NHS Rotherham Clinical Commissioning Group

Operational Executive – 13 September 2019 Strategic Clinical Executive – 18 September 2019

GP members committee – 30 October 2019

CCG Governing Body – 4 March 2020

2020/21 Medicines Management Transformation Scheme Project Overview

Lead Executive:	**Wendy Allott**
Lead Officer:	**Stuart Lakin Head of Medicines Management**
Lead GP:	**Sophie Holden**

Purpose:

To inform Governing Body of the Medicine Management Transformation Scheme opportunities identified and the progress made to date.

Background:

Table 1

Title	Saving	Investment	Progress
Specialist Infant Feeding	£100,000	£60,000	OE approved scheme 19th July 2019. Discussions initiated with dietetics department and relevant business manager
Stoma Prescribing systematic patient reviews	Ensures sustainability of £500,000 annual efficiency that the service delivers	£44,000	OE approved scheme 19th July 2019. Discussions initiated with lead stoma nurse and relevant business manager
Antidepressant prescribing	£125,000	To identified	An extensive patient engagement exercise has been undertaken across Rotherham. The results are that both patients and GPs are of the opinion that there is the potential for alternative options to antidepressant drugs to be considered in the management of low mood. The outcomes of the patient engagement are scheduled to be presented to VAR 30/09/19. (See appendix 1)
Diabetes Prescribing	£750,000	£125,000	A series of 48 searches have been designed tested are being run across GP systems. The results should identify the areas that are the main contributors to Rotherham's chronic underperformance regarding diabetes management. Audits are scheduled to be completed by October 2019 (See Appendix 2)
Chronic pain management	£250,000	£100,000	Discussions have begun with the TRFT acute pain service about designing a community based chronic pain service. (See Appendix 3)
Respiratory prescribing	£500,000	£80,000	A recommendation to include a Respiratory Pharmacist in the redesigned respiratory pathway was approved by OE 9/08/2019. A Job Description and Person Spec is being produced, (See Appendix 4)

Analysis of key issues and of risks

See .attached appendices
Appendix 1. Antidepressant Prescribing Appendix 2.
Diabetes Management Appendix 3 Chronic Pain
Management Appendix 4 Respiratory Prescribing

Patient, Public and Stakeholder Involvement:

1. A patient engagement exercise was undertaken in 2011 for the service redesign for prescribing stoma appliances. This engagement exercise is being repeated in 2019 as part of an ICS MM project. Rotherham does not need to participate in this exercise as the proposed ICS model has been operational in Rotherham since 2011.

2. An extensive patient engagement exercise has been conducted to obtain patients opinion and knowledge base of antidepressant drugs. This has governed the proposed work stream (See appendix 1)

Equality Impact:

Attached

Financial Implications:

See table 1 (Background)

Human Resource Implications:

Investment totals have been agreed during the QIPP planning progress.

Project	Investment	Comments
Antidepressant prescribing	To be identified	Investment not identified, pending discussion with VAR.
Diabetes Prescribing	£125,000	The nature of the investment will depend on the results of the diabetes audit.
Chronic pain management	£100,000	Proposed service is still being planned. The financial envelope has been agreed.
Respiratory prescribing	£80,000	Investment agreed by QIPP planning group.

Procurement Advice:

All proposed schemes involve investing into an established service. The exception being the chronic pain service, here the proposed model will be a pilot project and procurement advice will be sought if the proposed service model is to be commissioned on a permanent basis.

Data Protection Impact Assessment:

No personal data will be used.

The diabetes audits will not access personally identifiable data.

Approval history:

OE: 13 September 2019
SCE: 18 September 2019/25 September 2019

Recommendations:

Paper is for Approval

Appendix 1

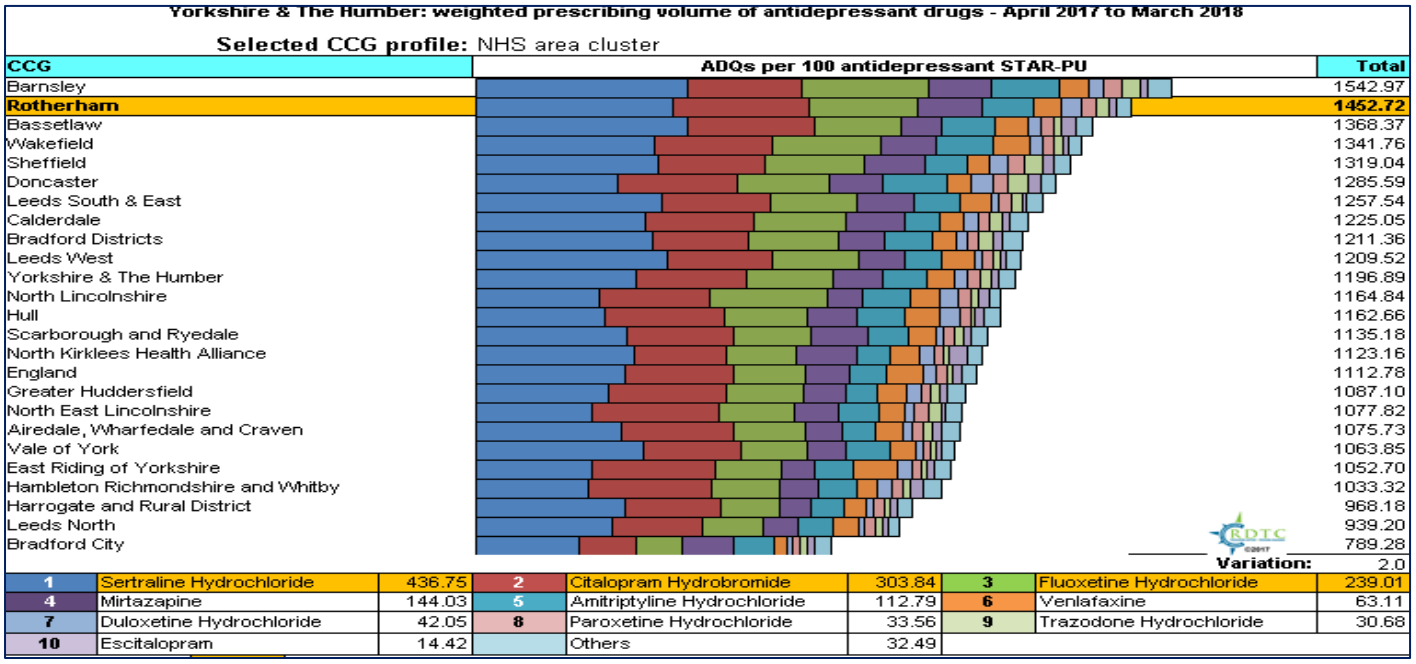
Discussion paper - Prescribing anti-depressants; considering the need and solutions

'its OK if you're not OK'

Antidepressant Prescribing - The Facts

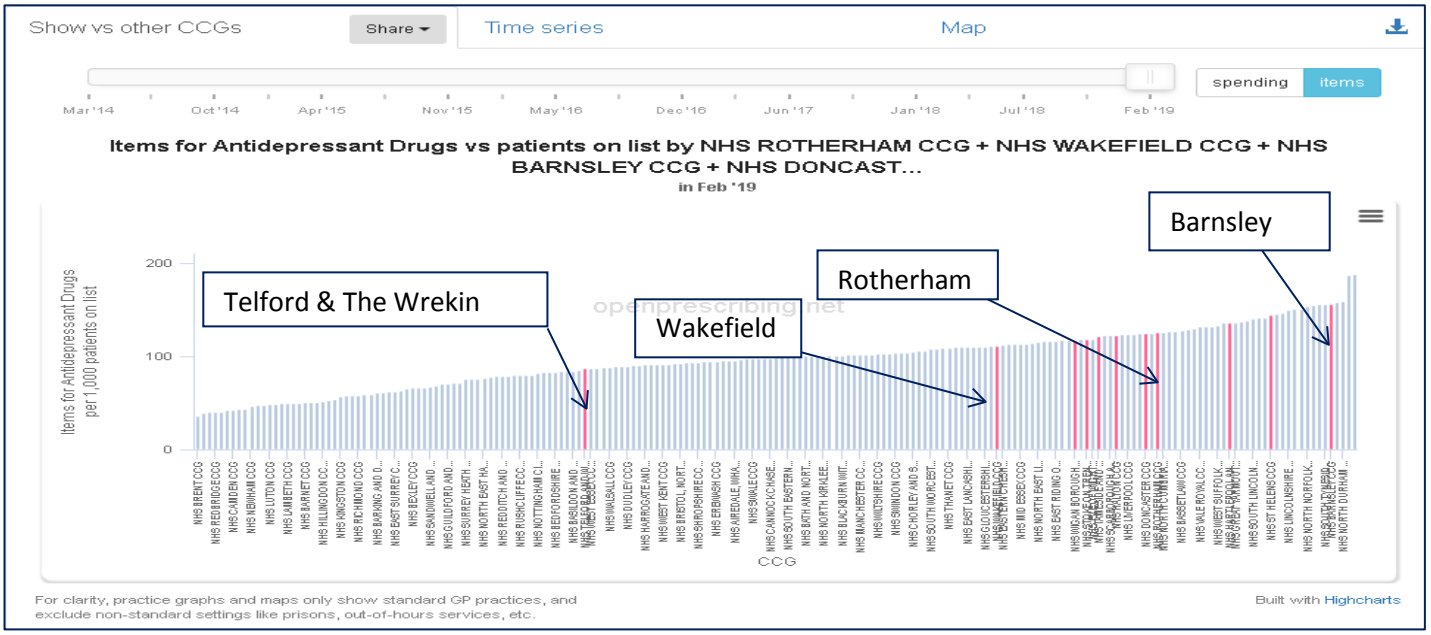
- 170% increase in antidepressant prescriptions since 2000 (England).
- 16% of English adults are taking an antidepressant.
    - 36% of patients take antidepressants for 5 years or more.
    - 26% of patients expect to be taking them for life.
- 56% 0f patients will experience withdrawal side effects (46% of patients describe these as being severe). Withdrawal is often confused with relapse. Less than 2% of patients recall being told anything about withdrawal issues. 65% of patients report never having discussed stopping/withdrawing antidepressants.
- 1/3rd of patients that have been taking antidepressants for more than two years have no evidence based reason for taking them recorded.
- Estimated 1.2 million UK antidepressant uses have no reasons recorded why they are taking them. (1).

As of May 2019 there are 25,360 patients in Rotherham with a repeat prescription for an antidepressant. This is the second highest prescribing rate per capita in Yorkshire.



This relative high rate of antidepressant prescribing has persisted for a number of years and hasn't decreased with the increase in IAPT (Improving Access to Psychological Therapies) provision.

In the 12 months to February 2019 Rotherham prescribed antidepressant drugs to the valve of £976,504. Detailed analysis shows that Rotherham's drug choice is evidenced based and in accordance with NICE guidelines and cost effective compared to the CCGs that Rotherham is matched against. However, the volume of antidepressants places Rotherham in the top 25% of CCGs, other South Yorkshire CCGs are in a similar position. However, there is a considerable variation in antidepressant prescribing across the CCGs that Right Care have matched Rotherham against.



The evidence base

In 2018 Lancet (C*omparative efficacy and acceptability of 21 antidepressant drugs for the treatment of adults with major depressive disorder: a systematic review and network meta-analysis*) analysed data from 522 trials involving 116,477 people, and found that 21 common anti-depressants were all more effective at reducing symptoms of acute depression than dummy pills.

NICE has concluded (on numerous occasions) that the efficacy of the different antidepressants is largely equivalent.

Antidepressants are meant to be taken for 9/12 months for a first episode of depression and for a maximum of 2 years for those experiencing further episodes. But increasingly more of us are staying on them for longer.

NICE – Antidepressants work best in which types of depression

In mild-to-moderate depression (diagnosed according to the DSM-5 classification), low-intensity psychological interventions (such as individual guided self-help, computerized cognitive behavioural therapy (CBT) or a structured group-based physical activity programme) are recommended.

Antidepressants are not used routinely for mild-to-moderate depression, but may be used for people with a history of depression.

The risk of recurrence is

- at least 50% after a first episode of depression
- 70% after a second episode and
- 90% after a third episode
- increased overall in people under 20 years of age and in elderly people.

Antidepressants (long-term of 2 years) are considered the most appropriate option in reoccurrence.

In moderate or severe depression, a combination of an antidepressant and high-intensity psychological intervention is recommended.

Long term side effects
SSRIs cause reduced blood clotting capacity because of a decreased concentration of the neurotransmitter serotonin in platelets. Patients are at slightly increased risk for internal bleeding, especially if they are also taking aspirin or another NSAID, such as ibuprofen or naproxen.

Evidence from 2018 longitudinal, cross-sectional, and prospective cohort studies suggests that the use of antidepressants at therapeutic doses is associated with decreased bone mineral density and increased fracture risk.

Issues with stopping
In general antidepressants are considered to be non-addictive. When stopping antidepressants NICE recommends reducing the dose or frequency of the antidepressant gradually over a 4-week period to minimize discontinuation symptoms. Recently it has been recognised that withdrawing antidepressants is more difficult and will usually take longer than indicated in the NICE guidance.

Discontinuation symptoms include dizziness, nausea, anxiety, diarrhoea, flu-like symptoms, and headache. They may occur when stopping or reducing the dose of any antidepressant.

Onset is usually within 5 days of stopping treatment. Occasionally, symptoms occur during tapering or after missed doses. These symptoms are usually mild and self-limiting, rarely lasting for more than 1–2 weeks. However, occasionally they can be severe, particularly if the drug is stopped abruptly.

What do GP's think?
Anecdotal feedback from GPs to the medicines management team has indicated the following:-

- Anti-depressants don't work well when they are prescribed for people experiencing life changes and events such as bereavement and relationship breakdown
- That GPs offer anti-depressants as there is little else to offer; GPs will admit that the antidepressant is not the answer but believe that the patient expects an intervention.
- That the wait for IAPT is too long, people need to be able to access something very quickly once they reach out to the GP

What do patients and the public think?
To further inform this work, between November 2018 and March 2019; the PPE manager and Medicines Management lead spoke with a number of groups. These included the Rotherham wide Patient Participation Group Network; however to balance this informed group; there was an additional focus on reaching small groups who rarely get the chance to contribute to discussions. In this instance, these included elderly people in sheltered accommodation, young mums, and men aged 16-25 with chaotic lifestyles; with around 60 people involved in the conversations.
BME communities were not approached at this stage, as the pattern of taking anti-depressant medication in this community is different.

Despite this huge variation in demographics, the themes from all groups included a number of common themes.

1. **The importance of community and social connections.**
   All groups referenced the lack of social contact in terms of exacerbating depression. For some, necessary contact was on social media, for other it was neighbours or family; contact, communication and community will be different for different people.

   How do we make sure that people are connected? What can we do to address this?

2. **Getting the message right**
   It was acknowledged by all groups that it was vital, yet challenging, to ensure that people will seek support when they need it- some will not seek help until in crisis. Others may stop taking meds within a couple of weeks if they are not felt to be working quickly; potentially putting themselves at risk.
   Also discussed was the difference between depression and needing to access support following a life event, with a suite of alternatives, and good, clear information. This includes the length of time that anti-depressants will take to work, and clarity about what they will and will not do.
   Participants also queried whether it is all depression sometimes the issues are anxiety, stress or just plain anger that are resulting in "low mood" but these issues all get the label depression.

How can we get out information that normalises issues, and emotions; reinforcing that:-

- *Its normal to feel low sometimes*
- *That anti-depressants are not a quick fix for all issues*
- *When and how people can access support- before crisis.*

3. **Support might not be from the doctor; but needs to be fast**
   It was clear that people understood the pressures on GPs; however once the decision had been made to contact the practice and seek support, to wait for several weeks for an appointment, then longer to access services was not seen as helpful. In addition, it was extremely clear that some counselling and talking therapy service had not worked well for some people; there were examples of people having accessed numerous services until they found one they could connect with – patronising and condescending services were mentioned a number of times. There will not be one solution for everyone, but should be a range of alternatives. Generally, the relationship and trust is more important than the name or profession in the case of a counsellor or someone to talk to – lived experience is valued deeply as is very fast – ie 24 hour – access. All participants placed value on quick access to support from someone that had "walked in their shoes" in other words someone that had had and managed their way through similar life experiences. This was considered more highly than support from a health care professional "that's just learned it all from a book".

   How can we ensure fast access to a range of alternatives?
   Is there scope for increased support from people with lived experience?

4. **Pragmatic and active support**
   There was considerable discussion about the problems that people had faced, and many examples of people starting to take anti-depressants because of extremely challenging life events. As one person put it '*… you are still broken inside, the problems are still there when you come off'.* For some people, much more practical help in respect of addressing their issues would be more helpful than counselling; for example in dealing with debt, housing issues, or single parenting. Discussions also indicated that the traditional counselling approach to these issues was not always helpful, but that non-judgemental and practical assistance might be.
   Mindfulness and alternative relaxation techniques such as meditation and yoga were mentioned as positive interventions; what was less helpful was when people are offered a lot of written text based information – a lady told us that she had been given a big document to work through, and at that point she just couldn't face it, rendering the intervention unhelpful.

   Is there enough access across the system to this sort of support?
   How can we make sure that people know that there are a range of support mechanisms; not all will work for each person in each case, and they may have to try alternatives to find the right approach for themselves?

References and bibliography

(1) A systematic review into the incidence, severity and duration of antidepressant withdrawal effects. Are guidelines evidence based?

Davies, J., Addictive Behaviours, https://doi.org/10.1016/j.addbeh.2018.08.027

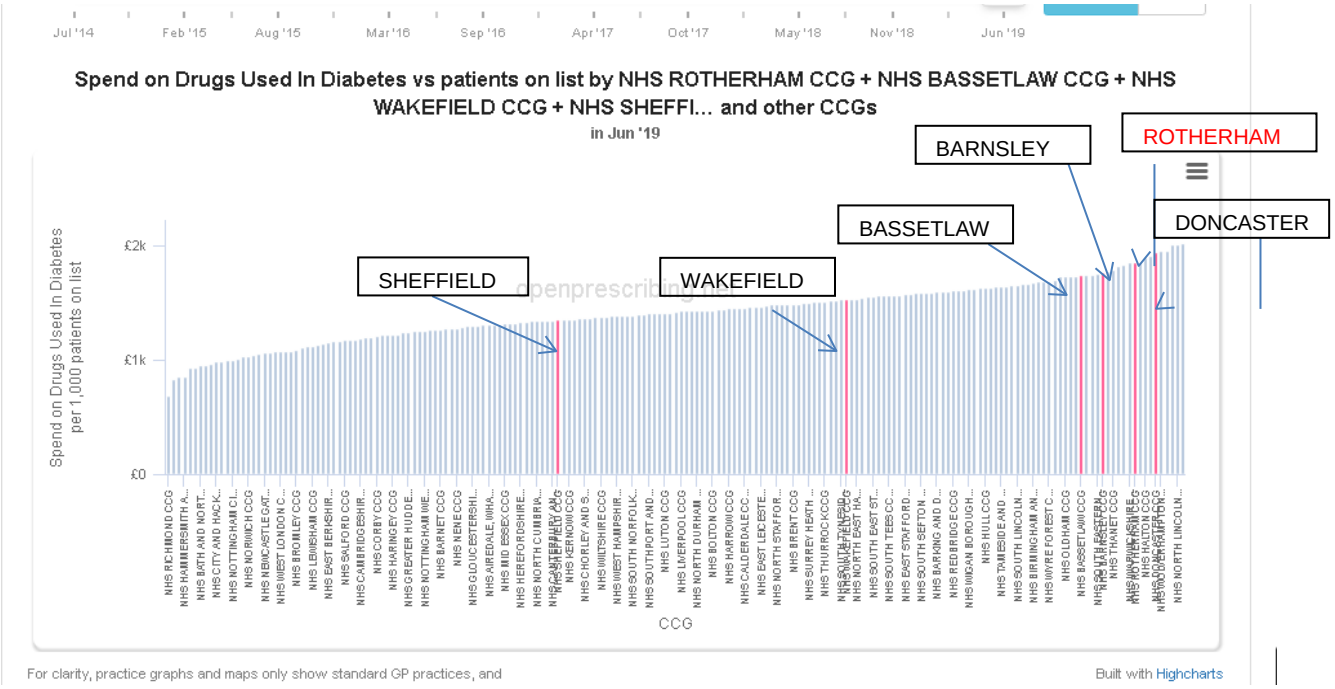
Appendix 2

Discussion paper diabetes prescribing and management

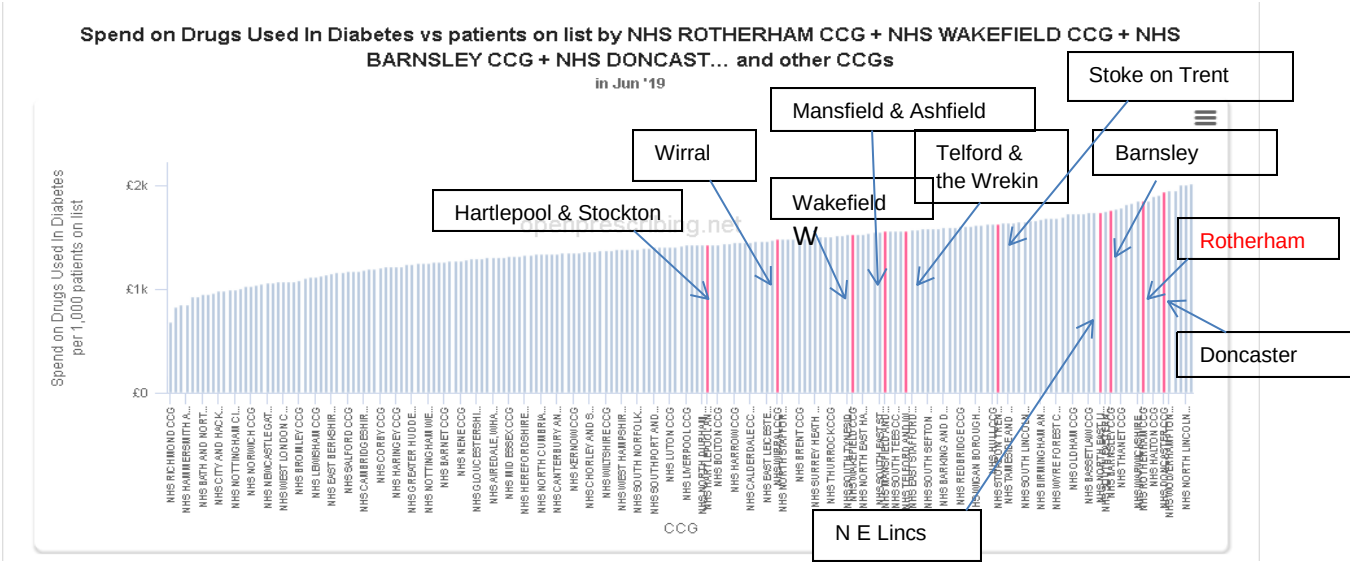
Prescribing – The facts

- Total expenditure diabetes medication in 2018/19 = £6,334,922 this is an increases of £857,640 (15.5%) on the previous financial year
- Diabetes management as the highest total prescribing cost of all therapeutic areas and the highest cost growth.
- Rotherham has the 10th highest prescribing diabetes prescribing costs in England based on population.(open prescribing 08/19 Graph 1)
- Rotherham has the highest prescribing costs per diabetes patient in the Yorkshire & Humber Region (RDTC April 2019) Graph 2.
- The Rotherham CCG MMT has undertaken and extensive switch programme for blood glucose testing systems and pen needles. As a result in these two areas of diabetes management Rotherham's cost /patient are below the national average. Despite this Rotherham still has comparatively high prescribing costs compared to CCGs in our PRESCQIPP Cluster. Graph 3

Graph 1



Graph 3 Diabetes prescribing costs PRESCQIPP cluster (CCGS demographically marched to Rotherham)



If Rotherham reduced its diabetes prescribing costs in line with Wakefield's (A CCG that is matched by PRESCQIPP & Right Care to Rotherham) this would release £750,000 / annum, although it will take 2-3 years minimum to release this efficiency.

Quality of diabetes management

Rotherham could justify its high diabetes prescribing costs if these were matched with positive outcomes for diabetes management.

HbA1c control is a measure of how well blood sugar (glucose) is controlled over the preceding 3 months.

Poor HbA1C control is associated with an increase in the microvascular complications associated with diabetes. Microvascular complications of diabetes are those long-term complications that affect small blood vessels. These typically include retinopathy, nephropathy, and neuropathy.

Retinopathy is divided into two main categories: Nonproliferative retinopathy and proliferative retinopathy.

Nonproliferative retinopathy is the development of microaneurysms, venous loops, retinal hemorrhages, hard exudates, and soft exudates.

Proliferative retinopathy is the presence of new blood vessels, with or without vitreous hemorrhage. It is a progression of nonproliferative retinopathy.

Diabetic nephropathy is defined as persistent proteinuria. It can progress to overt nephropathy, which is characterized by progressive decline in renal function resulting in end-stage renal disease.

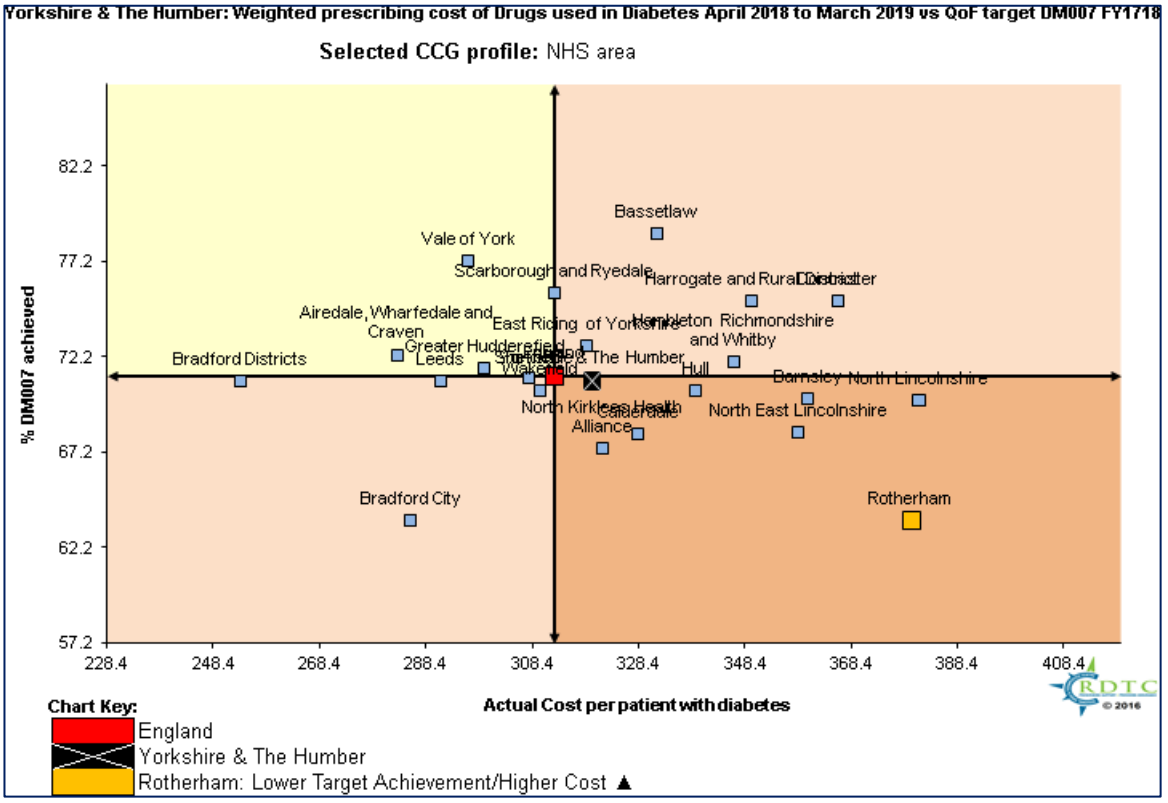
Neuropathy is a heterogeneous condition associated with nerve pathology. The condition is classified according to the nerves affected and includes focal, diffuse, sensory, motor, and autonomic neuropathy.

In summary diabetes and particularly poor HbA1C control is the leading cause of blindness, renal failure and limb amputation in the UK.

Graph 4 compares the drug costs/diabetes patients against HbA1C control marker QoF indicator DM007 % of patients with an HbA1c below 59 mmol\ml. Rotherham has the highest treatment costs\diabetic patient in Y&H and the worse performance on HbA1c control, unfortunately this has been the situation for the last ten years.

There are two further QoF indicators with tighter HbA1C values, DM007 is the easiest target and as expected Rotherham's performance is the weakest against all three of the QoF HbA1C indicators.

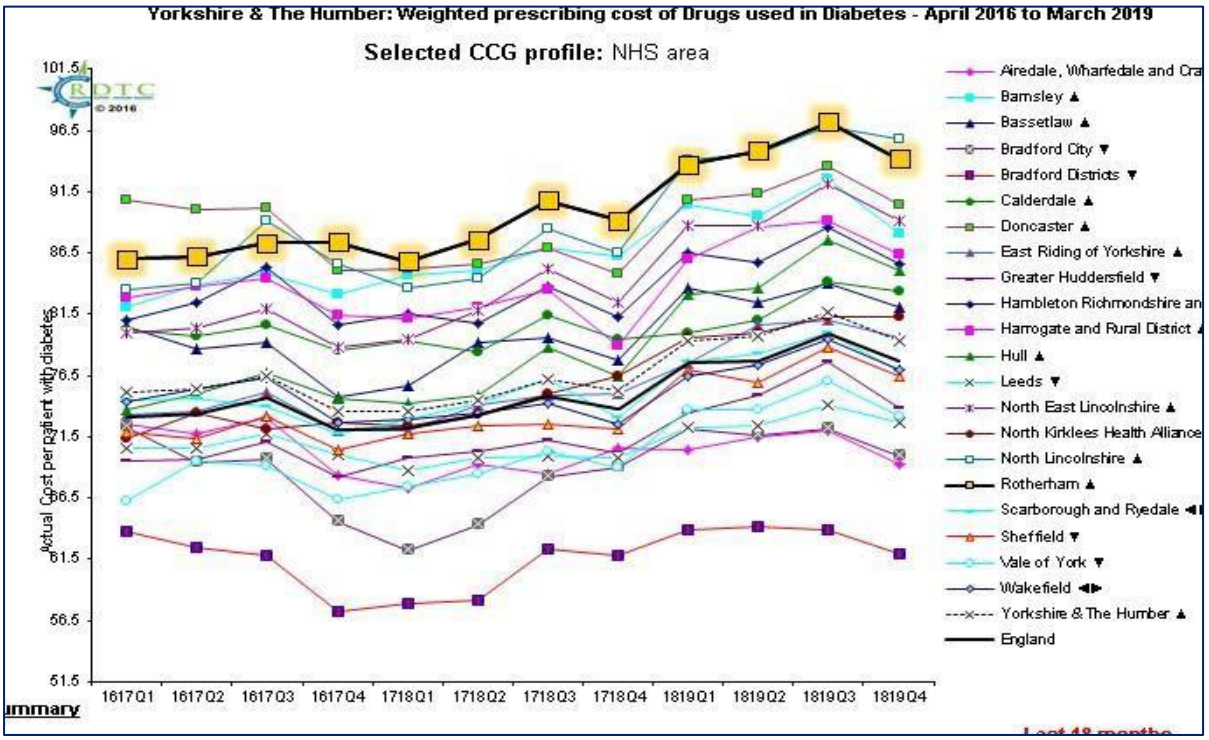
Graph 4



Diabetes Prescribing further analysis.

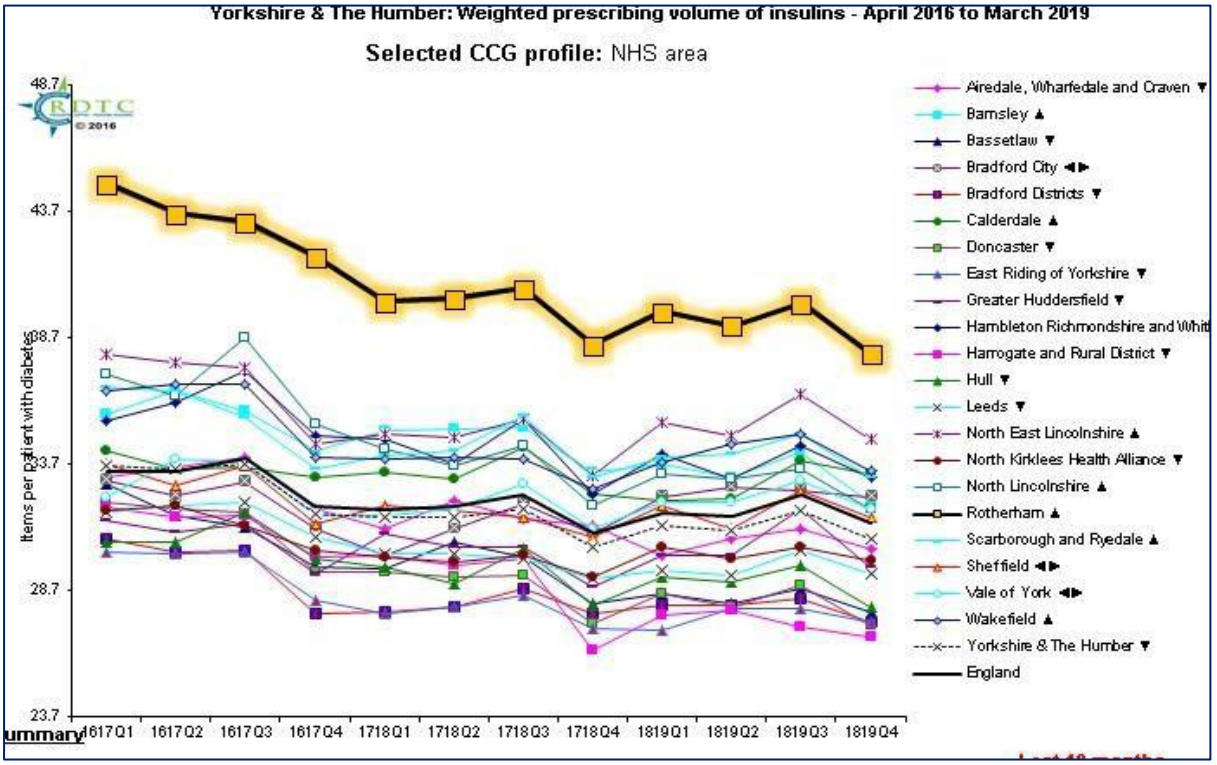
Rotherham has the highest diabetes prescribing costs/diabetes patient in Y&H (Graph 5)

Graph 5



Rotherham also has the highest insulin usage in Y&H this will be impacting on cost but is not improving HbA1c management. It is not clear whether there is actually more patients treated with insulin in Rotherham or greater waste due to the prescribed quantities not matching the monthly volume actually used by the patient. The cessation of third party ordering 2 years ago resulted in a decrease in insulin usage, this decrease has now levelled off. (Graph 6)

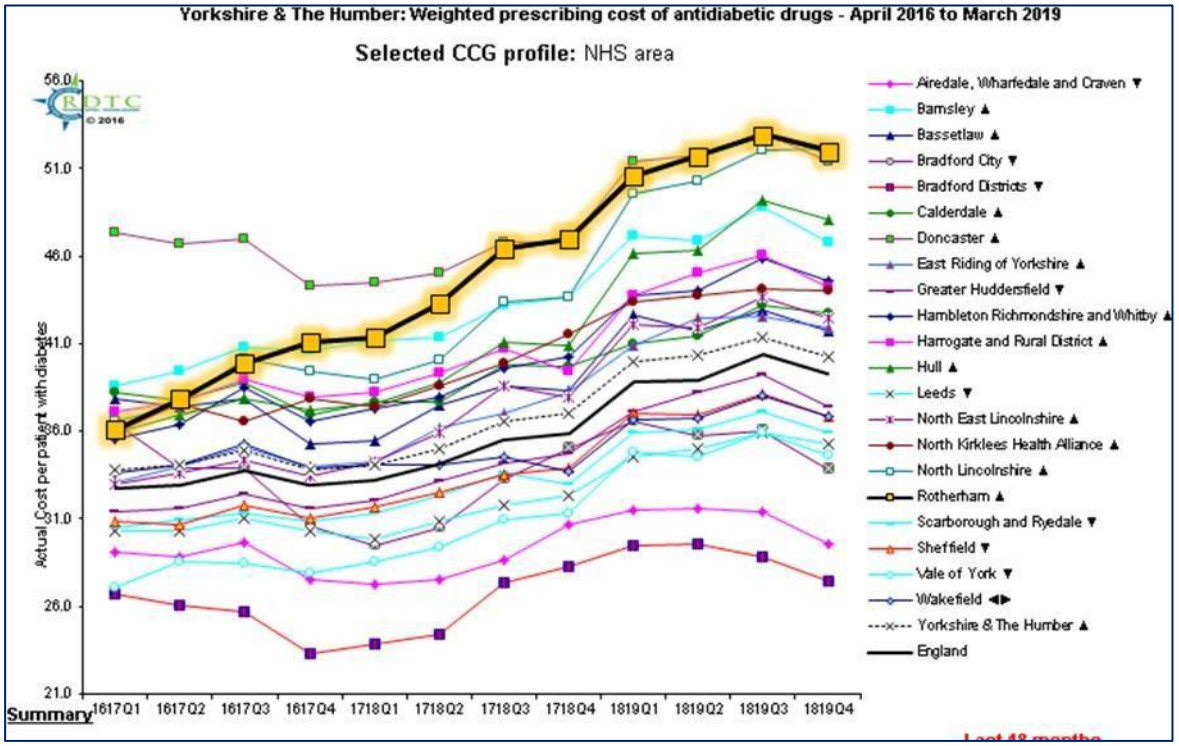
Graph 6



Over the last 5-6 years there has been a plethora of new antidiabetic drugs launched onto the UK market. These new agents have advantages in that they do not cause weight gain, this should make HbA1C control easier to manage. The new agents also are demonstrating positive cardio-vascular outcomes, resulting fewer MI's and lower incidents of CHD mortality. Diabetes is associated with a worsening of CVS risk factors.

Rotherham's has readily adopted the prescribing of these new diabetes agents as demonstrated in the increased cost of antidiabetic drugs (graph 7). Despite this there has been no overall improvement in HbA1c management.

Graph 7



Diabetes management improvement plan.

NHSE diabetes improvement funding has been utilised to engage a Medicine Management Technician one day a week to undertake a detailed prescribing analyses at practice level.

A total of 48 practice searches have been designed and tested and the weakest practices for the management of HbA1c identified. These searches are being run across all Rotherham practices and will identify Rotherham's areas of weakness in HbA1c management.

These results will then be used to redesign how diabetes is managed across Rotherham.

The aims of the redesigned service will be to;

- Improved HbA1C management thereby reducing the incident of microvascular complications.
- Improved patient experience.
- Offer greater support to practices
- Reduction in diabetes prescribing costs relative to similar CCGs

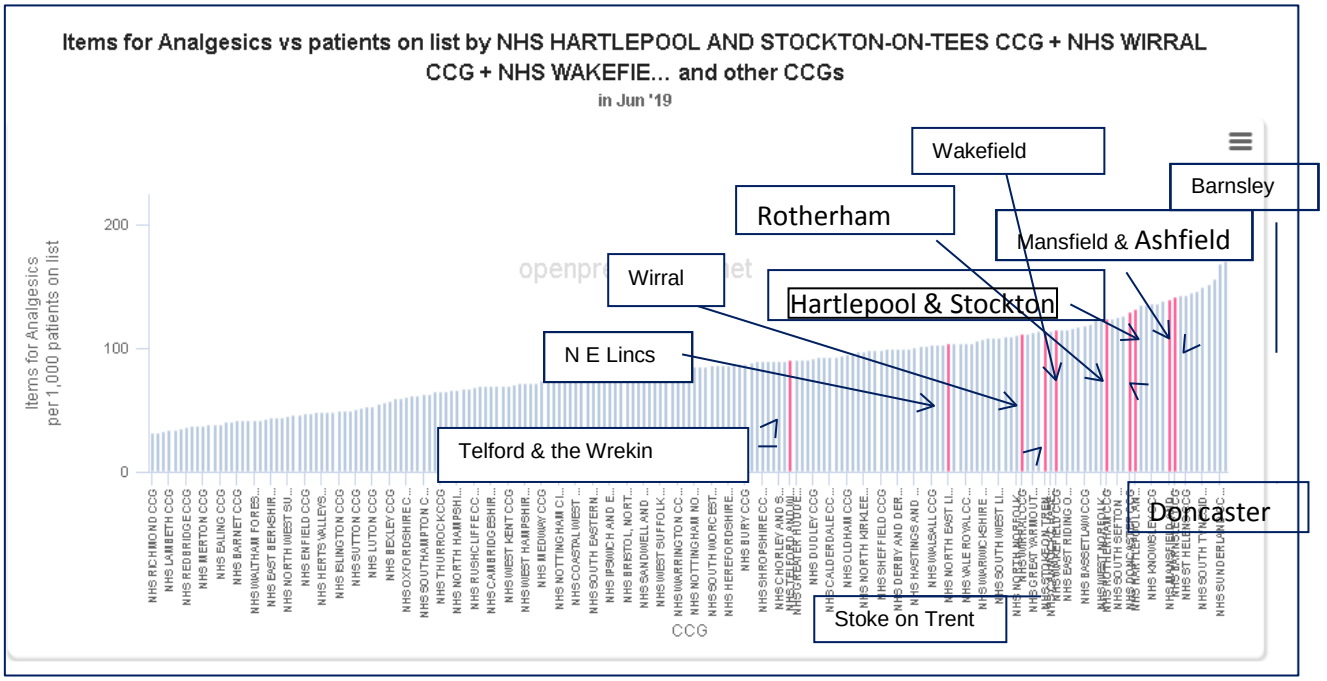
Appendix 3

Discussion paper; Prescribing and Chronic pain management.

Prescribing-The facts

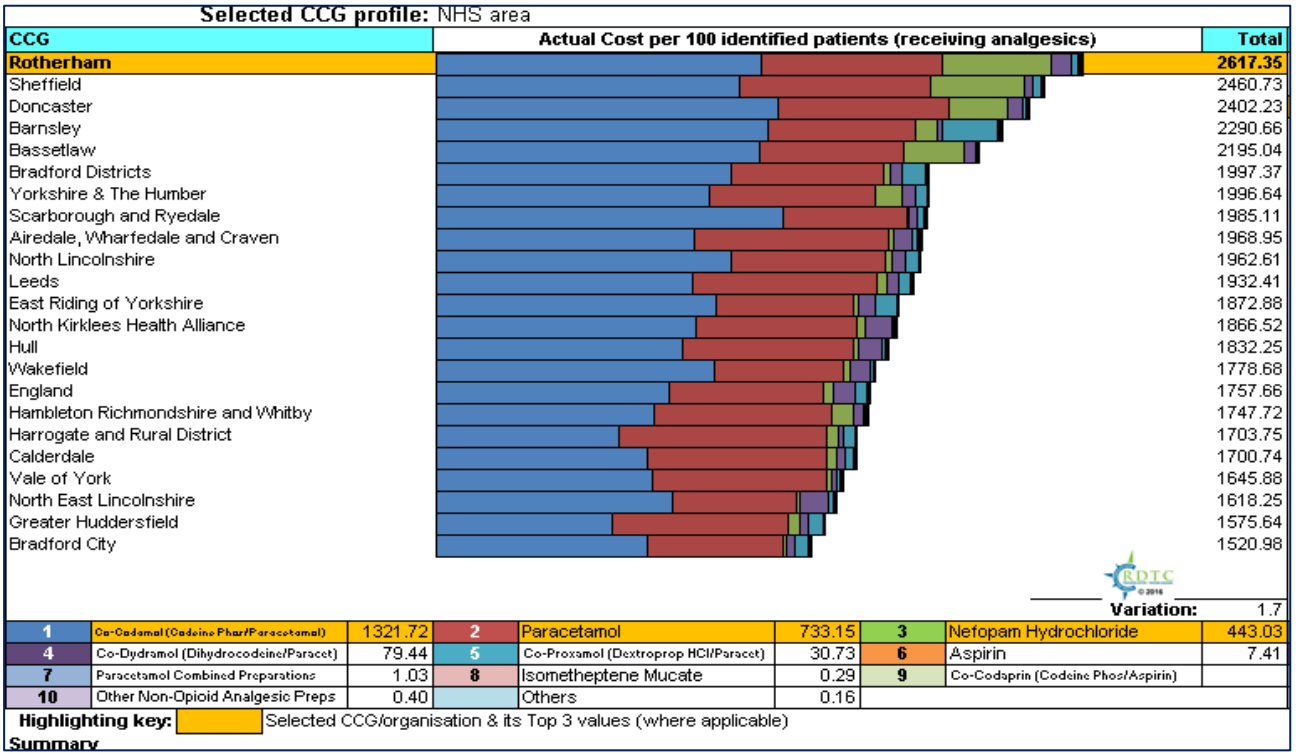
- NHS Rotherham CCG spent £2,752,147 on prescribed analgesics in the 12 months to June 2019 (Open prescribing August 2019).
- This gives Rotherham the 22nd highest analgesic costs\ patient in England. Rotherham's analgesic prescribing costs are in line with the CCGs that it is matched against (PRESCQIPP) Graph 1
- Rotherham has the highest non-opioid analgesic prescribing cost\patient in Y&H due to its heavy use of the drug nefopam see Graph 2 &3
- Rotherham's prescribing of opioid analgesics compares favourably against other CCGs in Y&H Graph 4 .However Rotherham is incurring unnecessary prescribing costs due to the heavy use of opioid patches. Graph 5

Graph 1

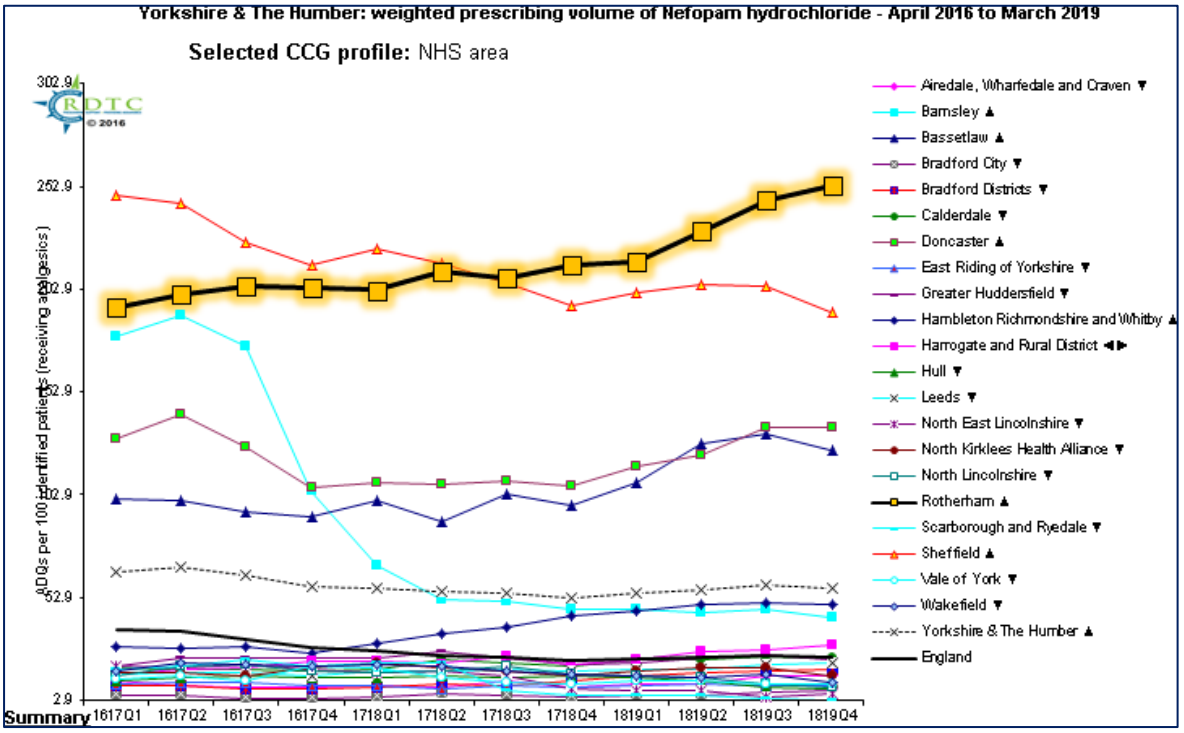


Graph 2

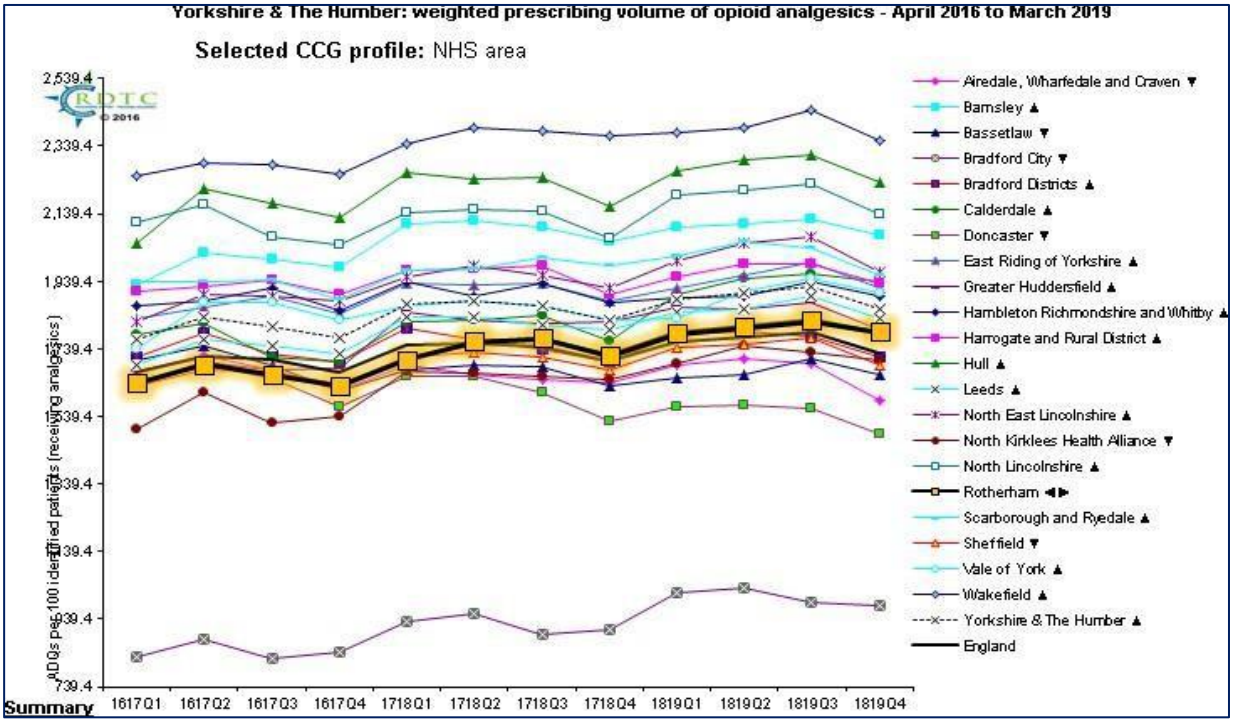
Non-opioid analgesic prescribing costs Y&H April 2016-March 2019



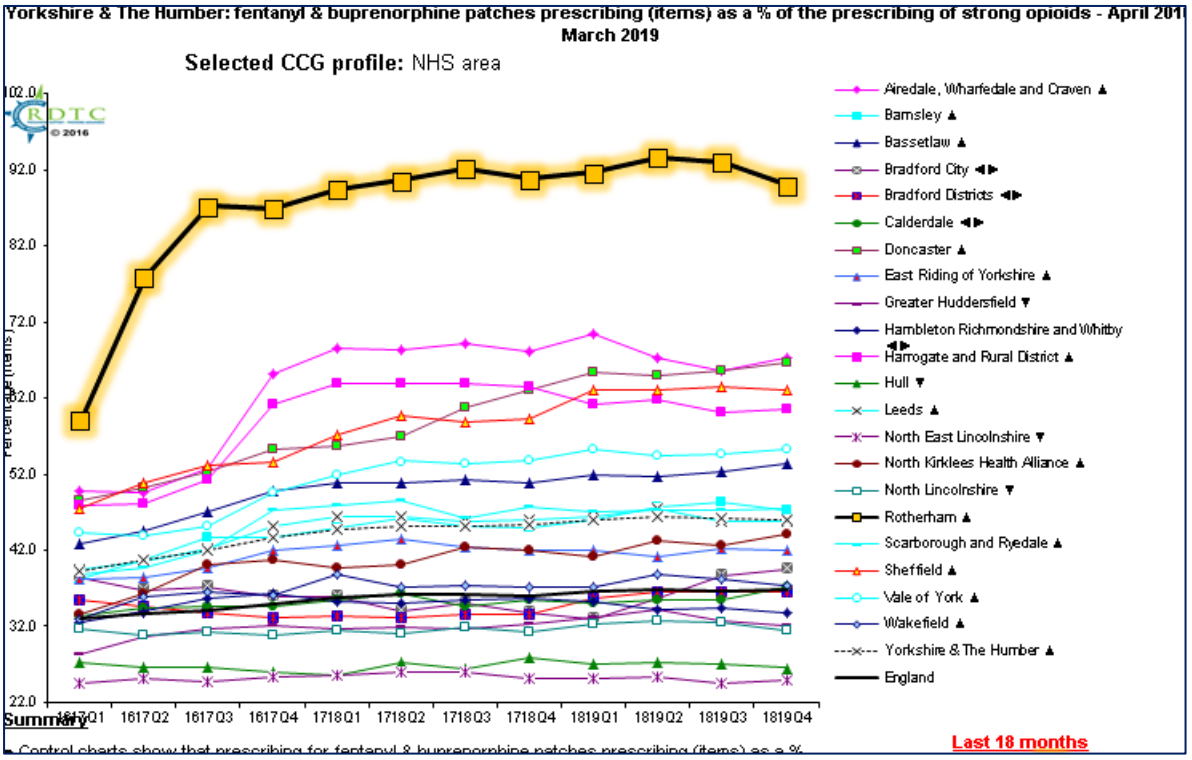
Graph 3



Graph 4



Graph 5



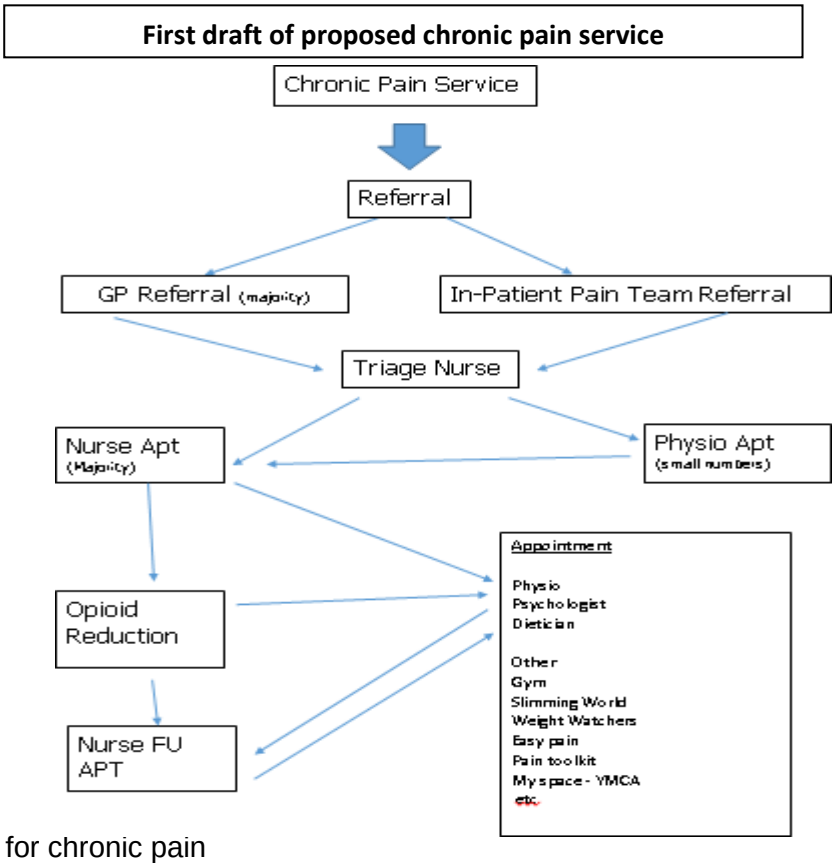
Chronic pain management improvement plan.

There is increasing concern nationally regarding the use of strong opioid analgesics to manage long term chronic non-palliative pain. The evidence clearly demonstrates that opioid analgesics are ineffective in managing long term pain of a neuropathic or skeletal nature.

Rotherham GPs have expressed long-standing reservations in the specialist pain services available to them based in Sheffield and Doncaster. GPs also admit to finding the management of chronic pain conditions challenging especially as complex nature of many chronic pain conditions cannot be addressed in a ten minute appointment.

Prescribing data indicates that whilst Rotherham's prescribing of analgesics and opioid analgesics is in line with that of similar CCGs, there is still the potential to release cost efficiencies, estimated to be around £250,000 /annum.

There is an opportunity for Rotherham to establish for a trial period a chronic pain service, utilising a range health care professionals. The proposed skill mix would be more affordable than a consultant led service model.



The proposed service would operate to the following KPI's

- Improved patient experience through the holistic management of their pain.
- Reduction in use of strong opioid analgesics
- Reduction in prescribing costs.
- Reduction in GP attendances for chronic pain
- Positive GP evaluation of the service.

It is proposed that each GP practice will be offered a number of slots dependent on its list size and the service will be located in the community (Accommodation has been offered by the GP Federation). After the trial period if the service has met all its KPIs then consideration will be given to commissioning the service on a permanent basis and scaling the service up depending on demand.

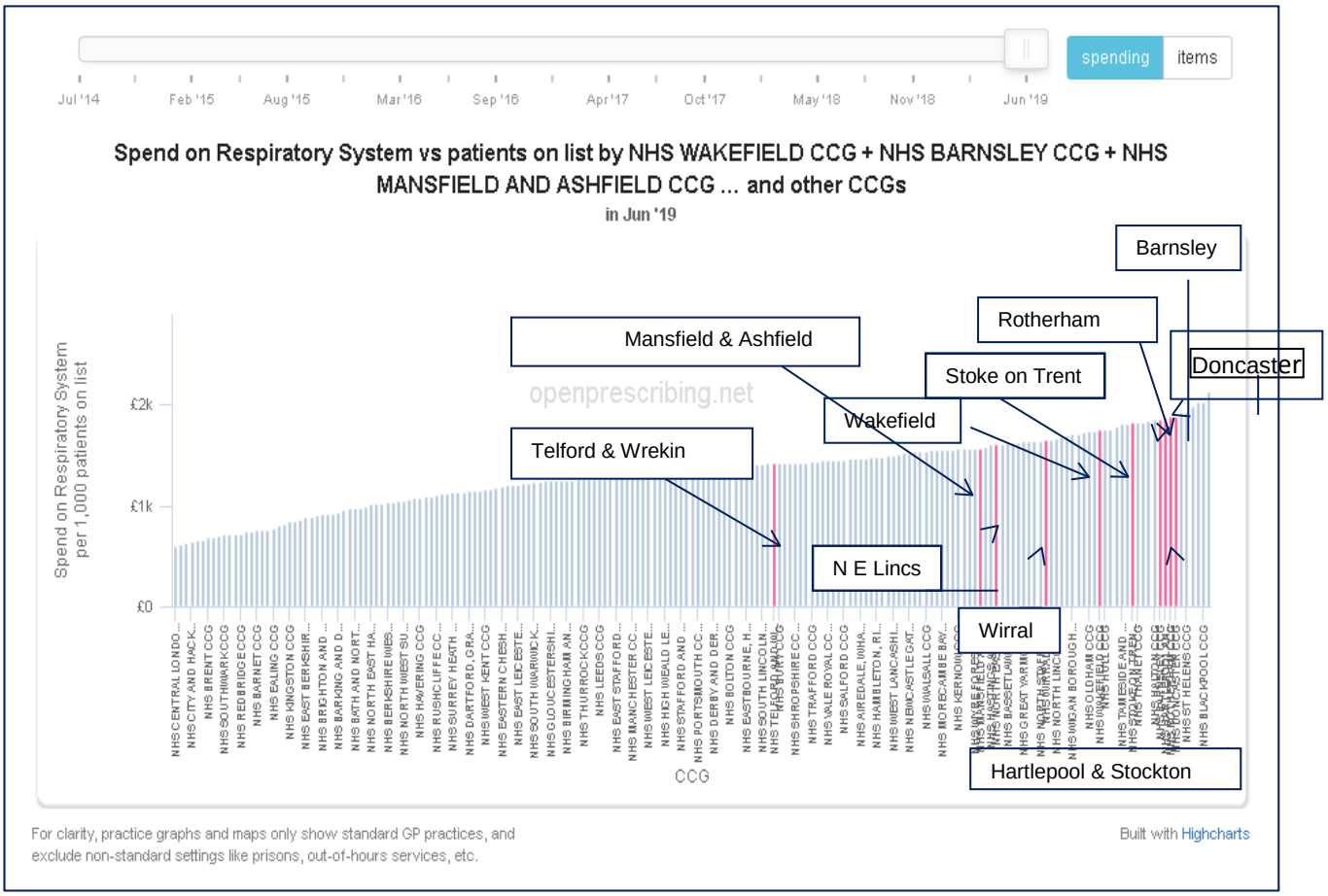
Appendix 4

Discussion paper; Prescribing and Respiratory Disease

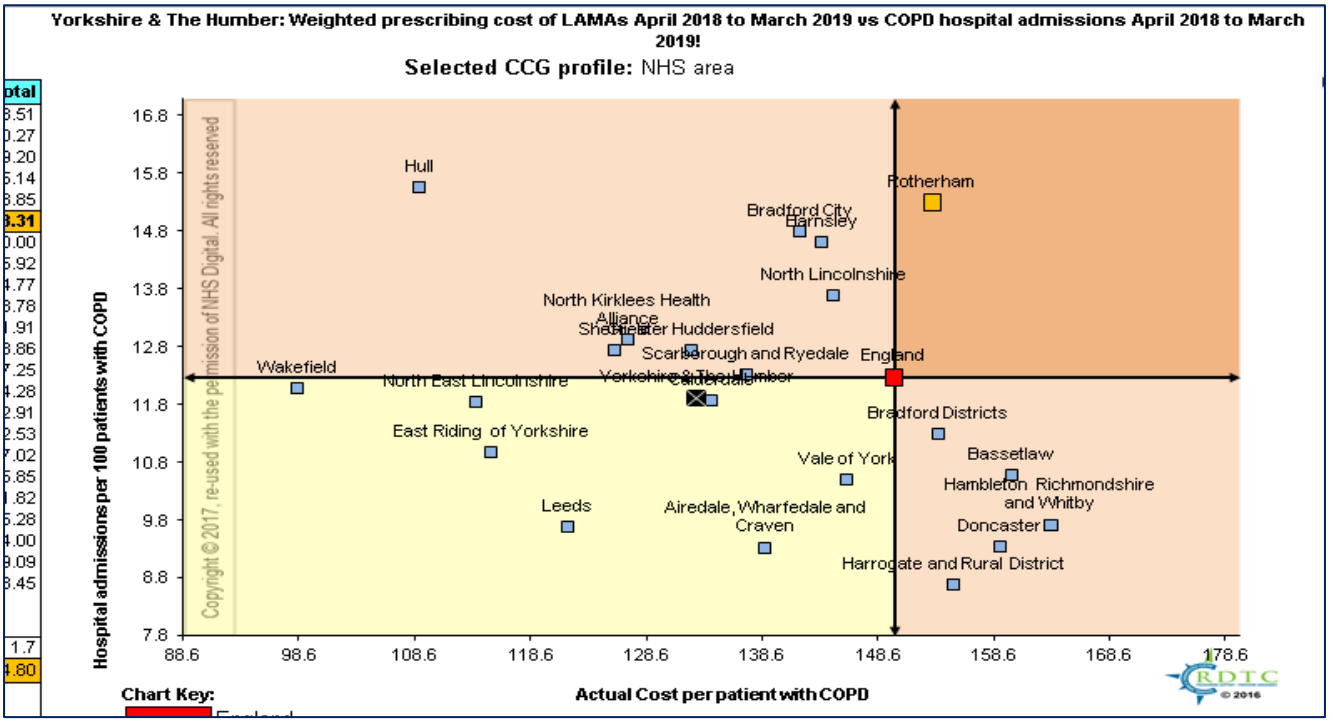
Prescribing the facts.

- Rotherham has the 8th highest prescribing costs (per resident) in England and the second highest amongst the group of CCGs that Rotherham is matched to. (PRESCQIPP) Graph 1(Open prescribing data)
- Total respiratory prescribing costs for respiratory drugs in the 12 months to June 2019 = £6,063,186.= 13.5% of all prescribing costs
- Regional Drug & Therapeutic Centre (RDTC) data demonstrates that Rotherham as a tendency to be an early adopter of new agents, but there is no evidence that this results in improved outcomes (Graph 2)
- When asthma admissions are also included (Graph 3) the picture improves but Rotherham still appears to have relatively high hospital admissions and comparatively high prescribing costs.

Graph 1

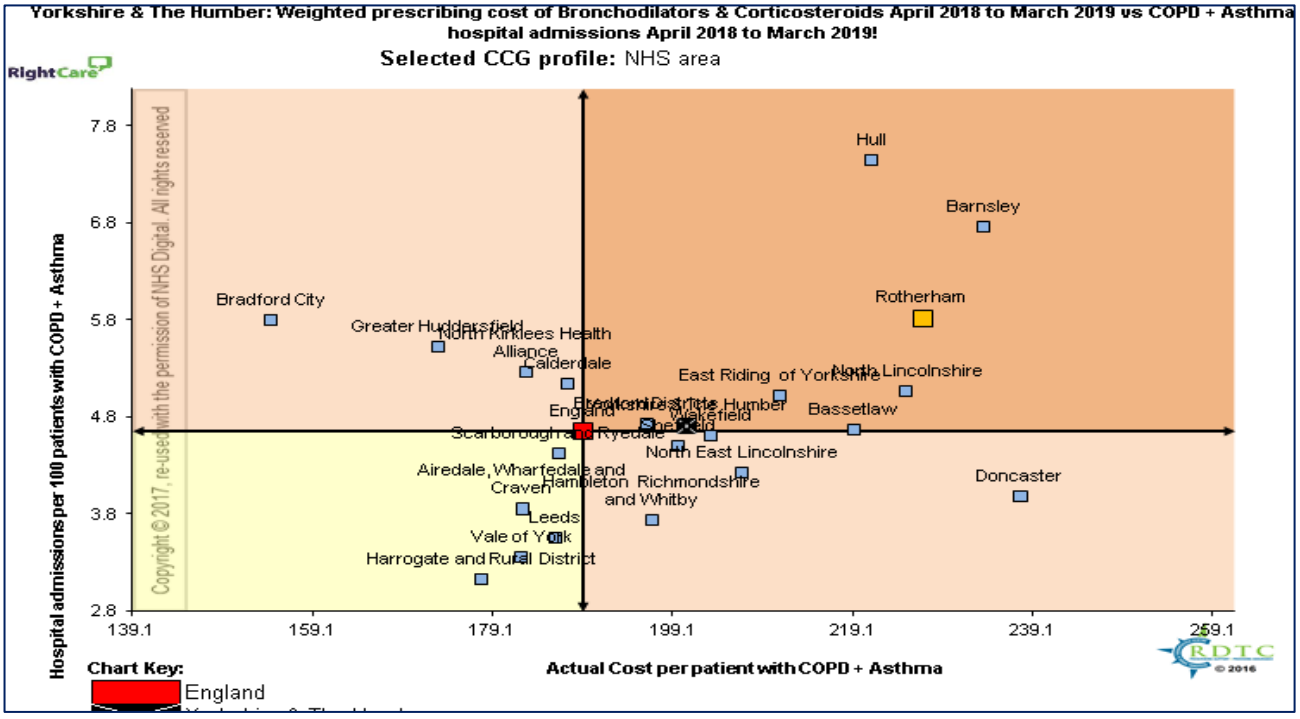


Graph 2



Rotherham is shown to have a high rate of COPD hospital admissions despite high respiratory prescribing costs. All other CCGs with similar high respiratory cost have below average COPD admissions. Although this may be due to coding issues connected with the Breathing Space service.

Graph 3



Case for a specialist Respiratory Pharmacist based in the community.
A paper was discussed at OE 9th August 2019 "Proposal to re-design Rotherham's Respiratory Pathway" a proposal was made to include a specialist respiratory pharmacist in the proposed new pathway. This proposal was supported by OE and later gained support from the Respiratory Task & Finish group particular from TRFT's Respiratory Consultant.

Specialist Respiratory Pharmacists are a regular part of the Medicine Management offer in acute trusts, however, such a position solely community based would be innovative Considering Rotherham's high expenditure on respiratory drugs and high COPD hospital admissions rate, although the accuracy of COPD admissions coding has been questioned, this innovative position has the potential to make a considerable contribution to the future of respiratory management in Rotherham.

Role of the community specialist respiratory pharmacist.

- Undertake holistic medication reviews (Not confined just to respiratory drugs)
- Facilitate the production of joint Primary\Secondary Care prescribing guidelines
    - There are currently 3 national respiratory guidelines NICE\ BTS British Thoracic Society & GOLD (International guidelines), The inconsistencies between these guidelines and the failure of clinicians across Rotherham to reach a consensus has hindered progress.
- Increase the community respiratory teams critical appraisal skills
    - Respiratory prescribing is an area of active ongoing research, the majority of clinical trials are sponsored by the pharmaceutical industry. The pharmaceutical industry is also very influential in the production of the recognised national\international guidelines. It is important that the community respiratory team have a consistent and co-ordinated approach to evaluating the continually changing evidence base.
- Mange relationships with the pharmaceutical industry.
    - Whilst a drug will lose its patent the inhaler device remains on patent forever. Much of the ongoing research concerns the advantages of one inhaler device versus another. Once a drug comes off patent a competitor has to launch the generic version in a different device. The pharmaceutical industry through sponsored training events and promotion is not only successful in promoting new products but also in preventing the uptake of competitors products post patent loss.
- Ensure the cost effectiveness of prescribing
    - There is a potential £500,000 cost efficiency that could be released if Rotherham could reduce its prescribing costs to that of similar CCGs that Rotherham is matched to.(12 months respiratory prescribing costs = £6,063,186.= 13.5% of all prescribing costs)
- Review the use of rescue & prophylaxis antibiotic prescribing in respiratory disease.
    - Rotherham is under scrutiny as a high volume antibiotic prescribing area. The use of antibiotics as rescue medication to prevent self-diagnosed chest infections needs to be reviewed as a matter of urgency.

Stuart Lakin
Head of Medicines Management
NHS Rotherham CCG
September 2019

NHS
Rotherham
Clinical Commissioning Group

2020/21 Transformation Scheme Profile

Scheme Number	Scheme Name
MM 1	**Antidepressant prescribing**

Section 1: Scheme Overview

Brief Description of Scheme	
To identify a range of services that a GP can offer patients in times of need\crisis for support and practical advice as an alternative option to a prescription for an antidepressant.	
Lead GP:	**Lead Officer:**
Sophie Holden	Stuart Lakin

Please identify what level of documentation this scheme needs for approval		
Standard Report Template	**High Level (brief) Business Case**	**Full Business Case**
Required by all schemes	√	

Section 2: Impact Assessments *(see enclosures)*

Impact Assessments	Yes	No	Has this triggered the need for further assessment?
Has a Quality Impact Assessment been carried out?	√		
Has an Equality and Engagement Impact Assessment been carried out?	√		
Has a Data Protection Impact Assessment been carried out?	√		

Section 3: High Level Value

What is the value of your Transformation Scheme		
£125,000		
Have you provided further financial information for your scheme *(completion of enclosure 1)*	**Yes**	**No**
		√

Section 4: Approval

Recommendation	
Reviewed by (OE Exec)	13thSeptember 2019
Date approved at OE	13th September 2019
Date approved at SCE	18th September 2019
Date approved at CCG Governing Body	2nd October 2019
Proposed frequency of review	On-going

Enclosures	
Enclosure 1	*Financial Information*
Enclosure 2	*Quality Impact Assessment*
Enclosure 3	*Equality and Engagement Impact Assessment*
Enclosure 4	*Data Protection Impact Assessment*

Appendices	
Appendix 1	*Risk Scoring*
Appendix 2	*Engagement Assessment*

Enclosure 1

Financial Information

Brief Description of where savings arise from

Rotherham has the 2nd highest rate of antidepressant prescribing in Y & H region. The cost efficiency is based on Rotherham reducing antidepressant prescribing to levels of CCGs that match it demographically.

Unscheduled drug price increases (No Cheaper Stock Available NCSO) could result in an actual cost increase despite a reduction in volume.

Profile of savings *(enter by month when the savings will be realised)*

	£		£
Apr- 20		Oct-20	£1000
May-20		Nov-20	£1000
Jun-20		Dec-20	£2000
Jul-20		Jan-21	£2000
Aug-20		Feb-21	£3000
Sep-20		Mar-21	£3000
		Total	**£12,000**

Please provide further appropriate financial information for your scheme:

In the 12 months to February 2019 NHS Rotherham spent £976,550 on antidepressant drugs (424, 407 . Rotherham CCG has the second highest prescribing rate for antidepressant prescriptions in Y & H.

An extensive patient engagement exercise discovered that patients thought that antidepressants were offered too readily and that other avenues of support should be offered.

Working with the voluntary sector a map of all voluntary agencies, that can offer patients support will be made available to GPs and directly to patients, who will be offered the option of choosing a non-pharmacological intervention.

Comparing Rotherham's antidepressant prescribing to CCGs it is matched against by Right Care and RDTC and 10% reduction in antidepressant prescriptions would not seem unreasonable at current prices this would produce an annual cost efficiency of approximately £100,000.

Enclosure 2

Quality Impact Assessment Screening Tool

Area of Quality Could the proposal impact *positive* ***(P)***, *negative* ***(N),*** *or neutral* ***(N/A)*** on any of the following:		**P/N or N/A**	**Risk score (if N)** *See app 1*	**Comments:** include reason for identifying impact as positive, negative or neutral
1	**Duty of Quality** *Consider: Compliance with NHS Constitution, Impact on partner organisations, Impact on organisations duty to safeguard children and vulnerable adults, Impact on other services within the organisation*	N/A		Patient choice is the key component of this scheme. In response to the patient engagement exercise the aim is to provide GPs with an increased range of interventions, other than just a prescription for an antidepressant.
2	**Clinical effectiveness** *Consider: Impact on provision of NICE compliant treatment, Impact on the implementation of evidence based practice, Impact on clinical outcomes, Impact on clinical leadership, Impact on the promotion of self-care, Impact on clinical engagement, mortality rates, readmission rates, safeguarding, partnership working*	P		NICE Guidance CG90 Depression in adults: recognition and management updated April 20181.4.1.1, "Do not use antidepressants routinely to treat persistent subthreshold depressive symptoms or mild depression because the risk–benefit ratio is poor. Recent studies have also found that antidepressants are more difficult to stop than first thought. By offering patients with initial early symptoms of depression a greater variety of interventions, this initiative will be in accordance with NICE guidance and the most recent evidence base.
3	**Patient Safety** *Consider: Impact on patient safety, Impact on avoidable harm, Impact on reliability of safety systems and processes, Impact on clinical workforce levels, competencies and experience, Impact on treatment times and procedures, Impact on safeguarding, Impact on systems and processes for ensuring that the risk of HCAIs is reduced, Impact upon clean and safe environments*	P		Antidepressants are useful but can cause dependency and can be difficult to stop. An extensive range of side effects can occur with these drugs and long term side effects include increased incidence of GI bleeding and osteoporosis. This initiative will reduce antidepressant usage in patients where the evidence base demonstrates they are least affective.
4	**Patient Experience** *Consider: Impact on patient informed choice and autonomy, Impact on patient access, Impact on dignity, respect and compassion, Impact on patients self-reported satisfaction on national/local surveys/ FFT, Impact on patients self-reported experience through the complaints process/PALS contacts, Impact on patient waiting times, Impact on the provision of individualised care, length of stay, privacy and dignity, discharge planning, collaborative working*	P		This initiative will improve patient choice in how they manage their symptoms. The initiative is in response to an extensive patient engagement exercise conducted across Rotherham.
For any scoring 12 and above, please consider whether this should be included in the CCGs risk register				

Assessment Completed by:	
Date of Assessment:	**17th January 2019**

Enclosure 3

Equality Impact and Engagement Assessment Form

Please retain one copy, and pass one copy to both the Equalities and Engagement leads

Scheme Number	Scheme Name
MM1	**Antidepressant prescribing**

Section 1: Equality Impact Assessment					
1.1	**Gathering of Information:** *This is the core of the analysis; how might the project or work impact on protected groups, with consideration of the General Equality Duty. Please add any general information here.*				
1.2	**Screening**				
	Please complete each area	**What key impact have you identified?**			**Information Source**
		Positive Impact *will actively promote or improve equality of opportunity*	**Neutral Impact** *where there are no notable consequences for any group.*	**Negative Impact** *negative or adverse impact causes disadvantage or exclusion* *If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures*	**What action,** *if any, is needed to address these issues and what difference will this make?* *For example: at this point no action is required. Further EIA screenings will be developed in future once there are recommendations to assess*
	Human Rights	Y	~~Y/N~~	~~Y/N~~	
	Age	Y	~~Y/N~~	~~Y/N~~	
	Carers	Y	~~Y/N~~	~~Y/N~~	
	Disability	Y	~~Y/N~~	~~Y/N~~	
	Sex	Y	~~Y/N~~	~~Y/N~~	
	Race	Y	~~Y/N~~	~~Y/N~~	
	Religion or belief	Y	~~Y/N~~	~~Y/N~~	
	Sexual Orientation	Y	~~Y/N~~	~~Y/N~~	
	Gender reassignment	Y	~~Y/N~~	~~Y/N~~	
	Pregnancy and maternity	Y	~~Y/N~~	~~Y/N~~	
	Marriage/civil partnership (only eliminating discrimination)	Y	~~Y/N~~	~~Y/N~~	
	Other relevant groups	Y	~~Y/N~~	~~Y/N~~	

For support or further information (in relation to EIA section) please contact: Alison Hague @ alisonhague@nhs.net

Section 2: Engagement Impact Assessment

2.1 What is the level of service change?

Refer to appendix 2 to assess the size of the change and tick the appropriate box

Level 1		Level 2	√	Level 3		Level 4	

Add additional information and rationale for this scoring below

A patient engagement exercise has been undertaken and it is the results of this exercise that resulted in this initiative.

2.2 Who are your stakeholders?

Consider using a mapping tool to identify stakeholders (resources can be found in the Project Management Checklist) - who is the change going to affect and how?
Complete below or attach or link to a mapping document

Patients – will be offered a greater choice of options to manage their symptoms

GPs– they will be able to offer their patients a greater range of options to manage their symptoms

2.3 What do we already know?

What do you already know about peoples' access, experience, health inequalities and health outcomes? Use intelligence from existing local, regional or national research, data, deliberative events or engagements.

Include any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight?

Describe how the existing or proposed engagement will be 'fair and proportionate', in relation to the activity?

Building on the EIA, how will you reach out to any community identified as having an impact by the scheme, are additional arrangements required?

2.4 Next Steps

As a result of this screening has further actions been identified	~~Yes~~	No

If yes, please describe actions	Further discussions with Engagement Lead	Completion of Full Engagement Plan	Other

Assessment Completed by:	
Date of Assessment:	**17th January 2019**

For support or further information (in relation to Engagement section) please contact: Helen Wyatt @ helen.wyatt6@nhs.net

Enclosure 4

Data Protection Impact Assessment

The below screening questions should be used inform whether a DPIA is necessary. This is not an exhaustive list therefore in the event of uncertainty, completion of a DPIA is recommended.

Scheme Number	Scheme Name
MM1	**Antidepressant prescribing**

Answering yes to any of these questions is an indication that a DPIA is required:

	Screening Questions	Yes	No
1	Will the project involve the collection of new identifiable or potentially identifiable data about individuals?		√
2	Will the project compel individuals to provide data about themselves? i.e. where they will have little awareness or choice.		√
3	Will identifiable data about individuals be shared with other organisations or people who have not previously had routine access to the data?		√
4	Are you using data about individuals for a purpose it is not currently used for or in a new way? i.e. using data collected to provide care for an evaluation of service development.		√
5	Where data about individuals is being used, would this be likely to raise privacy concerns or expectations? i.e. will it include health records, criminal records or other information that people may consider to be sensitive and private and may cause them concern or distress.		√
6	Will the project require you to contact individuals in ways which they may find intrusive? i.e. telephoning or emailing them without their prior consent.		√
7	Will the project result in you making decisions in ways which can have a significant impact on individuals? i.e. will it affect the care a person receives?		√
8	Does the project involve you using new technology which might be perceived as being privacy intrusive? i.e. using biometrics, facial recognition or automated decision making.		√
9	Is a service being transferred to a new supplier (or recontracted) and the end of an existing contract		√
10	Is processing of identifiable/potentially identifiable data being moved to a new organisation (but with same staff and processes)		√

Assessment Completed by:	
Date of Assessment:	**17th January 2019**

For further information or if a DPIA is required please contact Jonathan Mayes@ mayes.jonathan@nhs.net

Please retain a copy of this questionnaire within your project/system documentation.
Please note that once completed the following sections (1 to 4) should be extracted from the rest of this document prior to being included within the Publication Scheme.

NHS
Rotherham
Clinical Commissioning Group

2020/21 Transformation Scheme Profile

Scheme Number	Scheme Name
MM2	**Diabetes Prescribing**

Section 1: Scheme Overview

Brief Description of Scheme
NHSE diabetes improvement funding has been utilised to engage a Medicine Management Technician one day a week to undertake a detailed prescribing analyses at practice level. A total of 48 practice searches have been designed and tested and the weakest practices for the management of HbA1c identified. These searches are being run across all Rotherham practices and will identify Rotherham's areas of weakness in HbA1c management. These results will then be used to redesign how diabetes is managed across Rotherham. The aims of the redesigned service will be to; • Improved HbA1C management thereby reducing the incident of microvascular complications. • Improved patient experience. • Offer greater support to practices • Reduction in diabetes prescribing costs relative to similar CCGs • To ensure greater equity in the management of diabetes across Rotherham's practices.

Lead GP:	Lead Officer:
Dr Sophie Holden	Stuart Lakin

Please identify what level of documentation this scheme needs for approval		
Standard Report Template	**High Level (brief) Business Case**	**Full Business Case**
Required by all schemes	√	

Section 2: Impact Assessments *(see enclosures)*

Impact Assessments	Yes	No	Has this triggered the need for further assessment?
Has a Quality Impact Assessment been carried out?	√		
Has an Equality and Engagement Impact Assessment been carried out?	√		
Has a Data Protection Impact Assessment been carried out?	√		

Section 3: High Level Value

What is the value of your Transformation Scheme		
If Rotherham reduced its diabetes prescribing costs in line with Wakefield's (A CCG that is matched by PRESCQIPP & Right Care to Rotherham) this would release £750,000 / annum, although it will take 2-3 years minimum to release this efficiency		
Have you provided further financial information for your scheme *(completion of enclosure 1)*	**Yes**	**No**
	√	

Section 4: Approval

Recommendation	
Reviewed by (OE Exec)	13thSeptember 2019
Date approved at OE	13th September 2019
Date approved at SCE	18th September 2019
Date approved at CCG Governing Body	2nd October 2019
Proposed frequency of review	On-going

Enclosures	
Enclosure 1	*Financial Information*
Enclosure 2	*Quality Impact Assessment*
Enclosure 3	*Equality and Engagement Impact Assessment*
Enclosure 4	*Data Protection Impact Assessment*

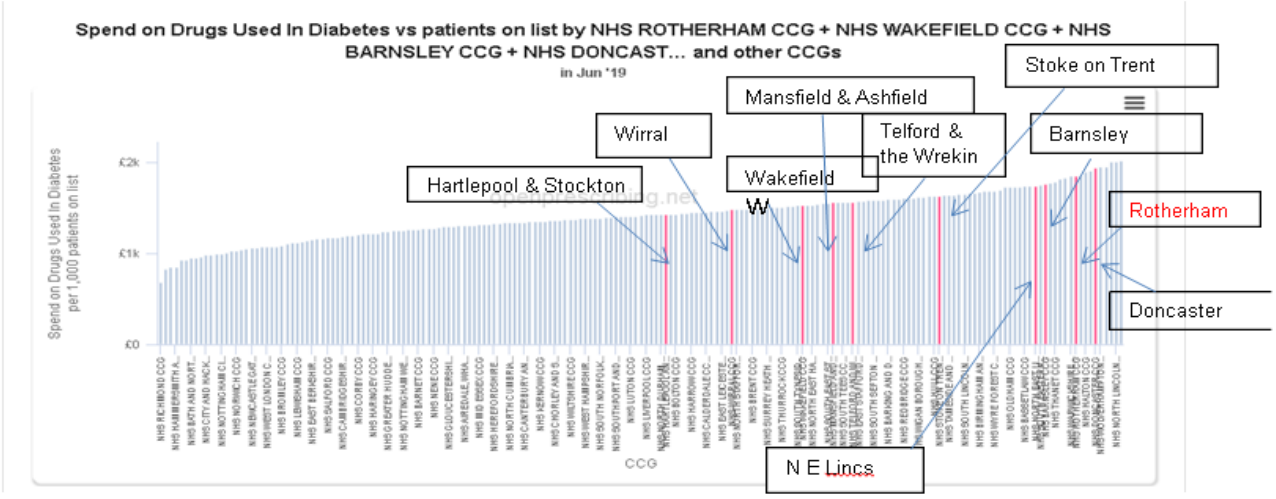
Appendices	
Appendix 1	*Risk Scoring*
Appendix 2	*Engagement Assessment*

Enclosure 1

Financial Information

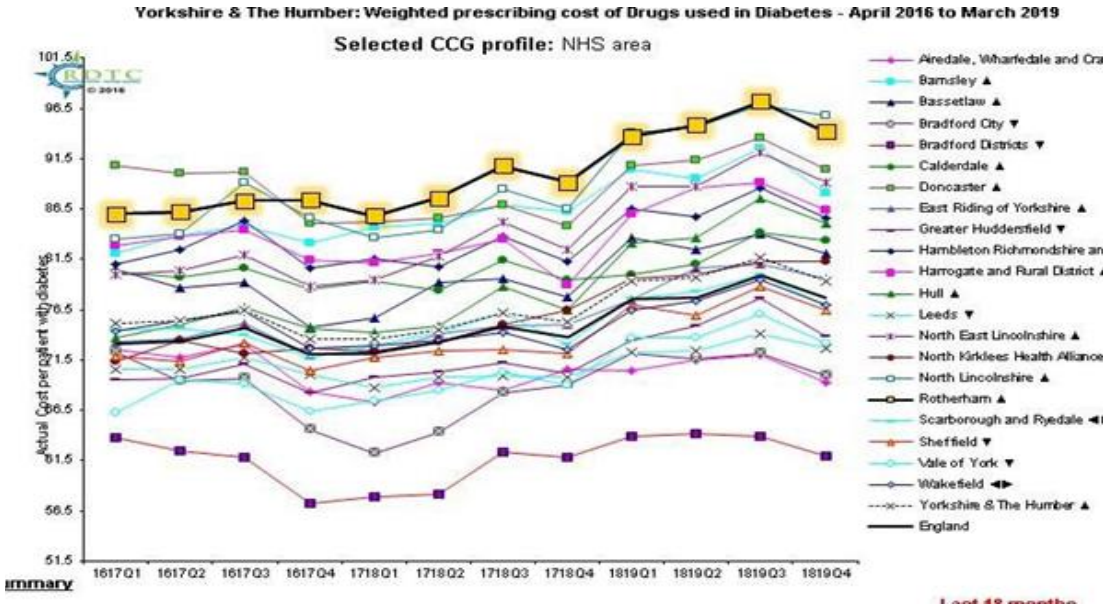
Brief Description of where savings arise from

- Total expenditure diabetes medication in 2018/19 = £6,334,922 this is an increases of £857,640 (15.5%) on the previous financial year
- Diabetes management as the highest total prescribing cost of all therapeutic areas and the highest cost growth.
- Rotherham has the 10th highest prescribing diabetes prescribing costs in England based on population.(open prescribing 08/19 Graph 1)
- Rotherham has the highest prescribing costs per diabetes patient in the Yorkshire & Humber Region (RDTC April 2019) Graph 2.
- The Rotherham CCG MMT has undertaken and extensive switch programme for blood glucose testing systems and pen needles. As a result in these two areas of diabetes management Rotherham's cost /patient are below the national average. Despite this Rotherham still has comparatively high prescribing costs compared to CCGs in our PRESCQIPP Cluster.



Profile of savings *(enter by month when the savings will be realised)*

	£		£
Apr- 20	£10,000	Oct-20	£50,000
May-20	£10,000	Nov-20	£50,000
Jun-20	£10,000	Dec-20	£50,000
Jul-20	£15,000	Jan-21	£50,000
Aug-20	£25,000	Feb-21	£50,000
Sep-20	£30,000	Mar-21	£50,000
		Total	**£400,000**



Please provide further appropriate financial information for your scheme:

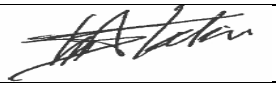
If Rotherham reduced its diabetes prescribing costs in line with Wakefield's* (A CCG that is matched by PRESCQIPP & Right Care to Rotherham) this would release £750,000 / annum, although it will take 2-3 years minimum to release this efficiency

*When the initial analysis was undertaken Rotherham was matched by Right Care into a cluster that contained Doncaster, Barnsley and Wakefield. These clusters have been revaluated and Rotherham is no longer matched against Wakefield and Doncaster.

Enclosure 2

Quality Impact Assessment Screening Tool

Area of Quality Could the proposal impact *positive* ***(P)***, *negative* ***(N),*** *or neutral* ***(N/A)*** on any of the following:		**P/N or N/A**	**Risk score (if N)** *See app 1*	**Comments:** include reason for identifying impact as positive, negative or neutral
1	**Duty of Quality** *Consider: Compliance with NHS Constitution, Impact on partner organisations, Impact on organisations duty to safeguard children and vulnerable adults, Impact on other services within the organisation*	N/A		
2	**Clinical effectiveness** *Consider: Impact on provision of NICE compliant treatment, Impact on the implementation of evidence based practice, Impact on clinical outcomes, Impact on clinical leadership, Impact on the promotion of self-care, Impact on clinical engagement, mortality rates, readmission rates, safeguarding, partnership working*	P		Rotherham continues to underperform on blood glucose management compared to other CCGs across York and the Humber area. Poor control of HbA1c will lead to renal failure, blindness and peripheral neuropathy. Improving diabetes management will result in long term patient benefits.
3	**Patient Safety** *Consider: Impact on patient safety, Impact on avoidable harm, Impact on reliability of safety systems and processes, Impact on clinical workforce levels, competencies and experience, Impact on treatment times and procedures, Impact on safeguarding, Impact on systems and processes for ensuring that the risk of HCAIs is reduced, Impact upon clean and safe environments*	N/A		
4	**Patient Experience** *Consider: Impact on patient informed choice and autonomy, Impact on patient access, Impact on dignity, respect and compassion, Impact on patients self-reported satisfaction on national/local surveys/ FFT, Impact on patients self-reported experience through the complaints process/PALS contacts, Impact on patient waiting times, Impact on the provision of individualised care, length of stay, privacy and dignity, discharge planning, collaborative working*	P		Improved diabetes management, will ultimately improve patient outcomes
For any scoring 12 and above, please consider whether this should be included in the CCGs risk register				

Assessment Completed by:	
Date of Assessment:	**27th January 2020**

Enclosure 3

Equality Impact and Engagement Assessment Form

Please retain one copy, and pass one copy to both the Equalities and Engagement leads

Scheme Number	Scheme Name
MM2	**Diabetes prescribing**

Section 1: Equality Impact Assessment

1.1 **Gathering of Information:** *This is the core of the analysis; how might the project or work impact on protected groups, with consideration of the General Equality Duty.*
Please add any general information here.

The aim of this scheme is to improve diabetes management across all patients.

1.2 **Screening**

Please complete each area	**What key impact have you identified?**			**Information Source**
	Positive Impact *will actively promote or improve equality of opportunity*	**Neutral Impact** *where there are no notable consequences for any group.*	**Negative Impact** *negative or adverse impact causes disadvantage or exclusion* *If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures*	**What action,** *if any, is needed to address these issues and what difference will this make?* *For example: at this point no action is required. Further EIA screenings will be developed in future once there are recommendations to assess*
Human Rights	Y	~~Y/N~~	~~Y/N~~	
Age	Y	~~Y/N~~	~~Y/N~~	
Carers	Y	~~Y/N~~	~~Y/N~~	
Disability	Y	~~Y/N~~	~~Y/N~~	
Sex	Y	~~Y/N~~	~~Y/N~~	
Race	Y	~~Y/N~~	~~Y/N~~	
Religion or belief	Y	~~Y/N~~	~~Y/N~~	
Sexual Orientation	Y	~~Y/N~~	~~Y/N~~	
Gender reassignment	Y	~~Y/N~~	~~Y/N~~	
Pregnancy and maternity	Y	~~Y/N~~	~~Y/N~~	
Marriage/civil partnership (only eliminating discrimination)	Y	~~Y/N~~	~~Y/N~~	
Other relevant groups	Y	~~Y/N~~	~~Y/N~~	

For support or further information (in relation to EIA section) please contact: Alison Hague @ alisonhague@nhs.net

Section 2: Engagement Impact Assessment

2.1 What is the level of service change?

Refer to appendix 2 to assess the size of the change and tick the appropriate box

Level 1	√	Level 2		Level 3		Level 4	

Add additional information and rationale for this scoring below

2.2 Who are your stakeholders?

Consider using a mapping tool to identify stakeholders (resources can be found in the Project Management Checklist) - who is the change going to affect and how?
Complete below or attach or link to a mapping document

Patients with diabetes

Practice staff GPs and other health care professionals

Rotherham Diabetes Specialist Nurses

2.3 What do we already know?

What do you already know about peoples' access, experience, health inequalities and health outcomes? Use intelligence from existing local, regional or national research, data, deliberative events or engagements.

Include any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight?

Describe how the existing or proposed engagement will be 'fair and proportionate', in relation to the activity?

Building on the EIA, how will you reach out to any community identified as having an impact by the scheme, are additional arrangements required?

There is a considerable variation between practices in how the manage HbA1C (long term blood glucose control).

Patients will have little insight whether their GP practice is good at managing their diabetes or not. Practice data has already been obtained and will be used to engage with the underperforming practices. Utilising the skills of the diabetes specialist nurses the underperforming practices will receive support to improve their skills in diabetes management.

The aim is to ensure that there is equity in the quality pf diabetes care that practices deliver across all 30 Rotherham GP practices.

2.4 Next Steps

As a result of this screening has further actions been identified	Yes	No
		√

If yes, please describe actions	Further discussions with Engagement Lead	Completion of Full Engagement Plan	Other

Assessment Completed by:	
Date of Assessment:	**24th January 2020**

Enclosure 4

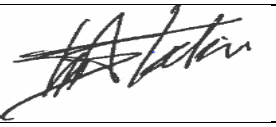
Data Protection Impact Assessment

The below screening questions should be used inform whether a DPIA is necessary. This is not an exhaustive list therefore in the event of uncertainty, completion of a DPIA is recommended.

Scheme Number	Scheme Name
MM2	**Diabetes prescribing**√

Answering yes to any of these questions is an indication that a DPIA is required:

	Screening Questions	Yes	No
1	Will the project involve the collection of new identifiable or potentially identifiable data about individuals?		√
2	Will the project compel individuals to provide data about themselves? i.e. where they will have little awareness or choice.		√
3	Will identifiable data about individuals be shared with other organisations or people who have not previously had routine access to the data?		√
4	Are you using data about individuals for a purpose it is not currently used for or in a new way? i.e. using data collected to provide care for an evaluation of service development.		√
5	Where data about individuals is being used, would this be likely to raise privacy concerns or expectations? i.e. will it include health records, criminal records or other information that people may consider to be sensitive and private and may cause them concern or distress.		√
6	Will the project require you to contact individuals in ways which they may find intrusive? i.e. telephoning or emailing them without their prior consent.		√
7	Will the project result in you making decisions in ways which can have a significant impact on individuals? i.e. will it affect the care a person receives?		√
8	Does the project involve you using new technology which might be perceived as being privacy intrusive? i.e. using biometrics, facial recognition or automated decision making.		√
9	Is a service being transferred to a new supplier (or recontracted) and the end of an existing contract		√
10	Is processing of identifiable/potentially identifiable data being moved to a new organisation (but with same staff and processes)		√

Assessment Completed by:	
Date of Assessment:	**20th January 2020**

For further information or if a DPIA is required please contact Jonathan Mayes@ mayes.jonathan@nhs.net

Please retain a copy of this questionnaire within your project/system documentation.
Please note that once completed the following sections (1 to 4) should be extracted from the rest of this document prior to being included within the Publication Scheme.

NHS
Rotherham
Clinical Commissioning Group

2020/21 Transformation Scheme Profile

Scheme Number	Scheme Name
MM3	**Pilot Chronic Pain Clinic**

Section 1: Scheme Overview

Brief Description of Scheme
There is increasing concern nationally regarding the use of strong opioid analgesics to manage long term chronic non-palliative pain. The evidence clearly demonstrates that opioid analgesics are ineffective in managing long term pain of a neuropathic or skeletal nature. Rotherham GPs have expressed long-standing reservations in the specialist pain services available to them based in Sheffield and Doncaster. GPs also admit to finding the management of chronic pain conditions challenging especially as the complex nature of many chronic pain conditions cannot be addressed in a ten minute appointment. Prescribing data indicates that whilst Rotherham's prescribing of analgesics and opioid analgesics is in line with that of similar CCGs, however, there is still the potential to release cost efficiencies, estimated to be around £250,000 /annum.

Lead GP:	Lead Officer:
Dr Sophie Holden	Stuart Lakin

Please identify what level of documentation this scheme needs for approval		
Standard Report Template	**High Level (brief) Business Case**	**Full Business Case**
Required by all schemes	√	

Section 2: Impact Assessments *(see enclosures)*

Impact Assessments	Yes	No	Has this triggered the need for further assessment?
Has a Quality Impact Assessment been carried out?	√		
Has an Equality and Engagement Impact Assessment been carried out?	√		
Has a Data Protection Impact Assessment been carried out?	√		

Section 3: High Level Value

What is the value of your Transformation Scheme
Prescribing data indicates that whilst Rotherham's prescribing of analgesics and opioid analgesics is in line with that of similar CCGs, however, there is still the potential to release cost efficiencies, estimated to be around £250,000 /annum. If the chronic pain pilot is successful it could reduce prescribing costs by up to £250,000/ annum

Have you provided further financial information for your scheme *(completion of enclosure 1)*	Yes	No
	√	

Section 4: Approval

Recommendation	
Reviewed by (OE Exec)	13thSeptember 2019
Date approved at OE	13th September 2019
Date approved at SCE	18th September 2019
Date approved at CCG Governing Body	2nd October 2019
Proposed frequency of review	On-going

Enclosures	
Enclosure 1	*Financial Information*
Enclosure 2	*Quality Impact Assessment*
Enclosure 3	*Equality and Engagement Impact Assessment*
Enclosure 4	*Data Protection Impact Assessment*

Appendices	
Appendix 1	*Risk Scoring*
Appendix 2	*Engagement Assessment*

Enclosure 1

Financial Information

Brief Description of where savings arise from
Prescribing data indicates that whilst Rotherham's prescribing of analgesics and opioid analgesics is in line with that of similar CCGs, however, there is still the potential to release cost efficiencies, estimated to be around £250,000 /annum
Profile of savings *(enter by month when the savings will be realised)*

	£		£
Apr- 20	£10,000	Oct-20	£25,000
May-20	£15,000	Nov-20	£25,000
Jun-20	£15,000	Dec-20	£25,000
Jul-20	£20,000	Jan-21	£25,000
Aug-20	£20,000	Feb-21	£25,000
Sep-20	£20,000	Mar-21	£25,000
		Total	**£250,000**

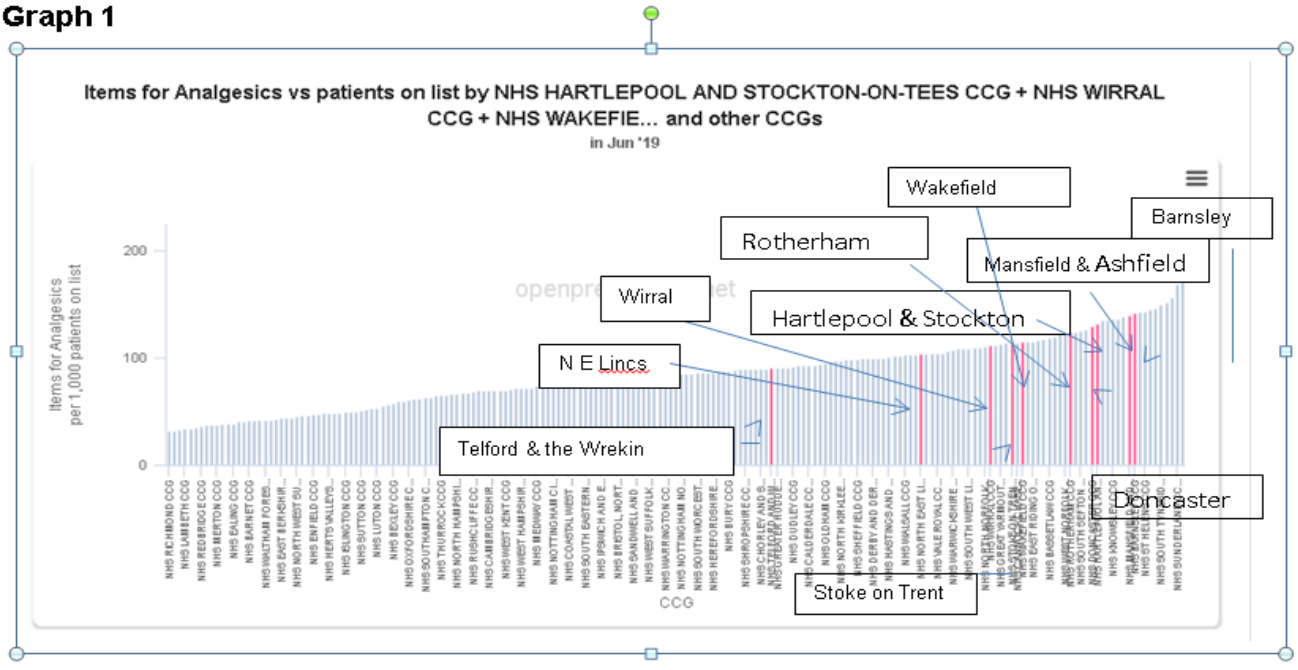
Please provide further appropriate financial information for your scheme:

- NHS Rotherham CCG spent £2,752,147 on prescribed analgesics in the 12 months to June 2019 (Open prescribing August 2019).

- This gives Rotherham the 22nd highest analgesic costs\ patient in England. Rotherham's analgesic prescribing costs are in line with the CCGs that it is matched against (PRESCQIPP) Graph 1

- •

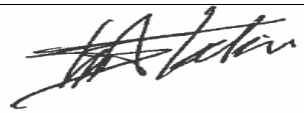
Graph 1



Enclosure 2

Quality Impact Assessment Screening Tool

Area of Quality Could the proposal impact *positive* ***(P)***, *negative* ***(N)***, *or neutral* ***(N/A)*** on any of the following:		**P/N or N/A**	**Risk score (if N)** *See app 1*	**Comments:** include reason for identifying impact as positive, negative or neutral
1	**Duty of Quality** *Consider: Compliance with NHS Constitution, Impact on partner organisations, Impact on organisations duty to safeguard children and vulnerable adults, Impact on other services within the organisation*	N/A		
2	**Clinical effectiveness** *Consider: Impact on provision of NICE compliant treatment, Impact on the implementation of evidence based practice, Impact on clinical outcomes, Impact on clinical leadership, Impact on the promotion of self-care, Impact on clinical engagement, mortality rates, readmission rates, safeguarding, partnership working*	P		• Improved patient experience through the holistic management of their pain. • Reduction in use of strong opioid analgesics • Reduction in prescribing costs. • Reduction in GP attendances for chronic pain • Positive GP evaluation of the service
	Patient Safety *Consider: Impact on patient safety, Impact on avoidable harm, Impact on reliability of safety systems and processes, Impact on clinical workforce levels, competencies and experience, Impact on treatment times and procedures, Impact on safeguarding, Impact on systems and processes for ensuring that the risk of HCAIs is reduced, Impact upon clean and safe environments*	P		The increasing use of opioid analgesics is a cause of national concern. It is recognised that they have limited effectiveness in managing chronic pain but can result in serious debilitating side effects. The aim of the chronic pain clinic will be to offer a holistic approach to pain management. If the pilot can demonstrate that it can manage pain without the use of opioid analgesics or can reduce patients dependency on these drugs this will improve both the patient experience and safety.
4	**Patient Experience** *Consider: Impact on patient informed choice and autonomy, Impact on patient access, Impact on dignity, respect and compassion, Impact on patients self-reported satisfaction on national/local surveys/ FFT, Impact on patients self-reported experience through the complaints process/PALS contacts, Impact on patient waiting times, Impact on the provision of individualised care, length of stay, privacy and dignity, discharge planning, collaborative working*	P		See above
For any scoring 12 and above, please consider whether this should be included in the CCGs risk register				

Assessment Completed by:	
Date of Assessment:	**27th January 2020**

Enclosure 3

Equality Impact and Engagement Assessment Form

Please retain one copy, and pass one copy to both the Equalities and Engagement leads

Scheme Number	Scheme Name
MM3	**Pilot Chronic Pain Clinic**

Section 1: Equality Impact Assessment

1.1 **Gathering of Information:** *This is the core of the analysis; how might the project or work impact on protected groups, with consideration of the General Equality Duty.*
Please add any general information here.

The aim of this scheme is to improve the management of chronic pain for all patients.

1.2 **Screening**

Please complete each area	**What key impact have you identified?**			**Information Source**
	Positive Impact *will actively promote or improve equality of opportunity*	**Neutral Impact** *where there are no notable consequences for any group.*	**Negative Impact** *negative or adverse impact causes disadvantage or exclusion* *If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures*	**What action,** *if any, is needed to address these issues and what difference will this make?* *For example: at this point no action is required. Further EIA screenings will be developed in future once there are recommendations to assess*
Human Rights	~~Y/N~~	Y	~~Y/N~~	
Age	Y	~~Y/N~~	~~Y/N~~	
Carers	Y	~~Y/N~~	~~Y/N~~	
Disability	Y	~~Y/N~~	~~Y/N~~	
Sex	Y	~~Y/N~~	~~Y/N~~	
Race	Y	~~Y/N~~	~~Y/N~~	
Religion or belief	Y	~~Y/N~~	~~Y/N~~	
Sexual Orientation	Y	~~Y/N~~	~~Y/N~~	
Gender reassignment	Y	~~Y/N~~	~~Y/N~~	
Pregnancy and maternity	~~Y/N~~	Y	~~Y/N~~	
Marriage/civil partnership (only eliminating discrimination)	~~Y/N~~	Y	~~Y/N~~	
Other relevant groups	y	~~Y/N~~	~~Y/N~~	

For support or further information (in relation to EIA section) please contact: Alison Hague @ alisonhague@nhs.net

Section 2: Engagement Impact Assessment

2.1 What is the level of service change?

Refer to appendix 2 to assess the size of the change and tick the appropriate box

Level 1	√	Level 2		Level 3		Level 4	

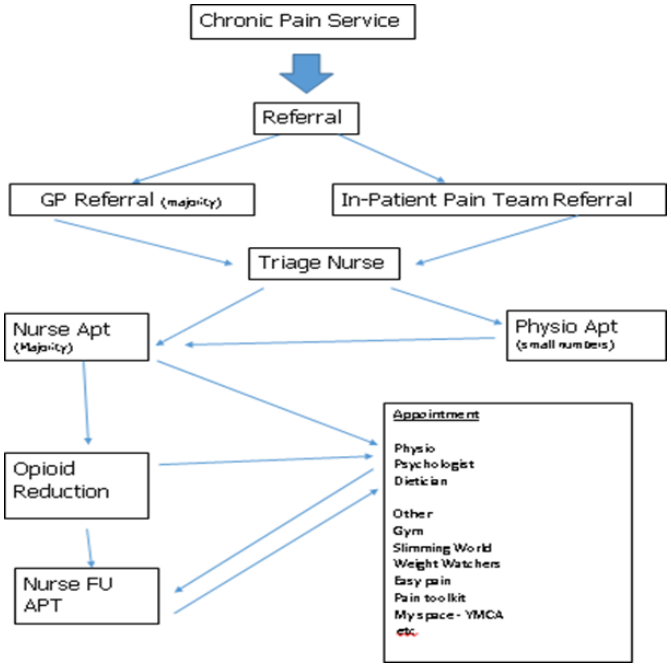
Add additional information and rationale for this scoring below

2.2 Who are your stakeholders?

Consider using a mapping tool to identify stakeholders (resources can be found in the Project Management Checklist) - who is the change going to affect and how?
Complete below or attach or link to a mapping document

Patients – Improved choice on how their chronic pain is managed

GPs and Practice staff – Provided with increased support in chronic pain management.



2.3 What do we already know?

What do you already know about peoples' access, experience, health inequalities and health outcomes? Use intelligence from existing local, regional or national research, data, deliberative events or engagements.

Include any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight?

Describe how the existing or proposed engagement will be 'fair and proportionate', in relation to the activity?

Building on the EIA, how will you reach out to any community identified as having an impact by the scheme, are additional arrangements required?

The pilot service will be evaluated; the patients experience will form a major part of this evaluation.

2.4 Next Steps

As a result of this screening has further actions been identified	Yes	No
		√

If yes, please describe actions	Further discussions with Engagement Lead	Completion of Full Engagement Plan	Other

Assessment Completed by:	
Date of Assessment:	**27th January 2020**

Enclosure 4

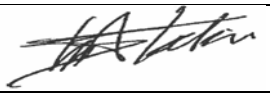
Data Protection Impact Assessment

The below screening questions should be used inform whether a DPIA is necessary. This is not an exhaustive list therefore in the event of uncertainty, completion of a DPIA is recommended.

Scheme Number	Scheme Name
MM3	**Pilot Chronic Pain Clinic**

Answering yes to any of these questions is an indication that a DPIA is required:

	Screening Questions	Yes	No
1	Will the project involve the collection of new identifiable or potentially identifiable data about individuals?		√
2	Will the project compel individuals to provide data about themselves? i.e. where they will have little awareness or choice.		√
3	Will identifiable data about individuals be shared with other organisations or people who have not previously had routine access to the data?		√
4	Are you using data about individuals for a purpose it is not currently used for or in a new way? i.e. using data collected to provide care for an evaluation of service development.		√
5	Where data about individuals is being used, would this be likely to raise privacy concerns or expectations? i.e. will it include health records, criminal records or other information that people may consider to be sensitive and private and may cause them concern or distress.		√
6	Will the project require you to contact individuals in ways which they may find intrusive? i.e. telephoning or emailing them without their prior consent.		√
7	Will the project result in you making decisions in ways which can have a significant impact on individuals? i.e. will it affect the care a person receives?		√
8	Does the project involve you using new technology which might be perceived as being privacy intrusive? i.e. using biometrics, facial recognition or automated decision making.		√
9	Is a service being transferred to a new supplier (or recontracted) and the end of an existing contract		√
10	Is processing of identifiable/potentially identifiable data being moved to a new organisation (but with same staff and processes)		√

Assessment Completed by:	
Date of Assessment:	**27th January 2020**

For further information or if a DPIA is required please contact Jonathan Mayes@ mayes.jonathan@nhs.net

Please retain a copy of this questionnaire within your project/system documentation.
Please note that once completed the following sections (1 to 4) should be extracted from the rest of this document prior to being included within the Publication Scheme.

2020/21 Transformation Scheme Profile

Scheme Number	Scheme Name
MM4	Specialist Respiratory Pharmacist

Section 1: Scheme Overview

Brief Description of Scheme

Role of the community specialist respiratory pharmacist.

- Undertake holistic medication reviews (Not confined just to respiratory drugs)
- Facilitate the production of joint Primary\Secondary Care prescribing guidelines
  - There are currently 3 national respiratory guidelines NICE\ BTS British Thoracic Society & GOLD (International guidelines). The inconsistencies between these guidelines and the failure of clinicians across Rotherham to reach a consensus has hindered progress.
- Increase the community respiratory teams critical appraisal skills
  - Respiratory prescribing is an area of active ongoing research, the majority of clinical trials are sponsored by the pharmaceutical industry. The pharmaceutical industry is also very influential in the production of the recognised national\international guidelines. It is important that the community respiratory team have a consistent and co-ordinated approach to evaluating the continually changing evidence base.
- Mange relationships with the pharmaceutical industry.
  - Whilst a drug will lose its patent the inhaler device remains on patent forever. Much of the ongoing research concerns the advantages of one inhaler device versus another. Once a drug comes off patent a competitor has to launch the generic version in a different device. The pharmaceutical industry through sponsored training events and promotion is not only successful in promoting new products but also in preventing the uptake of competitors products post patent loss.
- Ensure the cost effectiveness of prescribing
  - There is a potential £500,000 cost efficiency that could be released if Rotherham could reduce its prescribing costs to that of similar CCGs that Rotherham is matched to.(12 months respiratory prescribing costs = £6,063,186.= 13.5% of all prescribing costs)
  - Review the use of rescue & prophylaxis antibiotic prescribing in respiratory disease.
  - Rotherham is under scrutiny as a high volume antibiotic prescribing area. The use of antibiotics as rescue medication to prevent self-diagnosed chest infections needs to be reviewed as a matter of urgency.

Lead GP:	Lead Officer:
Dr Sophie Holden	Stuart Lakin

Please identify what level of documentation this scheme needs for approval		
Standard Report Template	**High Level (brief) Business Case**	**Full Business Case**
Required by all schemes	√	

Section 2: Impact Assessments *(see enclosures)*

Impact Assessments	Yes	No	Has this triggered the need for further assessment?
Has a Quality Impact Assessment been carried out?	√		
Has an Equality and Engagement Impact Assessment been carried out?	√		
Has a Data Protection Impact Assessment been carried out?	√		

Section 3: High Level Value

What is the value of your Transformation Scheme

£250,000 in year 1 (£500,000 in total)

Have you provided further financial information for your scheme *(completion of enclosure 1)*	Yes	No
	√	

Section 4: Approval

Recommendation	
Reviewed by (OE Exec)	13thSeptember 2019
Date approved at OE	13th September 2019
Date approved at SCE	18th September 2019
Date approved at CCG Governing Body	2nd October 2019
Proposed frequency of review	On-going

Enclosures	
Enclosure 1	*Financial Information*
Enclosure 2	*Quality Impact Assessment*
Enclosure 3	*Equality and Engagement Impact Assessment*
Enclosure 4	*Data Protection Impact Assessment*

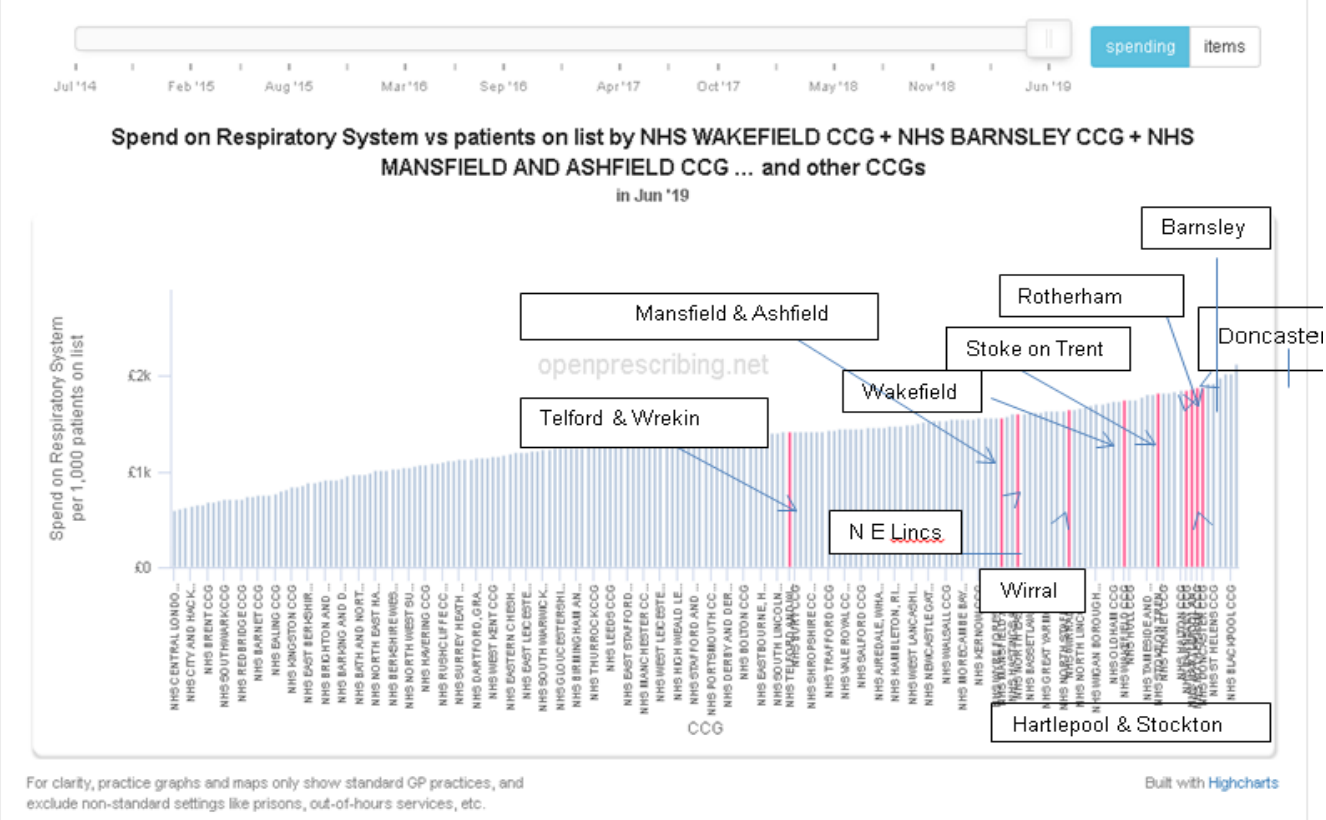
Appendices	
Appendix 1	*Risk Scoring*
Appendix 2	*Engagement Assessment*

Enclosure 1

Financial Information

Brief Description of where savings arise from

- Rotherham has the 8th highest prescribing costs (per resident) in England and the second highest amongst the group of CCGs that Rotherham is matched to. (PRESCQIPP) (Open prescribing data)
- Total respiratory prescribing costs for respiratory drugs in the 12 months to June 2019 = £6,063,186.= 13.5% of all prescribing costs
- Regional Drug & Therapeutic Centre (RDTC) data demonstrates that Rotherham as a tendency to be an early adopter of new agents, but there is no evidence that this results in improved outcomes



Profile of savings *(enter by month when the savings will be realised)*

	£		£
Apr- 20	£10,000	Oct-20	£20,000
May-20	£10,000	Nov-20	£30,000
Jun-20	£10,000	Dec-20	£30,000
Jul-20	£10,000	Jan-21	£30,000
Aug-20	£20,000	Feb-21	£30,000
Sep-20	£20,000	Mar-21	£30,000
		Total	

Enclosure 2

Quality Impact Assessment Screening Tool

Area of Quality Could the proposal impact *positive* ***(P)****, negative* ***(N),*** *or neutral* ***(N/A)*** on any of the following:		**P/N or N/A**	**Risk score (if N)** *See app 1*	**Comments:** include reason for identifying impact as positive, negative or neutral
1	**Duty of Quality** *Consider: Compliance with NHS Constitution, Impact on partner organisations, Impact on organisations duty to safeguard children and vulnerable adults, Impact on other services within the organisation*	P		This post will improve the quality of prescribing and ensure that respiratory prescribing mirrors the latest evidence base and agreed national guidance. It will improve the equity of prescribing across Rotherham's practices.
2	**Clinical effectiveness** *Consider: Impact on provision of NICE compliant treatment, Impact on the implementation of evidence based practice, Impact on clinical outcomes, Impact on clinical leadership, Impact on the promotion of self-care, Impact on clinical engagement, mortality rates, readmission rates, safeguarding, partnership working*	P		See above This post will; support and be integrated into the reconfigured breathing space service.
3	**Patient Safety** *Consider: Impact on patient safety, Impact on avoidable harm, Impact on reliability of safety systems and processes, Impact on clinical workforce levels, competencies and experience, Impact on treatment times and procedures, Impact on safeguarding, Impact on systems and processes for ensuring that the risk of HCAIs is reduced, Impact upon clean and safe environments*	N/A		
4	**Patient Experience** *Consider: Impact on patient informed choice and autonomy, Impact on patient access, Impact on dignity, respect and compassion, Impact on patients self-reported satisfaction on national/local surveys/ FFT, Impact on patients self-reported experience through the complaints process/PALS contacts, Impact on patient waiting times, Impact on the provision of individualised care, length of stay, privacy and dignity, discharge planning, collaborative working*	P		
For any scoring 12 and above, please consider whether this should be included in the CCGs risk register				

Assessment Completed by:	
Date of Assessment:	**28th January 2020**

Enclosure 3

Equality Impact and Engagement Assessment Form

Please retain one copy, and pass one copy to both the Equalities and Engagement leads

Scheme Number	Scheme Name
MM4	**Specialist Respiratory Pharmacist**

Section 1: Equality Impact Assessment

1.1 **Gathering of Information:** *This is the core of the analysis; how might the project or work impact on protected groups, with consideration of the General Equality Duty.*
Please add any general information here.

This post will ensure that there is greater equity of prescribing for all Rotherham patients. It will improve adherence of respiratory prescribing to the latest evidence base.

1.2 **Screening**

Please complete each area	**What key impact have you identified?**			**Information Source**
	Positive Impact *will actively promote or improve equality of opportunity*	**Neutral Impact** *where there are no notable consequences for any group.*	**Negative Impact** *negative or adverse impact causes disadvantage or exclusion* *If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures*	**What action,** *if any, is needed to address these issues and what difference will this make?* *For example: at this point no action is required. Further EIA screenings will be developed in future once there are recommendations to assess*
Human Rights	~~Y/N~~	Y	~~Y/N~~	
Age	~~Y/N~~	Y	~~Y/N~~	
Carers	~~Y/N~~	Y	~~Y/N~~	
Disability	~~Y/N~~	Y	~~Y/N~~	
Sex	~~Y/N~~	Y	~~Y/N~~	
Race	~~Y/N~~	Y	~~Y/N~~	
Religion or belief	~~Y/N~~	Y	~~Y/N~~	
Sexual Orientation	~~Y/N~~	Y	~~Y/N~~	
Gender reassignment	~~Y/N~~	Y	~~Y/N~~	
Pregnancy and maternity	~~Y/N~~	Y	~~Y/N~~	
Marriage/civil partnership (only eliminating discrimination)	~~Y/N~~	Y	~~Y/N~~	
Other relevant groups	~~Y/N~~	Y	~~Y/N~~	

For support or further information (in relation to EIA section) please contact: Alison Hague @ alisonhague@nhs.net

Section 2: Engagement Impact Assessment

2.1 What is the level of service change?

Refer to appendix 2 to assess the size of the change and tick the appropriate box

Level 1	√	Level 2		Level 3		Level 4	

Add additional information and rationale for this scoring below

2.2 Who are your stakeholders?

Consider using a mapping tool to identify stakeholders (resources can be found in the Project Management Checklist) - who is the change going to affect and how?
Complete below or attach or link to a mapping document

Improved support for practices and practice health care professionals with an interest in respiratory disease.
Widening the skill set of the reconfigured Breathing Space service.
Improved equity of prescribing for patient

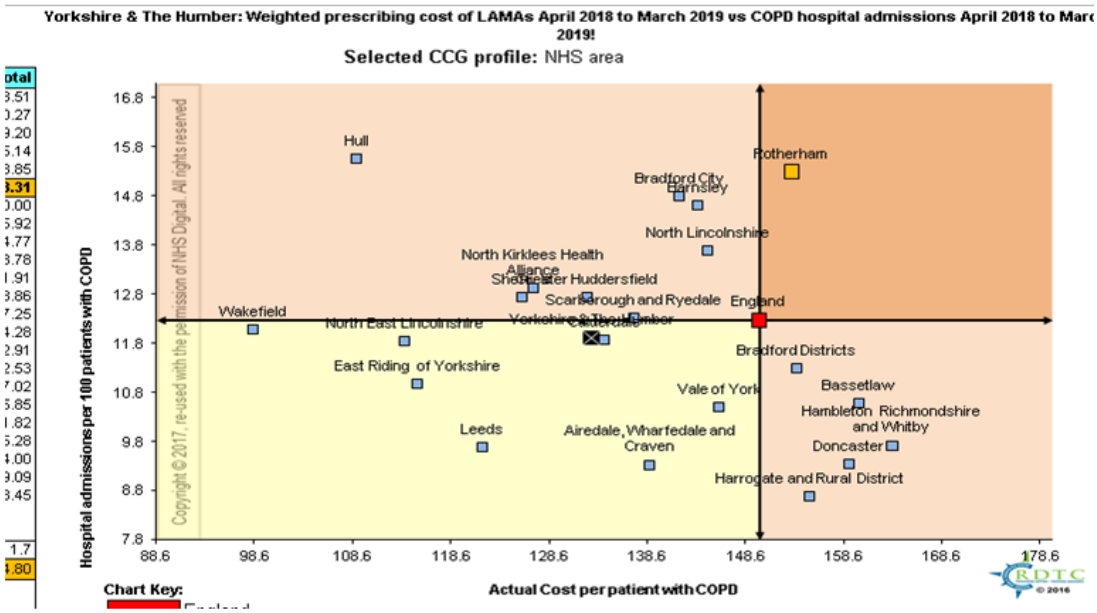
2.3 What do we already know?

What do you already know about peoples' access, experience, health inequalities and health outcomes? Use intelligence from existing local, regional or national research, data, deliberative events or engagements.

Include any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight?

Describe how the existing or proposed engagement will be 'fair and proportionate', in relation to the activity?

Building on the EIA, how will you reach out to any community identified as having an impact by the scheme, are additional arrangements required?



Rotherham is shown to have a high rate of COPD hospital admissions despite high respiratory prescribing costs. All other CCGs with similar high respiratory cost have below average COPD admissions. Although this may be due to coding issues connected with the Breathing Space service.
Work needs to be undertaken to explore if there is a significant variation in admission rates between Rotherham practices.

2.4 Next Steps

As a result of this screening has further actions been identified	Yes	No
		√

If yes, please describe actions	Further discussions with Engagement Lead	Completion of Full Engagement Plan	Other

Assessment Completed by:	
Date of Assessment:	**28th January 2020**

Enclosure 4

Data Protection Impact Assessment

The below screening questions should be used inform whether a DPIA is necessary. This is not an exhaustive list therefore in the event of uncertainty, completion of a DPIA is recommended.

Scheme Number	Scheme Name
MM4	√

Answering yes to any of these questions is an indication that a DPIA is required:

	Screening Questions	Yes	No
1	Will the project involve the collection of new identifiable or potentially identifiable data about individuals?		√
2	Will the project compel individuals to provide data about themselves? i.e. where they will have little awareness or choice.		√
3	Will identifiable data about individuals be shared with other organisations or people who have not previously had routine access to the data?		√
4	Are you using data about individuals for a purpose it is not currently used for or in a new way? i.e. using data collected to provide care for an evaluation of service development.		√
5	Where data about individuals is being used, would this be likely to raise privacy concerns or expectations? i.e. will it include health records, criminal records or other information that people may consider to be sensitive and private and may cause them concern or distress.		√
6	Will the project require you to contact individuals in ways which they may find intrusive? i.e. telephoning or emailing them without their prior consent.		√
7	Will the project result in you making decisions in ways which can have a significant impact on individuals? i.e. will it affect the care a person receives?		√
8	Does the project involve you using new technology which might be perceived as being privacy intrusive? i.e. using biometrics, facial recognition or automated decision making.		√
9	Is a service being transferred to a new supplier (or recontracted) and the end of an existing contract		√
10	Is processing of identifiable/potentially identifiable data being moved to a new organisation (but with same staff and processes)		√

Assessment Completed by:	
Date of Assessment:	**28th January 2020**

For further information or if a DPIA is required please contact Jonathan Mayes@ mayes.jonathan@nhs.net

Please retain a copy of this questionnaire within your project/system documentation.
Please note that once completed the following sections (1 to 4) should be extracted from the rest of this document prior to being included within the Publication Scheme.