">PrescQIPP CIC review</a>, and during the consultation more evidence was provided and an up to date evidence summary was deemed necessary and prepared by the Specialist Pharmacy Service to inform the joint clinical working group's recommendations. Based on this review and non-inclusion, the lidocaine plasters are included with defined exceptions.</p>
Further Resources and Guidance for CCGs and prescribers	<p><a href="#">NICE Clinical Knowledge Summaries - Post-herpetic neuralgia</a></p> <p>Patient information leaflets:  <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p> <p>Specialist Pharmacy Service lidocaine plasters evidence review:  <a href="https://www.england.nhs.uk/medicines/items-which-should-not-">https://www.england.nhs.uk/medicines/items-which-should-not-</a></p>

	<a href="#">be-routinely-prescribed/</a>
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#### 4.9 Liothyronine (including Armour Thyroid and liothyronine combination products)

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate liothyronine for any new patient</li> <li>Advise CCGs that individuals currently prescribed liothyronine should be reviewed by a consultant NHS endocrinologist with consideration given to switching to levothyroxine where clinically appropriate.</li> <li>Advise CCGs that a local decision, involving the Area Prescribing Committee (or equivalent) informed by National guidance (e.g. from NICE or the Regional Medicines Optimisation Committee), should be made regarding arrangements for on-going prescribing of liothyronine. This should be for individuals who, in exceptional circumstances, have an on-going need for liothyronine as confirmed by a consultant NHS endocrinologist.</li> </ul>
Exceptions and further recommendations	<p>The British Thyroid Association (BTA) advise that a small proportion of patients treated with levothyroxine continue to suffer with symptoms despite adequate biochemical correction.</p> <p>In these circumstances, where levothyroxine has failed and in line with BTA guidance, endocrinologists providing NHS services may recommend liothyronine for individual patients after a carefully audited trial of at least 3 months duration of liothyronine.</p> <p>Liothyronine is used for patients with thyroid cancer, in preparation for radioiodine ablation, iodine scanning, or stimulated thyroglobulin test. In these situations it is appropriate for patients to obtain their prescriptions from the centre undertaking the treatment and not be routinely obtained from primary care prescribers.</p>
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	<p>£34,802,312 (<a href="#">NHS Digital</a>)</p> <p>In addition £1,000,049 is spent on Liothyronine + Levothyroxine combination products e.g. armour thyroid</p>
Background and Rationale	Liothyronine (sometimes known as T3) is used to treat hypothyroidism. It has a similar action to levothyroxine but is more rapidly metabolised and has a more rapid effect. It is

	<p>sometimes used in combination with levothyroxine in products.</p> <p>The price (<a href="#">NHS Drug Tariff</a>) of liothyronine has risen significantly and there is limited evidence for efficacy above Levothyroxine.</p> <p>The British Thyroid Association, in their 2015 <a href="#">position statement</a>, state “<i>There is no convincing evidence to support routine use of thyroid extracts, L-T3 monotherapy, compounded thyroid hormones, iodine containing preparations, dietary supplementation and over the counter preparations in the management of hypothyroidism</i>”.</p> <p>Due to the significant costs associated with liothyronine and the limited evidence to support its routine prescribing in preference to levothyroxine, the joint clinical working group considered liothyronine suitable for inclusion in this guidance. However during the consultation we heard and received evidence about a cohort of patients who require liothyronine and the clinical working group felt it necessary to include some exceptions based on guidance from the British Thyroid Association.</p>
Further Resources and Guidance for CCGs and prescribers	<p><a href="#">British Thyroid Association Guidelines</a></p> <p><a href="#">UKMI Medicines Q&amp;A - What is the rationale for using a combination of levothyroxine and liothyronine (such as Armour® Thyroid) to treat hypothyroidism?</a></p> <p>Patient information leaflets:  <a href="https://www.prescipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>

## 4.10 Lutein and Antioxidants

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate lutein and antioxidants for any new patient</li> <li>Advise CCGs to support prescribers in deprescribing lutein and antioxidants in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£1,500,000 ( <a href="#">NHS Digital</a> )
Background and Rationale	<p>Lutein and antioxidants (e.g. vitamin A, C E and zinc) are supplements which are sometimes recommended for Age Related Macular Degeneration. A variety of supplements are available to purchase in health food stores and other outlets where they are promoted to assist with “eye health”.</p> <p>Two Cochrane Reviews have been conducted on this topic  <b>Antioxidant vitamin and mineral supplements for preventing age-related macular degeneration</b>  <a href="http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000253.p ub3/full">http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000253.p ub3/full</a>  <i>The authors conclude “There is accumulating evidence that taking vitamin E or beta-carotene supplements will not prevent or delay the onset of AMD. There is no evidence with respect to other antioxidant supplements, such as vitamin C, lutein and zeaxanthin, or any of the commonly marketed multivitamin combinations”.</i></p> <p><b>Antioxidant vitamin and mineral supplements for slowing the progression of age-related macular degeneration</b>  <a href="http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000254.p ub3/full">http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000254.p ub3/full</a>  <i>The authors conclude “People with AMD may experience delay in progression of the disease with antioxidant vitamin and mineral supplementation. This finding is drawn from one large trial conducted in a relatively well-nourished American population. The generalisability of these findings to other populations is not known.”</i></p> <p>PrescQIPP CIC has issued a <a href="#">bulletin</a> which did not find evidence to support prescribing of lutein and antioxidants routinely on the NHS. NICE have published draft consultation guidance on Age-Related Macular Degeneration and proposed that the effectiveness and cost-effectiveness of the use of lutein and</p>

	antioxidants is currently a research recommendation.
Further Resources and Guidance for CCGs and prescribers	<p><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Lutein and Antioxidants</a></p> <p><a href="#">NICE - Macular Degeneration</a></p> <p>Patient information leaflets:  <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>

#### 4.11 Omega-3 Fatty Acid Compounds

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate omega-3 Fatty Acids for any new patient.</li> <li>Advise CCGs to support prescribers in deprescribing omega-3 Fatty acids in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Item of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns
Annual Spend	£6,317,927 per annum ( <a href="#">NHS Digital</a> )
Background and Rationale	<p>Omega-3 fatty acid compounds are essential fatty acids which can be obtained from the diet. They are licensed for adjunct to diet and statin in type IIb or III hypertriglyceridemia; adjunct to diet in type IV hypertriglyceridemia; adjunct in secondary prevention in those who have had a myocardial infarction in the preceding 3 months.</p> <p>NICE have reviewed the evidence and advised they are not suitable for prescribing by making “Do not do” recommendations</p> <p><a href="#">Do not offer or advise people to use omega-3 fatty acid capsules or omega-3 fatty acid supplemented foods to prevent another myocardial infarction. If people choose to take omega-3 fatty acid capsules or eat omega-3 fatty acid supplemented foods, be aware that there is no evidence of harm.</a></p> <p><a href="#">Do not offer omega-3 fatty acid compounds for the prevention of cardiovascular disease to any of the following: people who are being treated for primary prevention, people who are being treated for secondary prevention, people with chronic kidney disease, people with type 1 diabetes, people with type 2 diabetes.</a></p>

	<p><u>Do not offer the combination of a bile acid sequestrant (anion exchange resin), fibrate, nicotinic acid or omega-3 fatty acid compound with a statin for the primary or secondary prevention of CVD.</u></p> <p><u>Do not offer omega-3 fatty acids to adults with non-alcoholic fatty liver disease because there is not enough evidence to recommend their use.</u></p> <p><u>Initiation of omega-3-acid ethyl esters supplements is not routinely recommended for patients who have had a myocardial infarction (MI) more than 3 months earlier.</u></p> <p><u>Do not use omega-3 fatty acids to manage sleep problems in children and young people with autism.</u></p> <p><u>People with familial hypercholesterolemia (FH) should not routinely be recommended to take omega-3 fatty acid supplements.</u></p> <p><u>Do not offer omega-3 or omega-6 fatty acid compounds to treat multiple sclerosis (MS). Explain that there is no evidence that they affect relapse frequency or progression of MS.</u></p> <p>The joint clinical working group agreed with NICE recommendations and considered omega-3 fatty acid compounds suitable for inclusion in this guidance.</p>
<p>Further Resources and Guidance for CCGs and prescribers</p>	<p><u><a href="#">NICE - Omega-3</a></u></p> <p><u><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Omega 3 Fatty Acids</a></u></p> <p>Patient information leaflets:  <u><a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></u></p>

## 4.12 Oxycodone and Naloxone Combination Product

Recommendation	<ul style="list-style-type: none"> <li>• Advise CCGs that prescribers in primary care should not initiate oxycodone and naloxone combination product for any new patient.</li> <li>• Advise CCGs to support prescribers in deprescribing oxycodone and naloxone combination product in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> <li>• Advise CCGs that if, in exceptional circumstances, there is a clinical need for oxycodone and naloxone combination product to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	£5,062,928 ( <a href="#">NHS Digital</a> )
Background and Rationale	<p>Oxycodone and naloxone combination product is used to treat severe pain and can also be used second line in restless legs syndrome. The opioid antagonist naloxone is added to counteract opioid-induced constipation by blocking the action of oxycodone at opioid receptors locally in the gut.</p> <p>PrescQIPP CIC have issued a <a href="#">bulletin</a> and did not identify a benefit of oxycodone and naloxone in a single product over other analgesia (with laxatives if necessary).</p> <p>Due to the significant cost of the oxycodone and naloxone combination product and the unclear role of the combination product in therapy compared with individual products, the joint clinical working group considered oxycodone and naloxone suitable for inclusion in this guidance.</p>
Further Resources and Guidance for CCGs and prescribers	<p><a href="#">Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain</a></p> <p><a href="#">Faye's story: good practice when prescribing opioids for chronic pain</a></p> <p><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Oxycodone and Naloxone Combination Product</a></p>

	<p>Patient information leaflets:  <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>
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#### 4.13 Paracetamol and Tramadol Combination Product

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate paracetamol and tramadol combination product for any new patient.</li> <li>Advise CCGs to support prescribers in deprescribing paracetamol and tramadol combination product in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	£1,980,000 ( <a href="#">NHS Digital</a> )
Background and Rationale	<p>Paracetamol and tramadol combination products are more expensive than the products with the individual components (<a href="#">Drug Tariff</a>).</p> <p>PrescQIPP CIC also issued a <a href="#">bulletin</a> which did not identify any significant advantages over individual products, however it does recognise that some people may prefer to take one product instead of two. There are also different strengths of tramadol (37.5mg) and paracetamol (325mg) in the combination product compared to commonly available individual preparations of tramadol (50mg) and paracetamol (500mg), although the <a href="#">PrescQIPP CIC review</a> found no evidence that combination product is more effective or safer than the individual preparations.</p> <p>Due to the significant extra cost of a combination product, the joint clinical working group considered paracetamol and tramadol combination products suitable for inclusion in this guidance.</p>
Further Resources and Guidance for CCGs and prescribers	<p><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Paracetamol and Tramadol Combination Product</a></p> <p>Patient information leaflets:  <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>

#### 4.14 Perindopril Arginine

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate perindopril arginine for any new patient.</li> <li>Advise CCGs to support prescribers in deprescribing perindopril arginine in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	£529,403 ( <a href="#">NHS Digital</a> )
Background and Rationale	<p>Perindopril is an ACE inhibitor used in heart failure, hypertension, diabetic nephropathy and prophylaxis of cardiovascular events. The perindopril arginine salt version was developed as it is more stable in extremes of climate than the perindopril erbumine salt, which results in a longer shelf-life. perindopril arginine is significantly more expensive than perindopril erbumine and a <a href="#">PrescQIPP CIC review</a> of the topic found there was no clinical advantage of the arginine salt.</p> <p><a href="#">NICE CG127: Hypertension in adults: diagnosis and management</a> recommends that prescribing costs are minimised.</p> <p>Due to the significant extra costs with the arginine salt and the availability of the erbumine salt, the joint clinical working group considered perindopril arginine suitable for inclusion in this guidance.</p>
Further Resources and Guidance for CCGs and prescribers	<p><a href="#">NICE CG127: Hypertension in adults: diagnosis and management</a></p> <p><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Perindopril Arginine</a></p> <p>Patient information leaflets:  <a href="https://www.prescgipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescgipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>

#### 4.15 Rubefacients (excluding topical NSAIDs<sup>5</sup>)

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate rubefacients (excluding topical NSAIDs) for any new patient.</li> <li>Advise CCGs to support prescribers in deprescribing rubefacients (excluding topical NSAIDs) in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£4,301,527 (source: NHS BSA)
Background and Rationale	<p>Rubefacients are topical preparations that cause irritation and reddening of the skin due to increased blood flow. They are believed to relieve pain in various musculoskeletal conditions and are available on prescription and in over-the-counter remedies. They may contain nicotinate compounds, salicylate compounds, essential oils and camphor.</p> <p>The <a href="#">BNF states</a> “<i>The evidence available does not support the use of topical rubefacients in acute or chronic musculoskeletal pain.</i>”</p> <p>NICE have issued the following “Do not do” recommendation: <a href="#">Do not offer rubefacients for treating osteoarthritis.</a></p> <p>Due to limited evidence and NICE recommendations the joint clinical working group considered rubefacients (excluding topical NSAIDs) suitable for inclusion in this guidance.</p>
Further Resources and Guidance for CCGs and prescribers	<p><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Rubefacients</a></p> <p><a href="#">NICE CG177 Osteoarthritis: care and management</a></p> <p><a href="#">BNF: Soft-tissue disorders</a></p> <p>Patient information leaflets: <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>

<sup>5</sup> This does not relate to topical non-steroidal anti-inflammatory drug (NSAID) items such as Ibuprofen and Diclofenac.

#### 4.16 Once Daily Tadalafil

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate once daily tadalafil for any new patient</li> <li>Advise CCGs to support prescribers in deprescribing once daily tadalafil in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Products which are clinically effective but where more cost-effective products are available this includes products that have been subject to excessive price inflation.
Annual Spend	£11,474,221 ( <a href="#">NHS Digital</a> )
Background and Rationale	<p>Tadalafil is a phosphodiesterase-5-inhibitor and is available in strengths of 2.5mg, 5mg, 10mg and 20mg used to treat erectile dysfunction. In addition 2.5mg and 5mg can be used to treat benign prostatic hyperplasia. Only 2.5mg and 5mg should be used once daily. 10mg and 20mg<sup>6</sup> are used in a “when required fashion”. Tadalafil can be prescribed for erectile dysfunction in circumstances as set out in part XVIII B of the <a href="#">Drug Tariff</a>.</p> <p>Benign Prostatic Hyperplasia: NICE terminated their technology appraisal (<a href="#">TA273</a>) due to receiving no evidence from the manufacturer. In <a href="#">NICE CG97: Lower Urinary Tract Symptoms in Men</a> NICE state that there is not enough evidence to recommend phosphodiesterase inhibitors in routine clinical practice.</p> <p>Erectile Dysfunction: PrescQIPP CIC have <a href="#">reviewed the evidence</a> for Tadalafil and although tadalafil is effective in treating erectile dysfunction, there is not enough evidence to routinely recommend once daily preparations in preference to “when required” preparations particularly as when required preparations are now available as a generic.</p> <p>Due to recommendations from NICE and that alternative tadalafil preparations are available, the joint clinical working group felt once daily tadalafil was suitable for inclusion in this guidance.</p>
Further Resources and Guidance for CCGs and	<p><a href="#">NICE CG97: Lower Urinary Tract Symptoms in Men</a></p> <p><a href="#">NICE Clinical knowledge Summaries - Erectile Dysfunction</a></p>

<sup>6</sup> \*There is also a 20mg once daily preparation, branded *Adcirca*, which is used to treat pulmonary hypertension. This recommendation does not apply to this product, however it should only be prescribed by specialist centres and not routinely prescribed in primary care.

prescribers	<p><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Once Daily Tadalafil</a></p> <p>Patient information leaflets:  <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>
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#### 4.17 Travel Vaccines (vaccines administered exclusively for the purposes of travel)

Recommendation	<ul style="list-style-type: none"> <li>Advise CCGs that prescribers in primary care should not initiate the stated vaccines exclusively for the purposes of travel for any new patient.</li> </ul> <p><b>N.B This is a restatement of existing regulations and no changes have been made as a result of this guidance.</b></p>
Exceptions and further recommendations	<p>The vaccines in this proposal are listed below and they may continue to be administered for purposes other than travel, if clinically appropriate.</p> <p>NHS England and NHS Clinical Commissioners recognise that the availability of vaccinations on the NHS for the purposes of travel can be confusing for prescribers and the public. The working group has recommended that Public Health England and Department of Health, working collaboratively with NHS England and NHS Clinical Commissioners, conduct a review of travel vaccination and publish the findings in Spring 2018.</p>
Category	Items which are clinically effective but due to the nature of the product, are deemed a low priority for NHS funding.
Annual Spend	<p>£4,540,351 (<a href="#">NHS Digital</a>)</p> <p>Only some of this total will be administered for the purposes of travel.</p>
Background and Rationale	<p>To note the following vaccines may still be administered on the NHS exclusively for the purposes of travel, if clinically appropriate, pending any future review:</p> <ul style="list-style-type: none"> <li>Cholera</li> <li>Diphtheria/Tetanus/Polio</li> <li>Hepatitis A</li> <li>Typhoid</li> </ul> <p>This guidance covers the following vaccinations which should not be prescribed on the NHS exclusively for the purposes of travel:</p> <ul style="list-style-type: none"> <li>Hepatitis B</li> <li>Japanese Encephalitis</li> <li>Meningitis ACWY</li> </ul>

	<ul style="list-style-type: none"> <li>• Yellow Fever</li> <li>• Tick-borne encephalitis</li> <li>• Rabies</li> <li>• BCG</li> </ul> <p>These vaccines should continue to be recommended for travel but the individual traveller will need to bear the cost of the vaccination.</p> <p>For all other indications, as outlined in Immunisation Against Infectious Disease – the green book – the vaccine remains free on the NHS.</p>
Further Resources and Guidance for CCGs and prescribers	<p><a href="#">The Green Book</a></p> <p><a href="#">Travel Health Pro (NaTHNaC)</a></p> <p><a href="#">PrescQIPP CIC Drugs to Review for Optimised Prescribing - Travel Guidance</a></p> <p>Patient information leaflets:  <a href="https://www.prescgipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescgipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>

#### 4.18 Trimipramine

Recommendation	<ul style="list-style-type: none"> <li>• Advise CCGs that prescribers in primary care should not initiate trimipramine for any new patient.</li> <li>• Advise CCGs to support prescribers in deprescribing trimipramine in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.</li> </ul>
Exceptions and further recommendations	No routine exceptions have been identified.
Category	Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.
Annual Spend	£19,835,783 ( <a href="#">NHS Digital</a> )
Background and Rationale	<p>Trimipramine is a tricyclic antidepressant (TCA) however the price of trimipramine is significantly more expensive than other antidepressants.</p> <p><a href="#">NICE CG90: Depression in Adults</a> recommends selective serotonin reuptake inhibitor (SSRI) antidepressants first line if medicines are indicated as they have a more favourable risk:benefit ratio compared to TCA. However if a TCA is required there are more cost-effective TCAs than trimipramine available.</p>

	<p>Due to the significant cost associated with trimipramine and the availability of alternative treatments, the joint clinical working group considered trimipramine suitable for inclusion in this guidance.</p>
Further Resources and Guidance for CCGs and prescribers	<p><a href="#">NICE CG90: Depression in Adults</a></p> <p><a href="#">NICE Clinical Knowledge Summaries – Depression</a></p> <p>Patient information leaflets: <a href="https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets">https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</a></p>

## Appendix 1

### Membership of the Joint Clinical Working group

Graham Jackson (Co-chair)	NHSCC Co-chair and Clinical Chair Aylesbury CCG	NHS Clinical Commissioners & Aylesbury Vale CCG
Bruce Warner (Co-chair)	Deputy Chief Pharmaceutical Officer	NHS England
Arvind Madan	Director of Primary Care and Deputy Medical Director	NHS England
Julie Wood	Chief Executive	NHS Clinical Commissioners
David Webb	Regional Pharmacist	NHS England
David Geddes	Director of Primary Care Commissioning	NHS England
Paul Chrisp	Programme Director, Medicines and Technologies Programme	NICE
Claire Potter	Medicines and Pharmacy	Department of Health
Carol Roberts	Chief Executive	PrescQIPP CIC
Margaret Dockey	Information Services Manager	NHS Business Services Authority
Manir Hussain	Local professional Network Chair & Assoc Director Medicines Optimisation	NHS England & North Staffs/Stoke on Trent CCGs
Duncan Jenkins	Pharmaceutical Public Health	Dudley Public Health/CCG
Kate Arnold	Head of Medicines and Primary Care Development	Solihull CCG
Paul Gouldstone	Head of Medicines Management	Enfield CCG
Steve Pike	Clinical Lead Medicines Management	Coastal West Sussex CCG
David Paynton	National Clinical Lead for Commissioning	Royal College of GPs
Robbie Turner	Director for England	Royal Pharmaceutical Society
Lauren Hughes	Director, Clinical Policy and Operations	NHS England

## Stakeholder Organisations

Association of the British Pharmaceutical Industry (ABPI)	NHS Clinical Commissioners
Aylesbury Vale CCG	NHS England
British Generic Manufacturers Association	NHS Improvement
British Medical Association (General Practitioners Committee)	NICE
Care Quality Commission	Patients Association
Department of Health	Pharmaceutical Services Negotiating Committee (PSNC)
Enfield CCG	PrescQIPP
General Medical Council	Public Health England
Healthwatch England	Royal Pharmaceutical Society
National Voices	

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**WOLVERHAMPTON CCG**
**GOVERNING BODY**  
**13 FEBRUARY 2018**
**Agenda item 9**

<b>TITLE OF REPORT:</b>	<b>Governing Body Assurance Framework</b>
<b>AUTHOR(s) OF REPORT:</b>	Peter McKenzie, Corporate Operations Manager
<b>MANAGEMENT LEAD:</b>	Mike Hastings, Director of Operations
<b>PURPOSE OF REPORT:</b>	To present the latest updated Governing Body Assurance Framework (GBAF) and Corporate Risk Register for the Governing Body's consideration.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain. Any confidential information relating to any risks has been redacted.
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>• This report includes the latest updated version of the GBAF and Strategic level risks.</li> <li>• Updates impacting on the risk profile for each objective in the GBAF are included that have led to the development of the overall scoring.</li> </ul>
<b>RECOMMENDATION:</b>	That the Governing Body <ul style="list-style-type: none"> <li>• Considers the Governing Body Assurance Framework</li> <li>• Notes movement/progression of high level risks</li> </ul>
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	This report details progress with developing the overall Board Assurance Framework and is therefore relevant to all of the aims and objectives.

## 1. BACKGROUND AND CURRENT SITUATION

- 1.1. The Governing Body considered a first iteration of a re-aligned Governing Body Assurance Framework (GBAF) in September 2017. This links to the strategic objectives articulated by the Governing Body in March 2017. The updated version of this framework is set out at **Appendix 1**.

## 2. ASSURANCE FRAMEWORK UPDATE

- 2.1. The updated GBAF gives an update on the risk profile against each of the defined Corporate Objectives. An assessment has been reached for each objective of the overall risk of it not being achieved. This is based on the updated risk profile, including the identified Corporate Risks that have been identified which impact on that objective. The score for each objective has been given, along with details of the trend since the previous assessment.
- 2.2. The Strategic Risk Register is outlined at **Appendix 2**. This given an update on each of the identified risks, including details from the Governing Body Committee's reviews of the risks assigned to them. Key issues for the Governing Body to consider are the newly identified risk CR18 from the Finance and Performance Committee in relation to the Long Term Financial Strategy, the downgrading of a number of risks including CR12 (New ways of working in Primary Care) and CR16 (Governing Body leadership) and that risk CR04 in relation to delegated commissioning is recommended for closure.
- 2.3. The Governing Body is asked to consider the updated GBAF and discuss any areas where greater assurance is required. The Governing Body are also asked to consider if any new strategic risks need to be articulated for the Strategic Risk Register.

## 3. COMMITTEE RISK REVIEWS

- 3.1. Governing Body Committees have continued to review their own assigned risk registers at each meeting. These discussions are supported by work in CCG teams to identify operational risks and discussion at team meetings to escalate risks as appropriate to committees. The Audit and Governance Committee are due to consider an updated Risk Management Strategy that clearly articulates this approach.

3.2. The current number of risks on each Committee Risk Register is as follows:-

Committee	Number of Risks				
	Red	Amber	Yellow	Green	TOTAL
Commissioning Committee	2	2	1	0	5
Finance and Performance Committee	0	7	5	0	12
Primary Care Commissioning Committee	0	4	1	0	5
Quality and Safety Committee	1	4	2	0	7

3.3. Additional staff capacity has been approved in the Operations Team to further support the implementation of the risk management strategy, in particular supporting staff to ensure committee risk registers are kept up to date.

#### 4. CLINICAL VIEW

4.1. A clinical view has not been sought for the purpose of this report; however, if relevant, a clinical view is always sought via the appropriate committee membership.

#### 5. PATIENT AND PUBLIC VIEW

5.1. Not applicable for the purpose of this report.

#### 6. KEY RISKS AND MITIGATIONS

6.1. The CCG BAF and Risk Register on-going refresh work is critical, as failure to identify and manage risks is a risk to the achievement of the CCG's strategic objectives.

#### 7. IMPACT ASSESFSMENT

##### *Financial and Resource Implications*

7.1. There are no financial implications arising from this report at this stage.

##### *Quality and Safety Implications*

7.2. Quality is at the heart of all CCG work and whilst no impact assessment has been undertaken for the purpose of this report, all risks have a patient safety and quality impact assessment

##### *Equality Implications*

7.3. There are no Equality Implications associated with this report.

***Legal and Policy Implications***

7.4. There are no legal implications arising from this report.

***Other Implications***

7.5. There are no other implications arising from this report

<b>Name</b>	Peter McKenzie
<b>Job Title</b>	Corporate Operations Manager
<b>Date:</b>	February 2018

**ATTACHED:**

Appendix 1 Governing Body Assurance Framework

Appendix 2 Corporate Risk Register

### 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.**

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	Not Applicable	
Public/ Patient View	Not Applicable	
Finance Implications discussed with Finance Team	Not Applicable	
Quality Implications discussed with Quality and Risk Team	Not Applicable	
Equality Implications discussed with CSU Equality and Inclusion Service	Not Applicable	
Information Governance implications discussed with IG Support Officer	Not Applicable	
Legal/ Policy implications discussed with Corporate Operations Manager	Report Owner	February 2018
Other Implications (Medicines management, estates, HR, IM&T etc.)	Not Applicable	
Any relevant data requirements discussed with CSU Business Intelligence	Not Applicable	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Peter McKenzie</b>	<b>02/02/2018</b>



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Governing Body Assurance Framework

BAF Objectives	Relevant Corporate Risks	Description	Change in risk profile	Key Controls in place	Initial Risk to objective being achieved (Pre-mitigation)	Residual Risk to objective being achieved post mitigation	Previous Rating (November 2017)	Trend
<b>1. Improving the quality and safety of the services we commission</b>								
a. <u>Ensure on-going safety and performance in the system</u> Continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions	CR02 - Cyber Attacks CR03 - NHS Constitutional Targets CR06 - Vocare CR09- Safeguarding Compliance CR13 - Maternity Services CR15 - CCG Staff Capacity Challenges	There are a number of high level risks associated with provider safety concerns listed on the Risk Register. In particular, the concerns about the Vocare Urgent Care Centre and the issues with maternity services at RWT have the potential to have a significant impact. In addition there is an underlying risk that mitigating action to address these concerns may divert resources from overall systemic improvement.	No new strategic risks identified. Finance and Performance Committee have identified an additional risk associated with winter pressures, particularly in A&E. Vocare improvement Board continues to meet and CQC re-inspection has identified good progress with the action plan with the remaining actions continuing to be progressed (including a focus on recruitment) however concerns remain - particularly around triage). Decreased sickness absence rates in maternity services at RWT are supporting the on-going performance improvements.	The CCG continues to actively monitor the quality of provision at all its providers. The CCG is engaged with a multiagency improvement board to support improvements at the Urgent Care Centre and is working with other CCGs across the STP to ensure a system level approach is taken to issues with Maternity services. Existing monitoring systems are in place to ensure that concerns about Quality are addressed at the earliest possible opportunity and to ensure that appropriate contractual levers can be used if necessary	Likelihood - 4 Impact - 4 16 Very High	Likelihood - 3 Impact - 4 12 High	Likelihood - 3 Impact - 4 12 High	↔
<b>2.Reducing health inequalities in Wolverhampton</b>								
a. <u>Improve and develop primary care in Wolverhampton</u> – Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this	CR11 - Primary Care Strategy Workforce Issues CR12 - New Ways of Working in Primary Care CR14 - Developing Local Accountable Care Models CR15 - CCG Staff Capacity Challenges	The CCG's Primary Care strategy is ambitious and aims to deliver significant improvements in care for patients in primary care in Wolverhampton. The scale of change itself has a number of inherent risks as it involves CCG Staff, GPs and practice staff considering significant changes to their ways of working. This comes on top of existing high demand for services and a recognised workforce challenge in Wolverhampton. The most significant risks identified relate to the ongoing development of new clinical groupings in the City that will be able to deliver new services, at scale in primary care across Wolverhampton	No new strategic risks have been identified and the existing risk around managing delegated functions has been recommended for closure now that support is secured within the in house contracting team. The Primary Care team is now fully established and supporting the implementation of the Primary Care Strategy milestone plan. This includes dedicated support for the New Models of Care groupings that are continuing to play a full role in the ongoing discussions about the development of an Accountable Care System in Wolverhampton	The CCG continues to support the development of Clinical Groupings with staff in the Primary Care team providing direct support. Progress with the Primary Care Strategy is being measured by a milestone plan through monthly checks and quarterly review meetings. Significant work continues to take place both locally and at an STP level to ensure that workforce challenges are addressed through both recruitment and upskilling of the existing workforce.	Likelihood - 4 Impact - 3 12 High	Likelihood - 2 Impact - 3 6 Moderate	Likelihood - 3 Impact - 3 9 High	↓
b. <u>Deliver new models of care that support care closer to home and improve management of Long Term Conditions</u> Supporting the development of Multi-Speciality Community Provider and Primary and Acute Care Systems to deliver more integrated services in Primary Care and Community settings	CR12 - New Ways of Working in Primary Care CR14 - Developing Local Accountable Care Models CR15 - CCG Staff Capacity Challenges CR16 - Governing Body Leadership	The CCG is working with partners in the City to support the development of an Accountable Care Model for Wolverhampton. This creates a number of significant risks as each organisation needs to balance their own priorities and challenges to deliver systemic change. In particular, there is a risk that relationships between partners may become strained as differing priorities are encountered. There are also significant challenges for CCG staff delivering these changes in addition to their existing responsibilities, particularly as they need to build their understanding of the impact of new models.	No new Strategic Risks Identified. Discussions continue with GP groupings and other stakeholders to shape proposals for an Accountable Care Alliance, including identifying clinical areas of priority. This will form part of broader discussions around Accountable Care systems in the Black Country which continue with NHS England and STP colleagues.	The CCG is working in partnership with the other organisations and is ensuring all work on new models is done collaboratively. Ernst Young have been engaged to support partners in developing proposals and efforts are being made to seek additional support from the wider NHS. Communication lines with staff are prioritised to ensure that all staff are briefed on the trajectory of work and that there are opportunities for questions to be raised to allay any concerns.	Likelihood - 3 Impact - 4 12 High	Likelihood - 2 Impact - 4 8 High	Likelihood - 3 Impact - 4 12 High	↓

Governing Body Assurance Framework

BAF Objectives	Relevant Corporate Risks	Description	Change in risk profile	Key Controls in place	Initial Risk to objective being achieved (Pre-mitigation)	Residual Risk to objective being achieved post mitigation	Previous Rating (November 2017)	Trend
<b>3. System effectiveness delivered within our financial envelope</b>								
<p>a. <u>Proactively drive our contribution to the Black Country STP</u> Play a leading role in the development and delivery of the Black Country STP to support material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country footprint.</p>	<p>CR07 - Failure to meet Overall Financial targets CR08 - New Ways of Working across the STP CR14 - Developing Local Accountable Care Models CR15 - CCG Staff Capacity Challenges CR16 - Governing Body Leadership</p>	<p>As the STP moves from being an integrated planning process to a more defined partnership, a number of risks emerge. In particular, the STP has the capacity to highlight tensions between efforts to develop locally appropriate models of care and strategic commissioning across the Black Country footprint. These tensions create risks associated with the relationships between organisations within the system as well as contributing to the overall risk related to CCG staff capacity in an uncertain environment. The national focus on STP delivery also has the potential to create challenges associated with financial delivery, as there maybe tensions between delivering the CCG's own financial targets and financial metrics and planning across the footprint.</p>	<p>No new Strategic Risks identified. Work continues to focus on local approaches to Accountable Care as part of the Place Based Workstream of the STP. The Black Country Joint Commissioning Committee is also progressing work to start collaborative commissioning across the 4 CCGs with Mental Health and Learning Disabilities identified as potential areas for collaboration. Following feedback from national regulators, partners across the STP are meeting in March to ensure that actions across the STP workstreams are progressing effectively. This will provide greater clarity on overarching work.</p>	<p>The CCG is ensuring that it remains fully engaged with the STP process as it continues to develop. CCG staff contribute to strategic leadership groups and all staff are briefed as part of ongoing internal communication plans. The STP has developed an MOU to which the Governing Body have signed up to ensure that there is clarity about the aims and objectives of the STP and how it links into other ongoing work streams.</p>	<p>Likelihood - 4 Impact - 4 16 Very High</p>	<p>Likelihood - 3 Impact - 4 12 High</p>	<p>Likelihood - 3 Impact - 4 12 High</p>	↔
<p>b. <u>Greater integration of health and social care services across Wolverhampton</u> Work with partners across the City to support the development and delivery of the emerging vision for transformation; including exploring the potential for an 'Accountable Care System.'</p>	<p>CR09 - BCF Programme CR14 - Developing Local Accountable Care Models CR17 - Failure to secure appropriate Estates Infrastructure funding</p>	<p>The CCG recognises that there are a number of risks associated with the Better Care Programme of work which underpins much of the work to integrate health and social care services. In particular the risks associated with the different challenges and priorities faced by the CCG and the Local Authority place some of the delivery of this programme at risk. Some of the risks highlighted above in relation to both developing local care models and the STP, in particular the potential tension between local and Black Country wide ways of working, also impact on the achievement of this objective.</p>	<p>No New Strategic risks identified. Section 75 Agreement and financial plans have been agreed to support delivery of BCF programme. As highlighted above, the discussions around the Accountable Care System are continuing and integration with social care services will be a significant success factor as a clinical strategy based on the new model is developed.</p>	<p>The CCG has a Section 75 agreement in place with the Local Authority which governs the partnership and the Pooled budget for the BCF. The CCG also continues to work collaboratively with partners on the development of new models of care in the system.</p>	<p>Likelihood - 3 Impact - 3 9 High</p>	<p>Likelihood - 2 Impact - 3 6 Moderate</p>	<p>Likelihood - 2 Impact - 3 6 Moderate</p>	↔
<p>c. <u>Continue to meet our Statutory Duties and responsibilities</u> Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework</p>	<p>CR01 - Failure to meet QIPP Targets CR05 - Mass Casualty Planning CR07 - Failure to meet overall Financial Targets CR15 - CCG Staff Capacity Challenges CR16 - Governing Body Leadership CR18 - Long Term Financial Strategy</p>	<p>As highlighted above, the CCG is working in an environment of significant change. This means that there is significant pressure on delivering existing responsibilities within existing staff resources. In particular, a number of key staff who have significant roles to play in meeting CCG commissioning, finance and performance duties are working on STP level work streams in addition to CCG responsibilities. These pressures are also impacting on providers who are facing significant and increasing demand for services which has an impact on their ability to meet statutory duties and targets, particularly when responding to unforeseen events that lead to greater regulatory pressure such as the Grenfell Tower disaster. The CCG also faces significant challenges meeting its financial duties, particularly ensuring that QIPP targets are met and that plans to manage demand within the system work effectively. Underpinning all of the CCG's work to meet these duties is the need for robust strategic and operational leadership and there is a risk that recent and upcoming changes to the make up of the CCG's Governing Body will have an impact on the strategic leadership of the organisation.</p>	<p>Finance and Performance Committee have identified an ongoing risk around the CCG's Long Term Financial Strategy. This recognises that, whilst actions are in place to ensure that the CCG delivers its financial responsibilities this year through use of non-recurrent reserves, the issues identified are potentially recurrent and will require further consideration. Risks around CCG Governing Body Leadership are reducing as new members familiarise themselves with their positions and the risk the delivery of delegated responsibility from NHS England is recommended for closure following the successful transfer of contracting staff. Proposals for delegation of responsibility to the Joint Committee continue to take into account how the CCG will be assured that statutory duties will continue to be delivered in a collaborative commissioning environment.</p>	<p>The CCG has clear accountability mechanisms in place for the delivery of statutory duties and uses robust performance management frameworks to ensure that providers are meeting their statutory responsibilities, particularly those relating to the NHS Constitution. This includes the use of a range of contractual mechanisms when appropriate. Robust plans and processes are in place to assure QIPP delivery, with clear lines of accountability into the Finance and Performance Committee to ensure that any slippages are dealt with promptly and effectively. Governing Body Members are in place and taking up roles within the organisation</p>	<p>Likelihood - 3 Impact - 3 9 High</p>	<p>Likelihood - 2 Impact - 3 6 Moderate</p>	<p>Likelihood - 2 Impact - 3 6 Moderate</p>	↔
<p>d. <u>Deliver improvements in the infrastructure for health and care across Wolverhampton</u> The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.</p>	<p>CR15 - CCG Staff Capacity Challenges CR17 - Failure to secure appropriate estates infrastructure investment</p>	<p>The CCG's programmes of work to improve infrastructure for health and care is heavily reliant on the recruitment and retention of appropriately skilled staff to support improvements in specialist IT systems in partnership with other organisations, this means that the risks associated with staff capacity will have an impact on the delivery of this objective. Plans to make improvements in estates across Wolverhampton are dependent on appropriate funding being available. The complex nature of the funding streams and the profile of the estate itself may put delivery of improvements at risk</p>	<p>No New Strategic risks identified. A number of proposals for investment in Primary Care estates are now progressing and discussions continue with partners on a common estates strategy. A number of successful bids have resulted in funding for the ongoing programme of IM&amp;T development work including development of remote consultation for GP practices and the development of a Shared Care Record with partners in Wolverhampton and the Black Country.</p>	<p>The CCG has a fully established IM&amp;T team in place working to a detailed strategy to support improvements, reporting into other work streams as a key enabler. This is supported by a robust SLA with RWT as our IT supplier to deliver technical services in line with agreed priorities. The CCG is working in partnership both locally and across the STP to ensure that improvements in estates are delivered in a targeted and strategic manner. Work continues to ensure GP practices are fully engaged in the development of plans and priorities.</p>	<p>Likelihood - 3 Impact - 3 9 High</p>	<p>Likelihood - 2 Impact - 3 6 Moderate</p>	<p>Likelihood - 2 Impact - 3 6 Moderate</p>	↔

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Datix Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR01	434	<b>Failure to meet QIPP Targets</b> QIPP Delivery is vital to ensuring that the CCG meets its financial targets. Challenging QIPP targets (including a £2m unallocated QIPP position at the beginning of year) puts the delivery of the CCG's financial targets at risk	Robust QIPP Process is in place, progress is being made towards identifying new schemes to deliver QIPP targets.	12/08/2016	Jan-18	3c - Meeting our Statutory Duties (Delivery of Financial duties)	Finance and Performance	Tony Gallagher	12	High	6	Moderate	↔
CR02	290	<b>Cyber Attacks</b> Cyber attacks on the IT network infrastructure could potentially lead to the loss of confidential data into the public domain if relevant security measures are not in place. There is also serious clinical/financial and operational risks should there be a major failure leaving the organisation unable to function normally. In such an instance, Business Continuity Plans would need to be enacted.	Robust SLA in place with RWT for IT systems Proactive approach to Cyber Security with consequent investment in cyber security approaches CCG EPPR and Business Continuity plans in place to address any issues should they arise	31/01/2014	Oct-17	1a - Monitoring ongoing safety and performance in the system	Executives	Mike Hastings	4	Moderate	4	Moderate	↔
CR03	FP04 - Increased activity at RWT FP11 - Winter Pressures - A&E Performance 475 Demand Management Plan Relationships with Providers Increase in Activity at RWT Provider capacity to demonstrate adherence to statutory duties	<b>NHS Constitutional Targets</b> There is a risk that ongoing pressure in the system will lead to Providers missing statutory NHS Constitutional targets with the associated impact on patient outcomes	CCG Performance Management Framework ensures robust monitoring of Constitutional Targets through meetings with providers, analysis of performance data and rigorous reporting through the Committee structures). Contract Management applied when necessary Whilst providers are not yet meeting all targets, performance is improving on key indicators Assurances are being sought that proposals for increased activity at RWT as a result of changes across the Black Country do not destabilise delivery. Additional pressure during winter is impacting on A&E in particular	28/02/2017	Jan-18	1a - Monitoring ongoing safety and performance in the system	Finance and Performance	Mike Hastings	8	High	6	Moderate	↔

## Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Datix Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR04	469 - Full Delegation Capacity 268 - Loss of Key Finance Staff 337 - Full Delegation 478 - GMS Contract Changes Capacity of NHSE Primary Care Hub	<b>CCG Staff Capacity to deliver new Commissioning Responsibilities</b> The CCG has taken on greater responsibility for commissioning Primary Care from NHS England. The additional work this requires is being met within existing resources which creates risks for delivery of this (and other) programmes of work	Additional Capacity has been created across the virtual Primary Care Team, including dedicated resource in Finance and Contracting. The recent decision to bring the Contracting Team 'In house' from the CSU also enables greater flexibility of resources when required. <b>Update</b> Primary Care Team is now fully staffed, transfer of Contracting team has taken place - <b>Risk Recommended for Closure</b>	31/01/2017	Jan-18	3c - Meeting our Statutory Duties (Delivery of commissioning responsibilities - delegated)	Executives	Steven Marshall	9	High	4	Moderate	↔
CR05	312	<b>Mass Casualty Planning</b> There is a risk that effective plans will not be in place for CCG and other agencies will not be in place	CCG is working in conjunction with other CCGs to ensure that there is regional capacity sharing and resilience. Training has taken place for key staff and a regional EPPR handbook is being developed. <b>Update</b> Public Health staffing resource has reduced. Work continues with Public Health and other partners to ensure key work is prioritised	01/05/2014	Jan-18	3c - Continue to meet statutory duties and responsibilities (Emergency Planning)	Quality and Safety	Mike Hastings	8	High	6	Moderate	↔
CR06	466 453 - Data Sharing 147 - Provider issues 472 - Procuring a Step in Provider 473 - Repeat Dressings	<b>Vocare</b> Ongoing issues with the provider mean that there are concerns about the overall safety and sustainability of the service	Vocare improvement Plan in place supported by local and regional assurance processes. Agreed plans are being worked through at regular Vocare improvement board. <b>Update</b> CQC re-inspection confirmed good progress had been made across most areas however CCG unannounced inspection continued to raise concerns about progress with key actions, particularly in relation to triage.	30/01/2017	Jan-18	1a - Monitoring ongoing safety and performance in the system	Quality and Safety	Sally Roberts	16	Very High	12	High	↔

## Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Datix Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR07	FP01- Tier 4 Obesity Services FP03 - Transforming Care FP05 - Over performance of Acute Contract FP06 - Prescribing Budget FP07 - CHC Budget FP12 - Winter Pressures - Financial Impact	<b>Failure to meet overall financial targets</b> Challenging financial targets mean that there is a risk that the CCG will not meet it's overall financial target.	Strong budget management supported by Finance team includes regular discussions with individual budget holders, Executive oversight and deep dives at least twice a year. Finance involvement in all aspects of CCG business including BCF, Business cases , contract monitoring. Budget Holder development sessions <b>Update</b> Progress in identifying QIPP schemes is reducing gap however schemes identified are mostly non- recurrent. Other non-recurrent resources are being utilised to support overall financial position	14/06/2016	Jan-18	3c Meeting our statutory duties (Meeting Financial duties)	Finance and Performance	Tony Gallagher	12	High	4	Moderate	↓
CR08	495	<b>New Ways of Working across the STP</b> The STP is complex and works across both providers commissioners and local authorities. This requires building new relationships and overcoming organisational barriers . Management capacity to fulfil new roles will be a risk to the CCG as well as the move to new ways of working with partners in a complex system	Relationships across the STP continue to develop, an MOU is being put into place and clear leadership for individual work streams are being identified and put into place. <b>Update</b> Following a review by NHSI, partners across the STP are working collaboratively to ensure leadership and support structures are in place to deliver work plans. A workshop is due to be held in March 2018 to agree next steps	21/06/17	Jan-18	3a - Proactively drive the CCG's Contribution to the Black Country STP	Governing Body	Helen Hibbs	16	Very High	6	Moderate	↔
CR09	489 - Safeguarding Midwife 321 - Provider DBS Check renewals	<b>Safeguarding Compliance</b> There are a number of interlinked issues with the delivery of safeguarding responsibilities across the system that create a risk that the CCG's statutory Duties will not be met	Issue with LAC health checks has now been resolved. Interim arrangements are in place for arrangements for Safeguarding in Midwifery Work continues on DBS checks and staff requiring repeat checks are being identified across the health economy <b>Update</b> Risk around Designated Doctor has now been closed	12/09/17	Jan-18	1a - Monitoring ongoing safety and performance in the system	Quality and Safety	Maxine Danks/ Steven Forsyth	12	High	6	Moderate	↔

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Datix Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR10	CC02 - Community Neighbourhood Teams CC03 - BCF Estates CC04 - Community Equipment Procurement 407 - Discharge to Assess (DIOC) Social Care Staffing Issues Relationship with Local Authority	<b>BCF Programme</b> The Better Care Fund Programme is an ambitious programme of work based on developing much closer integration between NHS and Local Authority Social Care services. There are significant risks associated with the programme not meeting its targets both financially and for patient outcomes	Programmes are being put into place and work continues to ensure that the impact of this work can be measured in an efficient and effective way. <b>Update</b> Section 75 Agreement for 2017/18 has now been signed to reflect agreed financial and risk share plans now in place	12/09/17	Jan-18	3b - Greater Integration of health and Social Care Services across Wolverhampton	Commissioning Committee	Steven Marshall	12	High	9	High	↔
CR11	PC01- Cost of new roles in Primary Care PC02 - Primary Care Retirements	<b>Primary Care Strategy - Workforce Issues</b> There are a number of issues associated with workforce in Primary Care that may create a risk to the delivery of the objectives of the strategy in creating a multiskilled workforce able to deliver care closer to home	Workforce development is a key strand of the Primary Care Strategy and is being robustly monitored. Milestone action plan is being developed to support task and finish group in delivering their programme of work. Additional capacity has been added to the Primary Care Team to support this work stream Work also continues collaboratively with other CCGs across the STP where appropriate. <b>Update</b> Workforce strategy agreed by Governing Body in November 2017 to support clear action plans	12/09/17	Jan-18	2a - Improve and develop Primary Care in Wolverhampton	Governing Body	Steven Marshall	12	High	12	High	↔
CR12	223 - Alliance Contractual Governance 467 - MCP New way of Working 468 - Group Capacity	<b>New Ways of Working in Primary Care</b> There are a number of issues with the developing new approach to working. This potentially puts at risk the benefits for patients and the prospect of system change	Substantive appointments now made in the Primary Care Team to support group working. Milestone plans developed to support the overall delivery of the Primary Care Strategy. Primary Care groups are actively involved in discussions to develop accountable care models in Wolverhampton. <b>Update</b> Groups are progressing with proposals for new service developments, including remote consultation solutions and Home visiting Services as pilot projects		Jan-18	2a - Improve and develop Primary Care in Wolverhampton	Primary Care Commissioning Committee	Steven Marshall	12	High	8	High	↓

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Datix Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR13	492 - Maternity Capacity & Demand	<b>Maternity Services</b> Following the decision to transfer a number of births from Walsall to Royal Wolverhampton Trust there have been consistently high midwife to birth ratios and there is a risk that the level of demand may affect the safety and sustainability of services	Maternity services are being actively monitored and local and regional action plans are being put into place. <b>Update</b> Bookings have reduced however deliveries have increased. Midwifery sickness absence rates are now improving	15/06/17	Jan-18	1a - Monitoring ongoing safety and performance in the system	Quality and Safety	Sally Roberts	12	High	9	High	↓
CR14	Relationship with Local Authority Capacity of Public Health to contribute to strategic change Relationship with local providers Complexity of financial modelling	<b>Developing Local Accountable Care Models</b> The potential complexity of the developing new models locally will mean having to balance competing priorities for different organisations and against other drivers in the system to clearly articulate the rationale for change and the direction of travel. This means that there is a risk that the objectives of improving patient care and delivering financial stability across the system will not be realised	The CCG is working collaboratively with partners in the system to develop plans to ensure that they are produced in an open and constructive way. Ernst Young are supporting the development of clear plans and proposals for discussion. <b>Update</b> Discussions continue with NHS England about support for the emerging model along with detailed discussions with GPs and other stakeholders	12/09/17	Jan-18	2b - Delivering new models of care that support care closer to home	Commissioning Committee	Steven Marshall	16	Very High	12	High	↔
CR15	Workload pressures of STP Workload pressures - Black Country Joint Commissioning Committee Impact of unexpected events on overall workload CSU Capacity	<b>CCG Staff Capacity Challenges</b> The level of change across the system means that existing staff resources are stretched to contribute to change based work streams including Black Country Joint Commissioning, STP and local models of care in addition to existing responsibilities. This creates a risk that gaps will be created as well as the existing risk of recruiting sufficiently skilled staff to fill any vacancies that arise in an uncertain environment.	Open lines of communication are being provided to staff through regular updates from STP and Joint Commissioning Committee meetings and through CCG staff briefings	12/09/17	Jan-18	3c - Meeting our statutory duties and responsibilities	Executives	Helen Hibbs	12	High	9	High	↔

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Datix Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR16		<p><b>Governing Body Leadership</b> The recent changes in the CCG's Governing Body, including changes in the Executive Team and the resignation of the chair have created a risk that it will become more difficult for the Governing Body to provide clear strategic leadership as new individuals familiarise themselves with the CCG and the issues it faces.</p>	<p>CCG Constitution change has been agreed with Member practices and submitted to NHS England Induction plans are being worked through with new Governing Body members and the clinical leadership structure has been developed to ensure that there are opportunities for Governing Body members to understand the CCG and how it functions. <b>Update</b> Governing Body members now taken up roles on committees and other induction measures continue</p>	12/09/17	Jan-18	3c - Meeting our statutory duties and responsibilities	Governing Body	Helen Hibbs	12	High	6	Moderate	↓
CR17	451 - Estates for Community Neighbourhood Teams Primary Care estate improvements	<p><b>Failure to secure appropriate Estates Infrastructure Funding</b> Much of the plans to improve services, particularly in Primary Care, is dependent on securing improvements in the facilities across Wolverhampton. There are a number of possible avenues for funding these improvements but there is a risk that the complex nature of the funding streams and the profile of the estate itself may put delivery of improvements at risk</p>	<p>The CCG is working with partners across the local health economy to develop collaborative and strategic plans for estates developments. GP practices are key partners and the CCG is working with a number of individual practices with identified needs to address these issues in a targeted manner. <b>Update</b> Funding sources have been identified for a number of proposed improvements in GP practices and the CCG continues to work with other partners to identify alternative sources of funding</p>	12/09/17	Jan-18	3d - Deliver improvements in the infrastructure for health and care across Wolverhampton	Primary Care Commissioning Committee	Mike Hastings	8	High	8	High	↔
CR18	FP01- Tier 4 Obesity Services FP03 - Transforming Care FP06 - Prescribing Budget FP07 - CHC Budget	<p><b>Failure to Deliver Long Term Financial Strategy</b> Recurrent Financial pressures across the system may make it difficult to deliver the CCG's financial plans for future years</p>	<p>Proactive approach to identifying QIPP schemes and embedding them in contracts. Work with partners to support alliance working with risk/ gain share. Proactive approach to financial planning to identify potential gaps and develop mitigating actions</p>	30/01/18	NEW	3c - Meeting our statutory duties and responsibilities	Finance and Perform	Tony Gallagher	20	Very High	16	Very High	*

**WOLVERHAMPTON CCG**

Governing Body  
 13<sup>th</sup> February 2018

Agenda item 10

<b>TITLE OF REPORT:</b>	<b>Commissioning Committee – Reporting Period January 2018</b>
<b>AUTHOR(s) OF REPORT:</b>	Dr Manjit Kainth
<b>MANAGEMENT LEAD:</b>	Mr Steven Marshall
<b>PURPOSE OF REPORT:</b>	To provide the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) with an update from the Commissioning Committee in January 2018.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain.
<b>KEY POINTS:</b>	This report is submitted to meet the Committee's constitutional requirement to provide a written summary of the matters considered at each meeting and to escalate any significant issues that need to be brought to the attention of the Governing Body.
<b>RECOMMENDATION:</b>	That the report is noted.
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	[Outline how the report is relevant to the Strategic Aims and objectives in the Board Assurance Framework – See Notes for Further information]
1. Improving the quality and safety of the services we commission	
2. Reducing Health Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	



## 1. BACKGROUND AND CURRENT SITUATION

- 1.1 The purpose of the report is to provide an update from Commissioning Committee to the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) for the period of January 2018.

## 2. MAIN BODY OF REPORT

### 2.1 Social Prescribing Service Commissioning Intentions

The Committee was presented with a proposal to continue the Social Prescribing Service for a further 12 months, from April 2018 to March 2019.

The Social Prescribing Pilot, currently in place, was implemented to improve:

- The quality of life of patients through education and low level support
- Patient satisfaction and experience
- The emotional health and wellbeing of patients
- Isolation
- Promote personalisation, self-care and independence
- Working relationships with other agencies in order to maximise the options available to patients
- Unnecessary hospital admissions and A&E attendances
- Demand on Primary Care by increasing patient's independence and wellbeing.

An extension of the contract would allow a more meaningful evaluation to take place.

The Committee approved the recommendation to continue the Social Prescribing Service for a further 12 months, from April 2018 to March 2019.

**Action – The Committee request that Governing Body note and support the above.**

### 2.2 Commissioning Committee Risk Profile

Corporate Organisational Risks:

CR14 – has reduced from Extreme to High

Committee Level Risks:



CC04 Very High – The rating has increased from High. However, there is an expectation that the risk should reduce once the Local Authority have confirmed the Community Equipment service will continue to be delivered.

CC08 Very High – A new risk has been added to the Committee’s Risk Profile, regarding RITs Capacity, as a result of Winter pressures.

**Action – The Committee request that Governing Body note the above.**

## 2.3 Contracting Update Report

*Royal Wolverhampton NHS Trust*

Main Issues with Activity:

- The overall acute activity position, across all commissioners, is over-performing by £921k which is a significant rise from the reported position of £56k in Month 5.
- Staffordshire CCGs (combined) are over performing by £855k. Outpatient activity is the largest contributor to this
- Non Elective Activity is the largest over performing Point of Delivery
- Cardiology is the largest over performing speciality
- Obstetrics and Urology are both above plan
- A&E has over performed at Month 7 by £543k, equal to 2,081 activities
- The CCG is forecasting an outturn of £1.75m and although the report states that RWT is forecasting a £3.093m year-end over-performance, it was confirmed that their position is now more closely aligned to the £1.75m

Contract Performance:

- RTT Incomplete – There has been a small improvement in performance and the Trust continue to focus on reducing the backlog.
- Diagnostics – Performance has deteriorated in November and the Trust is developing a Business Case for an extra £70k, to increase capacity, which will support the Cancer 62 day target.
- A&E (4 hour target) – The Trust has achieved above 90% throughout the financial year. However, performance for November 2017 dropped to 87.43%. The drop in performance relates to the increased number of A&E attendances in November, 319 more than November 2016.

- Cancer 62 Day Target – RWT predicted, correctly, non-achievement in 31 Day Sub Surgery, 62 Day Screening and 62 Day Wait for First Treatment for November 2017. Mitigating actions are in place and weekly escalation meetings continue.

Performance Sanctions:

- Month 5 (August) - £22, 350
- Month 6 (September) - £26, 000
- Month 7 (October) - £29, 677

Vocare Improvement Board – A summary from the meeting on 15<sup>th</sup> January 2018 was circulated and it was confirmed that improvements are being evidenced. Clinical Governance is in place and triaging is being undertaken in a more collaborative and constructive way.

Sepsis Counting and Coding Charge:

- An analysis of the impact has been completed by the CSU and this has been shared with the Trust as part of a formal challenge.
- A response has been sent back stating that the Trust disagrees with the CSU methodology, but they have not provided their own methodology.
- It is understood that NHS Improvement is due to issue guidance to providers on this issue.
- There is an outstanding letter from the CCG to the Trust. If guidance is not received by the end of January, this letter will be sent.

*Black Country Partnership Foundation Trust (BCPFT)*

Fines / Sanctions:

- A sanction has been issued of £250 for a late STEIS report in November.

Service Development Improvement Plan (SDIP):

- The SDIP requires review for 2018/19

Data Quality Improvement Plan (DQIP):

- Significant improvement is being made with e-discharge and rolling this out Trust wide.
- Issues still exist in relation to IAPT data

Finance – Over Performance:

- An over performance issue exists with regards to Adults / Older Adults inpatient beds
- The Trust has requested additional non-recurrent funding available to elevate the financial pressure on the Trust. However, it was noted that the CCG is not in a position to meet this request.

#### *WMAS Non-Emergency Patient Transport (NEPT)*

Following concerns raised about operational pressures, in December, Dr Helen Hibbs met with Mark Docherty at WMAS.

The outcome of the meeting was that a review of the current contract, concerns, KPI's / reporting should take place to ensure there is a focus on improving the quality of service provided for the patients that use NEPTs.

It was noted that the provider has indicated that they may want to terminate the contract early because of the pressures and financial loss experienced.

A meeting is due to take place on 26<sup>th</sup> January 2018, where the provider will be given the option to put a remedial action plan in place.

The Commissioning Committee Risk Profile will be updated to incorporate the risks associated with this contract.

**Action – The Committee request that Governing Body note the above.**

## 2.4 Procurement Update Report

**The Community Eye Service:** This service is a repeat of the Any Qualified Provider (AQP) procurement which was conducted in 2014. The schemes, included within the contract, have been reviewed by the CCG to ensure specifications reflect national guidelines. The contract was awarded to the Heart of West Midlands Primary Eyecare Ltd, which is the same provider that held the contract previously.

**Thrive in Work – Individual Placement and Support Service:** A procurement process was undertaken, led by Arden and GEM Commissioning Support Unit to select appropriate specialist providers. The contract was awarded to 3 providers across 4 lots. As the programme grant is provided by NHS England, the programme was required to identify a host CCG to receive the grant and provide a conduit of services



in order to run it. Wolverhampton CCG was selected as the host by West Midlands Combined Authority (WMCA).

Pipeline Projects: A number of projects are currently being scoped and are therefore potential procurements for 2018/19.

CSU Procurement Highlight Report: 3.25 units have been used YTD, which leaves 2.25 surplus. The surplus can be carried over into 2018/19.

**Action – The Committee request that Governing Body note the above.**

### 3. RECOMMENDATIONS

- Receive and discuss the report.
- Note the action being taken.

**Name:** Dr Manjit Kainth

**Job Title:** Lead for Commissioning & Contracting

**Date:** 29<sup>th</sup> January 2018

**WOLVERHAMPTON CCG**  
**Governing Body**  
**13 February 2018**

**Agenda item 11**

<b>TITLE OF REPORT:</b>	Executive Summary from Quality and Safety Committee
<b>AUTHOR(s) OF REPORT:</b>	Sukhi Parvez, Quality and Safety Manager/Maxine Danks, Deputy Director of Nursing
<b>MANAGEMENT LEAD:</b>	Sally Roberts Executive Director of Nursing
<b>PURPOSE OF REPORT:</b>	To provide the Governing Body detailed information collected via the clinical quality monitoring framework pertaining to provider services. Including performance against key clinical indicators (reported by exception).
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This report is confidential due to the sensitivity of data and level of detail.
<b>RECOMMENDATION:</b>	Provides assurance on quality and safety of care, and inform the Governing Body as to actions being taken to address areas of concern
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	<ol style="list-style-type: none"> <li>1. Improving the quality and safety of the services we commission</li> <li>2. Reducing Health Inequalities in Wolverhampton</li> </ol>

**Wolverhampton  
Clinical Commissioning Group**

**1. Key areas of concern are highlighted for the Governing Body below:**

	<b>Level 2 RAPS breached escalation to executives and/or contracting/Risk Summit/NHSE escalation</b>		
	<b>Level 2 RAPS in place</b>		
	<b>Level 1 close monitoring</b>		
	<b>Level 1 business as usual</b>		
Key issue	Comments	RAG	Page number in report
Page 148 Urgent Care provider	Vocare CQC Rating is INADEQUATE for the visit took place in March 2017 and a further CQC announced visit took place on 26 <sup>th</sup> October 2017. Vocare is expecting a further CQC visit before the end of this financial year. An unannounced visit by WCCG in Jan,18 highlighted serious concerns.		20
Maternity Performance Issues	The key performance indicators on maternity dashboard were a growing concern which was impacting on the quality and safety of the patients. It was escalated to NHSI, NHSE, LMS and Maternity STP. The provider has capped the maternity activity for the trust and there is slight improvement on the December, 18 maternity dashboard.		13
Non-Emergency patient transport service issues	Mainly there are performance issues with this provider with a potential for its impact on the quality issues. The provider has failed to meet reporting requirements i.e. Serious incidents, KPI's, Quality report etc and the current performance has not been at the levels expected and has recently impacted adversely upon the quality element of the service.		20
Mortality	Raised SHMI/HSMR. Action plan in place, Trust has commissioned independent coding, diagnostic, palliative and case note reviews. Internal practices strengthened. Update from extraordinary MORAG meeting (Nov, 2017) • Early indication from reviews suggests coding for palliative care and people dying in hospital		15

**NHS**  
**Wolverhampton**  
**Clinical Commissioning Group**

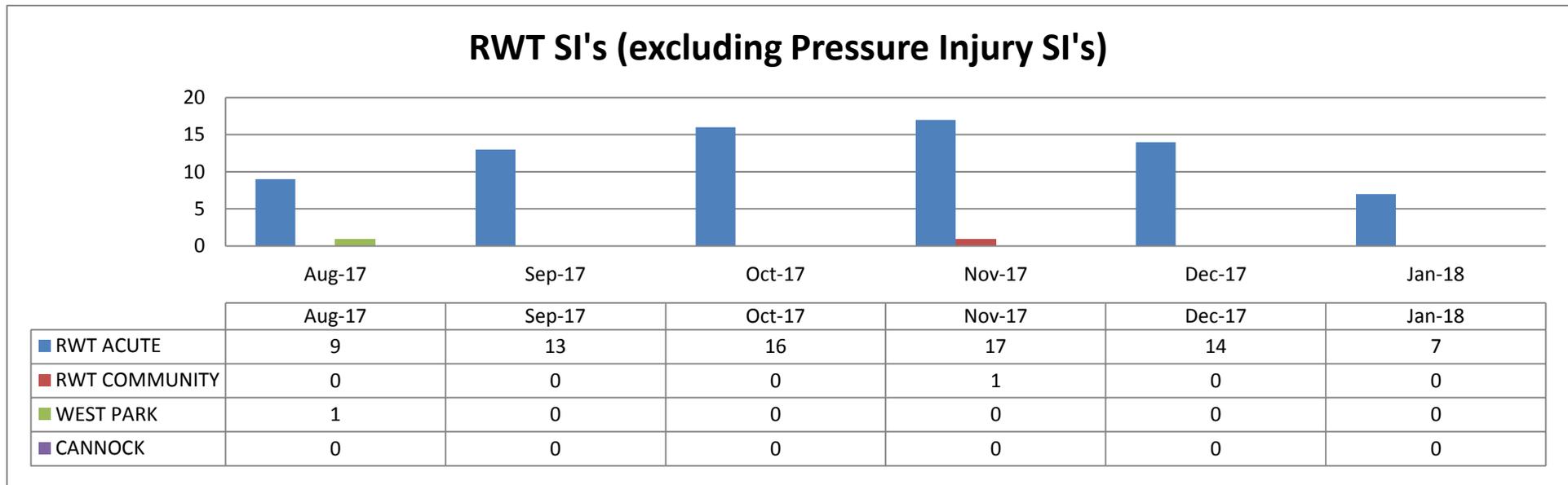
Increased number of NEs 16/17	16/17 total 5. 17/18 ytd total is 6. The QSC chair has asked the trust for a themed report to be presented at the March, 18 CQRM. The WCCG chair has formally raised this increase prevalence of never events issue with RWT chair.		13
Safety, experience and effectiveness	Continuous scrutiny on PIs, SIs, Falls, FFTs, Surveys, NICE, IPC etc. Improvements seen in avoidable pressure injuries, CDiff and falls. There is rise in the number of health care acquired infection and diagnostic delay incidents reported for Nov 2017.		5-13
Improving primary care services	Continuous monitoring of Infection Prevention ratings, Friends and Family Test, Quality Matters, Complaints, Serious Incidents , NICE, and Workforce.		QSC Agenda Item

**2. ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST**

The Governing Body is asked to note the following:

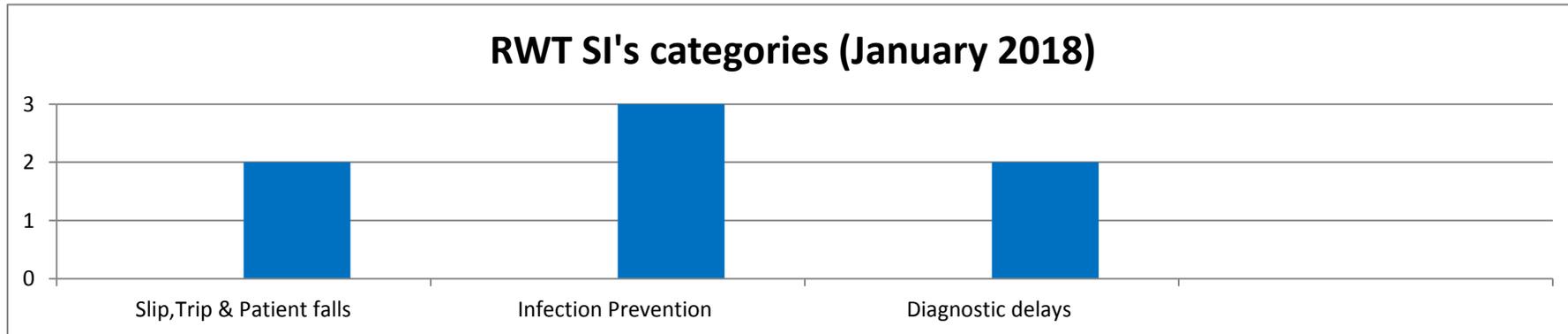
**2a Serious Incidents (excluding pressure injury incidents)**

**Fig.1**



7 Serious Incidents (SI's) were reported by RWT in this reporting period, which is a reduction from the 14 SI's reported for December 2017. A further breakdown of these SI's has been given in the graph overleaf.

**Fig.2**



**Fig.2** above shows 7 SI's reported for 3 serious incident categories (excludes pressure injury SI category) by RWT. Three of the infection prevention SI's reported for this reporting period relates to influenza outbreak (1), MRSA bacteraemia (1) and wound infection (1). The remaining 4 SI's are related to patient falls (2) and Diagnostic delays (2) in Emergency Department.

Every single serious incident is robustly scrutinised by the SISG panel to ensure that WCCG is assured that mitigation actions has been taken by the trust to prevent recurrence of these incident.

**Increase prevalence of Diagnostic & Treatment delay Serious Incidents at RWT Emergency Department**

In November 17 WCCG formally raised SBAR (Situation, Background, Assessment, Recommendation) with the provider due to increase prevalence in number of diagnostic and treatment delay SI's reported by Emergency Department( ED) at RWT. The trust was asked to undertake a deep dive into these SI's and were asked to present their findings for themed discussions at the January, 18 CQRM. The following actions have been undertaken by the trust to mitigate and prevent the reoccurrence of diagnostic and treatment delay SI's in ED:

**Radiology reporting-**

New inbox has been set up where all ED radiology reports are sent with a flagging system in place to review urgent/ suspicious findings.

**Senior Review-**

Senior review process agreed following RCEM guidelines and audited for compliance on a monthly basis.

**Locum Doctors-**

Revised induction pack for all locum doctors sent electronically to all booked locums prior to the shift. The use of ad hoc locums has reduced significantly with the vast majority being locums who have worked in the department for 2/3 years.

**Discharge safety-**

New discharge check list incorporated in ED documentation. Covers the review of Triage notes, ambulance handover, review of x-rays and blood results, portal or previous attendances on MSS the use of the WHO checklist, where appropriate, and has all clinical information been fully completed.

**Fast track referral process-**

Revised process established for fast track referral with Cancer Services and communicated to all staff

**ECG review-**

Agreed that all ECGs must be reviewed by a senior clinician, (audited monthly to ensure compliance).

**Triage process-**

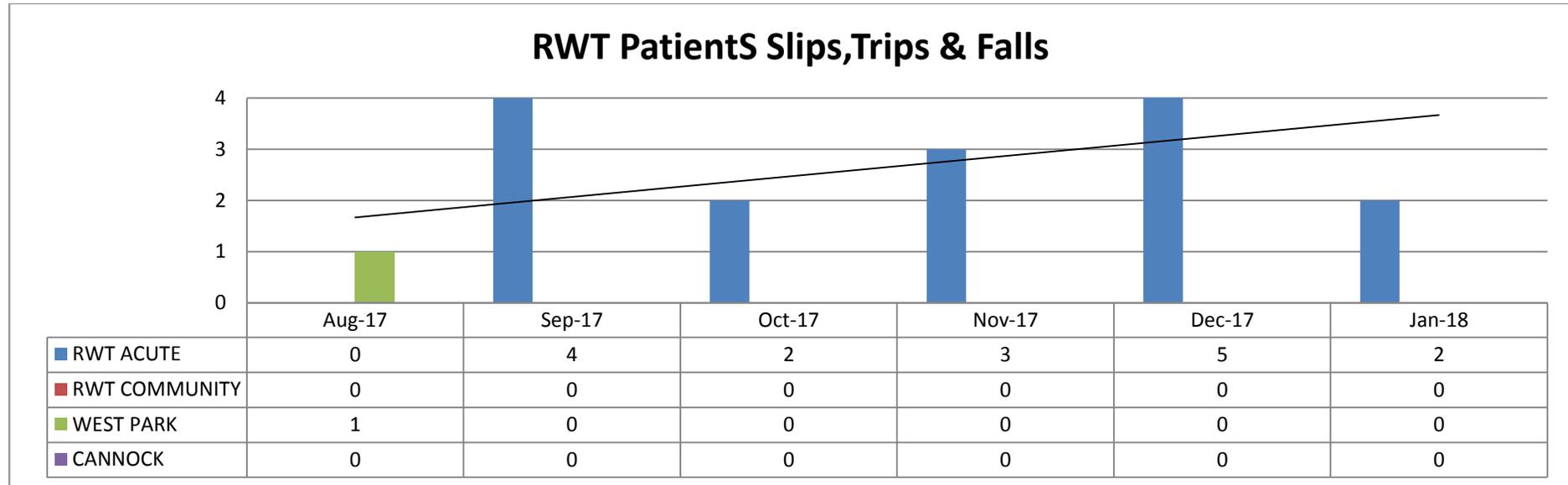
The triage process has been reviewed, and although it is not possible to amend the Manchester Triage model a nationally recognised tool, we have now advised all nurses to also consider urine output and alert clinicians to any patients who have not passed urine.

**Sharing of incident**

- Incidents and RCA are shared at the departmental governance meeting and with the individuals concerned.
- All RCAs are discussed as part of junior doctors teaching and a section of the department newsletter is dedicated to sharing RCAs.
- Nursing staff share any relevant RCAs at the departmental Nursing professional forum, and any issues identified for learning or change in practice are incorporated into junior doctor's induction at change over, Governance department now lead discussion at induction regarding serious untoward incidents,.
- There are notice boards in the first floor UECC corridor where we display items of interest, performance, complaints and complements and learning form incidents on a monthly basis.
- An ED doctors 'What's App' group has also been established for information sharing.

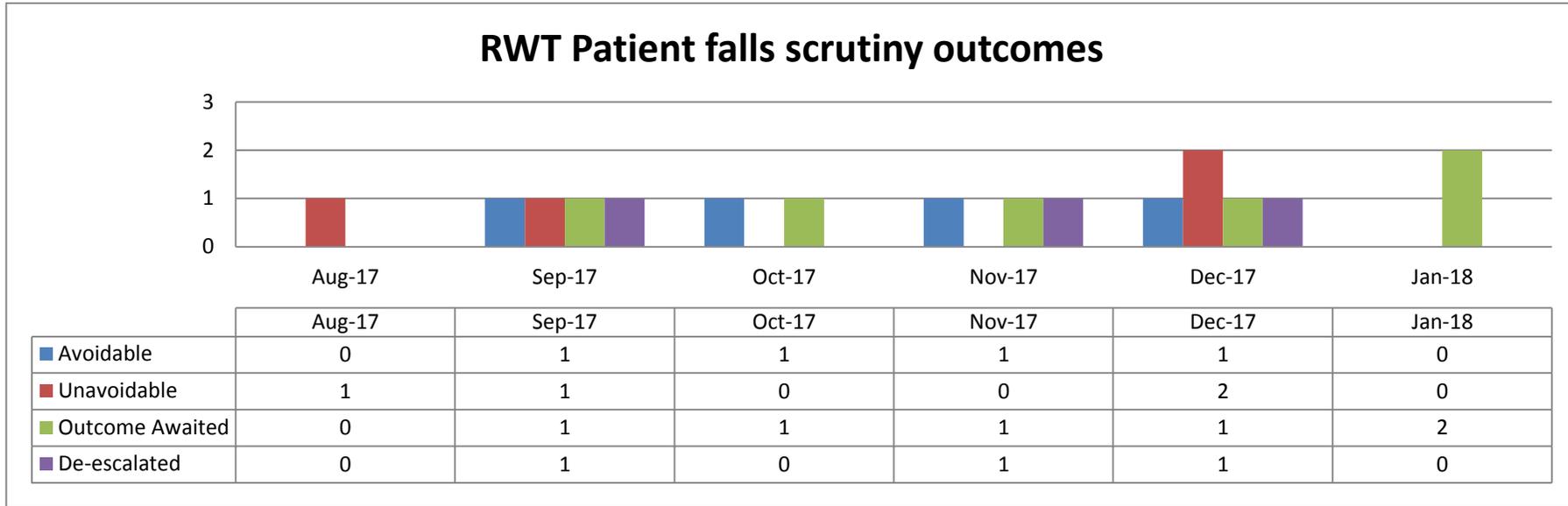
**Slip Trip and Patient Falls SI's (RWT)**

**Fig.3**



**Slip, Trip and fall's SI's:** There were 2 patient fall SI's reported for this reporting period and this is a reduction compared to 5 patient falls reported in November 2017. All patient fall SI's are discussed at the provider weekly scrutiny meeting and this meeting is regularly attended by the WCCG quality and safety manager.

Fig.4



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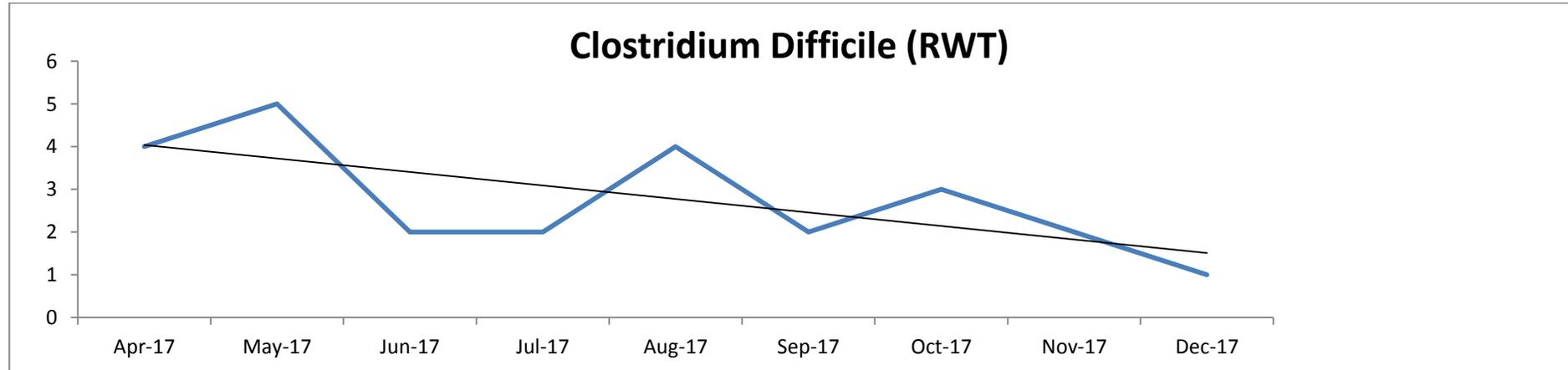
Fig.4 shows that there is a reduction in the number of avoidable patient falls for Q3.

Trust actions: Following roll out of the national falls collaborative report there is going to be a re-assessment of the early pilot wards and sustainability of actions implemented.

**Infection Prevention**

**Clostridium difficile**

**Fig.5**



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1 CDiff case was reported for December 2017 against a target of 3 for the month. The provider is currently 2 cases ahead of target at the end of month 9.

Trust actions: Sustainability actions continue from last year. Antimicrobial prescribing audits are being completed in most areas.

**CPE (Carbapenemase Producing Enterobacteriaceae)**

**Fig.6**

<b>Breakdown of CPE</b>	<b>Total</b>
2012/2013	2
2013/2014	8
2014/2015	8
2015/2016	12
2016/2017	18
2017/2018 to date (Nov)	26

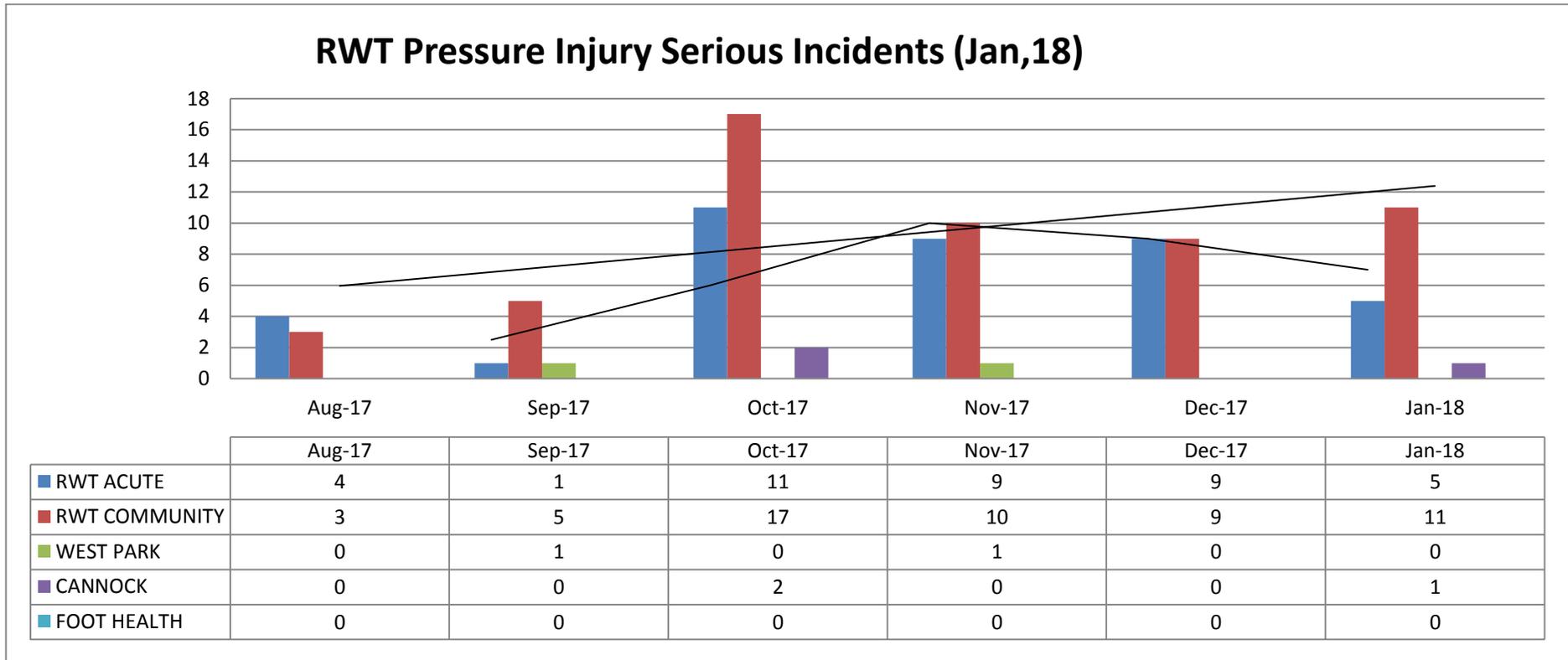
There were no new cases confirmed during December.

Trust actions: The new isolation matrix has been communicated. No cases were detected in December, 17; this is most likely natural variance rather than plan.

**MRSA Bacteraemia**

One case during the month, the trust is currently undertaking RCA into the case to fully understand and share learning across the organisation. RWT's target for the year is zero avoidable cases; however, they are currently 2 cases above their target at the end of month

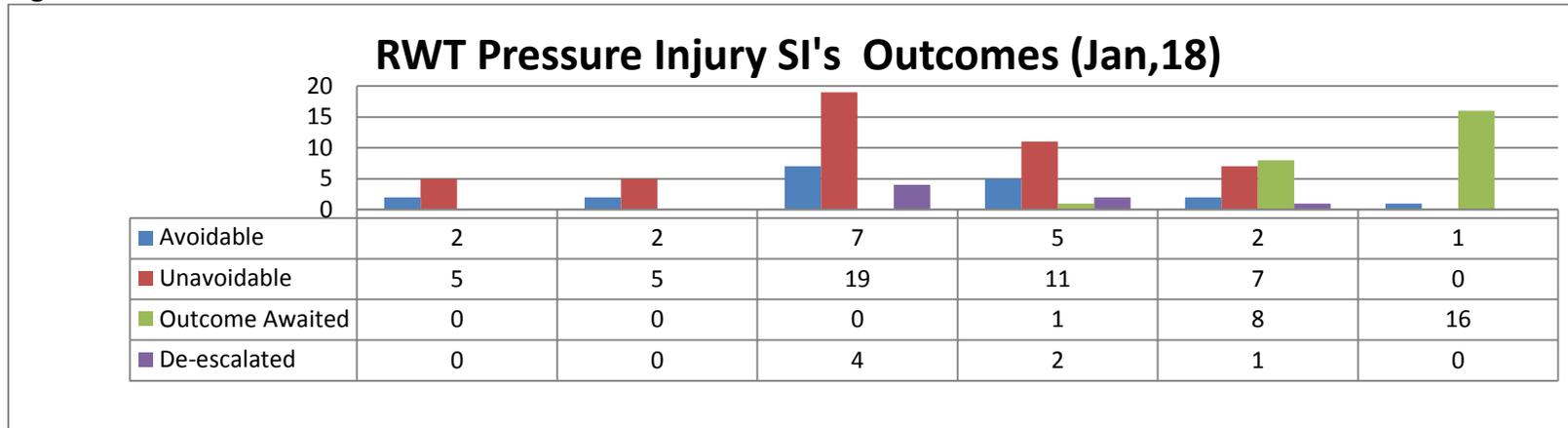
Fig.7



17 pressure injury (PI) incidents were reported for this reporting period, which is a slight reduction compared to 18 PI serious incidents reported for December 17.

3 of these serious incidents have been reported at Stage 4 PI and 14 PI SI's have been reported for Stage 3. The Q&S manager attends the weekly pressure injury scrutiny meetings. The individual pressure injury incidents are discussed in detail to deem if they were avoidable, seek assurance through current pressure injury management practices and to seek trust mitigation plans to prevent and manage these pressure injury serious incidents.

Fig.8



There has been a reduction in the number of avoidable pressure injuries and this is supported with the work of the national collaborative.

Trust actions:

- Scale up the pressure injury collaborative work to other areas and monitor the effects of changes relevant to their areas. Clinical Haematology ward has been nominated and analysis of their data and patient journey will start.
- Meet with the CCG regarding the Toto business case and night service plans.
- TV team to develop a newsletter to share lessons learnt.
- To report on the new accountability meeting benefits and challenges to the Chief Nurse, survey monkey has been completed and the report will be produced.
- All staff to continue to follow the minimum expected standards for pressure injury prevention.
- Communicate pressure injury collaborative quality improvements to the Professional Nurse Forum.

**RWT Never Events**

**Fig.9**

<b>Dec,16</b>	<b>1</b>	Retained foreign object post-procedure
<b>Mar,17</b>	<b>1</b>	Wrong implant/prosthesis
<b>Apr,17</b>	<b>1</b>	Retained foreign object post-procedure
<b>July,17</b>	<b>1</b>	Wrong site surgery
<b>Aug,17</b>	<b>1</b>	Wrong site surgery
<b>Oct,17</b>	<b>1</b>	Retained foreign object post-procedure
<b>Nov,17</b>	<b>2</b>	Wrong site surgery

No never event has been reported for this reporting period. However, the trust has reported 6 never events year to date. The WCCG quality and safety lead raised this with the provider at the last CQRM and the provider has been asked to provide a themed report for these never events at the February 18 CQRM meeting.

WCCG execs, NHSE and CQC have been made aware of the increase in the number of never events reported by the provider. The provider is currently undertaking full root cause analysis into these never events to identify learning which should mitigate reoccurrence.

The WCCG chair has escalated the never event prevalence concern with RWT chair. WCCG is in currently in process of arranging a meeting with RWT and the Governing Body will be briefed once this meeting has taken place.

**Maternity**

No maternity SI have been reported for this reporting period. The trust has highlighted that the numbers of bookings for December 2017 had gone down to 452 with zero outlier booking. The maternity dashboard highlights the following:

**Maternity dashboard update**

**Unexpected Term Admissions to NNU requiring level 3 care**

1 - Awaiting discussion through Governance.

**Caesarean Section Rates**

Elective rate 9.9% - within national target

Emergency rate 16.1%

**Midwife to Birth Ratio**

Midwife to birth ratio 1:31. Midwifery recruitment is underway for minimum vacancy. Birth rate + formal assessment of service is being supported and will commence 12th January 2018.

**Women booked by the service by 12 weeks and 6 days gestation:**

Booking by gestation 12+6 = 92.8%, this remains above the National target of 90%.

**Midwife Vacancies**

0.3%

**Actions taken by CCG:**

- Monthly discussion at CQRMs for assurance on actions i.e. recruitment plans, HR activity to address sickness, supervision and support for new staff.
- Current escalated Maternity commissioner meetings with RWT.
- Escalation to NHSE and NHSI

- Escalation meetings with RWT to discuss options and plans on maintaining safety. The Trust is providing assurance via adverse incident reviews, sickness, and recruitment activity.
- RWT and CCG entry on risk register.

### **Mortality**

The current published SHMI April 2016 to March 2017 for the trust is 1.15 (benchmark = 1, higher than expected) and the estimated SHMI (Healthcare Evaluation Data) August 2016 to July 2017 - 115 (benchmark 100, higher than expected) is indicating deterioration in their position. The trust has undertaken following actions to date to respond to the increased SMRs:

- Actions were agreed to investigate data variation and provide assurance in relation to clinical care and robustness of directorate mortality reviews
- External clinical review – completed, findings were shared with directorates. Clinicians to look at the recommendations and stage 2 reviews to be scheduled for the cases identified by the review
- External review of Pneumonia pathway – completed, awaiting final report
- External coding review – completed
- External data review – completed
- Internal work on data variation, review of processes, improvement of documentation and coding – in various stages of completion
- Responding to the CQC alert for Pneumonia mortality; internal audit completed

#### **External data review**

- The auditors highlighted that the Trust's actual mortality rate has not increased and it is in the lower quartile nationally.
- The reason behind increased SMRs is the lower expected death rate for the Trust, which is impacted on by data variation.
- The report highlights the palliative care coding rate being lower than the national average, which would contribute to the increase in HSMR by approximately 7-8 points.
- The decrease in ordinary admissions and changes in patient case mix and/ or coding are mentioned as other potential explanations for the raised SMRs. The auditors estimated that for every 1000 extra emergency admissions the SHMI would decrease by approximately 0.7 points.
- The report also mentions the rate of admissions coded with signs and symptoms as primary diagnosis, which would contribute to a lower expected death rate. It is recommended that this area is further explored to ensure robust procedures and adherence to best practice in coding.

**External coding review**

- A review of coding for a sample of 200 emergency admissions was undertaken by an external auditing company. The report was presented and discussed at the mortality committees. The findings of the audit were generally positive and recommendations were made in order to further improve the quality of data.

**National Guidance on Learning from Deaths**

- SJR (structured judgement review) methodology for reviewing care received by deceased patients rolled out in all specialties.
- 62% of deceased cases (April – October 2017) had an initial review within the directorate
- Working group set up to take forward the implementation of stage 2 reviews

**Items to Note from CQR Meeting – December 2017**

**Cancer Waiting Times/Cancer Target Compliance**

Site	Total Patients	Breaches	%
Breast	10	1	90.00%
Colorectal	5.5	3.5	36.36%
Gynaecology	12.5	6	52.00%
Haematology	2	0	100.00%
Head & Neck	0.5	0.5	0.00%
Lung	4.5	0.5	88.89%
Other	0	0	
Sarcoma	2	1	50.00%
Skin	16	0	100.00%
Upper GI	8	5	37.50%
Urology	21.5	4.5	79.07%
<b>Total</b>	<b>82.5</b>	<b>22</b>	<b>73.33%</b>

**31 Day Sub Surgery** - 7 patient breaches in month - all capacity issues.

**62 Day Traditional** - 26 patient breaches in month - 8 x Tertiary referrals received between days 32 and 83 of the patients pathway (operating guidelines state referrals should be made within 42 days), 7 x Capacity Issues, 5 x Patient Initiated, 2 x Further Investigations and 4 x Complex Pathways.

Of the tertiary referrals received 2 (25%) were received before day 42 of the pathway, and 2 (25%) were received after day 62 of the patient pathway.

**62 Day Screening** - 4 patient breaches in month - 2 x capacity issues and 2 x complex pathways.

**Patients over 104 days** - There are currently 15 patients at 104+ days on the cancer waiting list (compared with 15 reported in November), all of these patients have had a harm review and no harm has been identified.

**Wolverhampton  
Clinical Commissioning Group**

**Total Time Spent in Emergency Department (4 hours)**

	Target	Q2 2017/18				Q3 2017/18			Q3 2017/18
		Jul-17	Aug-17	Sep-17		Oct-17	Nov-17	Dec-17	
New Cross	95%	90.57%	88.18%	86.44%		86.88%	80.54%	78.41%	82.05%
Walk in Centre		100.00%	100.00%	100.00%		100.00%	100.00%	99.40%	99.80%
Cannock MIU		100.00%	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%
Vocare		95.94%	95.02%	96.22%		94.76%	92.12%	94.67%	93.90%
Combined		93.76%	92.09%	91.42%		91.55%	87.43%	87.03%	88.70%

**Ambulance Handover**

**Comments:** The fine for Ambulances during December was £45,400,00. This is based on 122 patients between 30-60 minutes @ £200 per patient and 21 patients >60 minutes @ £1,000 per patient. There was one patient who breached the 12 hour decision to admit target during December 2017, this was a child waiting for a PICU bed.

	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Number between 30-60 mins	0	33	69	54	27	48	70	46	99	122	
Number over 60 minutes	0	1	2	5	0	5	2	1	9	21	

Month 6 Quality Dashboard

Please refer to **Appendix 1** for Month 9 RWT SQPR.

**Safeguarding Adult & Children Mandatory Training Compliance**

Safeguarding Adult - Mandatory Training Compliance												
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Level 3	80.0%	80.0%	86.7%	93.3%	93.3%	93.3%	92.9%	92.9%	92.9%			

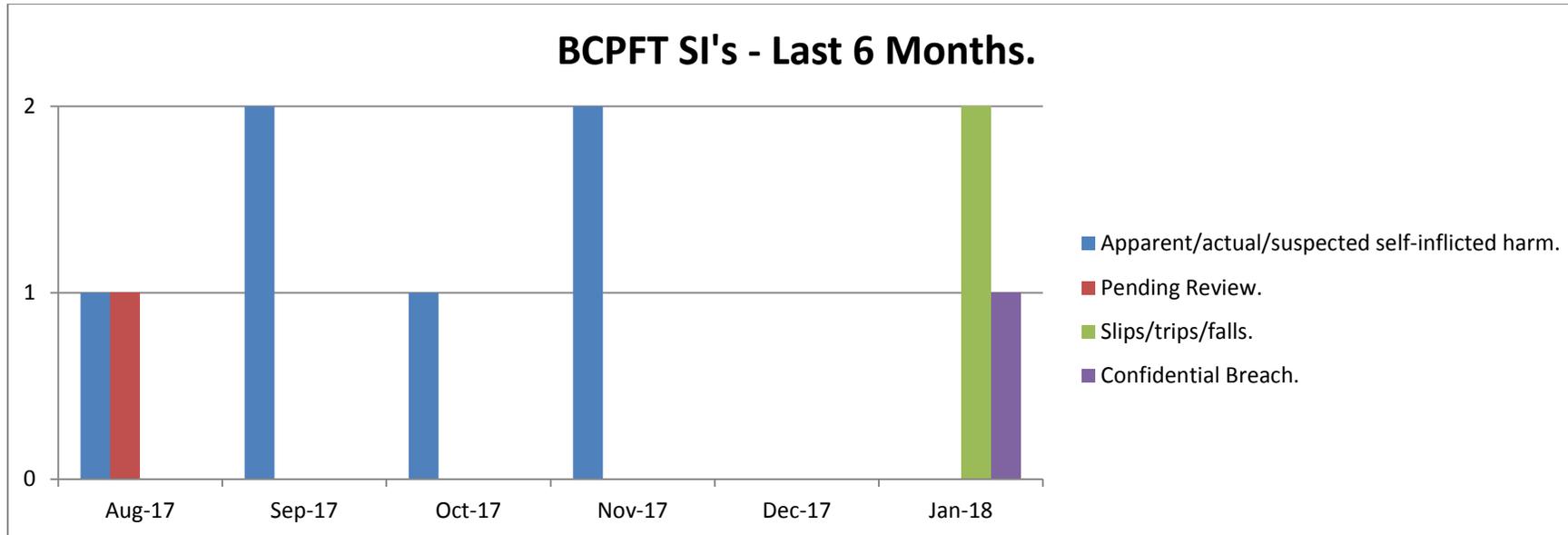
Safeguarding Children - Mandatory Training Compliance												
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Level 3	84.3%	87.3%	85.3%	87.7%	86.4%	83.9%	80.2%	82.4%	83.7%			

The provider is contractually compliant with achieving adult and children training compliance above 80% but they are struggling to achieve their internally set target compliance of 95% in both elements. The provider is taking required actions to meet their internal compliance and WCCG are monitoring their compliance through monthly CQRM's.

**3. BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST**

The Committee is asked to note the following:

**a) Serious Incidents**



There were 3 serious incidents (SI) reported by Black Country Partnership Foundation Trust for this reporting period compared to no SI reported for December 2017. 2 of these SI were reported for patient falls and once SI relates to confidential breach. The trust is currently undertaking full investigation into these SI.

A pressure injury serious incident for BCPFT still remains open on STEIS as WCCG disagree that this pressure injury was unavoidable as deemed by the provider. Please note that this incident remains open on STEIS since May 2016. The QSC chair has formally raised this issue with the provider and we are currently waiting for a response form the provider.

Items to note from CQRM held on the 9<sup>th</sup> January 2018 (theme: Learning Disabilities)

The number of incidents in October 2017 had increased from the previous month. These continue to be predominantly violence and aggression from patients towards staff.

There were 8 reported deaths, which were all clients known to services but occurred in either community settings or general hospitals. These were the only moderate harm or above incidents reported.

There were 7 prone restraints during October.

The Lead Nurse would be looking further into prone restraints, and will discuss these further with Band 6's during their development day.

There were no RIDDOR reportable incidents

There were 2 complaints and 3 concerns during October as detailed in the report. There were 9 compliments received.

The divisional audit programme and quality improvement priority is on track and making good progress. CQUIN quarterly reports have been submitted for the 3 CQUINS.

Sickness absence has shown a decrease. Turnover rates have increased. Appraisal compliance is good at 95.89%. Mandatory training has improved. The bank use has decreased as has agency spend.

The Learning Disability Division is continuing to work with Black Country Commissioners to agree a new TCP model.

Work has commenced in relation to TCT LD Clinical Work streams including, Transition Pathway and Physical Health.

#### **4. PRIVATE SECTOR PROVIDERS**

##### **Vocare**

There were no serious incident reported by Vocare for this reporting period. The CCG and Vocare have agreed a set of priority actions that must be delivered within the agreed timeframe. Progress has been made in this area although performance has not improved to the standards required as key actions require a period of time to embed into daily practice and realise the benefits over the longer term. Governing body agreed to extend the

  
**Wolverhampton**  
**Clinical Commissioning Group**

enhanced scrutiny until 1 February. Several performance issues are being addressed through Contract Performance Notices (CPN), and an Information Breach Notice.

The Vocare Improvement Board will continue to meet until sufficient progress has been made. NHSE Quality and Surveillance Group have agreed to stand down the NHSE Quality Surveillance Vocare meetings, with ongoing scrutiny/monitoring by NHSE taking place at the routine Quality Surveillance Group each month. This is likely to change following the visit detailed below

An unannounced visit to Vocare by WCCG took place on 29.01.2018 and there were number of serious concerns identified during the visit. The key concerns have been escalated to the Vocare senior management and they are currently undertaking full investigation into these concerns. The key concerns are listed as following:

- Unsafe staffing levels
- Escalation
- No clinical ownership/oversight of the service:
- Triage
- Information at reception
- Identification of Immediate Life Threatening conditions:
- Using the clinical system to escalate patient concerns
- Booked via 111

The provider was asked to provide clarity and assurance to WCCG for the priority actions relating to the above

WCCG actions:

- Escalated to WCCG chief officer and executive team
- Escalated to NHSE by WCCG chief officer
- Escalated to CQC
- Raise the key issues with provider at the CRM/CQRM
- Arrange further follow up visit

**NEPTS (Non-emergency Patient Transport Services) - WMAS**

An Information Breach Notice (IBN) was served to the provider in November 2017 in relation to the standard of Quality Report, Minimum Data Set and the Remedial Action Plan (RAP), the latter element being in support of a previous Contract Performance Notice issued in relation to the underperformance of key performance indicators (KPIs).

The Trust failed to respond to the IBN within the contractually required 5 operational days, therefore the Commissioners are currently withholding 1% of the monthly contract value until the Provider has satisfactorily rectified the relevant IBN. CQRM took place on 26th January and an open discussion took place between Provider and Commissioners as to the difficulties that were being experienced in achieving the KPIs due to the operational pressures being faced by the Trust and the potential risk of the Trust to serve notice on the contract. It was agreed that the Trust will review the KPIs with the aim of prioritising those that have the greatest impact on the quality of care and patient experience, they will present their proposal to the Commissioners by the 16th February for consideration and discussion at the next CQRM on the 23rd February.

**Probert Court**

The Probert court suspension has been lifted now with the caveat that Accord need to manage admissions based on risk stratification: staffing and patient complexity. Probert has actively recruited to the vacant posts and currently there are only two outstanding vacancies for staff nurses to which they are planning to recruit. All actions from the Probert Improvement Board meetings have been achieved therefore the board has been disbanded. WCCG will be closely monitoring the provider through monthly quality visits and monthly CQRM'S.

**Compton Hospice**

No Serious incident was reported for this reporting period. However, Compton has reported an unfortunate significant incident where a community CNS was hit by another car while she was on her way to undertake home visits. As she got out from her car to see the damage; she was threatened with a knife and her car was then stolen. There was a prescription pad and some information relating to two patients was left in the car as the nurse was on her way to complete the home visits. This incident has been appropriately reported to the relevant agencies.

**5. CHILDREN'S SAFEGUARDING**

Changes to Statutory guidance: Working Together to Safeguarding Children; and new regulations are currently out for government consultation. The WCCG Designated professionals attended a WSCB half day development day to participate in discussions to formulate a joint response.

The post of Deputy Designated Nurse has been filled with the successful candidate commenced on 3.1.2018

## **5.1 LAC Update**

Interviews took place at RWT for the Named Nurse Looked After Children (LAC) post. Both the designated nurse LAC (DNLAC) and Doctor LAC sat on the panel. Three care-leavers also formed a young person's panel. The post was offered and accepted the same day, with the successful candidate due to commence in post April 2018.

Concerns around the waiting times for LAC CAMHS are being addressed through the service re-design, and the CAMHS transformational plan. In addition CAMHS dashboard and indicators for 2018/2019 have been reviewed, with proposed amendments being discussed with BCPFT commissioning colleagues in February.

DNLAC chaired the 2<sup>nd</sup> CP-IS child protection information system (CP-IS) in January. It is anticipated that the system will go live within the Emergency Dept at RWT in April 2018 with a trial period of 3 months. The local authority are not anticipating that they will go live until May 2018, slightly later than anticipated. Next meeting to be held by the WCCG in February

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## **6. ADULT SAFEGUARDING**

### **6.1 Care Homes**

The SPACE programme continues to deliver quality improvement training, promoting falls training and the implementation of safety crosses and PDSA cycles with 18 homes continuing to be fully engaged. Care homes were recognised for their achievements in quality and safety improvements at an awards event during November 2017 receiving awards for most improved home

### **6.2 Adult Safeguarding**

A Lessons Learned briefing has been completed and shared with the NHSE Safeguarding Forum, following a Care Home Serious Incident which involved concerns regarding an increased number of deaths following an Influenza outbreak



## Wolverhampton Clinical Commissioning Group

The NHSE funded Violence Against Women and Girls project, hosted by the Refugee and Migrant Centre is on track. An update has been provided to Joanne Harrison, NHSE Regional Head of Safeguarding. A poster has been produced by the Designated Adult Safeguarding Lead, this will be presented at the NHSE 'Leading Change Adding Value' Conference in February 2018

A Team W presentation was carried out to Wolverhampton GP's in January 2018 to raise awareness of the GP Domestic Violence Training and Support Project which is due to be launched in February 2018. This is a joint collaborative project with WCCG, the Safer Wolverhampton Partnership and the Wolverhampton Domestic Violence Forum

The Designated Adult Safeguarding Lead has been assigned a LeDeR review to complete. As per the LeDeR guidance, this review triggers a Priority Themed/Multi Agency Review

The WSAB Safeguarding Adult Review Committee has commenced a Learning Review in January 2018

### 7. USER AND CARER EXPERIENCE

#### 7.1 New formal complaints



In December 2017 there were no new formal complaints registered by the CCG. The CCG also closed the only remaining open complaint that was registered in November 2017.

The CCG has also registered 6 concerns or complaints for other commissioned providers where the complainant has contacted the CCG in the first instance, in all 6 concerns or complaints, the complainant has been given the appropriate details of the provider for the provider to investigate in the first instance, or where consent was supplied, the CCG have forwarded the complaint / concern onto the provider responsible. The CCG received 1 concern that was not provider related that was resolved without the need for formal complaint escalation.

**8. HEALTH AND SAFETY**

STK have been contacted to conduct a Health and Safety Risk Management Audit and present report findings to the CCG in February/March 2018 in line with the Health and Safety Management plan.

Health & Wellbeing Programme of Work – currently discussed on agenda at Staff Forum. Head of Quality and Risk is current Health & Wellbeing Lead. It is advised that a new Health & Wellbeing Lead will need to be appointed as the current lead is due to leave the organisation in February 2018.

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**BOARD ASSURANCE FRAMEWORK/RISK REGISTER**

**a) Number/Breakdown of Risks on Datix:**

1 <sup>st</sup> November 2017	TOTAL
Open Risks	49
Extreme	6
High	22
Moderate	20
Low	1

**10. RECOMMENDATIONS**

  
**Wolverhampton**  
**Clinical Commissioning Group**

The Governing Body is requested to:

- **Receive** and **note** the information provided in this report.
- **Discuss** any aspects of concern and **agree** on action to be taken.

**Name:** Sukhdip Parvez/ Maxine Danks

**Job Title:** Quality & Patient Safety Manager/Deputy Director of Nursing

**Date:** 02.02.18

**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**

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	Details/Name	Date
Clinical View	X	01.02.18
Public/ Patient View	X	01.02.18
Finance Implications discussed with Finance Team	X	01.02.18
Quality Implications discussed with Quality and Risk Team	<b>M Boyce/ S Parvez</b>	01.02.18
Equality Implications discussed with CSU Equality and Inclusion Service	X	01.02.18
Information Governance implications discussed with IG Support Officer	X	01.02.18
Legal/ Policy implications discussed with Corporate Operations Manager	X	01.02.18
Other Implications (Medicines management, estates, HR, IM&T etc.)	X	01.02.18
Any relevant data requirements discussed with CSU Business Intelligence	X	01.02.18
<b>Signed off by Report Owner (Must be completed)</b>	<b>M Danks</b>	<b>01.02.18</b>

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**WOLVERHAMPTON CCG**

**GOVERNING BODY**

**Agenda item 12**

<b>Title of Report:</b>	<b>Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee - 30<sup>th</sup> January 2018</b>
<b>Report of:</b>	Tony Gallagher – Chief Finance Officer
<b>Contact:</b>	Tony Gallagher – Chief Finance Officer
<b>Governing Body Action Required:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>Purpose of Report:</b>	To provide an update of the WCCG Finance and Performance Committee to the Governing Body of the WCCG.
<b>Recommendations:</b>	<ul style="list-style-type: none"> <li>• <b>Receive</b> and <b>note</b> the information provided in this report.</li> </ul>
<b>Public or Private:</b>	This Report is intended for the public domain.
<b>Relevance to CCG Priority:</b>	The organisation has a number of finance and performance related statutory obligations including delivery of a robust financial position and adherence with NHS

	Constitutional Standards.
<b>Relevance to Board Assurance Framework (BAF):</b>	
<ul style="list-style-type: none"> <li>• <b>Domain 1:</b> A Well Led Organisation</li> </ul>	The CCG must secure the range of skills and capabilities it requires to deliver all of its Commissioning functions, using support functions effectively, and getting the best value for money; and has effective systems in place to ensure compliance with its statutory functions, meet a number of constitutional, national and locally set performance targets.
<ul style="list-style-type: none"> <li>• <b>Domain2:</b> Performance – delivery of commitments and improved outcomes</li> </ul>	The CCG must meet a number of constitutional, national and locally set performance targets.
<ul style="list-style-type: none"> <li>• <b>Domain 3:</b> Financial Management</li> </ul>	The CCG aims to generate financial stability in its position, managing budgets and expenditure to commission high quality, value for money services. The CCG must produce a medium to long term plan that allows it to meet its objectives in the future.

## 1. FINANCE POSITION

The Committee was asked to note the following year to date position against key financial performance indicators;

Financial Targets				
Statutory Duties	Target	FOT	Variance o(u)	RAG
Expenditure not to exceed income	£9.130m surplus	£9.130m surplus	Nil	G
Capital Resource not exceeded	nil	nil	Nil	G
Revenue Resource not exceeded	£404.034m	£404.034m	Nil	G
Revenue Administration Resource not exceeded	£5.535m	£5.342m	(£0.19m)	G

Non Statuory Duties	YTD Target	YTD Actual	Variance o(u)	RAG
Maximum closing cash balance £'000	351	209	(142)	G
Maximum closing cash balance %	1.25%	0.74%	-0.51%	G
BPPC NHS by No. Invoices (cum)	95%	100%	-5%	G
BPPC non NHS by No. Invoices (cum)	95%	97%	-2%	G
QIPP	£7.96m	£7.85m	£0.11m	A
Programme Cost £'000*	288,986	290,714	1,729	G
Reserves £'000*	1,602	0	(1,602)	G
Running Cost £'000*	4,151	4,004	(147)	G

- The net effect of the three identified lines (\*) is a small underspend of £20k.
- The CCG is anticipating meeting all its statutory duties in 2017/18 and in doing so has utilised all its reserves.
- Following a review of the financial position at M9 the level of risks has been adjusted to reflect those risks now incorporated into the FOT and the CCG is maintaining a nil net risk as mitigations match identified risks, (section 7).
- Programme Costs are forecast to overspend which is partially compensated for by under-spends on Running Costs.
- The financial position has been scrutinised in M9 and following the adoption of a series of assumptions informed by Budget Managers the recurrent overspend has reduced to £381k FOT which is currently offset by non-recurrent under-spends and the use of reserves. This has very serious implications for 18/19 onwards most importantly the level of QIPP will have to increase, (section 3).
- The key cause for the improving recurrent position is the movement of NCSO pressures to non recurrent as per NHSE guidance.
- The Main areas of deterioration can be identified as comprising Mental Health and Acute including NCAs.
- Royal Wolverhampton Trust (RWT) is giving concern as the M8 activity is indicating a potential forecast out turn (FOT) of c £2.5m.
- Other Providers such as Dudley Group are also over performing which appears to be linked to new HRGs and Specialist activity now in the CCG portfolio and the financial impact appears to have worsened after a period of stability in M8,
- Mental Health Complex cases are continuing to over perform. Assurances have been given by the MH Commissioner that spend will reduce and fall back in line with budget as cases are reviewed and costs reduced. This is now unlikely to occur thus increasing the pressure on budgets.
- Within Delegated Primary Care there is some flexibility to utilise in bringing forward plans and commit recurrent spend.
- Expenditure on GP prescribing has stabilised. The CCG continues to incorporate into the financial position the worst case position for NCSO drugs. NHSE have advised CCGs that pressures emanating from NCSO should be treated as non-recurrent. This has been reflected in the overall reporting.
- CHC/FNC continues to report an overall forecast under-spend but this has reduced again in month 9.

- No additional QIPP has been identified in M9. The CCG is reporting achieving its QIPP target as shortfall is being covered by reserves and other under-spends. However, actual achievement of reduced activity levels associated with QIPP schemes are not materialising, and are manifesting themselves in overspends, largely within the Acute portfolio.

The table below highlights year to date performance as reported to and discussed by the Committee;

	Annual Budget £'000	YTD Performance M09									In Month Movement Trend	In Month Movement £'000 o(u)	Previous Month FOT Variance £'000 o(u)
		Ytd Budget £'000	Ytd Actual £'000	Variance £'000 o/(u)	Var% o(u)	FOT Actual £'000	FOT Variance £'000	Var% o(u)					
Acute Services	194,561	145,921	147,120	1,199	0.8%	196,615	2,054	1.1%	●	587	1,466		
Mental Health Services	36,079	26,987	27,515	527	2.0%	36,584	505	1.4%	●	275	231		
Community Services	48,547	36,341	35,929	(412)	(1.1%)	47,965	(582)	(1.2%)	●	9	(591)		
Continuing Care	14,484	10,863	10,633	(230)	(2.1%)	14,178	(307)	(2.1%)	●	(20)	(286)		
Primary Care Services	52,253	39,190	39,512	322	0.8%	52,615	362	0.7%	●	(450)	812		
Delegated Primary Care	35,301	26,476	26,362	(114)	(0.4%)	34,801	(500)	(1.4%)	●	0	(500)		
Other Programme	4,277	3,208	3,644	436	13.6%	4,727	449	10.5%	●	(308)	757		
<b>Total Programme</b>	<b>385,503</b>	<b>288,986</b>	<b>290,714</b>	<b>1,729</b>	<b>0.6%</b>	<b>387,485</b>	<b>1,981</b>	<b>0.5%</b>	●	<b>93</b>	<b>1,888</b>		
Running Costs	5,535	4,151	4,004	(147)	(3.5%)	5,342	(193)	(3.5%)	●	(93)	(100)		
Reserves	3,866	1,602	0	(1,602)	(100.0%)	2,077	(1,788)	(46.3%)	●	0	(1,788)		
<b>Total Mandate</b>	<b>394,904</b>	<b>294,739</b>	<b>294,718</b>	<b>(21)</b>	<b>(0.0%)</b>	<b>394,904</b>	<b>(0)</b>	<b>(0.0%)</b>	●	<b>(0)</b>	<b>(0)</b>		
Target Surplus	9,130	6,847	0	(6,847)	(100.0%)	0	(9,130)	(100.0%)	●	0	(9,130)		
<b>Total</b>	<b>404,034</b>	<b>301,586</b>	<b>294,718</b>	<b>(6,868)</b>	<b>(2.3%)</b>	<b>394,904</b>	<b>(9,130)</b>	<b>(2.3%)</b>	●	<b>(0)</b>	<b>(9,130)</b>		

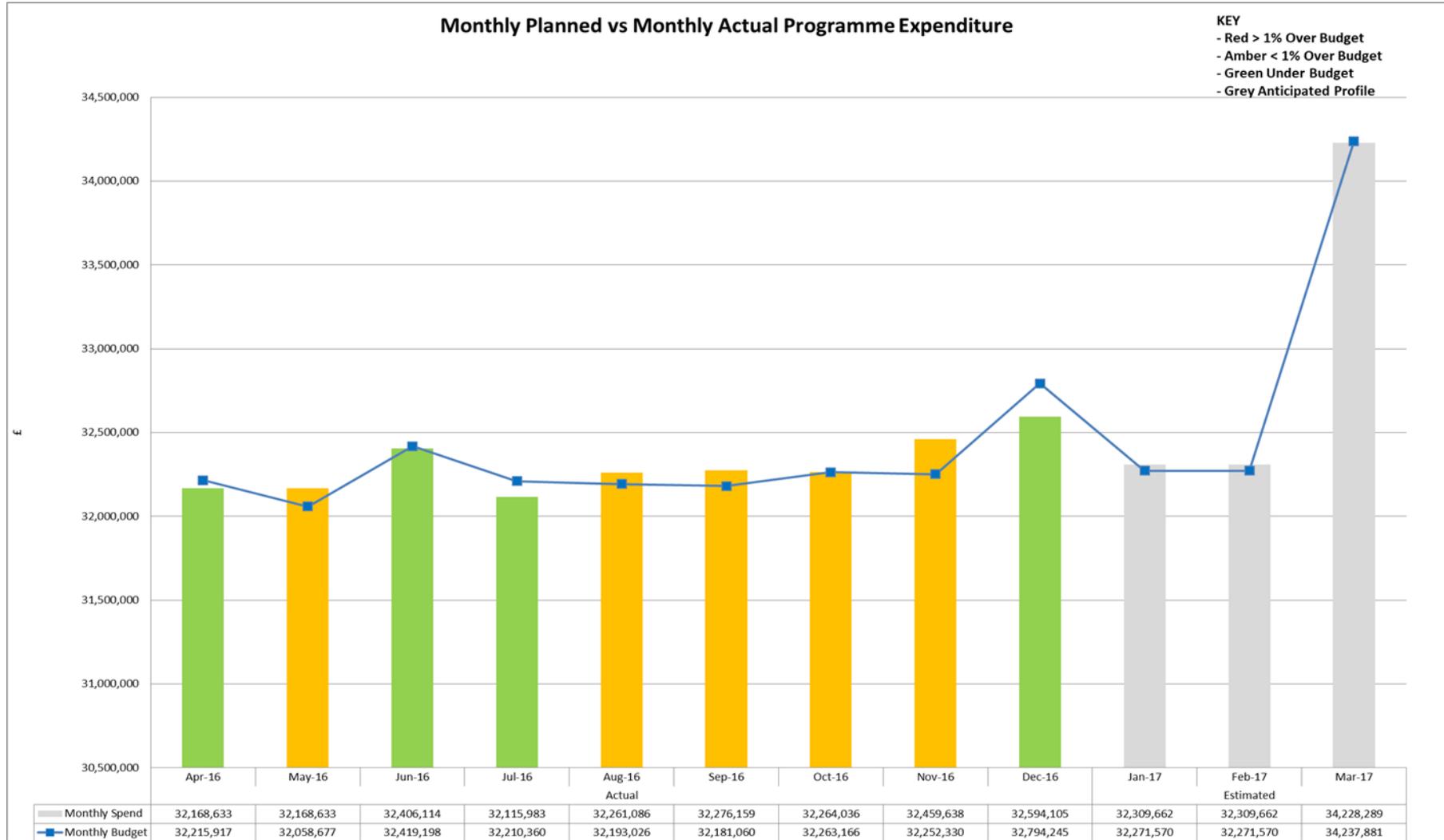
	Annual Budget £'000	Yr End Forecast £'000	Yr End Variance Total £'000 o(u)	Yr End Variance Recurrent £'000	Yr End Variance Non Recurrent	Yr End Variance %
Acute Services	194,561	196,615	2,054	2,312	(258)	0
Mental Health Services	36,079	36,584	505	235	270	0
Community Services	48,547	47,965	(582)	(390)	(192)	(0)
Continuing Care	14,484	14,178	(307)	(305)	(1)	(0)
Primary Care Services	52,253	52,615	362	(1,332)	1,694	0
Delegated Primary Care	35,301	34,801	(500)	0	(500)	(0)
Other Programme	4,277	4,727	449	6,369	(5,920)	0
<b>Total Programme</b>	<b>385,503</b>	<b>387,485</b>	<b>1,981</b>	<b>6,890</b>	<b>(4,909)</b>	<b>0</b>
Running Costs	5,535	5,342	(193)	0	(193)	(0)
Reserves	3,866	2,077	(1,788)	(1,788)	0	(0)
<b>Total Mandate</b>	<b>394,904</b>	<b>394,904</b>	<b>(0)</b>	<b>0</b>	<b>0</b>	<b>(0)</b>
Target Surplus	9,130	0	(9,130)	0	(9,130)	(1)
<b>Total</b>	<b>404,034</b>	<b>394,904</b>	<b>(9,130)</b>	<b>5,102</b>	<b>(14,232)</b>	<b>(0)</b>
<b>Recurrent/Non Recurrent Adjustment</b>				<b>(4,721)</b>	<b>4,721</b>	
<b>Removal of Target Surplus</b>					<b>9,130</b>	
<b>Residual Position</b>				<b>381</b>	<b>(381)</b>	

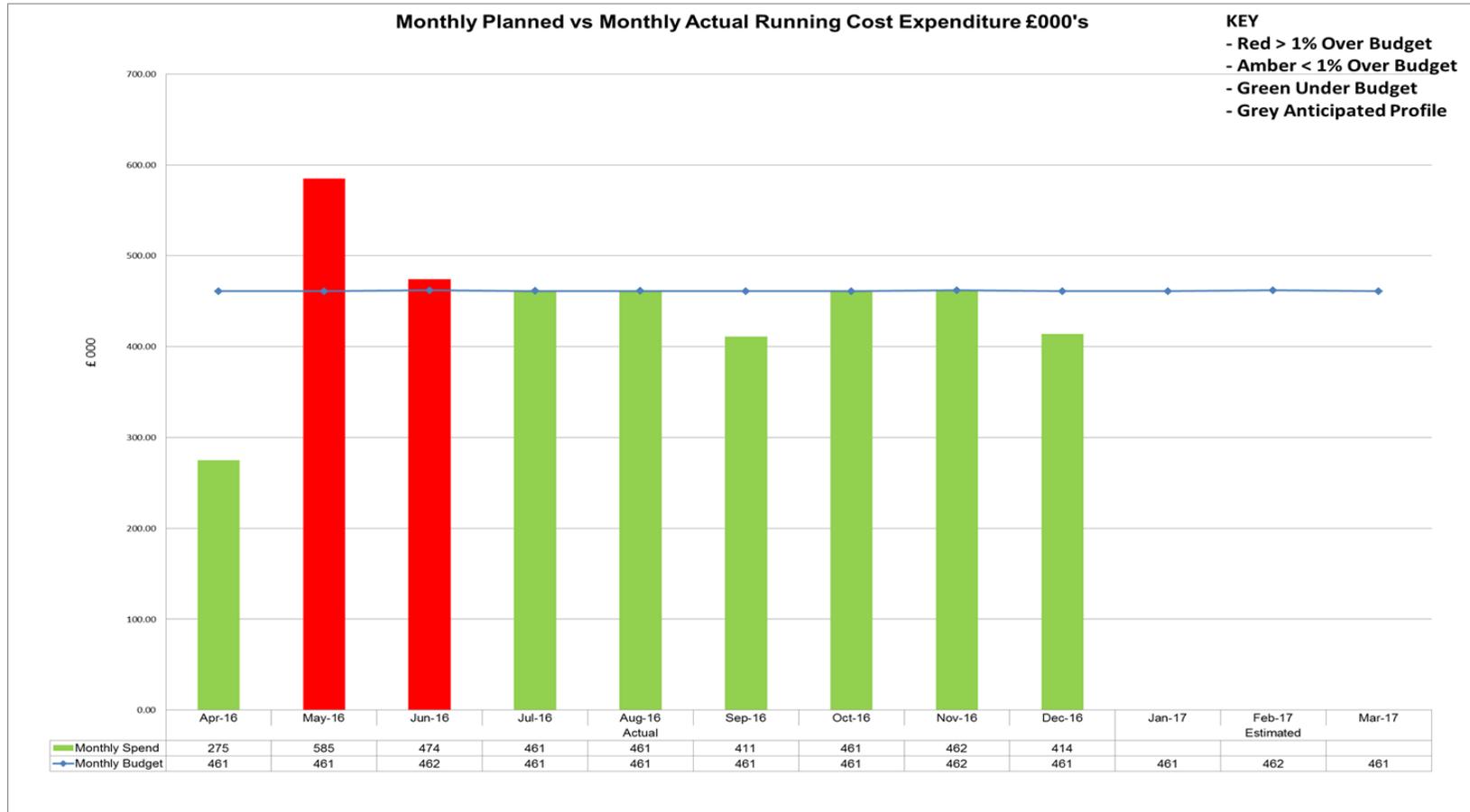
- Of the recurrent year end variance, £4.721m is a consequence of recurrent spend being offset by a non-recurrent allocation in relation to HRG4+ and IR (national coding and costing changes which impacted upon the 17/19 contract). The CCG will have a non-recurrent allocation again in 18/19 thereafter the sum should be incorporated into the new allocations published after the next CSR (Comprehensive spending review). This is reflected in the table above.
- The above table demonstrates that after adjusting for the required target and non-recurrent allocation, the CCG is overcommitted recurrently by £381k a decrease of £1.1m mainly as a result of moving the NCSO overspend to non-recurrent as per NHSE.
- To achieve the target surplus the CCG has utilised all of the Contingency Reserve, £1.780m. For 18/19 the CCG will need to reinstate the Contingency and this will be a first call on growth monies.

	Annual Recurrent £'000	Annual Non Recurrent £'000	Total £'000	Yr End Variance Recurrent £'000	Yr End Variance Non Recurrent £'000	Total £'000
Contingency Reserve	1,788	0	1,788	(1,788)	0	(1,788)
Mandated 0.5% of 1%	1,729	0	1,729	0	0	0
Delegated Primary Care 1%	348	0	348	0	0	0
<b>Total</b>	<b>3,866</b>	<b>0</b>	<b>3,866</b>	<b>(1,788)</b>	<b>0</b>	<b>(1,788)</b>

**Monthly Planned vs Monthly Actual Programme Expenditure**

**KEY**  
 - Red > 1% Over Budget  
 - Amber < 1% Over Budget  
 - Green Under Budget  
 - Grey Anticipated Profile





- Running costs historically have reported a stable position from M3 onwards and this is anticipated to continue through to year end. Traditionally the last 3 months of the financial year see a proportionally higher spend per month but overall a breakeven position is forecast at year end.

## 2. Delegated Primary Care

Delegated Primary Care allocations for 2017/18 as at M09 are £35.649m. The forecast outturn is £35.149m delivering an under-spend position.

- The table below shows the revised forecast for month 09;

	YTD budget £'000	YTD spend £'000	YTD Variance £'000 o/(u)	Annual Budget £'000	FOT £'000	Variance £'000 o/(u)	In Month Movement Trend	In Month Movement £'000 o/(u)	Previous Month FOT Variance £'000 o/(u)
General Practice GMS	15,751	15,789	38	21,002	21,002	0	●	0	0
General Practice PMS	1,357	1,349	(8)	1,809	1,809	0	●	0	0
Other List Based Services APMS incl	1,724	1,906	183	2,298	2,298	0	●	0	0
Premises	2,013	1,988	(25)	2,684	2,684	0	●	0	0
Premises Other	68	45	(22)	90	90	0	●	0	0
Enhanced services Delegated	634	626	(8)	845	845	0	●	0	0
QOF	2,716	2,692	(25)	3,622	3,622	0	●	0	0
Other GP Services	2,083	1,966	(117)	2,777	2,277	(500)	●	0	(500)
Delegated Contingency reserve	131	0	(131)	174	174	0	●	0	0
Delegated Primary Care 1% reserve	261	0	(261)	348	348	0	●	0	0
<b>Total</b>	<b>26,737</b>	<b>26,362</b>	<b>(375)</b>	<b>35,649</b>	<b>35,149</b>	<b>(500)</b>	●	<b>0</b>	<b>(500)</b>

The forecast outturn shows an under-spend of £500k against other GP services which relates to the release of an accrual previously managed by NHSE. The benefit is non recurrent in nature. The 0.5% contingency will be committed in line with the 2017/18 planning metrics. The CCG has plans in place to utilise this resource.

In line with national guidance the 1% Non-Recurrent Transformation Fund can be utilised in year non-recurrently to help and support the delegated services. The CCG has plans in place to meet this metric.

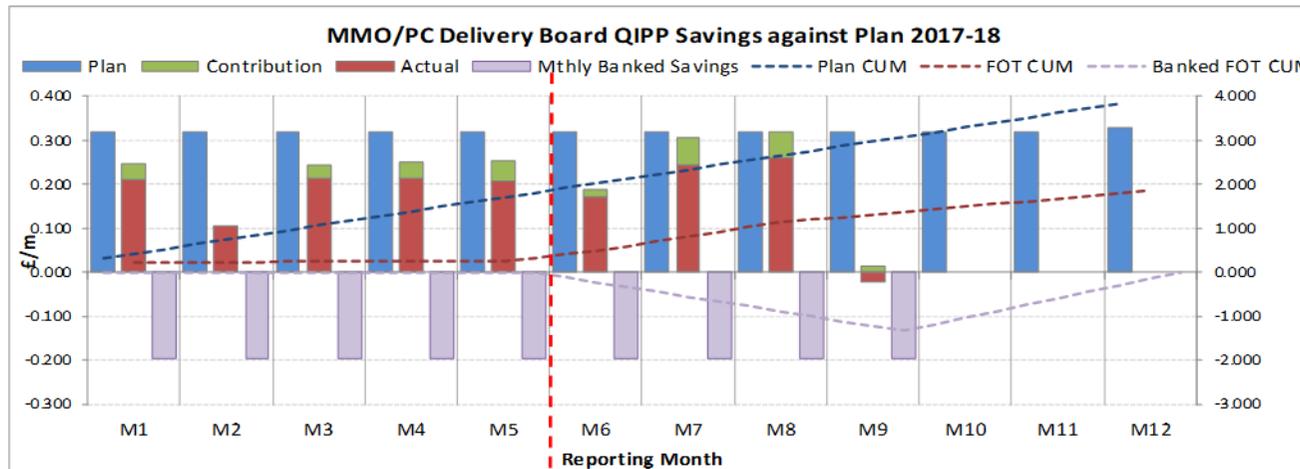
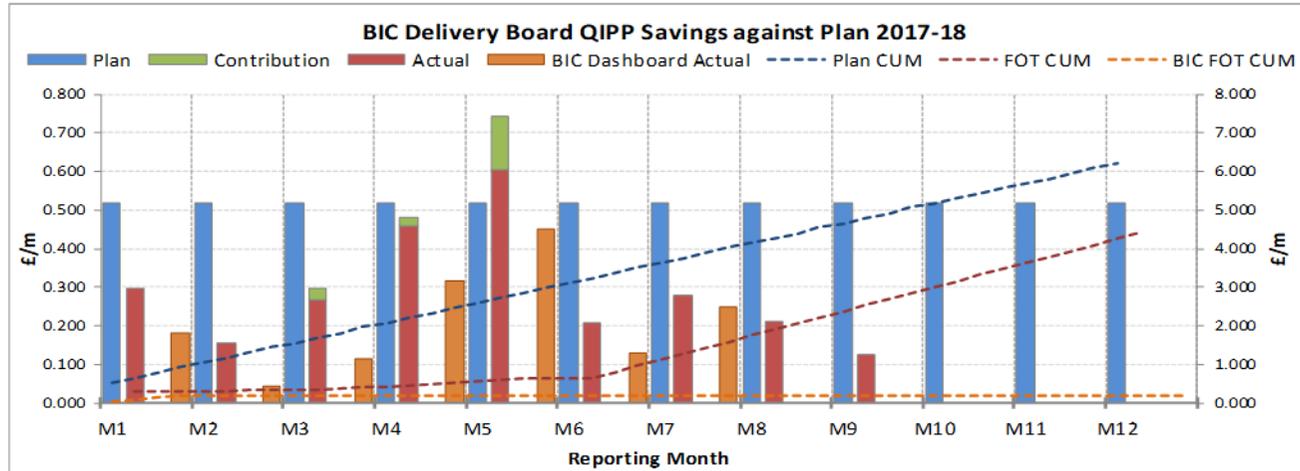
### 3. QIPP

The key points to note are as follows:

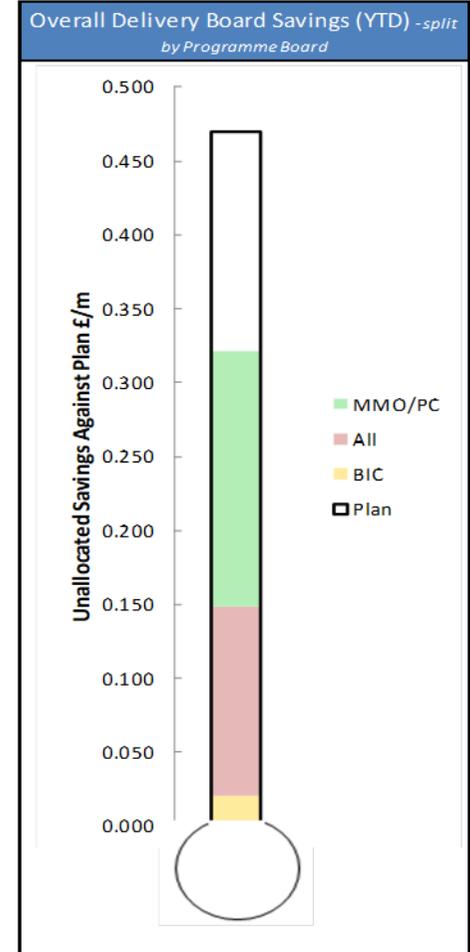
- Following the finalisation of the year end figure the plan QIPP target of £10.62m increased to £11m. As a result, the level of non-contracted QIPP without plans increased to £1.519m as £616k has identified plans.
- No additional QIPP has been identified in M9.
- Any non-recurrent QIPP will potentially be carried forward into the 18/19 target although the CCG is covering undelivered QIPP in its recurrent reported position.

**QIPP Programme Delivery Board**

Source : Annual Non ISFE Plan, Monthly Project Leads Updates and validated figures from Non ISFE Finance Return



<Merger of Boards from M6, monthly figures now include PC Investment



#### 4. STATEMENT OF FINANCIAL POSITION

The Statement of Financial Position (SoFP) as at 31st December 2017 is shown below.

	31 December '17 £'000	30 November '17 £'000	Change In Month £'000
<b>Non Current Assets</b>			
Assets	0	0	0
Accumulated Depreciation	0	0	0
	0	0	
<b>Current Assets</b>			
Trade and Other Receivables	1,870	1,865	5
Cash and Cash Equivalents	209	133	76
	2,079	1,998	
<b>Total Assets</b>	<b>2,079</b>	<b>1,998</b>	
<b>Current Liabilities</b>			
Trade and Other Payables	-32,258	-31,251	-1,007
	-32,258	-31,251	
<b>Total Assets less Current Liabilities</b>	<b>-30,179</b>	<b>-29,253</b>	
<b>TOTAL ASSETS EMPLOYED</b>	<b>-30,179</b>	<b>-29,253</b>	
<b>Financed by:</b>			
<b>TAXPAYERS EQUITY</b>			
General Fund	30,179	29,253	926
<b>TOTAL</b>	<b>30,179</b>	<b>29,253</b>	

Key points to note from the SoFP are:

- The CCG has achieved its cash target this month with an outturn of 0.74% against a target of no greater than 1.25%, (see 13.2 below);
- Performance continues to be high against the target of paying at least 95% of invoices within 30 days, (97% for non-NHS invoices and 100% for NHS invoices);

**5. PERFORMANCE**

The following tables are a summary of the performance information presented to the Committee;

**Executive Summary - Overview**

Nov-17

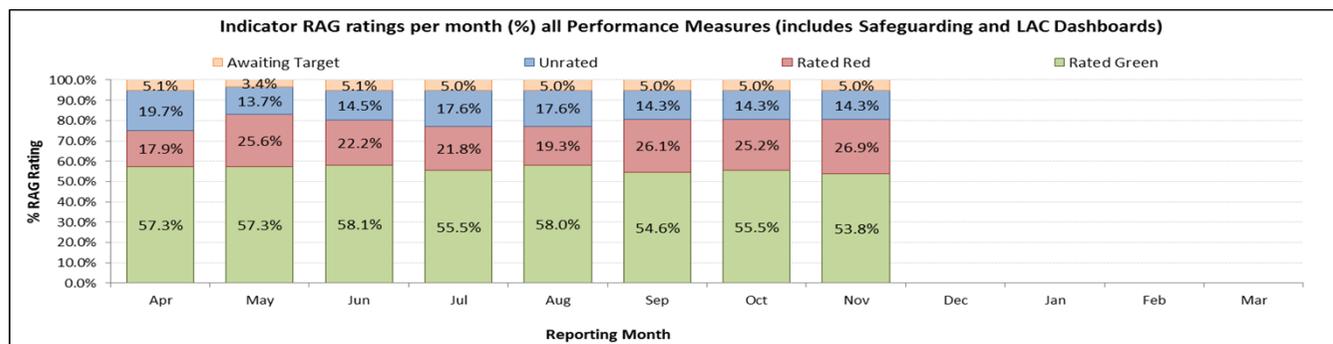
Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC or n/a *	Total
NHS Constitution	13	13	11	11	0	0	0	0	24
Outcomes Framework	7	7	9	9	10	10	0	0	26
Mental Health	26	24	5	7	5	5	0	0	36
Safeguarding - RWT	8	8	5	5	0	0	0	0	13
Looked After Children (LAC)	0	0	0	0	0	0	6	6	6
Safeguarding - BCP	12	12	0	0	2	2	0	0	14
<b>Totals</b>	<b>66</b>	<b>64</b>	<b>30</b>	<b>32</b>	<b>17</b>	<b>17</b>	<b>6</b>	<b>6</b>	<b>119</b>

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	No Submission (blank)	Previous Mth:	Target TBC or n/a *
NHS Constitution	54%	54%	46%	46%	0%	0%	0%	0%
Outcomes Framework	27%	27%	35%	35%	38%	38%	0%	0%
Mental Health	72%	67%	14%	19%	14%	14%	0%	0%
Safeguarding - RWT	62%	62%	38%	38%	0%	0%	0%	0%
Looked After Children (LAC)	0%	0%	0%	0%	0%	0%	100%	100%
Safeguarding - BCP	86%	86%	0%	0%	14%	14%	0%	0%
<b>Totals</b>	<b>55%</b>	<b>54%</b>	<b>25%</b>	<b>27%</b>	<b>14%</b>	<b>14%</b>	<b>5%</b>	<b>5%</b>

\* Note : Performance for Looked After Children (LAC) has been included on the Dashboard section of the report for information only as currently does not have targets or thresholds applied to the indicators.

**August 2017** : additional of C.Diff and MRSA indicators for the Black Country Partnership Foundation Trust reporting, increases number to 119 overall indicators

**October 2017** : Submissions from Black Country Partnership Foundation Trust have been split to show the Wolverhampton responsible figures from M7.



Exception highlights were as follows;

Indicator Ref:	Title and Narrative	Direction of Travel / Yr End Target
	<b>Royal Wolverhampton Hospital NHS Trust (RWT)</b>	

**Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral**

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
91.07%	91.50%	91.01%	91.09%	91.07%	90.80%	91.12%	91.23%					91.11%	92.00%



The performance data for headline Referral To Treatment (RTT - 18wks) Incompletes has seen an increase to 91.23% against the 92% target (92.10% STF target). When compared to the previous years performance, the validated National Unify2 figures show that there has been a 2% increase in the number of incompletes waiting (Nov16 = 91.08%, 2882 breaches out of 32312, Nov17 = 91.12%, 2900 breaches out of 33072). Failing specialties include : ENT (87.86%), General Surgery (89.60%), Ophthalmology (88.29%), Oral Surgery (81.47%), Plastic Surgery (81.17%), Trauma & Orthopaedics (89.44%) and Urology (83.57%). The Trust continue to focus on reducing the backlog where possible with monthly prediction reports circulated detailing priority patients and expected activity numbers for each month with targeted meetings with Directorates to discuss poor compliance/recording of outcomes. All specialty group managers have a plan in place to achieve a target in order for the headline performance target to be met by March 2018 with weekly activity versus plan reports shared with the Directorates and presented at Performance meetings.

The Trust have had to cancel some elective procedures in line with national guidance to ease bed pressure due to winter pressures within the system (including A&E and bed capacity). The majority of operations (approximately 80%) are currently Day Cases, with the majority of electives taking place at Cannock Hospital. The Trust have advised that they will know the overall urgent and time to recover performance after the end of January 2018.

Following an increase in referrals for diagnostic tests, the Trust have confirmed that challenges continue within Radiology (centred around CT and MRI Heart) and the Commissioner will continue to monitor performance and the impact on RTT. The Trust have confirmed that they are expecting the number of Elective procedures in January to fall due to Christmas and New years effect which is likely to impact performance. Early indications for the December performance have not been made available for inclusion within the F&P papers deadline.

**Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test**

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
98.88%	99.06%	99.48%	99.58%	99.20%	99.22%	99.06%	98.92%					99.18%	99.00%



The performance for Diagnostic Tests has seen a decline in November and has failed to achieve the 99% in month target (98.92%) and relates to 71 breaches (out of 6,563). All diagnostic test areas were at 100% in November with the exception of Computed Tomography (CT = 53 breaches out of 664 = 92.02% ) and Magnetic Resonance Imaging (MRI = 18 breaches out of 1,533 = 98.83%). Challenges continue within Radiology and are centred around CT and MRI Heart following an increase in referrals for these diagnostic tests near the end of the month. Additional sessions were utilised during November and December to accommodate the rise in referrals and in turn reduce the backlog. The Trusts Integrated Quality and Performance Report (IQPR) for November confirmed that there were 7 radiation incidents reported (including 5 near misses) against 24,612 examinations. Each breach is reviewed at the Contract Review and the Clinical Quality Review Meetings. Management of any serious incident is in line with the Serious Incident Framework (2015) which requires a Root Cause Analysis (RCA) and agreement of closure by the CCG once satisfied that the RCA investigation report and action plan meets required standards. As a Commissioner, the November performance calculates as 98.81% (49 breaches out of 4132) of which 46 relate to the Royal Wolverhampton NHS Trust, 3 to other Providers (compared to 32 breaches at the end of October):

Computed Tomography (CT) x 46 (all 36 x The Royal Wolverhampton)

MRI x 12 (2 x Birmingham Women's and Children's Hospital and 10 x The Royal Wolverhampton).

Early indications are that the December performance has seen an improvement to 99.12% and is therefore GREEN.

RWT\_EB4

**Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department**



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
92.52%	94.12%	93.44%	93.76%	92.09%	91.42%	91.55%	87.43%					92.04%	95.00%

The November performance has seen a decrease from the previous month to 87.43% and has failed to achieve the National Target (Type I and All Types) of 95% and the agreed 17/18 STF Trajectory for November of 92%. The performance can be split into the following : Emergency Department Type I (New Cross) - 80.54%, Walk-in Centre Type 4 - 100%, Cannock Minor Injury Unit (MIU) Type 3 - 100% and Vocare Type 3 - 92.12%.

When comparing the Nationally validated number of attendances from the previous year, there has been a 2.8% increase (Nov16: 18,791 - 92.08% compliance, Nov17: 19,314 - 87.43% compliance). The number of ambulance conveyances has also seen an increase of 5.1% (Nov16 = 3729, Nov17 = 3920).

The daily number of attendances increased over the course of the month with an average of 352 attendances per day with the maximum of 436 attendances occurring on Monday 20th November 2018. The Trust have submitted an Exception Report which confirms reasons for under performance as bed availability, issues with patient flow (decision making) and ambulances arriving in batches and therefore creating queues within the system. Actions highlighted include:

Active recruiting for substantive Emergency Department consultants. Bed meetings 3 to 5 times a day. Daily discharge levels sent across the Trust to ensure adequate patient flow and minimise breaches due to bed shortages with pre-admission bay opened to free cubicles of patients waiting for bed allocation. Staff are to ensure that To Take Out (TTO's - Prescription medication) and discharge summaries are completed as part of ward rounds with proactive use of the discharge lounge to prevent delays and bed blockers. New ambulance offload area to replace corridor offload. Influenza has increased pressure on the wards and the Flu Plan is in action with flu cases contained on wards C18 and C19 (respiratory) with flu testing available on site 7 days a week.

*Continued overleaf.*

**Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department - Continued**

Key Commissioner actions identified are :

Co-ordinated communications across the CCG, Trust and Primary Care regarding system capacity and pressures (including regional newspaper listings of GP Practice opening hours over the Holiday season, extended hour clinics (late and weekend clinics).

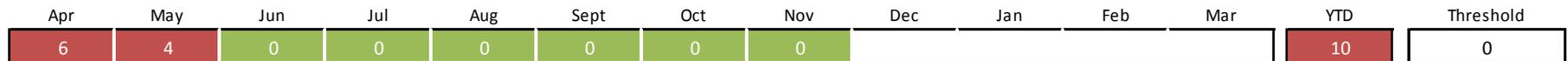
Rapid Intervention Team (RiTs) contacted to raise awareness of Primary Care Communications and potential of increased referrals.

The Commissioner brokerage team (Continuing Health Care) have been notified to be on standby for increased referrals and the Integrated Discharge Team are aware that all Medically Fit For Discharge (MFFD) patients are to be discharged as quickly as possible to clear backlogs. The Sustainability and Transformation Fund (STF) Payments guidance has been released and the Trust have confirmed that they will have failed payment due to the 95% 4hr target failures (part1). The Streaming section of the STF payment (part2) requires further clarification regarding the Type 3 activity inclusion as the Wolverhampton system classifies all Vocare activity as streamed. Early indications are that December has seen a decrease to 87.03% and therefore remains RED however, there has been positive progress with Vocare working closely with both the Trust and Commissioner to move more activity from the Emergency Department to the Urgent Care Centre and alleviate pressure, this includes additional funding from the Commissioner for additional staff within Vocare.

RWT\_EB4

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**Zero tolerance RTT waits over 52 weeks for incomplete pathways**



This indicator has breached the Year End zero threshold for 52 week waiters due to the April and May breaches for Orthodontic patients. The M8 performance confirms that there were no patients waiting over 52 weeks during November, however the Year End threshold has already breached for 2017/18 due to the performance in April and May. RTT performance (including 52 Week Waiters and Referral Diversions) continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. Early indications are that there are no further breaches during December.

RWT\_EBS4

**Trolley waits in A&E not longer than 12 hours**

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
0	0	0	0	0	0	0	1					1	0



The performance for the number of Trolley waits in A&E (not longer than 12 hours) has breached the zero threshold for the first time since June 2015. The CCG Quality and Safety Team liaise with Trusts involved (Royal Wolverhampton NHS Trust) to establish a timeline and assess if an indicator breach has occurred and if the incident also meets the Serious Incident Framework (2015) criteria. The Trust have since confirmed that the breach relates to a child awaiting a Paediatric Intensive Care Bed (PICU).

RWT\_EBS5

**Delayed Transfers - % occupied bed days - to exclude social care delays**

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
1.75%	2.10%	1.12%	1.58%	1.81%	1.49%	1.49%	1.66%					1.62%	2.00%



The Delayed Transfers of Care (DToC) indicator is based on the proportion of delays by occupied bed days (excluding Social Care) and has achieved both the 2.2% threshold in-month (excluding Social Care) reporting 1.66% for November and the 3.5% combined threshold (3.44%).

National DTOC submission data from the Unify2 collection system confirms that there were 807 total delay days for November at the Royal Wolverhampton Trust (of which 278 x Wolverhampton, 414 x Staffordshire, 65 x Walsall, 42 x Dudley and 8 x Shropshire). As a Commissioner, November delays days totals were : 278 x Royal Wolverhampton NHS Trust, 30 x South Staffordshire and Shropshire Healthcare, 2 x University Hospitals Birmingham, 143 x Black Country Partnership and 42 x Dudley Group of Hospitals. Following the new guidance the Director of Adult Social Services is to sign off all Delayed Transfers of Care and a DToC Directory has been developed with contact details of key individuals. Changes in the format of the numerator data received via the SQPR submission has been confirmed to match the revised methodology for the National monthly submissions and are based on the calculation of: Number of delay days divided by the number of days in the reporting month. Trust have confirmed that the denominator is based on a monthly average of the occupied bed days. Nationally reported performance percentages utilise the quarterly published occupied bed day figures (KH03 Unify2 submission) which are unavailable at time of the Trusts monthly submission, however the July reports confirm the combined performance as 5.09% and therefore RED. The Trust have indicated the following delay reasons for November:

- 22.6% - Delay Awaiting Assessment (prev 30.2% - decrease)
- 7.6% - Delay awaiting further NHS Care (prev 9.5% - decrease)
- 24.5% - Delay awaiting domiciliary package (prev 28.4% - decrease)
- 8.5% - Delay awaiting family choice (prev 4.3% - increase)
- 12.3% - Delay awaiting equipment/adaptations (prev 7.8% - increase)
- 0.9% - Delay awaiting public funding (prev 0.9% - no change)

Delayed Transfers of Care continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. A threshold of 3.5% by September 2017 (combined NHS and Social Care related delays) had been agreed between the Royal Wolverhampton Hospital and Local Authority (stretched from 4.9% to 3.5%) which has been achieved for October (3.44% combined delays).

Early indications are that the December performance is 1.11% and remains below the 2.2% threshold (excluding Social Care).

**E-Referral – ASI rates**

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
34.66%	32.42%	30.57%	37.38%	32.54%	26.04%	27.22%	25.55%					30.80%	10.00%



Performance for this indicator has achieved the 40% recovery trajectory threshold for November, achieving 25.55%. The National validated performance has since been confirmed as 28.34% (32.78% 1st Outpatient only). Analysis of the year on year performance shows that the Month 8 performance relates to a lower number of referrals (16/17 denominator = 4634, 17/18 denominator = 4736, an increase of 102) with performance declining from that of the same period in 2016/17 (17.11%). The Trust have submitted an exception report which has confirmed that increased demands on services and reduced capacity in some specialties due to staff shortages effecting performance with Ophthalmology, Paediatrics, Urology and Orthopaedics the areas facing the biggest challenges. Planned actions include : Identification of routine clinic slots for conversion to e-RS slots, conversion of slots to match sub-specialty requirements and demands, service review to identify any e-RS service gaps and updating the Directory of Services accordingly and as part of the E-referral Service (ERS) Commissioning for Quality and Innovation (CQUIN) Scheme, work has been on-going with individual specialties to identify additional capacity and conversion to direct booking. The Commissioner has queried the figures reported by the Trust via the Clinical Quality Review Meeting as they differ from the National validated reports eg November reported figures= 1210/4736 (25.55%), whereas the NHS Digital confirmed data = 1342/4736 (28.34%). The initial response has indicated that the difference in performance figures related to Dermatology activity and the CCG are awaiting confirmation from the Trust are to confirm if these figures are included. The National Appointment Slot Issue report for November 17 allows us to benchmark performance :

- Walsall Healthcare NHS Trust - 51.71 (1,140 issues out of 2,228 bookings)
- Sandwell and West Birmingham - 67.73 (3,977 issues out of 5,872 bookings)
- Dudley Group of Hospitals - 33.81 (1,927 issues out of 5,699 bookings)
- Royal Wolverhampton - 28.34 (1,342 issues out of 4,736 bookings)

The National performance (Acute Trusts only) for November has been confirmed as 15.29, with the West Midlands (Acute Trusts only) currently performing at 34.21.

Note : The National Data is based on the E-Referral System data only, The Royal Wolverhampton Trust data does not include urgent referrals as these are received via email, it is not known if other providers figures include or exclude these referrals.

**Black Country Partnership NHS Trust (BCP)**

**Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care\***



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
100.00%	95.45%	92.31%	95.83%	100.00%	89.74%	91.89%	94.44%					94.96%	95.00%

The performance for this indicator has seen an increase from the previous month however remains below the 95% target for the third consecutive month (94.44%) with YTD currently below target at 94.96%. The Wolverhampton breaches for November relates to 2 patients (out of 36) that did not received a follow up within 7 days from psychiatric in-patient care. An exception report has been provided by the Trust which includes details for each breach and actions taken to prevent future breaches. These include :

Meetings to be arranged to agree a more robust process for communication between wards and community staff.

A daily monitoring process established and relevant team contacted to prompt a 7 day follow up with the inclusion of escalation plan to ensure any system failures are communicated to Community Staff.

All staff in planned and urgent care have been contacted to ensure that they are following process (in line with the SOP) and issues with the lack of patient details on discharge needs to be addressed.

The Trust have confirmed the following reasons for breaching target :

1 x temporary network issues, discharge was not picked up within the 7 day timeframe, contact was made via telephone.

1 x patient self-discharged against clinical advice to move to London. Home Treatment Team in London contacted upon day of discharge to request a 7 day follow up, however was not due to take place until 11th December.

BCPFT\_EBS3

**IPC training programme adhered to as per locally agreed plan for each staff group. Compliance to agreed local plan.**  
**Quarterly confirmation of percentage of compliance**



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
80.33%	83.88%	87.07%	85.85%	85.08%	85.25%	83.64%	84.22%					84.42%	85.00%

The performance for the IPC training programme is based on a quarterly target of 85%, however figures are received on a monthly basis to monitor performance. The November performance has seen an increase however remains below target both in-month (84.22%) and Year To Date (84.42%). The submitted data for this indicator is at a Provider level and includes both Wolverhampton and Sandwell figures. As a Quarterly performance indicator, an exception report is not provided each month and will only be available if the full Quarter fails to achieve. Performance is discussed at the CQRM and CRM meetings with the Trust and the CCG will continue to monitor the monthly performance. To achieve the Quarterly target, a minimum of 88% performance will be required in December.

BCPFT\_LQGE06

**Delayed Transfers of Care to be maintained at a minimum level**

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
4.88%	1.57%	4.11%	4.03%	3.18%	4.54%	3.89%	10.50%					4.58%	7.50%



The Delayed Transfers of care programme (DTC) has seen a significant increase in November (10.50%) and has breached the 7.5% threshold. This performance relates to Wolverhampton only, the Sandwell performance has been confirmed as 1.72% and therefore remains GREEN.

As delayed discharges remain a National issue, performance will be monitored via the 2017/18 Local Quality Requirements contract and remain an agenda item on both the CCG's monthly performance call with NHS England (NHSE) and the Trusts CQRM meetings. The delayed discharges for Wolverhampton currently concern patients on our Older Adults Ward waiting for specialist nursing home beds and the Mental Health Commissioner is working with colleagues from the Continuing Health Care (CCG - CHC) Team and the Local Authority. The Trust have submitted an exception report for the November performance which confirms that the majority of delays are currently due to Older Adult patients awaiting placements (delays due to difficulty in finding providers, awaiting provider assessments, availability of placements and disputes between health care and social care). The Trust and Local Authority have completed a deep dive review of delayed discharges on the wards with findings leading to an agreement for a working group to be established to look at a multi-agency approach to systems to reduce delays in discharges. The Local Authority have provided a dedicated social worker to Penn Hospital who attends weekly reviews and engages with patients and Multi Disciplinary Teams (MDTs) for placements/housing and instigates early assessments for less complex patients to minimise assessment delays (limited to Adults rather than Older Adults).

Following the December Clinical Quality Review Meeting (CQRM), the Trust shared additional information regarding delays detailing timelines and actions taken. From April 2017 there has been a change to the methodology used for the submission of the National DTC returns. Data is no longer available for the number of patients delayed (on a monthly snapshot) and figures are based on the number of delayed days divided by the number of days in the month. The November National figures have been confirmed as follows for the Black Country Partnership (all commissioners) :

- NHS delay days = 2 and a 0.07 delayed bed day average (previously 52, 1.68 average)
- Social Care delay days = 70 and a 2.33 delayed bed day average (previously 22, 0.71 average)
- Both delay days = 112 and a 3.73 delayed bed day average (previously 7, 0.230 average)
- Trust Total = 184 delay days and a 6.13 delayed bed day average (previously 81, 2.61 average).

**Percentage of people who are moving to recovery of those who have completed treatment in the reporting period**  
[Target - >50%, Sanction: GC9]



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
51.05%	55.06%	56.74%	64.46%	50.68%	58.52%	58.65%	59.84%					56.87%	50.00%

The IAPT Moving to Recovery performance has previously been reported as part of the IAPT Dashboards and has consistently achieved over the 50% target. The performance for 2017/18 has continued this trend with 59.84% of patients moving to recovery during November 2017. However, this indicator has been included as part of the Horizon Scanning Report as there has been a variance in the figures published by NHS England. The Trust has met with the Commissioner regarding the variances in local and nationally reported performance. Small variances are expected due to differences in submission deadlines and performance methodologies (National performance is based on a rolling 3 month calculation whereas local data is in-month only), however other factors include the possible inclusion of Birmingham Mental Health Consortium (Herbert Road) of commissioner level data and possible data quality issues with the current system provider (PCMIS) downloads which was flagging discharged patients as still requiring a follow up and therefore included within the denominator calculation once uploaded to the Mental Health Minimum Data Set (MHMDS). Trust investigations have also highlighted that staff were not correctly discharging patients on the electronic systems and a new process document has been introduced to all staff who enter data onto the clinical system (including new and temporary staff) to confirm the exact process for discharging patients.

The CCG is assured that the Trust are taking appropriate actions to improve existing processes and data quality standards to ensure that any local and national data variances are minimised. As part of the assurance process, the CCG will continue to review the monthly local and national figures with the Trust to identify any unusual variances which require further investigation. The Trust have indicated that they are continuing efforts to minimise errors and ensure data is validated prior to future uploads and are working with the clinical system provider to do this. The Commissioner is also working with the Trust to look at options for an IAPT "Pop-up" shop in the city centre and/or University along with some additional communications to be developed to support the IAPT access target between now and the end of the financial year. The latest National data available is September 2017 and is currently reporting at 52.27% and is GREEN for the third consecutive month. The Trust continue to work closely with the system provider and providing regular updates to the Commissioner, NHS Digital, the Trust Boards and CQRM.

## 6. RISK and MITIGATION

The CCG submitted an annual plan which presented a nil net risk. Following discussion within the CCG the risk profile has changed to reflect changes between plan submission (March 2017), and Month 9, and continues to report a nil net risk.

The table below details the current risk assessment for the CCG' a risk of £2.0m with mitigations of £2.0m.

CCG RISKS & MITIGATIONS	Forecast Net Expenditure				RISKS (enter negative values only)						MITIGATIONS (enter positive values only)								TOTAL NET (RISK) / MITIGATION		
	Plan	Actual	Variance	Variance	Contract	QIPP	Performance Issues	Prescribing	Other	TOTAL RISKS	Contingency Held	Contract Reserves	Investments Uncommitted	Further QIPP Extensions	Non-Recurrent Measures	Delay / Reduce Investment Plans	Other Mitigations	Potential Funding		TOTAL MITIGATIONS	
	£m	£m	£m	%	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m		£m	£m
REVENUE RESOURCE LIMIT (IN YEAR)	394.904																				
REVENUE RESOURCE LIMIT (CUMULATIVE)	404.034																				
Acute Services	193.678	195.732	(2.055)	(1.1%)	(0.700)	(0.300)				(1.000)				0.300						0.300	(0.700)
Mental Health Services	36.079	36.584	(0.505)	(1.4%)		-				-				-						-	-
Community Health Services	48.547	47.965	0.582	1.2%		-				-				-						-	-
Continuing Care Services	14.484	14.178	0.307	2.1%		-				-				-						-	-
Primary Care Services	52.253	52.615	(0.362)	(0.7%)		-		(1.000)		(1.000)				-	1.000					1.000	-
Primary Care Co-Commissioning	35.649	35.149	0.500	1.4%		-				-				-	0.400					0.400	0.400
Other Programme Services	8.678	7.338	1.340	15.4%		-				-				-		0.300				0.300	0.300
<b>Commissioning Services Total</b>	<b>389.369</b>	<b>389.562</b>	<b>(0.193)</b>	<b>(0.0%)</b>	<b>(0.700)</b>	<b>(0.300)</b>	<b>-</b>	<b>(1.000)</b>	<b>-</b>	<b>(2.000)</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0.300</b>	<b>1.400</b>	<b>0.300</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>2.000</b>	<b>-</b>
Running Costs	5.535	5.342	0.193	3.5%		-				-				-						-	-
Unidentified QIPP						-				-				-						-	-
<b>TOTAL CCG NET EXPENDITURE</b>	<b>394.904</b>	<b>394.904</b>	<b>0.000</b>	<b>0.0%</b>	<b>(0.700)</b>	<b>(0.300)</b>	<b>-</b>	<b>(1.000)</b>	<b>-</b>	<b>(2.000)</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0.300</b>	<b>1.400</b>	<b>0.300</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>2.000</b>	<b>-</b>
IN YEAR UNDERSPEND / (DEFICIT)	-	0.000	0.000	0.0%																	
CUMULATIVE UNDERSPEND / (DEFICIT)	9.130	9.130	0.000	0.0%																	

There has been a change in reporting requirements to NHSE as the above table now reflects risk and mitigations by service line as well as by recurrent /non recurrent. It is clear that the CCG is carrying a recurrent risk, particularly in the Acute portfolio which is being offset by non-recurrent solutions.

A further potential risk not included in the financial position or the risk schedule relates to the outstanding issue with RWT £4.8m for lost income relating to Non Elective admissions. This issue has been escalated to NHSE at Regional level and the CCG is awaiting an update.

In summary the CCG is reporting the following:

	<b>£m Surplus(deficit)</b>	
Most Likely	£9.130	No risks or mitigations, <b>achieves</b> control total
Best Case	£11.130	Control total and mitigations achieved, risks do not materialise <b>achieves</b> control total
Risk adjusted case	£9.130	Adjusted risks and mitigations occur. CCG <b>achieves</b> control total
Worst Case	£7.130	Adjusted risks and no mitigations occur. CCG <b>misses</b> revised control total

## 7. Contract and Procurement Report

The Committee received the latest overview of contracts and procurement activities. There were no significant changes to the procurement plan to note.

## 8. Other Risk

Breaches in performance and increases in activity will result in an increase in costs to the CCG. Performance must be monitored and managed effectively to ensure providers are meeting the local and national agreed targets and are being managed to operate within the CCG's financial constraints. Activity and Finance performance is discussed monthly through the Finance and Performance Committee Meetings to provide members with updates and assurance of delivery against plans.

A decline in performance can directly affect patient care across the local healthcare economy. It is therefore imperative to ensure that quality of care is maintained and risks mitigated to ensure patient care is not impacted. Performance is monitored monthly through the Finance and Performance Committee and through the following committees; including Clinical Quality Review Meetings, Contract Review Meetings and Quality and Safety Committee.

There are potentially two additional risks not factored into the financial position or Risk schedule as follows:

- Any contribution to the currently disputed £4.8m invoice received from RWT in respect of lost income as Emergency activity continues to reduce (a national directive)
- Any potential financial consequences resulting from issues arising with services provided at the Urgent Care Centre (Vocare Ltd).

## 9. RECOMMENDATIONS

- **Receive and note** the information provided in this report.

**Name:** Lesley Sawrey  
**Job Title:** Deputy Chief Finance Officer  
**Date:** 30<sup>th</sup> January 2018

**Performance Indicators 17/18**

Current Month:

**Key:**

(based on if indicator required to be either Higher or Lower than target/threshold)

- ↑ Improved Performance from previous month
- ↓ Decline in Performance from previous month
- ↔ Performance has remained the same

17/18 Reference	Description - Indicators with exception reporting highlighted for info	Provider	Target	Latest Month Performance	In Mth RAG	YTD Performance	YTD RAG	Variance between Mth	Trend (null submissions will be blank) per Month													
									A	M	J	J	A	S	O	N	D	J	F	M		
RWT_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	RWT	92%	91.23%	R	91.11%	R	↑														
RWT_EB4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test	RWT	99%	98.92%	R	99.18%	G	↓														
RWT_EB5	Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	RWT	95%	87.43%	R	92.04%	R	↓														
RWT_EB6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	RWT	93%	93.57%	G	93.38%	G	↓														
RWT_EB7	Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	RWT	93%	93.39%	G	95.31%	G	↓														
RWT_EB8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	RWT	96%	97.39%	G	96.92%	G	↑														
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	RWT	94%	92.59%	R	89.86%	R	↑														
RWT_EB10	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen	RWT	98%	100.00%	G	100.00%	G	↔														
RWT_EB11	Percentage of service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy	RWT	94%	98.04%	G	98.65%	G	↑														
RWT_EB12	Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer.	RWT	85%	76.04%	R	75.45%	R	↓														
RWT_EB13	Percentage of Service Users waiting no more than 62 days from referral from an NHS Screening service to first definitive treatment for all cancers	RWT	90%	81.82%	R	86.56%	R	↓														
RWT_EBS1	Mixed sex accommodation breach	RWT	0	0.00	G	0.00	G	↔														
RWT_EBS2	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice	RWT	0	0.00	G	0.00	G	↔														
RWT_EAS4	Zero tolerance Methicillin-Resistant Staphylococcus Aureus	RWT	0	0.00	G	1.00	R	↑														
RWT_EAS5	Minimise rates of Clostridium Difficile	RWT	Mths 1-11 = 3 Mth 12 = 2	2.00	G	23.00	G	↔														
RWT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	RWT	0	0	G	10	R	↔														
RWT_EBS7a	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	RWT	0	99	R	446	R	↓														
RWT_EBS7b	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	RWT	0	9	R	25	R	↓														
RWT_EBS5	Trolley waits in A&E not longer than 12 hours	RWT	0	1	R	1	R	↓														
RWT_EBS6	No urgent operation should be cancelled for a second time	RWT	0	0	G	0	G	↔														
RWTCB_S10C	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance	RWT	95%	96.41%	G	95.53%	G	↑														
RWTCB_S10B	Duty of candour (Note : Yes = Compliance, No = Breach)	RWT	Yes	Yes	G	-	-															
RWTCB_S10D	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	RWT	99.00%	99.89%	G	99.87%	G	↑														
RWTCB_S10E	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	RWT	95.00%	98.92%	G	98.97%	G	↑														
RWT_LQR1	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all wards excluding assessment units.	RWT	95.00%	96.47%	G	95.21%	G	↑														
RWT_LQR2	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all assessment units (e.g. PAU, SAU, AMU, AAA, GAU etc.)	RWT	Q1 - 85% Q2 - 90% Q3 - 90% Q4 - 92.5%	84.98%	R	86.54%	R	↑														
RWT_LQR3	Delayed Transfers - % occupied bed days - to exclude social care delays	RWT	Q1 - 2.5% Q2 - 2.4% Q3 - 2.2% Q4 - 2.0%	1.66%	G	1.62%	G	↓														
RWT_LQR4	Serious incident (SI) reporting – SIs to be reported no later than 2 working days after the date of incident occurrence (as per SI Framework) Exceptions will be considered with Chief Nurse discussions. Note: Date of occurrence is equal to the date, the incident was discovered	RWT	0	0.00	G	4.00	R	↔														

17/18 Reference	Description - Indicators with exception reporting highlighted for info	Provider	Target	Latest Month Performance	In Mth RAG	YTD Performance	YTD RAG	Variance between Mth	Trend (null submissions will be blank) per Month
RWT_LQR5	Serious incident (SI) reporting – 72 hour review to be undertaken and uploaded onto the STEIS system by the provider (offline submission may be required where online submission is not possible). To be completed within 3 working days of the incident occurrence date. Note: Date of occurrence is equal to the date, the incident was discovered	RWT	0	0.00	G	2.00	R	→	
RWT_LQR6	Serious incident reporting - Share investigation report and action plan, all grades within timescales set out in NHS Serious Incident Framework. 60 working days of the incident being identified unless an independent investigation is required, in which case the deadline is 6 months from the date the investigation commenced.	RWT	0	5.00	R	17.00	R	↓	
RWT_LQR7	Number of cancelled operations - % of electives	RWT	0.80%	0.58%	G	0.38%	G	↓	
RWT_LQR11	% Completion of electronic CHC Checklist	RWT	Q1 - 86% Q2 - 90% Q3 - 94% Q4 - 98%	92.31%	R	94.56%	G	↓	
RWT_LQR12	E-Referral – ASI rates	RWT	10.00%	25.55%	R	30.80%	R	↑	
RWT_LQR13	Maternity - Antenatal - % of women booked by 12 weeks and 6 days	RWT	90.00%	93.60%	G	91.66%	G	↑	
RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	RWT	80.00%	83.78%	G	84.93%	G	↑	
RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	RWT	60.00%	72.58%	G	74.07%	G	↑	
RWT_LQR17	Best practice in Day Surgery - outpatient procedures - % of Day case procedures that are undertaken in an Outpatient setting	RWT	92.50%	99.34%	G	99.55%	G	↓	
RWT_LQR21	Safeguarding – failure to achieve thresholds for specific indicators as detailed in the Combined Safeguarding Dashboard. (Submit: Yes if all Dashboard is compliant, No if breaches)	RWT	Yes	No	R	-	-		
RWT_LQR28	All Staff Hand Hygiene Compliance	RWT	95.00%	93.71%	R	92.58%	R	↑	
RWT_LQR29	Infection Prevention Training Level 2	RWT	95.00%	95.87%	G	94.87%	R	↑	
BCPFT_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*	BCP	92.00%	98.31%	G	97.28%	G	↑	
BCPFT_EB54	Zero tolerance RTT waits over 52 weeks for incomplete pathways	BCP	0.00	0.00	G	0.00	G	→	
BCPFT_DC1	Duty of Candour	BCP	YES	Yes	G	-	-		
BCPFT_IAPT1	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance	BCP	90.00%	100.00%	G	100.00%	G	→	
BCPFT_EH4	Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral	BCP	50.00%	100.00%	G	90.63%	G	↑	
BCPFT_EH1	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within six weeks of referral	BCP	75.00%	96.00%	G	96.12%	G	↓	
BCPFT_EH2	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within 18 weeks of referral	BCP	95.00%	100.00%	G	100.00%	G	→	
BCPFT_EB51	Mixed sex accommodation breach	BCP	0	0	G	0	G	→	
BCPFT_EB53	Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric in-patient care*	BCP	95.00%	94.44%	R	94.96%	R	↑	
BCPFT_LQGE01a	Proportion of Patients accessing MH services who are on CPA who have a crisis management plan (people on CPA within 4 weeks of initiation of their CPA)	BCP	90.00%	100.00%	G	96.32%	G	→	
BCPFT_LQGE01b	Percentage of inpatients with a Crisis Management plan on discharge from secondary care. (NB: exclusions apply to patients who discharge themselves against clinical advice or who are AWOL)	BCP	100.00%	100.00%	G	98.13%	R	→	
BCPFT_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	BCP	80.00%	87.80%	G	90.83%	G	↓	
BCPFT_LQGE06	IPC training programme adhered to as per locally agreed plan for each staff group. Compliance to agreed local plan. Quarterly confirmation of percentage of compliance	BCP	85.00%	0.84	R	0.84	R	↑	
BCPFT_LQGE09	Evidence of using HONOS: Proportion of patients with a HONOS score	BCP	95.00%	96.88%	G	96.62%	G	↓	
BCPFT_LQGE10	Proportion of patients referred for inpatient admission who have gatekeeping assessment (Monitor definition 10)	BCP	95.00%	100.00%	G	99.64%	G	↑	
BCPFT_LQGE11	Delayed Transfers of Care to be maintained at a minimum level	BCP	7.50%	10.50%	R	4.58%	G	↓	
BCPFT_LQGE12a	% of Crisis assessments carried out within 4 hours (Wolverhampton Psychiatric Liaison Service Emergency)	BCP	95.00%	99.31%	G	96.86%	G	↓	
BCPFT_LQGE13a	% of Urgent assessments carried out within 48 hours (Wolverhampton Psychiatric Liaison Service)	BCP	85.00%	96.67%	G	92.46%	G	↓	
BCPFT_LQGE14b	% of Routine assessments carried out within 8 weeks (Wolverhampton Psychiatric Liaison Service Routine Referral)	BCP	85.00%	98.06%	G	98.11%	G	↓	
BCPFT_LQGE15	Percentage of SULs that are reported onto STEIS within 2 working days of notification of the incident	BCP	100.00%	100.00%	G	100.00%	G	→	

17/18 Reference	Description - Indicators with exception reporting highlighted for info	Provider	Target	Latest Month Performance	In Mth RAG	YTD Performance	YTD RAG	Variance between Mth	Trend (null submissions will be blank) per Month
BCPFT_LQGE16	Update of STEIS at 3 working days of the report. The provider will keep the CCG informed by updating STEIS following completion of 48 hour report (within 72 hours of reporting incident on STEIS. Day one commences as of reporting date). CCG will do monthly data checks to ensure sufficient information has been shared via STEIS and report back to CQRM.	BCP	100.00%	50.00%	R	93.75%	R	↓	
BCPFT_LQGE17	Provide commissioners with Level 1 (concise) and Level 2 (comprehensive) RCA reports within 60 working days and Level 3 (independent investigation) 6 months from the date the investigation is commissioned as per Serious Incident Framework 2015 page 41. All internal investigations should be supported by a clear investigation management plan.	BCP	100.00%	100.00%	G	81.25%	R	→	
BCPFT_LQIA01	Percentage of people who are moving to recovery of those who have completed treatment in the reporting period [Target - >50%, Sanction: GC9]	BCP	50.00%	59.84%	G	56.87%	G	↑	
BCPFT_LQIA02	75% of people engaged in the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral [Target - >75% Sanction: GC9]	BCP	75.00%	96.00%	G	96.12%	G	↓	
BCPFT_LQIA03	95% of people referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral [Target - >95%, Sanction: GC9]	BCP	95.00%	100.00%	G	100.00%	G	→	
BCPFT_LQIA05	People who have entered treatment as a proportion of people with anxiety or depression (local prevalence) [Target - Special Rules - 29,880 = 16.8% of prevalence.	BCP	1.40%	1.13%	R	1.42%	G	↓	
BCPFT_LQCA01	Percentage of children referred who have had initial assessment and treatment appointments within 18 weeks. This indicator will follow the rules applied in the 'Improving access to child and adolescent mental health services' reducing waiting times policy and practice guide (including guidance on the 18 weeks referral to treatment standard) in 'Documents Relied Upon'	BCP	90.00%	96.55%	G	98.79%	G	↓	
BCPFT_LQCA03	Percentage of all referrals from paediatric ward/s for self-harm assessed within 12 working hours of referral	BCP	95.00%	100.00%	G	100.00%	G	→	
BCPFT_LQCA04	Every person presenting at A&E with crisis seen within 4 hours. The clock starts when A&E make the referral to crisis.	BCP	100.00%	100.00%	G	100.00%	G	→	
BCPFT_EAS4	Zero Tolerance methicillin-resistant Staphylococcus aureus	BCP	0	0	G	0	G	→	
BCPFT_EAS5	Minimise rates of Clostridium Difficile	BCP	0	0	G	0	G	→	

**WOLVERHAMPTON CCG**  
**GOVERNING BODY MEETING**  
**13 FEBRUARY 2018**

**Agenda item 13**

<b>TITLE OF REPORT:</b>	Summary – Primary Care Commissioning Committee – 5 December 2017
<b>AUTHOR(s) OF REPORT:</b>	Sue McKie, Primary Care Commissioning Committee Chair
<b>MANAGEMENT LEAD:</b>	Mike Hastings, Associate Director of Operations
<b>PURPOSE OF REPORT:</b>	To provide the Governing Body with an update from the meeting of the Primary Care Commissioning Committee on 5 December 2017.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain.
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>• The results for the Friends and Family data slightly dipped for the month at 81% compared to the previous month of 82%. A Task and Finish Group has been set up to look at increasing engagement, uptake and promotion across practices.</li> <li>• The implementation plan for the General Practice Five Year Forward View continues to make good progress. There are currently 39 live projects with a further 3 due to commence, awaiting national guidance being received by the CCG.</li> </ul>
<b>RECOMMENDATION:</b>	The Governing Body is asked to note the progress made by the Primary Care Joint Commissioning Committee.
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	
1. Improving the quality and safety of the services we commission	The Primary Care Commissioning Committee monitors the quality and safety of General Practice.
2. Reducing Health Inequalities in Wolverhampton	The Primary Care Commissioning Committee works with clinical groups within Primary Care to transform delivery.

<p>3. System effectiveness delivered within our financial envelope</p>	<p>Primary Care issues are managed to enable Primary Care Strategy delivery.</p>
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## **1. BACKGROUND AND CURRENT SITUATION**

1.1. The Primary Care Commissioning Committee met on 5 December 2017. This report provides a summary of the issues discussed and the decisions made at those meetings.

## **2. PRIMARY CARE UPDATES**

### **Primary Care Commissioning Committee – 5 December 2017**

#### **2.1 Primary Care Quality Report**

2.1.1 The Committee received an overview of the activity in primary care and it was noted that the infection prevention standards and scores have improved since the new audit format was introduced and understanding of the process has grown.

2.1.2 The results for the Friends and Family data slightly dipped for the month at 81% compared to the previous month of 82%. A Task and Finish Group has been set up to look at increasing engagement, uptake and promotion across practices.

2.1.3 The Workforce Plan continues in line with the Primary Care Strategy, Sustainability and Transformation Plan (STP) and national drivers. An STP wide action plan has been submitted to NHS England. A video promoting primary care in the City is being produced and will be available on the CCG website shortly.

The Committee received the following update reports:-

#### **2.2 Governing Body Report / Primary Care Milestone Review Board Update**

2.2.1 The Committee were updated around the work progressed against the Primary Care Strategy and the work undertaken within each of the Task and Finish Groups. The Board reviewed and agreed the exception reports which were in relation to the following:

- Practices as Providers – Review of back office functions
- General Practice as Commissioners – Enhanced Services at scale
- Primary Care Contract Management – Risk / gain share agreement

2.2.2 The implementation plan for the General Practice Five Year Forward View continues to make good progress. There are currently 39 live projects with a further 3 due to commence, awaiting national guidance being received by the CCG.

#### **2.3 Primary Care Operational Management Group Meeting**

2.3.1 The Committee were updated around the discussions which took place at the Primary Care Operational Management Group on 21 November 2017. It was noted that the IT migration has highlighted some issues with the Docman 10 document management system when Practices are undergoing a merge, these issues are being reviewed.

2.3.2 The Care Quality Commission (CQC) provided an update on the practices they have visited and those that are planned. All the outcomes are published and available to view on the CQC website.

#### **2.4 Other Issues Considered**

2.4.1 The Committee met in private to receive a request for approval of the retirement of a GP from a Wolverhampton Practice, the business case for the Home Visiting Service Pilot Project and a request for the risk register to be split into corporate and strategic risks.

### **3. CLINICAL VIEW**

3.1. Not applicable.

### **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 by the Primary Care Operational Management Group.

### **6. IMPACT ASSESSMENT**

#### ***Financial and Resource Implications***

6.1. Any Financial implications have been considered and addressed at the appropriate forum.

#### ***Quality and Safety Implications***

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

***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:** Sue McKie  
**Job Title:** Lay Member for Public and Patient Involvement, Committee Chair  
**Date:** 29 January 2018



### 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.**

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	<b>N/A</b>	
Public/ Patient View	<b>N/A</b>	
Finance Implications discussed with Finance Team	<b>N/A</b>	
Quality Implications discussed with Quality and Risk Team	<b>N/A</b>	
Equality Implications discussed with CSU Equality and Inclusion Service	<b>N/A</b>	
Information Governance implications discussed with IG Support Officer	<b>N/A</b>	
Legal/ Policy implications discussed with Corporate Operations Manager	<b>N/A</b>	
Other Implications (Medicines management, estates, HR, IM&T etc.)	<b>N/A</b>	
Any relevant data requirements discussed with CSU Business Intelligence	<b>N/A</b>	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Sue McKie</b>	<b>29/01/18</b>

**WOLVERHAMPTON CCG**

**Governing Body**  
**13<sup>th</sup> February 2018**

**Agenda item 14**

<b>TITLE OF REPORT:</b>	Report of the Primary Care Milestone Delivery Board (January 2018)
<b>AUTHOR(S) OF REPORT:</b>	Jo Reynolds- Primary Care Development Manager
<b>MANAGEMENT LEAD:</b>	Sarah Southall- Head of Primary Care
<b>PURPOSE OF REPORT:</b>	To provide an update on the activities that have taken place in the past 3 months for two key programmes of work (Primary Care Strategy and General Practice Forward View).
<b>ACTION REQUIRED:</b>	<input checked="" type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This report has been prepared for consideration and discussion at the Public Governing Body Meeting.
<b>KEY POINTS:</b>	<p>The report provides detail of activities that have taken place during the period October through to the end of December therefore demonstrates where a series of achievements have been noted by the Board and also a focus on the activities that will be taking place during the period January to March 2018.</p> <p>Details pertaining to achievement and proposed activity should be noted for both programmes of work:-</p> <ul style="list-style-type: none"> <li>• Primary Care Strategy Implementation</li> <li>• There were 3 exception reports considered at the Milestone Review Board, all were accepted.</li> <li>• General Practice Forward View Implementation &amp; accompanying assessment looking to 2018/19</li> </ul>
<b>RECOMMENDATION:</b>	<p>The recommendations made to Governing Body regarding the content of this report are as follows:-</p> <ul style="list-style-type: none"> <li>• Receive and discuss this report, and the programmes of work contained within it.</li> <li>• Consider and approve the Primary Care Workforce Strategy following discussion among Group Leads and Task &amp; Finish Group Members.</li> </ul>
<b>LINK TO BOARD ASSURANCE FRAMEWORK</b>	1a , 2a, 3a, 3b, 3c, 3d

**Governing Body**  
**13<sup>th</sup> February 2018**



<b>AIMS &amp; OBJECTIVES:</b>	
1. Improving the quality and safety of the services we commission	Ensure on-going safety and performance in the system Continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions
2. Reducing Health Inequalities in Wolverhampton	Improve and develop primary care in Wolverhampton – Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this.
3. System effectiveness delivered within our financial envelope	<p>Proactively drive our contribution to the Black Country STP Play a leading role in the development and delivery of the Black Country STP to support material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country footprint</p> <p>Continue to meet our Statutory Duties and responsibilities Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework</p> <p>Deliver improvements in the infrastructure for health and care across Wolverhampton The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.</p> <p>Deliver improvements in the infrastructure for health and care across Wolverhampton The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.</p>



## 1. BACKGROUND AND CURRENT SITUATION

- 1.1 In 2016, The General Practice 5 Year Forward View was published in April 2016. It covers five areas: overall investment, workforce, workload, infrastructure and care redesign.

The CCG has developed two programmes of work to enable implementation of the Primary Care Strategy and General Practice Forward View. Both programmes have been in place since 2016 the content of both is largely attributed national direction & local improvement that seeks to achieve a sustainable primary care for the future. Whilst the Milestone Review Board receive reports in line with a full programme management office approach for the Primary Care Strategy the GPFV programme has been developed over a period of time based on national guidance.

Currently the programme has 85 projects defined these are reflective of the five chapters but also align with some of the work that had been identified within the CCGs Primary Care Strategy Programme of Work. By way of an overview the current programme has been broken down as follows:

<b>GPFV Programme of Work</b>	
<b>Chapter</b>	<b>Total Number of Projects</b>
1 Investment	7
2 Workforce	27
3 Workload	25
4 Infra-structure	21
5 Care Redesign	5
<b>Total(s)</b>	<b>85</b>

Appendix 1 provides an overview of the current milestone achievements for 2017/18 and Appendix 2 provides a more detailed assessment of the full programme of work by chapter, in a self-assessment format providing an indication of individual project status and progress being made spanning all 5 chapters of the GPFV.

Many of the projects overlap with the work of some Task and Finish Groups, some have been completed, many are now in progress. Some projects are yet to be released nationally and will be added to the CCG programme of work when further details become available from the General Practice Transformation Board (NHS England). Those that have been released have been included in the GPFV Self Assessment exposing the volume of activity that will be taking place particularly during 2018/19.



2. Primary Care Strategy - Task and Finish Group Updates

2.1 Workbooks are submitted on a monthly basis by programme leads, and monitored through a quarterly Milestone Review Board. A steering group meets in the intervening period to ensure no risks or slippage arise & if so they are duly escalated.

2.2 The programme was running in accordance with anticipated timescales hence there was no slippage on any part of the programme. Workbooks were reviewed for all task and finish groups, with acknowledgement from the responsible Director on current progress and next steps. The highlights are captured within the table below:-

<b>Practices as Providers Task &amp; Finish Group</b>	
<b>Achievements Past 3 Months</b>	<b>Priorities for Next 3 Months</b>
<ul style="list-style-type: none"> <li>Targeted Peer Review : service specification prepared &amp; shared with Clinical Reference Group.</li> <li>Frailty Pilot Review : mid term review undertaken, full benefits realisation to be undertaken at the end of the 12 month pilot.</li> <li>Home Visiting Pilot : Business Case approved for pilot to take place.</li> <li>Back Office Functions Review : commenced review with practice groups, exception report approved to extend timescale.</li> <li>Risk Stratification : service specification prepared &amp; shared with Clinical Reference Group.</li> <li>The Sound Doctor : service implemented October 2017</li> <li>Primary Care Counselling Service : extension of existing pilot &amp; approval for 3 year contract.</li> </ul>	<ul style="list-style-type: none"> <li>Implement Targeted Peer Review January 2018 with ongoing provision of refreshed data.</li> <li>Frailty Project will continue until the end of May 2018.</li> <li>Home Visiting Pilot : Service specification will be finalised &amp; posts personnel recruited. Pilot should be mobilised by late April 2018.</li> <li>Conclude back office functions review February 2018.</li> <li>Agree an all encompassing approach to Multi Disciplinary Team Meetings engaging with all practices across the city.</li> <li>Monitor all newly commissioned services via a centralised dashboard that can be used at group level and CCG meetings.</li> <li>Procure Primary Care Counselling Service beyond March 2018 (3 year contract)</li> </ul>
<b>Primary Care as Commissioners</b>	
<b>Achievements Past 3 Months</b>	<b>Priorities for Next 3 Months</b>
<ul style="list-style-type: none"> <li>Practice Group information sharing agreements reviewed &amp; data sharing configuration updated.</li> <li>Targeted Peer Review findings reviewed at Group Leads &amp; Members Meeting.</li> <li>Shortlist of services practice groups intend to deliver at scale.</li> <li>Group level development plans prepared &amp; agreed.</li> <li>Continued engagement with PPG Chairs &amp; promotional advertising for the wider public regarding improving access, care navigation etc.</li> </ul>	<ul style="list-style-type: none"> <li>Finalise changes to practice groupings, continue to amend if changes occur.</li> <li>Continue Targeted Peer Review &amp; improve data quality.</li> <li>Finalise delivery plans for Service Delivery at Scale (implement April 2018→)</li> <li>Continue to implement group level plans to enable maturity.</li> <li>Ongoing dialogue with PPG Chairs &amp; commitment to improved advertising to promote improving access &amp; new activities.</li> <li>Finalise QOF+ Framework &amp; implement</li> </ul>

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<ul style="list-style-type: none"> <li>• Developed a new process for identifying &amp; developing enhanced services/ investment in General Practice</li> <li>• Group Budget Statements introduced</li> <li>• Commissioned Services Dashboard in place (includes data for Quarters 1-3)</li> </ul>	<p>April 2018→</p> <ul style="list-style-type: none"> <li>• Review Commissioned Services Dashboard on an ongoing basis at Group Level to ensure active monitoring &amp; ownership.</li> </ul>
<p><b>Workforce</b></p>	
<p><b>Achievements Past 3 Months</b></p> <ul style="list-style-type: none"> <li>• Extensive programme of work continues to be deployed with oversight from the responsible Task &amp; Finish Group.</li> <li>• Primary Care Webpage developed , particular focus on recruitment &amp; General Practice vacancies.</li> <li>• CCG Primary Care Workforce Strategy prepared &amp; shared for approval</li> <li>• Primary Care Workforce Dashboard developed</li> <li>• STP Primary Care Workforce Strategy developed across the Black Country &amp; submitted to NHS England.</li> <li>• Continued delivery of extensive programme of training for Admin &amp; Reception staff, Practice Managers.</li> <li>• HCA Development programme agreed &amp; Practice Nurse Training Programme continues to be delivered in line with the Practice Nurse 10 Point Action Plan.</li> <li>• Explored opportunities for introducing apprenticeships in primary care.</li> <li>• Continued partnership working with stakeholders including Wolverhampton University, Royal Wolverhampton Trust &amp; Health Education West Midlands.</li> </ul>	<p><b>Priorities for Next 3 Months</b></p> <ul style="list-style-type: none"> <li>• City wide pharmacy review to be scheduled</li> <li>• Training needs analysis progressing</li> <li>• Publish a range of primary care case studies &amp; continue to develop advertising via website.</li> <li>• Commence implementation of Primary Care Workforce Strategy.</li> <li>• Review Workforce Dashboard at Group Level</li> <li>• Continue to develop &amp; deliver workforce training programme including GP leadership component.</li> <li>• Finalise apprenticeship opportunities &amp; introduce where feasible.</li> <li>• Continue to work with stakeholders</li> </ul>
<p><b>Contracting Task &amp; Finish Group</b></p>	
<p><b>1. Implementation of Virtual Alliance Contract</b></p> <ul style="list-style-type: none"> <li>• A working group has been established with RWT with the remit of developing a risk/ gain share approach (along the lines of the Bolton bucket model). Currently finance-led. Contracting input to occur in due course.</li> <li>• Contact made with Nottingham CCGs who have implemented an Alliance contract (as a MoU). Useful for information sharing/ lessons learnt</li> </ul>	<ul style="list-style-type: none"> <li>• Establish closer links with ACA Development Group</li> <li>• Opportunity for increased learning from across Black Country via the System Redesign Group (Risk/gain share)</li> <li>• Complete agreement for risk/gain share approach with RWT. Confirm arrangements for shadow monitoring in 18/19.</li> <li>• Complete Virtual Alliance Contract - ? over-achievability.</li> </ul>

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<p><u>Misses/Exceptions and Escalations</u></p> <ul style="list-style-type: none"> <li>• 1.3 – Agree different incentive categories (relating to the risk share arrangement). Deadline amended to end of March 2018.</li> <li>• 1.4 – Clearly identify the contracting mechanisms to be used. Deadline amended to end of March 2018.</li> <li>• 1.5 – Implement Virtual Alliance based contract Deadline amended to end of March 2018.</li> </ul> <p><b>2. Implementation of MCP/ PACS emerging care model and contract framework</b></p> <ul style="list-style-type: none"> <li>• Reviewed and appraised national guidance on MCP/ PACS models (2.1)</li> <li>• Initiated development of contract plan/ strategy for Primary Care (2.4)</li> <li>• Review of PCAST re what services we want from the MoU</li> <li>• Initiated contract mechanisms for Extended Primary Care Services (LESSs) to inform contract arrangements for 18/19 (2.3)</li> </ul> <p><u>Misses/Exceptions and Escalations</u></p> <ul style="list-style-type: none"> <li>• No misses or exceptions as such, however new milestones will be required</li> </ul>	<ul style="list-style-type: none"> <li>• Complete PC contract strategy (aim to bring to PCPRB in April)</li> <li>• Complete and issue Extended Primary Care Service contracts for 18.19</li> <li>• Review implementation plan and agree new milestones for 18.19</li> </ul>
<b>IT Task &amp; Finish Group</b>	
<p><b>Achievements Past 3 Months</b></p> <ul style="list-style-type: none"> <li>• Combined Grove and all saints merge with Caerleon took place on 11th December</li> <li>• Shared Care Record - Change in way secondary care data is processed identified an issue with the transfer of data from the acute system to the graphnet server. This is being reviewed to agree a way to send the data securely, still plan to go live with data in January, continue development of EPaCC's shared care plan</li> <li>• EMIS community - two clinical services modules have been rolled out.</li> <li>• EMIS Anywhere - deploying last tranche of laptops.</li> </ul>	<p><b>Priorities for Next 3 Months</b></p> <ul style="list-style-type: none"> <li>• Start planning for migration of Dr Cowen's April and Dr Bilas &amp; Thomas migration in May-June 2018</li> <li>• Shared Care Record -Work on VPN solution to transfer data between system C and RWT, continue development of EPaCC's shared care plan</li> <li>• EMIS community - Close project and move to BAU.</li> <li>• EMIS Anywhere - Mop up of devices to ensure that all practices have machines and that they are being used.</li> </ul>

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<ul style="list-style-type: none"> <li>• Patient Online Uptake: Work with Comms team to send out reminder to practices in GP bulletin.</li> <li>• Patient Online Detailed coded record – Reminded practices of requirement</li> <li>• Sound Doctor - Review Activity/Usage</li> <li>• E-Consultation Solutions -Had to resubmit bid to NHS England. Should receive funding confirmation in January 2018.</li> <li>• E-RS - Steering group meeting regularly, first draft of comms for Primary care been issued for review.</li> </ul>	<ul style="list-style-type: none"> <li>• Patient Online Uptake: Work with Comms team to send out reminder to practices in GP bulletin.</li> <li>• Patient Online Detailed coded record – Reminded practices of requirement</li> <li>• Sound Doctor - Review Activity/Usage</li> <li>• E-Consultation Solutions - Get funding confirmation complete MOU and start project.</li> <li>• E-RS - Appoint new Implementation officer in IM &amp; T to be key contact for E-RS. Attend E-RS National workshop in Birmingham.</li> </ul>
<b>Estates Task &amp; Finish Group</b>	
<b>Achievements Past 3 Months</b>	<b>Priorities for Next 3 Months</b>
<ul style="list-style-type: none"> <li>• Two schemes have been reallocated funding. With Showell Park and Parkfields dropping out of cohort 2, East Park and Newbridge surgery will absorb most of the vacant allocation.</li> <li>• East park have a conflict of interest and Newbridge have altered plans, weekly updates are being received and plans are still on course.</li> <li>• NHSPS practice lease issues have moved forward and practices have been offered new leases and are at the point of sign off.</li> <li>• Void space work is continuing and further discussions with NHSPS are planned. We have received a 'Hand back process' document which the CCG is currently reviewing.</li> </ul>	<ul style="list-style-type: none"> <li>• Arrange monthly meetings with 2 practices who are having issues/changes to EETF schemes.</li> <li>• Follow up Mapping tool so that final mpas can be produced with condition survey.</li> <li>• Void space work to be reviewed.</li> </ul>

### 2.3 Primary Care Workforce Strategy

One of the key requirements within the work programme was to develop a Primary Care Workforce Strategy to underpin achievement of a sustainable workforce for the future. The Workforce Task and Finish Group have been sighted on the development of this strategy and have provided a range of comments that have been incorporated into the document that has also been shared with Group Leads and Governing Body previously. The final draft document is attached for approval, a detail implementation plan and programme of work accompany the document. Governing Body should consider and confirm their endorsement. Our Vision is to develop and sustain a workforce built around the needs of our population, which has the skills, knowledge and values to transform at scale and delivery high quality care within Wolverhampton.



## 2.4 General Practice Five Year Forward Live Project Updates

### 2.4.1 Care Navigation

The preparatory measures for the inception of care navigation are moving forward. The current focus is training of staff, and ensuring practices are ready to utilise care navigation once it is launched in February.

The five navigation points in phase one are:-

- Community Pharmacy
- Minor Eye Conditions
- One You/ Healthy Lifestyles Service
- Carer Support
- Community Dentist

The five identified navigation pathways are well engaged with the programme, and are scheduled to attend face to face training with practice staff in January, this will follow online training also due to be undertaken in December. The IT requirements are all in place, templates including referral criteria have been built into the EMIS system ready for staff to navigate patients when appropriate.

Practices are taking up the offer of an informal training session delivered by the Primary Care Development Manager during their staff meetings or training sessions. The aim of these sessions is to answer any questions the staff may have and alleviating any concerns there are about incorporating Care Navigation in their daily working practices. The sessions are being accessed by staff who have not attended any of the previous training sessions, and are creating a consistent Wolverhampton wide message.

There has been online training available, for which all 220 licences that have been purchased have been used. There has also been a 'meet the provider' event, with 85 reception and admin staff attending, and an additional 45 places were requested. The aim of the session was to give staff a better understanding of the navigation points and the opportunity to ask questions. Both sets of training complimented each other, and have helped staff to feel comfortable and confident when navigating patients. We are in the process of organising more licences and a second 'meet the provider' event to help fulfil this demand.

A communications pack has been developed and circulated to support staff and patients with understanding the concept of care navigation, and the changes to the patient pathway as a result of this. Practice managers have been consulted on the content to ensure it is relevant to their needs, and it has also been discussed at the Practice Managers Forum & Lay Member for Patient & Public Engagement.

### 2.4.2 Online Consultation

A funding bid has been successful enabling the roll out of devices to support online consultation. The funding that has been awarded will enable a pilot project to take place, which will utilise skype based functionality to be used to provide online consultations.



This will enable practice groups willing to take part to access two pilots. One will be based in care homes, the other at group level providing online consultations via a dedicated resource for a range of appointment types that do not require a physical intervention.

A pilot for use in care homes is being developed, so that a home visit can be prevented by a skype type appointment taking place between a health professional that is in attendance, the patient, and a GP virtually.

#### 2.4.3 Practice Manager Diploma

As part of the General Practice Forward View, there is a commitment to investment in the development in practice managers (GPFV ref 2.19). Practice managers have had the opportunity to engage in one day, course specific training at an STP level, but have requested a more comprehensive training programme be explored.

The National Association of Primary Care are currently running a one year diploma in Advanced Primary Care Management. The course is a practical, online, focused, service development and business management diploma.

The course is suitable for those currently working at practice manager level, and aims to develop the skills to lead the transformation of primary care and develop new models of care. Candidates will gain the skills and competencies for managing primary care at scale within the NHS.

An expression of interest was requested from those practice managers interested, with 7 responses being received.

The course will use a combination of structured online learning and workplace learning based within the practice, allowing learning to be integrated into practice. There is one meeting, a plenary at the start of the course.

Non recurring funds are available 2017/18 & 2018/19 to fund the Diploma course £25,200 per year enabling 14 Practice Managers to enrol & complete the course.

#### 2.4.5 Improving Access and Transformational Fund Specifications

A specification has been developed to increase the access to appointments outside of core hours. There is a national target of an additional 30 minutes per 1000 population, with 100% coverage, be in place by March 2019. Transformational Fund has been used in 2017/18 to establish 20 minutes per 1000 population in preparation for this. The additional hours will need to be 8-8 Monday to Friday, with Saturdays Sundays and bank holidays also being part of this specification.

The specification for 2018/19 Transformational Fund has also been developed, with the focus on the 10 high impact actions and working at scale. 6 of the HI actions have been implemented within the current financial year, and will need maintaining and monitoring, and the remaining 4 HI actions will need to be developed over the duration of the specification term.

Specifications has been shared with group leads, and practice groups are holding discussions to develop delivery plans in response to this.

### **3 CLINICAL VIEW**

- 3.1 There are a range of clinical and non-clinical professionals leading this process in order to ensure that leadership decisions are clinically driven. Clinical representation at many Task and Finish Groups takes place on a regular basis & is overseen by the Milestone Review Board which also has clinical representation.

### **4 PATIENT AND PUBLIC VIEW**

- 4.1 Whilst patients and the public were engaged in the development of the strategy and a commissioning intentions event held in the summer specific to primary care the Governing Body should note that Practice based Patient Participation Groups are being encouraged to ensure their work with the practice(s) encompasses new models of care and the importance of patient and public engagement moving forward.
- 4.2 An update on Primary Care is provided to Patient Participation Group Chairs routinely, and meetings at group level have been introduced on a quarterly basis to ensure patients and the public are invited to share their suggestions on areas for improvement and take part in discussions about changes affecting patients within their respective practice group.

### **5 RISKS AND IMPLICATIONS**

#### ***Key Risks***

- 5.1 The Milestone Review Board has in place a risk register that captures the profile of risks associated with the program of work. Risks pertaining to the program are reviewed at each meeting and at this stage there are no red risks to raise.

There is a risk that practice groups will be unable to respond to the Improving Access requirements, so there are plans being put into place for this eventuality.

#### ***Financial and Resource Implications***

- 5.2 At this stage there are no financial and resource implications to consider, the resources needed have been discussed in the appropriate task and finish groups and at Milestone Review Board. All financial commitments have been allocated within the scope of the Primary Care resources, and finance colleagues are aware of the implications. .

#### ***Quality and Safety Implications***

- 5.3 Patient safety is first and foremost, the experience of patients accessing primary medical services as the programme becomes more established is anticipated to be met with positive experiences of care. The quality team will be engaged accordingly as service design takes place and evaluation of existing care delivery is undertaken.

#### ***Equality Implications***

- 5.4 The Strategy has a full equality analysis in place. This will require periodic review during the implementation phase.



**Medicines Management Implications**

5.5 The role of clinical pharmacist is an area of specific attention within the programme of work. A task and finish group has been established to ensure this role is utilised with maximum impact in the future.

**Legal and Policy Implications**

5.6 The Primary Care Strategy demonstrates how the CCG seeks to satisfy its statutory duties and takes account of the key principles defined within the General Practice Five Year Forward View.

**Name** Jo Reynolds  
**Job Title** Primary Care Development Manager  
**Date:** 29/01/2018

- Appendix 1** GPFV Programme of Work Milestone Plan 2017/18
- Appendix 2** GPFV Programme & Self Assessment 2018/19
- Appendix 3** Primary Care Workforce Strategy, Programme of Work & Implementation Plan

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	<b>S Reehana</b>	<b>05/02/2018</b>
Public/ Patient View		
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team		
Equality Implications discussed with CSU Equality and Inclusion Service		
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager		
Other Implications (Medicines management, estates, HR, IM&T etc.)		
Any relevant data requirements discussed with CSU Business Intelligence		
<b>Signed off by Report Owner (Must be completed)</b>	<b>S Marshall</b>	<b>05/02/2018</b>

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**Please note that the plan will be a working document and can be flexed to respond to increase demand and feedback, further initiatives and refining of plans will be taken forward by the respective workforce leads.**

Further initiatives will be added to increase target numbers which will be necessary to respond to increased population and GP demand over the next few years.

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	
<b>Governance</b>							
STP governance model and delivery vehicle agreed to include key work streams and leads	Proposed delivery model Submitted as part of strategy. Agreement including resource Workstreams	Exploring funding Opportunities to source GP clinical leadership on annual basis to provide clinical leadership	Agree Governance and key work streams leads. Co-ordinate and support Community Education Provider Networks (CEPNs) to ensure that these networks are led to be the key workforce and training supports, extending the skill-base within general practice and developing a workforce that can meet the challenge of new ways of working and by establishing them within the STPs.	TFG		Delivery mechanism delivering its key KPIs objectives as per plans	
	<ul style="list-style-type: none"> <li>Recruitment and retention</li> <li>New ways of working and staffing models</li> <li>Leadership and cultural change</li> <li>Nursing</li> <li>Links with STP</li> </ul>	Admin support to be provided via CEPN funding for CEPN network.	Work with STP finance to identify recurring budgets.	Work streams leads to develop specific plans and begin implementation of plans – quarterly reports and monitoring to STP board committees an completion of NHS returns as appropriate	Workforce TFG		2020
	CEPN reports KPIs monthly to HEE	Workstream leads to be agreed from existing CCG staff		Q1 Implementation quarterly reports and monitoring to STP board committees			
	Finance/funding to be identified		Q2: Implementation quarterly reports and monitoring to STP board committees				
<b>Recruitment and Retention- Contribution to increasing the number of doctors (Wolverhampton target: .....FTE 2020)</b>							

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
<b>Primary Care Workforce Strategy</b>  Analyse current state of primary care workforce data in order to identify gaps and agree priority workforce.	General workforce activities planned with data information from workforce dashboard.  ( Delivery plan figures have been inputted into model and target has been identified)	Time resource confirmed	Use workforce dashboard to develop an up to date assessment of current workforce in general practice across workload demands and identifying the practices in need of the greatest support. This will be completed via a workforce planning tool completed by HEE from data received from all practices.	WTFG	Meet with HEE workforce data team with end of March date to agree numbers and consideration given to additional initiatives that have been inputted into the model.	A general practice workforce strategy will provide strategic direction for primary care; supporting and describing goals and priorities for implementation and review. The strategy will ensure that all areas for workforce improvement are identified and actioned; in line with local system priorities and needs.
			Agree workforce plan and actions for delivery			
			Implementing plans and review impacts.			
			Consult with practices regarding the analysis undertaken in to confirm position.			
<b>International GP recruitment</b>	Wolverhampton have been awarded funding to allow up to ..... GPs to be recruited from overseas and ready to participate the IR induction programme	Funding from NHS England  Majority of funding will stay with NHS England to manage programme nationally in accordance with new extended programme.	Link with NHS England to follow their process	As per plan by 2020	GPs recruited onto the programme.	
			Follow project plan			
			Implementation			
			Implementation and review			
<b>International GP recruitment</b>	Wave 3 will be open up to the end of November for funding bids to be received.	Bid to include investment for an additional ..... GPs across the system.  Awaiting confirmation on success.	Write further bid for an extra ....GPs for Wolverhampton	As per plan by 2020	GPs recruited onto the programme.	
			if successful plan delivery			
			Implement action plan			
			Implement action plan			

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
<b>Increase the number of GP Fellowships</b>		Health Education England funding agreed for the STP	: Agree across all how we can use the funding to ensure equity of fellowships across Wolverhampton. Advertise GP Fellowship Opportunity via BMJ, NHS Jobs and Social Media	WTFG	End of 2018	Recruit additional GP fellowships.
			Shortlist applications, interview and offer fellowship (if appropriate). Confirm course, practice and funding.			
			GP Fellowship to commence in post.			
			Feedback and follow up about experience and progress.			
<b>Promote 'General Practice' to newly qualified staff in order to retain them in the area.</b>	newly qualified leave the area. Consider salary supplement to attract trainees to certain areas of the country call the Targeted Enhanced Recruitment Scheme.	STP finance to identify opportunities	explore the opportunities that the TER scheme presents and work with practices to apply where appropriate. Promote general practice and collaborate on a [social] marketing campaign – targeting newly qualified doctors that sets out the positive aspects and future careers in general practice Work more closely with the GP national recruitment office. Consider teaming up with local authority regarding an offer for newly qualified GPs i.e. subsidised housing, gym membership, and subsidised crèche, free public transport etc.		2020	newly qualified staff to be retained

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
			<p>Improve the scale of Training – identify resources for post Certificates of Completed Training (CCT) to applicants pursuing work in geographies hard to recruit. an academic programme of activity; an aspect of medical education and training related to the primary care agenda</p> <p>Explore foundations most likely to increase and stimulate recruitment in general practice include:</p> <ul style="list-style-type: none"> <li>• Exposure of medical students to successful GP role models</li> <li>• Early exposure to general practice</li> <li>• Supporting essential motivational factors and career determinants</li> <li>• Strategies to improve job satisfaction</li> </ul>			

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
			<ul style="list-style-type: none"> <li>Reducing job stressors such as work overload, lack of support and high demand</li> </ul>			
			Work with medical schools to conduct exit interviews and identify areas where improvement can be made.			
<b>Revitalisation newly qualified GPs</b>  support newly qualified GPs in the transition to primary care.	limited engagement	Approximately £.... per annum for engagement events via CEPN funding  Venue hire, refreshments etc.  Consider will CEPN funding be ongoing	Work with CEPN Members and GP Tutors to arrange engagement event. Establish commitment		Dec 2017	Links to measures to retain GPs
			Plan group meetings- agree worthwhile agenda		March 2018	
			Agree quarterly topics- support with venues etc.		June 2018	
			Agree topics- support with venues etc.		Sept 2018	
<b>Recruit pool of GPs as part of the national GP Career Plus Scheme</b>	Consider CCG to join national pilot using hosting model lead. Scheme started in July 2017 with currently 3 GPs on the scheme.	Year 1-  Consideration of future funding to sustain pilot	Engage with practices re. viability of scheme employment model across all CCGs. Further engagement activities to attract GPs who may otherwise leave the profession or area i.e. newly qualified or retiring. (Efforts will be made to ensure any engagement does not disable existing practice staff) Hold events to encourage take up of the scheme locally.		Dec 2017	
			Agree employment model across CCG. Consider sustainability and explore model such		March 2018	

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
			as a CCG resilience team.			
			Implementation and sharing best practice across the system and complete NHS England returns on progress.		June 2018	
			: Evaluate model		TBC	
<b>Promotion of primary care careers to students</b> Promote and encourage students to study medicine and apply for primary care careers	Meetings and relationships made with local colleges and schools  GP events at local colleges  student yearly events arranged.	Via CEPN administration funding  Consider- Will CEPN funding be long term?	Plan and agree career events across colleges and schools Produce careers leaflets – meet with primary care staff. Plan primary care video of careers	WTFG	Dec 2017	More informed colleges, schools and students regarding careers available in primary care and the level of education needed. More students are to be encouraged in a career in general practice.  Attendance at 5 local careers events per year Publication of Careers Booklet for Primary Care Annual GP seminar events attended by local sixth form and GCSE students
			finalise career leaflets Finalise careers video		Feb 2018	
			continue to roll out career events Link with HEE school experience pack and tap into inspiringthefuture.org		March 2018	
			Evaluate.		June 2018	
<b>Incentives to encourage GPs to stay in general practice</b> Incentive package developed (Individual care packages for GPs)	No system wide incentive package for GPs. Incentives normally via individual practices to encourage GPs to work i.e. different locum rates  (GP careers plus learning) individual care plans are currently not available.  Look at generic care packages for newly qualified, mid-career	Investment and funding could be significant i.e. based on 5K a year per GP or other personal incentives i.e. 15 minute appointment slots, flexible working etc. (confirm approx. costs )	Work with GPs to understand what incentives would encourage them to stay in Primary Care  Devise plan across CCG workforce leads to engage with GPs to understand practice and individual GP needs  Devise incentive package based on findings  Commence collation of GPs needs and potential care plans to	Group Managers	By the end of 2018	Incentive package used to encourage recruitment and retention.

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
	<p>thinking of retiring GPs as detailed in</p> <p>Further work is planned to devise care packages for individuals.</p>		<p>include timescales and any funding requirements</p> <p>Agree costings across the system and potential benefit impact</p> <p>: Implementation stage Evaluate pilot care plans with a view to rolling out if successful</p>			
<p><b>Fully realise funding opportunities that exist within the GP 10 point plan</b></p> <p>Funding is accessed via the opportunities with the 10 point plan to benefit practices</p>	<p>Not all funding opportunities are being explored and there is not full awareness of the benefits that currently exist nationally</p>	<p>Funding available via the GP 10 point plan</p> <p><b>Recruit</b></p> <ol style="list-style-type: none"> <li>1. Promoting general practice</li> <li>2. Improving the breadth of training</li> <li>3. Training hubs</li> <li>4. Targeted support</li> </ol> <p><b>Retain</b></p> <ol style="list-style-type: none"> <li>5. Investment in retainer schemes</li> <li>6. Improving the training capacity in general practice</li> <li>7. Incentives to remain in practice</li> <li>8. New ways of working</li> </ol> <p><b>Return</b></p> <ol style="list-style-type: none"> <li>9. Easy return to practice</li> <li>10. Targeted investment in returners</li> </ol>	<p>Understand the opportunities that are available nationally and fully explore the retainer scheme and engage with practices and GPs to further their understanding. <a href="https://heeoee.hee.nhs.uk/retainer">https://heeoee.hee.nhs.uk/retainer</a></p> <p>Q4: Communicate and engage with practices and support the submission of any funding bids</p> <p>Q1: Use funding to develop the particular area</p> <p>Identify the incentives to remain in practice (both pre-retirement and through other reasons). Invest in social marketing to identify the reasons for and opportunities to minimise GPs leaving the profession. Options include mentorships scheme, portfolio career towards the end of the working life along with a range of career pathways.</p>		Sep 2018	Additional funding for practices to develop initiatives within the 10 point plan

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	
<b>Scheme 2</b>			Q2: Implementation				
			Return to practice - recognise the different needs of those returning from work overseas or from a career break, to include working with the RCGP  Investment to attract GPs back into practice; targeting the areas of need				
<b>Supporting and implementing new roles within primary care – Including pharmacists, therapists etc.</b>							
<b>Increase the number of Clinical Pharmacists working within general practice.</b>	Successful clinical pharmacist bids in wave 1 and 2 across the CCGs. Clinical pharmacists are now taking an active role in a number of our practices and a number of these are already qualified to prescribe. Q3: Identify additional funding available from November 2017 Wave 3. Engage with practices about the benefits of having a clinical pharmacist in primary care practice. (System wide bid)	Funding from NHS England year 1 60%, year 2 40%, and year 3 20% to cover costs of new posts  STP will bid for any additional funding jointly as part of the STP commitment to work collaboratively.		Clinical Pharm TFG	Clinical Pharmacists	reduce the pressures and workloads of GPs b	
			March 2018				June 2018

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
	Q4: Map the practices interested in committing to support clinical pharmacists. Agree funding with Health Education England		Q2: Roles implemented in practice and begin to review their impact.		Sept 2018	
			Q3: Continue engagement with practices around the advantages of the role and encourage new ways of working.		Dec 2018	
			Q4: Identify interested practices for supporting clinical pharmacists in practice. Arrange for an event so interested practices can meet with practices seeing the benefits of the role implementation.		March 2019	
			Q1: Confirm plans and commence second round of recruitment.		June 2019	
			Q2: Continue to evaluate and roll out clinical pharmacists in practice.		Sept 2019	
<b>Increase the number of practices committed to supporting placements for Physicians Associates</b>	<p>A number of practices across the STP are supporting placements for PA students.</p> <p>PAs currently coming out of training have been recruited by the acute sector, there is potential opportunities for Primary Care in the future. Feedback from practices are that PAs would be more beneficial if prescribing was</p>	Health Education England funded placements direct to practices	<p>Q3: Trainees commence with placements in practices as agreed</p> <p>Look at ways that we can incentivise or encourage practices to create posts for PAs and sell the benefits. Feed into NHS survey re PAs education i.e.</p>		Dec 2017	Physician's associates work alongside GPs to provide medical care. The responsibilities of a physician's associate include taking medical histories, carrying out physical examinations, treating patients with chronic conditions, developing and delivering management plans, performing diagnostic

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
	part of their education. Feedback will collated via the recent PA survey from NHS England.		prescribing would be useful.			and therapeutic procedures and providing health and disease prevention advice to patients. The enable GPs to focus and prioritise their patients and workload. Supporting placements will encourage Physicians Associates, once qualified, to work in a primary care setting.
			Q4: Evaluation of training programme and placement.		March 2018	Increase the number of practices willing to support student placements by
			Q1: Engagement with local practices about the impact and benefits of supporting placements. Identify and confirm interested practices and inform universities. Support recruitment process		June 2018	PA position is supported by training i.e. prescribing course via universities in the future.
			Q2: Commencement of new roles		Sept 2018	
			Q3: Work with universities to identify further placements and assess impact on patient health.		Dec 2018	
			Q4: Continue roll out of role within primary care.		March 2019	
			Q1: Evaluate and monitor roles and impact. Share best practice.		June 2019	
			Q2: Establish a rolling programme for trainee placements and potential recruitment opportunities.		Sept 2019	

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
<b>Introduce paramedics within primary care.</b>	Placements for qualified paramedics working within general practice available.	Funding	Q3: Research best practice and familiarise the national toolkit. Consider rotational placements across provider organisations in order to not to destabilise the ambulance trust.	WTFG	Dec 2017	Increased GP capacity, reduction in referrals for unnecessary investigations or into secondary care, and high patient and GP satisfaction.  Pilot to be completed by 2018 with paramedic posts in place. additional paramedics across the area
			Q4: Agree proposal for new role and agree funding process. Engage with GPs and agree pilot sites.		March 2018	
			Q1: Recruit to new role.		June 2018	
			Q2: Evaluate and monitor new role.		Sept 2018	
<b>Explore funding for increasing the number of practice-based mental health therapists;</b> helping to transform the delivery of mental health services.	No specific funding identified within CCG budgets, however GPFV states funding will be available.  An increase in the number of practice-based mental health therapists would transform the delivery of mental health services in the local system. Mental health is a major element of the national health system and is critical to be part of the primary care workforce to aid resilience and strength.	Explore where funding has been received and hosted i.e. Mental Health Trust	Q3: Identify funding opportunities	2020	Greater access to mental health support and to increase the number of Mental health therapists by 2020.	
			Q4: Develop recruitment plan for Primary Care			
			Q1: Implement plan			
			Q2: Implement plan and review			
<b>Grow our own</b>  Through a number of education routes i.e. apprenticeships develop careers paths in primary care in order for staff to develop.	Currently there are a number of opportunities to increase apprenticeships in Primary care.  Medical assistant role and nursing associate roles have been developed which we look to encourage practices to take on.	Funding for medical assistant role-expression of interest to be been submitted	Q3: Devise a programme which identifies career development pathways for non-registered staff. Engage with practices to understand their needs and to promote benefits of the scheme.	From Sep 2018	Increase in the number of non-professional staff on apprentice programmes and career pathways.	
			Q4: Work with education providers to develop			

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
			programmes and communicate with practices and the local community			
			Q1: Implement plan			
			Q2: Implement plan			
<b>Scheme 3</b>						
<b>Upskilling and strengthening the nursing workforce (Must include GP Nurse 10 point plan) -</b>						
<b>Upskill the nursing workforce by implementing training and development opportunities</b>	A variety of training to cover specific and CPD based training has been commissioned	Via CEPN funding	Q3: Explore and identify any further nursing training needs and gaps.	Nominated lead for Scheme:	Dec 2017	Practice nurses have the clinical potential to relieve GP workload and, with training and education, they can support GPs by treating patients with their advanced skills. This would impact GPs; meaning that they could prioritise their patients and time.  Developed pool of skilled nurses for the management of long-term conditions relieving appointment pressure from the GPs and ANPs.  Upskill 25 practice nurses in minor illness and respiratory and enrol them on to an accredited course for completion.
			Q4: Analyse the training need e.g. respiratory.		March 2018	
			Q1: Implement training and education to meet needs.		June 2018	
			Q2: Evaluate.		Sept 2018	
<b>Increase nursing mentorship and student nurse placements in general practice</b>	Mentorship survey to be circulated with to assess current position of mentors. There is an opportunity to increase the nurse mentorships places across the patch. Preceptorship programme will support general practice nurses upon completion of the LMC course. It is an initial pilot	Funded from CEPN budgets agreed for 17/18	Q3: Identify further mentors within practice and practices supporting placements.		Dec 2017	Student nurses have an enhanced experience within primary care which should encourage positive recruitment outcomes for general practice.  Increase mentors by 20%. Increase number of placements by 20% (Current position TBC) by 2018.
			Q4: Work with universities to assess mentorship training needs.		March 2018	
			Q1: Placements to be agreed.		June 2018	
			Q2: Evaluate.		Sept 2018	

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
<b>Upskills Healthcare Assistants</b>	A number of HCAs enrolled on Health and Social Care Apprenticeships.	Funded from CEPN budgets agreed for 17/18	Q3: Identify HCAs skilled at Level 2		Dec 2017	Upskilling HCA from Level 2 to Level 3 means that they have the qualification and ability to carry out more complex tasks relating to patient care; supporting nurses and their workloads.  10 HCA to enrol onto Level 3 training per year.
			Q4: Meet with HCAs to offer the Level 3 training		March 2018	
			Q1: Confirm training and funding.		June 2018	
			Q2: Commence training and evaluate.		Sept 2018	

#### Scheme 4

#### Leadership and cultural change

<p>Increase the leadership skills and abilities for staff working in primary care and increase the number of practice staff enrolling in the NHS England 'GP Development Leaders Programme'.</p> <p>The future of General Practice and the way in which care will be delivered is changing. GPs, Nurses and other health professionals need to be supported across a range of activities to ensure that the services they offered are delivered in the most appropriate and cost-effective way. Practice managers and teams need to be appropriately skilled to meet future challenges. The local leadership training needs will be assessed and a proposal for an initial training programme,</p>	<p>Take the lead</p> <p>Monthly newsletter – outlining workforce training development and recruitment opportunities.</p>	Funding CPEN	Q3: Develop leadership programme based on need and agree content/funding.	Nominated lead for scheme:	Dec 2017	Increase the number of practices and staff partaking in leadership programmes by 50% (TBC).
			Full leadership training engagement with all practices.		March 2018	
			Agree a leadership course across the STP for GPs, Practice Managers etc. Via Red Whale and also agree working at scale course.		June 2018	
			Q4: Explore further national leadership opportunities and engage with practices to support uptake and need.		Sept 2018	
			Q1: Implementation			
			Devise leadership training resource with quarterly updates on local and opportunities.			
			Q2: Evaluate			

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
designed to meet the changing future of general practice and equipping employees with essential leadership abilities. The Improvement Leaders programme upskills key primary care leaders with the abilities and knowledge to implement, support and manage the changing landscape of general practice.						
<b>Engagement with Practices, Practice staff and the Public</b>  GPs are committed and engaged with initiatives as per the plan.  Practice staff have opportunities to input into workforce initiatives that will have a positive impact on supply and demand.	There are a number of vehicles used to engage with our GPs and clinicians as below; <ul style="list-style-type: none"> <li>• Clinical Leads</li> <li>• Clinical Executive Committee</li> <li>• Primary Care commissioning Committee</li> <li>• PTLs</li> <li>• Monthly newsletters via CEPN</li> </ul> There also primary care clinicians on all of our governing body committees.	TBC- small engagement budget required each year	Q3: Devise communication plan to share initiatives with all our practices		Ongoing	GPs recognise and are committed to the initiatives within the plan.
			Q4: Engage with practices via set committees, meetings etc.			
			Q1: Engagement sessions			
			Q2: Engagement sessions			
Increase and support the number of practices enrolling in the NHS England 'Time for Care Programme'. And Productive Practice programmes	GP practices to enrolled to take part in the programme and programmes have commenced	NHS England	Q3: Agree local priorities for the 'Time for Care' programme with practices and Health Education England via an engagement even on 21/02/2017.	Individual CCGs and member practices	Dec 2017	Through the identification of key priority areas, NHS England representatives work with practice staff to make sustainable changes to release time for patient care and treatment. For example, process efficiencies and workflow redesigns.  By the end of 2018, 50% of all practices are to enrol
			Q4: Roll out the programme amongst identified practices.		March 2018	
			Q1: Review impact.		Jun 2018	

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
			Q2: Evaluate pilots.		Sept 2018	onto the programme and have agreed priorities to release time for care.
<b>Making the better use of technology</b>						
<b>Making the better use of technology</b>	Currently technology is not being used to its full potential in supporting primary care workforce	GPFV	Q3: Understand the ongoing work within the GP IT workstream especially within the digital roadmap and the implications this has on workforce and how feed into this.  Look to build on the strength of electronic general practice records, primary care staff, including community nurses and health visitors. Explore opportunities to enable to access a common primary care record.	IMT	2020	Practice level compliance with the digital roadmap plan.
			Q4: Explore how email and electronic messaging can be used between primary care healthcare professionals and hospital specialists, enabling both to seek advice and give guidance on patient care, ensure IG compliance and clinical governance.			
			Q1: Link with initiatives such as digital roadmap and online consultations.			
			Q2: Primary care staff, including community nurses and health visitors, should use a common medical record			

Key deliverables	Baseline position	Investment (Inc. dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure
			based on the general practice electronic record.			
<b>10 High impact actions</b>						
<b>Implementation of the 10 high impact actions</b>	Work is being developed across the 10 high impact actions.	GPFV	Q3: Collect data on each practice in relation to their implementation plans for the 10 high impact actions.	CCG Primary Care team	2020	Each practice is delivering on the 10 high impact actions across the STP.
			Q4: Consider how to scale up work on the 10 high impact actions i.e. at locality or federation level			
			Q1: Devise plan to implement scaled up actions			
			Q2: Implement plan			
<b>Maximise sharing of back office functions within general practice</b>						
<b>Sharing back office functions</b>	Limited sharing of back office function across the STP currently.	TBC	Q3: Explore opportunities for sharing back office function in line new models of care such as localities or federation working	CCG Primary Care team	2020	Fully integrated back office functions across localities or federation realising optimum workflow and best value for money.
			Q4: Engage with practice to understand opportunities and practicalities			
			Q1: Devise plan to assist the integration of back office functions			
			Q2: Implementation of plan			



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GPFV Programme of Work					
Chapter	Total Number of Projects	Not Started	Achieved & Closed	In Progress within Timescale	Overdue and/or behind schedule
1 Investment	7	0	5	2	0
2 Workforce	27	10	3	14	0
3 Workload	25	12	4	9	0
4 Infra-structure	21	6	6	9	0
5 Care Redesign	5	1	0	4	0
<b>Total(s)</b>	<b>85</b>	<b>29</b>	<b>18</b>	<b>38</b>	<b>0</b>

Legend for Current Status	
Blue	Not started
Green	Achieved & closed
Amber	In progress within
Red	Overdue and/or behind

**GPFV Project Timeline 2018-20**

Project Title	Completed Projects	April to June 2018	July to September 2018	October to December 2018	January to March 2019	2019/20
Chapter 1 Investment	Monitoring & Investment Monitoring CCG Investment in General Practice Carr-Hill Formula Review	Messages down the finance route Development of Single LA/CCG Investment (BCF)				
Chapter 2 Workforce	Targetted financial incentives to GPs returning to work Further investment in leadership development Investment in practice nurse measures & access to mentorship training Extension of Clinical Pharmacy Scheme Care Navigation Practice Manager Development Service to prevent burnout	Increasing GPs into Training Practice Manager Development Programme/Diploma Investment in Leadership Development Refining GP Speciality Training National Recruitment Campaign (HEWM) International Recruitment Post CCT Fellowships Mental Health Therapists Medical Assistants Further Measure to Improve Work	National Recruitment Programme Investment in Leadership Development International Recruitment Campaign Practice Manager Development Programme/Diploma Extension of Clinical Pharmacy Scheme Mental Health Therapists Medical Assistants Multi-disciplinary training hub reproduced	National Recruitment Campaign International Recruitment Campaign Investment in Leadership Development Practice Manager Development Programme/Diploma Extension of Clinical Pharmacy Scheme Training for Physician Associates Mental Health Therapists Medical Assistants	National Recruitment Campaign International Recruitment Campaign Practice Manager Development Programme/Diploma Extension of Clinical Pharmacy Scheme Publication of evidence about retention	Val Wass work on Medical Schools Pharmacy Integration Fund Pilot Medical Assistant Role Publication of evidence about retention Nursing career framework & standards Investment in QNI education & practice standards
Chapter 3 Workforce	National programme of self care Reference to GPs influencing commissioning Programme to reduce burden of oversight Work & health measures including others to sign fit note	National Development Programme Consultant hotline advice (A&G) My NHS indicators Review of QOF & AUA DES Growth in mandatory trianing linked to appraisal & revalidation Social Prescribing Ambassador(s)	National Development Programme Consultant hotline advice (A&G) Standards for outpatient appointments My NHS Indicators Review of QOF & AUA DES EPS for Practice Hubs Issue guidance to HWBs for DH	National Development Programme Standards for outpatient appointments New software to automate tasks Simplified Data Reporting Incoming data from NHS providers all automated Accelerating moves to paper free NHS	New software to automate tasks Accelerating moves to paper free NHS Audit tool to help practices reduce demand Automated appointment measuring interface	Reformed 111 Service CQC Charges/Funding/Frequency of inspection Automated appointment measuring interface
Chapter 4 Infra-structure	Investment in practices to take up online consultations CCGs commission core GPIT WiFi Services in GP Practices Buying catalogue for IT goods/services Pharmacy summary care record Data & tools that benefit GPs	ETTF Programme Implement measures promised on premises Priority given to improve access (continuation of transformation fund & improving access fund) Apps & digital self care Work with supplier market choice of digital services Support groups to implement Hub level EMIS	ETTF Programme National framework for cost effective telephone/e-consult Support groups to implement Hub level EMIS Apps & digital self care Develop A&G Platform Online access for patients to accredited clinical triage systems	ETTF Programme Actions to support practices offer patients online self care & self management services Create innovative choice of digital services	ETTF Programme Implement measures promised on premises	ETTF Programme Funding to support education for patients & practitioners to utilise digital systems
Chapter 5 Care Redesign	Transformation Fund 2017/18 NMOC Contracting Options explored	National Development Programme Transformation Fund 2018/19 NMOC Contract Strategy Implemented Review of protected learning time arrangements for practice staff	National Development Programme Transformation Fund 2018/19 Review of protected learning time arrangements for practice staff	National Development Programme Transformation Fund 2018/19	National Development Programme Transformation Fund 2018/19	Deliver the access commitment Continuation of Transformation Funding Review NMOC/Contract

## Chapter 1 Investment

Project Ref	Project Title	Description	Current Status	Next Steps	Nominated Lead	Anticipated Completion	Closure Date	Continuity Arrangements
1.1	Monitoring of Investment	Established liaison between NHSE & CCG at both primary care & finance level(s).	Green	Allocations, spend & investment monitored via internal quarterly meetings to ensure funds are duly spent.	Sarah Southall	Dec-16	Dec-16	
1.2	Monitoring of CCG Investment in General Practice	CCG fully delegated since April 2017 & in receipt of delegated budgets.	Green	As above quarterly monitoring meetings held to ensure spend is within budget limitations.	Sarah Southall	Apr-17	Apr-17	
1.3	Messages down the finance route		Amber		Lesley Sawrey			
1.4	Carr-Hill formula review	Formula review undertaken at national level, new guidance published April 2016.	Green	Allocations will be in line with new guidance, copy in folder for further reference.	Sarah Southall	Summer 2016	Jul-16	Ensure national allocations are in line with Carr Hill Formula Review.
1.5	PMS contract reviews	PMS contracts reviewed 2017, reducing values discussed with practices affected.	Green	small number of PMS contracts remain.	Gill Shelley	Summer 2017	Summer 2017	
1.6	Indemnity	National review undertaken. Support schemes during winter pressures accessed by practices.	Green	Monitor impact of indemnity premiums as practices continue to implement working at scale. Premium(s) tend not to be affected if clinicians have full access to the clinical record.	Sarah Southall	Jan-17	Jan-17	Practice information sharing agreements & configuration within EMIS enables full access to patient clinical records. Ensure when practice movements occur agreement & configuration arrangements are reviewed.
1.7	Development of single LA/CCG investment arrangements into general practice through BCF	Community Neighbourhood Teams development to include Social Workers, Mental Health & input from specialist teams.	Amber	Mental Health Therapists Social Workers Community Neighbourhood Team	Andrea Smith	2017-20		

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Legend for Current Status	
Blue	Not started
Green	Achieved & closed
Amber	In progress within timescale
Red	Overdue and/or behind scheduled timescale

**Chapter 2 Workforce**

Project Ref	Project Title	Description	Current Status	Next Steps	Nominated Lead	Anticipated Completion	Closure Date	Continuity Arrangements
2.1	Increasing GPs into training	GP training places increased, uptake to full compliment not achieved 2016 nor 2017		Continue to monitor uptake / fill rate for Trainees in training practices Wolverhampton. Retention to be reviewed & monitored.	Marianne Thompson	2019/20		
2.2	Refining GP speciality training	Increase in GP speciality training places (linked to retention schemes).		GPSI opportunities to be revisited at group level. Competency requirements to be identified. Expressions of interest & specialities to be considered at Workforce TFG	Marianne Thompson	2019/20		
2.3	Val Wass work on medical schools	Choice not by Chance Report published November 2016		15 recommendations to be reviewed, report in folder	Marianne Thompson			
2.4	National recruitment campaign	Lead by HEWM		National advertising, events & campaigns implemented locally.	Marianne Thompson	2019/20		
2.5	International recruitment drive	First cohort commenced Feb 2017, report shared with WTFG Summer 2017, decision to defer till 2018.		Meeting due to be held STP level 8.12.17	Sarah Southall	2018/19		
2.6	250 Post CCT fellowships	GPs who wish to develop extended skills ie geriatric medicine, mental health etc also known as Portfolio Career. Training opportunities in in areas of poorest GP recruitment.		Identify Wolverhampton share & expressions of interest.	Marianne Thompson	2018/19		
2.7	Further measure to improve work	Simplify return to work routes new portfolio route to improve retention.			Marianne Thompson	2018/19		

2.8	Increase financial compensation of current retainer scheme	Targetted financial support for GPs to remain in practice.			Marianne Thompson	2018/19		
2.9	Targetted financial incentives to Gps returning to work	GP Retainer Scheme Induction & Refresher Schemes			Marianne Thompson	2018/19		
2.1	Publication of evidence about retention	Address concerns of workload, financial & educational support.			Marianne Thompson	2019/20		
2.11	Further investment in leadership development	Leadership programme(s) offered since 2016 (1 x 2015/16, 2 x 2016/17).		Further funds secured 2017/18 for PCH1&2 5 practices & RCGP facilitated session for MC2	Jo Reynolds	Mar-18		Further leadership development to be identified & project review carried out. Will become business as usual.
2.12	Investment in practice nurse measures	10 Point Action Plan Primary Care Workforce Strategy (STP & W'ton)		Responsive local plan in place, monitoring via Workforce TFG Practice Nurse & HCA Development Plans approved & programmes due to commence	Liz	2018/19		
2.13	Extension of clinical pharmacy scheme	Funding scheme to support clinical pharmacists working in general practice. Coverage to be extended all Wolverhampton Practices as far as reasonably possible.		2016/17 One successful bid 2017/18 Two successful bids CPs in post across a number of practices (1:30,000 shared model) Benefits realisation & Case Studies monitored via Workforce TFG.	Group Managers	2018/19		

2.14	Pharmacy integration fund	Will be introduced to look at how pharmacists, their teams & community pharmacy fit into wider NHS services in the local area		Pharmacy Peer Group Forum due to be introduced (Feb 2018) Direct Commissioning discussions with NHSE 2018/19	Jo Reynolds	2018-20		
2.15	Mental health therapists	Introduce new Mental Health Therapists practice based		Primary Mental Health Care Strategy Commissioning Mental Health Therapists on shared basis across practices as part of MDT working.	Sarah Fellows	2018/19		
2.16	Training of care navigators medical assistants reception & clerical staff	Admin & reception staff who are suitably skills to actively signpost patients & the public so that they see the right person in the right place. Reducing GP workload.		Cohort 1 pathways will go live February 2018. Cohort 2 pathways will be scoped & launched summer 2018	Jo Reynolds	2017/18		Cohort 2 pathways & continuous improvements from 2018/19
2.17	Pilot new medical assistant role	Support doctors in the smooth running of their surgery by handling routine administration & some basic clinical duties enabling the GP to focus on the patient. Medical Assistants will refer, arrangement appointments & follow ups.		Competency Framework awaited from HEE	Group Managers	2018-20		
2.18	Pilot new physiotherapy roles	Transforming out of hospital care through care navigation & direct access.		Care Navigation opportunity	Jo Reynolds	2018-20		
2.19	Investment in practice manager development	National allocation 2016/17 £10k - training programme commenced May 2017.		Further funds anticipated before March 2018 assigned to LMCs	Jo Reynolds	Mar-19		Additional funding from CCG for PM Diploma £25k supported due to commence Feb 2018 & further cohort summer 2018

2.2	Roll out nursing career framework & standards for general practice nurses	10 Point Action Plan Primary Care Workforce Strategy (STP & W'ton)		Responsive local plan in place, monitoring via Workforce TFG Practice Nurse & HCA Development Plans approved & programmes due to commence	Liz	2019/20		
2.21	General practice nurse access to mentorship training	Availability of nurse mentorship training programme		Nurse Mentorship Training commenced 2017, ongoing programme in place monitored via Workforce TFG in line with TNA.	Liz	2017/18	Dec-18	Group Level TNA in place to monitor & respond to demand.
2.22	Benefits for more committed locums	Improve attractiveness of partner & salaried positions.			Marianne Thompson			
2.23	Locum rates	Standardise locum rates across practice groups through negotiation with agencies/supply chain & potential introduction of a locum bank.		Back office functions review may confirm this as a priority for practice groups.	Marianne Thompson	2018/19		
2.24	National service for burn out	Occupational health service providing mental health support & wellbeing.		Service introduced by NHSE 2017, publicised locally & information available on NHSE website.	Sarah Southall	2017/18	Sep-17	
2.25	Training 1000 physician associates	Investment by HEE in training of 1,000 Pas to support general practice.		Training provided locally in Wolverhampton & student placements hosted by some practices however limitations to role ie prescribing.	Marianne Thompson	2018/19		
2.26	Implement QNI voluntary education & practice standards	To provide a highly skilled nursing workforce in general practice includes investment to fund training & practice standards (Queens Nursing Institute).		Nurse 10 point action plan in place, actively monitored via Workforce TFG.	Liz Corrigan	2019/20		

2.27	Multi-disciplinary training hubs in every part of England	Support the development of the wider workforce within General Practice.		SLA in place with Walsall CCG till March 2018. HEWM will be procuring at STP level 2018	Sarah Southall	2018/19		Continuity of provision currently being negotiated.
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Legend for Current Status	
Blue	Not started
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### Chapter 3 Workload

Project Ref	Project Title	Progress	Current Status	Next Steps	Nominated Lead	Anticipated Completion	Closure Date	Continuity Arrangements
3.1	National development programme	Support training of reception clerical staff to play a greater role in care navigation & handling clinical paperwork.		Document Management Procurement due to commence Care Navigation Training concluding, roll out commencing February Cohort 1 Pathways	Jo Reynolds	2018/19		
3.2	National programme of self care	Every opportunity to support people to play a greater role in their own health.		Linked to Care Navigation Introduced the Sound Doctor & Transformation Fund 2017/18 promoted the importance of practices advocating self care.	Jo Reynolds	2017/18		Commissioned Services Dashboard TSD Benefits Realisation Report
3.3	Reference to GPs influencing commissioning	GPs involved in/influencing commissioning decisions.		Group Leads Meeting Members Meetings Governing Body Membership Clinical Reference Group Relationship with LMC	Sarah Southall	2017/18	Dec-18	
3.4	Reference to reformed 111 service	Hubs & reformed urgent care; a new voluntary contract supporting integrated primary & community services such as integrating extended access with out of hours & urgent care services, 111 & clinical hubs.		NHS111 & Practice Group Hub Working Bank Holiday Scheme/Saturdays Investment in clinical hub via NR ££ 2017/18 Improving Access Delivery Plans at Group Level 2018/19 Review Urgent Care Centre Contract delivery options 2018/19	Dee Harris	2019/20		

3.5	Practice resilience programme	Leadership programme(s) offered since 2016 (1 x 2015/16, 2 x 2016/17).		Further funds secured 2017/18 for PCH1&2 5 practices & RCGP facilitated session for MC2	Jo Reynolds	2017/18		Due to conclude March 2018, will become business as usual.
3.6	New standards for outpatient appointments	More convenient access to care, a stronger focus on population health/prevention, more GPs and wider range of practice staff operating in more modern buildings & better integrated with community & preventative services, hospital specialists & mental health.		Practice groups maturing to provide out of hospital services in fit for purpose premises. Development of Community Neighbourhood Teams	Sarah Southall	2018/19		
3.7	New working group to look at hospital GP interface	BMA Guidance implemented April 2017		Revised process implemented Oct 17 Care Query Panel Meeting held fortnightly.	Sarah Southall	Apr-18		Review meeting due to be held in Feb-18 LMC, RWT & CCG.
3.8	Rapid testing programme on consultant hotline advice	Consultant Connect explored but declined by CRG.		Development of A&G & CAS currently being worked up via PAP TFG	Ranjit	2018/19		
3.9	New software to automate tasks	Automation of common tasks.			Steve Cook	2018/19		
3.1	CQC Charges - lead by CQC	Support to move to a 5 year inspection interval for good & outstanding practices.			CQC			
3.11	Funding for CQC	Streamlining the payment system			CQC			
3.12	My NHS Indicators	A set of key sentinel indicators published July 2016.			Jo Reynolds	2018/19		

3.13	Review of QOF & future of AUA DES	AUA DES changed April 2017 to focus on Frailty. Internal Steering Group to develop QOF+ formed also.		Priorities identified & outlines for QOF+ due to be worked up via CSU - implementation April 2018 (£1m recurring revenue investment)	Ranjit	Apr-18		Ranj to confirm.....
3.14	Simplified data reporting	Extraction of routine data to simplify reporting.			Steve Cook	2018/19		
3.15	Programme to reduce burden of oversight	Reduce the burden of hospital correspondence & GPs having to manage tasks for secondary care clinicians.		NHS Contractual requirement 2017/18 onwards Local process & arrangements for reimbursement in place.	Sarah Southall	Summer 2018	Oct-18	Process revised in light of further guidance & monitoring report due to be considered at meeting with RWT clinicians.
3.16	Review payments processes	CCG Payments process revised & shared with Practice Managers.		LMC feedback required before distribution to practices	Jo Reynolds	Dec-17		
3.17	Accelerating moves to paper free NHS	Assisting primary care become paper free not just within practices but across the wider health care system through interoperable systems		The Big Paper Switch Off ie E-referral	Steve Cook	2018/19		
3.18	Electronic prescriptions	EPS in place across all practices in the city.		EPS not available for hub working, yet to be resolved.	Jo Reynolds	2018/19		
3.19	Incoming data from NHS providers, all digital	Providers will submit data to a Strategic Data Collection System Portal using a downloadable proforma ie improving access.			Steve Cook	2018/19		
3.20	Audit tool to help practices identify how they can reduce demand	Audit of potentially avoidable appointments in General Practice will support reducing workload.			Steve Cook	2018-20		

3.21	Automated appointment measuring interface	Making Time in General Practice Report			Steve Cook	2018-20		
3.22	Growth in mandatory training & link to appraisal & revalidation	Funding & support schemes to help stabilise & improve the primary care workforce through training & recruitment of GPs & investment in staff.			Group Managers	2018/19		
3.23	Promote social prescribing & create national champion	Social prescribing initiatives supported by 35 national ambassadors & advocates promoting the GP role.			Jo Reynolds	2018/19		
3.24	Issue guidance to HWBs for DH	DoH will issue guidance to Health & Wellbeing Boards asking them to ensure that joint health & wellbeing strategies include action across health, social care, public health and wider.			Sarah Southall	2018/19		
3.25	Work & health measures including others to sign fit note	GPs will not have to sign fit notes for hospital patients.		NHS Contract 2017-19 makes it mandatory for hospitals to write fit notes for patients that were admitted by hospital staff, discharged or attended an outpatient clinic.	Sarah Southall	2017/18	Oct-18	Primary Secondary Care Interface process

Legend for Current Status	
Blue	Not started
Green	Achieved & closed
Amber	In progress within timescale
Red	Overdue and/or behind scheduled timescale

## Chapter 4 Infrastructure

Project Ref	Project Title	Description	Current Status	Next Steps	Nominated Lead	Anticipated Completion	Closure Date	Continuity Arrangements
4.1	Run estates & technology transformation fund	ETTF programme in place		3 year programme agreed/funded	Steve Cook	ongoing		
4.2	Implement measures promised on premises	NHS England will fund stamp duty & land tax costs for practices signing leases with NHS PS from May 2016 till the end of October 2017			Tally Kalea			
4.3	Work with NHS PS to identify how we can underwrite lease agreements				Tally Kalea			
4.4	Work with CHP to mobilise public & private partnerships				Tally Kalea			
4.5	Investment for practices to take up online consultation systems	National allocations confirmed over 3 year period.		First allocation 2017/18 (Jan-18)	Steve Cook	Nov-17	Jan-18	See 4.14
4.6	Ensuring CCGs commission core GP IT services	Core GPIT Services		Commissioned by CCG	Steve Cook	2016	2016	
4.7	Ensuring that priority given to things to help access	National & local funds fully utilised to assist with improved access Winter 2016 & 2017 Practice & hub delivery, including bank holidays has been pump primed via Transformation / A&E Delivery Board / Non Recurring Revenue		Delivery plan submitted to NHSE Dec17 Group level delivery from April 2018→ due to be collated & finalised	Jo Reynolds	Mar-19		
4.8	WIFI services in GP practices	All practices have WIFI except Rosevillas.		Rosevillas will be relocating to the Croft in 2018.	Steve Cook	Feb-17	Mar-18	

4.9	Apps & digital self care	New core requirements ie digital patient records, specialist support, outbound electronic messaging etc.		currently scoping options	Steve Cook & Jo Reynolds	Review Sept 2018		111 app release
4.1	Accredited catalogue & buying framework for IT products & services			provided by arden and GEM CSU proc dept	Steve Cook	complete		
4.11	Work with supplier market to create wide & innovative choice of digital services				Steve Cook	ongoing		
4.12	Complete roll out of pharmacy summary care record			Midlands and Lancs CSU	Steve Cook	complete		
4.13	£45m programme to stimulate uptake of online consultation by every practice	As 4.5 above		Bid submitted to NHS Digital Dec-17 Project Team to be formed Jan-18	Steve Cook	Summer 2018	Jan-19	
4.14	Actions to support practices offer patients more online self care & self management services	National allocation £68k 2017/18 anticipated Jan 2018. Bid prepared & submitted Dec-17		Bid submitted to NHS Digital Dec-17 Project Team to be formed Jan-18	Steve Cook	Mar-20		
4.15	Online access for patients to accredited clinical triage systems			in discussions with EMIS to trial software as soon as available	Steve Cook	review sept 2018		
4.16	The ability to access data & tools that aid GPs (and local commissioners)			is available within graphnet	Steve Cook	Complete		
4.17	Enhancements to the advice & guidance platform on the e-referral system	Develop advice & guidance beyond 6 specialties currently in use locally.			Steve Cook	Autumn 2018		
4.18	A national framework for the cost effective purchase of telephone & e-consultation tools	Framework yet to be defined by NHS Digital			Steve Cook	TBD		

4.19	Funding to support education & support for patients & practitioners to utilise digital services	Awaiting further clarification			Steve Cook	TBD		
4.20	Support federated practices by enabling appointments in one practice	Practice groups already working at scale.		Phased roll out of hub level EMIS systems currently under way.	Steve Cook	Summer 2018		
4.21	Let healthcare professionals from different settings inform & update a practice through sending/management	Awaiting further clarification			Steve Cook	TBD		

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**Chapter 5 Care Redesign**

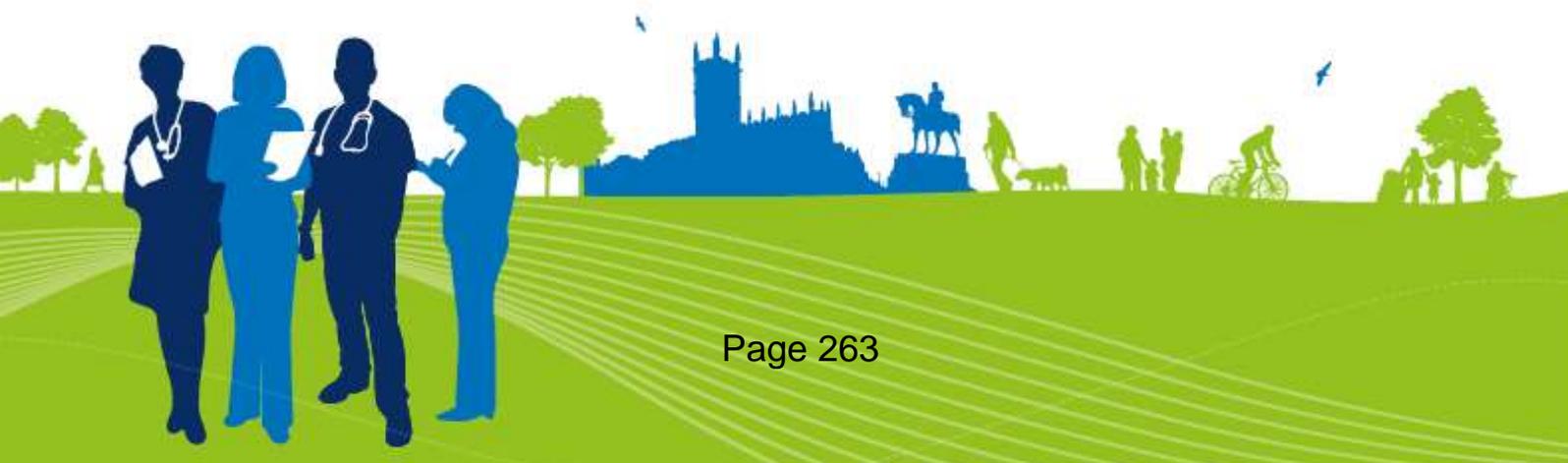
Project Ref	Project Title	Description	Current Status	Next Steps	Nominated Lead	Anticipated Completion	Closure Date	Continuity Arrangements
5.1	Deliver the access commitment	30 minutes per 1,000 patients 2018/19 45 minutes per 1,000 patients 2019/20		Delivery plan assured by NHSE Dec 17 Service Specification prepared & ready for approval. Delivery Plans currently being worked up at group level.	Jo Reynolds	2019/20		
5.2	Ensure CCGs provide £171m work of support	CCGs to provide £3.00 per patient transformational funding.		Year 1 Service Specification & Assurance Reports Year 2 Service Specification ready for approval.	Jo Reynolds	2018/19		
5.3	New MCP Contract (NMOC)	MCP contracting explored, ACA preferred solution.		ACA Development Group meeting (Nov-Mar)	Sarah Southall	Apr-18		Shadow year to commence April-18→
5.4	National Development Programme	Releasing Time for Care Programme		STP Event held summer 2017 Priority areas were Document Management (procurement due to commence) & Leadership Training (sessions to be arranged for summer 2018)	Jo Reynolds	Sep-18		
5.5	Protected learning time for practices	Dedicated training sessions to allow general practice staff to attend training.		Review of Team W effectiveness currently underway. Monitoring via Group Leads.	Jo Reynolds	Summer 2018		Support from MT till late March

Legend for Current Status	
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# Draft – Wolverhampton CCG

## Primary Care Workforce Strategy



<b>DOCUMENT STATUS:</b>	<b>Draft for approval</b>
<b>DATE ISSUED:</b>	<b>12<sup>th</sup> January 2018</b>
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VERSION	DATE	AMENDMENT HISTORY
<b>1</b>	<b>21/11/17</b>	<b>Comments from Task &amp; Finish Group</b>
<b>2</b>	<b>30/11/17</b>	<b>Comments from Governing Body</b>
<b>3</b>	<b>February 2018</b>	<b>Final Draft for Approval at February Governing Body</b>

#### REVIEWERS

This document has been reviewed by:

NAME	TITLE/RESPONSIBILITY	DATE	VERSION
Workforce Task and Finish Group Leads		21.11.17	1
Governing Body		04.12.17	2
Workforce Task & Finish Group Milestone Review Board	Workforce Programme of Work Workforce Programme of Work	January 2018	3

#### APPROVALS

This document has been approved by:

GROUP/COMMITTEE	DATE	VERSION
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Governing Body via enclosure with Primary Care members monthly report	11.12.17	V2
Workforce Task and Finish Group	16.01.18	V3
Milestone Review Board	18.1.18	V3
Governing Body	13.2.18	V3

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Workforce Task and Finish Group	Pending approval	Electronic	
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Milestone Review Board	Pending approval	Electronic	

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## RELATED DOCUMENTS

These documents will provide additional information:

<b>REF NUMBER</b>	<b>DOCUMENT REFERENCE NUMBER</b>	<b>TITLE</b>	<b>VERSION</b>
		STP Workforce Strategy	
		Programme of Work	

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## **Introduction**

The General Practice five year forward view (DH 2016) sets out a programme of work on how general practices can aspire, change and develop to deliver a new model of care. It outlines actions to support and develop the evolving workforce. The plan aims to achieve a net increase of 5000 WTE GP within the 5 year plan. Further development to fund new roles that include mental health therapists and clinical pharmacists in general practice. Development monies for practice nurses, physician assistants, receptionists and practice managers will be made available. The vision for Primary Care in Wolverhampton is to deliver universally accessible high quality out of hospital service that promotes health and wellbeing of our local community ensure that our population receive the right treatment at the right time and in the right place reduce early death and improve the quality of life of those living with long term conditions: and reduce health inequalities. (Primary Health Care Strategy 2016-2020) To have a workforce that is sufficient, responsive and adaptable and puts the patients at the centre of their care is the key to our success as a CCG. The right and sufficient workforce is an enabler for delivery of all new solutions for health care provision, paying particular attention to meeting patient expectations of access and care closer to home, with increased integration of service and greater provision of service over weekends and out of hours.

The workforce strategy provides a clear vision and objectives for the CCG which will align with the Strategic Transformation Plan.

Our focus is on the training and education of new and existing staff, recruitment to existing and new roles, retaining the skilled people that we have, coupled with managing demand and embracing a culture fit for the future we will change service delivery and meet the demand.

## **National Context**

Over 90% of all contacts with the NHS occur within general practice, with the average member of the public seeing a GP six times a year, double the number of visits of a decade ago. Increasing demands have been placed on general practice, in part due to the growth in our population who are living longer, with more complex multiple health conditions. This has been compounded by a reduction in the proportion of funding for primary care and a lack of growth in the primary care workforce relative to the increase in demand.

By 2021, in excess of one million people are predicted to be living with dementia and by 2030; 3 million people will be living with or beyond cancer. By 2035 it is predicted that there will be an additional 550,000 cases of diabetes, 400,000 additional cases of heart disease and the number of people with multiple long term conditions will increase from 1.9 million in 2008 to 2.9 million by 2018. 18 million patients are estimated to suffer from a chronic condition, with the majority of these individuals being managed by GPs. Approximately 53% of patients in England report having long term health problems, many of which will have been treated by GPs as part of their care.

Within this context, the pressures on general practice will not reduce in the foreseeable future and therefore an immediate renewed focus on general practice has been required.

## **Five Year Forward View**

Published by NHS England in 2016 the Five Year Forward View sets out a plan to stabilise and transform general practice through additional investment and support in relation to workload, workforce infrastructure and care navigation.

The Forward View acknowledges the need for a suitably skilled workforce to deliver these new models of care.

NHS England is investing £500 million in a national sustainability and transformation package to support GP practices, which includes additional funds from local clinical commissioning groups (CCGs).

It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development program to speed up transformation of services. They will be committing to an increase in investment to support general practice over the next five years.

The plan was developed with the Royal College of General Practitioners (RCGP) and Health Education England (HEE) and contains over 80 specific, practical and funded steps to:

- channel investment
- grow and develop the workforce
- streamline the workload
- improve infrastructure
- and support practices to redesign their services to patients

Our local implementation plan has been developed and approved by NHS England and is well underway.

## **Local Context**

Wolverhampton has a model based on practices working in groups. The types of primary care groups currently operating are as follows:-

Both primary and secondary care and senior managers are committed to the following principles to pursue a Wolverhampton approach to Accountable Care.

Our proposals for an Accountable Care Alliance are set out in a Draft Prospectus and negotiations among stakeholders continue to take place. The vision for Primary Care is that it will be delivered at scale, across multidisciplinary integrated teams, 7 days per week offering prevention and treatment services.

Our strategy must be clinically led. The clinical workforce must be deployed effectively across the health system, removing artificial distinctions between “primary” and “secondary” clinicians. We will support the professional development of all existing staff. There is strong clinical support across the health system to work in this way

- We will create shared governance across the parties which will provide system leadership
- We will provide a clear vision for our system that will be our joint public commitment and hold ourselves mutually accountable for delivering this
- The alliance partnerships work will be patient-centred. We will focus services around the patient, developing innovative unified pathways that provide a more consistent quality of care across Wolverhampton
- We will shift resources from hospital to out of hospital services so that more patients are supported proactively in their home and communities
- We will focus on health, developing our approach to health promotion and disease prevention to support the wellbeing of our communities alongside the care that we already provide
- We must be financially sustainable, making the best use of the resources that we have collectively. This will mean amending the current payment methods as they do not always incentivise best practice

### **Vertically Integrated (VI) Practices**

VI Practices are aligned to Royal Wolverhampton Hospital Trust. The model is one where a sub-contracting arrangement is in place between the named GP on the contract and the Trust. The principle behind this model is that care between the acute trust and primary care is better integrated, with patient pathways improved through being one organisation. There are currently 8 practices within Wolverhampton tied into this model.

### **Primary Care Home (PCH) Groups**

The structure of the Primary Care Home Group model is based on National Association of Primary Care (NAPC) guidance. PCH groups work towards an integrated workforce, with a strong focus on:

1. Partnerships spanning primary, secondary and social care:
2. A combined focus on personalised care with improved population health outcomes.
3. Aligned clinical and financial drivers through a unified, capitated budget (a budget calculated per person) with appropriate shared risks and rewards.

4. Provision of care to a defined and registered population of between 30,000 and 50,000.

### **Medical Chambers**

Medical Chambers follows this guidance, but operates under a MOU (Memorandum of Understanding) rather than forming a company limited by guarantee, as the home groups have done.

Wolverhampton currently has two primary care homes operating as Limited Companies. This constitutes 17 member practices aligned to the two PCH groups who work in line with NAPC Guidance to actively implement the Primary Care Home model. There are a further 18 practices also following NAPC Guidance who have chosen to form 2 Medical Chambers, each group is functioning in line with an agreed memorandum of understanding. A further 8 practices are aligned to the Vertical Integration Model; one of the contracts is an APMS that is held by the trust in a caretaking capacity. The remaining 7 practices have chosen to sub contract their GMS Contract(s) to the trust and operate in line with an integration agreement.

By following this model, primary care groups are better positioned to be working at scale, sharing workforce, and better positioned to develop teams within the group.

The CCG are committed to investing in Primary Care and General Practice to deliver the national benchmark to ensure that we have a sustainable PC.

### **Black Country STP**

General Practice is the foundation of the NHS, but services are under significant pressure both locally and nationally. In order to address this issue, NHS England through the General Practice Forward View (GPFV) has set out an ambitious Strategy for General Practice focusing on 5 key areas - care redesign, workforce, workload, investment and infrastructure to increase the sustainability.

Black Country STP is made up of five places across four CCGs, with a population of 1.4 million and 236 GP practices providing care to our patients. The STP is one system, with one single strategy having 4 strong identities within it. Our Vision for Primary Care is that it will be delivered at scale, across multidisciplinary integrated teams, 7 days per week offering prevention and treatment services to reduce demand, integrated with partners and our Local Authorities.

The STP Primary Care Workforce Strategy sets out our vision for the workforce in General Practice and describes in detail how the STP and the LWAB will support and equip member practices with the necessary skills, workforce and infrastructure to deliver an efficient, resilient and sustainable service for our local population: Recruit – Retrain and Transform.

Across the Black Country, 236 practices support over 1.4 million patients. Detail regarding disposition of age profiles for GPs as shown below.

#### Number of GPs and practices across Black Country STP

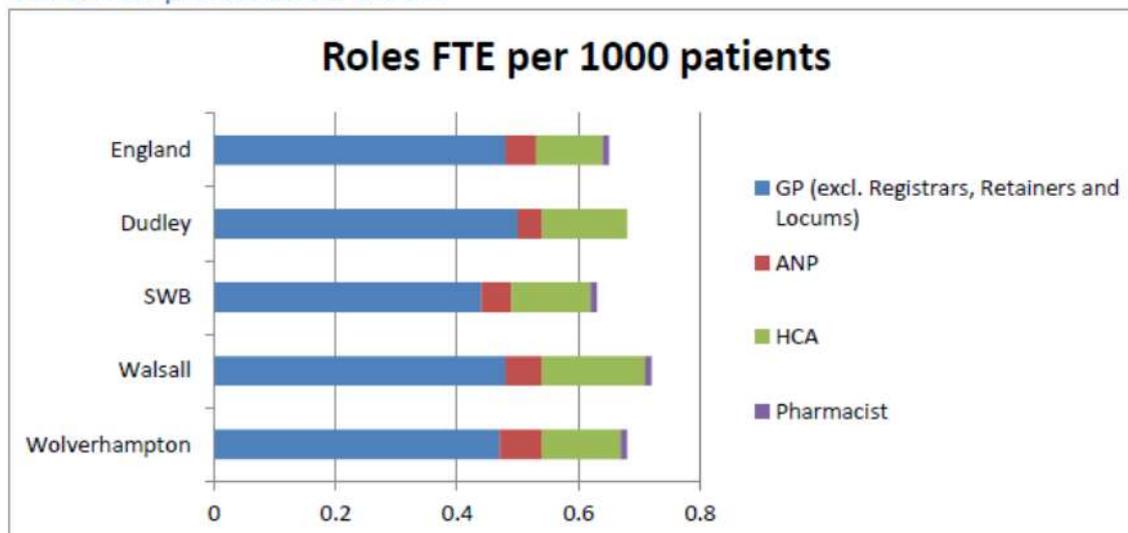
	Practices	Patients	GP Headcount	GP Headcount aged 55 or over	GP Headcount aged 60 or over	GP FTE
NHS Dudley CCG	45	318335	192	45	18	155.4
NHS Sandwell and West Birmingham CCG	88	563794	339	91	68	245.5
NHS Walsall CCG	59	283267	194	49	33	147.3
NHS Wolverhampton CCG	44	277006	157	31	17	133.3
<b>Black Country STP</b>	<b>236</b>	<b>1442402</b>	<b>882</b>	<b>216</b>	<b>136</b>	<b>681.6</b>

Further comparable data highlights the position of Wolverhampton within the local STP.

#### Patients per role FTE – taken from NHS Digital practice level indicators data

	GP (excl. Registrars, Retainers and Locums)	Nurse (incl. ANP)	ANP	HCA	Pharmacist
<b>England</b>	2,074	3,753	20,578	8,904	111,248
<b>Dudley</b>	1,984	3,659	23,039	7,286	504,915
<b>SWB</b>	2,282	3,884	20,128	7,887	85,409
<b>Walsall</b>	2,099	3,271	16,541	5,907	118,313
<b>Wolverhampton</b>	2,143	3,680	13,619	7,758	142,489

## Clinical role profiles across the STP



## Clinical roles FTE per 1000 pts

	GP (excl. Registrars, Retainers and Locums)	Nurse (incl. ANP)	ANP	HCA	Pharmacist
<b>England</b>	0.48	0.27	0.05	0.11	0.01
<b>Dudley</b>	0.50	0.27	0.04	0.14	0.00
<b>SWB</b>	0.44	0.26	0.05	0.13	0.01
<b>Walsall</b>	0.48	0.31	0.06	0.17	0.01
<b>Wolverhampton</b>	0.47	0.27	0.07	0.13	0.01

The Accountable Care System (ACS) involves leadership from all 18 STP partners focusing on delivering both strategic and operations transformation of the health and care system. Working together will ensure the future sustainability of the system through the local integration of health care.

## Initiatives for Workforce Development

Practices coming together to form larger partnerships that, in turn, afford greater resilience to deliver through developing a shared workforce, underpinned by the range of new roles practices are being encouraged to adopt.

The Resilience Programme that has been used as a means to prevent practices falling over and planning for perceived shortfalls in delivery of their contract. Access to national allocations for this programme is helping practices to plan to prevent failure & alert CCGs to the need for help sooner. Learning from these events should also factor so that across the STP we are helping practices to identify what can go wrong, how to avoid it and to recognise how such problems can be mitigated

HEE Modelling suggests a gap of 222 GPs, 26% of anticipated demand by 2020. This modelling is based on assumptions of retirement of all GPs aged 55 and over within the next four years. A caveat to this is that there is a difference of 27.1 FTE GPs between the HEE baseline modelling and the June 2017 NHS digital experimental data. The local CCG Workforce data analysis suggests that no all GPs will retire within 4 years if aged 55 or over. The Black Country STP share is 127 GPs.

The HEE forecast supply modelling suggests 196 cumulative retirements by 2020 identified from a baseline assumption of 100% of GPs over 55 retiring. The HEE modelling allows for 80% of the over 55s retiring -157 retirements. The 80% assumption is more strongly supported than the 100% assumption based on previous analysis by the CCGs.

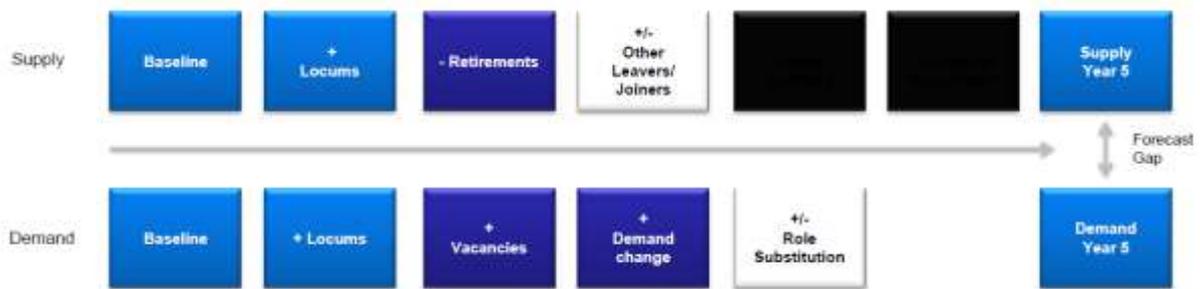
Our workforce dashboard will capture a clear picture of turnover of GPs and Practice Nurses to ensure that we are proactive in replacing and sustaining capacity within the general practice team.

### **Workforce Supply and Demand**

NHS Digital workforce returns at practice level indicators together with HEE Midlands GP Supply forecast (September 2017) provided the workforce picture for the STP. However, there are reservations around accuracy of the workforce picture that this presents, including the age profile and assumptions based thereon.

Wolverhampton CCG have developed a workforce dashboard to capture the true workforce picture and have sight of the changes on a month by month basis to enable accurate planning and delivery of service to include clinical and non-clinical roles.

The dashboard will be monitored by the Group Manager(s) to ensure accuracy of data and continued compliance. This is a priority for group level meetings/board meetings and that where vacancies are foreseen that the respective group consider how they are replaced and the practice remains resilient.



This must be owned at Group level through the upkeep of the workforce dashboard.

## Our Vision

Our shared vision with recommendations from the GPFV is to develop and sustain a workforce built around the needs of our population, which has the skills, knowledge and values to transform at scale and delivery high quality care within Wolverhampton

Our program of work sets out our robust plan to introduce the new roles that will lead to delivering our strategy.

As practice groups mature and the wider accountable care model develop the employment of personnel may not necessarily be by individual practices. A variety of employment opportunities can be explored including a nominated practice within a practice group or a joint venture organisation will provide expertise and may be a more cost effective solution to share the risk of employment as workforce structures develop across health and social care.



Our vision will be achieved through delivery of the Workforce programme over the coming years. (workforce delivery plan appendix 3 )

## Workforce Cost Impact

Consistent and sustainable funding is required from Health Education England (HEE) and NHS England over the next 3-5 years and is essential to the planning for the Black Country STP and for the continued investment in primary care. HEE have already made significant cuts in relation to a number of training schemes and has reduced the CEPN budget by 30%. If we are to achieve the ambitions of the GPFV and the new models of care, investment in other primary care roles and training must be continued to ensure sustainability for the future. Significant investment is required across the range of new roles and retaining current workforce including, but not limited to:

- Fundamentals of General Practice Nursing courses
- Advanced Clinical Practice MSc courses
- Mental health therapists
- Physicians Associates, including creation of PA Ambassadors
- Primary care fellowships

The STP intends to focus on the local refugee scheme in the first instance with a view to reviewing an application for International Recruitment by phase 3. If the STP is successful in its local scheme it would need financial support from the national GPFV fund to continue to support the local refugees into education, regulation and eventually back into practice. If the STP could tap into the international recruitment money for our local scheme, it is anticipated that this cost over five years would be £4.2 million (based on estimated costs of £25,000 per candidate).

## Development of Current Workforce

In addition to the development of new roles and new ways of the working, workforce transformation can also occur through the investment and development of current staff. Investing in the current workforce will not only provide a positive working environment but is known to support the retention of the workforce. The below initiatives are currently being developed for roll out across the Black Country STP member practices, supported and led by the CCGs and CEPNs. It will be a priority of the CCG to make available training and re-training opportunities for existing GPs.

**Care Navigation Training:** pilot phase summer 2017, full rollout from year two, engagement with patient groups.

**Effective Telephony Training:** secured funding through NHS England's Practice Resilience programme for training for clinical and non-clinical staff.

**Practice Manager Development Programme:** transformation funds received from NHS England in March 2017, commissioned across the Black Country STP footprint, coordinated by Sandwell & West Birmingham CEPN, 22 modules June 2017-March 2018 with further continued investment in this training up to 2020.

**Multi-disciplinary Team (MDT):** support for practice groups to develop and run MDTs within multiple practices.

**Nurse Mentorship:** to increase nurse mentors, and thereby increase student nurse placements, by funding training and backfill.

## Community Education Provider Networks (CEPNS)/Training Hubs

Local Community Education Provider Networks (CEPNs) are commissioned by Health Education West Midlands (HEWM) as a new way of developing the primary care workforce in response to the current health agenda. CEPNs work to enable primary care transformation through programmes of ongoing training and development for practice staff. The CEPN contract is held by Walsall Alliance in Wolverhampton. Partnership with the CEPNs is essential to the delivery of some of the proposals for role and workforce development in the GPFV. Re-procurement of the existing contract is anticipated early 2018 and likely to be on STP footprint.

## Apprentices

Apprentices are becoming an increasingly important part of the workforce in many industries. The government sees apprenticeships as a key part of upskilling and developing the workforce to meet future needs. Some General Practices have, in the past, employed business and admin apprentices but until recently, clinical apprenticeships had not been available. However, apprenticeships now encompass both clinical and non-clinical roles. Local Higher Education Institutions (HEIs) have

Developed Nurse Apprenticeship programmes and the recently introduced Nurse Assistant role is set to become an apprenticeship. Other clinical apprenticeships due to be introduced include pharmacy technicians, Occupational Therapy and Physiotherapy assistants, paramedics and physician associates.

One of the key areas of work in Primary Care is around workforce planning to mitigate the number of practice staff who are due to retire within the next 20 years and also to broaden the range of staff within General Practice, needed to meet the challenges in Primary Care. The Queens Nursing Institute, in their report of 2015, General Practice Nursing in the 21st Century: A Time of Opportunity stated that nationally 33.4% of General Practice Nurses are due to retire by 2020. At the moment there are insufficient numbers of Newly Qualified nurses choosing to work within Primary Care. Steps are underway to rectify this situation, such as the introduction of the Fundamentals of General Practice Nursing programme, designed to support and skill up newly qualified nurses in Primary Care. The CCG and local HEIs have worked hard to encourage pre-registration students to undertake a placement in Primary Care. Anecdotal evidence collected from such students suggest that up to a third of students will seriously consider a career in General Practice following a successful placement.

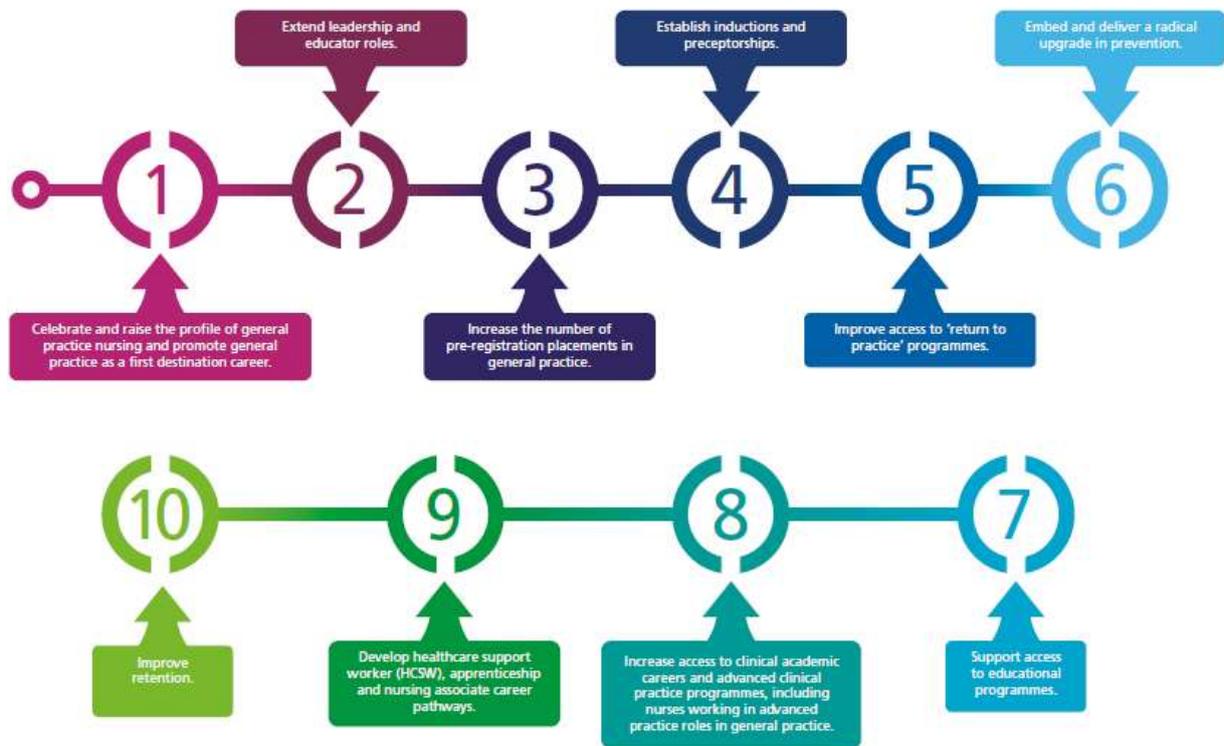
An option available to General Practice is to consider apprenticeships as a means of recruiting new staff and upskilling current staff to move into either different or expanded roles.

When the CEPNs (Community Education Provider Networks) were established in 2014, one of their KPIs was to increase the number of apprenticeships in Primary Care, as a means of supporting General Practices to improve resilience in order to meet future demand.

### **General Practice Nursing Ten Point Action**

Health Education England published the Practice Nursing ten point action plans in July 2017. Promoting the importance of general practice nursing the report provides details of potential use, risk and recommendations to develop and support the workforce. Upskilling existing nurses, ensuring availability of student nursing mentors and placements are areas of importance so too are measures to retain existing staff remains a high priority. This implementation can ensure general practice nursing remains a vital component of the primary care workforce for the future (Appendix 3).

## Ten point action plan



## Introducing New Roles

The principles of the workforce development for primary care include:

1. Identifying and developing new roles
2. Review and redefine current ways of working
3. Expand opportunities for portfolio careers and flexible working options
4. Enabling digital technology innovations to better manage workload

## New Roles

The workforce initiatives consider the total workforce in primary care that will support the management of the supply and demand of GP numbers as already identified.

**Healthcare assistants (HCA)**

**Provide** clinical support for GPs to enable them to allocate more time for patients with complex problems.

**Health and wellbeing co-ordinators:**

Enable patients to maintain their health and wellbeing and improve self-management of their condition.

**Physician associates:**

Work to the medical model in the diagnosis and management of conditions in general practice and hospital settings, with the supervision of medical practitioners.

**Care coordinators/navigators:**

Provide a central co-ordination role on behalf of the patient, working with their wider care team covering health, social care, voluntary and other local services.

**Medical Assistants:**

This role will support doctors in the smooth running of their surgery. They will handle routine administration and some basic clinical duties, enabling the GP to focus on more complex patients.

**Clinical pharmacists:**

Work as part of the general practice team to resolve day-to-day medicine issues and consult with and treat patients directly. This includes providing extra help to manage long-term conditions, advice for those on multiple medications and better access to health checks. The role is pivotal to improving the quality of care and ensuring

**Practice based Physiotherapists:**

Using direct access to physiotherapy as an alternative to seeing a GP, patients would be given the option to book themselves an assessment directly with the MSK practitioner. This could take place either face to face or over the phone. During the assessment the practitioner, where appropriate, could provide: advice and exercises along with a self-management plan; referral for further physiotherapy; referral to an appropriate service e.g. podiatry. These roles could demonstrate cost savings to local health economies in terms of prescribing and placing patients on the correct pathway of care, investigations and secondary care referral, as well as easing the burden on the general practitioner workforce.

**Nurse mentors:**

Increasing the number of qualified mentors in the existing GPN workforce is anticipated to support an increase in the number of student placement learning opportunities for student nurses who express an interest in pursuing a career in primary care, strengthening the likelihood of those students considering a career in general practice.

**Social Prescribing:**

Recognised for the benefits it can bring for patients, including better quality of life, improved mental and emotional wellbeing, and lower levels of depression and anxiety. It also has the potential to reduce patients' reliance on NHS services, easing pressure on accident and emergency wards and hard-pressed GPs.

**Mental Health Therapists:**

The GPFV outlines that there will be 3,000 new fully funded mental health therapists nationally to work in general practice by 2021. This should help individuals to seek help at an early stage, noting that general practice staff has a role to play in recognising when early referral or treatment may be indicated for someone at risk of falling out of work.

**Nurse Associates:**

The Nursing Associate role is a new support role that will sit alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients. ... Its introduction has the potential to transform the nursing and care workforce - with clear entry and career progression points.

**Implementation of Strategy**

Wolverhampton CCG will continue to support and enable primary care workforce development through new ways of working. Access to innovation funding, commission new roles, pilot new roles and building relationships with other partners to ensure workforce development is a key enabler for transformation. A detailed delivery plan with a focus on cultural change will assist us achieve the goals within the plan.

Group Managers will maintain the dashboard, monitor the delivery plan and share with the appropriate task and finish groups to ensure completion of the project. Group meetings will have sight of the plan and focus on any updates or actions at practice level that are required to ensure our information is accurate.

The CCG will encourage practices to invest in line with commissioned services to ensure sufficient capacity to serve patient population as recommended by the global sum, currently 0.58 WTE per 1000 patients.

Delivery Plan	Key Deliverables	Baseline Position	Action / Milestone	Action Owner (Organisation)	Milestone Delivery Date	Success Measure	KPIs / Plan Trajectory
<b>Workforce</b>							
Local Workforce Dashboard	Validate accuracy of Local Workforce Dashboard	First draft of local Workforce Dashboard	Meeting with WCCG November 2017	CCG Group Leads	March 2018	Understanding the gaps in local Workforce Dashboard to inform further development	All CCG understand gaps and agree plan to address
	Use the local Workforce Dashboard within Practices to model the gaps in existing and future Workforce and then develop an action	March 2018 and regular updates	Ongoing development of the primary care workforce plan at group level	Group Leads and Group Meetings	April 2018	Primary Care Workforce Implementation Plan in place	1st Draft to be developed by March 2018 and implemented thereafter
NHSE National Initiative; GP Retainer Scheme, GP Induction and Refresher and International Recruitment	Engagement with practices to promote awareness of availability of national schemes	Practices currently participating in the GP Retainer Scheme	Practice engagement International recruitment etc	CCG Primary Care Leads	On-Going	All practices aware of support available	100% of practices aware of national support offers through NHSE
Back Office functions and clinical leadership - please refer to Workload Delivery Plan		Workforce Task group meetings (monthly)	Monthly review	Director of Nursing	January 2018 onwards	Dashboard, Audit program of work	Dashboard
Workforce Task and Finish Group Programme of work	Primary Strategy and GPFV						

## Delivery plan

The Workforce Task and Finish Group will be responsible for delivering the agreed program of work. (Appendix 1) They will establish and maintain strong links with stakeholder educational establishments for medical, nursing and non-clinical staff groups. Complete the clinical pharmacist model in line with national direction and monitor performance through the workforce dashboard. The Workforce Task and Finish Group will complete the reshape through the communications plan and sub groups that include the roles of practices and GP Managers. The CCG commissioned prescribing and advice and QIPP delivery. Further collaborative working with STP and GPFV will complete the plan.

## Risks

The financial constraints and workload pressures now faced in general practice are acute. Release of staff for training is an issue for most practices as this often results in an impact on service provision or additional costs if the person goes out during working hours. Some practices still view training their workforce as a risk, that is, where they invest in skills development for individuals, neighbouring practices will 'poach' experienced and trained staff. The opportunity cost of staff development therefore needs to be recognised and supported for all practices. Evidence and experience shows where these obstacles have been overcome practices have seen the benefits of investing in training their workforces.

A further risk of assuming the point that GPs will retire is mitigated by the information provided within the workforce dashboard.

Improvement will be over a period of time in line with a national programme that is delivered locally/STP footprint and will also need to ensure that the introduction & implementation of new measures needs to be monitored to ensure benefits are realised and sustained.

WCCG recognises that workforce development is a responsibility that requires engagement, testing and evaluation. Recruitment to new roles remains the responsibility of our Contractors supported by their respective Group Manager(s).

## **Conclusion**

It's important at this point to make the correlation with strategy implementation plan as well as the GP5YFV projects that have begun to be launched such as GP Resilience Programme / Vulnerable Practice Programme, Training for Admin & Reception staff, Time for Care and Practice Manager Development training. The extensity of both the GPFV and Primary Care Programme of Work will enable realisation of this Strategy.

Access to these will be overseen by the Primary Care Team within the CCG to ensure that all practices/groups are appropriately represented & the benefits realisation from taking part in these programmes is recognised and learning shared across the groups.

## **References and Bibliography**

Five year forward view: Department of Health 2016  
<https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>  
GP five year forward view, Department of Health 2016  
<https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>  
Workforce Planning in the NHS: Kings Fund 2015  
<http://www.kingsfund.org.uk/publications/workforce-planning-nhs>  
Primary Care Health Care Strategy: WCCG 2016-2020

## **Enclosures**

Local Workforce Dashboard  
Programme of Work  
Workforce Delivery Plan

GPFV Milestone Plan 2017/2018

Quarter 1	
Investment In General Practice	New Models of care organisations established. Local Models PCH1 & PCH2, Medical Chambers and VI established
	Project commenced to explore feasibility of Consultant Connect - GP access to hospital consultant hotline for advice and support (discussed at CRG).
	Arrangement in place for additional Bank Holiday coverage via Practice Group Hubs (commenced Easter Bank Holiday).

Quarter 2	
Investment In General Practice	Transformation Fund Specification (Additional 20 minutes per 1,000 patients, working at scale & implementation of 6/10 high impact actions) delivery plans received & implemented VI & PCH1. PCH2 & Unity plan produced & implementation anticipated by October 2017.
	Arrangement in place for additional Bank Holiday coverage via Practice Group Hubs (August Bank Holiday).
	The Sound Doctor - self care provision commissioned and mobilised
	Transformation Fund Specification - Quarter 1 assurance reports received & shared with PCSC

Quarter 3	
Investment In General Practice	Accessing records across practices - all practices to be aligned with preferred MOC. Practices working at scale.
	Share draft Transformation Fund Specification (including improving access) for 2018/19 with Group Leads
	further consideration should be given to developing additional CAS(s) & Advice & Guidance
	Bank holiday cover provided by each practice group over christmas/new year bank holiday period.
	Transformation Fund Delivery Plan implemented by PCH2 and Medical Chambers
	Sound Doctor- Self Care Provision conclude launch.

Quarter 4	
Investment In General Practice	Transformation Fund Specification - Quarter 3 assurance reports received & shared with PCSC
	Finalise Transformation Fund Specification for 2018/19 with Practice Groups
	Sound Doctor- review effectiveness

Quarter 1	
Workforce	Practice Manager Development Programme launched (May 2017)
	Care Navigation Training/ WIN launch
	Occupational Health Service in place for GPs
	Interest in overseas recruitment scoped
	Monitoring of practices accessing training for staff through CEPN
	Healthy Living Pharmacy, in collaboration with PH, programme of work developed

Quarter 2	
Workforce	Practice Manager Development Programme on-going
	Care Navigation training/ WIN held
	Aspiring Practice Manager training held
	Advanced Care navigation development session
	Implemented Wolverhampton primary care vacancy webpage
	development of a 'Wolverhampton' video
	Wave 2 Clinical Pharmacists recruitment commenced
	Practice Nurses Mentors increased following completion of training.
	Continued involvement in the HLP programme of work, enabling joint working between practice(s) and community pharmacy
	Monitoring of practices accessing training for staff through CEPN

Quarter 3	
Workforce	Practice Manager Development Programme on-going
	Document Management System scoped
	Effective Telephone Consultations- Clinical and nonclinical held
	continuation of the development sessions and promotion of advanced care navigation. Programme launched with practices and online training resource available.
	Stakeholder list finalised for Wolverhampton Primary Care Vacancy Bulletin
	Launch Working in Wolverhampton video
	development of pages on intranet and external website to encourage potential workforce and increase engagement with new & existing staff
	overseas recruitment- STP level
	Wave 2 Clinical Pharmacists deployed across practice groups
	Continue to increase number of Practice Nurses Mentors

Quarter 4	
Workforce	Practice Manager Development Programme concludes
	Document Management System Project continues
	direct patient access to physiotherapists
	Review effectiveness of Care Navigation Training & implementation of new ways of working.
	Practice Makes Perfect facilitated by CCG Quality Team
	Pilot of Medical Assistant roles developed (pending availability of competency framework from HEWM)
	Monitoring uptake of training available to practices via CEPN
	Continued involvement in the HLP programme of work, enabling joint working between general practice and community pharmacy
	Mental Health therapists in PC - pending funding/guidance

Quarter 1	
Workload	Consultant Connect discussed at CRG (as above)

Quarter 2	
Workload	Bid for resilience funding submitted & approved.
	3 practices in receipt of 16/17 funding nearer completion of the programme.
	*6 programme for care homes rolled out via NHS 111
	111 Access to GP appointments developed by Urgent care lead

Quarter 3	
Workload	PCH to commence Quickstart Programme using resilience funding 17/18 to implement programme
	3 practices in receipt of Resilience funding 16/17 to finish programme
	Review effectiveness of resilience programme (2 practices due to conclude)
	Review take up of 111 appointments

Quarter 4	
Workload	Review take up of 111 appointments following bank holiday period.
	Finalise QOF+ prepare for implementation April 2018


		QOF+ framework developed, best practice scoped

		Further consideration should be given to developing additional CAS(s) & Advice & Guidance
		QOF+ framework plan to implement new model alongside Public Health


Quarter 1		
Practice Infrastructure		Programme of standardisation of GP clinical system (EMIS) across all practices continued (2017/18)
		Roll out of pharmacy summary care record

Quarter 2		
		Standardisation of GP clinical system across remaining practices
		Ask NHS live across Wolverhampton

Quarter 3		
		Standardisation of GP clinical system across remaining practices

Quarter 4		
		standardisation of GP clinical system across remaining practices

Quarter 1		
Care Redesign		GP protected learning time (Team W) overseen by Group Leads, new format introduced.

Quarter 2		
		Emis remote consultation project (4 practice groups) including information sharing agreements & configuration
		GP protected learning time (Team W) working well, to continue to be planned and supported by Group Leads Meeting.

Quarter 3		
		EMIS remote consultation software to be utilised as part of extended access hub working
		Review effectiveness / attendance at protected learning time events (Team W) via Group Leads.

Quarter 4		
		Anticipate implementation of shadow year ACA (MCP light contract) by April 2018
		Review effectiveness / attendance at protected learning time events (Team W) via Group Leads.

**WOLVERHAMPTON CCG**
**Governing Body**  
**13 February 2018**
**Agenda item 15**

<b>TITLE OF REPORT:</b>	<b>Communication and Participation update</b>
<b>AUTHOR(S) OF REPORT:</b>	Sue McKie, Patient and Public Involvement Lay Member Helen Cook, Communications, Marketing & Engagement Manager
<b>MANAGEMENT LEAD:</b>	Mike Hastings – Director of Operations
<b>PURPOSE OF REPORT:</b>	This report updates the Governing Body on the key communications and participation activities in December 2017 and January 2018.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This report is intended for the <b>public</b> domain
<b>KEY POINTS:</b>	The key points to note from the report are: 2.1.1 <b>Minor Eye Conditions Service (MECS)</b> 2.1.3 <b>Winter Campaign</b> 2.1.4 <b>Extended opening in Primary Care</b>
<b>RECOMMENDATION:</b>	<ul style="list-style-type: none"> <li>• <b>Receive</b> and <b>discuss</b> this report</li> <li>• <b>Note</b> the action being taken</li> </ul>
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	
1. Improving the quality and safety of the services we commission	<ul style="list-style-type: none"> <li>• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions.</li> <li>• Works in partnership with others.</li> </ul>
2. Reducing Health Inequalities in Wolverhampton	<ul style="list-style-type: none"> <li>• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions.</li> <li>• Works in partnership with others.</li> <li>• Delivering key mandate requirements and NHS Constitution standards.</li> </ul>
3. System effectiveness delivered within our financial envelope	<ul style="list-style-type: none"> <li>• Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment</li> </ul>



	Framework.
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## 1. BACKGROUND AND CURRENT SITUATION

To update the Governing Body on the key activities which have taken place December 2017 and January 2018, to provide assurance that the Communication and Participation Strategy of the CCG is being delivered effectively.

## 2. KEY UPDATES

### 2.1. Communication

#### 2.1.1 Minor Eye Conditions Service (MECS)

The MECS campaign has continued its web and social media presence following its launch in autumn last year. We have seen a lot of interest in our MECS campaign, both from public and patients.

Following our successful event in November, we have been working with students at Wolverhampton University on an exciting project which involves a song writing competition. A press release on our collaboration with the University was sent out during January and was picked up by the Wolverhampton Chronicle. The project, a song writing competition closes at the end of January.

***Students in challenge on health campaign***

*Wolverhampton Chronicle (Main), 18/01/2018, p.19*

*Health bosses from Wolverhampton Clinical Commissioning group and academics in Wolverhampton are joining to promote health-related campaigns around the city. The first joint working venture is an initiative focusing on minor eye conditions.*

We still have two more events being planned and social media posts now include short videos about the MECS service.

Peter Rockett MECS interview (1:30m version) <https://youtu.be/Hoj6b5RhNhQ>

Peter Rockett MECS interview (30sec version) <https://youtu.be/Q7CxCTf-hOQ>

Full details on MECS at <https://wolverhamptonccg.nhs.uk/your-health-services/eye-care-service-mecs>

#### 2.1.2 Press Releases

Press releases since the last meeting have included:

- Be prepared – stock up your medicine cabinet now!
- 12 Days of winter animation helps people in the Black Country to get the right care
- Play your care right in the Black Country
- Christmas and New Year Pharmacy opening times 17/18
- Take advantage of pharmacies over the festive season
- Call NHS111 to get the right care this winter
- Stay safe and well in cold weather
- New Year, new you – make some resolutions to improve your health
- New university partnership bringing Wolverhampton eye care into focus



- A little does a lot – alternative ways to live healthily in the New Year
- Walk this way to brighten your mood
- Smear test plea for women in Wolverhampton as screening attendance falls
- It's not too late to vaccinate for people at risk from 'Aussie flu'
- Its Time to Talk about mental health

### 2.1.3 **Winter Campaign – Stay Well**

The winter campaign has continued its national focus on stay well messages.

Press releases and tweets have been issued on the Black Country footprint for the STP and locally we had two public events in December. One was held at Sainsburys and one at a gym.

Planning is underway for our outreach events in February to enable us to spread the messages further into the community and talk to people about how to stay well in Wolverhampton and access services most appropriately.

See our Stay Well website pages for more information

<https://wolverhamptonccg.nhs.uk/your-health-services/stay-well-this-winter>

### 2.1.4 **Extended opening in Primary Care**

We are working with our colleagues in Primary Care and Pharmacy to promote their extended opening hours, particularly for cover over the Christmas and New Year holidays. There were a series of newspaper advertising, web advertising, leaflets and information on our website to inform people of GP opening over the holiday time and beyond.

We are continuing with newspaper and digital advertising to promote ongoing Saturday extended opening hours in Primary Care.

## 2.2. **Communication & Engagement with members and stakeholders**

### 2.2.1 **GP Bulletin**

The GP bulletin is a fortnightly bulletin and is sent to GPs, Practice Managers and GP staff across Wolverhampton city.

### 2.2.2 **Practice Nurse Bulletin**

The Dec/Jan edition of the Practice Nurse Bulletin included the following topics:

- Practice Makes Perfect Forum
- An Introduction to Constructive Coaching Conversations
- RCNI Community Nursing Award
- West Midlands Leadership Academy
- LeDeR Monthly Update
- NHS Solihull CCG and RCN West Midlands



### 2.2.3 Practice Managers Forum

The PM Forum has not met yet this year, but has started planning for discussion topics and the schedule of meetings in 2018. At the November meeting, the attendees shared their thoughts on how the meeting would be of most value to them, both in content and in frequency. With the practices now working much more closely in their respective groups, it was felt that the PM meeting needed to evolve to meet their new, changing needs.

## 3. CLINICAL VIEW

GP members are key to the success of the CCG and their involvement in the decision-making process, engagement framework and the commissioning cycle is paramount to clinically-led commissioning. GP leads for the new models of care have been meeting with their network PPG Chairs to allow information on the new models, and provide an opportunity for the Chairs to ask questions. All the new groupings have decided to meet on a regular quarterly basis.

## 4. PATIENT AND PUBLIC VIEWS

Patient, carers, committee members and stakeholders are all involved in the engagement framework, the commissioning cycle, committees and consultation work of the CCG.

Reports following consultations and public engagement are made available online on the CCG website. 'You said – we did' information is also available online following the outcome of the annual Commissioning Intentions events and decision by the Governing Body.

- 4.1 The PPG Chair / Citizen Forum meeting took place in January with an attendance of nine members. The meeting commenced with feedback from each of the practice / forum representatives. As agreed at the November meeting, the group were provided with details of the up to date four GP groupings and dates of future group meetings. It was noted that there have been some changes of group titles. It was also agreed that Dee Harris would attend to provide an update on the urgent care centre, following issues raised by members regarding routes of access and other matters. Dee outlined the complexities of delivering this service and this was followed by a lively debate from the group.

The meeting also considered future working arrangements and revised Terms of Reference to be agreed at the next meeting.

## 5. LAY MEMBER MEETINGS – attended:

- 5.1 Primary Care Commissioning Meeting  
CCG Governing Body Meeting  
CCG Governing Body Development meeting  
Quality and Safety Meeting  
1:1 Induction meetings



## 6. KEY RISKS AND MITIGATIONS

N/A

## 7. IMPACT ASSESSMENT

7.1. **Financial and Resource Implications** - None known

7.2. **Quality and Safety Implications** - Any patient stories (soft intelligence) received are passed onto Quality & Safety team for use in improvements to quality of services.

7.3. **Equality Implications** - Any engagement or consultations undertaken have all equality and inclusion issues considered fully.

7.4. **Legal and Policy Implications** - N/A

7.5. **Other Implications** - N/A

**Name: Sue McKie**

**Job Title:** Lay Member for Patient and Public Involvement

**Date: 1 February 2018**

**ATTACHED:** none

## RELEVANT BACKGROUND PAPERS

NHS Act 2006 (Section 242) – consultation and engagement

NHS Five Year Forward View – Engaging Local people

NHS Constitution 2016 – patients’ rights to be involved

NHS Five year Forward View (Including national/CCG policies and frameworks)

NHS The General Practice Forward View (GP Forward View), April 2016

NHS Patient and Public Participation in Commissioning health and social care. 2017. PG Ref 06663



## 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.

	<b>Details/ Name</b>	<b>Date</b>
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	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Sue McKie</b>	<b>01 February 2018</b>



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**MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON 14th NOVEMBER 2017,  
COMMENCING AT 10.30AM, IN THE MAIN CCG MEETING ROOM, WOLVERHAMPTON  
SCIENCE PARK.**

<b>PRESENT:</b>	Dr R Rajcholan	-	WCCG Board Member (Chair)
	Jim Oatridge	-	Interim chair WCCG
	Marlene Lambeth	-	Patient Representative
	Alicia Price	-	Patient Representative
	Steven Forsyth	-	Head of Quality & Risk
	Sukhdip Parvez	-	Quality & Patient Safety Manager
	Dr A Chandock	-	Secondary Care Consultant
	Danielle Cole	-	Administrative Officer
<b>APOLOGIES:</b>	Peter Price	-	Independent Member

**1. APOLOGIES & INTRODUCTIONS**

Introductions were made and the above apologies were noted by members.

**2. DECLARATIONS OF INTEREST**

No declarations of interest were raised.

**3. MINUTES & ACTIONS OF THE LAST MEETING**

**3.1 Minutes of the 10<sup>th</sup> October 2017**

The minutes of the meeting held on the 10<sup>th</sup> October 2017 were approved as an accurate record.

**3.2 Action Log from meeting held on the 10<sup>th</sup> October 2017**

Key actions from the action log were discussed as follows and an updated version of the action log would be circulated with the minutes:

Action 5.2 – Agreed to close as the information is included in this meetings Primary Care Report.

Action 5.7 – SF stated a conversation has been held with the Science Parks Head of Estates who has advised a new cleaning regime has been put in place and to allow this to be embed prior to escalating. Agreed to close.



Action 5.8 – Action remains open.

Action 5.8 – Action remains open.

Action 7.1 – SF stated SP has received the quarterly report of maternity incidents that do not trigger serious incidents. The report will be reviewed at the SISG Meeting (Serious Incident Scrutiny Group) and an external review of the incidents has also been requested. Agreed to close.

Action 4.1 – SP confirmed data has been received. Agreed to close.

Action 5.1 - Action remains open. DC to check status and forward to SF.

Action 6.1 – SF noted he does not believe Datix will be used in terms of managing risks however, excel may be used moving forward. JO raised concern with regards to how excel may be controlled as it is not a live system. The Committee agreed to close this action and to reopen in another forum as the Quality and Safety Committee cannot influence as it sits with the Director of Operations. SF to draft an email explaining it has been agreed to assign this action to Audit and Governance. RR to send as chair of the Quality and Safety Committee.

Action 5.4 – Agreed to close.

RR highlighted an action on page four of the minutes has not been included within the action log. SF noted the action has been raised with Sarah Fellows however, has not received a response. SP to follow up and DC to add to action log.

#### **4. MATTERS ARISING**

No Matters Arising was raised.

#### **5. ASSURANCE REPORTS**

##### **5.1 Monthly Quality Report**

Report was noted by all present. SP provided a brief summary of the report.

Urgent Care Provider

SP stated the CQC Inspection Report for Vocare from the visit in March 2017 has been rated as inadequate overall and a further visit by CQC took place on 26<sup>th</sup> October 2017, according to Vocare it was an assuring visit. The latest CQC visit has acknowledged overall progress made in the following areas; significant events and the sharing of learning, medicine and other alerts, recruitment, recruitment processes and evidence, clinical audits,



quality of documentation and communication. A random sample of ten clinical records was reviewed and of those two records; observations were required given the reasons for presenting at the UCC. However, concerns was raised relating to waiting times for children, especially those that are booked via NHS111 as they may have been assessed prior to presenting at the Urgent Care Centre. To mitigate this concern Vocare will be implementing additional safety netting for all NHS111 booked appointments with children under one years old receiving a triage on arrival as if they had self-presented and children over the age of one receiving a triage if the wait time is above two hours. In terms of urgent care practitioners who see children, competence assessments are being undertaken and if there is a staffing issue the patient can be directed to the Emergency Department.

SP added a contract performance notice is in place. The action plan contains 292 actions and of those 33 remain outstanding. At the Improvement Board held on 6<sup>th</sup> November 2017 NHSE, CQC and Healthwatch have noted the positive steps Vocare have made locally and nationally.

A coordinated unannounced visit to Wolverhampton UCC in conjunction with Stafford and Cannock, East Staffordshire, South East Staffordshire, Seisdon and Peninsula, North Staffordshire and Stoke CCG took place on the evening of Thursday 5<sup>th</sup> October. The aim of this visit was to explore staffing across the patch. Key elements identified from the Wolverhampton unannounced visit were that clinician productivity is not good however, the UCC was very well staffed. Home visiting was also highlighted as a concern.

SP stated that CCG have received a whistleblowing letter of complaint from a member of staff which was noted at the Improvement Board. Once a response has been received feedback will be provided at the next Committee.

Vocare have announced they have been taken over by Totally PLC.

Vocare has worked closely with Wolverhampton's Quality Team a serious incident workshop has been run by the team at Vocare's request. The workshop was attended from across the country. The workshop was well received and has resulted in actions which will now form part of a national work plan to build continuous improvement in the identification and management of serious incidents.

**Action:- SP to check if Vocare notify GPs when a child leaves the UCC and has not waited to be seen.**



## Maternity Performance Issues

SP highlighted the key performance indicators on the maternity dashboard are a growing concern which is impacting on quality and safety. There has been an increase in the admission of babies at the neonatal unit; five neonatal deaths have been reported to date. The Elective C Section rate has also increased to 16%. The number of women booking to give birth has increased significantly in last 12 months. The midwife to birth ratio has deteriorated from 1:29 in April 2016 to 1:32 in August 2017. In terms of serious incidents there has been three reported for the maternity services since October 2017 and in total six has been reported since June 2017.

SP noted due to the increase in bookings the Trust confirmed at the last Clinical Quality Review Meeting a letter would be issued on Thursday 26<sup>th</sup> October 2017 to all Chief Executives and Accountable Officers in the Black County to notify that RWT are capping births as of the 13th November 2017. This does not impact on in-utero transfers or the 500 births from Walsall.

Dr Chandock asked for the following information “the number of deliveries, the exact delivery rate, the numbers deferred from the booking and how many from out of area”.

SP responded that this information is currently not available to the WCCG but the provider does capture this information internally to monitor all maternity activity.

SP further added vacancy rate is currently at 3% which demonstrates 1:32 is due to birth numbers rather because of vacancies.

## Non-Emergency patient transport service

SP noted mainly there are performance issues with this provider with a potential for its impact on the quality issues. The provider has failed to meet reporting requirements to submit Quality Reports, KPIs and serious incidents (SI) and the current performance has not been at the levels expected and has recently impacted adversely upon the quality of the service. The Quality Team regularly attends CQRMs since June 2017 where it was highlighted that the provider has failed to report two potential STEIS reportable serious incidents and that are of significant concern to the commissioner. The provider has responded to the information breach notice but the issue of two potential SI's was not reported. One of the potential SI (unexpected death) was deemed as not reportable but there was a disagreement between WCCG and provider in terms of the second incident (patient fall and fracture) due the patient harm threshold. WCCG has liaised with NHSE Quality Lead and they have also deemed this incident as serious harm and therefore meet SI reportable criteria.



## Mortality

SP stated RWTs most recent HSMR and SHMI data is indicating deterioration. An action plan is in place and the Trust has commissioned independent coding, diagnostic, palliative and case note reviews. The next MORAG meeting will be held in November and update will be provided at December's Committee.

## Step Down care home provider

SP noted there were a number of quality concerns raised at the initial quality visit. WCCG have since been managing, monitoring and supporting the provider. The suspension has been lifted with the caveat that Accord need to manage admissions based on risk stratification; staffing and patient complexity. WCCG will be closely monitoring the provider's progress with improving the quality of care through quality visits and CQRMs. The last Improvement Board will take place in November 2017.

## Never Events 16/17

SP noted one Never Event has been reported in October 2017. There is a total of five never events reported year to date. There is a concern as there is a reoccurring theme. SF requested a themed report to be added to February's 2018 CQRM agenda, this will allow enough time to undertake investigations. Committee agreed.

**Action: - DC to add Never Events as a themed report to Februarys 2018 CQRM agenda.**

SP stated the following three key issues have been highlighted at RWTs CQRM;

- Late patient moves
- Late observations
- Cardiac arrest outcomes. A themed report is due to be discussed at Novembers CQRM.

SP stated 28 pressure injury incidents have been reported for this reporting period which is significantly a high number for this financial year for both acute and community services. WCCG Quality and Safety Manager has contacted the lead tissue viability nurse for RWT who has stated the increase is due to end of life patients, complexed cases and incidents not reported correctly. RWT will undertake full RCAs into all incidents.

There is significant rise in the number of diagnostic delay incidents reported for October 2017 which is a concern. WCCG head of quality has raised a SBAR with the chief nurse at RWT and has requested to provide a themed report to be presented at January 2018 CQRM.



SP noted RWT has reported one MRSA bacteraemia. The Trust will undertake a full RCA.

There has been significant improvement for compliance for Adults' and Children safeguarding level 3 training however, the Trust has failed to meet their internal 95% compliance.

SP stated there are a number of serious incidents that remain open for BCPFT due to having failed to provide the requested response to the WCCG Quality Team. An extra ordinary SISG meeting was arranged where the provider was invited to attend this meeting to discuss all of the open SI's unfortunately this meeting was cancelled due to the provider unable to submit any SI responses prior to the meeting. However, a meeting has been scheduled for 30<sup>th</sup> November 2017. The pressure injury serious incident which occurred in June 2016 remains outstanding due to the disagreement between the CCG and the provider. The Deputy Director of Nursing has liaised with NHSE to act as an arbitrator to settle the dispute; NHSE confirmed the pressure injury was avoidable. The CCG are awaiting the final RCA from BCPFT. SF stated if the provider does not reply by Tuesday 12<sup>th</sup> December 2017 SF requested for the Committee to escalate and formally write to the provider.

**Action: - The CCG are awaiting the final RCA from BCPFT. SF stated if the provider does not reply by Tuesday 12th December 2017 SF requested for the Committee to escalate and formally write to the providers board members**

ML raised a concern relating to an incident at RWT.

**Action: - ML to forward details to SF.**

## 5.2 Primary Care Quality Report

The report was noted by all.

LC stated the following;

The new infection prevention (IP) audit has now been ratified and is in use at all sites, it has caused the overall rating to drop slightly because the measure is against new guidance. Issues around environment were identified as the main reason that gradings have reduced. LC highlighted one practice received a red rating in August 2017, Primary Care Liaison for IP is working with the practice, a three month follow up will be undertaken and a progress report will be provided.

WCCG have not received any untoward medicine alerts. The routine alerts are submitted directly to practices.

WCCG Friends and Family Test (FFT) overall response as a proportion of list size was 1.2%, which is the same for the previous month and was significantly better than both the regional and national average. There are eight practices in total where no data was submitted or data was suppressed in August 2017. The overall response rate is slightly lower than the national average.

The majority of responses have again come via tablet/kiosk for this month. There has been a significant increase in SMS text.

FFT is also triangulated with NHSE Dashboard and GP Patient Survey data when available and along with Quality Matters, SIs and complaints.

There are currently 18 Quality Matters open. The majority of current incidents relate to information governance breaches, this is currently being reviewed in-depth by the Quality Team. All incidents here will be reported to PPIGG for logging and escalation once the practice has responded to the request for further information.

LC noted the graph on page nine of the report, the data for May, June and July 2017 is not correct due to a backlog. However, Quality Matters incidents are now up to date and all Primary Care incidents have been forwarded to the relevant practice.

JO asked should the definition and clarity of breaches be included within the report. Committee agreed.

**Action:- LC to include the definition and clarity of each Quality Matters Information Governance breaches within future reports.**

No complaints or compliments relating to Primary Care are noted for the CCG.

There is currently one incident being investigated within Primary Care. The incident relates to a treatment delay, this is currently being investigated at the practice and has been escalated to NHSE.

One issue was referred to the Performance Information Gathering Group (PPIG) on 14<sup>th</sup> September 2017 that relates to a near miss due to an IT system issue. The group were assured with the CCG and GP response and asked for the communication to be sent out to practices by the CCG to be shared for reference. The meeting held on 28<sup>th</sup> September 2017 included four issues raised, three were referred by the CCG and included: IG breach, Performance and Contractual which were all closed however, the performance issue has since been reopened.

The NICE assurance framework guidance is currently being reviewed and will be applied in line with the peer review system for GPs.

The CCG received two CQC inspection reports with a 'good' rating and two practices currently have a 'requires improvement'. The two practices are being monitored by the Primary Care



and contracting team with input from the Quality Team.

There are currently 18 risks relating to Primary Care which are recorded on Datix and monitored on a monthly basis by the Quality and Risk Team.

JO queried if the reporting for Primary Care and Secondary care is consistent. SF responded the CCG are developing how Primary Care is monitored.

### 5.3 Safeguarding Adults, Children and Looked After Children Quarterly Report

Annette Lawrence highlighted the following points;

- NHSE have developed and piloted a Self – Assessment Tool (SAT) to be used by CCGs to provide assurances to NHSE. This has now been extended to include all CCGs across the West Midlands. The electronic NHSE SAT has been completed by WCCG Safeguarding Team and this replaces the previous SAT. It is expected that peer review of SAT submissions will take place in the near future. Work is being carried out by NHSE to develop SAT tools for providers in 2018.
- A rolling programme of WCCG and GP safeguarding training has been developed, with level 3 GP training commencing in September 2017. This includes: Safeguarding Adults, Safeguarding Children, Domestic Abuse, Female Genital Mutilation and recently the CCG have commissioned a drama group.
- WCCG have been successful in a bid to NHSE for money to fund a project in collaboration with the Refugee and Migrant Centre and the Wolverhampton Domestic Violence Forum. Training of new arrivals will commence next month and progress of the training will be fed back to NHSE.
- The GP Domestic violence training and support project is due to be launched in January 2018 and will be rolled out initially for an 18 month period.

Lorraine Millard highlighted the following points;

- Following the publication in February 2017 of the CQC report of its review of health services relating to safeguarding children and services for looked after children in Wolverhampton that took place in July 2016, an action plan was developed by WCCG to address the recommendations made.
- On 11<sup>th</sup> August 2017 the WCCG Chief Officer received a letter from the investigation Lawyer written on behalf of the chair of the inquiry into the historical child sexual abuse in Wolverhampton. Wolverhampton's response was collated and submitted within timescale with evidence provided as requested.
- WCCG have recently appointed a Deputy Designated Nurse for Safeguarding Children, the on boarding checks are still in process and will hopefully be in post from January 2018.



Fiona Brennan highlighted the following points;

- Wolverhampton continues to have a relatively high number of looked after children, but comparable with neighbouring authorities.
- Approximately 60% of Wolverhampton children are placed outside of the City.
- RWT will extend their geographical coverage, undertaking review health assessments for all Wolverhampton's children placed within 50 miles of the City. It is anticipated that the new arrangements will commence in March 2018 and will provide a dedicated health care professional to improve consistency and quality of care offered to our children placed further afield.
- Only 8% of Wolverhampton's children are currently placed further than 50 miles away. WCCG will remain responsible for co-ordinating their health care.
- Following contractual negotiations between WCCG and RWT, key performance indicators were added to the RWT LAC dashboard in September 2017.
- A paediatric consultant was recruited to in September 2017 within RWT and the appointee will be undertaking the role of Named Doctor LAC.
- The service specification for CAMHS is under review. There have been concerns that some of the children have been refused a service on the grounds of placement instability in spite of statutory guidance which states that this should not be the case. This will also be addressed as part of the ongoing CAMHS Transformational plan going forward.
- Orange Wolverhampton campaign will commence from the 25<sup>th</sup> November 2017 until 10<sup>th</sup> December 2017.

#### 5.4 Medicines Optimisation Quarterly Report

David Birch highlighted the following points;

- Members of the public and healthcare professionals can use the yellow card scheme website to report any suspected side effects or safety concerns with e-cigarettes and e-liquids used for vaping.
- The CCG commissions a service where clinical pharmacists and technicians visit practices on a weekly basis to undertake safety work alongside the CCG requirements around QUIPP and cost control prescribing.
- Eclipse Live is based on GP data from the GP system which identifies medication that may be potentially causing harm. The team took action or brought to the attention of clinicians 53 Eclipse Live Red alerts between July and September 2017.
- At the request of the CCG, the team collected data in ten practices related to the prescribing of bisophosphonates. Patients prescribed bisophosphonates for more than five years in Wolverhampton may benefit from a review and a discussion regarding stopping treatment.
- The CCG are offering a Prescribing Incentive Scheme to GP practices to review and if appropriate revise current prescribing practice.
- The overall rates for antibiotic prescribing must be equal to or below 1.161 for the period April 2017 to March 2018. The CCG target is 1.161 and to August 2017 is 0.997 which is under target.



- RWT continue to ensure that all hospital FP10 prescriptions issued by the provider are used to support generic prescribing or brand prescribing were appropriate and not used by-pass the formulary.
- Black Country Partnership continue to work to ensure that patients on shared care drugs have an agreement in place and that there is a process and training to be embedded for the use of ESCAs.
- NHSE publish a dashboard which they hope will further help CCGs to understand how well their local populations are being support to optimise medicines use and inform local planning.
- The antibiotic strategy is to reduce antibiotic items. The antibiotic formulary is regularly reviewed.
- The antimicrobial sub-group worked with young people in order to educate on antibiotics and reduce demand. This project won a National Antibiotic Award in the Child and Family category.

RR queried if and when will the AMR survey tool highlighted on page 5 of the annual antibiotics report be rolled out to GPs. DB agreed to check when the survey tool is intended to be implemented.

RR queried on page 3 of the annual antibiotics report when to use Bismuth according to local guidelines. DB agreed to check guidelines outside of meeting.

**Action:- DB to check if the AMR Survey Tool is planned to be rolled out to GPs and when.**

**Action:- DB to check guidelines for when to use Bismuth.**

#### 5.5 Quality in Care Homes Quarterly Report

Molly Henriques-Dillon sent apologies. Report was noted by all.

#### 5.6 Workforce Race Equality Standards

The report was noted by all.

Juliet Herbert (JH) highlighted the following;

- Appendix 1 of the report highlighted key issues and gaps identified from the WRES template.
- The draft WRES action plan notes the 'identifying means for collecting' as actions. The CCG need to ensure the information if readily available is included within the next WRES. The action plan focuses on how the information is going to be collected.
- There is a focus on relevant Equality and Diversity training as this anticipated it will reduce the percentage of staff that says they are experiencing harassment and bullying.
- There has been a slight change to indicator nine of the WRES template.
- Predominantly HR has a lot of responsibility for the action plan. A meeting is required to be scheduled between JH and HR to discuss the action plan. Unfortunately due to diary



commitments the meeting has been difficult to schedule. SF requested an update at next meeting.

**Action :- JH to provide an update regarding the meeting with HR discussing the WRES action plan.**

## 6.1 Quality and Safety Risk Register

PS highlighted at present there is a total of nine risks attributed to the committee. One is a new risk and two potentially for closure.

Risk 476 – Named Dr LAC – Agreed to close.

Risk 499 (new) – Review Health Assessments for Looked after Children – it was identified there was a backlog which has now been cleared. Agreed to close.

Risk 466 – Out of hours provider – A further update is due on 16<sup>th</sup> November 2017 around the three month target for improvement in priority areas. A further update will be provided at next month's committee.

Risk 489 – Inappropriate arrangements for a Named Midwife – The circumstances remain the same. The Head of Safeguarding is in discussion with the Head of Midwifery on how this can be progressed.

Risk 414 – Quetiapine – optimising use within the Health Economy – SF stated the risk is more suitably placed with Primary Care. PS to update risk to state 'discussed at committee, 15-16 CQUIN is now closed, the risk within Primary care remains open'.

**Action:- PS to update risk 414 to state "discussed at committee, 15-16 CQUIN is now closed, the risk within Primary care remains open".**

## 7. ITEMS FOR CONSIDERATION

### 7.1 Policies for ratification

The Safeguarding Children, Young People and Adults with Care and Support Needs from Harm and Abuse Commissioning policy was noted by committee. The policy has been ratified.

## 8. **FEEDBACK FROM ASSOCIATED FORUMS**

### 8.1 Draft CCG Governing Body Minutes

The minutes were noted by the committee.

### 8.2 Health & Wellbeing Board Minutes



The minutes were noted by the committee.

8.3 Quality Surveillance Group Minutes

No Minutes Available

8.4 Draft Commissioning Committee Minutes

The minutes were noted by the committee.

8.5 Primary Care Operational Management Group Minutes

The minutes were noted by the committee.

8.6 Clinical Mortality Oversight Group Minutes

No minutes were available for the meeting.

**9. ITEMS FOR ESCALATION/FEEDBACK TO CCG GOVERNING BODY**

No items for escalation.

**10. ANY OTHER BUSINESS**

No items raised

**11. DATE AND TIME OF NEXT MEETING**

***Tuesday 12<sup>th</sup> December 2017, 10.30am – 12.30pm; CCG Main Meeting Room.***



**MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON 12th DECEMBER 2017,  
COMMENCING AT 10.30AM, IN THE MAIN CCG MEETING ROOM, WOLVERHAMPTON  
SCIENCE PARK.**

<b>PRESENT:</b>	Dr R Rajcholan	-	WCCG Board Member (Chair)
	Sue McKie	-	Public Health / Lay Member
	Alicia Price	-	Patient Representative
	Steven Forsyth	-	Head of Quality & Risk
	Sukhdip Parvez	-	Quality & Patient Safety Manager
	Danielle Cole	-	Administrative Officer

<b>APOLOGIES:</b>	Peter Price	-	Independent Member
	Jim Oatridge	-	Interim chair WCCG
	Marlene Lambeth	-	Patient Representative
	Dr Julian Parkes	-	Deputy Chair for Quality & Safety
	Kerry Walters	-	Public Health

**1. APOLOGIES & INTRODUCTIONS**

Introductions were made and the above apologies were noted by members.

**2. DECLARATIONS OF INTEREST**

Sue Mckie was present at the meeting as a Lay member for patient and public involvement but also as a public health employee.

**3. MINUTES & ACTIONS OF THE LAST MEETING**

**3.1 Minutes of the 14<sup>th</sup> November 2017**

The minutes of the meeting held on the 14<sup>th</sup> November 2017 were approved as an accurate record with the following exceptions:

Page two action 6.1 SF requested for the action to be amended to state 'SF noted he was uncertain whether Datix or Excel will be used going forward to manage risk on behalf the CCG'.

**3.2 Action Log from meeting held on the 10<sup>th</sup> October 2017**

Key actions from the action log were discussed as follows and an updated version of the action log would be circulated with the minutes:

Action 5.1 – SP stated that Vocare make 3 attempts to contact the child; ring the local ED to



see if they have presented there and then a card drop. The details of the attempts are entered on to the Adastr notes which will appear on the post-event message sent to the GP. Agreed to close.

Action 5.1 – SP noted the Never Event themed report is scheduled for February 2018 CQRM.

Action 5.1 – SP noted correspondence has been sent to the Director of Nursing at BCPFT, a response has not been received to date. SF requested action needs to be taken on behalf the Committee. The Committee agreed if a response was not received by the close of play Tuesday 12<sup>th</sup> December 2017 a formal letter needs to be issued to the providers board members.

Action 5.1 – Agreed to close.

Action 5.2 – Agreed to close.

Action 5.4 – Agreed to close.

Action 5.4 – Action remains open. DC to forward email from David Birch.

Action 5.6 – Item on agenda. Agreed to close.

Action 6.1 – Item on agenda. Agreed to close.

Action 5.1 – SP noted Reference 34 of the IAPT scorecard relates to the measurement of the patients improvement in terms of use of evidence based tools to monitor mood and impact on patients functioning. Agreed to close.

Action 5.8 – DC to forward action assigned to Maxine Danks to Joanne Lake.

Action 5.8 – DC to forward action assigned to Maxine Danks to Joanne Lake.

Action 5.1 – Helen Hibbs has advised that the CCG are not pursuing the appointment of a GP Mortality Reviewer at this time. Agreed to close.

Action 6.1 – Agreed to close. DC to email Peter McKenzie and Peter Price explaining the Committee agreed to sign this action to Audit & Governance.

#### **4. MATTERS ARISING**

No Matters Arising was raised.



## **5. ASSURANCE REPORTS**

### 5.1 Monthly Quality Report

Report was noted by all present. SP provided a brief summary of the report.

#### Urgent Care Provider (UCC)

SP stated the CQC Inspection Report for Vocare from the visit in March 2017 has been rated as inadequate and a follow up visit took place in October 2017, who have acknowledged overall progress has been made. The CCG and UCC agreed a set of priority actions that were to be delivered by November 2017, Governing Body has agreed to extend the enhanced scrutiny until 1<sup>st</sup> February 2018. Several performance issues are being addressed through Contract Performance Notices and an Information Breach Notice. A planned quality visit will take place over the Christmas period. NHSE Quality and Surveillance Group have agreed to stand down the NHSE Quality Surveillance meetings, with ongoing scrutiny / monitoring by NHSE taking place at the routine Quality Surveillance Group each month.

#### Maternity Performance Issues

SP highlighted the key performance indicators on the maternity dashboard are a growing concern which is impacting on quality and safety. The number of women booking to give birth at RWT has increased significantly in the last 12 months. The midwife to birth ratio has deteriorated from 1:29 in April 2016 to 1:31 in October 2017. The current midwife sickness rate for October is 5% which is above the Trusts target of 3.25%.

SP added a letter has been sent by the Chief Executive at RWT informing all Chief Executives and Accountable Officers in the Black Country of maternity capping from 13<sup>th</sup> November 2017 confirming that the Maternity Unit will continue to accept bookings from the commissioned Wolverhampton and designated South Staffordshire GP practices, along with the agreed geographical split of catchment population with the six GP practices within the Willenhall area in order to continue to support Walsall NHS Trust.

SP noted the current midwife vacancy rate is 0.7% which is an improved position.

SM queried if the breakdown of maternity activity by area is known. SF responded Business Intelligence can provide the information and would be useful to be available for each Quality and Safety Committee.

***Action: Business Intelligence to be asked to provide a breakdown of maternity activity by area on a monthly basis.***

SF noted due to the increase in neonatal deaths SF requested at the next Clinical Quality Review meeting (CQRM) to ask RWT if there is a link between perinatal deaths and the



increase in capacity over the last 12 months.

**Action: SP to ask RWT at the next CQRM if there is a link between perinatal deaths and the increase in capacity and to look retrospectively over the last 12 months.**

RR noted there have been a number of serious incidents relating to maternity. SP responded for added scrutiny all serious incidents relating to maternity are reviewed externally and escalated to the Trust. RR requested at the next CQRM for RWT to provide a breakdown on serious incidents prior to June 2017.

**Action: RR requested at the next CQRM for RWT to provide a breakdown on serious incidents prior to June 2017.**

#### Non-Emergency patient transport service

SP noted there are performance issues with this provider with a potential for its impact on the quality issues. The provider has failed to meet reporting requirements to submit quality reports, KPIs and serious incidents (SI) and the current performance has not been at the levels expected and has recently impacted adversely upon the quality of the service.

The Quality Team regularly attends CQRMs since June 2017 where it was highlighted that the provider has failed to report two potential STEIS reportable serious incidents and that are of significant concern to the commissioner. The provider has responded to the information breach notice but the issue of two potential SI's was not reported. One of the potential SI (unexpected death) was deemed as not reportable but there was a disagreement between WCCG and provider in terms of the second incident (patient fall and fracture) due the patient harm threshold. WCCG has liaised with NHSE Quality Lead and they have also deemed this incident as a serious harm and therefore meet SI reportable criteria. SP added the CCG have not received a response from the provider and therefore, all details have been forwarded to the Director of Nursing at NHS England to escalate.

#### Mortality

SP stated RWTs most recent HSMR and SHMI data is indicating deterioration. An action plan is in place and the Trust has commissioned independent coding, diagnostic, palliative and case note reviews. The recent MORAG meeting held in November 2017 was attended by WCCG Chief Officer.

SP noted RWT has highlighted the issues relate to the new admission model and secondly, how the data is coded. RR requested at the next CQRM for RWT to provide more information on the new admission model.

**Action: RR requested at the next CQRM for RWT to provide more information on the new admission model.**



## Never Events 16/17

SP noted there is a total of six never events reported year to date. There is a concern as there is a reoccurring theme. In addition to the themed report to be presented at February 2018 CQRM, the CCG chair has agreed to formally write to the chair at RWT raising concern of the number of Never Events reported.

SF noted WCCG have received confirmation from Sandwell and West Birmingham CCG who are lead commissioners for Marie Stopes that concerns have been raised since November 2017 in terms of the estate, governance and safety for Marie Stopes C Surgical Services at Sandwell Centre. There is not a significant amount of women from Wolverhampton affected but all those that were impacted have been offered appointments elsewhere. The ongoing concerns continue with Marie Stopes. SP will pick up this month in terms of how this has impacted on Wolverhampton women. RR to raise at Governing Body.

## 5.2 Primary Care Quality Report

The report was noted by all.

LC highlighted the following points from the report;

- Influenza vaccination uptakes for Wolverhampton show an average uptake across all ages of 34.8%. The 65 plus group is where the uptake is the highest and the lowest being two and three year olds.
- WCCG have not received any untoward medicine alerts.
- There are nine practices in total where no data was submitted or data was suppressed in August 2017.
- A friends and family test working group has been established to look at relaunch to ensure it's on the agenda.
- WCCG Friends and Family Test (FFT) overall response as a proportion of list size was 1.1%, which is the same for the previous month and was significantly better than both the regional and national average. The overall response rate is slightly lower than the national average. The majority of responses have again come via tablet/kiosk for this month. There has been a significant increase in SMS text.
- There has been 18 Quality Matters in total that are on-going, the majority of current incidents relates to information governance breaches due to patients being given incorrect blood forms, this is currently being reviewed in-depth by the Quality Team. In addition that has also been a number of inappropriate referrals by GPs. GPs in all cases have provided a rationale for their actions and have acknowledged that they could contact a colleague within the Trust for advice'. RR stated this is not the case and is difficult to contact a colleague at RWT. LC responded this has been previously highlighted and will be raised at the Operational Management Group.



There have also been a small number of prescribing issues picked up by outside agencies; these are still undergoing investigation at the practice level.

- In quarter 1 there were five complaints received regarding Wolverhampton GP practices, these relate to clinical treatment, appointments, communication and inaccurate records. One out of the five complaints was upheld which relates to clinical treatment. There were 43 complaints relating to GP practices for 2016/17 which is 9.1% of West Midlands GP complaints dealt with by NHSE.
- From the PPIGG meeting held on 9<sup>th</sup> November five issues were referred relating to information governance breaches and performance issues.
- The NICE assurance group met in November 2017 where the latest guidelines were discussed. The assurance framework around NICE guidance is currently being reviewed and will be applied in line with the peer review system for GPs.
- There have been no CQC inspections in Wolverhampton in November 2017.
- There are currently 19 risks relating to primary care on the register. The majority of risks are up to date
- The workforce implementation plan has been revised in line with new milestones and action points from STP and national drivers.

### 5.3 Infection Prevention Contract report

Matt Reid (MR) highlighted the following points from the report;

- The care home infection prevalence project for 2017/18 has focused on urinary tract infection (UTI) only and interventions to encourage and raise awareness with regard to the identification of UTI and importance of hydration in Wolverhampton Care Homes. A launch took place back in November 2017 which was well attended.
- The impact of GP enhanced audits was minimal in most practices visited in in quarter 1 however; there is a marked impact in quarter two.
- Two dental audits have been completed by the IP team in quarter 2. Six returns from self-assessment and one dental practice is currently under review.
- The Government has reviewed its commitment to reduce healthcare associated Gram negative bacteraemia by 50% by 2021. The target for 2017/18 is a 10% decrease in all cases of E. Coli bacteraemia.
- Users of long urinary catheters remains between 500 and 600 in Wolverhampton. The current preferred list of products has been in place for over a year and is currently under review to ensure clinical and cost effectiveness, this is expected to further reduce costs and improve clinical outcomes in catheterised patients.
- A Catheter Safety Project funded by NSHI and undertaken by the Continence care Team has reviewed over 400 long term catheterised patients and identified over 130 with troublesome catheters to date.
- The 120k funding received from Public Health is being withdrawn from April 2018. This will have a grave impact on how the IP team deliver upon many of the outputs. RR to raise at Governing Body.



- RR queried on page 4 of the report if the 'non-urology catheterised patients' does this relate to patients who present at A & E who are not under a urologist. MR agreed to confirm outside of meeting.

**Action:- MR to confirm outside of meeting query relating to the 'non-urology catheterised patients' on page 4 of the report.**

#### 5.4 Business Continuity Quarterly Report

Tally Kalea sent apologies. Report was noted by all, no questions raised.

#### 5.5 Finance and Performance Report

Gus Bahia sent apologies. Report was noted by all, no questions raised.

#### 5.6 Workforce Race Equality Standards Action Plan

Juliet Herbert confirmed a meeting was held with the HR department who confirmed they were happy with the WRES action plan.

### 6. RISK REGISTER

#### 6.1 Quality and Safety Risk Register

PS highlighted at present there is a total of seven risks attributed to the committee. PS noted the following;

Risk 502 LAC CAMHs has recently been added to the register. Following the presentation of the LAC CAMHS annual report, it transpires the average wait for LAC is currently standing at 40 weeks, compared to that of their peers of 10 weeks. The Key performance indicator for wait times is set at 18 weeks. A review is due in January 2018 and update will be provided at the next committee.

Risk 489 Inappropriate arrangements for a named midwife at RWT. The circumstances remain the same. The Head of Safeguarding is in discussion with the Head of Midwifery on how this can be progressed. The risk will be reviewed at the end of December 2017

### 7. ITEMS FOR CONSIDERATION

#### 7.1 Policies for ratification

No policies for ratification.



## 8. FEEDBACK FROM ASSOCIATED FORUMS

### 8.1 CCG Governing Body Minutes

The minutes were noted by the committee.

### 8.2 Health & Wellbeing Board Minutes

The minutes were noted by the committee.

### 8.3 Quality Surveillance Group Minutes

The minutes were noted by the committee.

### 8.4 Draft Commissioning Committee Minutes

The minutes were noted by the committee.

### 8.5 Primary Care Operational Management Group Minutes

The minutes were noted by the committee.

### 8.6 Clinical Mortality Oversight Group Minutes

No minutes were available for the meeting.

### 8.7 NICE Group Minutes

The minutes were noted by the committee.

## 9. ITEMS FOR ESCALATION/FEEDBACK TO CCG GOVERNING BODY

1. Marie Stopes - concerns have been raised since November 2017 in terms of the estate, governance and safety for Marie Stopes C Surgical Services at Sandwell Centre.
2. Infection Prevention – 120k Public Health funding withdrawn from April 2018 to support infection prevention.
3. Mortality –To ask Chief Officer if an update is available from the RWT MORAG meeting.



**10. ANY OTHER BUSINESS**

SM asked if a child presents at the Urgent Care Centre with a parent who is not registered with a GP is this flagged. SP responded a SOP is in place and included within the Quality Report.

**11. DATE AND TIME OF NEXT MEETING**

***Tuesday 9<sup>th</sup> January 2018, 10.30am – 12.30pm; CCG Main Meeting Room.***

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**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP**

**Finance and Performance Committee**

**Minutes of the meeting held on 28<sup>th</sup> November 2017  
Science Park, Wolverhampton**

**Present:**

Mr L Trigg	Independent Committee Member (Chair)
Mr T Gallagher	Chief Finance Officer
Mr M Hastings	Director of Operations
Dr D Bush	Governing Body GP, Finance and Performance Lead
Dr M Asghar	Governing Body GP, Deputy Finance and Performance Lead (part meeting)

**In regular attendance:**

Mrs L Sawrey	Deputy Chief Finance Officer
Mr G Bahia	Business and Operations Manager
Mr V Middlemiss	Head of Contracting and Procurement

**In attendance**

Mrs H Pidoux	Administrative Team Manager
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**1. Apologies**

Apologies were submitted by Mr Marshall and Mr Hartland.

**2. Declarations of Interest**

FP.218 There were no declarations of interest.

**3. Minutes of the last meetings held on 31<sup>st</sup> October 2017**

FP.219 The minutes of the last meeting were agreed as a correct record with the following minor amendments to be made;

- FP.211 - Item 114 on resolution log– BCG to be changed to BCF
- FP 214 Black Country Partnership Foundation Trust – commissioning intentions should read as 2018/9.

#### **4. Resolution Log**

FP.220

- Item 114 (FP.204) – Letter to be sent to Wolverhampton City Council clarifying the CCG’s position on the BCF Risk Share Arrangement for 2017/18 – Mr Gallagher confirmed that a conversation had taken place with David Watts, Director of Adult Services. The Local Authority had agreed to the proposal set out in the original letter and this has been confirmed by email. The outcome is that the Risk Share Pool has been capped at £250k. The CCG will only be responsible for services it has commissioned.
- Item 115 (FP.205) – Impact of NHS Digital Referral Assessment Service (RAS) in Primary Care to be checked - Mr Middlemiss noted that due to the Black Country Partnerships Foundation Trust’s proposed merger the introduction of this Service had been delayed until at least April 2018. It was agreed to close this action and for an update to be brought back in February 2018. It was noted that the implications on Primary Care need to be considered.
- Item 116 (FP.213) – Finance report – discrepancy in the running costs reporting of pay for Governing Body member and the Chair and non executives to be reviewed – Mrs Sawrey noted that she had emailed an explanation of this to the Chair and Mr Trigg confirmed that this had given the clarification he required - action was closed.

#### **5. Matters Arising from the minutes of the meeting held on 31<sup>st</sup> October 2017**

FP.221 There were no matters arising to discuss from the last meeting.

#### **6. Contract and Procurement Report**

FP.222 Mr Middlemiss presented the key points of the report as follows;

##### Royal Wolverhampton NHS Trust

Performance Sanctions - It was confirmed that since the report had been written the total sanctions for Month 6 (17/18) had been agreed at £26,000. This was mainly attributed to ambulance handover time breaches. This related to 30 minute breaches rather than 60 minutes which was an improvement year on year when both targets were breached.

Sepsis Counting and Coding Change – Discussed at the last CRM meeting as the CCG and Trust have differing views about cost neutrality. It is the CCG view that this should operate like any other counting and coding, whereby a shadow year applies and that any financial increase resulting from the change will need to be reimbursed. A letter is being prepared setting out a formal challenge which will be sent to the Trust. To support this analysis of the impact completed by

the CSU will be included. It was noted that this is a national issue and the Trust will benefit financially in future years.

Cancer Activity Transfer – The Trust will include updates in relation to this as part of the monthly exception reporting process. The CCG has requested clarity of the number of patients to gain an understanding of the impact on achievement of the Cancer 62 day standard, which is not currently being achieved. The Trust is anticipating that there will be an adverse impact. There is also likely to be additional pressure applied to diagnostic reporting.

Overall there is a risk that constitutional standards could and will be affected by this additional activity and, therefore, it has been recorded as a risk at Board level by the CCG's Director of Operations.

Regular updates on the situation will be reported to the Committee.

Contract Round 2018/19 – This has commenced and it had been agreed that separate meetings will be held to progress the risk/gain share approach. The intention is to deliver changes by March 2018 for implementation in 2018/19. If this is not achievable the risk/gain share approach would be introduced in shadow form in 2018/19.

It was noted that there is a national variation which must be signed by 31<sup>st</sup> December and implemented by 1<sup>st</sup> January. The content of the variation includes revised Ambulance KPIs, changes to Learning from Deaths, GP referrals to be e-referrals from Oct 2018 and restricted sale of drinks with high sugar content; with the main impact of the variation being changes to service conditions for these issues. Overall the changes are not significant in terms of content and the timeframe does not have to drive completion and sign off of locally agreed variations. However, it was agreed that, as far as is practically possible, the aim is to have an agreed financial position by the end of December, in order to align with anticipated national reporting timeframes.

RWT have yet to share with the CCG their Forecast Outturn and baseline figure, these are now not expected until week commencing 4<sup>th</sup> December. It was highlighted that this is impacting on the discussions as without this information it is not possible to compare this with CCG figures and highlight any gaps.

The overspend at RWT is a significant risk to the CCG achieving year-end balance, actions are in place to remain in the cost envelope, however, without the figures from RWT this cannot be addressed. This information is also required for detailed modelling to take place in relation to the risk/gain share approach.

## Black Country Partnership Foundation Trust

Mr Middlemiss noted that since the report had been submitted a commissioning intentions letter had been finalised and sent to the Trust. The more complex areas of the contract i.e. STP are being discussed on a Black Country wide basis.

## Nuffield

Mr Middlemiss reported that a letter setting out the commissioning intentions for 2018/19 had been issued. The CCG is proposing to re-base the plan so that it is set at a more realistic level for the rest of this year and next year. This amount is affordable to the CCG if it does not exceed current allocation.

## Urgent Care Centre (UCC)

A third Contract Performance Notice had been issued due to the continued failure of the telephone call back performance metrics. Discussions had taken place with the CCG's Chief Officer about the level of performance against the 4 hour target as it should be possible to achieve this. The Chief Officer is to write to the Vocare Director to escalate these concerns.

It was noted that there had been no change in performance levels following the takeover of ownership and that these issues had been discussed at the Governing Body meeting private session.

Mr Hastings raised a point relating to a national contract variation. From October 2018 if any referrals are not made by ERS these will be rejected by RWT as they will not be paid for these. Work is ongoing to prepare for these changes and the CCG is supporting both the provider and primary care.

Discussion took place regarding the ongoing failure of the Trust to achieve the target for available appointment slots and the concern that the introduction of the contract variation for referrals will significantly worsen the situation.

Resolved – The Committee:

- noted the contents of the report and actions being taken.

## **7. Finance Report**

FP. 223 Mrs Sawrey introduced the report relating to month 7, October.

The following key points were highlighted and discussed;

- The CCG is anticipating meeting all its statutory duties in 2017/18 and in doing so has utilised all its contingency reserves.

- Programme Costs are forecast to overspend which is partially compensated for by underspends on Running Costs
- Reporting that meeting QIPP, however, there is slippage as some schemes are not delivering, this is being offset by the use of reserves. No additional QIPP savings against the unallocated target had been identified in month 7.
- A nil net risk is being maintained as mitigations match identified risks which had reduced to around £2m.
- The CCG's cash performance has improved in October with the RAG being reviewed to Green.
- Due to a change in NHSE reporting requirements the CCG had undertaken a remapping of codes and services. This had affected the groupings of services and therefore it had not been possible to provide movements between months with the exception of Continuing Care, Prescribing, Delegated Primary Care and Running Costs. This will be re-instated going forward.
- RWT is giving concern as activity is indicating a potential forecast outturn of around £2m. The CCG is seeing new HRG codes being used as a result of the expansion of codes in 17/18, which carry a higher tariff i.e. Sepsis.
- Prescribing had deteriorated following the inclusion of new figures relating to 'No Cheaper Stock Obtainable' (NCSO) drugs. The associated data had been reviewed and reflects the cost pressure of £2-3m. The list of NCSO drugs is growing which worsen the position. NHSE's Direct of Finance, Brian Hanford has made a representation on behalf of CCG's for additional funding to cover this.
- The Local Authority had accepted the CCG's proposed cap of £250k in relation to the Risk Share Agreement for the Better Care Fund.

Mrs Sawrey raised that the concern for 2018/19 is the level of QIPP savings to be achieved to maintain balance. The Long Term Financial Model is indicating that the total will be around £11m, however, this is expected to raise to between £12m and £14m when slippage in 2017/18 and the amount being covered by non-recurrent monies is taken into account. Whilst the numbers are similar to this year and national planning assumptions indicate QIPP should be around £11m, the challenge is to find where additional savings can be found.

It was noted that the CCG's monthly Programme Boards received exception reports and actions to address failing schemes. It was considered that there can be instances when schemes deliver but over perform and then savings are not realised.

*Dr Asghar joined the meeting*

Resolved: The Committee noted;

- the contents of the report

## **8. Performance Report**

FP.224 Mr Bahia highlighted the key points of the Executive Summary relating to Month 6 performance, which were considered as follows;

- RTT – the original STF trajectory had been breached and the deadline had been revised to achieve by end of March 2018. September performance was 90.80% which was the worst of the year.

A data quality/validation exercise is ongoing to attain accurate numbers in relation to the Paediatric orthopaedic activity which is transferring from Walsall Manor Hospital to RWT. Additional clinics are being held to clear the backlog. An online training package is being developed for all admin staff to help validate waiting lists.

Concern remains in relation to the impact this will have on the achievement of Cancer wait performance

- A&E Urgent Care Performance – this indicator is becoming more challenging. Performance for September was 91.4% which was just ahead of the STF trajectory. There had been a 1.8% increase in attendances year on year. Recent figures are showing that winter pressures are impacting performance levels.

The STF payment was achieved in quarter 2. In quarter 3 the STF trajectory has been revised from 92% to 90% or if performance exceeds that of the same period last year payment will be made.

There are pressures in paediatrics as beds and wards have been closed due to cases of Norovirus.

Vocare performance issues continue. Initiatives are being put in place to increase the speed of the flow of patients.

Returns requested by NHSE to give assurance that plans are in place for the winter pressure period had been submitted. Actions include advertising in the local press regarding access to primary care over the Christmas and New Year period.

A&E Delivery Board is developing plans as to how to spend the winter funding monies.

It was noted that performance was improving, however, this has slipped again in November and it is a similar position across the region.

- 62 day cancer waits – NHSE is giving significant focus to this indicator. There are ongoing discussions between Trusts across the STP around a shared breach policy for Tertiary Referrals. Accountable Officers (AOs) have been invited to attend monthly/6 weekly Risk and Review Meetings with other AO's from across the STP to discuss shared issues affecting performance across the area.

A new Recovery Action Plan (RAP) is in place for recovery by end of March 2018. Actions in place include ongoing weekly radiology waiting list initiatives, weekly escalation meetings, a Cancer Patient Tracking list is being made available weekly to executives.

The additional Oncology work taken on from City/Sandwell will impact performance regarding this target. It may also impact RTT and diagnostics.

Urology remains an issue although RWT have recruited to vacant posts. The problems remain with the waits for robotic surgery.

Funding for cancer specialist who is reviewing early diagnosis pathways and theatre utilisation is running out.

- Delayed Transfer of Care (DToCs) – Performance is ahead of trajectory for health, however, issues still remain with social care delays predominantly those which are out of area patients. Approximately 40% of the delays for health and social care are attributed to Staffordshire.
- E-Referral – Appointment Slot Issues (ASI) rates – there are a number of issues that are being addressed and a review of the recovery trajectory shows that there is an expectation that performance will decline before it improves.
- C. Diff – this indicator is slightly ahead of threshold year to date. There is significant improvement year on year, 19 in 2017/18 compared to 31 in 2016/17. The threshold for C.Diff breaches is 35 for the full year.
- Ambulance handover breaches – breaches are increasing in relation to 30 minute handovers, however, there has been a decrease in the number of breaches for over the 60 minute threshold.
- E-Discharge – all wards continue to perform well. Assessment units are a challenge and are still below target. The main issues

are Gynaecology Assessment Unit (GAU) and Surgical Emergency Unit (SEU). Training for staff is in place and exception reports are provided.

Mr Bahia informed the Committee that the Improvement & Assurance Framework, (IAF), against which the CCG is assessed at year end, has been received. There are a small number of new indicators, small changes to others and some have been removed. The exiting process of assurance remains the same.

Dr Asghar and Dr Bush raised that whilst the majority of discharges from RWT have improved there are still issues with those received from the A&E department as these are seldom accurate and contain very little detail. It was suggest that this could be improved by introducing a structure to the content to be completed.

Resolved: The Committee noted

- the content of the report
- the comments made regarding the A&E department discharges

## **8. Any other Business**

FP.225 The Committee received the latest risks relevant to the Committee, corporate and organisational level risks. It was requested that members review the current ratings and feedback any comments to Mr Hastings or Peter McKenzie, Corporate Operations Manager.

It was agreed to circulate the matrix so that the consequences of the risk can be considered and for the Datix reference to be included in future reports.

Resolved: The Committee;

- noted the contents of the report
- asked that the matrix was circulated
- requested that the Datix reference is added to future reports
- agreed to review the current ratings and feedback any comments

## **9. Date and time of next meeting**

FP.226 Due to the timing of the December meeting it was agreed that this would be a virtual meeting. The reports for the standing items would be circulated and any comments fed back.

**Signed:**

**Dated:**

**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP  
PRIMARY CARE COMMISSIONING COMMITTEE**

Minutes of the Primary Care Commissioning Committee Meeting (Public)  
Held on Tuesday 7<sup>th</sup> November 2017, Commencing at 2.00 pm in the in the Stephenson  
Room, Technology Centre, Wolverhampton Science Park

**MEMBERS ~  
Wolverhampton CCG ~**

		Present
Sue McKie	Chair	Yes
Dr David Bush	Locality Chair / GP	Yes
Dr Manjit Kainth	Locality Chair / GP	Yes
Dr Salma Reehana	Clinical Chair of the Governing Body	Yes
Steven Marshall	Director of Strategy & Transformation	Yes
Les Trigg	Lay Member (Vice Chair)	Yes

**NHS England ~**

Bal Dhami	Contract Manager	Yes
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**Independent Patient Representatives ~**

Sarah Gaytten	Independent Patient Representative	No
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**Non-Voting Observers ~**

Katie Spence	Consultant in Public Health on behalf of the Health and Wellbeing Representative	No
Tracy Cresswell	Wolverhampton Healthwatch Representative	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
Dr Helen Hibbs	Chief Officer (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
Liz Corrigan	Primary Care Quality Manager Assurance Coordinator	Yes
Lesley Sawrey	Deputy CFO (WCCG)	Yes
Laura Russell	Primary Care PMO Administrator (WCCG – minutes)	Yes

## **Welcome and Introductions**

WPCC130 Ms McKie welcomed attendees to the meeting and introductions took place.

## **Apologies for absence**

WPCC131 Apologies were submitted on behalf of Tony Gallagher, Jeff Blankley, Jane Worton and Sarah Gaytten.

## **Declarations of Interest**

WPCC132 Dr Bush, Dr Kainth and Dr Reehana declared that, as GPs they have a standing interest in all items related to primary care.

Ms McKie declared she works two days a week within Public Health at Wolverhampton Local Authority.

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 Primary Care Commissioning Committee Meeting Held on the 5<sup>th</sup> September 2017**

WPCC133 RESOLVED:

That the minutes of the previous meeting held on 5<sup>th</sup> September 2017 were approved as an accurate record.

## **Matters arising from the minutes**

WPCC134 There were no matters arising from the minutes.

**RESOLUTION: That the above is noted.**

## **Committee Action Points**

WPCC135 **Minute Number PCC302 – Premises Charges (Rent Reimbursement)**  
The CCG are still awaiting the cost directives. Action to remain open.

### **Minute Number WPCC114a – Primary Care Quality Report**

Ms Corrigan agreed to provide a snap shot of the risks within future reports. Mr McKenzie noted that the risks were being discussed within the Private meeting. Agreed to close the action.

### **Minute Number WPCC114b – Primary Care Quality Report**

Ms Corrigan noted the report now included charts with time series of information. Agreed to close the action.

### **Minute Number WPCC117 – Provision of Services post Dr Mudigonda Retirement from a partnership to single handed Contract – Business Case.**

Ms Shelley informed the Committee the report is not due back until 12 months' time. It was noted they are still awaiting confirmation as to what new model of care structure they are going to align to.

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

### **Primary Care Quality Report**

WPCC136 Ms Corrigan presented the quality report to the Committee which provides an overview of activity in primary care and assurances around mitigation and the actions taken when issues have arisen.

The following was highlighted to the Committee;

- There are no major concerns with Infection Prevention. Three reports have been received in the last month from the provider The Royal Wolverhampton NHS Trust, two practices have scored bronze and one has scored silver.
- Overall the practices with no submission for Friends and Family Test has reduced for the month of August (7% compared to 11% in July). The suppressed data has remained the same for the month at four practices and the total number of practices with no data available was eight. The number of responses which were rated at positive (extremely likely or likely) was 82% (3464). The Friends and Family activity is being monitored on a monthly basis through the Primary Care Operational Management Group and via the NHS England Primary Care Dashboard.
- The quality matters incidents are now up to date and all primary care incidents have been forwarded to the relevant practices.
- The assurance framework around NICE guidance is currently being reviewed and will be applied in line with peer review system for GPs.
- The Workforce implementation plan has been revised to include new milestones including actions from the STP, 10 high point actions and national drivers.
- A Project Manager for workforce is now in place and working closely with the Primary Care Team.

- The Trainee Nursing Associates are now on placement and the nurses are undertaking Fundamentals of Practice Nursing. They have been invited to a conference in London to discuss their experiences in primary care.
- Funding allocation for practice and advanced clinical practice courses has been agreed and two individuals have applied for the fundamentals in practice nursing and four for the advanced clinical practice course.

Dr Hibbs noted in terms of the workforce plan, there is also an STP wide directive which states they have to recruit to a certain amount of GPs in a short amount of time. Dr Hibbs asked how the work in Wolverhampton dovetails into the STP wide recruitment drive.

Mrs Southall stated there is an STP working group and the share of GPs for Wolverhampton and the Black Country is 127 by 2020. NHS England have requested an STP Primary Care Workforce Strategy, which an initial draft has been submitted for comment. There is also a programme of work attached to the Primary Care Task and Finish Group that captures actions associated with recruitment and retention. In the Strategy the early indication based on data is that across the Black Country they will not achieve the recruitment target of 127 GPs by 2020. The Committee agreed that a two way approach needs to be considered in terms of transformation of workforce as well as aiming for national targets.

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

### **WCCG Quarterly Finance Report**

WPCC137 Mrs Sawrey presented to Committee the CCG quarterly finance report, which outlines the CCGs financial position at month 6.

The delegated primary care allocations for 2017/2018 as at month 6 are £35,513m. The forecast outturn is £35,013m delivering a underspend position. The forecast outturn indicates an underspend of £500k against other GP services which relates to pre delegated i.e. 2016/17. The CCG has been given the income to offset the expenditure and consequently the CCG is reporting a non-recurrent benefit of £500k.

In relation to primary care reserves the forecast outturn includes a 1% Non-Recurrent Transformation Fund and a 0.5% contingency in line with the 2017/18 planning metrics. In line with national guidance the 1% non-recurrent transformation fund can be utilized in year non-recurrently to help support the delegated services.

It was highlighted that the £500k underspend could only be used on non-recurrent projects and be committed before March 2018.

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

## **Governing Body Report/Primary Care Strategy Committee Update**

WPCC138 Mrs Southall informed the Committee the report presented had been shared with the Governing Body at the October meeting, based on activity during the month of September 2017. The report details the work progressed against the Primary Care Strategy and each Task and Finish Group. The Governing Body agreed the status of the programme of work and to the name change from a Committee to a Programme Board, which would now report on a quarterly basis.

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

## **Primary Care Operations Management Group Update**

WPCC139 Mrs Southall informed the Committee of the discussions which took place at the Primary Care Operational Management Group meeting on the 24<sup>th</sup> October 2017 and highlighted the following points;

- The IT migration plan remains on track and currently there are only four practices left to migrate over onto EMIS.
- An options paper regarding increasing the update and analysis of qualitative data from Friends and Family Test was presented.
- The demand management plan was provided and supported by the group.
- The contract visit programme continues and there have been no significant issues raised.
- The issues regarding the CHIS system have now been resolved.

**RESOLUTION: That the above was noted**

## **Any Other Business**

WPCC140 There were no items raised.

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

WPCC141 **Date, Time & Venue of Next Committee Meeting**  
Tuesday 5<sup>th</sup> December 2017 at 2.00pm in PC108, 1<sup>st</sup> Floor, Creative Industries Centre, Wolverhampton Science Park.

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**WOLVERHAMPTON CLINICAL COMMISSIONING  
GROUP COMMISSIONING COMMITTEE**

Minutes of the Commissioning Committee Meeting held on Thursday 23<sup>rd</sup> November 2017 commencing at 1.00 pm in the Main CCG Meeting Room, Wolverhampton Science Park

**MEMBERS ~**

**Clinical ~**

**Present**

Dr M Kainth (Chair)	Lead for Commissioning & Contracting	Yes
Dr Gulati	Deputy Lead for Commissioning & Contracting	Yes

**Patient Representatives ~**

Malcolm Reynolds	Patient Representative	Yes
Cyril Randles	Patient Representative	Yes

**Management ~**

Steven Marshall	Director of Strategy & Transformation	Yes
Tony Gallagher	Chief Finance Officer	Yes
Sarah Smith	Interim Head of Commissioning - WCC	No

**In Attendance ~**

Liz Hull	Administrative Officer	Yes
Vic Middlemiss	Head of Contracting & Procurement	Yes
Peter McKenzie	Corporate Operations Manager	Yes
Mark Williams	Wolverhampton City Council	Yes
Claire Morrissey	Solutions & Development Manager	Yes (part)
Katrina McCormick	Children's Commissioning	Yes (part)

**Apologies for absence**

Apologies were submitted on behalf of Juliet Grainger.

**Declarations of Interest**

CCM643 Dr Kainth declared an interest as a GP.

RESOLVED: That the above is noted.

## Minutes

CCM644 The minutes of the last Committee meeting, which took place on 26<sup>th</sup> October 2017 agreed as a true and accurate record.

RESOLVED: That the above is noted.

## Matters Arising

CCM645 (CCM592) Contracting & Procurement Report – Improvement Board (Vocare): Cyril Randles and Max Reynolds raised concerns about Vocare and the Urgent Care Centre, following receipt of minutes from the Vocare Improvement Board meeting that took place in August. The Committee noted a request that lessons are learnt from contractual issues that have arisen with regards to the provider and landlord.

RESOLUTION: That the above is noted and an action agreed to table an implementation timetable as Any Other Business at the next meeting.

## Committee Action Points

CCM646 (CCM619) Direct Access Diagnosis Spirometry Business Case: VM looking to implement a Programme of Work to test out the Business Case that came from the Trust and explore the option of a delivery model that would be Primary Care led.

RESOLVED: That the above is noted, action closed and a new action was agreed for Vic Middlemiss to provide an update at the next Committee meeting.

(CCM637) Contracting and Procurement Report – Sepsis Coding: It was confirmed that the CSU are adopting the same methodology across all CCG's, excluding Staffordshire who has taken a different approach.

RESOLVED: That the above is noted and action closed.

(CCM638) Primary Care Counselling Service – An options paper to be submitted to the Committee meeting in January 2018.

RESOLVED: That the above is noted and action agreed for Ranjit Khular to present the options paper in January 2018,

(CCM640) MSK Service – Agreed action is closed.

RESOLVED: That the above is noted.

## Review of Risks

CCM647 Peter McKenzie presented a list of risks that Commissioning Committee has responsibility for.

Following a review of the risks, it was agreed that risk CC01, CC06 and CC07 could be closed.

RESOLUTION: That the above is noted and an action agreed for Peter McKenzie to send Cyril Randles a copy of the risk management protocol.

## Contracting Update Report

CCM648 Vic Middlemiss provided the Committee with a monthly overview of key contractual issues and areas of concern including actions proposed or being taken to address issues. Highlights of the report presented include the following:

### *Royal Wolverhampton NHS Trust*

Sepsis Counting and Coding Change - The Committee was advised last month that a national counting and coding change has been implemented regarding sepsis.

A lengthy discussion took place about this issue at the October CRM, during which different views were expressed about cost neutrality. The Trust's view is if they lose income then that is not cost neutral. The CCG view is that it should operate like any other counting and coding, whereby a shadow year applies and that any financial increase resulting from the change will need to be reimbursed.

An analysis of the impact has now been completed by the CSU and this will be shared with the Trust as part of a formal challenge.

Cancer Activity Transfer: The Trust has confirmed there is going to be a 70/30 split of the Oncology and Gynaecology Oncology work from City/ Sandwell Hospital. The City work (70%) will go to University Hospital of Birmingham (UHB) and Birmingham Women's Hospital (BWH) with the Sandwell work (30%) coming to the Royal Wolverhampton Hospital. The existing Service Level Agreement (SLA) will cease from 22<sup>nd</sup> October 2017.

The Trust is anticipating that this will adversely impact on the Cancer 62 day standard. However, the full impact on performance cannot be predicted at present as potential numbers to RWT from Sandwell, via patient choice, is currently not clear.

Overall there is a risk that constitutional standards could and will be affected by this additional activity and therefore it has been recorded as a risk at Trust Board by the CCG Director of Operations.

### *Black Country Partnership Foundation Trust (BCPFT)*

Data Quality Improvement Plan (DQIP): The DQIP has been agreed and a contract variation sent to the Trust. Meetings are being held monthly to work through the actions jointly, with the ultimate aim of improving data quality.

A number of CAMHS indicators that are being monitored by NHSE are not on the monthly performance report or in the DQIP. Work needs to be done with commissioners and provider to agree these indicators and capture the data.

CAMHS (LAC) a report provided in November for 2017-18 suggested that LAC waiting times reached up to 80 weeks in October 2016 and the average waiting time was 41 weeks. However, Sarah Smith informed the Committee that waiting times have improved and this information is not accurate. Vic Middlemiss responded that the data inaccuracy is being addressed and clarity will be provided in the report submitted to the Committee in January 2018.

Learning Disability (LD) Psychiatrists – Letter of Concern: The CCG had raised an issue with the Trust back in July, expressing concern that community based psychiatrists were being used as receiving consultants for patients in Assessment and Treatment beds.

The CCG has since received confirmation that this practice has changed and that the LD consultants, whilst having some presence in the inpatient unit, are no longer being used as receiving consultants.

### *Nuffield*

At the Contract Review Meeting in October, the CCG proposed re-basing the Nuffield plan so that it is set at a more realistic level for the rest of this year and next year. Following discussion it was agreed that the CCG will complete a proposal using months' 1-5 data.

### *Primary Care Contract Issues*

MGS Practice: Contract Breach Notice – It was confirmed that the Practice remains closed.

RESOLVED: That the above is noted.

## **Community Falls Service Specification**

CCM649 Claire Morrissey presented the Committee with the draft Community Falls Prevention Service Specification, based on a tiered model of care, with a focus on prevention, proactive multi-factorial assessment and case management. It was noted that the Specification had been approved by the Better Integrated Care Programme Board.

RESOLVED: The Committee approved the Service Specification and it was agreed that if the service is not re-developed by 1<sup>st</sup> April 2018, a re-procurement exercise would take place.

## **CAMHS Transformation Refresh 2017-2020**

CCM650 Katrina McCormick presented the CAMHS Transformation Refresh 2017-2020, on behalf of Margaret Courts. It was requested that the Committee endorse the approach set out in the report.

It was noted that NHS England has issued some conditions, which led to the development of an Action Plan.

RESOLVED: The CAMHS Transformation Refresh 2017-2020 was approved by the Committee.

## **Any Other Business**

### **Project Process**

CCM651 Steven Marshall provided the Committee with assurance of the project process in place.

RESOLVED: That the above is noted.

### **Sue McKie – Lay Member for Patient Involvement**

CCM652 Steven Marshall to find out when Sue McKie took over from Pat Roberts, and feedback to the Committee, so that patient representatives can be introduced to her.

RESOLUTION: That the above is noted and an action agreed for Steven Marshall to feedback Sue McKie's start date to the Committee.

## **Date, Time and Venue of Next Meeting**

CCM653 Thursday 25<sup>th</sup> January 2018 at 1.15pm in the CCG Main Meeting Room

RESOLVED: That the above is noted.

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# Health and Wellbeing Board

Minutes - 10 January 2018

## Attendance

### Members of the Health and Wellbeing Board

Councillor Val Gibson	Cabinet Member for Children & Young People
Councillor Paul Singh	Conservative
Councillor Paul Sweet	Cabinet Member for Public Health and Well Being
Bhawna Solanki	University of Wolverhampton
David Baker	West Midlands Fire Service
David Loughton CBE	Royal Wolverhampton Hospital NHS Trust
Dr Helen Hibbs	Wolverhampton Clinical Commissioning Group
Elizabeth Learoyd	Healthwatch Wolverhampton
Emma Bennett	Director of Children's Services
Helen Child	Third Sector Partnership
John Denley	Director of Public Health
Jeremy Vanes	Royal Wolverhampton Hospital NHS Trust
Linda Sanders	Independent Chair of Adults and Children's Safeguarding Board
Mark Taylor	Strategic Director - People
Sarah Smith	Head of Strategic Commissioning
Steven Marshall	Wolverhampton Clinical Commissioning Group
Councillor Jasbir Jaspal	Chair of the Health Scrutiny Panel – as an observer

### Employees

Madeleine Freewood	Development Manager - City Health
Helen Tambini	Democratic Services Officer

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## Part 1 – items open to the press and public

*Item No.*      *Title*

- Apologies for absence**  
Apologies for absence were received from Councillor Roger Lawrence, Councillor Sandra Samuels OBE, Brendan Clifford, Chief Superintendent Jayne Meir, David Watts, Dr Alexandra Hopkins and Tim Johnson.
- Notification of substitute members**  
Bhawna Solanki attended on behalf of Dr Alexandra Hopkins.
- Declarations of interest**  
There were no declarations of interest made.

4 **Minutes of the previous meeting - 18 October 2017**

Resolved:

That the minutes of the meeting held on 18 October 2017 be confirmed as a correct record and signed by the Chair.

5 **Matters arising**

There were no matters arising from the minutes of the previous meeting.

6 **Health and Wellbeing Board Forward Plan 2017-2018**

Helen Tambini, Democratic Services Officer presented the report and highlighted key points.

John Denley, Director for Public Health confirmed that the Public Health Annual Report 2016-2017 would include a vision for public health and business going forward.

Linda Sanders, Independent Chair of Adults and Children's Safeguarding Board advised that the Adults and Children's Safeguarding Annual Reports would be available in the Autumn for the Board to receive.

In answer to a question regarding the rate of progress nationally for Placed Based Commissioning, Steven Marshall, Wolverhampton Clinical Commissioning Group (CCG) and Mike Sharon, Royal Wolverhampton Hospital NHS Trust (RWT) advised that there were no fixed models to follow and it was expected that each area would shape its own development and Wolverhampton wanted to be ahead with progress. National policy was changing and it was hoped that in the next six months some progress would be made.

Madeleine Freewood, Development Manager – City Health referred to item 10 on the agenda which proposed a five-step action plan for strengthen governance and system leadership within the Board. As part of that action plan, it was recommended that several issues would be added to the Forward Plan and that could be considered at the next Agenda Group meeting.

Resolved:

1. That the Board approve the current Forward Plan.
2. That the Adults Safeguarding Board Annual Report and the Children's Safeguarding Board Annual Report be added to the Forward Plan for consideration in Autumn 2018.

7 **Wolverhampton CCG Operational Plan 2017-2019 Update**

Steven Marshall, Wolverhampton CCG stated that the Wolverhampton CCG Operational Plan was a standing agenda item. The NHS had amended the annual cycle and it had now become a two-year plan. As the Operational Plan was still live, it was considered appropriate to give an overview of the key priorities and main activities of the last year.

Steven Marshall gave the following Operating Plan update:

Local Place Based Models of Care/Primary Care:

- Primary care groupings established, joint working underway with hub working together to deliver increased access in primary care on weekends and bank

holidays. Discussions underway to identify services that could be delivered at scale across primary care, for example wound care and joint injections.

- Development of Local Quality and Outcomes Framework (QOF) scheme underway.
- Performance dashboards developed for each care model to help determine patient outcomes, demand and variation.
- Working with key stakeholders across the health economy to develop an Accountable Care Alliance model, aiming towards shadow form by 1 April 2018.
- Implemented risk stratification, social prescribing and enhanced rapid response service provision which will help strengthen partnership/multidisciplinary (MDT) working with Health and Social Care as well as delivering admission avoidance and care closer to home.
- Two-way text messaging currently being piloted with a view to being rolled out to all practices by the end of the financial year.
- First phase of Care Navigation being rolled out in primary care (Minor Eye Conditions, Minor Ailments Scheme, etc.)
- Primary Workforce Strategy drafted and in the process of being finalised.
- Clinical Pharmacists working in practice groups.
- Practices undertaken Practice Resilience training.

Urgent and Emergency Care/Improving Flow and Admission Avoidance:

- Discharge to Assess Pathways implemented across all wards, regional recognition for D2A work and Direct Transfers of Care (DTOCs) reduced on track to hit NHS England trajectory.
- Frail elderly pathways being developed and falls service being redesigned in partnership with trust to have a much greater focus on prevention.
- Step up beds commissioned.
- Developed Integrated Emergency Care Passport jointly with Social Care, West Midlands Ambulance Service and RWT.
- Rapid response service provision has been enhanced to include seven days a week provision (over six months 3,375 patients were seen, 3,155 were successfully treated in the community, representing an 85% admission avoidance rate).
- Enhanced risk stratification and MDT approach with primary and community and social care services.
- Launch of red bag scheme.
- A&E Delivery Board is continuing to support schemes that will help improve patient flow and reduce impact on A&E during the winter period.

Elective Care:

- Musculoskeletal (MSK) service is embedded, community eye care services have been recently re-procured and work is ongoing with the Trust to redesign ophthalmology pathways and shift services into the community closer to home where possible.
- Currently scoping out opportunities to implement clinical assessment services in other specialities.
- The CCG is also currently in the process of reviewing and redesigning other pathways such as wound care pathway, End of Life, neuro rehab and heart failure.
- Continuing to support practices with offering choice to patients at point of referral.

- Working with providers to ensure patients are not waiting more than 18 weeks from referral to treatment and ensuring remedial action plans are put in place where required to deliver improvements.

Cancer:

- Strategic Cancer Group set up, responsible for ensuring oversight and implementation of Achieving World Outcomes Strategy.
- Recovery and Health Wellbeing sessions being delivered by RWT for breast cancer patients and looking to roll out to further specialities.
- Working with Cancer Research UK and GP practices to improve knowledge and information.
- Working with Cancer Research, RWT, GP practices and other key stakeholder to improve uptake of bowel screening.

Mental Health:

- Implementation of Primary Care Counselling Service.
- Improved access and waiting times, early intervention in psychosis and eating disorders with additional investment and remodelling of the pathways.
- Pump priming investment in peri-natal mental health (including multi-agency training) running this programme for our Sustainability and Transformation Plan (STP).
- Recommissioned autism and Attention Deficit Hyperactivity Disorder (ADHD) diagnostic are on a pathway for adults.
- Reducing out of area placements (acute overflow and specialist).
- Better Care Fund – focus on urgent mental health care pathway, further alignment of all age 24/7 crisis care as part of crisis concordant with a focus to move to mental health liaison core 24.
- CAHMS Transformation Plan developed with focus on (Children and Young People (CYP), IAPY, CAHMS crisis services, tier 3 and improved access to tier 4, increasing access prevalent population).

In answer to a question regarding End of Life care, Steven Marshall confirmed that those were better for cancer patients due to the additional resources and focus. There was also a difference depending on where you lived in the city and it was hoped to standardise that. As there were no additional resources, any investment in one area would mean a loss in another and it was a question of prioritisation.

The Chair advised that hospices provided services for cancer patients; however, it was much more difficult to decide the type of End of Life care required for people suffering from other, longer term conditions.

In answer to a question regarding the priorities for improving primary care, Steven Marshall confirmed that quality and coverage were the key elements, with GPs working collaboratively using a multi-disciplined model. That included GP practices merging to provide better quality services in the community.

Helen Child, Third Sector Partnership stated that better care in the community was welcomed and she referred to the importance of supporting people with mental health issues, as many were left without support if they did not meet specific criteria.

Steven Marshall advised that previously under urgent care pathways some people had not meet the criteria and had been left without support. However, with primary care counselling and a more considered approach it was hoped to avoid that in the future.

The Chair advised that if the Operational Plan was updated before next year then a report would be submitted to the Board, if not the Board would receive the update report in 2019.

Resolved:

That the verbal update be noted.

**8 Future of Acute Services**

David Loughton CBE, Royal Wolverhampton Hospital NHS Trust and Mike Sharon, Royal Wolverhampton Hospital NHS Trust gave a presentation on the Future of Acute Services in the Black Country and highlighted key points.

Councillor Sweet referred to the pressure on acute services and the excellent work undertaken by staff at the RWT to minimise the impact on the public.

David Loughton CBE referred to maternity services and confirmed that the Trust had not experienced any problems in filling vacancies and the ratio of midwives to births was currently at target.

In answer to a question regarding changes to patient geography, David Loughton CBE advised that the changes since 2013-2014 were based on volume of numbers and he confirmed that people were happy with the service at Cannock.

Resolved:

That the update be noted.

**9 Wolverhampton Pharmaceutical Needs Assessment 2018-2021**

Seeta Wakefield, Public Health Speciality Registrar presented the report and gave a presentation on the Wolverhampton Pharmaceutical Needs Assessment 2018-2021 and highlighted key points.

She advised that 256 members of the public had responded to the pharmacy survey. The key findings of the survey related to opening times, accessibility and facilities. She confirmed that in terms of opening times and accessibility there were now several pharmacies open from 7am weekdays, several on Saturdays and 10 were open on Sundays. Those 10 were concentrated in more deprived areas where people could walk or there was good public transport; with people from more affluent areas more likely to be able to access those facilities by car. Most pharmacies were within a 30-minute drive or walk, or could be accessed by public transport. In respect of facilities, most had staff that could speak other languages; there was greater wheelchair access, more consultation rooms and home dispensing.

She confirmed that Lloyds Pharmacies would be releasing 190 pharmacies nationally (either through closure or by selling them to other pharmacies). There were eight Lloyds pharmacies in Wolverhampton; however, as yet there was no notification of how many, if any, would be affected, and if they were, in what way. Public Health would continue to monitor the situation on behalf of the Board.

The Chair referred to the important work undertaken by pharmacies in providing general health care advice.

John Denley, Director for Public Health referred to the importance of pharmacies in attracting people and other businesses to an area as they were very good businesses.

Jeremy Vanes, Royal Wolverhampton Hospital NHS Trust suggested that the Board would benefit from speaking with pharmacist to build a level of awareness regarding where and how to provide services.

Helen Child, Third Sector Partnership stated that it was often pharmacy staff who noticed problems at first hand, as they often saw people on a regular basis and during home visits and it was important that those skills were utilised appropriately.

John Denley advised that although facilities and building fabric were important, the most important thing was the build-up of relationships and being part of the community.

Seeta Wakefield confirmed that of the 64 customer facing pharmacies, 63 had closed rooms and the only outstanding pharmacy was looking to add a room.

Helen Child and Linda Sanders both referred to the terminology in correspondence and suggested that it would be helpful to simplify it.

Seeta Wakefield confirmed that this year timescales had been very tight; however, in future years issues including language, terminology and accessibility would be looked at more closely. She also advised that the HWBB would be consulted at an earlier stage next time in the process.

Councillor Sweet stated that he was aware of one pharmacy that had a private consultation room; however, it was very small and at the back of the premises and had limited availability.

Seeta Wakefield acknowledged that the situation was not perfect; however, improvements continued to be made to make premises more accessible, with 55 being wheelchair accessible.

Resolved:

That the report and presentation be noted.

10

### **Strengthening Governance and System Leadership**

Madeleine Freewood, Development Manager – City Health presented the report and highlighted key points and asked the Board to consider the five recommendations.

The Chair stated that it was a very opportune moment to undertake a review and the recommendations should be supported.

Linda Sanders, Independent Chair of the Adults and Children's Safeguarding Board supported the recommendations and suggested that as part of the review, thought should be given to how the Board evidenced outcomes and impact. She referred to the joint protocol document referred to in the report, which was in the process of being reviewed, a pre-meeting had been scheduled for February 2018 and a meeting

would be held on 22 March 2018. She referred to the development of a HWBB Communications Strategy and suggested the potential value of aligning that with other partnership board communication plans. She referred to the Be Safe Junior Safeguarding Board and the important issues raised by members, including aspects around feeling safe, tackling drugs and alcohol abuse, domestic violence, guns, gangs and knife crime and the use of social media. Members had requested more information about partnership boards, in particular quarterly updates and as the Chair already provided meeting updates, it would be possible to add the Be Safe Junior Safeguarding Board to the mailing list.

Resolved:

That the Health and Wellbeing Board agree the five-step Action Plan, including the five recommendations listed below, to strengthen the governance and system leadership of the Board:

1. 360-degree review.
2. Update the Joint Health and Wellbeing Strategy for Board approval in July 2018.
3. Development of a Health and Wellbeing Board Engagement and Communications Plan, including mapping community stakeholders.
4. Develop a Wolverhampton specific Health and Wellbeing Board identity, including branding and web presence.
5. Identify opportunities for learning from others.

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# Black Country and West Birmingham Joint Commissioning Committee (JCC)

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## Minutes of Meeting dated 10<sup>th</sup> January 2018

### Members:

Prof. Nick Harding – Chairman, Sandwell & West Birmingham CCG  
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG  
James Green – Chief Finance Officer, Sandwell & West Birmingham CCG  
Angela Poulton - Programme Director – Joint Commissioning Committee  
Matthew Hartland – Chief Finance and Operating Officer, Dudley CCG; Strategic Chief Finance Officer Walsall and Wolverhampton CCG's  
Mike Abel – Lay Member, Walsall CCG  
Salma Reehana – Chair, Wolverhampton CCG  
Dr Anand Rischie – Chairman, Walsall CCG  
Julie Jasper – Lay Member, Dudley CCG and Sandwell and West Birmingham CCG  
Simon Collings – Assistant Director of Specialised Commissioning, NHS England  
Peter Price – Lay Member, Wolverhampton CCG  
Jim Oatridge – Lay Member, Wolverhampton CCG

### In Attendance:

Charlotte Harris – Note Taker, NHS England  
Laura Broster – Director of Communications and Public Insight  
Sarah Fellows - Mental Health Commissioning Manager  
Ali Shaukat – Programme Manager

### Apologies:

Helen Hibbs – Accountable Officer, Wolverhampton CCG  
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG  
Dr David Hegarty – Chairman, Dudley CCG  
Dr Ruth Tapparo, GP/Board Member, Dudley CCG.  
Paula Furnival, Director of Adult Social Care, Walsall MBC

## 1. INTRODUCTION

- 1.1 Nick Harding welcomed members, introduced Charlotte Harris and thanked Jackie Eades for her support to the JCC.
- 1.2 Apologies noted as above.
- 1.3 There are four members who have not submitted their signed declarations of interest forms, and the request was made for them to be provided by the end of the month. Nick Harding asked the committee if anyone had any declarations of interest they wished to declare in relation to the agenda for the meeting. None were given.

**Action: Outstanding declaration of interest forms to be provided to Charlotte Harris by the end of January.**

- 1.4 The minutes of the meeting held on 14<sup>th</sup> December were agreed as an accurate record of the meeting with the following exceptions:
  - Section 4.4 'option' should be 'optional'

- Section 9.7 'public' should be 'publicly'

1.5 Paul Maubach referred to section 9.6 in the previous minutes and section 4.3 of the corresponding report, informing members that Walsall CCG's Governing Body felt that the wording relating to the matter in the update paper (section 1.2.6c) presented to them did not reflect the nature of the discussion. Walsall's Governing Body did not support the lead CCG acting in isolation. It was confirmed that this is not an issue with the minutes but the JCC Update paper which is in the process of being presented to Governing Bodies. Angela Poulton reminded members that when this matter was discussed, it had been agreed that the lead CCG at the very least should speak to an Exec level manager in all the other CCGs before proceeding. James Green stated that agreement is being sought for the continuation of existing practice where one CCG takes decisions and implements actions on behalf of other CCGs in the Black Country where the pace of decision making and delivery will not allow a fully collaborative approach, subject to a locally determined operational scheme of delegation and the lead CCG specifically gaining approval from a Director level officer of the other CCGs.

**Action: Angela Poulton to circulate the revised wording in relation to 1.2.6c to Governance leads and Chief Financial Officers to ensure consistency of agreement by all CCG Governing Bodies.**

1.6 With reference to the minutes to the meeting held on 28<sup>th</sup> September 2017, Angela Poulton informed members that section 4.4 of the September JCC minutes stated that Walsall CCG were "locating a GP surgery onto the Manor site" when this should read had "suggested GP triage at the Manor".

1.7 The action register was reviewed (see action table at end of the notes). Actions delivered were confirmed and other taken within the agenda. Regarding action 051, Simon Collings confirmed that the Specialised Services Commissioners have no concerns with Vascular Services delivery and that Dudley Group of Hospitals NHS Trust are not on the list of providers not compliant with the 7-day standard. An overview of Specialised Services Commissioning Strategy was given and emphasised that any changes to where services will be provided will not be made without public consultation. In response to Laura Broster, Simon Collings confirmed that public and patient involvement support was being provided at a regional level by Jessamy Kinghorn.

## 2. CORE BUSINESS

2.1 Nick Harding informed that the STP had not met since the last meeting. Paul Maubach had attended the West Midlands meeting of Accountable Officers the day before and fed back that NHSE are increasingly channelling commissioning requests on an STP basis, including future operating plans. Paul Maubach stated that this is pertinent to the discussion in establishing joint commissioning capability later on the agenda. Angela Poulton added there is likely to be greater scrutiny regarding mental health and potentially at STP level going forward, with a particular focus on compliance with the Mental Health investment standard.

2.2 Nick Harding confirmed that the Clinical Leadership Group is meeting on the 25<sup>th</sup> January and the agenda will cover Respiratory, Hypertension and Urgent Care. NHSE are increasingly asking for STP leads for specific areas and a recent request had been for a Black Country Stroke lead to participate in the West Midlands review that includes Thrombectomy. Dr Anand Rischie referred to the request for expressions of interest in August and asked for a progress update. Angela Poulton reported that the level of interest from GPs had been good but there had been concerns that no secondary care expressions had been received as a mix of both was considered important. The decision taken at the

September Clinical Leadership Group was to identify appropriate candidates through clinical networks and leads, and to approach individuals when there was definitive pieces of work to be undertaken.

- 2.3 Nick Harding stated that nominated clinical leads for the STP were now needed, and that as the lead for Urgent Care is a much larger job than perhaps other lead roles individual consideration will need to be given prior to making appointments. There was discussion regarding the link between JCC progress and governance arrangements, and a view shared that STP clinical leads might benefit from being plugged into a CCG-led programme management approach for delivery. Paul Maubach shared the CCG lead process being used in Worcester. Nick Harding suggested a discussion be held between Paul Maubach, Andy Williams and Helen Hibbs to explore how leads can be appointed and agreed with Simon Collings suggestion to include Specialised Services. Paul Maubach stated that this could be an opportunity to speak to Alison Tonge to see what resources NHSE have to assist.

**Action: Paul Maubach, Andy Williams and Helen Hibbs to meet to explore the appointment process to STP Clinical Lead roles before the February JCC.**

- 2.4 Angela Poulton provided a verbal update on progress made in relation to commissioning responsibilities delegated to the JCC. In relation to commissioning the Black Country Mental Health Crisis, Intensive Community Support and Paediatric Liaison Service for Children and Young People, the specification is near completion and discussions underway with mental health providers. Regarding Transforming Care Partnership Learning Disabilities and Autism services, this Committee has responsibility for ensuring patient reviews are undertaken and the non-recurrent development funding is spent according to the agreed plan. Sandwell and West Birmingham CCG are acting as the lead coordinating CCG, and the lead Senior Commissioning Manager is preparing a timeline from approval of proposed clinical model to operational commencement date. There are indications that the proposed future community model and the associated shared view of the financial implications for each CCG should be ready for presentation to the JCC at the February meeting.

*Angela Poulton left the meeting to collect Sarah Fellows and Shaukat Ali.*

- 2.5 Nick Harding referred members to the current risk register. There was a discussion about the format and on the suggestion of Jim Oatridge it was agreed that the risk registers of all four CCGs will be reviewed by the Joint Governance Forum and a recommendation made regarding a shared template for all four CCGs and the JCC to use going forward.

**Action: Risk registers be reviewed by the joint governance forum with a view to recommending a standard template at Feb JCC to be used by all CCGs and the JCC.**

*Angela Poulton re-joins the meeting.*

### **3. DECISIONS REQUIRED**

#### **3.1 Establishing Joint Commissioning Capability for the Black Country**

- 3.1.1 Angela Poulton referred members to the paper. There are currently two issues: the need for clarity in relation to commissioning for West Birmingham as Governing Bodies approved to remove responsibility for this geography in December and the need to strengthen the contribution of this committee to STP performance. The JCC needs to agree how to establish the capability to provide a united commissioning response to performance issues. In addition the relationship between the JCC/CCGs and a future Accountable Care System (ACS) arrangement, and associated risks and opportunities need to be determined. Angela Poulton informed the committee that Helen Hibbs had shared that Alison Tonge is delivering

ACS development workshops and the need to ensure there is no overlap in the work plan arising out of today's discussion.

- 3.1.2 There was a discussion about the impact of having the right governance arrangements to enable the JCC to take a definitive view on matters and ensure the appropriate actions take place. Nick Harding shared that the experiences in other parts of the country, with Manchester cited as a specific example, highlight that waiting to achieve the right governance arrangements will delay progress and delivery. Manchester are on their fourth governance arrangement so far.
- 3.1.3 Paul Maubach shared the discussion held by the STP Sponsor Group, describing the three strands of the STP: the Partnership agenda with its focus on the wider determinants of health, the local place-based agenda with associated structures and the NHS agenda requiring the implementation of a robust financial and strategic plan. The JCC represents a single forum out of which clear processes and schemes of delegation to drive through implementation of the plan relating to the NHS strand, and this agenda should be the focus for this Committee. Paul Maubach shared that through discussions with other Accountable Officers in the West Midlands the approach to delivering the NHS agenda is through joint commissioning committee Programme Management Office (PMO) arrangements being established. The view was expressed that establishing a PMO would not be sufficient by itself.
- 3.1.4 There was discussion about the current remit CCGs have in relation to leading strategy development, performance management and service redesign and the option to replicate this for the STP via the JCC with identified resources. Paul Maubach shared that the resources will have to come from CCGs and the consideration now needed regarding how the STP is structured to deliver its priorities and how CCGs reorganise, aligning existing staff to create teams focussing on lead areas. A view is needed on what the shared capacity between the four CCGs is to do this, and the associated commitment to do this. It was acknowledged that to date STP leads were doing the STP element of their work in addition to their substantive job, and that CCGs need to create performance and commissioning capacity that is properly resourced. Simon Collings suggested that if the JCC is seen as a tangible STP vehicle then other resources could be assigned to it.
- 3.1.5 Jim Oatridge stated that there was still the need to clarify the purpose and remit of the JCC, and what needs to be achieved by it. Nick Harding shared that increasingly NHSE will want to work at STP level rather than with individual CCGs. Mike Abel referred members to the need to be careful about the language being used in relation to identifying resources to ensure it is clear that it is not new resources that are being created but the redistribution and realignment of existing staff resources. Paul Maubach stated that there are some key performance issues that need performance management and/or service reviews, and referred members to the seven clinical priorities recommended to this Committee by the Clinical Leadership Group in September 2017.
- 3.1.6 Paul Maubach raised the disconnect that exists between the JCC and the STP as the JCC does not include West Birmingham, and shared that Andy Williams will be taking a paper to Sandwell and West Birmingham CCG's Governing Body regarding the future relationship Sandwell has with West Birmingham. West Birmingham currently sits across two systems, and attending to the NHS agenda was felt to need the JCC to be aligned to the STP. It was agreed that it needs to be clear where decisions relating to both parts of Sandwell and West Birmingham's geography will be taken so the JCC can work out what it needs to operate effectively going forward. Nick Harding confirmed that Sandwell and West Birmingham will confirm the arrangements in due course.

3.1.7 Nick Harding referred to the key decisions required in the paper. It was confirmed that the JCC is committed to taking effective control of service reviews and performance reviews, and now needs to agree how it will do this. Paul Maubach suggested the Accountable Officers (AOs), Chief Finance Officers (CFOs) and Angela Poulton meet to decide where the CCGs will get best value from doing things once, what to resource jointly and to agree actions to resource properly before the next JCC. The different perspectives that exist regarding the relationship the JCC has to the future ACS was agreed will require a further meeting after the February JCC to allow for a wider strategic debate with Chairs and lay representatives.

**Actions:**

- **Charlotte Harris to arrange a meeting between AO's, CFO's and Angela Poulton to discuss where the CCGs will get best value from doing things once, what to resource jointly and to agree actions to resource properly before the next JCC meeting.**
- **Charlotte Harris to arrange a meeting between AOs/CFOs/Chairs/Lay representatives for a wider strategic debate regarding the relationship the JCC has to the future ACS to be scheduled between the February and March JCC meetings.**

3.1.8 There was a discussion regarding the difference between the STP and the future ACS is and the need for due diligence to understand the risks involved in developing into the ACS with a shared control total. Paul Maubach requested that James Green and Matthew Hartland to develop a plan for the next committee meeting setting out the plan to undertaking the necessary due diligence and how to involve providers.

**Action: James Green and Matthew Hartland to develop a plan for the next committee meeting on how to undertake the necessary diligence to support the Black Country STP becoming an ACS in the future.**

## **3.2 Specialised Commissioning**

3.2.1 Simon Collings explained that there had been a number of issues with cancer services in Sandwell and West Birmingham, and the three core elements are Chemotherapy, Specialist Gynaecology Oncology surgery and Acute Oncology. In October 2017 it became clear that there were insufficient enough consultants to deliver the service safely at Sandwell and West Birmingham NHS Trust and the decision taken to transfer services to University Hospital Birmingham commencing end March 2018 a temporary arrangement for 12 months. The patient and public involvement was confirmed and the Joint Overview and Scrutiny Committee briefed, with a further briefing on the 25<sup>th</sup> January. The Trust gave notice to cease providing Gynaecology Oncology and owing to the complexity of surgery patients require other providers are unable to develop services to accommodate this change in six months. Services will be delivered by other providers from July 2018 to ensure safe provision.

3.2.2 There was a discussion about the long term development plan for specialised services in the Black Country. NHS England must be accountable for commissioning Specialised Services as it is written into the Health and Social Care Act. In the West Midlands there was a move

to try to devolve some services (dialysis, allergies, chemotherapy, HIV) to be commissioned by CCGs and the JCC seen as a good vehicle with which to engage for this purpose. This effectively stopped in July 2017, with 'seat at the table' continuing via the JCC but largely delivered through the Specialised Commissioning Oversight Board. There is a paper on devolution going to the Oversight Board Group on 12<sup>th</sup> January. Paul Maubach requested finance and activity data for Specialised Services for the Black Country.

**Action: Simon Collings to provide the finance and activity data for Specialised Services provided for Black Country registered patients at future JCC meetings.**

### **3.3 Perinatal Mental Health (Pilot Clinical Proposal)**

- 3.3.1 Sarah Fellows and Ali Shaukat summarised the paper presented and requested approval to proceed with submitting a joint bid for new transformation funding and to set perinatal mental health clinics in all Black Country acute hospitals (only Sandwell and West Birmingham Hospitals NHS Trust currently has a clinic). Matthew Hartland raised concerns as there is no guarantee of securing the additional money and the need to ensure Directors of Commissioning and CFO's sign off the clinical model and financial implications. This would ensure lessons have been learnt from the joint CAMHS bid in the autumn last year. Laura Broster offered communications and engagement support. There was discussion regarding the need to be able to evaluate the impact of developing the services with the new funding.
- 3.3.2 Nick Harding stated that it would be good to be able to report in a few years' time the number of lives saved as a result of this service development and associated investment. The JCC confirmed support to establish clinics in all acute hospitals subject to the costed clinical model being signed off by appropriate officers in all CCGs and the evaluation approach being agreed.

#### **Actions:**

- **Shaukat Ali to circulate the current version of the bid.**
- **The clinical model and financial implications for the perinatal mental service to be signed off by the Director of Commissioning and CFO for each CCG before the final draft of the bid is produced.**
- **Sarah Fellows/Shaukat Ali to include a clear evaluation methodology with outcome measures prior to and for inclusion in the bid document submitted.**
- **The final bid document to be circulated and agreed by each CCG prior to submission to NHSE.**

### **5. Subgroup Updates (Consent Agenda)**

- 4.1 Reports were noted by members. With regard to the Systems Design & Contractual Frameworks Subgroup, Paul Maubach indicated that its current work should be completed by June 2018.
- 4.2 Laura Broster informed the committee that there was a decision not to do an all-staff communications as the majority of the meeting discussed the STP position. It was agreed that the communications that will be sent after today's meeting will reflect main items from

both meetings. In drafting staff communications care is needed to ensure items are presented as recommendations where further approval to proposals are required.

## **5. Summary of Actions and Any Other Business**

5.1 Angela Poulton informed the Committee that Mike Hastings had suggested the establishment of a workgroup that he will lead to develop a way to enable Cancer Multi-disciplinary Teams to access electronic patient records. The benefits of this include shortening the care pathway (62 day target), and informing the clinicians of the range of co-morbidities patients have and unnecessary repeat diagnostics. The JCC supported the work to be done.

5.2 Mike Abel suggested the format of papers need to be reviewed as there are missing items.

**Action: Angela Poulton to review the format of JCC papers and use of templates.**

## **6. Date of Next Meeting – *please note time of meeting***

Thursday 15<sup>th</sup> February 2018, 15.30-17.30, Dudley CCG, Orange Room, 2<sup>nd</sup> Floor, BHHSCC, DY5 1RU

## JCC Action Log

No.	Date	Action	Lead	Status Update
068	19 <sup>th</sup> Oct 2017	Jim Oatridge to present the ratified Joint Governance Group Terms of Reference at the next appropriate JCC meeting	Jim Oatridge	Meeting on 29 <sup>th</sup> January
069	10 <sup>th</sup> Jan 2018	Outstanding declaration of interest forms to be provided to Charlotte Harris by the end of January	JCC members	
070	10 <sup>th</sup> Jan 2018	Angela Poulton to circulate the revised wording in relation to 1.2.6c to Governance leads and Chief Financial Officers to ensure consistency of agreement by all CCG Governing Bodies	Angela Poulton	
071	10 <sup>th</sup> Jan 2018	Paul Maubach, Andy Williams and Helen Hibbs to meet to explore the appointment process to STP Clinical Lead roles before the February JCC.	Paul Maubach	
072	10 <sup>th</sup> Jan 2018	Risk registers be reviewed by the joint governance forum with a view to recommending a standard template at Feb JCC to be used by all CCGs and the JCC.	Jim Oatridge	
073	10 <sup>th</sup> Jan 2018	Charlotte Harris to arrange a meeting between AO's, CFO's and Angela Poulton to discuss where the CCGs will get best value from doing things once, what to resource jointly and to agree actions to resource properly before the next JCC meeting.	Charlotte Harris	
074	10 <sup>th</sup> Jan 2018	Charlotte Harris to arrange a meeting between AOs/CFOs/Chairs/Lay representatives for a wider strategic debate regarding the relationship the JCC has to the future ACS to be scheduled between the February and March JCC meetings	Charlotte Harris	
075	10 <sup>th</sup> Jan 2018	James Green and Matthew Hartland to develop a plan for the next committee meeting on how to undertake the necessary diligence to support the Black Country STP becoming an ACS in the future.	James Green and Matthew Hartland	
076	10 <sup>th</sup> Jan 2018	Simon Collings to provide the finance and activity data for Specialised Services provided for Black Country registered patients at future JCC meetings.	Simon Collings	
077	10 <sup>th</sup> Jan 2018	Perinatal Mental Health Joint Bid (Pilot Clinics) <ul style="list-style-type: none"> <li>Shaukat Ali to circulate the current version of the bid</li> <li>The clinical model and financial implications for the perinatal mental service to be signed off by the Director of Commissioning and CFO for each CCG before the final draft of the bid is produced</li> <li>Sarah Fellows/Shaukat Ali to include a clear evaluation methodology with outcome measures prior to and for inclusion in the bid document submitted</li> <li>The final bid document to be circulated and agreed by each CCG prior to submission to NHSE</li> </ul>	Sarah Fellows/Shaukat Ali	
078	10 <sup>th</sup> Jan 2018	Angela Poulton to review the format of JCC papers and use of templates	Angela Poulton	