SUMMARY OF REPORT:

The Greater Manchester health and care system is confirming its strategy to achieve the “safe, efficient, effective use of and research into medicines to enable the best possible outcomes”.

KEY MESSAGES:

This is how we will deliver medicines excellence across Greater Manchester. It acknowledges the work that needs to be addressed across localities and that this may differ across and within sectors. This first phase of implementation will be reviewed a year after it has been agreed.

The success of reducing variation and improving prescribing, dispensing and administration of medicines will improve outcomes for patients of Greater Manchester. This is one plan where addressing polypharmacy, de-prescribing, medication reviews, diverting patients away from GP practices and A&E would generate the funding to reinvest in future innovations for medicines.

Medicines Excellence calls for a truly integrated and system based approach to medicines with a clear expectation that localities will have the necessary governance mechanisms in place to ensure coordination across the care spectrum of home, primary, community and hospital care settings. All aspects of medicines delivery need to join up so that the organisations involved work collaboratively in pursuit of the strategy for the benefit of the patient and value for money for the tax payer.

Medicines Excellence focuses on the short-term objectives. For each area an overall objective has been compiled at the end of each intervention which will support the
actions that will need to be implemented to achieve this objective. It should be noted
that Localities of Greater Manchester will determine which areas they will focus on
depending on the needs of their patients and that successes will be shared across
Greater Manchester.

**PURPOSE OF REPORT:**

To update the Board on the progress of the Greater Manchester Medicines Excellence Plan.

**RECOMMENDATION:**

The Greater Manchester Health & Care Board is asked to:

- Support the implementation of the short-term objectives 2018-2021 set out in
  the Medicines Excellence plan.

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Medicines Excellence

Draft v13 Greater Manchester Medicines Strategy Implementation Plan: Short Term Objectives 2018-2021
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Introduction

The Greater Manchester Medicine Strategy sets out a five year vision to achieve the “safe, efficient, effective use of and research into medicines to enable the best possible outcomes”.

For the vision to be successful professions across primary, secondary and community care will need to work together and feedback to the economy their successes in the delivery of medicines excellence.

An implementation plan task and finish group drawn from experts in the field of medicines from Greater Manchester was established to review and identify priority areas.

The conclusions of the group were as follows:

- Initially to focus on short term objectives and phase the wider Implementation Plan over the five year period.
- There is a need for a proactive approach to “accelerate implementation of best practice” building on existing evidence based initiatives.
- Target key therapeutic areas such as respiratory, cardiovascular, mental health and diabetes to improve the quality of prescribing and patient outcomes.
- Reduce polypharmacy with a focus on eliminating inappropriate medication for people with learning disabilities and mental health conditions. This requires a collaborative approach to reduce the use of powerful medicines in these patient cohorts.
- Initiatives to be presented in a standardised proforma and agreed through the governance route before implementation.

Leads have been identified for each initiative within the Strategy:

- Clinical Commissioning Groups – Medicine Optimisation teams
- Clinical Standards Board formerly Greater Manchester Medicine Management Group (GMMMG)
- Pharmacy Local Professional Network (PLPN)
- Greater Manchester Health and Social Care Partnership (GMHSCP)
- Health Innovation Manchester (HInM)
- Chief Pharmacists – NHS Acute Trusts and Mental Health Trusts
- Primary Care Advisory Group (PCAG)

This implementation plan highlights initiatives that are to be implemented in the short term, i.e. 2018-2021. There will be two further plans for the medium and long term initiatives. The plan consists of existing initiatives that require accelerated implementation across Greater Manchester and new initiatives to be agreed; enabling commissioning decisions to be agreed by the relevant stakeholders.

A separate piece of work is required to develop a dashboard to monitor the progress of the initiatives both qualitatively and quantitatively. The overall objectives within this document will be captured in addition to quality indicators developed with the Medicine Optimisation
Teams and the Chief Pharmacists within the Localities and progress will be monitored through the quarterly CCG Assurance meetings.

The ambition is to standardise prescribing, dispensing, administration, purchasing and innovation of medicines across Greater Manchester by 2021. This will be achieved through quality improvement methodology and should not be mistaken for a lack of ambition. The outcomes and rewards in the improvement of quality of life, treatment and outcomes to the patient should not be underestimated.

This is a framework of how we can deliver medicines excellence across Greater Manchester. It acknowledges the work that needs to be addressed across localities and that this may differ across and within sectors. This first phase of implementation will be reviewed a year after it has been agreed.

The success of reducing variation and improving prescribing, dispensing and administration of medicines will improve outcomes for patients of Greater Manchester. This is one plan where addressing polypharmacy, de-prescribing, medication reviews, diverting patients away from GP practices and A&E would generate the funding to reinvest in future innovations for medicines.

The Medicines strategy calls for a truly integrated and system based approach to medicines with a clear expectation that localities will have the necessary governance mechanisms in place to ensure coordination across the care spectrum of home, primary, community and hospital care settings. All aspects of medicines delivery need to join up so that the organisations involved work collaboratively in pursuit of the strategy for the benefit of the patient and value for money for the tax payer.

This Medicines Strategy Implementation Plan focuses on the short-term objectives. For each area an overall objective has been compiled at the end of each intervention which will support the actions that will need to be implemented to achieve this objective. It should be noted that Localities of Greater Manchester will determine which areas they will focus on depending on the needs of their patients and that successes will be shared across Greater Manchester.

1 Supporting prevention and self-care

1.1 What do we want to achieve

Encourage and reduce reliance on medicines through promoting and supporting appropriate self-care and prevention.

1.2 Short term objectives (2018-2021)

1.2.1 Social Prescribing

Social Prescribing – is based on link workers, such as care navigators, providing a bridging role between statutory services (such as GP practices) and non-medical community-based support for health and wellbeing (such as exercise or arts on prescription). It is a structured and supported referral and introduction process, rather than simple signposting. There is a clear evidence base that social prescribing improves health and wellbeing outcomes for
people as well as reducing demand for statutory services (by around 25%). By supporting better self-care and resilience, social prescribing can reduce dependency on prescribed medication and enable people to access support and activities in their communities, which in turn can slow the decline of pre-existing conditions and prolong independent living.

Social prescribing connects people with non-medical support in their local community; therefore a strong and vibrant voluntary, community and social enterprise (VCSE) sector is essential. These community-based activities, which promote self-care and improve health and wellbeing, are largely delivered by VCSE organisations and community groups. Many of these will be small, un-constituted groups that do not have the infrastructure to compete for funding through procurement and contracts, so commissioners need a clear medium to longer-term investment strategy, using a combination of grant funding as well as contracts with larger VCSE organisations. This public sector commitment often makes it easier for VCSE organisations and groups to attract funding from other sources. Community assets can also be developed through the social prescribing work itself, for example, GP practices supporting patient groups to set up their own support groups and activities.

The Partnership is committed to a Greater Manchester wide adoption of social prescribing, as a mainstream service offering that is universally available. Social prescribing already exists and provides a valuable service in many parts of Greater Manchester.

A baseline review of the current state of social prescribing across GM has been commissioned from Salford CVS and the University of Salford; a final report has yet to be released.

**Target:** In 2018/19 the Localities will accelerate rolling out social prescribing programmes across Greater Manchester as a consistent feature of integrated neighbourhood models of care and support. Our aim is that all localities have social prescribing programmes fully implemented by the end of 2019/20.

**Lead:** Localities to make commissioning decision

**1.2.2 The Healthy Living Pharmacy (HLP)**

This programme was launched in GM in 2016/17. This programme includes the inclusion of dementia friends and a practice having a dementia friendly practice environment. The HLP programme centres on population health initiatives such as stop smoking, cancer awareness, alcohol safe limits, physical activity, healthy weight, food and diet, mental wellbeing, support for people with long term conditions and sexual health. Training has been delivered to support the pharmacy teams. Further plans are in progress to embed the training and development into a sustainable programme for the future. The programme has also been developed into a healthy living framework and rolled out to optometry and dental practices to link primary care providers at a locality level.

For people with mental health conditions the Healthy Living Pharmacy model could provide a valuable service as these patients die 15-20 years earlier before a person without a serious mental illness.
Target – Full population coverage by September 2019 for all three professional groups.

Lead: Local Professional Networks

1.2.3 Community Pharmacy being the first port of call for treatment pathways to support self-management.

In Greater Manchester there are 700 Community Pharmacies who all have support for self-care within their ‘core’ contract; this is an essential service. They also have a responsibility for signposting information and linking to the public health campaigns. This service is available to patients, carers as well as the general public. The Community Pharmacy essential service delivery is assured via the Community Pharmacy Assurance Framework (CPAF).

A Quality Payments Scheme, which forms part of the Community Pharmacy Contractual Framework (CPCF), was introduced on 1st December 2016. The original version of the scheme ran until 31st March 2018 and a total of £75 million of national funding was paid to community pharmacies for meeting the specified quality criteria. The extensive work undertaken by GM pharmacies to date has entitled them to receive circa £4m of the national allocation.

In March 2018, it was announced that the scheme would be extended for the first six months of 2018/19, as part of interim arrangements prior to substantive negotiations for 2018/19 being undertaken and confirmation has been received that the scheme is to be extended to March 2019. The extended scheme has a review point in June 2018. The results of the November 2017 submission for Greater Manchester were very encouraging and demonstrate the contribution towards quality and outcomes.

Supporting people, particularly frail, vulnerable and older people to manage medicines, live independently at home and stay out of hospital, are all areas that community pharmacy teams can contribute to and is the key to supporting the future of the NHS, at a time when it is facing ongoing constraints on its funding.

Whilst many of our patients are able to visit the pharmacy to access services there is a growing cohort of patients who cannot. These are often the most vulnerable of our patients who have limited access to services in the community. This service would allow pharmacists to provide a range of agreed commissioned services in patients’ homes to ensure that all have equal access to healthcare services. Currently:

- 3.64 million people in the UK aged 65+ live alone
- Nearly 200,000 older people in the UK do not receive the help they need to get out of their house or flat
- 9% of older people feel trapped in their own homes and 6% of older people (nearly 600,000) leave their house once a week or less
- 52% of older people agree that those who plan services do not pay enough attention to the needs of older people
• An estimated 4 million older people in the UK (36% of people aged 65-74 and 47% of those aged 75+) have a limiting longstanding illness. This equates to 40% of all people aged 65+
• Of the 18.7 million adults admitted to hospital last year, around 7.6 million (41%) were aged 65+
• People aged 65+ make up 42% of elective admissions and 43% of emergency admissions to hospital and up to 23% of all A&E attendances and 47% of admissions to hospital from A&E.

Action: This is a short to medium term objective to explore with Commissioners, the Local Medical Committees and Providers how Community Pharmacy can support the Frailty agenda.

Lead: Local Pharmaceutical Committees (Greater Manchester & Bolton), Pharmacy Local Professional Network, Direct Commissioning- Pharmacy

1.2.3.1. New Urgent Medicines Supply Advance Service (NUMSAS)

Requests for medicines needed urgently account for about 2% of all completed NHS 111 calls. These calls normally default to a GP out of hour’s appointment to arrange an urgent prescription and as a result block access to GP appointments for patients with greater clinical need. The New Urgent Medicines Supply Advance Service (NUMSAS), pharmacy service was introduced as a pilot Advanced Pharmacy Service from 2016 and launched across GM in July 2017. The service is being piloted nationally until 30th September 2018, to evaluate the impact on the urgent care system to inform future commissioning.

The number of community pharmacy providers has risen steadily to a current level of over 50 pharmacies actively providing this service. Every locality across GM has at least one pharmacy providing the service. Between July and December 2017 there were 2417 consultations/interactions with patients, following referral from NHS 111. These patients may have normally been directed to OOH or could have decided to attend at an urgent care setting or A&E department. The service has supported patients to address urgent medication needs, particularly of evenings, weekends and bank holidays and ensures continuity in management of long term conditions.

A national dashboard is being developed to support localities to identify need for the service and where to focus their attention for commissioning of services. A national decision will be made in the autumn whether to continue the service and if so this service will be funded nationally.

Target: Utilise the dashboard information to highlight and act on inappropriate supply of medicines until the NHS England announcement in September 2018.

Increase the number of pharmacies providing the NUMSAS service to 15% coverage by December 2018 to ensure full population coverage.

Lead: Direct Commissioning Team – Pharmacy
1.2.4 Conditions for which over the counter items should not routinely be prescribed in primary care: A consultation on guidance for CCGs


In the year prior to June 2017, the NHS spent approximately £569 million on prescriptions for medicines which can be purchased over the counter from a pharmacy and other outlets such as supermarkets.

These prescriptions include items for a condition:

- That is considered to be self-limiting and so does not need treatment as it will heal of its own accord;
- Which lends itself to self-care, i.e. that the person suffering does not normally need to seek medical care but may decide to seek help with symptom relief from a local pharmacy and use an over the counter medicine.
- Vitamins/minerals and probiotics have also been included in the consultation proposals as items of low clinical effectiveness which are of high cost to the NHS.

NHS England has partnered with NHS Clinical Commissioners to carry out the consultation after CCGs asked for a nationally coordinated approach to the development of commissioning guidance in this area to ensure consistency and address unwarranted variation.

The intention is to produce a consistent, national framework for CCGs to use.

Guidance was made available on the 30 April 2018 for CCGs not to prescribe drugs that can be purchased over-the-counter. NHS England has stated that CCGs need to conduct a Local Equality Impact Assessment to assess the impact on their local populations; this will address the Public Health issues raised within the consultation.

1.2.4.1 General Exceptions to the Guidance:

There are however, certain scenarios where patients should continue to have their treatments prescribed and these are outlined below:

- Patients prescribed an over the counter treatment for a long term condition (e.g. regular pain relief for chronic arthritis or treatments for inflammatory bowel disease).
- For the treatment of more complex forms of minor illnesses (e.g. severe migraines that are unresponsive to over the counter medicines).
- For those patients that have symptoms that suggest the condition is not minor (i.e. those with red flag symptoms for example indigestion with very bad pain).
- Treatment for complex patients (e.g. immunosuppressed patients).
- Patients on prescription only treatments.
- Patients prescribed over the counter products to treat an adverse effect or symptom of a more complex illness and/or prescription only medications should continue to have these products prescribed on the NHS.
- Circumstances where the product licence doesn’t allow the product to be sold over the counter to certain groups of patients. This may vary by medicine, but could
include babies, children and/or women who are pregnant or breast-feeding. Community pharmacists will be aware of what these are and can advise accordingly.

- Patients with a minor condition suitable for self-care that has not responded sufficiently to treatment with an over the counter product.
- Patients where the clinician considers that the presenting symptom is due to a condition that would not be considered a minor condition.
- Circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care.
- Individual patients where the clinician considers that their ability to self-manage is compromised as a consequence of medical, mental health or significant social vulnerability to the extent that their health and/or wellbeing could be adversely affected, if reliant on self-care. To note that being exempt from paying a prescription charge does not automatically warrant an exception to the guidance. Consideration should also be given to safeguarding issues.

This guidance should provide capacity within GP practices if patients are self-medicating, however, there is a public health issue where vulnerable patients groups may not be able to afford to purchase treatments over-the-counter. One scenario is that of a family where a child has head lice and infects the family and the school because they cannot afford to purchase the necessary treatment. A Greater Manchester minor ailment service commissioned from community pharmacies provides a mechanism to enable provision of medicines for the most deprived of our communities that have an evidence base demonstrating value for NHS resources.

Ensure the secondary and community care providers are aware of the changes to restrict prescribing of over-the-counter medicines for which they send referrals to GPs to prescribe.

Action: To implement the over-the-counter guidance.

Target: Clinical Standards Board to develop guidance across Greater Manchester by end of 2018.

Lead: Clinical Standards Board, Locality Medicine Optimisation Teams

1.2.5a Minor ailment scheme – Community Pharmacy

Nationally, it is estimated that 57 million GP consultations a year are for minor ailments, costing the NHS a total of £2 billion. The ambition of the Greater Manchester (GM) devolution agenda is to achieve both clinical and financial sustainability. A Pharmacy Minor Ailments Scheme (PMAS), operating consistently on a GM footprint, can make an important contribution to both of these goals. By shifting the relevant care to a pharmacy setting, PMAS can alleviate pressure on GP practices and release time for more suitable conditions.

In Greater Manchester we have a minor ailment scheme in 60% of localities. The scheme diverts activity away from GP practices and A&E to community pharmacy to provide a list of agreed medicines to treat a number of conditions. There has been a cost benefit analysis undertaken modelled on the best available evidence.
The medicines utilised within the scheme are low cost to the NHS and the scheme provides advice and guidance to patients presenting in the community pharmacy. A review of this commissioned service will be undertaken following local Equality Impact Assessment as advised within the over-the-counter prescribing guidance.

The data below is derived from questionnaire responses within the CCG’s currently operating the programme. The findings show that the Greater Manchester scheme over a five year period will save approximately:

- 170,000 GP appointments
- 500 A&E attendances
- 3,500 presentations at Out-of-Hours and Walk-In-Centres

Over a five year period per Clinical Commissioning Group this equates to:

- 14,000 GP appointments
- 350 appointments per practice
- 26,000 hours of GP consultation time.

It is important to acknowledge these findings within the broader financial constraints of the current health and social care system, which means that it is unlikely that these gross savings will result in significant cashable returns. The current GM CBA model assumes that the cashability conversion rate of GP appointments (both short and long term) is 0%. Instead, the purpose of a GM Minor Ailments Scheme is to relieve capacity in primary care, including pressure on GP practices, and to release appointments for more suitable purposes (such as patients with long term conditions).

Action: Localities to review the requirement for a minor ailment scheme following an Equality Impact Assessment.

Target – December 2018 (NB detailed within the GM Business Plan)

Lead: Pharmacy Local Professional Network and Localities

1.2.5b NHS proposal to reduce prescribing over the counter medicines – ‘Optometry First’ Greater Manchester Minor Eye Conditions Service (MECS)

Minor eye conditions are a significant driver of health service demand and cost. It is estimated that 1.5-2% of GP appointments are eye-related; the incidence of presentations to hospital eye casualty services is thought to be 20-30 per 1,000 per year. Ophthalmology is the speciality with the second highest cause of attendance at Greater Manchester (GM) hospitals, with some 390,000 outpatient appointments in 2014/15.

The Greater Manchester Minor Eye Conditions Service (MECS), *Optometry First*, seeks to divert demand away from GPs and acute settings by making use of the skills of primary care optometrists to assess, manage and prioritise patients presenting with recent onset minor eye conditions. Patients are seen quickly and receive high-quality eye advice and treatment from qualified clinicians in a safe, convenient and appropriate environment. A cost benefit analysis has been completed.
The prescribing of over-the-counter products used for eyes is included in the consultation and there is a section with the Greater Manchester Medicine Management Group Formulary. A review of the formulary section is required, working closely with the Local Professional Network for Eye Health to fully understand how ceasing the prescribing of these medicines by a GP impacts on patient care, especially the use of antibiotic eye drops and for the treatment of dry eyes.

The aspiration is that the Optometry First service and the community pharmacy minor ailment service will improve the appropriate supply of medicines to appropriate patients reducing GP and A&E attendances. Four localities have already implemented MECS.

**Action- This is part of the roll out of the Primary Eyecare Service Framework, which is scheduled for roll out from April 2019 which includes MECS.**

**Lead: Local Professional Networks and Localities**

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<tr>
<th>Overall objective for supporting prevention and self-care:</th>
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<tr>
<td><strong>Objective:</strong> Increase access to alternative services for patients, public and carers reducing pressure on GP practice appointments and A&amp;E.</td>
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<tr>
<td><strong>Objective:</strong> Reduce the prescribing of over-the-counter medicines by GPs in line with the NHS England and Clinical Standards Board guidance; target to be set by each Locality – to be monitored through the CCG Medicines Business Intelligence tool.</td>
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<td><strong>Timescale:</strong> 2020</td>
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<td><strong>Lead:</strong> Pharmacy Local Professional Network and Localities</td>
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2 Safer use of medicines

**2.1 What do we want to achieve**

Reduce the prescribing of antimicrobials and reduce the avoidable harm caused by medicines. Develop an open and transparent culture of reporting and learning from medication errors.

**2.2 Short term objectives (2018-2021)**

**2.2.1 Reduce Prescribing of Antimicrobials**

This is an agenda for all localities whether national or local. NHS England has established targets within their Quality Premiums to reduce the prescribing of antibacterial drugs within Clinical Commissioning Groups; the Localities include these targets in their annual plans. The localities all have examples of good practice in the reduction of antimicrobial prescribing. This practice needs to be accelerated across Greater Manchester.

A dashboard has been developed to monitor antimicrobials that have been dispensed, EPACT2 which is available to all Clinical Commissioning Groups. The NHS England
Antibiotic Quality Premium Monitoring Dashboard has been produced to support monitoring CCG performance in the delivery of the Antibiotic Quality Premium. The EPACT2 dashboard is published monthly and reports on performance with the primary care antibiotic prescribing indicators; these are defined in the Quality Premium Guidance document.

2.2.1.1 Antimicrobial Stewardship Dashboard

In collaboration with NHS Improvement, the Antimicrobial Stewardship Dashboard is being developed to support the national Antimicrobial Resistance Strategy. The Government is committed to lead the international fight against AMR, setting out new ambitions to do this. Following the O’Neill Review of AMR, the Government has set the following ambitions:

- 50% reduction of preventable Gram-negative bloodstream infections (GNBSIs) by 2020/21
- 50% reduction of the number of inappropriate antimicrobial prescriptions by 2020

The Antimicrobial Stewardship Dashboard will support delivery of both of these ambitions, providing prescribing data to support local stewardship activity and reporting, and linking to relevant AMR resources such as the PHE AMR Portal and NICE guidelines.

In Greater Manchester there is an annual Antimicrobial Resistance campaign in primary care for each of the four primary care contractors.

Further discussion needs to take place with secondary care around the advice to primary care to prescribe antibiotics.

2.2.1.2 Examples of an innovation in reducing prescribing of antimicrobials from Localities

Localities have explored innovative approaches to reducing the prescribing of antimicrobials:

a) Heywood, Middleton and Rochdale Clinical Commissioning Group introduced C-reactive protein (CRP) testing in GP Practices.

This strategy is aiming to reduce antibiotic use in primary care by guiding antibiotic treatment through the use of a point-of-care biomarker. Evidence to support the clinical and cost-effectiveness of C-reactive protein (CRP) testing for the management of lower respiratory tract infections in primary care has been established and in some European countries it is a standard of care. In the UK, the role and use of CRP has yet to be established but the recent NICE clinical guidelines on pneumonia recommended that a CRP test should be considered if, after clinical assessment, it is not clear whether antibiotics should be prescribed. Furthermore, in the updated Public Health England (PHE) Primary Care Guidance (May 2016) for acute cough and bronchitis, CRP testing is recommended.

b) Tameside and Glossop has introduced a practice based model where there has been investment in a specialist pharmacist to work with practices to change prescribing habits of antimicrobials. This has shown excellent outcomes. This has led to a whole team culture change including the receptionists and practice nurses and GPs, as it was noted that
frontline staff may face more challenges than GPs when patients present for repeat antibiotics.

The practice came to realise that although they share management with patients, when it comes to antibiotics, patients do not prescribe – the practice do, and with shared management also comes clinical responsibility.

Although the change has been difficult, to their surprise, the majority of patients have respected their honesty and many seem relieved that antibiotics are not required for their condition. It is possible that this has been helped by media coverage of the issue.

Each of the localities will have different approaches to addressing this agenda across primary, community and secondary care our objective is to address the national targets and supersede them whilst sharing good practice that can be shared and implemented across Greater Manchester

2.2.2 NHS England Clinical Pharmacists in GP practice pilot.

An intervention to support the reduction of avoidable harm caused by medicine has been rolled out across Greater Manchester. The NHS England clinical pharmacists in GP practice pilot is part of the GP Forward View. For Greater Manchester, this programme is linked to the transformation programme through the devolution agreement. The pilot is open to General Medical Service (GMS) providers, noting that this can be through a GP federation or collaborations of individual GP practices. The GMHSCP pilot has several key planned outcomes:

- Addressing potential GP workforce shortages
- Making use of non-medical prescribers
- Increase GP practice clinical service capacity and improving patient access
- Reducing waste medicines
- Improving patient outcomes
- Improved use of additional health professional skills and abilities within the local health economy
- Increasing patient safety.

The agreed GMHSCP funding for the programme is £7.5 million, which includes GMSHCP contribution towards the delivery at each locality, training pathway and independent non-medical prescribing qualification for each pharmacist.

The pilot application process is run in alignment with phase two of the wider NHS England programme across four waves throughout 2017/18. Across the GMHSCP footprint we have approved five locality bids during wave one; one as part of wave two and are currently assessing a bid for wave three. There are also three sites that were successful in bidding for phase one of the wider NHS England programme and have been delivering services since 2015/16.

Currently there are approximately sixty pharmacists in post across GM working as part of the pilot programme and delivering clinical services to patients. The pharmacists will complete GMHSCP funded pathway training (delivered by the Centre for Postgraduate Pharmacy
Education) and an independent non-medical prescribing qualification as part of the programme.

There is an element of medicines cost efficiency and value linked to the activities of the clinical pharmacists. However, this is not the core focus of the programme, which is improving patient outcomes / safety and optimising the use of pharmacists’ skills across the GM health economy.

Actions:

- Decision to be made by each locality to continue to bid for monies for clinical pharmacists;
- Long term objective to commission mental health pharmacists to support GP practices.
- Provide evidence at a partnership level for the effectiveness of clinical pharmacists from all localities to prepare for long term investment.

Target – full population coverage for clinical pharmacists in localities by June 2019.

Leads: Locality Medicine Optimisation Teams and Direct Commissioning - Pharmacy

2.2.3 NHS England Medicine Optimisation in Care Homes model (MOCH)

The safer use of medicines within care homes is a priority. A Greater Manchester Medicines policy for care homes will be developed with providers, commissioners and users to improve the safe administration, prescribing, storage and ordering of medication for people within a care home environment. This will form part of a wider programme across Greater Manchester supporting care homes, care providers and carers.

Guidance is available from NICE which will be used as a starting point with the development and implementation of this policy. This is a short term priority which will require the collaborative working of the partnership with minimal cost implications in its development; implementation of the policy will require a business case.

NHS England has introduced the Medicines Optimisation in Care Home component of the Pharmacy Integration Fund. Greater Manchester has been awarded an allocation. The plan is to integrate clinical pharmacists and pharmacy technicians into health and social care settings to improve medicines management within care homes and optimise medicines for their individual residents by undertaking face-to-face medication reviews.

Actions:

- Implement the “plan on a page” for the Medicines Optimisation in Care Homes model approved by NHS England by December 2018.
- Develop and implement a care home medicine policy incorporating mental health across Greater Manchester care homes by September 2019

Leads: Locality Medicine Optimisation Teams and GMHSCP
2.2.4 Salford MedicAtion Safety dasHboard (SMASH) and Pharmacist-led Information technology iNtervention for reducing Clinically important ERrors in medication management (PINCER)

Salford Clinical Commissioning Group recruited clinical pharmacists to support general practices in identifying patients with complex medication regimens to improve adherence and reduce the use of multiple drugs. In addition to improving the quality and outcomes for patients the cost associated with medication is being reduced.

Salford Clinical Commissioning Group is undertaking research with Manchester University to examine the effectiveness of their clinical pharmacists being supported by a software tool to identify complex medication regimens and record the effectiveness of the intervention. This research initiative is being promoted nationally by Manchester University; hopefully it will be adopted and funded nationally when the evaluation is published later this year. Preliminary findings are very promising; once the final evaluation is presented a decision can be made to look at the possible acceleration of this model / tool for the whole of Greater Manchester.

Evidence has been provided by Health Innovation Manchester which supports this work being undertaken in Salford. There is evidence of reductions in error rates from the pharmacist-led information technology intervention for reducing clinically important errors in general practice prescribing (PINCER). This methodology underpins the tool being used within Salford CCG. Prescribing errors in general practices are not common – but when they happen they can be an expensive cause of safety incidents, illness, hospitalisation and even death.

An economic analysis demonstrated an overall reduction in costs of £2,679 per practice and an increase in quality of life of patients (0.81 Quality Adjusted Life Years per practice). Rolling out to 1,387 GP practices nationwide (by end 2019/20) PINCER will prevent over 46,000 hazardous errors in the first two years of the licence period saving £2M of NHS and £12M social care costs.

The PINCER prison research funded by Greater Manchester Mental Health (GMMH) will deliver by 2020. The PINCER mental health is a longer term objective as a PhD student has been appointed for a 5 year project.

Actions:
- Share evaluation of the Manchester University programme for SMASH across Greater Manchester.
- Implement findings of the PINCER prison research
- Implement PINCER findings for Mental Health

Lead: Health Innovation Manchester, Mental Health Trusts

2.2.5 Develop an open and transparent culture of reporting and learning from medication errors

The evidence base is strong for improving safety by reporting and learning from medication errors. Organisations across Greater Manchester have implemented reporting systems for medication errors. A Greater Manchester innovation has been the development and
implementation of the Controlled Drug reporting system, now adopted across England. This has changed practice across Greater Manchester by encouraging an open culture of reporting; through supporting practitioners rather than censuring them.

Although some localities have reporting systems for medication related issues, there is not one system capturing information about medicine incidents to enable shared learning across Greater Manchester. The system needs to reduce duplication of work, be easily accessible and responsive to organisations to monitor from a central point. We have such a system operational in Greater Manchester which is being adopted by all NHS England teams and is used by most Providers across Greater Manchester; the Controlled Drug reporting system.

**Objective**

- Develop and implement a single reporting system for medication errors by November 2018 to be fully operational by all providers both NHS and Private Health and Social Care by 2020.

**Lead: GMHSCP in collaboration with all Providers**

**2.2.6 Clinical handover to community pharmacists (TCAM)**

Another area where the safety of medicines is compromised for patients is the transfer of information concerning their medication. The continuity of patient care when transitioning from one healthcare setting to another is a national priority. Studies have indicated that the details of changes to patient's medication are not always effectively transferred from the hospital to community setting leading to readmissions and extended hospital stays. An AHSN supported study evaluated an electronic transfer of care initiative and demonstrated significantly lower rates of readmissions and shorter hospital stays. The Transfer of Care around Medicines programme will be rolled out to 40 trusts nationwide with the objective of preventing 6,000 hospital readmissions over two years saving £19 million of NHS costs.

This is another area where we work closely with the AHSN to deliver a crucial agenda. The AHSN role would be to:

- Actively promote and support implementation with trusts
- Project manage dissemination and spread amongst trusts in the region
- Provide analysis of data for evidence and feedback
- Provide opportunities for collaborative working to share best practice.

The benefit assumptions are:

Published longitudinal studies based upon the active referral of patients discharged from hospital to community pharmacy in Newcastle and on the Isle of Wight allowed Pinnacle Health to develop a cost benefit simulation of the programme, which the national rollout simulation has used. NHS benefits accrue from reduced length of stay, which fell from 13 days to a mean of 7.2 days. This difference has been costed at £400 per bed day.

- The review also found 30 day hospital readmission reduced from 16.05% to 5.79% for the cohort. A value of £2,358 has been used following analysis of relevant HRG coding.
• Additional readmission benefits for 30-60 days (6.1% reduction) and 60-90 days (5.8% reduction) have not been costed.

The spread assumptions are:

• Within Wessex AHSN, who developed and spread the programme locally, 2,216 patients were affected by the programme. Scaling this to the total England GP register population (QoF, 2017) gives an indicative total affected population of 43,088 patients per year
• During the first three years of roll out, 25% of trusts have been included in modelling, equating to 9,788 additional patients each year benefiting from the programme.

Data to be collected:

• Patient outcome data over a baseline and intervention period.
• Process implementation data to demonstrate engagement and correlate implementation with outcomes.

The Partnership commissioned a cost benefit analysis by the GMCA Research Unit to examine the feasibility of implementing this service across Greater Manchester before 2020. The CBA concluded that there is a return on investment of 1:25. A business case has been developed to support investment in this programme; however to date the investment has not been realised. It is expected that the programme would take up to two years to rollout across Greater Manchester.

Action: A business case has been compiled. There is a need to ensure the Mental Health Trusts and other providers are included in this programme.

Target – Commence October 2018 with a two year programme to roll out across GM.

Lead: Pharmacy Local Professional Network and Chief Pharmacists

2.2.7 Polypharmacy

Polypharmacy is defined as the use of multiple medications by a patient generally, but not exclusively, older adults aged 65 and over. Polypharmacy is a key issue in health and social care, as evidence suggests that being on multiple medications increases the individuals’ risk of harm and contributes to hospital admissions and poor therapeutic outcomes. Indeed, patients on 10 or more medicines are over 300% more likely to be admitted to hospital.

The List of comparators available on a dashboard is as follows:

• Average number of unique medicines per patient
• Percentage of patients prescribed 8/10/15/20 or more unique medicines
• Percentage of patients with an anticholinergic burden score of 6/9/12 or greater
• Multiple prescribing of anticoagulant and antiplatelet medicines
• Percentage of patients prescribed two or more unique medicines likely to cause kidney injury (DAMN medicines).
Action: This is integral to the workload being undertaken by the Clinical Pharmacists in practice and Care Homes which directly impacts on polypharmacy.

Target: Localities to set a target to show a reduction in the number of polypharmacy medicines prescribed to patients aged 65 and above by 2020 - Monitored through the EPACT2 dashboard.

Lead: Locality Medicine Optimisation teams

2.2.8 Reduce the avoidable harm caused by medicine – STOMP

Stopping Over Medication of People (STOMP) with a learning disability, autism or both with psychotropic medicines is a national project involving many different organisations which are helping to stop the over use of these medicines. STOMP is about helping people to stay well and have a good quality of life the principles of this programme are also applied to patients with dementia.

The aims of STOMP are to:

- encourage people to have regular check-ups about their medicines
- make sure doctors and other health professionals involve people, families and support staff in decisions about medicines
- inform everyone about non-drug therapies and practical ways of supporting people so they are less likely to need as much medicine, if any.

Actions:

- Reduce the inappropriate prescribing of Antipsychotics in patients with a Learning Disability and dementia.

Lead: Localities; Mental Health Trusts

2.2.9 Medicine related hospital admissions

A set of prescribing indicators have been developed as part of a programme of work to reduce medication error and promote safer use of medicines, including prescribing, dispensing, administration and monitoring. The programme of work is in response to the World Health Organisation (WHO) global challenge – Medication without Harm, (https://www.gov.uk/government/publications/medication-errors-short-life-working-group-report).

The NHS BSA has constructed a dashboard as an experimental piece of work. This is the first time prescribing data has been linked to admissions data at a national level; this will continue to evolve.

The purpose of the indicators is to identify hospital admissions that may be associated with prescribing that potentially increases the risk of harm, and to quantify patients at potentially increased risk.

The aim of the indicators is to:
- support local reviews of prescribing, alongside other risk factors for potential harm;
- minimise the use of medicines that are unnecessary and where harm may outweigh benefits
- identify where the risk of harm can be reduced or mitigated including prescribing of alternative medicines or medicines that mitigate risk e.g. gastro-protective agents
- reduce the number of hospital admissions that may be associated with medicines
- reduce the number of patients that are potentially at increased risk of hospital admission that may be associated with medicines.

The analysis only highlights the potential risk of harm and possible association with hospital admission. Any review of benefits and risks of prescribing should be undertaken on an individual patient basis.

<table>
<thead>
<tr>
<th>Overall objectives to ensure safer use of medicines:</th>
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<tbody>
<tr>
<td><strong>Objective 1:</strong> To deliver the CCG Antibiotic Quality Premium. To be monitored through the NHS England Antibiotic Quality Premium Monitoring Dashboard at the Quarterly CCG Assurance meetings.</td>
</tr>
<tr>
<td><strong>Objective 2:</strong> To reduce the prescribing of unnecessary medicines in patients aged 75 and above by 20% utilising Clinical Pharmacists. To be monitored through the Polypharmacy EPACT 2 dashboard.</td>
</tr>
<tr>
<td><strong>Timescale:</strong> By 2020 / 21</td>
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<tr>
<td><strong>Lead:</strong> Locality Medicine Optimisation teams and Chief Pharmacists.</td>
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### 3 Person centred care and support

#### 3.1 What do we want to achieve
All prescribing should be a shared decision between the patient and prescriber, to understand the benefits and risk of treatments. Tailoring medicines regimes (targeted, precision medicine) to individuals or cohorts e.g. care home residents to reduce polypharmacy, wasteful or unnecessary treatment and improve outcomes and value is a priority within the medicines strategy.

#### 3.2 Short term objectives (2018-2021)

Implementation of the initiatives in sections one and two of this Implementation Plan will contribute to person centred care and support. There is a suite of resources available on the NICE website to support shared decision making. Expertise and specialist knowledge, practical help and support for implementation is also available from the NICE field team, medicines education team and NICE medicines and prescribing Associates (of which there are two in the GM area).

#### 3.2.1 Extend the New Medicines Service (NMS) Advanced Pharmacy Service
The New Medicines Service is currently funded from a central budget and operational in Greater Manchester as an advanced Community Pharmacy Service. The evidence base for this service has been produced nationally.

There is an opportunity to develop this service to follow up 80% of all newly prescribed medicines by introducing a locally commissioned service through community pharmacy. There is evidence that this service does increase patient medicine adherence by 10% compared with normal practice, which translated into increased health gain at reduced overall cost.

Actions:

- Localities to decide whether to commission a service to follow up 80% of all newly prescribed medicines including patients with mental health issues. This will require a business case and will be decided locally.

Lead: GMHSCP Direct Commissioners and Localities

<table>
<thead>
<tr>
<th>Overall objective for Person and Centred Care</th>
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<tbody>
<tr>
<td>Objective: To have 100 Clinical Pharmacists embedded in multi-disciplinary teams in GP practices and Care Homes with Independent Prescriber status</td>
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<tr>
<td>Timescale: 2025</td>
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<tr>
<td>Lead: Localities</td>
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4 Standardised, best value, care

4.1 What do we want to achieve

Establish a systematic approach to standardising and improving the value and outcomes of care led by the Clinical Standards Board. Ensure where appropriate the Medicine Implementation Plan links to all strategies and policies to ensure medicines are appropriately prescribed with outcomes. Reduce unwarranted variation across Greater Manchester led by the Clinical Commissioning Group Medicine Optimisation teams and the Chief Pharmacists Group to raise the quality of prescribing, dispensing and administration of medicines.

4.2 Short term objectives (2018-2020)

4.2.1 NICE Technology Appraisals

To implement and assess clinical and financial impact of NICE Technology Appraisals. As the majority of NICE Appraisals are relevant to Secondary Care they have established governance processes where all of the NICE technology appraisals are assessed and an action plan to implement would be agreed and shared at Board level. However, there is a need to ensure that uptake is monitored and audited to confirm medicines are used in line with NICE.
In Primary Care there is no process to gain assurance that NICE technology appraisals have been assessed and actioned. A solution is to develop a process to enable (through a template) a primary care contractor to make a declaration to provide assurance that the NICE technology appraisals have been processed within their practice.

NICE has a plethora of tools to support the standardisation agenda which are available and relevant to all the sectors dealing with medicines. A development from NICE is a tool for Integrated Care Organisations / Sustainable and Transformation Partnerships to deliver high quality medicine optimisation to be released later this year.

The Declaration would form part of the incident reporting system and would initially be voluntary with a view to becoming part of any quality initiatives. This piece of work will be led with the NICE field team working closely with the quality function within the partnership.

Actions:

- **Develop and implement a web based process for declarations for NICE technologies to be made by primary care contractors linked to the incident reporting system.**
- **Roll out the NICE Integrated Care Organisations / Sustainable and Transformation Partnerships medicine optimisation tool.**

**Lead: GMHSCP – Quality team and NICE**

4.2.2 Acceleration of good practice

4.2.2.1 Primary care

The majority of prescribing takes place in primary care; there is also a wide variation in prescribing expenditure. Our objective is to standardise prescribing practice across Greater Manchester ensuring that there is high quality prescribing, improve patient outcomes and evidence based, cost-effective prescribing.

In Bury Clinical Commissioning Group there has been a significant amount of work focussing on prescribing quality and evidenced based prescribing which has achieved a prescribing average below the England average. They have shown how standardising prescribing can improve quality, outcomes and provide best value care. This is a goal we should strive to achieve over the next three years recognising that this will occur at differing times across the Greater Manchester Localities. In theory, if all Clinical Commissioning Groups in Greater Manchester reduced unwarranted prescribing spend to the current England average spend – a potential saving of circa £60M could be saved across Greater Manchester. The evidence for this figure is circumstantial and had not be properly evaluated; we do know the variation is considerable across Greater Manchester and England. This objective will yield cost efficiencies whilst ensure evidenced-based prescribing.

This work requires constant communication with patients so an informed decision can be made with the patient to either stop prescribing a drug, change to drug to a more cost-effective drug or request the patient purchases their drug over-the-counter.
There are a plethora of easily accessible data resources available to Medicine Optimisation Teams, Clinical pharmacists and community pharmacists to support prescribers to prescribe the most evidenced based safe and cost effective medicine.

The Greater Manchester CCGs have agreed the following areas to focus on for 2018/19. Note that this is an iterative plan that will be monitored through the quarterly CCG assurance meetings:

- Antibiotics
- Over The Counter (OTC) / Self Care
- Drugs of Limited Clinical Value
- Development of pathways for use across Greater Manchester
  - Frailty
  - Management of Individual Funding Requests
  - Migraine
  - Dermatology
- High Cost Drugs management

**Actions**

- Medicine Optimisation teams have identified the priority areas for their localities; we will ensure that their successes are shared across Greater Manchester to accelerate learning at scale.
- Develop and implement effective GP practice Repeat Prescribing policies.
- Focus, where applicable on “generic prescribing”
- Agree and implement an average prescribing spend for Greater Manchester that localities work towards.

**Lead: Locality Medicine Optimisation Teams**

### 4.2.2.2 GM Hospital Pharmacy Transformation Collaborative

Lord Carter of Coles report, published in February 2016, identified significant variation in operational productivity and efficiency across NHS acute hospitals. A series of hospital pharmacy recommendations were included within the final report; providing a transformational focus, with the underlying message being to enhance medicines optimisation through investment into clinical patient facing activities. The challenge set out by Lord Carter is to position more than 80% of Trusts’ pharmacy resource into delivering direct medicines optimisation activities, medicines governance and safety remits by 2020.

Responsible for delivering Lord Carter’s recommendations across GM is the Hospital Pharmacy Transformation Collaborative (GMHPTC). Established by provider Chief Pharmacists in 2016, GMHPTC is a distinct project within GMHSCP Transformation Theme 4 - Standardising Clinical Support and Corporate Functions. Reviewing the pharmacy services categorised as ‘infrastructure’ by Lord Carter is the priority for GMHPTC and work streams are fully established scoping, supporting and delivering hospital pharmacy transformation across the region as illustrated in the schematic below.
Medicines optimisation, therefore motivates and focuses GMHPTC service reviews as infrastructure collaboration generates operational and workforce efficiencies which locally can be reinvested into clinical patient facing roles. This shift in service delivery for hospital pharmacy ensures clinical outcomes and financial investments into medicines across GM are optimally managed.

Endorsing the introduction and commissioning of Consultant Pharmacist posts across GM is a GMHPTC priority initiative which will deliver effective use of medicines. A Consultant Pharmacist is an experienced pharmacist clinician who has the necessary expertise and clinical leadership to drive improvements in patient care across healthcare boundaries. These clinically innovative posts will therefore ensure optimal pharmaceutical outcomes for patients and will support the wider GM medicines strategy deliver its short, medium and long term ambitions.

The three Greater Manchester Mental Health Trusts are included within the main GMHPTC with a mental health subgroup reporting back as one of a number of commissioned work streams. This ensures the needs of all secondary care pharmacy services are considered across GM. The mental health subgroup is leading the work related to the medicines optimisation needs of acute providers when managing people with a mental illness. This is on behalf of the North of England and agreed through the All England Chief Pharmacists network.

The second Lord Carter of Coles report was published on 24th May 2018 entitled ‘NHS operational productivity: unwarranted variations Mental Health Services and Community Health Services’. This report will be reviewed as part of the GMHPTC programme.
Actions:

- GMHPTC, through its collaborative work plan and shared Hospital Pharmacy Transformation Programmes, will achieve Lord Carter benchmarks by 2020 in agreement with NHS Improvement and NHS England.

- Review the impact and implementation of the second Lord Carter of Coles mental health and community services report. This will require GM wide liaison with community services providers.

- Infrastructure workforce efficiencies will be reinvested into direct medicines optimisation activities, medicines governance and safety remits supporting the wider regional strategy.

- Introduce and test Consultant Pharmacist posts across selected therapeutic areas within GM. Effectiveness and clinical outcomes delivered will build the case for long term investment.

Lead: Greater Manchester Hospital Pharmacy Transformation Collaborative

4.2.3 Standardisation of Prescribing in Care Pathways

The Greater Manchester Clinical Standards Board has the following priority areas identified for implementation in 2018/19. Their plan is iterative and is flexed to meet the priorities for the Greater Manchester population:

Antimicrobial stewardship: GMMMG is to support all CCGs to achieve the required QP target of “Additional reduction in Items per Specific Therapeutic group Age-Sex Related Prescribing Unit (STAR-PU) equal to or below 0.965 items per STAR-PU”, by identifying areas for improvement and sharing of successful initiatives across GM

Biosimilars: to improve the uptake of biosimilars across GM and manage the effective entry of adalimumab biosimilar across GM. The uptake of biosimilar medicines across GM has been slower than other areas of the UK, with associated savings being lower.

“Adalimumab is the highest spend drug to the NHS, with a CCG commissioned spend of £20m in 2017/18. It is the next biologic to come off patent in October 2018, potentially there could be a saving of between 25 and 50% during the 12 months following launch. The GMMMG biosimilar adalimumab implementation project aims for a coordinated action within the GM health economy, facilitating successful uptake of biosimilar adalimumab and maximising the savings from the very beginning of implementation.”

Drugs of Low Clinical Value: NHS England issued guidance to CCGs listing 18 drugs or drug groups which should not routinely be prescribed in primary care, this work is intended to improve the quality of prescribing by reducing and stopping prescribing of drugs which have little clinical value and in some cases, drugs for which safety concerns exist. Spend on cost ineffective treatment diverts resources form more effective treatment. GMMMG introduced the “Do not prescribe (DNP)” list (and later the Grey list) across GM in 2011, and these lists now include 81 entries. Of the 18 drugs / drug groups listed on the NHSE list, only
six have not already been considered by GMMMG. Spend across GM CCGs for items which are a low priority for funding (November 2016 to October 2017 inclusive) sits at just under £5.2M, with a spend variation of £411k to £1.1M across the CCGs. GMMMG will manage the continued drive to reduce GM prescribing of drugs of low clinical value with the support of AGG in delivering conversion of this guidance to policy.

1. **Ophthalmology:** To explore the opportunity across the GM health economy to commission the use of Avastin (unlicensed for this indication) in macular pathways.

A more detailed work plan incorporating details of the other GMMMG work streams e.g. implementation of the GMMMG COPD pathway, guidance to support the reduction in opioid prescribing is available on the GMMMG website.

As per current GMMMG process there will be an opportunity for GMMMG to scope the topics directed to the Clinical Standards Board in order that the appropriateness and capacity of each topic be determined and scheduled accordingly. Where a topic could be undertaken more effectively by another route or body CSB will direct accordingly.

**Action:** Implement Clinical Standard Board work plan for 2018/19 and thereafter.

**Lead:** Clinical Standards Board, Chief Pharmacists & Localities

The NICE medicines optimisation standards to be implemented as national English evidence-based guidance and, if this is done in line with the recommendations, has benefits such as embedding of shared decision making, learning from medication related incidents, and clinically appropriate medication reviews.

The NICE guidance on Medicine Optimisation provides guidance on:

- Managing medicines for adults receiving social care in the community and the ‘Right’: the person’s right to decline.
- Systems for identifying, reporting and learning from medicines-related patient safety incidents.
- Medicines-related communication systems for when patients move from one care setting to another.
- Medicines reconciliation and medication review.
- Self-management plans.
- Patient decision aids.
- The use of patient decision aids in consultations involving medicines.

**4.2.4 Standardisation of prescribing for children and young people with long term conditions**

Greater Manchester Children’s Health and Wellbeing Strategy 2018 – 2022 has ten objectives; one of which is to reduce unnecessary and inappropriate hospital admissions for children and young people, especially those who have long term conditions such as asthma, diabetes and epilepsy. A gap has been identified; there is no prescribing included in the guidance for asthma for children.

This will be achieved by piloting a community children’s hub, the introduction of a ‘passport’ for children and young people with all types of long term conditions. A framework will be
developed for preventing avoidable admissions including GP / Pediatrician; observation assessment units and Children's Community Nursing teams.

Consistent care pathways for asthma, diabetes and epilepsy including prevention and transition will be implemented. This will require the development and implementation of medicine taking into account and the developments in digital aids to improve outcomes.

Actions:
- Reduce variation and waste, while improving quality and safety through clinical review.
- Ensure Greater Manchester trusts are in the top quartile of the NHS Improvement top ten medicines measures.
- To improve the prescribing of medication in Greater Manchester monitoring through national benchmarking dashboards including the Medicines Optimisation Dashboard, Key therapeutic topics, RightCare, PHE fingertips, Carter.
- Informatics and data is shared openly across Organisations.
- Ensure compliance with NICE guidance.
- Ensure prescribing of medication is embedded in the care pathways for asthma, diabetes and epilepsy for children and young people.

Lead: Clinical Standards Board

<table>
<thead>
<tr>
<th>Overall objectives for standardised, best value, care</th>
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<tbody>
<tr>
<td><strong>Objective 1:</strong> Prescribing of drugs in primary care is 80% for agreed specified chapters within the Clinical Standards Board Medicines Formulary.</td>
</tr>
<tr>
<td><strong>Objective 2:</strong> 90% uptake of best value biosimilars within 12 months of launch</td>
</tr>
<tr>
<td><strong>Objective 3:</strong> Achieve Lord Carter benchmarks by 2020 in agreement with NHS Improvement and NHS England</td>
</tr>
<tr>
<td><strong>Timescale:</strong> 2021</td>
</tr>
<tr>
<td><strong>Lead:</strong> Clinical Standards Board, Chief Pharmacists, Medicine Optimisation teams</td>
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5 Innovation and research

5.1 What do we want to achieve

That Greater Manchester will be a leader of biomedical research and accelerate adoption of innovation in the United Kingdom.

5.2 Short term objectives (2018-2021)
- Aim that everyone taking medicines can be part of a trial
- Reduce the gap of research for cancer v Mental Health and dementia
5.2.1 Single research process, gateway and tariff agreed for Greater Manchester sites.

A commercial and non-commercial research process has been established via the Greater Manchester Research Hub. Other initiatives include a Greater Manchester route map or initiating clinical trials and education and training days to build capability in research initiation and delivery. The Greater Manchester Research Hub has established a process for costing and contracting commercial and non-commercial research, designed through collaboration with the conurbation’s most research active organisations (via the Academic Health Science centre function).

5.2.2 Collaboration with the Industry

Health Innovation Manchester (HInM) has established a pipeline of innovation projects through a memorandum of understanding with the Association of the British Pharmaceutical Industry (ABPI) and a further memorandum of understanding is in train with the Association of British Healthcare Industries (ABHI). Expertise and process has been established within HInM to accelerate the pace of innovation across Greater Manchester. The HInM Innovation Nexus provides a means of discovering, developing and deploying innovation across the Greater Manchester conurbation and wider through HInM’s connection with the network of AHSNs.

5.2.3 Identification of studies and technologies for adoption

We will identify those studies and technologies that show greatest promise, if adopted, to transform mainstream care and generate clinically and financially sustainable models of care. This will include exploiting world-leading experimental medicine opportunities in respiratory, dermatology, musculoskeletal, audiology and cancer (advance radiotherapy, precision medicine and prevention and early detection) through the NIHR Manchester Biomedical Research Centre and NIHR Manchester Clinical Research Facility (MFT and Christie).

Through HInM, there is access to the NIHR Patient Safety Translational Research Centre (one of only three national centres in the UK) with a focus on medicines safety in primary and transitional care settings. Studies and technologies that show promise will be assessed by the HInM Innovation Prioritisation and Monitoring Committee (IPMC) which has representation from a number of key stakeholders across the GM Health and Social Care Partnership before implementation, which may require services to be commissioned.

Actions:

- Encourage primary care providers to sign up to contribute to research; this could include either as trial sites or data contributors.
- A prioritised programme of research in place with implementation plans and proposals waiting for inclusion.

Lead: Health Innovation Manchester
5.2.4 Programme to eradicate Hepatitis C virus

Hepatitis C virus (Hep C) infection is now curable utilising two to four months of well tolerated oral therapy. This has allowed modelling to demonstrate the feasibility of elimination of this infection as a public health issue at a population level.

Greater Manchester has significant issues with Hep C including a high prevalence and significant impacts on health, healthcare utilisation and social costs. A significant challenge is many of the individuals with this infection are either undiagnosed, or have been diagnosed but are not engaged with specialist services that can provide curative treatment. Therefore the programme is largely based on initiatives to diagnose the undiagnosed and engage the dis-engaged.

The only way the elimination ambition is going to be achieved is by treating more patients. This would not only significantly exceed the current NHS England Cap, but also exceed the numbers proposed by NICE in their financial modelling. This is predicated on an estimated 17,450 patients with Hep C currently living in Greater Manchester and assumes that (a) there is agreement to exceed the NHS England cap (b) the patients can be found to the levels predicted (c) are prepared to be treated and (d) there is aligned investment to match the level of ambition.

Action: A business case is being compiled for the commissioning of a community pharmacy service to provide point of care testing and treatment management of Hepatitis C as we have acquired the drug to support the eradication process.

Lead: Health Innovation Manchester

5.2.5 COPD programme

The focus of the COPD programme is the improved implementation of the GMMMG guidelines and the adherence to medicines that are recommended in the formulary, launched in October 2017.

This programme will:
- improve appropriate prescribing
- increased uptake of pulmonary rehabilitation
- increase number of COPD patients offered smoking cessation advice without the requirement for direct support
- raised awareness and support for patient support groups
- increase the number of Health Care Professionals completing the online education modules in the COPD learning hub
- increase number of COPD patients having flu vaccination

This will be delivered through the range of support offers such as virtual clinics and digital apps.
## Overall objective for Innovation and Research

**Objective 1:** Develop and implement a programme to eliminate Hepatitis C

**Objective 2:** Develop and implement a COPD programme to improve outcomes for patients with COPD; to reduce hospital admissions and A&E attendances; with agreed targets across all sectors

**Timescale:** 2020

**Lead:** Health Innovation Manchester

### 6 Workforce

#### 6.1 What do we want to achieve

The Greater Manchester Pharmacy Local Professional Network (LPN) has agreed to form a task and finish group with the aim of developing a strategy or framework and implementation plan for the recruitment, development and retention of pharmacy professionals and their teams.

#### 6.2 Short term objectives (2018-2021)

The Pharmacy LPN Workforce Group (PWG) will inform the development of a GM Primary Care workforce strategy that is being developed as part of the GM Primary Care Strategy. The Pharmacy LPN recognises that, in developing a strategy for pharmacy in primary care, there must be involvement of all sectors of pharmacy to reflect the changing role of pharmacy teams and the need to create a mobile, responsive pharmacy workforce to meet the needs of patients and the public in Greater Manchester.

The key responsibilities of the PWG are to develop:

- A pharmacy workforce strategy to include all sectors of pharmacy and all members of pharmacy teams
- A pharmacy primary care workforce programme to inform the primary care workforce strategy
- Workforce plans that are cognisant of the wider context and aspiration for better population health, wellbeing and medicines use in Greater Manchester
- Reflections on new roles and their implications for the wider pharmacy workforce e.g. in general practice, care homes, integrated urgent care, advanced and consultant practice
- System leadership policy and education strategies for the whole pharmacy workforce
- A rationale for pharmacy professionals to work more effectively and flexibly across sectors
- An implementation plan to deliver the strategy and programme
- A communication plan for stakeholders
Effective links with the HEE North School of Pharmacy and Medicines Optimisation and education and training providers for pharmacy professionals in Greater Manchester

The membership of the pharmacy workforce group will include representatives from:

- Community pharmacy
- Hospital pharmacy
- Industrial pharmacy
- Academic pharmacy
- General practice pharmacy
- CCG medicines optimisation pharmacy teams
- Mental health
- Pharmacy technician education
- Commissioners of pharmacy services

Meeting Frequency

The Pharmacy Workforce Group will meet face-to-face twice during the period of strategy development. The group will convene virtual meetings at least monthly until the end of December 2018, and will then agree a working plan for implementation through 2019. Between meetings there will be calls for information and requests to comment on iterations of the workforce strategy and implementation documents.

Accountability

The PWG will report progress - through the Pharmacy LPN Chair - to the Primary Care Workforce Reference Group which reports to the GM Workforce Collaborative and ultimately the GM Health and Care Board.

Guidance for the Development of Consultant Pharmacist Posts was published in 2005. There have been many changes in the pharmacy profession and the NHS in the last 13 years.

A draft of updated guidance has been written and aims to create a fresh approach to consultant pharmacist development in line with the current and emerging drivers for change within the NHS, while retaining the emphasis on the four pillars of expert practice, research, leadership and education.

The Consultant Pharmacist Guidance Stakeholder Group and the All England Chief Pharmacists, we are seeking views on the draft; the consultation will be open from 4th to 30th September 2018.

Medicine Optimisation in Care Homes (MOCH)

There are 27 training places available for the MOCH programme. This is will funded by NHS England for programme salary supported pharmacists and pharmacy technicians. CPPE
and HEE have developed a fair process for allocating the non-salary supported training places.

Criteria for allocating non-programme places

- Pharmacists and pharmacy technicians must be working in a care home setting for at least 2 days per week (0.4WTE). This ensures the learning is supported by regular practice in the care setting to support trainees.
- Employing (providing) organisation must commit to the training pathway and release staff for the 28 days of protected learning time over 18 months and provide travelling and other incidental expenses as required.
- Potential non-salary supported learners must be made aware that there is also a similar amount of self-directed learning to do in their own time.
- Employing (providing) organisation must allocate a clinical supervisor (training will be provided by CPPE).

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<thead>
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<th>Overall objectives for Workforce</th>
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<tbody>
<tr>
<td><strong>Objective 1:</strong> To have 100 Clinical Pharmacists supporting GP practices across Greater Manchester.</td>
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<td><strong>Objective 2:</strong> To have 27 pharmacists / technicians attend the Medicine Optimisation in Care Home’s training.</td>
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<tr>
<td><strong>Objective 2:</strong> To have three to five Consultant Pharmacists across Greater Manchester (depending on the outcome of the PWG scoping and strategy).</td>
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<td><strong>Timescale:</strong> 2021</td>
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<td><strong>Lead:</strong> Hospital Pharmacy Transformation Collaborative; Pharmacy Local Professional Network</td>
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7 Conclusion

7.1 Medicines Excellence is the aim of the Greater Manchester Medicine Health & Social Care Partnership; this document provides the first stage in its implementation. As a framework we have identified leads for all the areas highlighted in this Implementation Plan:

- Clinical Commissioning Groups – Medicine Optimisation teams
- Clinical Standards Board formerly Greater Manchester Medicine Management Group (GMMM)
- Pharmacy Local Professional Network (PLPN)
- Greater Manchester Health and Social Care Partnership (GMHSCP)
- Health Innovation Manchester (HInM)
Many of the initiatives within this plan are currently operational but not across the whole of Greater Manchester. Cost Benefit Analysis has been undertaken on schemes where benefit can be realised from diverting patients away from the GP practice and/or A&E. Reducing variation and improving the prescribing of medication will improve outcomes. This will be achieved by the implementation of medication reviews, improved repeat prescribing policies, addressing polypharmacy and de-prescribing. None of these are quick wins but will provide a sustainable improvement and release funds which will need to be invested in any newly diagnosed patients identified with a long-term condition.

The additional clinical support through NHS England and that invested by the Clinical Commissioning Groups together with the existing Medicine Optimisation teams across Greater Manchester will improve the quality of prescribing whilst utilising a different skill mix both in General Practice and Care Homes.

The Chief Pharmacists have a programme of work to deliver that is both challenging and innovative. There will be improved safety for medicines when the national reporting system is implemented to support our quality agenda.

Innovation will run alongside this programme of standardisation working closely with Health Innovation Manchester and the Pharmaceutical Industry to introduce new medicines and devices to improve patient outcomes.

There will be challenges in how we apply guidance when released; a choice to adopt or adapt or not to follow this will be made in conjunction with all relevant partners across the Partnership.