NHS
Wakefield
Clinical Commissioning Group

Improvement in Prescribing Plan (ImPP)

2017/18

Version:	**3.0 FINAL**
Approved by:	**Probity Committee**
Date Approved:	**28 March 2017**
Authors:	**Joanne Fitzpatrick/ Dr Chris Barraclough**
Date issued:	**31 March 2017**

General Practice Improvement in Prescribing Plan (ImPP) 2017/18

Introduction

The 2016/17 ImPP Scheme along with other Quality, Innovation, Productivity, and Prevention (QIPP) indicators have significantly contributed to improving the quality in certain areas of prescribing where safety concerns have been identified e.g. reducing overall prescribing rates of antibacterials; and stepping down from high dose proton pump inhibitors (PPIs). In addition to the quality areas, other indicators have brought about a control of cost growth in those areas where more cost-effective products can be prescribed.

Prescribing is a key QIPP target locally and nationally. The ImPP indicators have been agreed with the QIPP agenda in mind and offer real opportunities for maintaining or improving quality and enhancing value for money.

The ImPP is constantly reviewed to ensure that it remains the most appropriate scheme that will work in partnership with GP practices and Federations in Wakefield; whilst continuing to improve and maintain quality and cost-efficiency of local prescribing.

The 17/18 scheme has been changed quite markedly with a modular approach to indicators that have been allocated using the QIPP acronym methodology of Quality, Innovation, Productivity, and Prevention.
Diagram 1 on page 7 demonstrates the details of these 4 parts.

Payment Structure

Payments will be made pro-rata for achievement of thresholds **and** on a weighted capitation basis as per the table below:

Practice list size	£ per point	Max payment
0 – 4,999	£75	£7,500
5,000 – 9,999	£100	£10,000
10,000 – 14,999	£125	£12,500
15,000 – 19,999	£150	£15,000
20,000 – 24,999	£175	£17,500
25,000 – 29,999	£200	£20,000
30,000 – 39,999	£225	£22,500

The payment for achieving maximum points will be: **10% of practice award**
The payment for achieving cost growth equal to or less than 0% will be: **5% of practice award**
The payment for achieving underspend against budget will be: **10% of practice award**

Rationale for Choice of Indicators

Indicators are chosen to support NHS Wakefield CCG practices and Federations to achieve prescribing targets by encouraging quality, cost-effective and safe prescribing. The rationale for choice of these indicators consists of the following:

- Prescribing indicators for the National QIPP Key Therapeutic Topics 2017
- NHS England/MHRA Patient Safety Alert: Improving Medication Error Incident Reporting and Learning
- NHS England Quality Premium 2017/19
- CQC safety ratings
- NHSE Medicines Optimisation Dashboard and Right Care publications
- Report of the National Audit Office on Prescribing Costs in Primary Care[1]
- Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts
- NICE technology appraisal, quality standards, and clinical guidelines implementation
- Local clinical pathways and medicines optimisation guidelines
- Reducing medicines-related risks to patients
- Local QIPP medicines optimisation initiatives

Monitoring

NHS Prescription Services ePACT data will be used on a monthly basis (non-cumulative) to measure performance and each practice will be provided with a report on its performance against the ImPP indicators, along with areas identified for cost savings. Figures based on the quarter October to December 2016, excluding antibacterials, will be provided to practices at the launch of the ImPP for benchmarking purposes.
Prescribing data from Q4 2017/18 will be used for the measurement of achievement against prescribing indicators for the purposes of the ImPP; UTI antibacterial prescribing indicator will be based on data from the full year from June 2015 to May 2016. Targets will be set at the beginning of the year using national benchmarking as a guide, unless stated otherwise.

NHS BSA Information Services Portal will be utilised to obtain data on a monthly basis (non-cumulative) to measure performance for the innovative indicators electronic transfer of prescriptions and electronic Repeat Dispensing. The number of patients with a repeatable prescription and signed up for online services will be extracted from the GP clinical system.

Data from March 2018 will be used for the measurement against all three innovative indicators.

[1] Prescribing Costs in Primary Care, National Audit Office
http://www.nao.org.uk/publications/0607/prescribing_costs_in_primary_c.aspx

Support

Clinical Pharmacy teams or the Medicines Optimisation team will work with practices in to support the maximising of cost effectiveness, quality, and patient safety in relation to medicines. This support will be in the form of audit and drug switch guidance materials; providing recommendations and facilitating meetings in order to achieve ImPP indicators; but will not necessarily include hands-on support in carrying out the transactional work that is required to achieve the award.

Improvement in Prescribing Plan 2017/18

Outline

Practice meets the eligibility criteria described below **and** works towards achieving the indicators within the 4 components of the triangle in diagram 1. It is advised that the practice develops an internal plan for their own use for improvement in those indicators where they are not achieving the specified target.

Payment will be dependent upon achievement of the eligibility criteria and the practice's position at the end of 2017/18 in relation to the targets set.

1. Eligibility criteria for payments from indicator achievement:

a. **Prescribing Lead GP Role:** The Prescribing Lead GP takes an **active** leadership role within the practice and engage with members of the Medicines Optimisation team to undertake work allocated in a timely manner; this will include attendance at all Prescribing Lead Events hosted by NHS Wakefield CCG Medicines Optimisation team. It is expected that any non-attendance will only be in **exceptional circumstances** and that the practice will contact the Medicines Optimisation team to provide a briefing of the content of the event at a practice meeting within 4 weeks of the event taking place.

b. **Patient Safety:** The practice Medicines Safety Champion to have an active and engaging role within the practice and with the Medicines Safety Officer. Report (using the recommended incident reporting system) at least 2 medicines-related incidents per 1000 practice-registered patients during the year 2017/18: individual targets will be shared with practice.

c. **Prescribing Support Software: ScriptSwitch:** Practice can demonstrate it has actively engaged in the implementation and utilisation of prescribing support software e.g. ScriptSwitch®:

1) **Productivity:** this will be monitored by the number of items logged at prescriber level; this may indicate whether all or specific prescribers in a practice are actively using ScriptSwitch® (SS). Those practices with low items will be

contacted by a member of the MOT to check for any problems with activation. The number of computer terminals active should correlate with the number of prescribers. Prescribers who purposefully continue to deactivate SS will inevitably lead to the practice not achieving eligibility criteria.

2) **Red and Black Drug Information messages**: Practice data will be monitored to identify when prescribers override messages which recommend that a red or black drug should not be prescribed. This is a safety concern and unless prescribers who continue to prescribe the medication without sending mitigating information via the SS feedback mechanism to support their prescribing decision could affect the achievement of this eligibility criteria.

See Appendix 2

d. **Annual Meeting with Medicines Optimisation:** Attendance by the majority of prescribers (minimum of 75% of GPs and 75% NMPs[2]); other clinical staff; practice managers and prescription clerks in the practice at an annual prescribing meeting with a member of the Medicines Optimisation Team at the beginning of the financial year to review prescribing and set a future plan to address any areas for improvement or innovation; plus further meetings throughout the year as required.

2. Quality

The practice undertakes at least one audit from a practice-specific list. The audit tool will be provided by Medicines Optimisation; and it is expected that the initial audit and implementation of changes required within the practice is completed by 31st July 2017. A re-audit is to be performed by 31st January 2018. A short report on both audit and re-audit using the template provided (Appendix 4) is to be submitted by 31st August 2017 and 28th February 2018 respectively.

This component of the ImPP scheme is weighted with 20 points.

3. Innovation

The practice is to achieve the targets stated below in relation to prescribing for patients (non-dispensing patients only for dispensing practices for b and c[3]) in the following areas:

a) Number of patients on repeat prescriptions signed up to the online ordering service[4] – Target 50% (5 points)
b) Number of prescription items being issued via electronic repeat dispensing (eRD) – Target 10% (10 points)
c) Number of <u>all</u> prescription items (repeats, acutes and RD) being issued via electronic transfer of prescriptions (ETP) – Target 56%[5] (5 points)

Final measure will be based on March 2018 data

This component of the ImPP scheme is weighted as above

4. Productivity

The practice achieves practice-specific productivity indicators described in table 1.

This component of the ImPP scheme is weighted as following:

Number of Indicators Achieved	Points Awarded
1 out of 5	5
2 out of 5	8
3 out of 5	15
4 out of 5	20
5 out of 5	30

5. Prevention

The practice achieves both of the 2 prevention indicators described in table 1.

This component of the ImPP scheme is weighted with 30 points.

6. Bonus Awards

a) A bonus of 10% of the total practice award will be provided to those practices that achieve 100 points in the 4 components of the scheme.
b) A bonus of 10% of the total award will be provided to those practices that underspend against their allocated prescribing budget.
c) A bonus of 5% of the total award will be provided to those practices who achieve a cost growth (Q4 17/18 vs Q4 16/17) of either: 0% or less **or** a reduction in 2 percentage points.

Notes

1. Prescribing budgets will be notionally adjusted in the context of the ImPP if there is a 5% increase or decrease in practice ASTRO-PUs between April 2017 and March 2018
2. MOT discretion will be applied in exceptional circumstances
3. Dispensing practices - percentage of non-dispensing patients will be used to calculate achievement e.g non-dispensing patients account for 75%, then 75% of 10% = target for practice of 7.5%.
4. This measure is different to the NHSE target for ‘electronic patient facing services’ which looks at all registered patients who have signed up to online services

5. Measure based on GMS target value. Estimated 70% prescriptions issued are repeats with target of 80% of these being transmitted electronically. Therefore 80% of 70% is 56% all prescriptions

Diagram 1: Components of 2017/18 ImPP Scheme

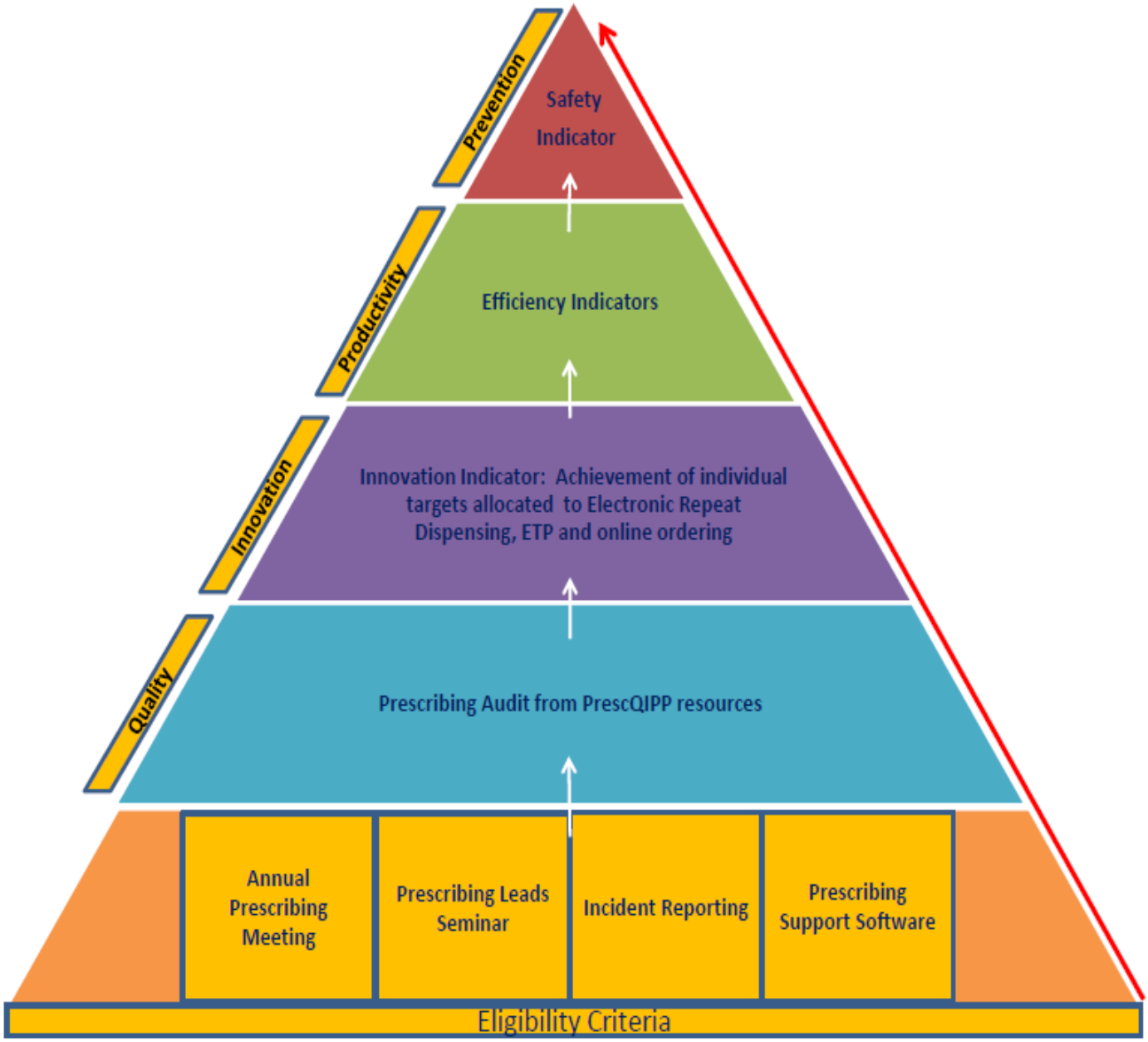

Table 1: Quality Audits, Innovation, Productivity, and Prevention Indicators		
Quality	**Choose ONE from the following list of audits chosen specifically for your practice:**	
	Inhaled Corticosteroid Inhalers	Audit patients with COPD, confirming severity of disease and reviewing the need for ICS combination inhalers in patients with mild and moderate severity only and less than 2 exacerbations in last 12 months. Patients with mixed disease (asthma and COPD) will still need to be maintained with inhaled corticosteroids or diagnosis to be reviewed. Optimise the use of high dose inhaled corticosteroids for asthma in adults (age 12 and over) and children (aged up to 12) and ensure they are prescribed safely and effectively and that the devices are being used correctly. If a child is under 5 and being prescribed high dose inhaled corticosteroids, this could be considered off label use.
	Infant Feeds	Audit patients prescribed infant formulae to ensure that prescribing is in line with local and national guidance and appropriate for the age of the infant in terms of choice and quantity. The aim is to maximise the use of appropriate over-the-counter (OTC) products; rationalise quantities on prescription; prescribe / recommend the correct products for the different conditions; identify appropriate onward referral; discontinue prescriptions when necessary.
	Appropriate Prescribing in PKU	Audit patients prescribed medicines for PKU and low-protein food products. Phenylketonuria is the most commonly inherited protein metabolic disease. Prescribing for these patients can be complex. The aim of this audit is to ensure that patients have a confirmed diagnosis which is coded in their records; are receiving regular review to ensure ongoing appropriateness for the patient's dietary needs and quantities on prescription are appropriate.
	Immediate Release Fentanyl	Immediate release fentanyl has a NICE 'do not do' as a first line treatment for breakthrough pain. The aim if this audit is to identify patients prescribed an immediate release fentanyl product and assess if it is being used in accordance with local and national guidance. Immediate release fentanyl that is not being prescribed or used in accordance with local and national guidance (or where it is not clear) should be reviewed by an appropriate person. A switch to immediate-release morphine should be considered as should stopping treatment where indicated.

	Lidocaine Patches	Audit and review prescribing to ensure that this product is only prescribed in primary care for its licensed indication of PHN. Ensure directions for use are clearly stated and that patients use only for 12 hours within 24 hour period. Treatment outcome should be re-evaluated after 2-4 weeks. If there has been no response after this period treatment must be discontinued. Treatment should be reassessed at regular intervals to decide whether the amount of plasters needed to cover the painful area can be reduced, or if the plaster-free period can be extended.Patients should be reviewed regularly to ascertain effectiveness. Drug holiday and deprescribing must be considered for all patients. For unlicensed indications, prescribing must be referred back to the Consultant.
	Wound Care	Audit repeat prescriptions for wound care products and ascertain ongoing need. Ensure that prescribing requests for wound care products are in line with local formulary and that the quantities requested are rationale. Ensure that requests are made via the dedicated order form and not via a clinical system task alone.
	Urinary Incontinence Antimuscarinics	Audit prescribing to ensure in line with the Wakefield OAB pathway and national guidelines. Urinary incontinence is a common problem and its prevalence increases with increasing age. NICE and local guidelines recommend that first line treatment should be bladder training and if this is not effective, anticholinergic medication should be offered. On-going treatment should be reviewed regularly. However, in practice, medication may be continued long term without consideration of effectiveness, patient perceptions of success or adverse effects. Current research has reported an increase in cognitive decline and mortality in patients prescribed anticholinergic medication.

Innovation	**Achieve the targets (weighted individually) below in relation to electronic optimisation**	
	Patients on repeat prescriptions signed up to the online ordering service	Achievement of 50% of patients who have a repeatable prescription and access to patient facing services to order their medicines online Ordering prescriptions online has many benefits for practices and patients including improved convenience; full electronic audit trail; less risk of transcription errors and administrative cost reductions
	Number of prescription items being issued via electronic repeat dispensing (eRD)	Achievement of 10% of all prescription items that are issued via the electronic Repeat Dispensing (eRD) scheme eRD is a convenient way for appropriate patients to have their regular medicines dispensed. It can help improve quality and safety and reduce GP practice workload dealing with the administrative elements of repeat prescribing
	Number of all prescription items (repeats, acutes and RD) being issued via electronic transfer of prescriptions (ETP)	Achievement of 56% of all prescription items to be processed via ETP The electronic transfer of prescriptions can streamline the prescribing process, providing an electronic audit trail and reduce the issue of 'lost' prescriptions
Productivity	**Achieve 5 Productivity Indicators. Choice will be from indicators that have been specifically allocated to your practice**	
	Capsaicin Cream (Q,C) **Measure: Capsaicin Cream Cost per ASTRO-PU** **Target: £14.50**	Review existing prescribing and consider stopping. Evidence for effectiveness is lacking and this product can cause localised burning, stinging or erythema. Consider alternative treatments for patients unless the below applies: • NICE states that capsaicin cream should be considered for people with localised neuropathic pain who wish to avoid, or who **cannot tolerate**, oral treatments • The NICE Clinical Guideline (CG) for osteoarthritis states that topical capsaicin should be considered as an adjunct to core treatments for knee or hand osteoarthritis
	Ocular lubricants (Q,C)	Review ongoing need & viscosity of product prescribed to ensure clinically indicated. Switch to cost-effective products in line with WCCG pathway http://skyline.wakefieldccg.nhs.uk/Interact/Pages/Content/Document.aspx?id=4032

	Measure: Cost Effective Ocular Lubricant Items as a % of all Ocular Lubricant Items **Target: 75%**	
	Emollients (Q,C) **Measure: Cost effective Emollient Items as a % of all Emollients** **Target: 45%**	Promote self-care. If clinically indicated, switch to cost-effective products in line with local guidelines http://skyline.wakefieldccg.nhs.uk/Interact/Pages/Content/Document.aspx?id=3151
	DROP list (Q,C) **Measure: DROP List Items per ASTRO-PU** **Target: 7.34**	The **D**rugs to **R**eview for **O**ptimised **P**rescribing list prepared by PrescQIPP is a useful tool to use as a benchmark for those products that are less suitable for prescribing. The PrescQIPP DROP list has been amended locally; lists of DROP drugs will be made available to individual practices for them to identify and prioritise their own areas of work
	Calcium and Vitamin D product switch (Q,C) **Measure: Low cost chewable Calcium and Vitamin D Items as a % of all chewable Calcium and Vitamin D** **Target: 80%**	Review prescribing to ensure clinically indicated. Switch to cost-effective 'one dose daily' product to support patient adherence
	Combination ICS + LABA prescribing (Q,C) **Measure: Cost-effective ICS/LABA Combination Inhalers as a % of all ICS/LABA Combination inhalers** **Target: 65%**	More cost-effective steroid/LABA combination inhalers are now available for the management of asthma and COPD. Consider prescribing these devices in asthma patients who are new to the steroid/LABA asthma management treatment step; or for those patients who are have poor compliance with their current steroid/LABA combination device. Ensure good counselling is provided on the use of the inhaler and check that the patient uses the device effectively before prescribing.
	Nefopam (Q,C) **Measure: Nefopam Cost per STAR-PU** **Target: £11.50**	Review prescribing and switch to alternative analgesia where appropriate. The evidence identified on the use of nefopam for chronic pain relief is not sufficient to support a recommendation The side effects of Nefopam may be additive.
	High Cost Drug Tariff items (Q,C) **Measure: High Cost Drug Tariff products Cost per ASTRO PU** **Target: £68.94**	Review prescribing of these high cost legacy medicines to identify ongoing need. Switch to cost-effective, safe and evidence-based alternatives. List of drugs with appropriate alternatives to be provided to clinicians.
	Drugs for treatment of Erectile Dysfunction (Q,C) **Measure: Oral Erectile Dysfunction Drugs Cost per Astro-PU**	Increase the proportion of sildenafil prescribed for erectile dysfunction compared to other more expensive phosphodiesterase type-5 (PDE5) inhibitors. Ensure that patients who are not able to have generic sildenafil are prescribed an alternative PDE5 on a private prescription, unless the

	Target: £53.92	'SLS' criteria is met. Ensure patients are prescribed appropriate quantities of PDE5 per prescription based on individual need and prescriber's clinical discretion. http://skyline.wakefieldccg.nhs.uk/Interact/Pages/Content/Document.aspx?id=3497
	Laxatives (Q,C) **Measure: Laxatives Items per ASTRO-PU** **Target: 6.01**	Review prescribing of laxatives to ensure still indicated and appropriate. Reduce stimulant laxative prescribing where possible as a quality initiative. Review patients' other medicines (check OTC) to ascertain if these cause constipation and stop or modify these drugs if appropriate. Offer dietary and lifestyle advice.
	DPP-4 Inhibitors ('gliptins') (C) **Measure: Low cost 'gliptin' items as a % of all 'gliptin' Items** **Target: 60%**	Review current prescribing in line with NICE guidelines for diabetes and switch to most cost-effective DPP-4 inhibitor ('gliptin') product where treatment is to be continued and it is appropriate to do so. New prescribing should be for the most cost-effective product.
Prevention	**Achieve both of the following Prevention Indicators:**	
	Trimethoprim: Nitrofurantoin prescribing ratio based on practice baseline data (June15-May16) for 2017/18 to be less than 1.527	The NHS England Quality Premium for 2017/18 has a large focus on the reduction of inappropriate prescribing for urinary tract infections (UTI) in primary care. There has been a rise in the number of *E.Coli* bacteraemia cases in elderly people; this is attributed to the choice of antibiotic and inappropriate prescribing in urinary tract infection (UTI). It is recommended that nitrofurantoin is the drug of choice for UTI in over 70 years. Further support materials will be provided to practices.
	A 10% reduction (or greater) in the number of trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June15-May16)	

Appendix 1

Practice Use of Improvement in Prescribing Plan (ImPP) Payments

The Department of Health produced guidance for Primary Care Organisations on 'Strategies to Achieve Cost-effective Prescribing' (October 2010 Gateway reference 14802). This states ***"All payments under a scheme should go into practice funds and not to individuals. The scheme rules should specify that payments must be used for the benefit of patients, and, for audit purposes, practices should keep written records of expenditure"***

The Executive Approvals Group has applied increased scrutiny to the way in which the awards are spent, in order to ensure that they are used for direct patient benefit, and that the items have not already been funded by the CCG. To this end, practices may find that items that have been approved in the past may no longer be allowed under the stricter criteria. In order to promote greater transparency and consistency, any claims will be assessed by a panel to assess suitability for reimbursement.

For 2017/18, patient engagement on the planning of how to spend the reward is strongly encouraged and therefore it is recommended that the practice's Patient Participation Group (PPG) has involvement in this process. The final decision of how reward money will be spent within the specified criteria will be the decision of the practice. The PPG Chair should sign the payment claim form (Appendix 2) before submitting to the CCG to indicate the group has been involved.

Before committing to large amounts of expenditure, it is advised that practices contact the MOT for advice on whether this request will be approved under the terms of the scheme.

The ImPP shall be such that a payment shall be made to a practice only on condition that is to be applied:

a) For the benefit of patients of the practice;
b) Having regard to the need to ensure value for money;
c) For any one or more of the purposes specified in Part I (see below) and not for any of the purposes specified in Part II (see below); and
d) Within one year of the end of the financial year in respect of which the ImPP payment was due.

Part I Authorised purposes of ImPP payments:

NB Federations may amalgamate practice ImPP awards if they wish to spend it on an initiative that fits the authorised criteria.

1. The purchase of material or equipment from a pre-approved list which will be agreed by the Wakefield CCG and which will directly benefit the patient by provision of services closer to home rather than an outpatient setting including diagnostic equipment e.g. C-reactive Protein (CRP) tests for pneumonia, ambulatory blood pressure monitors, ECG machines, nebulisers, foetal heart detectors, spirometers, cryothermic probes and defibrillators – excluding recurrent costs, such as staff costs and consumables, but allowing costs of training for the use of new approved equipment.

2. Where the scheme will deliver financial savings, such as sessional payment to eg dietitians, tissue viability nurses, commissioned medicines optimisation support.

3. The purchase of material or equipment which will benefit the safe and efficient operation of the Practice including telephone and mobile equipment, switchboard headphones, laptops or mobile tablet devices, patient information display systems, notice boards, patient booking systems, electronic or bar coded dispensing systems. All IT and electronic systems will be required to meet Department of Health and, if applicable, Wakefield CCG specifications.

4. The purchase of material or equipment relating to training and health education including television, DVDs, leaflets and posters and payment for advice on how best to disseminate health education advice to patients.

5. The purchase of material or equipment to improve medicines adherence and to reduce prescription waste including patient decision aids, food fortification guide and other relevant leaflets and posters.

6. The purchase of training directly related to medicines optimisation and backfill for practice staff e.g. CPD for practice nurses, prescribing clerks etc. **NB not mandatory training.**

7. The purchase of items that improve the patient experience of 'care'. Such items could be identified via feedback from patient questionnaires and satisfaction surveys and must be discussed with the practice's PPG. Examples include making adjustments that enable the practice to become dementia friendly; waiting room and consultation room chairs for patients who require additional musculoskeletal support and specialist equipment to assist those patients with reduced mobility and dexterity within the consultation room. Rationale for each purchase is to be evidenced on the dedicated claim form and will be reviewed by the panel prior to approval.

Part II Purposes on which ImPP payments may NOT be spent include:

1. The purchase of services or equipment which are unconnected with health care or which are expected to be covered already by GMS/PMS contracts.

2. To reduce a Practices' contribution to the employment costs of existing Practice staff.

3. The purchase of land or premises.

4. To pay off pre-existing loans taken out by members of the Practice

5. The purchase of drugs, medicines or appliances or other items which have been funded by other NHS sources.

6. The purchase of hospital services.

7. The improvement of facilities which are intended solely for the benefit of Practice staff.

8. Any item that increases the capital value of the Practice premises.

9. Items for the sole purpose of enhancing comfort or convenience for patients in the Practice, including: standard furniture, furnishings, security features, heating/air conditioning, vending machines or minor improvements to Practice premises, such as:

new carpet, (including the improvement of the Practice environment by decorating, cleaning or other maintenance tasks). These should be regarded as Practice expenses and do not support the delivery of the commissioning objectives of Wakefield CCG (unless the improvement is linked to a new service in the Practice which meet the Wakefield CCG priorities)

10. Consumables that practices would use in the normal course of business, e.g. office consumables, ink cartridges, disposable instruments, cleaning materials and replaceable parts of medical equipment.

How to Make a Claim:

Those practices that have achieved an award will be informed by letter of the amount they have achieved

Practices are encouraged to make claims throughout the financial year. Processing of the claims may be delayed if they are all submitted just before the end of February deadline.

Practices should submit an invoice to the Medicines Optimisation Team **accompanied by the following:**

- **1718 ImPP Payment Request Form (Appendix 2) detailing how their purchased item fits the criteria above and will directly benefit patients**
- **Proof of payment**

Appropriate requests which fulfil the necessary criteria will be processed and paid to the practice.

Claims for payments and proof of payment for the 2017/18 ImPP must be submitted to the CCG for processing by 28 February 2019. Claims after this date will be void

Appendix 2

PAYMENT REQUEST FORM

1718 ImPP (Improvement in Prescribing Plan) Claim

COVER NOTE

Name of Practice:

Sr No	Item & its Use detailed ***Example:** Portable Curtain Rail – used for patient privacy*	Rationale (detail benefit to patients) *This maintains patient privacy and dignity e.g. if a patient faints or requires treatment in a public area of the Practice*	Cost (incl VAT)	CCG Use Only	
1.					
2.					
3.					
4.					
5.					
FINAL TOTAL (including VAT)					

The above expenditure has been discussed with the Practice's Patient Participation Group representatives

PPG Chair Name: **Signature:**
Date:

PLEASE NOTE:

- All claims must be submitted with Invoices & Proof of Payment
- All claimed items need to be clearly marked / highlighted on both the invoice as well as proof of payment
- Proof of payment to be submitted in the form of a bank statement copy or an email acknowledgement from the supplier
- Photocopies of a cheque will not be accepted as Proof of Payment
- Ambiguous claims will be referred to a scrutiny panel for consultation (this may delay approval and payment)
- Claims submitted after February 28th will not be processed
- For any submissions made in the last 2 weeks in February, there may be a delay in processing and payment due to the sheer volume of claims received at that time
- Incomplete forms will be returned for your completion and this may delay processing and payment

Appendix 3

ScriptSwitch®

ScriptSwitch® is a real time prescribing support tool allowing locally authored advice to be presented to clinicians at the point of prescribing through prompts on the clinical information system. With the potential to support both national guidance and local initiatives, ScriptSwitch® can be used to promote cost-effective, consistent, and quality prescribing patterns. Using a simple one screen interface, requiring only a single click to continue, ScriptSwitch® will enable the Medicines Optimisation team to provide straight forward non-invasive messages to support prescribers.

It is important that all prescribers are activated to receive ScriptSwitch® so as to receive the benefits described above.

The centralised reporting system can indicate the number of items logged on the ScriptSwitch® system by practice; it also informs how many of these items generated a message. If the number of items logged is low, this may indicate that not all prescribers within the practice are activated to receive ScriptSwitch® and this will be used as part of the eligibility criteria for the ImPP.

Although the system will give advice, it does not diminish clinical choice as prescribers can choose to prescribe against the advice given if they feel that it is clinically appropriate to do so. Each time a prescriber accepts or rejects advice given the system records it, and a monthly report will indicate the proportion of switches accepted or rejected and calculate the actual savings that the practice has made by accepting a suggested switch.

The Medicines Optimisation team are responsible for the building and maintenance of the prescribing profile. Prescribers are requested to contact the Medicines Optimisation team if there are any messages that are causing concern.

Appendix 4

ImPP 2017-18 Audit Report Template

Practice name:

Audit title:

Date Completed:

Number of patients identified	Numbers of records audited

Outcomes:
Please provide the following information:

1. Overview of the audit findings / results (how do the results compare with the audit criteria?)
2. Changes required to current practice
3. How these changes have been / will be implemented

IMPORTANT - Please do not include any identifiable patient information

Re-audit date: 31st January 2018

Return to Renuka.Damle@wakefieldccg.nhs.uk by *31st August 2017*

ImPP 2017-18 Re-Audit Report Template

Practice name:
Re-audit title:

Date re-audit completed:

Number of patients identified	Numbers of records audited

Outcomes:
Please provide the following information:

1. Overview of the audit findings / results (how do the results compare with the audit criteria and the original audit results?)
2. Any further changes to practice required?

IMPORTANT - Please do not include any identifiable patient information

Return to Renuka.Damle@wakefieldccg.nhs.uk by *28th February 2018*

Version	Date	Author	Status	Comment
0.1	*January 2017*	*Joanne Fitzpatrick*	*Draft*	*First draft of Scheme for consultation with MOG*
0.2	*January 2017*	*Lyndsey Clayton; Carly Day*	*Draft*	*Addition of topics for efficiency indicator; targets for innovation indicator; removal of Network achievement incentive; addition of ImPP claim form; addition of mandate for PPG to agree reward spend*
0.3	*February 2017*	*Lyndsey Clayton*	*Draft*	*Added additional information under ScriptSwitch eligibility to highlight red and black drug messages being overridden.*
0.4	*March 2017*	*Carly Day*	*Draft*	*Innovative Indicators - Amended weighting; added measure information and weighting for dispensing practices*
0.5	*March 2017*	*Carly Day/Joanne Fitzpatrick*	*Draft*	*Addition of rationale for indicators; change to meds incident reporting from 3 to 2 per 1000 pts; change of online ordering % from 55% to 50%; addition of measuring progress via GP clinical system; addition of reference to support materials. Addition of UTI rationale*
0.6	*March 2017*	*Carly Day*	*Draft*	*Following Probity Committee - Changed target of 3 productivity indicators to 5; changed claim submission deadline to 28 Feb 2019; changed data source for measuring innovation EPS & eRD indicators to NHS BSA portal*
0.7	*March 2017*	*Joanne Fitzpatrick*	*Draft*	*Amended wording from gliptin to DPP-4 inhibitor; plus graduated points scoring for productivity indicators. Awaiting audit template for final version. Measures and targets added to productivity indicators*
1.0	*March 2017*		*Final*	
2.0	*April 2017*	*Carly Day*	*Final*	*Amended wording regarding PPG involvement in the claim process following misinterpretation*
3.0	*August 2017*	*Carly Day*	*Final*	*Amendments to Appendix I – Claim Criteria. Part I clause 7 and Part II clause 9*