NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

CCG REPORT COVER SHEET

Meeting Title:	**CCG Governing Body in Public**				**Date: 5 March 2019**		
Report Title:	**Chief Officer's Report**				**Agenda Item: 2.6**		
Chief Officer:	Jan Thomas, Chief Officer						
Clinical Lead:							
Report Author:	Sharon Fox, Associate Director of Corporate Affairs (CCG Secretary)						
Document Status:	Final						
Report Summary:	The report provides a brief update of issues to bring to the Governing Body's attention since our last meeting in public on 8 January 2019.						
Report Purpose:	**For Assurance**		**For Decision**	**X**	**For Approval**		**For Recommendation**
Recommendation:	The Governing Body is asked to note the Chief Officer Report for March 2019. The Governing Body is asked to support the recommendation not to go out to election for the two GP Member posts that are coming to the end of their current terms, subject to a wider discussion on GP Governing Body membership which is underway. The Governing Body is asked to note the EU Exit Preparedness Position Statement set out at Appendix 1. The Governing Body is asked to endorse the work of the Clinical Executive Committee. The Governing Body is asked to formally ratify the recommendations from the last two Joint Prescribing Group meetings attached at Appendix 2 and 3.						
Link to Corporate Objective:	**Objective 1 – Delivering the Improvement Plan for 2018/19 and beyond;**						**X**
	Objective 2 – Delivering the Financial Plan for 2018-2019						**X**
	Objective 3 – Delivering national must dos and service priorities set out in the National Planning Guidance						**X**
	Objective 4 – Ensuring clear oversight of patient safety and quality						**X**
	Objective 5 – Ensuring robust governance arrangements are in place to ensure the CCG delivers its statutory duties						**X**
	Objective 6 – Ensuring delivery of robust engagement and communications plans to support delivery						**X**
CAF (Strategic Risk) Reference	**Description of Risk**						**Current Risk Score**
CAF12	Failure to achieve the Financial Control total agreed with NHS England						20 (R)
CAF16	Risk to delivery of QIPP Plan (Transformation)						20 (R)
CAF19	Failure to deliver key NHS Constitution Targets						16 (R)
CAF20	Failure to deliver the CCG's Improvement and Delivery Plan 2018-2019						12 (A)
CAF22	Risk to maintaining robust CCG Governance Arrangements						12 (A)
G3	Failure to adequately prepare for a no deal EU Exit						12 (A)
NHSE CCG IAF Links	**IAF 1 Domain 1 - Better Health**				**X**		
	IAF 2 Domain 2 - Better Care				**X**		
	IAF 3 Domain 3 - Sustainability:				**X**		
	IAF 4 Domain 4 - Leadership				**X**		
Resource implications:	N/A						
Chief Officer/ SRO Sign Off:	Jan Thomas, Chief Officer						
Chief Finance Officer Sign Off: (if required)	N/A						
Legal implications including equality and diversity assessment:	N/A						
Conflicts of Interest	As recorded in the CCG's Governing Body Declaration of Interest Register.						
Report history:	Produced for this meeting						
Next steps:	As per recommendations						

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MEETING: **GOVERNING BODY IN PUBLIC**

AGENDA ITEM: **2.6** **SECTION:** **GENERAL ISSUES**

DATE: **5 MARCH 2019**

TITLE: **CHIEF OFFICER'S REPORT**

FROM: **JAN THOMAS**
CHIEF OFFICER

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1 ISSUE

1.1 This report provides an overview of key issues to bring to the Governing Body's attention since our last meeting in public on 8 January 2019.

2. OPERATIONS

2.1 As part of our Improvement and Delivery Plan, the CCG has now finalised integrated reporting which includes Finance, Performance, Quality and Activity into one Integrated Performance Report (IPR). This is presented at Agenda Item 4.2, and was fully considered by the new Integrated Performance and Assurance Committee at its meeting in February 2019. I would highlight the following issues to the Governing Body in my capacity as Chief Officer.

2.1.1 Finance – Month 10 - At Month 10, the CCG is reporting a year to date position of £1.1m above plan, but remains on track to deliver the deficit control total of £35.1m agreed with NHS England (NHSE). Key movements in the forecast outturn include a deterioration in the Section 117 spend (£452k), NHS Continuing Healthcare (£728k) and delegated commissioning (£170k). This is offset by improvements in the acute forecast and use of reserves.

2.1.2 QIPP - I am pleased to report that the year to date QIPP delivery is ahead of plan with a full year forecast £1.4M ahead of plan. The CCG is formally reporting a fully mitigated risk profile, but the position remains volatile and £1.8m of mitigations are still to be identified. NHSE is fully sighted on the CCG's risk position.

2.1.3 Performance - The CCG is currently on weekly escalation calls with the NHSE Regional Team in relation to the performance of North West Anglia NHS Foundation Trust (NWAFT). A&E performance at Peterborough City Hospital is of significant concern and has been highlighted nationally. There are a number of factors that have resulted in the level of performance including patient handover delays, workforce issues and professional standards, data management and high delayed transfers of care. The CCG is supporting the Trust to improve its operational resilience. In addition, the CCG's Chief Nurse has undertaken a visit to A&E which led to some positive actions to maintain patient safety during surge.

2.1.4 Quality - Whilst not reported in the February IPR, I am pleased to advised the Governing Body that Addenbrooke's and the Rosie Hospitals has received a Care Quality Commission rating of Good following a visit in October 2018. The Trust is rated Outstanding for caring across all of its services. The Trust continues to be rated Requires Improvement for responsive and acknowledges the work that is needed to match capacity with demand. I am also pleased to advise the Governing Body that the Arthur Rank Hospice has been recognised as outstanding by the Care Quality Commission in its latest inspection.

2.2 Financial Plan 2019-2020

As the Governing Body is aware, the CCG received five year allocations in December 2018. Within the allocation, the CCG distance from target is not being sufficiently addressed over the 5-year allocation timeframe. NHSE has also set our control total for this year which is a £25m deficit. This remains a significant challenge for the CCG. The CCG has submitted an initial plan of a £35m deficit to NHS England. We are currently in discussion with the Regional Director of Commissioning and Operations regarding our Financial Plan for 2019-2020. I will keep the Governing Body updated on progress.

3. GOVERNANCE

3.1 There are a number of issues to bring to the Governing Body in relation to the Constitution.

3.1.1 Pilot Committee Structure and Interim Governance Framework - The new pilot Committee Structure has now been fully implemented supported by the Interim Governance Framework which was approved by the Governing Body at our last meeting. NHSE has agreed that the CCG should operate the new arrangements on a pilot basis without the need to vary the CCG's Constitution at this stage.

3.1.2 GP Membership - Since establishment, the CCG has had eight GPs on the Governing Body. This was to reflect the previous eight locality groups. We agreed to retain eight GPs when we dissolved the locality arrangements in 2016. However, as part of the overall review of clinical leadership, running costs and our governance framework, it is anticipated that we will aim to reduce the number of GPs, whilst retaining a clinical majority on the Governing Body. We have started initial discussions with the Local Medical Committee prior to any engagement with our Member Practices. Two GPs are coming to the end of their tenure at the end of March 2019. Whilst this review is underway, we do not propose to re-appoint to these two posts. The Governing Body is asked to support this recommendation.

3.1.3 GB Member Terms/Tenure - In preparing our Constitution in 2012 and in the absence of any specific guidance at the time, the CCG included in its establishment the requirement for non-executive members of the Governing Body (GPs, Lay Members, Secondary Care Doctor) to be appointed for a maximum of two terms (2 or 3 years). We have checked with NHSE and now understand that there is no such requirement. We aim to amend the Constitution so that it is more flexible going forward. A paper detailing proposed changes to the CCG's Constitution at this stage are set out at Agenda Item 2.8.

3.1.4 Model Constitution – As I reported to the Governing Body previously, NHSE has issued a new model Constitution. Whilst a move to adopt the new Model Constitution is not mandated by NHSE, I have asked the Secretary to the Governing Body to undertake a desk top review of our current Constitution against the model Constitution, with a view to simplifying some areas of the existing document. It is proposed that this is brought back to the Governing Body for review alongside the proposed changes in GP Governing Body membership described in Section 3.1.2 above.

4. ORGANISATIONAL DEVELOPMENT AND STAFFING

4.1 Staff Development Session

We are holding an additional Staff Development Session on the afternoon of Thursday 20 March 2019. The aim of the session will reflect on our progress during 2018-2019 and to set the scene for our key priorities in 2019-2020. The Session will also build upon the You Own It We Own It theme of our Organisational Development Plan, and promote team building and staff engagement. Members of the Governing Body are welcome to attend.

4.2 Chief Officer – Changes to Portfolio

As the Governing Body is aware, the new Chief Officer Team has now been fully in place for three months. Together with the Chief Officers, I have had an opportunity to review how this is operating. With agreement from the Chief Operating Officer, and the Medical Director, we have transferred the overall responsibility for primary care to the Medical Director's portfolio. We consider that this aligns more closely with this role, and in particular in relation to the implementation of the new GP Contract Framework and establishment of Primary Care Networks.

5. PREPARING FOR EU EXIT

5.1 As I reported to the Governing Body, the EU Exit Operational Readiness Guidance sets out the actions the health and care system in England should take to prepare for a 'no deal' scenario. A Position Statement set out at **Appendix A** provides assurance to the Governing Body on our progress to date.

6. SPECIALIST FERTILITY SERVICES UPDATE

6.1 In September 2017 the routine commissioning of any specialist fertility services was suspended following public consultation, other than for two specified exceptions. The two exceptions to the suspension were egg/sperm/embryo storage for cancer patients and sperm washing provided to men who have a chronic viral infection, whose female partner does not, and where intrauterine insemination is being considered.

6.2 The following recommendations were agreed to address concerns raised during the consultation:

- The CCG will monitor through the contract, where contractually possible, multiple births via first round of IVF that have taken place abroad and any associated complications and costs.

- The CCG will monitor through the contract, where contractually possible, the impact on mental health services and any associated and costs.

6.3 The CCG committed to review the decision at the end of the funding formula period which is 31 March 2019. The review of the provision of specialist fertility services (IVF) will include an assessment of the CCG's financial position, including the impact of the withdrawal of the service on multiple birth levels and any impact experienced by mental health services.

6.4 The CCG is in the process of gathering this data and Healthwatch is also compiling information to submit to the Governing Body which they will be providing by the end of April 2019. The Governing Body will review all this information at its next meeting on 14 May 2019.

7. CLINICAL EXECUTIVE COMMITTEE OVERVIEW

7.1 Set out below are some of the key issues which have been considered by the Clinical Executive Committee (CEC) since our last meeting in public.

7.1.1 **Joint Prescribing Group -** CEC received, discussed and approved the recommendations from the Cambridgeshire and Peterborough Joint Prescribing Group (JPG) recommendations from the meeting held in November 2018. These are set out in **Appendix 2.**

The provision of Adalimumab Biosimilars was considered as a separate item by CEC. The recommendation approved by CEC is included within the **Appendix** referenced above.

CEC also received and approved the recommendations from the meeting of the JPG held in January 2019. These are set out in **Appendix 3.**

7.1.2 **Nutritional Provision -** CEC agreed in principle to a suggested approach for the future re-procurement of nutritional services, but requested that further detailed scoping on the proposed external support be taken forward.

7.2 **Clinical Policies Forum Recommendations -** CEC approved a number of reviewed policies in line with its delegated authority as follows:

- Benign Skin or Soft Tissue Lesions Lower Clinical Priority
- Complementary and Alternative Therapies Lower Clinical Priority Policy
- Interventions for Haemorrhoids Surgical Threshold Policy
- The reclassified Assessment of Haematuria in Primary Care Clinical Threshold Policy

7.2.1 CEC acknowledged the work in progress with the reviewed Varicose Vein Interventions Surgical Threshold Policy. CEC acknowledged the work in progress with the reviewed Surgery for Tonsillitis: Tonsillectomy and Adenoidectomy Surgical Threshold Policy. CEC also acknowledged the updated briefing paper on Levels of Evidence/Study Quality in Relation to Policy Development. CEC acknowledged the position with the NHS England Evidence Based Interventions consultation, published guidance and continued work.

7.3 In addition to the above, CEC also received updates on the Improvement & Delivery Plan; Financial Planning for 2019/20; Winter Assurance and Delayed Transfers of Care plus an overview of the NHS Long Term Plan and future work, all of which are already covered in this report or appear elsewhere on the Governing Body agenda.

8 URGENT DECISIONS

8.1 CCG IT Modernisation

8.1.1 As we reported to the Governing Body last week, the CCG has been successful in achieving two capital bids for IT funding from NHSE totalling £2.6m. These bids are part of an annual process whereby the CCG applies and controls capital funding received from NHSE for the purposes of maintaining business as usual GP IT services and transformation across primary care. This year, however, the CCG was also given the opportunity to bid for capital funding to support modernisation of the CCG's IT equipment. We have been successful in obtaining £400k for CCG modernisation which is included in the capital award.

8.1.2 The Chief Finance Officer has signed the Memorandum of Understanding with NHSE for both schemes. There is a requirement for these funds to be utilised by the end of March 2019 and equipment is being purchased via a National Framework Supplier. In relation to the £400k awarded to the CCG, sign off to spend this amount of capital is required by the Governing Body under Standing Financial Instructions. Due to the timescales for completing this work, and as advised virtually, the CCG Chair and Accountable Officer have taken an Urgent Decision to proceed following approval from the Chief Officer Team.

8.1.3 The Governing Body is asked to formally ratify the decision.

8.2 Carers Service Procurement

8.2.1 The CCG is required to confirm its funding commitment to the Joint Carers Procurement which is led by Cambridgeshire County Council, Peterborough City Council and the CCG. This relates to the Carers Strategy which was agreed by all organisations in August 2018. As part of this commitment the CCG agreed to jointly recommission carers services across Cambridgeshire and Peterborough. The CCG presently commissions carers services under a grant agreement with the Carers Trust to the value of £365k per annum. At this point in the process the Local Authorities (as Lead Commissioner) need the CCG to make a decision about committing funding to the joined Carers procurement for a period of up to 4 years, commencing from April 2020 and to extend the current arrangement with the Carers Trust until March 2020.

8.2.2 The CCG is presently finalising the financial elements of this proposal in liaison with the Local Authorities. The Governing Body is therefore asked to agree, in line with Standing Orders (SO 3.8.1), that this matter be exercised as an Urgent Decision by the Accountable Officer and Chair, having first consulted with at least two members of the Governing Body, one of whom must be a Lay Member. The resulting decision will then be reported to the next meeting of the Governing Body for formal ratification.

9 RECOMMENDATION

9.1 The Governing Body is asked to note the Chief Officer Report for March 2019.

9.2 The Governing Body is asked to support the recommendation not to go out to election for the two GP Member posts that are coming to the end of their current terms, subject to a wider discussion on GP Governing Body membership which is underway.

9.3 The Governing Body is asked to note the EU Exit Preparedness Position Statement set out at Appendix 1.

9.4 The Governing Body is asked to endorse the work of the Clinical Executive Committee.

9.5 The Governing Body is asked to formally ratify the recommendations from the last two Joint Prescribing Group meetings attached at Appendix 2 and 3.

9.6 The Governing Body is asked to formally ratify the Urgent Decision in relation to capital spending for CCG IT Modernisation.

9.7 The Governing Body is asked to agree, in line with Standing Orders (SO 3.8.1), that the decision regarding the Carers Services Procurement be exercised as an Urgent Decision by the Accountable Officer and Chair, having first consulted with at least two members of the Governing Body, one of whom must be a Lay Member. The resulting decision will then be reported to the next meeting of the Governing Body for formal ratification.

Author: ***Sharon Fox***
Associate Director of Corporate Affairs (CCG Secretary),
27 February 2019

Appendix 1 EU Exit Organisational Readiness Position Statement
Appendix 2 Joint Prescribing Group recommendations – November 2018
Appendix 3 Joint Prescribing Group recommendations – January 2018

Appendix A

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

SUBJECT: EU EXIT – ORGANISATIONAL READINESS POSITION STATEMENT

PURPOSE: FOR INFORMATION / ASSURANCE

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1. INTRODUCTION

1.1 CCGs and providers are required to ensure that their Boards and Governing Bodies are sighted on EU Exit planning and preparedness. This position statement is to provide assurance to the Governing Body on the CCG's progress in delivering the European Union (EU) Exit Organisational Readiness Guidance published by the Department of Health and Social Care on 21 December 2018.

2. ROLES AND RESPONSIBILITIES

2.1 The Senior Responsible Owner for EU Exit Organisational Readiness is the Chief Officer. The Management Lead is the Associate Director of Corporate Affairs (CCG Secretary).

2.2 The CCG has established a Task and Finish Group to take forward this work. This reports to the Chief Officer Team on a weekly basis.

2.3 A Local Health Resilience Partnership Cambridgeshire and Peterborough EU Exit Preparedness Health and Care Group (LHRP EUEPHCG) has been established. This is chaired by the CCG's EU Exit Management Lead and includes SROs and Management Leads for EU Exit and EPRR leads from across the system. This meets on a fortnightly basis.

2.4 A single point of contact email address has been set up for all EU Exit communications.

3. PROGRESS TO DATE

3.1 The EU Exit Operational Readiness Guidance sets out the actions the health and care system in England should take to prepare for a 'no deal' scenario. This guidance covers seven key areas of activity:

- supply of medicines and vaccines;
- supply of medical devices and clinical consumables;
- supply of non-clinical consumables, goods and services;
- workforce;
- reciprocal healthcare;
- research and clinical trials; and
- data sharing, processing and access.

The CCG has submitted a self-assessment return to NHSE. It is anticipated that further assurance processes will be put in place in the coming weeks.

3.2 Specific tasks are also identified within the Guidance and our progress against this is set out below:

Task	Progress to date
Risk assessment of the seven key areas identified above, potential increases in demand associated with the wider impacts of a "no deal" exit and locally specific risk	The CCG has completed the self-assessment process established by NHSE. A risk register has been developed through the self-assessment process. The Risk Register will be monitored by the Chief Officer Team. This is marked Official Sensitive and will not be shared publicly in line with guidance from NHSE.
Business continuity planning, and ensuring business continuity plans across the health and care system are robust	Organisations across the Cambridgeshire and Peterborough Health System including the CCG are reviewing their Business Continuity Plans against a potential no deal EU Exit. Progress is monitored through the
Testing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure they are fit for purpose	The CCG conducted a table-top exercise on 13 February 2019 to test the CCG's Business Continuity Plan against a couple of scenarios which link to EU Exit. The learning from the Exercise will be incorporated into a revised Business Continuity Plan which will be brought to the Governing Body for formal ratification in March 2019. A system-wide Table Top Exercise led by the CCG was run on the 25 February 2019 which tested preparedness against a number of EU Exit scenarios. Over 50 delegates from across the health and care system attended. The Outcomes for Review are being developed to supporting further planning and preparedness.
Ensuring communication and escalation plans are appropriate, and reviewing capacity and activity plans, as well as annual leave and on call command and control arrangements around the 29 March 2019	The CCG's Head of Communications and Engagement is working with Communications Leads across the East to ensure that there is a co-ordinated approach to communications. The CCG is reviewing its Incident Response Plan should a Critical or Major Incident be declared. Additional resilience will be provided to support our on call arrangements should this be required.
Reviewing resilience on data-sharing, processing and access	The CCG has reviewed resilience on data-sharing, processing and access; no specific issues have been identified.
Recording costs (both revenue and capital) incurred in complying with the Guidance.	Staff involved in the process have been recording the costs of their time in complying with the Guidance. This will be collated at the end of the process.

3.3 A key requirement from the EU Organisational Readiness Guidance is to gain assurance from our providers are completing the appropriate actions in relation to their business. In addition to sharing their self-assessment outcomes, the LHRP EUEPHCG receives an update on planning and preparedness at each meeting.

4. NATIONAL ASSURANCE

4.1 A national Operational Response Centre (ORC) which includes NHS England, NHS Improvement and Public Health England has been established. This will lead on responding to any disruption to the delivery of health and care services in England, that may be caused or affected by EU exit. These arrangements will be mirrored at a regional level. Nationally, extensive planning and contingency measures have been put in place for the healthcare system nationally. Details are now starting to be disseminated:

4.2 The Minister of State for Health, Stephen Hammond, provided a written statement to the House of Commons on 25 February 2019 outlining the Department of Health and Social Care's plans for continuity of medicines and medical products in the event of a no deal EU exit. This described the multi-layered approach that has been put in place which is summarised as follows:

- Building up buffer stocks and stockpiling before the 29 March 2019 for
  - Medicines
  - Medical Devices and Clinical Consumables
  - Blood Tissues and Transport
  - Vaccines and Counter Measures
  - Suppliers for Clinical Trials
- Buying extra warehouse space to store these products including ambient, refrigerated and controlled drug storage
- Securing, via the Department of Transport, additional roll on, roll of freight capacity, away from the short straits from 29 March 2019
- Making changes to, or clarifications of, certain regulatory requirements
- Strengthening the processes and resources used to deal with shortages.

4.3 The statement concludes that the multi layered approach is essential: A combination of securing freight, buffer stocks, stockpiling and warehousing, and regulatory requirements, will be needed to help ensure the continuation of medicines and medical supplies in the event of a no deal exit. It reiterates the message that local stockpiling is unnecessary and could cause shortages in other areas, which could put patient care at risk. It is important that patients order their repeat prescriptions as normal and keep taking their medicines as normal. A copy of the full statement is available via the following link:

https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2019-02-25/HCWS1358/

5. KEY RISKS AND IMPACTS

5.1 The current CCG Assurance Framework and Risk Register (CAF) includes references to EU Exit across a number of risks. An over-arching risk has now been added to Version 5 of the CAF as follows:

Failure to adequately prepare for a no deal EU Exit - This is scored at 16, reduced to 12 with the mitigations that have already been put in place. High level actions and mitigations to address any gaps are included on the CAF.

5.2 A system-wide Drug Shortage Group has been established across the Cambridgeshire and Peterborough system. It is led by the CCG with representatives from the Local Pharmaceutical Committee and our provider Trusts.

5.3 The CCG's Standard Operating Procedure for the management of drug shortages and associated operating flow chart has been updated which now includes escalation to the regional pharmacist. The CCG Brexit Medicines Newsletter has been written and circulated to all Prescribers. A presentation on preparedness was provided to the Cambridgeshire and Peterborough EU Exit Preparedness Health and Care Group on 22 February 2019.

5.4 Workforce continues to be a risk, particularly in relation to staffing within the domiciliary care sector which could have an impact on demand across the health and care system. The Local Authorities are members of the Cambridgeshire and Peterborough EU Exit Preparedness Health and Care Group and we will continue to monitor impacts through this Group.

5.5 Guidance is yet to be published in relation to Reciprocal Healthcare. All organisations have been asked to confirm that they have the capacity to undertake further training if there are any changes to reciprocal healthcare arrangements.

5.6 We have been advised not to expect any additional funding to support this process. The Governing Body should be aware that the work to date has had a significant impact on the workload of some individuals. This is being regularly reviewed.

6. NEXT STEPS

6.1 The CCG's Task and Finish Group is starting to plan for the reporting requirements that are anticipated from March 2019. The Chief Officer Team will oversee this work.

6.2 The CCG will finalise its over-arching EU Exit Organisational Readiness Framework which will sit above the CCG's Incident Response Plan and Business Continuity Plan once the exercises described above once the outcomes for review have been finalised.

Sharon Fox,
EU Exit Management Lead
27 February 2019

APPENDIX 2

Cambridgeshire & Peterborough Joint Prescribing Recommendations - November 2018

Medication / Medical Device	Financial Impact to Primary Care (annual)		Comments
	Saving	Cost Pressure	
Doxylamine and pyridoxine (Xonvea®) for nausea and vomiting in pregnancy	Cost avoidance. *Cost of current treatment ~ £7 per course vs. £211.90 for Xonvea®* (cost per patient)		Xonvea® is **NOT RECOMMENDED** for prescribing in primary or secondary care. CPJPG members agreed that based on the evidence and safety data available at present for this licensed treatment and the comparative evidence available for established treatments (generally unlicensed), doxylamine and pyridoxine (Xonvea) should be added to the formulary as not recommended but that this decision should be reviewed in 12 months when more evidence and long term safety data may be available.
Flixonase® Nasules for the management of oral lichen planus in adults and children ≥ 16 years (off-label indication)	Cost of betamethasone soluble and Flixonase® Nasules for this indication are equivalent in cost. Therefore, the financial impact of this decision is cost neutral.		Flixonase® Nasules are **RECOMMENDED** '' **Specialist initiation without shared care guidance**, second line to betamethasone soluble. Members reviewed the evidence, safety information and finance information provided and supported use 2nd line or 1st line where betamethasone soluble (licensed treatment) is unavailable or contraindicated.
Senna to replace bisacodyl as 1st line stimulant laxative in Primary Care	£32,924		Senna is **RECOMMENDED 1st line formulary choice in both Primary and Secondary Care** (**Self-Care** to be considered where a patient is willing and able) If all current bisacodyl prescribing is switched to senna in primary care this would be a cost saving of £32,924 per annum. This is likely to be further improved by implementation of the CCG self-care policy.
Continuous Glucose Monitoring (Adults)		Annual cost for 14 patients: £53,110 This is the cost for the transmitter and sensors. This cost pressure does not take into account decreases in	CGM (adults) is **RECOMMENDED Hospital Only** for the following Type 1 DM patient groups: • Adults who have more than one episode a year of severe hypoglycaemia resulting in cognitive impairment requiring external assistance for recovery, despite optimisation of diabetes care • Adults with persistent hypoglycaemia unawareness with disabling hypoglycaemia, despite optimisation of diabetes care or where the person is unable to communicate symptoms of hypoglycaemia.

Medication / Medical Device	Financial Impact to Primary Care (annual)		Comments
	Saving	Cost Pressure	
		emergency admissions and required blood glucose testing strips. This cost pressure is also off-set by the current funding of 9 patients through IFR agreement.	The use of CGM will be audited and recommendations reviewed after 1 year. It is anticipated that 1.4 patients per 100,000 total population will be eligible for CGM under this policy (14 patients per annum across C&P population) Funding will be available for 6 months initially, with continuation if treatment aims are achieved and maintained. These include: • Reduction in number of hypoglycaemic events • Achievement and maintenance of target HbA1c • Reduction in hospital admissions or ambulance requests
Continuous Glucose Monitoring (Paediatrics)		Annual cost for 47 patients: £249,617 This is the cost for the transmitter and sensors. This cost pressure does not take into account decreases in emergency admissions and required blood glucose testing strips. This cost pressure is also off-set by the current funding of 38 patients through IFR agreement.	CGM (paeds) is **RECOMMENDED Hospital Only** for the following Type 1 DM patient groups: • Children diagnosed aged < 2years old • Children who have more than one episode a year of severe hypoglycaemia resulting in cognitive impairment requiring external assistance for recovery, despite optimisation of diabetes care • Children with persistent hypoglycaemia unawareness with disabling hypoglycaemia, despite optimisation of diabetes care or where the person is unable to communicate symptoms of hypoglycaemia. The use of CGM will be audited and recommendations reviewed after 1 year. It is anticipated that 4.7 patients per 100,000 total population will be eligible for CGM under this policy (47 patients per annum across C&P population) Funding will continue for 3 years or until the child is 5 years old (whichever is sooner), if treatment aims are achieved and maintained. These include: • Reduction in number of hypoglycaemic events • Achievement and maintenance of target HbA1c • Reduction in hospital admissions or ambulance requests where applicable
Colesevelam for the Management of Bile Acid Malabsorption causing Diarrhoea,		Based on comparative cost to colesytramine	Colesevelam is **RECOMMENDED Specialist initiation without shared care guidance – 2nd line option** after colestyramine and where

Medication / Medical Device	Financial Impact to Primary Care (annual)		Comments
	Saving	Cost Pressure	
Refractor to conventional Bile Acid Sequestrants (Off-label)		– additional cost pressure associated with prescribing colesevelam for 15 patients per annum is £12,306.	conventional anti-diarrhoea medications have failed. It is estimated that 15 patients per year will require colesevelam where colestyramine has been ineffective. This cost pressure on prescribing will be offset by decreased appointments in both primary and secondary care (gastro appointment estimated at £78-£117 depending on single or multiprofessional appointment)
Reclassification of SGLT2	Cost neutral as drug is already being prescribed in primary care after specialist recommendation. Change in formulary status may reduce unnecessary referrals and stop more expensive medications being prescribed before considering SGLT2s.		SGLTs medications are **RECOMMENDED suitable for prescribing in Primary and Secondary Care** SGLT2 medications currently require specialist advise before initiation in primary care. In accordance with the NICE diabetes treatment pathway (type 2) costlier medications further down the pathway are classified as suitable for GP prescribing which forces clinicians in primary care to either refer to secondary care unnecessarily or prescribe a treatment further down an agreed pathway, at greater expense.

Adalimumab Biosimilars:

Following separate consideration the CCG Clinical Executive Committee (15.01.19) approved the following recommendations

Approved the reimbursement of adalimumab using the shadow reference price until 31st March 2019 for both new and existing patients prescribed adalimumab in line with our commissioning positions (NICE Technology Appraisals). This will allow clinicians and patients to agree independent to commissioning which biosimilar is most acceptable to the patient (citrate or non-citrate containing)

Acknowledged that the CCG will be required to reimburse providers from 1st April 2019 until the end of the tender (30th November 2019) using the reference price as set by NHS England.

Noted that commissioning options will be presented prior to 30th November 19 when the current tender expires.

Endorsed that the CCG will provide notice to CUHFT in relation to the current funding arrangement for the band 7 (1wte) nurse, resourced to support switching to biosimilar. This will now be funded through the (shadow) reference price.

Endorsed that savings due to the price decrease associated with Humira® will be used to ensure the providers high cost drugs budget are balanced and any surplus remains within the CCG High Cost Drugs budget

APPENDIX 3

Cambridgeshire & Peterborough Joint Prescribing Recommendations - January 2019

Medication / Medical Device	Financial Impact to Primary Care (annual)		Comments
	Saving	Cost Pressure	
Prescribing of Growth Hormone in Children (EoE Priorities Advisory Committee (PAC) guidance)	Somatropin is already being prescribed in line with PAC guidance / NICE TA recommendations. Addition of Nordiflex pre-filled pen to the list of acceptable devices is cost neutral.		Somatropin is recommended as a treatment option for children with growth failure associated with several NICE Technology appraisal listed conditions. Prescribing is currently in primary care / secondary care depending on the device which is prescribed. Members agreed to support the updated PAC guidance which aligns to current prescribing, with the exception of the **addition of Nordiflex pre-filled pen which is an additional device (prescribable by secondary care only).** This is excluded from national tariff but is similar in cost to other devices currently being prescribed through secondary care. CPJPG members approved a prescribing support document for primary care. All monitoring to be retained by the specialist.
Espranor® (buprenorphine oral lyophilisate) licensed for substitution treatment for opioid drug dependence, within a framework of medical, social and psychological treatment.	No additional cost impact in primary care as prescribing to remain with specialist service.		Espranor® is **RECOMMENDED ‘’ Specialist Service / Hospital Prescribing only”** No prescribing in primary care is recommended. Members reviewed the evidence, safety information and finance information provided and supported that if CGL wished to prescribe the formulary should be updated to support this but prescribing should remain with the service and not passed to primary care. If prescribing were transferred to primary care this would be a cost pressure in comparison to prescribing current sublingual formulations of buprenorphine, which does occur in a small number of practices across the CCG in conjunction with CGL.
Cetraxal Plus® (ciprofloxacin / fluocinolone acetonide ear drops)	No additional cost impact in primary care. Alternative options already on formulary are more cost effective.		Newly licensed medications added to the formulary as ‘**Non-Formulary’**
Crysvita® (burosumab) for subcutaneous injection	No additional cost impact in primary care as clinical condition is NHS England commissioned.		Newly licensed medications added to the formulary as ‘**Non-Formulary’**
Ertugliflozin	No additional cost impact in primary care. Alternative options already on formulary are cost effective.		Newly licensed medications added to the formulary as ‘**Non-Formulary’**