Vale of York
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

25 July 2017, 9.30am to 12 noon

George Hudson Boardroom , West Offices, Station Rise, York YO1 6GA

AGENDA

Prior to the commencement of the meeting a period of up to 10 minutes will be set aside for questions or comments from members of the public who have registered in advance their wish to participate in respect of the business of the meeting; this will start at 9.30am.

1.	Verbal	Welcome and Introductions		
2.	Verbal	Apologies		
3.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
4. 9.45	Pages 3 to 12	Minutes of the meeting held on 30 May 2017	To Approve	Keith Ramsay
5.	Verbal	Matters Arising		All
6. 9.55	Pages 13 to 18	Primary Care Commissioning Financial Report	To Receive	Tracey Preece
7. 10.15	Pages 19 to 26	Primary Care Dashboard Development	To Approve	Michelle Carrington
8. 10.35	Verbal	Practice Visits: Update	To Note	Andrew Phillips
9. 10.45	Pages 27 to 65	Enhanced Service Review	To Support and Approve	Tracey Preece / Michelle Carrington
10. 11.15	Pages 67 to 69	Notional Rents	To Approve	Tracey Preece

11. 11.25	Present -ation	Quality and Outcomes Framework	To Receive	Heather Marsh
12. 11.45	Pages 71 to 76	NHS England Primary Care Update	To Receive	Heather Marsh
13. 11.55	Verbal	Key Messages to the Governing Body	To Agree	All
14.	Verbal	Next meeting: 9.30am, 19 September 2017 at West Offices	To Note	All

A glossary of commonly used primary care terms is available at:

http://www.valeofyorkccg.nhs.uk/data/uploads/about-us/pccc/primary-care-acronyms.pdf

Item 4

Minutes of the Primary Care Co-Commissioning Committee held on 30 May 2017 at West Offices, York

Present

Keith Ramsay (KR) - Chair	CCG Lay Chair
David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Chris Clarke (CC)	Senior Commissioning Manager Primary Care, NHS England
Phil Mettam (PM)	Accountable Officer
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Tracey Preece (TP)	Chief Finance Officer

In Attendance (Non Voting)

Kathleen Briers (KB)	Healthwatch York Representative
Dr David Hartley (DH) – part	GP, Council of Representatives Member
Dr John Lethem (JL)	Local Medical Committee Liaison Officer, Selby and York
Shaun Macey (SM)	Head of Transformation and Delivery
Dr Tim Maycock (TM) for item 10	Clinical Director
Dr Andrew Phillips (AP)	Joint Medical Director
Michèle Saidman (MS)	Executive Assistant

Apologies

Dr Lorraine Boyd (LB)	GP, Council of Representatives Member
Sharon Stolz (SS)	Director of Public Health, City of York Council.

Unless stated otherwise the above are from NHS Vale of York CCG

There were no members of the public in attendance and no questions had been submitted by members of the public.

The agenda was considered in the following order.

1. Welcome and Introductions

KR welcomed everyone to the meeting noting attendance from NHS England of David Iley (DI), Primary Care Assistant Contracts Manager, and Heather Marsh (HM), Head of Locality Programmes.

2. Apologies

As noted above.

3. Declarations of Interest in Relation to the Business of the Meeting

DH declared a direct pecuniary interest in respect of items 6 and 7. JL declared a direct pecuniary interest in respect of item 7 and in item 6 during the discussion. All other declarations of interests in relation to the business of the meeting were as per the Register of Interests.

4. Minutes of the meeting held on 28 March 2017

The minutes of the meeting held on 28 March were agreed subject to amendment on page 7 item 8 to read under the first Committee resolution:

'… ringfencing of between £90,000 and £100,000 of the £316.656.50…'

The Committee

Approved the minutes of the meeting held on 28 March 2017 subject to the above amendment.

5. Matters Arising

PCC6 Primary Care Commissioning Committee Terms of Reference – Role of the Committee in the context of the Accountable Care Partnership Board: KR advised that this was ongoing.

PCC12 South Milford Surgery and Tadcaster Proposals to move to Leeds North CCG: SM advised that there were no further developments to report.

PCC14 Primary Care Commissioning Financial Report – Management and clinical support for Practices: AP referred to the report on Practice visits at agenda item 10 and noted support would also be provided via the NHS England primary care support to the CCG.

PCC15 Accountable Care System Update: At the May meeting of the Council of Representatives DH, Dr Paula Evans and Dr Lesley Godfrey had agreed to attend the Committee on a rotation basis, along with LB & JL. JL noted that he was also seeking representation from the South Locality.

PCC16 Estates Overview: SM reported that, following discussion at the Executive Committee, the CCG's prioritised bids had been submitted to NHS England. He referred to the report at agenda item 11 in this regard.

A number of matters were noted as agenda items.

The Committee:

Noted the updates.

7. Personal Medical Services Monies 2017/18 Update

TP referred to the decisions at the Committee's March meeting regarding Personal Medical Services monies for 2017/18 and reported that a number of GPs at the May meeting of the Council of Representatives had requested the proposed principles for reinvestment be reviewed. She noted that, following the agreed review of Local Enhanced Services, DI and HM from NHS England were providing primary care expertise to support prioritisation of schemes; JL was also involved. The results would be reported to the Committee.

Members sought and received clarification on potential alternative contracting arrangements for Local Enhanced Services, including potential contracting through the localities.

JL referred to his declaration of interest in this item as a GP in General Practice who would receive benefit from payment. He noted that, in addition to amber drugs for psychotropic medication as discussed at the previous Committee, resources for other listed psychotropic drugs to support shared care would be welcomed. MC supported prioritisation of psychotropic drugs which would benefit patients in terms of waiting times and DH requested that all mental health drugs be prioritised to improve patient flow.

In response to TP advising that the prioritisation work had begun and that money could be backdated to 1 April 2017, PM proposed that the review of Local Enhanced Services be expedited by delegation to TP, MC and SM to work with JL and DI. They would agree criteria and prioritise the Local Enhanced Services scheme providing a retrospective report to the July meeting of the Committee and keeping members informed of progress between meetings.

JL sought clarification as to whether Enhanced Services in general would receive an uplift in year. TP explained that the CCG's financial plan included an uplift for demographics but not for price. The latter may follow as a result of the review and prioritisation in the event of the CCG being an outlier in terms of payment levels. DH expressed concern from a Practice perspective that no inflationary uplift in real terms had the impact of a reduction. He also noted workforce pressures.

PM requested that the review of Local Enhanced Services include comparison with other areas to identify whether the CCG was an outlier in terms of price and uplift. He noted that, in addition to a report to the July meeting and the electronic updates to members referred to above, he would include an update in his regular report to the Governing Body on 13 July.

SM referred to the revised proposal for the £223,237 of Personal Medical Services to be allocated to support the development of locality working arrangements in 2017/18 noting these had been developed in discussion with the Chair and Deputy Chair of the Council of Representatives:

i) Costs to support GP attendance at locality meetings. Practices would be asked to calculate the costs of GP attendance at Accountable Care System and locality board meetings across the full 2017/18 financial year. This

amount would be ringfenced to support GP attendance and engagement at these meetings. Payment would be made monthly to Practices based on attendance numbers.

ii) Funding to support a GP lead in each of the localities who would work across their locality to develop the programme of work and secure engagement with each locality's constituent Practices to develop their sustainability and manage demand. This would involve meeting with Practices, other system Partners, and working with CCG teams to support the delivery of the priorities as described in section 1. GP leads for each locality would be expected to report back to the Accountable Care System and locality boards on progress and any learning that could be shared. The Committee was being asked to approve funding on the basis that the North and South localities should each release a GP for one session per week, and the Central locality should release two sessions of GP time per week to support this work. A total of 208 sessions per year at a locum backfill rate of £300 per session would equate to approximately £62,500 per year.

iii) It was suggested that any remaining funding, after deducting the amounts in sections i) and ii) above should be offered through localities to support constituent Practices in the management of demand. This could cover a range of projects across individual or groups of Practices, including meetings to share learning and to develop collaborative ways of working. A short 'plan-on-a-page' approach would be used to capture proposed plans and ensure alignment with the agreed principles.

In respect of (iii) DH noted that a number of members of the Council of Representatives had expressed the view that the remaining funding should support workforce. TP advised that Dr Paula Evans, Chair of the Council of Representatives had reported that the North and South localities supported the proposal as described above.

Discussion included the need for assurance that the principles and previous lessons learnt were supported by all Practices, whether there was potential for innovation to improve patient care, and the key role of an outcomes based approach. TP emphasised that the CCG's existing processes would be utilised to ensure an audit trail and noted that the agreement being sought was for 2017/18 only. SM advised that other funding would be available in future years and that the CCG would work with GP leads and Practices on collaborative and innovative approaches.

The Committee:

1. In respect of the ringfenced £93,419.50 delegated responsibility for the review and prioritisation of Local Enhanced Services to TP, MC and SM to work with NHS England with immediate effect.
2. Requested a report on prioritisation of Local Enhanced Services, including where the CCG was an outlier in terms of price and uplift, to the next meeting.
3. Agreed the revised proposal for 2017/18 Personal Medical Services monies as detailed above.

9. CCG Support for General Practice in Development of New Models of Care

PM referred to the previous agenda item which would provide the resource for Practices to participate in the locality meetings and the Accountable Care System Partnership Board. He noted that the locality groups were meeting on a regular basis and that forthcoming discussion would focus on reducing acute care costs in a way that did not create disproportionate work for General Practice but fulfilled the NHS England requirements.

PM explained that the Accountable Care System Partnership Board provided a structure to bring together the discussions. He noted that the three localities had differing priorities, dependent on local pressures, but the same aim of delivering outcomes and efficiencies to take cost out of the system. PM proposed that a progress report, including risks and associated mitigation, be presented at the July Committee meeting.

The Committee:

1. Noted the update.
2. Requested a progress report on taking cost out of the system for the July meeting.

6. Primary Care Commissioning Financial Report

TP presented the report which provided information on financial performance of primary care commissioning as at month 12 of 2016/17 and financial plans for 2017/18 and 2018/19. She explained in respect of the former that the £1.4m underspend related mainly to the rent rebates, as discussed at the previous meeting of the Committee, and noted with regard to the latter that the overall CCG financial plan had not yet been approved by NHS England.

DH and JL described issues for Practices due to delays in notional rent reviews and increases in rent. CC advised that work was taking place to align District Valuer and NHS Property rent review timescales. He agreed to look into the concerns expressed and report back to TP before the next Committee meeting.

JL declared an interest and sought and received confirmation from TP that the information relating to General Medical Services expenditure should read that it was based on weighted, not actual, list sizes per capita.

TP referred to the Quality and Outcomes Framework information within the report and sought members' views on its future inclusion and presentation. She highlighted 100%, or near 100%, achievement of the points by a number of Practices in 2015/16 and posed a question about whether there should be a level of expectation.

Discussion included the need to triangulate detailed information to understand the Quality and Outcomes Framework, its historic context, and request for inclusion of an explanatory appendix of services provided through Quality and Outcomes Framework achievement. PM noted the potential for locality based consideration and the need to focus on ensuring sustained General Practice.

DH left the meeting

TP proposed that a working group comprising GPs and members of the Finance and Contracting Team develop a proposal for reporting Quality and Outcomes Framework information. KB's offer of support from Healthwatch was welcomed.

The Committee:

1. Received the primary care commissioning financial report.
2. Noted that CC would look into concerns about delays in Practice notional rent reviews and report back to TP.
3. Agreed that a working group develop a proposal in respect of reporting Quality and Outcomes Framework information.

8. Primary Care Dashboard: Update on Progress

MC referred to the report which provided an update on development of a primary care quality dashboard. She noted that, although progress was delayed which was multifactorial including slower than anticipated development of the Dr Foster tool, this was in the overall context of all Practices being rated as "Good" by the Care Quality Commission.

In response to SP referring to the Limited Assurance Internal Audit Report on Primary Care Commissioning (Quality), MC reported on discussion with the Council of Representatives in respect of quality indicators, proposed a single primary care dashboard for presentation at appropriate committees, and confirmed that a primary care dashboard would be available for the July meeting but that its refinement would be ongoing. MC noted that the dashboard would include additional performance data so it gave a more complete quality and performance picture.

SM reported on discussion with a software company that was working with NHS England. They were piloting software for operational data for General Practice and had offered to work with a number of Practices on a 12 month pilot, free of charge, to manage demand. Practices would need to consent to data sharing and the commissioner would receive anonymised information. SM noted that, if this proved of benefit, consideration could be given to purchasing the software which was currently only available to EMIS Practices though discussion was taking place about extending it to SystmOne.

Members sought and received assurance that lessons were being learnt from other CCGs but noted reliance on analytical data.

The Committee:

1. Noted that a Primary Care Dashboard would be presented at the July meeting.
2. Noted the potential for a 12 month software pilot with a number of Practices.

TM joined the meeting

10. General Practice Visits – Summary to April 2017

TM presented the summary report from Practice visits by members of the CCG team. The information would inform how the CCG took actions to support and resource the strengthening and sustainability of General Practice, to address any concerns or issues by Practice staff, and to inform CCG policy going forward. The main themes related to workforce and workload, skill mix, Practice resilience, premises and estates, impact of other commissioned services, support from the CCG and technology.

Members welcomed the report, sought and received clarification on a number of the themes, and requested a further report to the next meeting, including a matrix of the issues, proposed next steps, resource implications and expected outcomes. Detailed discussion ensued which included the context of locality working, recognition that workforce was a concern both locally and nationally with appointment times and the requirement for 8am to 8pm working being highlighted, and the need for reduced bureaucracy for Practices particularly in relation to the Referral Support Service. SM noted that investment of resilience funding, expected from NHS England to support Practices, would be prioritised following review of identified issues. AP advised that the Practices visits would continue in the context of both an individual and locality basis.

PM highlighted the need for the report requested to inform development of a business model within localities to begin to address workforce and demand issues and to create sustainable General Practice. He referred to the financial challenge across the system and the need for a change in approach working through the Council of Representatives and the Primary Care Commissioning Committee whilst ensuring the CCG's governance requirements were met.

JL welcomed the report and highlighted that there were a number of areas where "quick wins" could be implemented. He noted he had proposed establishment of a small working group comprising representatives of the CCG and the Local Medical Committee to progress work relating to aspects of the Referral Support Service. JL also referred to discussion at the Community Nursing Workforce presentation at the Council of Representatives welcoming the engagement with primary care and MC noted the joint working in this regard on a generic approach to community nursing.

The Committee:

1. Received the summary report of visits to General Practice to April 2017.
2. Requested a further report for the next meeting.

11. NHS England Update

CC referred to the report which provided an update on Clinical Pharmacists in General Practice, Personal Medical Services /Alternative Provider Medical Services uplift for 2017/18, Estates and Technology Transformation Fund, and Sickness and

Parental Leave Protocol. Members sought and received clarification on a number of aspects of the report. In relation to Clinical Pharmacists in General Practice CC noted that further detail would be provided in the next report.

The Committee:

Noted the updates.

12. Next meeting

9.30am on 25 July 2017.

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE

SCHEDULE OF MATTERS ARISING FROM THE MEETING HELD ON 30 MAY 2017 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCC6	28 February 2017 28 March 2017	Primary Care Commissioning Committee Terms of Reference	• Discussion to take place of the role of the Committee in the context of the Accountable Care Partnership Board with the Executive Director of Planning and Governance • KR to discuss with PM	SM KR/PM	 Ongoing
PCC12	28 February 2017 30 May 2017	South Milford Surgery and Tadcaster Proposals to move to Leeds North CCG	• Discussion to take place with South Milford Surgery and Tadcaster Medical Centre regarding their expressions of interest to move to Leeds North CCG and the views of Leeds North CCG also to be sought	SM	30 April 2017 Ongoing
PCC15	28 March 2017	Accountable Care System Update	• Representation of up to two GPs from each locality to be progressed	PM	Ongoing
PCC17	30 May 2017	Personal Medical Services Monies 2017/18 Update	• Report on prioritisation of Local Enhanced Services	TP	25 July 2017

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCC18	30 May 2017	CCG Support for General Practice in Development of New Models of Care	• Progress report on taking cost out of the system	TP	25 July 2017
PCC19	30 May 2017	Primary Care Commissioning Financial Report	• Concerns about delays in Practice notional rent reviews to be looked into and reported back to TP	CC	Before July meeting
PCC20	30 May 2017	Primary Care Commissioning Financial Report	• Working group to be established to develop a proposal in respect of reporting Quality and Outcomes Framework information	TP	25 July 2017
PCC21	30 May 2017	General Practice Visits – Summary to April 2017	• Further report to include a matrix of the issues, proposed next steps, resource implications and expected outcomes	SM	25 July 2017

Item Number: 6

Name of Presenter: Tracey Preece

Meeting of the Primary Care Commissioning Committee

25 July 2017

NHS
Vale of York
Clinical Commissioning Group

Primary Care Commissioning Financial Report

Purpose of Report *(Select from list)*
For Information

Reason for Report

To brief members on the financial performance of Primary Care Commissioning as at the end of June 2017.

This report also provides an update on the allocation of PMS Premium monies.

Strategic Priority Links

☐Strengthening Primary Care
☐Reducing Demand on System
☐Fully Integrated OOH Care
☐Sustainable acute hospital/ single acute contract
☐Transformed MH/LD/ Complex Care
☐System transformations
☒Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks

☒Financial
☐Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

The Primary Care Commissioning Committee is asked to note the financial position as at month 3.

Responsible Executive Director and Title	Report Author and Title
Tracey Preece, Chief Finance Officer	Caroline Goldsmith, Deputy Head of Finance

NHS Vale of York Clinical Commissioning Group Primary Care Commissioning Financial Report

Report produced: July 2017

Financial Period: April 2017 to June 2017

Introduction

This report details the financial position of the CCG's Primary Care co-commissioning areas at year to date and at forecast outturn level.

It also includes an update on the proposed apportionment of PMS premium monies between localities.

Financial position – Month 3

The table below sets out the outturn position as at month 3.

Area	Cumulative To Date				Forecast Outturn		
	Budget £000	Actual £000	Variance £000		Budget £000	Actual £000	Variance £000
Primary Care - GMS	5,189	5,161	29		20,758	20,758	0
Primary Care - PMS	2,149	2,086	62		8,594	8,594	0
Primary Care - Enhanced Services	278	277	0		1,110	1,110	0
Primary Care - Other GP services	708	745	(38)		2,988	2,988	0
Primary Care - Premises Costs	1,062	1,063	(2)		4,248	4,248	0
Primary Care - QOF	1,025	1,060	(35)		4,099	4,099	0
Sub Total	**10,410**	**10,393**	**17**		**41,797**	**41,797**	**0**

Note that the total FOT has increased from the previously reported figure of £41,758k as a result of updates to the 2017/18 CCG financial plan for the capped expenditure process. This additional £39k has been included as a contingency with other GP services.

GMS has been calculated based upon current list size, resulting in a year to date variance of £29k.

Slippage on the 17/18 PMS premium funding accounts for £56k of the variance on PMS however this is being reported under primary care in the CCG dashboard.

The year to date position on other GP services is showing an overspend of £38k, due in the main part to increased costs within admin for new retainers and on-going sickness claims.

QOF has been accrued based upon 16/17 points and prevalence at 17/18 prices with an increase of 0.7% for estimated demographic growth.

PMS premium monies

The update paper presented to the Committee on 30 May 2017 provided a revised proposal for the allocation of the PMS premium monies in three parts as follows:

1) Costs to support GP attendance at Locality meetings, Unplanned Care Steering Group meetings and Accountable Care System Partnership Board.
2) Funding to support a GP lead in each of the localities who will work across their locality to develop the programme of work and secure engagement with each locality's constituent Practices to develop their sustainability and manage demand.
3) Any remaining funding should be offered through localities to support constituent Practices in the management of demand.

The indicative cost of each of these three parts is shown in the table below.

	Cost per locality			
	North	South	Central	Total
	£	£	£	£
2017/18 PMS reinvestment monies	43,559	54,448	125,231	223,237
Part 1) Locality meetings	4,080	4,080	6,120	14,280
Part 1) Unplanned Care Steering Group	2,040	-	4,080	6,120
Part 1) Accountable Care System Partnership Board	1,020	1,020	4,590	6,630
Part 2) GP sessions	15,600	15,600	31,200	62,400
Remaining for part 3	**20,819**	**33,748**	**79,241**	**133,808**

These costs are based upon a number of assumptions as follows:

- Locality meetings are held monthly, last two hours and are attended by 2 North GPs, 2 South GPs and 3 Central GPs.
- The Unplanned Care Steering Group meetings are held monthly, last two hours and are attended by 1 North GP and 2 Central GPs.
- Accountable Care System Partnership Board meetings are held quarterly, last 3 hours and are attended by 1 North GP, 1 South GP, 2 Central GPs, 1 GP on behalf of LMC and 1 Practice Manager.
- GP time is reimbursed at £85 per hour, Practice Manager time is reimbursed at £42.50 per hour.
- GP sessions are reimbursed at £300 per session with a frequency of one per week.

Note that the costs above will change if attendance varies.

Recommendation

The Primary Care Commissioning Committee are asked note the financial position of Primary Care Commissioning as at month 3 and the suggested split for the PMS premium monies.

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Item Number: 7

Name of Presenter: Michelle Carrington

Meeting of the Primary Care Commissioning Committee

Date of meeting:
25 July 2017

NHS
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Clinical Commissioning Group

Report Title – Primary Care Dashboard Development

Purpose of Report *(Select from list)*
For Approval

Reason for Report
A Quality Outcomes Framework has been developed and agreed with Audit Committee, Council of Representatives and Primary Care Commissioning Committee (PCCC). At the last PCCC it was requested that a fuller dashboard be developed to include other performance metrics. A draft of such a dashboard is presented here with proposed next steps described.

Strategic Priority Links

☒Strengthening Primary Care
☒Reducing Demand on System
☐Fully Integrated OOH Care
☐Sustainable acute hospital/ single acute contract
☒Transformed MH/LD/ Complex Care
☒System transformations
☐Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks

☐Financial
☐Legal
☒Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

To discuss and endorse the draft dashboard indicators and to support the next steps outlined in the paper.

Responsible Executive Director and Title	Report Author and Title
Michelle Carrington Executive Director of Quality and Nursing	Michelle Carrington Executive Director of Quality and Nursing

Primary Care Commissioning Committee

Primary Care Dashboard Development

Background

A Quality Outcomes Framework has been developed and agreed with Audit Committee, Council of Representatives and Primary Care Commissioning Committee (PCCC). At the last PCCC it was requested that a fuller dashboard be developed to include other performance metrics. A draft of such a dashboard is presented here.

Progress since the last PCCC

Development meetings have been held with the Head of Transformation and Delivery, Head of Contracts, Senior BI analyst from EMBED, in house data analysts, Assistant Director Delivery and Performance and the Chief Nurse.

The draft indicators are based on the NHS Outcomes Framework Domains as a way forward for discussion and agreement. The in-house data analysts mapped all available data from a large number of data sources and a very large data set now exists.

This initial ‘proof of concept’ is essentially a mixture of manual tables and screen grabs from the data sources available, along with some context around each indicator. Going forwards the Committee needs to be aware that there will be a requirement to build something more consistent in layout, which can only come when the content of the initial draft is accepted by Primary Care and CCG colleagues.

It is anticipated that there will be a significant overhead for development time that is needed once we have a clear idea of what content is required. 90% of the data in this report will need to be manually taken from websites and publications, which means that automating things will not be possible. An Excel tool would most likely be required to store backing data and automatically produce charts and text for the final report product. Depending on the final number of indicators required, development time could run into several weeks based on the band 3 analyst support working on this as a sole project (less time if more BI resource could be prioritised for this) but this is well on its way.

However, the majority of indicators are published annually, which means only indicators that are published more frequently would need to be updated for, say, a quarterly report. If the excel file is set-up correctly then it may only take 1-2 days of analyst time to update and publish each time.

Next steps

Due to the length of time is has taken to map the available data sources, it has not yet been possible to showcase the proposed draft dashboard and the data which sits behind it, with NHSE primary care colleagues or Chair of Council of Representatives and this will be part of the next steps. Once agreed we will be able to develop a regular report and also highlight where there may be areas of concern or variation.

It is also proposed that exceptions are reported in the Performance Report along with performance of other providers and in line with the CCG work programmes and will be presented to Finance and Performance Committee at a future date.

PCCC may wish to focus at times on specific issues or request deep dives into the data on occasion.

Further next steps will consist of:

- Chair of Council of Reps discussion
- Sense check of the dashboard and the use of the data with Council of Reps
- Discussion regarding the potential for a private session of the PCCC to review all the available data
- Sense check against all the other dashboards for the CCG programmes of work
- Sense check against data packs developed for localities and individual practices
- Similarly triangulation with the national integrated assurance framework (IAF) in relation to any indicators for primary care and well-being
- There will need to be a discussion at Executive Committee regarding the resource required to continue the development and on-going support to the dashboard
- Links to on-going discussions regarding any alternatives to QOF will need to be part of any further developments

The Dashboard

The overview of proposed indicators is below. What will follow on from the overview are some examples of how the data is presented from the data sources. Some data is not yet available.

Recommendations

To discuss and endorse the draft dashboard indicators and to support the next steps outlined in the paper.

Overview of Primary Care Performance Indicators:

Domain	Indicators	Source	Level	Last update	Frequency
Local Benchmarking	Emergency Admissions: standarised Rates by Practice	Practice Benchmarking Tool	CCG, Practice	2016-17, May 2017	Monthly
	A&E attendances: Standarised Rates by Practice	Practice Benchmarking Tool	CCG, Practice	2016-17, May 2017	Monthly
	Planned Care Admissions: standarised Rates by Practice	Practice Benchmarking Tool	CCG, Practice	2016-17, May 2017	Monthly
	OP First: Standarised Rates by Practice	Practice Benchmarking Tool	CCG, Practice	2016-17, May 2017	Monthly
Preventing People from Dying Prematurely	Rates of Cancer Admissions	Public Health England	CCG, Practice	2015/16	Annual
	Rates of smoking cessation advice for long term conditions (LTCs)	Public Health England	CCG, Practice	2015/16	Annual
	Rates of mental health (depression)	Public Health England	CCG, Practice	2015/16	Annual
	Rates of serious mental illness	Public Health England	CCG, Practice	2015/16	Annual
	Vacs in pregnancy – flu and pertussis	Imm Forms	CCG, Practice	Jan-17	monthly
	Two Week Wait	Public Health England	CCG, Practice	2015/16	Annual
	Diabetes BP Monitoring	Public Health England	CCG, Practice	2015/16	Annual
	AF on Anticoagulation	Public Health England	CCG, Practice	2015/16	Annual
	Cervical Smears	Public Health England	CCG, Practice	2015/16	Annual
	Health checks for mental Ilness	Public Health England	CCG, Practice	2013/14	Annual
	Flu vaccinations (over 65)	Imm Forms	CCG, Practice	Jan-17	
	Flu vaccination (at risk)	Imm Forms	CCG, Practice	Jan-17	
	AF Prevalence	Public Health England	CCG, Practice	2015/16	Annual
	CHD Prevalence	Public Health England	CCG, Practice	2015/16	Annual
	COPD Prevalence	Public Health England	CCG, Practice	2015/16	Annual
	Asthma Prevalence	Public Health England	CCG, Practice	2015/16	Annual
	Diabetes Prevalence	Public Health England	CCG, Practice	2015/16	Annual

Enhancing quality of life for people with LTCs	Diagnosis rates for COPD	Public Health England	CCG, Practice	2015/16	Annual
	Prevalence rates for dementia	Public Health England	CCG, Practice	2015/16	Annual
	MH – antipsychotic meds for dementia	in progress			
	MH – annual health assessments for those with dementia	in progress			
	MH – shared care agreements in pl	in progress			
	LD - % of LD patients on the register	in progress			
	LD – those who have had an annual health assessment	QOF Database	CCG, Practice	2015-16	Annual
	Cancer screening in LD population	NHS Digital Tool	CCG, Practice	2015-16	Annual
	Flu vac rates in those with LTCs	Imm Forms	CCG, Practice	Jan-17	Annual
	Emergency Admissions	Primary Care Web Tool	Practice	Jul15-Jun16	Annual
	AE Attendances	Primary Care Web Tool	Practice	Jul15-Jun16	Annual
	CHD Admissions	Primary Care Web Tool	Practice	Jul15-Jun16	Annual
	Asthma Admissions	Primary Care Web Tool	Practice	Jul15-Jun16	Annual
	Diabetes Admissions	Primary Care Web Tool	Practice	Jul15-Jun16	Annual
	COPD Admissions	Primary Care Web Tool	Practice	Jul15-Jun16	Annual
	Dementia Admissions	Primary Care Web Tool	Practice	Jul15-Jun16	Annual
	Diabetes Cholesterol monitoring	Public Health England	CCG, Practice	2015/16	Annual
	Diabetes HbA1C monitoring	Public Health England	CCG, Practice	2015/16	Annual
	CHD cholesterol monitoring	Public Health England	CCG, Practice	2013/14	Annual
	SMI and a BP check	Primary Care Web Tool	Practice	2015/16	Annual
	SMI and cholesterol Check	Primary Care Web Tool	Practice	2014/15	Annual
	SMI and BM check	Primary Care Web Tool	Practice	2014/15	Annual

Helping people recover from a period of illness / injury	Emergency admission rates for people with LTCs	In Progress			
	Rate of A&E attendances	In progress			
	AF on anticoagulation	Public Health England	CCG, Practice	2014/15	Annual
	Flu Vaccination (at risk)	Imm Forms	CCG, Practice	Jan-17	
	Emergency Admissions	Primary Care Web Tool	Practice	Jul15-Jun16	Annual
	AE Admissions	in progress			
	ACS Admissions	in progress			
	Diabetes Retinal Screening	Primary Care Web Tool	Practice	Jul15-Jun16	Annual
Helping people have a positive experience of care	Antibacterial prescribing	Primary Care Web Tool	Practice	Jul15-Jun16	Annual
	Satisfaction with quality of consultation at GP practice	GP Practice Survey - in progress	CCG, Practice	Jul-17	
	How good was the GP / Nurse at giving you enough time	GP Practice Survey	CCG, Practice	Jul-17	
	How good was the GP / Nurse at listening to you	GP Practice Survey	CCG, Practice	Jul-17	
	How good was the GP / Nurse at explaining tests or treatment	GP Practice Survey	CCG, Practice	Jul-17	
	How good was the GP / Nurse at involving you in decisions about your care	GP Practice Survey	CCG, Practice	Jul-17	
	How good was the GP / Nurse at treating you with care and concern	GP Practice Survey	CCG, Practice	Jul-17	
	Did you have confidence and trust in the GP / Nurse you saw and spoke to	GP Practice Survey	CCG, Practice	Jul-17	
	How confident are you that you can manage your own health	GP Practice Survey - in progress	CCG, Practice	Jul-17	
	Satisfaction in being able to see preferred doctor	GP Practice Survey - in progress	CCG, Practice	Jul-17	
	Satisfaction with accessing primary care	GP Practice Survey	CCG, Practice	Jul-17	
	Able to get an appointment to see / speak to someone	GP Practice Survey	CCG, Practice	Jul-17	
	Satisfaction with opening hours	GP Practice Survey	CCG, Practice	Jul-17	
	How easy is it to get through on the phone.	GP Practice Survey	CCG, Practice	Jul-17	
	End of life – those patients on the register	in progress			
	End of life – those with plans and reviewed regularly	in progress			
	End of life – regular review of people in care homes	in progress			
	End of life – death in preferred place	in progress			
	Carers – processes in place for identifying carers	GPs to share	Practice		
	Carers – offering flu vacs to carers	Gps to share	Practice		
	CQC ratings	CQC website	Practice		
	Patient feedback – complaints	GPs needs to agree to share NHS	CCG, Practice		
	Patient feedback – PPG group activity	Victoria - in progress			
	Patient feedback – friends and family (F&F)	NHS England	CCG, Practice		

Treating and caring for people in a safe environment	Significant event audits – themes and trends	GPs to share			
	Serious incidents	GPs to share			
	Adverse incidents	GPs to share			
	HCAIs – Cdiff, MRSA (and UTI when measured described more)	EMBED/ Public Health - in progre	CCG	April2016 - June 201	Monthly
	Safeguarding processes and training	Primary Care Safeguarding Lead			
	Reduction in cold chain incidents (imms / vacs improvement plan for CCG)	Imm Forms	CCG	April- June 2017	Monthly?

Michelle Carrington

Chief Nurse

Item Number: 9

Name of Presenter: Tracey Preece and Michelle Carrington

Meeting of the Primary Care Commissioning Committee **Date of meeting:** **25 July 2017**	NHS Vale of York Clinical Commissioning Group

Report Title – Enhanced Service Review

Purpose of Report
For Decision

Reason for Report

Update the Committee on the Vale of York CCG Enhanced Services

Strategic Priority Links

☒Strengthening Primary Care
☒Reducing Demand on System
☐Fully Integrated OOH Care
☐Sustainable acute hospital/ single acute contract
☒Transformed MH/LD/ Complex Care
☐System transformations
☐Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks	**Covalent Risk Reference and Covalent Description**
☒Financial ☐Legal ☒Primary Care ☐Equalities	

Emerging Risks (not yet on Covalent)

Any revision of activity based contracts carries a risk in terms of outturn against forecast spend. The Amber Drugs – Near Patient Testing service will be offered to Practices through a contract variation from 1st August 2017. This will enable the CCG to monitor the part-year spend across the remainder of the financial year for 2017/18 and assess whether the allocated budget is sufficient to meet the full year effect of this service going forward and plan accordingly.

Recommendations

The Committee is asked to:

- Support the development of a working group to review the priority Enhanced Services as part of reviewing all in the coming months with a view to implementing any agreed service changes from the start of next financial year, 1st April 2018.
- Support the uplift of all Enhanced Service agreements by 1% effective 1st April 2017 (with the exception of Near Patient Testing) to support primary care.
- Approve the YORLMC request to update the Near Patient Testing – Amber Drugs Service Specification, through a contract variation, by including the monitoring of anti-psychotic drugs, and additional drugs included in the Harrogate & Rural District CCG model. It is proposed that this should be with effect from 1st August 2017 whilst the wider Enhanced Service review is undertaken.
- Confirm the preferred funding arrangements for 2017/18 with a further proposal to come to resolve this recurrently in 2018/19 as part of the wider review.

Responsible Executive Director and Title	**Report Author and Title**
Tracey Preece - Chief Finance Officer Michelle Carrington – Executive Director of Quality and Nursing	David Iley - NHS England North (Yorkshire and The Humber) Primary Care Assistant Contracts Manager

Enhanced Service Review

1. Background

1.1 Current Services

GP Practices in the Vale of York provide core medical services through General Medical Service (GMS) and Personal Medical Service (PMS) contracts. In addition there are a range of Enhanced Service agreements commissioned by Vale of York (VoY) CCG. These Enhanced Services are a range of historic Primary Care Trust agreements as well more recently commissioned services. With the exception of PSA and Anticoagulation, service item payments for all Enhanced Services have not been increased in line with any contract change or cost of living increase over the last 5 years.

The Enhanced Services currently commissioned by the CCG are as follows;

- Anti-Coagulation Monitoring Levels 1-3
- Near Patient Testing and Amber Drugs
- Student Health
- Minor Injury Services Cost per Case
- Neonatal Checks
- Complex Wound Care
- Care of Homeless
- Bone Protection Services
- Minor Injury Capitation
- Wound Care and Suture Removal
- Diabetes
- Anti-Coagulation Level 4
- Prostate Specific Antigen
- Long Acting Removable Contraceptive (LARC)
- Low Vision Aids
- Ophthalmology
- Phlebotomy

Participation for each scheme by GP Practice can be seen in appendix 1 (with the exception of LARC, Low Vision Aids, Ophthalmology and Phlebotomy). Practices are not contractually required to deliver all of the services and are able to sign up to individual schemes creating a variation in service provision across the patch.

1.2 Financial position

The financial position with regards to Enhanced Service spend is as follows. This includes the comparison of actual payments made in relation to 2016/17.

LES	2016/17 M12 FOT	1% Uplift	Demographic Growth	2017/18 Plan		Actual Outturn 2016/17
Anti-Coag L1-3	215,907	2,159	1,295	219,362		59,987
Anti-Coag L4	0	0	0	0		153,169
Minor Injury	153,882	1,539	923	156,344		153,882
Near Patient Testing	360,467	3,605	2,163	366,234		360,467
Phlebotomy	140,327	1,403	842	142,572		140,327
Student Health	47,167	472	283	47,922		47,167
Wound Care	114,769	1,148	689	116,605		114,769
PSA	45,560	456	273	46,289		30,160
Bone Protection	16,915	169	101	17,186		13,045
Care of Homeless	26,067	261	156	26,484		26,067
Complex Wound Care	131,352	1,314	788	133,454		126,510
Minor Injury Cost per Case	27,344	273	164	27,781		35,148
Neonatal	11,136	111	67	11,315		11,093
Diabetes	122,230	1,226	824	124,281		115,410
Sub-Total	**1,413,121**	**14,135**	**8,570**	**1,435,826**		**1,387,199**
LARC Nimbus	156,000	1,560	936	158,496		166,704
LARC recharge to CYC	-142,953	-1,430	-858	-145,240		-142,953
LARC NYCC	21,929	219	132	22,280		2,398
Ophthalmology	118,515	1,185	711	120,412		123,133
Low Vision Aids	3,048	30	18	3,097		2,837
Vexatious Patients	707	7	4	718		707
D-Dimers*	4,848	48	29	4,925		4,294
Sub-Total	**162,094**	**1,621**	**973**	**164,688**		**157,119**
Total	**1,575,216**	**15,756**	**9,542**	**1,600,514**		**1,544,318**
Anti-Coag QIPP reinvestment				**317,932**		
Total in Plan for 2017/18				**1,918,446.29**		

The Month 12 forecast outturn of £1,575,216 used for budget setting purposes is £30,898 more than what was ultimately claimed and paid for in relation to 2016/17. It is anticipated that there will be increased costs associated with the LARC NYCC payments in 2017/18, up to £19,882 more. Assuming all other claims remain consistent this could leave a balance of £11,016 available within the 2017/18 budget.

1.3 Enhanced Service Review (all services)

Following a request from the Executive Group and Primary Care Commissioning Committee to consider a further review of the existing enhanced services, the next steps are proposed:

- Currently the majority of the Enhanced Services are commissioned at practice level however we are now aware that for many of these services a “place based “ footprint may provide a more comprehensive, integrated and cost efficient service, with better access for patients. This approach needs to be incorporated into the review (e.g. complex wound care may require a level of skill that individual practices may not have, and patients therefore may need to travel to hospital services, when a more local community based service may be able to be established across ‘place’ . These Population Enhanced Services could be commissioned across a range of practices working at scale. This work needs to be undertaken in partnership with Practices and the local medical committee, YORLMC. Review process to include consideration of the clinical spec, population needs, service delivery footprint, costs, and tariffs.

- Work with YORLMC to identify other individual enhanced services to be reviewed and updated and whether any could be decommissioned or re-specified and re-commissioned. Following an internal meeting at the CCG, Complex Wound Care, Diabetes and Bone Protection Services were identified as priority schemes to be reviewed.

- Large scale / transformational review – consider what other CCGs have done nationally (e.g. Sunderland CCG who have developed a Quality Premium with practices using enhanced service funding). Once the above individual review has been completed, alternative ways of commission and contracting for these services could be explored to look at how we can provide longer term, more sustainable services that support the development of primary care.

Enhanced Service reviews are to be completed within the current year so that we can start to deliver services under the new specifications in 2018/19. This is taking into account the need to issue three months' notice on the current services or specifications.

1.4 Contract Uplift

Whilst the wider review is being completed, YORLMC have requested that all enhanced services are uplifted to support general practice recognising that service item payments for all Enhanced Services have not been increased in line with any contract change or cost of living increase over the last 5 years with the exception of PSA and Anticoagulation.

The CCG has made a planning assumption of a 1% uplift to all enhanced services within its financial plan for 2017/18, amounting to an overall increase of £15,756. However the CCG's Financial Plan has not yet been approved and feedback on York system-wide Capped Expenditure Process plans has not been received at the time of writing. The initial internal prioritisation exercise suggested that this funding could be used either to uplift current fees by 1% or added to the available resource to support specific LES uplifts. YORLMC preference is for the 1% uplift to be applied across all schemes. This also has the benefit of creating the time and space through the latter half of 2017/18 to undertake the review properly.

2017/18 Enhanced Service contracts have already been agreed and signed up to by practices and there would therefore be a need to vary these contracts for either the whole of or remaining year payments if an uplift was applied. There is considerable resource implication to this in the time required to update the prices and issue amended contracts to all practices.

1.5 Near Patient Testing – Amber Drugs

A paper was submitted to the VoY CCG Executive Committee in April 2017 to consider a revision to the Near Patient Testing – Amber Drugs Service Specification (see appendix 2). This was following a request from YORLMC who requested for the service specification to be updated. This was to incorporate a number of drugs not currently in the service specification that require near patient testing, ensuring that

primary care providers are being appropriately reimbursed for the work required. It will also ensure that prescribing and monitoring that is suitable and safe for primary care does not present in secondary care services which would be inconvenient for patients and more costly to the wider system.

YORLMC requested to move to a service specification that was built on the current specification and included the monitoring of anti-psychotic drugs, and additional drugs included in the Harrogate & Rural District (HaRD) CCG model. Hambleton, Richmondshire and Whitby (HRW) CCG have a different service specification that was also considered in the paper (appendix 2). The Executive Committee also wanted to know if Scarborough and Ryedale (S&R) CCG commissioned a third model or whether there was a national service specification available. Since then S&R CCG have confirmed that they have a similar service specification to Vale of York CCG; therefore there would be no benefit in moving to their model.

In order to assess the impact of the proposed moves the CCG has had to assess the following:

- **The additional cost of moving bandings** – Drugs within the HaRD CCG Enhanced Service that are paid at a different banding to those within the Vale of York
- **The additional cost of new drugs** – New drugs not previously within the Vale of York Enhanced Service, but part of the HaRD CCG payment
- **The continuation of drugs** – Those drugs not in the HaRD CCG Enhanced Service, but which will be continuing from the existing Vale of York CCG Enhanced Service

Moving bandings

This has been quantified by using last year's patient data to calculate payments for this year on the new bandings. This is anticipated to equate to an increase of £56,716.02 compared to the existing Enhanced Service.

New drugs

Using data taken from SystmOne on the number of patients receiving specified drugs on repeat prescription this has then been extrapolated to all practices in the Vale of York CCG. This was then multiplied up by the cost per Banding and is anticipated to equate to an increase of £41,244.54. A proportion of this spend relates to the prescribing of anti-psychotics for which a patient needs to be on the QoF register in order for payment to flow. For the purposes of this report this is assumed to be at 100% as no allowance has been made to assess what proportion may meet this requirement.

Continuation of drugs

It had previously been anticipated that where the Vale of York had an Enhanced Service for drugs that were not on the HaRD CCG list these would have been removed from the costing. However, the proposed amalgamation does not do this and therefore this will continue at £18,168.29.

The total additional cost of moving to the amalgamated Vale of York CCG and Harrogate & Rural CCG model is £97,960.56 per annum compared to the HRW CCG model which is anticipated to cost an additional £54,481. This is largely due to the HRW CCG model having a separate banding for anti-psychotics meaning they are paid at a lower rate than the HaRD CCG model. If the HaRD CCG model was brought into effect from 1st August 2017 this would equate to £65,307.04 in-year impact.

The additional funding for either model would need to be made either from the available balance in the 2017/18 Enhanced Service budget and / or from the PMS premium re-investment monies. £93,420 was carried forward due to an underspend of PMS re-investment monies in General Practice during the 2016/17 financial year that has been ring fenced for Enhanced Services.

The £223,237 available from the 2017/18 PMS reinvestment monies is to be allocated based on weighted Practice size to support General Practice engagement in the emerging locality programmes, and the development of an Accountable Care System. However, £4,540.56 may be required to fund the additional costs described above in 2017/18 if done with effect from 1st April 2017.

Although the combined VoY/HaRD CCG model is forecast to have a greater cost implication, it is favoured by the LMC. YORLMC have not indicated that another individual Enhanced Service review has become more of a priority over Near Patient Testing – Amber Drugs since the paper (appendix 2) was initially submitted.

Any revision of activity based contracts carries a risk in terms of outturn against forecast spend. The Amber Drugs – Near Patient Testing service will be offered to Practices through a contract variation from 1st August 2017. This will enable the CCG to monitor the part-year spend across the remainder of the financial year for 2017/18 and assess whether the additional budget is sufficient to meet the full year effect of this service going forward and plan accordingly.

2. Conclusion

Even though the Enhanced Service funding sits within the core CCG budget rather than the Primary Care budget allocation, as the services fall under primary care the Primary Care Commissioning Committee will need to come to an agreement regarding any re-investment of primary care funding and priorities across the range of Enhanced Service schemes.

3. Recommendation

The Committee is asked to:

- Support the development of a working group to review the priority Enhanced Services as part of reviewing all in the coming months with a view to implementing any agreed service changes from the start of next financial year, 1st April 2018.

- Support the uplift of all Enhanced Service agreements by 1% effective 1st April 2017 (with the exception of Near Patient Testing) to support primary care.

- Approve the YORLMC request to update the Near Patient Testing – Amber Drugs Service Specification, through a contract variation, by including the monitoring of anti-psychotic drugs, and additional drugs included in the Harrogate & Rural District CCG model. It is proposed that this should be with effect from 1st August 2017 whilst the wider Enhanced Service review is undertaken.

- Confirm the preferred funding arrangements for 2017/18 with a further proposal to come to resolve this recurrently in 2018/19 as part of the wider review.

Appendix 1

Practice Name	Practice Number	Anti-Coagulation Levels 1-3	Near Patient Testing and Amber Drugs	Student Health	Minor Injury Cost per Case	Neonatal	Complex Wound	Care of Homeless	BPS	Minor Injury Capitation	Wound Care a	Phlebotomy	Diabetes	Anti-Coagulation Level 4	PSA
POCKLINGTON GROUP PRACTICE	B81036														
MILLFIELD SURGERY YO61 3JR	B82002														
PRIORY MEDICAL GROUP YO31 7SX	B82005														
ESCRICK SURGERY	B82018														
DALTON TERRACE SURGERY	B82021														
HAXBY GROUP PRACTICE	B82026														
SHERBURN GROUP PRACTICE	B82031														
PICKERING MEDICAL PRACTICE	B82033														
BEECH TREE SURGERY	B82041														
UNITY HEALTH	B82047														
TOLLERTON SURGERY	B82064														
HELMSLEY SURGERY	B82068														
THE OLD SCHOOL MEDICAL PRACTICE	B82071														
SOUTH MILFORD SURGERY	B82073														
POSTERNGATE SURGERY	B82074														
KIRKBYMOORSIDE SURGERY	B82077														
STILLINGTON SURGERY	B82079														
MY HEALTH	B82080														
ELVINGTON MEDICAL PRACTICE	B82081														
YORK MEDICAL GROUP	B82083														
SCOTT ROAD MEDICAL CENTRE	B82097														
JORVIKGILLYGATE MEDICAL PRACTICE	B82098														
FRONT STREET SURGERY	B82100														
EAST PARADE	B82103														
TADCASTER MEDICAL CENTRE	B82105														
TERRINGTON SURGERY	B82619														

Appendix 2

Update to Near Patient Testing – Amber Drugs Service Specification

12th April 2017

Presented by: Dr Shaun O'Connell
Author: Laura Angus

Background:

National Context

The treatment of several diseases within the fields of medicine, particularly in rheumatology and psychiatry, is increasingly reliant on drugs that while clinically effective, need regular blood tests or other investigations such as ECG or blood pressure monitoring. This is due to the potentially serious side-effects that these drugs can occasionally cause. It has been shown that the incidence of side-effects can be reduced significantly if this monitoring is carried out in a well-organised way, close to the patient's home.

Prior to April 2013, a local adaptation of a National Enhanced Service for Near Patient Testing (NPT) defined what drugs were included within the service, general detail of the expected safety and partnership working requirements of the service, the agreed banding of different drugs and the payments the bands would attract.

For many diseases a drug's effectiveness is monitored by hospital specialists while the prescribing and monitoring for side effects is done by the GP. This organised model is typically delivered under a shared care arrangement, with clear and locally agreed guidelines (SCGs) between hospital and primary care representatives. Drugs that fall into this category are locally called 'amber – shared care' (amber-SC). For many drugs there may be a greater level of baseline testing and monitoring involved before the GP is asked to take on prescribing and more routine monitoring.

Another 'amber' category exists for drugs that require initiation either by an appropriate hospital specialist or on their recommendation. These drugs do not require SCGs because any monitoring requirements are considered as relatively standard primary care activity. Red drugs, however, should only be prescribed within the hospital by appropriate specialists but GPs will be informed of the drugs involved and the progress in the management of the patient's disease. Green drugs are those that can typically be initiated in primary care by the patient's GP or another prescriber.

Many SCGs exist, with variation influenced by the side effect profile of the drug, the condition being treated (with different tolerance levels and doses being used) and between hospitals. It should be expected that specialist teams in different hospitals may not all delegate the monitoring requirements to GPs in the same way. It is also noted that green and non-shared care amber drugs can require monitoring and if this is significant for GP practices then they should be considered for inclusion in this service.

Local Context

NHS Vale of York Clinical Commissioning Group benefits from a close working relationship with the main local providers of York Teaching Hospital NHS Foundation and Tees, Esk and Wear Valleys NHS Foundation Trust. Joint decision making and partnership working at the local Medicine Commissioning Committee supports the timely transfer of some of the regular drug monitoring requirements of patient's treatments to their GP. The Medicine Commissioning Committee will determine if a drug is suitable for shared care and generate drug specific shared care guidelines to explicitly define the roles and relationships between the GPs and hospital specialists. Vale of York Clinical Commissioning Group will then agree in partnership with local primary care providers through their representative body (YORLMC), how much work is involved for the GP practice and the corresponding payment this work should attract.

At Clinical Commissioning Group level, the overall level of payment can be influenced by factors such as drugs moving from one payment band to another, changes in local specialists prescribing patterns and pathways of care, e.g. NICE guidance and drugs being removed or added to lists. It is important to ensure that prescribing and monitoring that is suitable for primary care does not get blocked into secondary care which would be inconvenient for patients and unnecessarily expensive for Vale of York Clinical Commissioning Group.

From April 2013, the funding of some of the more specialist drugs shifted to NHS England. Where these treatments are only provided within secondary care, Vale of York Clinical Commissioning Group does not incur costs. In localities within the NHS, some of these drugs are still managed under shared care arrangements. Until funding and prescribing arrangements are transferred, the Clinical Commissioning Group and hospital trusts will continue to ensure safe prescribing and monitoring is applied

The current Vale of York Near Patient Testing and Amber Drugs Service Specification has been in place since 2013 and has not been reviewed or updated – see appendix 1.

Action for Executive Committee

The local medical committee – YORLMC – have requested that the Vale of York Near Patient Testing Amber Drugs Service Specification is updated to ensure that it truly represents the number of drugs that require near patient testing and hence primary care providers are being appropriately reimbursed for the work required.

YORLMC have requested to move to the same service specification as Harrogate and Rural District Clinical Commissioning Group – see appendix 2.

However, Hambleton and Richmondshire CCG have a different service specification which also requires consideration – see attached.

HaRD CCG Banding criteria and service payments for 'Monitoring of Drugs in Primary Care'

Banding	Payment per drug patient	Typical monitoring
Band 1	£91.95	high intensity monitoring
Band 2	£45.97	intermediate
Band 3	£7.15	closer to routine and/or infrequent

These bandings are the same as current Vale of York bandings however there are more drugs listed in HaRD service specification vs. the current Vale of York specification. YORLMC have requested that some drugs move bandings from band 3 to band 2, in line with HaRD CCG and also a number of additional drugs are added, in line with HaRD CCG.

The estimated cost impact of moving to HaRD CCG service spec for Vale of York CCG: ~£98,309 per annum

HRW CCG has slightly different bandings, HRW class anti-psychotics as 'band 2b' and pay £26.56 for this band (as opposed to £45.97 in HaRD)

There are also more drugs in HRW CCG service spec than current Vale of York service spec and some drugs move bandings, in line with request from YORLMC

HRW CCG Banding criteria and service payments for 'Monitoring of Drugs in Primary Care'

Banding	Payment per drug patient	Typical monitoring
Band 1	£91.95	high intensity monitoring
Band 2a	£45.97	intermediate
Band 2b	£26.56	anti-psychotics
Band 3	£7.15	closer to routine and/or infrequent

The estimated cost impact of moving to HRW CCG service spec for Vale of York CCG: ~£54,481 per annum

Explanation of Calculation/Estimation of Cost Impact

HaRD CCG Medicines Management Team (MMT) has inputted/commented on both the service specifications for HaRD CCG and HRW CCG. The MMT have supported the evaluation of what monitoring is required for each drug and hence why each drug should be placed in the different bandings – rationale for this is shown in appendix 3.

The calculation for drugs that are moving banding is based on how many existing claims Vale of York receive for those drugs, i.e. we know the number of existing patients and can calculate based on banding price increase (or decrease).

The calculation for the additional drugs is estimated. It is known how many patients are on these drugs for Systm One practices, a search can be completed for number of patients that currently have these drugs on their repeat template. The same search cannot be completed for EMIS Web practices and hence can only be estimated by scaling up from the Systm One Figures - Systm One covers 205,300/350,000 Vale of York population. The actual may be more or less.

Moved Bandings Calculation

Moved bandings for HaRD	Patients	Old cost	Old cost	New cost	New cost	Cost difference
From 3 to 2						
amisulpiride	103.00	£7.15	£736.45	£45.97	£4,734.91	£3,998.46
methylphenidate	158.00	£7.15	£1,129.70	£45.97	£7,263.26	£6,133.56
olanzapine	719.00	£7.15	£5,140.85	£45.97	£33,052.43	£27,911.58
quetiapine	480.00	£7.15	£3,432.00	£45.97	£22,065.60	£18,633.60
risperidone	284.00	£7.15	£2,030.60	£45.97	£13,055.48	£11,024.88
						£0.00
From 2 to 3						£0.00
amiodarone	281.00	£45.97	£12,917.57	£7.15	£2,009.15	-£10,908.42
						£56,794

Moved bandings for HRW	Patients	Old cost	Old cost	New cost	New cost	Cost difference
From 3 to 2a						
methylphenidate	158.00	£7.15	£1,129.70	£45.97	£7,263.26	£6,133.56
From 3 to 2b						
amisulpiride	103.00	£7.15	£736.45	£26.56	£2,735.68	£1,999.23
olanzapine	719.00	£7.15	£5,140.85	£26.56	£19,096.64	£13,955.79
quetiapine	480.00	£7.15	£3,432.00	£26.56	£12,748.80	£9,316.80
risperidone	284.00	£7.15	£2,030.60	£26.56	£7,543.04	£5,512.44

From 2 to 3							
amiodarone		£281.00	£45.97	£12,917.57	£7.15	£2,009.15	-£10,908.42
							£26,009

Additional Drugs Calculation

Band	From S1 Report tool Population 205,300		Scaled up for VoY Population 350,000	Cost for HRW SS	Cost increase for VoY HRW SS	Cost for HaRD SS	Cost increase for VoY HaRD SS
Band 2a	30	0.0001 46	51	£45.97	£ 2,351.12	£45.97	£ 2,351.12
Band 2b	386	0.0018 8	658	£26.56	£ 17,478.11	£45.97	£ 30,251.08
Band 3	709	0.0034 53	1209	£7.15	£ 8,642.34	£7.15	£ 8,642.34
					£ 28,472		**£ 41,245**

Total = Changed Bandings plus Additional Drugs

	HRW	HaRD
Changed bandings	£ 26,009.00	£ 56,794.00
Additional drugs	£ 28,472.00	£ 41,245.00
	£ 54,481.00	**£ 98,039.00**

Summary of Options

Option Title	Advantages/ Benefits	Disadvantages/ Constraints	Recommended Y/N
1. Do nothing	No cost impact	• Against the request of YORLMC • Not supporting primary care providers to provide appropriate monitoring of required drugs. The evidence that the incidence of side effects can be reduced significantly if this monitoring is carried out using an organised system closer to the patient's home (rather than in hospital). Therefore greater risk of patient harm. • Risk that prescribers will refuse to take on the prescribing of these drugs – either patient required to travel to secondary care providers – inconvenience for patients and greater cost for CCG OR patients do not receive the drugs they require.	No

2. Move to HaRD CCG Service Spec	• In line with YORLMC request • Supports primary care providers to provide appropriate monitoring of required drugs. The evidence that the incidence of side effects can be reduced significantly if this monitoring is carried out using an organised system closer to the patient's home (rather than in hospital). • Reduces risk that prescribers will refuse to take on the prescribing of these drugs – see option 1 disadvantages	• Greatest cost impact • ~£98,039	?
3. Moved to HRW CCG Service Spec	• In line with YORLMC request • Supports primary care providers to provide appropriate monitoring of required drugs. The evidence that the incidence of side effects can be reduced significantly if this monitoring is carried out using an organised system closer to the patient's home (rather than in hospital). • Reduces risk that prescribers will refuse to take on the prescribing of these drugs – see option 1 disadvantages	• Cost impact – but less than option 2 • ~£54,481 • Not as requested by YORLMC • Still a risk that prescribers will refuse to take on the prescribing of these drugs – as would prefer option 2.	?

Action for Executive Committee

Executive Committee are requested to:

- ✓ Consider options as presented above in summary of options

ENDS

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	Monitoring of Drugs in Primary Care
Commissioner Lead	NHS Vale of York CCG
Provider Lead	
Period	April 1st 2017 – March 31st 2018
Date of Review	April 2017

1. Population Needs

1.1 National / Local context and evidence base

National Context

The treatment of several diseases within the fields of medicine, particularly in rheumatology and psychiatry, is increasingly reliant on drugs that while clinically effective, need regular blood tests or other investigations such as ECG or blood pressure monitoring. This is due to the potentially serious side-effects that these drugs can occasionally cause. It has been shown that the incidence of side-effects can be reduced significantly if this monitoring is carried out in a well-organised way, close to the patient's home.

Prior to April 2013, a local adaptation of a National Enhanced Service for Near Patient Testing (NPT) defined what drugs were included within the service, general detail of the expected safety and partnership working requirements of the service, the agreed banding of different drugs and the payments the bands would attract.

Background

The effective treatment of some diseases can rely on the use of drugs that, while clinically effective, need regular monitoring. This may be due to the potentially serious side-effects these drugs occasionally cause. A nationally developed enhanced service was created on the evidence that the incidence of side effects can be reduced significantly if this monitoring is carried out using an organised system closer to the patient's home (rather than in hospital). The term used for this was near patient testing (NPT).

For many diseases a drug's effectiveness is monitored by hospital specialists while the prescribing and monitoring for side effects is done by the GP. This organised model is typically delivered under a shared care arrangement, with clear and locally agreed guidelines (SCGs) between hospital and primary care representatives. Drugs that fall into this category are locally called 'amber – shared care' (amber-SC). For many drugs there may be a greater level of baseline testing and monitoring involved before the GP is

asked to take on prescribing and more routine monitoring.

Another 'amber' category exists for drugs that require initiation either by an appropriate hospital specialist or on their recommendation. These drugs do not require SCGs because any monitoring requirements are considered as relatively standard primary care activity. Red drugs, however, should only be prescribed within the hospital by appropriate specialists but GPs will be informed of the drugs involved and the progress in the management of the patient's disease. Green drugs are those that can typically be initiated in primary care by the patient's GP or another prescriber.

Many SCGs exist, with variation influenced by the side effect profile of the drug, the condition being treated (with different tolerance levels and doses being used) and between hospitals. It should be expected that specialist teams in different hospitals may not all delegate the monitoring requirements to GPs in the same way. It is also noted that green and non-shared care amber drugs can require monitoring and if this is significant for GP practices then they should be considered for inclusion in this service.

Local Context

Vale of York Clinical Commissioning Group benefits from a close working relationship with the main local providers of York Teaching Hospitals NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust. Joint decision making and partnership working at the local Medicines Commissioning Committee supports the timely transfer of some of the regular drug monitoring requirements of patient's treatments to their GP. The Medicines Commissioning Committee will determine if a drug is suitable for shared care and generate drug specific shared care guidelines to explicitly define the roles and relationships between the GPs and hospital specialists. Vale of York Clinical Commissioning Group will then agree in partnership with local primary care providers through their representative body (YORLMC), how much work is involved for the GP practice and the corresponding payment this work should attract.

At Clinical Commissioning Group level, the overall level of payment can be influenced by factors such as drugs moving from one payment band to another, changes in local specialists prescribing patterns and pathways of care, e.g. NICE guidance and drugs being removed or added to lists. It is important to ensure that prescribing and monitoring that is suitable for primary care does not get blocked into secondary care which would be inconvenient for patients and unnecessarily expensive for Vale of York Clinical Commissioning Group.

From April 2013, the funding of some of the more specialist drugs shifted to NHS England. Where these treatments are only provided within secondary care, Vale of York Clinical Commissioning Group will not incur costs. In localities within the NHS, some of these drugs are still managed under shared care arrangements. Until funding and prescribing arrangements are transferred, the Clinical Commissioning Group and hospital trusts will continue to ensure safe prescribing and monitoring is applied.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

The NHS Outcomes Framework sets five "domains" through which the effectiveness of health care will be measured (Department of Health, 2011):

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

2.2 Local Defined Outcomes

Service Outcomes will include:

- A safe and convenient service for patients
- Improved treatment compliance for patients
- Effective and efficient use of NHS resource

3. Scope

3.1 Aims and objectives of service

The service should ensure :

- Patient safety is not compromised by the application of convenience or for the financial benefits of the commissioner or primary care provider.
- Therapy with the relevant drug is only started for recognised indications and should be reviewed by appropriate clinicians to determine continuation or extension of therapy.
- Patients' disease and treatment are appropriately stabilised or controlled under secondary care management before the GP takes responsibility for shared care maintenance.
- The use of resources by the NHS is efficient.

3.2 Service description/care pathway

Delivery of Service

Practices are responsible for:

- Accessing local shared care arrangements, SCGs and working as part of the local health system under this service and within national clinical guidance.
- Practices should be compliant with local commissioning policies on the prescribing of amber drugs.
- Producing and maintaining an up-to-date register of all drug monitoring service patients, indicating patient name, date of birth and the drug(s) involved. Details of the indication, duration of treatment and last hospital appointment should be easily identifiable from each patient's computerised medical records within the practice.

- Ensuring effective systematic call and recall of patients takes place either in a hospital or general practice setting and that patients are not lost from follow-up. The level and frequency of call and recall will be appropriate to the drug but can include opportunistic review.
- Ensuring the practice has a system in place to ensure that the repeat prescribing of these drugs is safe and effective.
- Ensuring all patients (including newly initiated and /or their carers) have received appropriate education and advice from the initiating clinician on the management of and prevention of secondary complications of their treatment. This should include written information where appropriate.
- Ensuring all patients (and /or their carers and support staff) are kept informed by the initiating provider organisation of how to access appropriate and relevant information.
- Ensure that the patient has an individual management plan from the initiating provider, which gives the reason for treatment, the planned duration, the monitoring timetable and, if appropriate, the therapeutic range to be attained.
- Identifying a lead individual to be a principle point of communication with the relevant hospital trust or provider or voluntary sector (where appropriate e.g. alcohol addiction services) and Vale of York Clinical Commissioning Group on the delivery of shared care arrangements and amber drug monitoring.
- Working together with other professionals when appropriate.
- Ensuring health professionals involved in the care of patients in the service have the appropriate levels of competencies and training – and ensuring all staff involved in providing any aspect of care under this service have the necessary training and skills to do so.
- Where appropriate, refer patients promptly to other necessary services and relevant support agencies using locally agreed guidelines and referral policies where they exist.
- Maintaining adequate records of the service provided, incorporating all known information relating to any significant events e.g. hospital admissions, death of which the practice has been notified.
- Perform an annual review which should include:
    - Brief details as to arrangements for each of the aspects highlighted in the service.
    - Details as to any computer assisted decision making equipment used and arrangements for internal and external quality assurance.
    - Details as to any near patient testing equipment used and arrangements for internal and external quality assurance.
    - Details of training and education relevant to the drug monitoring service.
    - Details of the standards used for the control of the relevant condition.
    - Assurance that any staff member responsible for prescribing must have developed the necessary skills to prescribe safely.
- Providing Vale of York Clinical Commissioning Group with data (as requested) of the use of drugs included in the service.

Performance Monitoring/ Management

- Data collected by GP Practice and submitted to CCG on request will identify the following information relevant on the date(s) specified by the CCG:
    - Number of qualifying patients in each banding (see appendix 1 for definition of banding)
    - Number of qualifying patients on each drug (see appendix 2 for drug list associated with

each band).

- Practice will qualify for one payment per patient per qualifying drug. If a patient is on more than one qualifying drug then the payment will be made for each drug.

3.3 Population Covered

The population covered is all NHS patients registered with GP practices in Vale of York CCG.

3.4 Any acceptance and exclusion criteria and thresholds

Inclusions

- Drugs that are specified within the CCG's bandings for 'Monitoring of Drugs in Primary Care', which will be accessible on the CCG website.
- Some drugs may be included, not based on the monitoring requirements involved, but due to the additional workload the practice would need to deliver in order for the drug to be prescribed and administered safely in primary care.
- Patients to whom the practice has been actively prescribing or monitoring a specified qualifying drug during the relevant financial year.

Exclusions

Although a GP's prescribing will adhere to NHS regulations and the current Drug Tariff, there may be occasions when their intention to prescribe is not explicitly described in the above arrangements. Examples include:

- The Clinical Commissioning Group does not routinely commission that treatment for the specified indication. Prescribing will be out-with this service agreement.
- The Clinical Commissioning Group has not yet stated or considered it commissioning position: the GP should highlight this to the Medicines Management Team or the Clinical Commissioning Group Prescribing Lead for potential fast tracking. Prescribing will be out-with this service agreement but a subsequent decision by the Clinical Commissioning Group will be backdated for the financial year in which the decision was made.
- Shared care guidelines do not exist for a shared care drug - If the drug is commissioned then the GP should seek advice from the Medicines Management Team. The GP can ask the specialist to continue to prescribe or they can agree to take on prescribing responsibilities but in doing so will be out-with this service agreement. Any subsequent production of an SCG and banding decision by the CCG will be backdated for the financial year in which the decision was made.
- An amber-SC (or green or amber) drug has not been given a banding – If unsure the GP should seek advice from the Medicines Management Team. The GP should prescribe if clinically appropriate but doing so will be out-with this service agreement. Any subsequent banding decision by the Clinical Commissioning Group will be backdated for the financial year in which the decision was made.
- Patients receiving a qualifying drug but none of the prescribing or monitoring for that drug has been by the GP practice during the relevant financial year.

3.5 Interdependence with other services or providers

Medicines Commissioning Committee

The Medicines Commissioning Committee will determine the method for red-amber-green classification of drugs as well as agree what category a drug is in and associated SCGs between primary and secondary care. It will also facilitate review of previous decisions on the red-amber- green categorisation.

Banding Group for Monitoring of Drugs in Primary Care

Vale of York Clinical Commissioning Group will create a 'Banding Group for Monitoring of Drugs in Primary Care' to apply to the process to new additions to the service and to reband existing drugs. This group will review and recommend payments for each banding once per year in preparation for application during the next financial year.

Tertiary Providers

Links to tertiary providers will also ensure there is greater consistency beyond the edge of the locality.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Standards, guidelines and recommendations, as specified by bodies such as NICE and MHRA, should be followed to ensure patient safety is optimised. Procedures within the practice should be promptly amended in response to the release of or changes in such standards, guidance or recommendations.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Standards, guidelines and recommendations, as specified by professional bodies and competent advisory bodies such as Royal Colleges, should be followed to ensure patient safety is optimised. Procedures within the practice should be promptly amended in response to the release of or changes in such standards, guidance or recommendations.

4.3 Applicable local standards

Accreditation

Those doctors who have previously provided services similar to this service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the service shall be deemed professionally qualified to do so. GPs and GP practices should notify the CCG of any change in these circumstances.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

Untoward Events

When a patient prescribed a drug included in the service dies or is admitted to hospital in circumstances that the clinician believes may possibly be attributable to deficiencies in the treatment provided under the service, the practitioners or appropriate representative of the practice will give notifications:

- In addition to their statutory obligations.
- To the CCG Governance lead and the Medical Director of NHS England – North Yorkshire and Humber within 72 hours of the information becoming known to the practitioner or his/her practice.

Clinical Audit

There should be ongoing annual clinical audit to ensure quality review and improvement. Evidence of audit will be requested by the CCG.

Scope of Local Service

Providers will be surveyed at the commencement of the year (and midway through the year in a full-year) to determine the drugs for which the practice is providing a service and the numbers of patients for each drug. Providers will be deemed to be providing the service for only those drugs declared in the survey of patient numbers.

5.2 **Applicable CQUIN goals (See Schedule 4 Part E)**

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

Not applicable.

Appendix 1:

Banding criteria and service payments for 'Monitoring of Drugs in Primary Care'

Banding	Payment per drug patient per year	Typical monitoring requirements
Band 1	£91.95	high intensity monitoring
Band 2	£45.97	intermediate
Band 3	£7.15	closer to routine and/or infrequent

Band 1: **£91.95 per drug per patient per year**

Monitoring every one-two months of U&Es, LFTs, FBCs.

Include ECG, respiratory function tests etc. more than once a year.

Verbal interview and record keeping of symptom checklist.

Reporting of concerns to specialist.

Band 2: **£45.97 per drug per patient per year**

Monitoring more than twice a year up to and including every three months.

Include ECG, respiratory function tests etc. once a year.

Verbal interview and record keeping of symptom checklist.

Reporting of concerns to specialist.

Band 3: **£7.15 per drug per patient per year**

Monitoring twice a year or less often

Two or more of the following: U&Es, LFTs, FBCs

Verbal interview and record keeping of symptom checklist.

Reporting of concerns to specialist.

Appendix 2:

Banding decisions on drugs included in the 'Monitoring of Drugs in Primary Care' service

Shared care guidelines can be accessed at:

http://www.yorkandscarboroughformulary.nhs.uk/

Band 1

Frequent blood testing, in respect of the following specified drugs:

Auranofin (po)	Azathioprine (po)
Ciclosporin (po)	
Leflunomide (po)	Mercaptopurine (po)
Methotrexate (po)	Mycophenolate (po)
Penicillamine (po)	Sodium aurothiomalate (inj)
Sulphasalazine (po)	Tacrolimus (po)

Band 2

Monitoring, including blood testing, or other special monitoring or other special circumstances, in respect of the following drugs:

Atomoxetine (po) new for Vale of York – Amber SCG on YS formulary

Degarelix (imp) – added 2016 to NPT

Dexamfetamine (po) new for Vale of York – Amber SCG on YS formulary

Denosumab (inj)

Dronedarone (po)

Entecavir (po) – new for Vale of York - Red on YS formulary but is being Rx

Flutamide (po)

Goserelin (imp)

Lamivudine (po) – new for Vale of York - Red on YS formulary but is being Rx

Leuprorelin (inj)

Methylphenidate (po) - changed banding from 3 to 2 for VoY – Amber SCG on YS formulary

Riluzole (po)

Somatropin (inj) – on VoY but not HaRD - Amber SCG on YS formulary

Tenofovir (po) - – new for Vale of York - Red on YS formulary but is being Rx

Topiramate (po) – on VoY but not HaRD - Amber SI on YS formulary

Triptorelin (inj) new for Vale of York – Amber SI on YS formulary

Vigabatrin (po) - on VoY but not HaRD - Amber SI on YS formulary

Anti-psychotics: note claims should be submitted only where these drugs are prescribed for patients on the QOF Mental Health register (i.e. Read coded as having a history of schizophrenia, bipolar affective disorder or other psychoses).

Amisulpiride (po)-changed banding from 3 to 2 for VoY – Amber TEWV SI

Aripiprazole (po) new for Vale of York – grey on YS formulary

Benperidol (po) new for Vale of York – Amber TEWV SI on YS formulary – not SCG

Chlorpromazine (po) new for Vale of York – currently green on YS formulary

Flupentixol (po/ inj) – new for Vale of York – grey on YS formulary

Fluphenazine (inj) – new for Vale of York – not on YS formulary but being Rx

Haloperidol (po) – new for Vale of York – currently green on YS formulary

Olanzapine (po) - changed banding from 3 to 2 for VoY – Amber TEWV SI

Paliperidone (po) – new for Vale of York – grey on YS formulary

Pericyazine (po) – new for Vale of York – not on YS formulary but being Rx

Perphenazine (po) – new for Vale of York – not on YS formulary but being Rx

Pimozide (po) - new for Vale of York – not on YS formulary but being Rx

Pipotiazine (inj) – new for Vale of York – grey on YS formulary

Promazine (po) – new for Vale of York – Amber TEWV SI on YS formulary

Quetiapine (po) - changed banding from 3 to 2 for VoY Amber TEWV SI on YS formulary

Risperidone (po/ inj) - changed banding from 3 to 2 for VoY - Amber SR AND Amber SCG

Sulpiride (po) - new for Vale of York – Amber TEWV SI on YS formulary

Trifluoperazine (po) – new for Vale of York - Amber TEWV SI on YS formulary

Zuclopenthixol (po/ inj))

Band 3

Routine monitoring of the following drugs:

Amiodarone (po) – was Band 2 for Vale of York, moved to band 3 –Amber SCG on YS formulary

Apomorphine (inj) – new for Vale of York –Amber SCG on YS formulary

Darbepoetin alfa (inj) -

Donepezil (po)

Epoetin (inj)

Galantamine (po)

Hydroxychlorquine sulphate (po) – new for Vale of York –Amber SCG on YS formulary

Lanreotide (inj) new for Vale of York –Amber SCG on YS formulary

Memantine (po)

Octreotide (inj)

Rivastigmine (po)

Modafanil (po) - new for Vale of York –Amber SCG on YS formulary

NOT included on Vale of York but are on HaRD CCG:

Band 1

Cyclophosphamide (po) is on HaRD but not VoY – as Red in VoY and no prescribing is occurring

Band 2

Adefovir (po) – Not on YS formulary. Would be Red and no prescribing is occurring

Cost of drugs that have moved bandings

Moved bandings for HaRD	Patients	Old cost	Old cost	New cost	New cost	Cost difference
From 3 to 2						
amisulpiride	103.00	£7.15	£736.45	£45.97	£4,734.91	£3,998.46
methylphenidate	158.00	£7.15	£1,129.70	£45.97	£7,263.26	£6,133.56
olanzapine	719.00	£7.15	£5,140.85	£45.97	£33,052.43	£27,911.58
quetiapine	480.00	£7.15	£3,432.00	£45.97	£22,065.60	£18,633.60
risperidone	284.00	£7.15	£2,030.60	£45.97	£13,055.48	£11,024.88
						£0.00
From 2 to 3						£0.00
amiodarone	281.00	£45.97	£12,917.57	£7.15	£2,009.15	-£10,908.42
						£56,793.66

Additional drugs Cost increase for VoY HaRD SS
£ 2,351.12
£ 30,251.08
£ 8,642.34
£ 41,245

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	Monitoring of Drugs in Primary Care
Commissioner Lead	NHS Vale of York CCG
Provider Lead	
Period	April 1st 2017 – March 31st 2018
Date of Review	April 2017

1. Population Needs

1.1 National / Local context and evidence base

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Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

2.2 Local Defined Outcomes

Service Outcomes will include:

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- Improved treatment compliance for patients
- Effective and efficient use of NHS resource

3. Scope

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The service should ensure :

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each band).

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3.4 Any acceptance and exclusion criteria and thresholds

Inclusions

- Drugs that are specified within the CCG's bandings for 'Monitoring of Drugs in Primary Care', which will be accessible on the CCG website.
- Some drugs may be included, not based on the monitoring requirements involved, but due to the additional workload the practice would need to deliver in order for the drug to be prescribed and administered safely in primary care.
- Patients to whom the practice has been actively prescribing or monitoring a specified qualifying drug during the relevant financial year.

Exclusions

Although a GP's prescribing will adhere to NHS regulations and the current Drug Tariff, there may be occasions when their intention to prescribe is not explicitly described in the above arrangements. Examples include:

- The Clinical Commissioning Group does not routinely commission that treatment for the specified indication. Prescribing will be out-with this service agreement.
- The Clinical Commissioning Group has not yet stated or considered it commissioning position: the GP should highlight this to the Medicines Management Team or the Clinical Commissioning Group Prescribing Lead for potential fast tracking. Prescribing will be out-with this service agreement but a subsequent decision by the Clinical Commissioning Group will be backdated for the financial year in which the decision was made.
- Shared care guidelines do not exist for a shared care drug - If the drug is commissioned then the GP should seek advice from the Medicines Management Team. The GP can ask the specialist to continue to prescribe or they can agree to take on prescribing responsibilities but in doing so will be out-with this service agreement. Any subsequent production of an SCG and banding decision by the CCG will be backdated for the financial year in which the decision was made.
- An amber-SC (or green or amber) drug has not been given a banding – If unsure the GP should seek advice from the Medicines Management Team. The GP should prescribe if clinically appropriate but doing so will be out-with this service agreement. Any subsequent banding decision by the Clinical Commissioning Group will be backdated for the financial year in which the decision was made.
- Patients receiving a qualifying drug but none of the prescribing or monitoring for that drug has been by the GP practice during the relevant financial year.

3.5 Interdependence with other services or providers

Medicines Commissioning Committee

The Medicines Commissioning Committee will determine the method for red-amber-green classification of drugs as well as agree what category a drug is in and associated SCGs between primary and secondary care. It will also facilitate review of previous decisions on the red-amber- green categorisation.

Banding Group for Monitoring of Drugs in Primary Care

Vale of York Clinical Commissioning Group will create a 'Banding Group for Monitoring of Drugs in Primary Care' to apply to the process to new additions to the service and to reband existing drugs. This group will review and recommend payments for each banding once per year in preparation for application during the next financial year.

Tertiary Providers

Links to tertiary providers will also ensure there is greater consistency beyond the edge of the locality.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Standards, guidelines and recommendations, as specified by bodies such as NICE and MHRA, should be followed to ensure patient safety is optimised. Procedures within the practice should be promptly amended in response to the release of or changes in such standards, guidance or recommendations.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Standards, guidelines and recommendations, as specified by professional bodies and competent advisory bodies such as Royal Colleges, should be followed to ensure patient safety is optimised. Procedures within the practice should be promptly amended in response to the release of or changes in such standards, guidance or recommendations.

4.3 Applicable local standards

Accreditation

Those doctors who have previously provided services similar to this service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the service shall be deemed professionally qualified to do so. GPs and GP practices should notify the CCG of any change in these circumstances.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

Untoward Events

When a patient prescribed a drug included in the service dies or is admitted to hospital in circumstances that the clinician believes may possibly be attributable to deficiencies in the treatment provided under the service, the practitioners or appropriate representative of the practice will give notifications:

- In addition to their statutory obligations.
- To the CCG Governance lead and the Medical Director of NHS England – North Yorkshire and Humber within 72 hours of the information becoming known to the practitioner or his/her practice.

Clinical Audit

There should be ongoing annual clinical audit to ensure quality review and improvement. Evidence of audit will be requested by the CCG.

Scope of Local Service

Providers will be surveyed at the commencement of the year (and midway through the year in a full-year) to determine the drugs for which the practice is providing a service and the numbers of patients for each drug. Providers will be deemed to be providing the service for only those drugs declared in the survey of patient numbers.

5.2 **Applicable CQUIN goals (See Schedule 4 Part E)**

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

Not applicable.

Appendix 1:

Banding criteria and service payments for 'Monitoring of Drugs in Primary Care'

Banding	Payment per drug patient per year	Typical monitoring requirements
Band 1	£91.95	high intensity monitoring
Band 2a	£45.97	intermediate
Band 2b	£26.56	anti-psychotics
Band 3	£7.15	closer to routine and/or infrequent

The following general definitions are used to assist determination of which banding specific drugs will fall into. The detail below is NOT the definition of monitoring requirements for each drug within that banding. For monitoring requirements for each drug, please refer to the current monitoring or shared care guidelines for the drug (or group of drugs) from the relative hospital provider.

Band 1: **£91.95 per drug per patient per year**

Monitoring every one-two months of U&Es, LFTs, FBCs.
Include ECG, respiratory function tests etc. more than once a year.
Verbal interview and record keeping of symptom checklist.
Reporting of concerns to specialist.

Band 2a: **£45.97 per drug per patient per year**

Monitoring more than twice a year up to and including every three months.
Include ECG, respiratory function tests etc. once a year.
Verbal interview and record keeping of symptom checklist.
Reporting of concerns to specialist.

Band 2b: **£26.56 per drug per patient per year**

Monitoring typically twice a year but may be up to and including every three months.
Include ECG, respiratory function tests etc. once or twice a year in relevant patients.
Verbal interview and record keeping of symptom checklist.
Reporting of concerns to specialist.

Band 3: **£7.15 per drug per patient per year**

Monitoring twice a year or less often
Two or more of the following: U&Es, LFTs, FBCs
Verbal interview and record keeping of symptom checklist.
Reporting of concerns to specialist.

Appendix 2:

Banding decisions on drugs included in the 'Monitoring of Drugs in Primary Care' service

Shared care guidelines can be accessed at:

http://www.yorkandscarboroughformulary.nhs.uk/

Band 1

Frequent blood testing, in respect of the following specified drugs:

Auranofin (po)	Azathioprine (po)
Ciclosporin (po)	
Leflunomide (po)	Mercaptopurine (po)
Methotrexate (po)	Mycophenolate (po)
Penicillamine (po)	Sodium aurothiomalate (inj)
Sulphasalazine (po)	Tacrolimus (po)

Band 2a

Monitoring, including blood testing, or other special monitoring or other special circumstances, in respect of the following drugs:

Atomoxetine (po) new for Vale of York – Amber SCG on YS formulary

Degarelix (imp) – added 2016 to NPT

Dexamfetamine (po) new for Vale of York – Amber SCG on YS formulary

Denosumab (inj)

Dronedarone (po)

Entecavir (po) – new for Vale of York - Red on YS formulary but is being Rx

Flutamide (po)

Goserelin (imp)

Lamivudine (po) – new for Vale of York - Red on YS formulary but is being Rx

Leuprorelin (inj)

Methylphenidate (po) - changed banding from 3 to 2 for VoY – Amber SCG on YS formulary

Riluzole (po)

Somatropin (inj) – on VoY but not HaRD - Amber SCG on YS formulary

Tenofovir (po) - – new for Vale of York - Red on YS formulary but is being Rx

Topiramate (po) – on VoY but not HaRD - Amber SI on YS formulary

Triptorelin (inj) new for Vale of York – Amber SI on YS formulary

Vigabatrin (po) - on VoY but not HaRD - Amber SI on YS formulary

Band 2b:

Anti-psychotics: note claims should be submitted only where these drugs are prescribed for patients on the QOF Mental Health register (i.e. Read coded as having a history of schizophrenia, bipolar affective disorder or other psychoses).

Amisulpiride (po) changed banding from 3 to 2 for VoY – Amber TEWV SI

Aripiprazole (po) new for Vale of York – grey on YS formulary

Benperidol (po) new for Vale of York – Amber TEWV SI on YS formulary – not SCG

Chlorpromazine (po) new for Vale of York – currently green on YS formulary

Flupentixol (po/ inj) – new for Vale of York – grey on YS formulary

Fluphenazine (inj) – new for Vale of York – not on YS formulary but being Rx

Haloperidol (po) – new for Vale of York – currently green on YS formulary

Olanzapine (po) - changed banding from 3 to 2 for VoY – Amber TEWV SI

Paliperidone (po) – new for Vale of York – grey on YS formulary

Pericyazine (po) – new for Vale of York – not on YS formulary but being Rx

Perphenazine (po) – new for Vale of York – not on YS formulary but being Rx

Pimozide (po) - new for Vale of York – not on YS formulary but being Rx

Pipotiazine (inj) – new for Vale of York – grey on YS formulary

Promazine (po) – new for Vale of York – Amber TEWV SI on YS formulary

Quetiapine (po) - changed banding from 3 to 2 for VoY Amber TEWV SI on YS formulary

Risperidone (po/ inj) - changed banding from 3 to 2 for VoY - Amber SR AND Amber SCG

Sulpiride (po) - new for Vale of York – Amber TEWV SI on YS formulary

Trifluoperazine (po) – new for Vale of York - Amber TEWV SI on YS formulary

Zuclopenthixol (po/ inj))

Band 3

Routine monitoring of the following drugs:

Amiodarone (po) – was Band 2 for Vale of York, moved to band 3 –Amber SCG on YS formulary

Apomorphine (inj) – new for Vale of York –Amber SCG on YS formulary

Darbepoetin alfa (inj) -

Donepezil (po)

Epoetin (inj)

Galantamine (po)

Hydroxychlorquine sulphate (po) – new for Vale of York –Amber SCG on YS formulary

Lanreotide (inj) new for Vale of York –Amber SCG on YS formulary

Memantine (po)

Octreotide (inj)

Rivastigmine (po)

Modafanil (po) - new for Vale of York –Amber SCG on YS formulary

NOT included on Vale of York but are on HaRD CCG:

Band 1

Cyclophosphamide (po) is on HaRD but not VoY – as Red in VoY and no prescribing is occurring

Band 2

Adefovir (po) – Not on YS formulary. Would be Red and no prescribing is occurring

Cost of drugs that have moved bandings

Moved bandings for HRW	Patients	Old cost	Old cost	New cost	New cost	Cost difference
From 3 to 2a						
methylphenidate	158.00	£7.15	£1,129.70	£45.97	£7,263.26	£6,133.56
From 3 to 2b						
amisulpiride	103.00	£7.15	£736.45	£26.56	£2,735.68	£1,999.23
olanzapine	719.00	£7.15	£5,140.85	£26.56	£19,096.64	£13,955.79
quetiapine	480.00	£7.15	£3,432.00	£26.56	£12,748.80	£9,316.80
risperidone	284.00	£7.15	£2,030.60	£26.56	£7,543.04	£5,512.44
From 2 to 3						
amiodarone	281.00	£45.97	£12,917.57	£7.15	£2,009.15	-£10,908.42
						£26,009.40

Additional Drugs

Cost increase for VoY HRW SS
£ 2,351.12
£ 17,478.11
£ 8,642.34
£ 28,472

Guidelines for the Monitoring of Adult Patients on Drugs included in the 'Monitoring of Drugs in Primary Care' LES

Produced by Christopher Ranson, Senior Pharmacist

Version 2 Date Produced 14th June 2015 Review Date: 1st April 2016

Below is a spreadsheet summarising the monitoring requirements associated with the amber shared care drug list. This can be used as a guide but GPs should still familiarise themselves with the actual shared care guidelines.

They refer to shared care guidelines that have been agreed with clinicians at Harrogate district foundation hospital trust, the ones relating to mental health have been produced by TEWV and the specialist ones have been produced by Leeds teaching hospital.

This table will be correct at the time of production and will be reviewed on an annual basis

Column1	Column2	Column3	Column4	Column5	Column6	Column7	Column8	Column9	Column10
Band 1									
Definition: Monitoring every one-two months of U&Es, LFTs, FBCs. Include ECG, respiratory function tests etc more than once a year. Verbal interview and record keeping of symptom checklist. Reporting of concerns to specialist.									
	Drug	**Baseline monitoring**			**Routine monitoring**	**Link to shared care guideline**			
	Oral Auranofin	FBC, U+E, Creatinine, LFT, Urinalysis			FBC, Urinalysis = monthly	No shared care agreement available.			
	Azathioprine	FBC, U&E, Cr, LFT, Consider TMPT assay and Hep B/C status			FBC , LFTs, U+Es every 2 Weeks for 2 months and then monthly for 4 months then 3 monthly (assuming dose is stable) Repeat FBC, LFTs, U+Es at weeks 2, 4 and 8 after dose change, and then 3 monthly unless informed otherwise by the specialist. At consultation ask about oral ulceration, unexplained bruising/ bleeding, rash, sore throat.	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=10&SubSectionRef=10.01.03&SubSectionID=E100#2562			
	Ciclosporin (transplants)	Please refer to shared care guideline			Please refer to shared care guideline and clinic letter as this can differ dependent on how stable the patient is and type of transplant.	http://www.leedsformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=8&SubSectionRef=08.02.02&SubSectionID=A100#2171	The link is to Leeds shared care guidelines. If your patient is managed by a different centre please refer to their shared care guidelines.		
	Ciclosporin	BP, Urinalysis, FBC, U+E, LFT, Urate, lipids, Creatinine. Consider Pregnancy test			BP, U+Es, LFTs every 2 weeks until dose stable then monthly for 4 months, then every 3 months. Lipids every 3 months for further 6 months and if no change to results then no routine moniotring required (otherwise continue every 3 months).	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=8&SubSectionRef=08.02.02&SubSectionID=A100#3253			
	Cyclophosphamide	FBC, LFT, U&E,Creatinine, Urinalysis, ESR (Rheumatology)			FBC, U+E, LFTs weekly for 4 weeks then fortnightly for 8 weeks then monthly.	No shared care agreement available.			
	IM Gold	FBC, LFT, U&E,Creatinine, Urinalysis, chest x-ray			FBC and Urinalysis at the time of each injection (Provided blood results are stable, the results of the FBC need not be available before the injection is given but must be available before the next injection (i.e. it is permissible to work one FBC in arrears). Urinalysis must be done before each injection	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=10&SubSectionRef=10.01.03&SubSectionID=E100#2474	No shared care agreement in place for rheumatoid arthritis, IBD and dermatology, please refer to the yorkshire DMARD guidelines.		
	Leflunomide	FBC, U&E, LFT, Creatinine, BP. Consider chest x-ray, pulmonary function tests, and Quantiferon test.			BP, FBC, LFT = 2 weekly for 2 months then monthly for 4 months then 3 monthly thereafter.	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=10&SubSectionRef=10.01.03&SubSectionID=A100			
	Mercaptopurine	FBC, LFT, U+E, TPMT			FBC, LFT 2 weekly for 2 months, then monthly for 4 months, then 3 monthly. U+Es every 6 months	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=1&SubSectionRef=01.05.03&SubSectionID=A100#4841			
	Methotrexate	FBC, U&E, LFT, CXR, PFT. PIIINP for dermatology patients only			FBC/ LFT/ U+E/ Cr: Fortnightly for 8 weeks; then monthly for 4 months then 3 monthly thereafter (unless dose changes). On dose increase – at week 2,4, 8 and then every 3 months as above. PIIINP (Dermatology patients only) every 3 months. At consultations ask about oral ulceration, unexplained bruising/ bleeding, rash, sore throat or dry cough.	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=10&SubSectionRef=10.01.03&SubSectionID=E100#2474			
	Mycophenolate (Transplants)	Please refer to shared care guideline			Please refer to shared care guideline and clinic letter as this can differ dependent on how stable the patient is and type of transplant.	http://www.leedsformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=8&SubSectionRef=08.02.01&SubSectionID=A100#2168	Please the link is to Leeds shared care guidelines. If your patient is managed by a different centre please refer to their shared care guidelines.		
	Mycophenolate	BP, CrCl, FBC, U&E, LFT. Consider pregnancy test. Hepatitis B + C status. Varicella immune status			FBC, LFTs, U&E: Fortnightly for the first 2 months. Then once a month for 4 months, then every 3 months thereafter.	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=8&SubSectionRef=08.02.01&SubSectionID=A100#2168			
	Penicillamine	Urinalysis, FBC, U&E			FBC, U+E, Urinalysis = 2-weekly for 2 months, and then monthly for 4 months, and then 3 monthly. On dose increase by specialist – at weeks 2,4, 8 and then resume 3 monthly regimen unless informed otherwise by the specialist.	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=10&SubSectionRef=10.01.03&SubSectionID=A100			
	Sulfasalazine	FBC, U+E (including urinalysis, LFT, serum folate			FBC/ LFT: 2 weekly for 2 months, monthly for 4 months then 3 monthly. U+Es monthly for 3 months and then when indicated.	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=10&SubSectionRef=10.01.03&SubSectionID=A100	No shared care agreement in place for rheumatoid arthritis, IBD and dermatology, please refer to the yorkshire DMARD guidelines.		
	Tacrolimus (Transplants)	Please refer to shared care guideline from the tarnsplant centre			Please refer to shared care guideline and clinic letter as this can differ dependent on how stable the patient is and type of transplant.	http://www.leedsformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=8&SubSectionRef=08.02.02&SubSectionID=A100#2175	Please the link is to Leeds shared care guidelines. If your patient is managed by a different centre please refer to their shared care guidelines.		
Column1	Column2	Column3	Column4	Column5	Column6	Column7	Column8	Column9	Column10
Band 2									
Definition: Monitoring more than twice a year up to and including every 3 months.	**Include ECG, respiratory function tests etc. once a year**								
	Verbal interview and record keeping of symptom checklist.								

	Reporting of concerns to specialist			
	Drug	**Baseline monitoring**	**Routine monitoring**	
	adefovir (for Hep B)	Hep B markers, LFTs, FBC, U+Es	Hep B Load, FBC and clotting screen, LFT, U+E including phosphate monthly for 3 months, then 3 monthly for 1 year then 6 monthly.If high risk renal patient then continue to monitor 3 monthly.	http://www.leedsformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=5&SubSectionRef=05.03.03&SubSectionID=A100#1880
	Antipsychotics (see overleaf for full list)	LFTs, U+Es, Cr, FBC, lipids, BP, weight, BMI, ECG (pre and post initiation), blood glucose, Prolactin	LFTs: annually	
			U+E, Cr: annually or: • after dose increases. • symptoms of suggestive of cardiac disease • during periods of acute intercurrent illness.	
			FBC : if unexplained infection or fever.	
			Prolactin: Annually	
			Blood glucose: 3 months then annually (except olanzapine which is one month after starting then annually)	
			Lipids: : 3 months then annually (except olanzapine which is one month after starting then annually)	
			BP : Annually	
			ECG: consider 6 monthly ECG in high risk patients only	Consider in following circumstances: there is known ischaemic heart disease, structural heart disease, or QT prolongation • there are other factors that increase the risk of arrhythmias (e.g. co-prescription of other drugs that prolong the QT interval, such as tricyclic antidepressants or macrolides; use of more than one antipsychotic • use of a single antipsychotic in doses greater than BNF levels • hypokalaemia • hypocalcaemia • hypomagnesaemia http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=
			Weight : every 3 months for first year then annually.	
	Atomoxetine	Height (for children and not adults), weight, BP, heart rate, ECG only if history of cardiovascular disease.	Height = every 6 months (children only) and weight = at 3 months then every 6 months (adults at 3 months only), BP & pulse – at each dose change, and then every 6 months.	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=4&SubSectionRef=04.04&SubSectionID=A100#1133
	Denosumab	U+E, Cr, Ca, Dental examination, Dexa scan	Calcium check within 2 weeks of initiation. Calcium prior to each injection and if suspected symptoms of hypocalcaemia . Administration every 6 months	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=6&SubSectionRef=06.06.02&SubSectionID=A100#3359
	Dexamfetamine	Height, weight, BP, heart rate, ECG only if history of cardiovascular disease.	Height and weight = every 6 months, BP & pulse – at each dose change, and every 3 months	No shared care agreement in place but monitoring is the same as for atomoxetine and methylphenidate
	Dronedarone	LFTs, U+Es, creatinine, ECG	LFTs= monthly (6mths), 9 months, then annually. U+E, cr = 6 monthly, ECG = 6 monthly	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=2&SubSectionRef=02.03.02&SubSectionID=B100#3301
	Entecavir (for Hep B)	Hep B markers, LFTs, FBC + clotting screen, U+Es	Hep B Load, FBC, LFT, U+E 3 monthly for 1 year then 6 monthly.	http://www.leedsformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=5&SubSectionRef=05.03.03&SubSectionID=A100#1881
	Flutamide	Baseline FBC & U&Es, including LFTs & prostate-specific antigen (I	PSA, U&Es, LFTs and FBC every 3 months	No shared care agreement in place yet.
	Goserelin	No monitoring	Administration every 3 months	
	Lamivudine (Hep B)	Hep B markers, LFTs, FBC + clotting screen, U+Es	Hep B Load, FBC, LFT, U+E 3 monthly for 1 year then 6 monthly.	http://www.leedsformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=5&SubSectionRef=05.03.01&SubSectionID=B100#1769
	Leuproreline (prostate cancer)	No monitoring	Adminisration every 3 months	
	Leuproreline (hormone gender reasignment)	U+Es, Cr, FBC, U+E, TFTs, glucose, cholesterol, Oestradiol, testosterone, Prolactin, LH, FSH	U+Es, Cr, FBC, LFTs, TFTs, cholesterol, Oestradiol, testosterone, Prolactin, LH, FSH every 3-6 months during hormone stabilisation period and prior to clinic appointments.	http://www.leedsformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=8&SubSectionRef=08.03.04.02&SubSectionID=C100#2215
	Methylphenidate	Height (for children only, not adults), weight, BP, heart rate, ECG only if history of cardiovascular disease	Height = every 6 months (children only) and weight = at 3 months then every 6 months (adults at 3 months only), BP & pulse – at each dose change, and then every 6 months.	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=4&SubSectionRef=04.04&SubSectionID=A100#1133
	Riluzole	FBC, LFT, U+Es	LFT and FBC monthly x3 months, then 3 monthly up to 1 year then annually.	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=4&SubSectionRef=04.09.03&SubSectionID=A100#1624
	Tenofovir (Hep B)	Hep B markers, LFTs, FBC + clotting screen, U+Es including phospl	Hep B Load, FBC, LFT, U+E 3 monthly for 1 year then 6 monthly.	http://www.leedsformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=5&SubSectionRef=05.03.01&SubSectionID=B100#1769
	Triptorelin (inj)	No monitoring	Adminisration every 3 or 6 months	

Column1	Column2	Column3	Column4	Column5	Column6	Column7	Column8	Column9	Column10
Band 3									
Definition	**Monitoring twice a year or less often**								
	Drug	**Baseline monitoring**			**Routine monitoring**				
	Amiodarone	ECG, U+Es, LFTs, TFTs, Chest x-ray			LFTs and U+Es = every 6 months , TFTs = 3 months then every 6 months. Chest x-ray should only be repeated if signs of respiratory disease. Any changes to vision and the patient should be seen by an optometrist.	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=2&SubSectionRef=02.03.02&SubSectionID=C100#844			
	Apomorphine	Coombs test (for autoimmune hemolytic anemia) FBC, LFTs,			Coombs test and FBC, LFTs, U&Es and BP at 6 monthly intervals	No shared care agreement at present			
	Darbopoetin	FBC, ferritin			FBC, Ferritin, U+Es abd bone profile monthly during the correction phase and then every 2-3 mont	Blood tests will be done by specialists and blood pressure monitoring by GP practice	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=		
	Dementia drugs: Donepizil, rivastigmin	MMSE, weight, global, functional and behavioural assessment			MMSE, weight, global, functional and behavioural assessment every 6 months	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=4&SubSectionRef=04.11&SubSectionID=A100#1709			
	Epoetin	FBC, ferritin			FBC, Ferritin BP as stated by renal team	No shared care agreement at present			
	Hydroxychlorquine sulphate (po)	FBC, LFTs, U+Es. Ophthalmological examination only if pre existing ocular pathology			Renal function: In over 70s or if pre-existing renal impairment or known hypertension/ diabetes, Annual check should be carried out. Annual visual acuity/ fundoscopy and amsler charting by optometrist	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=10&SubSectionRef=10.01.03&SubSectionID=D100#2471			
	Lanreotide	Dependent on indication, please see shared care guideline			The hospital specialist will perform ongoing medical and biochemical assessment of response to therapy.	http://www.leedsformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=8&SubSectionRef=08.03.04.03&SubSectionID=A100#2218			
	Octreotide	Dependent on indication, please see shared care guideline			The hospital specialist will perform ongoing medical and biochemical assessment of response to therapy.	http://www.leedsformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=8&SubSectionRef=08.03.04.03&SubSectionID=A100#2218			
	Modafanil (po)	ECG			Blood pressure and heart rate every 6 months	http://www.harrogateformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=4&SubSectionRef=04.04&SubSectionID=A100#1149			

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Item Number: 10

Name of Presenter: Tracey Preece

Meeting of the Primary Care Commissioning Committee

Date of meeting:
25 July 2017

NHS
Vale of York
Clinical Commissioning Group

Report Title – Notional Rents

Purpose of Report
For Approval

Reason for Report
The purpose of this report is to detail and approve the impact of the most recent notional rent reviews for the following practices as informed by the NHS England Primary Care finance team:

Gale Farm Surgery
Millfield Surgery
MyHealth Group
Drs Jones and McPherson
Front Street Surgery
Terrington Surgery
Beech Tree Surgery

Strategic Priority Links

☒Strengthening Primary Care
☐Reducing Demand on System
☐Fully Integrated OOH Care
☐Sustainable acute hospital/ single acute contract
☐Transformed MH/LD/ Complex Care
☐System transformations
☐Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks

☒Financial
☐Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

N/A

Emerging Risks (not yet on Covalent) N/A
Recommendations The Primary Care Commissioning Committee is asked to approve these adjustments.

Responsible Executive Director and Title	**Report Author and Title**
Tracey Preece, Chief Finance Officer	Michael Ash-McMahon, Deputy Chief Finance Officer

Notional rent reviews

Practice	Site	Reason	Current Notional Rent per annum	Revised Notional Rent per annum	Change per annum	With effect from
Gale Farm Surgery	Old Forge Surgery, The Green, Upper Poppleton	Rooms formerly occupied by Acute Trust now vacated by them and re-occupied by GPs, 2 rooms first floor clearly disused and confirmed with Practice Manager. These are the Bathroom and Kitchen of the former flat. District Nurses office now included.	58,690	61,000	2,310	Feb-17
Millfield Surgery	Millfield Surgery, Millfield Lane, York	Purpose built 1993 mainly single storey with small first floor. Set on edge of town just off A19. Part of premises was abated but now abatement has ceased as of 2016.	58,400	63,775	5,375	May-17
MyHealth Group	Strensall Health Care Centre, Southfields Road, Strensall	Following appeal of the last review in June 2015 a final valuation has now been agreed upon. Since the last review, the property has had minor improvements including a new air conditioning unit in the server room, some new windows, two new boilers and one of the consulting rooms has been converted into a treatment room. Chiropody and District Nurses share space within the building, but there are no subleases in place.	128,000	130,245	2,245	Jun-15
Drs Jones & McPherson	The Surgery, North Back Lane, Stillington, York	Regular review. The property comprises a single storey purpose built surgery in a village location.	30,100	31,150	1,050	Apr-17
Front Street Surgery	Front Street, Acomb, York	The actual rent is on tenant full repairing and insuring basis and has been adjusted to CMR terms. Rent also appears to be historic and inclusive of VAT	106,800	108,988	2,188	Nov-16
Terrington Surgery	Terrington Surgery, North Back Lane, Terrington, York	The property comprises a purpose built 2 storey surgery which externally gives the impression of being a house. Only part of the first floor is practice accommodation with the rest being used as storage by the former GP.	24,700	25,375	675	Oct-16
Beech Tree Surgery	Riccall Surgery, Main Street, Riccall	The property is a small purpose built surgery in a village setting. The property has undergone minor improvement works in recent years including installing new units, lighting and heaters	11,925	12,125	200	Mar-17

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Item Number: 12

Name of Presenter: Heather Marsh

Meeting of the Primary Care Commissioning Committee

Date of meeting:
25 July 2017

NHS
Vale of York
Clinical Commissioning Group

Report Title – Primary Care Update

Purpose of Report
For Information

Reason for Report

Summary from NHS England North of standard items (including contracts, planning and finance) that fall under the co-commissioning agenda.

Strategic Priority Links

- ☒Primary Care/ Integrated Care
- ☐Urgent Care
- ☐Effective Organisation
- ☐Mental Health/Vulnerable People
- ☐Planned Care/ Cancer
- ☐Prescribing
- ☐Financial Sustainability

Local Authority Area

- ☒CCG Footprint
- ☐City of York Council
- ☐East Riding of Yorkshire Council
- ☐North Yorkshire County Council

Impacts/ Key Risks

- ☐Financial
- ☐Legal
- ☐Primary Care
- ☐Equalities

Covalent Risk Reference and Covalent Description

Recommendations

N/A

Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam Accountable Officer	David Iley Primary Care Assistant Contracts Manager NHS England – North

Vale of York Update

Prepared by David Iley

Primary Care Assistant Contracts Manager

NHS ENGLAND – North (Yorkshire and The Humber)

11 July 2017

1. Estates and Technology Fund (ETTF)

During a meeting on Friday 23rd June between NHS England and Steph Porter at the Partnership Commissioning Unit (on behalf of the CCG) the list of ETTF schemes were reviewed and re-prioritised in light of concerns that schemes were being developed that either couldn't be delivered under the ETTF programme or were unaffordable to the CCG due to an anticipated high revenue impact.

Two high priority schemes (1 x new build covering Sherburn and South Milford Practices and 1 x improvement grant for the Carlton branch of Beech Tree Surgery) have now been selected to be progressed through ETTF. The next stage for both schemes is for the CCG to submit a Project Initiation Document (PID) to NHS England to secure funding.

CCG initial Ranking	Title	Proposal	Value Capital	Projected Revenue Impact
This scheme did not attract an ETTF bid as a new build but as 2 separate IGs.	Sherburn and South Milford Practices	New Build via a third party developer	£8.5 m This cost includes the value of the developer purchasing the two GP practice properties	If a capital grant of £1.5m is secured, the developer has agreed to keep the current rental values the same for the abatement period of 15 years
Action to date There has been significant discussions with both the parish council and the district council where it is recognised that there is a need to invest in the health services to reflect the growing needs of the population expansion.				
ACTION FOLLOWING MEETING ON 23/6/17 **To progress the scheme as the # 1 priority New Build due to the ability to deliver under the ETTF programme and the cost neutral revenue position of the project (15 year abatement period). PID to be developed by Steph Porter and submitted by the CCG.**				

CCG Ranking	Title	Proposal	Value Capital	Projected Revenue Impact
Original ranking #11 Proposed new ranking #1 of the improvement grant bids	Beech Tree-Carlton Branch	purchase and reconfiguration to give 1 additional consulting room and improve overall compliance.	Original bid was £350,000 which included purchase price. Revised bid is now for the improvement grant of £250k.	Not known but likely to be an increase of circa £20k annually
Action to date The practice was faced with the end of the lease and the possibility of losing access to the site, so they purchased the building to secure services in the rural location.				

CCG Ranking	Title	Proposal	Value Capital	Projected Revenue Impact
ACTION FOLLOWING MEETING ON 23/6/17 **Reprioritise as priority # 1 of Improvement Grants. This scheme is to be progressed and could be delivered in 17/18. Steph Porter is going to undertake a site visit and confirm the revenue position which is expected to be minimal. CCG to submit a PID to secure 66% Capital costs through ETTF.**				

2. Dispensing Services Quality Scheme (DSQS)

GP Practices were emailed the 2017/2018 DSQS documentation on Friday 2nd June 2017. 16 of the 17 dispensing practices in the Vale of York have signed up to this year's scheme. The deadline for the initial submission of information is 31st December 2017.

The Committee is asked to note this update

3. GP Clinical Waste

Across Yorkshire and Humber NHS England continues to hold historic contracts with a number of clinical waste providers to collect waste from General Practices. Additionally, there are a number of General Practices who directly hold contracts with a clinical waste provider and receive reimbursement through the Statement of Financial Entitlements and the Premises Directions.

NHS England completed a national procurement process and in doing so confirmed the providers on a call-off framework for each region. This new approach will deliver a number of benefits including improved quality standards, consistency, better management of contracts and value for money. More can be read about this Framework Agreement at www.england.nhs.uk/clinicalwaste

The NHS England Commercial Team have been working with all NHS England Local Teams including Yorkshire and The Humber to appoint suppliers from the framework in a phased approach. A number of operational issues have arisen in the areas that have already been awarded which are now being worked through and resolved. This has meant a delay to the roll out in our area which we had hoped would have commenced by now, however as we are able to learn from the experiences of other Local Teams we'll be in a better position when it comes to mobilising the contracts in our area. We hope to have a more specific timeframe available to share with you within the coming weeks.

The Committee is asked to note this update

4. Resilience Funding

The information and process for this year's resilience funding was circulated to CCGs on Friday 7th July. CCGs have been asked to liaise with their GP Practices to ensure submissions are made by 20th July. All submissions will then go to a Humber, Coast & Vale STP panel for approval and consistency across the area. The panel will sit w/c 24th July 2017.

The Committee is asked to note this update

5. Practice Based Pharmacist Scheme

The first waves of applications for the clinical pharmacy roll out programme have been assessed and over 730 sites, covering nearly 6 million patients, will benefit from the skill mix and knowledge that clinical pharmacists bring to general practice.

Applications through Wave 2 of the scheme have now been assessed by a local panel. 5 applications were received from the North Yorkshire and Humber locality, 3 of which were approved at a local level and were passed forward for further assessment by a regional and national panel. One of the 3 forwarded for further approval was an application from York CCG on behalf of Priory Medical Group, covering a total population of 213,478 patients. This scheme has now been approved by the regional and national panels. NHS England will be contacting the applicant with confirmation of the decision.

Submission deadlines for Waves 3 and 4:

Wave	Submission of applications by	Information on supported applications to NHS England national team	National Moderation Panel Meeting
3	15nd September 2017	13th October 2017	23rd October 2017
4	19th January 2018	16th February 2018	26th February 2018

The Committee is asked to note this update

6. Rent Reviews

At the last Primary Care Commissioning Meeting concerns were raised regarding delays to notional rent reviews. NHS England have reviewed the timeline for all 'in process' reviews for the GP Practices in the Vale of York and have only identified a

small number of reviews that have been outstanding for a significant period of time. Any delay to the review has been due to the GP Practice not returning the Current Market Rental (CMR) form to initiate the valuation. NHS England have been making attempts to expedite these with the practices; however they cannot be completed until the practice's returns the CMR form as requested.