

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body

will take place on Tuesday 8th May 2018 commencing at 1.00 pm

at Wolverhampton Science Park, Stephenson Room

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 10 April 2018
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

Attendees ~

Dr S Reehana

Chair

Clinical

Dr D Bush

Board Member

Dr R Gulati

Board Member

Dr M Kainth

Board Member

Dr J Parkes

Board Member

Dr R Rajcholan

Board Member

Management

Mr T Gallagher

Chief Finance Officer – Walsall/Wolverhampton

Mr M Hastings

Director of Operations

Mr S Marshall

Director of Strategy and Transformation

Ms S Roberts

Chief Nurse Director of Quality

Lay Members/Consultant

Mr A Chandock

Secondary Care Consultant

Mr J Oatridge

Lay Member

Mr P Price

Lay Member

Ms H Ryan

Lay Member

Mr L Trigg

Lay Member

In Attendance

Ms H Cook

Engagement, Communications and Marketing Manager (part)

Ms S Gill

Health Watch representative

Ms K Garbutt

Administrative Officer

Mr M Hartland

Chief Finance Officer – Dudley CCG (Strategic Financial Adviser)

Mr P McKenzie

Corporate Operations Manager

Ms S Southall

Head of Primary Care (part)

Apologies for absence

Apologies were received from Ms S McKie, Mr D Watts, Dr H Hibbs, Mr J Denley and Dr Asghar.

Declarations of Interest

WCCG.2069 There were no declarations of interest declared.

RESOLVED: That the above is noted.

Minutes of the meeting of the Wolverhampton Clinical Commissioning Group Governing

WCCG.2070 **WCCG.2044 Quality and Safety Committee**

Dr R Rajcholan pointed out that the third paragraph should read “Dr Rajcholan highlighted that there had been a delay in A&E at the Royal Wolverhampton Trust (RWT) regarding fast track referrals. A revised process has been established for fast track referrals with cancer services which will be dealt within A&E without the need for a GP to action.

RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 13 February 2018 be approved as a correct record.

Matters arising from the Minutes

WCCG.2071 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

WCCG.2072 RESOLVED: That the progress report against actions requested at previous Board meetings be noted.

Chief Officer Report

WCCG.2073 Mr S Marshall presented the report. He highlighted that the Wolverhampton Clinical Commissioning Group (WCCG) have launched a recruitment campaign to attract GPs and general practice staff to come and work in Wolverhampton.

He pointed out that the Black Country Sustainability and Transformation Plan continues to meet and is currently reviewing its governance. He added that the CCG is working in partnership with our local GPs, The Royal Wolverhampton Trust, Black Country Partnership Foundation Trust and the Local Authority to agree how we will work in a more integrated way in Wolverhampton.

Dr R Gulati asked if the governance arrangements relating to the proposed integrated arrangements had been agreed. Mr Marshall confirmed the Clinical Commissioning Group (CCG) is working in partnership with our local GPs, RWT, Black Country Partnership Foundation Trust and the Local Authority to agree how we will work in a more integrated way in Wolverhampton. Clinicians have been meeting together to agree the pathways of care that we will look at in the first instance.

RESOLVED: That the above is noted

Commissioning Committee

WCCG.2074 Dr M Kainth gave an overview of the report. He pointed out the service specification for online counselling service for Children/Young People (CYP). The Committee approved the service specification and agreed for the procurement of the service to commence.

Dr Kainth highlighted that the CCG Medicines Optimisation Team wishes to continue to offer a prescribing incentive scheme to its GP practices for 2018/19. The Committee approved the amendments to the Quality Prescribing Scheme for 2018/19 and supported the Work Plan.

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.2075 Ms S Roberts presented the report and highlighted the key issues. Vocare has been rated inadequate for the March 2017 Care Quality Commission (CQC) visit. A further announced focused inspection was carried out by CQC on the 26 October 2017 in relation to the warning notices issued in July 2017. An unannounced visit by WCCG in January 2018 highlighted further concerns, pertaining to triage, performance and paediatric triage arrangements. The CQC re-visited Vocare in February 2018 and whilst the full report is awaited some improvements were noted. She confirmed that a meeting had taken place between Dr Reehana, RWT and Vocare and assurances have been provided.

Ms Roberts highlighted that mortality increased over the winter period and further work needs to be carried out to understand any reasons for this. She referred to the cancer waiting times as detailed on page 21 of the report. RWT are undertaking harm reviews, to ensure that patients having to wait for treatment are not clinically impacted. The CCG have written to RWT regarding concerns about the potential impact on patients' treatment and their wellbeing and also asking if patients are supported to make fully informed choices about their treatment. A meeting is scheduled to take place relating to harm reviews and the Governing Body will be kept informed. Mr A Chandock suggested a report be submitted detailing information relating to the internal harm review.

Mr Chandock pointed out that RWT will be picking up some work from Birmingham City Hospital around gynecology oncology patients.

Mr T Gallagher and Mr M Hartland arrived

Mr P Price pointed out a non-clinical issue, relating to health and safety had been raised around the reception area within the Science Park undergoing a refurbishment and this is not due to be completed until July/August 2018.

RESOLVED: That the above is noted.

Finance and Performance Committee

WCCG.2076

Mr Gallagher presented the reports. He referred to the report from the 27 March 2018 and pointed out the table on page 3 detailing the position against key financial performance indicators. They are all rated green with the exception of Quality, Innovation, Productivity and Prevention (QIPP). However we have a non-recurrent support to ensure deliver of the QIPP target.

He pointed out the key areas of variance on page 4. RWT is giving concern as the month 10 activity is indicating a potential forecast outturn of overspend of £2.8m as a result of higher than expected activity in January for non-elective activity. Mr Gallagher referred to the table on page 5 of the report and confirmed the audit is progressing well.

The CCG continually reviews its levels of risk and as anticipated, as the financial year progresses the level of risk diminishes as issues are built into the financial year progresses the level of risk diminishes as issues are built into the financial position. As a result the level of reported risk for month 11 has reduced to £500k which is mainly within the acute portfolio.

Mr L Trigg expressed concerns around the worsening performance and increasing costs around complex cases and asked if this is the real issue. Mr Gallagher confirmed the acute sector is focused on the complex cases.

Mr Gallagher referred to the Finance Plan and Budget for 2018/19 and gave an overview. He referred to page 3 of the report which outlines the allocation allocated to Wolverhampton CCG. All commissioners need to purchase acute activity which is outlined on page 5. Our contract with RWT has been agreed.

The CCG has identified risks included within the 2018/19 budgets which totally £3.5m and highlighted the key risks on page 9 of the report.

RESOLVED: That the Governing Body received and agreed the Finance Plan and Budget for 2018/19.

Audit and Governance Committee

WCCG.2077 Mr Price referred to the report and gave an overview. He pointed out that the Senior Internal Audit Manager had met with the Executive Team to discuss the Annual Internal Audit plan and any concerns they may have. Information collated would be used to draft the plan. The final plan will be considered for approval at the next meeting. The Audit Manager reported that good progress on the CCG's risk management arrangements had been made since the last Audit and Governance Committee meeting.

RESOLVED: That the above is noted.

Primary Care Commissioning Committee

WCCG.2078 Mr Hastings presented the report. He pointed out the Out of Area Registration Scheme. There is a gap in commissioning services for patients living in the Wolverhampton area but who live outside their practice boundary and are therefore deemed out of area.

Mr Hastings highlighted that the Care Navigation face to face training took place on the 24 January 2018 and the programme has now launched. The second cohort of pathways is currently being identified.

The plans for Extended Access/Winter Opening were noted as being in place and offered appointments to patients every day except Christmas Day and New Year's Eve. Dr D Bush stated that the ambition is to offer more appointments in future years. Mr Hastings added that a full review will be carried out. Ms S Gill asked if the templates to be used are fully operational within practices. Mr Hastings confirmed all practices have the

templates and training has taken place. Ms H Ryan confirmed all the relevant information is available on the templates and if a template is not suitable for a patient an appointment is made.

RESOLVED: That the above is noted

Communication and Engagement update

WCCG.2079 Ms H Cook gave a brief overview of the report. She referred to the Minor Eye Conditions Services (MECS) campaign which has continued its web and social media presence following its launch in autumn last year. She stated that an evaluation report will be carried out regarding the service in June/July 2018.

Ms Cook stated that the winter campaign has continued its national focus on stay well messages. Unfortunately due to snowy weather our planned engagement with youth membership of Health Watch Wolverhampton was cancelled. This has now been rescheduled for the 19 April 2018.

She stated that we are working with our colleagues in Primary Care and Pharmacy to promote their extended opening hours for cover over the Easter holidays. She reported that it was clear that the information on the website was being used as it received several hits in a short space of time. Dr Bush asked which advertising is most effective. Ms Cook confirmed there has been a multi campaign regarding advertising.

Ms Gill stated patients are not kept informed which model of care their GP practice is operating in. This is a real issue and work needs to be carried out with GP practices to ensure that patients are aware of the work taking place and how this affects them. Dr Rajcholan confirmed this is advertised within her practice. Over Easter all the clinics were full and it was a good experience for patients.

RESOLVED: That the above is noted.

CCG Annual Equality Report

WCCG.2080 RESOLVED: That the above is noted.

CCG Equality Objectives

WCCG.2081 RESOLVED: That the above is noted.

Minutes of the Quality and Safety Committee

WCCG.2082 RESOLVED: That the minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.2083 RESOLVED: That the minutes are noted.

Minutes of the Primary Care Commissioning Committee

WCCG.2084 RESOLVED: That the minutes are noted.

Minutes of the Commissioning Committee

WCCG.2085 RESOLVED: That the minutes are noted.

Minutes of the Audit and Governance Committee

WCCG.2086 RESOLVED: That the minutes are noted.

Black Country and West Birmingham Commissioning Board Minutes

WCCG.2087 RESOLVED: That the minutes are noted.

Any Other Business

WCCG.2088 RESOLVED: That the above is noted.

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

WCCG.2089 RESOLVED: That the above is noted.

Ms S Southall arrived

Primary Care Programme Milestone Review

WCCG.2090 Ms S Southall presented the report. 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 to national direction and local improvement that seeks to achieve a sustainable primary care for the future.

Ms Southall highlighted the General Practice Forward View programme of work on page 5 of the report. Appendix 1 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. She referred to the live project updates detailed on pages 5 to 7 of the report.

Mr Marshall referred to the draft Primary Care Workforce Strategy and queried the number of patients per Clinical Pharmacist in Dudley. Ms Southall confirmed she will check and amend the document. Ms Ryan referred to the peer group formed in March 2018 what the projects are. Ms Southall stated these are ~

- Mapping the patient pathway
- Working together on an ongoing basis and appreciate what is taking place in each work place
- One message to all, consistent messages to pharmacists and patients, a range of resources they could all use.

RESOLVED: That the above is noted.

Date of Next Meeting

WCCG.2091 The Board noted that the next meeting was due to be held on **Tuesday 8 May 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

Wolverhampton Clinical Commissioning Group Governing Body

Action List

8 May 2018

Date of meeting	Minute Number	Action	By When	By Whom	Status
13.02.18	WCCG.2040	Items which should not routinely be prescribed in Primary Care – Hemant Patel to return to the Governing Body with further information.	10 April 2018/ 8 May 2018	Hemant Patel	A report to be brought back to the Governing Body in May 2018.
13.02.18	WCCG.2041	Conditions for which over the counter items should not routinely be prescribed in Primary Care - Hemant Patel responds to the national consultation	10 April 2018/ 8 May 2018	Hemant Patel	A report to be brought back to the Governing Body in May 2018.

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WOLVERHAMPTON CCG
GOVERNING BODY
8 MAY 2018

Agenda item 6

TITLE OF REPORT:	Chief Officer Report
AUTHOR(s) OF REPORT:	Dr Helen Hibbs – Chief Officer
MANAGEMENT LEAD:	Dr Helen Hibbs – Chief Officer
PURPOSE OF REPORT:	To update the Governing Body on matters relating to the overall running of Wolverhampton Clinical Commissioning Group.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	<ul style="list-style-type: none"> Multiple pieces of work are ongoing around development of the Health and Social Care System.
RECOMMENDATION:	That the Governing Body note the content of the report.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	<p>This report provides assurance to the Governing Body of robust leadership across the CCG in delivery of its statutory duties.</p> <p>By its nature, this briefing includes matters relating to all domains contained within the BAF.</p>
2. Reducing Health 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 (WCCG).

2. CHIEF OFFICER REPORT

2.1 End of Year Assurance Meeting

- 2.1.1 The End of Year Assurance Meeting for the CCG with NHS England was held on 18 April 2018. This was a useful opportunity for the CCG to showcase its work and we received positive feedback on the day. The outcome of the assurance process has to go through a number of moderation stages and we will not have formal feedback until July 2018.

2.2 Mental Health Transforming Care Together (TCT) and Next Steps for the Black Country

- 2.2.1 The TCT programme is no longer going ahead. However, the two Mental Health Trusts in the Black Country are continuing to work closely together to ensure that the positive benefits that have accrued as part of the programme are not lost. A Black Country Mental Health Summit is planned for May 2018 which will bring together clinicians and managers to review the Black Country Mental Health Strategy and plans for ongoing delivery of Mental Health Services in the Black Country.

2.3 Sustainability and Transformation Plan (STP)

- 2.3.1 A refresh of the leadership of the Black Country STP is currently taking place. I have agreed to provide support in the form of Senior Responsible Officer in addition we are currently in the process of appointing an independent chair and refreshing the programme delivery arrangements. The programmes of work continue to include development of local alliances or organisations in each of the localities, work to look at acute and mental health services which need to be provided at scale and work around wider determinates of health.

2.4 Integrated Care System (ICS)

- 2.4.1 STP partners are embarking on a twelve week development programme commissioned by NHS England which will provide us with advice and tools to enable the system to evolve to become an Integrated Care System.

2.5 Integrated Alliance

- 2.5.1 In addition to the overarching Integrated Care System work, we continue to work in Wolverhampton to develop an alliance arrangement with Primary Care Acute and Community Services, Mental Health and the Local Authority. Current discussions are focussing on the clinical model and the evolving governance arrangements.

2.6 **Better Care Fund (BCF)**

- 2.6.1 Regional presentation – The Adult Community work stream were invited to present at the regional BCF event in February 2018. The programme was represented by colleagues from CCG, City of Wolverhampton Council, The Royal Wolverhampton NHS Trust and Housing. The presentation was received well and as a result we have been invited to further events and to take part in a Local Learning Visit by the national Better Care Team.
- 2.6.2 National Development Group – NHS England / Association of Directors of Adult Social Services (ADASS) have set up a number of National Development Groups to feed into the consultation of the health and Social care Green Paper. The team in Wolverhampton are involved in 1-1 interviews and a workshop in London this week in support of this national development.
- 2.6.3 Rapid Intervention Teams (RITs) – The success of the RITs team has seen further investment this year into Community Services with the service being extended both in hours (8.00-10.00 7 days per week) and in the size of the team – more senior nursing staff and support Healthcare Assistants (HCAs) being recruited into the team. This will further see a reduction in emergency admissions to hospital.
- 2.6.4 We are working closely with Housing colleagues who are now a key part of the integrated discharge team at the hospital and work closely with the admission avoidance teams. This has resulted in increased admission avoidance and is supporting the reduction of Delayed Transfers of Care (DTC).
- 2.6.5 The extremely challenging DTC target has been met thanks to a number of interventions from housing, implementation of the High Impact Change model and the roll out of discharge to assess (D2A).

2.7 **SPACE (Safer Provision and Care Excellence) – Year 1 Evaluation**

- 2.7.1 The West Midlands Collaboration for Leadership in Applied Health Research and Care (CLAHRC-WM) commissioned to evaluate the 2 year SPACE programme, produced a report on findings after one year since the programme commenced.
- 2.7.2 The report draws on evidence from surveys, case studies and interviews of care home managers and staff assessing workforce characteristics, safety climate and Safety Attitudes Questionnaire (SAQ) as well as analysis of routinely-collected CCG data which compares adverse event rates at 18 participating care homes.
- 2.7.3 The return rates for surveys was extremely good at 45.9% much higher than expected and responses showed that scores on the SAQ had been maintained at the high levels reported before SPACE was launched.
- 2.7.4 The key findings highlighted in the report were that the majority of care homes demonstrated:-
- Improvements in relation to falls, nutrition, diet and hydration, ulcers/wound management, and risk monitoring systems.

- That there was evidence of strong engagement from most care homes in uptake of risk monitoring tools.
- There had been positive engagement with quality Improvement methodology, techniques and approaches such as Plan-Do-Study-Act (PDSA) techniques and Appreciative Inquiry.
- Adverse event rates for falls had significantly reduced.
- Rates for Urinary Tract Infections (UTIs) and pressure injuries had also fallen.
- Semi-structured interviews with managers and staff in the case study sites demonstrated positive attitudes towards the programme, and a sense that the programme was having a demonstrable impact on safety.
- There was widespread reporting of feelings of empowerment, benefits of manager peer support and pride from staff about the work they had done to improve safety in their workplaces.

2.7.5 Year 2 of the programme will also include development of a sustainability plan which will comprise of a strategy to roll out of the programme across the care home sector.

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.

Name	Dr Helen Hibbs
Job Title	Chief Officer
Date:	25 April 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.

	Details/ Name	Date
Clinical View	N/A	
Public/ Patient View	N/A	
Finance Implications discussed with Finance Team	N/A	
Quality Implications discussed with Quality and Risk Team	N/A	
Equality Implications discussed with CSU Equality and Inclusion Service	N/A	
Information Governance implications discussed with IG Support Officer	N/A	
Legal/ Policy implications discussed with Corporate Operations Manager	N/A	
Other Implications (Medicines management, estates, HR, IM&T etc.)	N/A	
Any relevant data requirements discussed with CSU Business Intelligence	N/A	
Signed off by Report Owner (Must be completed)	Dr Helen Hibbs	25/04/18



WOLVERHAMPTON CCG
GOVERNING BODY
8 May 2018
Agenda item 7

TITLE OF REPORT:	NHS England Consultation on Items which should not routinely be prescribed in Primary Care (Medicines of limited clinical value)
AUTHOR(s) OF REPORT:	Hemant Patel, Head of Medicines Optimisation
MANAGEMENT LEAD:	Sally Roberts, Chief Nurse and Director of Quality
PURPOSE OF REPORT:	<p>To discuss the findings of the recent NHSE consultation exercise on items that should not be routinely prescribed in Primary care, in order to reduce unwarranted variation.</p> <p>To share with Governing Body the GP members views with regards implementation.</p> <p>To provide a proposal for implementation of the findings</p>
ACTION REQUIRED:	<input checked="" type="checkbox"/> Decision <input type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	Public.
KEY POINTS:	<ul style="list-style-type: none"> • NHS England have completed a consultation exercise on developing guidance for CCGs on items that should not be routinely prescribed in Primary Care • 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. • GP members views were obtained with regards the recommendations and they were broadly in support of the consultation Consideration needs to be given to a patient and public engagement process to be run by the CCG to support the recommendations, in line with legal advice received. The CCG GB is asked to support the recommendations laid out within the report

<p>RECOMMENDATION:</p>	<p>That the Governing Body</p> <ol style="list-style-type: none"> 1) Support the principle outcome of the NHS England consultation on Items which should not routinely be prescribed in Primary Care. 2) Support the decision to include a process of engagement and involvement, followed by a series of communications aimed at supporting patients and practices to implement the outcome, within a defined timeframe for implementation.
<p>LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:</p>	
<p>1. Improving the quality and safety of the services we commission</p>	<p>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</p>
<p>2. Reducing Health Inequalities in Wolverhampton</p>	
<p>3. System effectiveness delivered within our financial envelope</p>	<p>Working to support the recommendations in the guidance from NHS England on prescribing will aim to support the management of the prescribing budget.</p>

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. The consultation ran from July to October 2017 and the outcome was published on 30th November and is available on the NHS England website <https://www.engage.england.nhs.uk/consultation/items-routinely-prescribed/>
- 1.2. GP members were asked for their opinions of the recommendations at the members meeting on 31st January 2018.
- 1.3. Governing body requested legal opinion to be obtained to determine whether any local consultation was required to compliment the national consultation.

- 1.4. Legal advice recommends the CCG include a process of engagement and involvement to support the implementation.
- 1.5. With the support of CSU Communication and Engagement Team, we propose a series of engagement & involvement events to advise the local population of the recommendations and through a patient involvement approach (most likely patients will have been identified for the involvement group via their long term condition, or they will have been identified as having used/or be using the group of identified medicines). The most suitable communication strategy for Wolverhampton will then be determined. Our intention is to ensure effective engagement and discussion with PPG Chairs, Citizen Forum Groups and Patient Partners. The intention will be to go live with full recommendation from October 1st 2018.
- 1.6. Our GP members and non-medical prescribers will also have a face to face opportunity to engage with the Medicines Optimisation Team, Primary Care Medicines Team and the CCG Exec Team to discuss Implementation of the recommendations.

2. NHS England Consultation outcome

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

NHS England has published guidance for all prescribers 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
- Herbal treatments
- Omega-3 Fatty Acid Compounds (fish oil)
- Co-proxamol
- Rubefaciants (excluding topical NSAIDS)
- Lutein and Antioxidants
- Glucosamine and Chondroitin

2.3. NHS England Consultation Guidance

The following recommendations have been made for each of the 18 medicines:-

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

- 1) Co-proxamol
- 2) Prolonged-release Doxazosin (also known as Doxazosin Modified Release)
- 3) Glucosamine and Chondroitin
- 4) Herbal Treatments
- 5) Homeopathy
- 6) Paracetamol and Tramadol Combination Product
- 7) Perindopril Arginine
- 8) Rubefacients (excluding topical NSAIDs)
- 9) Once Daily Tadalafil
- 10) Trimipramine
- 11) Lutein and Antioxidants
- 12) Omega-3 Fatty Acid Compounds

For the following three medicines there is additional advice for CCGs, in exceptional circumstances, there is a clinical need for following medicines to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.

- 13) Dosulepin
- 14) Lidocaine Plasters
- 15) Oxycodone and Naloxone Combination Product

Further exceptions are applied to those above to the following three medicines

- 16) Immediate Release Fentanyl
- 17) Liothyronine (including Armour Thyroid and liothyronine combination products)
- 18) Travel Vaccines (vaccines administered exclusively for the purposes of travel)



The planned communication strategy will support this implementation.

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.

PATIENT AND PUBLIC VIEW

- 3.2. 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. Further engagement is planned prior to implementation of the guidance.

4. KEY RISKS AND MITIGATIONS

The planned implementation process will require significant engagement with public; clinicians and stakeholders, this process, including risks and mitigations will be managed by meds management team in collaboration with communication and engagement colleagues and will be reported through MMOPC and by exception to Governing Body.

5. IMPACT ASSESSMENT

Financial and Resource Implications

- 5.1 Potential saving of 100K, this is identified as a QIPP saving for 18/19.

Quality and Safety Implications

- 5.2 None identified but will be managed through risks and issues log as per implementation process.

Equality Implications

- 5.3 Equality and Health Inequalities

An initial Equality and Health Inequalities Assessment (EHIA) has been carried out by NHSE on these proposals and this can be read via the following link

<https://www.england.nhs.uk/about/equality/>

A local EQIA is underway and this process will be overseen by Modernisation, Medicines Optimisation Primary Care Programme Board

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 its own policies and commissioning decisions.

Other Implications

- 5.5 None



Name Hemant Patel
Job Title Head of Medicines Optimisation
Date: 25 April 2018

ATTACHED:

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

Mills & Reeve - Advice in relation to the implementation of results of national consultations relating to prescribing

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View & GP member group	GP Members Dr Stone	31/01/2018 17/04/2018
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	Sally Robert	25/04/18
Equality Implications discussed with CSU Equality and Inclusion Service	David King 24/04/18 as part of EIA review	
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.)	As per report	
Any relevant data requirements discussed with CSU Business Intelligence	N/a	
Signed off by Report Owner (Must be completed)	Hemant Patel	25/04/2017

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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 items¹ were dispensed in primary care at a cost of £9.2billion². 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

¹ 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](#).

² [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 exceptional³ 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

³ 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’s⁴”.

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 21st July – 21st 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

⁴ 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"> 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.
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 (NHS Digital)
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: November 2007, January 2011</p> <p>PrescQIPP CIC Drugs to Review for Optimised Prescribing - Co-proxamol</p> <p>Patient information leaflets: https://www.prescgipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</p>

4.2 Dosulepin

Recommendation	<ul style="list-style-type: none"> • 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.
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 (NHS Digital)
Background and Rationale	<p>Dosulepin, formerly known as dothiepin, is a tricyclic antidepressant. NICE CG90: Depression in Adults 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>NICE CG90: Depression in Adults</p> <p>PrescQIPP CIC Drugs to Review for Optimised Prescribing - Dosulepin</p> <p>Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</p>

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

Recommendation	<ul style="list-style-type: none"> 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.
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 (NHS Digital)
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 (NHS Drug Tariff).</p> <p>NICE CG127 Hypertension in adults: diagnosis and management recognises that doxazosin should be used in treatment but does not identify benefits of prolonged-release above immediate release.</p> <p>NICE CG97 Lower urinary tract symptoms in men: 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>NICE CG127 Hypertension in adults: diagnosis and management</p> <p>NICE CG97 Lower urinary tract symptoms in men</p> <p>PrescQIPP CIC Drugs to Review for Optimised Prescribing - Prolonged Release Doxazosin</p> <p>BNF - Doxazosin</p>

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

<p>Recommendation</p>	<ul style="list-style-type: none"> • 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.
<p>Exceptions and further recommendations</p>	<p>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 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 (NHS Digital)</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. NICE CG140 Opioids in Palliative Care 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>Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain</p> <p>PrescQIPP CIC Drugs to Review for Optimised Prescribing - Immediate Release Fentanyl</p> <p>Faye's story: good practice when prescribing opioids for chronic pain</p> <p>Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</p>
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4.5 Glucosamine and Chondroitin

Recommendation	<ul style="list-style-type: none"> 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.
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 (NHS Digital)
Background and Rationale	<p>Glucosamine and Chondroitin are nutraceuticals which used to improve pain associated with osteoarthritis. The BNF 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>NICE CG177: Osteoarthritis care and management 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	BNF

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

Recommendation	<ul style="list-style-type: none"> • 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.
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>GOV.UK Traditional herbal medicines: registration form and guidance</p> <p>GOV.UK Herbal medicines granted a traditional herbal registration (THR)</p> <p>Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</p>

4.7 Homeopathy

Recommendation	<ul style="list-style-type: none"> 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.
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 (NHS Digital)
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: https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/</p> <p>GOV.UK Register a homeopathic medicine or remedy</p> <p>Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</p>

4.8 Lidocaine Plasters

Recommendation	<ul style="list-style-type: none"> 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.
Exceptions and further recommendations	<p>These recommendations do not apply to patients who have been treated in line with NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings 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 (NHS Digital)</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>NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings does not recommend lidocaine plasters for treating neuropathic pain.</p> <p>The joint clinical working group also considered a PrescQIPP CIC review, 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>NICE Clinical Knowledge Summaries - Post-herpetic neuralgia</p> <p>Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</p> <p>Specialist Pharmacy Service lidocaine plasters evidence review: https://www.england.nhs.uk/medicines/items-which-should-not-</p>

	be-routinely-prescribed/
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4.9 Liothyronine (including Armour Thyroid and liothyronine combination products)

Recommendation	<ul style="list-style-type: none"> 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	<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 (NHS Digital)</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 (NHS Drug Tariff) of liothyronine has risen significantly and there is limited evidence for efficacy above Levothyroxine.</p> <p>The British Thyroid Association, in their 2015 position statement, 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>British Thyroid Association Guidelines</p> <p>UKMI Medicines Q&A - What is the rationale for using a combination of levothyroxine and liothyronine (such as Armour® Thyroid) to treat hypothyroidism?</p> <p>Patient information leaflets: https://www.prescripp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</p>

4.10 Lutein and Antioxidants

Recommendation	<ul style="list-style-type: none"> 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.
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 (NHS Digital)
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 Antioxidant vitamin and mineral supplements for preventing age-related macular degeneration http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000253.pub3/full The authors conclude “<i>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>Antioxidant vitamin and mineral supplements for slowing the progression of age-related macular degeneration http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000254.pub3/full The authors conclude “<i>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 bulletin 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>PrescQIPP CIC Drugs to Review for Optimised Prescribing - Lutein and Antioxidants</p> <p>NICE - Macular Degeneration</p> <p>Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</p>

4.11 Omega-3 Fatty Acid Compounds

Recommendation	<ul style="list-style-type: none"> 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 omega-3 Fatty acids in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
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 (NHS Digital)
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>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.</p> <p>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.</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>NICE - Omega-3</u></p> <p><u>PrescQIPP CIC Drugs to Review for Optimised Prescribing - Omega 3 Fatty Acids</u></p> <p>Patient information leaflets: <u>https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</u></p>

4.12 Oxycodone and Naloxone Combination Product

Recommendation	<ul style="list-style-type: none"> • 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 multi-disciplinary team and/or other healthcare professional.
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 (NHS Digital)
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 bulletin 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>Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain</p> <p>Faye's story: good practice when prescribing opioids for chronic pain</p> <p>PrescQIPP CIC Drugs to Review for Optimised Prescribing - Oxycodone and Naloxone Combination Product</p>

	Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets
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4.13 Paracetamol and Tramadol Combination Product

Recommendation	<ul style="list-style-type: none"> 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.
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 (NHS Digital)
Background and Rationale	<p>Paracetamol and tramadol combination products are more expensive than the products with the individual components (Drug Tariff).</p> <p>PrescQIPP CIC also issued a bulletin 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 PrescQIPP CIC review 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	PrescQIPP CIC Drugs to Review for Optimised Prescribing - Paracetamol and Tramadol Combination Product Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets

4.14 Perindopril Arginine

Recommendation	<ul style="list-style-type: none"> • 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.
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 (NHS Digital)
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 PrescQIPP CIC review of the topic found there was no clinical advantage of the arginine salt.</p> <p>NICE CG127: Hypertension in adults: diagnosis and management 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>NICE CG127: Hypertension in adults: diagnosis and management</p> <p>PrescQIPP CIC Drugs to Review for Optimised Prescribing - Perindopril Arginine</p> <p>Patient information leaflets: https://www.prescgipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</p>

4.15 Rubefacients (excluding topical NSAIDs⁵)

Recommendation	<ul style="list-style-type: none"> Advise CCGs that prescribers in primary care should not initiate rubefacients (excluding topical NSAIDs) for any new patient. 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.
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 BNF states “<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: Do not offer rubefacients for treating osteoarthritis.</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>PrescQIPP CIC Drugs to Review for Optimised Prescribing - Rubefacients</p> <p>NICE CG177 Osteoarthritis: care and management</p> <p>BNF: Soft-tissue disorders</p> <p>Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</p>

⁵ 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"> 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.
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 (NHS Digital)
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 20mg⁶ 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 Drug Tariff.</p> <p>Benign Prostatic Hyperplasia: NICE terminated their technology appraisal (TA273) due to receiving no evidence from the manufacturer. In NICE CG97: Lower Urinary Tract Symptoms in Men NICE state that there is not enough evidence to recommend phosphodiesterase inhibitors in routine clinical practice.</p> <p>Erectile Dysfunction: PrescQIPP CIC have reviewed the evidence 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>NICE CG97: Lower Urinary Tract Symptoms in Men</p> <p>NICE Clinical knowledge Summaries - Erectile Dysfunction</p>

⁶ *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>PrescQIPP CIC Drugs to Review for Optimised Prescribing - Once Daily Tadalafil</p> <p>Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</p>
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4.17 Travel Vaccines (vaccines administered exclusively for the purposes of travel)

Recommendation	<ul style="list-style-type: none"> Advise CCGs that prescribers in primary care should not initiate the stated vaccines exclusively for the purposes of travel for any new patient. <p>N.B This is a restatement of existing regulations and no changes have been made as a result of this guidance.</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 (NHS Digital)</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"> Cholera Diphtheria/Tetanus/Polio Hepatitis A Typhoid <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"> Hepatitis B Japanese Encephalitis Meningitis ACWY

	<ul style="list-style-type: none"> • Yellow Fever • Tick-borne encephalitis • Rabies • BCG <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>The Green Book</p> <p>Travel Health Pro (NaTHNaC)</p> <p>PrescQIPP CIC Drugs to Review for Optimised Prescribing - Travel Guidance</p> <p>Patient information leaflets: https://www.prescgipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</p>

4.18 Trimipramine

Recommendation	<ul style="list-style-type: none"> • 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.
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 (NHS Digital)
Background and Rationale	<p>Trimipramine is a tricyclic antidepressant (TCA) however the price of trimipramine is significantly more expensive than other antidepressants.</p> <p>NICE CG90: Depression in Adults 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>NICE CG90: Depression in Adults</p> <p>NICE Clinical Knowledge Summaries – Depression</p> <p>Patient information leaflets: https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets</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
8 MAY 2018

Agenda item 8

TITLE OF REPORT:	NHS England Consultation on conditions for which over the counter (OTC) items should not routinely be prescribed in primary care:
AUTHOR(s) OF REPORT:	Hemant Patel, Head of Medicines Optimisation
MANAGEMENT LEAD:	Sally Roberts, Chief Nurse and Director of Quality
PURPOSE OF REPORT:	To discuss the principle outcome of the 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, with regards its application in Wolverhampton.
ACTION REQUIRED:	<input checked="" type="checkbox"/> Decision <input type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	Public.
KEY POINTS:	<ul style="list-style-type: none"> • NHS England have completed a consultation exercise on developing guidance for CCGs on conditions for which over the counter items should not routinely be prescribed in primary care: • 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. • Meds management have sought GP member's views, who have agreed in principle to support the outcome of the consultation. • Local GPs raised concern with regards the impact of this guidance for those patients and particularly children, where socio economic factors may adversely affect individuals, this requires further understanding and a full equality impact of the recommendations is proposed prior to implementation. • Mills & Reeve advice is to undertake engagement and



	involvement events with patients and clinicians.
RECOMMENDATION:	<p>That the Governing Body</p> <ol style="list-style-type: none"> 1) Support the outcome of the NHS England consultation on conditions for which over the counter items should not routinely be prescribed in primary care. 2) Undertake a full impact analysis prior to implementation, taking into account GP members views as per Appendix 1. 3) Support a process of engagement and involvement events, followed by a series of communications aimed at supporting patients and practices to implement the outcome.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
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	
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 undertaken 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 ran for twelve weeks from 20th December 2017 until 14th March 2018 and WCCG supported Primary care events to ensure local feedback was provided, the outcome was published on 30th November is available on the NHS

England website <https://www.england.nhs.uk/medicines/conditions-for-which-over-the-counter-items-should-not-routinely-be-prescribed/>

- 1.3. Legal advice has been sought, which recommends the CCG undertakes a process of engagement to support the implementation of the NHSE outcome
- 1.4. Meds management team will be working with communication colleagues to undertake a series of engagement & involvement events for public and GP members/non-medical prescribers. This will enable CCG to fully understand the impact of identified medicines withdrawal locally. We will also create and disseminate an online survey which will be distributed widely through our PPG Chairs, Citizen Forum Groups and Patient Partners.
- 1.5. The outcome of engagement will result in a marketing campaign to both the public and stakeholders to communicate the changes. This will be delivered during October 2108.

2. NHS England Consultation outcome

“NHS England has published guidance to free up current NHS spend for frontline care each year by curbing prescriptions for ‘over the counter’ medicines such as those for constipation and athletes foot.

Curbing routine prescribing for minor, short-term conditions, many of which will cure themselves or cause no long term effect on health, will free up NHS funds for frontline care.

The [guidance](#) will not affect prescribing of over the counter items for longer term or more complex conditions or where minor illnesses are symptomatic or a side effect of something more serious.

The new over the counter medicines guidance will curb the routine prescribing of products that are for:” It is important to note implementation of the guidance may help curb routine prescribing but isn’t guaranteed.

- **A self-limiting condition**, which does not require any medical advice or treatment as it will clear up on its own, such as sore throats, coughs and colds

- **A condition that is suitable for self-care**, which can be treated with items that can easily be purchased over the counter from a pharmacy, such as indigestion, mouth ulcers and warts and verrucae.

The guidance does not apply to people with long-term or more complex conditions who will continue to get their usual prescriptions.

People who receive free prescriptions will not automatically be exempt from the guidance.

For patients where the clinician considers that their ability to self-manage is compromised as a consequence of medical, mental health or significant social vulnerability; these patients will continue to receive prescriptions for over the counter items subject to the item being clinically effective.

Conditions for which prescribing should be restricted

1. Probiotics
2. Vitamins and minerals
3. Acute Sore Throat
4. Infrequent Cold Sores of the lip.
5. Conjunctivitis
6. Coughs and colds and nasal congestion
7. Cradle Cap (Seborrhoeic dermatitis – infants)
8. Haemorrhoids
9. Infant Colic
10. Mild Cystitis
11. Mild Irritant 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
24. Sunburn
25. Sun Protection
26. Mild to Moderate Hay fever/Seasonal Rhinitis
27. Minor burns and scalds
28. Minor conditions associated with pain, discomfort and/fever. (e.g. aches and sprains, headache, period pain, back pain)
29. Mouth ulcers
30. Nappy Rash
31. Oral Thrush
32. Prevention of dental caries
33. Ringworm/Athletes foot
34. Teething/Mild toothache
35. Threadworms
36. Travel Sickness
37. Warts and Verrucae

When implementing this guidance, CCGs will need to supply patients with further information on signposting so that they are able to access the right service. This guidance is not intended to discourage patients from going to the GP practice when it is appropriate to do so.

It is envisioned that in most cases (unless specified) these minor conditions will clear up with appropriate self-care. If symptoms are not improving or responding to treatment, then patients should be encouraged to seek further advice.

CCGs will also need to take account of their latest local Pharmaceutical Needs Assessment (PNA) and consider the impact of this guidance on rural areas and access to a pharmacy and pharmacy medicines.

To note that for vitamins, minerals, probiotics and those self-limiting conditions where there is limited evidence of clinical effectiveness for the treatments used (e.g. OTC items for cough, sore throat and infant colic), then the general exceptions do not apply. Specific exceptions are included (if applicable) under the relevant item and/or condition. This may need to be considered further when implementing the guidance locally.

General exceptions that apply to the recommendation to selfcare

This guidance is intended to encourage people to self-care for minor illnesses as the first stage of treatment. It is envisioned that in most cases (unless specified) these minor conditions will clear up with appropriate self-care. If symptoms are not improving or responding to treatment, then patients should be encouraged to seek further advice.

When implementing this guidance, CCGs will need to supply patients with better Information on signposting so that they are able to access the right service. This guidance is not intended to discourage patients from going to the GP practice when it is appropriate to do so.

To note that for vitamins, minerals, probiotics and those self-limiting conditions where there is limited evidence of clinical effectiveness for the treatments used (e.g. OTC items for cough, sore throat and infant colic), then the general exceptions do not apply. Specific exceptions are included (if applicable) under the relevant item and/or condition. This may need to be considered further when implementing the guidance locally.

This guidance applies to all patients, including those who would be exempt from paying prescription charges, unless they fall under the exceptions outlined.

CCGs will need to ensure that community pharmacists are reminded of 'red flag' symptoms for patients presenting with symptoms related to the conditions covered by this consultation.

Prescribers and/or community pharmacists should refer patients to NHS Choices, the Self Care Forum or NHS 111 for further advice on when they should seek GP Care.

General Exceptions to the Guidance:

There are a number of exceptions within the recommendations. These will be referenced and included within the engagement and communication plan for the public and clinicians. These have already been included within the Equality impact assessment undertaken.

These exceptions are outlined below:

1. Patients prescribed an OTC treatment for a long term condition (e.g. regular pain relief for chronic arthritis or treatments for inflammatory bowel disease).
2. For the treatment of more complex forms of minor illnesses (e.g. severe migraines that are unresponsive to over the counter medicines).
3. For those patients that have symptoms that suggest the condition is not minor (i.e. those with red flag symptoms for example indigestion with very bad pain.)
4. Treatment for complex patients (e.g. immunosuppressed patients).
5. Patients on prescription only treatments.
6. 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.
7. 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 breastfeeding. Community Pharmacists will be aware of what these are and can advise accordingly.
8. Patients with a minor condition suitable for self-care that has not responded sufficiently to treatment with an OTC product.
9. Patients where the clinician considers that the presenting symptom is due to a condition that would not be considered a minor condition.
10. Circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care.
11. **Individual patients where the clinician considers that their ability to self-manage is compromised as a consequence of medical, mental health or significant social vulnerability to the extent that their health and/or wellbeing could be adversely affected, if reliant on self-care.**

To note that being exempt from paying a prescription charge does not automatically warrant an exception to the guidance. Consideration should also be given to safeguarding issues.

3 CLINICAL VIEW

- 3.1 The views of the Clinical Members of the Governing Body have been sought through discussion of this paper (see attachment)

PATIENT AND PUBLIC VIEW

- 3.2 The consultation received over 7K 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. There may be potential patient safety risks if management of this guidance is not well managed, however this will be mitigated through local stakeholder and engagement events and effective communication strategy for implementation.
- 4.2. Based on prescribing data we have identified a potential saving of 250K which has been included within QIPP plans for 18/19. . Any potential savings need to be weighed against the cost of alternative treatments being prescribed.
- 4.3. There may be a risk that alternative, more potent or more expensive items are prescribed as a result, this will be mitigated through the engagement and communication events and monitored via ePACT searches (Prescribing Data).

5 IMPACT ASSESSMENT

Financial and Resource Implications

- a. Based on prescribing data there may be a potential saving of 250K if this is implemented mid-year. Any potential savings need to be weighed against the cost of alternative treatments being prescribed.

Quality and Safety Implications

- b. See Key risks and mitigations above.

Equality Implications

- c. NHS England included equality implications during the development of the recommendations. A full equality impact analysis has been carried out (see attachment)

Legal and Policy Implications

- d. 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 its own policies and commissioning decisions.

Other Implications

- e. None

Name Hemant Patel
Job Title Head of Medicines Optimisation
Date: 25.04.2018

ATTACHED:

NHS England Consultation Document Items which should not routinely be prescribed in primary care:

GP member's views obtained at members meeting on 31st January 2018.

Mills & Reeve - Advice in relation to the implementation of results of national consultations relating to prescribing

Equality Impact assessment Form

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	GP members & sought via paper Dr Anna Stone	31.01.18 & 13/02/18 17/04/18
Public/ Patient View	Sought via Paper	13/02/18
Finance Implications discussed with Finance Team	N/a	
Quality Implications discussed with Quality and Risk Team	Sally Roberts	25/04/18
Equality Implications discussed with CSU Equality and Inclusion Service	David King	24/04/18
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.)	As per report	
Any relevant data requirements discussed with CSU Business Intelligence	N/a	
Signed off by Report Owner (Must be completed)	Hemant Patel	25/04/2018





Equality Analysis Form

Name of Project/Review	NHS England Consultation on conditions for which over the counter items should not routinely be prescribed in primary care	
Project Reference number		
Project Lead Name	Hemant Patel	
Project Lead Title	Head of Medicines Optimisation	
Project Lead Contact Number & Email	01902 445281 hemant.patel1@nhs.net	
Date of Submission	23.04.2018	
Version	1.1	
Is the document:		
A proposal of new service or pathway	YES	
A strategy, policy or project (or similar)	YES	
A review of existing service, pathway or project	YES	
Who holds overall responsibility for the project/policy/ strategy/ service redesign etc		
Sally Roberts, Chief Nurse and Director of Quality		
Who else has been involved in the development?		
GP members NHS England recommendations		

Equality Analysis Form

Section A - Project Details

Preliminary Analysis – *copy the details used in the scoping report*

- NHS England have completed a consultation exercise on developing guidance for CCGs on conditions for which over the counter items should not routinely be prescribed in primary care:
 - 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.
 - Medicines optimisation team have sought GP members views, who have agreed in principle to support the outcome of the consultation.
 - Local GPs raised concern with regards the impact of this guidance for those patients and particularly children, where socio economic factors may adversely affect individuals, this requires further understanding and a full equality impact of the recommendations is proposed prior to implementation.
 - Mills & Reeve advice is to undertake engagement and involvement events with patients and clinicians.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

This will affect patients, practices, community pharmacies and urgent care providers

Section B – Screening Analysis

Equality Analysis Screening

It is vital that the CCG ensures that it demonstrates that it is meeting its legal duty, as the responsible manager you will need to identify whether a Full Equality Analysis is required.

A full EA will only not be required if none of the following aspects are identified and you are confident there is no impact.

E.g. ‘This report is for information only’ or ‘The decision has not been made by the CCG’ or ‘The decision will not have any impact on patients or staff’. (Very few decisions affect all groups equally and this is not a rationale for not completing an EA.)

Screening Questions	YES or NO
<p>Is the CCG making a decision where the outcome will affect patients or staff?</p> <p><i>For example will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.</i></p>	Yes
<p>If the CCG is enacting a decision taken by others, e.g. NHS England or Local Authority - does it have discretion to change, modify or mitigate the decision?</p>	Yes
<p>Is the board/committee being asked to make a decision on the basis that this proposal will have a consequential effect on any change? e.g. Financial changes</p>	Yes
<p>Will this decision impact on how a provider delivers its services to patients, directly or indirectly?</p>	Yes
<p>Will this decision impact on any third parties financial position (i.e. Provider, Local Authority, GP Practices)? <i>For example are you removing funding from theirs or any contract?</i></p>	no
<p>If you have answered NO to ALL the above questions, please provide supporting narrative to explain why none of the above apply.</p> <p><i>(Advice and guidance can be sought from the equality team if required).</i></p>	

Equality Analysis Form

If the answer to **ALL** the questions in the screening questions is “**NO**”, please complete the below section only and do not complete a full assessment.

Please forward the form with any supporting documentation to Blackcountry.Equality@ardengemcsu.nhs.uk

These initial assessments will be saved and retained as part of the CCG’s audit trail. These will also be periodically audited as part of the CCG’s Quality Assurance process and the findings reported to the Chief Nurse, PMO Lead and the CCG’s Governance team.

Please ensure you are happy with the conclusion you have made, advice and guidance can be sought from: David.king17@nhs.net or Equality@ardengemcsu.nhs.uk

Sign Off / Approval (Section A and B)

Title	Name	Date
Project Lead	Hemant Patel	23.04.18
Equality and Inclusion Officer	David King	
Equality and Inclusion Comments	Has gone straight to Full EA.	
Programme Board Review		
Programme Board Chair		

If any of the screening questions have been answered “**YES**” then please forward your initial assessment to David.king17@nhs.net or Equality@ardengemcsu.nhs.uk

And complete the next section of the Equality Form Assessment, once you are ready to request approval of the change from the appropriate approval board.

If you required any support to complete the FULL Equality form, please contact the Equality Manager.

The Completed EA will then require a final sign off as per section 10.

Section C - Full Equality Analysis Section

If at an initial stage further information is needed to complete a section this should be recorded and updated in subsequent versions of the EA. An Equality Analysis is a developing document, if you need further information for any section then this should be recorded in the relevant section in the form and dated.

1. Evidence used

What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses

NHS England carried out an Equality Impact Analysis as part of the consultation and subsequent recommendations.

Census demographics – Wolverhampton provide healthcare services for the circa 270,000 patients who are registered with a GP in Wolverhampton.

Wolverhampton is a diverse city and 32 per cent of our population belongs to black minority ethnic (BME) communities compared to 15 per cent for England.

Wolverhampton is amongst the most deprived areas within the country ranking as the 11th most deprived local authority area in England. In recent years unemployment has fallen in the city but remains the sixth highest unemployment rate per local authority in England.

Prescription data via ePACT.

Comments and feedback from GP Members

Corporate Assurance Impact

State overarching, strategy, policy, legislation this review or service change is compliant with	NHS England Consultation on conditions for which over the counter items should not routinely be prescribed in primary care.
Will this review or service change fit with the CCGs Boards Assurance Framework Aim and Objectives? If yes, please indicate which ones (<i>see notes page for guidance</i>)	
What is the intended benefit from this review or service change?	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. If patients choose to self-manage these

Equality Analysis Form

1. Evidence used	
<i>What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses</i>	
	conditions it will potentially free up availability for appointments within GP practices.
Who is intended to benefit from the implementation of this review or service change?	Patients Practices CCG
What are the key outcomes/ benefits for the groups identified above?	Patients may receive treatment sooner Practices would have an increased availability for appointments for patients with more complex conditions CCG – would spend less on OTC medicines
Will the review or service change meet any statutory requirements, outcomes or targets?	

2. Impact of decision	
<i>In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.</i>	
2.1 Age <i>Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.</i>	
Currently 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. If they met the criteria of the recommendation they may be required to purchase their own treatment unless the practice deems they meet criteria to continue prescribing. There could be an adverse impact on children as they rely on adults to make purchasing decisions. However some of these patients will fall under a particular exemption meaning they would receive a prescription. In addition the CCG continue to commission services (Pharmacy first scheme & MECS service) available which allow patients to receive treatment without charge for minor ailments. Patients will be signposted to this if appropriate.	
2.2 Disability <i>Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/learning disabilities, cognitive impairments.</i>	

Equality Analysis Form

2. Impact of decision

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.

A patient with a continuing physical disability which means they cannot go out without the help of another person would currently have the treatment/s mentioned in this consultation funded/prescribed and possibly delivered by their nominated community pharmacy.

Vulnerable patient groups' e.g. frail elderly, patients with disabilities or mental health problems, care home patients etc. may struggle to access appropriate medication if not prescribed.

However they may fall into one exemption which may mean the patient would still receive a prescription. Two of the key exceptions from the recommendations are noted below :-

1. Circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care.
2. Individual patients where the clinician considers that their ability to self-manage is compromised as a consequence of medical, mental health or significant social vulnerability to the extent that their health and/or wellbeing could be adversely affected, if reliant on self-care. To note that being exempt from paying a prescription charge does not automatically warrant an exception to the guidance. Consideration should also be given to safeguarding issues.
3. Consideration will also be given to patients with a learning disability or additional communication / support needs.

2.3 Gender reassignment (including transgender)

Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.

No impact identified

2.4 Marriage and civil partnership

Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.

No impact identified

2.5 Pregnancy and maternity

Describe any impact and evidence in relation to Pregnancy and Maternity. This can include working arrangements, part time working and caring responsibilities.

Equality Analysis Form

2. Impact of decision

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.

Currently women who are pregnant or recently given birth would have recourse to receiving these items for the conditions mentioned in this consultation without charge.

The woman could continue to obtain treatment if provided via the MECS and Pharmacy First Service. In addition if they meet the exception criteria they could continue to receive these treatments via a prescription without charge.

2.6 Race

Describe race-related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures and language barriers.

There is a risk if communication of these recommendations (and their application) does not consider those patients where English is not their first language and could lead to confusion.

This could be mitigated with effective communication to patients and support for practices.

2.7 Religion or belief

Describe any impact and evidence in relation to religion, belief or no belief on service delivery or patient experience. This can include dietary needs, consent and end of life issues.

No impact identified

2.8 Sex

Describe any impact and evidence in relation to men and women. This could include access to services and employment.

No impact identified

2.9 Sexual orientation

Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.

No impact identified

Equality Analysis Form

2. Impact of decision

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.

2.10 Carers

Describe any impact and evidence in relation to part-time working, shift-patterns, general caring responsibilities. (Not a legal requirement but a CCG priority and best practice)

A patient with a continuing disability (e.g. physical or Mental Health condition) which means they cannot go out without the help of another person (carer) would currently have the treatment/s mentioned in this consultation funded/prescribed and possibly delivered by their nominated community pharmacy. Going forward this might no longer be the case.

However they may fall into one exemption which may mean the patient would still receive a prescription. Two of the key exceptions from the recommendations are noted below :-

1. Circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care.
2. Individual patients where the clinician considers that their ability to self-manage is compromised as a consequence of medical, mental health or significant social vulnerability to the extent that their health and/or wellbeing could be adversely affected, if reliant on self-care. To note that being exempt from paying a prescription charge does not automatically warrant an exception to the guidance. Consideration should also be given to safeguarding issues.

2.11 Other disadvantaged groups

Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the CCG in meeting its legal duties to identify and reduce health inequalities.

Wolverhampton is the 11th most deprived local authority in the country. The national recommendations don't consider socio economic factors (poverty) and its impact on patients. Purchasing OTC products may not be an option for some. This could possibly impact on a group of patients considered.

People on low incomes may not self-treat adequately and therefore there is the risk that they will then present to Urgent Care/ Accident and Emergency or emergency services with a condition that has deteriorated.

The MECS and Pharmacy First Service would mitigate against this as would the general exceptions included.

Equality Analysis Form

3. Human rights

The principles are Fairness, Respect, Equality, Dignity and Autonomy.

Will the proposal impact on human rights?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Are any actions required to ensure patients' or staff human rights are protected?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>

If so what actions are needed? Please explain below.

Ensure the exemptions and how to manage them are made clear to patients and practices.

As part of the implementation of this guidance, it is important that the CCGs need to supply patients with enhanced information on signposting so that they are able to access the right service. This could be done through care navigation, 111 services, local promotion of self-care and pharmacy services.

It is important to note that this guidance is not intended to discourage patients from going to the GP when it is appropriate to do so and indeed GPs will continue to recommend relevant treatments, however, they may no longer prescribe those medications covered by this.

4. How will you measure how the proposal impacts health inequalities?

The CCG has a legal duty to identify and reduce health inequalities.

e.g. patients with a learning disability were accessing cancer screening in substantially smaller numbers than other patients. By revising the pathway the CCG is able to show increased take up from this group, this a positive impact on this health inequality.

Feedback from patients and practices. The CCG will periodically review this feedback to help update this EA and recommendations.

Equality Analysis Form

4. How will you measure how the proposal impacts health inequalities?

The CCG has a legal duty to identify and reduce health inequalities.

e.g. patients with a learning disability were accessing cancer screening in substantially smaller numbers than other patients. By revising the pathway the CCG is able to show increased take up from this group, this a positive impact on this health inequality.

5. Engagement/consultation

What engagement is planned or has already been done to support this project?

Engagement activity	With who? <i>e.g. protected characteristic/group/community</i>	Date
Meds management team will be working with communication colleagues to undertake a series of engagement & involvement events for public and Gp members/non-medical prescribers. This will enable CCG to fully understand the impact of identified medicines withdrawal locally. We will also create and disseminate an online survey which will be distributed widely through our PPG Chairs, Citizen Forum Groups and Patient Partners.	With the public and specific patient groups that include some who may have been prescribed treatments for conditions covered by the recommendations. In addition we will aim to involve GP members & non-medical prescribers. PPG Chairs, Citizen Forum Groups and Patient Partners.	June, July & August 2018
The outcome of engagement will result in a marketing campaign to both the public and stakeholders to communicate the changes.	public and stakeholders	This will be delivered during September 2108.

Please summarise below the key finding / feedback from your engagement activity and how this will shape the policy/service decisions e.g. patient told us, so we will... (If a supporting document is available, please provide it or a link to the document)

Equality Analysis Form

5. Engagement/consultation

What engagement is planned or has already been done to support this project?

Engagement activity	With who? <i>e.g. protected characteristic/group/community</i>	Date

6. Mitigations and changes

If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over the counter medication. It was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore an exception is provided for this group which has resolved the issue.

It should be noted that the CCG policy is guidance for primary care prescribers. The final decision to prescribe will remain with the prescriber. However, due regard needs to be given to professional guidance around resource management.

In addition the CCG continue to commission services (Pharmacy first scheme & MECS service) available which allow patients to receive treatment without charge for minor ailments.

Patients may fall into one of many exemptions which may result in the patient receiving a prescription. Two of the key exceptions from the recommendations are noted below :-

1. Circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care.
2. Individual patients where the clinician considers that their ability to self-manage is compromised as a consequence of medical, mental health or significant social vulnerability to the extent that their health and/or wellbeing could be adversely affected, if reliant on self-care. To note that being exempt from paying a prescription charge does not automatically warrant an exception to the guidance. Consideration should also be given to safeguarding issues.

The CCG policy will also be reviewed if:

- There is new relevant national guidance
- The APC issues new verdicts on any new medicines and items
- Any applications for change to the status of specific medicines and items in the schedule are made by local clinicians and approved by the APC
- Every two years (as per the review date on front sheet)

Equality Analysis Form

7. Is further work required to complete this EA?

Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)

Work needed	Section	When	Date completed
e.g. Further engagement with disabled service users to identify key concerns around using the service.	2 - Disability	June to July'17	September 2017
Evaluation from engagement & involvement		August 2018	September 2018

8. Development of the Equality Analysis

If the EA has been updated from a previous version please summarise the changes made and the rationale for the change, e.g. Additional information may have been received – examples can include consultation feedback, service Activity data

Version	Change and Rationale	Version Date
e.g. Version 0.1	The impact on wheelchair users identified additional blue badge spaces are required on site to improve access for this group.	26 September 2017

9. Preparation for Sign off

	Please Tick
1) Send the completed Equality Analysis with your documentation to Equality@ardengemcsu.nhs.uk and David.king17@nhs.net for feedback prior to Executive Director (ED) sign-off.	
2) Make arrangements to have the EA put on the appropriate programme board agenda	
3) Use the Action / version section to record the changes you are intending to make to the document and the timescales for completion.	

10. Final Sign off

The Completed EA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process.

The completed form should also be sent to PMO so that the CCG can maintain an up to date log of all EAs.

Equality Analysis Form

10. Final Sign off

The Completed EA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process.

The completed form should also be sent to PMO so that the CCG can maintain an up to date log of all EAs.

Version approved:

Designated People

Project officer* (Senior Officer responsible including action plan)

Name:

Date:

Equality & Inclusion Review and Quality Assurance

Name: David King

Date: 24/4/18

Executive Director Review:

Name:

Date:

Name of **Approval Board** (e.g. *Commissioning Committee; Governing Body; Primary Care Commissioning Committee*) at which the EA was agreed at:

Approval Board:

Approval Board Ref Number:

Chair:

Date:

Comments:

Actions from the Approval Board to complete:

Review date for action plan (section 7):

BOARD ASSURANCE FRAMEWORK NOTES

(Please **DELETE** before submission)

Following a review of the BAF, it will now be based on the risks associated with the CCG achieving its strategic aims and objectives as follows:-

Strategic Aims	Strategic Objectives
1. Improving the quality and safety of the services we commission	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

Equality Analysis Form

<p>2. Reducing health inequalities in Wolverhampton</p>	<p>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</p> <p>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</p>
<p>3. System effectiveness delivered within our financial envelope</p>	<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>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>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>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>

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

	<u>Agree y/n (provide comments if no)</u>
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?
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		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 -	15	10		Caveats = Social/economic grounds
3	Cold Sores	15	10		Caveats = Social/economic grounds-
4	Conjunctivitis	15	10		Caveats = Social/economic grounds/ children under 1 If Pharmacy could refer to MECS
5	Coughs and colds and nasal congestion	15	10		Caveats = Social/economic grounds
6	Cradle Cap (Seborrhoeic dermatitis – infants)	21	4		Caveats = Social/economic grounds Thought it could be severe in some and require treatment.
7	Haemorrhoids	7	8	10	Caveats – children Disagree – concern it would mask more sinister disease.
8	Mild Cystitis	10		15	Difficult to implement – what would constitute as mild
9	Mild Dry Skin/Sunburn -	21	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: Guidance for CCGs

GATEWAY APPROVAL NUMBER: 07851

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 Who is this commissioning 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, unless they can articulate a valid reason to do otherwise, 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. 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.

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.

1.2 Why have we developed this guidance?

In the year prior to June 2017, the NHS spent approximately £569 million¹ on prescriptions for medicines, 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. the person suffering does not normally need to seek medical advice and can manage the condition by purchasing OTC items directly.

These prescriptions also include other common 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, or on items for which there is little evidence of clinical effectiveness, these resources can be used for other higher priority areas that have a greater impact for patients, support improvements in services and/or deliver transformation that will ensure the long-term sustainability of the NHS.

¹ Refined BSA data to June 2017

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 £2.18² from a pharmacy whereas the cost to the NHS is over £3.00³ 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 conditions 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.

Research⁴ 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 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.)⁵:

- 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 operations⁶.

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 How has this guidance been developed?

Clinical Commissioning Groups (CCGs) asked for a nationally co-ordinated approach to producing commissioning guidance. NHS England and NHS Clinical Commissioners (NHSCC) therefore sought to provide a national framework for

² Online pharmacy checked December 2017

³ [Drug Tariff online](#)

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

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

⁶ [Drug Tariff online](#)

guidance, with the aim of supporting consistent local implementation decisions and agreed to consult jointly on any proposals

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 and Social Care, PrescQIPP and CCG representatives.

As a result of our work, NHS England and NHSCC identified conditions which may fall under one or more of the categories listed in section 1.2.

NHS England then consulted on *items which should not be routinely prescribed in primary care* (21st July – 21st 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.

Feedback from this consultation showed that there was general support (65% agreed with our proposed criteria to assess items for potential restriction).

The clinical working group was consulted on several proposed approaches to limiting the prescription of OTC medicines and, based on their guidance, we mapped OTC products to the conditions for which they are typically prescribed. **We refined the approach to develop restrictions based on type and severity of condition rather than products.**

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

As a result of this exercise, nine additional minor conditions were identified which we 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.

We focused on developing guidance for the list of 33 conditions which would fall into one of the following categories:

- 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 classified these as:

- Items of limited clinical effectiveness, where there is a lack of robust evidence for clinical effectiveness; however there may be certain indications where they may continue to be prescribed and these are outlined within the exceptions under the relevant item.

The group then assigned one of the following three recommendations for each condition (or item):

- Advise CCGs that **[item]** should not be routinely prescribed in primary care due to **limited evidence of clinical effectiveness**.
- Advise CCGs 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 that a prescription for treatment of **[condition]** should not routinely be offered in primary care as the condition is **appropriate for self-care**.

In reaching its recommendations the joint clinical working group considered evidence from the following organisations or groups:

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

The group's recommendations on the items and conditions within this guidance were publicly consulted on for a period of 12 weeks, from 20th December 2017 – 14th March 2018. During the consultation we heard from members of the public, patients and their representative groups, NHS staff, CCGs, Trusts, 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: *Conditions for which over the counter items 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 response and discussions through webinars and engagement events, as well as recommendations from the joint clinical working group who considered the feedback in detail.

Whilst overall the final guidance remains largely unchanged from the draft guidance published in December 2017, there have been some important refinements and clarifications made and these are detailed below:

As a result of feedback received for further clarity on the exceptions, the following statements were approved by the clinical working group and now have been included under the '*General Exceptions*' heading:

- This guidance applies to all patients, including those who would be exempt from paying prescription charges, unless they fall under the exceptions outlined.
- When implementing this guidance, CCGs will need to supply patients with further information on signposting so that they are able to access the right service. This guidance is not intended to discourage patients from going to the GP when it is appropriate to do so.
- It is envisioned that in most cases (unless specified) these minor conditions will clear up with appropriate self-care. If symptoms are not improving or responding to treatment, then patients should be encouraged to seek further advice.
- CCGs will also need to take account of their latest local Pharmaceutical Needs Assessment (PNA) and consider the impact of this guidance on rural areas and access to a pharmacy and pharmacy medicines.
- To note that for vitamins, minerals, probiotics and those self-limiting conditions where there is limited evidence of clinical effectiveness for the treatments used (e.g. OTC items for cough, sore throat and infant colic), then the general exceptions do not apply. Specific exceptions are included (if applicable) under the relevant item and/or condition. This may need to be considered further when implementing the guidance locally.

The clinical working group also further refined the final exception around vulnerability as follows, to clarify that it applies to individual patients and that being exempt from prescription charges does not indicate that you would automatically be exempt from this guidance.

Individual patients where the clinician considers that their ability to self-manage is compromised as a consequence of medical, mental health or significant social

vulnerability to the extent that their health and/or wellbeing could be adversely affected if reliant on self-care. To note that being exempt from paying a prescription charge does not automatically warrant an exception to the guidance.

Vitamins and Minerals – during the consultation we heard that the list of exceptions should be amended to include all types of medically diagnosed vitamin or mineral deficiency, including for those patients who may have a lifelong condition or have undergone surgery that results in malabsorption. This is in line with the current ACBS guidance for prescribers and was approved by the joint clinical working group. It was also noted that vitamin D analogues such as alfacalcidol are prescription only medicines and would continue to be prescribed. During the consultation we also heard from the pharmaceutical industry that maintenance treatment for vitamin D therapy should be an exception as it is included in PHE guidance. The working group considered this and agreed that whilst maintenance therapy is recommended, there is no indication that this needs to be prescribed; vitamin D supplements can be bought cheaply and easily. The PHE guidance also does not distinguish between the general public and at risk patients. The clinical working group therefore agreed that vitamin D maintenance therapy would not be included as an exception.

Cold Sores – During the consultation we heard that further clarity was required on the description for this condition. The clinical working group agreed the description for this condition should be amended to clarify that this refers to *infrequent cold sores of the lip*.

Cradle Cap – During the consultation we received feedback that a specific exception should apply to this condition. The clinical working group agreed to refine this to include the exception “*If causing distress to the infant and not improving*”.

Contact Dermatitis – Following feedback the clinical working group agreed that this condition should remain but that the description should be amended to mild irritant dermatitis.

Dandruff - Following a request for clarification the clinical working group agreed the rationale should be amended to define dandruff as a “mild scaling of the scalp without itching”, and to include the statement “Patients should be encouraged to manage mild dandruff with long term over the counter treatments”.

Head Lice – Following feedback from various organisations around the need to specify that wet combing should be first line treatment, the clinical working group agreed that the following sentence should be included: *‘Head lice can be treated by wet combing; chemical treatment is only recommended in exceptional circumstances and in these cases over the counter medicines can be purchased from a pharmacy’*

Infrequent Constipation – During the consultation we heard that further information was needed within the rationale for this condition. The clinical working group agreed that the rationale should be amended to include the following additional information:

Pharmacists can help if diet and lifestyle changes aren't helping. They can suggest an over the counter laxative. Most laxatives work within 3 days. They should be used for a short time only. Laxatives are not recommended for children unless they are prescribed by a GP. This guidance applies to short term, infrequent constipation caused by changes in lifestyle or diet such as lack of water or movement or changes in diet.

Mild Acne –The clinical working group agreed that additional information should be added into the rationale to clarify that patients should be encouraged to manage this condition with long term use of over the counter products.

Mild dry skin/sunburn/sun protection - The British Association of Dermatologists (BAD) advised that mild dry skin and sunburn be separated out, rather than being classified as a single condition. The clinical working group agreed that it would be sensible to separate this out into three separate conditions - mild dry skin, sunburn due to excessive sun exposure, and sun protection - with the overall recommendation for each remaining the same. This increases the number of conditions to 35.

Nappy Rash - The clinical working group agreed that the rationale should be refined to clarify that this condition usually clears up after about three to seven days if recommended hygiene tips are followed.

Ring worm/Athletes Foot – following feedback the clinical working group agreed that lymphoedema or history of lower limb cellulitis should be included as an exception for this condition.

As a result of what we heard, the joint clinical working group did not feel it necessary to amend the proposed recommendations for any remaining conditions or items.

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

This guidance is intended to encourage people to self-care for minor illnesses as the first stage of treatment. It is envisioned that in most cases (unless specified) these minor conditions will clear up with appropriate self-care. If symptoms are not improving or responding to treatment, then patients should be encouraged to seek further advice.

When implementing this guidance, CCGs will need to supply patients with better information on signposting so that they are able to access the right service. This guidance is not intended to discourage patients from going to the GP when it is appropriate to do so.

To note that for vitamins, minerals, probiotics and those self-limiting conditions where there is limited evidence of clinical effectiveness for the treatments used (e.g. OTC

items for cough, sore throat and infant colic), then the general exceptions do not apply. Specific exceptions are included (if applicable) under the relevant item and/or condition. This may need to be considered further when implementing the guidance locally.

This guidance applies to all patients, including those who would be exempt from paying prescription charges, unless they fall under the exceptions outlined.

CCGs will need to 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.**

CCGs will also need to take account of their latest local Pharmaceutical Needs Assessment (PNA) and consider the impact of this guidance on rural areas and dispensing doctors in particular.

General Exceptions to the Guidance:

There are however, certain scenarios where patients should continue to have their treatments prescribed and these are outlined below:

- Patients prescribed an OTC treatment for a long term condition (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).
- For those patients that have symptoms that suggest the condition is not minor (i.e. those with red flag symptoms for example indigestion with very bad pain.)
- Treatment for complex patients (e.g. immunosuppressed patients).
- Patients on prescription only treatments.
- 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.
- 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 condition.
- Circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care.
- Individual patients where the clinician considers that their ability to self-manage is compromised as a consequence of medical, mental health or significant social vulnerability to the extent that their health and/or wellbeing could be adversely affected, if reliant on self-care. To note that being exempt from paying a prescription charge does not automatically warrant an exception to the guidance. Consideration should also be given to safeguarding issues.

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. MHRA 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 the guidance to CCGs on prescribing in 35 conditions that have been identified as being suitable for self-care and the 2 items based on the latest available evidence and the clinical consensus that has been reached by our joint clinical working group.

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 earlier.

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 usually 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 commissioning guidance *Conditions for which over the counter items should not routinely be prescribed in primary care*.

4 Recommendations

Our final recommendations for the 35 minor conditions and two items of limited clinical effectiveness are listed below.

4.1 Items of limited clinical effectiveness

4.1.1 Probiotics

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 Public Health England C.difficile guidance and NICE CG 84 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"> 1. Public Health England C.difficile guidance 2. NICE CG 84:Diarrhoea and vomiting caused by gastroenteritis in under 5s: diagnosis and management 3. PrescQIPP CIC: Probiotics
Recommendation	Advise CCGs that probiotics should not be routinely prescribed in primary care due to limited evidence of clinical effectiveness.
Exceptions	ACBS approved indication or as per local policy.

4.1.2 Vitamins and minerals

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 Authority (MHRA) to confirm their quality, safety and efficacy before reaching the market.</p>

	<p>Any prescribing not in-line with listed exceptions should be discontinued.</p> <p>This guidance does not apply to prescription only vitamin D analogues such as alfacalcidol and these should continue to be prescribed.</p>
References	<ol style="list-style-type: none"> 1) PrescQIPP bulletin 107, August 2015; the prescribing of vitamins and minerals including vitamin B preparations (DROP-list) 2) NHS Choices: Supplements, Who Needs Them? A behind the Headlines Report, June 2011 3) NHS Choices: Do I need vitamin Supplements? Accessed October 2017 4) Healthy Start Vitamins
Recommendation	<p>Advise CCGs that vitamins and minerals should not be routinely prescribed in primary care due to limited evidence of clinical effectiveness.</p>
Exceptions	<p>Medically diagnosed deficiency, including for those patients who may have a lifelong or chronic condition or have undergone surgery that results in malabsorption. Continuing need should however be reviewed on a regular basis.</p> <p><i>NB maintenance or preventative treatment is not an exception.</i></p> <p>Calcium and vitamin D for osteoporosis.</p> <p>Malnutrition including alcoholism (see NICE guidance)</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

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"> 1. NHS Choices: Sore Throat- accessed October 2017 2. NICE CKS: Sore Throat - Acute accessed October 2017
Recommendation	Advise CCGs 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	'Red Flag' symptoms

4.2.2 Infrequent cold sores of the lip

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>
References	<ol style="list-style-type: none"> 1. NHS Choices: Cold sore (herpes simplex virus) accessed October 2017 2. NICE CKS: Herpes Simplex Oral accessed October 2017
Recommendation	Advise CCGs 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	Immunocompromised patients. 'Red flag' symptoms

4.2.3 Conjunctivitis

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"> • In severe bacterial cases, antibiotic eye drops and eye ointments can be used to clear the infection. • Irritant conjunctivitis will clear up as soon as whatever is causing it is removed. • Allergic conjunctivitis can usually be treated with anti-allergy medications such as antihistamines. The substance that caused the allergy should be avoided. <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. Public Health England (PHE) advises that children with infective conjunctivitis do not need to be excluded from school, nursery or child minders, and it does not state any requirement for treatment with topical antibiotics.</p>
References	<ol style="list-style-type: none"> 1. NHS Choices: Conjunctivitis accessed October 2017 2. NICE CKS: Conjunctivitis - Infective accessed October 2017 3. PHE Advice for schools: September 2017 4. NICE Medicines evidence commentary: conjunctivitis and inappropriate prescribing.
Recommendation	Advise CCGs 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	'Red Flag' symptoms

4.2.4 Coughs and colds and nasal congestion

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"> 1. NHS Choices: Common Cold accessed October 2017 2. NICE CKS: Common Cold accessed October 2017

	3. PrescQIPP: Coughs and Colds.
Recommendation	Advise CCGs 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	'Red Flag' symptoms

4.2.5 Cradle Cap (Seborrhoeic dermatitis – infants)

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"> 1. NHS Choices: Cradle Cap accessed October 2017 2. NICE CKS: Seborrhoeic dermatitis accessed October 2017
Recommendation	Advise CCGs 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	If causing distress to the infant and not improving

4.2.6 Haemorrhoids

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"> 1. NHS Choices: Haemorrhoids accessed October 2017 2. NICE CKS: Haemorrhoids accessed October 2017
Recommendation	Advise CCGs 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	'Red Flag' symptoms

4.2.7 Infant Colic

Annual Spend	c.<£100,000
Rationale for recommendation	<p>As colic eventually improves on its own, medical treatment isn't usually recommended.</p> <p>There are some over-the-counter treatments available that could be tried however; there is limited evidence for the effectiveness of these treatments.</p>
References:	<ol style="list-style-type: none"> 1. NHS Choices: Colic accessed October 2017 2. NICE CKS: Colic Infantile accessed October 2017 3. PrescQIPP: Infant Colic
Recommendation	Advise CCGs 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	'Red Flag' Symptoms

4.2.8 Mild Cystitis

Annual Spend	c. £300,000
Rationale for recommendation	<p>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.</p> <p>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.</p> <p>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.</p>
References:	<ol style="list-style-type: none"> 1. NHS Choices: Cystitis accessed October 2017 2. NICE CKS: Urinary tract infection (lower) - women accessed October 2017.
Recommendation	Advise CCGs 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	'Red Flag' symptoms

4.3 Minor Conditions Suitable for Self- Care

4.3.1 Mild Irritant Dermatitis

Annual Spend	c. £14,500,000
Rationale for recommendation	<p>Irritant 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"> 1. NHS Choices: Contact Dermatitis accessed October 2017 2. NICE CKS: Dermatitis - contact accessed October 2017
Recommendation	Advise CCGs 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

Annual Spend	c. £4,500,000
Rationale for recommendation	<p>Dandruff is a common skin condition. It can be defined as mild scaling of the scalp without itching. Dandruff isn't contagious or harmful and can be easily treated with over the counter anti-fungal shampoos.</p> <p>A GP appointment is unnecessary. Patients should be encouraged to manage mild dandruff with long term over the counter treatments.</p>
References	<ol style="list-style-type: none"> 1. NHS Choices: Dandruff accessed October 2017 2. NICE CKS: Scenario: Seborrhoeic dermatitis - scalp and beard accessed October 2017
Recommendation	Advise CCGs 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)

Annual Spend	c. £2,800,000
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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"> 1. NHS Choices: Diarrhoea accessed October 2017 2. NICE CKS: Diarrhoea - adult's assessment accessed October 2017
Recommendation	Advise CCGs 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

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"> 1. NHS Choices: Dry eye syndrome accessed October 2017 2. NICE CKS: Dry eye syndrome accessed October 2017
Recommendation	Advise CCGs 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

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"> 1. NHS Choices: Earwax build-up accessed October 2017 2. NICE CKS: Earwax Summary accessed October 2017
Recommendation	Advise CCGs 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)

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 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"> 1. NHS Choices: Hyperhidrosis accessed October 2017 2. NICE CKS: Hyperhidrosis accessed October 2017
Recommendation	Advise CCGs 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

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>Live head lice can be treated by wet combing; chemical treatment</p>

	is only recommended in exceptional circumstances and in these cases over the counter medicines can be purchased from a pharmacy. If appropriate 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.
References:	<ol style="list-style-type: none"> 1. NHS Choices: Head Lice and nits accessed October 2017 2. NICE CKS: Head Lice accessed October 2017
Recommendation	Advise CCGs 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

Annual Spend	£7,500,000
Rationale for recommendation	<p>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> <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"> 1. NHS Choices: Indigestion accessed October 2017 2. NICE CKS: Dyspepsia - proven functional accessed October 2017
Recommendation	Advise CCGs 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

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. Pharmacists can help if diet and lifestyle changes aren't helping.</p>

	<p>They can suggest an over the counter laxative. Most laxatives work within 3 days. They should only be used for a short time only.</p> <p>Laxatives are not recommended for children unless they are prescribed by a GP. This guidance applies to short term, infrequent constipation caused by changes in lifestyle or diet such as lack of water or movement or changes in diet.</p>
References	<ol style="list-style-type: none"> 1. NHS Choices: Constipation accessed October 2017. 2. NICE CKS: Constipation accessed October 2017
Recommendation	Advise CCGs 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

Annual Spend	c. £700,000
Rationale for recommendation	<p>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 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"> 1. NHS Choices: Migraine accessed October 2017 2. NICE CKS: Migraine accessed October 2017
Recommendation	Advise CCGs 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

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"> 1. NHS Choices: Insect bites and stings accessed October 2017

	2. NICE CKS: Insect bites and stings accessed October 2017
Recommendation	Advise CCGs 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

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> <p>Patients should be encouraged to manage mild acne with long term use of over the counter products.</p>
References:	<ol style="list-style-type: none"> 1. NHS Choices: Acne accessed October 2017 2. NICE CKS: Acne Vulgaris accessed October 2017
Recommendation	Advise CCGs 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

Annual Spend	c. £33,000
Rationale for recommendation	Emollients are often used to help manage dry, itchy or scaly skin conditions. Patients with mild dry skin can be successfully managed using over the counter products on a long term basis.
References:	<ol style="list-style-type: none"> 1. NHS Choices: Emollients accessed October 2017 2. NICE CKS: Eczema - atopic accessed October 2017. 3. PrescQIPP: sunscreens
Recommendation	Advise CCGs that a prescription for treatment of dry skin should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	See earlier for general exceptions.

4.3.14 Sunburn due to excessive sun exposure

Annual Spend	c. £33,000
Rationale for recommendation	Most people manage sun burn symptoms themselves or prevent symptoms developing, using sun protection, by using products

	that can easily be bought in a pharmacy or supermarket.
References:	1. NHS Choices: Sunburn accessed October 2017
Recommendation	Advise CCGs that a prescription for treatment of sunburn should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	See earlier for general exceptions.

4.3.15 Sun Protection

Annual Spend	c. £33,000
Rationale for recommendation	Most people manage sun burn symptoms themselves or prevent symptoms developing, using sun protection, by using products that can easily be bought in a pharmacy or supermarket.
References:	1. PrescQIPP: sunscreens
Recommendation	Advise CCGs that a prescription for sun protection should not routinely be offered in primary care as the condition is appropriate for self-care.
Exceptions	ACBS approved indication of photodermatoses (i.e. where skin protection should be prescribed) See earlier for general exceptions.

4.3.16 Mild to Moderate Hay fever/Seasonal Rhinitis

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. NHS Choices: Hay fever accessed October 2017 2. NICE CKS: Allergic rhinitis - Summary accessed October 2017 3. PrescQIPP: Hay fever
Recommendation	Advise CCGs 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.

4.3.17 Minor burns and scalds

Annual Spend	c. £200,000
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Rationale for recommendation	<p>Burns and scalds are damage to the skin caused by heat. Both are treated in the same way.</p> <p>Depending on how serious a burn is, it is possible to treat burns at home.</p> <p>Antiseptic creams and treatments for burns should be included in any products kept in a medicine cabinet at home.</p>
References:	<ol style="list-style-type: none"> 1. NHS Choices: Burns and Scalds accessed October 2017. 2. NICE CKS: Burns and scalds accessed October 2017
Recommendation	Advise CCGs 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	<p>See earlier for general exceptions.</p> <p>No routine exceptions have been identified.</p> <p>However more serious burns always require professional medical attention. Burns requiring hospital A&E treatment include but are not limited to:</p> <ul style="list-style-type: none"> • all chemical and electrical burns; • large or deep burns; • burns that cause white or charred skin; • burns on the face, hands, arms, feet, legs or genitals that cause blisters.

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

Annual Spend	c. £38,200,000
Rationale for recommendation	<p>In most cases, headaches, period pain, mild fever and back pain can be treated at home with over-the-counter painkillers and 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 conditions 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"> 1. NHS Choices: Living with Pain accessed October 2017. 2. NHS Choices: Your medicine cabinet 3. NICE CKS: Mild to Moderate Pain accessed October

	4. 2017 PrescQIPP:analgesia resources
Recommendation	Advise CCGs 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.

4.3.19 Mouth ulcers

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:	1. NHS Choices: Mouth ulcers accessed October 2017. 2. NICE CKS: Aphthous ulcer accessed October 2017
Recommendation	Advise CCGs 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.

4.3.20 Nappy Rash

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 to seven days if recommended hygiene tips are followed.
References:	1. NHS Choices: Pregnancy and baby - Nappy Rash accessed October 2017 2. NICE CKS: Nappy rash accessed October 2017
Recommendation	Advise CCGs 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.

4.3.21 Oral Thrush

Annual Spend	c. £4,500,000
Rationale for recommendation	<p>Oral Thrush is a minor condition that can be treated without the need for a GP consultation or prescription in the first instance.</p> <p>It is common in babies and older people with dentures or those using steroid inhalers.</p> <p>It can easily be treated with over the counter gel.</p>
References:	<ol style="list-style-type: none"> 1. NHS Choices: Oral Thrush (adults) accessed October 2017 2. NHS Choices: Oral Thrush (babies) accessed October 2017 3. NICE CKS: Candida Oral accessed October 2017
Recommendation	Advise CCGs 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.

4.3.22 Prevention of dental caries

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. Some higher fluoride toothpastes (~1500 ppm) and mouthwashes can be purchased over the counter.
References:	<ol style="list-style-type: none"> 1. NHS Choices: Tooth Decay accessed October 2017. 2. PrescQIPP: Dental products
Recommendation	Advise CCGs 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.

4.3.23 Ringworm/Athletes foot

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</p>

	contagious and easily spread so it is important to practice good foot hygiene.
References:	<ol style="list-style-type: none"> 1. NHS Choices: Athletes Foot accessed October 2017. 2. NHS Choices: Ring Worm accessed October 2017 3. NICE CKS: Fungal Skin Infection - Foot accessed October 2017
Recommendation	Advise CCGs 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	Lymphoedema or history of lower limb cellulitis. See earlier for general exceptions.

4.3.24 Teething/Mild toothache

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 whilst awaiting a dental appointment for further investigation.</p>
References:	<ol style="list-style-type: none"> 1. NHS Choices: Toothache accessed October 2017. 2. NICE CKS: Teething accessed October 2017
Recommendation	Advise CCGs 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.

4.3.25 Threadworms

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</p>

	swallow. Strict hygiene measures can also help clear up a threadworm infection and reduce the likelihood of reinfection Everyone in the household will require treatment, even if they don't have symptoms.
References:	1. NHS Choices: Threadworms accessed October 2017 2. NICE CKS: Threadworm accessed October 2017
Recommendation	Advise CCGs 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.

4.3.26 Travel Sickness

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	1. NHS Choices: Travel Sickness accessed October 2017. 2. Patient info: Travel Sickness accessed October 2017
Recommendation	Advise CCGs 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.

4.3.27 Warts and Verrucae

Annual Spend	c. £900,000
Rationale for recommendation	Most people will have warts at some point in their life. They are generally harmless and tend to go away on their own eventually. Several treatments can be purchased from a pharmacy to get rid of warts and verrucae more quickly if patients require treatment.
References:	1. NHS Choices: Warts and Verruca's accessed October 2017. 2. NICE CKS: Warts and Verrucae References accessed October 2017
Recommendation	Advise CCGs 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.

Appendix 1 - Conditions for which prescribing should be restricted

1. Probiotics
2. Vitamins and minerals
3. Acute Sore Throat
4. Infrequent Cold Sores of the lip.
5. Conjunctivitis
6. Coughs and colds and nasal congestion
7. Cradle Cap (Seborrhoeic dermatitis – infants)
8. Haemorrhoids
9. Infant Colic
10. Mild Cystitis
11. Mild Irritant 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
24. Sunburn
25. Sun Protection
26. Mild to Moderate Hay fever/Seasonal Rhinitis
27. Minor burns and scalds
28. Minor conditions associated with pain, discomfort and/fever. (e.g. aches and sprains, headache, period pain, back pain)
29. Mouth ulcers
30. Nappy Rash
31. Oral Thrush
32. Prevention of dental caries
33. Ringworm/Athletes foot
34. Teething/Mild toothache
35. Threadworms
36. Travel Sickness
37. 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	Emollient creams, ointments and lotions
Sunburn/Sun Protection	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

WOLVERHAMPTON CCG

GOVERNING BODY

8 May 2018

Agenda item 9

TITLE OF REPORT:	NHS England Consultation on Gluten Free Prescribing
AUTHOR(s) OF REPORT:	Hemant Patel, Head of Medicines Optimisation
MANAGEMENT LEAD:	Sally Roberts, Chief Nurse and Director of Quality
PURPOSE OF REPORT:	This report requests the Governing Body support the principle on Gluten Free (GF) Prescribing. To support the GP members views with respect to implementation. To acknowledge the legal advice provided by Mills & Reeve.
ACTION REQUIRED:	<input checked="" type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	Public. The outcome will be uploaded onto the consultation website
KEY POINTS:	<ul style="list-style-type: none"> • NHS England has completed a consultation exercise on developing guidance for CCGs on Gluten Free Prescribing in Primary Care. • The guidance aims to reduce unwarranted variation by providing clear guidance to CCGs on Gluten Free Prescribing in Primary Care to ensure that best value is obtained from prescribing budgets. • Governing Body are asked to consider the evidence supplied in order to support the recommendations made . • Mills & Reeve advice is to undertake a degree of engagement and involvement with patients and clinicians.
RECOMMENDATION:	That the Governing Body <ol style="list-style-type: none"> 1) Support the principle outcome of the NHS England consultation on Gluten Free Prescribing in Primary Care. 2) Await further national review, expected Dec 2018 with regards restriction of additional products.
LINK TO BOARD ASSURANCE FRAMEWORK	



AIMS & OBJECTIVES:	
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. Wolverhampton CCGs has historically supported the coeliac society recommendations with regards the availability of healthy Gluten Free foods and fall in line with the recommending number of units of GF foods available on prescription. NHS England has undertaken a national consultation on the development of guidance for CCGs on Gluten Free Prescribing in primary care. A public consultation was launched on 31st March 2017 and was open for submission of responses to 22nd June 2017. The outcome was published on 31st January 2018 and is available on the NHS England website
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/678181/report_of_responses_-_gluten_free_food_prescribing_consultation.pdf
- 1.2. The Government reported in January 2018 that the preferred option was to retain a limited range of bread and mix products on prescription. Accordingly, biscuits, cereals, grains/flours and pasta will no longer be available on prescription and will be removed from the Drug Tariff. Policy officials will engage with key stakeholders to ensure that the range of products that remain in Part XV of the Drug Tariff will be cost effective for NHS prescribing and provide patients with basic provisions to support adherence to a GF diet.
- 1.3 Legal advice states once the regulations have been amended, the CCG will be required to implement them.

- 1.4 The CCG should await the impact of the regulatory changes before proceeding with a full patient consultation exercise on further restriction of Gluten Free prescribing. The CCG currently spends £164K on GF prescribing. With regulatory changes adopted the potential overall annual saving will be £56k. In addition the department of health are working with manufacturers and patients to produce a finite list which aims to reduce the spend further, this is likely to be regulatory in application and is expected to be completed in Dec 18
- 1.5 During the NHSE consultations on GF prescribing in Primary Care, WCCG advertised the consultations to the Wolverhampton public on the CCG website, via a featured article on the home page, which linked directly to the NHSE consultation web pages. With the support of CSU Communication and Engagement Team, the CCG will be making practices and patients aware of the recommendations and proposed changes and supporting the transition.

2. NHS England Consultation outcome

- 2.1 The consultation sought views on three options:

Option 1: Make no changes to the National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations 2004.

Option 2: To add all GF foods to Schedule 1 of the above regulations to end the prescribing of GF foods in primary care.

Option 3: To only allow the prescribing of certain GF foods (e.g. bread and flour) in primary care, by amending Schedule 1 of the above regulations.

The health minister preferred option 3, to restrict prescribing to certain GF products. This is likely to result in retaining a smaller range of bread and mixes, as the preferred product types following the consultation. To implement changes to the availability of GF foods requires the amendment of Schedule 1 to the National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations 2004, and amending the list of approved GF products in Part XV of the Drug Tariff.

2.2 Equality and Health Inequalities

An Equality and Health Inequalities Assessment (EHIA) has been undertaken.

Detailed information can be found at <https://www.england.nhs.uk/about/equality/>

3 CLINICAL VIEW

- 3.1 Local discussions with Governing Body members have fully supported the recommendations made within this report.

PATIENT AND PUBLIC VIEW

- 3.2 The national consultation received nearly 8K responses seeking public and patient views on this matter and the CCG had made the link to the consultation available on its website. Further restriction of any GF foods will require local consideration for consultation.

4 KEY RISKS AND MITIGATIONS

- 4.1 Potential reputational damage, however, this is mitigated by national regulatory requirement.
- 4.2 Potential for additional prescribing of allowable foods, however, this is mitigated by support for the transition and audit.

5 IMPACT ASSESSMENT

Financial and Resource Implications

- 5.1 Proposed QIPP saving of £56k (Annual saving).

Quality and Safety Implications

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

Equality Implications

- 5.3 An Equality and Health Inequalities Assessment (EHIA) has been undertaken. Detailed information can be found at <https://www.england.nhs.uk/about/equality/>

Legal and Policy Implications

- 5.4 The NHS England Commissioning recommendations will be implemented by means of legislation, thus it must be complied with by CCGs because it is law.

Other Implications

- 5.5 The guidance will impact positively on Medicines Optimisation and the prescribing budget.

Name Hemant Patel
Job Title Head of Medicines Optimisation
Date: 25 April 2018

ATTACHED:

NHS England Consultation Document Report of Responses Following the Public Consultation on Gluten Free Prescribing

Mills & Reeve - Advice in relation to the implementation of results of national consultations relating to prescribing

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View & GP member group	GP Members Dr Stone	31/01/18 17/04/18
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	Sally Roberts	19/04/18
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.)	As per report	
Any relevant data requirements discussed with CSU Business Intelligence	N/a	
Signed off by Report Owner (Must be completed)	Hemant Patel	25/04/2017



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Report of Responses Following the Public Consultation on Gluten Free Prescribing

Availability of Gluten Free Food on Prescription in
Primary Care

DH ID box
Title: Report of responses following the public consultation on gluten free prescribing
Author: /Medicines and Pharmacy Directorate/Medicines, Regulation and Prescribing Branch/PPL/17080
Document Purpose: Corporate Report
Publication date: January 2018
Target audience: Professional and representative bodies GPs Clinicians Pharmacists Patient Associations Members of the public Managers Commissioners Directors of Public Health Clinical Commissioning Groups
Contact details: Medicines, Regulation and Prescribing Branch, Department of Health & Social Care, Room 2E14, Quarry House Quarry Hill, Leeds, LS2 7UE

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[Department of Health & Social Care](#)

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Executive summary

The Department of Health & Social Care launched a public consultation to seek views on whether or not to make any changes to the availability of gluten free (GF) foods that can be prescribed in primary care.

Staple GF foods are available on prescription to patients diagnosed with gluten sensitivity enteropathies, and have been since the late 1960s when the availability of GF foods was limited. GF foods are now readily available in supermarkets and a wider range of naturally GF food types are now available, so the ability of patients to obtain these foods without a prescription has greatly increased.

Changes to the prescribing of GF foods could save NHS resources and reduce the primary care prescription drugs bill by up to £22.4 million per annum¹.

Many Clinical Commissioning Groups (CCGs) now have limited types or units of GF foods available on prescription². A number of CCGs provide only bread and flour; several have stopped prescribing all GF foods. CCGs were set up to ensure that their local populations receive the medicines and treatments they require, with locally managed resources. Differing approaches to the availability of GF foods is creating regional variations across England.

A public consultation was launched on 31st March 2017 and was open for submission of responses to 22nd June. The consultation sought views on three options:

- Option 1: Make no changes to the National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations 2004.
- Option 2: To add all GF foods to Schedule 1 of the above regulations to end the prescribing of GF foods in primary care.
- Option 3: To only allow the prescribing of certain GF foods (e.g. bread and flour) in primary care, by amending Schedule 1 of the above regulations.

This report provides information about the consultation responses and the analysis undertaken, additional evidence that supported the Impact Assessment has been incorporated into the Impact Assessment which is published separately alongside this report.

The health minister's preferred option is option 3 - to restrict prescribing to certain GF products. This is likely to result in retaining a smaller range of bread and mixes, as the preferred product types following the consultation.

To implement changes to the availability of GF foods requires the amendment of Schedule 1 to the National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations 2004, and amending the list of approved GF products in Part XV of the Drug Tariff.

¹ Prescription Cost Analysis (England) 2016

² CCG websites and <https://www.coeliac.org.uk/gluten-free-diet-and-lifestyle/prescriptions/prescription-policies/>

1. Introduction

- 1.1. The Department of Health & Social Care (DHSC) launched a public consultation to seek views on whether any changes should be made to prescribing legislation on GF foods. A range of options were set out in the consultation document, which included ending the prescribing of GF foods by adding them to the Schedule 1 to the National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations 2004, or restricting their availability by way of amending these Regulations. Schedule 1 is commonly known as the blacklist, and GPs are not permitted to prescribe products from this list at NHS expense.
- 1.2. In certain conditions some food and cosmetic preparations have the characteristics of drugs; these are known as "borderline substances" and include GF foods. Individual GF food products are submitted by manufacturers for inclusion in the Drug Tariff for consideration by the Advisory Committee on Borderline Substances (ACBS). The committee recommends products for inclusion on the Drug Tariff based on product type and cost effectiveness, indicating their suitability to be prescribed in primary care.
- 1.3. GF foods are prescribed for people suffering from established gluten sensitive enteropathies, which include coeliac disease. When someone has coeliac disease their small intestine becomes inflamed if they eat food containing gluten. This reaction to gluten makes it difficult for them to digest food and nutrients. Gluten is found in foods that contain wheat, barley and rye (such as bread, pasta, cakes and some breakfast cereals). Screening for coeliac disease involves a two-stage process; a blood test to help identify people who may have coeliac disease and a biopsy to confirm the diagnosis. For patients who may have dermatitis herpetiformis (an itchy rash caused by gluten intolerance) a skin biopsy may be taken to confirm it.
- 1.4. Staple GF foods have been available on prescription to patients diagnosed with gluten sensitivity enteropathies since the late 1960s when the availability of GF foods was limited. GF foods are now readily available in supermarkets and a wider range of naturally GF food types are available, meaning that the ability of patients to obtain these foods without a prescription has greatly increased.
- 1.5. Many CCGs have made changes to local prescribing formularies and have restricted or ended supply of GF food³. This regional variation is leading to inequality of access. The prescribing position in CCGs in England (July 2017) is shown in Table 1. This concern was reflected in responses from many patients and other respondents. See Chapter 4.

Table 1 - CCG Prescribing Status

Prescribing Arrangements (July 2017)	Number of CCGs
Following Coeliac UK guidelines	78
Ended all GF foods on prescription (for all patients)	25

³ <https://www.coeliac.org.uk/gluten-free-diet-and-lifestyle/prescriptions/prescription-policies/>

Report of Responses Following the Public Consultation on Gluten Free Prescribing

No restrictions	4
Other restrictions (type, quantities)	102

- 1.6. The national charity - Coeliac UK⁴ - provides advice and guidance to patients with coeliac disease on following a GF diet, and has a range of resources to support them. They provide recommendations on the units of GF foods that patients should be prescribed based on their gender, age and whether they are pregnant or breastfeeding. CCGs often use these guidelines to inform local prescribing formularies.
- 1.7. The consultation document set out three options which were:
- Option 1: Make no changes to the National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations 2004.
 - Option 2: To add all GF foods to Schedule 1 of the above regulations to end the prescribing of GF foods in primary care.
 - Option 3: To only allow the prescribing of certain GF foods (e.g. certain types of bread and flour) in primary care.
- 1.8. DHSC launched the consultation on 31st March 2017 and it closed on 22nd June 2017. It received 7941 responses. These included 7549 online responses, 250 e-mails, and 142 letters/paper response forms.
- 1.9. These responses have been read and evaluated and this report summarises the main themes that emerged and provides a breakdown of responses and respondent type.

⁴ <https://www.coeliac.org.uk/home/>

2. Awareness and Engagement Activities

- 2.1. The Department decided to consult on the proposals to change the prescribing of GF foods given the potential impact on patients.
- 2.2. As part of awareness and engagement activities policy officials wrote to a range of organisations, which included, Coeliac UK, the British Specialist Nutrition Association (BSNA), and the Royal College of General Practitioners, to inform them of the public consultation. This encouraged a wide response rate from a range of organisations, patients and interested stakeholders.
 - 2.2.1. Stakeholder meetings were held with Coeliac UK and the BSNA, along with representatives from Juvella and Glutafin (suppliers of GF foods).
 - 2.2.2. Telephone discussions took place with 18 representatives from CCGs; some of which covered multiple and/or regionally clustered CCGs. Many CCGs had already made local changes to the prescribing of GF foods and some shared their findings from local consultation exercises. A couple of CCGs were able to share their analysis on patient impact when changes had been made in previous years.
- 2.3. The consultation was run on the Gov.UK digital platform and the GF page had 14277 hits during the live consultation period. Policy officials shared a link to the GF page with key stakeholders. In addition the Department's communication team utilised "Twitter" to publicise the consultation.
- 2.4. The national charity, Coeliac UK, promoted the consultation and encouraged their members to respond, they included a link on their website which enabled patients to locate the consultation and submit responses as patients or parents/carers of patients.
- 2.5. The British Dietetic Association (BDA) also promoted the consultation and encouraged its members to submit a response.
- 2.6. Correspondence was received from Members of Parliament on behalf of their constituents, although this mainly related to changes made at CCG level and did not directly relate to the national consultation. In our responses to such correspondence we included a link to the national consultation to enable correspondents to respond.
- 2.7. NHS England (NHSE) announced their plans to review provision of items which should not routinely be prescribed in primary care; they launched a public consultation⁵ which closed on 21st October, this referenced the DHSC GF consultation. We will continue to work with NHSE, NHS Clinical Commissioners (NHSCC), CCGs, patients and industry on next steps.

⁵ https://www.engage.england.nhs.uk/consultation/items-routinely-prescribed/supporting_documents/Consultation%20Items%20not%20routinely%20prescribed%20in%20primary%20care%20FINAL1809.pdf

3. Summary of Responses

- 3.1. A total of 7941 responses were received, of these 7549 were submitted on-line; 250 via e-mail to a dedicated GF mailbox, and 142 postal response forms/letters.
- 3.2. The Department's aim was to seek views from a wide range of interested parties, it was not a straight forward "vote" based upon numbers answering "yes" or "no" to the pre-determined questions. The response form was designed to allow respondents to state a "yes" or "no" answer and add the context of their response through an explanatory narrative. The following paragraphs show in detail the number of responses for each question, and a full evaluation follows in Chapter 4. Please note not all respondents answered every question.

Table 2: Q1 Do you think that GF foods should be available on prescription?

	Yes	No	Not Answered	Total
Number	6459	1456	26	7941
Percentage	81.3%	18.3%	0.3%	

Table 3 - Q2 Do you think GF prescribing should be restricted to certain foods?

	Yes	No	Not Answered	Total
Number	5582	2249	110	7941
Percentage	70.3%	28.3%	1.4%	

Table 4 - Q3 Do you think the range of bread products available on NHS prescription should be limited?

	Yes	No	Not Answered	Total
Number	3737	4062	142	7941
Percentage	47.1%	51.2%	1.8%	

3.3. Respondents were asked to select a "respondent type" from a drop down menu which they felt closely matched their stakeholder type. The responses were categorised into "respondent type" as follows:

Table 5 - Respondent Type and Numbers

Respondent Type	Number of Responses
Charity	2
Clinical Commissioning Group (CCG)	125
GP Practice	10
Health Professional	1150
Member of the Public	259
Other	131
Other NHS Organisation	83
Parent/Family Member	712
Patient	5420
Private Company/Manufacturer	35
Professional Association	14

A breakdown of replies to questions, by respondent type, is contained in Annex A.

4. Evaluation of Responses

Literature Review

- 4.1. As part of the consultation process policy officials undertook a review of the information provided. This involved; accessing information contained in journal articles, reading and reviewing content, reviewing website content, summarising key points and relevance by theme. Literature was collated and scrutinised for relevant and factual information linking to the evidence requested in the consultation stage Impact Assessment.
- 4.2. Many of the key stakeholders provided comprehensive referencing to support information provided, this was reviewed and is contained in the updated Impact Assessment. Issues relating to health inequalities have been included in a separate Equality Impact Assessment (EqIA) document.
- 4.3. Both these documents will be published alongside this report.

Points of common agreement

- 4.4. Several points of agreement were evident from the responses received. These have been summarised below:
 - 4.4.1. It was agreed by many respondents that Coeliac Disease (CD) is a disease state and that food is like a medicine for those patients and adherence to a GF diet is the only way of managing the condition and preventing further ill health related to CD.
 - 4.4.2. The cost to purchase formulated GF food from retail outlets is more expensive than non-formulated GF food. This is especially the case for bread products where the gap between these products is more significant.
 - 4.4.3. The quality of prescription products when compared to shop bought products can differ. Some prescription products are fortified to provide additional nutrients to patients to avoid malnutrition or vitamin deficiency.
 - 4.4.4. The availability of GF foods is not always consistent and many smaller/local shops do not always stock a range of GF food. GF food is not routinely available in food banks or budget supermarkets. For patients/parents/carers that rely on food banks, they will need to select foods that are naturally GF such as meat, fish, rice, fruit and vegetables to ensure they adhere to a GF diet.
 - 4.4.5. Patients in rural areas may depend on pharmacy deliveries for their GF foods, and may have difficulty in obtaining GF supplies from local shops.
 - 4.4.6. The shelf life of fresh bread products can lead to waste if not collected from the pharmacy in a timely manner. The patient has to rely on freezing surplus fresh bread to avoid waste as pack sizes can often contain 6 - 8 loaves.
 - 4.4.7. The local changes made by CCGs have led to inconsistencies for patients in England and this is causing inequality in access to GF food on prescription.
 - 4.4.8. There are also many different approaches between CCGs which have led to inequality of access to ranges, types or quantities of GF food available on prescription.

- 4.4.9. Some CCGs have made changes without consultation, this has excluded patients, their representatives and others from having a say in how their local services are delivered.
- 4.4.10. Pharmacies are set up and managed to issue medicines and medical supplies and are not equipped to deal with holding large stocks of foods which often have a short shelf life, or are bulky.
- 4.4.11. Out of pocket expenses (OOPE) can be significant on some GF products, especially on fresh bread. Some CCGs have managed these out of the system through alternative GF supply models.
- 4.4.12. All GF food products listed in the Drug Tariff are "branded" products, whilst some retail outlets supply generic/own brand GF products.
- 4.4.13. The ACBS "recommended" list contains staple GF products, yet prescribing data⁶ shows that luxury products such as cakes, pastries and sweet biscuits are prescribed. The majority of respondents agreed that only staple products should be available at NHS expense.

Main issues raised

- 4.5. GF foods are not consistently available in local shops or budget supermarkets. There is often unreliable stock and/or limited range in larger supermarkets, products may also have short expiry or "use by" dates. Certain brands of GF food are not available to buy in supermarkets, limiting patient choice.
- 4.6. The majority of respondents who favoured option 3 requested bread and mixes to remain on prescription due to; inconsistencies in availability, taste differences between prescription only products and those available in supermarkets, the price differences (especially bread), and accessibility, especially those who relied on pharmacy deliveries. Patients stated that GF mixes offered a more flexible option as they could be used at home to make a variety of foods.
- 4.7. Many respondents stated that the money spent on GF food could be better utilised across the NHS, and as GF food is not a medicine it should not be provided by the NHS. It was also stated that patients with other food intolerances or allergies do not get their food on prescription.
- 4.8. Parents or carers of children have requested that GF staples, especially bread, remain on prescription to prevent children feeling "different" to their peers, for example, the ability to take a packed lunch (sandwiches) to school. Some CCGs have retained GF prescribing for those under 18. Additionally this group are less likely to make their own dietary choices; this is especially the case for young children, as they rely on a parent/carer to purchase and prepare their meals. Information provided through the consultation stated that the lack of adherence to a GF diet could impact on the growth rate of children, delay puberty and make them susceptible to other auto immune conditions.

⁶ Prescription Cost Analysis (England) 2016

Key themes

- 4.9. Many free text responses were consistent across respondents from different types, e.g. patients, carers, healthcare professionals and others. These have been collated below.

Accessibility

- 4.10. It was stated by patients and carers that prescriptions form a reliable and accessible source of GF staple foods.
- 4.11. Respondents said that those without transport or housebound patients, struggled to obtain GF food and that collection or home deliveries from a pharmacy were a convenient arrangement.

Adherence to a GF Diet

- 4.12. The importance of adherence to a strict GF diet is the only way in which coeliac disease can be managed. A strict GF diet avoids ill health and additional expense of treatment on the NHS. Evidence was provided by a health professional showing that patients who consume gluten in their diet could significantly impact their longer term health. This is detrimental to society and an additional burden on the NHS.
- 4.13. Many patient respondents said that a prescription for GF food helped them to adhere to a GF diet, especially for newly diagnosed patients. Respondents stated that the prescription route meant that patients felt supported by their GP and were more likely to access an annual health review, as recommended by the National Institute for Health and Care Excellence (NICE).⁷
- 4.14. Respondents acknowledged that it was important to follow a balanced healthy diet with the right mix of carbohydrates, which often consisted of formulated GF food.

Affordability of GF foods

- 4.15. Respondents said that GF foods remain substantially more expensive than their gluten containing equivalents.
- 4.16. Many respondents reported an adverse impact on the family food shopping bill, of up to £10 per week should they have to purchase their own GF food. (Patient respondents and Coeliac UK). This was compounded if the household had more than one coeliac patient, e.g. siblings, or a parent requiring GF food.
- 4.17. As noted in the consultation document it was highlighted that the cost of GF foods to the NHS was substantially higher than what is charged in a supermarket. This is because the price the NHS pays includes an amount for dispensing fees and delivery costs, and the GF formulated prescription food is often fortified with additional nutrients that may be lacking in a coeliac patient's diet.

Appropriate use of NHS resources

- 4.18. Evidence suggests the NHS faces higher prices for formulated GF foods than patients, for example through increased delivery costs when handling fresh food (that is, pharmacies are less well-equipped to handle fresh foods than a supermarket is). Table 6, below, based on evidence from CCGs, illustrates this difference.

⁷ National Institute for Health and Care Excellence NG20 (2015) Coeliac disease: recognition, assessment and management

Table 6: Relative pricing of GF foods

Gluten-Free (GF) product	Clinical Commissioning Group (CCG)	CCG estimate of cost of GF product on prescription to the NHS	CCG estimate of cost of GF product in supermarket	Supermarket own-brand price of gluten-containing equivalent(s) ⁸
3 bags of gluten-free pasta (500g)	Herefordshire	£20.97	£5.04	£3.60
1 bag of gluten-free pasta (500g)	West Hampshire	Between £2.72 and £11.25	Between £1.35 and £2	£1.20
1 bag of gluten-free pasta (500g)	Telford	Between £3.60 and £6.60	Between £1.50 and £1.99	£1.20

- 4.19. Evidence from the CCGs suggests that the NHS pays much more than the consumer for the same gluten-free products. Upon further investigation, there is little transparency on how NHS costs are comprised. In discussion with CCGs, the general consensus was that costs are shared between the manufacturers, a dispensing fee, a pharmacy fee and a delivery charge. Again, this may mean that the costs to consumers are overestimated.
- 4.20. Many respondents stated that GF food for a coeliac patient was like a medicine and should remain on prescription. Others felt that it was not a medicine and should not be available on the NHS and that GP services should not be used as grocers.
- 4.21. Some respondents said that the money spent on GF foods could be allocated elsewhere in the NHS, and that some prescribed GF food consisted of luxury items, e.g. part-baked bread, biscuits.
- 4.22. Some respondents were surprised to hear that food could be obtained on prescription, whilst some patients with coeliac disease stated that they preferred to make their own choices of either formulated GF food, or naturally GF food, so did not obtain a prescription, but sought a wider variety in retail outlets.
- 4.23. Respondents stated that GF food costs per patient equated to approximately £180 per patient per year, making it a cheap and effective "treatment" for coeliac disease. Whilst others felt that providing any food on prescription was a waste of taxpayers' money, and this should be re-invested in other treatment areas.
- 4.24. It was noted in responses that the prescribing route was inefficient as it required the GP to review the list of ACBS approved products and vary prescriptions according to the patient's preference. This was viewed as a waste of GP time, unless an annual review was taking place.
- 4.25. GF products prescribed are "branded" products; it was felt that there should be "generic" versions available, at a pre-determined price, or a "capped" price.

⁸ Data taken from www.sainsburys.co.uk

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- 4.26. GF products, especially fresh bread have a short shelf life which can contribute to waste; this is especially the case if the patient does not collect their GF food from the pharmacy once the prescription has been fulfilled. If patients do not have the capacity to store/freeze these products this can also lead to food waste.

Availability of GF foods

- 4.27. Respondents from the patient group said that bread and flour obtained on prescription formed a large part of their staple diet. They expressed a wish to retain supplies of GF food either on prescription or via an alternative route.
- 4.28. It was stated that many local shops/convenience stores and budget supermarkets did not stock GF foods, and there was reported inconsistency in stocks in large supermarkets.
- 4.29. Others felt that GF products were now widely available in supermarkets, budget stores and on-line which enabled patients to buy their own, making the case for ending GF prescriptions.

Dietary and Nutrition Advice

- 4.30. Many patients agreed that access to dietary advice supported their ability to follow a GF diet. Some said they had either no dietary advice, or that this was limited. Those patients whose CCGs had ended the prescribing of GF foods often no longer had an annual review of their condition, unless visiting their GP for another health reason.
- 4.31. Nutritionists said that when they were involved in a patient's health care they were able to look at the whole aspect of the diet and provide specific advice about that patient's needs, which could fluctuate and be impacted by other factors, for example, another medical condition.
- 4.32. Dieticians stated that it was crucial to avoid malnourishment in patients and to ensure they had an adequate balance of nutrients to remain healthy. They reported that GF prescription food helped patients maintain a healthy diet and fortified GF food enabled patients to receive additional nutrients as opposed to requiring vitamin or mineral supplements.

Dieticians, patients and other healthcare professionals said that food labelling had improved and this helped patients make informed choices about their diets. They were concerned that without GF fortified foods patients could suffer from malnutrition.

Health costs of untreated coeliac disease

- 4.33. Coeliac patients can develop other longer term health conditions if they do not adhere to a GF diet. This would result in additional treatment costs to the NHS. An estimate of these was set out in the consultation stage impact assessment, which has been updated to reflect information submitted as part of the consultation process.
- 4.34. Respondents provided references and literature reviews to supply additional evidence which has been reviewed and evaluated as part of the updated impact assessment.

Health inequalities

- 4.35. Many respondents felt that as coeliac patients and treatment for the condition was through the provision of GF food, then they were disadvantaged when compared to patients that required a medicine or medical intervention, for another clinical indication.

- 4.36. Concerns were raised over a number of inequalities to particular groups should any changes be made to the provision of GF food on prescription. These are explored in Chapter 5, and detailed in the published Equality Impact Assessment.

Quality

- 4.37. Respondents stated that the quality of supermarket GF products varied and were often inferior to those obtained on prescription. Bread products on prescription are often fortified with additional nutrients.
- 4.38. Patients felt that the GF flour was often unusable and led to waste, many respondents stated that they preferred a GF mix which contained other ingredients and allowed them to make more palatable and flexible GF products, such as bread rolls or a loaf of bread.
- 4.39. Some respondents reported that GF formulated foods often contained higher levels of fat and/or sugar to improve their palatability which did not necessarily contribute to healthy eating.

System Abuse and Waste

- 4.40. Some respondents stated that the prescription system for GF food is inappropriately misused, and some patients; obtain quantities of GF food to feed the whole family, over order GF food and stock pile supplies, which can lead to food wastage. It was reported that some luxury items continue to be prescribed.
- 4.41. Respondents stated that some people follow a GF diet as a lifestyle choice, believing that this is a healthy diet and that this leads to dietary fads and puts at risk the availability of GF items in shops. Others felt that GF prescriptions were their entitlement and should not be restricted or ended.

Variety

- 4.42. Some patients said that it remained important for them to have choice in their GF products. Health professionals reported "taste fatigue" if patients just had the same products continuously, as such a wide variety of products should remain.

Key Stakeholder Responses

- 4.43. In response to the consultation many organisations submitted completed questionnaires or letters setting out their views and those of their members. These have been considered and evaluated as part of the analysis. The main points of their correspondence/questionnaires have been summarised by respondent.

Coeliac UK's Response

- 4.44. Coeliac UK is the largest coeliac disease charity in the world with over 60,000 members. They represent views of patients and encouraged individuals to respond to the consultation. Policy officials met with the CEO and their Director of Policy and Campaigns to hear their views, and Coeliac UK also submitted a comprehensive written response. The key points raised in Coeliac UK's response were:
- Following a GF diet is the only treatment of coeliac disease and GF prescriptions help with adherence.
 - Dietary advice to patients is inconsistent across England.
 - Following a GF diet can be financially burdensome on low income families, especially those with more than one coeliac patient in the household.

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- GF food on prescription helps address inequalities and is a cost effective means of getting staple GF foods to patients.
- A rationalisation of the GF foods in the Drug Tariff is needed.
- A competitive procurement process for GF food would deliver better value for money for the NHS.

British Specialist Nutrition Association (BSNA) Response

4.45. The BSNA represents the manufacturers of foods designed to meet the needs of people with special nutritional requirements, including GF foods. Policy officials met with the BSNA Director General and representatives from Glutafin and Juvela (manufacturers of GF food). The BSNA submitted a written response to the consultation which raised the following key points:

- GF food prescriptions are an important contribution to the successful management of coeliac disease.
- GF prescriptions should supplement the patient's diet.
- GF prescriptions provide a guaranteed reasonable supply of GF foods to assist patients in adhering to a GF diet.
- A review of the existing ACBS recommended list should be undertaken to create a simplified list of staple products.
- A core range of products should be available to support patient choice.

British Dietetic Association (BDA) Response

4.46. The BDA represents the dietetic workforce, it is a trade union and professional body representing the professional, educational, public and workplace interests of its members. Membership includes; dietitians, practitioners, researchers, educators, support workers and students. They responded to the consultation with comments as follows:

- The cost of GF food remains significantly more expensive than gluten containing standard foods, this can impact patient's adherence to a GF diet.
- The availability of GF foods can be harder to access in smaller or budget shops, especially in rural areas, where on-line delivery from supermarkets may also be limited.
- Patient's adherence rates to GF diets vary depending upon demographic, clinical and psychosocial factors. In response to a BSNA survey, out of 1000 respondents 88% agreed that receiving GF foods on prescription was important to their adherence. Contact with a healthcare professional may also suffer if GF prescriptions were not provided.
- Commercially formulated GF foods are less likely to be fortified than their prescription counterparts. Additional nutrients are essential to a coeliac patient, and the risk of nutritional deficiency and poor diet may be reduced with products available on prescription.

Royal Colleges and the Royal Pharmaceutical Society

4.47. Responses were received from The Royal College of Nursing, The Royal College of GPs, The Royal College of Physicians, The Royal College of Paediatrics and Child Health, and The Royal Pharmaceutical Society. They were not supportive of the removal of GF foods at NHS expense, though suggested other delivery models may be feasible and could make NHS cost savings. In summary their comments included:

- Certain GF foods should be available, especially to those patients on a low income, or who have reduced access, for example rural areas, limited mobility.
- GPs need to maintain their clinical judgement to identify and support the most vulnerable patients.
- There is a risk that patient health will be impacted if GF food is no longer available at NHS expense and this in turn would lead to increased costs for the NHS.
- Equal access to a GF diet should be maintained to minimise the impact of health inequalities.
- A national voucher scheme should be instigated to reflect the Scottish GF Service which is pharmacy led, thus relieving GP time and making use of community pharmacists.
- Access to expert dietary advice and guidance needs to be in place to support coeliac patients in maintaining a GF diet, in addition to improved food labelling.

5. The Public Sector Equality Duty (PSED) and Health Duties

- 5.1. When taking decisions public authorities are required to have due regard to the Public Sector Equality Duty (PSED), often referred to as the general equality duty. This duty was created by the Equality Act 2010 and came into force in April 2011. Under this duty, which is set out in section 149 of the Equality Act, those subject to the general equality duty must have due regard to the need to:
- Eliminate unlawful discrimination, harassment and victimisation
 - Advance equality of opportunity between different groups
 - Foster good relations between different groups
- 5.2. The duty to have due regard to the need to eliminate discrimination covers age, disability, sex, gender re-assignment, pregnancy and maternity, race, religion or belief and sexual orientation.
- 5.3. The Secretary of State has a duty under the NHS Act 2006 (Section 1A) to secure an improvement in the quality of services. The release of funds from any GF food prescribing would be re-deployed into other parts of the system. He also has a duty under Section 1C to reduce inequalities. The Equality Impact Assessment published alongside this document details potential impacts and mitigation of policy changes.
- 5.4. A full assessment of our statutory duties, including our PSED duties will be published which will analyse the equality issues that have emerged from the consultation responses, some of the key themes that emerged are summarised below.
- 5.5. Families who are on low incomes are likely to feel a greater impact from any changes as they may currently be eligible for free prescriptions. Some households may have multiple coeliac disease members making the increased cost to their weekly food shopping more significant.
- 5.6. It is acknowledged that bread remains a staple part of many people's diet, including patients with coeliac disease. The impact of changes to the availability of GF foods on prescription could be greater on those who are experiencing economic deprivation as GF bread remains more expensive than its gluten containing counterpart.
- 5.7. Although coeliac disease is not a disability, patients with limited mobility and the elderly may have problems obtaining non-prescription GF items as they often rely on home deliveries by pharmacies. Whilst they can purchase GF foods on-line for home delivery by a supermarket or on-line retailer, many may not be able to quickly adapt to changes to access of GF food.
- 5.8. People with additional auto immune conditions could find themselves in a situation whereby their medication to treat that condition is provided on prescription, but their GF food is not. This may impact on them visiting their GP regularly and may risk detrimental ill health.
- 5.9. Respondents from the parent/carer group raised concerns about access of GF food for children and the elderly, as these groups were more likely to have their dietary choices made for them. Elderly patients and younger children often rely on GF prescriptions to support their meals which may be prepared by a parent or carer.

6. Alternative Delivery Models

6.1. As part of the consultation a number of organisations suggested alternative delivery models to ensure that patients continued to have access to GF food at NHS expense. These alternative delivery models are listed below.

Non-prescription route (Vouchers)

- Supermarket voucher scheme (pre-paid card) e.g. Vale of York CCG
- Pharmacy voucher scheme ("prescription" voucher) e.g. Rotherham CCG
- Healthy Start Scheme NHS voucher, this is a means tested voucher to provide milk, fruit and vegetables, infant formula and vitamins.

Supply chain improvements

- Supply chain improvement (to avoid Out of Pocket Expenses (OOPE)) and improved procurement by NHS

Dietetic Service

- A GF supply service led by dieticians who understand nutritional requirements for patients at their various life stages, this would ensure that nutrition was adapted to that individual's needs. Any health issues could be quickly identified and referred to other appropriate services.

Revised Prescription (FP10)

- Changes to quantity, costs, patient type, or product type in any combination (see chapter 7).
- Generic prescription wording e.g. "GF food item - x units". Patients could decide which staple GF item to obtain.

The advantages and disadvantages of these alternatives are summarised in table 6.

Table 6 - Summary of Suggested Delivery Models

Option	Advantages	Disadvantages
Supermarket voucher scheme	Widely accepted in the retail sector Patient convenience Free up GP time Less prescriptions to process	Expensive administration Opportunity for fraud (e.g. not used on GF products) Could be used on non-staple GF items (conflict with healthy eating messages) Could increase demand as those who don't currently obtain prescriptions calim vouchers
Pharmacy voucher scheme	Tailored patient approach Dietetic support and advice	Separate negotiations by each CCG with pharmacies/retail outlets ⁹ Opportunity for fraud (dependent upon local scrutiny)
Healthy Start Scheme - NHS food vouchers	Means tested benefit Wide range of retailers already partake	Vouchers are for pregnant women and children under 4 - coeliac disease is not often diagnosed in very young children
Supply chain improvements	Fewer out of pocket expenses Issues of availability improved	Challenge by manufacturers Requires investment of time and resources to establish
Dietetic service	Tailored patient approach Advice and guidance to patient from nutrition expert Cost savings as based on patient need - avoid over ordering/stock piling	Workforce issues - e.g. number of NHS dieticians Requires investment of time and resources to establish
Revised prescription route (changes or generic prescribing)	Fewer products for GP to review/select Patient choice of product to suit own preferences Reduce waste Support adherence to GF diet	Restrictions for patient choice and preferences Inconsistency/confusing pharmacy dispensing e.g. 400g loaf, 525g loaf = 1 item

⁹ There is already provision in Directions for pharmacies to provide a 'gluten free food supply service' as an enhanced service.

7. Consultation - Suggested Options

7.1. The public consultation focussed on three options:

- Option 1 - Make no changes to the legislation in respect of prescribing GF foods
- Option 2 - End all prescribing of GF foods.
- Option 3 - Restrict the type of GF foods available on NHS prescription.

Option 3 focussed on the restrictions to the types of GF food that could be made to generate savings whilst ensuring patient health was not impacted.

7.2. Respondents to the consultation suggested a wide range of options that could be more flexible to meet the needs of patients and still result in savings to the drugs bill. These **suggested options** have been grouped into four areas and summarised below.

Product types

7.3. Make a reduction in the range of GF foods listed in the Drug Tariff.

7.4. To allow only ACBS approved products to be prescribed, ensuring luxury items are not prescribed.

7.5. Restrict to bread only - respondents stated that bread is a staple part of their diet and it remains the most expensive single GF formulated product when compared to gluten containing bread.

7.6. Restrict to the most popular types of products currently prescribed. The most popular items are white and brown sliced loaves.

7.7. To retain "mixes" as opposed to GF flour - patients stated that mixes were a versatile product which could be used to make a variety of products, e.g. bread rolls, pizza bases etc. and that GF flour was difficult to bake with.

Product quantities

7.8. Undertake a review of the number of GF units prescribed. As part of the consultation the majority of health professionals/clinicians stated that the national prescribing guidelines by Coeliac UK are used to decide the number of units a patient should receive on a monthly basis. Some respondents felt that this led to system abuse, (e.g. ordering their monthly entitlement even if not required), food wastage and stock-piling.

7.9. Pharmacists reported that product waste often occurred when repeat prescriptions were issued, ordered by the pharmacy and then not dispensed to the patient. This was especially the case with fresh bread products and led to waste and storage issues.

Price

7.10. Undertake a price review or price reduction in GF products listed in the Drug Tariff. A price reduction may encourage competition as happens with commercially available products. The Advisory Committee on Borderline Substances (ACBS) could be involved in a review to ensure fairness and consistency to manufacturers.

7.11. Introduce a price cap on GF products that the NHS would agree to supply, for example a maximum re-imburement price for a GF product. This could reflect an average price evaluation to ensure fairness and equity to manufacturers.

7.12. Introduce a price freeze on all GF ACBS approved products.

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- 7.13. Allocate a "lowest price" approach for all GF ACBS approved products, for all product types.
- 7.14. An option suggested by several respondents reflected that patients should contribute to the cost of their GF food, as everyone has to buy food, e.g. a part subsidy approach whereby a patient pays a contribution to the cost of their GF prescription.

Patient Status

- 7.15. Provide prescriptions for children only. Evidence provided in the consultation stated that children with coeliac disease could suffer by failing to thrive and grow, and delayed puberty. Children often have their food product purchases and meal choices made by a parent or carer. It is important that children can access a GF diet.
- 7.16. Concern was expressed by elderly patients that they rely on home deliveries of prescription items, including GF food, as mobility is an issue for them. They would be able to purchase GF foods on-line for home delivery. This patient group may take longer to adapt to any changes made in the prescribing of GF food.
- 7.17. To continue to provide prescriptions to those on low incomes. The prescription charge exemption categories already include those on certain benefits.
- 7.18. An option to provide prescriptions for those patients who have been newly diagnosed, e.g. for the first year, which would help patients adapt their diets and become accustomed to new eating habits.

Summary

- 7.19. The above options will be given further consideration to evaluate future savings.

8. Next Steps

- 8.1. The minister's preferred option is Option 3 - to retain a limited range of bread and mix products on prescription. This means that GF foods from the following categories will no longer be available for prescribing; biscuits, cereals, cooking aids, grains/flours and pasta.
- 8.2. Work will begin on amending the National Health Service (General Medical Services Contracts)(Prescription of Drugs etc.) Regulations 2004, Schedule 1, and then removing these products from the Drug Tariff.
- 8.3. Policy officials will engage with key stakeholders to ensure that the range of products that remain in Part XV of the Drug Tariff will be cost effective for NHS prescribing and provide patients with basic provisions to support adherence to a GF diet.

Annex A - Breakdown by Respondent Type

Respondents were asked to select a "respondent type" from a drop down menu which they felt closely matched their organisational type. The classification selected by the respondent has been used for the tables below.

Charity

- 2 responses:
 - Coeliac UK
 - Age UK

	Q1. Do you think GF foods should be available on prescription in primary care?	Q2. Do you think GF prescribing should be restricted to certain foods?	Q3. Do you think the range of bread products available on NHS prescription should be limited?
YES	2	2	2
NO	0	0	0
NOT ANSWERED	0	0	0

Clinical Commissioning Groups (CCGs)

- 125 responses (some responses covered more than one CCG)
- 57 CCGs were identified as responding (some unable to attribute to a CCG as location not given)

	Q1. Do you think GF foods should be available on prescription in primary care?	Q2. Do you think GF prescribing should be restricted to certain foods?	Q3. Do you think the range of bread products available on NHS prescription should be limited?
YES	18	52	78
NO	106	67	40
NOT ANSWERED	1	6	7

GP Practices

- 10 responses

	Q1. Do you think GF foods should be available on prescription in primary care?	Q2. Do you think GF prescribing should be restricted to certain foods?	Q3. Do you think the range of bread products available on NHS prescription should be limited?
YES	10	6	8
NO	0	4	2
NOT ANSWERED	0	0	0

Health Professionals

- 1150 responses
 - Pharmacists
 - Medicines management managers
 - Community nutrition groups

	Q1. Do you think GF foods should be available on prescription in primary care?	Q2. Do you think GF prescribing should be restricted to certain foods?	Q3. Do you think the range of bread products available on NHS prescription should be limited?
YES	381	674	785
NO	766	459	344
NOT ANSWERED	3	17	21

Members of the public

- 259 responses

	Q1. Do you think GF foods should be available on prescription in primary care?	Q2. Do you think GF prescribing should be restricted to certain foods?	Q3. Do you think the range of bread products available on NHS prescription should be limited?
YES	172	151	121
NO	83	90	113
NOT ANSWERED	4	18	25

Other Respondents

- 131 responses
 - Students
 - Pharmacies
 - Retired health professionals

	Q1. Do you think GF foods should be available on prescription in primary care?	Q2. Do you think GF prescribing should be restricted to certain foods?	Q3. Do you think the range of bread products available on NHS prescription should be limited?
YES	73	80	82
NO	58	51	49
NOT ANSWERED	0	0	0

“Other NHS Organisation”

- 83 responses
 - General Practices
 - Medicines management teams
 - Dietetic Services

	Q1. Do you think GF foods should be available on prescription in primary care?	Q2. Do you think GF prescribing should be restricted to certain foods?	Q3. Do you think the range of bread products available on NHS prescription should be limited?
YES	51	41	35
NO	32	41	47
NOT ANSWERED	0	0	1

Parent/Family Member

- 712 responses
 - Parents of coeliac children
 - Spouses and/or carers of patients
 - Other relatives e.g. grandparents

	Do you think GF foods should be available on prescription in primary care?	Do you think GF prescribing should be restricted to certain foods?	Do you think the range of bread products available on NHS prescription should be limited?
YES	675	496	260
NO	36	209	443
NOT ANSWERED	1	7	9

Patients:

- 5420 responses

	Do you think GF foods should be available on prescription in primary care?	Do you think GF prescribing should be restricted to certain foods?	Do you think the range of bread products available on NHS prescription should be limited?
YES	5031	4049	2346
NO	372	1313	2999
NOT ANSWERED	17	58	75

Professional Associations Responses

- 14 responses
 - Medical Royal Colleges
 - Local Pharmaceutical Committees
 - Dietetic Associations

	Q1. Do you think GF foods should be available on prescription in primary care?	Q2. Do you think GF prescribing should be restricted to certain foods?	Q3. Do you think the range of bread products available on NHS prescription should be limited?
YES	12	9	7
NO	2	1	3
NOT ANSWERED	0	4	4

Private Company/Manufacturer

- 35 responses

	Q1. Do you think GF foods should be available on prescription in primary care?	Q2. Do you think GF prescribing should be restricted to certain foods?	Q3. Do you think the range of bread products available on NHS prescription should be limited?
YES	33	21	13
NO	2	14	22
NOT ANSWERED	0	0	0

Annex B - Question and Answer

1. What is coeliac disease?

Coeliac disease (CD) is a serious medical condition where the body's immune system attacks its own tissue when gluten is eaten.

2. Is there any cure?

The only medical treatment for CD is strict adherence to a gluten-free (GF) diet for life. Gluten is not necessary for a healthy diet and patients can safely exclude it from their diet and still eat healthily without purchasing formulated foods. Naturally GF foods include meat, fish, vegetables, fruit, rice and most dairy products.

In practice, patients usually adhere to a GF diet through some combination of naturally GF food and formulated GF food both purchased privately and obtained through prescription.

3. What are the implications of not following a GF diet?

Non-adherence to GF diets among patients with gluten sensitivity enteropathies can cause serious health problems. According to NICE, those who are not following a strict GF diet are at a higher risk of long term complications, including osteoporosis, ulcerative jejunitis, intestinal malignancy, functional hyposplenism, vitamin D deficiency and iron deficiency. Other guidance, that of the British Society of Gastroenterology, identifies CD patients as being at increased risk of osteoporosis and bone fracture.

4. Why are gluten-free foods available on the NHS?

Gluten-free (GF) foods are available on prescription to patients diagnosed with gluten sensitivity enteropathies, including coeliac disease.

The original policy aim of prescribing GF foods was to encourage patients to adhere to a GF diet, when availability of formulated GF foods was limited. This helped prevent more complex health problems from developing.

As formulated GF foods (and naturally GF foods including meat, fish, vegetables, fruit, rice and most dairy products) are now available to purchase in supermarkets and other outlets, the policy objective is to make cost savings through restricting the prescribing of GF foods, whilst maintaining adherence among patients and so avoiding detrimental health effects.

5. How much does the NHS spend on the prescribing of gluten-free foods?

Data from 2016 shows that nationally the NHS spent £22.4 million on the basic cost of GF foods. This mainly related to the prescribing of staple foods such as bread, flour and pasta but also to non-staple items including biscuits, cakes and pastries which were all prescribed at NHS expense. In addition to the basic cost, there are significant on-costs for Clinical Commissioning Groups to consider in the form of dispensing fees and the cost of primary care consultations to offer prescriptions.

6. Why does the Government want to make changes to the availability of GF foods?

The main societal benefit of spending in the NHS is the provision of health gains to patients. Despite inconsistencies in the provision in some supermarkets and other food outlets, availability of GF foods is such that patients can access a range of products without a prescription. More health gains would be generated if prescribing expenditure was reduced, and the funds used elsewhere in the NHS.

Today, GF foods are available in supermarkets and other food outlets where patients can purchase items in-store or online.

The consultation presented respondents with 3 options:

Option 1: Make no changes to the National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations 2004. Under this option GF foods would continue to be prescribed in primary care at NHS expense as now.

Option 2: To add all GF foods to Schedule 1 of the above regulations to end the prescribing of GF foods in primary care. Under this option no GF foods would be available on prescription in primary care.

Option 3: To only allow the prescribing of certain GF foods (e.g. bread and flour) in primary care, by amending Schedule 1 of the above regulations.

7. What option has the Government decided upon?

The Government has decided on option 3 to restrict GF prescriptions to certain foods. This would deliver savings to the NHS and help mitigate the risk that those on lower incomes would not be able to purchase their own GF foods from retail outlets where price is often higher and availability more limited. The majority of respondents preferred this.

8. What were the common themes of the consultation?

Several common themes emerged, including:

- Affordability and range of gluten-free foods in supermarkets, particularly for those vulnerable groups on low incomes
- Adherence to a gluten-free diet
- Complications resulting from untreated coeliac disease

9. How many responses did the consultation receive?

The Department of Health & Social Care (DHSC) received almost 8,000 responses. These came from a wide range of stakeholders including patients, health care professionals, national associations, manufacturers of gluten-free foods, charities and NHS organisations.

10. What about changes already made in some Clinical Commissioning Groups (CCGs)?

It is for CCGs to decide how they commission local services to best meet the needs of their populations. Some CCGs have made changes that go beyond restricting to a staple range of products, and many have done so following patient engagement and/or consultation. They may

wish to undertake a review of their position taking into account patient feedback and the impact of their change. As a consequence they may or may not wish to adapt their position.

11. What happens next?

The DHSC will undertake work on the draft regulations which will restrict all gluten free products, with the exception of some bread and mix products. Amending the Regulations is a complex piece of work that will take some time to develop and implement.

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WOLVERHAMPTON CCG
GOVERNING BODY
8 MAY 2018
Agenda item 10

TITLE OF REPORT:	Governing Body Assurance Framework and Risk Register
AUTHOR(S) OF REPORT:	Peter McKenzie, Corporate Operations Manager
MANAGEMENT LEAD:	Mike Hastings, Director of Operations
PURPOSE OF REPORT:	To outline to the Governing Body the latest position on the CCG's Risk Management arrangements, including the latest updated Governing Body Assurance Framework (GBAF) and Corporate Risk Register.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain. Any confidential information relating to any risks has been redacted.
KEY POINTS:	<ul style="list-style-type: none"> • This report outlines the current work underway to support risk management across the CCG, including the work of the Governing Body Committees. • The Committees have been progressing reviews of risks assigned to them, identifying and escalating additional risks as appropriate. • A copy of the latest draft of the GBAF and Corporate Register are attached for the Governing Body's consideration.
RECOMMENDATION:	That the Governing Body considers the report and updated Governing Body Assurance Framework and risk profile for the CCG.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS &	This report details progress with developing the overall Board Assurance Framework and is therefore relevant to all of the aims and objectives.

OBJECTIVES:	
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1. BACKGROUND AND CURRENT SITUATION

- 1.1. The Governing Body considers the Governing Body Assurance Framework on a quarterly basis. The Audit and Governance Committee is responsible for maintaining an overview of the CCG's arrangements for managing risk and providing assurance to the Governing Body that they are operating effectively. The Committee agreed an updated version of the Risk Management Strategy in February 2018.
- 1.2. The CCG's risk management arrangements are designed to provide assurance to the Governing Body that risks to the CCG achieving its objectives are identified and effectively managed. A key element of this is the CCG's Governing Body Assurance Framework (GBAF) which outlines the overall risk to the CCG achieving each of its Corporate Objectives. This is supported by a Corporate level and Committee level risk register as well as regular risk assessment and review by teams throughout the CCG.

2. ASSURANCE FRAMEWORK UPDATE

- 2.1. The attached draft of the GBAF has been considered by the Audit and Governance Committee meeting in April 2018 and gives an update on the risk profile against each of the defined Corporate Objectives. This has been used to make an assessment for each objective based on the overall risk of it not being achieved. To support the Governing Body, an indicative score from the management team is given based on the updated risk profile, including the identified Corporate Risks which impact on the achievement of each objective. Details of the change in score from the previous assessment of the GBAF in February 2018 are provided for reference.
- 2.2. The management assessment of the overall risk level for each objective has not changed on this occasion and details of the reasons for each assessment have been provided in the narrative. This includes details of new and reducing risks associated with each objective identified at both a Corporate and committee level. The Governing Body is asked to consider and discuss whether the assessment for each objective is appropriate.
- 2.3. A key support for the development of the GBAF is the CCG's Strategic Risk Register, which includes an update on each of the identified risks, including those subject to risk reviews by the Governing Body Committees, which take place at each

meeting. The key changes to risks since the Governing Body considered the register in February are as follows:-

- **CR01 – Failure to meet QIPP targets, CR07 – Failure to meet overall financial targets & CR 18 – Failure to Deliver Long Term Financial Strategy**
As part of their review of risks, the Finance and Performance Committee have discussed the most effective way to articulate and manage risks associated with financial performance. The committee notes that as the level of risk associated with meeting financial targets may change over time as a result of in year actions. The Committee ask the Governing Body to consider the most appropriate way to manage these risks on the risk register, whether to articulate and manage the risk for the specific financial year separately on a year on year basis or to maintain a global risk, recognising that the risk level will ‘reset’ at the beginning of each new financial year.
- **CR08 – New Ways of working across the STP**
The score for this risk has been increased to 9 as a result of plans to implement new leadership arrangements for the STP. Whilst the Senior Responsible Officer has been identified, work to recruit an independent chair and programme director is still to take place.
- **CR09 – Safeguarding Compliance**
Following the closure of underlying risks associated with DBS checks and named Doctor provision by the Quality and Safety Committee the Corporate risk is recommended for closure. Quality and Safety Committee will continue to manage the residual risk associated with safeguarding provision in midwifery.
- **CR19 – Transforming Care Partnership** An additional Corporate risk associated with the Black Country Transforming Care for Learning Disabilities programme has been identified, which is supported by relevant committee risks at Finance and Performance and Quality and Safety committee. The Governing Body is asked to consider which committee should own and manage this risk.

3. COMMITTEE RISK REVIEWS

- 3.1. In addition to supporting the Governing Body with their review of the Strategic Risk Register, Committees have also 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.

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	1	2	1	0	4
Finance and Performance Committee	0	7	5	0	12
Primary Care Commissioning Committee	0	4	1	0	5
Quality and Safety Committee	1	2	1	0	4

3.3. Discussions of the risk profile at committees is becoming an embedded part of the committees operation. This includes not just discussing the risks outlined on the committee's risk register, but also considering whether risks are identified as a result of issues discussed throughout the meeting.

4. RISK MANAGEMENT ARRANGEMENTS

4.1. Following the review of risk management arrangements, staffing capacity is now in place in the Operations team and a work programme to support the implementation of the revised risk management strategy is being developed. This will include a programme of staff training, work with individual CCG teams and work with committee chairs to ensure that they are able to fulfil their responsibilities in managing risk at committees. Work also continues to ensure that the necessary technical and administrative supporting processes are working effectively.

5. CLINICAL VIEW

5.1. 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.

6. PATIENT AND PUBLIC VIEW

6.1. Not applicable for the purpose of this report.

7. KEY RISKS AND MITIGATIONS

7.1. 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.

8. IMPACT ASSEFSMENT

Financial and Resource Implications

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

Quality and Safety Implications

8.2. 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

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

Legal and Policy Implications

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

Other Implications

8.5. There are no other implications arising from this report

Name	Peter McKenzie
Job Title	Corporate Operations Manager
Date:	April 2018

ATTACHED:

GBAF and 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.

	Details/ Name	Date
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	26/04/2018
Other Implications (Medicines management, estates, HR, IM&T etc.)	Not Applicable	
Any relevant data requirements discussed with CSU Business Intelligence	Not Applicable	
Signed off by Report Owner (Must be completed)	Peter McKenzie	26/04/2018



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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 (February 2018)	Trend
1. Improving the quality and safety of the services we commission								
a. 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	CR02 - Cyber Attacks CR03 - NHS Constitutional Targets CR06 - Vocare CR09- Safeguarding Compliance CR13 - Maternity Services CR15 - CCG Staff Capacity Challenges CR19 - Transforming Care Partnership	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.	A new strategic risk associated with the Transforming Care Partnership has been identified, this follows Finance and Performance Committee and Quality and Safety Committees identifying risks associated with this programme of work. Quality and Safety Committee have also added risks associated with Mortality and Never Events to their risk register. The strategic risk associated with safeguarding compliance is recommended for closure following work to address specific risks. The risk identified by the Finance and Performance Committee associated with winter pressures has been closed. Work continues to address the concerns associated with performance associated with Vocare with the CCG maintaining a positive working arrangement.	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	↔
2.Reducing health inequalities in Wolverhampton								
a. 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	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. Governing Body is receiving assurance on the delivery of the Primary Care strategy, with groups now operating at scale and developing proposals for new services. GPs from groupings participating in discussions with secondary care colleagues to identify clinical priorities for local place based care models.	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 - 2 Impact - 3 6 Moderate	↔
b. Deliver new models of care that support care closer to home and improve management of Long Term Conditions 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 a local place based system including identifying clinical areas of priority. The CCG is equipped to take a leading role in the development of a broader integrated approach across the Black Country Health and Care economy.	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 - 2 Impact - 4 8 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 (February 2018)	Trend
3. System effectiveness delivered within our financial envelope								
a. 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.	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	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 may be tensions between delivering the CCG's own financial targets and financial metrics and planning across the footprint.	No new Strategic Risks identified. Risk around new ways of working in the STP has increased to reflect a degree of uncertainty around future leadership. The CCG's Accountable Officer has been nominated as the lead for the development of Integrated Care Systems approaches across the Black Country and the CCG is well placed to play a leading role in the broader work of the CCG. As well as leading roles in the Mental Health and Infrastructure work streams, the CCG is continuing to contribute to the development of the STP clinical strategy and the work of the Joint Commissioning Committee	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.	Likelihood - 4 Impact - 4 16 Very High	Likelihood - 3 Impact - 4 12 High	Likelihood - 3 Impact - 4 12 High	↔
b. Greater integration of health and social care services across Wolverhampton 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.'	CR09 - BCF Programme CR14 - Developing Local Accountable Care Models CR17 - Failure to secure appropriate Estates Infrastructure funding	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.	No New Strategic risks identified. Committee level risks around the infrastructure required for new ways of working have been clarified and risk levels relating to the capacity of existing community based teams that support BCF outcomes have also reduced. As highlighted above, plans for a broader integrated system both locally in Wolverhampton and the wider Black Country continue.	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.	Likelihood - 3 Impact - 3 9 High	Likelihood - 2 Impact - 3 6 Moderate	Likelihood - 2 Impact - 3 6 Moderate	↔
c. 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	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	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.	No new strategic risks have been identified. The Finance and Performance Committee have raised a new risk associated with Cancer performance, which is being closely scrutinised by NHS England. Risk levels associated with CCG staff capacity and Governing Body leadership remain stable	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	Likelihood - 3 Impact - 3 9 High	Likelihood - 2 Impact - 3 6 Moderate	Likelihood - 2 Impact - 3 6 Moderate	↔
d. 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.	CR15 - CCG Staff Capacity Challenges CR17 - Failure to secure appropriate estates infrastructure investment	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	No New Strategic risks identified. Work on existing estates plans continue, with a number of primary care projects now underway. The CCG is working collaboratively with partners across Wolverhampton to develop a robust approach to Data Sharing through the Insight Shared Care Record which will enable integrated care delivery and service planning. This involves consideration of the specific information and privacy risks associated with the use of technology and the CCG and partners are working to understand these potential risks.	The CCG has a fully established IM&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.	Likelihood - 3 Impact - 3 9 High	Likelihood - 2 Impact - 3 6 Moderate	Likelihood - 2 Impact - 3 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
CR01		Failure to meet QIPP Targets 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. Update QIPP Plans in place for 2018/19 following NHSE Scrutiny of Planning Process. Work through Delivery Boards continues to ensure that progress is made to identify unallocated QIPP	12/08/2016	Mar-18	3c - Meeting our Statutory Duties (Delivery of Financial duties)	Finance and Performance	Tony Gallagher	12	High	6	Moderate	↔
CR02		Cyber Attacks 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	FP06 - Increased Activity at RWT FP13 - 62 Day Cancer Target	NHS Constitutional Targets 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 Update The Finance and Performance Committee has closed the identified risk around winter pressures and raised a new specific risk around the 62 Cancer day target, which is being closely scrutinised at NHS England level.	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
CR05		Mass Casualty Planning 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. Update 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	Vocare 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. Update CCG scrutiny of agreed recovery plan continues. Whilst Vocare are demonstrating positive commitment to improvement, challenges remain around leadership and recruitment and retention in particular. Governing Body scrutiny of progress continues	30/01/2017	Apr-18	1a - Monitoring ongoing safety and performance in the system	Quality and Safety	Sally Roberts	16	Very High	12	High	↔
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	Failure to meet overall financial targets 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 Update Financial position has been landed for 2017/18 - Governing Body are asked to consider whether a new risk for 2018/19 is opened or the existing risk is re-assessed	14/06/2016	Mar-18	3c Meeting our statutory duties (Meeting Financial duties)	Finance and Performance	Tony Gallagher	12	High	4	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
CR08	495	<p>New Ways of Working across the STP 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</p>	<p>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. Update Proposals for new STP Leadership, including an independent Chair and dedicated Programme Management support have been agreed. Work continues, including further executive discussion and participation in a national support programme for Integrated Care Systems</p>	21/06/2017	Jan-18	3a - Proactively drive the CCG's Contribution to the Black Country STP	Governing Body	Helen Hibbs	16	Very High	9	High	↑
CR09	489 - Safeguarding Midwife	<p>Safeguarding Compliance 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</p>	<p>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 Update Specific risk around DBS checks has now been closed. Residual risk around safeguarding in midwifery is being managed by Quality and Safety Committee Risk recommended for closure</p>	12/09/2017	Apr-18	1a - Monitoring ongoing safety and performance in the system	Quality and Safety	Sally Roberts	12	High	4	Moderate	↓
CR10	CC04 - Community Equipment CC10 - Community and Neighbourhood Teams	<p>BCF Programme 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</p>	<p>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. Update Section 75 Agreement for 2017/18 has now been signed to reflect agreed financial and risk share plans now in place. Committee risks relating to Community and Neighbourhood teams clarified</p>	12/09/2017	Mar-18	3b - Greater Integration of health and Social Care Services across Wolverhampton	Commissioning Committee	Steven Marshall	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
CR11	PC01- Cost of new roles in Primary Care PC02 - Primary Care Retirements	Primary Care Strategy - Workforce Issues 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	12/09/2017	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	New Ways of Working in Primary Care 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. Update 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	↔
CR13	492 - Maternity Capacity & Demand	Maternity Services 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. Update Bookings have reduced however deliveries have increased. Midwifery sickness absence rates are now improving	15/06/2017	Jan-18	1a - Monitoring ongoing safety and performance in the system	Quality and Safety	Sally Roberts	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
CR14	Relationship with Local Authority Capacity of Public Health to contribute to strategic change Relationship with local providers Complexity of financial modelling	Developing Local Accountable Care Models 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. Update Clinical discussions between GPs and Secondary Care colleagues are taking place to develop clinical priorities. Colleagues across the system are considering the financial and governance implications of changing arrangements to reflect clinical priorities.	12/09/2017	Apr-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	CCG Staff Capacity Challenges 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	12/09/2017	Jan-18	3c - Meeting our statutory duties and responsibilities	Executives	Helen Hibbs	12	High	9	High	↔
CR16		Governing Body Leadership 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.	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. Update New Governing Body Members are now in place and will be undertaking appraisals with the Chair in the near future	12/09/2017	Apr-18	3c - Meeting our statutory duties and responsibilities	Governing Body	Helen Hibbs	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
CR17	451 - Estates for Community Neighbourhood Teams Primary Care estate improvements	Failure to secure appropriate Estates Infrastructure Funding 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	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. Update 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	12/09/2017	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	Failure to Deliver Long Term Financial Strategy Recurrent Financial pressures across the system may make it difficult to deliver the CCG's financial plans for future years	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 Update Financial Plan for 18/19 now submitted showing risks of around £3.5m. Mitigations have been identified for all of these risks but the plan includes a significant QIPP target and the use of nonrecurrent contingencies to meet financial targets.	30/01/2018	Mar-18	3c - Meeting our statutory duties and responsibilities	Finance and Performance	Tony Gallagher	20	Very High	16	Very 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
CR19	FP14 - Transforming Care - Financial Impact QSC - Transforming Care - Quality Impact	Transforming Care Partnership There are a number of risks to the delivery of the Black Country Transforming Care Partnership's programme of work that cause result in a failure to deliver improvements in the quality of service for patients with Learning Disabilities	Black Country Joint Commissioning Committee has delegated authority for oversight of the programme of work across the four CCGs Programme Management for the partnership resourced by Sandwell and West Birmingham CCG with Wolverhampton AO acting as SRO Collaborative work underway to understand patient cohort and their needs Joint finance work to understand financial impacts	NEW	NEW	1a - Monitoring ongoing safety and performance in the system	TBC	Sally Roberts	16	Very High	12	High	*

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WOLVERHAMPTON CCG

Governing Body
8th May 2018

Agenda item 11

TITLE OF REPORT:	Primary Care Strategy Delivery (April 2018)
AUTHOR(s) OF REPORT:	Jo Reynolds - Primary Care Development Manager
MANAGEMENT LEAD:	Sarah Southall - Head of Primary Care
PURPOSE OF REPORT:	To provide an overview of the discussions that took place at Milestone Review Board with particular focus on two key programmes of work (Primary Care Strategy and General Practice Forward View) since the last report, presented to the Governing Body on 10 th April 2018.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This report has been prepared for consideration and discussion at the Public Governing Body Meeting.
KEY POINTS:	The Milestone Review Board last met in April and meets at quarterly intervals. This report confirms the continued pace of progress being sustained in response to both the Primary Care Strategy & General Practice Forward View.
RECOMMENDATION:	<p>The recommendations made to Governing Body regarding the content of this report are as follows:-</p> <ul style="list-style-type: none"> • Receive and discuss this report, and the programmes of work contained within it. • Note the updates provided for each work programme.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	<ol style="list-style-type: none"> 1a Improving the quality and safety of the services we commission 2 Reducing Health Inequalities 3 System effectiveness delivered within our financial envelope



1. BACKGROUND AND CURRENT SITUATION

1.1 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 to national direction & local improvement that seeks to achieve a sustainable primary care for the future. A full programme management office approach is taken for the Primary Care Strategy the GPFV programme and has been developed over a period of time based on guidance from NHS England.

2.0 Primary Care Programme(s) of Work

2.1 Primary Care Strategy

Task and Finish Group Updates are captured routinely via a series of workbooks & submitted to the Programme Office and will continue to be subject to review at monthly intervals.

The programme was reviewed, one exception was reported assocrunning 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:-

Practices as Providers Task & Finish Group	
Progress made in the last three months	Next steps for the next three months
<p>Back office functions review completed. Groups have identified which areas they wish to progress, these include subscriptions & other non-clinical support services.</p> <p>The Home Visiting service pilot project business case and service specification have been approved at Primary Care Commissioning Committee. Mobilisation of the project is anticipated towards the end of Quarter 1.</p> <p>The service specification for the 2018/19 Improving Access has been approved & implementation commenced at group level.</p> <p>Transformation Fund Service Specification has been developed with approval from PC Commissioning committee. Delivery plans are currently being finalised for consideration in May 2018.</p> <p>The QOF+ Scheme 2018/19 has been finalised & shared for consideration with a range of forums. Feedback captured and final changes made. Approval is anticipated in May, implementation will take place thereafter.</p>	<p>Launch the Home Visiting Pilot in partnership with Primary Care and Royal Wolverhampton Trust.</p> <p>Monitor & advertise opening hours in access hubs in line with new national standards.</p> <p>To launch the QOF+ 2018/19 Scheme across all practice groups to include scheme sign up and ensure monitoring is in place.</p> <p>Evaluation of the Frailty Clinic pilot project in PCH1 and make recommendations for future roll out/ development.</p> <p>To work with the Enhanced Health in Care Homes Steering Group, develop a revised service specification for an enhanced model of primary care support for Care Homes.</p> <p>Review delivery plans practice groups ie potential Diabetes Clinic aimed at patients aged 30-50 as part of the Primary Care Home 1 hub.</p>



<p>A local improvement plan for the completion of Learning Disabilities Health checks has been developed and will be monitored by the Task and Finish Group going forward. The improvement plan has been developed in collaboration with the SEND lead and Learning Disabilities Commissioner.</p> <p>Primary Care Counselling contract has been awarded with Relate (3 year contract).</p>	<p>Ensure delivery plans for NHS Health Checks are in place across all practice groups and implementation is underway focussing on improved activity.</p> <p>Scope a series of service redesign projects that have been suggested by GP colleagues on Foot Health, Audiology (self-referral) and Nursing Home referral to dietician.</p>
<p>Primary Care as Commissioners</p>	
<p>Targeted Peer Review service specification has been approved and all practice groups have a forward programme of Peer Review meetings in place for 2018/19.</p> <p>A scoping paper presented to Programme Board regarding increasing utilisation of Choose and Book Advice and Guidance. A practice training workshop took place in April including a refresher on Advice and Guidance. A business case will be prepared for June.</p> <p>The Mental Health Primary Care Steering Group are also scoping a potential service development for Advice and Guidance with BCPFT.</p> <p>Practice level dashboard(s) continue to be developed capturing a range of sources of data confirm activity/performance ie QOF, commissioned services etc.</p> <p>Workshop held with stakeholders regarding Multi Disciplinary Team Meetings, design opportunities identified and will be used to inform the content of a final draft service specification that enables structured MDT Meetings to be introduced.</p> <p>Discussions with the provider of Sound Doctor (self help video(s)) have taken place with a view to materials being available in languages other than English & utilisation/effectiveness of the service provided to date.</p>	<p>To monitor Targeted Peer Review activity on a monthly basis identifying learning / actions from each meeting. Findings will continue to be reviewed by clinical leaders.</p> <p>To ensure a regular report on Choose and Book Advice and Guidance at practice level and by clinical specialty is in place.</p> <p>To have oversight of QOF (national) activity routinely reviewed by the Task & Finish Group.</p> <p>Develop a detailed proposal for Advice and Guidance in Mental Health.</p> <p>Review the current practice level dashboard with practices and have received feedback on how the data can be used at practice/ group level.</p> <p>Finalised service specification for GP input into MDT Meetings based on outcomes from design workshop.</p> <p>Utilisation data for Sound Doctor & availability of materials in other languages.</p> <p>Implementation of practice group transformation schemes by June 2018.</p>



Workforce	
<p>Primary Care Strategy prepared, feedback obtained leading to GB approval April 2018 International GP Recruitment Application submitted February 2018 CCT Fellowship Application submitted April 2018 Training & development programme for Care Navigation, Practice Managers, HCAs Primary Care Webpage developed case studies (new roles, PPG Chair etc), videos & other content prepared, vacancy page – linked to RCGP Communications reaching out / advertising via Social media ie LinkedIn page, Twitter introduced, presence at recruitment fairs ie Wolverhampton Uni also exploring RCGP & Bham Uni etc, exhibition materials also prepared & in place Suite of job descriptions for primary care library to aid practices in recruiting to primary care roles. CEPN ££ extended by HEE beyond contract end date (8+4) Nurse Facilitator support from Dudley also confirmed. Workforce dashboard figures collated for GPs, Nursing, CP, Admin roles (NHS Digital) Secured £10k non recurring funding from Health Education England towards support in place for workforce planning.</p>	<p>Implementation of Workforce Strategy implementation of initiatives pertaining to the age profile</p> <ul style="list-style-type: none"> - channel investment - grow and develop the workforce - streamline the workload - improve infrastructure - and support practices to redesign their services to patients <p>Next steps following feedback from NHSE ie IGPR & CCT Fellowships MECC Resources due to be distributed to practices Survey of primary care staff who have attended training 2017/18 due to conclude (May 2018) & analysis report will be prepared (June WTFG). Mental Health Therapists – improve the interface between MH and PC Strengthen links with STP Local Workforce Delivery Board (LWAB) & associated sub groups. Focus on interdependencies with Contracting TFG and financial investment requirements to ensure we are working towards a sustainable primary care Commence delivery of 2018/19 work programme & monitor activity via critical path.</p>
Contracting Task & Finish Group	
<p>Primary Care Contracting Strategy is currently being developed by the Task and Finish Group. The Primary Care Advice, Support and Transformation support will continue to be provided by NHS England in addition to existing resource within the CCG. NHS England will continue to commission Direct Enhanced Services in 2018/2019. Risk Gain share approaches across the Black Country have been considered by the Task and Finish Group. Priorities for 2018/19 agreed & defined in new work programme.</p>	<p>Meeting schedule in place & Terms of Reference to be updated. Workshop on Primary Care Contracting, commissioning & finance inter-dependencies will be held to define where work programmes overlap/influence delivery. Launch 2018/19 programme of work and review risks to reflect the revised priorities/planning milestones.</p>



IT Task & Finish Group	
<p>Shared Care Record - Funding from NHS England approved and quote received from Graphnet to continue development of the solution.</p> <p>The migration planning/preparation continues in line with the CCGs programme, next system go live scheduled for May 23rd 2018.</p> <p>Project Manager to deliver E-Consultations is now in post and has commenced development of project documentation to deliver online triage and video consultation within practices identified to participate in the pilot.</p> <p>A schedule has been developed for facilitators to visit practices during March and April 2018 to encourage the uptake of patient online.</p> <p>Text Messaging solution – Two way texting has been rolled out to almost all practices, remaining sites will go live shortly.</p> <p>GP appointment access utilisation tool: Tool to be deployed centrally by NHS England.</p> <p>E-RS Workshop held for all practices, well attended.</p>	<p>Joint working with Sound Doctor to review utilisation and effectiveness .</p> <p>Text Messaging solution – complete installation/roll out to final sites and ensure that all training is completed.</p> <p>GP appointment access utilisation tool to be deployed centrally by NHS England.</p> <p>E-Consultation Solutions - Agree deployment dates with stakeholders to enable trial to commence.</p> <p>E-RS - new 2ww implementation date to be confirmed, list for PSO exclusions, continued support for practices.</p>
Estates Task & Finish Group	
<p>Void space targets have been met. On-going programme should reduce this by £100k in 2018/19</p> <p>Newbridge and East Park have now met the ETTF criteria. They are now awaiting sign off from NHSE and CCG so that their respective developments can proceed.</p>	<p>Request that NHSPS can move forward with developments on Heads of Terms</p> <p>Work with other cohort 1 schemes to finalise sign off so that they can start building work</p> <p>Complete STP workbook to add schemes to possible future developments</p>

Also at this meeting there were a series of other service development items considered, as follows:-

- Special Access Service (formerly Zero Tolerance) Business Case, Policy & Service Specification
- QOF+ Scheme 2018/19 Update
- Out of Area Patient Service Specification
- Learning Disabilities Health Checks Service Specification
- Minor Surgery Service Specification

Each item was supported and approval of funding would be sought from Primary Care Commissioning Committee in May with the exception of Learning Disabilities Health Checks & Minor Surgery as the improvement plan required no additional funding.



2.2 General Practice Forward View

The forward view comprises of 5 strands of work spanning investment, workforce, workload, infrastructure and care redesign. 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 status has been broken down as follows:

GPFV Programme of Work					
Chapter	Not Started	Achieved & Closed	In Progress	Overdue	Total Projects
1 Investment	0	6	1	0	7
2 Workforce	9	3	15	0	27
3 Workload	4	6	15	0	25
4 Infra-structure	6	6	9	0	21
5 Care Redesign	1	0	4	0	5
Total(s)	20	21	44	0	85

Appendix 1 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.

Some projects overlap with the work of Task and Finish Groups that were established to implement the primary care strategy.

2.2.1 Project Updates

A series of specific updates were provided for projects that had commenced, as follows:-

Chapter 1 - Transformation Projects 2018/19

Delivery plans are currently being prepared by practice groups to demonstrate how they will improve patient care / service delivery within their practice group(s), delivery plans are due by the end of April & projects anticipated to be up and running by the end of June. The delivery plans will also focus work pertaining to the 10 high impact actions and working at scale. Six of the high impact actions have been implemented in 2017/18 and will be maintained on an ongoing basis. The remaining 4 high impact actions will be implemented during 2018/19.

Chapter 2 - Practice Manager Training

Practice Managers have had the opportunity to take part in an RCGP session to help them focus on working at scale, and develop plans as practice groups. Unity have had their session earlier this month, with the next session for the PCH groups and VI in the coming weeks.



Chapter 2 – HCA Training

As part of the CCGs commitment to developing Health Care Assistants training in COPD/Asthma & weight management commenced in April 2018 with tissue viability & NHS Health Checks training also planned later in the programme.

Chapter 2 – Post CCT Fellowships

An application had been completed at STP level and submitted to Health Education England for consideration. The application seeks to secure 10 fellowships for newly trained GPs to work with practices across the STP, expressions of interest have been received from practices within each CCG. The outcome is anticipated in May 2018.

Chapter 2 – Leadership Development

Team Building Training for Managers working as part of a practice group has also been delivered by the RCGP to enable a series of priorities and timescales for delivery to be identified.

Chapter 2 – Clinical Pharmacists in Primary Care

As part on the ongoing introduction of practice level Clinical Pharmacists a citywide Pharmacy Peer Group has been established. The group is made up of pharmacy colleagues from a number of settings including community, hospital & general practice and have committed to reviewing the role they play in the patient pathway, familiarisation with pharmacy roles in different care settings and developing consistent patient information. The group are due to meet again in May.

Chapter 3 – Care Navigation

Evaluation has commenced of Cohort 1 pathways and scoping for Cohort 2 also underway. A further stakeholder event is planned for June 2018 and will lead to launching further pathways for Care Navigators to advise on from September 2018.

Chapter 3 – Review of QOF & Local Investment

A local scheme for 2018/19 has been developed in addition to the existing national quality outcomes framework. The local scheme will focus on priorities identified by member practices with a focus on preventing disease ie diabetes, alcohol and obesity. Funding approval is anticipated in May with a view to launch in June 2018.

Chapter 4 - Document Management/Workflow Optimisation

Service specification developed and associated impact assessments were considered & agreed in principle, business case to be considered at Primary Care Commissioning Committee in May in order for procurement to commence.

Chapter 4 - Online Consultation

Steps have been taken in the development of the pilot project which will enable both online consultations and video communication. Pilot Practices have been identified and the documentation required, such as data sharing agreements, has been developed. Both projects are anticipated to be live by May 2018.

Chapter 5 - Improving Access- Movement of deadline

At the March Regional Access group NHSE asked areas to review the delivery plans to see if any schemes could be brought forward to an earlier delivery than the October 2018 deadline. After discussion with groups, a bid was submitted to receive additional funding and has been agreed by NHS England.

Unity, VI and PCH2 have all agreed to increase their capacity to increase to 83% from July (25 mins per 1000) and 100% (30 mins/ 1000) from August onwards.

PCH2 have also agreed to move their trajectory forward, and will be providing 100% (30 mins/ 1000) from 1st September.

The revised trajectory for improving access is as follows-

Revised Trajectory					
April	May	June	July	August	September
67%	67%	67%	75%	84%	100%

Each practice group will continue to advertise opening and availability of additional appointments at their respective hub. Discussions also continue with Patient Participation Group Chairs so that they are aware, this compliments advertising on our website & local newspapers too.

3 CLINICAL VIEW

- 3.1 There are a range of clinical and non-clinical professionals involved in the delivery & oversight of both primary care programmes of work. Leadership decisions are clinically driven with representation at many Task and Finish Groups from clinicians from across the city.

4 PATIENT AND PUBLIC VIEW

- 4.1 The CCG has lay member involvement in a range of projects and forums pertaining to primary care. Patient Participation Group Chairs receive regular updates from the primary care team regarding up and coming projects & developments, their feedback is encouraged & valued. Plans are being finalised for engagement arrangements with the public for 2018/19, these will be underpinned by the CCGs Communications & Engagement Strategy.

5 RISKS AND IMPLICATIONS

Key Risks

- 5.1 The Milestone Review Board, who oversee this programme of work, 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.

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. The workforce task and finish group tracks the progress and effectiveness of the role.

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 April 2018

Appendix 1 GPFV Programme & Self Assessment 2018/19 (updated March 2018)



	Details/ Name	Date
Clinical View	S Reehana	
Public/ Patient View	S McKie	
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team	S Roberts	
Equality Implications discussed with CSU Equality and Inclusion Service	NA	
Information Governance implications discussed with IG Support Officer	NA	
Legal/ Policy implications discussed with Corporate Operations Manager	NA	
Other Implications (Medicines management, estates, HR, IM&T etc.)	NA	
Any relevant data requirements discussed with CSU Business Intelligence	NA	
Signed off by Report Owner (Must be completed)	S Marshall	26.4.18



GPFV Programme of Work					
Chapter	Total Number of Projects	Not Started	Achieved & Closed	In Progress within Timescale	Overdue and/or behind
1 Investment	7	0	6	1	0
2 Workforce	27	9	3	15	0
3 Workload	25	4	6	15	0
4 Infra-structure	21	6	6	9	0
5 Care Redesign	5	1	0	4	0
Total(s)	85	20	21	44	0

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 Citywide Pharmacy Peer Group Formed Direct Commissioning Discussions commenced	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 Pharmacy Peer Group	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 reprocured	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 Post CCT Fellowships/Portfolio Careers Practice Manager Development Programme/Diploma Extension of Clinical Pharmacy Scheme Publication of evidence about retention	Val Warr 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 training 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
1.1	Monitoring of Investment	Established liaison between NHSE & CCG at both primary care & finance level(s).		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.		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	National Allocations are made via notification to CFO & where necessary assurance reporting requested via NHSE on specific allocations.		Allocations are being made on an ongoing basis, although some are to a nominated CCG within the STP resulting in invoicing the nominated CCG. Continue with existing arrangements.	Lesley Sawrey	Mar-18	Mar-18
1.4	Carr-Hill formula review	Formula review undertaken at national level, new guidance published April 2016.		Allocations will be in line with new guidance, copy in folder for further reference.	Sarah Southall	Summer 2016	Jul-16
1.5	PMS contract reviews	PMS contracts reviewed 2017, reducing values discussed with practices affected.		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.		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
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		Mental Health Therapists Social Workers Community Neighbourhood Team	Andrea Smith	2017-20	

Legend for Current Status	
Blue	Not started
Green	Achieved & closed
Amber	In progress within timescale
Red	Overdue and/or behind scheduled timescale

**Continuity
Arrangements**

Continue with existing arrangements & close liaison with Finance colleagues.

Ensure national allocations are in line with Carr Hill Formula Review

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Practice information sharing agreements & configuration within EMIS enables full access to patient clinical records. Ensure when practice movements occur agreement & configuration arrangements are

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. IGPR Application submitted February 2018. Network with Uni(s) established, placements encouraged. Linked to retention.	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	Sarah Southall	2018/19		
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 STP Application submitted February 2018, outcome awaited	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. STP Application submitted to HEE April 2018	Sarah Southall	2018/19		
2.7	Further measure to improve work	Simplify return to work routes new portfolio route to improve retention.			Sarah Southall	2018/19		
2.8	Increase financial compensation of current retainer scheme	Targetted financial support for GPs to remain in practice.			Sarah Southall	2018/19		
2.9	Targetted financial incentives to Gps returning to work	GP Retainer Scheme Induction & Refresher Schemes			Sarah Southall	2018/19		
2.1	Publication of evidence about retention	Address concerns of workload, financial & educational support.			Sarah Southall	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.	Hemant Patel	2018/19		Benefits Realisation planned Summer 2018
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 (Feb 2018) Direct Commissioning discussions with NHSE 2018/19	Sarah Southall	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	Summer 2018		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 up		Competency Framework awaited from HEE	Sarah Southall	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.			Sarah Southall			
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.	Sarah Southall	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	NHS England manage/monitor/review effectiveness of scheme
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. Funding extended 8 Months (April to November) 2018. HEWM will be procuring at STP level 2018.	Sarah Southall	2018/19		Continuity of provision until November.

Legend for Current Status	
Blue	Not started
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Amber	In progress within timescale
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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 Stakehold engagement underway for Cohort 2 pathways Review of effectiveness of Cohort 1 Pathways May 2018	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	Sarah Southall	2017/18	Dec-18	Continued involvement in commissioning discussions/decisions.
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		Business as usual. Group Level Training Needs Analysis process.
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 - workshop held, model to be finalised.	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. Review meeting held with RWT February 18 including LMC, process working well, reduction in care queries, panel continues to meet	Sarah Southall	Apr-18		Extending good practice to Mental Health Provider - Mental Health Stakeholder Group. Continue to monitor review the effectiveness of the existing arrangements for RWT.
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 A&G Scoping Report prepared for PDB April. CASs also under development ophthalmology & cardiology	Ranjit Khular	2018/19		

3.9	New software to automate tasks	Automation of common tasks.		The CCG are scanning solutions to automate tasks. As part of this we have completed a full refresh of our automated arrival solution in practices to save receptionist time and inncrease patient flow.	Steve Cook	2018/19		GP's will continue to work as usual untill automated solutions for taskks are implemented
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			Check allocations / Contract
3.12	My NHS Indicators	A set of key sentinel indicators published July 2016.		Indicators identified & CCG dashboard in development quality, resilience & outcome indicators.	Sarah Southall	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 Khular	Apr-18		QOF monitoring arrangements being worked through with IM&T Facilitator Team. Further development of Group Level monitoring also being explored. QOF+ drafted, searches due to be created.
3.14	Simplified data reporting	Extraction of routine data to simplify reporting.		The CCG will look to use the Graphnet data repository to support reporting Requirements	Steve Cook	2018/19		The CCG will look to use the Graphnet data repository to support reporting Requirements
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		New template is in place

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 i.e. E-referral	Steve Cook	2018/19		Wolverhampton CCG are fully engaged with the Acute provider to support paper switch off all referrals being sent via E-RS Event 11 April
3.18	Electronic prescriptions	EPS in place across all practices in the city.		EPS not available for hub working, yet to be resolved.	Steve Cook	2018/19		EPS is live at all practices, GGG working to find solution to hub working
3.19	Incoming data from NHS providers, all digital	Providers will submit data to a Strategic Data Collection Systems Portal using a downloadable proforma i.e. improving access.		The CCG is working with providers to ensure they use the data Landing Portal	Steve Cook	2018/19		Work with providers to transition to new portal
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.		Project due to start in 2018	Steve Cook	2018-20		Project due to start in 2018
3.21	Automated appointment measuring interface	Making Time in General Practice Report		Pilot sites identified. Team W presentation to be given	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		Team W content reviewed & recruitment of GPs via RCGP & CCG advertising.	Sarah Southall	2018/19		
3.23	Promote social prescribing & create national champion	Social prescribing initiatives supported by 35 national ambassadors & advocates promoting the GP role.		Ambassador Event & opportunities promoted, not yet held.	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 working well & extending to Mental Health provider also. Care Query Panel meetings regularly.

Legend for Current Status	
Blue	Not started
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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		The ETTF Bids that have been successful, are been run in line with PRINCE2 project management Methodology
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	The CCG have continued to provide core GPIT services via an SLA with Royal Wolverhampton Trust
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 Achievement of national target on track for September 2018 (all groups)	Jo Reynolds	Mar-19		Early implementation anticipated September 2018
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	Project Complete

4.9	Apps & digital self care	New core requirements i.e. digital patient records, specialist support, outbound electronic messaging etc.		currently scoping options	Steve Cook & Jo Reynolds	Review Sept 2018		
4.10	Accredited catalogue & buying framework for IT products & services			provided by arden and GEM CSU proc dept	Steve Cook	complete		Working with Midlands and Lancs CSU to identify joint buying opportunities
4.11	Work with supplier market to create wide & innovative choice of digital services				Steve Cook	ongoing		Have worked with suppliers to identify opportunities to introduce innovative digital services
4.12	Complete roll out of pharmacy summary care record			Midlands and Lancs CSU	Steve Cook	complete		Project 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 Manager appointed & hardware/software procured. EMIS Triage & Video Consultation pilot sites identified and discussions commenced March 2018 - pilot go live anticipated late May 2018.	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		see 4.13 above

4.15	Online access for patients to accredited clinical triage systems	EMIS Triage Solution & Video Consultation		in discussions with EMIS software available & keen to roll out to pilot sites. Agreed with Egton to have a trial of the EMIS Triage, pilot sites Grove Practice, Video Consultation with Grove & medical chambers practices & care homes they are working with (Newlyn). NHSE Regional Lead is due to liaise with IT regarding progress of project. Data sharing & discussions with IG taking place, also visiting Belvedere as part of ongoing discussions (22.3.18)	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		Wolverhampton have a Shared Care Record that is being developed to support GP's and Commissioners while operating within Information Governance Guidelines
4.17	Enhancements to the advice & guidance platform on the e-referral system	Develop advice & guidance beyond 6 specialties currently in use locally.		Currently 11 specialties live, not all well utilised.	Steve Cook/Ranjit Kular	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		waiting for information from NHS Digital	Steve Cook	TBD		
4.19	Funding to support education & support for patients & practitioners to utilise digital services	Awaiting further clarification		The CCG utilise its IM & T facilitator team to support patient and practices make use of the digital services. We are also looking get EMIS to provide additional support to the federated GP Groups	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		This is supported via the provision of the EMIS Remote consultation which supports practices booking appointments and holding consultations with patients who belong to practices within the federated GP Group
4.21	Let healthcare professionals from different settings inform & update a practice through sending/management	Awaiting further clarification		The CCG are in the process of upgrading Docman to version 10. Patient data is also available through the shared care record.	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 NHSE have supplied additional funding to bring the deadline forward to August/ september. Delivery Plans have been ammended to reflect this	Jo Reynolds	2019/20		
5.2	Ensure CCGs provide £171m work of support	CCGs to provide £3.00 per patient transformational funding.		Year 1 Assurance Reports for 2017/18to be submitted April Year 2 Delivery plans to be submitted April, for delivery in June	Jo Reynolds	2018/19		
5.3	New MCP Contract (NMOC)	MCP contracting explored, ACA preferred solution.		ACA Development Group meeting (Nov→) Clinical pathway priorities identified, workshops commenced (Mental Health) others will be held during Q1/2.	Sarah Southall	Apr-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		will continue to be captured in Training Tracker
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		

Legend for Current Status	
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WOLVERHAMPTON CCG
Governing Body
8th May 2018
Agenda item 12

TITLE OF REPORT:	Commissioning Committee Summary Report
AUTHOR(S) OF REPORT:	Dr Manjit Kainth
MANAGEMENT LEAD:	Mr Steven Marshall
PURPOSE OF REPORT:	To provide the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) with an update from the Commissioning Committee in April 2018.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	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.
RECOMMENDATION:	That the report is noted.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	[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 April 2018.

2. MAIN BODY OF REPORT

2.1 Risks

Corporate level risks – there were no issues to bring to the Committee’s attention.

Committee level risks:

CC08 RITS Capacity - The Committee approved a recommendation to close this risk.

Action - That Governing Body notes the update provided.

2.2 Community Falls Service Redesign

The Committee was provided with an assurance report and an update regarding the redesign of the Community Falls Prevention Service.

No issues were identified.

Action - That Governing Body notes the above.

2.3 Nigh Repositioning Service Pilot

The Committee was presented with a business case for the commissioning of a 6 month pilot of a service to provide night-time interventions for patients living at home affected by pressure injuries.

The Committee approved the business case and requested that the pilot should be for a period of 12 months to allow a more robust evaluation process.

Action - That Governing Body notes the decision made by the Committee.

2.4 Contracting Update

Royal Wolverhampton NHS Trust

Contract Performance (activity and finance)

Month 10 finance and activity data was presented at the March 18 Contract Review Meeting (CRM).

The main issues with RWT activity discussed at the CRM were as follows:

Over-performance – the contract is over performing by £2.1m at Month 10; this is a significant movement from Month 9 which was £674k over for all commissioners.

The Wolverhampton CCG element of the Month 10 over-performance equates to £1.17m.

Contract Performance (key performance indicators/quality)

Referral to Treatment – For February 18 this was reported at 90.38% which is below the agreed trajectory (91.81%). The Trust has failed to meet the operational standard relating to the percentage of service users on an incomplete RTT pathway waiting no more than 18 weeks from referral since April 2016. Discussions are being undertaken with clinical staff to increase capacity and reduce backlog to support the achievement of the recovery trajectory

Cancer 62 Days - Cancer 62 days has not achieved throughout the financial year and is presently being reported at 64.12% in February 18 which is the lowest it has been in all the financial year. Further details regarding this are referenced in the Performance report.

Ambulance Handovers – The Trust reported an unprecedented increase in delayed Ambulance handovers during January 18 (199 reported 15 minutes delays in January 18; the highest of the contract year). The February 18 position remains in contractual breach, but is an improvement from the previous month i.e. 102 reported 15 minute delays.

Performance Sanctions

Sanctions have been agreed for Month 10 (January 18) at £113,800, this was predominately due to Ambulance Handovers (as above).

Black Country Partnership Foundation Trust (BCPFT)

Service Development Improvement Plan (SDIP)

The STP is working on reviewing specifications and some (particularly CAMHS specs) are in the final review stage. There is a timetable for review as part of this work and it was agreed to align local SDIP meetings with the STP timetable.

Sandwell and West Birmingham (SWB) CCG have shared a plan for reviewing the mental health specs in line with the STP but more locally for both CCGs. This has been shared with

all commissioners from both CCGs to update on their current status with specific specifications. Once this has been reviewed a further meeting will be required to discuss the further development of those specs that remain out of date.

Data Quality Improvement Plan (DQIP)

Work with the DQIP is progressing well and the CCG have been informed (verbally) that the Trust have achieved 16.8% of their IAPT access rate target (against a target of 16.5%) This is a massive achievement as the Trust has attended a number of community events over the past few weeks to approach as many people as possible. This has required extra hours to be put in from staff during evenings and weekends and the service has worked hard to achieve this at the last minute. Formal figures will be available on the 15th working day of this month (23rd April 2018).

The Trust has agreed to implement advice and guidance for GPs and clinicians and has opened dialogue with primary care regarding this and e-referrals. SWBCCG have advised that they have additional investment that they would like to give to BCPFT to fund DOCMAN for all CCGs across the STP. The Trust has welcomed this and will work with SWBCCG to implement this by October 2018. WCCG has also welcomed this as the system can be used for e-referrals, e-discharge and sharing documents, for example clinical letters.

Contract Performance Notice - Infection Prevention Training

There is a joint Remedial Action Plan for Infection Prevention training. The indicator has failed for Q3. Performance for January was 87% against a target of 85% and 90% in February. We have received verbal assurance that March is also above target, therefore the Trust should achieve Q4 target.

Finance - Over performance (inpatients)

There is an over performance issue on Adults/ Older Adults inpatient beds. A number of meetings have been held to reach an agreement that is cost effective for both organisations but the issue is still outstanding. The Trust put forward a proposal that included a tolerance, cap and marginal rate. The CCG has agreed to apply a 2% tolerance and 5% cap with any under/ over-performance to be processed at a marginal rate of 60% to the Acute inpatient and Older adult inpatients. The maximum exposure for both organisations under this arrangement would be £143k.

The CCG has sent a counter offer to BCPFT to include beds at the MacArthur Unit and agreed to apply the above principles to the MacArthur Ward with the caveat that we remove one bed from the plan. This is on the basis that we have not fully utilised the beds on this ward and therefore wish to commission based on current activity. BCPFT are yet to respond to this and a further meeting has been scheduled.

Nuffield

2018/19 Contract changes

Focus continues to be on agreeing the 2018/19 contract. The draft contract has been shared with the Provider and the CCG is currently awaiting comment/agreement. The main basis of

the CCG's offer is a rebased activity plan which reflects 17/18 outturn (increased plan value is £3.277m). This year's contract massively over-performed and a more accurate plan will therefore enable more robust activity monitoring.

Urgent Care/ Ambulance/ Patient Transport

Urgent Care Centre

The Provider has been given a revised two month timeframe which ceases in April 18 by which certain improvements are expected. As part of the two month improvement plan weekly updates are provided by Vocare. This covers areas such as:

- Relocation of Home visit despatchers
- Home visit breach audit
- Review of Demand Capacity

A meeting has taken place between RWT, Vocare and CCG representatives to discuss how more patients can be triaged from ED to the UCC. Subsequent to this a further process mapping meeting has been arranged with all stakeholder to commence a pathway review.

WMAS Emergency & Urgent Ambulance Service

At the Commissioners Meeting held on 1st March 2018, it was noted that performance has been maintained despite the contract being 11% over plan. Performance for category 2 is exceptional and categories 3 and 4 are also being achieved well within the required response standards.

It was further noted that the Ambulance Improvement Group are conducting a national Spring review into ARP and this will be fed back into the Commissioners Meeting in order to gauge a national viewpoint as well as a local one.

For Wolverhampton CCG, month 11 YTD over performance is £325,000.

WMAS – Non-Emergency Patient Transport Service (NEPTS)

In December 2017 West Midlands Ambulance Service raised concern regarding the contract and performance management process with Wolverhampton and Dudley CCGs for the Non-Emergency Patient Transport Service. In response to this, the CCGs welcomed a proposal by WMAS, received in February 2018, suggesting a number of changes; financial payment process (no funding change), data processing, quality reporting, contract review meeting terms of reference, exception reporting and key performance indicators. Both Dudley and Wolverhampton CCG teams considered the proposals in detail and were in the main supportive.

Further correspondence and discussion has since taken place including a letter from the CCG to WMAS acknowledging their latest letter and outlining agreed items to be provided, closure of the Information Breach Notice, and the CCG's intention to draft a Contract Variation Agreement to reflect the changes that have been agreed.

Other Contracts

Staffordshire and Stoke on Trent Partnership Trust (SSoTP)

There is still significant over performance with the SSoTP contract in particular within the district nursing service. This has been raised with the provider at their CQRM in March and the CCG are awaiting a response from the host CCG as the provider requested time to investigate.

Accord Housing Association – Victoria Court

Contractual and financial terms have been agreed between the CCG and Accord for a new contract arrangement for Victoria Court. This agreement centres on 8 inpatient beds for specialist rehabilitation and 3 beds for step down (following admission in Penn Hospital). The Local Authority has agreed to pay an increased top up amount for the 8 beds, based on actual usage, whilst the step down beds are fully funded by the CCG. A contract has been drafted and we are on track to have this finalised by the end of March.

In parallel with this, Accord has put forward a proposal to the CCG for void losses incurred during the 2017/18 year; the claim is for circa £95k. The CCG has agreed to pay £75,000 of these void losses as Victoria Court confirmed that in order to provide a 24 hour service they must remain fully staffed regardless of the number of patients that they have in the unit.

Their current staff mix includes a manager and deputy and 4 nurses, 3 of which are backfilled by agency staff. There is only 1 current vacancy for support staff.

Accord also requested for the CCG to cover all redundancy costs should they not be awarded the contract beyond March 2019. The CCG has agreed to cover only statutory redundancy costs under this scenario, however if Accord advise that they will no longer offer the service and wish to terminate the contract the CCG will not be liable for any redundancy costs. Accord is yet to respond to this proposal.

Cygnnet Health Care

It has recently come to light that BCC CCG does not have any agreement in place for us to be associates to their contract and we have not been included on any of their contracts in previous years.

The approximate spend with Cygnnet is £2 million and arrangements from 1st April 2018 will need to be discussed and considered as we do not have any contractual agreements in place currently. A meeting has been arranged with the provider to discuss and agree next steps. This is anticipated to take place before the end of April.

Action - That Governing Body notes the decision made by the Committee.



3. RECOMMENDATIONS

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

Name: Dr Manjit Kainth

Job Title: Lead for Commissioning & Contracting

Date: 27th April 2018

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WOLVERHAMPTON CCG
Governing Body
Tuesday 8th May 2018
Agenda item 13

Page 221

TITLE OF REPORT:	Executive Summary and Quality and Safety Committee report (May, 2018)
AUTHOR(s) OF REPORT:	Sally Roberts Chief Nurse & Director of Quality Sukhdip Parvez, Quality and Patient Safety Manager
MANAGEMENT LEAD:	Sally Roberts Chief Nurse & Director of Quality
PURPOSE OF REPORT:	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). A summary is provided and the May Quality and Safety Committee report is included in Appendix 1
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This report is confidential due to the sensitivity of data and level of detail.
RECOMMENDATION:	Provides assurance on quality and safety of care, and inform the Governing Body as to actions being taken to address areas of concern
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	<ol style="list-style-type: none"> 1. Improving the quality and safety of the services we commission 2. Reducing Health Inequalities in Wolverhampton

Agenda Item 13

	Level 2 RAPS breached escalation to executives and/or contracting/Risk Summit/NHSE escalation	
	Level 2 RAPS in place	
	Level 1 close monitoring	
	Level 1 business as usual	
Key issue	Comments	RAG
Urgent Care Provider	<p>Vocare has been rated inadequate for the March 2017 CQC visit. A further announced focused inspection was carried out by CQC on 26 October 2017 in relation to the warning notices issued in July 2017. An unannounced visit by WCCG in January 2018 highlighted further concerns, pertaining to triage, performance and paediatric triage arrangements.</p> <p>The CQC re-visited Vocare in February 2018 and preliminary report suggests that Vocare has been rated '<u>Requires Improvement</u>' and the final report is awaited. An initial 8 week improvement plan was been agreed between CCG and Vocare and weekly reviews have been ongoing. A further revised 8 week improvement plan is now in place and weekly monitoring continues by CCG.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • 6 weekly Vocare Improvement Board meetings • Announced and unannounced visits by WCCG • No Serious incidents reported by Vocare since Oct,17 • Front door process mapping to be undertaken in May, led by CCG. • Senior oversight of improvement plan in place by Vocare, triage response rates remain an improving picture with 78.7% reported for 13-18th April. Four hour performance was reported as 98% for same April period. • Home visiting and call back performance remains challenging 	

	<ul style="list-style-type: none"> • Workforce capacity and demand review completed and shared with CCG • Appointment of senior operations manager has provided local leadership and oversight. • Clinical Rota Co-Ordinator role now appointed to local position, all local dispatchers now appointed • Two team leaders appointed, in addition to four GP roles. 	
<p>Maternity Performance Issues</p>	<p>The Provider has currently capped the maternity activity for the Trust (capping where the Trust takes referrals from), this does not apply to Wolverhampton women. The current Midwife to birth ratio is 1:30, with national rate standing at 1:28. <i>Caesarean rates:</i> Elective rate 12.2% (target is less than 12%) and Emergency rate 17.1% (target is less than 14%)</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • Continuous monitoring for SI's, complaints or any other emerging quality issues pertaining to maternity, no emerging themes or trends have been identified. • Maternity activity capped by provider • Midwifery vacancy rate reported as 1.3% for March, 2018, an increase of 1% since Feb, but below trust target. • Midwife sickness rate reported as 6.3% for March, 2018, a slight increase compared to 6.2% reported at Feb 2018. • Awaiting outcome of review by National Team (Birth Rate Plus) – the Trust is expected to receive this at the end of March/beginning of April 2018, formal feedback will be provided at May,18 CQRM. • RWT undertaking an internal review of caesarean section performance and initial review has suggested that in 60% of cases (category 3 & 4) it was the acuity of the patients i.e. diabetes. A full report of these findings will be presented at May 18 CQRM. 	
<p>Non-Emergency patient transport service issues</p>	<p>Recent performance issues with this provider have a potential to impact on poor patient experience. The provider had previously failed to meet reporting requirements i.e. Serious incidents, KPI's, Quality reporting and current performance was not at the contract level expected</p>	

	<p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • Continuous monitoring for Serious Incidents, complaints or any other emerging quality issues with consideration to any themes or trends that may arise, no emerging themes at present. • Contract now agreed to support strengthening of commissioning arrangements, to include closer reporting and monitoring of agreed KPI's 	
Mortality	<p>The estimated SHMI for November 2016 to October 2017 was 117.4 and banded higher than expected. At the next NHS Digital publication, the SHMI for RWT for the period October 2016 to September 2017 is estimated to be 1.18 and again banded higher than expected. RWT is a national outlier for this performance. The crude mortality trends have not seen any significant changes, the expected mortality rate for RWT continues to be lower than England's. The actual crude mortality for in-hospital deaths is lower in 2018 compared with the previous three years at the trust.</p> <p>For the period April 2017 – January 2018 there were 1651 adult inpatient deaths at the Trust. Of these 67.4% had an initial mortality review by the end of January and 46.7% had a review using the SJR methodology, which was introduced in August 2017.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Clinicians have been trained to undertake Stage 2 reviews and a working group has been set up to set out a method for allocating cases for stage 2 reviews in accordance with the established policy. • Work is in progress to implement the changes in the creation of finished consultant episodes on admission to AMU. • Changes have been made to clerking documentation to improve the clarity of primary 	

	<p>diagnoses and comorbidities on admission to hospital, thus aiding richer coding.</p> <ul style="list-style-type: none"> • The Head of Coding and Data quality has drafted a plan to address education and collaborative working between coders and clinicians with the aim to improve documentation accuracy. • Further understanding and more detailed work is required to identify concrete measures for monitoring progress and improvements. • To further explore a local system approach to mortality, with specific reference to patient deaths within 30 days of hospital discharge, ensuring end of life pathways are robust. • Logged on the WCCG risk register as a high risk. 	
<p>Increased number of NEs 16/17</p>	<p>6 Never Events reported by RWT for 2017/18 year to date. The trust has further reported 2 new Never Events for year 2018/2019.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • Continuous monitoring for SI's, complaints or any other emerging quality issues • Scrutiny and challenge via bi-monthly SISG (Serious Incident Scrutiny Group) meetings with provider present • Robust scrutiny of all Never Events before closure on STEIS (Strategic Executive Information System) • WCCG senior exec board has met with RWT board on 18.04.2018 to seek board assurance of actions being undertaken by the trust to prevent/mitigate reoccurrence of never events. • RWHT have requested further support from AFPP to review culture and practice within clinical theatre environment, including application of WHO checklist, to be reported back to CCG once review completed. • CCG have instigated rapid responses to recent never events, including immediate assurance call with DON and unannounced visit to theatre area involved in recent never event. 	

	<ul style="list-style-type: none"> • Agreement to seek wider learning event for Bham, Solihull and Black Country to be sought through QSG. • Failure to ensure robust 'Checking' process is identified as an emerging theme of never events 	
Safety, experience and effectiveness	<p>Continuous scrutiny of Pressure Injuries, Serious Incidents, Falls, FFTs, Surveys, NICE and IPC.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Bi-monthly SISG (Serious Incident Scrutiny Group) meetings with provider present. • WCCG attends weekly PILLA (Pressure Injury Lesson Learned Accountability) meetings. • Continued improvements seen in avoidable pressure injuries, CDiff and falls. • 4 patient falls with serious harm was reported in March 2018 • 1 stage 3 pressure injury was deemed as avoidable for March,18 • WCCG attends RWT monthly Pressure Injury Steering Group. 	
Improving primary care services	<p>Continuous monitoring of Infection Prevention ratings, Friends and Family Test, Quality Matters, Complaints, Serious Incidents , NICE, and Workforce.</p>	
Cancer Performance	<p>Cancer performance for the trust remains an area requiring further assurance. In particular 62 and 104 day cancer performance requires further assurance to ensure any potential or actual impact of harm for patients is understood and mitigated.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • CCG Chief Nurse and Chief Operating Officer have met with RWHT COO and lead cancer clinician to seek further assurance with regards performance, a range of actions are underway following the meeting, these include: • Awaiting assurance documentation form the trust pertaining to harm review process undertaken by the trust • How evidence of duty of candour is supported • Attendance at weekly cancer PTL meeting for further assurance and scrutiny of 	

	<p>performance agreed with RWHT</p> <ul style="list-style-type: none"> • Speciality level performance data awaited from Trust • Agreed focus of scrutiny with regards 104 day waits initially • IST to undertake a review of tracker activity on behalf of the trust during May/June • Agreement to utilise UHB tertiary referral forms agreed by the trust • The revised RAP has been rejected by the CCG with regards the trajectory set by the trust and a discussion with regards revised trajectory is currently on going • WCCG have requested to see a report on the work that has been done by Millar Bowness for head and neck pathways and to ascertain if some of the improvements would be transferrable to other cancer sites, this is awaited but expected May. • Additional capacity has been identified in radiotherapy for CT scanning although workforce may be challenging to support this. • Remains a high risk on both RWHT and WCCG risk registers • Cancer network and NHSE are sighted on current performance and support the ongoing work with the trust <p>A further was provided at the April,18 CQRM :</p> <ul style="list-style-type: none"> • Additional Saturday clinics • Business case for additional clinical support • Strengthening PTL meetings process • Improving diagnostic pathways • Cytology Incident <p>In April, 18 WCCG was made aware about a cervical screening incident at RWT. A review meeting has taken place, led by PHE to agree a range of actions; these include effective communications, to include patient & GP letters. This incident was discussed in length and it was decided this incident</p>	
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	doesn't meet the criteria to be reported as a serious incident. A further update is currently awaited.	
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Please see Appendix 1 for a full copy of the Monthly Quality and Risk Report – Quality and Safety Committee 8th May 2018 (March, 18 data)

WOLVERHAMPTON CCG
Quality and Safety Committee
Tuesday 08th May 2018

TITLE OF REPORT:	Monthly Quality and Risk Report
AUTHOR(S) OF REPORT:	Sally Roberts, Chief Nurse and Director of Quality Sukhdip Parvez, Quality & Safety Manager Molly Henriques Dillon, QNA Lead Matthew Boyce , Quality assurance coordinator Fiona Brennan, Designated Nurse for Looked After Children Annette Lawrence, Designated Adult Safeguarding Lead Lorraine Millard, Designated Nurse Safeguarding Children Liz Corrigan, Primary care assurance Coordinator
MANAGEMENT LEAD:	Sally Roberts, Chief Nurse and Director of Quality
PURPOSE OF REPORT:	To provide evidence and assurance of the management and monitoring of the clinical quality framework and where assurance cannot be provided to share mitigation or seek escalation from committee of further actions that may be required. The report includes performance against key clinical indicators for the reporting period March 2018 (reported by exception).
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This report is confidential due to the sensitivity of data and level of detail.
RECOMMENDATION:	Submitted for assurance to the Quality and Safety Committee
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	<ol style="list-style-type: none"> 1. Improving the quality and safety of the services we commission 2. Reducing Health Inequalities in Wolverhampton

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Section 5 – Children’s Safeguarding	Page 39
Section 6 – Adults Safeguarding	Page 40
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Section 8 – Recommendations	Page 42

1. Key areas of concern are highlighted for the Quality & Safety Committee below:

	Level 2 RAPS breached escalation to executives and/or contracting/Risk Summit/NHSE escalation
	Level 2 RAPS in place
	Level 1 close monitoring
	Level 1 business as usual

Key issue	Comments	Risk Mitigation	R A G	Page number in report
Urgent Care Provider Page 231	<p>Vocare has been rated inadequate for the March 2017 CQC visit. A further announced focused inspection was carried out by CQC on 26 October 2017 in relation to the warning notices issued in July 2017. An unannounced visit by WCCG in January 2018 highlighted further concerns, pertaining to triage, performance and paediatric triage arrangements.</p> <p>The CQC re-visited Vocare in February 2018 and whilst full report is awaited some improvements were noted. An 8 week improvement plan has been agreed between CCG and Vocare and weekly reviews have been ongoing.</p>	<p>Vocare has been rated inadequate for the March 2017 CQC visit. A further announced focused inspection was carried out by CQC on 26 October 2017 in relation to the warning notices issued in July 2017. An unannounced visit by WCCG in January 2018 highlighted further concerns, pertaining to triage, performance and paediatric triage arrangements. The CQC re-visited Vocare in February 2018 and preliminary report suggests that Vocare has been rated '<u>Requires Improvement</u>' and the final report is awaited. An initial 8 week improvement plan was been agreed between CCG and Vocare and weekly reviews have been ongoing. A further revised 8 week improvement plan is now in place and weekly monitoring continues by CCG.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • 6 weekly Vocare Improvement Board meetings • Announced and unannounced visits by WCCG • No Serious incidents reported by Vocare since Oct,17 		38

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Page 33</p>		<ul style="list-style-type: none"> • Front door process mapping to be undertaken in May, led by WCCG. • Senior oversight of improvement plan in place by Vocare, triage response rates remain an improving picture with 78.7% reported for 13-18th April. Four hour performance was reported as 98% for same April period. • Home visiting and call back performance remains challenging • Workforce capacity and demand review completed and shared with CCG • Appointment of senior operations manager has provided local leadership and oversight. • Clinical Rota Co-Ordinator role now appointed to local position, all local dispatchers now appointed • Two team leaders appointed, in addition to four GP roles. 		
<p>Cancer performance</p>	<p>Cancer performance for the trust remains an area requiring further assurance. In particular 62 and 104 day cancer performance requires further assurance to ensure any potential or actual impact of harm for patients is understood and mitigated.</p>	<p>Cancer performance for the trust remains an area requiring further assurance. In particular 62 and 104 day cancer performance requires further assurance to ensure any potential or actual impact of harm for patients is understood and mitigated.</p> <p>Risk Mitigation:</p> <p>CCG Chief Nurse and Chief Operating Officer have met with RWHT COO and lead cancer clinician to seek further assurance with regards performance, a range of actions are underway following the meeting, these include:</p> <ul style="list-style-type: none"> • Awaiting assurance documentation form the trust pertaining 		<p>33</p>

- to harm review process undertaken by the trust
- How evidence of duty of candour is supported
 - Attendance at weekly cancer PTL meeting for further assurance and scrutiny of performance agreed with RWHT
 - Speciality level performance data awaited from Trust
 - Agreed focus of scrutiny with regards 104 day waits initially
 - IST to undertake a review of tracker activity on behalf of the trust during May/June
 - Agreement to utilise UHB tertiary referral forms agreed by the trust
 - The revised RAP has been rejected by the CCG with regards the trajectory set by the trust and a discussion with regards revised trajectory is currently on going
 - WCCG have requested to see a report on the work that has been done by Millar Bowness for head and neck pathways and to ascertain if some of the improvements would be transferrable to other cancer sites, this is awaited but expected May.
 - Additional capacity has been identified in radiotherapy for CT scanning although workforce may be challenging to support this.
 - Remains a high risk on both RWHT and WCCG risk registers
Cancer network and NHSE are sighted on current performance and support the ongoing work with the trust

<p>Maternity Performance Issues</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Page 234</p>	<p>The Provider has currently capped the maternity activity for the Trust (capping where the Trust takes referrals from), this does not apply to Wolverhampton women. The current Midwife to birth ratio is 1:30, with national rate standing at 1:28. <i>Caesarean rates:</i> Elective rate 12.2% (target is less than 12%) and Emergency rate 17.1% (target is less than 14%)</p>	<p>The Provider has currently capped the maternity activity for the Trust (capping where the Trust takes referrals from), this does not apply to Wolverhampton women. The current Midwife to birth ratio is 1:30, with national rate standing at 1:28. <i>Caesarean rates:</i> Elective rate 12.2% (target is less than 12%) and Emergency rate 17.1% (target is less than 14%)</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • Continuous monitoring for SI's, complaints or any other emerging quality issues pertaining to maternity, no emerging themes or trends have been identified. • Maternity activity capped by provider • Midwifery vacancy rate reported as 1.3% for March, 2018, an increase of 1% since Feb, but below trust target. • Midwife sickness rate reported as 6.3% for March, 2018, a slight increase compared to 6.2% reported at Feb 2018. • Awaiting outcome of review by National Team (Birth Rate Plus) – the Trust is expected to receive this at the end of March/beginning of April 2018, formal feedback will be provided at May, 18 CQRM. • RWT undertaking an internal review of caesarean section performance and initial review has suggested that in 60% of cases (category 3 & 4) it was the acuity of the patients i.e. diabetes. A full report of these findings will be presented at May 18 CQRM. 	<p>29</p>
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<p>Non-Emergency patient transport service issues</p>	<p>There are performance issues with this provider with a potential for its impact on quality. The provider has failed to meet reporting requirements i.e. Serious incidents, KPI's, Quality reporting and current performance is not at the level expected</p>	<p>Recent performance issues with this provider have a potential to impact on a poor patient experience. The provider had previously failed to meet reporting requirements i.e. Serious incidents, KPI's, Quality reporting and current performance was not at the contract level expected</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • Continuous monitoring for Serious Incidents, complaints or any other emerging quality issues with consideration to any themes or trends that may arise, no emerging themes at present. • Contract now agreed to support strengthening of commissioning arrangements, to include closer reporting and monitoring of agreed KPI's 	<p>38</p>
<p>Mortality</p>	<p>The estimated SHMI for November 2016 to October 2017 was 117.4 and banded higher than expected. At the next NHS Digital publication, the SHMI for RWT for the period October 2016 to September 2017 is estimated to be 1.18 and again banded higher than expected. RWT is a national outlier for this performance. The crude mortality trends have not seen any significant changes, the expected mortality rate for RWT continues to be lower than England's. The actual crude mortality for in-hospital deaths is lower in 2018 compared with the previous three years at the trust. For the</p>	<ul style="list-style-type: none"> • Clinicians have been trained to undertake Stage 2 reviews and a working group has been set up to set out a method for allocating cases for stage 2 reviews in accordance with the established policy. • Work is in progress to implement the changes in the creation of finished consultant episodes on admission to AMU. • Changes have been made to clerking documentation to improve the clarity of primary diagnoses and comorbidities on admission to hospital, thus aiding richer coding. • The Head of Coding and Data quality has drafted a plan to address education and collaborative working between coders and clinicians with the aim to improve documentation 	<p>31</p>

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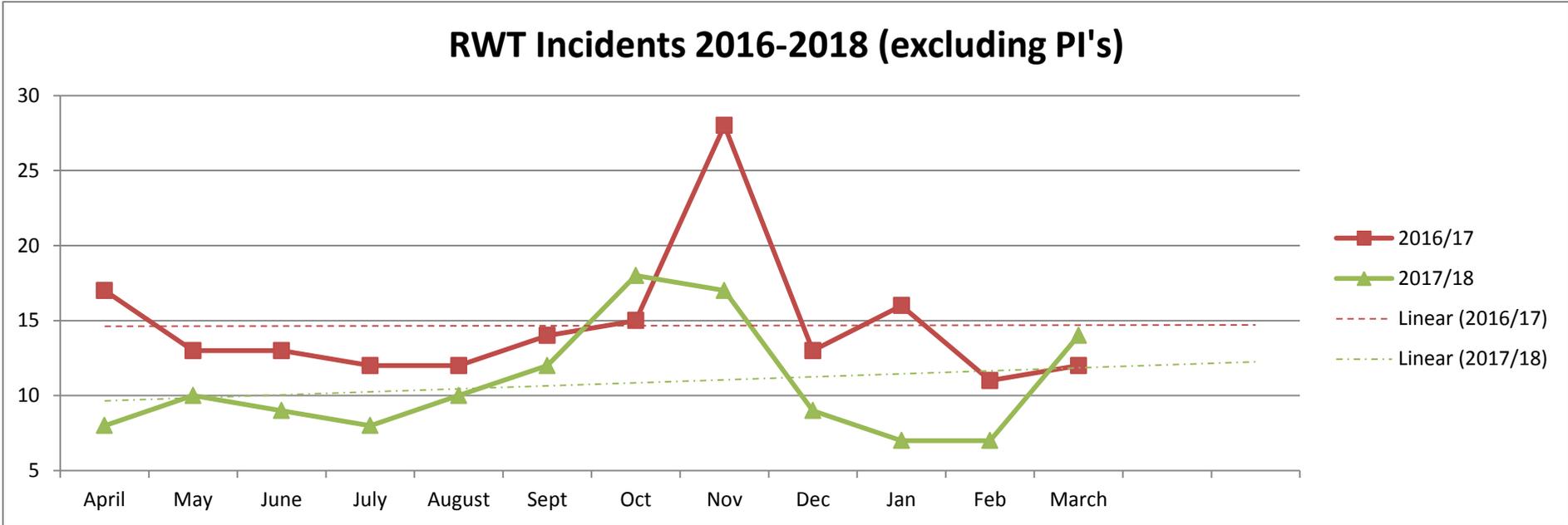
	<p>period April 2017 – January 2018 there were 1651 adult inpatient deaths at the Trust. Of these 67.4% had an initial mortality review by the end of January and 46.7% had a review using the SJR methodology, which was introduced in August 2017.</p>	<p>accuracy.</p> <ul style="list-style-type: none"> • Further understanding and more detailed work is required to identify concrete measures for monitoring progress and improvements. • To further explore a local system approach to mortality, with specific reference to patient deaths within 30 days of hospital discharge, ensuring end of life pathways are robust. • Logged on the WCCG risk register as a high risk. 		
<p>Increase in number of Never Events 2017/2018</p>	<p>6 Never Events reported by RWT for 2017/18. A further two never events reported for 18/19 to date.</p>	<p>6 Never Events reported by RWT for 2017/18 year to date. The trust has further reported 2 new Never Events for year 2018/2019.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • Continuous monitoring for SI's, complaints or any other emerging quality issues • Scrutiny and challenge via bi-monthly SISG (Serious Incident Scrutiny Group) meetings with provider present • Robust scrutiny of all Never Events before closure on STEIS (Strategic Executive Information System) • WCCG senior exec board has met with RWT board on 18.04.2018 to seek board assurance of actions being undertaken by the trust to prevent/mitigate reoccurrence of never events. • RWHT have requested further support from AFPP to review culture and practice within clinical theatre environment, including application of WHO checklist, to be reported back to CCG once review completed. • CCG have instigated rapid responses to recent never events, 		<p>27</p>

		<p>including immediate assurance call with DON and unannounced visit to theatre area involved in recent never event.</p> <ul style="list-style-type: none"> • Agreement to seek wider learning event for Bham, Solihull and Black Country to be sought through QSG. • Failure to ensure robust 'Checking' process is identified as an emerging theme of never events 		
<p>Safety, experience and effectiveness</p> <p>Page 237</p>	<p>Continuous scrutiny of Pressure Injuries, Serious Incidents, Falls, FFTs, Surveys, NICE and IPC.</p>	<p>Continuous scrutiny of Pressure Injuries, Serious Incidents, Falls, FFTs, Surveys, NICE and IPC.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Bi-monthly SISG (Serious Incident Scrutiny Group) meetings with provider present. • WCCG attends weekly PILLA (Pressure Injury Lesson Learned Accountability) meetings. • Continued improvements seen in avoidable pressure injuries, CDiff and falls. • 4 patient falls with serious harm was reported in March, 2018 1 stage 3 pressure injury was deemed as avoidable for March,18 • WCCG attends RWT monthly Pressure Injury Steering Group. 		<p>Through out the report</p>
<p>Improving primary care services</p>	<p>Continuous monitoring of Infection Prevention ratings, Friends and Family Test, Quality Matters, Complaints, Serious Incidents , NICE, and Workforce.</p>	<ul style="list-style-type: none"> • Monthly assurance report was provided to Q+SC in February 2018 • QAC attends Primary Care Operational Management Group; Primary Care Commissioning Committee and Workforce Task and Finish Group 		<p>N/A</p>

- | | | | | |
|--|--|---|--|--|
| | | <ul style="list-style-type: none">• QAC also attends Practice Collaborative Contracting visits• Liaison with Public Health around vaccine and screening uptake | | |
|--|--|---|--|--|

2. ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

Serious Incidents



Page 239

14 Serious Incidents were reported in March 2018, which is a significant rise compared to 7 SI's reported in Feb, 18. All these SI's were reported under 7 SI categories and a brief description into all these SI's has been given below:

Slip, Trip & Patient falls – 4 (2 patient falls occurred at the acute trust site and 2 falls occurred at Cannock hospital site)

Infection Prevention - 2 (1 incident relates to C.Diff case and 1 incident has been reported for Influenza A)

Information Governance - 1 (this SI relates to Information breach concerning medical and social information by staff on Children's Ward)

Treatment Delays - 1 (requested abdominal CT guided biopsy for the patient was delayed for three months)

Pending review - 3 (All these 3 cases relates to unexpected deaths)

Diagnostic delays - 2(1 X failure to follow MSCC (Metastatic Spinal Cord Compression) pathway, 1 X failure to follow up on a chest x-ray results)

Surgical incident - 1(Failure to carry out a planned Tooth extraction procedure)

The trust is currently undertaking full RCA into all these serious incidents and the final report will be submitted to WCCG for closure by June, 2018.

2.1 RWT Diagnostic and Treatment delay SI's Q3 (Oct 17-Dec 17) deep dive exercise undertaken by WCCG

Summary

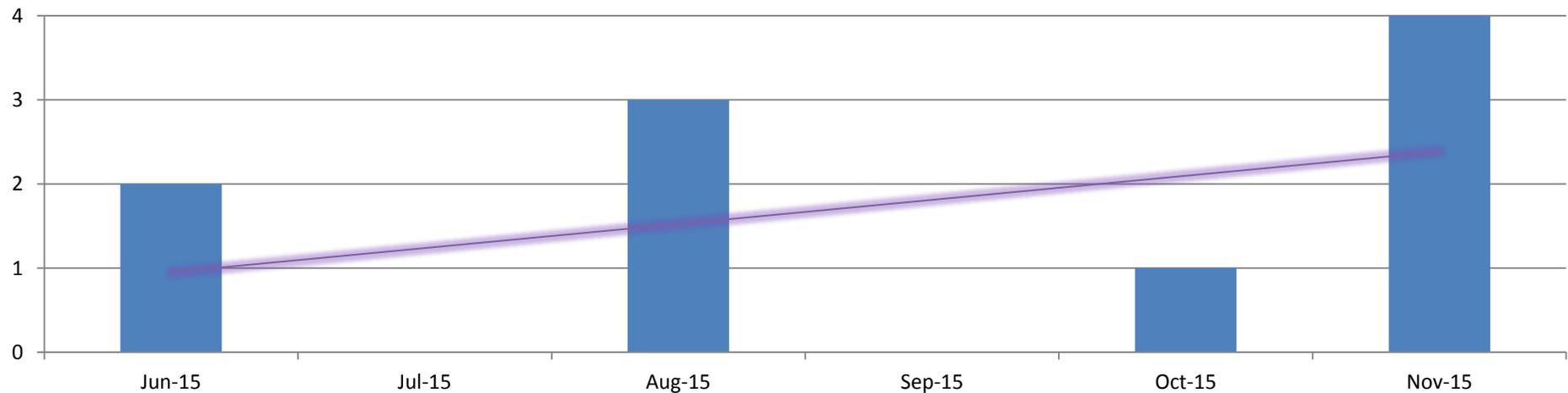
This report summarises the serious incidents reported to WCCG under diagnostic and treatment delay category for Q3 (October 2017 – December 2017). This deep dive exercise was undertaken by WCCG quality team to identify themes and trends and to seek assurance with information about the initial actions taken to mitigate the associated risks into these reported serious incidents.

Background

Since June 2015 there has been an increasing trend of Diagnostic/Treatment Delay serious Incidents at RWT therefore, SBAR was raised in earlier part of 2015 and a further SBAR was raised with the provider in May 2016. The trust responded to the SBAR raised by WCCG –

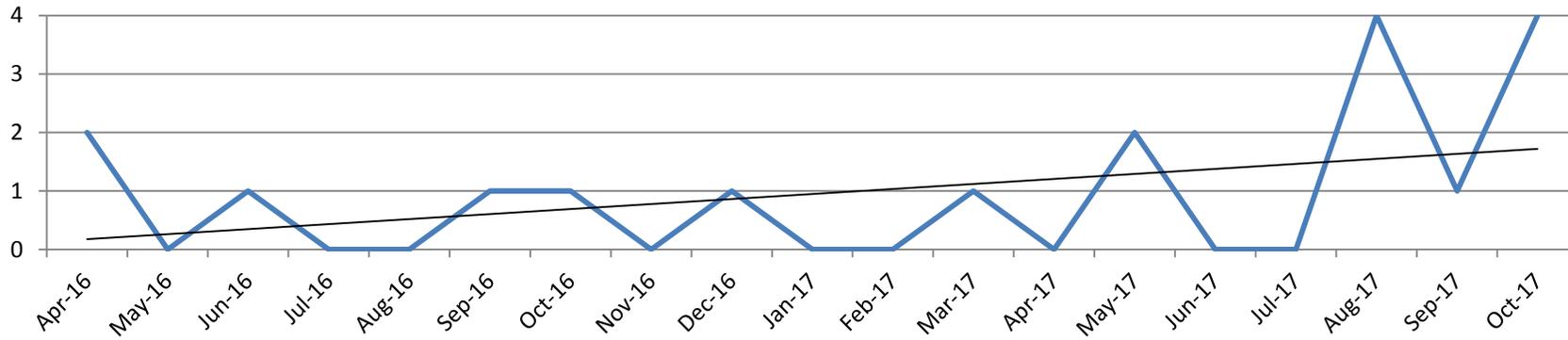
Delayed Diagnosis. 12 incidents were detailed with root causes and assurance was provided that a small working party has commenced a review of current protocols and the development of more effective systems to manage this risk across the organisation.

Treatment/diagnostic delay incidents meeting SI criteria

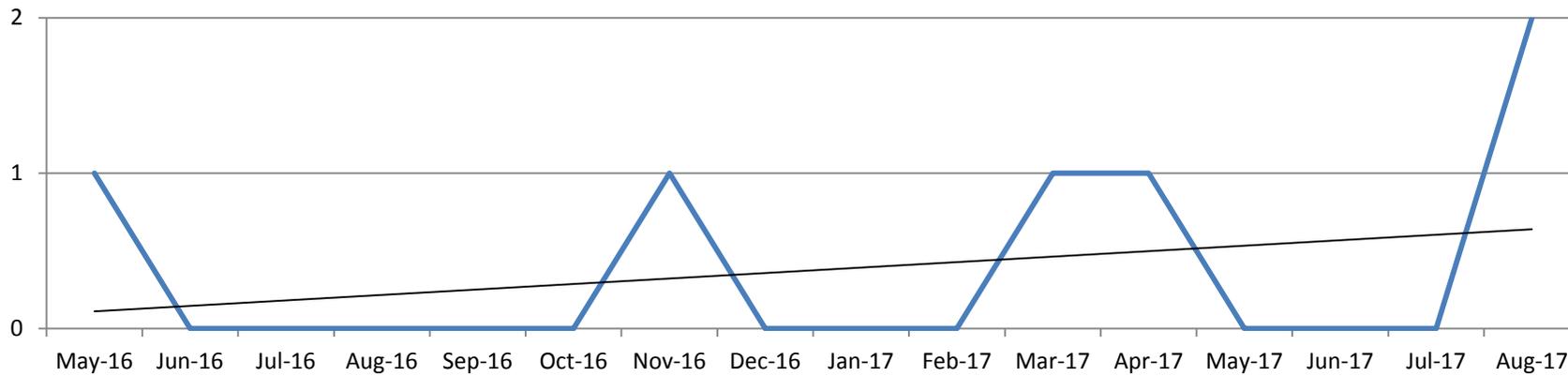


A further SBAR was formally raised with RWT on 3rd November 2017 about the increase in diagnostic incidents and WCCG requested a themed discussion of their findings to be presented at the January, 18 CQRM.

Diagnostic delay incidents meeting SI criteria

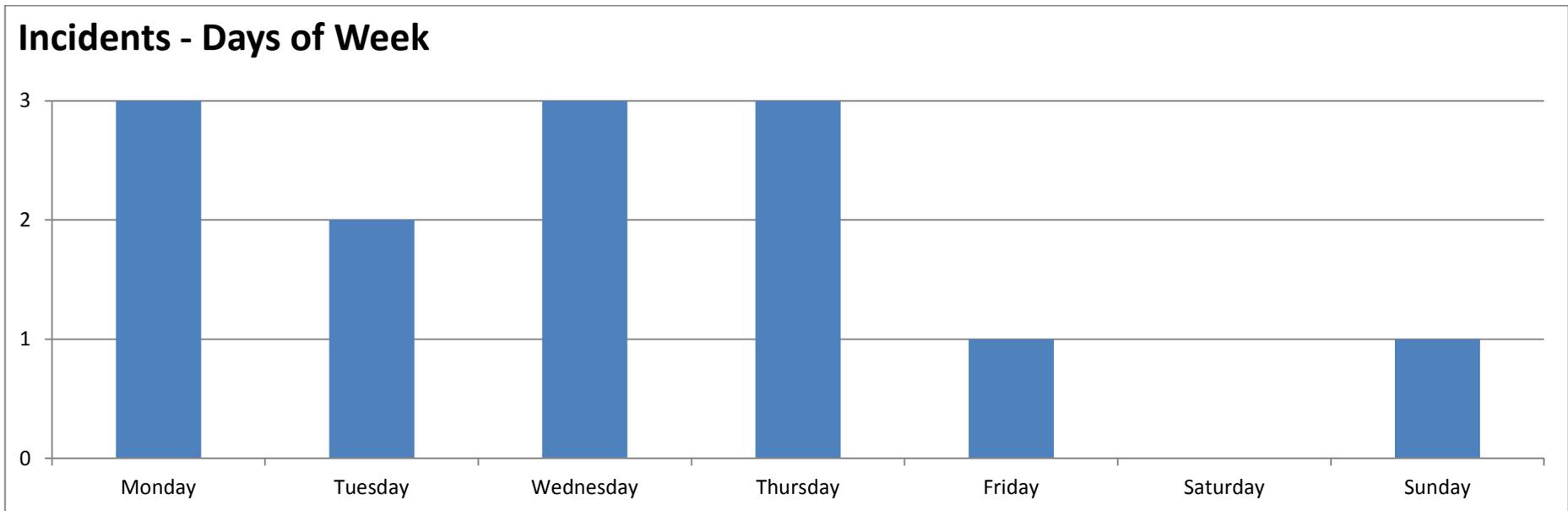


Treatment delays



The trust responded to the SBAR in the January, 18 CQRM with following actions identified and implemented in the Emergency Department.

A further review of Diagnostic/Treatment delay SI's reported in Q3 (2017/2018) has been requested by the WCCG chief nurse to establish any themes or trends from a WCCG prospective. A total of 13 SI's were reported for the Diagnostic/Treatment delay category for Q3, with 7 having been fully investigated and final RCA submitted to WCCG for closure. The remaining 5 RCA's are outstanding, but within allocated timeframe for submission to WCCG for closure. Of this total it is worth noting, 11 incidents have been reported for Diagnostic delay and 1 incident for treatment delay category. The retrospective review considered a range of areas and findings are detailed below:

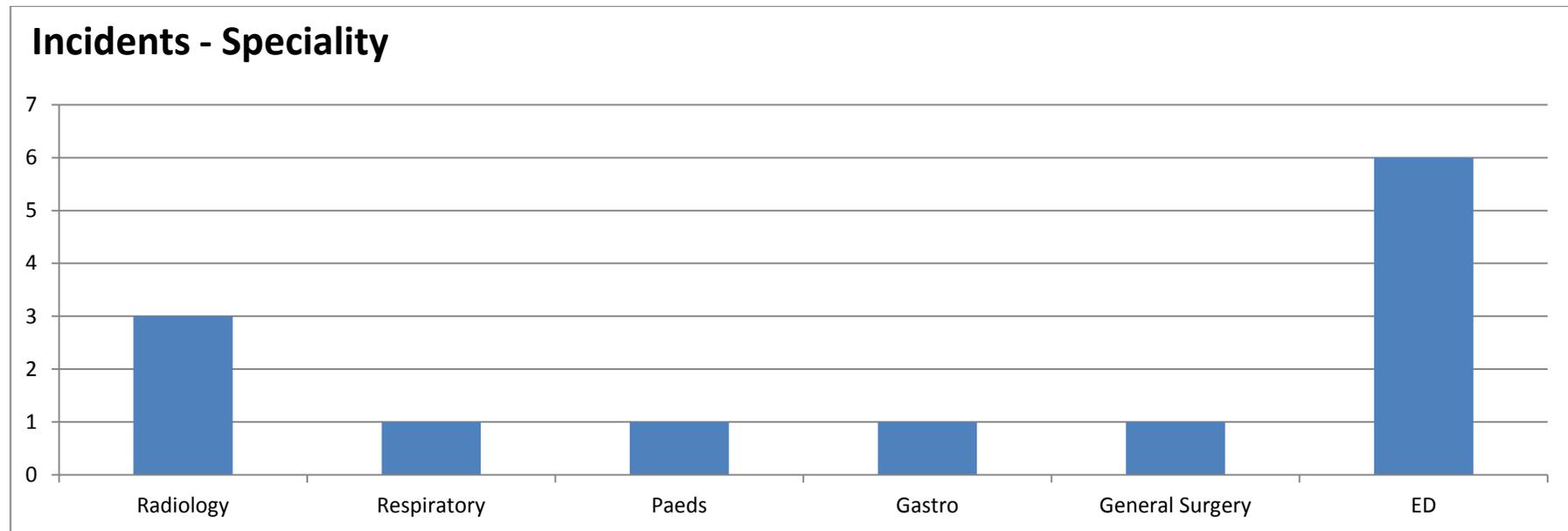


Serious Incidents occurrence:

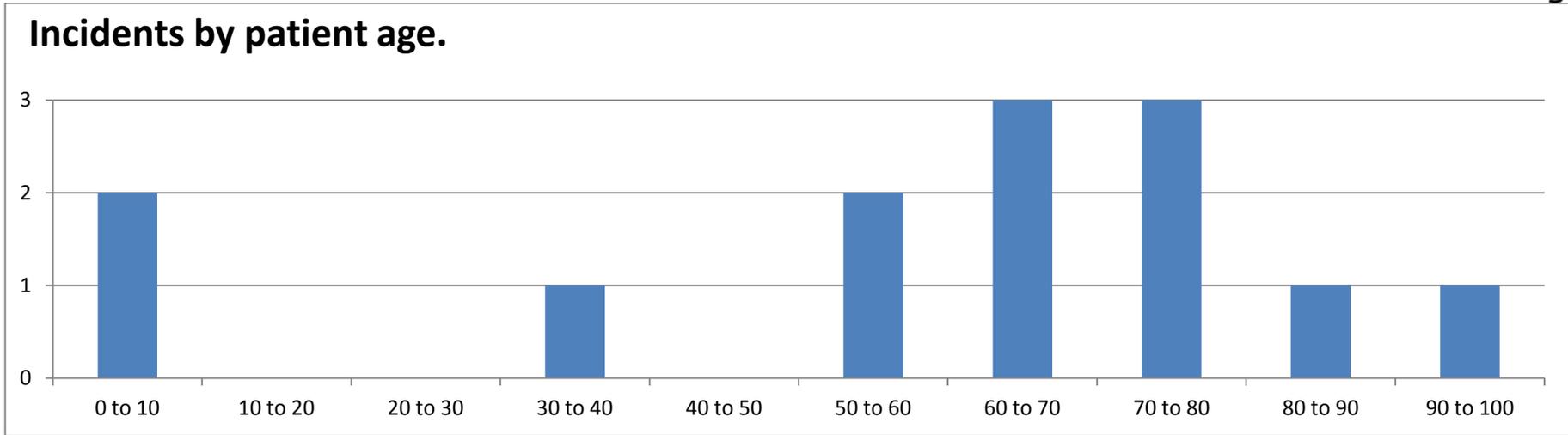
No trends have been identified in terms of incidents having occurred on any particular day i.e. weekends etc. Interesting to note however, that the majority of incidents occurred during the weekday

Serious Incidents occurred by hour of the day :

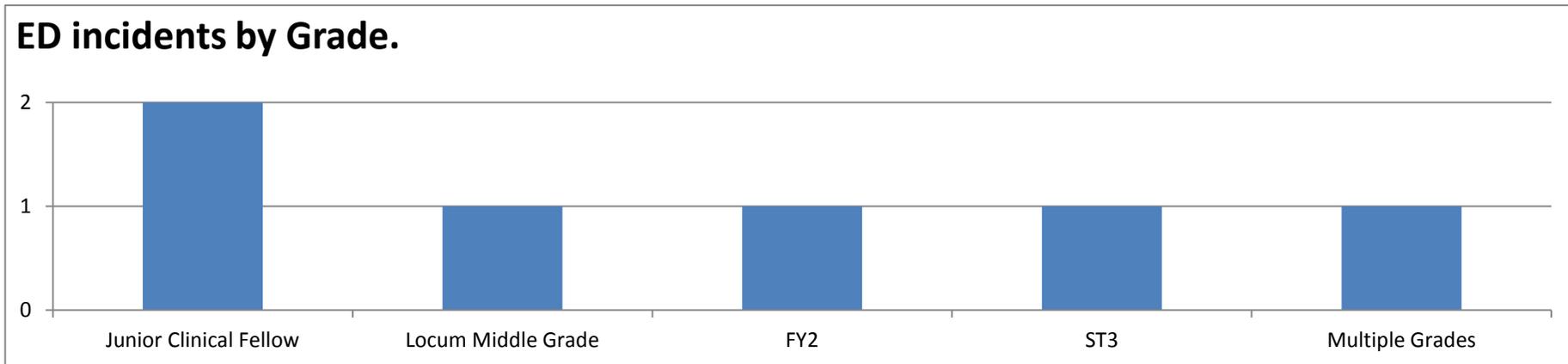
No trends have been identified regarding the time of incidents having occurred.



Out of 13 SI's reported by RWT, 6 SI's were related to ED and this is similar trend in the last two SBAR's where majority of diagnostic/treatment incidents occurred or were related to emergency department.



Out of 13 incidents reported, 10 were reported in patients above the age of 50.



Of the incident data available we know that 4 out of 6 patients were seen by junior doctors in ED. There is no documentation to support that the patient's clinical assessment or patients discharge decision was ever discussed with senior clinician or ED consultant in any of these cases.

Issues arising from review of incidents to date:

- Lack of senior oversight in decision making
- ECG abnormality not recognised by paramedic
- Lack of immediate diagnostics request by Triage nurse and Doctor for a patient with collapse
- Failure to follow up on diagnostic reporting • clerking doctor unaware of local clinical guidelines
- Information from nursing triage/handover not adequately addressed by doctor
- Consent policy not followed for stage 1 consent.
- Repeated cancellation of appointments due to unavailability of face-to-face interpreters.

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Assurance from the provider

Radiology reporting: New inbox set up where all ED radiology reports are sent to 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.

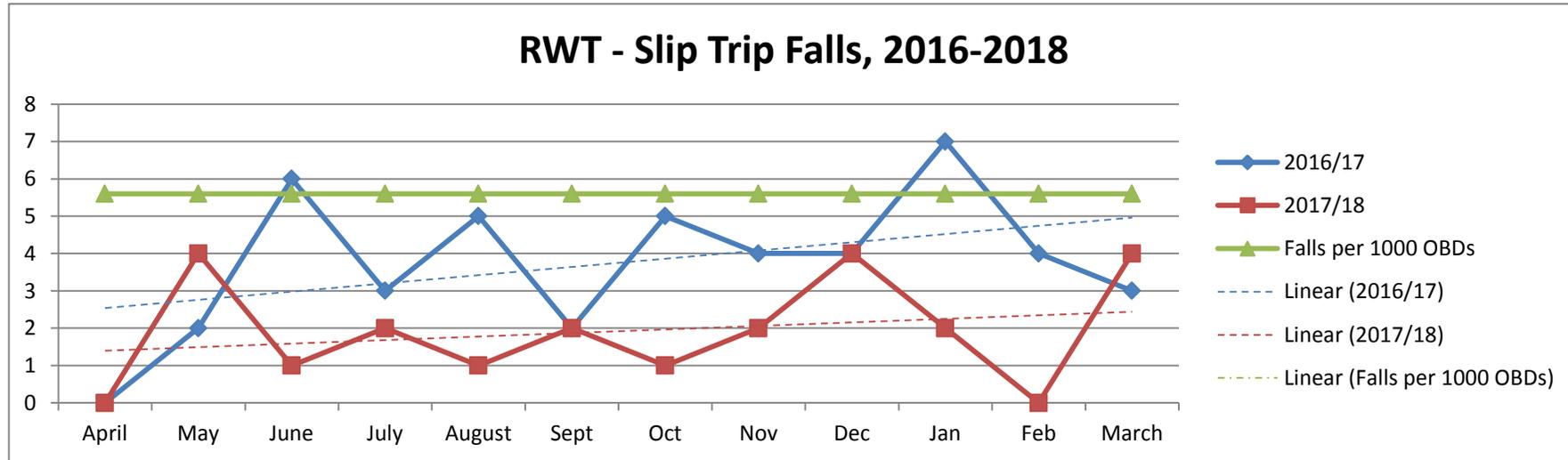
Current challenge from WCCG

- Tracking and review of diagnostic results by a responsible clinician prior to patient discharge from ED
- Robust clinical supervision/clinical support mechanism process for all junior doctors
- Empowering nurses and junior doctors to improve patient outcomes
- Shared decision making regarding patient care treatment plan and discharge from ED
- Consultant sign off for any patient who returns to ED within 72 hours
- Improving staff awareness and access to ED Sop's, policies and clinical pathways
- Improving critical aspects of ED documentation and communication by all clinicians
- Improving staff awareness of IG practices in ED
- Regular audits to check overall compliance

Emerging themes for further review and consideration:

1. Lack of senior oversight in decision making by junior Drs
2. Handover documentation/process does not appear to be systematic
3. Process for checking, not always followed

Slip Trip and Patient Falls SI's (RWT)



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There were 4 patient falls meeting SI criteria reported for March 18 which is a significant rise in number of falls reported compared to zero patient falls reported in February 18. Two of the patient falls were reported from trust acute site and 2 patient falls occurred at Cannock hospital site. 2 out of 4 patient falls were deemed unavoidable; with 1 patient fall deemed as avoidable and 1 patient fall is still awaiting falls scrutiny outcome.

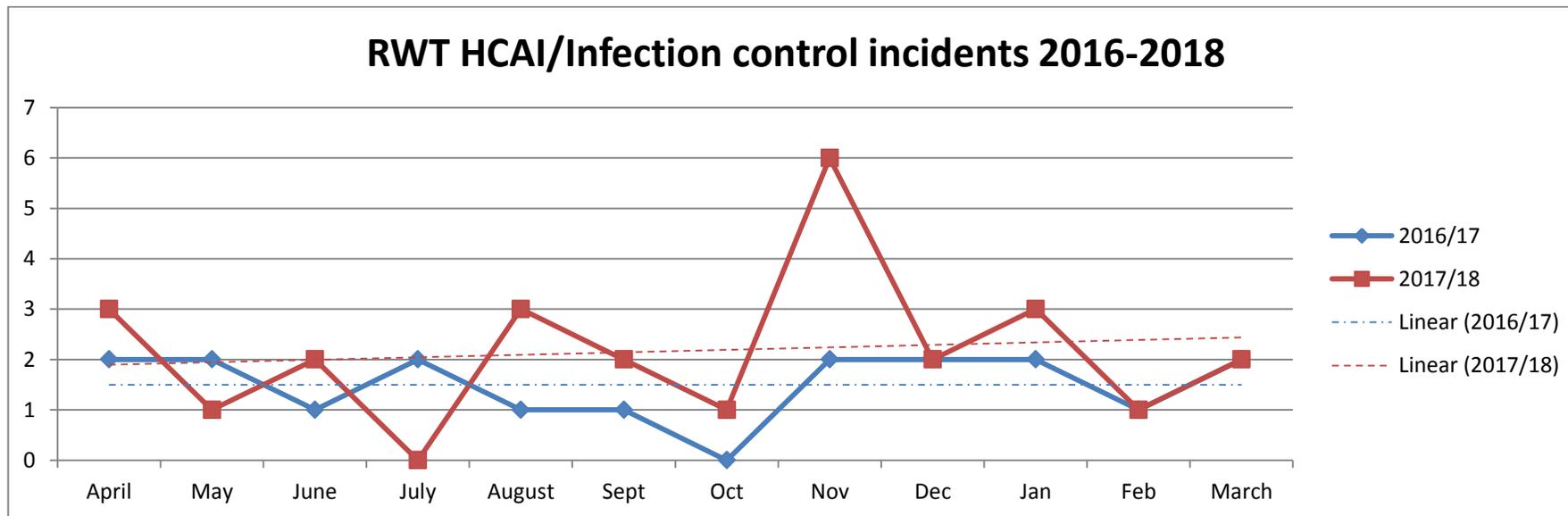
Themes identified during March, 18 falls scrutiny were as follows:

1. Medical team had not completed falls risk assessment part b.
2. Ward had not considered moving patient to a higher observation bed.
3. Medical and nursing team had not reviewed level of falls risk when patient became more unwell.
4. No provision of a high/low bed to reduce risk of harm.

Assurance

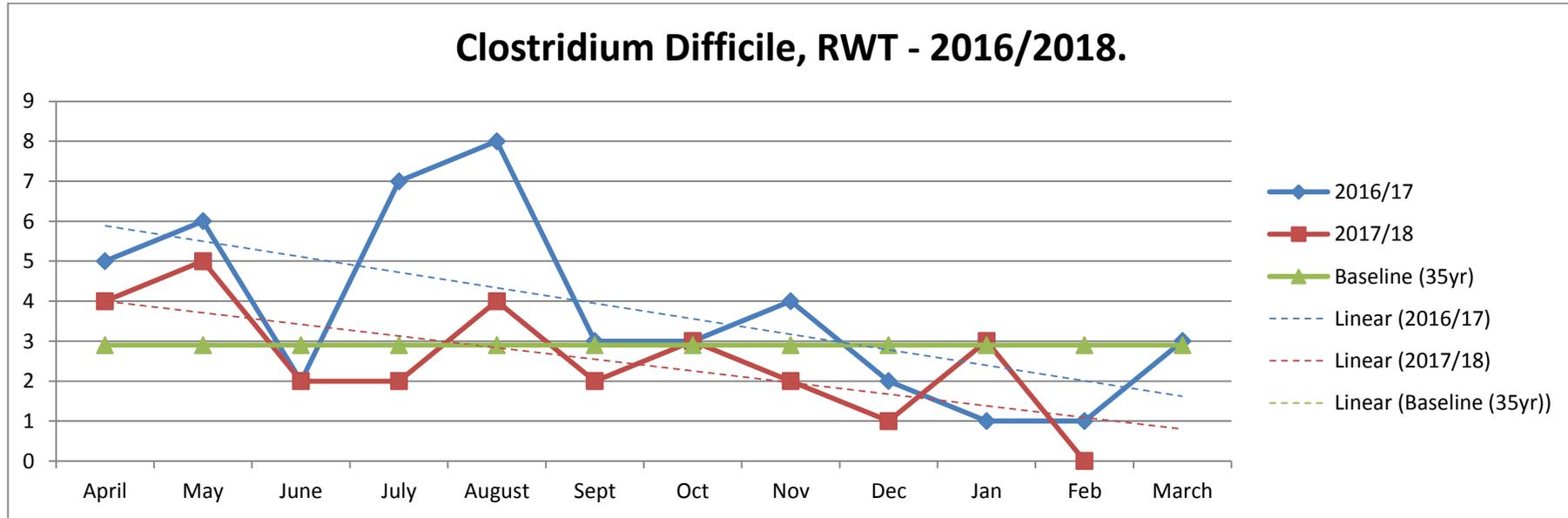
The WCCG quality and safety manager attends the weekly falls accountability meeting and also attends the monthly falls steering group meeting to seek further assurance regarding falls prevention strategies of the trust. The trust has already implemented tag nursing and arm length nursing initiatives to prevent patient falls in healthcare settings. Following roll out of the national falls collaborative the trust is undertaking the re-assessment of the early pilot wards to ensure sustainability of actions implemented. All patient falls incidents are robustly scrutinised by WCCG SISG panel before closure on STEIS.

Infection Prevention



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2 infection prevention serious incidents were reported for Feb, 18. One case relates to 3 cases of Influenza A identified on Ward 2 West Park in a 24hr period and the patient was treated as per pathway recommendations. The second case relates to 2 cases of Clostridium difficile attributed to C24 within a 28 day period identical by VNTR (variable number tandem repeat) and the trust is currently undertaking full RCA to identify root cause and learning to prevent reoccurrence of these incidents.



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No CDiff cases were positively reported by toxin test; therefore 0 were attributable to RWT using the external definition of attribution, against a target of 2 for Feb, 18. The Trust is now 4 cases ahead of target at the end of month 11.

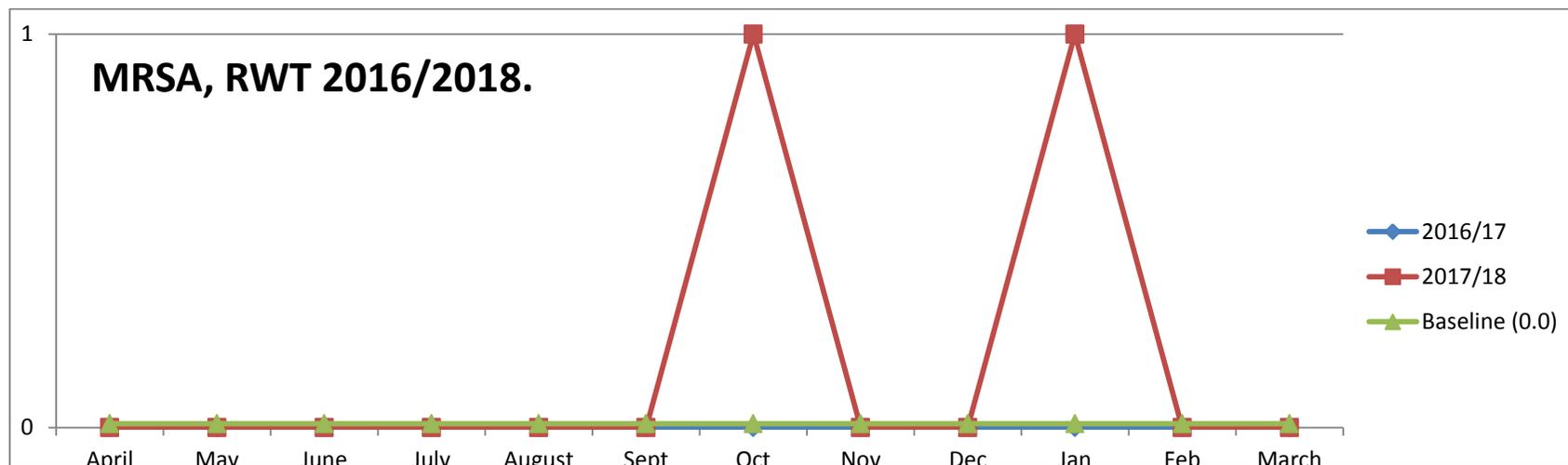
Trust actions:

- Sustainability actions continue from last year.
- Antimicrobial prescribing audits are being completed in most areas
- Trust wide IP audits report and action plan
- Use of disposable mop heads and single use curtains
- Regular deep cleaning programme for all clinical areas

Assurance

WCCG attends the RWT monthly IPCG (Infection Prevention Control Group) and RWT monthly PSIG (Patient safety Improvement group) meetings to seek assurance that the Trusts Infection Prevention and Control Strategy is fully implemented, and that policies are in place to ensure best practice and to reduce HCAs. The WCCG Quality Team also attends regular QRV's (Quality Review Visits) to clinical areas to monitor staff compliance with all IP practice.

MRSA Bacteraemia



No new MRSA bacteraemia has been reported for March, 18.

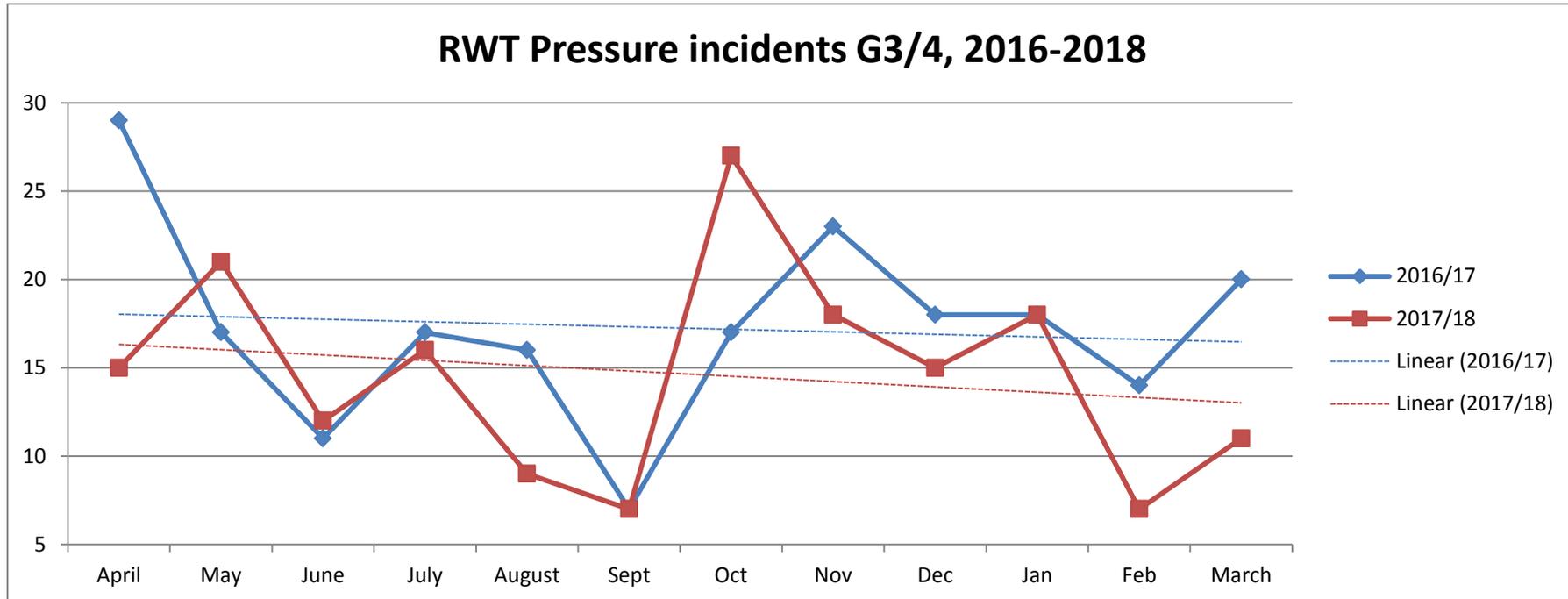
Previously, the trust reported two new MRSA bacteraemia in Oct, 17 & Jan, 18 and these two SI's has been closed on the STEIS. The themes identified from these two RCA's are as follows:

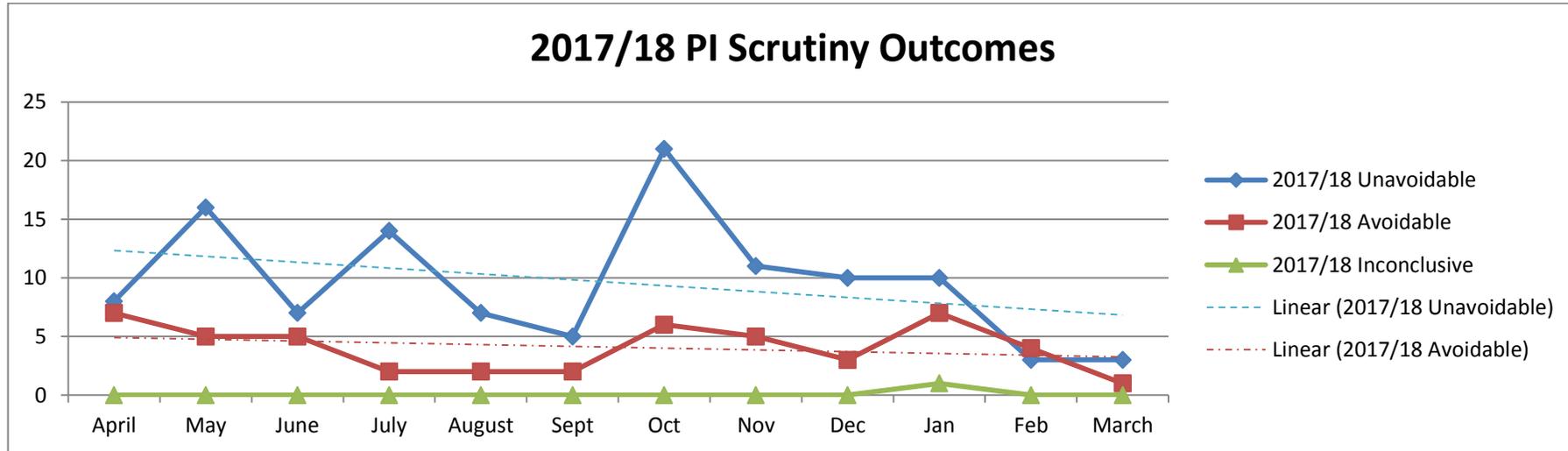
1. Non – compliance with MRSA screening on two occasions
2. Monitoring of invasive devices
3. No evidence of High Impact Intervention audit since April 2017
4. No environmental audits undertaken from June 2017 to September 2017

Trust is working on the following recommendations to prevent reoccurrence of similar SI's:

1. Staff to read IP03 - MRSA and MSSA Screening and Compliance Monitoring Guidelines
2. To achieve 100% staff completing Hand Hygiene training
3. To achieve 100% staff completing IP level 2 mandatory training
4. Cannulas to be monitored at least 8 hourly including recording VIP scores
5. Staff to be reminded to swab any skin lesions or abrasions, particularly when patients have complex skin conditions.
6. High Impact Interventions 1a, 1b, 2a and 2b to be completed in absence of specific tool for PICC (Peripherally inserted central catheter) lines.

Pressure Injury Serious Incidents





11 pressure injury incidents were reported for this reporting period which is a slight increase compared to 7 PI's reported in January 18. There were 8 category 3 and 3 category 4 pressure injuries reported for this reporting period. 2 pressure injuries were reported as avoidable, 5 pressure injuries reported as unavoidable and 1 pressure injury was deemed as inconclusive. The remaining 3 pressure injuries are still waiting to go through the scrutiny process.

The themes identified at the March 18 pressure injury scrutiny were:

- Gaps in intervention charts
- Gaps in skin assessment

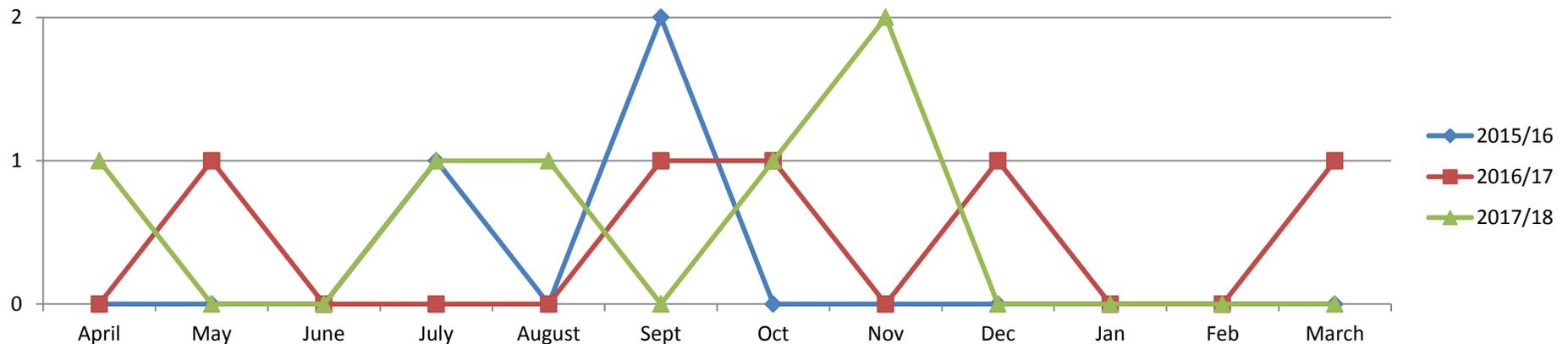
The trust is currently undertaking full RCA into all these avoidable pressure injuries and the final RCA's will be submitted to WCCG before May, 18. The Q&S manager attends the weekly pressure injury scrutiny meetings to provide further scrutiny to avoidability process.

Trust actions:

- Ward areas with an increase of incidents or recurrent avoidable incidents have had bespoke training on pressure injury prevention
- Pressure injury policy has been sent for comments and due to be agreed with the Tissue Viability Group on 21st March, so this can then be sent for approval via the Policy Group.
- The CCG have confirmed they are working with social services, to agree the financial envelope for the new equipment tender process. This now includes plans for a night service.
- The Trust will be a reference site for a MESI ABPI medical device that can assess arterial flow on patients with leg injuries quicker than a handheld device

RWT Never Events

Never Events at RWT 2015-18.



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Apr17 - 1 Retained foreign object post-procedure

July17 - 1 Wrong site surgery

Aug17 - 1 Wrong site surgery

Quality and Safety Committee Final

May 2018 v0.2(f)

Oct17 - 1 Retained foreign object post-procedure

Nov17 - 2 Wrong site surgery

The trust has reported 6 never events for 2017/2018 and all have been reported under surgical category i.e. wrong body part removed x 2, wrong site injected x 2, retained foreign object x 2. The common themes identified from these NE's are:

- Human Error
- Miscommunication
- Team Engagement
- Failure to follow policy or protocol
- Distraction
- Changes in list order
- Fatigue, work load and stress
- Bilateral pathology
- Inappropriate delegation of pre-operative list
- Failure to seek and give advice

RWT approach to mitigate Never Events

- Education
- Personal reflections and personal support
- Dissemination of all NE'S RCA's
- Human factors training
- Modifying LocSSIP's
- AfPP(Association for perioperative practice)Commission
- CQC national never event project

Assurance:

- Escalated at the RWT CQRM and trust to present the Never Events themed report at the April, 18 CQRM.

- WCCG senior exec board has met with RWT board on 18.04.2018 to seek board assurance of actions being undertaken by the trust to mitigate further never events from occurring.
- Continuous monitoring and scrutiny for all serious incidents and never events
- WCCG quality team to regularly attend RWT quality review visits
- WCCG quality team attends monthly Quality & Safety intelligence group meeting to seek assurance by regularly monitoring trust compliance for WHO surgical checklists and LOCSSIPS audits.

Maternity

No maternity incidents were reported for this reporting period. However, since June, 17 there have been 9 maternity incidents reported by the trust.

	Target	Q3 Results 2017/18				Q4 Results 2017/18		
		Oct-17	Nov-17	Dec-17		Jan-18	Feb-18	Mar-18
Adms of Full Term Babies to Neo Natal Unit	0	3	0	1		0	1	3
Elective C-Section Rates	<12%	13.4%	11.0%	9.9%		11.4%	12.6%	12.2%
Emergency C-Section Rates	<14%	12.9%	17.4%	16.1%		17.0%	20.6%	17.1%
Maternal Deaths	0	0	0	0		0	0	0
Midwife to Birth ratio	< /= 30	31.5	31.0	31.0		31.0	31.0	30
Bookings at 12+6 weeks	>90%	92.2%	93.6%	92.8%		90.5%	89.6%	91.3%
Babies being cooled (Born here)	0	2	0	0		0	1	2
Breast Feeding Initiated	>64%	63.8%	68.1%	62.2%		61.0%	62.6%	66.6%
Early Neonatal Death (born here)	3	4	0	0		3	0	0
Number of Mothers Delivered	< /= 416	448	482	434		428	374	403

Caesarean Section Rates

Elective rate 12.2%
Emergency rate 17.1%

Midwife to Birth Ratio

Midwife to birth ratio 1:30, this is driven by the number of births. Midwifery recruitment is continuing for minimum vacancy.

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

Booking by gestation 12+6 = 91.3%.

Assurance

- 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.
- Deep dive review to be reported at April CQRM by Head of Midwifery against current maternity dashboard.
- 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.
- WCCG to attend RWT Maternity QRV visit planned for 2018/2019.

Mortality

Mortality Indicators: The Royal Wolverhampton NHS Trust

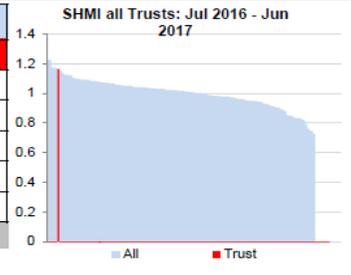


Published SHMI (HSCIC): Oct 2013 - Sep 2014 to Jul 2016 - Jun 2017

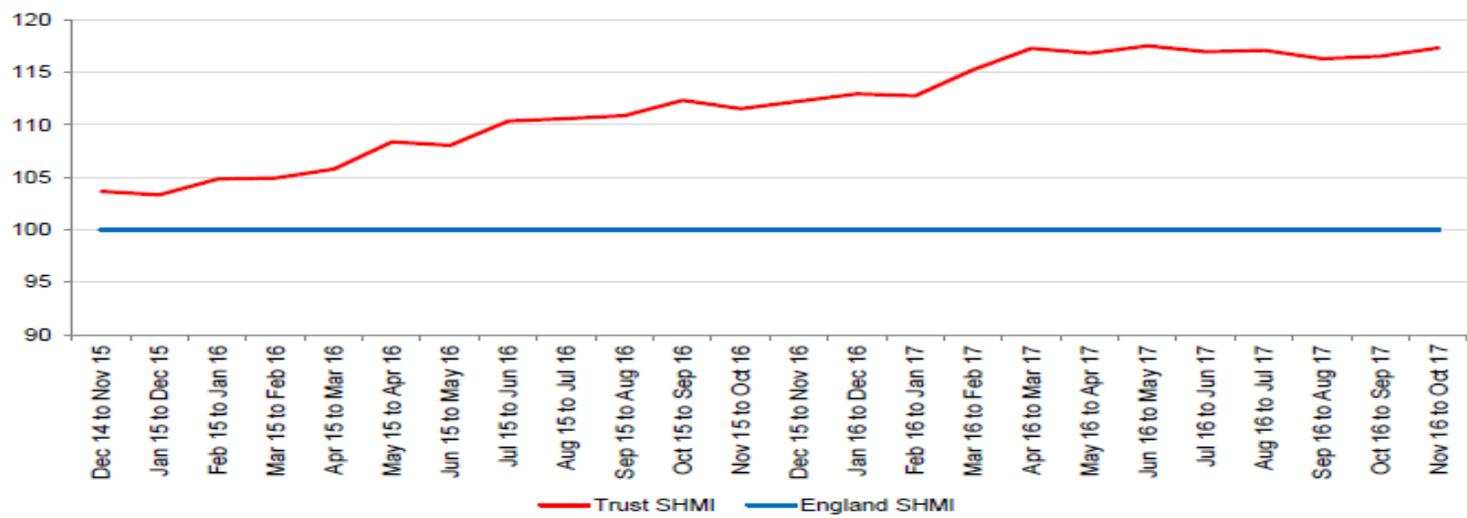
Data	Oct 2013 - Sep 2014	Jan 2014 - Dec 2014	Apr 2014 - Mar 2015	Jul 2014 - Jun 2015	Oct 2014 - Sep 2015	Jan 2015 - Dec 2015	Apr 2015 - Mar 2016	Jul 2015 - Jun 2016	Oct 2015 - Sep 2016	Jan 2016 - Dec 2016	Apr 2016 - Mar 2017	Jul 2016 - Jun 2017
SHMI	0.98	0.98	0.99	1.00	1.00	1.04	1.06	1.10	1.12	1.11	1.15	1.16
Crude Mortality Rate	3.4%	3.4%	3.6%	3.6%	3.6%	3.7%	3.6%	3.6%	3.6%	3.6%	3.7%	3.7%
England Crude Mortality Rate	3.1%	3.1%	3.1%	3.3%	3.3%	3.3%	3.3%	3.2%	3.2%	3.2%	3.3%	3.3%
Deaths in excess of expected	0	0	0	0	11	96	144	231	272	249	337	362
Lower Limit	0.90	0.91	0.91	0.90	0.91	0.90	0.90	0.89	0.89	0.90	0.89	0.89
Upper Limit	1.11	1.10	1.10	1.11	1.10	1.11	1.11	1.12	1.12	1.12	1.12	1.12

*Values for forecast SHMI are multiplied by a factor of 100, ie a published SHMI score of 0.95 equates to a forecast SHMI score of 95

High Outlier Low Outlier



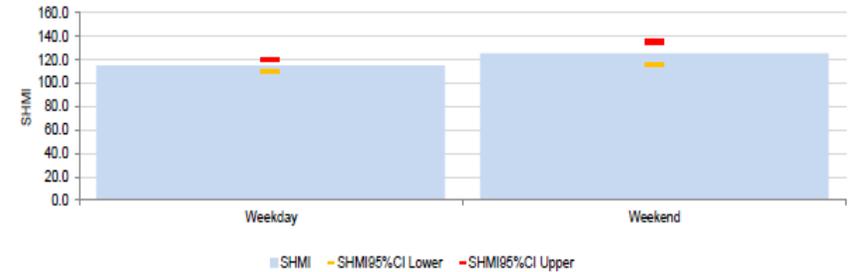
SHMI (rolling 12 month) to Oct 2017



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SHMI (HED) - Weekday and Weekend mortality: to Oct 2017

Time of week	SHMI	SHMI95% CI Lower	SHMI95% CI Upper	Expected number of deaths	Number of observed mortalities	Excess deaths
Weekday	115.0	109.9	120.2	1690.2	1943	252.8
Weekend	125.3	115.8	135.3	514.0	644	130.0



Statistically higher than average

The estimated SHMI for November 2016 to October 2017 was 117.4 and banded higher than expected. At the next NHS Digital publication, the SHMI for RWT for the period October 2016 to September 2017 is estimated to be 1.18 and again banded higher than expected. RWT is a national outlier for this performance. The crude mortality trends have not seen any significant changes, the expected mortality rate for RWT continues to be lower than England's. The actual crude mortality for in-hospital deaths is lower in 2018 compared with the previous three years at the trust.

For the period April 2017 – January 2018 there were 1651 adult inpatient deaths at the Trust. Of these 67.4% had an initial mortality review by the end of January and 46.7% had a review using the SJR methodology, which was introduced in August 2017.

Risk Mitigation:

- Clinicians have been trained to undertake Stage 2 reviews and a working group has been set up to set out a method for allocating cases for stage 2 reviews in accordance with the established policy.
- Work is in progress to implement the changes in the creation of finished consultant episodes on admission to AMU.
- Changes have been made to clerking documentation to improve the clarity of primary diagnoses and comorbidities on admission to hospital, thus aiding richer coding.

- The Head of Coding and Data quality has drafted a plan to address education and collaborative working between coders and clinicians with the aim to improve documentation accuracy.
- Further understanding and more detailed work is required to identify concrete measures for monitoring progress and improvements.

To further explore a local system approach to mortality, with specific reference to patient deaths within 30 days of hospital discharge, ensuring end of life pathways are robust.

Cancer Waiting Times/Cancer Target Compliance

	Target	Q3 2017/18			Q4 2017/18			
		Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Mar-18
2 Week Wait Cancer	93%	94.85%	93.54%	88.57%	90.78%	93.91%	91.52%	Excluding Tertiary Referrals
2WW Breast Symptomatic	93%	97.45%	93.39%	53.00%	93.33%	95.28%	87.60%	
31 Day to First Treatment	96%	97.51%	97.82%	97.35%	96.36%	97.06%	96.21%	
31 Day Sub Treatment - Anti Cancer Drug	98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
31 Day Sub Treatment - Surgery	94%	94.59%	94.55%	85.71%	71.70%	84.85%	82.50%	
31 Day Sub Treatment - Radiotherapy	94%	97.58%	98.04%	96.05%	98.06%	100.00%	90.54%	
62 Day Wait for First Treatment	85%	76.99%	76.34%	73.94%	70.66%	66.85%	74.13%	76.92%
62 Day Wait - Screening	90%	100.00%	82.46%	74.19%	60.00%	92.31%	74.07%	75.00%
62 Day Wait - Consultant Upgrade (local target)	88%	93.20%	93.53%	89.47%	90.82%	86.00%	90.00%	91.94%

62 Day Target by Cancer Site

Site	Total Patients	Breaches	%
Breast	18	1	94.44%
Colorectal	10	4	60.00%
Gynaecology	5.5	3	45.45%
Haematology	4	0	100%
Head & Neck	4	3.5	12.50%
Lung	4	1	75.00%
Other	0	0	
Sarcoma	0	0	
Skin	20.5	0	100%
Upper GI	12	5.5	54.17%
Urology	22.5	8	64.44%
Total	100.5	26	74.13%

2 Week Wait - 112 patient breaches in month - 66 x patient initiated, 41 x capacity, 5 x late referrals
2 Week wait breast symptomatic - 15 patient breaches in month - 7 x patient initiated, 8 x capacity issues
31 Day sub radiotherapy - 7 patient breaches in month - all capacity issues
31 Day Sub Surgery - 7 x patient breaches in month - all capacity issues.
62 Day Traditional - 26 patient breaches in month - 4 x Tertiary referrals received between days 40 and 104 of the patients pathway (operating guidelines state referrals should be made within 42 days), 10.5 x Capacity Issues, 1 x Patient Initiated and 1 x Complex Pathways, 7 x Further investigations required, 0.5 x Delay in receiving information from tertiary referral, 2 x referral out to other trust
 Of the tertiary referrals received 3 (75%) were received after day 40 of the pathway, and 1 (25%) was received after day 100 of the patient pathway.
62 Day screening - 3.5 patient breaches in month - 3 x capacity issues, 0.5 x tertiary referral
Patients over 104 days - There are currently 21 patients at 104+ days on the cancer waiting list (compared with 21 reported in February), all of these patients have had a harm review and no harm has been identified.

RWT is currently predicting possible failure of the 2 Week Wait, 2 Week Wait Breast Symptomatic, 31 Day Sub Surgery, 31 Day Sub Radiotherapy, 62 Day Wait for first treatment and 62 Day Wait Screening For March 2018, validation is on-going. Final cancer data is uploaded nationally 6 weeks after month end. Cancer performance for the trust remains an area requiring further assurance. In particular 62 and 104 day cancer performance requires further assurance to ensure any potential or actual impact of harm for patients is understood and mitigated.

Risk Mitigation:

- CCG Chief Nurse and Chief Operating Officer have met with RWHT COO and lead cancer clinician to seek further assurance with regards performance, a range of actions are underway following the meeting, these include:
 - Awaiting assurance documentation from the trust pertaining to harm review process undertaken by the trust
 - How evidence of duty of candour is supported
 - Attendance at weekly cancer PTL meeting for further assurance and scrutiny of performance agreed with RWHT
 - Speciality level performance data awaited from Trust
 - Agreed focus of scrutiny with regards 104 day waits initially
 - IST to undertake a review of tracker activity on behalf of the trust during May/June
 - Agreement to utilise UHB tertiary referral forms agreed by the trust
- The revised RAP has been rejected by the CCG with regards the trajectory set by the trust and a discussion with regards revised trajectory is currently on going
- WCCG have requested to see a report on the work that has been done by Millar Bowness for head and neck pathways and to ascertain if some of the improvements would be transferrable to other cancer sites, this is awaited but expected May.
- Additional capacity has been identified in radiotherapy for CT scanning although workforce may be challenging to support this.
- Remains a high risk on both RWHT and WCCG risk registers
- Cancer network and NHSE are sighted on current performance and support the ongoing work with the trust

Cytology Incident

In April, 18 WCCG was made aware about a cervical screening incident at RWT. A review meeting has taken place, led by PHE to agree a range of actions, these include effective communications, to include patient & GP letters. This incident was discussed in length and it was decided this incident doesn't meet the criteria to be reported as a serious incident. A further update is currently awaited.

Total Time Spent in Emergency Department (4 hours)

Urgent Care
Total Time Spent in Emergency Department (4 hours)

	Target	Q3 2017/18			Q4 2017/18		
		Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
New Cross	95%	86.88%	80.54%	78.41%	73.80%	76.08%	74.57%
Walk in Centre		100.00%	100.00%	99.40%	100.00%	100.00%	100.00%
Cannock MIU		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Vocare		94.76%	92.12%	94.67%	93.90%	96.29%	96.02%
Combined		91.55%	87.43%	87.03%	84.73%	86.27%	85.08%



Ambulance Handover

	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Number between 30-60 mins	0	33	69	54	27	48	70	46	99	122	199	102	131
Number over 60 minutes	0	1	2	5	0	5	2	1	9	21	66	28	22

Comments: The fine for Ambulances during March was £48,200.00. This is based on 131 patients between 30-60 minutes @ £200 per patient and 22 patients >60 minutes @ £1,000 per patient.

There were no patients who breached the 12 hour decision to admit target during March 2018.

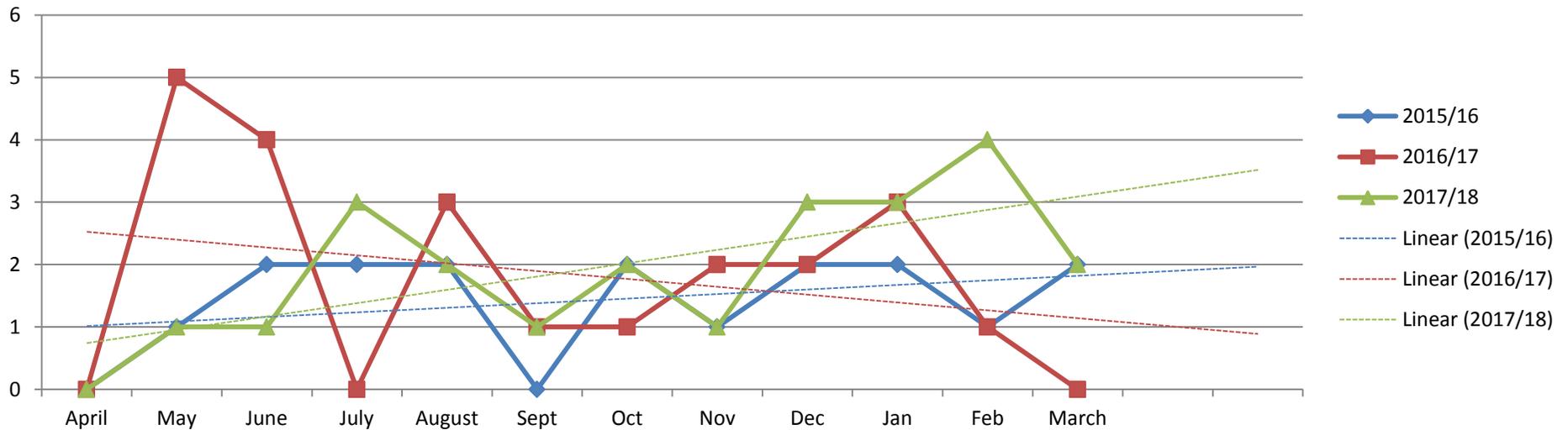
The Trust failed to achieve both Type 1 and the All Types target for the month. Activity pressures in the system continued in March as had been expected throughout, the trust overall performance for March was 85.08%, RWT ranking 64th nationally, and 51st for quarter 4. There were no patients who breached the 12 hour decision to admit target during the month.

2. BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

The Committee is asked to note the following:

a) Serious Incidents

BCPFT Incidents 2015-2018



There were 2 serious incidents reported under by Black Country Partnership Foundation Trust in March 2018 compared to 4 SI's reported for February, 18.

These two SI's were reported under Apparent/actual/suspected self-inflicted harm meeting SI criteria category. The trust is undertaking full RCA into these two SI's and the final RCA will be submitted to WCCG for closure in June, 18.

BCPFT CQRM

Items to note from CQRM held on the 6th March 2018 (theme: CAMHS)

- 23 incidents were reported across the CYPF Division for the reporting period.
- There was no medication error incidents reported during January 2018. (January data used due to BCP reporting cycle)
- There were no STEIS reportable incidents or Never Events reported during January 2017 across the CYPF division.
- There were currently 14 active risks for CYPF services.
- The audit plan had been agreed by the Division including the NICE guidelines baseline audits. This plan had been actively monitored by the Clinical Effectiveness Group. CQUINs are monitored separately with regular meeting with commissioners.
- Across the Division, sickness rates are below the KPI, even though there had been a slight increase in both short-term & long term sickness. The Trust had met its KPIs for Safeguarding Training, Specialist Mandatory Training, and Mandatory training.

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BCPFT Safeguarding incident

There has been a safeguarding concern raised by Birmingham Cross City CCG with regards an unannounced visit undertaken at Daisy Bank, an assessment centre for LD patients overseen by Black Country Foundation NHS Trust. Significant concerns with regards medication management, use of restraint, availability of meaningful activities, possible use of cohesive practices and the culture and leadership of the service. There were no Wolverhampton patients within the unit at the time of the visit, although Birmingham, Walsall and Dudley had patients placed and also undertook responsive visits to the unit. BCPFT undertook an immediate response and mobilised senior clinical managers to undertake an unannounced inspection to the unit over the weekend (the following day after Bham visit), additional follow up visits have been undertaken by the trust and there were no immediate risks identified as a result of the visit. Some practice issues were identified but remedial mitigation was immediately sought and these are now resolved. The issue identified as possible coercive practice was managed with immediate effect by the BCPFT leadership team to ensure it ceased once made aware of it. Staff has since received training as to why the use of the intervention was incorrect.

As a result of the level of concern a responsive visit was also undertaken by CQC, verbal feedback from the Chief Nurse advises CQC found that least restrictive practice was being implemented, with person centred physical intervention plans that were detailed, person centred and reflected the dynamic and complex needs of the patients using the service. Strategies were in place for monitoring and reviewing the use of medication, its prescription and administration. They found that patients appeared happy and that staff were able to demonstrate an awareness of their individual needs and appropriate strategies to engage them effectively. The two inspectors that visited Daisy Bank were assured following the inspection that patients were safe, receiving appropriate care and treatment reflective of their individual needs and that the culture of the service was positive and patient centred.

3. PRIVATE SECTOR PROVIDERS

VOCARE

There were no serious incidents reported by Vocare in March, 2018

Assurance due to ongoing concerns:

- Monthly CQRM/CRM meetings
- 6 weekly Vocare Improvement board meetings
- Announced and unannounced visits by WCCG
- WCCG weekly Vocare progress review meetings
- 8 week turnaround plan has been negotiated with the provider. A recent CQC follow up visit has been completed and verbal feedback provided with evidence of some improvement
- Continuous monitoring for SI's, complaints or any other emerging quality issues

NEPTS (Non-emergency Patient Transport Services) - WMAS

As previously reported to Q&SC that there was difference of opinion between the CCG and WMAS as to whether an incident that took place in March 2017 was reportable due to patient harm threshold, this was escalated to NHSE in December, and it was further escalated to NHSI by NHSE in January, 18 and decision still remains outstanding at the time of reporting.

Assurance:

- Monthly CQRM/CRM meetings
- Continuous monitoring for SI's, complaints or any other emerging quality issues pertaining to the service, considering any themes/trends that may arise
- Escalated to chief officer/NHSE

KPI's are currently being reviewed by WCCG/DCCG based on a proposal by WMAS

4. CHILDRENS SAFETY

4.1. Safeguarding Children

SCR

The Serious Case Review Committee of Wolverhampton SCB held an extraordinary meeting to discuss the case of the Wolverhampton child murdered in February 2018. A recommendation was made to the Independent Chair of WSCB that a SCR should be carried out.

WCCG are also involved in a SCR taking place in Croydon, both with the provision of information and attending as a panel member – sharing this responsibility with the LA Head of Safeguarding.

Joint Targeted Area Inspection (JTAI)

In January 2016, the government published guidance on a new multi-agency inspection framework called the JTAI. The JTAIs are joint inspections carried out by Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspectorate of the Constabulary (HMIC) and Her Majesty's Inspectorate of Prisons and Probation (HMIP).

The JTAs are unannounced and Wolverhampton should expect (alongside any other local authority in England) that we may be called upon for inspection, with WCCG playing a key role. Work is underway, led by the LA and WSCB Manager, to ensure appropriate arrangements are in place across the partnership to enable all partners to respond effectively. The WCCG Designated Nurses are working closely with the board manager and in liaison with the safeguarding leads from RWT and BCPFT to ensure arrangements are in place for their respective organisations.

5.2 LAC Update

- The WCCG were informed in March of a medication error on a looked after young man who is tri-partite funded through the External Placement Panel. He resides at Priory Rugeley Horizon School in Staffordshire, a residential home for complex physical needs. He was given an unintentional increase of his Sertraline from 50mg to 100mg. Following a thorough investigation by children's social care, a number of actions were taken, including notifying Ofsted, and recommendations were made. Assurance was sought that the young man involved suffered no negative side effects.
- The Designated Nurse LAC undertook an announced quality assurance visit on the 28th March to review the health files in order to offer assurance to the CCG that appropriate actions have been taken. It was evident from the visit that significant learning had occurred as a result of the medication error, and immediate changes to practise had been implemented appropriately. Health documentation was clear and up to date.
- Further recommendations were made as a result of the visit and incorporated within the report. There were no additional concerns identified.

5. ADULT SAFETY

6.1 Care Homes

The last Quality Assurance in Care Homes report was presented in February 2018 for Q3.

The Q4 report will be presented at the next meeting.

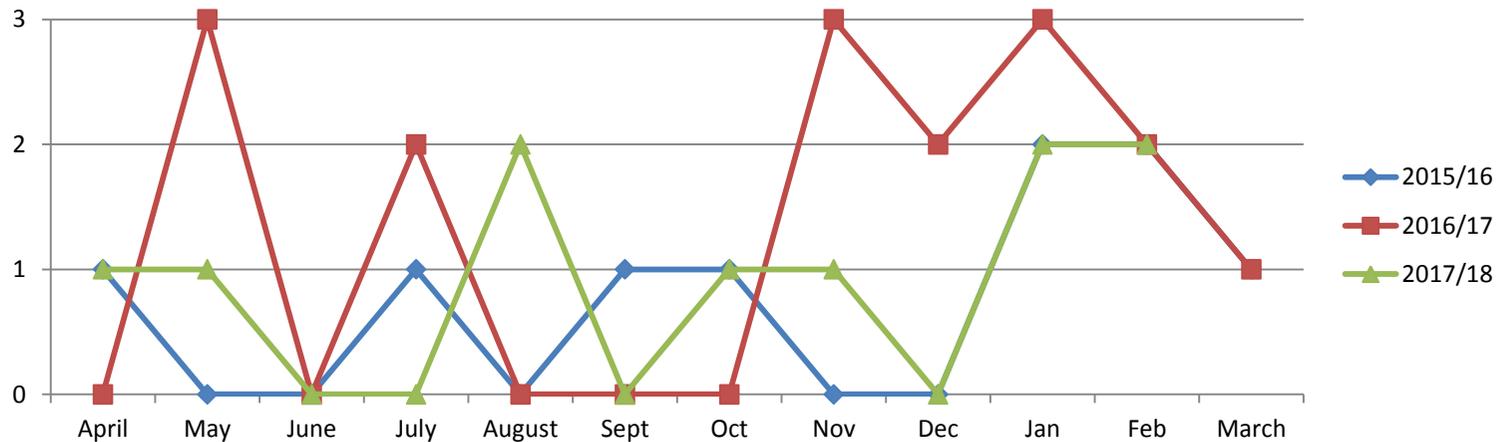
6.2 Adult Safeguarding

- **SAR – 01/2018** – the agency overview report for the GP has been completed. Recommendations are currently being agreed
- **Project update** – Empowerment of Hard to Reach Communities in the Prevention of Violence against Women and Girls - **26 women and 35 men** have completed training- thus targets have been exceeded- (even despite the delaying of the March women’s session), the men’s target has been exceeded by 300%-. 7 sessions have been held: 3 for women and 4 for men- an extra session for males was held to increase numbers. All participants have been invited to give written feedback this has been extremely positive. 100% participants felt that they had learned from the session, that the session would help them pass on messages about this topic to their community and that they now knew where and how they could access support if they became aware of a crime in this area. The project will continue to run until November 20.

7 USER AND CARER EXPERIENCE

7.1 Formal Complaints.

CCG Formal Complaints



Within February 2018 there were two new formal complaints registered by the CCG. One of the complaints was investigated and closed; the other complaint is ongoing within timeframe.

The CCG has also registered 9 concerns or complaints for other commissioned providers where the complainant has contacted the CCG in the first instance, in all 9 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. There is one formal complaint ongoing in total at the end of February 2018.

7.2 NICE Assurance

The next NICE Assurance Group meeting will be held in May 2018.

8. RECOMMENDATIONS

The Committee 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: Sally Roberts

Job Title: Chief Nurse

Date: April, 2018

	Details/Name	Date
Clinical View	S Parvez	25.04.2018
Public/ Patient View	N/A	
Finance Implications discussed with Finance Team	N/A	
Quality Implications discussed with Quality and Risk Team	S Parvez	25.04.2018
Equality Implications discussed with CSU Equality and Inclusion Service	N/A	
Information Governance implications discussed with IG Support Officer	N/A	
Legal/ Policy implications discussed with Corporate Operations Manager	N/A	
Other Implications (Medicines management, estates, HR, IM&T etc.)	N/A	
Any relevant data requirements discussed with CSU Business Intelligence	N/A	
Signed off by Report Owner (Must be completed)	S Parvez	25.04.2018

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WOLVERHAMPTON CCG

GOVERNING BODY – Tuesday 8 May 2018

Agenda item 14

Title of Report:	Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 24th April 2018
Report of:	Tony Gallagher – Chief Finance Officer
Contact:	Tony Gallagher – Chief Finance Officer
Governing Body Action Required:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
Purpose of Report:	To provide an update of the WCCG Finance and Performance Committee to the Governing Body of the WCCG.
Recommendations:	<ul style="list-style-type: none"> • Receive and note the information provided in this report.
Public or Private:	This Report is intended for the public domain.
Relevance to CCG Priority:	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.
Relevance to Board Assurance Framework (BAF):	
<ul style="list-style-type: none"> • Domain 1: A Well Led Organisation 	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"> • Domain2: Performance – delivery of commitments and improved outcomes 	The CCG must meet a number of constitutional, national and locally set performance targets.
<ul style="list-style-type: none"> • Domain 3: Financial Management 	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	Out turn	Variance o(u)	RAG
Expenditure not to exceed income	£9.130m surplus	£11.286m surplus	(£2.156m)	G
Capital Resource not exceeded	nil	nil	Nil	G
Revenue Resource not exceeded	£405.516m	£405.516m	Nil	G
Revenue Administration Resource not exceeded	£5.535m	£5.326m	(£0.209m)	G

Non Statuory Duties	YTD Target	YTD Actual	Variance o(u)	RAG
Maximum closing cash balance	£415k	£85k	(£330k)	G
Maximum closing cash balance %	1.25%	0.26%	(0.99%)	G
BPPC NHS by No. Invoices (cum)	95%	99%	(4%)	G
BPPC non-NHS by No. Invoices (cum)	95%	98%	(3%)	G
QIPP	£10.61m	£10.58m	£0.03m	A
Programme Cost *	£386,985k	£388,904k	£1,918k	G
Reserves *	£3,866k	£0k	(£3,866k)	G
Running Cost *	£5,535k	£5,326k	(£209k)	G

- The position presented is a reflection of the unaudited Annual Accounts.
- The net effect of the three identified lines (*) is an under spend.
- The CCG has been required to increase its control total (surplus) from £9.130m to £11.26m as a result of NHSE guidance to release the 0.5% reserve (£1.73m) and £400k relating to the release of the benefit of Cat M drugs.
- Programme Costs overspent which was fully compensated for by under-spends on Running Costs and reserves.
- Royal Wolverhampton Trust (RWT) M11 data indicates a potential forecast out turn (FOT) of c £2.8m. This level has been incorporated within the position.
- Mental Health Complex cases are continuing to over perform.
- Within Delegated Primary Care there is a considerable level of flexibility. Any uncommitted budget has been used non-recurrently to support the financial position as the Delegated Primary Care budget is ring fenced on a recurrent basis
- Prescribing has reported an increased underspend due to the release of the benefit of Category M Drugs (off patent)
- No additional QIPP has been identified in M12. The CCG is reporting achieving its QIPP target as shortfall is being covered by reserves and other under-spends. However, the actual achievement of reduced activity levels associated with QIPP schemes has not materialised in full and is manifesting itself 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 M12					
		Outturn £'000	Variance £'000 o/(u)	Var % o(u)	In Month Movement Trend	In Month Movement £'000 o(u)	Previous Month FOT Variance £'000 o/(u)
Acute Services	194,673	198,010	3,337	1.7%	●	454	2,883
Mental Health Services	36,248	36,719	470	1.3%	●	231	239
Community Services	48,547	47,738	(810)	(1.7%)	●	(172)	(638)
Continuing Care	14,485	13,922	(563)	(3.9%)	●	(98)	(465)
Primary Care Services	52,374	52,224	(149)	(0.3%)	●	(444)	295
Delegated Primary Care	35,302	34,428	(874)	(2.5%)	●	(84)	(790)
Other Programme	5,356	5,864	507	9.5%	●	(33)	540
Total Programme	386,985	388,904	1,918	0.5%	●	(145)	2,063
Running Costs	5,535	5,326	(209)	(3.8%)	●	66	(275)
Reserves	3,866	0	(3,866)	(100.0%)	●	(2,078)	(1,788)
Total Mandate	396,386	394,230	(2,156)	(0.5%)	●	(2,156)	0
Target Surplus	9,130	0	(9,130)	(100.0%)	●	0	(9,130)
Total	405,516	394,230	(11,286)	(2.8%)	●	(2,156)	(9,130)

	Annual Budget £'000	Outturn £'000	Variance £'000 o(u)	Yr End Variance Recurrent £'000	Yr End Variance Non Recurrent	Yr End Variance %
Acute Services	194,673	198,010	3,337	2,080	1,257	0
Mental Health Services	36,248	36,719	470	1,029	(559)	0
Community Services	48,547	47,738	(810)	71	(881)	(0)
Continuing Care	14,485	13,922	(563)	(406)	(158)	(0)
Primary Care Services	52,374	52,224	(149)	(1,285)	1,136	(0)
Delegated Primary Care	35,302	34,428	(874)	0	(1,222)	(0)
Other Programme	5,356	5,864	507	6,418	(5,910)	0
Total Programme	386,985	388,904	1,918	7,907	(6,337)	0
Running Costs	5,535	5,326	(209)	0	(209)	(0)
Reserves	3,866	0	(3,866)	(3,518)	0	(1)
Total Mandate	396,386	394,230	(2,156)	0	0	(0)
Target Surplus	9,130	0	(9,130)	0	(9,130)	(1)
Total	405,516	394,230	(11,286)	4,389	(15,675)	(0)
Recurrent/Non Recurrent Adjustment				(4,721)	4,721	
Removal of Target Surplus					9,130	
Residual Position				(332)	(1,824)	

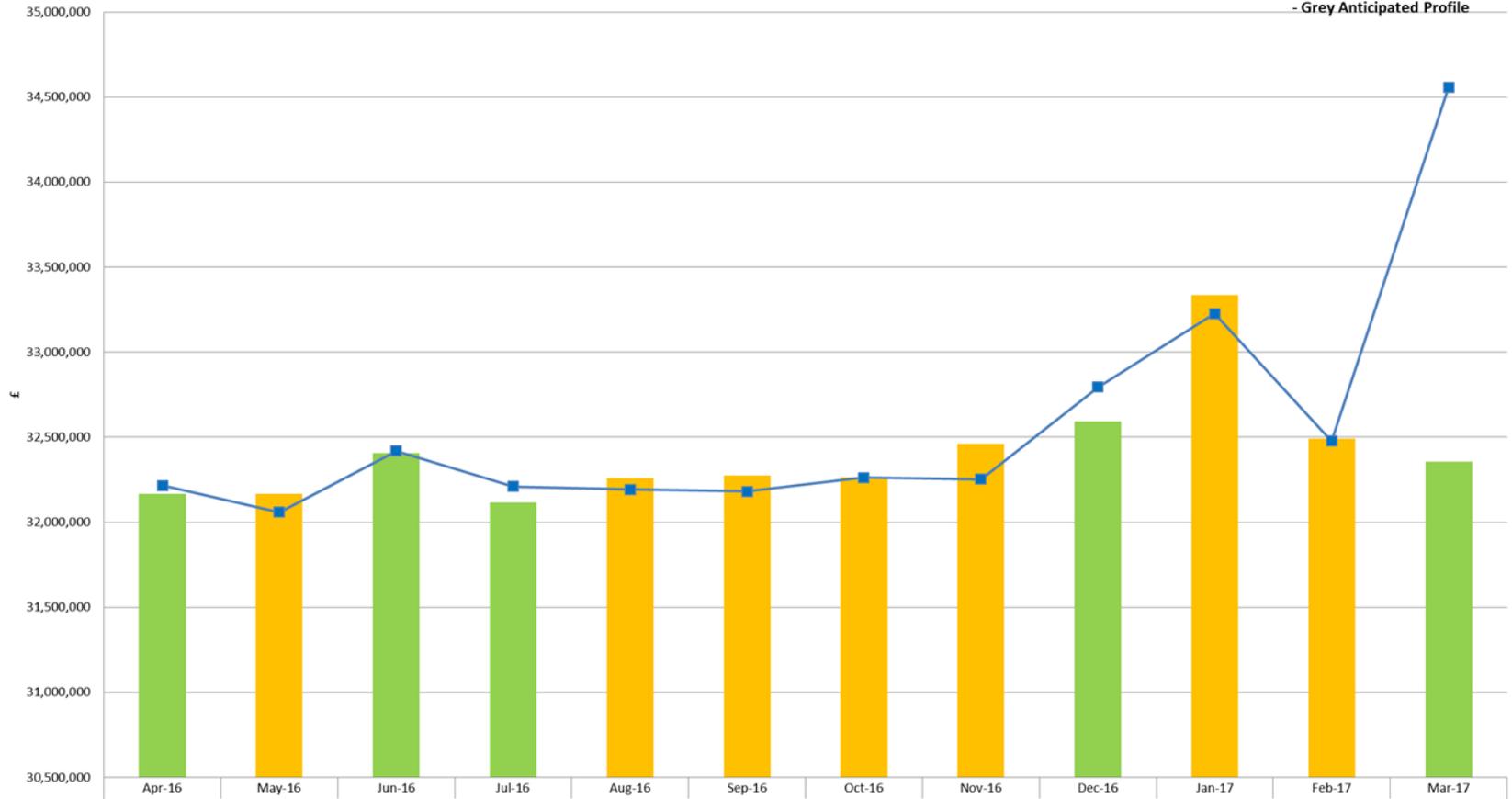
- Of the recurrent year end variance, £4.721m is a consequence of recurrent spend being offset by a non-recurrent allocation in relation to HRG4+ and IR (national coding and costing changes which impacted upon the 17/18 contract). The CCG will have a non-recurrent allocation again in 18/19. Thereafter 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 £0.332m as a result of small budget movements and technical adjustments.
- 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. This is clearly detailed in the following table.

- As mandated by NHSE the CCG has released 0.5% of its 1% reserve.

	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	(1,729)	0	(1,729)
Delegated Primary Care 1%	348	0	348	0	(348)	(348)
Total	3,866	0	3,866	(3,518)	(348)	(3,866)

Monthly Planned vs Monthly Actual Programme Expenditure

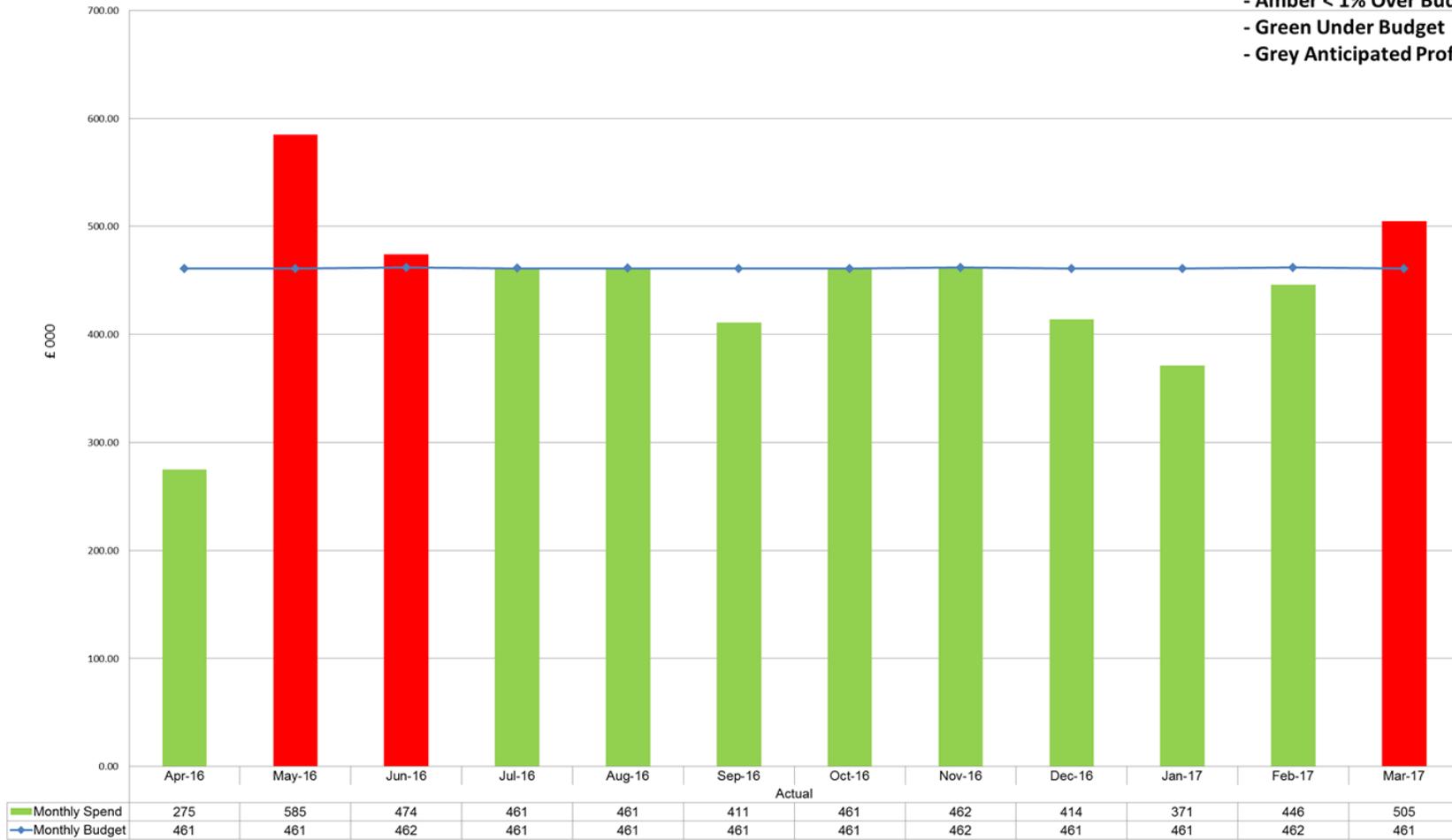
KEY
 - Red > 1% Over Budget
 - Amber < 1% Over Budget
 - Green Under Budget
 - Grey Anticipated Profile



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Monthly Spend	32,168,633	32,168,633	32,406,114	32,115,983	32,261,086	32,276,159	32,264,036	32,459,638	32,594,105	33,337,005	32,493,783	32,358,422
Monthly Budget	32,215,917	32,058,677	32,419,198	32,210,360	32,193,026	32,181,060	32,263,166	32,252,330	32,794,245	33,226,569	32,477,982	34,558,470

Monthly Planned vs Monthly Actual Running Cost Expenditure £000's

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.

2. Delegated Primary Care

- Delegated Primary Care allocations for 2017/18 as at M12 are £35.650m. The forecast outturn is £34.428m delivering an underspend position of £1.221m.

- This underspend position of £1.22m relates to the release of an accrual previously managed by NHSE of £790k. The additional underspend (£433k) relates to schemes which did not materialise in 17/18 and will commence in 18/19.

- The 0.5% contingency and 1% reserve has be committed in line with the 2017/18 planning metrics under other GP Services.

- The table below shows the out turn for month 12:

	Annual Budget £'000	Outturn £'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	21,002	21,000	(2)	●	(2)	0
General Practice PMS	1,809	1,769	(40)	●	(40)	0
Other List Based Services APMS incl	2,298	2,587	289	●	289	0
Premises	2,684	2,873	189	●	189	0
Premises Other	90	61	(29)	●	(29)	0
Enhanced services Delegated	845	660	(185)	●	(185)	0
QOF	3,622	3,750	128	●	128	0
Other GP Services	2,777	1,727	(1,050)	●	(260)	(790)
Delegated Contingency reserve	174	0	(174)	●	(174)	0
Delegated Primary Care 1% reserve	348	0	(348)	●	(348)	0
Total	35,649	34,428	(1,221)	●	(431)	(790)

3. QIPP

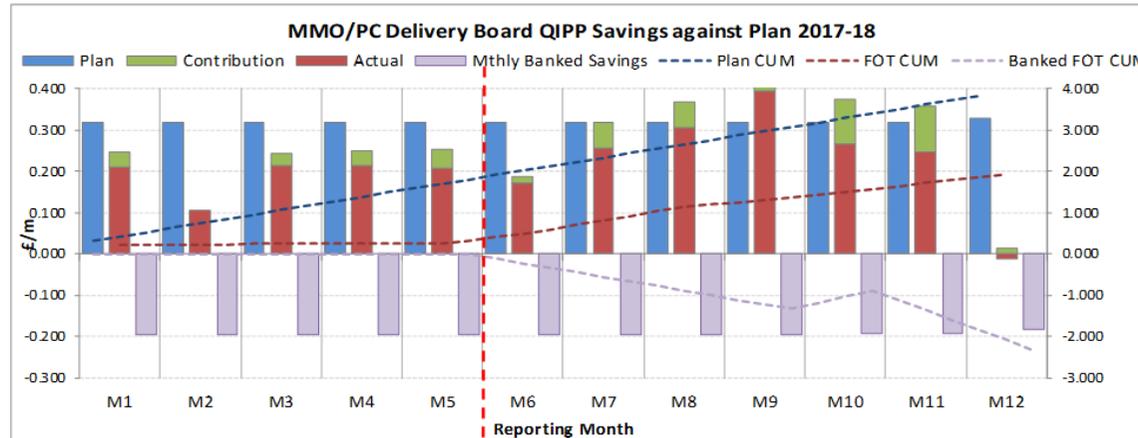
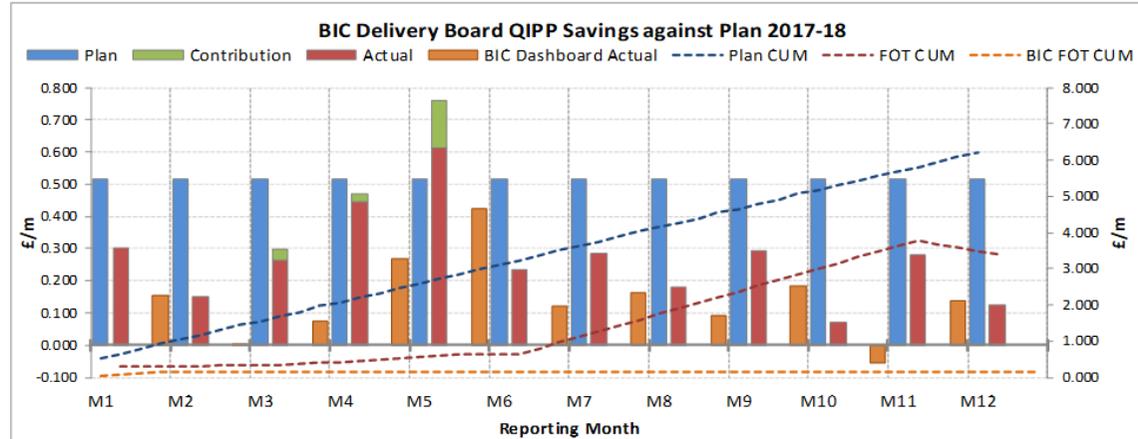
The key points to note are as follows:

- 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 M12.
- QIPP schemes have delivered c 55% of the overall total leaving £4.756m to be covered through reserves and general underspends therefore enabling the overall QIPP target to be delivered.
- 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.

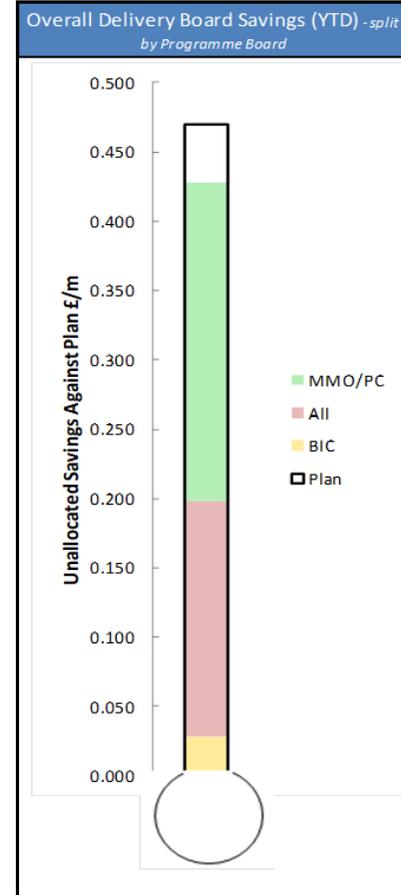
Mth 12 - Mar 17/18

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 March 2018 is shown below.

	31 March '18 £'000	28 February '18 £'000	Change In Month £'000
Non Current Assets			
Assets	0	0	0
Accumulated Depreciation	0	0	0
	0	0	
Current Assets			
Trade and Other Receivables	2,708	1,461	1,247
Cash and Cash Equivalents	85	81	4
	2,793	1,543	
Total Assets	2,793	1,543	
Current Liabilities			
Trade and Other Payables	-35,111	-35,130	19
	-35,111	-35,130	
Total Assets less Current Liabilities	-32,318	-33,588	
TOTAL ASSETS EMPLOYED	-32,318	-33,588	
Financed by:			
TAXPAYERS EQUITY			
General Fund	32,318	33,587	-1,270
TOTAL	32,318	33,587	

Key points to note from the SoFP are:

- The CCG has achieved its cash target for the year with an outturn of 0.26% against a target of no greater than 1.25%, (see 13.2 below);
- The CCG ended the year with a high performance against the BPPC target of paying at least 95% of invoices within 30 days, (98% for non-NHS invoices and 99% for NHS invoices);

5. PERFORMANCE

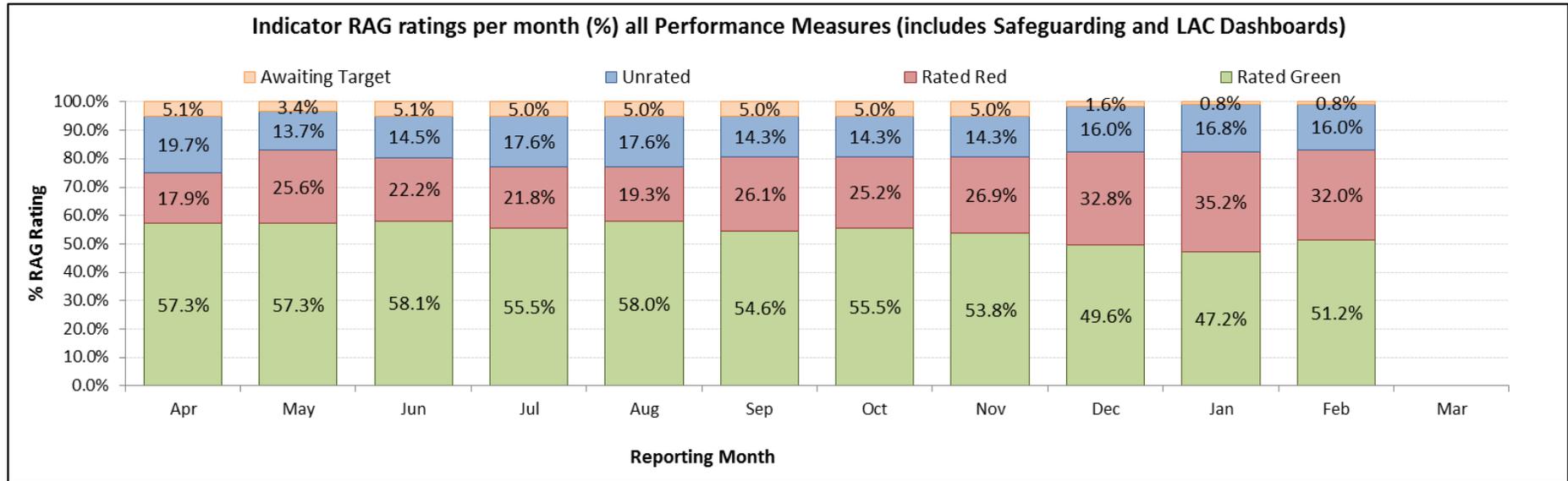
The following tables are a summary of the performance information presented to the Committee;

Executive Summary - Overview

Feb-18

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC or n/a *	Total
NHS Constitution	10	12	14	12	0	0	0	0	24
Outcomes Framework	6	5	8	10	12	11	0	0	26
Mental Health	24	27	12	9	5	5	0	0	41
Safeguarding - RWT	6	7	7	6	0	0	0	0	13
Looked After Children (LAC)	1	1	3	3	2	2	1	1	7
Safeguarding - BCP	12	12	0	0	2	2	0	0	14
Totals	59	64	44	40	21	20	1	1	125

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	No Submission (blank)	Previous Mth:	Target TBC or n/a *
NHS Constitution	42%	50%	58%	50%	0%	0%	0%	0%
Outcomes Framework	23%	19%	31%	38%	46%	42%	0%	0%
Mental Health	59%	66%	29%	22%	12%	12%	0%	0%
Safeguarding - RWT	46%	54%	54%	46%	0%	0%	0%	0%
Looked After Children (LAC)	14%	14%	43%	43%	29%	29%	14%	14%
Safeguarding - BCP	86%	86%	0%	0%	14%	14%	0%	0%
Totals	47%	51%	35%	32%	17%	16%	1%	1%



Executive Summary as follows:

Executive Summary - Key Points

Feb - 17/18

Indicator Ref & Current Performance	Direction of Travel	Title and Narrative
RWT_EB3		Referral to Treatment (18 Weeks) - Incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral (>92%)
90.38%		The performance for the headline Referral To Treatment (RTT - 18wks) Incompletes has seen an increase to 90.38% and has failed to achieve the 92% National Target, 92.1% STF Target. Failing specialties include: ENT (89.18%), General Surgery (87.48%), Ophthalmology (88.22%), Oral Surgery (81.20%), Plastic Surgery (72.54%), Trauma & Orthopaedics (85.89%) and Urology (85.25%).
RWT_EB5		A&E Urgent Care Performance - A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department (>95%)
86.27%		February has seen an increase in performance to 86.27% Failed to achieve National (95%) target and the 17/18 STF trajectory of 93.50% with a decrease of 11.76% in the number of attendances from previous month (from 21,016 attendances in January to 18,545 in February). Highest performance across Black Country and above average for England, Midlands & East, West Midlands and Black Country Sustainability and Transformation Partnership (STP).
RWT_EB12		Cancer 62 Day Waits - Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer (>85%)
64.12%		The performance for the 62 Day from Referral to 1st definitive treatment has failed to achieve both the 85% National target and the revised STF trajectory of 82.5% for February and has seen a decrease in performance to 64.12% in month (71.95% excluding tertiary referrals). Early indications are that the March performance has seen a decrease in performance to 74.51% and remains below the STF recovery trajectory.

RWT_LQR3	Delayed Transfers of Care - % occupied bed days - to exclude social care delays (<2.2% Q3)
1.30%	↓
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 2.0% threshold in-month (excluding Social Care) reporting 1.30% for February and the 3.5% combined threshold (3.09%).	
RWT_LQR12	E-Referral - ASI Rates - Appointment Slot Issues (<10%)
20.39%	↓
The February performance for Appointment Slot Issues (ASI) indicator has been confirmed as 20.39% and remains above the 10% threshold and the 13% recovery trajectory. The CCG Quality Team have confirmed that the Trust are currently not meeting the locally agreed ASI trajectory as part of the National E-Referral CQUIN for 2017/18, however the CQUIN measures ASI rate per 1st Outpatient booking not the rate per Direct Booking Service (DBS) as per the Local Quality Indicator (LQR). The national CQUIN currently expires at the end of March 2018 and NHSE will not be extending to 18/19 and the Commissioner will propose LQRs that reflects the milestones in the CQUIN. Note : The National Data is based on the E-Referral System data only, The Royal Wolverhampton NHS 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.	

Exception highlights were as follows;

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

RWT_EB3
RWT_EB3
RWT_EB3

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%	90.02%	90.26%	90.38%	90.38%	90.87%	92.00%

The performance for the headline Referral To Treatment (RTT - 18wks) Incompletes has seen an increase to 90.38% and has failed to achieve the 92% National Target, 92.1% STF Target. When compared to the previous year's performance, the validated National Unify2 figures show that there has been a 1.86% increase in the number of incompletes waiting (Feb17 = 90.78%, 2,928 breaches out of 31,758, Feb18 = 90.38%, 3,111 breaches out of 32,349).

Failing specialties include: ENT (89.18%), General Surgery (87.48%), Ophthalmology (88.22%), Oral Surgery (81.20%), Plastic Surgery (72.54%), Trauma & Orthopaedics (85.89%) and Urology (85.25%). The Trust have submitted a Remedial Action Plan (RAP) which provides actions to improve performance by issue heading :

Waiting List Validation and Utilising : Daily and weekly validations, reviews of patients on waiting lists, reviews of patients fit for surgery, switching operating time and consultation time to suit demand

Pathway Validation : Review of diagnostic waiting times and validation of all patients on the pathway to highlight errors and trends, forecast priority patients and identify bottle-necks

Reporting/Monitoring : Continuation of inpatient prediction reports - show expected activity numbers, priority patients and current backlog with specialties to be issued with their own monthly trajectories to aid achievement of Trust compliance

Capacity/Demand : Day Case lists to continue on Saturdays, re-utilise all "cancelled/vacant" sessions and utilisation of Cannock theatres for appropriate cases, review of waiting list by procedure to support targeted lists and assist with pre-op planning

DNA Rates : Exploration for reasons behind patient Did Not Attend (DNA) and utilisation of telephone "text" messaging reminder service

Training : E-learning competency/training package is to be agreed by the end of March 2018 and will be made mandatory for all PAS users with RTT responsibilities and access, departments with error trends as identified via the waiting list validation will receive 1:1 training. Initial early indications were that the March performance achieved target (92.01%), however this figure is yet to be verified.

RWT_EB3

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%	87.03%	84.73%	86.27%		90.40%	95.00%

Increase in performance to 86.27% - failed to achieve National (95%) target and the 17/18 STF trajectory of 93.50%

Decrease of 11.76% in the number of attendances from previous month (from 21,016 attendances in January to 18,545 in February)

Reasons for underperformance: Patient flow (decision making), bed availability, ambulances arriving in batches creating queues, continued pressures on A&E nationally, staffing (consultants) and capacity. Trust Performance Exception Report Actions :

Improved signposting/triaging functions and closer working with Vocare

Actively recruiting for substantive Emergency Department Consultants

Pre-admission bay opened to free cubicles of patients waiting for bed allocation

Daily discharge levels set across the Trust to ensure adequate patient flow and minimise breaches due to bed shortages

Frailty building (new sub department in ED) has a phased implementation plan which commenced January 2018 with additional elements coming on line as the building is released. Attendances remain high (average 360 per day) with highest number of attendances on Tuesday 6th February 2018 (414 attendances, 187 breaches = 54.83%)

A&E performance continues to be discussed with the Trust at the A&E Delivery Board, Clinical Quality Review Meeting (CQRM) and Contract Review Meeting (CRM)

Highest performance across Black Country and above average for England, Midlands & East, West Midlands and Black Country Sustainability and Transformation Partnership (STP).

Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer.



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
77.40%	77.30%	71.56%	77.09%	75.00%	72.96%	76.25%	76.04%	71.08%	70.12%	64.12%		73.54%	85.00%

The performance for the 62 Day from Referral to 1st definitive treatment has failed to achieve both the 85% National target and the revised STF trajectory of 82.5% for February and has seen a decrease in performance to 64.12% in month (71.95% excluding tertiary referrals). The Trust have since confirmed via the Integrated Quality and Performance Report (IQPR) that there were 5 tertiary referrals that were received after day 62 of the patient pathway and had therefore already breached standard. Analysis by Cancer site confirms that all areas breached standard with the exception of Breast (93.75%) and Skin (90.0%). Additional support has been requested from the Cancer Collaborative to work with clinical teams to review end to end stage of treatment pathways. The Cancer Strategic Clinical Network (SCN) has been requested to provide support on tertiary pathways.

Details of any breaches over 104 days (that have been subject to a harm review) are discussed at the Quality Surveillance Group (QSG), specific reasons for the January breaches included : 6 x Capacity, 2 x Patient Choice, 3 x Clinical Complexity, 9 x Late Tertiary Referral and 1 x Other (referred on to another provider on day 38 of the patient pathway). Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end and February performance has been confirmed as 67.54% (31 patients breaching target out of 95.5) and therefore remains RED. Performance is discussed at the CQRM and CRM meetings with the Trust. Early indications are that the March performance has seen an increase in performance to 74.51% however remains below the STF recovery trajectory and with a Year End performance of 73.62%.

RWT_EB12

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Zero tolerance RTT waits over 52 weeks for incomplete pathways



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
6	4	0	0	0	0	0	0	0	0	0		10	0

This indicator has breached the Year End zero threshold for 52 week waiters due to the April and May breaches for Orthodontic patients. The M11 performance confirms that there were no patients waiting over 52 weeks during February, 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. The National validated data for February confirms that there 3 x Wolverhampton patients breaching 52 weeks: 1 x University Hospitals of North Midlands NHS Trust and 2 x Royal Orthopaedic Hospital (Birmingham) all of which are Trauma & Orthopaedic specialty breaches. This brings the Commissioner Year to Date total to 16. Early indications are that there are no further Trust breaches during March 2018.

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	2		4	0



The performance for the number of Trolley waits in A&E (not longer than 12 hours) breached the zero threshold for February with 2 additional breaches, with previously breaches in November and December, the Year to Date total of 4 breaches has already breached the Year End threshold. The breaches are under investigation and updates on outcomes have been requested as part of the Contract Review Meeting. Early indications are that there are no further breaches reported for March.

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%	1.11%	1.02%	1.30%		1.49%	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 2.0% threshold in-month (excluding Social Care) reporting 1.30% for February and the 3.5% combined threshold (3.09%).

National DTOC submission data from the Unify2 collection system confirms that there were 675 total delay days for February at the Royal Wolverhampton NHS Trust (of which 222 x Wolverhampton, 323 x Staffordshire, 47 x Walsall, 78 x Dudley and 5 x Shropshire).

As a Commissioner, February delays days totals were : 222 x Royal Wolverhampton NHS Trust, 84 x South Staffordshire and Shropshire Healthcare, 30 x Black Country Partnership and 16 x Sandwell and West Birmingham 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. The Trust have indicated the following delay reasons for February:

- 27.8% - Delay awaiting assessment (prev 20.3% - increase)
- 6.2% - Delay awaiting further NHS Care (prev 13.5% - decrease)
- 29.9% - Delay awaiting domiciliary package (prev 27.0% - increase)
- 4.1% - Delay awaiting family choice (prev 8.1% - decrease)
- 8.3% - Delay awaiting equipment/adaptations (prev 9.5% - decrease)
- 2.1% - Delay awaiting public funding (prev 0.0% - increase)

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 NHS Trust and Local Authority (stretched from 4.9% to 3.5%) which has been achieved since November 2017 (with February combined delays achieving 3.09%).

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%	16.65%	17.26%	20.39%		27.33%	10.00%



The February performance for Appointment Slot Issues (ASI) indicator has been confirmed as 20.39% and remains above the 10% threshold and the 13% recovery trajectory. The CCG Quality Team have confirmed that the Trust are currently not meeting the locally agreed ASI trajectory as part of the National E-Referral CQUIN for 2017/18, however the CQUIN measures ASI rate per 1st Outpatient booking not the rate per Direct Booking Service (DBS) as per the Local Quality Indicator (LQR). The national CQUIN currently expires at the end of March 2018 and NHSE will not be extending to 18/19 and the Commissioner will propose LQRs that reflects the milestones in the CQUIN. The Trusts exception report confirms actions to improve performance include :

Review of demand and capacity for all specialties as part of the e-RS CQUIN

Identifying routine clinic slots for conversion to e-RS slots

Converting slots to match sub-specialty requirement/demands

Services are reviewing to see if there are currently any gaps on the e-RS system and adding new services and updating the Directory of Services accordingly The National Appointment Slot Issue report for February 2018 allows us to benchmark performance :

Walsall Healthcare NHS Trust - 29.22 (764 issues out of 2,615 bookings)

Dudley Group of Hospitals - 29.06 (1,580 issues out of 5,437 bookings)

Royal Wolverhampton - 20.39 (955 issues out of 4,684 bookings)

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%	90.63%	95.24%	96.55%		94.74%	95.00%

The percentage of service users (under adult mental illness specialties on CPA) receiving a follow up within 7 days of discharge has achieved the 95% target for February (96.55%), however due to previous below target performance (September to December) remains below Year to Date (94.74%).

Previously submitted exception reports provided by the Trust indicated actions taken to prevent future breaches. These included :

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.

Ward staff are to double check telephone numbers and addresses on patients discharge.

Performance continues to be monitored and raised at the Contract Review Meetings with the Trust.

BCPFT_EBS3

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%	13.69%	7.68%	4.81%		5.71%	7.50%



The Delayed Transfers of care programme (DTC) has seen a reduction of delays since December, with February reporting 4.81% against the 7.5% threshold for the first time since October 2017. This performance relates to Wolverhampton only, the Sandwell performance has been confirmed as 1.81% and therefore remains GREEN.

As delayed discharges remain a National issue, performance will monitored via the 2017/18 Local Quality Requirements and remain an agenda item on both the CCG's monthly performance call with NHS England (NHSE) and the Trust's CQRM meetings. The delayed discharges for Wolverhampton predominantly concern patients on the Older Adults Ward waiting placements. Placement difficulties (resulting in delays) include : sourcing of providers, awaiting provider assessments, placement availability and funding disputes between Health and Social Care. Since the addition of a dedicated Local Authority Social Worker attendance to weekly reviews and engage with patients and Multi-Disciplinary Teams (MDT) earlier for placements/housing the number of delays has decreased. 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 February national figures have been confirmed as follows for the Black Country Partnership (all commissioners) :

NHS delay days = 56 and a 2.00 delayed bed day average (previously 33, 1.06 average)

Social Care delay days = 64 and a 2.29 delayed bed day average (previously 50, 1.61 average)

Both delay days = 28 and a 1.0 delayed bed day average (previously 111, 3.58 average)

Trust Total = 148 delay days and a 5.29 delayed bed day average (previously 194, 6.26 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%	69.14%	60.00%	57.78%		58.35%	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 57.78% of patients moving to recovery during February 2018. 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 national data reports have been confirmed as a rolling quarter whereas the local submission is based on monthly figures. Using the rolling quarter methodology, the equivalent December performance calculates as 61.61%. The latest National data available is December 2017 and is currently reporting at 55.88% and is GREEN for the sixth 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.

BCPFT_LQIA01

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.]



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
	1.53%	1.68%	1.46%	1.35%	1.44%	1.41%	1.39%	1.13%	0.75%	1.42%	1.30%		1.35%	1.40%
(Cumulative)	1.53%	3.21%	4.67%	6.01%	7.45%	8.86%	10.25%	11.39%	12.13%	13.55%	14.85%		14.85%	16.80%

This indicator is based on the number of people entering treatment as a proportion of people with anxiety or depression (a local prevalence - 29,880) with a Year End target confirmed Nationally as 16.8% (in month 1.399%). Performance had seen a decrease in performance over the winter period with Month 9 reporting the lowest performance to date of 0.75%, however January saw a positive increase to 1.42%. The February performance has seen further decrease to 1.30% in-month and due to the decline over Quarter 3, the Year To Date remains below the cumulative target (14.85% against 15.40% target). The Trust have met with the Commissioner to discuss options available to increase the access rate with potential participation in community events across Wolverhampton to boost March performance to achieve the 16.8% target. Additional Saturday clinics have been run throughout March to ensure achievement by Year End. Recruitment and vacancies remains a national issue, however, with the additional scheduled sessions, the Trust have increased the number of patients entering treatment and have verbally confirmed that the 16.8% has been achieved. An access rate forecast has been developed to 2020/21 to highlight the number of patients required each month to achieve the staggered target (18/19 = 19%, 19/20 = 21%, 20/21 = 25%) and includes a breakdown of Long Term Condition (LTC) splits required as part of the annual targets.

BCPFT_LQIA05

6. 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.

7. Risk Report

The Committee received and considered an overview of the risk profile for the Committee including Corporate and Committee level risks.

8. Draft Finance and Performance Committee Annual Report

The Committee received the draft report for consideration and took assurance that it has discharged its duties as set out in its terms of reference

9. 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).

10. RECOMMENDATIONS

- **Receive and note** the information provided in this report.

Name: Lesley Sawrey
Job Title: Deputy Chief Finance Officer
Date: 24th April 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%	90.38%	R	90.87%	R	↑															
RWT_EB4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test	RWT	99%	99.16%	G	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%	86.27%	R	90.40%	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%	93.74%	G	92.73%	R	↑															
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%	95.33%	G	91.29%	R	↑															
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%	96.89%	G	96.80%	G	↑															
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	RWT	94%	84.85%	R	87.30%	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	99.85%	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%	100.00%	G	97.28%	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%	64.12%	R	73.54%	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%	92.31%	G	83.27%	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	2.00	R	↔															
RWT_EAS5	Minimise rates of Clostridium Difficile	RWT	Mths 1-11 = 3 Mth 12 = 2	0.00	G	28.00	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	102	R	869	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	28	R	140	R	↑															
RWT_EBS5	Trolley waits in A&E not longer than 12 hours	RWT	0	2	R	4	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%	95.76%	G	95.62%	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%	99.54%	G	99.77%	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%	98.87%	G	98.94%	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%	95.82%	G	95.25%	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%	86.05%	R	85.41%	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%	1.30%	G	1.49%	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	7.00	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														
									A	M	J	J	A	S	O	N	D	J	F	M	Yr End		
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%	96.30%	G	98.78%	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	⇒															
BCPFT_EH9	The number of new children and young people aged 0-18 receiving treatment from NHS funded community services in the reporting period	BCP	30.00%	18.23%	R	17.76%	R	↓															
BCPFT_EH10a	Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral (0-19 year olds)	BCP	85.00%	100.00%	G	66.67%	R	↑															
BCPFT_EH11a	Number of CYP with ED (urgent cases) referred with suspected ED that start treatment within 1 week of referral (0-19 year olds)	BCP	85.00%	100.00%	G	100.00%	G	⇒															
BCPFT_EH10b	Number of patients with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral (19 year olds and above)	BCP	85.00%	100.00%	G	100.00%	G	⇒															
BCPFT_EH11b	Number of patients with ED (urgent cases) referred with suspected ED that start treatment within 1 week of referral (19 year olds and above)	BCP	85.00%	100.00%	G	100.00%	G	⇒															

**WOLVERHAMPTON CCG
 GOVERNING BODY
 8 May 2018**

Agenda item 15

TITLE OF REPORT:	Summary – Wolverhampton Clinical Commissioning Group(WCCG) Audit and Governance Committee (AGC) – 17 April 2017
AUTHOR(S) OF REPORT:	Peter Price – Interim Chair, Audit and Governance Committee
MANAGEMENT LEAD:	Tony Gallagher – Chief Finance Officer
PURPOSE OF REPORT:	<ul style="list-style-type: none"> To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	<ul style="list-style-type: none"> To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.
RECOMMENDATION:	<ul style="list-style-type: none"> Receive this report and note the actions taken by the Audit and Governance Committee
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	n/a
2. Reducing Health Inequalities in Wolverhampton	n/a
3. System effectiveness delivered within our financial envelope	n/a

1. BACKGROUND AND CURRENT SITUATION

1.1 Internal Auditor Progress Report 2017/18

The Senior Internal Audit Manager reported that progress had been made with the Board Assurance Framework. The Senior Internal Audit Manager reported on multiple areas including Conflicts of Interest, Risk Management, Information Governance, Arrangements with the CSU in relation to procurement and Follow-up. The draft audit opinion was satisfactory with some improvements required.

1.2 Draft Internal Audit Annual Report

The Draft Internal Audit Annual Report showed the work that had been done for the year including the draft opinion for the year. This was noted.

1.3 External Audit Progress Report

The Engagement Lead for the External Auditors presented their report on progress and findings for the year. The initial findings reported satisfactory performance but this would be formally reported at the May Audit and Governance Committee Meeting.

1.4 Counter Fraud Annual Report

The Counter Fraud Annual Report was shared with the Audit and Governance Committee. This was approved.

1.5 Risk Register/Board Assurance Framework

The Audit and Governance Committee were presented with a paper outlining plans to support risk management across the CCG. The Committee were asked to comment on the GBAF prior to its consideration at the next meeting of the Governing Body. The committee confirmed its satisfaction with progress

1.6 Draft Governance Statement

The Corporate Operations Manager presented the Draft Governance Statement to the Audit and Governance Committee. Comments feedback from the Committee had been incorporated in the draft which had been reviewed by the Chief Officer.

1.7 Draft Committee Annual Report

The Corporate Operations Manager the report had followed a similar pattern from last year in terms of format and themes. This was noted.

1.8 Final Review of Effectiveness

Members had independently reviewed the effectiveness of the committee and feedback comments to the Corporate Operations Manager who would develop an action plan.

1.9 Feedback to and from the Audit and Governance Committee and Wolverhampton CCG Governing Body Meetings and Black Country Joint Governance Forum

The Chair of the Audit and Governance Committee and Chair of the Black Country Joint Governance Forum updated respectively from each committee.

1.10 Draft Final Accounts

The Audit and Governance Committee were presented with the draft accounts by the Director of Finance and the Head of Financial Resources. Work was going to plan and on target to be submitted on 29 May 2018.

1.11 Losses and Compensation Payments – Quarter 4 2017/18

There was 2 losses and 1 special payments were reported in quarter 4 2017/18

1.12 Suspensions, Waiver and Breaches of SO/PFPS

There were no suspensions of SO/PFPS in quarter 4 of 2017/18

1.13 Receivable/Payable Greater than £10,000 and over 6 months old

The Committee noted that as at 31 March 2018, there were 0 receivables and 11 payables over £10,000 and greater than 6 months old.

CLINICAL VIEW

1.1. N/A

2. PATIENT AND PUBLIC VIEW

2.1. N/A

3. KEY RISKS AND MITIGATIONS

3.1. The Audit and Governance Committee will regularly scrutinise the risk register and Board Assurance Framework of the CCG to gain assurance that processes for the recording and management of risk are robust. If risk is not scrutinised at all levels of the organisation, particularly at Governing Body level, the CCG could suffer a loss of control with potentially significant results.

4. IMPACT ASSESSMENT

Financial and Resource Implications

4.1. N/A

Quality and Safety Implications

4.2. N/A

Equality Implications

4.3. N/A

Legal and Policy Implications

4.4. N/A

Other Implications

4.5. N/A

Name: Tony Gallagher
Job Title: Chief Finance Officer
Date: 18 April 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.

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

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WOLVERHAMPTON CCG
Governing Body
8 May 2018
Agenda item 16

TITLE OF REPORT:	Communication and Participation update
AUTHOR(s) OF REPORT:	Sue McKie, Patient and Public Involvement Lay Member Helen Cook, Communications, Marketing & Engagement Manager
MANAGEMENT LEAD:	Mike Hastings – Director of Operations
PURPOSE OF REPORT:	This report updates the Governing Body on the key communications and participation activities in April 2018.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This report is intended for the public domain
KEY POINTS:	The key points to note from the report are: 2.1.1 Extended opening for Pharmacy and GP surgeries – May Bank Holiday 2.2.5 Annual Report
RECOMMENDATION:	<ul style="list-style-type: none"> • Receive and discuss this report • Note the action being taken
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	<ul style="list-style-type: none"> • Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions. • Works in partnership with others.
2. Reducing Health Inequalities in Wolverhampton	<ul style="list-style-type: none"> • Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions. • Works in partnership with others. • Delivering key mandate requirements and NHS Constitution standards.
3. System effectiveness delivered within our financial envelope	<ul style="list-style-type: none"> • 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.



1. BACKGROUND AND CURRENT SITUATION

To update the Governing Body on the key activities which have taken place April 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 Extended opening for Pharmacy and GP surgeries May Bank Holiday

Extended bank holiday opening is shown on our website in advance of the two May Bank Holidays.

2.1.2 Press Releases

Press releases since the last meeting have included:

- Earlier bowel cancer screening will save lives in Wolverhampton
- May Bank Holidays 2018 Pharmacy opening in Wolverhampton
- Black Country and West Birmingham STP announces new SRO

2.2. Communication & Engagement with members and stakeholders

2.2.1 GP Bulletin

The GP bulletin is a twice monthly and is sent to GPs, Practice Managers and GP staff across Wolverhampton city.

2.2.2 Practice Nurse Bulletin

The April/May edition of the Practice Nurse Bulletin included the following topics:

- Healthy Lifestyles Service (HLS) Wolverhampton Public Health
- Primary Care conference
- Respiratory Academy Clinical Platform academy
- Wolverhampton Safeguarding News
- Thrive into Work update
- Direct Access Spirometry Service
- Child Health Promotion course

2.2.3 Members Meeting

The next GP Members Meeting will take place on 2 May. Preparations have begun.

2.2.4 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.

2.2.5 Annual Report

We have compiled and submitted the first draft to NHS England of this year's Annual Report. We are currently making the required amendments ready for the next submission to NHSE.



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 PPG Chair / Citizen Forum Meeting

This group met in April to refine the Terms of Reference, but the outcome has not yet been shared. The TORs will be an agenda item on 15 May with an aim to finalise and agree them at the meeting.

4.2 Joint Engagement Assurance Meeting

We met on 24 April. We received updates from RWT, particularly around their new complaints policy. Wolverhampton Healthwatch shared information about their Emergency Department survey which had been completed recently, and that their Listening Tour had been completed. The issues raised from the tour will be discussed at their next Board. We had an update about Practice Managers across the city and their work with the local Dementia Action Alliance to help to ensure that GP Practices become more dementia friendly. We also received, Quality, Communications and CCG Strategic updates, sharing CCG information with our partners and public.

5. LAY MEMBER MEETINGS – attended:

- 5.1 Joint Engagement Assurance Meeting
CCG Governing Body Development meeting

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: 30 April 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.

	Details/ Name	Date
Clinical View	n/a	
Public / Patient View	n/a	
Finance Implications discussed with Finance Team	n/a	
Quality Implications discussed with Quality and Risk Team	n/a	
Equality Implications discussed with CSU Equality and Inclusion Service	n/a	
Information Governance implications discussed with IG Support Officer	n/a	
Legal/ Policy implications discussed with Corporate Operations Manager	n/a	
Other Implications (Medicines management, estates, HR, IM&T etc.)	n/a	
Any relevant data requirements discussed with CSU Business Intelligence	n/a	
Signed off by Report Owner (Must be completed)	Sue McKie	30 April 2018



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MINUTES OF THE QUALITY & SAFETY COMMITTEE
CCG MAIN MEETING ROOM - 13th MARCH 2018 - 10.30 AM

PRESENT: Dr R Rajcholan WCCG Board Member (Chair)
Jim Oatridge Lay Member
Liz Corrigan PC Quality Assurance Co-ordinator
Marlene Lambeth Patient Representative
Annette Lawrence Designated Adult Safeguarding Lead
Sue McKie Patient/Public Involvement Lay Member
Kelly Huckvale (Part) IG Lead
Phil Strickland (Part) Quality Assurance Co-ordinator
David King (Part) Equality & Human Rights Manager
Liz Hull Administrative Officer

APOLOGIES: Sally Roberts Chief Nurse & Director of Quality
Peter Price Independent Member
Alicia Price Patient Representative
Sukhdip Parvez Quality & Patient Safety Manager

QSC027 APOLOGIES & INTRODUCTIONS

Apologies were noted by members and introductions took place.

RESOLVED: That the above is noted.

QSC028 DECLARATIONS OF INTEREST

Sue McKie declared that she currently works, two days a week, for Public Health.

RESOLVED: That the above is noted.

QSC029 MINUTES & ACTIONS OF THE LAST MEETING

Minutes of the 13th February 2018

The minutes of the meeting held on the 13th February 2018 were approved as a true and accurate record.

RESOLVED: That the above is noted.



Action Log from meeting held on the 13th February 2018

The Action Log was reviewed and updated.

RESOLVED: That the above is noted.

QSC030 MATTERS ARISING

None discussed.

RESOLVED: That the above is noted.

QSC031 ASSURANCE REPORTS**QSC032 Primary Care Report**

Liz Corrigan presented the Committee with an overview of activity in Primary Care:

Infection Prevention

- Four practices have received a low rating for Infection Prevention, following an audit.
- The Committee was assured that the CCG and the Infection Prevention Team at RWT are supporting the practices appropriately and returns are also being monitored.

Influenza Vaccination

- Continues to be monitored.

Medicine Alerts

- None to review.

Friends and Family Test

- The current position is fairly stable.
- A new policy will take effect from May and it is anticipated that this will increase responses further.

Quality Matters Incidents

- Themes remain static, with Information Governance breaches resulting from incorrect blood forms being given to patients remaining as the most frequent.
- All Primary Care incidents have been forwarded to the relevant practices and NHS England where appropriate.



Complaints

- 12 GP complaints have been received since the beginning of November.
- NHS England is now sharing complaints data which will be triangulated with other data.
- All complaints reported to NHS England are logged via PPIGG for escalation as appropriate.

Serious Incidents

- 2 live incidents are currently under investigation relating to a delayed diagnosis of a child and a stroke secondary to rare diagnosis. The practices involved have been asked to provide a Root Cause Analysis, an Action Plan and assurances to the CCG.
- All incidents are reported to the NHS England PPIGG Group.

Nice / Clinical Audit

- The Assurance Framework around NICE guidance is currently being reviewed and will be applied in line with the Peer Review System for GPs.

CQC Inspections and Ratings

- Practice ratings were reviewed and it was confirmed that those that require improvement are picked up as part of a collaborative contract visit.

RESOLUTION: An action was agreed, that going forward the information for this section of the report should be more dynamic rather than static.

Risk Register

- The current risk status was reviewed and the Committee was advised that an extreme risk has also been added to the register, which is being dealt with.
- The register continues to be monitored by the Quality Team and the Primary Care Commissioning Committee, with feedback provided to the risk handlers regarding updates and closure of risk to ensure that issues are being dealt with in a timely manner.

Workforce

- The implementation plan has been revised in line with new milestones and action points from STP and national drivers.
- Practice Nurse Retirement – An entry has been recorded on the Risk Register with regards to Practice Nurse anticipated retirements over the next 5 years.

RESOLVED: The Committee welcomed the report and noted its contents.



11 am Liz Corrigan left the meeting

11 am David King joined the Committee

QSC033 **CCG Annual Equality Report**

David King presented the Committee with a report to showcase the CCG's annual equality activity and requested approval for the EDS2 to be published on the CCG website by 30th March 2018. Assurance was given that there are no issues outstanding that the CCG need to be aware of.

Approval was requested from the Committee in relation to the 4 CCG equality objectives recommended by David King – 2 for patient outcomes and 2 in relation to the CCG workforce. It was suggested that an agreed timeline of 3 years, to achieve the objectives, should be applied with the option to extend to a fourth year if required.

It was confirmed that the Equality Objectives Action Plan could be influenced by any feedback received from patient groups.

11.10 am Kelly Huckvale joined the Committee

RESOLUTION: The Committee approved the EDS2 and equality objectives, in principal, subject to approval by the Chief Nurse and Director of Quality. An action was therefore agreed for David King to take this matter forward with Sally Roberts before publishing on the CCG website.

An action was also agreed for David King to provide Dr Rajcholan with more information about the possible identification of funding for GP advice and training in relation to the SEND agenda.

11.20 am David King left the meeting

QSC034 **Information Governance Toolkit Report**

Kelly Huckvale requested that the Committee:

- Delegate approval of the sign off of the CCG's Information Governance Toolkit submission to the CCG's Information Governance Lead (Peter McKenzie) and the Senior Information Risk Owner (Tony Gallagher).
- Approve the revised Staff Information Governance Handbook.

RESOLUTION: The Committee approved the recommendations within the report.



11.30 am Kelly Huckvale left the meeting

QSC035 Quality Report

Annette Lawrence presented the Committee with a summary of the Monthly Quality and Risk Report. The following key points were noted:

Urgent Care Provider

The CCG has reviewed the Improvement Plan completed by Vocare in response to the recent CCG and CQC visits, which will be updated and reviewed weekly by the CCG. An 8 week Assurance Plan has also been developed, by the CCG Quality Lead and the Urgent Care Lead. This will detail a range of assurance activities to be undertaken over the next few weeks, to seek further assurance that the Improvement Plan is robust and evidencing improvement.

Maternity Performance Issues

- Bookings - the number of bookings for January 2018 increased slightly with 2 outliers.
- Caesarean Section Rates – The emergency rate of 17% is above national target due to high risk complex cases.
- Midwife to Birth Ratio – Currently 1:31
- Monthly discussions are taking place at CQRMs for assurance around recruitment plans, sickness absence management and supervision/support for new staff.
- Escalation meetings are taking place with the Trust to discuss options and plans for maintaining safety.
- Escalation to NHSE and NHSI is taking place where necessary.
- Entries made on RWT and CCG Risk Register.

WMAS Non-Emergency Patient Transport Services (NEPTS)

No Quality issues reported by the provider.

Mortality

- An external data review was undertaken, which identified that the Trust's actual mortality rate has not increased and is in the lower quartile nationally.

Never Events – No NE's reported in January 2018.

Serious Incidents (SI's)

- 7 SI's were reported for the reporting period, which is the lowest number recorded in the past 3 years. The incidents related to slip/trip/falls and infection prevention.



Children's Safety – Safeguarding Children

- Changes to statutory guidance – Working Together to Safeguard Children; and new regulations are currently out for Government consultation. The CCG has participated in discussions to formulate a joint response with WSCB.
- The final report and recommendations to be published following the completion of the SCR for Child G.

Adult Safety – SPACE

- During February a quality improvement workshop was held, to support collaborative working and sustainability of the SPACE programme. Themes identified through performance monitoring data are being fed into and information the QNA Work Plan.

RESOLUTION: The Committee noted the report and the following actions were agreed:

- Dr Rajcholan to raise queries at the CQRM in relation to capping and emergency C-sections.
- Dr Rajcholan to challenge performance for Cancer waiting times at the next CQRM.
- Sally Roberts to provide Dr Rajcholan with more detailed information in relation to cancer breaches and ambulance delays. Also to be included within the report going forward.

11.40 am Philip Strickland joined the Committee

QSC036 Evaluation of Revised Quality Report

Positive feedback was received from all members of the Committee that were present.

RESOLVED: That the above is noted.

QSC037 **RISK REVIEW**

Quality & Safety Risk Register Update

Philip Strickland provided the Committee with an update:

- Extreme Risks
 - 466 Out of Hours Provider: inaccurate reporting of performance data/quality assurance - NHS England Quality and Surveillance Group are considering a heightened level of scrutiny. The Governing Body are being kept informed and Vocare has produced an 8 week recovery plan which is being closely monitored and scrutinised alongside performance outcomes.



- High Risks
 - 489 Inappropriate arrangements for a Named Midwife at RWT – Continues to be progressed by the Head of Safeguarding and Head of Midwifery.
 - 492 Maternity capacity and demand – The number of bookings in November 2017 had gone down from 522 to 500 but the number of deliveries increased from 422 to 448. Midwife sickness rates are improving and the midwife vacancy rate is now only 0.3%.
 - 493 PTS poor performance – Measures have been put in place to improve performance.
 - 312 Mass casualty planning – No review since August.

- Moderate
 - 502 LAC CAMHS – Children’s Commissioner and DNLAC have agreed KPI’s for LAC to be included in 17/18 contracts with exceptions reported to CQRM.

- Low
 - 321 Safe Working Practices – Following identification of provider arrangements this is no longer considered a risk and was therefore recommended for closure by the Committee.

RESOLUTION: The Committee noted the update provided and approved the recommendation to close risk 321.

QSC038 ITEMS FOR CONSIDERATION

QSC039 Policies for Consideration

None.

RESOLVED: That the above is noted.

QSC040 Terms of Reference Review

Agreed to defer to the next meeting.

RESOLUTION: Action agreed for Kelly Kavanagh to check with Sally Roberts about sharing the draft terms of reference before the next meeting.

QSC041 FEEDBACK FROM ASSOCIATED FORUMS

QSC042 CCG Governing Body Minutes

No issues were raised.

QSC043 Health & Wellbeing Board Minutes

No minutes to review.



QSC044 Draft Quality Surveillance Group Minutes

No minutes to review.

QSC045 Commissioning Committee Minutes

No issues were raised.

QSC046 Primary Care Operational Group Minutes

A query was raised with regards to Dr Bagary's practices. An action was agreed for Sally Roberts to look into this.

QSC047 Clinical Mortality Oversight Group Minutes

No minutes to review.

QSC048 NICE Group Minutes

No minutes to review.

RESOLVED: That the above is noted.

QSC049 ITEMS FOR ESCALATION / FEEDBACK TO CCG GOVERNING BODY

None.

QSC050 ANY OTHER BUSINESS

None.

RESOLVED: That the above is noted.

Date of Next Meeting:

Tuesday 10th April 2018 at 10.30am to 12.30pm in the CCG Main Meeting Room



WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

**Minutes of the meeting held on 27th March 2018
Science Park, Wolverhampton**

Present:

Mr L Trigg	Independent Committee Member (Chair)
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

In regular attendance:

Mrs L Sawrey	Deputy Chief Finance Officer
Mr M Dhura	Senior Contract Manager
Mr P McKenzie	Corporate Operations Manager (part meeting)

In attendance

Mrs H Pidoux	Administrative Team Manager
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1. Apologies

Apologies were submitted by Mr Gallagher, Mr Marshall and Mr Middlemiss.

2. Declarations of Interest

FP.247 There were no declarations of interest.

3. Minutes of the last meetings held on 27th February 2018

FP.248 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.249 Item 120 (FP.243) - Recommendation to Governing Body to sign off the budget for 2018/19 – Mrs Sawrey to pick up with Mr Gallagher.

Item 121 (FP.2.44) - Risk relating to TCP on going plans to be added to the Committee Level Risk Register – risk added -action closed.

Item 122 (FP.244) – Adding a Corporate Risk relating to TCP performance and quality to be raised with Chief Nurse, Director of Quality – discussion had taken place and risk added – action closed.

Item 123 (FP.244) Risk relating to Cancer 62 Day waits to be added to Committee Level Risk Register - risk added – action closed.

5. Matters Arising from the minutes of the meeting held on 27th February 2018

FP.250 There were no matters arising to discuss from the last meeting.

6. Performance Report

FP.251 Mr Hastings highlighted the key points of the Executive Summary relating to Month 10 performance. The following was considered;

- RTT – Continues to miss the 92% target. As this had been removed from the STF payments there is less focus on this area. It is currently rated as Amber by NHSE and is not under scrutiny. It relates to a small cohort of patients and the CCG will continue to monitor to ensure performance does not deteriorate.
- A&E – continues to fail to meet target. However, RWT performance is better than the Black Country. Focus is not on RWT as it remains in the top 25% highest performers nationally.
- Cancer 62 day waits – This continues to be an area of focus for both NHS England (NHSE) and NHS Improvement (NHSI). The Recovery Action Plan is being reviewed by RWT as the CCG had requested that this should be more operational and measureable rather than high level clinical. This is monitored through the Clinical Quality Review Meeting (CQRM).

Mr Hastings reported that he participates in a telephone call each Friday which includes the Clinical Lead and Chief Operating Officer from RWT and representatives from both NHSE and NHSI.

This is being overseen by Mr Hastings from a performance aspect and Sally Roberts, Chief Nurse, Director of Quality for the Quality aspect. A meeting is to be arranged for them to meet with Gwen Nuttall, Chief Operating Officer and Simon Grummett, Clinical Lead from RWT.

The PTL meeting at RWT had been changed and is now more operational. For the last three weeks representation has included Executive Directors, cancer co-ordinators and diagnostic representatives. The meetings review all pathways (cancer sites) and allow the co-ordinators to obtain required information quickly.

Mr Hastings reported that the NHSE Cancer Alliance is working with UHB to develop a referral template to smooth the pathway for tertiary referrals. The aim is to roll this out across the Black Country.

- DTOC – has achieved the threshold in-month (excluding Social Care) and the combined threshold.
- E-referrals ASI rates - performance is at 17.26% which is above the 10% threshold, however, had achieved the 20% recovery trajectory. The Trust continues to report paper switch off is on target for October, however, there is still a lot of work to be done.
- Never Event – as discussed at the last meeting this was reported for a Wolverhampton patient at the Nuffield Hospital in December 7. An initial 48 hour report is to be submitted to the CCG's Quality and Risk Team, with the final Root Cause Analysis due for scrutiny by the end of March 18.

Mr Trigg highlighted that costs are increasing for RWT whilst performance is decreasing and queried how the Committee could monitor this. It was noted that whilst the number of patients is not increasing significantly the complexity and co-morbidity is increasing. Mr Sawrey reported that HRG codes are analysed and this information could be summarised and reported back to the Committee.

Resolved: The Committee;

- noted the contents of the report.
- analysis of HRG coding to be shared at a future date

7. Finance Report

FP. 252 Mrs Sawrey introduced the report relating to month 11, February 2018

The following key points were highlighted and discussed;

- Financial metrics are being met and the CCG is on target to meet duties.
- RWT is giving concern as there is currently an overspend of £2.8m. It is expected that this will be reduced by approximately £500k, following challenges and the outcome of 2 audits, VI practices and referrals to physiotherapy rather than utilising the MSK pathway and POLCV.

- Community Contract – there are concerns regarding district nursing and that the CCG is paying more for the activity. This will be challenged going forward around recruitment and recording of activity on PAS.
- Readmissions within 28 days of treatment – sanctions of just under £1m had been imposed. There is a need to identify the reason for the readmissions and actions to address this. RWT had submitted business cases to bid against this of £1.2m; the CCG had agreed to pay £77k.

Mr McKenzie joined the meeting.

- Transformational monies – RWT had made a £1.8m bid to reduce fixed costs, this is being considered by the CCG.
- QIPP – the actual achievement of reduced activity levels associated with QIPP schemes are not materialising, and are manifesting themselves in overspends, largely within the Acute portfolio. It was noted that the shortfall in QIPP this year will be carried over into next year.

Resolved: The Committee noted the contents of the report and the areas of concern

8. Contract and Procurement Report

FP.253 Mr Duhra presented the key points of the report as follows;

Royal Wolverhampton NHS Trust

The CCG had agreed a contract offer with RWT for 2018/19, which incorporates national planning guidance and QIPP requirements.

The Staffordshire element of the RWT contract is in dispute due to a financial gap which had reduced to around £4m. RWT and Staffordshire are discussing risk share block arrangements and keeping the CCG aware of progress. This is to be agreed without prejudice so that Wolverhampton does not have to follow this. The deadline for these discussions is 20th April 18.

Rheumatology referrals – agreement regarding payments had been made and this is to be picked up with the Provider to agree going forward.

Care Quality Commission – Overall, following an unannounced visit, the Trust had reported to the CCG that the inspectors gave a positive review. One area of concern was with regards to the discharge lounge as there were some significant delays with patients waiting to be transported.

Cancer Two Week Wait (Breast Symptoms) – the Trust had failed to achieve this indicator for two consecutive months, the first time in this contract year. This was due to a 20% increase in referrals in December 17 which was not planned for. Neither the CCG nor the provider is aware of any national campaigns or local promotions to explain the recent influx on demand.

Performance Sanctions - Sanctions for Month 9 are the highest month to date at £84,900. This is predominately due to an increase in ambulance handover breaches, one MRSA breach and quarterly fines for cancer.

Emergency Care Data Set (ECDS) – CQUIN put in place to improve the alignment of coding. The CCG had raised concerns with regards to the potential finance impact of this. It had been agreed with RWT that this would be cost neutral to March 2019. The analysis of financial variances to be shared to enable this to be monitored.

Black Country Partnership Foundation Trust

The difference in the finance position had decreased and it is anticipated that this will be concluded soon.

Urgent Care Centre

An 8 week improvement plan had been implemented and weekly updates are provided to the CCG each Monday. Improvements are being seen and the provider is communicating well with the CCG. A recent Contract Review meeting went well. An exception reporting system is being developed in line with the process for other providers.

A meeting was recently held between CCG, RWT and Vocare to discuss improving the integration between the services. The aim is to move activity from A&E which should be going to the UCC, up to 70 patients a day which the contract allows for. The next steps are to review a day's activity, identify the preferred pathway and take lessons learned from this.

Resolved – The Committee

- noted the contents of the report
- actions being taken

9. Risk Report

FP.254 Mr McKenzie presented the latest risks relevant to corporate organisational and Committee level risks relevant to this meeting.

Changes to Corporate Risks

- CR01- Failure to meet QIPP Targets – QIPP Plan for 2018/19 had been submitted. This will be an ongoing risk.

- CR03 – NHS Constitutional Targets – an additional risk had been added to this Committee’s risk register (FP13) in respect of the 62 Cancer Target.
- CR07 – Failure to meet overall financial targets – discussion took place regarding closing the risk for 2017/18 and opening a new risk for 2018/19. It was agreed that consideration should be given to this being 2 risks; the current risk i.e. for the financial year and future risks to be considered further into the financial year.
- CR18 – Failure to Deliver Long Term Financial Strategy – it was agreed that it should be made clear which financial year this risk relates to and should be updated as plans are submitted. It was also agreed that the overall risk level should remain at 16 (very high).

Committee level risks;

New risks added were reported as:

- FP13 – 62 Day Cancer Waits –This target is receiving close scrutiny locally and nationally. Mitigation work is ongoing to address.
- FP14 – Transforming Care Partnership – Financial Impact – a query was raised regarding the ownership of the Corporate Risks in relation to this area. It was noted that the Governing Body will clarify ownership of these.

The existing risks were noted and discussed as follows;

- FP03 – Transforming Care and FP13 - it was agreed to close FP03 as this has been superseded by FP14.
- FP04 – Increased activity at RWT – it was clarified that this is closely monitored and mitigation work is ongoing. It was agreed that the risk should remain however the level of risk should be reduced.
- FP12 – Winter Pressures – Financial Impact – it was agreed to close this risk as the position for 2017/18 had been landed and this is overseen by the A&E Delivery Board.

It was note that there was no change in the risk position of CHC budgets, property services or the general ledger and controls.

Resolved: The Committee;

- Noted the changes to the Corporate and Committee Level Risk Registers
- The following actions to be undertaken
 - Corporate Risk
 - CR07 – to be closed for 2017/18 and reopened for 2018/19 (to be considered if this should be 2 risks, current and future)

Committee Level Risk

- FP03 and FP12 to be closed
- FP04 risk level to be reduced

10. Any other Business

FP.255 There were no items to discuss under any other business.

11. Date and time of next meeting

FP.256 Tuesday 24th April 2018 at 3.15pm

Signed:

Dated:

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**WOLVERHAMPTON CLINICAL COMMISSIONING
GROUP COMMISSIONING COMMITTEE**

Minutes of the Commissioning Committee Meeting held on Thursday 29th March 2018 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
Sally Roberts	Chief Nurse & Director of Quality	No
Sarah Smith	Head of Commissioning - WCC	Yes

In Attendance ~

Liz Hull	Administrative Officer	Yes
Mandeep Duhra	Senior Contract Manager	Yes
Peter McKenzie	Corporate Operations Manager	Yes
Hemant Patel	Head of Medicines Optimisation	Yes (Part)
Margaret Courts	Children's Commissioning Manager	Yes (Part)

Apologies for absence

Apologies were submitted on behalf of Sally Roberts and Vic Middlemiss.

Declarations of Interest

CCM673 None.

RESOLVED: That the above is noted.

Minutes

CCM674 The minutes of the last Committee meeting, which took place on 22nd February 2018 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM675 None.

RESOLVED: That the above is noted.

Committee Action Points

CCM676 (CCM660) NEPTS Contract: The Risk Register has been updated. Action closed.

(CCM668) Risk Review of CC02 and CC03: The duplication in risks has been addressed and the Risk Register updated to reflect this. Action Closed.

RESOLVED: That the above is noted.

Review of Risks

CCM677 Corporate level risks – there were no issues to bring to the Committee’s attention.

Committee level risks:

CC08 RITS Capacity - The Committee approved a recommendation to reduce the risk score from 20 to 12.

RESOLUTION: That the above is noted and the Risk Register is updated to reflect a new risk score for CC08.

Service specification for online counselling service for Children/Young People (CYP)

CCM678 Margaret Courts presented the Committee with a report and requested approval from the Committee to agree the service specification for the online digital counselling service for Children and Young People aged 11-18 to commence in April 2018.

Provision of this service will support Wolverhampton CCG to meet access targets for CYP. The target, set by the Government, is that at least 35% of CYP with a diagnosable mental health condition receive treatment from an NHS funded service by 2020/21. This includes online counselling and face to face provision via Tiers 2 and 3.

The Committee approved the service specification and agreed for the procurement of the service to commence.

RESOLVED: That the above is noted.

Revised Quality Prescribing Service Specification

CCM679 Hemant Patel joined the Committee to present the revised Quality Prescribing Service Specification.

The CCG Medicines Optimisation Team wishes to continue to offer a prescribing incentive scheme to its GP practices for 2018/19 and requested approval to progress. This has been supported by the Modernisation Medicines Optimisation and Primary Care Programme Board.

The CCG has historically offered a GP Quality Incentive Scheme to support the QIPP agenda. The Medicines Optimisation Team is proposing to continue the scheme with a revised offer.

Payments are made based on a population of 270,000. No additional funds are required beyond the current budget of £450K to incentivise change in prescribing. It is an invest-to-save scheme with the knowledge that payment is only made on the successful achievement of the scheme. This approach was agreed in principle by a group consisting of the CCG Chair, GP Prescribing Lead and locality leads in 2015/16.

The scheme will deliver patient level benefits which are not accounted for in financial terms. These benefits and potential harm avoidance are realised from lower use of NSAIDs, inhaled corticosteroids as well as the long term effects on antimicrobial resistance with appropriate use of antibiotics. It should be noted that savings from certain items are not accounted for, such as Quality Premium payments.

The Committee approved the amendments to the Quality Prescribing Scheme for 2018/19 and supported the Work Plan.

RESOLVED: That the above is noted.

Contracting Update

CCM680 Mandeep Duhra presented an update for Contracting.

Royal Wolverhampton NHS Trust

The contract with the Royal Wolverhampton Hospital NHS Trust has been agreed for 2018/19, which includes an agreement with the Staffs CCG at £94.2m. Staffs CCG are continuing to have regular meetings with the Trust, with the view to potentially agreeing a risk/gain share model on some elements of the contract. There is a deadline of 20th April to reach a conclusion on these discussions and if

an agreement cannot be met, normal National Tariff terms will continue to be applied to the contract.

Contract Performance Issues

Contract Performance (Activity and Finance)

Over-performance – The contract is over performing by £674k at month 9 for all commissioners. Wolverhampton CCG is over performing by £345k.

Rheumatology Referrals – It has been agreed that the CCG will pay an enhanced tariff for new outpatients exceeding plan for the period of 1st April to 30th December.

Care Quality Commission Unannounced Visit – Overall, feedback was positive. However, one area of concern was identified in relation to the significant delays in the Discharge Lounge. A follow up visit has taken place and feedback has been very positive.

Contract Performance (Key Performance Indicators/Quality)

Referral to Treatment – Performance was slightly below the agreed trajectory, in January, due to Winter pressures, which resulted in cancellation of some elective procedures to ease bed pressure. Discussions are taking place with clinical staff to increase capacity and reduce backlogs.

Cancer Two Week Wait (Breast Symptoms) – A 20% increase in referrals, during December, resulted in the Trust failing to meet the key performance indicator.

Cancer 62 Days – Performance has dropped for the third consecutive month. The Trust has submitted an Exception Report which confirms continued capacity issues in Urology, Radiology and Gynaecology.

Performance Sanctions

Sanctions agreed for Month 9 are £84,900.

Black Country Partnership Foundation Trust (BCPFT)

Performance/ Quality Issues

Data Quality Improvement Plan (DQIP)

Work with the DQIP is progressing and reporting of long term conditions is now being provided by the Trust.

There is an issue with IAPT access rates and the Trust has advised that they may struggle to achieve against target.

Urgent Care/ Ambulance/ Patient Transport

Urgent Care Centre

The Provider has been given a revised two month timeframe which ceases in April 2018 by which certain improvements are expected. As part of the two month improvement plan weekly updates are provided by Vocare and feedback is generally positive.

WMAS – Non-Emergency Patient Transport Service (NEPTS)

- Wolverhampton and Dudley CCGs have welcomed a proposal from WMAS, suggesting a number of changes; financial payment process (no funding change), data processing, quality report, contract review meeting ToR, exception reporting and key performance indicators. Both CCGs are, in the main, supportive and assurance has been provided by WMAS that such revisions will improve the management and performance of the contract, and lead to an improved service for our patients.

Approval of these changes was supported by the Committee.

- An agreement is currently in place with E-Zec Medical Transport Services Ltc, to transport Wolverhampton CCG patients to and from Cannock Hospital. Following consideration by the CCG and discussion with WMAS, it is recommended that the agreement is resolved from 1st July 2018. No formal contract is in place so there is no minimum notice period.

The Committee approved this change.

RESOLVED: That the above is noted.

Any Other Business

CCM681 None.

RESOLVED: That the above is noted.

Date, Time and Venue of Next Meeting

CCM682 Thursday 26th April 2018 at 1pm in the CCG Main Meeting Room

RESOLVED: That the above is noted.

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**Wolverhampton Clinical Commissioning Group
Audit and Governance Committee**

Minutes of the meeting held on 20 February 2018 commencing at 11.00am
In Armstrong Room, Science Park, Wolverhampton

Attendees:

Members:

Mr P Price	Chairman
Mr D Cullis	Independent Lay Member
Mr J Oatridge	Deputy Chair of the Governing Body and Audit and Governance Committee (partial meeting)
Mr L Trigg	Independent Lay Member

In Regular Attendance:

Mr P McKenzie	Corporate Operations Manager, WCCG
Miss M Patel	Administrative Support Officer, WCCG (minute taker)

In Attendance:

Mr T Gallagher	Chief Finance Officer, WCCG and Walsall CCG
Mr N Mohan	Senior Manager, LCFS, PwC
Mr M Stocks	Partner, External Audit, Grant Thornton
Ms M Tongue	Head of Financial Resources, WCCG
Ms J Watson	Senior Internal Audit Manager, PwC

Apologies for attendance:

AGC/18/01 Apologies for absence were submitted by Dr Hibbs.

Declarations of Interest

AGC/18/02 Mr Cullis advised that he had now changed job roles and had submitted a new Declarations of Interest Form to the CCG reflecting the change.

Minutes of the last meeting held on 18 July 2017

AGC/18/03 The minutes of the last meeting were agreed as a correct record with the emittance of the word 'her' in the sentence on page 1. The sentence should read 'Ms Watson asked to declare for information that Dr Julian Parkes who was currently a member of the Wolverhampton Clinical Commissioning Group Governing Body was her GP.'

Matters arising (not on resolution log)

AGC/18/04 There were no matters arising to discuss.

Resolution Log

- AGC/18/05 The resolution log was discussed as follows;
- Item 99 (AGC/17/86a) – Ms Watson to meet with Mr Gallagher to discuss internal audit reporting of actions – Meeting had taken place and this was on agenda. Close.
 - Item 100 (AGC/17/86b) - An update on internal audit follow up to any recommendations to actions to be brought to next meeting – On agenda.
 - Item 101 (AGC/17/87a) – Risks from each committee meeting to be brought back to next meeting – On agenda.
 - Item 102 (AGC/17/87b) - A report on the observations by Ms Watson and internal audit at committee meetings be brought back to the next meeting – Verbal Update to be given.
 - Item 104 (AGC/17/93) - Mr Gallagher to look into the number of contracts that are up for renewal and report back to the committee including the current contract with Mills and Reeves – The Mills and Reeves contract would need to be looked at via the procurement process. The information regarding the other contracts would be circulated externally by Mr Gallagher.
 - Item 105 (AGC/17/95) - Mr Grayson to liaise with Mr McKenzie around LSM updates to staff – Mr Grayson had attended a staff meeting and briefings/newsletters were circulated to staff.
 - Item 106 (AGC/17/96a) - A full report on GDPR to be brought back to the meeting in February 2018 – On agenda.
 - Item 108 (AGC/17/96c) - Committee members to review and send back any comments to Miss Patel. This will then be circulated at the next meeting with the agreed amendments – Information had been provided and circulated.

Internal Audit Plan 2018/2019

AGC/18/06 Ms Watson gave a verbal update on this agenda item.

The Internal Audit team had met with members of the the Executive Team and talked through their findings of report writing, national themes and this year would reflect on the Board Assurance Framework (BAF). Ms Watson would be meeting with the Executive Team on the 28 February 2018 to plan using the BAF, findings of previous audit work, themes and areas the Executive team identified. This information would be used to draft a risk based plan. This would then be circulated to the Audit Chair and then brought back to the Committee for comments.

RESOLUTION: The Committee:

- Report to be brought to next meeting for approval.

Internal Audit Progress Report

AGC/18/07 Ms Watson presented the Internal Audit Progress Report and gave a summary on the below items against the 2017/18 Internal Audit Plan:

- Corporate Governance – Primary Care Co-commissioning.
- Conflicts of Interest
- Risk Management
- Finance
- Better Care Fund
- Arrangements with the CSU
- QIPP
- Information Governance
- Audit follow-up

Mr Oatridge arrived.

Ms Watson advised that some actions had still not been delivered. Mr Hastings – Director of Operations had implemented new changes which had seen a marked improvement in areas particularly related to risk.

The committee provided the below comments:

- Felt that the new system was working much better and that information presented was much more accurate.
- Risk was now a fundamental agenda item on agendas but needed developing further in other committees.
- Risk was everyone's responsibility.
- Dashboards and Deep Dives were used better.

Ms Watson and her team would try and go to City of Wolverhampton Council in order to complete their fieldwork on the Better Care Fund for this quarter. The Internal Audit team would be revisiting their report and comments they had been made about the Commissioning Support Unit (CSU) as the CSU had felt they were of a negative nature.

It had been identified that team time was being utilised better for QIPP and there had been an improvement in reporting. The report on Information Governance was being drafted and Ms Watson would circulate this before the next Committee Meeting.

The Lay Members felt that it would be a good idea for the Internal Audit report to contain management comments including any when there was no agreement on recommendations made by the Internal Audit team. Mr Gallagher informed the Committee that the Management Team had agreed all of the actions made by Internal Audit but was in agreement that comments should be added to the final report.

RESOLUTION: The Committee:

- Noted the report.
- Ms Watson to circulate the IG report before the next meeting.

- Ms Watson to add any management comments to report.

External Audit Plan

AGC/18/08 Mr Stocks presented the first external audit plan produced by Grant Thornton for the CCG.

Areas discussed were:

- Deep Business Understanding
- Significant Risks Identified
- Other Matters
- Materiality
- Value for Money Arrangements
- Audit Logistics, Team and Fees
- Independence and Non-Audit Services

Mr Stocks informed the Committee that Wolverhampton was the only CCG who had delivered their QIPP Plan and had a surplus. The annual assessment was also outstanding.

Mr Oatridge commented that he felt that the report focused from an STP point of view rather than a CCG point of view. Mr Stocks said that he would take the comments on board.

RESOLUTION: The Committee:

- Noted the Plan.

Draft Counter Fraud Plan

AGC/18/09 Mr Mohan presented the Annual Counter Fraud Work Plan 2018/19 to the Committee had been allocated a similar level of resource to last year. The highest level of risk assessment was around leavers and Mr Mohan asked the Committee to feedback to managers to reinforce the recommendations that had previously been made by Ms Watson and Internal Audit.

Mr Price asked if any references were made to the Organisational Risk Register. Mr Mohan said that it might be useful to have an extra column indicating if there was anything on the fraud risk register that needed to be escalated.

The Counter Fraud Progress Report to be discussed under the agenda item 'For Information' had not been circulated to the Committee. Miss Patel was asked to circulate the attachment after the meeting and that any comments were sent back to Mr Mohan by Friday 9 March 2018.

RESOLUTION: The Committee:

- Noted the Annual Counter Fraud Work Plan 2018/19.
- Miss Patel to circulate the Counter Fraud Progress Report to committee members with comments to be sent back to Mr Mohan by Friday 9 March 2018.

Risk Register Reporting/Board Assurance Framework

AGC/18/10 Mr McKenzie presented a report on the Risk Register and Board Assurance Framework. This was the latest version of the paper which had also been presented to the Governing Body Meeting in February 2018. In addition the Committee were also presented with the Update Risk Management Strategy which they were asked to approve.

Risk was now looked at in a much more robust way in greater detail at individual committees. There was ongoing cultural work going on in the organisation to look at risk. Mr McKenzie that he had now recruited internal support to help with the work he was undertaking. There was now more involvement from the Governing Body in addressing and looking at the risks on the corporate risk registers.

The committee were in agreement that the work undertaken by the Director of Operations and Mr McKenzie was significant and a marked improvement on last year and welcomed the changes.

RESOLUTION: The Committee:

- Noted the report and its recommendations.
- Approved the Risk Management Strategy.

Draft GBAF – February Audit Committee

AGC/18/11 This was discussed under (AGC/18/10) Risk Register Reporting/Board Assurance Framework.

Risk Management Strategy

AGC/18/12 This was discussed under (AGC/18/10) Risk Register Reporting/Board Assurance Framework.

Governance Statement

AGC/18/13 Mr McKenzie shared the draft Annual Governance Statement with the Audit and Governance Committee which included reference to changes in risk management and the impact of the cyber-attacks and the CCG response. The Accountable Officer had seen the draft statement and was happy with it. Mr McKenzie asked for any comments from the Committee.

Mr Price asked that reference was made to the Black Country Joint Commissioning Committee and also the impact and changes that commissioning had on the CCG.

Mr Oatridge felt that that the statement should incorporate more of the achievements of the CCG including where progress had been made and also the fact that the CCG had been rated outstanding.

RESOLUTION: The Committee:

- Received assurance from the report.
- Mr McKenzie would incorporate the comments of the Committee members in the Governance statement.

Draft Committee Annual Report

AGC/18/14 Mr McKenzie advised that he had been looking at the Committee Annual Report. The same format and themes had been used as last year. The Governing Body had received assurance from the report which had also been discussed with Internal Audit.

The Committee were asked to support the approach to the Annual Report and the proposed changes to the Committee Terms of Reference. Mr Oatridge asked if the outcome of the Audit and Governance Committee Effectiveness Questionnaire could be feedback to the Governing Body.

RESOLUTION: The Committee:

- Approved the Annual Report
- Approved the Terms of Reference
- Approved the Review of Committee Effectiveness
- Outcome of the Audit and Governance Committee Effectiveness Questionnaire to be feedback to the Governing Body.

Draft Review of Terms of Reference

AGC/18/15 This was discussed under (AGC/18/14) Draft Committee Annual Report.

Draft Review of Effectiveness including Audit Committee Questionnaire

AGC/18/16 This was discussed under (AGC/18/14) Draft Committee Annual Report.

General Data Protection Regulation (GDPR)

AGC/18/17 The GDPR will come into force in May 2018. The paper presented to the Committee gave an outline of arrangements for the CCG including training for staff, communications and updates being provided at the Quality and Safety Committee as well as this committee.

An action plan has been developed to support the CCG's preparation for implementation of the new legislation and is being supported by Arden and Gem CSU.

RESOLUTION: The Committee:

- Noted the report

Feedback to and from the Audit and Governance Committee and Wolverhampton CCG Governing Body Meetings and Black Country Joint Governance Forum

AGC/18/18

Governing Body:

- The high risk regarding Vocare and its provision at the Urgent Care Centre in Wolverhampton. An action plan was in place.
- The financial position of the CCG was also highlighted as a risk.

Black Country Joint Commissioning Committee:

- The Terms of Reference had now been agreed following concerns that had been raised from West Birmingham.
- The Committee had discussed using a standard template for the risk registers at each CCG and had tasked the Governance Task and Finish Group to look at this.
- The Governance Task and Finish Group to look at risk around joint committee working and reporting.

RESOLUTION: The Committee:

- Noted the update

Final Accounts and their preparation plan including update on submission of Month 9 accounts

AGC/18/19

Mr Gallagher and Ms Tongue highlighted the below:

- That the committee had been presented with the draft accounts with working balances.
- The accounts would be finalised by 24 April 2018 with a view to produce the full accounts on 29 May 2018.
- Mr Gallagher and Ms Tongue were looking into a coding error which had been identified.
- The 2017/2018 position only shows expenditure until Month 9 whereas the 2016/2017 expenditure showed until Month 10.
- The process had gone well and the CCG were able to evidence why there were variances between the CCG and the Providers.
- The CCG does not anticipate any risks associated with the process.

RESOLUTION: The Committee:

- Noted the report

Losses and Compensation Payments – Quarter 3 2018/19

AGC/18/20

Mr Gallagher presented this report and advised the Committee that there was 1 loss of £36.12 during quarter 3 of 2017/2018 relating to the write-off of a salary overpayment to a previous CCG lay member. There were no special payments during the same quarter.

RESOLUTION: The Committee:

- Noted the report

Suspension, Waiver and Breaches of SO/PFPS

AGC/18/21 Mr Gallagher noted the below in quarter 3 of 2017/18:

- During quarter 3 of 2017/18 there were 20 invoices in breach of PFPs (2.70% of all invoices paid);
- 2 waivers were raised during quarter 3;
- 33 non-healthcare invoices were paid without a purchase order being raised during quarters 1 - 3.

RESOLUTION: The Committee:

- Noted the report

Receivable/Payable Greater than £10,000 and over 6 months old

AGC/18/22 The Committee noted that as at 31 December 2017 there were:

- No sales invoice greater than 10k and over 6 months old.
- 13 purchase ledger invoices greater than £10k and over 6 months old.
- The £4.8m invoice sent by RWT continued to be disputed by the CCG.

RESOLUTION: The Committee:

- Noted the above.

NHS CFA Strategy

AGC/18/23 Mr Mohan presented the NHS CFA Strategy for information.

RESOLUTION: The Committee:

- Received the report for information.

Any Other Business

AGC/18/24 There were no items to discuss.

Date and time of next meeting

AGC/18/25 Tuesday 17 April 2017 at 11am in the Armstrong room at Wolverhampton Science Park