NHS Hastings and Rother Clinical Commissioning Group
NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group

Medicines Optimisation Strategy 2015-2018

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Executive Summary

Medicines play a crucial role in maintaining health, preventing illness, managing chronic conditions and curing disease. In an era of significant economic, demographic and technological challenge it is crucial that patients get the best quality outcomes from their medicines. The vision and objectives within this strategy set out a significant change in direction for our management of medicine use.

We currently spend £66m per year on Primary Care prescribing across our two CCGs (Eastbourne, Hailsham and Seaford (EHS) - £32m and Hastings and Rother (HR) - £34m). To date, the focus of the CCG Medicines Management team has been on the delivery of evidence-based medicine and cost-effective drug choices and the team have had some significant success, particularly around change management at GP practice level. However, when compared with higher performing CCGs the potential annual efficiencies over the next three years are approximately £1M for EHS CCG and £1.5M for HR CCG.

To realise the potential efficiencies from the prescribing budget we will need to increase the capacity and skills in Primary Care to change how we use medicines at practice and locality level. Our work will need to include engagement of the partner organisations in joint policy across the whole health economy with leadership for implementation provided by the specialists for each therapeutic area.

A new emphasis is required to deliver Medicines Optimisation which aims to engage with patients to better understand their issues around medicines and to co-develop solutions that support them with their medicines taking. There will be specific focus around medicines use in care homes and in the over 75s because of our particular demographics and the known adverse impact of high medicine usage in the frail elderly population (polypharmacy).

The East Sussex Better Together (ESBT) programme affords us the opportunity to work much more collaboratively across health and social care boundaries to ensure that there is adequate support throughout the medicines pathway to secure the desired outcomes for patients as well as delivering value for money for our CCGs. We will aim to increase capacity by integrating pharmacists' skills into co-ordinated primary care for patients and configure new medicines optimisation services around the locality model outlined in the CCGs Primary Care Strategy 2014-19.

Introduction

This strategy outlines how EHS and HR CCGs are going to optimise the use of medicines over the next three years and realise the potential efficiencies from the prescribing budget. It has been developed through engagement with practices, localities, patients and partner organisations.

The strategy provides a context for Medicines Optimisation locally and details the vision and six key objectives for 2015-18. An implementation plan outlines the details of implementation over the next three years.

Context

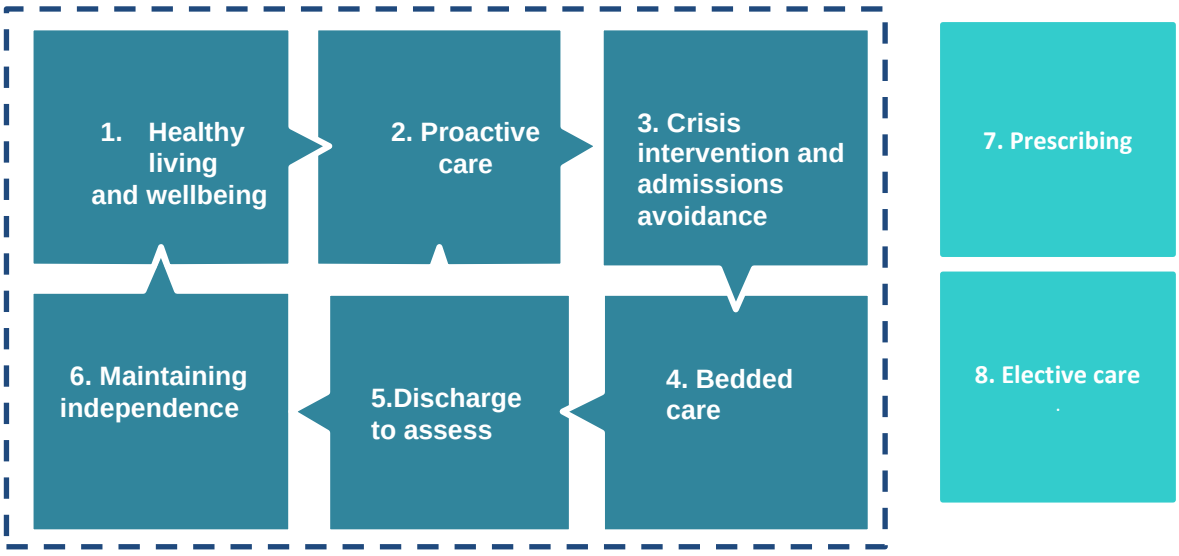
National Context

Medicines Optimisation (MO) represents a fundamental step change in approach to medicines use that centres on the individual patient and their experiences.[1] It is a national priority cited in many key policy documents such as the NHS Five Year Forward View, the NHS Outcomes Framework, The NHS belongs to people: a Call to Action, and Everyone Counts: planning for patient- key measures. The focus is to help patients to improve their outcomes, reduce wastage of medicines and improve medicines safety.

Local Context

East Sussex Better Together

The ESBT programmeme was launched in August 2014 set out a shared five-year strategy to co-ordinate the plans of the health and social care commissioners in East Sussex. There is an ambitious transformation programmee to create a sustainable health and social care system by 2018/19. MO has been identified as one of the eight improvement interventions in its own right but is also recognised as being integral to each of the other areas.



The new care models outlined in the NHS Five Year View and the development of Co-commisioning means we are likely to see changes in the landscape of the NHS

locally and there will be opportunities to shape services that will optimise the use of medicines for our patients.

Influences on prescribing

The influences on prescribing practice are multifactorial and, other than patient demographics, include influences from secondary care and other partner services, influence from the Pharmaceutical Industry, patient beliefs and expectations, influence from peers and the available skill mix to manage change in prescribing practice.

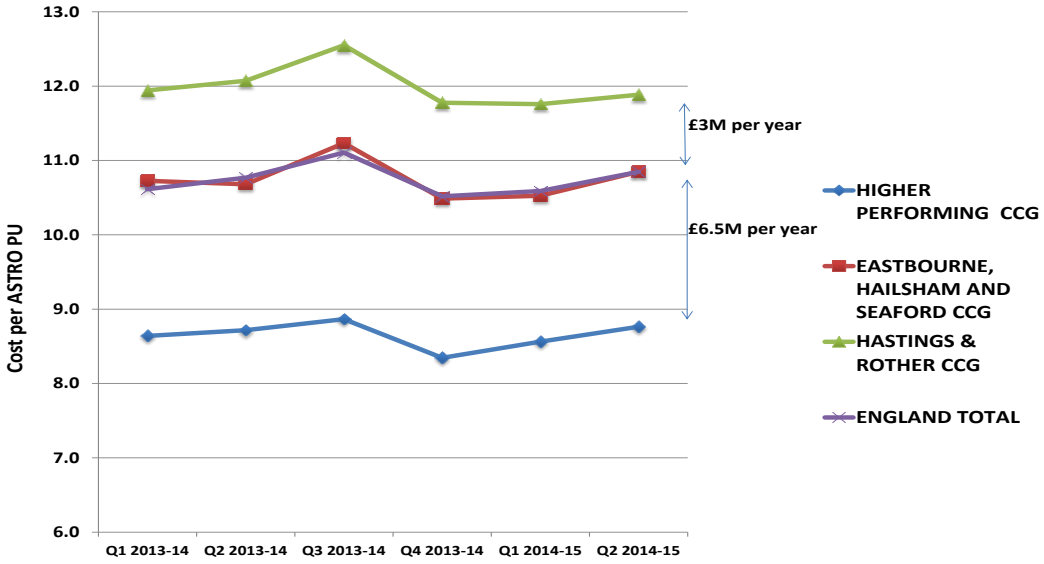
EHS and HR CCGs employ a Medicines Management team of six pharmacists and three pharmacy technicians to support implementation of policy at practice level. They jointly operate an Area Prescribing Committee with their local acute provider NHS East Sussex Healthcare Trust (ESHT) and a representative from their Mental Health Trust, NHS Sussex Partnership Foundation Trust (SPFT). The Committee manages and monitors implementation of the East Sussex Health Economy Joint Formulary.

Primary Care Prescribing

The annual Primary Care prescribing budget for EHS CCG is £32m and for HR CCG is £34m. Prescribing is the most common healthcare intervention and primary care prescribing represents around 20% of the total healthcare budget available to CCGs.

EHS prescribing costs more or less mirror the national average prescribing costs. HR CCG prescribing costs are approximately £3m per year above the national average but the gap is slowly reducing. (see Figure 1 below)

Figure 1: CCG trends in prescribing costs against the national average

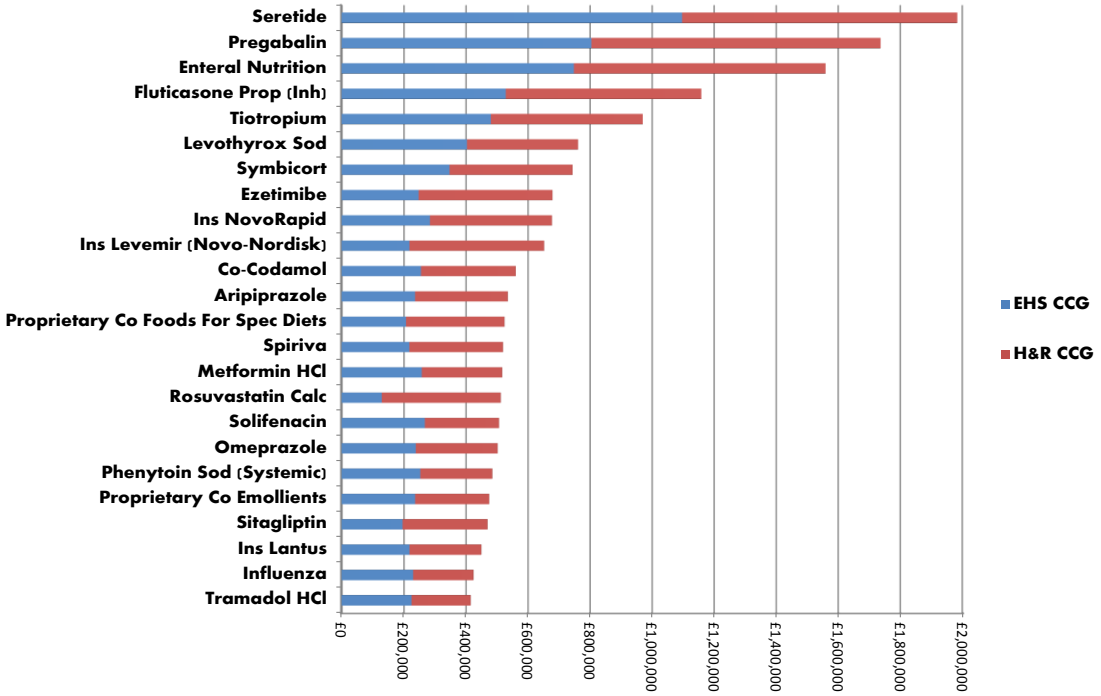


Note: Cost per ASTRO-PUs – represents the cost per population weighted for age and sex of the population)

When both CCGs are compared to one of the higher performing CCGs there are significant differences in prescribing costs. The age, sex, temporary resident prescribing unit (ASTRO-PU) does take the age of the population into account but there will be different demographics in terms of deprivation of their populations. In addition, there is considerable variation in prescribing costs between practices within both CCGs.

The majority of our expenditure on medicines is necessary and benficial to patient outcome; influenza vaccine being a good example. However Figure 2 demonstrates that there are some high cost areas of prescribing where there are opportunities to rationalise without compromising patient care e.g. pain management (Pregabalin), respiratory prescribing and diabetes treatments. A minor proportion of the expenditure is out of our control such as phenytoin where the supply shortages have inflated the market price of the medicine.

Figure 2: Top 20 prescribing costs for EHS and HR CCGs (2013/14)



Medicines Optimisation Key Facts

Applying national research to our local population gives us the following key facts:

- Avoidable medicines waste in primary care is estimated to be £150m per year.[2] This means that for our two CCGs over £1m worth of medicines waste could be avoided each year.

- Research tells us that only 50% of medicines are taken as the prescriber intended.[3] This means that across both our CCGs over £30m investment in medicines may not be resulting in the desired outcome.
- 5% of hospital admissions are due to the ineffective or inappropriate use of medicines; this increases to 17% of unplanned admissions in the frail elderly.[4,5] In 2014 there were over 900 non-elective acute admissions from care homes in each of our CCGs.
- Care home use of medicines study finds that 70% of residents were exposed to one or more medication errors every day.[6] We have 144 care homes across our two CCGs with over 5,000 residents.

This context gives us the drivers for the following vision and objectives of our strategy.

Vision

By March 2018:	Achieved through:
Patients will be empowered to be equal partners in all decisions about their medicines	•Continued public engagement that allows the patient experience to influence how medicines optimisation services are designed •Implementation of NICE approved Shared Decision Aids
We will have a strong culture of quality and safety assurance with respect to the use of medicines	•Clinicians aiming to prescribe 5 medicines or fewer for frail elderly patients unless there is a documented holistic medication review that supports the prescribing of more medicines •There will be an accurate and timely record of medication when patients are transferred between care settings as part of multi-agency care planning
The financial resource invested in medicines will represent value for money and deliver the best outcomes for patients	•An Area Prescribing Committee in place that fully engages across the whole health and social care economy •Reduction in inappropriate practice variability in prescribing of medicines •Robust reporting and governance arrangements for managing the financial and clinical risk associated with medicines
We will have a competent workforce to deliver Medicines Optimisation	•Patients and their carers who are having problems with medicines can access a pharmaceutical service that is integrated with the rest of their health and social care. •The CCG possesses the skills and competencies requried to commission care pathways that ensure patients gets the optimum use out of their medicines

The Key Strategic Objectives are:

1. Supporting Patients with their medicines
2. Improving the quality and safety of medicines use
3. Reducing inappropriate variations in Primary Care Prescribing
4. Medicines Optimisation integrated across Health and Social Care
5. Managing the clinical and financial risks associated with medicines
6. Developing the workforce to deliver the strategy

1. Supporting Patients with their Medicines

1.1. Patient engagement in Shaping Services

There are particular issues locally with how patients access medicines which would benefit from further patient engagement to co-design solutions; e.g. patients accessing Out of Hours services inappropriately for prescriptions for routine medicines that could be obtained 'in-hours' from their GPs, or patients attending the GP for minor ailments or self-limiting conditions that could be dealt with by community pharmacists. The Medicines Management team will work collaboratively with the CCG Patient Engagement team, Local Pharmaceutical Committee (LPC), Primary Care and Urgent Care commissioning colleagues to develop alternative services for access to medicines e.g. community pharmacy minor ailment scheme. This will feed into the ESBT Programme Self-care workstream.

1.2. Shared Decision Making

Engaging patients in making decisions about their medicines should be a routine part of prescribing practice. There is evidence that use of Patient Decision Aids is beneficial in involving the patient to understand the risk/benefit of their treatment options. We will work with local GP champions to adapt the nationally available Patient Decision Aids so they are available electronically for practical use during their consultations.

1.3. Integration of Community Pharmacy Medicine Optimisation services

We will work collaboratively with NHS England and community pharmacists across our CCGs to improve the integration of their services with the rest of health and social care and thereby maximise the potential to achieve our Medicines Optimisation vision. Community pharmacy Medicines Optimisation services such as

Medicine Use Reviews (MURs) and New Medicines Service (NMS) support patients to make the best use out of their medicines and will become an integral part of our Primary Care system. We will work with the prescribers to develop a single system for communication and referral to community pharmacists locally and a system to evaluate the outcomes from these services. It is likely that as co-commissioning develops there may be opportunities for delegation of community pharmacy services from NHS England to CCGs. This will give us the freedom to co-design services locally that will be fit to meet the needs of our population.

We will continue to ensure that the CCG involves local community pharmacists in medicine policy and guideline development and communicates to all community pharmacists through a regular newsletter and education events.

1.4. Reduction in medicines wasted

Repeat prescriptions are defined as prescriptions issued without a consultation between the prescriber and patient. They account for 60-70% by cost and 80% by volume of all prescription items dispensed in primary care. Repeat prescribing is of major importance to patients who want a convenient and accessible service that they have confidence in, and feel safe with. However, where there is a superficial review process and where the issuing of repeat prescriptions is poorly managed, there are risks in terms of medicines waste and medication safety. The Medicines Management team will continue improve their repeat prescribing processes by working with practices to implement the CCG guidance on prescribing processes.

Our CCGs are currently engaged in the implementation of the national Electronic Prescription Services. Utilisation of the electronic repeat dispensing service will include an adherence check by community pharmacists. This should identify repeat medicines that are not required before they are dispensed and hence reduce waste. There is an opportunity to improve patient outcomes by communicating the results of the adherence check with the prescriber and the CCG will work with local clinicians on how this could be incentivised and implemented locally.

The CCG will continually engage with patient groups on how we could better communicate with the public through our Patient Participation Groups on what can be done from a patient's perspective to reduce medicines waste.

Key Success Indicators for supporting patients with their medicines

The Medicines Management team will work on developing outcome measures that will demonstrate impact on patient outcomes

e.g. anticoagulation rates for atrial fibrillation (AF) patients. The current outcome measure can only focus on the financial outcomes from reducing waste – see Section 3 and 4.

Process Indicators	Baseline 2014/15		Target by April 2018	
	HR CCG	EHS CCG	HR CCG	EHS CCG
% of practices that are transmitting prescriptions electronically	0%	43%	100%	100%
% of practices using patient specific decision aids that are integrated into the GP software systems.	0%	0%	100%	100%

2. Improving the Quality and Safety of Medicine use

2.1. Transfer of care

Research shows that between 30-70% of patients have either an error or an unintentional change or their medicines when they are discharged from one care setting to another.[7] This includes transfer from the hospital to home or to a care home or an intermediate service and vice versa. It usually involves transfer of information from the GP to another provider and back to the GP again.

The Royal Pharmaceutical Society has published core principles and responsibilities; endorsed by other professional Royal Colleges that underpin the safe and accurate transfer of information about medicines whenever a patient transfers between providers.[8] The CCGs will use commissioning levers such as Commissioning for Quality and Innovation (CQUINs), Quality Premiums etc. to support providers to implement these principles.

The Medicines Management team will work with the Quality team to place particular emphasis on reporting and monitoring of incidents relating to transfer of care and learning shared through the 'One click' Feedback Newsletter and the Prescribing Newsletter.

2.2. Polypharmacy in the frail elderly and care homes

Polypharmacy, the use of multiple medicines by a patient, is driven by growth of an ageing population and the rising prevalence of multi-morbidity. In the past decade, the average number of items prescribed for each person per year in England has increased by more than 50%. For some people polypharmacy will extend life expectancy and improve quality of life, if their use of medicines has been optimised. However, for other patients 'problematic' polypharmacy can lead to an increased risk of drug interactions and adverse drug reactions (ADRs), together with impaired adherence to medication and quality of life for patients.[9]

Polypharmacy is a particular concern in older people as their risk of ADRs is heightened by age-related physiological changes. Multi-morbidity and polypharmacy increase clinical workload so doctors, pharmacists and nurses need to work

coherently as a team with a balanced skill mix. The CCGs strategy will be to work with the ESBT programme to ensure that appropriate pharmacists and pharmacy technician skills are integrated into the locality model, with a particular focus on deprescribing and polypharmacy in the frail elderly population and care homes.

2.3. Tackling Addiction to Prescription Drugs

The Medicines Management team regularly monitor Controlled Drug prescribing and other drugs of potential abuse. Any unusual prescribing or areas of concern are raised with the prescriber and escalated to the Controlled Drugs Accountable Officer, when appropriate. Both CCGs have high benzodiazepine, pregabalin and oxycodone prescribing compared with national averages. The CCG's Medicines Management team will work with the local Drug and Alcohol Team (DAAT) commissioners to ensure services are commissioned to support practices managing patients who are addicted to prescription drugs.

2.4. Antimicrobial Stewardship

There is considerable variability between the levels of antimicrobial prescribing within both CCGs; almost 25% of EHS CCG practices and 50% of HR CCG practices are prescribing above the national average levels of antimicrobial items. There is evidence of high quality antimicrobial stewardship in terms of risk of Healthcare Acquired Infections e.g. both CCGs are significantly below the national average for prescribing of antibiotics associated with Clostridium difficile infections. The Medicines Management team will provide benchmarking data to practices on a quarterly basis and reductions in the volumes of antimicrobial prescribing will be included in GPs annual prescribing review.

Key Success Indicators for Improving the quality and safety of medicines use

We currently do not capture any local data that quantifies the levels of polypharmacy in our patients. It is accepted that some polypharmacy is appropriate but that in general high levels are not a good indication of safe prescribing. We will work with GP colleagues and local geriatricians to develop an indicator that could demonstrate progress in this area.

Process Indicators	Baseline 2014/15		Target by April 2018	
	HR CCG	EHS CCG	HR CCG	EHS CCG
% if nursing home residents that have a documented medication review that addresses polypharmacy and involves the patient and/or their relatives.	Not known	Not known	100%	100%
Outcome Indicators	**Baseline 2014/15**		**Target by April 2018**	
	HR	**EHS**	**HR**	**EHS**

	CCG	CCG	CCG	CCG
Reduction in volume of antimicrobial prescribing (Target of 2% reduction in items per specific therapeutic age-sex related prescribing unit [STAR PU])	0.364	0.317	0.357	0.311
Our CCGs position nationally for prescribing of drugs acting on benzodiazepine receptors (Average daily quantities (ADQ)/STAR PU across 210 CCGs)	12th Highest CCG	25th highest CCG	Median	Median

3. Reducing inappropriate variations in Primary Care Prescribing

Both CCGs have a long history of successful medicines management input at GP practice level. Every practice across the two CCGs has engaged with the Medicines Management team and the annual Prescribing Support Scheme. In past years there is evidence of successful implementation of change in both the cost and quality of prescribing e.g. reduced costs of prescribing of 'specials' medicines and reduced prescribing of antibiotics associated with Clostridium Difficile infection.

To realise the potential efficiencies in both CCGs, there will need to be increased efforts to motivate and support change at practice level.

3.1. Annual Prescribing Workplan and Prescribing Support Scheme

The CCG clinical leads for prescribing and the Medicines Management team have formed a GP Prescribing Group to agree the priority areas for managing change in Primary Care prescribing. An annual workplan for the Medicines Management team and Prescribing Support Scheme will be consulted on through the Practice Operational Forums and approved at the GP Prescribing Group. The focus of the schemes over the next three years will be to reduce practice variation in both the cost and quality of their prescribing. The inter-practice variation is a greater challenge in HR CCG than it is in EHS CCG. The Medicines Management team are looking to use some additional funding from the Health Inequalities budget to support practices to manage change in benzodiazepine and opiate prescribing – see Section 2.3

The annual prescribing workplan will include projects that develop more of a whole systems approach and seek to involve clinicians outside of Primary Care e.g. acute clinicians and community staff such as dietitians and continence nurses.

The team are available to respond to medicine-related queries from practices by both telephone and email and maintain a Medicines Management Helpline at Bexhill Hospital which aims to respond to practice queries within the same working day.

3.2. Practice Support Work

Each practice will receive an annual prescribing review presented by a pharmacist member of the team. Practices are encouraged to involve all of their clinical team in the discussion, including non-medical prescribers and practice nurses. Depending on the practices' baseline prescribing costs they will be asked to agree an annual cost containment and quality improvement plan, specific to their practice. The Medicines Management team will be expanded to increase the use of Band 7 Pharmacists and Pharmacy Technicians to support practices to deliver safe and cost-effective prescribing.

3.3. Benchmarking

National indicators for prescribing cost and quality are used to identify areas where the CCGs are outliers. Local practices are benchmarked for these indicators with the aim to reduce inappropriate practice variability in these areas.

Prescribing dashboards are provided quarterly to allow practices and the Governing Body to monitor progress against key prescribing cost and quality indicators. Outliers will be supported by the Medicines Management team to change their prescribing practice.

3.4. Communication

The Medicines Management team will continue to communicate key medicines optimisation messages to local clinicians and patients through the Prescribing Newsletter, Community Pharmacy Newsletter, Locality meetings, the CCG Intranet and Internet web pages.

Opportunities to make better use of the IT systems/electronic decision support tools to support prescribers e.g. making the web-based formulary more user-friendly, linking Scriptswitch to the formulary or other relevant guidance or utilising GP software templates to optimise the use of medicines.

Key Success Indicators for Reducing inappropriate variations in Primary Care Prescribing

Process Indicators	Baseline 2014/15		Target by April 2018	
	HR CCG	EHS CCG	HR CCG	EHS CCG
% of GP practices participating in the prescribing support scheme	100%	100%	100%	100%
Outcome Indicators	**Baseline 2014/15**		**Target by April 2018**	
	HR CCG	**EHS CCG**	**HR CCG**	**EHS CCG**
Reduction in gap between highest and lowest	9.156	4.093	8.074	3.568

performing practices in terms of the quality prescribing indicator relating to benzodiazepines (Variance ADQ/STAR PU)				
Reduction in gap between highest and lowest performing practices within the CCG in terms of prescribing costs (Variance cost per ASTRO PU)	£18.33	£14.69	£10.57	£10.40

4. Medicines Optimisation integrated across Health and Social care

Medicines are the most common treatment intervention and most care pathways involve medicines. We need to use the opportunity of our whole system service redesign to promote an integrated approach to medicine use across the pathway, improving patients' outcomes, experience and cost effectiveness.

4.1. Managed Entry of New Drugs and Joint formulary

Our CCGs have governance processes in place to evaluate and manage the entry of new medicines across the healthcare economy through the implementation of the East Sussex Health Economy Formulary. Annual horizon scanning for New Drugs will be carried out jointly with ESHT and prioritised by the Area Prescribing Committee (APC). The financial impact will be included in the annual Commissioning Intentions.

The Medicines Management team will be supported by the GP clinical leads and GP contract leads to engage provider clinicians across Primary and Secondary care in the joint formulary process and the APC. The specialists for each therapeutic area will be expected to input into the process and provide leadership on the implementation of the joint formulary through guideline development and educational events.

The CCG Medicines Management team and ESHT pharmacy team will provide the APC with six-monthly reports on the implementation of their recommendations so that the committee can monitor and agree action on areas of concern.

4.2. Commissioning across Health and Social Care

The CCG will ensure that appropriate pharmaceutical expertise is provided to the commissioning of new services and service redesign to promote the optimum use of medicines. This will include provision of pharmaceutical expertise into service specifications, tender exercises and final contracts.

We will work collaboratively with our partner providers in acute and mental health organisations to ensure service developments consider the safe use of medicines across the interfaces between primary and secondary care e.g. Shared care protocols for prescribing of anti-psychotic medicines.

The Medicines Management team will also work with commissioners of Social Care to develop integrated policies that support the optimum use of medicine e.g. handling of medicines by personal carers.

An accurate record of patients' medicines will be crucial to the successful implementation of shared care plans or shared records. We will work with IT colleagues and partner organisations on the practical implementation of the Royal

Pharmaceutical Society of Great Britain (RPSGB) standards for medicine records (see section 2.1).

We will support our local NHS England Area Team and the Local Authority to complete the Pharmaceutical Needs Assessments and commission Community Pharmacy services that optimise the use of medicines for our population.

4.3. High cost Drugs (HCDs)

The cost of medicines to the NHS rose by 7.6% overall but by 15.1% in hospitals from 2012/13. This is mostly driven by the growth in High Cost Drugs which are outside of the national tariff payments. The CCGs currently spend approximately £10m on High Cost Drugs (e.g. Anti-TNF medicines used in rheumatology and Lucentis used in ophthalmology)

The CCGs seeks assurance from providers that they are adhering to National Institute for Health and Clinical Excellence (NICE) and local commissioning policy. This data is received using the Bluteq electronic reporting system and should allow for validation of invoices for all High Cost Drugs. The CCG will work collaboratively will our providers to obtain useful data to allow assurance of value for money for this high cost area. Where opportunities arise to deliver efficiencies we will look to use contractual levers to support our providers to deliver those efficiencies e.g. CQUINs

The CCGs will need to prepare for the expected transfer in 2016/17, of additional commissioning responsibilities from NHS England relating to cancer drugs and Specialised Commissioning pathways (including impact assessment and inclusion on risk register where appropriate).

Key Success Indicators for Medicines Optimisation integrated across health and social care

The Area Prescribing Committee will be requesting data from providers to allow it to monitor the implementation of its recommendations across Primary and Secondary care.

Process Indicators	Baseline 2014/15		Target by April 2018	
	HR CCG	EHS CCG	HR CCG	EHS CCG
Quarterly Area Prescribing Committee meetings that are quorate	50%	100%	100%	100%
% of High Cost Drug invoices that have been validated using the Bluteq reporting system	0	0	80%	80%

5. Managing the clinical and financial risks associated with medicines

The CCG Governing Bodies should be provided with assurance that both the clinical and financial risks associated with medicines are being effectively identified and appropriately managed. A recent internal audit has identified some gaps in the governance structures which will be addressed by the implementation of the governance structures and reporting arrangements outlined in Appendix 1

5.1. Budgetary management

The CCG Medicines Management team have a reputation for successful management of the Primary Care Prescribing budget and working with practices to deliver impressive efficiencies year on year. The team work closely with the Governing body GP prescribing leads and finance colleagues to agree the annual Primary Care prescribing budgets and Quality Innovation, Productivity and Prevention (QIPP) efficiencies each year.

The budget setting methodology and Prescribing Support Scheme are annually approved by the CCGs Governing bodies. Monthly monitoring and forecasting is carried out by the Medicines Management team in collaboration with finance colleagues. These are reported through the QIPP Assurance group and to the Governing Bodies as part of the finance report.

5.2. Implementation of NICE Guidance, NPSA and other national guidance

Members of the Medicines Management team currently work with National Institute for Health and Care Excellence (NICE) on development of guidance and implementation of an Associate network. An assurance process for implementation of NICE guidance relating to medicines is included in the Terms of Reference and Operating Framework for the Area Prescribing Committee. All NICE approved medicines will be included in the Joint Formulary within three months of the NICE guidance publication.

The Medicines Management team works closely with the CCG Quality and Safety team to monitor the Implementation of National Patient Safety Agency (NPSA) alerts, Chief Medical Officer (CMO) guidance and other national directives relating to safety, quality and medicines optimisation. Progress will be reported through the Area Prescribing Committee, the CCGs Quality and Governance Committees and East Sussex Healthcare NHS Trust (ESHT) Medicines Safety Group.

5.3. Medicines Safety Incidents

Our Primary Care Strategy aims to develop processes to drive learning from safety incidents in partnership with partner agencies. Practices will be encouraged to use the e-form (recently revised by NHS England) to report patient safety incidents to the National Reporting and Learning system. Prescribers will also be encouraged to

feedback incidents or complaints involving our providers, using the local 'One Click' reporting system. Interface incidents will be fed back to the relevant organisations Medicines Safety Committee.

The Head of Medicines management is the Medicines Safety Officer for both CCGs; the role involves monitoring reports and identifying any trends or risk relating to medicine use. Learning will be shared with prescribers from medicine-related incidents, Medicines Healthcare and Regulatory Agency (MHRA) alerts or warnings, through the Prescribing Newsletter.

5.4. Partnership working with the Pharmaceutical Industry

The Department of Health has issued Best Practice guidance for the Joint Working between the NHS and the Pharmaceutical Industry and encourages organisations and their staff to consider opportunities for partnership working where the benefits that this could bring to patient care and the difference it can make to their health and well-being are clearly advantageous.[10, 11]

The Medicines Management team will work with finance colleagues and member practices to review the current CCG policy and processes to allow transparent consideration of all joint working/sponsorship proposals. We will work through the practical implementation of a policy that will aim to be of mutual benefit with the principal beneficiary being the patient.

Key Success Indicators for Financial and Clinical Governance

Process Indicators	**Baseline 2014-15**		**Target by April 2018**	
	H&R CCG	**EHS CCG**	**H&R CCG**	**EHS CCG**
% of NICE approved new drugs(or indications) that have been considered by the Area Prescribing Committee and an implementation plan agreed	50%	50%	100%	100%
Outcome Indicators	**Baseline 2014-15**		**Target by April 2018**	
	H&R CCG	**EHS CCG**	**H&R CCG**	**EHS CCG**
Management of CCG prescribing budgets within agreed allocation	100%	100%	100%	100%
% of NICE approved drugs that are added to the formulary within three months of publication	90%	90%	100%	100%

6. Developing the workforce to deliver the strategy

6.1. Medicines Optimisation skills across Health and Social care

The Medicines Management team will use opportunities such as Membership Engagement and Learning Events (MELE) and locality events to provide GP, non-medical prescribers and practice nurse education on Medicines Optimisation. These sessions will relate to the annual prescribing workplan.

The CCGs are keen to harness the potential that pharmacist's skills could offer to increase capacity in Primary Care; both in terms of community pharmacists and pharmacists working within practices or federations. The local pharmacy workforce will not currently have all the consultation or clinical examination skills to deliver their full potential. MM team will work with the Local Pharmaceutical Committee (LPC), Health Education Kent Surrey Sussex (HEKSS) and the Centre for Pharmacy Postgraduate Education (CPPE) tutor to develop a strategy to develop the skills and knowledge that the pharmacists will need to take on new roles in Primary Care. This will feed into the CCGs' Primary Care Workforce Strategy.

The Medicines Management team will use benchmarking tools to monitor the pharmaceutical services our provider services are providing to our patients e.g. ward based clinical pharmacy services. We will be particularly focussed on meeting the increased pharmaceutical needs in the community health staff as care shifts 'closer to home' e.g. IV therapy, mental health services.

6.3 Medical leadership for Medicines Optimisation

The CCGs will each have a Governing Body GP member who leads on Medicines Optimisation for the organisation. They work closely with the Medicines Management team to monitor and support delivery of our strategy. There is an additional GP from each CCG engaged to represent local GPs on the Area Prescribing Committee.

6.1. The CCGs Medicines Management Team

The resource and skill mix of the current Medicines Management team will be reviewed to provide a workforce that can deliver this strategy. Namely there will be increased use of Prescribing Support Technicians and Prescribing Support Pharmacists (Band 7) to implement change at practice level. This will be an 'invest to save' initiative and a business case developed to expand the team at the senior level to allow the team to take a more strategic approach to influence Medicines Optimisation across the whole of the care pathway.

The CCGs will need to ensure that they retain the workforce to discharge their legal duties with regard to medicines e.g. Medication Safety Officer (MSO), professional advice to the Individual Funding Request (IFR) process, approval of Patient Group

Directions (PGDs). As co-commissioning progresses the resources required for these functions are likely to increase.

Key Success Indicators for Workforce development

Process Indicators	Baseline 2014/15		Target by April 2018	
	HR CCG	EHS CCG	HR CCG	EHS CCG
Number of whole time equivalent (whole time equivalent (wte)) clinical pharmacists carrying out medication reviews at practice/locality level	0 wte	0.15 wte	2 wte	2wte
Vacancy rate (%) in the Medicines Management team	25%	25%	0%	0%

7. Financial Summary

The estimated financial savings from the Prescribing element of the ESBT programme are summarised below together with the estimated investment requirements. The Medicines Management team will develop business cases to support the investment in the new clinical pharmacy service.

	HR CCG £'000	EHS CCG £'000
Expected Financial Savings		
Year 1	£1,673	£1,100
Year 2	£1,543	£1,115
Year 3	£1,792	£1,170
Proposed Additional Investment		
Year 1	£150	£150
Year 2	£200	£200
Year 3	£250	£250

Summary

This strategy represents our shared vision to optimise the use of medicines for our patients. Medicines are involved in every service the CCGs commission and they are more likely to deliver against their strategic priorities if they can improve their use of medicines. Whilst we acknowledge that there is a huge challenge to overcome we believe that delivering the objectives outlined in this strategy will move us towards our vision.

Appendix 2 details the implementation plan for the first year of the strategy and also contains some of the work that we know will follow into year two and three. Appendix 3 details the therapeutic areas of prescribing that general practice will be focussing on for 2015/16.

Both of these appendices will be reviewed annually in light of emerging evidence base for medicine use. We will also be looking to use any opportunities afforded by the changing NHS landscape to further develop Medicines Optimisation services e.g. ESBT programme, implementation of co-commissioning.

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Appendix 1: Governance Accountability and Reporting arrangements

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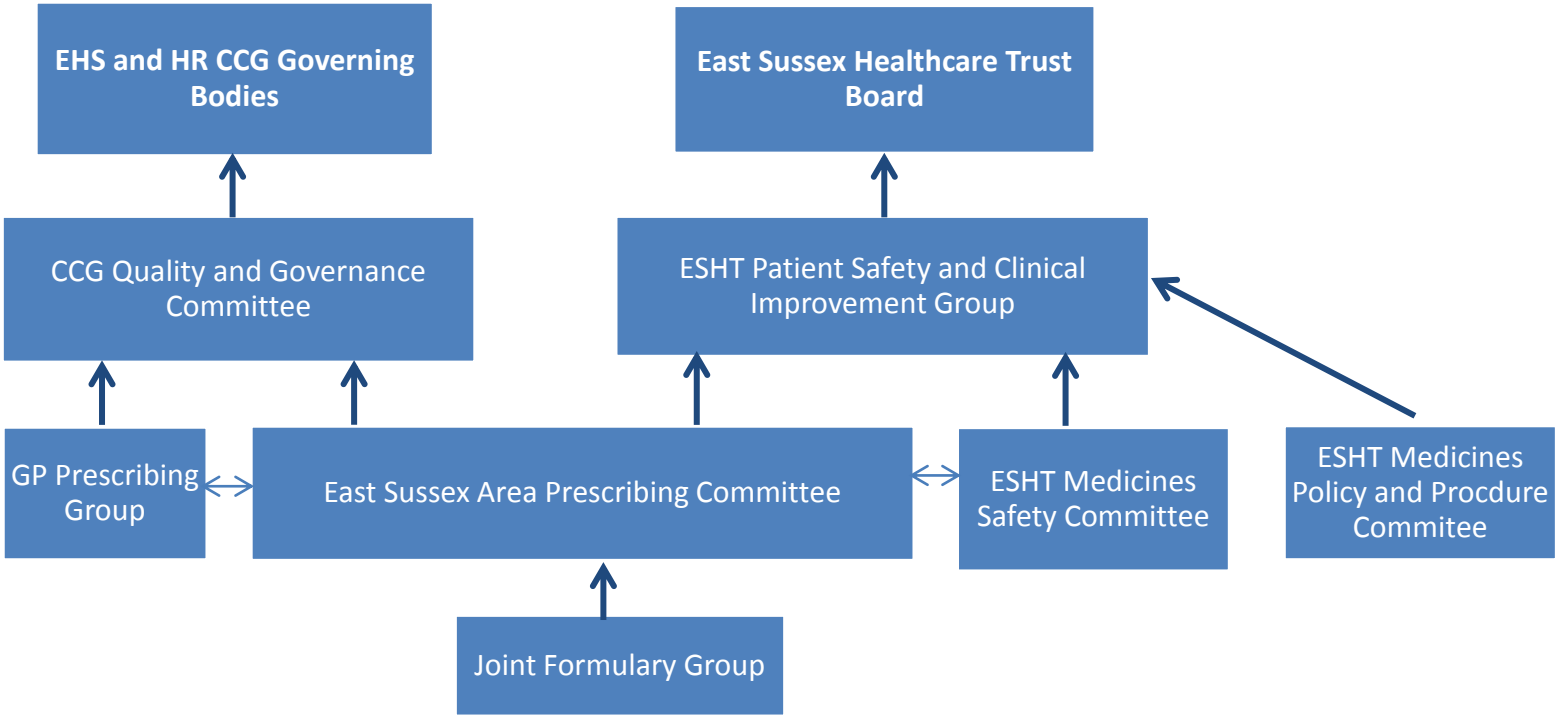
EHS and HR CCG Governing Bodies
East Sussex Healthcare Trust Board
CCG Quality and Governance Committee
ESHT Patient Safety and Clinical Improvement Group
GP Prescribing Group
East Sussex Area Prescribing Committee
ESHT Medicines Safety Committee
ESHT Medicines Policy and Procdure Commitee
Joint Formulary Group

Appendix 2 Medicine Optimisation Implementation Plan

Objective	Actions	By Whom	Investment/ Savings	Timescale
1. Supporting Patients with their medicines				
2015/16				
Implementation of electronic transfer of prescriptions	Medicines Management team to support IT colleagues with roll-out across both CCGs	HG EPRS project board		Mar 16
Community pharmacy minor ailment scheme pilot and evaluation	Provide pharmaceutical advice on the implementation and the evaluation of the scheme	NH/RP		Apr 16
Implementation of Shared Decision making	Pilot integrated electronic versions of Patient decision aid for with 'champion' GPs (starting with anti-coagulation and lipid-lowering treatments)	KI		Dec 16
Integrate Community pharmacy Medicines Optimisation services into Primary Care	Pain management training for CPs on how to support patients undergoing changes as a result of PSS pregabalin reviews Support consultation skills training for CPs provided by KSS Leadership Collaborative Respiratory training in collaboration with CPPE tutor to support PSS High dose ICS reviews	EC/LPC KSS Leadership collaborative CPPE Tutor		Apr 15 Jun 15

Objective	Actions	By Whom	Investment/ Savings	Timescale
A public campaign to reduce medicines waste will be co-designed with Patient Participation Groups and delivered across both CCGs	Short task and finish group with interested PPG members to design a scheme across both CCGs	CCG PPI lead Medicines Management team	£6K each CCG	Mar 16
2016/17				
Implementation of repeat dispensing service	Support GPs and community pharmacists to identify suitable patients for repeat dispensing. Identify opportunities to improve adherence and reduce waste and develop incentives to deliver these.	EPR Medicines Management team LPC GP leads	£150K across both CCGs/£500K	Sep 16
Implementation of Shared Decision making	Evaluate and if successful roll-out tools to other therapeutic areas	KI		Mar 17
Emergency repeat prescription service	Review the Surrey pilots and national audit data for emergency repeat prescription requests and agree how to progress for our CCGs			Jun 16
Integrate Community pharmacy Medicines Optimisation services into Primary Care	Evaluate and if successful roll-out to support further years GP PSS and other projects			Apr 16
2. Improving the quality and safety of medicines use				
2015/16				
Improve transfer of information on medicines at admission and	Medicines-related elements of the clinical correspondence CQUIN	Medicines Management		Mar 16

Objective	Actions	By Whom	Investment/ Savings	Timescale
discharge from our acute providers	implemented with ESHT CQUIN implementation group and ESHT Medicines Safety Group RPS Standards for transfer of information included in Intermediate care service specifications and other service specifications	team Commissioning leads CQUIN group ESHT Medicines Safety Committee		
Reduction of inappropriate Polypharmacy	Business case developed for clinical pharmacy support with a particular focus on the frail elderly in nursing homes. Develop indicator for monitoring progress Service commissioned and embedded in ESBT workstreams. Education provided to all prescribers on deprescribing management of polypharamcy on the frail elderly	Medicines Management team GP leads ESHT Geriatrician ESBT Locality Workstream Medicines Management team ESHT Geriatrician	£1	Apr 15 Sep 15 Dec 15
Reduction in inappropriate prescribing of drugs with potential for abuse	Implementation of an in-reach specialist service to practices in HR CCG, funded through the Health Inequalities investment fund.	DAAT lead commissioner Medicines Management team		Apr 15
Improve reporting and learning	Promote use of the National Learning	Medicines		Mar 16

Objective	Actions	By Whom	Investment/ Savings	Timescale
from medicine-related incidents and near misses	and Reporting System e-form for practice reporting of medicine-related incidents Incidents report relating to the interface reported to ESHT medicines safety group –	Management team		
2016/17				
Reduction of inappropriate Polypharmacy	Evaluation of Year 1 of clinical pharmacy service and roll-out to all care homes and housebound patients	Medicines Management team		Mar 17
Reduction in inappropriate prescribing of drugs with potential for abuse	Evaluate HR pilot and if successful consider roll-out to high prescribers across both CCGs	Medicines Management team DAAT lead commissioner		Mar 17
3. Reducing inappropriate variations in Primary Care Prescribing				
2015/16				
Review of PSS 2014-15 and implementation of PSS 2015-16	Individual practice prescribing review focussed on therapeutic areas see Appendix 3 Clinical review of patients prescribed pregabalin and high dose ICS	Medicines Management team	EHS = £140K/£0.6M HR = £190K/£1.1M	Apr 15
Cost and quality prescribing indicators to be monitored communicated to prescribers	Prescribing dashboard and QAT dashboard published quarterly	RP/HG and CSU BI		Quarterly

Objective	Actions	By Whom	Investment/ Savings	Timescale
Communication of key MO messages to local clinicians	Prescribing newsletter published Community pharmacy newsletter MO update as a standing item on member practice locality meetings	RP TP Medicines Management team		Monthly Quarterly Monthly
2016/17				
Review of PSS 2015-16 and implementation of PSS 2016-17	TBC	Medicines Management team GP Prescribing group		Apr 16
Monitoring and communication as above		Medicines Management team		Monthly Quarterly
2017/18				
Review of PSS 2016-17 and implementation of PSS 2017-18	TBC	Medicines Management team GP prescribing group		Apr 17
Monitoring and communication as above				Monthly Quarterly
4. Medicines Optimisation integrated across Health and Social Care				
2015/16				
Process in place for the managed entry of new drugs and the	Horizon-scanning completed jointly with ESHT and prioritised at the Area	GE/ESHT pharmacy lead		

Objective	Actions	By Whom	Investment/ Savings	Timescale
implementation of a Joint Formulary.	Prescribing Committee Process for monitoring implementation of APC recommendations in place	APC GE/APC		
CCGs investment in High cost drugs represents best value for money	Obtain accurate invoice data from providers and patient level data from the Bluteq system to allow validation of invoices from High Cost Drugs Complete annual horizon scanning for new drugs or indications and feed into the providers Commissioning Intentions Explore opportunities with our providers to improve the cost-effectiveness of medicines used e.g. use of biosimilars and approve through the APC	GE/ESHT pharmacy lead APC		Mar 15 Jun 15
2016/17				
Management of risk from expected transfer of specialised commissioning responsibilities from NHS England	Action plan agreed at the Area prescribing committee that covers the clinical and financial risks to the proposed changes.	GE		Mar 16
5. Managing the clinical and financial risks associated with medicines				
2015/16				
Approval of budget setting methodology and Prescribing	Horizon scanning completed and annual, prescribing budget and	GP leads Finance lead		Mar 15

Objective	Actions	By Whom	Investment/ Savings	Timescale
Support Scheme by CCG GBs	workplan agreed at GP prescribing group.	EC/GE		
Promote and monitor NRLS incident reports and One click incident reports	Prescribing newsletter to report identified trends or risks and share learning on how to mitigate those risks.	Provider MSOs		Monthly
Reporting arrangements in place to provide GB with assurance that Medicines Management clinical and financial risks are being managed	Agree Terms of Reference (ToR) for GP prescribing group Provide monthly finance reports to GB Provide minutes and exception reports from the APC to the CCG Quality and Governance Committee Risk register used appropriately and reviewed monthly	Medicines Management team Finance lead GP leads Medicines Management team		Apr Monthly Quarterly Monthly
2016/17				Mar 16
As above - reviewed for annual MO workplan for 2016-17	TBC	Medicines Management team GP Prescribing Group		
Transparent process in place for active consideration of all partnership working across both CCGs	Scope current arrangements for partnership working with the Industry and review policy	EC		Sep 16
2017/18				
As above and reviewed in light of annual MO workplan for 2017-18	TBC	Medicines Management team		Mar 17

Objective	Actions	By Whom	Investment/ Savings	Timescale
		GP Prescribing Group		
6. Developing the workforce to deliver the strategy				
2015/16				
Using MELE and other opportunities to deliver MO education	Pain management – GPs MELE and CPs Respiratory training – practice nurses and GPs delivered through localities 'Deprescribing' and management of polypharmacy in the frail elderly - GPs	KI RP EC		April 2015 Jun 2015 Sep 2015
Pharmacy included in the Primary Care Workforce Strategy	Recruitment and retention to vacancies in Medicines Management team Local pharmacists (community pharmacists and practice/locality employed) developed and skilled to provide the appropriate support to Primary Care	HEKSS LPC EC NH		
Agree business plan for CCG Medicines Management team expansion	Recruit and increase skill mix in Medicines Management team to support the delivery of this strategy	EC	£150K across both CCGs	June 2015
2016/17				
Using MELE and other opportunities to deliver MO	Programme TBC depending on workplan	Medicines Management		

Objective	Actions	By Whom	Investment/ Savings	Timescale
education		team		
Implementation of rotational posts for junior pharmacists	Recruitment and retention to vacancies in Medicines Management team	EC		
2017/18				
Using MELE and other opportunities to deliver MO education	Programme TBC depending on workplan	Medicines Management team		

Appendix 3: Annual Prescribing Workplan for General Practice 2015-16

Therapeutic Area	Potential QIPP Savings* H&R £'000	EHS £'000	Process	Investment	Investment 2015-16 H&R £'000	EHS £'000
Generic Prescribing						
Potential savings from prescribing generically	£135	£25	**PSS 2015-16** Quaterly searches at practice level with specific focus on some dispensing practices			
High qty of Lantoprost eye drops prescribed by brand	£25	£15	CQUIN to improve software in ESHT Opthamology department to allow all letters to switch to the generic version by default	Included in acute contract budget		
GastroIntestinal						
Quality target to reduce high dose PPI prescribing	£0	£0	**Q PSS 2015-16** and new QuAT target			
Switch from Asacol to Octasa	£6	£25	Review formulary chapter and approve at Jun APC			
Lipid Lowering Drugs						
Target outlying practices in both CCGs, particularly around use of Ezetimibe in H&R	£126	£45	**PSS 2015-16** Implementation of Lipid-lowering guidance			
Inhaled Corticosteroids						
Increase use of cost-effective low/moderate dose of inhaled corticosteroids	£100	£100	**PSS CLINICAL REVIEW** 'Review' and 'Step down' tools for High Dose ICS agreed with Respiratory network and approved at Mar APC.			
Antimicrobials						
Quality target to reduce overall prescribing	£0	£0	**Q PSS 2015-16** and contuine QuAT target. Also CQC target and National Quality Premium Target			
Reduce use of Minocycline			Produce guidance and use PSS cost containment plan for high volume practices			
Antidepressants						
Venlafaxine - promote switching from MR to IR	£75	£75	**PSS 2015-16** Joint guidance with SPFT approved at Jan 15 APC			
Promote appropriate use and cost effective antidepressant choices			**PSS 2015-16**			
Benzodiazepines						
Reducing inappropriate use of drugs acting on benzodiazepine receptors	£50		**Q PSS 2015-16** and contuine QuAT target. Also CQC target. In-reach specialist DAAT service to be provided to support practices to treat addicion to prescription drugs	Initial pilot funded through inequality fund in H&R		
Pain management						
Reduce inappropriate use of pregablin (25% in outliers)	£150	£113	**PSS CLINICAL REVIEW** Review of Chronic Pain Management using tools and guidance approved at Jan 15 APC			
			Education events provided through CCG protected learning events			
Reduce inappropriate use of oxycodone MR and Targinact (10% in outliers)	£25	£10	**PSS 2015-16** Develop and agree SOPs for switches to morphine (and laxative) at practice level			
Reduce inapprorpriate use of opioid patches (10% in outliers)	£41	£10	**PSS 2015-16** Promote formulary and further guidance on use of patches			
NSAIDs						
Quality target - focus on outlying practices to reduce use of Coxibs	£6	£2	**Q PSS 2015-16** and contuine QuAT target. Also CQC target			
Urinary frequency						
Increase use of cost-effective treatments	£50	£20	**PSS 2015-16** Formulary review			
Erectile Dysfunction Drugs						
Reduce use of Cialis once-a-day			Formulary review			
Woundcare						
Reduce use of non-formulary dressings and over-ordering of woundcare products (10%)	£115	£37	**PSS 2015-16** Joint formulary across all providers approved at Jun APC and guidance produced on hig-cost areas			
Nutrition						
Reduce inappropriate use of sip feeds (20%)	£70	£70	**PSS 2015-16** Review formulary section and commission in-reach dietetic services to support practices to review prescribing	Funded from contract rebate from Nutricia (£50K)		
Reduce inappropriate use of infant feeds (10%)	£15	£15	**PSS 2015-16**			
Continence						
Reducing inappropriate use of continence products (5% reduction)	£32	£41	**PSS 2015-16**			
Prescribing for Clinical Need						
Reduction in non-formulary Emollients and inappropriatete use (10% red in outliers	£23	£10	Target specific practices			
Reduce use of antifungal nail paint (spending £30k in total)	£1	£8	Target specific practices			
TOTAL Savings	**£1,045**	**£621**	**GP Support Scheme**		**£140**	**£140**

PSS = Prescribing Support Scheme