NHS
North Lincolnshire
Clinical Commissioning Group

Date:	21st June 2018
Meeting:	Governing Body
Item Number:	Item 10.1
Public/Private:	Public ☒ Private ☐

Author: *(Name, Title)*	Jane Ellerton, Head of Strategic Commissioning
GB Lead: *(Name, Title)*	Julie Warren, Chief Operating Officer
Director approval (name)	Julie Warren, Chief Operating Officer
Director Signature	

Report Title:
CCG Programme Briefs
Decisions to be made:
For approval

Continue to improve the quality of services	☒	**Improve patient experience**		☒
Reduced unwarranted variations in services	☒	**Reduce the inequalities gap in North Lincolnshire**		☒
Deliver the best outcomes for every patient	☒	**Statutory/Regulatory**		☐
Purpose (tick one only)	Approval ☒	Information ☐	To note ☐	Decision ☐

Executive Summary (Question, Options, Recommendations):

NL CCG agreed its strategic priorities for 2018/19 in March 2018. These comprise six programmes; Prevention; Primary Care; Acute Commissioning; Out of Hospital Model; Vulnerable People and Medicines Optimisation. Each programme has an identified clinical and managerial lead and programme briefs have been developed for these programmes. A number of these programmes have been further broken down to sub-programme level as set out below.

Programme	**Sub-programmes**
Acute Commissioning	Planned care
	Unplanned care
Primary Care	Estates and Transformation
	Investment
	Local Digital Roadmap
	Recruitment and Retention

	Sustainability
	Out of Hospital
Vulnerable People	Continuing Healthcare
	Mental Health and Learning Disability
Medicines Management	Medicines Optimisation

The brief for the Prevention programme will be finalised once the GP lead for prevention is in post. Delivery of these programmes is monitored by the Programme Delivery Board which meets monthly.

Each programme will be required to identify the quality and financial benefits. At this stage, financial savings, where applicable are described at programme level, however these will be further articulated and profiled within project level plans. This delivery will also be monitored via the Programme Delivery Group.

Recommendations	1. Approval of programme briefs 2. Note that the monitoring of programme delivery is via the Programme Delivery Board	
Report history		
Equality Impact	Yes ☐ No ☒	
Sustainability	Yes ☐ No ☒	
Risk	Yes ☐ No ☒	
Legal	Yes ☐ No ☒	
Finance	Yes ☐ No ☒	

Patient, Public, Clinical and Stakeholder Engagement to date									
	N/A	***Y***	***N***	***Date***		***N/A***	***Y***	***N***	***Date***
Patient:	☐	☐	☒		**Clinical:**	☐	☐	☒	
Public:	☐	☐	☒		**Other:**	☐	☐	☒	

PROGRAMME BRIEF: 2018/19

MANDATORY COMPLETION - FOR APPROVAL TO PRODUCE BUSINESS CASE.

PROGRAMME NAME	Acute Commissioning	**PROJECT NAME :**	Planned	**PROJECT TYPE**	**Richard Young**	**EXPECTED BUSINESS CASE SIZE (S/M/L)**
PROJECT LEAD	Rebecca Bowen	**CLINICAL LEAD :**	Satpal Shekhewat	**EXECUTIVE SPONSOR**		Business cases will be developed at Project Level

A) STRATEGIC CASE & SUMMARY BUSINESS RATIONALE

PROJECT DESCRIPTION	MAIN EVIDENCE BASE	MAIN INTERDEPENDENCIES / WIDER IMPACT

The acute; planned care programme includes a number of workstreams which together will support delivery of the CCG's commissioning intentions and QIPP savings. These workstreams also feature in the NLaG contract programme plan which will support delivery of the desired contract value. All workstreams will ensure that services are safe, efficient, fit for purpose and of high quality.
The workstreams are as follows:
- Gastroenterology
- Demand Management impact on acute to include:
  - ERS & A&G
  - Diabetes
  - Respiratory
  - Cardiology
  - MSK
  - Community Diagnostics
  - Community Gynae +/- Urology
- Daycase to Outpatient
- OP follow up
- Dermatology
- Capacity planning/ RTT (including opportunities within Independant Sector)
- Cancer waits and re-design
- Non - Emergency Patient Transport (NEPT)
- Ophthalmology
- Neurology
- Pathology pricing review
- High Cost Drug review
- Goole NRC review
- Implications of the Grant Thornton review and Utilisation Management audit.
	1) NHS 5 Year Forward View
	
	2) Humber Coast and Vale STP (Mar 2018) Outpatient's Programme
	
	3) NHS E High Impact Change Model - MSK Triage (2017)
	
	4) Humber Acute Services Review
	
	5) GIRFT - Getting it right first time.
	
	6) Rightcare
	
	7) Cancer Strategy Implementation Plan
		Acute Commissioning; Unplanned Programme
		
		Out of Hospital Programme
		
		meds Management programme
		
		Humber Acute Services Review
		
		Planned Care Transformation Boards
		
		Planned Care Board
		
		STP programme Place Based Plan
		
		Vulnerable People Programme
		
		Primary Care Programme
		
		Demand Management Strategy
		
		NLaG Contract Programme and Contract Transformation Board.

OUTLINE OF EXPECTED BENEFITS (TO BE INVESTIGATED FURTHER IN THE BUSINESS CASE)
1. To ensure that patients can access high quality acute planned care services in a timely manner. 2. To ensure that all referrals are in line with local policies and procedures, reducing variation. 3. Capacity is aligned with levels of appropriate demand. 4. Better ouctomes for patients 5. Services commissioned are value for money. 6. Commissioned services are aligned with national and regional workstreams 7. A system wide, shared single version of the truth regarding the NLaG contract.

FIT WITH THE CCG'S STRATEGIC PRIORITIES	
Out of Hospital	Yes
Acute Commissioning	Yes - Unplanned
Prevention	
Primary Care	Yes
Mental Health	
Meds Management	Yes

MAIN ASSUMPTIONS	
1)	That there is sufficient capacity in place to deliver the projects within the programme
2)	That there is sufficuent provider workforce to deliver the services
3)	That the NLaG contract programme will be delivered
4)	That Primary care and Acute will engage in and support delivery of the demand management workstreams
5)	That the trust will reduce capcaity in line with any reducing demands. No unplanned/ not agreed catch up in RTT (otherwise financial risk)
6)	That the NLaG contract will run at PbR for 18/19

B) MANAGEMENT CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

SUMMARY OF KEY STAKEHOLDERS	EXPECTED RESOURCE TO DELIVER THE PROJECT (Commissioning, Contracting, Finance, Engagement etc). PLEASE DISTINGUISH BETWEEN IMPLEMENTATION & ONGOING REQUIREMENTS	HIGH MILESTONES TO COMPLETE THE PROJECT (The Critical Path Only)	TARGET DATES	INITIAL RAG RATING
NLaG(and other acute providers)	Commissioning	Develop NLaG Contract Programme Plan for delivery	20/04/2018	
NEL CCG (and other local commissioners)	Contracting	Initial project PIDs developed for planned care workstreams	01-Jun-18	
Primary Care- General Practice	Finance	PTS reprocurement complete	06-Mar-19	
Independent Sector including Virgin	Comms and Engagement	Electronic referrals Fully rolled out	01-Oct-18	
STP	Business Intelligence	NLaG Contract CVs in place for DC-OP (backdated) and for acute assessment services	01-Jul-18	
Cancer Alliance	Quality & Governance	NLaG contract capacity plan agreed	04-May-18	
NHS E & NHS I	Primary Care	Advice and Guidance in place across all agreed spcialties (possibly be phased)	31-Mar-19	
Public and Patients		Ophthalmology Review Complete	01-Aug-18	
Meds Management		Goole NRC revised specification with agreed approval processes in place and CVd into contract with new local tariffs	01-Jul-18	

C) FINANCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

ESTIMATED SAVINGS (Gross)

Key savings	In Year £'000	FYE £'000	Comments
Recurrent net savings: £594,000 2018/19 net savings £297,000 To be developed further Planned care QIPP targets for 18/19 = £4.1m Overall NLaG contract gap currently £7.4m			
Total Project Savings	**£ 594,000**	**£ 297,000**	

ESTIMATED SUMMARY COSTS (GROSS)

Capital Costs	In Year £'000	FYE £'000	Comments (e.g. Capital Expenditure Funding Availability)
Total Capital Costs	**£**	**£**	

Revenue costs:	In Year £'000	FYE £'000	Comments
Total Revenue Costs	**£**	**£**	
Total Project Costs	**£ -**	**£ -**	
Net Position [Cost /(Savings)]	**£ -**	**£ -**	

D) COMMERCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

PROPOSED PROCUREMENT STRATEGY	EXPECTED CONTRACTUAL ISSUES	KEY DATES START	KEY DATES END

NET PROJECT COST / SAVINGS £'000s	In Year	FYE
	£ 594,000	**£ 297,000**

Sign off

Executive Sponsor (Electronic Sign off)	Clinical Lead (Electronic Sign Off)	Project Lead	Business Case approved For Development - Target Completion Dates

PROGRAMME BRIEF: 2018/19

MANDATORY COMPLETION - FOR APPROVAL TO PRODUCE BUSINESS CASE.

PROGRAMME NAME	Acute Commissioning	**PROJECT NAME :**	Unplanned	**PROJECT TYPE**	**Richard Young**	**EXPECTED BUSINESS CASE SIZE (S/M/L)**
PROJECT LEAD	Rebecca Bowen	**CLINICAL LEAD :**	Neveen Samuel	**EXECUTIVE SPONSOR**		Business cases will be developed at project level

A) STRATEGIC CASE & SUMMARY BUSINESS RATIONALE

PROJECT DESCRIPTION	MAIN EVIDENCE BASE	MAIN INTERDEPENDENCIES / WIDER IMPACT
The acute; unplanned care programme includes a number of workstreams which together will support delivery of the CCGs commissioning intentions and QIPP savings. This will also include development and implementation of the CCG's Unplanned Care vision. Some of these workstreams also feature in the NLaG contract programme plan which will support delivery of the desired contract value. All workstreams will ensure that services are safe, efficient, fit for purpose and of high quality. The workstreams are as follows: - Urgent Treatment Centre (including exisitng A&E, SPA, GPOOHs, PC Streaming, Extended Access & local CAS) - IUC (including 111 and core CAS) - Winter - D2A and Trusted Assessor - Acute Assessment and Management (AEC & Frailty) - Implications of the Grant Thornton review and Utilisation Management audit.	1) NHS 5 Year Forward View 2) Integrated Urgent Care national specification 3) Urgent Treatment Centre standards 4) Humber Acute Services Review 5) GIRFT - Getting it right first time. 6) National Ambulance Response Programe (ARP)	Acute Commissioning; Planned Programme (incl PTS) Out of Hospital Programme (incl NL BCF) Meds Management programme Humber Acute Services Review A&E Delivery Board STP programme - Place BAsed Plan Vulnerable People Programme Primary Care Programme NLaG Contract Programme and Contract Transformation Board. Urgent and Emergency Care Network.

OUTLINE OF EXPECTED BENEFITS (TO BE INVESTIGATED FURTHER IN THE BUSINESS CASE)
1. To ensure that patients can access high quality unplanned care services in a timely manner, appropriate to their clinical need 2. Capacity is aligned with levels of appropriate demand. 3. Better outomes for patients 4. Services commissioned are value for money. 5. Commissioned services are aligned with national and regional workstreams 6. Services that provide appropraite advice to patients with an Unplanned need, in a joined up manner meaning that patient only tell their story once.

FIT WITH THE CCG'S STRATEGIC PRIORITIES	
Out of Hospital	Yes
Acute Commissioning	Yes - planned
Prevention	Yes
Primary Care	Yes
Mental Health	Yes
Meds Management	

MAIN ASSUMPTIONS	
1)	That NLaG will allow another provider on site to deliver the UTC
2)	That providers will engage in year to start to deliver the std within the IUC spec and UTC model prior to full re-commission
3)	That there is sufficient capacity in Primary Care and Community Services to support delivery of a UTC
4)	That the UTC will include Primary Care Extended Access
5)	That the YAS 111 regional contract will be extended should the procurement not complete by April 19 to avoid any gap in service
6)	That Local Authority and wider system partners will engage in development and delivery of the 18/19 winter plan

B) MANAGEMENT CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

SUMMARY OF KEY STAKEHOLDERS	EXPECTED RESOURCE TO DELIVER THE PROJECT (Commissioning, Contracting, Finance, Engagement etc). PLEASE DISTINGUISH BETWEEN IMPLEMENTATION & ONGOING REQUIREMENTS	HIGH MILESTONES TO COMPLETE THE PROJECT (The Critical Path Only)	TARGET DATES	INITIAL RAG RATING
NLaG(and other acute providers)	Commissioning	Urgent treatment Centre in place	01/04/2019	
NEL CCG (and other local commissioners)	Contracting	Acute assessment tariffs agreed and in place	01-Jul-18	
Primary Care- General Practice	Finance	Winter capacity and demand plan submitted	30-Apr-18	
EMAS & YAS (999 & 111)	Comms and Engagement	Regional IUC proccurement complete and service in place	01/04/2019	
STP	Business Intelligence	D2A model finalised an in place for winter	01-Oct-18	
NHS E & NHS I	Quality & Governance	NLaG Contract Programme Plan in place	20-Apr-18	
RdaSH	Primary Care	Service specs in place for non PbR elements of service in NLaG	01-Oct-18	
Public	Procurement			
NL Council				
Other local providers, eg CCL and Safecare				

C) FINANCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

ESTIMATED SAVINGS (Gross)

Key savings	In Year £'000	FYE £'000	Comments
TBC - as QIPP not finalised but anticipated to be £2.7m in the NLaG contract.No clear understanding yet as to capital funding requirements for UTC. NLaG have already received £900k capital for PC Streaming which needs to be utilised for UTC instead.			

Total Project Savings	£ -	£ -

ESTIMATED SUMMARY COSTS (GROSS)

Capital Costs	In Year £'000	FYE £'000	Comments (e.g. Capital Expenditure Funding Availability)
Total Capital Costs	£	£	

Revenue costs:	In Year £'000	FYE £'000	Comments
Total Revenue Costs	£	£	

Total Project Costs	£ -	£ -
Net Position [Cost /(Savings)]	£ -	£ -

D) COMMERCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

PROPOSED PROCUREMENT STRATEGY	EXPECTED CONTRACTUAL ISSUES

KEY DATES	
START	END

NET PROJECT COST / SAVINGS £'000s	In Year	FYE
	£ -	£ -

Sign off

Executive Sponsor (Electronic Sign off)	Clinical Lead (Electronic Sign Off)	Project Lead	Business Case approved For Development - Target Completion Dates

PROJECT BRIEF: 2018/19

MANDATORY COMPLETION - FOR APPROVAL TO PRODUCE BUSINESS CASE.

PROGRAMME NAME	Out of Hospital Programme Brief	PROJECT NAME :	Programme Brief	PROJECT TYPE		EXPECTED BUSINESS CASE SIZE (S/M/L)
PROJECT LEAD	Jane Ellerton	CLINICAL LEAD :	Dr Baig	EXECUTIVE SPONSOR	Julie Warren	L

A) STRATEGIC CASE & SUMMARY BUSINESS RATIONALE

PROJECT DESCRIPTION	MAIN EVIDENCE BASE	MAIN INTERDEPENDENCIES / WIDER IMPACT
This Programme contributes to delivery of the CCG strategic priority for Out of Hospital, increasing provision of community based services and reducing the proportion of care delivered within the hospital setting. It delivers the 2018/19 priority of; defining a new community service model, reconfiguring existing services into care groups (covering prevention, detection and diagnosis, management and rehabilitation), addressing pyhsical mental and social well-being and commissioning for outcomes. The programme has 6 key Projects 1) Recommissioning of Community Services 1.1. Development of business case and model for community based diagnostics 1.2. Development of business case and model for community based gynae, +/- urology 2) Implementation and Review of BCF Plan 3) Implement the MSK High Impact Elective Programme requirements 4)TBD Implementation of community Cardiorespiratory service (prior to procurement) 5) Implement Pathway Improvements across 3 areas 5.1 PSA Shared care; PSA monitoring (prostate cancer high value pathway) 5.2 DVT 5.3 GSF 5.4 SAFE model 6) Review and refresh Intermediate care; future model 6.1 Step up/down provision (Note Weight Management Startegy to sit under prevention)	1) NHS 5 Year Forward view - Out-of-hospital care needs to become a much larger part of what the NHS does. 2) NHS 7 Day Services - The NHS Services, Seven Days a Week Forum developed 10 clinical standards to end variations in outcomes at the weekend. These Priority Clinical Standards are:• Standard 5: Access to Diagnostics 3) Royal College of Obstetricians and Gynaecologists (2011) ..Many investigational procedures such as hysteroscopy can be provided in...community setting, which improves access for women, increases efficiency and reduces cost. 4) The Royal College of Surgeons (2013) Commissioning Guide Rectal Bleeding, Direct access flexible sigmoidoscopy services should be available to primary care. Direct Access Rectal Bleed Services…One stop clinics in… specialist community… may provide good value for patients….. One stop clinics should offer both investigation and treatment. 5) Humber Coast and Vale STP (Mar 2018) Outpatient's Programme The ambition to deliver improvement to the Outpatient system is one of several focus areas across the HCV STP, with core objectives to reduce cost, activity, and improve patient experience at a time of rising demand and increasing cost pressures. 6) NHS E High Impact Change Model - MSK Triage (2017) 7) National programmes e.g. Right Care GIRFT The above policy review is not intended to be an exhaustive list.	Acute Hospital Programme (Planned and Unplanned) Humber Acute Review Planned Care Transformation Boards STP work / CCGs within the STP who are also undergoing reconfiguration Mental Health / Children's and Acute Commissioning Strategy Demand Management Strategy Place Based Plan

OUTLINE OF EXPECTED BENEFITS (TO BE INVESTIGATED FURTHER IN THE BUSINESS CASE)	FIT WITH THE CCG'S STRATEGIC PRIORITIES		MAIN ASSUMPTIONS
The main benefits to this programme are: 1) A more simplified health system - with integrated pathways in a number of key areas 2) A reduced need for planned and unplanned hospital attendances (saving financial resource and freeing up hospital capacity) 3) Better / quicker access to health services for service users (both in community and secondary care) 4) More collaborative working across health and social care for the benefit of the system and service users Recommissioning of Community Services will have the following outcomes to achieve: 1. There will be a more co-ordinated approach and people will have a clear point of contact and only have to tell their story once 2. Service users will receive access to high quality interventions that improve their health and well-being 3. Service users are kept well informed and involved in their care. 4. Service users have excellent access and are highly satisfied with services 5. People will feel able to self-manage and feel empowered to maintain or improve independence and feel an increased connection with the community 6. People living in care homes receive well-coordinated and proactive support, reducing the likelihood of their health deteriorating and care homes are supported 7. People are discharged from hospital in a timely, planned manner, with the right level of support in place 8. Reduced A&E/avoidable unplanned hospital admissions through delivery of community based care 9. Stakeholders have excellent access and high satisfaction with services 10. A reduced number of residents being admitted to care homes	**Out of Hospital**	Yes	1) Activity will divert from Secondary Care to Community and so finance will follow (updated 14/2)
	Acute Commissioning	Yes	2)NLAG will become part of a bigger Acute model/provider in 3-5 years and will focus on Acute work (updated 14/2)
	Prevention		3) MCP / one provider is the future route . ACP terminology to cease (updated 14/2)
	Primary Care		4) Primary Care delivery will focus on core GMS/APMS and so everything else needs be considered as part of community. (updated 14/2)
	Mental Health		5) Integrated Commissioning with NLC will continue (BCF / Intermediate Care)
	Meds Management		6) community based care will cost no more than hospital based care and provide better qualitry of service

B) MANAGEMENT CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

SUMMARY OF KEY STAKEHOLDERS	EXPECTED RESOURCE TO DELIVER THE PROJECT (Commissioning, Contracting, Finance, Engagement etc). PLEASE DISTINGUISH BETWEEN IMPLEMENTATION & ONGOING REQUIREMENTS	HIGH MILESTONES TO COMPLETE THE PROJECT (The Critical Path Only)	TARGET DATES	INITIAL RAG RATING
P&CC / CoM	Commissioning	Community Model and Specs Sign Off	31/03/18	Red
NLC	Quality	Recast community services project plan with revised timescales	04/05/18	
NLAG (Acute & Community)	Business Intelligence	Create Execs high level options paper for MSK compliance	11/05/18	
Service Users	Finance	Community Services Stakeholder engagement conducted	30/05/18	
Independent Community Providers	Primary Care	Community Services Procurement launch	15/06/18	
NHS England	Contracting	Report taken to P&CC on Community Diagnsotics	20/06/18	
Primary Care	Community Services Project Team	Report taken to P&CC on Community Gynae / Urology / Gastro	20/06/18	
	Meds Management	Report taken to P&CC on recommendations for MSK	20/06/18	
	Procurement	Report with recommendations on future of BCF to Execs	30/06/18	
		Implement MSK recommendations / Promote New Pathways	01/07/18	
		Interim community cardiorespiratory service in place	30/718	
		Development of new BCF plan	31/08/18	
		Sign off of new BCF plan	30/09/18	
		Community Services Procurement End	31/10/18	
		Community Services Contract Award	08/11/18	
		Community Services Contract Live Date	01/04/19	

C) FINANCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

ESTIMATED SAVINGS (Gross)

Key savings	In Year £'000	FYE £'000	Comments
Aiming for a c.6% saving on Community Budget (c.£1m) and 10-15% saving on hospital acute activity (c. £250K)			
Total Project Savings	£ -	£ -	

ESTIMATED SUMMARY COSTS (GROSS)

Capital Costs	In Year £'000	FYE £'000	Comments (e.g. Capital Expenditure Funding Availability)
Total Capital Costs	£	£	

Revenue costs:	In Year £'000	FYE £'000	Comments
Total Revenue Costs	£	£	
Total Project Costs	£ -	£ -	
Net Position [Cost /(Savings)]	£ -	£ -	

D) COMMERCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

PROPOSED PROCUREMENT STRATEGY	EXPECTED CONTRACTUAL ISSUES
Community contract: Mixed approach based on care group; Competitive Procurement with Negotiation/ Potential transfer to NLC/ open procurement	

KEY DATES	
START	END

NET PROJECT COST / SAVINGS £'000s	In Year	FYE
	£ -	£ -

Sign off

Executive Sponsor (Electronic Sign off)	Clinical Lead (Electronic Sign Off)	Project Lead	Business Case approved For Development - Target Completion Dates

PROJECT BRIEF: 2018/19

MANDATORY COMPLETION - FOR APPROVAL TO PRODUCE BUSINESS CASE.

PROGRAMME NAME	PC Network Sustainability	**PROJECT NAME :**	Network Sustainability	**PROJECT TYPE**	**Geoff Day**	**EXPECTED BUSINESS CASE SIZE (S/M/L)**
PROJECT LEAD	Erica Ellerington	**CLINICAL LEAD :**	Dr S Modan	**EXECUTIVE SPONSOR**		N/A

A) STRATEGIC CASE & SUMMARY BUSINESS RATIONALE

PROJECT DESCRIPTION	**MAIN EVIDENCE BASE**	**MAIN INTERDEPENDENCIES / WIDER IMPACT**
Key enabler to the development of locality based commissioning and working at scale is the delivery of: Developing PC networks will provide a framework to secure a sustainable model of PC and enable locality based commissioning. In line with NHS Operational Planning guidance delivery of Extended Access to general practice will be in two phases: Commissioning of interim service for extended access - Q3 2018/19 Commissioning of permanent model for extended access - Q4 2018/19.	NHS Operational Planning guidance GPFV as supported by NL CCG Patient Consultation 2017	The development of the Urgent Treatment Centre Outcome of full procurement GP OOH e-consult

OUTLINE OF EXPECTED BENEFITS (TO BE INVESTIGATED FURTHER IN THE BUSINESS CASE)	**FIT WITH THE CCG'S STRATEGIC PRIORITIES**		**MAIN ASSUMPTIONS**
Improved access and increased choice for patients to PC Better use of clinical capacity. Reduction in unplanned activity. Reduced pressure on general practice (enhanced staff retention) Compliance with national directives.	**Out of Hospital**	Yes	**I1) increase in unplanned activity out of hospital**
	Acute Commissioning	Yes	**2) reduction in unplanned activity in hospital.**
	Prevention	Yes	**3) Improves access to LTC clinics out of hours**
	Primary Care	Yes	**4) Builds capacity and enhances patient access**
	Mental Health		**5)**
	Meds Management		**6)**

B) MANAGEMENT CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

SUMMARY OF KEY STAKEHOLDERS	**EXPECTED RESOURCE TO DELIVER THE PROJECT (Commissioning, Contracting, Finance, Engagement etc.). PLEASE DISTINGUISH BETWEEN IMPLEMENTATION & ONGOING REQUIREMENTS**	**HIGH MILESTONES TO COMPLETE THE PROJECT (The Critical Path Only)**	**TARGET DATES**	**INITIAL RAG RATING**
General Practice - Clinicians, Practice Managers etc,	Finance - implementation and ongoing; Engagement - Implementation and Ongoing; Commissioning - Implementation and Ongoing; Quality - Implementation and Ongoing; IM&T - implementation and ongoing; Contracting - implementation and ongoing; Procurement - implementation;	Extended access interim contract	Q3 2018/19	
Patients		Extended access full contract	Q4 2018/19	
Partner organisations e.g. community services / NLaG		PC sustainability plan	Q4 2018/19	
NHSE				
eMBED				

C) FINANCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

ESTIMATED SAVINGS (Gross)

Key savings	**In Year £'000**	**FYE £'000**	**Comments**
£3.34 per weighted population for interim contract - £630,936 PM Development monies - £4500.00 Resilience monies - £3,000.00			

Total Project Savings	**£ 638,436**	**£ -**

ESTIMATED SUMMARY COSTS (GROSS)

Capital Costs	**In Year £'000**	**FYE £'000**	**Comments (e.g. Capital Expenditure Funding Availability)**
Total Capital Costs	**£**	**£**	

Revenue costs:	**In Year £'000**	**FYE £'000**	**Comments**
Total Revenue Costs		**£**	

Total Project Costs	**£ 638,436**	**£ -**
Net Position [Cost /(Savings)]	**£ -**	**£ 638,436**

D) COMMERCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

PROPOSED PROCUREMENT STRATEGY
Interim contract - VEAT notice **Permanent contract - full market procurement**

EXPECTED CONTRACTUAL ISSUES
derstanding of implications of achieving a single contract model from APMS and National Standard Contr

KEY DATES	
START	**END**
01/04/2018	31/03/2019

NET PROJECT COST / SAVINGS £'000s	**In Year**	**FYE**
	£ 638,436	**£ -**

Sign off

Executive Sponsor (Electronic Sign off)	**Clinical Lead (Electronic Sign Off)**	**Project Lead**	**Business Case approved For Development - Target Completion Dates**

PROJECT BRIEF: 2018/19

MANDATORY COMPLETION - FOR APPROVAL TO PRODUCE BUSINESS CASE.

PROGRAMME NAME	Estates and Technology	**PROJECT NAME :**		**PROJECT TYPE**		**EXPECTED BUSINESS CASE SIZE (S/M/L)**
PROJECT LEAD	Chris Clarke	**CLINICAL LEAD :**	Dr Salim Modan	**EXECUTIVE SPONSOR**	**Geoff Day**	

A) STRATEGIC CASE & SUMMARY BUSINESS RATIONALE

PROJECT DESCRIPTION	**MAIN EVIDENCE BASE**		**MAIN INTERDEPENDENCIES / WIDER IMPACT**
Developing an estates strategy for primary medical care in North Lincolnshire to enable the prioritisation of schemes to be developed. To ensure premises are fit for purpose and used appropriately, which delivers value for money. Supports the delivery of the primary care strategy	CCG Estates stratgey		CCG service strategies: Primary care Out of Hospital Financial Planning LA development proposals
OUTLINE OF EXPECTED BENEFITS (TO BE INVESTIGATED FURTHER IN THE BUSINESS CASE)	**FIT WITH THE CCG'S STRATEGIC PRIORITIES**		**MAIN ASSUMPTIONS**
Flexible and fit for purpose premises that enable delivery of the CCG service strategies The ability to prioritise schemes for development - invetsment of monies	**Out of Hospital**	Yes	**1) Gives intelligence around capacity and flexibility to deliver services across the health and care system**
	Acute Commissioning	Yes	**2)Gives intelligence around capacity and flexibility to deliver services across the health and care system**
	Prevention	Yes	**3)Gives intelligence around capacity and flexibility to deliver services across the health and care system**
	Primary Care	Yes	**4)Gives intelligence around capacity and flexibility to deliver services across the health and care system**
	Mental Health	Yes	**5)Gives intelligence around capacity and flexibility to deliver services across the health and care system**
	Meds Management		**6)**

B) MANAGEMENT CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

SUMMARY OF KEY STAKEHOLDERS	**EXPECTED RESOURCE TO DELIVER THE PROJECT (Commissioning, Contracting, Finance, Engagement etc). PLEASE DISTINGUISH BETWEEN IMPLEMENTATION & ONGOING REQUIREMENTS**	**HIGH MILESTONES TO COMPLETE THE PROJECT (The Critical Path Only)**	**TARGET DATES**	**INITIAL RAG RATING**
General Practice	GP practices - Implementation	**Strategic review primary care estate**	**Jul-18**	
NHS property Services	LA planning -Ongoing			
NHS England	Finance - implementation			
3rd party Developers	Primary care directorate - Implementation			
Patients and Public				

C) FINANCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

ESTIMATED SAVINGS (Gross)

Key savings	**In Year £'000**	**FYE £'000**	**Comments**
No saving identified			
Total Project Savings	**£ -**	**£ -**	

ESTIMATED SUMMARY COSTS (GROSS)

Capital Costs	**In Year £'000**	**FYE £'000**	**Comments (e.g. Capital Expenditure Funding Availability)**
Total Capital Costs	**£**	**£**	

Revenue costs:	**In Year £'000**	**FYE £'000**	**Comments**
Total Revenue Costs	**£**	**£**	NHSE transformation funding has been sourced to deliver the strategy

Total Project Costs	**£ -**	**£ -**
Net Position [Cost /(Savings)]	**£ -**	**£ -**

D) COMMERCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

PROPOSED PROCUREMENT STRATEGY	**EXPECTED CONTRACTUAL ISSUES**
Not relevant at this stage	None

KEY DATES	
START	**END**
Apr-18	Mar-19

NET PROJECT COST / SAVINGS £'000s	**In Year**	**FYE**
	£ -	**£ -**

Sign off

Executive Sponsor (Electronic Sign off)	**Clinical Lead (Electronic Sign Off)**	**Project Lead**	**Business Case approved For Development - Target Completion Dates**

PROJECT BRIEF: 2018/19

MANDATORY COMPLETION - FOR APPROVAL TO PRODUCE BUSINESS CASE.

PROGRAMME NAME	PC Investment	**PROJECT NAME :**	Investment	**PROJECT TYPE**	**Geoff Day**	**EXPECTED BUSINESS CASE SIZE (S/M/L)**
PROJECT LEAD	Helen Phillips / Erica Ellerington	**CLINICAL LEAD :**	Dr S Modan	**EXECUTIVE SPONSOR**		N/A

A) STRATEGIC CASE & SUMMARY BUSINESS RATIONALE

PROJECT DESCRIPTION	**MAIN EVIDENCE BASE**	**MAIN INTERDEPENDENCIES / WIDER IMPACT**
Recognising the pressures being faced by PC and the opportunities afforded by the investment set out in the GP forward view, this project aims to maximise the use of those funds to deliver a transformed and sustainable PC and improve access. Below the key elements of the programme are outlined: 1 £3 per head transformational fund 2 PMS reinvestment 3 resilience funding	GPFV Soft intelligence from GP access survey and other sources.	Recruitment and retention Engagement from practices around the transformation agenda Development of care networks Development of out of hospital programme (reliant upon a list size, sustainable, at scale PC service)

OUTLINE OF EXPECTED BENEFITS (TO BE INVESTIGATED FURTHER IN THE BUSINESS CASE)	**FIT WITH THE CCG'S STRATEGIC PRIORITIES**		**MAIN ASSUMPTIONS**
Greater clinical job satisfaction Improved recruitment and retention Improved and extended access for patients Sustainable PC fit for the future Better outcomes for patients	**Out of Hospital**	Yes	**1) Development of out of hospital programme (reliant upon a list size, sustainable, at scale PC service)**
	Acute Commissioning		**2)**
	Prevention		**3)**
	Primary Care	Yes	**4) In line with GPFV investment plans**
	Mental Health		**5)**
	Meds Management		**6)**

B) MANAGEMENT CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

SUMMARY OF KEY STAKEHOLDERS	**EXPECTED RESOURCE TO DELIVER THE PROJECT (Commissioning, Contracting, Finance, Engagement etc.). PLEASE DISTINGUISH BETWEEN IMPLEMENTATION & ONGOING REQUIREMENTS**	**HIGH MILESTONES TO COMPLETE THE PROJECT (The Critical Path Only)**	**TARGET DATES**	**INITIAL RAG RATING**
General Practice	Finance - Implementation; Engagement - Ongoing; Commissioning - Ongoing; Quality - Ongoing; IM&T - ongoing;	£3 per head	Q4 2019/20	
Patients		PMS reinvestment	Q4 2018/19	
Partner organisations e.g. community services		Resilience funding	Q3 2018/19	
NHSE		Online consultation	Q4 2018/19	
		Prescribing course	Q2 2018/19	

C) FINANCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

ESTIMATED SAVINGS (Gross)

Key savings	**In Year £'000**	**FYE £'000**	**Comments**
PMS premium reinvestment £123k 17/18 and 18/19 Resilience funding - TBC Online consultation - £49,224.45 2018/19 Prescribing course - TBC			
Total Project Savings	**£ 172,224**	**£ -**	

ESTIMATED SUMMARY COSTS (GROSS)

Capital Costs	**In Year £'000**	**FYE £'000**	**Comments (e.g. Capital Expenditure Funding Availability)**
Total Capital Costs	**£**	**£**	

Revenue costs:	**In Year £'000**	**FYE £'000**	**Comments**
Total Revenue Costs	**£ 172,224**	**£**	
Total Project Costs	**£ 172,224**	**£ -**	
Net Position [Cost /(Savings)]	**£ -**	**£ 172,224**	

D) COMMERCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

PROPOSED PROCUREMENT STRATEGY
Direct investment into PC aligned to the GPFV in the main does not require procurement. The exception in this programme has been the online consulting programme where an STP wide procurement has been undertaken.

EXPECTED CONTRACTUAL ISSUES
N/A

KEY DATES	
START	**END**
1/4/208	31/03/2020

NET PROJECT COST / SAVINGS £'000s	**In Year**	**FYE**
	£ 172,224	**£ -**

Sign off

Executive Sponsor (Electronic Sign off)	**Clinical Lead (Electronic Sign Off)**	**Project Lead**	**Business Case approved For Development - Target Completion Dates**

PROJECT BRIEF: 2018/19

MANDATORY COMPLETION - FOR APPROVAL TO PRODUCE BUSINESS CASE.

PROGRAMME NAME	Local Digital Roadmap (primary care)	**PROJECT NAME :**		**PROJECT TYPE**		**EXPECTED BUSINESS CASE SIZE (S/M/L)**
PROJECT LEAD	John Mitchell	**CLINICAL LEAD :**	Dr Salim Modan	**EXECUTIVE SPONSOR**	**Geoff Day**	

A) STRATEGIC CASE & SUMMARY BUSINESS RATIONALE

PROJECT DESCRIPTION	**MAIN EVIDENCE BASE**	**MAIN INTERDEPENDENCIES / WIDER IMPACT**
A comittment to make best use of information technology to improve patient acces and make best use of clincical capacity: This work is braodly split into thse key elements: e consult Electronic refrral e discharge Patient online GP connect Enhanced Summary Care Record	National directive - link with John.	Implementation of GP forward view, out of hospital care and the care networks eMBED delivery board LDR work on integrated records

OUTLINE OF EXPECTED BENEFITS (TO BE INVESTIGATED FURTHER IN THE BUSINESS CASE)	**FIT WITH THE CCG'S STRATEGIC PRIORITIES**		**MAIN ASSUMPTIONS**
TBC	**Out of Hospital**	Yes	1) This programme will enable sharing of patient inormation to aid decisoin making and make most appropriate use of clinical time. E conslut will support people to more effectively access appropriate health and care services.
	Acute Commissioning	Yes	2)This programme will enable sharing of patient inormation to aid decisoin making and make most appropriate use of clinical time
	Prevention	Yes	3)This programme will enable sharing of patient inormation to aid decisoin making and make most appropriate use of clinical time. E conslut will support people to more effectively access appropriate health and care services.
	Primary Care	Yes	4)This programme will enable sharing of patient inormation to aid decisoin making and make most appropriate use of clinical time. E conslut will support people to more effectively access appropriate health and care services.
	Mental Health	Yes	5)This programme will enable sharing of patient inormation to aid decisoin making and make most appropriate use of clinical time. E conslut will support people to more effectively access appropriate health and care services.
	Meds Management	Yes	6)This programme will enable sharing of patient inormation to aid decisoin making and make most appropriate use of clinical time. Clinicians will have improved ability to make decisions around appropriate prescribing, with access to the full patient record.

B) MANAGEMENT CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

SUMMARY OF KEY STAKEHOLDERS	**EXPECTED RESOURCE TO DELIVER THE PROJECT (Commissioning, Contracting, Finance, Engagement etc). PLEASE DISTINGUISH BETWEEN IMPLEMENTATION & ONGOING REQUIREMENTS**	**HIGH MILESTONES TO COMPLETE THE PROJECT (The Critical Path Only)**	**TARGET DATES**	**INITIAL RAG RATING**
General Practice	GP practices - Ongoing			
System suppliers	Acute/Community providers -Ongoing			
LDR Board	Finance - implementation			
eMBED/NHS digital	Primary care directorate - Ongoing			
Patients and Public	eMBED - contracting Engagement - ongoing (large) CCG IT management	**Systems go live**	**Mar-19**	

C) FINANCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

ESTIMATED SAVINGS (Gross)

Key savings	**In Year £'000**	**FYE £'000**	**Comments**
TBC			
Total Project Savings	**£ -**	**£ -**	

ESTIMATED SUMMARY COSTS (GROSS)

Capital Costs	**In Year £'000**	**FYE £'000**	**Comments (e.g. Capital Expenditure Funding Availability)**
Total Capital Costs	**£**	**£**	

Revenue costs:	**In Year £'000**	**FYE £'000**	**Comments**
Total Revenue Costs	**£**	**£**	
Total Project Costs	**£ -**	**£ -**	
Net Position [Cost /(Savings)]	**£ -**	**£ -**	

D) COMMERCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

PROPOSED PROCUREMENT STRATEGY	**EXPECTED CONTRACTUAL ISSUES**
STP wide procurement for econsult concluded.	From October 18 E-referral will be part of the GP contract

KEY DATES	
START	**END**

NET PROJECT COST / SAVINGS £'000s	**In Year**	**FYE**
	£ -	**£ -**

Sign off

Executive Sponsor (Electronic Sign off)	**Clinical Lead (Electronic Sign Off)**	**Project Lead**	**Business Case approved For Development - Target Completion Dates**

PROJECT BRIEF: 2018/19

MANDATORY COMPLETION - FOR APPROVAL TO PRODUCE BUSINESS CASE.

PROGRAMME NAME	PC Recruitment and Retention	**PROJECT NAME :**	Recruitment and Retention	**PROJECT TYPE**	**Geoff Day**	**EXPECTED BUSINESS CASE SIZE (S/M/L)**
PROJECT LEAD	Helen Phillips	**CLINICAL LEAD :**	Dr S Modan	**EXECUTIVE SPONSOR**		N/A

A) STRATEGIC CASE & SUMMARY BUSINESS RATIONALE

PROJECT DESCRIPTION	**MAIN EVIDENCE BASE**	**MAIN INTERDEPENDENCIES / WIDER IMPACT**
Recruitment and retention of PC staff is under increasing pressure, this workstream aims to take advantage of the investment available through the GP forward view to support increasing the workforce and the opprotunity to look at skill mix within GP practices. Below are the key elements of the programme: 1 Workforce strategy 2 International Recruitment 3 Clinical Pharmacist Programme	GPFV Soft intelligence from GP access survey and other sources.	Recruitment and retention Engagement from practices around the transformation agenda Development of care networks Development of out of hospital programme (reliant upon a list size, sustainable, at scale PC service)

OUTLINE OF EXPECTED BENEFITS (TO BE INVESTIGATED FURTHER IN THE BUSINESS CASE)	**FIT WITH THE CCG'S STRATEGIC PRIORITIES**		**MAIN ASSUMPTIONS**
Improved recruitment and retention Improved and extended access for patients Sustainable PC fit for the future Better outcomes for patients Greater clinical job satisfaction	**Out of Hospital**	Yes	**1) Development of out of hospital programme (reliant upon a list size, sustainable, at scale PC service)**
	Acute Commissioning		**2)**
	Prevention		**3)**
	Primary Care	Yes	**4) In line with GPFV investment plans**
	Mental Health		**5)**
	Meds Management		**6)**

B) MANAGEMENT CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

SUMMARY OF KEY STAKEHOLDERS	**EXPECTED RESOURCE TO DELIVER THE PROJECT (Commissioning, Contracting, Finance, Engagement etc.). PLEASE DISTINGUISH BETWEEN IMPLEMENTATION & ONGOING REQUIREMENTS**	**HIGH MILESTONES TO COMPLETE THE PROJECT (The Critical Path Only)**	**TARGET DATES**	**INITIAL RAG RATING**
General Practice	Finance - funding available through GPFV; Engagement - Ongoing; Commissioning - Ongoing; Quality - Ongoing; IM&T - ongoing;	Workforce strategy to inform future programme of work	Q4 2019/20	
Patients		GPs willing to work in North Lincolnshire from Europe	Q4 2018/19	
Partner organisations e.g. community services		Practice / Locality engagement into the Clinical Pharmacist Programme	Q3 2018/19	
NHSE			Q4 2018/19	
			Q2 2018/19	

C) FINANCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

ESTIMATED SAVINGS (Gross)

Key savings	**In Year £'000**	**FYE £'000**	**Comments**
There are no identified savings however with a more resilient workforce patients should be able to seek healthcare closer to home reducing the reliance on acute presentations at hospital and GP OOH			

Total Project Savings	**£ 172,224**	**£ -**

ESTIMATED SUMMARY COSTS (GROSS)

Capital Costs	**In Year £'000**	**FYE £'000**	**Comments (e.g. Capital Expenditure Funding Availability)**
Total Capital Costs	**£468k**	**£**	Funding approved by NHS E GPFV monies based on 13

Revenue costs:	**In Year £'000**	**FYE £'000**	**Comments**
Total Revenue Costs	**£**	**£**	

Total Project Costs	**£ -**	**£ -**
Net Position [Cost /(Savings)]	**£ -**	**£ -**

D) COMMERCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

PROPOSED PROCUREMENT STRATEGY
The recruitment agency used for International Recruitment has already been through a procurement process for HCV STP. No other procurement is required.

EXPECTED CONTRACTUAL ISSUES
N/A

KEY DATES	
START	**END**
1/4/208	31/03/2020

NET PROJECT COST / SAVINGS £'000s	**In Year**	**FYE**
		£ -

Sign off

Executive Sponsor (Electronic Sign off)	**Clinical Lead (Electronic Sign Off)**	**Project Lead**	**Business Case approved For Development - Target Completion Dates**

PROJECT BRIEF: 2018/19

MANDATORY COMPLETION - FOR APPROVAL TO PRODUCE BUSINESS CASE.

PROGRAMME NAME	Continuing Health Care	**PROJECT NAME :**		**PROJECT TYPE**	**John Pattinson**	**EXPECTED BUSINESS CASE SIZE (S/M/L)**
PROJECT LEAD	Patrick Bowen	**CLINICAL LEAD :**	Faisel Baig	**EXECUTIVE SPONSOR**		L

A) STRATEGIC CASE & SUMMARY BUSINESS RATIONALE

PROJECT DESCRIPTION	MAIN EVIDENCE BASE	MAIN INTERDEPENDENCIES / WIDER IMPACT
Achieving the national framework metrics *Reducing the number of false fast tracks* *Review capacity and demand* *Reviewing business admin to support the back office functions including personal health budgets and direct payments* *Data analysis and development of an approved provider list in partnership with the local authority* *Trialling a compliance app with a view to establishing that as a quality improvement and compliance tool for individual placements*	*NHS planning guidance* *Population profile* *Transforming Care* *National service framework for CHC* *Right to request (PHBDP)*	QIPP delivery Local Authority - as people are moved out of hospital into individual placements there will be a potential impact on LA. Community Servces Review

OUTLINE OF EXPECTED BENEFITS (TO BE INVESTIGATED FURTHER IN THE BUSINESS CASE)	FIT WITH THE CCG'S STRATEGIC PRIORITIES		MAIN ASSUMPTIONS
Attainment of the national service metrics *Reduction in cost* *Quality improvements*	**Out of Hospital**	YES	**1) We will keep people at home for as long as possible using a community based model, weherever that can meet their needs.**
	Acute Commissioning	YES	**2) This will impact on inpatient flows through effective use of discharge pathways**
	Prevention	YES	**3) Reducing the non elective activity from the care home sector**
	Primary Care	YES	**4) Through the enhanced care home framework there is likely to be a closer link between primary care and people who are eligible for CHC**
	Mental Health	NO	**5) No direct impact**
	Meds Management	NO	**6) no direct impact**

B) MANAGEMENT CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

SUMMARY OF KEY STAKEHOLDERS	EXPECTED RESOURCE TO DELIVER THE PROJECT (Commissioning, Contracting, Finance, Engagement etc). PLEASE DISTINGUISH BETWEEN IMPLEMENTATION & ONGOING REQUIREMENTS	HIGH MILESTONES TO COMPLETE THE PROJECT (The Critical Path Only)	TARGET DATES	INITIAL RAG RATING
CCG	*Commissioning - potentially 2 band 6 WTE fixed term*	**Review capacity and demand top reprofile resources and fidelity to the national framework delivery**	**End of Q1**	
LA	Finance - Meduim impact	**Data analysis and market management for approved provider lists**	**Early Q3**	
RDaSH	Contracting - Medium impact	**Discharge pathways to reduce false fast tracks**	**End of Q1**	
STP	Comms and Engagement - Low	**Redesign of discharge pathways complete**	**End of Q2**	
EMAS	Business Intelligence - Medium	**Achieving the national service metrics**	**End of Q3**	
NLAG	Quality - Medium	**Review of business admin and identify internal efficiences for back office functions**	**End of Q2**	
Public				
Independent sector				

C) FINANCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

ESTIMATED SAVINGS (Gross)

Key savings	In Year £'000	FYE £'000	Comments
Circa £1.9M through reduction in fast tracks and operating efficiences			

Total Project Savings	**£ 1,900,000**	**£ 1,900,000**

ESTIMATED SUMMARY COSTS (GROSS)

Capital Costs	In Year £'000	FYE £'000	Comments (e.g. Capital Expenditure Funding Availability)
Total Capital Costs	**£ 45,000**	**£45,000**	

Revenue costs:	In Year £'000	FYE £'000	Comments
Total Revenue Costs	**£**	**£**	

Total Project Costs	**£ 45,000**	**£ 45,000**
Net Position [Cost /(Savings)]	**£ -**	**£ 45,000**

D) COMMERCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

PROPOSED PROCUREMENT STRATEGY	EXPECTED CONTRACTUAL ISSUES
Develop approved provider list	Potential for contract disputes on an individual basis

KEY DATES	
START	END
Apr-18	Mar-19

NET PROJECT COST / SAVINGS £'000s	In Year	FYE
	£ 1,855,000	**£ 1,855,000**

Sign off

Executive Sponsor (Electronic Sign off)	Clinical Lead (Electronic Sign Off)	Project Lead	Business Case approved For Development - Target Completion Dates

PROJECT BRIEF: 2018/19

MANDATORY COMPLETION - FOR APPROVAL TO PRODUCE BUSINESS CASE.

PROGRAMME NAME	Mental Health and LD	PROJECT NAME :		PROJECT TYPE		EXPECTED BUSINESS CASE SIZE (S/M/L)
PROJECT LEAD	Samantha Helmick	CLINICAL LEAD :	Faisel Baig	EXECUTIVE SPONSOR	John Pattinson	L

A) STRATEGIC CASE & SUMMARY BUSINESS RATIONALE

PROJECT DESCRIPTION	MAIN EVIDENCE BASE	MAIN INTERDEPENDENCIES / WIDER IMPACT
1) Transforming care - reducing number of people in hospital beds with LD by the end of March 2019 (CCG target is 3 people- currently 5). *2) Review of service contract for mental health with RDaSH and have agreed changes to be implemented in Q1 2018/19 - these include:* *- Eating disorders for CAMHS* *- under 5's for ASD* *- IAPT Cluster* *- Dementia Pathways* *- ADHD & ASD* *- Community Mental Health Teams* *3) Urgent Care Crisis response - all age & Psychiatric Liaison* *4) Case Management: Out of Area placements including PICU and Individual Placements - reduced expenditure (currently placing 85 people at cost of £7.2M per year, Aim to reduce the number of people being placed and bring spend down to circa £3.5M* *5) Perinatal Mental Health* *6) Strategic review with the local authority - system redesign looking at univerasl targetted and specialist support arrangements.*	*NHS planning guidance* *FYFV* *Population profile* *Transforming Care* *Crisis Care Concordat*	QIPP delivery Local Authority - as people are moved out of hospital into individual placements there will be an impact on LA. Development of the Urgent Treatment Centre Acute Commissioning - Unplanned Care Programme A&E Delivery Board NLaG Contract Programme & Contract Transformation Board STP Programme - Place Based Plan

OUTLINE OF EXPECTED BENEFITS (TO BE INVESTIGATED FURTHER IN THE BUSINESS CASE)	FIT WITH THE CCG'S STRATEGIC PRIORITIES		MAIN ASSUMPTIONS
Bettter value for money - invest in more local services in line with FYFV *Deliver care that maximises people's independence*	Out of Hospital	YES	1) We will keep people at home for as long as possible using a community based model
	Acute Commissioning	YES	2) Better support for people who are in acute hospital setting with mental health related problems
	Prevention	YES	3) Preventing unneccesary urgent demand through A+E
	Primary Care	NO	4) No direct impact
	Mental Health	YES	5) Helping to support individuals to reach their optimum level of functioning and maximum level of independence
	Meds Management	YES	6) Reducing number of anti pyschotics used for people with a LD.

B) MANAGEMENT CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

SUMMARY OF KEY STAKEHOLDERS	EXPECTED RESOURCE TO DELIVER THE PROJECT (Commissioning, Contracting, Finance, Engagement etc). PLEASE DISTINGUISH BETWEEN IMPLEMENTATION & ONGOING REQUIREMENTS	HIGH MILESTONES TO COMPLETE THE PROJECT (The Critical Path Only)	TARGET DATES	INITIAL RAG RATING
CCG (s)	Commissioning	**Service reviews complete**	**End of Q1**	
LA	Finance	**Review of all individual placements**	**End of Q2**	
RDaSH	Contracting	**Review of strategic commissioning direction by the end of Q3**	**End of Q3**	
Police	Comms and Engagement	**Rehab and recovery model established within the local mental health sysetm**	**End of Q4**	
MIND & other independent sector	Business Intelligence			
NLAG	Quality			
Public				
STP & TCP				
EMAS				

C) FINANCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

ESTIMATED SAVINGS (Gross)

Key savings	In Year	FYE	Comments
		£'000	
£1.86M - Based on estimated savings by reducing individual placements and responsible commissioner disputes.			

Total Project Savings	£1,860,000	£ -

ESTIMATED SUMMARY COSTS (GROSS)

Capital Costs	In Year	FYE	Comments (e.g. Capital Expenditure Funding Availability)
	£'000	£'000	
Total Capital Costs	£	£	No new costs

Revenue costs:	In Year	FYE	Comments
	£'000	£'000	
Total Revenue Costs	£	£	

Total Project Costs	£ -	£ -

Net Position [Cost /(Savings)]	£ -	£ -

D) COMMERCIAL CASE (TO BE DETAILED FURTHER IN THE BUSINESS CASE)

PROPOSED PROCUREMENT STRATEGY	EXPECTED CONTRACTUAL ISSUES
N/A	Differences over activity levels for IAPT May need to rebase activity levels following the Scotter merger

KEY DATES	
START	END
Apr-18	Mar-19

NET PROJECT COST / SAVINGS £'000s	In Year	FYE
	£ 1,860,000	£ -

Sign off

Executive Sponsor (Electronic Sign off)	Clinical Lead (Electronic Sign Off)	Project Lead	Business Case approved For Development - Target Completion Dates

Partners in improving local health

North of England Commissioning Support

NECS At Scale Approaches to Medicines Optimisation QIPP 2018/2019

Introduction

With increasing pressure on prescribing budgets many CCGs are facing the same issues in trying to change prescribing practice and patient behaviour in order to reduce demand and tackle rising costs.

NHS England has proposed a cost increase to overall primary care budgets of 1.9% to account for inflation for 2018/19; the Horizon Scanning document[1] has recommended applying a 1% cost efficiency[2] to this for QIPP to allow for a final uplift to prescribing budgets between 0% and 1% on outturn. Actual QIPP cost efficiency savings targets should be determined locally based on current spend, anticipated pressures arising from an increased focus on treating patients in the community and ongoing cost savings initiatives.

Current and previous years QIPP delivery by NECS and in-house CCG medicine optimisation (MO) teams has led to a decrease in cost growth and the key question is whether this can be sustained going forward as many of the quick wins have now been exhausted.

Continued cost efficiency delivery is now proving difficult due to the increasing number of conditions established drugs are being used for, and there is significant financial risk due to generic drug supply issues caused by supply constraints, targeted switch programmes and exchange rate shifts following the Brexit vote.

As NECS MO provides support to 16 CCGs, there is huge potential to benefit from joint working across the NECS footprint with a coherent approach providing consistent messaging, reductions in duplication and helping to address unwarranted variation.

One of the key elements with any initiative is deciding where to focus the limited resources available to implement any initiatives to deliver the greatest impact and provide efficiencies through joint production and sharing of implementation tactics and approaches.

This paper sets out the proposal for a common approach to therapeutic areas where there is an opportunity to tackle them at scale.

Background and current approaches

Over previous years there have been opportunities to identify and switch medication to alternatives with a lower acquisition cost within the same therapeutic class. However, much

[1] North East and North Cumbria Horizon Scanning Document 2018- 2019. Key Considerations for CCG Commissioners published in December 2017 by NECS MO and Regional Drug and Therapeutics Centre (RDTC)

[2] Cost efficiency is the savings target is the proposed % FOTT for 2017/18 that will be delivered as a reduction in expenditure in 2018/19

of the easier switch work has now been done meaning that savings from switches is either more involved or simpler switch options are much more limited.

In the coming financial year (2018/19) there will be no windfall savings as significant as those from the Lyrica® (pregabalin) patent expiry (initial potential savings calculated as £371,233 per 100,000 population) but there may be some more limited savings[3] from a small number of patents that have recently expired (see below):

Brand (drug)	Patent expiry date	Expected windfall
Crestor® (rosuvastatin)	December 2017	£34,000 per 100,000 population
Cialis® (tadalafil)	November 2017	£20,000 per 100,000 people
Levitra® (vardenafil)	October 2018	£2,000 per 100,000 people

Nationally, between November 2016 and October 2017, the average Net Ingredient Cost (NIC) per prescription item was £8.18, and over the year the NIC per patient was £153.26. Putting these figures into context, every £500k of QIPP saving would require the equivalent of completely stopping 61,120 prescriptions, or stopping all prescribing for 3260 people.

Existing ongoing cost saving initiatives will continue to be delivered and include:

- Primary care rebates schemes
- Core MO work focusing on inappropriate Red Drug prescribing in primary care
- Unnecessary specially prepared unlicensed medicines (specials) and high cost drugs
- Full year or rollover savings figures
- Savings from decision support software applications
- Polypharmacy reviews

Deprescribing as part of a polypharmacy reviews, as a quality intervention, can have considerable benefits for an individual patient. However, delivery of significant savings needs to be carefully balanced with staff utilisation and delivery of other initiatives. This can be successfully delivered in the care home setting as well as within GP practice settings. Potential savings based on work undertaken by NECS MO show that for each full time[4] pharmacist annual savings of over £110k prescribing savings can be delivered in the care home setting. In addition, the theoretical costs associated with prevention of adverse drug events through harm prevention, add further quality and safety which in previous work was estimated to be between £188 and £425 per review[5]. Similar GP practice based reviews have been shown to deliver savings in excess of £50k per wte[4] pharmacist per year.

There are a number of initiatives in place or in development through existing NECS MO work such as:

- PbR excluded High Cost Drugs
- Electronic repeat dispensing,
- Reduction in the prescribing of gluten free products,

[3] Savings are predicated on the generic availability and a change in Drug Tariff category
[4] Savings estimated based on one wte spending 2/3rds of their time on medication reviews.
[5] Estimated cost avoidance based on ScHARR model and work undertaken by NECS MO in 2015. Costs avoided associated with potential hospitalisation or additional treatment costs associated with severity of potential adverse drug event avoided

- Wound care product supply,
- Oral nutritional support.

The NHS RightCare approach supports CCGs in identifying prescribing and other cost savings for specific clinical pathways, aiming to reduce unwarranted variation. Identifying initiatives for the prescribing aspects of the pathways can support CCGs in tackling them.

Additionally, there are ongoing quality initiatives that do not release an obvious saving to the prescribing budget, but can influence CCG budgets, clinician time, hospital admissions and other savings to the wider healthcare economy. These include the NHSE Quality Premium scheme for antimicrobial stewardship, and Electronic Repeat Dispensing.

Given the size of this task, new approaches are needed to tackle spend in order to change prescribing behaviours and patient demand whilst ensuring that the right medication is prescribed to the right person, for the right condition, at the right time. By doing this high quality cost-effective prescribing is built into the system whilst at the same time driving out waste.

Discussion

In November 2017 NECS invited input from stakeholders (prescribers, medicines optimisation staff, CCG and practice staff) via an online survey to assist with informing the priorities for the 2018-19 QIPP plan. The top 5 areas, which respondents highlighted that they felt intervention would be welcome, were in order:

1. Polypharmacy Medication reviews
2. Managed Repeats & Waste
3. Pain Review
4. ONS
5. Respiratory

In addition to this, and to inform the potential saving opportunities data provided by PrescQIPP from 115 indicators (Appendix 1) has been reviewed at individual CCG level[6]. This allows common areas across the CCGs to be identified and common approaches to tackle the identified issues developed. The final choice of indicators has been chosen based on the collective CCG benefit from moving into the top quartile.

With some indicators there is considerable overlap particularly where an indicator looks at a therapeutic area as a whole whilst another indicator targets a specific drug within that same field.

With this in mind however it is possible to rank the indicators in order of potential benefit as calculated by PrescQIPP and then group high ranking indicators within the same therapeutic area.

The full range of indicators from PrescQIPP can be seen in appendix 2 ranked in order of the collective saving opportunities.

[6] The choice of indicators has been chosen based on collective CCG benefit from moving into top quartile.

Tackling the top 20* indicators

*Of the 115 indicators, the global indicators of "Items per 1,000 Astro PU" and "NIC per Astro PU" are naturally placed highest up the ranking as these cover all prescribing and this paper focusses on the next top 20 highest ranked indicators.

Table 1 - Top 20* indicators with the highest collective benefit if initiatives are delivered so that prescribing expenditure is equivalent to the top national quartile (25th percentile) expenditure

Rank	Therapeutic Area	Indicator
1	Global Indicator	Items per 1,000 Astro PU
2	Global Indicator	NIC per Astro PU
3	Stoma & Incontinence	Stoma products cost per 1,000 patients
4	Dressings	Dressings cost per 1,000 patients
5	Self Care	Selfcare ALL
6	Stoma & Incontinence	Continence products cost per 1,000 patients
7	Oral Nutrition	Sip feeds cost per 1,000 patients
8	Self Care	Analgesia excl. POM & cough/cold remedies
9	Analgesia	Opioids cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU
10	Oral Nutrition	Infant feeds cost per 1,000 patients UNDER 5 (excl. tube & sip)
11	Self Care	Upset Stomach
12	Urology	Drugs for urinary incontinence (BNF 7.4.2) cost per 1,000 cost based Astro PUs
13	Analgesia	Oxycodone MR cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU
14	Appliances	Drop-List Devices ALL
15	Urology	Generic sildenafil as a % of all PDE5 inhibitors for ED
16	Specials	Total specials cost per 1,000 patients
17	Diabetes	Blood glucose testing strips cost per 1,000 QoF registered patients with diabetes mellitus aged over 17 (2015/16)
18	Analgesia	Opioid patches cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU
19	Analgesia	Nefopam cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU
20	Self Care	Antihistamines (POM)
21	Respiratory	Low/moderate dose ICS/LABA inhalers as a % of all ICS/LABA inhalers
22	Appliances	Anal Irrigation System

From this table it is possible to see that there are some therapeutic areas with a number of indicators in the top 20 meaning these could be tackled together as part of a single initiative. At the same time, the therapeutic area approach could take into account other indicators in the top 50 and could be considered at the same time.

Table 2 – Top 20* indicators for potential savings grouped with other indicators for the same therapeutic area but within the top 52 indicators

Therapeutic Area	Indicators in top 22 for potential savings (note top 2 are global indicators)	Rank	Indicators to be considered at same time (as are in top 52)	Rank
Stoma/ continence	Stoma products cost per 1,000 patients	3	-	-
	Continence products cost per 1,000 patients	6	-	-
Dressings	Dressings cost per 1,000 patients	4	-	-
Self care	Selfcare ALL	5	Emollients cost per 1,000 patients	29
	Analgesia excl. POM & cough/cold remedies	8	Emollients (OTC)	30
	Upset Stomach	11	HeartBurn and Indigeston	32
	Antihistamines (POM)	20	Conjunctivitis	40
	-		Nasal Sprays (OTC)	47
	-		Travel Sickness	49
			Antihistamines (OTC)	51
Analgesia	Opioids cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU	9	Gabapentin and pregabalin cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU	25
	Oxycodone MR cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU	13	Lidocaine patch (versatis, lidoderm)	24
	Nefopam cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU	19	Fentanyl immediate release formulations	35
	Opioid patches cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU	18	Low cost opioid patches as a % of all opioid patches	45
	-		Oxycodone/naloxone (targinact)	52
Oral nutrition	Sip feeds cost per 1,000 patients	7	Preferred powdered ONS as a % of all sip feeds	27
	Infant feeds cost per 1,000 patients UNDER 5 (excl. tube & sip)	10	Gluten free cost per 1,000 patients	36
Urology	Drugs for urinary incontinence (BNF 7.4.2) cost per 1,000 cost based Astro PUs	12	Tadalafil (cialis once-a-day)	34
	Generic sildenafil as a % of all PDE5 inhibitors for ED	15	Low cost drugs for urinary incontinence as a	42

			% of all drugs for urinary incontinence (BNF 7.4.2)	
Appliances	Drop-List Devices ALL	14	Lymphoedema Garments	31
	Anal Irrigation System	22	-	-
Specials	Total specials cost per 1,000 patients	16	Special order products cost per 1,000 patients	23
			Drug tariff special order products cost per 1,000 patients	33
Diabetes	Blood glucose testing strips cost per 1,000 QoF registered patients with diabetes mellitus aged over 17 (2015/16)	17	Generic metformin as a % of all anti-diabetic drugs (BNF 6.1.2)	28
	-		NPH intermediate acting insulin as a % of all intermediate and long acting insulins	44
	-		NPH biphasic as a % of all biphasic insulins	48
Respiratory	Low/moderate dose ICS/LABA inhalers as a % of all ICS/LABA inhalers	21	Least costly low/moderate dose ICS/LABA inhaler as a % of all low/moderate dose ICS/LABA inhalers	43

At Scale Approach

Given the identified areas where there is most potential for savings, NECS will be scoping the potential in developing a suite of materials to support QIPP in the following areas:

- Self-Care
- Oral Nutrition
- Wound care products
- Analgesia
- Urology
- Appliances
- Specials
- Diabetes
- Respiratory
- Stoma/ Incontinence
- Prescribing Processes

In order to reduce unnecessary duplication this will look at work already done across the 16 CCGs where Medicines Optimisation Services are provided by NECS, alongside resources available elsewhere, such as PrescQIPP, to develop resource packs to support the delivery of each QIPP initiative in an identified therapeutic areas. These resource packs will include a range of supporting materials such as; standard operating procedures (SOPs) to drive consistency; key performance indicators to measure and monitor progress; communication media such as posters and leaflets; policies; and project plans to facilitate implementation at a local level.

Each CCG can identify which initiatives will be of most benefit to them by using the PrescQIPP figures for their individual CCG as shown in appendix 2 ; this will allow a mix and match approach to meet the priorities of individual CCGs.

It is expected that initiative packs will be ready for the beginning of the 2018/19 financial year.

Actual cost efficiency delivery will be based on local circumstance, current spend, anticipated pressures arising and capacity to implement initiatives to deliver cost saving efficiencies in 2018/19. It should also be noted that potential savings in the table are only for indicative purposes and not all of these savings will be able to be released.

CCGs may continue with existing ongoing cost saving initiatives as part of their existing QIPP plan such as:

- Primary care rebates schemes
- Core MO work focusing on inappropriate Red Drug prescribing in primary care
- Unnecessary specially prepared unlicensed medicines (specials) and high cost drugs
- Full year or rollover savings figures
- Savings from decision support software applications
- Polypharmacy reviews

Additionally work will be implemented as per the guidance published for CCGs on items which should not be routinely prescribed in primary care https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/ and the consultation on prescribing over the counter medicines which has just been announced https://www.engage.england.nhs.uk/consultation/over-the-counter-items-not-routinely-prescribed/.

Other medicines optimisation work plan project areas include:

- Biosimilars opportunity utilisation - Ensure the health economy benefits from further increased usage of biosimilar biologics. In 2018/2019 there is the launch of the adalimumab biosimilar and further utilisation of infliximab, rituximab and etanercept biosimilars offer savings.
- High cost drugs – Ensure necessary challenges to PbR excluded drugs/ High Cost Drug recharges from secondary care providers. NECS have produced a QIPP 'Menu of Opportunities' for all CCGs to choose and this is an area for inclusion in this. Ensure alignment to National Tariff guidance related to PbR excluded drugs
- OptimiseRx – Clinical decision support software optimisation - The project is aiming to achieve the cost effective and quality QIPP savings from the use of OptimiseRx. Delivering patient-specific best practice, safety and cost-saving guidance to local prescribers. OptimiseRx combines evidence-based best practice, safety and cost-effective prescribing messages, delivered in real time at the point of care. Innovative and intelligent, OptimiseRx is seamlessly integrated with the prescribing workflow of the clinical system, providing healthcare professionals with guidance based on individual patient record.

- Reviewing the clinical and cost effectiveness of medicines in different therapeutic areas; reviewing and implementing changes in low priority medicines, reducing polypharmacy and medicines wastage.

North Lincolnshire Proposed Medicines Optimisation Work Plan 2018/2019

Ref	Therapeutic area	Description (Indicators in top 22 for potential savings)	Opportunity (with assumed change rate) (£)	Aspirational Opportunity (100%) (£)
1	**Analgesia**	Opioids cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU	33,428 (15%)	222,854
		Lidocaine patch (versatis, lidoderm)	1,364 (20%)	6,821
		Opioid patches cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU	TBC*	224,861
2	**Stoma/ continence**	Stoma products cost per 1,000 patients	TBC *	720,498
		Continence products cost per 1,000 patients	TBC *	366,277
3	**Dressings**	Dressings cost per 1,000 patients	TBC*	799,161
4	**Low priority medicines** https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/	Tadalafil (cialis once-a-day)	14,261 (20%)	71,305
		Liothyronine	3,724 (20%)	18,620
		Oxycodone/naloxone (targinact)	1,867 (20%)	9,338
		Lutein and antioxidant vitamins	1,447 (20%)	7,239
		Tramacet (combination product paracetamol with tramadol)	1,853 (20%)	9,266
		Rubefacients	2,018 (20%)	10,090
5	**Oral nutrition**	Sip feeds cost per 1,000 patients	TBC *	350,858
		Infant feeds cost per 1,000 patients UNDER 5 (excl. tube & sip)	21,887 (20%)	109,439
		Gluten free cost per 1,000 patients	21,803 (40%)	54,509
6	**Self-care**	Self-care (All)	32,919 (10%)	329,195
7	**Core work (specials, red drugs, high cost drugs, and unspecified drug codes)**	Specials, red drugs, high cost drugs, and unspecified drug codes. This core work will also include some elements of ongoing opportunities as identified by the cost efficiency calculator	239,832	239,832

8	**Pharmaceutical Rebates**	CCG approved rebates	30,561	61,121
9	**Primary Care Prescribing Medicines Optimisation - roll through from 2017/2018**	Primary Care Prescribing Medicines Optimisation - roll through from 2017/2018	309,461	309,461
10	**Biosimilars opportunity utilisation**	Ensure the health economy benefits from further increased usage of biosimilar biologics. In 2018/2019 there is the launch of the adalimumab biosimilar and further utilisation of infliximab, rituximab and etanercept biosimilars offer savings. **NB: This is dependent on secondary care engagement**	150,000	150,000
11	**High cost drugs**	challenges/checks relevant to PbR excluded/high costs drugs	TBC *	
12	**OptimiseRx**	Clinical decision support software optimisation	TBC	TBC
13	**Antibiotics**	As per Quality Premium	Quality area - direct prescribing savings not significant	
14	**Polypharmacy reviews**	Reviewing the clinical and cost effectiveness of medicines in different therapeutic areas; reviewing and implementing changes in low priority medicines, reducing polypharmacy and medicines wastage.	TBC	
15	**Electronic repeat dispensing**	Support to CCG for practices to implement electronic repeat dispensing		
			866,425	3,920,745

TBC * - These are longer term projects and savings opportunity is dependent on actions developed and implemented from the NECS QIPP group.

Recommendation

The CCG executives are asked:

1. If they wish to be included in the at scale QIPP initiative
2. To consider a 1.9% uplift on forecast outturn in line with Horizon Scanning Document recommendations
3. To set a cost efficiency of a minimum 1% of forecast outturn[1]
4. To approve the proposed medicines optimisation work plan for 2018/19 project areas

Appendix 1 – 115 Indicators

Rank	Indicator
1	Items per 1,000 Astro PU
2	NIC per Astro PU
3	Stoma products cost per 1,000 patients
4	Dressings cost per 1,000 patients
5	Selfcare ALL
6	Continence products cost per 1,000 patients
7	Sip feeds cost per 1,000 patients
8	Analgesia excl. POM & cough/cold remedies
9	Opioids cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU
10	Infant feeds cost per 1,000 patients UNDER 5 (excl. tube & sip)
11	Upset Stomach
12	Drugs for urinary incontinence (BNF 7.4.2) cost per 1,000 cost based Astro PUs
13	Oxycodone MR cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU
14	Drop-List Devices ALL
15	Generic sildenafil as a % of all PDE5 inhibitors for ED
16	Total specials cost per 1,000 patients
17	Blood glucose testing strips cost per 1,000 QoF registered patients with diabetes mellitus aged over 17 (2015/16)
18	Opioid patches cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU
19	Nefopam cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU
20	Antihistamines (POM)
21	Low/moderate dose ICS/LABA inhalers as a % of all ICS/LABA inhalers
22	Anal Irrigation System
23	Special order products cost per 1,000 patients
24	Lidocaine patch (versatis, lidoderm)
25	Gabapentin and pregabalin cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU
26	Generic low cost statins as a % of all statins
27	Preferred powdered ONS as a % of all sip feeds
28	Generic metformin as a % of all anti-diabetic drugs (BNF 6.1.2)
29	Emollients cost per 1,000 patients
30	Emollients (OTC)
31	Lymphoedema Garments
32	HeartBurn and Indigeston
33	Drug tariff special order products cost per 1,000 patients
34	Tadalafil (cialis once-a-day)
35	Fentanyl immediate release formulations
36	Gluten free cost per 1,000 patients
37	Low cost quetiapine MR as a % of all quetiapine MR
38	Liothyronine
39	DROP-List ALL
40	Conjunctivitis
41	Generic latanoprost (including combinations) as a % of of prostaglandin eye drops
42	Low cost drugs for urinary incontinence as a % of all drugs for urinary incontinence (BNF 7.4.2)
43	Least costly low/moderate dose ICS/LABA inhaler as a % of all low/moderate dose ICS/LABA inhalers
44	NPH intermediate acting insulin as a % of all intermediate and long acting insulins
45	Low cost opioid patches as a % of all opioid patches

Generic standard release atypical antipsychotics as a % of all atypical antipsychotics
Nasal Sprays (OTC)
NPH biphasic as a % of all biphasic insulins
Travel Sickness
Other lipid regulating drugs BNF 2.12 subset as a % of total items BNF 2.12
Antihistamines (OTC)
Oxycodone/naloxone (targinact)
Unspecified specials cost per 1,000 patients
Least costly insulin (less than #6 per 100) disposable needles as a % of all insulin disposable needles
Co-proxamol
Travel vaccines not prescribable on NHS
Stoma Garments
Low cost blood glucose testing strips (less than #9 per 50 strips) as a % of all strips
Generically available dementia drugs as a % of all dementia drugs (BNF 4.11)
Skin Rash
Eflornithine cream (vaniqua) for hirsutism
Blood ketone testing strips cost per 1,000 QoF registered patients with diabetes mellitus aged over 17 (2015/16)
Gluten free items excl. all bread, flour & mixes cost per 1,000 patients
Vitamins and minerals
Head Lice & Scabies
Omega-3 and other fish oils
Lutein and antioxidant vitamins
Quetiapine standard release as a % of all quetiapine items (Chem Sub 0402010AB)
Deodorants
Rubefacients
Dental products on FP10
Cannabis sativa
Dry Mouth Products
Low cost blood glucose testing strips (less than £10 per 50 strips) as a % of all strips
Eczema
Fungal Infection
Plantar Pressure Offloading Devices
Doxazosin MR
Dosulepin
Cough and cold remedies
Tramacet (combination product paracetamol with tramadol)
Biosimilar insuline glargine (abasaglar) as a % of all insuline glargine (excl. high dose)
Silk Garments
Inhalation Solutions
Colic
Generic gabapentin as a % of all gabapentin / pregabalin
Ear Wax Softening Medical Devices
Aliskiren (rasilez)
Haemorrhoid treatments (excl. POM)
Oscillating Positive Expiratory Pressure Device
Urine testing strips cost per 1,000 QoF registered patients with diabetes mellitus aged over 17 (2015/16)
Probiotics
Nasal Products
Glucosamine

95 Sunscreens
96 Coversyl arginine and branded coversyl
97 Minocycline for acne
98 Amiodarone
99 Other Appliances
100 Sleep Problems
101 Cold Sore
102 Eye Compress
103 Complementary therapies
104 Threadworm
105 Auto Inflation Device
106 Insert For Female Stress Incont
107 Cycloidal Vibration Accessories
108 Pelvic Toning Devices
109 Head Lice Device
110 Needle-Free Insulin Delivery System
111 Bacterial Decolonisation Products
112 Belladonna Adhesive Plaster
113 Acne Treatment
114 Inspiratory Muscle Training Devices
115 Electrical Stimulating Wound Device

Appendix 2 – potential benefit from moving into to quartile for each indicator. Note there is considerable overlap between some indicators meaning benefit may be double counted. Zero saving is given where CCGs are already in the top 25% for that indicator.

Therapeutic Area	PrescQipp Indicator	CALDERDALE cost avoidance	CALDERDALE ranking	DARLINGTON cost avoidance	DARLINGTON ranking	DDES cost avoidance	DDES ranking	EAST RIDING OF YORKSHIRE cost avoidance	EAST RIDING OF YORKSHIRE ranking	HaST cost avoidance	HaST ranking	HULL cost avoidance	HULL ranking	MORECAMBE BAY cost avoidance	MORECAMBE BAY ranking	NEWCASTLE GATESHEAD cost avoidance	NEWCASTLE GATESHEAD ranking	NORTH CUMBRIA cost avoidance	NORTH CUMBRIA ranking	NORTH DURHAM cost avoidance	NORTH DURHAM ranking	NORTH EAST LINCOLNSHIRE cost avoidance	NORTH EAST LINCOLNSHIRE ranking	NORTH LINCOLNSHIRE cost avoidance	NORTH LINCOLNSHIRE ranking	NORTH TYNESIDE cost avoidance	NORTH TYNESIDE ranking	NORTHUMBERLAND cost avoidance	NORTHUMBERLAND ranking	SOUTH TEES cost avoidance	SOUTH TEES ranking	SOUTH TYNESIDE cost avoidance	SOUTH TYNESIDE ranking	SUNDERLAND cost avoidance	SUNDERLAND ranking	Sum of collective financial benefit	Rank of collective financial benefit
Stoma & Incontinence	Stoma products cost per 1,000 patients	£377,971	5	£215,540	5	£860,993	4	£1,001,000	3	£261,749	7	£637,874	5	£953,041	3	£947,850	6	£984,149	3	£844,114	3	£372,079	4	£720,498	4	£379,419	5	£619,851	4	£832,805	3	£287,438	6	£875,468	3	£11,171,339	3
Stoma & Incontinence	Continence products cost per 1,000 patients	£137,948	13	£270,903	4	£669,618	6	£409,318	6	£294,021	6	£86,576	22	£777,670	5	£737,641	8	£379,265	6	£363,309	7	£155,834	9	£366,277	5	£499,981	3	£815,218	3	£663,270	5	£151,970	10	£665,742	5	£7,444,511	6
Dressings	Dressings cost per 1,000 patients	£580,928	3	£303,393	3	£959,089	3	£204,977	12	£544,413	4	£0	85	£887,397	4	£1,589,730	3	£603,624	4	£620,325	4	£851,254	3	£799,161	3	£0	66	£0	71	£266,466	11	£388,218	5	£654,600	6	£9,233,575	4
Self Care	Self care ALL	£270,594	6	£187,612	7	£776,035	5	£511,092	5	£650,624	3	£656,057	4	£117,401	12	£1,283,310	4	£422,772	5	£532,030	5	£42,305	18	£329,195	7	£390,529	4	£424,279	5	£811,962	4	£430,324	3	£870,453	4	£8,706,574	5
Self Care	Analgesia excl. POM & cough/cold remedies	£109,122	16	£84,389	13	£352,083	8	£176,670	15	£252,833	8	£243,177	7	£281,226	7	£793,440	7	£230,881	9	£300,121	8	£59,556	15	£114,812	17	£273,744	6	£376,534	6	£294,178	10	£219,425	8	£455,923	8	£4,618,114	8
Self Care	Upset Stomach	£42,860	30	£43,002	24	£249,558	11	£136,689	16	£235,390	9	£98,432	20	£63,030	18	£453,432	9	£116,774	11	£137,815	17	£19,842	26	£64,318	22	£251,435	8	£231,898	10	£221,539	14	£187,764	9	£271,916	10	£2,875,694	11
Self Care	Antihistamines (POM)	£108,696	17	£17,645	31	£71,179	28	£119,636	19	£76,415	23	£158,462	13	£15,553	31	£231,839	15	£77,418	19	£81,862	26	£33,467	22	£44,099	27	£25,072	24	£60,197	21	£99,589	18	£27,694	22	£152,957	18	£1,401,779	20
Self Care	Emollients cost per 1,000 patients	£49,817	26	£93,111	12	£82,471	26	£76,505	23	£113,689	16	£116,938	16	£0	75	£0	78	£0	75	£41,119	35	£0	69	£17,436	38	£0	66	£0	71	£226,460	13	£28,818	20	£0	85	£846,365	29
Self Care	Emollients (OTC)	£44,436	28	£59,196	19	£100,918	23	£116,215	20	£92,184	20	£166,948	12	£0	75	£0	78	£0	75	£31,127	37	£0	69	£23,484	31	£0	66	£0	71	£159,478	16	£8,830	39	£0	85	£802,815	30
Self Care	Heartburn and Indigestion	£15,865	48	£7,999	37	£44,095	33	£93,129	21	£46,047	25	£62,029	25	£28,813	26	£6,794	55	£91,396	13	£16,007	51	£18,052	27	£130,468	14	£5,882	36	£14,083	34	£69,595	27	£209	76	£23,726	37	£674,190	32
Self Care	Conjunctivitis	£15,946	47	£8,412	36	£27,016	38	£17,877	38	£24,666	30	£16,564	44	£16,085	29	£54,013	28	£28,352	25	£22,902	42	£9,878	32	£22,268	32	£11,454	30	£30,052	28	£37,507	34	£18,240	25	£18,043	40	£379,274	40
Self Care	Nasal Sprays (OTC)	£0	93	£0	77	£15,795	46	£23,056	37	£20,448	32	£4,598	59	£20,968	27	£42,416	32	£8,713	38	£18,040	46	£9,848	33	£11,244	45	£16,942	28	£27,363	29	£27,704	36	£13,678	29	£9,805	48	£270,617	47
Self Care	Travel Sickness	£4,611	66	£2,671	47	£27,919	36	£8,656	51	£16,533	36	£3,798	62	£10,845	38	£30,492	36	£8,307	40	£20,012	43	£5,864	42	£7,595	50	£12,544	29	£22,186	32	£20,875	38	£14,727	28	£32,410	33	£250,044	49
Self Care	Antihistamines (OTC)	£41,991	32	£4,699	41	£26,763	39	£8,921	50	£13,971	40	£0	85	£0	75	£19,690	40	£12,441	32	£16,176	50	£1,966	52	£7,445	51	£5,951	35	£10,124	35	£18,391	41	£11,347	31	£6,189	58	£206,045	51
Analgesia	Opioids cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STARPU	£198,531	8	£46,286	22	£245,272	12	£334,820	7	£206,280	10	£228,017	9	£91,205	16	£395,293	10	£61,960	21	£197,690	12	£83,657	10	£222,854	9	£178,167	10	£176,957	12	£455,017	7	£67,952	14	£254,163	12	£3,444,120	9
Analgesia	Oxycodone MR cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STARPU	£32,564	34	£65,239	18	£129,056	20	£213,477	10	£111,197	18	£241,175	8	£29,822	24	£222,362	16	£87,623	15	£87,692	25	£36,969	21	£137,430	13	£77,553	15	£122,445	14	£217,937	15	£135,366	11	£189,360	15	£2,137,266	13
Analgesia	Opioid patches cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STARPU	£67,605	22	£94,372	11	£196,061	14	£317,559	8	£170,424	11	£269,828	6	£96,540	15	£0	78	£0	75	£45,623	32	£0	69	£224,861	8	£0	66	£0	71	£140,304	17	£0	81	£0	85	£1,623,176	18
Analgesia	Nefopam cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STARPU	£27,220	36	£16,545	33	£85,894	24	£5,548	59	£124,666	14	£25,371	35	£0	75	£143,920	22	£78,188	18	£205,220	11	£11,042	31	£13,016	42	£214,008	9	£243,192	9	£82,541	22	£229,524	7	£88,877	19	£1,594,770	19
Analgesia	Lidocaine patch (versatis, lidoderm)	£68,907	21	£148,338	9	£73,565	27	£49,965	29	£117,242	15	£74,647	23	£12,247	35	£104,649	24	£8,611	39	£143,592	16	£0	69	£6,821	54	£62,961	18	£76,941	18	£99,227	19	£7,342	43	£22,305	38	£1,077,359	24
Analgesia	Gabapentin and pregabalin cost per 1,000 Total Analgesics (BNF 4.7.1. & 4.7.2) COST based STARPU	£0	93	£0	77	£600,838	7	£0	85	£0	79	£0	85	£0	75	£0	78	£0	75	£381,314	6	£0	69	£0	85	£73,744	17	£0	71	£0	88	£0	81	£0	85	£1,056,896	25
Analgesia	Fentanyl immediate release formulations	£31,642	35	£659	66	£105,627	21	£0	85	£39,980	26	£0	85	£0	75	£8,403	50	£87,192	16	£27,776	39	£0	69	£2,210	68	£50,661	21	£76,033	19	£73,320	25	£17,411	27	£51,352	25	£572,265	35
Analgesia	Low cost opioid patches as a % of all opioid patches	£0	93	£0	77	£0	84	£0	85	£16,901	35	£0	85	£0	75	£30,759	35	£0	75	£0	87	£0	69	£32,977	29	£39,296	22	£55,467	22	£64,705	28	£4,192	51	£33,887	32	£278,183	45
Analgesia	Oxycodone/naloxone (targinact)	£8,694	56	£15,639	34	£5,362	58	£14,961	45	£12,495	42	£1,999	67	£0	75	£25,177	38	£294	67	£31,123	38	£0	69	£9,338	48	£0	66	£0	71	£36,281	35	£28,396	21	£9,944	47	£199,705	52
Oral Nutrition	Sip feeds cost per 1,000 patients	£523,110	4	£188,613	6	£312,186	10	£646,051	4	£136,015	12	£775,866	3	£215,605	8	£960,714	5	£59,933	22	£93,008	24	£298,731	5	£350,858	6	£765,878	7	£358,814	7	£656,539	6	£389,505	4	£509,821	7	£6,741,247	7
Oral Nutrition	Infant feeds cost per 1,000 patients UNDER 5 (excl. tube & sip)	£0	93	£104,876	10	£336,942	9	£205,330	11	£403,091	5	£181,590	11	£106,764	13	£303,552	12	£238,722	8	£219,378	9	£224,322	7	£109,439	18	£85,414	13	£309,299	8	£319,334	9	£1,593	59	£210,886	14	£3,360,532	10
Oral Nutrition	Preferred powdered ONS as a % of all sip feeds	£48,371	27	£0	77	£0	84	£73,971	24	£12,071	43	£47,153	29	£33,469	22	£205,534	17	£72,199	20	£0	87	£76,307	13	£88,456	19	£73,804	16	£81,768	16	£4,310	63	£64,219	15	£65,450	23	£947,083	27
Oral Nutrition	Gluten free cost per 1,000 patients	£63,327	23	£12,053	35	£25,792	40	£60,185	26	£35,171	27	£58,947	27	£19,551	28	£35,327	34	£0	75	£27,647	40	£8,135	37	£54,509	23	£33,636	23	£41,403	24	£40,807	32	£13,468	30	£26,186	35	£556,143	36
Urology	Drugs for urinary incontinence (BNF 7.4.2) cost per 1,000 cost based Astro Pils	£142,230	11	£17,264	32	£164,842	15	£242,829	9	£129,708	13	£156,848	14	£0	75	£270,579	13	£0	75	£129,898	20	£38,183	19	£174,967	11	£119,091	11	£80,722	17	£378,705	8	£25,728	23	£178,640	17	£2,250,234	12
Urology	Generic sildenafil as a % of all PDE5 inhibitors for ED	£96,603	18	£58,877	20	£142,043	16	£189,850	14	£99,536	19	£134,022	15	£96,661	14	£169,491	21	£81,219	17	£207,579	10	£37,669	20	£128,062	16	£60,765	19	£185,680	11	£88,714	21	£79,039	13	£181,322	16	£2,036,631	15
Urology	Tadalafil (cialis once-a-day)	£21,384	41	£27,143	28	£57,290	32	£90,822	22	£19,258	33	£45,103	30	£0	75	£4,878	58	£0	75	£116,907	21	£28,888	23	£71,305	21	£0	66	£1,957	56	£27,481	37	£24,520	24	£77,321	22	£614,257	34
Urology	Low cost drugs for urinary incontinence as a % of all drugs for urinary incontinence (BNF 7.4.2)	£18,308	46	£0	77	£0	84	£48,459	30	£16,245	37	£48,487	28	£0	75	£0	78	£0	75	£0	87	£0	69	£88,302	20	£0	66	£0	71	£98,029	20	£9,899	35	£27,107	34	£354,836	42
Appliances	Drug List Devices ALL	£111,658	15	£75,222	14	£129,373	19	£53,513	28	£64,685	24	£109,938	17	£208,837	9	£197,847	18	£332,765	7	£179,185	13	£4,041	44	£0	83	£82,679	14	£113,871	15	£80,759	23	£10,660	33	£316,883	9	£2,071,916	14
Appliances	Anal Irrigation System	£43,939	29	£65,523	17	£150,732	18	£46,903	31	£83,872	22	£0	85	£60,428	19	£111,083	23	£89,569	14	£133,520	18	£0	69	£0	83	£51,103	20	£68,653	20	£54,917	30	£11,337	32	£264,916	11	£1,216,496	22
Appliances	Lymphoedema Garments	£62,321	24	£7,691	38	£0	84	£8,285	54	£0	79	£108,146	18	£147,011	11	£41,378	33	£208,577	10	£17,459	47	£24,210	25	£0	83	£18,108	27	£43,283	23	£882	74	£3,993	52	£43,997	27	£730,340	31
Specials	Total specials cost per 1,000 patients	£213,167	7	£162,011	8	£238,058	13	£61,333	25	£0	79	£92,343	21	£0	75	£384,635	11	£0	75	£157,952	15	£250,049	6	£44,537	26	£0	66	£0	71	£74,533	24	£0	81	£23,738	36	£1,702,355	16
Specials	Special order products cost per 1,000 patients	£157,363	10	£96,949	21	£84,300	25	£59,064	27	£0	79	£32,238	33	£36,815	21	£236,922	14	£0	75	£109,188	22	£223,175	8	£23,901	30	£0	66	£0	71	£37,943	33	£4,556	50	£46,285	26	£1,108,698	23
Specials	Drug tariff special order products cost per 1,000 patients	£21,142	42	£35,454	25	£135,189	17	£16,557	41	£29,475	29	£61,408	26	£0	75	£193,008	19	£0	75	£48,206	31	£27,660	24	£11,269	44	£0	66	£17,678	33	£42,225	31	£6,744	44	£6,585	57	£652,600	33
Diabetes	Blood glucose testing strips cost per 1,000 QoF registered patients with diabetes mellitus age cover 17 (2015/16)	£87,660	20	£0	77	£64,025	31	£124,536	18	£86,880	21	£105,745	19	£599,591	6	£80,802	26	£0	75	£131,113	19	£80,059	12	£164,759	12	£0	66	£0	71	£58,125	29	£0	81	£82,539	20	£1,665,834	17
Diabetes	Generic metformin as a % of all anti-diabetic drugs (BNF 6.1.2)	£140,301	12	£34,187	26	£27,252	37	£128,376	17	£14,737	39	£188,218	10	£0	75	£0	78	£11,681	33	£0	87	£61,745	14	£129,087	15	£0	66	£0	71	£0	88	£98,262	12	£53,768	24	£887,615	28
Diabetes	NPH intermediate acting insulin as a % of all intermediate and long acting insulins	£4,946	64	£3,154	45	£13,882	47	£6,502	56	£0	79	£0	85	£0	75	£0	78	£0	75	£63,682	28	£83,301	11	£35,454	28	£0	66	£0	71	£19,753	39	£51,598	16	£12,926	41	£295,198	44
Diabetes	NPH biphasic as a % of all biphasic insulins	£20,586	43	£6,688	40	£0	84	£34,864	34	£0	79	£20,426	41	£0	75	£0	78	£28,619	24	£13,414	53	£58,289	16	£51,305	24	£0	66	£0	71	£0	88	£34,653	18	£0	85	£268,844	48
Respiratory	Low/moderate dose ICS/LABA inhalers as a % of all ICS/LABA inhalers	£25,954	37	£32,605	27	£65,095	30	£0	85	£112,224	17	£0	85	£0	75	£179,702	20	£0	75	£97,156	23	£0	69	£0	83	£103,980	12	£158,694	13	£233,294	12	£32,780	19	£233,540	13	£1,275,024	21
Respiratory	Least costly low/moderate dose ICS/LABA inhaler as a % of all low/moderate dose ICS/LABA inhalers	£2,492	75	£3,266	43	£0	84	£0	85	£20,726	31	£0	85	£0	75	£50,494	30	£49,774	23	£16,607	48	£0	69	£0	83	£0	66	£36,606	26	£73,141	26	£0	81	£43,148	28	£296,252	43