NHS
Wolverhampton
Clinical Commissioning Group

Meeting of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 22nd May 2018 at 2.30pm
Stephenson Room, Technology Centre, Wolverhampton Science Park

A G E N D A

1	Welcome and Introductions	Chair	Verbal
2	Apologies	Chair	Verbal
3	Declarations of Interest	All	Verbal
4	Minutes of the meeting held on 6th February 2018	Chair	1 - 6
5	Matters Arising from the Minutes	Chair	Verbal
6	Committee Action Points	Chair	7 - 10
7	Quarterly Finance Report	Tony Gallagher	11 - 16
8	Primary Care Quality Report	Sally Roberts	17 - 30
9	Governing Body Report/Primary Care Strategy Committee Update	Sarah Southall	31 - 40
10	Primary Care Operational Management Group Update	Mike Hastings	Verbal
11	Primary Care Counselling Service	Ranjit Khular	41 - 64
12	Document Management Business Case/Service Specification and Impact Assessments	Jo Reynolds	65 - 92
13	Improving Access Business Case/Service Specification and Impact Assessments	Jo Reynolds	93 - 118
14	Out of Area Registration: In Hours Urgent Primary Medical Care	Jo Reynolds	119 - 146
15	QOF+ Scheme 2018/19 Business Case	Simon Bourne	147 - 220
16	Any Other Business	All	Verbal
17	Date of Next Meeting Tuesday 5th June 2018 at 2.00pm in PC108 Room, Creative Industries Building, Wolverhampton Science Park		

NHS
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For further information on this agenda or about the meeting generally, or to submit apologies for absence, please contact Laura Russell on 01902 44613 or email laura.russell4@nhs.net

MEMBERSHIP	
Wolverhampton CCG	Dr Bush Dr Hibbs Mr Marshall Dr Reehana Ms McKie Ms Roberts Les Trigg
NHS England	Mr Dhami
Patient Representatives	Sarah Gaytten
Invitees (Non-Voting)	Tracy Cresswell (Healthwatch) John Denley (Health and Wellbeing Board)

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee Meeting (Public)
Held on Tuesday 6th February 2018, Commencing at 2.00 pm in the in the Stephenson Room, Technology Centre, Wolverhampton Science Park

MEMBERS ~
Wolverhampton CCG ~

		Present
Sue McKie	Chair	Yes
Dr David Bush	Locality Chair / GP	No
Dr Manjit Kainth	Locality Chair / GP	Yes
Dr Salma Reehana	Clinical Chair of the Governing Body	Yes
Steven Marshall	Director of Strategy & Transformation	Yes
Sally Roberts	Chief Nurse	Yes
Les Trigg	Lay Member (Vice Chair)	Yes

NHS England ~

Bal Dhami	Contract Manager	Yes

Independent Patient Representatives ~

Sarah Gaytten	Independent Patient Representative	Yes

Non-Voting Observers ~

Tracy Cresswell	Wolverhampton Healthwatch Representative	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
Jeff Blankley	Chair - Wolverhampton LPC	No

In attendance ~

Mike Hastings	Associate Director of Operations (WCCG)	No
Dr Helen Hibbs	Chief Officer (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
Liz Corrigan	Primary Care Quality Manager Assurance Coordinator	No
Jane Worton	Primary Care Liaison Manager	No
Sheila Gill	Chair of Healthwatch	Yes
Hemant Patel	Head of Medicines Optimisation	Yes
Laura Russell	Primary Care PMO Administrator (WCCG – minutes)	Yes

Welcomes and Introductions

WPCC175 Ms McKie welcomed attendees to the meeting and introductions took place.

Apologies for absence

WPCC176 Apologies were submitted on behalf of Jane Worton, Mike Hastings, Lesley Sawrey, Liz Corrigan and Jeff Blankley.

Declarations of Interest

WPCC177 Dr Kainth and Dr Reehana declared that, as GPs they have a standing interest in all items related to primary care.

Ms McKie declared she works two days a week with Public Health at the Wolverhampton Local Authority.

As these declarations did not constitute a conflict of interest, all participants remained in the meeting whilst these items were discussed.

RESOLVED: That the above is noted

Minutes of the Primary Care Commissioning Committee Meeting Held on the 5th December 2017.

WPCC178 **RESOLVED:**

That the minutes of the previous meeting held on the 5th December 2017 were approved as an accurate record.

Matters Arising from the minutes

WPCC179 There were no matters arising from the minutes.

RESOLUTION: That the above is noted.

Committee Action Points

WPCC180 **Minute Number PCC302a - Premises Charges (Rent Reimbursement)**
It was noted the CCG have been informed the cost directives were still awaited. Action to remain open.

Minute Number WPCC117 - Provision of Services post Dr Mudigonda Retirement from a Partnership to single handed contract - Business Case
A report expected in September 2018 from Ms Shelley regarding the progress made to secure a partner onto the contract.

Minute Number WPCC159 – Primary Care Quality Report
It was confirmed this had been included within the report. Action closed.

Minute Number WPCC160 - Governing Body Report/Primary Care Milestone Programme Review Board Update.
It was reported the data had been received and continues to be monitored through the dashboard. The utilisation of sound doctor is low and work continues to look at driving improvement. Action closed.

RESOLVED: That the above is noted.

Primary Care Quality Report

WPCC181 Ms McKie informed the Committee Ms Corrigan was unable to attend the meeting to present the report and has provided a comparison of the two months. Ms McKie asked if there were any comments and noted the report was for assurance. The Committee accepted the report.

RESOLVED: That the above is noted.

Quarterly WCCG Finance Report

WPCC182 Ms McKie advised the Committee Ms Sawrey was unable to attend the meeting to present the report which had been circulated for the Committees comments. Mr Trigg informed the Committee the report had been discussed at the Finance and Performance Committee and the Primary Care budget is on target and there are no areas of concern. The Committee accepted the report.

The Committee discussed the need to ensure Finance representation on a quarterly basis to present the report and to make sure their meeting does not clash with the Committee.

RESOLVED: That the above is noted.

Governing Body Report/Primary Care Milestone Review Board Update

WPCC183 Ms Southall informed the Committee the report presented has been shared with the Governing Body at the December meeting, based on the November activity. The following points were highlighted to the Committee;

- Care Navigation – The Care Navigation face to face training took place on the 24th January 2018 and the programme has now launched. The second co-hort of pathways are being discussed and identified.
- Document Management - is the next phase of programmes to be implemented to support the on-going development of non-clinical staff.
- Extended access/winter opening – The plans for access over the winter period were in place and offered appointments to patients every day except Christmas day and New Year's Eve. The winter pressures scheme funded by

the CCG continues, aiming to increase the number of appointments available to patients during December 2017 - March 2018.

- Workforce Strategy - This will be shared with the Governing Body in February 2018 for ratification.

RESOLVED: That the above is noted.

Primary Care Operational Management Group Update

WPCC184 Mr McKenzie gave the following update on behalf of Mr Hastings of the discussions which took place at the Primary Care Operational Management Group Meeting on the 22nd January 2018;

- Programme of the ongoing merges were shared and discussed.
- In relation to estates some of the practices are signing agreements to start work the end of this financial year. There have been implications with NHS Property Services leases and cost directives.
- CQC have undertaken a number of inspections to Primary Care premises and 1 report has been published for Dr Fowler which received a rating of 'good'.
- An update was provided on Public Health Commissioning Strategy and the impact on the services such as smoking sensation.

Discussions took place regarding the new models of care and the decisions made on how they formed. It confirmed that GPs have worked together to from the new models of care and updates have been provided at the PPG chairs meetings. It was highlighted the practices have been encouraged to work with their patient population, it was suggested that work could be undertaken such as sharing learning to support those PPG meetings where they have low attendance.

RESOLVED: That the above is noted.

Services out of Area Registration Scheme Report

WPCC185 Ms Southall presented the above report to the committee which highlighted that there is a gap in commissioning services, for patients living in Wolverhampton area but who live outside their practice boundary and therefore deemed out of area. The following key points were highlighted;

- NHS England originally commissioned this service for CCGs, these arrangements end on 31 March 2017.
- The requirement for the CCG to commission such a service was not identified during the 'Preparing for Full Delegation' process.
- The CCG became aware of a gap in provision summer 2017 & following liaison with a range of colleagues identified that draft guidance dated January 2017 existed.
- Based on NHSE's guidance a local service specification has been developed for consideration in order to address the current gap in commissioning.

The Committee was asked to grant approval for expressions of interest from practices/groups and other local providers to be obtained in order to address this gap in commissioning. The Committee reviewed the report and agreed to the report's recommendations.

RESOLVED: That the above is noted.

Mr Patel entered the meeting

Pharmacy First Scheme or all Patients

WPCC186 Mr Patel presented the report to the Committee which is seeking approval for funding to commission the pharmacy first scheme for all age groups from April 2018 until March 2019. This would therefore be a continuation of an existing service.

The CCG currently commissions a service for over 16's, however the service for under 16's is commissioned by NHS England, which will be decommissioned on the 31st March 2018.

The activity for patients over the age of 16 for 2016/17 was 2,750 consultations. The consultation cost was £5. Therefore the cost of the consultations for the year was £13,750. In addition the drug costs were £7,999. Total cost of the service in the last financial year was £21,749.

The activity for patients under the age of 16 for 2016/17 were 3,852 consultations. The consultation cost was £5. Therefore the cost of the consultations for the year was £19,260. In addition the drug costs were £10,991. The total costs for under 16s therefore were: £30,251.

It was highlighted that patients will be made aware of this service by GP practice staff using the proposed care navigation system and community pharmacists and their staff.

The risks of not continuing to commission the service would place greater demand on the GP Practices, Urgent Care, Walk in Centres and the A&E Department.

Mr Patel noted that a total budget of £60K will be required and this will be split between the primary care budget and the prescribing budget. Primary care will fund the consultation costs and drug costs will be funded from prescribing.

Mr Trigg queried the one year scheme and his concerns if patients build confidence with the scheme then is stops after March 2019. It was stated that a national consultation on the proposed commissioning policy may restrict NHS funds for over the counter and self-care medicines and until this is concluded. It has been advised to commission a 12 month non-recurring contract until the review has been concluded.

The Committee reviewed the report and relevant appendices and agreed to the report recommendation that the CCG commission this service until March 2019. The Committee also requested to have an update in 6 months' time.
RESOLUTION: Mr Patel to report on progress to the Committee in 6 months' time.

Any Other Business

WPCC187 There were no further items raised by the Committee.

Date, Time and Venue of the Next Meeting

Tuesday 3rd April 2018 at 3.30pm in PC108, 1st Floor, Creative Industries Centre, Wolverhampton Science Park.

Primary Care Joint Commissioning Committee Actions Log

Open Items

Action No	Date of meeting	Minute Number	Item	By When	By Whom	Action Update
35b	**08.02.17**	**PCC302a**	**Premises Charges (Rent Reimbursement)**	May 2017	NHS England	08.02.17 - Awaiting the new cost directives to provide clarity on rent reimbursement in relation to when Practices allow other service providers to be use their rooms such as midwives. 07.03.17 - NHS England confirmed they are still awaiting the new cost directives and have been informed they should receive this in April 2017. This will help to provide clarity on rent reimbursement in relation to when Practices allow other service providers using their rooms such as midwives. 04.04.17 - NHS England confirmed they are still awaiting the new cost directives and will inform the CCG once this has been received. This will help to provide clarity on rent reimbursement in relation to when Practices allow other service providers using their rooms such as midwives. 06.06.17 - The Committee was informed that the cost directives have been put on hold due to purdah. Action to remain open. 07.06.17 – Action to remain open cost directives still awaited.

						01.08.17 – Action to remain open the CCG have received advice and guidance from NHS England regarding the use of rooms for none GMS. The CCG are still awaiting the cost directives. 05.09.17 - The CCG are still awaiting the cost directives. 07.11.17 - The CCG are still awaiting the cost directives. 05.12.17 – CCG informed the cost directives will be made available in January 2018. 06.02.18 - It was noted the CCG have been informed the cost directives were still awaited.

Primary Care Commissioning Committee Actions Log (public)

Action No	Date of meeting	Minute Number	Item	By When	By Whom	Action Update
10	**05.09.17**	**WPCC117**	**Provision of Services post Dr Mudigonda Retirement from a Partnership to single handed contract – Business Case** Ms Shelley agreed to report back to the practice that the Committee request in line with the with the business case they meet the expectation of reporting back in 12 months' time that they have a partner on the contract and that they have aligned to a new model of care	September 2018	Ms Shelley	07.11.17 - Ms Shelley informed the Committee the report is not due back until 12 months' time. It was noted they are still awaiting confirmation as to what new model of care they are going to align to. 05.12.17 – Report due September 2018 and confirmation received that the practice will align to primary Care Home 1. 06.02.18 - Report due September 2018

13	**06.02.18**	**WPCC186**	**Pharmacy First Scheme or all Patients** Mr Patel to report on progress to the Committee in 6 months' time.	August 2018	Hemant Patel	

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Public Primary Care Commissioning Committee
22nd May 2018

TITLE OF REPORT:	Financial Position as at Month 12, March 2018
AUTHOR(s) OF REPORT:	Sunita Chhokar-Senior Finance Manager Primary Care
MANAGEMENT LEAD:	Tony Gallagher, Chief Finance Officer
PURPOSE OF REPORT:	To report the CCG financial position at Month 12, March 2018
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• M12 underspend • Financial metrics being met • Additional allocations
RECOMMENDATION:	The Committee note the content of the report
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	<u>Ensure on-going safety and performance in the system</u> Continually check, monitor and encourage providers to improve the value for money of patient services ensuring that patients are always at the centre of all our commissioning decisions to ensure the right care is provided at the right time in the right place
2. Reducing Health Inequalities in Wolverhampton	<u>Improve and develop primary care in Wolverhampton</u> – Delivering a robust financial management service to support our Primary Care Strategy to innovate, lead and transform the way

	local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this <u>Support the delivery new models of care that support care closer to home and improve management of Long Term Conditions</u> by developing robust financial modelling and monitoring in a flexible way to meet the needs of the emerging New Models of Care.
3. System effectiveness delivered within our financial envelope	<u>Continue to meet our Statutory Duties and responsibilities</u> Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework <u>Deliver improvements in the infrastructure for health and care across Wolverhampton</u> The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.

1. Delegated Primary Care

The final Delegated Primary Care Allocations for 2017/18 is £35.650m. The Outturn is £34.428m delivering an underspend position of £1.221m.

The CCG achieved the planning metrics for 2017/18 are as follows:-

- Contingency delivered across all expenditure areas of 0.5%
- Non Recurrent Transformation Fund of 1%. As the CCG is not required to deliver a surplus of 1% on their GP Services Allocations this resource can be committed on a non recurring basis.

2. Allocations

The CCG has received an additonal allocation of £1k from NHSE for TPP (The Phoenix Partnership system phase 1) on a non recurrent basis in M12.

3. M12 Outturn position

	Annual Budget £'000	Outturn £'000	Variance £'000 o/(u)	In Month Movement Trend	In Month Movement £'000 o/(u)	Previous Month FOT Variance £'000 o/(u)
General Practice GMS	21,002	21,000	(2)		(2)	0
General Practice PMS	1,809	1,769	(40)		(40)	0
Other List Based Services APMS incl	2,298	2,587	289		289	0
Premises	2,684	2,873	189		189	0
Premises Other	90	61	(29)		(29)	0
Enhanced services Delegated	845	660	(185)		(185)	0
QOF	3,622	3,750	128		128	0
Other GP Services	2,777	1,727	(1,050)		(260)	(790)
Delegated Contingency reserve	174	0	(174)		(174)	0
Delegated Primary Care 1% reserve	348	0	(348)		(348)	0
Total	**35,649**	**34,428**	**(1,221)**		**(431)**	**(790)**

The Outturn indicates an underspend of £1,221m across Delegated Primary Care of which £790k is against Other GP services which relates to the release of accruals relating to pre delegation ie 16/17.The CCG has received the income to offset expected expenditure. However, as a result of a lower level of actual spend being incurred the CCG is reporting a non recurrent benefit of £790k (ie no further expenditure has occurred this financial year relating to 16/17). The additional £431k relates to schemes which slipped and expenditure did not materialise in 17/18 but will commence in 18/19.

A full review has been carried out in month 12 which includes the following updates:

- Recalculation of Global Sum Payments,GMS PMS and APMS Contract payments based on the Janurary 2018 updated list sizes
- Updated Out of Hours using Q4 list sizes
- Review of PMS Transitional Payments compared to the payments made to date
- Updated QOF forecast using CQRS reports

- Review of DES forecasts based on activity to date and sign up from practices
- Review of premises forecasts based on information provided from the premises team
- Review of locum reimbursements (maternity/paternity etc) based on approved applications
- Forecast updated based on seniority payments for Q4.

4. Primary Care Reserves

The Outturn includes a 1% Non-Recurrent Transformation Fund, and a 0.5% contingency in line with the 2017/18 planning metrics.

- The 0.5% contingency and 1% reserve has be committed in line with the 2017/18 planning metrics under other GP Services

5. PMS premium reserves

The PMS premium was fully committed in 17/18 on the following schemes:

Schemes	£
EOL	111,549
Mental Health Counselling-Relate	134,283
PITS	20,000
QOF +	228,168
Total	494,000

6. Conclusion

Since the CCG has had full responsibility for Delegated Primary Care it has developed the strategy to be aligned to 5 year forward view which has given benefits for patient and the public including:

- Saturday Hub Opening
- Imporved Access opening
- Providing training for practices nurses

The variance underspend of which £431k relates to 17/18 schemes which will commence in 18/19. In 18/19 the CCG will ensure a tighter monitoring of schemes to ensure the resource is fully committed.

Recommendations

The Committee is asked to:

- Note the contents of this report.

Name: Sunita Chhokar
Job Title: Senior Finance Manager
Date: 25/04/18

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	NA	
Public/ Patient View	NA	
Finance Implications discussed with Finance Team	**Sunita Chhokar**	**25.04.18**
Quality Implications discussed with Quality and Risk Team	NA	
Equality Implications discussed with CSU Equality and Inclusion Service	NA	
Information Governance implications discussed with IG Support Officer	NA	
Legal/ Policy implications discussed with Corporate Operations Manager	NA	
Other Implications (Medicines management, estates, HR, IM&T etc.)	NA	
Any relevant data requirements discussed with CSU Business Intelligence	NA	
Signed off by Report Owner (Must be completed)	**Lesley Sawrey**	**25.4.18**

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WOLVERHAMPTON CCG

PRIMARY CARE OPERATIONAL MANAGEMENT GROUP 2ND MAY 2018

TITLE OF REPORT:	Primary Care Monthly Report
AUTHOR(s) OF REPORT:	Liz Corrigan – Primary Care Quality Assurance Coordinator
MANAGEMENT LEAD:	Sally Roberts
PURPOSE OF REPORT:	To provide an overview of activity in primary care, and assurances around mitigation and actions taken where issues have arisen.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain OR This report is confidential for the following reasons
KEY POINTS:	• Overview of Primary Care Activity
RECOMMENDATION:	Assurance only
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Providing information around activity in primary care and highlighting actions taken around management and mitigation of risks
2. Reducing Health Inequalities in Wolverhampton	N/A
3. System effectiveness delivered within our financial envelope	N/A

PRIMARY CARE QUALITY DASHBOARD

RAG Ratings: 1a Business as usual; 1b Monitoring; 2 Recovery Action Plan in place; 3 RAP and escalation

Issue	Concern	RAG rating
IP	Low IP audit rating for four practices (one in August review on-going and three in December). New cycle of audits due to begin. NHS England have reported low ordering rates for flu vaccine to cover outstanding patients indicating uptake may be affected.	1b
MRHA	Nil to report	1a
FFT	Non submission for: • 7 practices (2 have provided data to CCG) • Zero submission for 3 practices • Suppressed data for 2 practices.	1b
Quality Matters	• 9 open Quality Matters identified • No new and 9 ongoing • 7 closures.	1b
Complaints	• Details of 18 GP complaints reported to NHSE received since November 2017 • 2 complaints still open • 16 complaints closed	1a
Serious Incidents	Two incidents currently being investigated RCA available for both, further information requested.	1b
Escalation to NHSE	One incident was identified via NHSE complaints and will be managed via PAG.	1b
NICE	No issues to report.	1a
CQC	Two practices have received a “Requires Improvement” rating and are being monitored.	1b
Workforce	Working in Wolverhampton video for recruitment now complete awaiting final edit Work around international recruitment continues.	1a

1. BACKGROUND AND CURRENT SITUATION

This report provides an overview of primary care activity in Wolverhampton and related narrative. This aims to provide an assurance of monitoring of key areas of activity and mitigation where risks are identified.

2. INFECTION PREVENTION

Infection prevention is provided by Royal Wolverhampton Hospitals with a dedicated link nurse for primary care. Information for the most recent visits and audits are shown below.

IP Audit Ratings: Gold 97-100%; Silver 91-96%; Bronze 85-90%; No rating ≤84%

By the end of March 2018 38 sites had received a visit with an average rating of 91% (silver):

- 3 – Gold (7.9%)
- 20 –Silver (52.6%)
- 11 – Bronze (28.9%)
- 4 – Red (10.6%)

MRSA Bacteraemia:
None to report.

Influenza Vaccination:
Across the board uptake for Wolverhampton is lower than both regional and national averages. Information on individual practice uptake has been shared with locality managers.

Assurances:
The CCG and IP are supporting practices who had red ratings, where appropriate. Other practices with outstanding actions are also currently being followed up by IP. Monitoring of returns is also being undertaken by the Primary Care Quality Assurance Coordinator in conjunction with the IP team and by the Primary Care Team.

Continued monitoring of flu vaccine ordering and uptake is being undertaken by Public Health and NHSE and a city wide flu vaccine task group is currently being set up by the PH Health Improvement team.

3. MEDICINES ALERTS

Overview:
Healthcare professionals are informed about the alerts via a monthly newsletter (Tablet Bytes). In addition, ScriptSwitch messages and/or PMR searches are used to inform healthcare professionals where appropriate.

Suspected adverse drug reactions should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) through the Yellow Card Scheme (www.mhra.gov.uk/yellowcard).

Drug, device and Field Safety Notices to date links are below – these are forwarded directly to practices by NHS England:

https://www.gov.uk/drug-device-alerts

Assurances:
The management of alerts is part of both the GP contract and a requirement under CQC registration. Practices are required to keep a record of alerts and actions taken for scrutiny. At present this is not monitored directly by the CCG. There are currently no direct actions required by CCG.

4. FRIENDS AND FAMILY TEST

Uptake:
The figures for March 2018 FFT submissions (February 2018 figures) are shown below compared with the previous two months and the regional and national averages.

Figure 1: FFT 3 Month Data

Percentage	December	January	February	West Midlands	England
Total number of practices	42	42	42	2154	7243
Practices responded	85.7% ⇧ *36/42*	90.2% ⇔ *38/42*	83.3% ⇩ *35/42*	74.7% ⇩	66.2% ⇧
No submission	4.8% ⇧ *2/42*	4.8% ⇔ *2/42*	11.9% ⇧ *7/42*	25.3% ⇩	31.7% ⇧
Zero submission	2.4% ⇩ *1/42*	2.4% ⇔ *1/42*	7.1% ⇧ *3/42*	N/A	N/A
Suppressed data	7.1% ⇩ *3/42*	2.4% ⇩ *1/42*	4.8% ⇧ *2/42*	13.7% ⇔	11.5% ⇔
Total number with no data	14.3% ⇩ *6/42*	9.5% ⇔ *4/42*	28.6% ⇧ *10/42*	39.1% ⇩	37.9% ⇩
Response rate	1.6% ⇔	1.6% ⇔	1.6% ⇔	0.7% ⇔	0.6% ⇔

Figure 2: 3 Month FFT Data Comparison

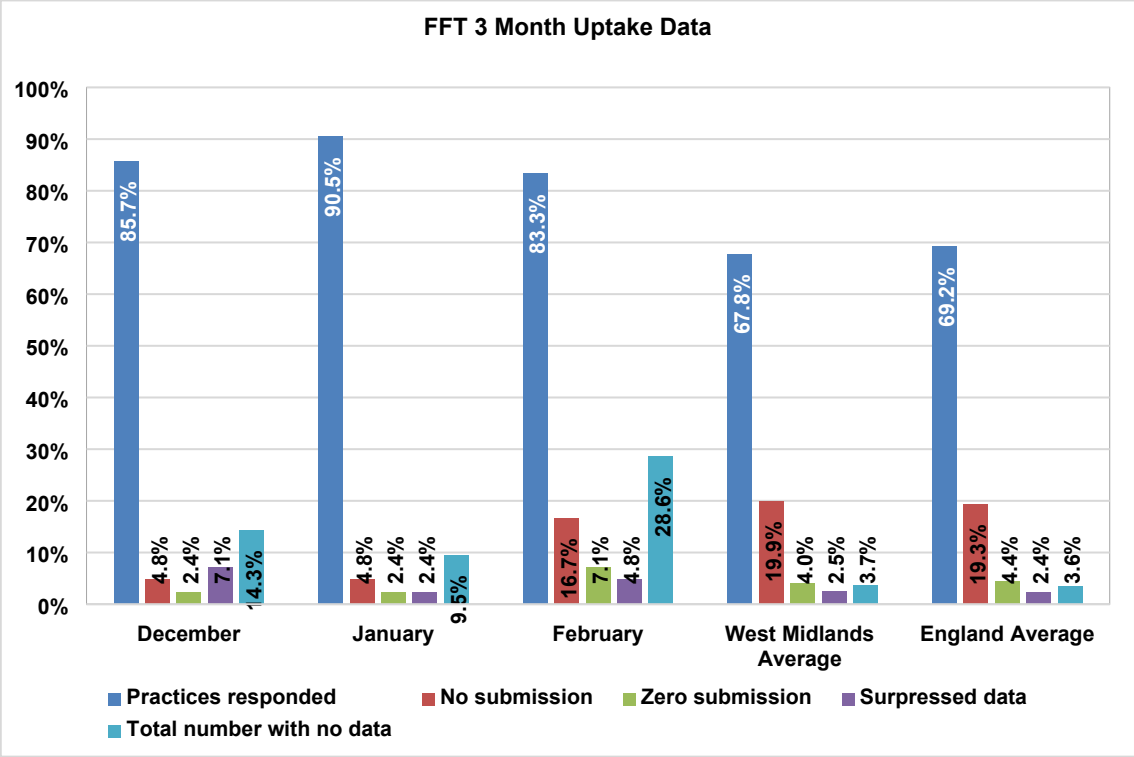


Figure 3: Practices with no submission or supressed data in March 2018

Practice	Data not submitted/suppressed	Comments
No submission	7	2 practices have provided their data to CCG for inclusion
Zero submission	3	
Suppressed data	2	

This month overall more practices had no submission at 16.7%; suppressed data (fewer than 5 submissions) had increased slightly to 4.8%, the total number of practices with no data available had also increased, whereas the regional and national trend were stable from previous months. Response for WCCG as a proportion of list size was 1.6% which is the same as last month and still significantly better than both the regional and national averages of 0.7% and 0.6% respectively.

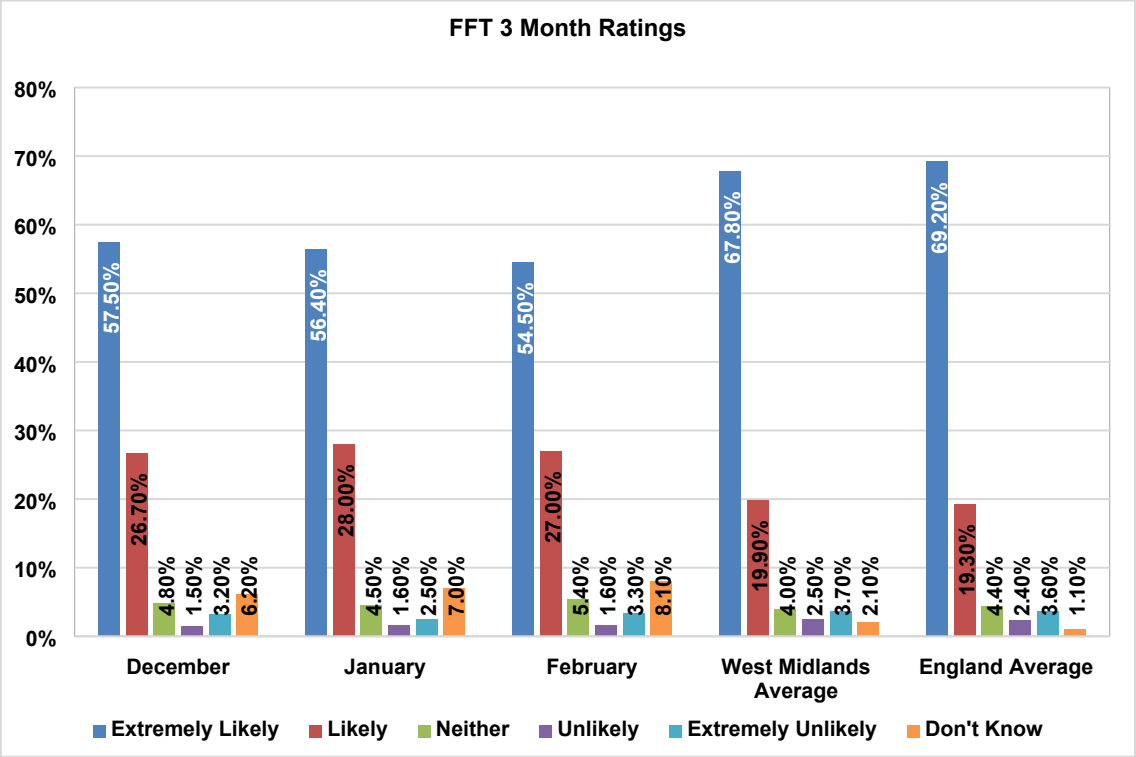
Ten practices are also identified as having a higher than average (1.6%) uptake with a range of 9.3% - 1.8% and this will be shared with locality managers as an on-going matter to encourage sharing of good practice:

Ratings:

Figure 4: FFT 3 Month Ratings

Percentage	December	January	February	West Midlands Average	England Average
Extremely Likely	57.5%	56.4%	54.5%	67.8%	69.2%
Likely	26.7%	28.0%	27.0%	19.9%	19.3%
Neither	4.8%	4.5%	5.4%	4.0%	4.4%
Unlikely	1.5%	1.6%	1.6%	2.5%	2.4%
Extremely Unlikely	3.2%	2.5%	3.3%	3.7%	3.6%
Don't Know	6.2%	7.0%	8.1%	2.1%	1.1%

Figure 5: FFT 3 Months Ratings Data Comparison



Overall responses remain positive (82% would recommend their practice) and ratings are stable, but are still lower than regional (88%) and national (89%) averages. Again 14% gave either a “don’t know” or “neither” answer compared to 6.1% regionally and 5.5% nationally and this is rising on a monthly basis. There remains a strong correlation between these responses and submission via practice check in screens and SMS text, indicating that patients may be unsure over what response to give, or unclear regarding use of the technology.

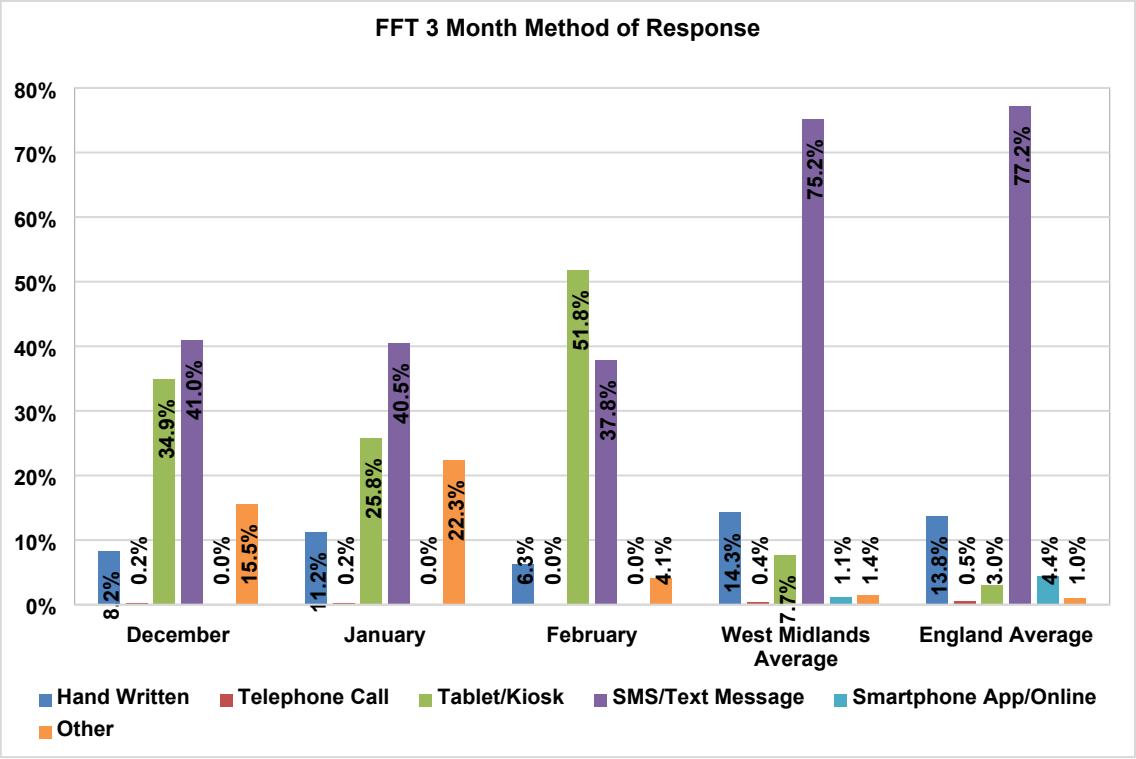
Method of Response:

Figure 6: FFT 3 Month Method of Response

Percentage	December	January	February	West Midlands Average	England Average
Hand Written	8.2%	11.2%	6.3%	14.3%	13.8%

Telephone Call	0.2%	0.2%	0.0%	0.4%	0.5%
Tablet/Kiosk	34.9%	25.8%	51.8%	7.7%	3.0%
SMS/Text Message	41.0%	40.5%	37.8%	75.2%	77.2%
Smartphone App/Online	0.0%	0.0%	0.0%	1.1%	4.4%
Other	15.5%	22.3%	4.1%	1.4%	1.0%

Figure 7: FFT 3 Month Method of Response Comparison



This month the majority of responses have again come via SMS text which is reflective of CCG initiative to promote two-way texting for practices (37.8%) and Tablet/Kiosk (51.8%). Handwritten responses have significantly reduced over the last few months and are now at 6.3%, lower than the national and regional averages shown above in Figure 9, although these are also falling as electronic technology takes precedence. Please note that some practices do not appear to record the method of collection.

Assurances

A FFT policy has now been developed and this has been shared with the LMC who are happy with it, next steps are to forward this to Primary Care Commissioning Committee for approval and embed into GP contract in June.

FFT activity is being monitored on a monthly basis by the Operational Management Group, FFT working group (next meeting TBC) and via the NHSE Primary Care Dashboard. Non responders, suppressed and zero data is monitored monthly, practices that do not submit are contacted by the Primary Care Contract Manager or locality managers and appropriate advice and support offered to facilitate compliance. Those that fail to submit on a regular basis may receive a contract breach notice, and a number of sites are being monitored closely. Wolverhampton LMC have offered to support the process to avoid the need for breach notices to be applied. Information from FFT is also triangulated with NHSE

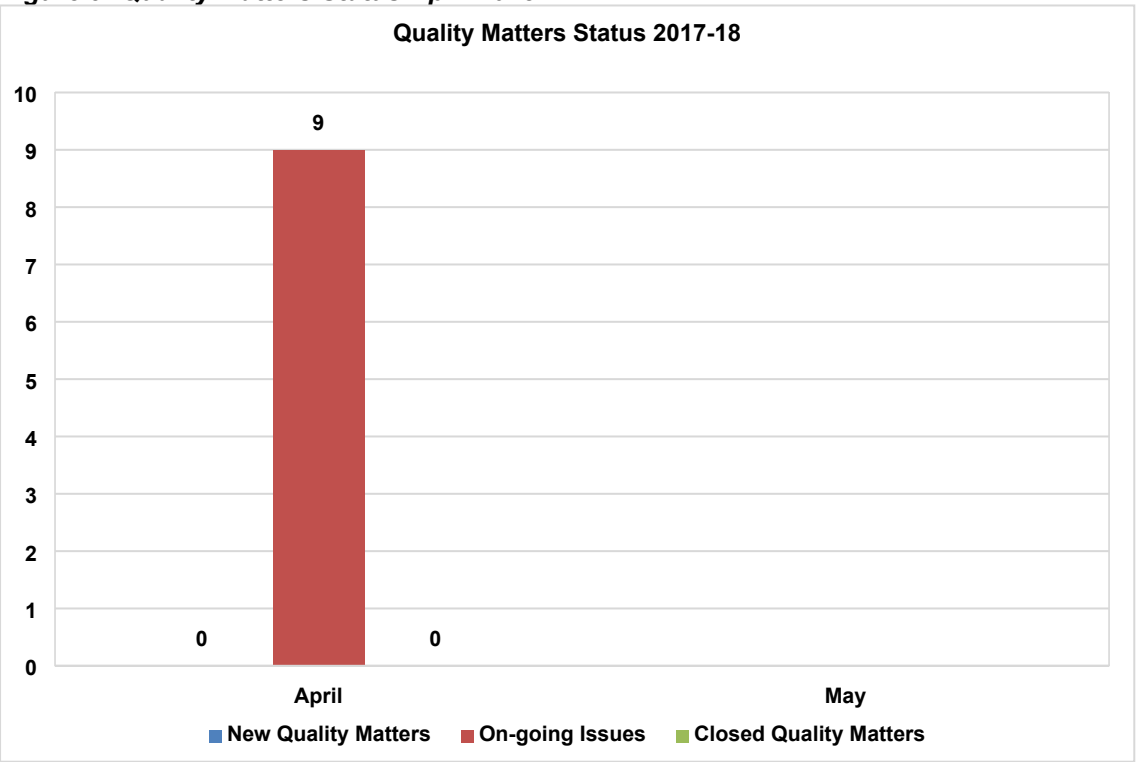
Dashboard and GP Patient Survey data when available and with Quality Matters, SIs and complaints.

5. QUALITY MATTERS

Figure 8: Quality Matters Status and Variance

Status	Number	Variance from last month
New	0	0
On-going	9	-7
Closed	7	7
Total	9	-7

Figure 9: Quality Matters Status April 2018



Activity via the Quality Matters process is shown above, this is reviewed monthly. Quality issues relating to GPs are reported to NHS England Professional and Practice Information Gathering Group (PPIGG) for logging and escalation where appropriate.

Assurances:

Quality Matters continue to be monitored, and all Primary Care incidents have been forwarded to the relevant practices and to NHSE where appropriate. Practices are asked to provide evidence of investigation and learning from these incidents and this is provided to NHSE who will then escalate accordingly and feedback to the CCG or to the Serious Incident Scrutiny Group for further consideration.

6. COMPLAINTS

The CCG continues to be copied in on new complaints from NHSE as they are reported, 18 GP complaints have been received since the beginning of November. The breakdown of reports are as follows.

Figure 10: Complaints Reported to NHSE Since November 2017

Month	Number
November	6
December	3
January	4
February	3
March	2
April	0

Assurances:
The CCG does not have oversight of GP complaints dealt with within the surgery. NHSE is now sharing complaints data and this can be triangulated with other data e.g. SIs and Quality Matters. All complaints reported to NHSE are logged via PPIGG for appropriate escalation, this includes local actions e.g. additional training or serious incident reporting. Practices must provide evidence of their complaints procedure and handling for CQC and for the CCG Collaborative Contracting team.

7. SERIOUS INCIDENTS

There are two incidents currently under investigation:

Assurances:
The practices involved have been asked to provide an RCA and action plan and assurances to the CCG that they have put learning and action points into practice. All serious incidents are reported to NHS England PPIGG group for logging and appropriate escalation and feedback is provided to the CCG.

8. ESCALATION TO NHS ENGLAND

There are a number of incidents due to be referred to the next meeting following receipt of actions/learning from practices.

Assurances:
Assurances around NHSE escalation are provided by bi-weekly feedback from action logs from PPIGG meetings and quarterly reports relating to complaints raised and their outcomes. Any action from escalation is shared via PPIGG and reports, however comprehensive information is not always available. PPIGG outcomes are shared with Primary Care Contract Manager and Primary Care Liaison Manager and practice visits set up if necessary. Data is triangulated with other information i.e. Quality Matters, FFT, IP audits and complaints.

9. NICE/CLINICAL AUDIT

The NICE assurance group met in February 2017 where the latest guidelines were discussed, this is currently under review and up to date information will be presented at the next meeting. Guidance relevant to primary care from the last NICE meeting is shown below. For the latest list of published guidance please see this link.

Figure 11: NICE Guidance Relevant to Primary Care

Guideline	Published	Primary Care
TA494 - Naltrexone–bupropion for managing overweight and obesity	Dec-17	x
TA493 - Cladribine tablets for treating relapsing–remitting multiple sclerosis	Dec-17	x
QS124 - UPDATE - Suspected cancer.	Dec-17	x
DG14 - UPDATE - Atrial fibrillation and heart valve disease: self-monitoring coagulation status using point-of-care coagulometers (the CoaguChek XS system).	Dec-17	x
CG128 - UPDATE - Autism spectrum disorder in under 19s: recognition, referral and diagnosis	Dec-17	x
NG84 - Sore throat (acute): antimicrobial prescribing	Jan-18	x
NG83 - Oesophago-gastric cancer: assessment and management in adults	Jan-18	x
NG82 - Age-related macular degeneration	Jan-18	x
TA506 - Lesinurad for treating chronic hyperuricaemia in people with gout.	Feb-18	x
QS164 - Parkinson's disease	Feb-18	x
NG85 - Pancreatic cancer in adults: diagnosis and management	Feb-18	x
CG44 - UPDATE - Heavy menstrual bleeding: assessment and management	Feb-18	x
TA161 - UPDATE - Raloxifene and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women.	Feb-18	x
TA464 - UPDATE - Bisphosphonates for treating osteoporosis	Feb-18	x
QS93 - UPDATE - Atrial fibrillation	Feb-18	x
CG147 - UPDATE - Peripheral arterial disease: diagnosis and management	Feb-18	x
TA160 - UPDATE - Raloxifene for the primary prevention of osteoporotic fragility fractures in postmenopausal women	Feb-18	x

Assurances:

The assurance framework around NICE guidance is currently being reviewed and will be applied in line with the peer review system for GPs, this is on-going and discussions are due to commence imminently. Relevant NICE guidance is identified by Dr Booshan and forwarded to GPs for consideration.

10. CQC INSEPECTIONS AND RATINGS

To date from April 2017 18 practices have received an inspection, 16 have been rated Good and 2 rated Requires Improvement.

Assurances:
The two practices that currently have a Requires Improvement rating and are being monitored by the Primary Care and contracting team with input from the Quality Team, one practice was previously rated requires improvement but at revisit was rated good. Site visits have been undertaken or are planned and outstanding issues and concerns escalated as appropriate.

11. WORKFORCE

Work continues to refine the workforce development plan in line with STP and national drivers.

Attraction:
Working in Wolverhampton video is now complete and awaiting final edit. CSU continues to collate information to amend the CCG intranet site to include more comprehensive information around workforce and training. CCG continue to attend relevant workforce fairs locally.

Recruitment:
Work continues around international recruitment of GPs with bid recently submitted, numbers of staff to be confirmed c/o STP.

Information about new Nursing Associate and Registered Nurse apprenticeships shared with primary care and links to University of Wolverhampton provided. A further 5000 NAs will be recruited through the apprenticeship scheme this year with additional funding support from HEE.

Further details about Return to Practice programmes provided by Health Education England, for consideration at next Workforce Task and Finish Group.

Development:
The local Practice Nurse Education forum continues all session dates are finalised and most have been booked in advance. We plan to further develop this with additional training sessions currently being explored with support from Dovetail.

HCA training has been finalised and will cover respiratory conditions and weight management, this is being provided by Education for Health. Further clinical training is being considered in conjunction with the Training Hub.

GPFV training programmes continue and include Care Navigator and Reception Staff training and Practice Manager training.

Retention:
Further work around retention will be undertaken as part of STP, GPFV and national drivers from the 10 Point Action Plan.

Assurances:

The workforce implementation plan has been revised to reflect new initiatives and programmes of work, and the workbook is now also revised. Priority is being given to the development of the Workforce Strategy in line with new national and regional programmes of work

12. CLINICAL VIEW

Not applicable

13. PATIENT AND PUBLIC VIEW

Not applicable

14. KEY RISKS AND MITIGATIONS

See section 9.

15. IMPACT ASSESSMENT

Not applicable.

16. ADDITIONAL PAPERS

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
8th May 2018

Agenda item 11

TITLE OF REPORT:	Primary Care Strategy Delivery (April 2018)
AUTHOR(s) OF REPORT:	Jo Reynolds - Primary Care Development Manager
MANAGEMENT LEAD:	Sarah Southall - Head of Primary Care
PURPOSE OF REPORT:	To provide an overview of the discussions that took place at Milestone Review Board with particular focus on two key programmes of work (Primary Care Strategy and General Practice Forward View) since the last report, presented to the Governing Body on 10th April 2018.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This report has been prepared for consideration and discussion at the Public Governing Body Meeting.
KEY POINTS:	The Milestone Review Board last met in April and meets at quarterly intervals. This report confirms the continued pace of progress being sustained in response to both the Primary Care Strategy & General Practice Forward View.
RECOMMENDATION:	The recommendations made to Governing Body regarding the content of this report are as follows:- • Receive and discuss this report, and the programmes of work contained within it. • Note the updates provided for each work programme.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1a Improving the quality and safety of the services we commission 2 Reducing Health Inequalities 3 System effectiveness delivered within our financial envelope

1. BACKGROUND AND CURRENT SITUATION

1.1 The CCG has developed two programmes of work to enable implementation of the Primary Care Strategy and General Practice Forward View. Both programmes have been in place since 2016 the content of both is largely attributed to national direction & local improvement that seeks to achieve a sustainable primary care for the future. A full programme management office approach is taken for the Primary Care Strategy the GPFV programme and has been developed over a period of time based on guidance from NHS England.

2.0 Primary Care Programme(s) of Work

2.1 Primary Care Strategy

Task and Finish Group Updates are captured routinely via a series of workbooks & submitted to the Programme Office and will continue to be subject to review at monthly intervals.

The programme was reviewed, one exception was reported assocrunning in accordance with anticipated timescales hence there was no slippage on any part of the programme. Workbooks were reviewed for all task and finish groups, with acknowledgement from the responsible Director on current progress and next steps. The highlights are captured within the table below:-

Practices as Providers Task & Finish Group	
Progress made in the last three months	**Next steps for the next three months**
Back office functions review completed. Groups have identified which areas they wish to progress, these include subscriptions & other non-clinical support services. The Home Visiting service pilot project business case and service specification have been approved at Primary Care Commissioning Committee. Mobilisation of the project is anticipated towards the end of Quarter 1. The service specification for the 2018/19 Improving Access has been approved & implementation commenced at group level. Transformation Fund Service Specification has been developed with approval from PC Commissioning committee. Delivery plans are currently being finalised for consideration in May 2018. The QOF+ Scheme 2018/19 has been finalised & shared for consideration with a range of forums. Feedback captured and final changes made. Approval is anticipated in May, implementation will take place thereafter.	Launch the Home Visiting Pilot in partnership with Primary Care and Royal Wolverhampton Trust. Monitor & advertise opening hours in access hubs in line with new national standards. To launch the QOF+ 2018/19 Scheme across all practice groups to include scheme sign up and ensure monitoring is in place. Evaluation of the Frailty Clinic pilot project in PCH1 and make recommendations for future roll out/ development. To work with the Enhanced Health in Care Homes Steering Group, develop a revised service specification for an enhanced model of primary care support for Care Homes. Review delivery plans practice groups ie potential Diabetes Clinic aimed at patients aged 30-50 as part of the Primary Care Home 1 hub.

A local improvement plan for the completion of Learning Disabilities Health checks has been developed and will be monitored by the Task and Finish Group going forward. The improvement plan has been developed in collaboration with the SEND lead and Learning Disabilities Commissioner. Primary Care Counselling contract has been awarded with Relate (3 year contract).	Ensure delivery plans for NHS Health Checks are in place across all practice groups and implementation is underway focussing on improved activity. Scope a series of service redesign projects that have been suggested by GP colleagues on Foot Health, Audiology (self-referral) and Nursing Home referral to dietician.
Primary Care as Commissioners	
Targeted Peer Review service specification has been approved and all practice groups have a forward programme of Peer Review meetings in place for 2018/19. A scoping paper presented to Programme Board regarding increasing utilisation of Choose and Book Advice and Guidance. A practice training workshop took place in April including a refresher on Advice and Guidance. A business case will be prepared for June. The Mental Health Primary Care Steering Group are also scoping a potential service development for Advice and Guidance with BCPFT. Practice level dashboard(s) continue to be developed capturing a range of sources of data confirm activity/performance ie QOF, commissioned services etc. Workshop held with stakeholders regarding Multi Disciplinary Team Meetings, design opportunities identified and will be used to inform the content of a final draft service specification that enables structured MDT Meetings to be introduced. Discussions with the provider of Sound Doctor (self help video(s)) have taken place with a view to materials being available in languages other than English & utilisation/effectiveness of the service provided to date.	To monitor Targeted Peer Review activity on a monthly basis identifying learning / actions from each meeting. Findings will continue to be reviewed by clinical leaders. To ensure a regular report on Choose and Book Advice and Guidance at practice level and by clinical specialty is in place. To have oversight of QOF (national) activity routinely reviewed by the Task & Finish Group. Develop a detailed proposal for Advice and Guidance in Mental Health. Review the current practice level dashboard with practices and have received feedback on how the data can be used at practice/ group level. Finalised service specification for GP input into MDT Meetings based on outcomes from design workshop. Utilisation data for Sound Doctor & availability of materials in other languages. Implementation of practice group transformation schemes by June 2018.

Workforce	
Primary Care Strategy prepared, feedback obtained leading to GB approval April 2018 International GP Recruitment Application submitted February 2018 CCT Fellowship Application submitted April 2018 Training & development programme for Care Navigation, Practice Managers, HCAs Primary Care Webpage developed case studies (new roles, PPG Chair etc), videos & other content prepared, vacancy page – linked to RCGP Communications reaching out / advertising via Social media ie LinkedIn page, Twitter introduced, presence at recruitment fairs ie Wolverhampton Uni also exploring RCGP & Bham Uni etc, exhibition materials also prepared & in place Suite of job descriptions for primary care library to aid practices in recruiting to primary care roles. CEPN ££ extended by HEE beyond contract end date (8+4) Nurse Facilitator support from Dudley also confirmed. Workforce dashboard figures collated for GPs, Nursing, CP, Admin roles (NHS Digital) Secured £10k non recurring funding from Health Education England towards support in place for workforce planning.	Implementation of Workforce Strategy implementation of initiatives pertaining to the age profile - channel investment - grow and develop the workforce - streamline the workload - improve infrastructure - and support practices to redesign their services to patients Next steps following feedback from NHSE ie IGPR & CCT Fellowships MECC Resources due to be distributed to practices Survey of primary care staff who have attended training 2017/18 due to conclude (May 2018) & analysis report will be prepared (June WTFG). Mental Health Therapists – improve the interface between MH and PC Strengthen links with STP Local Workforce Delivery Board (LWAB) & associated sub groups. Focus on interdependencies with Contracting TFG and financial investment requirements to ensure we are working towards a sustainable primary care Commence delivery of 2018/19 work programme & monitor activity via critical path.
Contracting Task & Finish Group	
Primary Care Contracting Strategy is currently being developed by the Task and Finish Group. The Primary Care Advice, Support and Transformation support will continue to be provided by NHS England in addition to existing resource within the CCG. NHS England will continue to commission Direct Enhanced Services in 2018/2019. Risk Gain share approaches across the Black Country have been considered by the Task and Finish Group. Priorities for 2018/19 agreed & defined in new work programme.	Meeting schedule in place & Terms of Reference to be updated. Workshop on Primary Care Contracting, commissioning & finance inter-dependancies will be held to define where work programmes overlap/influence delivery. Launch 2018/19 programme of work and review risks to reflect the revised priorities/planning milestones.

IT Task & Finish Group	
Shared Care Record - Funding from NHS England approved and quote received from Graphnet to continue development of the solution. The migration planning/preparation continues in line with the CCGs programme, next system go live scheduled for May 23rd 2018. Project Manager to deliver E-Consultations is now in post and has commenced development of project documentation to deliver online triage and video consultation within practices identified to participate in the pilot. A schedule has been developed for facilitators to visit practices during March and April 2018 to encourage the uptake of patient online. Text Messaging solution – Two way texting has been rolled out to almost all practices, remaining sites will go live shortly. GP appointment access utilisation tool: Tool to be deployed centrally by NHS England. E-RS Workshop held for all practices, well attended.	Joint working with Sound Doctor to review utilisation and effectiveness . Text Messaging solution – complete installation/roll out to final sites and ensure that all training is completed. GP appointment access utilisation tool to be deployed centrally by NHS England. E-Consultation Solutions - Agree deployment dates with stakeholders to enable trial to commence. E-RS - new 2ww implementation date to be confirmed, list for PSO exclusions, continued support for practices.
Estates Task & Finish Group	
Void space targets have been met. On-going programme should reduce this by £100k in 2018/19 Newbridge and East Park have now met the ETTF criteria. They are now awaiting sign off from NHSE and CCG so that their respective developments can proceed.	Request that NHSPS can move forward with developments on Heads of Terms Work with other cohort 1 schemes to finalise sign off so that they can start building work Complete STP workbook to add schemes to possible future developments

Also at this meeting there were a series of other service development items considered, as follows:-

- Special Access Service (formerly Zero Tolerance) Business Case, Policy & Service Specification
- QOF+ Scheme 2018/19 Update
- Out of Area Patient Service Specification
- Learning Disabilities Health Checks Service Specification
- Minor Surgery Service Specification

Each item was supported and approval of funding would be sought from Primary Care Commissioning Committee in May with the exception of Learning Disabilities Health Checks & Minor Surgery as the improvement plan required no additional funding.

2.2 General Practice Forward View

The forward view comprises of 5 strands of work spanning investment, workforce, workload, infrastructure and care redesign. Currently the programme has 85 projects defined these are reflective of the five chapters but also align with some of the work that had been identified within the CCGs Primary Care Strategy Programme of Work. By way of an overview the current programme status has been broken down as follows:

GPFV Programme of Work					
Chapter	**Not Started**	**Achieved & Closed**	**In Progress**	**Overdue**	**Total Projects**
1 Investment	**0**	6	1	0	7
2 Workforce	9	3	15	0	27
3 Workload	4	6	15	0	25
4 Infra-structure	6	6	9	0	21
5 Care Redesign	1	0	4	0	5
Total(s)	**20**	**21**	**44**	**0**	**85**

Appendix 1 provides a more detailed assessment of the full programme of work by chapter in a self-assessment format providing an indication of individual project status and progress being made spanning all 5 chapters of the GPFV.

Some projects overlap with the work of Task and Finish Groups that were established to implement the primary care strategy.

2.2.1 Project Updates

A series of specific updates were provided for projects that had commenced, as follows:-

Chapter 1 - Transformation Projects 2018/19

Delivery plans are currently being prepared by practice groups to demonstrate how they will improve patient care / service delivery within their practice group(s), delivery plans are due by the end of April & projects anticipated to be up and running by the end of June. The delivery plans will also focus work pertaining to the 10 high impact actions and working at scale. Six of the high impact actions have been implemented in 2017/18 and will be maintained on an ongoing basis. The remaining 4 high impact actions will be implemented during 2018/19.

Chapter 2 - Practice Manager Training

Practice Managers have had the opportunity to take part in an RCGP session to help them focus on working at scale, and develop plans as practice groups. Unity have had their session earlier this month, with the next session for the PCH groups and VI in the coming weeks.

Chapter 2 – HCA Training
As part of the CCGs commitment to developing Health Care Assistants training in COPD/Asthma & weight management commenced in April 2018 with tissue viability & NHS Health Checks training also planned later in the programme.

Chapter 2 – Post CCT Fellowships
An application had been completed at STP level and submitted to Health Education England for consideration. The application seeks to secure 10 fellowships for newly trained GPs to work with practices across the STP, expressions of interest have been received from practices within each CCG. The outcome is anticipated in May 2018.

Chapter 2 – Leadership Development
Team Building Training for Managers working as part of a practice group has also been delivered by the RCGP to enable a series of priorities and timescales for delivery to be identified.

Chapter 2 – Clinical Pharmacists in Primary Care
As part on the ongoing introduction of practice level Clinical Pharmacists a citywide Pharmacy Peer Group has been established. The group is made up of pharmacy colleagues from a number of settings including community, hospital & general practice and have committed to reviewing the role they play in the patient pathway, familiarisation with pharmacy roles in different care settings and developing consistent patient information. The group are due to meet again in May.

Chapter 3 – Care Navigation
Evaluation has commenced of Cohort 1 pathways and scoping for Cohort 2 also underway. A further stakeholder event is planned for June 2018 and will lead to launching further pathways for Care Navigators to advise on from September 2018.

Chapter 3 – Review of QOF & Local Investment
A local scheme for 2018/19 has been developed in addition to the existing national quality outcomes framework. The local scheme will focus on priorities identified by member practices with a focus on preventing disease ie diabetes, alcohol and obesity. Funding approval is anticipated in May with a view to launch in June 2018.

Chapter 4 - Document Management/Workflow Optimisation
Service specification developed and associated impact assessments were considered & agreed in principle, business case to be considered at Primary Care Commissioning Committee in May in order for procurement to commence.

Chapter 4 - Online Consultation
Steps have been taken in the development of the pilot project which will enable both online consultations and video communication. Pilot Practices have been identified and the documentation required, such as data sharing agreements, has been developed. Both projects are anticipated to be live by May 2018.

Chapter 5 - Improving Access- Movement of deadline
At the March Regional Access group NHSE asked areas to review the delivery plans to see if any schemes could be brought forward to an earlier delivery than the October 2018 deadline. After discussion with groups, a bid was submitted to receive additional funding and has been agreed by NHS England.

Unity, VI and PCH2 have all agreed to increase their capacity to increase to 83% from July (25 mins per 1000) and 100% (30 mins/ 1000) from August onwards.

PCH2 have also agreed to move their trajectory forward, and will be providing 100% (30 mins/ 1000) from 1st September.

The revised trajectory for improving access is as follows-

Revised Trajectory					
April	May	June	July	August	September
67%	67%	67%	75%	84%	100%

Each practice group will continue to advertise opening and availability of additional appointments at their respective hub. Discussions also continue with Patient Participation Group Chairs so that they are aware, this compliments advertising on our website & local newspapers too.

3 CLINICAL VIEW

3.1 There are a range of clinical and non-clinical professionals involved in the delivery & oversight of both primary care programmes of work. Leadership decisions are clinically driven with representation at many Task and Finish Groups from clinicians from across the city.

4 PATIENT AND PUBLIC VIEW

4.1 The CCG has lay member involvement in a range of projects and forums pertaining to primary care. Patient Participation Group Chairs receive regular updates from the primary care team regarding up and coming projects & developments, their feedback is encouraged & valued. Plans are being finalised for engagement arrangements with the public for 2018/19, these will be underpinned by the CCGs Communications & Engagement Strategy.

5 RISKS AND IMPLICATIONS

Key Risks

5.1 The Milestone Review Board, who oversee this programme of work, has in place a risk register that captures the profile of risks associated with the program of work. Risks pertaining to the program are reviewed at each meeting and at this stage there are no red risks to raise.

Financial and Resource Implications

5.2 At this stage there are no financial and resource implications to consider, the resources needed have been discussed in the appropriate task and finish groups and at Milestone Review Board. All financial commitments have been allocated within the scope of the Primary Care resources, and finance colleagues are aware of the implications. .

Quality and Safety Implications

5.3 Patient safety is first and foremost, the experience of patients accessing primary medical services as the programme becomes more established is anticipated to be met with positive experiences

of care. The quality team will be engaged accordingly as service design takes place and evaluation of existing care delivery is undertaken.

Equality Implications

5.4 The Strategy has a full equality analysis in place. This will require periodic review during the implementation phase.

Medicines Management Implications

5.5 The role of clinical pharmacist is an area of specific attention within the programme of work. The workforce task and finish group tracks the progress and effectiveness of the role.

Legal and Policy Implications

5.6 The Primary Care Strategy demonstrates how the CCG seeks to satisfy its statutory duties and takes account of the key principles defined within the General Practice Five Year Forward View.

Name	Jo Reynolds
Job Title	Primary Care Development Manager
Date	April 2018

Appendix 1 GPFV Programme & Self Assessment 2018/19 (updated March 2018)

	Details/ Name	Date
Clinical View	S Reehana	
Public/ Patient View	S McKie	
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team	S Roberts	
Equality Implications discussed with CSU Equality and Inclusion Service	NA	
Information Governance implications discussed with IG Support Officer	NA	
Legal/ Policy implications discussed with Corporate Operations Manager	NA	
Other Implications (Medicines management, estates, HR, IM&T etc.)	NA	
Any relevant data requirements discussed with CSU Business Intelligence	NA	
Signed off by Report Owner (Must be completed)	S Marshall	26.4.1 8

WOLVERHAMPTON CCG

PRIMARY CARE COMMISSIONING COMMITTEE
MAY 2018

TITLE OF REPORT:	Primary Care Counselling Service
AUTHOR(s) OF REPORT:	Ranjit Khular, Primary Care Transformation Manager
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	To provide the Primary Care Commissioning Committee with a progress report on the Primary Care Counselling service which is being funded from PMS premium monies.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• The Primary Care Counselling service was commissioned as a six month pilot scheme commencing in June 2017 which was subsequently extended following a positive evaluation report. • A contract for a three- year service operational from 1 April 2018 to 31 March 2021 was awarded to a consortium lead by Relate Birmingham. • The report summarises activity to date and presents some patient outcomes/ case studies
RECOMMENDATION:	For Primary Care Commissioning Committee to note the contents of this report.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Reducing Health Inequalities in Wolverhampton	a. Improve and develop primary care in Wolverhampton – Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this b. Deliver new models of care that support care closer to home and improve management of Long Term Conditions Supporting the development of Multi-Speciality Community Provider and Primary and Acute Care Systems to deliver more integrated services in Primary Care and Community settings

1. BACKGROUND AND CURRENT SITUATION

1.1 In line with the Mental Health Five Year Forward View for Mental Health which proposed to improve the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma, the CCG have been working to improve the experience of those experiencing common mental health disorders such as stress, depression and anxiety.

1.2 In recognition of this the CCG commissioned a local Primary Care Counselling Service as a six month pilot project. This mini- procurement process was facilitated by the Central Midlands and Lancashire Commissioning Support Unit. . The procurement was undertaken as an Expressions of Interest process. The expressions of Interest went out to a number of local organisations.

1.3 The mini-procurement concluded in April 2017. The successful bid was a consortium bid submitted by Relate Birmingham with Aspiring Futures CIC, The Disability Resource Centre and The Haven. The current service went live on 1 June 2017, initially for a six month period.

1.4 The key features of the Primary Care Counselling Service are to provide counselling support to patients with very low level anxiety and depression related to life events within a primary care setting as an alternative referral source for people who do not meet the criteria for Healthy Minds.

The Primary Care Counselling Service currently will provide a number of solution-focussed quality psychological therapy/ counselling interventions to patients. Specifically services include:

- Counselling for Low Mood and Life Events,
- Low level Cognitive Behavioural Therapy
- Focussed counselling for depression anxiety or life events

The following issues are also likely to be relevant in patients referred to the service:

- Physical Illness – and its consequences including Long Term Conditions
- Loss and Bereavement – adjustment to change
- Stress – work, finances etc, trauma, life crisis
- Carer's Issues

1.5 Referrals can only made by GPs or, Primary Care Health Team members. The service is not a crisis service and therefore there is no capacity to offer urgent appointments or to respond to patients experiencing acute mental health crisis or distress.

The service was commissioned to deliver the following level of activity:

2010 hours of counselling at £40.00 per hour over a 6 month period, with an initial 6 week period of delivering 60 hours per week, increasing to 82 hours per week for the last 20 weeks. The service model upon which this resource is based consists of an initial assessment

followed by six 1:1 counselling sessions.

1.6 In October 2017 a report was presented to the Commissioning Committee which presented an evaluation of the current service. This evaluation presented qualitative data on a cohort of patients that had accessed the service which demonstrated a positive impact of the service on patients' mental wellbeing using three different outcomes measures (CORE 10, PHQ9 and GAD7). A series of case studies were also presented which demonstrated positive outcomes reported by patients who had accessed the services.

1.7 On the basis of this recommendation, Commissioning Committee agreed for the contract to be extended to the end of the financial year (end of March 2018) and also recommended that a longer term solution was scoped and presented back to the Committee.

1.8 Following the discussion at October 2017 Commissioning Committee a meeting took place with representatives from Contracting, Primary Care and the Mental Health commissioner to consider options for the future commissioning of this service. The following agreements were made:

The group recommended the procurement of the Primary Care Counselling service over a longer period of time e.g. three years. Assuming that the service is commissioned as per the existing hours of provision at the same hourly rates this indicates that the value of the contract over a 12 month period would be as follows:

82 hours of counselling x 52 weeks per year =	4264 hours
4264 hours x £40 =	**£170,560**

A three year contract would therefore equate to a total contractual value of **£511,680.**

A report was presented to Commissioning Committee where this recommendation was supported.

1.9 A full service specification for the Primary Care Counselling Service was developed. GP members were invited to comment on a draft service specification which was presented to the Clinical Reference Group in December. The specification which was subsequently amended and approved by the Primary Care Commissioning Committee is included in Appendix 1 of this report

The value of the three year contract came within the EU procurement threshold of £589k, as per Public Contract Regulations 2015. This meant that the CCG was not required to conduct a formal procurement exercise.

1.10 Instead it was recommended to the committee that a mini-procurement process was conducted whereby expressions of interest would be sought from potential providers. The existing provider Relate was clearly be in a strong position to bid but rather than directly award the three year contract to the current provider , it was considered best practice to undertake a competitive process particularly in view of the specification being revised. The following organisations were invited to bid for the contract:

- ACCI
- Relate

- Terence Higgins Trust
- Wolverhampton Voluntary Sector Council
- Kaleidoscope
- Base 25

Tender submissions were received from the following organisations:

- Kaleidoscope
- Relate

1.11 A tender evaluation session took place with representation from the Primary Care Team, Contracting and Quality to evaluate the submissions.

The outcome from the tender evaluation process was that a three year contract was awarded to Relate. Relate is the lead provider in the consortium with partners Aspiring Futures CIC, The Disability Resource Centre and The Haven, Base 25 and Terence Higgins Trust.

As the new contract has been awarded to the existing lead provider there was no gap in service delivery between the two contracts.

2. ACTIVITY AND OUTCOMES

2.1 Referrals to the service

Since the service was commissioned the number of referrals by month have been as follows:

Month	Number of referrals
2017	
June	51
July	73
August	67
September	78
October	115
November	135
December	73
2018	
January	86
February	121
March	144
April	125

A breakdown of referrals by individual practice has been provided in Appendix 2.
Of the 943 referrals made from June 2017 to March 2018:

142 patients did not respond to the provider when contacted to arrange for an initial assessment

89 patients did not wish to engage with the service at that point in time. On these occasions the provider notified the referring GP of the outcome.

54 patients referrals were not considered appropriate for the service, and the provider notified the referring GP of the reason why it was not considered an appropriate service for the patient at that point in time.

86 patients did not attend all the appointments as agreed

Reasons for referral:

Of the 943 referrals received between June 2017 and March 2018, the reason(s) for referral has been recorded as follows:

Reason for referral	**Number of referrals ***
Physical Illness – and its consequences including Long Term Conditions	99
Loss and Bereavement – adjustment to change	195
Stress – work, finances etc, trauma, life crisis	595
Carer's Issues	34
Other reason	248

*Referring GPs can record more than one reason as a reason for referral.

There has been a spread of referrals across all practice groups and individual GP practices, and regular communications have been included in group level newsletters. The service have also requested an opportunity to address local GPs as part of an upcoming Team W session.

2.2 Patient level outcomes

The service routinely administers a number of patient reported Outcome tools which are as follows:

2.2.1 CORE Assessment

The CORE assessment tool is a generic measure of psychological distress and draws upon the views of what practitioners considered to be the most important generic aspects of psychological wellbeing health to measure. The CORE comprises 4 domains: Well-being (4 items), Symptoms (12 items) Functioning (12 items) and Risk (6 items)

Across a sample of 100 patients the average measures against the CORE tool were **20.9** before the intervention and **13.5** after the intervention.

2.2.2 PHQ9

Patient Health Questionnaire (PHQ-9) it is used to monitor the severity of depression and response to treatment. Assessment against the tool will stratify the patient at on of the 4 tiers:

- Minimal depression 0-4
- Mild depression 5-9
- Moderate depression 10-14
- Moderately severe depression 15-19
- Severe depression 20-27

Across a sample of 100 patients the average measures against the PHQ9 tool were **15.5** before the intervention and **8.8** after the intervention.

2.2.3 GAD 7

Generalised Anxiety Disorder Assessment (GAD-7) This easy-to-use self-administered patient questionnaire is used as a screening tool and severity measure for generalised anxiety disorder (GAD)

The scores from the assessment indicate as following:

- 5- 9 mild anxiety disorder
- 10-14 moderate anxiety disorder
- 15 or above severe anxiety disorder

Across a sample of 100 patients the average measures against the PHQ9 tool were **13.8** before the intervention and **7.8** after the intervention.

A full summary of the outcome measures for a sample of 100 patients is presented in Appendix 3.

A proportion of the activity delivered by this service contributes towards the CCG's target of delivering access to the Improving Access to Psychological Therapies (IAPT) programme target. Work is being undertaken with the provider to ensure that the relevant activity is being recorded as IAPT activity.

3. CLINICAL VIEW

3.1. The service has been well received by GP colleagues. The following comment was made by a referring GP:

"Feed back from patients has been excellent and I am less stressed as I can access timely and excellent care for patients that were previously waiting for 6 months with healthy minds and therefore seeing me a lot whilst waiting."

Dr G Pickavance, Newbridge Surgery

4. PATIENT AND PUBLIC VIEW

4.1. The provider has collated a series of care studies from patients who have been referred to the service. A sample of these can be found in Appendix 4 of this report

5. KEY RISKS AND MITIGATIONS

5.1 The provider asked the CCG to fund the cost of interpreters in attendance during counselling sessions for two patients during the course of the pilot scheme. This provision comes at a significant cost to the provider During the period of the pilot scheme the cost of interpreters has been met by the CCG on a case by case basis. However for the duration of the new contract the cost of the interpreter is to be met by the provider.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. The overall cost of the service equates to £170,560 per year

Quality and Safety Implications

6.2 This service is deemed to be an early intervention as it is supporting those with mild to moderate symptoms of stress, depression.

The outcomes data presented in the report indicates that the intervention is bringing about an improvement in the mental wellbeing of patients.

Equality Implications

6.3 A full EIA is currently being completed in retrospect; the provider has access to Interpreter services where the language needs of a service user cannot be met by the counsellors.

Legal and Policy Implications

6.4 Referrals are made from GPs/ Practice teams to the provider by nhs.net secure email. The provider is working towards the NHS Information Toolkit and has been allocated a secure nhs.net email to receive referrals securely.

Other Implications

N/A

Name	**Ranjit Khular**
Job Title	**Primary Care Transformation Manager**
Date:	**11 May 2018**

ATTACHED:

Appendix 1	Service specification
Appendix	Volume of referrals to the service by practice group/ practice June 2017 to March 2018
Appendix 3	Case Studies
Appendix 4	Qualitative evaluation of the Primary Care Counselling service

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	**Date**
Clinical View		
Public/ Patient View		
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team		
Equality Implications discussed with CSU Equality and Inclusion Service		
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager		
Other Implications (Medicines management, estates, HR, IM&T etc.)		
Any relevant data requirements discussed with CSU Business Intelligence		
Signed off by Report Owner (Must be completed)	**R Khular**	**12 May 2018**

APPENDIX ONE - Service specification

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	**Primary Care Counseling Service**
Commissioner Lead	**NHS Wolverhampton CCG**
Provider Lead	
Period	**1 April 2018 – 31 March 2021**
Date of Review	**31 March 2019**

1. Population Needs

1.1 National/local context and evidence base

"The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services".

Mental health problems are widespread, at times disabling, yet often hidden. People who would go to their GP with chest pains will suffer depression or anxiety in silence. According to the Five Year Forward View for Mental Health, one in four adults experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.

Commissioning and delivery of safe, sound and supportive mental health services and care pathways is a key strategic priority for our health and social care economy and is aligned with a number of other key deliverables such as reducing health inequalities, reducing the impact of long term conditions upon quality of life and improving patient experience as outlined in our Wolverhampton Health and Well-Being Board Strategy, the CCG's Operational Plan and the CCG's 5 Year Strategic Plan.

The commissioner seeks to promote the well-being of individuals in the Wolverhampton community by providing accessible, quality counseling services for adults over the age of 18, utilising a system that emphasizes trust, respect, confidentiality, and compassion.

We are committed to quality mental health care that is provided in a collaborative effort with the patients overall health strategies and an array of medical services offered within primary care services. We are further committed to the philosophy of a recovery and solution focused service, in line with counselling services offered by non-statutory providers across our city.

A significant proportion of consultations with GPs are related to mental health difficulties. Approximately half of the 9000 practices in England employ a counsellor. Current evidence suggests that counselling can be useful in the treatment of mild to moderate mental health problems in the short-term (up to 6 months).

In the provision of any service the CCG would encourage practices to demonstrate collaborative working with other practices within their clinical network or beyond which will enable coverage of the provision across a range of locations.

There is evidence to suggest that counsellors working in primary care can reduce the overall cost of care by causing a decrease in the number of referral to psychiatrists, and ordering fewer prescriptions (Bower, 2000).

The CCG wishes to improve access to low level and preventative interventions that support patients to achieve a more optimal state of mental well-being in a less structured and more flexible way than is sometimes offered by statutory services providing psychological therapies as per IAPT models and guidance.

This service is commissioned in line with the national strategy '***No Health without Mental Health'* 2011** which states as outcomes, amongst others:

> More people with mental health problems will recover. i.e. more people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live
>
> In addition, more people will have a positive experience of care and support, and fewer people will experience stigma and discrimination.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	yes
Domain 3	Helping people to recover from episodes of ill-health or following injury	yes
Domain 4	Ensuring people have a positive experience of care	yes
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	yes

2.2 Local defined outcomes

Improved mental health, as measured by recognised outcome measures used by the service Positive recovery outcomes for individuals include:

- Increased ability to manage mental health
- Encourage social networks, including an increase in the ability to find work, training and access education
- Improvement in the ability to develop and maintain personal and family relationships
- Increase in self-esteem, trust and hope.

3. Scope

3.1 Aims and objectives of service

Aims:

- To alleviate mental distress and contribute towards to improvement of mental health through a local Primary Care Counselling service.
- To ensure access for all groups within the local community
- To deliver an evidence based intervention to patients

The aim of this service is to provide solution focused and supportive counseling to patients with very low level anxiety and depression related to life events within a primary care setting as an alternative referral source for people who do not meet the criteria for Wolverhampton Healthy Minds.

The model enables counselors to gain experience within a supportive, well supervised, setting.

The intended outcome is to improve well-being, and speed the recovery of patients, which will also release general practitioner consultations for other patients.

The Primary Care Counselling Service currently will provide a number of solution- focused quality counselling interventions to patients. Specifically services include:

- Counselling for Low Mood and Life Events,
- Low level Cognitive Behavioural Therapy
- Counselling interventions to support patients who have anger management issues / difficulties
- Focused counseling for depression anxiety or life events

The following issues are also likely to be relevant in patients referred to the service:

- Physical Illness – and its consequences including Long Term Conditions
- Loss and Bereavement – adjustment to change
- Stress – work, finances etc, trauma, life crisis
- Anger management issues
- Carer's Issues

In all instances the privacy, safety and dignity of the patient will be paramount and the counselling service will work with the GP and Primary Care and Secondary Care professionals where / as required to ensure that patients requiring higher levels of support are identified and referred into the appropriate services in a timely and effective manner.

The service will be delivered in community settings including GP surgeries where possible.

The provider will use a range of marketing tools to promote and raise the profile of the service. Examples of this include a leaflet and information for professionals and patients. The provider will promote the service in GP practices through the provision of leaflets and posters.

All counsellors delivering the interventions will as a minimum:

- Be qualified to Diploma level
- Have attended mandatory training which must be renewed every 2 years
- Have up to date DBS checks
- Have access to regular supervision, both individual and group level

- Have at least 4 years' experience of delivering counselling to individuals with relevant presenting issues

3.2 Service description/care pathway

Referrals can only be made by GPs or, Primary Care Health Team members. This is not a crisis service and therefore there is no capacity to offer urgent appointments or to respond to patients experiencing acute mental health crisis or distress. The service will not accept self referrals

It is intended that the counselling service will be offered to patients with low levels of mental health need who would not meet the criteria in terms of level and types of need for referral into secondary mental health services and / or the primary care facing secondary mental health services such as IAPT (Integrated Access to Psychological Therapies), that are provided by Wolverhampton Healthy Minds / The Well-being service.

This means therefore that the counselling service is suitable for patients who have been assessed as not meeting 'caseness' , require 'watchful waiting' and / or patients who require lower levels of support than those offered by these services.

Referrals can be made to the service by any General Practitioner or member of the Primary Care team. All referrals to the service must be made by using the referral form which is uploaded onto GP clinical systems. The completed referral form must be transmitted by secure email to the providers secure email.

Upon receipt of the referral, the provider will contact the service user within 7 days to book a convenient time for an initial assessment within 14 days. If the assessment indicates that the counselling service is appropriate for the patient, the counselling will commence as soon as possible, with dates and times agreed with the patient. The provider will work to a 7 session model –offering an assessment and up to 6 further appointments per case. The provider will offer all appointment sites to all patients to enable patients to have a choice of times and locations.

The service will be available during normal working hours (9am to 5pm) Monday to Friday. In addition to this there will be a minimum of one evening session.

The provider will deliver the interventions from a range of locations within the city, allowing patients to exercise choice. Where possible interventions will be delivered from GP surgeries, if appropriate intervention rooms are available.

The provider will administer the following diagnostic tests at the beginning of the intervention to establish a baseline of the service users mental wellbeing:

PHQ9 which is a multipurpose instrument for diagnosing, monitoring and measuring the severity of depression

GAD7 which is a self-administered patient questionnaire is used as a screening tool and severity measure for generalised anxiety disorder

CORE 10 which is a generic, short, and easy-to-use assessment measure for common presentations of psychological distress in UK primary care mental health settings.

The provider will repeat the above tests at the end of the intervention as a means of measuring the progress made by the patient.

After the initial assessment the provider will agree a date, time and venue for the next intervention. The patient will receive up to 6 one hour sessions with the counsellor.

Individual counselling sessions should last one hour, of which a minimum 50 minutes should be face to face between the counsellor and client.

If a client has complex needs or requires help beyond the capability of the service, they should be referred to the Community Mental Health Team, with appropriate notification to their GP, subject to consent.

At the end of the counselling sessions, clients should be given information on ways to sustain progress they have made, and seek further support as required.

3.3 Population covered

Any patient registered with a Wolverhampton GP aged 18 or over can access the service upon referral from their GP or any member of the primary care team.

3.4 Any acceptance and exclusion criteria and thresholds

The following patients are not deemed to be appropriate for the service:

- Patients experiencing acute mental health crisis or distress
- Patients under the age of 18

3.5 Interdependence with other services/providers

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The following are applicable in the delivery of this service:

NICE Clinical Guideline: Depression in adults: recognition and management (CG90)

NICE Clinical Guideline: Common mental health problems: identification and pathways to care (CG123)

NICE Clinical Guideline: Depression in adults with a chronic physical health problem: recognition and management (CG91)

NICE Quality Standard: Anxiety disorder quality standard: QS53

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Applicable local standards.

- The service must be free at the point of use.
- Rooms used for counselling purposes should be private and free from interruption, furnished appropriately and when counselling is taking place, used exclusively for that purpose.
- Outcome measures must be used for all clients and these must be reported to the commissioner to inform evaluation of the service.

The provider will report the following to the Commissioner:

- Number of referrals in the reporting month
- Number of referrals accepted onto the providers caseload
- Number of referrals by referring General practice
- Issues most pertinent to the referral:
    - Physical illness - & it's consequences incl long term conditions
    - Loss & bereavement - adjustment to change
    - Stress - work, finances etc trauma, life crisis
    - Carers issues
    - Other

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

5.2 Applicable CQUIN goals

6. Location of Provider Premises

The Provider's Premises are located at:

7. Individual Service User Placement

APPENDIX TWO

REFERRALS BY GP PRACTICE GROUP/ PRACTICE JUNE 2017 TO MARCH 2018

PRIMARY CARE HOME 1

PRACTICE	NUMBER OF REFERRALS
M92016 - TUDOR MEDICAL CENTRE	29
M92629 - DRS KHARWADKAR & MAJI	21
M92019 - KEATS GROVE SURGERY	-
M92030 - CHURCH STREET SURGERY	14
M92649 - DR MUDIGONDA	1
M92630 - EAST PARK MEDICAL PRACTICE	10
M92012 - DUNCAN STREET PRIMARY CARE PARTNERSHIP	126
M92029 - NEWBRIDGE SURGERY	132
M92607 - WHITMORE REANS MEDICAL PRACTICE	7
TOTAL	**340**

PRIMARY CARE HOME 2

PRACTICE	**NUMBER OF REFERRALS**
M92647 - BRADLEY MEDICAL CENTRE	0
M92003 - DR SURYANI	0
Y02736 - SHOWELL PARK HEALTH CENTRE	7
M92609 - ASHFIELD ROAD SURGERY	38
M92039 - DR ST PIERRE-LIBBERTON	28
M92009 - PRESTBURY MEDICAL PRACTICE	24
M92013 - WODEN ROAD SURGERY	25
TOTAL	146

MEDICAL CHAMBER

PRACTICE	**NUMBER OF REFERRALS**
Y02757 - BILSTON URBAN VILLAGE MEDICAL CENTRE	9
M92015 - IH MEDICAL (DRS PAHWA)	7
M92627 - DR SHARMA	28
M92040 - MAYFIELD MEDICAL CENTRE	-
M92024 - PARKFIELD MEDICAL CENTRE	103
M92043 - PENN SURGERY	63
Y02636 - INTRA HEALTH LIMITED (PENNFIELDS)	7
M92640 - THE SURGERY - DR WHITEHOUSE	1
M92010 - LOWER GREEN HC- TETTENHALL	26

M92008 - CASTLECROFT MEDICAL PRACTICE	37
M92022 - DR RAJCHOLAN	1
M92041 - PROBERT ROAD SURGERY	24
M92014 - FOWLER	11
M92001 - POPLARS MEDICAL CENTRE	5
M92004 - PRIMROSE LANE PRACTICE	-
M92026 - DR BILAS - Ashmore Road	41
TOTAL	**358**

PRACTICES ALIGNED WITH ROYAL WOLVERHAMPTON NHS TRUST

PRACTICE	**NUMBER OF REFERRALS**
M92007 - LEA ROAD MEDICAL PRACTICE	26
M92002 - ALFRED SQUIRE MEDICAL PRACTICE	19
Y02735 - ETTINGSHALL MEDICAL CENTRE	6
M92654 - BRADLEY CLINIC PRACTICE (MGS)	2
M92042 - WEST PARK SURGERY - DRS SIDHU KOODARUTH	5
M92044 - DRS DE ROSA & WILLIAMS	8
M92011 - PENN MANOR MEDICAL PRACTICE	31
M92006 - COALWAY ROAD MEDICAL PRACTICE	-
M92028 - THORNLEY STREET MEDICAL CENTRE	2
TOTAL	**99**

APPENDIX THREE

Qualitative evaluation of the Primary Care Counselling service for a sample of 100 patients accessing the service

		CORE 10 SCORES			PHQ-9 SCORES			GAD 7 SCORES		
CLIENT NO	GENDER	START SCORE	END SCORE	DIFF	START SCORE	END SCORE	DIFF	START SCORE	END SCORE	DIFF
1	F	30	26	-4	22	14	-8	17	13	-4
2	F	26	20	-6	21	17	-4	17	16	-1
3	F	2	1	-1	1	0	-1	2	1	-1
4	F	22	10	-12	20	4	-16	18	5	-13
5	M	13	5	-8	6	4	-2	4	3	-1
6	M	20	29	9	27	20	-7	15	14	-1
7	F	29	11	-18	19	4	-15	18	3	-15
8	F	20	15	-5	21	7	-14	15	0	-15
9	F	6	9	3	5	4	-1	5	4	-1
10	F	27	2	-25	23	2	-21	16	1	-15
11	M	3	2	-1	7	0	-7	2	0	-2
12	F	19	21	2	17	8	-9	17	5	-12
13	F	14	7	-7	12	2	-10	11	2	-9
14	F	25	16	-9	8	14	6	6	12	6
15	F	29	9	-20	16	7	-9	15	6	-9
16	F	18	15	-3	8	10	2	5	4	-1
17	F	24	7	-17	24	2	-22	21	8	-13
18	M	21	11	-10	12	6	-6	14	9	-5
19	F	21	22	1	16	19	3	16	17	1
20	M	20	20	0	6	12	6	11	12	1
21	F	30	15	-15	17	10	-7	21	9	-12
22	M	32	15	-17	20	6	-14	19	5	-14
23	F	15	6	-9	10	4	-6	13	5	-8
24	M	20	3	-17	10	2	-8	21	6	-15
25	M	21	9	-12	15	4	-11	17	6	-11
26	F	27	22	-5	15	13	-2	19	12	-7
27	M	24	11	-13	21	6	-15	17	6	-11
28	F	23	21	-2	22	12	-10	19	10	-9
29	F	15	8	-7	8	5	-3	13	9	-4
30	M	27	27	0	20	20	0	18	15	-3
31	F	10	6	-4	6	0	-6	7	1	-6
32	F	9	15	6	6	9	3	9	11	2
33	M	25	18	-7	21	11	-10	14	8	-6
34	F	20	16	-4	17	15	-2	24	28	4
35	M	17	8	-9	17	10	-7	13	5	-8
36	F	10	12	2	3	6	3	20	2	-18

37	F	23	14	-9	20	14	6	8	7	-1
38	F	33	14	-19	23	0	-23	14	0	-14
39	F	19	21	3	14	18	4	10	16	6
40	M	31	28	-3	21	2	-19	20	2	-18
41	F	32	31	-1	23	22	-1	21	21	0
42	M	28	7	-21	20	6	-14	19	6	-13
43	F	24	30	6	12	22	10	7	21	14
44	M	27	13	-14	21	17	-4	17	14	-3
45	F	30	24	-6	24	13	-11	21	15	-6
46	F	23	0	-23	14	1	-13	20	0	-20
47	F	8	2	-6	9	6	-3	6	4	-2
48	F	18	8	-10	11	5	-6	11	4	-7
49	F	13	1	-12	15	0	-15	13	0	-13
50	M	26	14	-12	21	8	-13	18	8	-10
51	M	23	13	-10	19	3	-16	16	6	-10
52	F	11	1	-10	7	0	-7	8	0	-8
53	F	10	3	-7	8	3	-5	9	1	-8
54	F	25	21	-4	8	5	-18	17	7	-10
55	F	21	18	-3	22	16	-6	16	16	0
56	M	21	9	-12	10	5	-5	14	9	-5
57	F	27	0	-27	22	0	-22	19	0	-19
58	F	16	22	6	12	14	2	12	14	2
59	M	18	20	2	13	14	1	16	19	3
60	M	17	27	10	21	14	-7	19	10	-9
61	F	17	7	-10	14	2	-12	12	2	-10
62	F	21	10	-11	13	2	-11	10	2	-8
63	M	27	13	-14	17	3	-14	15	4	-11
64	F	13	5	-8	4	0	-4	4	1	-3
65	F	22	12	-10	16	13	-3	14	8	-6
66	M	10	7	-3	10	8	-2	8	7	-1
67	M	14	8	-6	19	6	-13	19	4	-15
68	F	19	17	-2	16	16	0	14	13	-1
69	F	33	26	-7	23	18	-5	20	14	-6
70	F	29	6	-23	21	0	-21	21	1	-20
71	M	26	9	-17	20	9	-11	11	5	-6
72	M	24	27	3	19	19	0	15	11	-4
73	F	28	30	2	21	22	1	19	15	-4
74	F	14	0	-14	5	0	-5	6	0	-6
75	F	19	15	-4	11	10	-1	13	9	-4
76	F	14	24	10	7	23	16	6	21	15
77	M	29	24	-5	15	17	2	17	13	-4
78	F	18	7	-9	13	3	-10	12	3	-9
79	F	29	16	-13	16	11	-5	15	8	-7
80	F	12	7	-5	4	5	1	3	1	-52
81	M	22	12	-10	20	3	-17	21	6	-15

82	M	18	9	-9	13	7	-6	15	9	-6
83	F	28	15	-13	18	15	-3	21	16	-5
84	M	27	12	-15	14	7	-7	18	9	-9
85	F	34	26	-8	25	21	-4	19	17	-2
86	M	19	13	-6	18	4	-14	8	6	-2
87	M	25	9	-16	11	2	-9	9	0	-9
88	M	15	17	2	15	12	-3	11	10	-1
89	F	18	13	-5	16	19	3	11	17	6
90	M	23	17	-6	16	11	-5	12	8	-4
91	F	13	12	-1	10	9	-1	10	7	-3
92	F	24	11	-13	23	12	-11	14	12	-2
93	M	14	6	-8	15	4	-11	10	4	-6
94	F	19	8	-11	18	2	-16	11	3	-8
95	F	16	5	-11	15	9	-6	14	4	-10
96	F	17	7	-10	13	3	-10	8	2	-6
97	F	29	33	4	23	23	0	13	16	3
98	F	23	24	1	20	16	-4	1	2	1
99	F	26	12	-14	21	9	-12	20	6	-14
100	F	17	6	-11	13	4	-9	14	6	-8
	average	**20.8**	**13.5**	**-7.3**	**15.3**	**8.8**	**-6.6**	**13.7**	**7.8**	**-6.5**

APPENDIX FOUR

Case Study 1

Presenting Issues

Stress, Anxiety, Anger, Loss. Low self-esteem coming mainly from his disbelief of how his deceased uncle and his son have treated him.

Process

The client was unsure whether he would attend the session. He could not see how counselling could help. He realised that he was a fixer but could not fix his sons alcoholism. He equally admitted that his uncle, who was his closest friend, had left him in a state of shock because of the vicious attack on him personally. His uncle's severe mental health in his latter years had caused the vitriol and abuse. The client saw that his lack of control of these issues made him annoyed and even angry at members of his family. The family is important to him, He said in closing the first session that he was glad that he had decided to attend.

He had thought a lot about the first session and had more understanding of his role in his life. He said that he now realised as a pleaser/fixer he had always followed his mother's example of how to "not rock the boat". This was causing problems at work as well as at home and giving him extra stress. His son and daughter were leaving home and although he didn't like the family diminishing at home it was the best thing for him. He recalled a trauma while on holiday recently in Madeira .While there he had taken ill and was hospitalised but the insurance company did not pay the bill quickly and he was not allowed to leave. He knew that he suffered from the "White Coat Syndrome" but until his now recent realisation had not understood that it was his lack of ability to fix that was the major problem.

No need for sixth session. The client was more than happy with his progress and has come to the conclusion that his wants are more important and therefor he has a far greater belief in himself .

His home life and work life are much better .

Core 10 at last session now 2. PHQ-9 now 0. Gad-7 now 0

Case study 2

Counsellor/psychotherapist :Yasmeen Bibi

Client: White British female 20 +

Presenting issues:

Low mood, mild depression, stress, low confidence, loss, bereavement, trust issues. Client presented a history of self-harm and tried to commit suicide *in* 2015.

Client *is* taking anti-depressants.

Safe guarding and risk assessment form was completed with the client. Since she didn't present a current threat no action was taken.

Process:

Client was feeling very overwhelmed and cried in her first two sessions. She was holding on to a lot of guilt. She tried to commit suicide just a few months before her mother died of undiagnosed cancer.

Client was able to explore her history starting from her childhood. She had a secure childhood. She was bullied in school. There was a traumatic event in her life during her teen years that resulted in her feeling isolated. She started to self-harm. She reflected that she has suffered from low self- esteem all her life but it went bad and she tried to kill her-self. A couple of months after her mother died of undiagnosed cancer, leaving her with a constant feeling of mourning. She has been off work since Feb 2017. She was unable to go back to work.

Client was able to reflect that she was holding on to a lot of shame for letting her mother down just before her death. Client was also able to see that she was going through her own emotional and self- esteem issues that were making her feel very isolated. She was able to rationalise that there was no way she could have known that her mother was not well or going to die just a couple of months
after her attempted suicide.

We worked together to make an action plan for the client. This helped her to identify her needs, set goals and take actions to achieve those goals giving her a choice to celebrate her life without feeling guilty.

It was also identified that the client was scared of forgetting her mother's memory, hence she would spend a couple of days every week to mourn/cry/feel overwhelmed. That had become a ritual with the client. It was discussed there may be other ways to celebrate the memory of her mother by celebrating life, doing well and feeling happy for herself. She reflected that her mother was a happy person and she would want her to be happy.

During therapy client went back to part time work and was looking forward to full time work in a couple of weeks6.

Outcome:

On her last session the client said that there had been no episodes of low moods for the last 2 weeks. She is going back to full time to work. Client started meditation and breathing exercises and said feels at peace and contended. She said she feels that she has a voice and she is able to express her feelings of love towards her siblings.

Core 10 score at assessment: 23

Core 10 score at the last session :2

Client's feedback:

"Counselling has helped me rationalise things and see a different perspective. It's helped me to realise I can change things and feel good and not worry about other people's opinion.

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Primary Care Commissioning Committee
Tuesday 22 May 2018

TITLE OF REPORT:	Document Management
AUTHOR(s) OF REPORT:	Jo Reynolds, Primary Care Development Manager
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	To share a business case that has been prepared for consideration by the committee for Document Management 2018/19
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• Document management is part of the 5 Year GP Forward View • The attached specification and business case are regarding to training for admin staff, to enable the skills to manage clinical correspondence effectively. • The aim of the programme is to free up GP time by enhancing the admin role
RECOMMENDATION:	The committee are required to receive & consider the Business Case with a view to approval in order for the specification to be advertised and a supplier identified.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1. Improving the quality and safety of the services we commission : Continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions. 2. Reducing Health Inequalities in Wolverhampton : Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this. 3. System effectiveness delivered within our financial envelope : The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.

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SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

Service Specification No.	
Service	Document Management
Commissioner Lead	Jo Reynolds
Provider Lead	
Period	April 2018- March 2019
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

The General Practice Forward View (GP Forward View), published in April 2016, commits to an extra £2.4 billion a year to support general practice services by 2020/21. It will improve patient care and access, and invest in new ways of providing primary care.

Productive workflow is one of the 10 high impact actions taken from the strategy that we will focus on in 2018/19. This specification is to support this work, and to enable staff to be more effective within their roles.

Wolverhampton has a patient population of 288,898, whose primary care needs are met by 44 General Practices. These are divided into 5 practice groups. Each practice will need to be involved in this programme of work, to ensure a consistent approach across the city.

All practices operate on either EMiS or System One.

2. Scope

Correspondence management involves clerical staff coding incoming clinical correspondence, taking actions where appropriate, including forwarding it to another member of the team, or passing the letter to a GP for action if a clinical decision is required. It is a more advanced task than document processing or coding alone. It requires clerical staff to be skilled and confident to make decisions about how to code a letter and its contents in the patient record, how to use

an approved protocol for deciding which letters need to be sent to a GP and with what level of urgency, and when to ask for help. In order to do this effectively, staff require training and development of their skills and confidence.

3. Aims

1. To reduce the impact medical correspondence has on GP workload by diverting to other trained professionals
2. To provide reception and admin staff with the skills and confidence to effectively deal with correspondence on the GPs behalf, and ensure that it is reflected in the patients care
3. To identify and tackle issues in the flow of documents within the practice, implementing a new systematic approach to processing incoming clinical correspondence
4. To have a safe, efficient and robust system to facilitate audit of the document processing.
5. The training will help delegates understand the importance of accurate Read / SNOWMED CT Coding and understanding medical terminology.

4. Service description

The aim of this programme is to obtain a standardized approach to correspondence management across Wolverhampton. This will be taught through a training programme, with the successful provider developing the protocols to compliment the training they have delivered. The successful provider will be expected to deliver training and then follow up to ensure the protocols have been implemented and the practice is utilizing the skills of those trained. An evaluation of the effectiveness will take place once the work is completed and is seen as business as usual.

The Processing of clinical correspondence is required in a timely, safe and efficient manner, ensuring that medical records are up to date, by a suitably trained professional.

A member of clerical staff in the practice will be given this additional training and relevant protocols in order to support the GP in clinical administration tasks. All incoming correspondence about patients from hospitals and other sources will then be processed by a member of the clerical team, releasing GP time. Staff require training to effectively look for what is required in a clinical letter, and code it appropriately. Reception and admin staff need to be skilled and confident in ascertaining patient need and appropriate action to be taken from this.

Working against the standard protocols developed in-house and refined through continuous improvement, each letter needs to be read and may need to be actioned. The appropriately trained member of the team reads the letter, enters details into the patient's record and takes appropriate follow-on action, and identifying any duplication. In some cases this involves other members of the team, or booking the patient an appointment. Letters that require urgent action will be passed onto the GP.

The successful provider will be required to work closely with GP partners to identify issues that currently occur when managing the flow of documents. They will then be required to support the change of focus from volume to process, leading to the redesign of the process.

Protocols and processes will need to be developed in conjunction with practices, to ensure quality and consistent auditable activity is taking place. The practice will be provided with or supported to produce standard protocols for the handling of clinical correspondence utilising accurate recording of high quality data.
The training received and the protocols developed will not lead to an increase in the MDU or MPS indemnity costs or invalidate said indemnity.

Practices will need to be revisited after 6 months, to quality check that the learning is being applied and to quantify the impact. During this period The practice will be supported to refine, through continuous improvement, the protocols developed.

The involvement of appropriate clinical governance & supervision within each practice will need to be clearly communicated by the training provider and agreed before training is delivered.

The readiness of each practice to be willing and able to change their working procedures in order to receive the benefits of this new approach will be assessed and training not undertaken if the benefits cannot be delivered.
Proposals should include any requirements for venue, training equipment, access to IT or clinical systems. The CCG will provide the training venues.

5. Payment

The total budget available for this is up to £0.40 per patient.

6. Outcomes-

1. Patients receive speedier action
2. Improve the detail in coding
3. Improved monitoring and management of certain conditions
4. Improved staff competency
5. Following training, all incoming correspondence about patients will be able to be processed safely by a member of the clerical team.
6. Practices will have been supported to ensure that 80-90 per cent of letters could be processed without the involvement of a GP
7. Practices will see the benefit of a reduction in the average GP workload for managing clinical correspondence of at least 50%.

7 Population covered

All patients registered to a Wolverhampton GP Practice

8 Timescales

The desired delivery timeline for the training sessions will be Spring 2018, therefore the successful provider will need to have availability during this time.

Provision of supporting document management operating procedures will be supplied by the successful provider, sufficient for at least one copy per practice (42 practices) at the time of delivering the training.

Practices will need to be revisited 6 months after training takes place, and work will need to be completed on all aspects by March 2019.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

All practices taking part in the scheme are expected to work within usual contractual terms and conditions.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

5.2 Applicable CQUIN goals

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Appendix A- List Sizes

Clinical system	Locality		Row Labels	Actual List Size QTR 4	Normalised Weighted List Size Oct 17
PCH 1 Wolverhampton Total Health (Group Lead Dr G Pickavance)					
E	NE	M92016	M92016 - TUDOR MEDICAL CENTRE	16799	17,090
T	NE	M92629	M92629 - DRS KHARWADKAR & MAJI	3556	3,108
E	NE	M92019	M92019 - KEATS GROVE SURGERY	6417	6,508
E	SE	M92030	M92030 - CHURCH STREET SURGERY	5325	5,474
E	SE	M92649	M92649 - DR MUDIGONDA	3727	4,148
E	SE	M92630	M92630 - EAST PARK MEDICAL PRACTICE	5310	5,573
E	SW	M92029	M92029 - NEWBRIDGE SURGERY	4603	5,133
E	SW	M92607	M92607 - WHITMORE REANS MEDICAL PRACTICE	13502	14,063
Total				**59239**	**61097**
PCH2 Wolverhampton Care Collaborative (Group Lead Dr P Mundlur)					
E	SE	M92612	M92612 - GROVE MEDICAL CENTRE (Healthcare and Beyond - inc Grove, Caerleon (PMS) and All Saints & Rose Villlas)	12734	13,906
E	SE	M92647	M92647 - BRADLEY MEDICAL CENTRE	3024	3,513
E	SE	M92003	M92003 - DR SURYANI	1723	1,910
T	NE	Y02736	Y02736 - SHOWELL PARK HEALTH CENTRE	4896	4,189
E	NE	M92609	M92609 - ASHFIELD ROAD SURGERY	5170	4,995
E	NE	M92039	M92039 - DR ST PIERRE-LIBBERTON	6461	6,772
E	NE	M92009	M92009 - PRESTBURY MEDICAL PRACTICE	14390	16,058
E	NE	M92013	M92013 - WODEN ROAD SURGERY	6816	7,303
Total				**55214**	**58646**
Not Yet Aligned to a Model of Care/Group					
			All practices are now aligned to a practice group		
Medical Chambers 1 (Group Lead Dr K Ahmed)					
T	SE	Y02757	Y02757 - BILSTON URBAN VILLAGE MEDICAL CENTRE	6644	6,552
E	SE	M92015	M92015 - IH MEDICAL (DRS PAHWA)	2610	2,464
E	SE	M92627	M92627 - DR SHARMA	3200	3,622
E	SE	M92040	M92040 - MAYFIELD MEDICAL CENTRE	7250	8,338
E	SW	M92043	M92043 - PENN SURGERY	5238	5,686
T	SW	Y02636	Y02636 - INTRA HEALTH LIMITED (PENNFIELDS)	4513	4,571
	SW	M92640	M92640 - THE SURGERY - DR WHITEHOUSE	2420	2,422
E	NE	M92022	M92022 - DR RAJCHOLAN	4119	4203
E	NE	M92041	M92041 - PROBERT ROAD SURGERY	4599	4,245
E	NE	M92014	M92014 - FOWLER	1994	2,101
E	NE	M92001	M92001 - POPLARS MEDICAL CENTRE	3,587	3,564.00
E	NE	M92004	M92004 - PRIMROSE LANE PRACTICE	3025	3,404
T	NE	M92026	M92026 - DR BILAS - Ashmore Road	3828	4,012
				53027	**55,184**
Medical Chambers 2 (Contact Dr A Johnson/Dr S Agarwal)					
E	SE	M92012	M92012 - DUNCAN STREET PRIMARY CARE PARTNERSH	9604	10,098
E	SE	M92024	M92024 - PARKFIELD MEDICAL CENTRE	13477	14,205
E	SW	M92010	M92010 - LOWER GREEN HC- TETTENHALL	11964	12,982
T	SW	M92008	M92008 - CASTLECROFT MEDICAL PRACTICE	12382	13,195
T	SW	M92006	M92006 - COALWAY ROAD MEDICAL PRACTICE	5139	5,239
				52566	**55,719**
Vertical Integration RWT					
E	SW	M92007	M92007 - LEA ROAD MEDICAL PRACTICE	6619	6,292
E	NE	M92002	M92002 - THE GROUP PRACTICE ALFRED SQUIRE ROAD	8321	9,695
E	SE	Y02735	Y02735 - ETTINGSHALL MEDICAL CENTRE	4231	4,572
E	SE	M92654	*M92654 - BRADLEY CLINIC PRACTICE*	7727	8,179
E	SW	M92042	M92042 - WEST PARK SURGERY - DRS SIDHU KOODARU	3509	3,568
E	SW	M92044	M92044 - DRS DE ROSA & WILLIAMS	4264	4,594
E	SW	M92011	M92011 - PENN MANOR MEDICAL PRACTICE	11537	11,836
E	SW	M92028	M92028 - THORNLEY STREET MEDICAL CENTRE	10057	9,516
				30407	**58,252**
				62,421	65,118
				52,032	54,625
				53,027	55,184
				52,566	55,719
				30,407	58,252
				250,453	**288,898**

Appendix B- Staff Numbers

TBC

NHS
Wolverhampton
Clinical Commissioning Group

FULL Equality Analysis Form

Step 1	Document Ownership

Name of Project/Review	**Document Management**
Project Reference number	
Project Lead Name	**Jo Reynolds**
Project Lead Title	**Primary Care Development Manager**
Project Lead Contact Number & Email	*jo.reynolds2@nhs.net* *01902 442579*
Date of Submission	
Is the document:	
A proposal of new service or pathway	**NO**
A strategy, policy or project (or similar)	**YES**
A review of existing service, pathway or project	**YES**
Has a Preliminary Appraisal already been completed	**NO**
If the Preliminary Appraisal confirmed that a full EA was NOT required, please only complete step's one and two.	

Step 2	Establishing Relevance

Public Sector Equality Duties

To ensure compliance with the Equality Act 2010, all strategies or policies or projects, proposals for a new service or pathway, or changes to an existing service or pathway, should be assessed for their relevance to equality – for patients, the public, and for staff. The general equality duty requires that when exercising its functions that the NHS has due regard to the need to:

- Eliminate unlawful discrimination, harassment , victimisation and any other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristics and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

Protected Characteristics

You need to analyse the effect on equality for all protected characteristics – namely: Age, Disability, Sex, Race, Gender reassignment, Sexual Orientation, Religion and Belief; Pregnancy and Maternity, Marriage and Civil Partnership. Please also consider other groups who are currently outside the scope of the Act, but who may have a significant relationship with NHS services (for example Carers, homeless people, travelling communities, sex-workers and migrant groups).

With reference to the Public Sector Equality Duties and the Protected Characteristics is an Equality Analysis required? YES/NO

Please summarise your conclusion if an equality analysis is <u>not</u> required (please refer to the Preliminary EA for the reason why)

If a full EA is **not** required, please attach step's 1 &2 from the FULL EA; the Preliminary EA and the Business Case and email these to the Equality and Inclusion Business Partner for reference and audit **david.king@ardengemcsu.nhs.uk** and **equality@ardengemcsu.nhs.uk**

If you have now concluded that the project/document **is relevant**, and a FULL EA is required please contact the Equality lead to complete the FULL equality analysis together.

David King (Hons), MA, PhD. Equality and Human Rights Manager

M: 07500 826611

E: david.king@ardengemcsu.nhs.uk
E: david.king17@nhs.net (confidential matters)
W: ardengemcsu.nhs.uk

Or

equality@ardengemcsu.nhs.uk

Step 3	Responsibility, Development, Aims and Purpose

Who holds overall responsibility for the project/policy/ strategy/ service redesign etc	Sarah Southall, Head of Primary care
Who else has been involved in the development?	Jo Reynolds, Primary Care Development Manager

Purpose and aims: (briefly describe the overall purpose and aims of the service – for a new service – describe the rationale and need for the proposal, referring to evidence sources. For a change in service or pathway – specify exactly what will change and the rationale/ evidence, including which CCG priority this will contribute to):

Document management involves clerical staff coding incoming clinical correspondence, taking actions where appropriate, including forwarding it to another member of the team, or passing the letter to a GP for action if a clinical decision is required. It is a more advanced task than document processing or coding alone. It requires clerical staff to be skilled and confident to make decisions about how to code a letter and its contents in the patient record, how to use an approved protocol for deciding which letters need to be sent to a GP and with what level of urgency, and when to ask for help. In order to do this effectively, staff require training and development of their skills and confidence. The aim of this programme is to obtain a standardized approach to correspondence management across Wolverhampton. This will be taught through a training programme, with the successful provider developing the protocols to compliment the training they have delivered. The successful provider will be expected to deliver training and then follow up to ensure the protocols have been implemented and the practice is utilizing the skills of those trained.

State overarching, strategy, policy, legislation this review is compliant with	GP5 Year Forward View 2016-2021
Does this fit with the CCGs Aims?	
What is the intended benefit from this review?	1. Following training, all incoming correspondence about patients will be able to be processed safely by a member of the clerical team. 2. Practices will have been supported to ensure that 80-90 per cent of letters could be processed without the involvement of a GP 3. Practices will see the benefit of a reduction in the average GP workload for managing clinical correspondence of at least 50%.
Who is intended to benefit from the implementation of this piece of work?	Practice staff, Patients
What are the key outcomes/ benefits for the groups identified above?	1. Patients receive speedier action 2. Improve the detail in coding 3. Improved monitoring and management of certain conditions 4. Improved staff competency
Does it meet any statutory requirements, outcomes or targets?	
Does it contribute to the Equality Delivery System Goals? (specify goals and related outcomes)*	1. Better health outcomes 2. Improved patient access and experience

*Equality Delivery System goals are fully explained in the Equality analysis guidance notes

Step 4	Protected Characteristics – analysis of impact
Please provide analysis of both the positive and negative impacts of the proposal against each of the protected characteristics providing details on the evidence (both qualitative and quantitive) used. If the work is targeted towards a particular group (s) – provide justification e.g. women only services. Any gaps in evidence should be accounted for and included in your Action Plan.	

Age **Impact and evidence:** Consider and detail impact and evidence across all age groups.	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Document Management will impact on correspondence received by the practice, there is no particular impact on any single age group.**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Disability **Impact and evidence:** Consider and detail impact and evidence on disability (this includes physical, sensory, learning, long-term conditions and mental health) and if any **reasonable adjustments** may be required to avoid a disabled patient, or member of staff, from being disadvantaged by the proposal.	
Is this group affected by this Appraisal	**Yes**
Positive Impact	**Document Management will impact on correspondence received by the practice, which will be processed the same way for all correspondence received regardless of the patients characteristics**

Negative Impact	**Where patients have a disability or long term condition, it is especially important that relevant correspondence is managed timely, as there may be an increased volume. Due regard needs to be given to individuals circumstances when dealing with such a patient.** **It is important that where a patient has additional communication needs this is taken into account**
Impact Rating **H = High** **M = Medium** **L = Low**	

Sex **Impact and evidence:** Consider and detail impact and evidence on both males and females	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Document Management will impact on correspondence received by the practice, which will be processed the same way for all correspondence received regardless of the patients characteristics**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Race **Impact and evidence:** Consider and detail impact and evidence on ethnic groups	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Document Management will impact on correspondence received by the practice, which will be processed the same way for all correspondence received regardless of the patients characteristics**
Negative	**It is important that where a patient has additional communication needs**

Impact	**this is taken into account**
Impact Rating **H = High** **M = Medium** **L = Low**	

Religion or Belief **Impact and evidence:** Consider and detail impact and evidence on people of different religions, beliefs (and those who may have no religion)	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Document Management will impact on correspondence received by the practice, which will be processed the same way for all correspondence received regardless of the patients characteristics**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Sexual Orientation **Impact and evidence:** Consider and detail impact and evidence on people of different sexual orientations	
Is this group affected by this Appraisal	**NO**

Positive Impact	**Document Management will impact on correspondence received by the practice, which will be processed the same way for all correspondence received regardless of the patients characteristics**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Gender Reassignment/ Transgender **Impact and evidence:** Consider and detail impact and evidence on transgender people	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Document Management will impact on correspondence received by the practice, which will be processed the same way for all correspondence received regardless of the patients characteristics**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Pregnancy and Maternity **Impact and evidence:** Consider and detail impact and evidence on work arrangements, breastfeeding etc.	
Is this group affected by this	**NO**

Appraisal	
Positive Impact	**Document Management will impact on correspondence received by the practice, which will be processed the same way for all correspondence received regardless of the patients characteristics**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Marriage and Civil Partnership **Impact and evidence:** Consider and detail impact and evidence on employees who are married or in a civil partnership	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Document Management will impact on correspondence received by the practice, which will be processed the same way for all correspondence received regardless of the patients characteristics**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Other Excluded Groups/ Multiple and social deprivation **Impact and evidence:** Consider and detail impact and evidence on groups that do not readily fall under the protected characteristics such as carers, transient communities, ex-offenders, asylum seekers, sex-workers, and homeless people.

Is this group affected by this Appraisal	**YES**
Positive Impact	**Document Management will impact on correspondence received by the practice, which will be processed the same way for all correspondence received regardless of the patients characteristics**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Public Sector Equality Duty (PSED)	
Please provide details on how the proposal contributes to:	
Eliminating unlawful discrimination, harassment and victimisation;	The process of coding documents supports GPs to provide equitable access for all patients. Where a patient has particular needs these are taken into account
Advancing equality of opportunity between people who share a protected characteristic and those who do not;	
Fostering good relations between people who share a protected characteristic and those who do not.	

Provide detail of cumulative impact of this and other proposals: (Please consider whether this proposal, when combined with other decisions made by the CCG, might have a contributory positive or negative impact on the Public Sector Equality Duty.)
There are no implications for this development, or any other known developments that would have an impact on the Public Sector Equality Duty.

Step 5	NHS Constitution and Human Rights
Checklist – how does this proposal affect the rights of patients set out in the NHS Constitution or their Human Rights?	

	Constitutional Rights	Yes/No	Please explain
a.	Could this result in a person being treated in an inhuman or degrading way?	No	There are no provisions within the Document Management programme of work that will result in any person using the service, or other person to be treated in an inhuman or degrading way.
b.	Does the proposal respect a patient's dignity, confidentiality, and the requirement for their consent?	No	There are no provisions within the Document Management programme of work that will result in any patient's dignity, confidentiality being compromised.
c.	Do patients have the opportunity to be involved in discussions and decisions about their own healthcare arising from this proposal?	Yes	The GP will involve patients in discussions about their treatment as part of consultation. Document management will not

			affect this
d.	Do patients and their families have an opportunity to be involved (directly or through representatives) in decisions made about the **planning** of healthcare services arising from this proposal?	No	Patients will not be directly involved in this process. The planning of healthcare services is outside of the scope of this process.
e.	Will the person's right to respect for private and family life be interfered with?	No	The practice will not share any details of the individual with any third party without the informed consent of the patient.
f.	Will it affect a person's right to life?	No	The practice will not compromise an individual's right to life
g.	Will this affect a person's right not to be discriminated against?	No	This process will not result in a patient being discriminated against.
h.	Will this affect a person's right to freedom of thought, conscience and religion?	No	This process will not restrict a person's right to freedom of thought, conscience and religion

Step 6	**Engagement and Involvement (Duty to involve – s242 NHS Act 2006) Francis Recommendations 135**
a) How have you involved users, carers and community groups in developing this proposal? (Please give details of any research/consultation drawn on (desk reviews – including complaints, PALS, incidents, patient and community feedback, surveys etc)). **b) Also give details of any specific discussions or consultations you have carried out to develop this proposal** – with users, carers, protected characteristic groups and/or their representatives, other communities of interest (e.g. user groups, forums, workshops, focus groups, open days etc.). **c) How have you used this information to inform the proposal?**	
There has not been any involvement with any users or carers; this has not been undertaken by the CCG. This process is to streamline back office functions, patients are not part of this process.	

Member GPs have been consulted and have been involved in this proposal.

d) Have you involved any other partner agencies (such as Local Authorities, Health and Well-being boards, Health Scrutiny Committees, Local Healthwatch, Public Health, CSU or CCG)

Please give details of any involvement to date or planned:

Healthwatch are aware of the programme of work

Step 7	**Including people who need to know**

Please consider the way in which the proposal will be explained to a wider audience.

(Will translation or interpretation materials be required (audio, pictorial, Braille as well as alternative languages); are there any particular approaches required for different cultures using outreach or advocacy support**;** is some targeted marketing required?

Communications regarding the process and the requirements of referring GPs is being communicated via group managers

Step 8	**Monitoring Arrangements**
Please identify the monitoring arrangements that will be introduced to ensure that the effect of the proposal does not result in a disproportionate impact on any protected group (e.g. by creating an unintended barrier); For example, including contractual requirements to provide equality monitoring data on those accessing the service or making complaints.	
Practice groups will be required to produce a quarterly assurance report to the CCG detailing the progress made on their delivery plans within the quarter.	

Which committee / Board / group will receive updates on the monitoring?	
Name:	**How often reports will be presented.**
Primary Care Strategy Committee	This work is overseen by the Primary Care Strategy Committee who will receive regular updates on the progress.

Step 9	**Decision Making**
Taking the equality analysis and the engagement into consideration, and the duties around the Public Sector Equality Duty, you should now identify what your next step will be for the proposal	
Decision steps available	**Rationale for your decision**
Continue unchanged	There are no considerations within the above Equality Impact Analysis which require any changes to the original plan.

Adjust the proposal (please detail the changes you will make in the Action Plan at **Step 10**)	N/A
Fundamental review of / stop the proposal	N/A

Step 10	**Action Plan**
Please reference all actions identified above & any additional actions required to ensure that this proposal can be implemented in compliance with Equality legislation, NHS Constitution and Human Rights requirements.	

Action	What will it achieve or address?	Lead Person	Timescale
No Actions proposed	N/A	N/A	N/A

Step 11	**Preparation for sign off**	**Please tick**
1)	Send the completed Equality Analysis with your documentation to **david.king@ardengemcsu.nhs.uk** or **equality@ardengemcsu.nhs.uk** for feedback prior to Executive Director (ED) sign-off.	
2)	Make arrangements to have the EA put on the appropriate programme board agenda	
3)	Use the Action Plan to record the changes you are intending to make to the document and the timescales for completion. A review date for the action	

plan will be recorded by the programme board.	

Step 12	**Sign off/ Approval**

Designated People	**Date**
Project officer* (Senior Officer responsible including action plan) Name: Jo Reynolds Signature: Jo Reynolds	16.04.18
Equality & Inclusion Business Partner: Name: David King	19/4/18
Executive Director: Name: Signature:	
Name of Approval Board, at which the EIA was agreed at: Board: Chair:	
Review date for action plan:	

***as the Project Manager/Senior Responsible Officer you need to be assured that you have sufficient information about the likely effects of the policy in order to ensure proper consideration is given to the statutory equality duties.**

Once all the above Approvals have been completed, resend the completed form to the Equality Lead for reference and Audit

After Sign Off
1. Confirm with Equality & Inclusion Business Partner or CSU's Equality Team who will record the Executive Director decision and what meeting it will be recorded at. 2. Confirm with Equality & Inclusion Business Partner or Equality Team who will record the programme board decision and programme board title and date. 3. Arrange for publication of the Equality Analysis on the CCG's website.

Advice, information and support is available from the Equality and Diversity Team

David King (Hons), MA, PhD.

M: 07500 826611

E: david.king@ardengemcsu.nhs.uk
E: david.king17@nhs.net (confidential matters)
W: ardengemcsu.nhs.uk

Or

equality@ardengemcsu.nhs.uk

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NHS
Wolverhampton
Clinical Commissioning Group

Data Protection Impact Assessment (DPIA)

Key Information – please be as comprehensive as possible (Section A)	
Name of Project	Document Management
Project Reference Number	
Project Lead Name	Jo Reynolds
Project Lead Title	Primary Care Development Manager
Project Lead Contact Number & Email	jo.reynolds2@nhs.net 01902 442579
Date completed	04/04/2018
Information Asset Owner ***The senior person(s) responsible for the system/software/process***	Sarah Southall, Head of Primary Care
Description of project:	Correspondence management involves clerical staff coding incoming clinical correspondence, taking actions where appropriate, including forwarding it to another member of the team, or passing the letter to a GP for action if a clinical decision is required. It is a more advanced task than document processing or coding alone. It requires clerical staff to be skilled and confident to make decisions about how to code a letter and its contents in the patient record, how to use an approved protocol for deciding which letters need to be sent to a GP and with what level of urgency, and when to ask for help. In order to do this effectively, staff require training and development of their skills and confidence. The aim of this programme is to obtain a standardized approach to correspondence management across Wolverhampton. This will be taught through a training programme, with the successful provider developing the protocols to compliment the training they have delivered. The successful provider will be expected to deliver training and then follow up to ensure the protocols have been implemented and the practice is utilizing the skills of those trained.

Will the project involve any data from which individuals could be identified (including pseudonymised data)?	**Yes- patient records and associated correspondence**

IF THE PROJECT WILL NOT INVOLVE ANY DATA FROM WHICH AN INDIVIDUAL COULD BE IDENTIFIED, YOU DO NOT NEED TO ANSWER ANY FURTHER QUESTIONS AND A FULL DPIA IS NOT REQUIRED.

If a full DPIA is **not** required, please forward Section A to the IG Officer for Arden & GEM CSU.

Email: Kelly.Huckvale@ardengemcsu.nhs.uk

The IG Officer will review and return the form with the below section completed, the form can then be presented to the relevant board for approval and sign off.

Sign Off / Approval (Section A only)

Title	Name	Signature	Date
Project Lead			
IG Officer	Kelly Huckvale		30/04/2018
IG Officer Comments	I have reviewed the project description and after further discussion with the project lead, established that there are no privacy concerns. The aim of this particular project is to implementing a protocol for staff to follow to standardise the approach to correspondence management across Wolverhampton and providing training in order to do so.		
Programme Board			
Programme Board Chair			

IF THE PROJECT WILL INVOLVE ANY DATA FROM WHICH AN INDIVIDUAL COULD BE IDENTIFIED.

PLEASE CONTACT THE IG OFFICER TO COMPLETE SECTION B TOGETHER.

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Primary Care Commissioning Committee
Tuesday 22 May 2018

TITLE OF REPORT:	Improving Access 2018/19
AUTHOR(s) OF REPORT:	Jo Reynolds, Primary Care Development Manager
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	To share a business case that has been prepared for consideration by the committee for Improving Access 2018/19
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• Improving Access is a nationally mandated service for extending the opening times of primary care, on a hub basis • There is a requirement to deliver 1.5 hours extra per evening (Monday to Friday, after 6:30 pm) and Saturday and Sunday appointments • The deadline to achieve this is 1st September 2018 • Delivery plans have been submitted by practice groups to demonstrate how they will achieve this trajectory.
RECOMMENDATION:	The committee are required to receive & consider the Business Case, and approve the continuation of this work programme.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1. Improving the quality and safety of the services we commission : Continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions. 2. Reducing Health Inequalities in Wolverhampton : Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this. 3. System effectiveness delivered within our financial envelope : The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.

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SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

Service Specification No.	
Service	Improving Access 2018-19
Commissioner Lead	Sarah Southall, Head of Primary Care
Provider Lead	
Period	April 2018- March 2019
Date of Review	March 2019

1. Population Needs

1.1 National/local context and evidence base

The General Practice 5 Year Forward View is a national response to the challenges that are faced in General Practice. The NHS needs to transform how care is delivered due to demographic changes increasing demand for healthcare services, and the available resources are not increasing at the same rate. Services provided in primary care, and particularly those offered by local GPs, are already under severe pressure. So that local people can continue to receive the same (or better) levels of service than they currently enjoy, the CCG needs to support new ways of working that help GPs and primary care become sustainable in the longer term.

The *General Practice Forward View* provides the support for practices to build the capacity and capabilities required to meet these needs, including support to adopt new ways of working (at individual, practice and network or federation level) and to develop different ways of managing clinical demand. In addition to increasing self-care, this includes the use of different triage methods and development of the broader workforce, or alternative services.

In delivering improved access we will want to secure transformation in general practice, including a step change in our use of digital technologies, support for urgent care and changes in general practice services that lay the foundations for general practice providers to move to a model of more integrated services through delivery of new models of care as we describe in the General Practice Forward View and Five Year Forward View.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	√
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	√
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	√

2.2 Local defined outcomes

The following outcomes are taken from the CCG Primary Care Strategy

• promote the health and wellbeing of our local community
• ensure that our population receive the right treatment at the right time and in the right place
• reduce early death and improve the quality of life of those living with long term conditions; and
• reduce health inequalities
• Access to a range of standard primary medical services 8am to 8 pm 7 days a week through a combination of GP practice, extended Hours and Out of Hours Services provision with full access to a patient's notes irrespective of how or where access occurs.

3. Scope

3.1 Aims and objectives of service

In Wolverhampton we have been supporting the development of new models of care that enable practices to work together at scale to improve access to primary care services. Our primary care strategy is built on the foundations as detailed in the General Practice Forward View and sets out how we will transform primary care in Wolverhampton.

Over the past year, substantial progress has been made in developing new models of care groups. All Practices in Wolverhampton are now aligned to a primary care group, and commissioning of transformation fund work streams has been happening on a group level.

Hub working within these groups has been established, with practices sharing patient records under data sharing agreements using EMIS remote. Extended access aims to build on this work, so that capacity meets the national requirements set out in this specification.

Drivers for this Incentive scheme:	
Our Vision for Primary Health Care in Wolverhampton as per the Primary Health Care Strategy 2016-2021 is to deliver universally accessible high quality out of hospital services that:- • promote the health and wellbeing of our local community • ensure that our population receive the right treatment at the right time and in the right	Treating Patients in the Community from 2016-2021 the CCG will prioritise developing:- • access to a range of standard primary medical services 8am to 8 pm 7 days a week through a combination of GP practice, • Extended Hours and Out of Hours Services provision with full access to a patient's notes irrespective of how or where access occurs.

place • reduce early death and improve the quality of life of those living with long term conditions; and • reduce health inequalities	• This will include use of technology to develop a number of non-face- to-face consultations including emails and telephone triage of the majority of appointment requests.

3.3 Core Requirements
National allocations for improving access are designed to be used to stimulate development of at scale providers for improved access, stimulate implementation of the 10 high impact actions to free up GP time, and secure sustainability of general practice.

In addition to the 10 High Impact Actions NHS England have identified 7 core requirements to delivering improved access to primary care.
It is acceptable for urgent and emergency care and extended access services to be integrated. For example, UTC and extended access operating from the same place and working together. It will be crucial to ensure integration of extended access with out of hours and urgent care services, including NHS 111, UTCs and local clinical hubs. NHS 111 should be able to book extended access as part of the urgent care offer. Additional access funding is intended to develop general practice at scale as part of a wider set of integral services, not just deliver additional appointments.

These 7 requirements would be the initial priorities for practice groups implementing Improved Access:

Timing of appointments:
Commission weekday provision of access to pre-bookable and same day appointments to general practice services in **evenings (after 6.30pm)** to provide an additional 1.5 hours.
Commission **weekend provision of access to pre-bookable and same day appointments** on both Saturdays and Sundays to meet local population needs.

Practices will be required to provide robust evidence, based on utilisation rates, for the proposed disposition of services at quarterly intervals to confirm progress against their agreed model of delivery within a specified format.

Capacity
In order to manage the workload effectively practices are encouraged to **work at scale within their practice group to share their resources**. Central to this will be discussion not only at practice level but also with patients' involved to ensure their suggestions are given consideration and the proposed delivery model is co-produced between both parties.

Practices are required to **provide incremental additional minutes per 1000 patients during 2018/19 as set out below**, to be achieved through working at scale. 100% of the population will need to be able to access this provision, and will need to be on a 7 day basis continuously throughout the year (including bank holidays). This is now mandated and that practice groups need to submit a plan for how they will seek to deliver this extended access. Working from the group lists we will be able to calculate the additional time per practice group.

2018/19

Q1	Q2	Q3	Q4
20 mins/1000 patients	20 mins/1000 patients	30 mins/1000 patients	30 mins/1000 patients

Measurement
Ensure usage of a nationally commissioned new tool to be introduced during 20171/8 to automatically measure appointment activity by all participating practices, both in-hours and in extended hours. This will enable improvements in matching capacity to times of great demand.

Local reporting will also be required.

Advertising and ease of access

Ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity into the community , so that it is clear to patients how they can access these appointments and associated service;

Ensure ease of access for patients including:
All practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services
Patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.

Digital

Use of digital approaches, such as online consultation and two way texting, to support new models of care in general practice will be pivotal to the success of working at scale and achievement of the 10 High Impact Actions. Therefore, **suitable and sufficient interoperability within clinical systems to enable information sharing must be in place.** The CCG's GP Forward View Implementation Plan seeks to ensure this is achieved as a priority.

Inequalities

Practices will be required to demonstrate that they have not **only involved patients in the delivery plan** but also on an ongoing basis demonstrate how they have **collected and reviewed patient feedback**. This will of course assist them in identifying early indications of patient satisfaction levels and areas that may require change/ intervention. Any inequalities in patients experience can then be identified as an early warning and addressed.

Practices will need to demonstrate that an assessment of population requirements has taken place, and that work has been done to identify and plan pathways for vulnerable patients.

Almost all practices are able to fulfil this requirement at the time of this specification being compiled.

Effective access to wider whole system services

Whilst working towards the 10 High Impact Actions the practice team will **navigate the patient to the most appropriate professional** within the practice team and/ or via social prescribers that will be readily available in the city. This will enable effective connection to other services **enabling patients to receive the right care at the right time in the right place**.

Care Navigators will play a key role in achieving this requirement.

3.4 Improving Access for All

The General Practice Patient Survey suggested that some groups of patients are experiencing barriers in accessing primary care services and the National Audit Office has proposed that new initiatives should work towards reducing these inequalities as well as improving access overall.

The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. These are the "protected characteristics".

Under the Health and Social Care Act 2012, CCGs must, in the exercise of their functions, have regard to the need to reduce inequalities between patients with respect to their ability to access health services, and reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

One of the seven core requirements for implementing improved access is to address issues of inequalities in patient's experience of accessing general practice, identified by local evidence, and put

actions in place to resolve this. Greater emphasis is being placed on inequalities and improving access for harder to reach groups. Practices will need to be able to demonstrate that work has taken placeto identify individuals and groups sharing one or more protected characteristics that do not currently experience easy access to general practice services, and subsequently do not experience the same health outcomes as the rest of the population. Guidance from the NHS Planning and Contracting guidance 2017/19 identifies the areas where this needs to be addressed below, as outlined below. Further explanation can be found at https://www.england.nhs.uk/wp-content/uploads/2017/07/inequalities-resource-nov17.pdf

1) staying healthy/ identification of the problem- poor health literacy

Health literacy is defined as "The personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health." World Health Organisation (WHO), 2015. It defines a person's ability to know when and where to seek support.

Some groups are more at risk of developing a health and wellbeing problem due to an experience such as drug and alcohol addiction, gang or serious youth violence, harmful sexual practices, domestic violence or harmful cultural / religious practices such as female genital mutilation and modern day slavery. For these groups it can be difficult to identify health issues which require intervention or to make a decision to seek help.

Consideration is needed for health materials, as 43% do not understand health information in the format that NHS provides it in.. other methods that may be considered include Health Champions- utilizing volunteers to engage other patients, organise activities and provide support.

2) self care/ decision to seek help

Personal factors such as literacy and educational status, expectations of aging, stoicism and self-esteem can all affect an individual's decision to seek help at an appropriate time resources available (such as finances, support from friends and family, transport) carer responsibilities; perceptions of health services (such as perceived limited resources in healthcare) and historic experience of healthcare, all play a role in supporting or hindering an individuals decision to seek help.

New migrants, refugees and asylum seekers may struggle, especially if they feel uncertain about their entitlements, perceive a lack of need for healthcare or hold any fears about an overlap between health and immigration services

Limited knowledge of what services are available and referrals to specialist services also impacts on an individuals choice to seek help.

Practices will be expected to consider the significance of their planned activity on these groups, and the impact that it may have.

The waiting room environment/ experience can have an impact on these principals, so consideration should be given to Signage, information about apt timings, and information on other services that are available. Jayex screens should be utilised for a number of different promotions.

3) actively seek help

Patients need to feel a sense of belonging to the practice with which they are registered, in order to be engaged with their provider and be active about seeking help when needing it.

For example, newly arrived migrants may have no previous experience or knowledge of the health care system, so may require support to access and navigate the process.

The homeless, offenders, Gypsy, Traveller, and Roma communities and people in some rural

communities experience health inequalities. These people are at an additional disadvantage because of their potential lack of internet access or broadband.

NHS England's "Inclusion Health" definition includes groups of people who are not usually well provided for by healthcare services and have poorer health outcomes. ** include link4) obtain an appointment

There are barriers to accessing Gp registration for example inability to provide paperwork. There are also barriers in the booking process that disadvantage certain characteristics and communities. For example, these with hearing impairments, difficulty in using the system/ phone, short time frames offered such as on the day only appointments.

Consideration needs to be given to internal processes that will enable a better access route for appointments.

4) get to an appointment

There are various issues that may influence attendance to appointments, including

Family commitments, Geographical location, Access to transport and Work/ school commitments. These issues need to be considered when developing access and services. Different types of consultation may be suitable in these circumstances, and may enable access.

3. 4 Service description/care pathway

Practices and their respective model of care should consider each of the 10 High Impact Actions and develop a series of actions to undertake during the period to demonstrate how individual practices and their respective practice groups will work collaboratively to achieve improvements against the 10 high impact actions and demonstrate at Q4 (Jan- Mar 2019) what the extent of success has been.

As part of the development and monitoring of the delivery plan the CCG expects practices/ practice groups to demonstrate how the patients voice has been encouraged, heard and acted upon so that it is duly reflected in the success that is reported.

Practice groups can consider other outcomes that they wish to deliver for their practice population, however Practice groups should refer to the 7 Core Requirements where appropriate when describing the actions to deliver the 10 High Impact Actions and the expected outcomes.

3.5 Payment

Practice groups taking part in the scheme will receive payment based on their practice list size. Payment will be made at a rate of £3.34 per patient.

3.6 Monitoring and Reporting Requirements

Practice groups will be required to produce a quarterly assurance report to the CCG detailing the progress made on their delivery plans within the quarter.
A reporting template is attached in appendix A, and will need to be completed by each practice/ clinical network participating in the scheme to allow the CCG to monitor progress.

Practices will be required to use the national tool supplied by NHSE to report progress, workload, and appointment capacity so that appointment activity can be better matched to supply demand.

3.7 Population covered

This service specification can be adopted by all practices within Wolverhampton. Therefore all patients registered with a practice in Wolverhampton can benefit from the interventions proposed herein.

3.8 Any acceptance and exclusion criteria and thresholds

Practices must be open during core hours (between the hours of 8:00 am and 6:30 pm). Practices that regularly close for half a day on a weekly basis will not ordinarily qualify for the DES. Practices must ensure they are open with a level of reception and medical cover also available. Practices should be offering an minimum of 70 appointments per 1000 patients per week, where this is not being achieved an improvement trajectory will be required to achieve the standard within the financial year.

3.9 Interdependencies with other services/ providers

Practices have already opted out of providing GP out of Hours. Close liaison between the commissioned out of hours provider, 11 provider and GP access hubs should be maintained via the CCG.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

All practices taking part in the scheme are expected to work within usual contractual terms and conditions.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 4D)

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

This will be confirmed within the individual delivery plans.

Appendix A

Improving Access Hub Monitoring													
Date of session-													
			Patient registered practice										
		TOTAL	(group practice name)	(group practice name)	(group practice name)	(group practice name)	(group practice name)	(group practice name)	(group practice name)	(group practice name)	(group practice name)	(group practice name)	(group practice name)
Availibility	Appointments available through 111												
	Appointments pre-bookable through practice												
	Appointments availible to walk ins												
	Total number of appointments available												
Take up of appointments	appointments booked by 111 directly.												
	appointments booked by practice directly.												
	Appointments utilised by walk ins												
	Appointmets utilised from other areas (please state in comments)												
	Total appointments where a patient was seen.												
	percentage take up of practice appointments												
Clinic Type	GP f-2-f												
	Nurse f-2-f												
	Clinical Pharmacist												
	GP (telephone)												
	Other												
Did Not Attend (DNA)	GP f-2-f												
	Nurse f-2-f												
	Clinical pharmacist												
	GP (telephone)												
	Other												
	TOTAL												

NHS
Wolverhampton
Clinical Commissioning Group

FULL Equality Analysis Form

Step 1	Document Ownership

Name of Project/Review	**Improving Access Specification**
Project Reference number	
Project Lead Name	**Jo Reynolds**
Project Lead Title	**Primary Care Development Manager**
Project Lead Contact Number & Email	**01902 442579** **Jo.reynolds2@nhs.net**
Date of Submission	**02/01/2018**
Is the document:	
A proposal of new service or pathway	**YES/~~NO~~**
A strategy, policy or project (or similar)	**~~YES~~/NO**
A review of existing service, pathway or project	**~~YES~~/NO**
Has a Preliminary Appraisal already been completed	**YES/~~NO~~**
If the Preliminary Appraisal confirmed that a full EA was NOT required, please only complete step's one and two.	

Step 2	Establishing Relevance

Public Sector Equality Duties

To ensure compliance with the Equality Act 2010, all strategies or policies or projects, proposals for a new service or pathway, or changes to an existing service or pathway, should be assessed for their relevance to equality – for patients, the public, and for staff. The general equality duty requires that when exercising its functions that the NHS has due regard to the need to:

- Eliminate unlawful discrimination, harassment , victimisation and any other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristics and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

Protected Characteristics

You need to analyse the effect on equality for all protected characteristics – namely: Age, Disability, Sex, Race, Gender reassignment, Sexual Orientation, Religion and Belief; Pregnancy and Maternity, Marriage and Civil Partnership. Please also consider other groups who are currently outside the scope of the Act, but who may have a significant relationship with NHS services (for example Carers, homeless people, travelling communities, sex-workers and migrant groups).

With reference to the Public Sector Equality Duties and the Protected Characteristics is an Equality Analysis required? YES/~~NO~~

Please summarise your conclusion if an equality analysis is <u>not</u> required (please refer to the Preliminary EA for the reason why)

If a full EA is **not** required, please attach step's 1 &2 from the FULL EA; the Preliminary EA and the Business Case and email these to the Equality and Inclusion Business Partner for reference and audit Juliet.herbert1@nhs.net and equality@ardengemcsu.nhs.uk

If you have now concluded that the project/document **is relevant**, and a FULL EA is required please contact the Equality lead to complete the FULL equality analysis together.

Juliet Herbert - Equality and Inclusion Business Partner, Arden & Greater East Midlands CSU

Email: **juliet.herbert1@nhs.net**

Mobile: 07780 33 82 82

Or

equality@ardengemcsu.nhs.uk

Step 3	Responsibility, Development, Aims and Purpose

Who holds overall responsibility for the project/policy/ strategy/ service redesign etc	Sarah Southall, Head of Primary Care
Who else has been involved in the development?	Jo Reynolds, Primary Care Development Manager

Purpose and aims: (briefly describe the overall purpose and aims of the service – for a new service – describe the rationale and need for the proposal, referring to evidence sources. For a change in service or pathway – specify exactly what will change and the rationale/ evidence, including which CCG priority this will contribute to):

Improving access to general practice and other primary care services is a priority for reforming the NHS. The national driver of seeking accessible Primary Care services 8am to 8pm, seven days a week is one of the main drivers in the transformation of how primary care is delivered.

The extension in hours would seek to enable practices to offer more or longer GP sessions which in effect offers an improving primary care service to improve overall patient access to primary medical services. The additional capacity would also be used to compliment the ongoing development of new models of care, particularly practices working at scale to meet the needs & demands of their patient population.

This is a nationally mandated requirement as part of the GP Five Year Forward View.

State overarching, strategy, policy, legislation this review is compliant with	General Practice Forward View
Does this fit with the CCGs Aims?	Yes
What is the intended benefit from this review?	1. Better health outcomes 2. Improved patient access and experience
Who is intended to benefit from the implementation of this piece of work?	Patients registered with the GP Practices across Wolverhampton.
What are the key outcomes/ benefits for the groups identified above?	• Reduced demand on appointments within core hours • Increase flexibility for patients to obtain an appointment around other commitments • Patients will have improved access to care • It will prevent some patients from attending the Urgent Care Centre.

Does it meet any statutory requirements, outcomes or targets?	Improving access is part of the GPFV programme of work, which is a national response to the challenges facing General Practice. the implementation of the improved access we will want to secure transformation in general practice, including a step change in our use of digital technologies, support for urgent care and changes in general practice services that lay the foundations for general practice providers to move to a model of more integrated services through delivery of new models of care as we describe in the General Practice Forward View and Five Year Forward View.
Does it contribute to the Equality Delivery System Goals? (specify goals and related outcomes)*	1. Better health outcomes 2. Improved patient access and experience

*Equality Delivery System goals are fully explained in the Equality analysis guidance notes

Step 4	**Protected Characteristics – analysis of impact**
Please provide analysis of both the positive and negative impacts of the proposal against each of the protected characteristics providing details on the evidence (both qualitative and quantitive) used. If the work is targeted towards a particular group (s) – provide justification e.g. women only services. Any gaps in evidence should be accounted for and included in your Action Plan.	

Age **Impact and evidence:** Consider and detail impact and evidence across all age groups.	
Is this group affected by this Appraisal	**~~YES~~/NO**
Positive Impact	The improving access opening will mean that additional appointments will be available to all age ranges as patients registered with a Wolverhampton GP practice. People of working age and children will be able to access wrap around care, at times that are beneficial
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	**L**

Disability **Impact and evidence:** Consider and detail impact and evidence on disability (this includes physical, sensory, learning, long-term conditions and mental health) and if any **reasonable adjustments** may be required to avoid a disabled patient, or member of staff, from being disadvantaged by the proposal.	
Is this group affected by this Appraisal	**YES/NO**
Positive Impact	The increase in appointments will help those with long term chronic conditions, access care in a more timely manner, as patients registered with a Wolverhampton GP practice.
Negative Impact	The additional appointments will be hub based, so there may be an impact if individuals have mobility issues. The location/ distance to the hub may have an impact on their ability to access the provision.
Impact Rating **H = High** **M = Medium** **L = Low**	**M**

Sex **Impact and evidence:** Consider and detail impact and evidence on both males and females	
Is this group affected by this Appraisal	**~~YES~~/NO**
Positive Impact	The additional appointments provided by improving access will be available to both male and female patients as patients registered with a Wolverhampton GP practice.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	**L**

Race **Impact and evidence:** Consider and detail impact and evidence on ethnic groups	
Is this group affected by this Appraisal	**YES/NO**
Positive Impact	The service will be available to patients registered with a Wolverhampton GP practice from all races and will not be to the disadvantage to any person of a specific race. Any issues relating to language and communication will be considered by the practice, as with routine appointments, and measures put in place. There is no specific impact identified around race, and communication needs will still be met.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	**L**

Religion or Belief **Impact and evidence:** Consider and detail impact and evidence on people of different religions, beliefs (and those who may have no religion)	
Is this group affected by this Appraisal	**YES/NO**
Positive Impact	The improving access provision will be available to people from all religions and beliefs, as patients registered with a Wolverhampton GP practice.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	**L**

Sexual Orientation **Impact and evidence:** Consider and detail impact and evidence on people of different sexual orientations	
Is this group affected by this Appraisal	**YES/NO**
Positive Impact	The improving access provision will be available to people from all sexual orientations, as patients registered with a Wolverhampton GP practice.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	**L**

Gender Reassignment/ Transgender **Impact and evidence:** Consider and detail impact and evidence on transgender people	
Is this group affected by this Appraisal	**~~YES~~/NO**
Positive Impact	The improving access provision will be available to people who have undergone gender reassignment or identify as being transgender, as patients registered with a Wolverhampton GP practice.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	**L**

Pregnancy and Maternity **Impact and evidence:** Consider and detail impact and evidence on work arrangements, breastfeeding etc.	
Is this group affected by this Appraisal	**~~YES~~/NO**
Positive Impact	The improving access provision will be available to any woman who requires treatment in a primary care setting during and after her pregnancy, as patients registered with a Wolverhampton GP practice.
Negative Impact	**Travel across city to the hub may be an issue for this group**
Impact Rating **H = High** **M = Medium** **L = Low**	**L**

Marriage and Civil Partnership **Impact and evidence:** Consider and detail impact and evidence on employees who are married or in a civil partnership	
Is this group affected by this Appraisal	**~~YES~~/NO**
Positive Impact	The improving access provision will be available for all persons with regardless of their marital status, as patients registered with a Wolverhampton GP practice.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	**L**

Other Excluded Groups/ Multiple and social deprivation **Impact and evidence:** Consider and detail impact and evidence on groups that do not readily fall under the protected characteristics such as carers, transient communities, ex-offenders, asylum seekers, sex-workers, and homeless people.	
Is this group affected by this Appraisal	**YES/NO**
Positive Impact	The appointments provided by improving access will be outside of core hours, therefore will increase opportunities for accessing appointments for those with other commitments such as carers.
Negative Impact	Patients will be required to be registered with a Wolverhampton GP practice in order to access appointments. If a patient needed to travel to access an appointment, this may have an economic impact on the individual
Impact Rating **H = High** **M = Medium** **L = Low**	

Public Sector Equality Duty (PSED)	
Please provide details on how the proposal contributes to:	
Eliminating unlawful discrimination, harassment and victimisation;	This service provides equal access for all – it is available on a population basis to everyone registered with the participating GP Practices. As registered patients are from across the protected characteristics, this will support advancing equality of opportunity on an individual basis as well as between people who share a protected characteristic, and this equally applies to fostering good relations.
Advancing equality of opportunity between people who share a protected characteristic and those who do not;	
Fostering good relations between people who share a protected characteristic and those who do not.	

Provide detail of cumulative impact of this and other proposals: (Please consider whether this proposal, when combined with other decisions made by the CCG, might have a contributory positive or negative impact on the Public Sector Equality Duty.)
There are no implications for this development, or any other known developments that would have an impact on the Public Sector Equality Duty.

Step 5 NHS Constitution and Human Rights
Checklist – how does this proposal affect the rights of patients set out in the NHS Constitution or their Human Rights?

	Constitutional Rights	Yes/No	Please explain
a.	Could this result in a person being treated in an inhuman or degrading way?	No	There are no provisions within the improving access provision that will result in any person using the service, or other person to be treated in an inhuman or degrading way.
b.	Does the proposal respect a patient's dignity, confidentiality, and the requirement for their consent?	No	There are no provisions within the improving access provision that will result in any patient's dignity, confidentiality being compromised.

c.	Do patients have the opportunity to be involved in discussions and decisions about their own healthcare arising from this proposal?	Yes	Appointments provided for patients as part of improving access will have the same opportunities and processes in place as standard appointments held within core hours
d.	Do patients and their families have an opportunity to be involved (directly or through representatives) in decisions made about the **planning** of healthcare services arising from this proposal?	No	Appointments provided for patients as part of improving access will have the same opportunities and processes in place as standard appointments held within core hours
e.	Will the person's right to respect for private and family life be interfered with?	No	The service will not share any details of the individual with any third party.
f.	Will it affect a person's right to life?	No	The service will not compromise an individual's right to life
g.	Will this affect a person's right not to be discriminated against?	No	Accessing the improving access appointments will not result in a patient being discriminated against.
h.	Will this affect a person's right to freedom of thought, conscience and religion?	No	Accessing improving access provision will not restrict a person's right to freedom of thought, conscience and religion

Step 6	**Engagement and Involvement (Duty to involve – s242 NHS Act 2006) Francis Recommendations 135**

How have you involved users, carers and community groups in developing this proposal?
(Please give details of any research/consultation drawn on (desk reviews – including complaints, PALS, incidents, patient and community feedback, surveys etc)).

Also give details of any specific discussions or consultations you have carried out to develop this proposal – with users, carers, protected characteristic groups and/or their representatives, other communities of interest (e.g. user groups, forums, workshops, focus groups, open days etc.).

How have you used this information to inform the proposal?

No, any involvement with any users or carers has not been undertaken by the CCG. The proposal has been developed in collaboration with group leads, and GP leads from practice groups.
The role of the group lead is to work closely with the practice groups, and support the development of services based on patient need. They work closely with PPG groups and have supported the implementation of the current provision, that the improving access programme of work will build upon.

This is a nationally mandated requirement as part of the GP Five Tear Forward View, which is a national response to the challenges faced in General practice.

Have you involved any other partner agencies (such as Local Authorities, Health and Well-being boards, Health Scrutiny Committees, Local Healthwatch, Public Health, CSU or CCG)

Please give details of any involvement to date or planned:

The Improving Access specification has been discussed in a number of forums where there are representation from other agencies

Step 7	**Including people who need to know**

Please consider the way in which the proposal will be explained to a wider audience. (Will translation or interpretation materials be required (audio, pictorial, Braille as well as alternative languages); are there any particular approaches required for different cultures using outreach or advocacy support**;** is some targeted marketing required?

A Communications plan has been produced to help patients registered with the Wolverhampton GP Practices involved to explain the changes to practice opening times.

Step 8	**Monitoring Arrangements**

Please identify the monitoring arrangements that will be introduced to ensure that the effect of the proposal does not result in a disproportionate impact on any protected group (e.g. by creating an unintended barrier); For example, including contractual requirements to provide equality monitoring data on those accessing the service or making complaints.

The provider will be required to submit a monitoring report which will include equality monitoring data of all the patients who are accessing the service. This data will be monitored on a regular basis to assure the commissioner that the service is being accessed by all protected groups. Any issues highlighted by this process will be escalated and development plans will be put in place, with support from the group leads to improve performance.

Which committee / Board / group will receive updates on the monitoring?	
Name:	**How often reports will be presented.**
This Project is overseen by the Primary Care Milestone Review Board who will receive regular updates on the implementation and outcomes delivered by the project.	A six monthly report on the utilisation of the service will enable the committee to monitor the uptake and impact of the project and consider proposals after the duration of the initial pilot.

Step 9 Decision Making	
Taking the equality analysis and the engagement into consideration, and the duties around the Public Sector Equality Duty, you should now identify what your next step will be for the proposal	
Decision steps available	**Rationale for your decision**
Continue unchanged	Risk is low
Adjust the proposal (please detail the changes you will make in the Action Plan at **Step 10**)	
Fundamental review of / stop the proposal	

Step 10 Action Plan
Please reference all actions identified above & any additional actions required to ensure that this proposal can be implemented in compliance with Equality legislation, NHS Constitution and Human Rights requirements.

Action	What will it achieve or address?	Lead Person	Timescale
No Actions proposed	N/A	N/A	N/A

Step 11	Preparation for sign off	Please tick
1) Send the completed Equality Analysis with your documentation to juliet.herbert1@nhs.net or equality@ardengemcsu.nhs.uk for feedback prior to Executive Director (ED) sign-off.		
2) Make arrangements to have the EA put on the appropriate programme board agenda		
3) Use the Action Plan to record the changes you are intending to make to the document and the timescales for completion. A review date for the action plan will be recorded by the programme board.		

Step 12	Sign off/ Approval

Designated People	Date
Project officer* (Senior Officer responsible including action plan) Name: Jo Reynolds Signature: Jo Reynolds	16.04.18
Equality & Inclusion Business Partner: Name: David King	19/4/18
Executive Director: Name: Signature:	
Name of Approval Board, at which the EIA was agreed at: Board: Chair:	
Review date for action plan:	

***as the Project Manager/Senior Responsible Officer you need to be assured that you have sufficient information about the likely effects of the policy in order to ensure proper consideration is given to the statutory equality duties.**

Once all the above approvals have been completed, resend the completed form to the Equality Lead for reference and Audit

After Sign Off
1. Confirm with Equality & Inclusion Business Partner or CSU's Equality Team who will record the Executive Director decision and what meeting it will be recorded at. 2. Confirm with Equality & Inclusion Business Partner or Equality Team who will record the programme board decision and programme board title and date. 3. Arrange for publication of the Equality Analysis on the CCG's website.

Advice, information and support is available from the Equality and Diversity Team

Juliet Herbert - Equality and Inclusion Business Partner
Arden & Greater East Midlands CSU

Email: **juliet.herbert1@nhs.net**

Mobile: 07780 33 82 82

Or

equality@ardengemcsu.nhs.uk

NHS
Wolverhampton
Clinical Commissioning Group

Data Protection Impact Assessment (DPIA)

Key Information – please be as comprehensive as possible (Section A)	
Name of Project	Improving Access 2018/19
Project Reference Number	
Project Lead Name	Jo Reynolds
Project Lead Title	Primary Care Development Manager
Project Lead Contact Number & Email	jo.reynolds2@nhs.net 01902 442579
Date completed	04/04/2018
Information Asset Owner ***The senior person(s) responsible for the system/software/process***	Sarah Southall, Head of Primary Care
Description of project:	Improving access to general practice and other primary care services is a priority for reforming the NHS. The national driver of seeking accessible Primary Care services 8am to 8pm, seven days a week is one of the main drivers in the transformation of how primary care is delivered. The extension in hours would seek to enable practices to offer more or longer GP sessions which in effect offers an improving primary care service to improve overall patient access to primary medical services. The additional capacity would also be used to compliment the ongoing development of new models of care, particularly practices working at scale to meet the needs & demands of their patient population. This is a nationally mandated requirement as part of the GP Five Year Forward View.

Will the project involve any data from which individuals could be identified (including pseudonymised data)?	**Yes- patient records**

IF THE PROJECT WILL NOT INVOLVE ANY DATA FROM WHICH AN INDIVIDUAL COULD BE IDENTIFIED, YOU DO NOT NEED TO ANSWER ANY FURTHER QUESTIONS AND A FULL DPIA IS NOT REQUIRED.

If a full DPIA is **not** required, please forward Section A to the IG Officer for Arden & GEM CSU.

Email: Kelly.Huckvale@ardengemcsu.nhs.uk

The IG Officer will review and return the form with the below section completed, the form can then be presented to the relevant board for approval and sign off.

Sign Off / Approval (Section A only)

Title	Name	Signature	Date
Project Lead			
IG Officer	Kelly Huckvale		25/04/2018
IG Officer Comments	I have reviewed the project description and screening questions and after further discussion with the project lead, established that there is no change in process or different ways of handling personal data and therefore no privacy concerns, this project is simply an extension to working hours within the practice.		
Programme Board			
Programme Board Chair			

IF THE PROJECT WILL INVOLVE ANY DATA FROM WHICH AN INDIVIDUAL COULD BE IDENTIFIED.

PLEASE CONTACT THE IG OFFICER TO COMPLETE SECTION B TOGETHER.

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
Primary Care Commissioning Committee
Tuesday 22 May 2018

TITLE OF REPORT:	Out of Area Registration: In Hours Urgent Primary Medical Care (Including Home Visits) Enhanced Service
AUTHOR(s) OF REPORT:	Jo Reynolds, Primary Care Development Manager
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	To share a business case that has been prepared for consideration by the committee for Document Management 2018/19
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• Out of Area allows access to local GP practices for patients who are registered with a practice away from home without access to home visits • The service is for when patients cannot be reasonably expected to attend their registered practice. • This will be in periods when urgent care is required, and where the patients' medical condition is such that it would be clinically inappropriate for the patient to go to their registered practice.
RECOMMENDATION:	The committee are required to receive & consider the Business Case with a view to approval.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1. Improving the quality and safety of the services we commission : Continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions. 2. Reducing Health Inequalities in Wolverhampton : Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this. 3. System effectiveness delivered within our financial envelope : The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.

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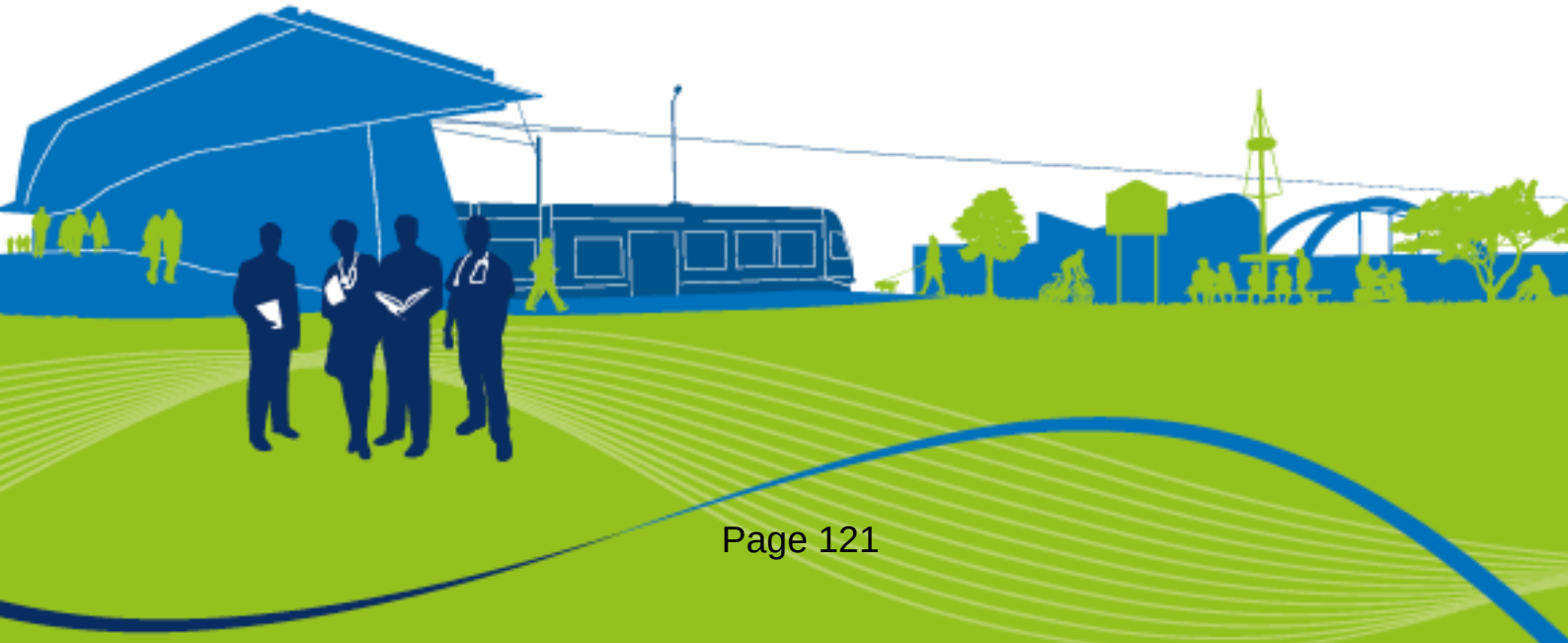
Expression of Interest v1.1

Out of Area Registration:
In Hours Urgent Primary Medical Care (Including Home Visits) Enhanced Service



Expression of Interest

1. Requirements

This enhanced service has been designed to support the out of area patient registration arrangements that were introduced on 5th January 2015 to extend choice of GP practice. GP practices have always had the ability register patients who live out of area but with no difference to any other permanent registration (e.g. including requirements to provide home visits). Such discretion remains for GP practices alongside the new arrangements.

It seeks to secure access to local GP practices for patients living in the practice area but who are registered with a practice away from home without access to home visits, if they cannot be reasonably expected to attend their registered practice. This will be in periods when urgent care is required, and where the patients' medical condition is such that it would be clinically inappropriate for the patient to go to their registered practice.

This specification puts into place arrangements to deliver these services on a Wolverhampton wide basis. It will ensure that access is provided to a local provider for an urgent consultation with a GP or other health care professional when it is not clinically appropriate for the patient to attend their registered practice. This will include home visits where necessary.

2. Remuneration

Payment under this enhanced service for each consultation at the practice (excluding home visits but may include telephone/skype consultations.) is **£15.87 per GP (or other healthcare professional as appropriate) consultation.**

The payment for a home visit under this enhanced service is **£60 per home visit.**

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3. Evaluation of bids

In the event of the receipt of multiple bids from Practices the CCG reserves the right to hold a quality based evaluation and selection process.

4. Closing date

Expressions of Interest are invited for this requirement and to be returned to jo.reynolds2@nhs.net no later than Friday 23rd March 2018.

If you require further information, please contact Jo Reynolds, Primary Care Development Manager on 01902 442579

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	**Out Of Area Registration:** **In Hours Urgent Primary Medical Care (Including Home Visits) Enhanced Service**
Commissioner Lead	
Provider Lead	
Period	**1st May 2018- 30th April 2019**
Date of Review	**January 2019**

1 Introduction

1.1 This enhanced service has been designed to support the out of area patient registration arrangements that were introduced on 5th January 2015 to extend choice of GP practice. GP practices have always had the ability register patients who live out of area but with no difference to any other permanent registration (e.g. including requirements to provide home visits). Such discretion remains for GP practices alongside the new arrangements.

1.2 It seeks to secure access to local GP practices for patients living in the practice area but who are registered with a practice away from home without access to home visits, if they cannot be reasonably expected to attend their registered practice. This will be in periods when urgent care is required, and where the patients' medical condition is such that it would be clinically inappropriate for the patient to go to their registered practice.

1.3 This specification puts into place arrangements to deliver these services on a Wolverhampton wide basis. It will ensure that access is provided to a local provider for an urgent consultation with a GP or other health care professional when it is not clinically appropriate for the patient to attend their registered practice. This will include home visits where necessary.

2 Purpose

2.1 This enhanced service specification aims to secure the delivery of care to patients who are registered with a GP practice away from home under the new arrangements (out of area registered without home visiting duties) and who require urgent care and cannot

reasonably be expected to attend their registered practice on clinical grounds (i.e. in general this would not be expected to apply to patients who live in close proximity to but outside their practice area).

2.2 The service will provide urgent and local care, as deemed clinically necessary by the appointed GP practice, for such patients living in the appointed practice's boundary area, as follows:

2.2.1 Access to essential primary medical care services for patients who fall ill at home during the weekday in hours period (8.00am to 6.30pm; Monday to Friday, excluding bank holidays) or who are recovering at home after a period of hospitalisation; and,

2.2.2 Home visits (where clinically required).

2.3 GP practices choosing to participate in this enhanced service will be required to ensure secure and robust processes are in place to communicate details of the care provided under this enhanced service to the patient's registered practice.

3 Requirements

3.1 Practices must ensure that information about access to their services for patients who are registered with out of area practices are provided to NHS 111 for recording on the Directory of Services in order for patients to be directed to their service as and when required. Practices will hold responsibility for ensuring the DOS is up to date at all times.

3.2 The practice must ensure that they have mechanisms in place to provide services to patients who are resident in Wolverhampton but who are registered with an out of area practice.

3.3 Access for those who fall ill at home during the in hours period (8.00am to 6.30pm; Monday to Friday, excluding bank holidays) or who are recovering at home after a period of hospitalisation, this means:

3.3.1 The provision of essential medical services to those patients who are, or believe themselves to be ill with conditions from which recovery is generally expected

3.3.2 offering a consultation for the purpose of identifying any need for treatment or further investigation and making available any such treatment or further investigation as is necessary and appropriate

3.3.3 sign post to an alternative service where it is clinically appropriate to do so. This could include sign posting to a local pharmacy, the urgent treatment centre, or referring back to their registered GP.

3.4 Home visits (where deemed clinically necessary by the provider) to provide essential medical services to those patients who, in the reasonable opinion of the contractor, attendance on the patient is required and it is inappropriate for them to attend at the practice premises or that of the alternative urgent care provision, such as the walk in centre or urgent treatment centre.

3.5 The practice must ensure that they have a robust system in place to transfer information securely, about any care given, to the patients registered practice within no more than 24 hours of the consultation.

3.6 The practice must complete a claim form to be submitted on a quarterly basis.

4 Monitoring

4.1 Where a practice chooses to offer this service, the monitoring required will be the number of out of area registered patient accessing services and in the case of each out of area patient the number of consultations provided (and of those consultations which were home visits). A standard template will be provided for these returns.

4.2 The practice will be required to provide clinical details of each attendance to the patient's registered practice following the consultation in a timely manner to ensure that the patients' clinical record is kept updated.

5 Payment

5.1 In hours care at the practice

Payment under this enhanced service for each consultation at the practice (excluding home visits but may include telephone/skype consultations.) is **£15.87 per GP (or other healthcare professional as appropriate) consultation.**

Should any individual patient be consulted at least four times in any 12 month period this will be a trigger for a review by the patient's registered practice as to whether it is more clinically appropriate and practical for the patient to register with a practice closer to home. Further details on this review process are given in main NHS England guidance.

5.2 Home Visiting

The payment for a home visit under this enhanced service is **£60 per home visit.**

Should any individual patient receive a home visits on more than two occasions in any 12 month period this will, again, trigger a review by patient's registered practice as to whether it is more clinically appropriate for that patient to register with a practice closer to home. Again, further details on such reviews will be given in NHS England guidance.

5.3 payments will be made quarterly via submission of the standard template.

6 Other issues relevant to Choice of GP Practice

6.1 Practices that are eligible to provide services under this specification are only those that are currently maintaining an open list status.

6.2 Existing GP health centres, walk-in centres or minor injuries units that already have unregistered patient services included in their current service contract are excluded from provision of those services under this specification

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FULL Equality Analysis Form

Step 1	Document Ownership

Name of Project/Review	**Out Of Area Registration:** **In Hours Urgent Primary Medical Care (Including Home Visits) Enhanced Service**
Project Reference number	
Project Lead Name	**Jo Reynolds**
Project Lead Title	**Primary Care Development Manager**
Project Lead Contact Number & Email	*jo.reynolds2@nhs.net* *01902 442579*
Date of Submission	

Is the document:	
A proposal of new service or pathway	**NO**
A strategy, policy or project (or similar)	**YES**
A review of existing service, pathway or project	**YES**
Has a Preliminary Appraisal already been completed	**NO**

If the Preliminary Appraisal confirmed that a full EA was NOT required, please only complete step's one and two.

Step 2	Establishing Relevance

Public Sector Equality Duties

To ensure compliance with the Equality Act 2010, all strategies or policies or projects, proposals for a new service or pathway, or changes to an existing service or pathway, should be assessed for their relevance to equality – for patients, the public, and for staff. The general equality duty requires that when exercising its functions that the NHS has due regard to the need to:

- Eliminate unlawful discrimination, harassment , victimisation and any other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristics and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

Protected Characteristics

You need to analyse the effect on equality for all protected characteristics – namely: Age, Disability, Sex, Race, Gender reassignment, Sexual Orientation, Religion and Belief; Pregnancy and Maternity, Marriage and Civil Partnership. Please also consider other groups who are

currently outside the scope of the Act, but who may have a significant relationship with NHS services (for example Carers, homeless people, travelling communities, sex-workers and migrant groups).

With reference to the Public Sector Equality Duties and the Protected Characteristics is an Equality Analysis required? YES/NO

Please summarise your conclusion if an equality analysis is <u>not</u> required (please refer to the Preliminary EA for the reason why)

If a full EA is **<u>not</u>** required, please attach step's 1 &2 from the FULL EA; the Preliminary EA and the Business Case and email these to the Equality and Inclusion Business Partner for reference and audit **david.king@ardengemcsu.nhs.uk** and **equality@ardengemcsu.nhs.uk**

If you have now concluded that the project/document **<u>is relevant</u>**, and a FULL EA is required please contact the Equality lead to complete the FULL equality analysis together.

David King (Hons), MA, PhD. Equality and Human Rights Manager

M: 07500 826611

E: david.king@ardengemcsu.nhs.uk
E: david.king17@nhs.net (confidential matters)
W: ardengemcsu.nhs.uk

Or

equality@ardengemcsu.nhs.uk

Step 3	Responsibility, Development, Aims and Purpose

Who holds overall responsibility for the project/policy/ strategy/ service redesign etc	Sarah Southall, Head of Primary care
Who else has been involved in the development?	Jo Reynolds, Primary Care Development Manager

Purpose and aims: (briefly describe the overall purpose and aims of the service – for a new service – describe the rationale and need for the proposal, referring to evidence sources. For a change in service or pathway – specify exactly what will change and the rationale/ evidence, including which CCG priority this will contribute to):

This service enables access to local GP practices for patients living in the practice area but who are registered with a practice away from home without access to home visits, if they cannot be reasonably expected to attend their registered practice. This will be in periods when urgent care is required, and where the patients' medical condition is such that it would be clinically inappropriate for the patient to go to their registered practice.

This specification puts into place arrangements to deliver these services on a Wolverhampton wide basis. It will ensure that access is provided to a local provider for an urgent consultation with a GP or other health care professional when it is not clinically appropriate for the patient to attend their registered practice. This will include home visits where necessary.

State overarching, strategy, policy, legislation this review is compliant with	

Does this fit with the CCGs Aims?	<table><tr><td>**Domain 1**</td><td>**Preventing people from dying prematurely**</td><td></td></tr><tr><td>**Domain 2**</td><td>**Enhancing quality of life for people with long-term conditions**</td><td></td></tr><tr><td>**Domain 3**</td><td>**Helping people to recover from episodes of ill-health or following injury**</td><td>**x**</td></tr><tr><td>**Domain 4**</td><td>**Ensuring people have a positive experience of care**</td><td>**X**</td></tr><tr><td>**Domain 5**</td><td>**Treating and caring for people in safe environment and protecting them from avoidable harm**</td><td>**X**</td></tr></table>
What is the intended benefit from this review?	access is provided to a local provider for an urgent consultation with a GP or other health care professional when it is not clinically appropriate for the patient to attend their registered practice
Who is intended to benefit from the implementation of this piece of work?	patients living in the practice area but who are registered with a practice away from home without access to home visits, if they cannot be reasonably expected to attend their registered practice.
What are the key outcomes/ benefits for the groups identified above?	
Does it meet any statutory requirements, outcomes or targets?	
Does it contribute to the Equality Delivery System Goals? (specify goals and related outcomes)*	1. Better health outcomes 2. Improved patient access and experience

*Equality Delivery System goals are fully explained in the Equality analysis guidance notes

Step 4	Protected Characteristics – analysis of impact
Please provide analysis of both the positive and negative impacts of the proposal against each of the protected characteristics providing details on the evidence (both qualitative and quantitive) used. If the work is targeted towards a particular group (s) – provide justification e.g. women only services. Any gaps in evidence should be accounted for and included in your Action Plan.	

Age **Impact and evidence:** Consider and detail impact and evidence across all age groups.	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Patients will be able to access appointments as long as they are living in the practice area** **Patients that have age related issues, disabilities, or life long conditions are encouraged to register with a practice within their area so that they can access appointments and home visits easily**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Disability **Impact and evidence:** Consider and detail impact and evidence on disability (this includes physical, sensory, learning, long-term conditions and mental health) and if any **reasonable adjustments** may be required to avoid a disabled patient, or member of staff, from being disadvantaged by the proposal.	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Patients will be able to access appointments as long as they are living in the practice area. If a home visit is seen as medically appropriate it will be provided** **Patients that have disabilities, or life long conditions are encouraged to register with a practice within their area so that they can access appointments and home visits easily**
Negative Impact	

Impact Rating **H = High** **M = Medium** **L = Low**	

Sex **Impact and evidence:** Consider and detail impact and evidence on both males and females	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Patients will be able to access appointments as long as they are living in the practice area** **Consideration will be given to any requests for visits from a specific gender of GP, if reasonable**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Race **Impact and evidence:** Consider and detail impact and evidence on ethnic groups	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Patients will be able to access appointments as long as they are living in the practice area**
Negative Impact	
Impact Rating **H = High**	

M = Medium **L = Low**	

Religion or Belief **Impact and evidence:** Consider and detail impact and evidence on people of different religions, beliefs (and those who may have no religion)	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Patients will be able to access appointments as long as they are living in the practice area**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Sexual Orientation **Impact and evidence:** Consider and detail impact and evidence on people of different sexual orientations	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Patients will be able to access appointments as long as they are living in the practice area**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Gender Reassignment/ Transgender **Impact and evidence:** Consider and detail impact and evidence on transgender people	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Patients will be able to access appointments as long as they are living in the practice area**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Pregnancy and Maternity **Impact and evidence:** Consider and detail impact and evidence on work arrangements, breastfeeding etc.	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Patients will be able to access appointments as long as they are living in the practice area, throughout their pregnancy and afterwards**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Marriage and Civil Partnership **Impact and evidence:** Consider and detail impact and evidence on employees who are married or in a civil partnership	
Is this group affected by this Appraisal	**NO**
Positive Impact	**Patients will be able to access appointments as long as they are living in the practice area, regardless of their marital status**
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Other Excluded Groups/ Multiple and social deprivation **Impact and evidence:** Consider and detail impact and evidence on groups that do not readily fall under the protected characteristics such as carers, transient communities, ex-offenders, asylum seekers, sex-workers, and homeless people.	
Is this group affected by this Appraisal	**YES**
Positive Impact	**Patients will be able to access appointments as long as they are living in the practice area, and are registered with a Wolverhampton GP**
Negative Impact	**In order to access the appointments, patients need access to a telephone**
Impact Rating **H = High** **M = Medium** **L = Low**	

Public Sector Equality Duty (PSED)	
Please provide details on how the proposal contributes to:	
Eliminating unlawful discrimination, harassment and victimisation;	The service supports GPs to provide equitable access for all patients.
Advancing equality of opportunity between people who share a protected characteristic and those who do not;	
Fostering good relations between people who share a protected characteristic and those who do not.	

Provide detail of cumulative impact of this and other proposals: (Please consider whether this proposal, when combined with other decisions made by the CCG, might have a contributory positive or negative impact on the Public Sector Equality Duty.)
There are no implications for this development, or any other known developments that would have an impact on the Public Sector Equality Duty.

Step 5	NHS Constitution and Human Rights
Checklist – how does this proposal affect the rights of patients set out in the NHS Constitution or their Human Rights?	

	Constitutional Rights	Yes/No	Please explain
a.	Could this result in a person being treated in an inhuman or degrading way?	No	There are no provisions within the Out of Area scheme that will result in any person using the service, or other person to be treated in an inhuman or degrading way.
b.	Does the proposal respect a patient's dignity, confidentiality, and the requirement for their consent?	No	There are no provisions within the Out of Area scheme that will result in any patient's dignity, confidentiality being compromised.
c.	Do patients have the opportunity to be involved in discussions and decisions about their own healthcare arising from this proposal?	Yes	The GP will involve patients in discussions about their treatment as part of consultation.
d.	Do patients and their families have an opportunity to be involved (directly or through representatives) in decisions made about the **planning** of healthcare services arising from this proposal?	No	Patients will not be directly involved in this process. The planning of healthcare services is outside of the scope of this process.
e.	Will the person's right to respect for private and family life be interfered with?	No	The practice will not share any details of the individual with any third party without the informed consent of the patient.
f.	Will it affect a person's right to life?	No	The practice will not compromise an individual's right to life
g.	Will this affect a person's right not to be discriminated against?	No	This scheme will not result in a patient being discriminated against.
h.	Will this affect a person's right to freedom of thought, conscience and religion?	No	This scheme will not restrict a person's right to freedom of thought, conscience and religion

Step 6	Engagement and Involvement (Duty to involve – s242 NHS Act 2006) Francis Recommendations 135
a) How have you involved users, carers and community groups in developing this proposal? (Please give details of any research/consultation drawn on (desk reviews – including complaints, PALS, incidents, patient and community feedback, surveys etc)). **b) Also give details of any specific discussions or consultations you have carried out to develop this proposal** – with users, carers, protected characteristic groups and/or their representatives, other communities of interest (e.g. user groups, forums, workshops, focus groups, open days etc.). **c) How have you used this information to inform the proposal?**	
There has not been any involvement with any users or carers; this has not been undertaken by the CCG. Member GPs have been consulted and have been involved in this proposal.	

d) Have you involved any other partner agencies (such as Local Authorities, Health and Well-being boards, Health Scrutiny Committees, Local Healthwatch, Public Health, CSU or CCG) **Please give details of any involvement to date or planned:**
No

Step 7	Including people who need to know
Please consider the way in which the proposal will be explained to a wider audience. (Will translation or interpretation materials be required (audio, pictorial, Braille as well as alternative languages); are there any particular approaches required for different cultures using outreach or advocacy support**;** is some targeted marketing required?	
Communications regarding the process and the requirements of referring GPs is being communicated via group managers	

Step 8	Monitoring Arrangements
Please identify the monitoring arrangements that will be introduced to ensure that the effect of the proposal does not result in a disproportionate impact on any protected group (e.g. by creating an unintended barrier); For example, including contractual requirements to provide equality monitoring data on those accessing the service or making complaints.	
Practices will submit monitoring and payment claims on a quarterly basis.	

Which committee / Board / group will receive updates on the monitoring?	
Name:	**How often reports will be presented.**
Primary Care Strategy Committee	This work is overseen by the Primary Care Strategy Committee who will receive regular updates on the progress.

Step 9 Decision Making	
Taking the equality analysis and the engagement into consideration, and the duties around the Public Sector Equality Duty, you should now identify what your next step will be for the proposal	
Decision steps available	**Rationale for your decision**
Continue unchanged	There are no considerations within the above Equality Impact Analysis which require any changes to the original plan.
Adjust the proposal (please detail the changes you will make in the Action Plan at **Step 10**)	N/A
Fundamental review of / stop the proposal	N/A

Step 10 Action Plan
Please reference all actions identified above & any additional actions required to ensure that this proposal can be implemented in compliance with Equality legislation, NHS Constitution and Human Rights requirements.

Action	What will it achieve or address?	Lead Person	Timescale
No Actions proposed	N/A	N/A	N/A

Step 11	Preparation for sign off	Please tick
1) Send the completed Equality Analysis with your documentation to **david.king@ardengemcsu.nhs.uk** or **equality@ardengemcsu.nhs.uk** for feedback prior to Executive Director (ED) sign-off.		
2) Make arrangements to have the EA put on the appropriate programme board agenda		
3) Use the Action Plan to record the changes you are intending to make to the document and the timescales for completion. A review date for the action plan will be recorded by the programme board.		

Step 12	Sign off/ Approval

Designated People	Date
Project officer* (Senior Officer responsible including action plan) Name: Jo Reynolds Signature: Jo Reynolds	16.04.18
Equality & Inclusion Business Partner: Name: David King	19/4/18
Executive Director: Name: Signature:	
Name of Approval Board, at which the EIA was agreed at: Board: Chair:	
Review date for action plan:	

***as the Project Manager/Senior Responsible Officer you need to be assured that you have sufficient information about the likely effects of the policy in order to ensure proper consideration is given to the statutory equality duties.**

Once all the above Approvals have been completed, resend the completed form to the Equality Lead for reference and Audit

After Sign Off
1. Confirm with Equality & Inclusion Business Partner or CSU's Equality Team who will record the Executive Director decision and what meeting it will be recorded at. 2. Confirm with Equality & Inclusion Business Partner or Equality Team who will record the programme board decision and programme board title and date. 3. Arrange for publication of the Equality Analysis on the CCG's website.

Advice, information and support is available from the Equality and Diversity Team

David King (Hons), MA, PhD.

M: 07500 826611

E: david.king@ardengemcsu.nhs.uk
E: david.king17@nhs.net (confidential matters)
W: ardengemcsu.nhs.uk

Or

equality@ardengemcsu.nhs.uk

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NHS
Wolverhampton
Clinical Commissioning Group

Data Protection Impact Assessment (DPIA)

Key Information – please be as comprehensive as possible (Section A)	
Name of Project	**Out Of Area Registration:** **In Hours Urgent Primary Medical Care (Including Home Visits) Enhanced Service**
Project Reference Number	
Project Lead Name	Jo Reynolds
Project Lead Title	Primary Care Development Manager
Project Lead Contact Number & Email	jo.reynolds2@nhs.net 01902 442579
Date completed	04/04/2018
Information Asset Owner ***The senior person(s) responsible for the system/software/process***	Sarah Southall, Head of Primary Care
Description of project:	This service enables access to local GP practices for patients living in the practice area but who are registered with a practice away from home without access to home visits, if they cannot be reasonably expected to attend their registered practice. This will be in periods when urgent care is required, and where the patients' medical condition is such that it would be clinically inappropriate for the patient to go to their registered practice. This specification puts into place arrangements to deliver these services on a Wolverhampton wide basis. It will ensure that access is provided to a local provider for an urgent consultation with a GP or other health care professional when it is not clinically appropriate for the patient to attend their registered practice. This will include home visits where necessary.

Will the project involve any data from which individuals could be identified (including pseudonymised data)?	**Yes- patient records**

IF THE PROJECT WILL NOT INVOLVE ANY DATA FROM WHICH AN INDIVIDUAL COULD BE IDENTIFIED, YOU DO NOT NEED TO ANSWER ANY FURTHER QUESTIONS AND A FULL DPIA IS NOT REQUIRED.

If a full DPIA is **not** required, please forward Section A to the IG Officer for Arden & GEM CSU.

Email: Kelly.Huckvale@ardengemcsu.nhs.uk

The IG Officer will review and return the form with the below section completed, the form can then be presented to the relevant board for approval and sign off.

Sign Off / Approval (Section A only)

Title	Name	Signature	Date
Project Lead			
IG Officer	Kelly Huckvale		25/04/2018
IG Officer Comments	I have reviewed the project description and discussed with the project lead. This is an extension to a service already offered, giving patients the ability to access health care services outsider of their area, access in hours urgent primary medical care, including home visits. I have not identified any privacy risks.		
Programme Board			
Programme Board Chair			

IF THE PROJECT WILL INVOLVE ANY DATA FROM WHICH AN INDIVIDUAL COULD BE IDENTIFIED.

PLEASE CONTACT THE IG OFFICER TO COMPLETE SECTION B TOGETHER.

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Primary Care Commissioning Committee
Tuesday 22 May 2018

TITLE OF REPORT:	QOF+ Scheme 2018/19 Business Case
AUTHOR(s) OF REPORT:	Sarah Southall, Head of Primary Care
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	To share a business case that has been prepared for consideration by the committee for a new scheme QOF+ 2018/19.
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• The Business Case and supporting documents have been prepared based on development of a new scheme for practices to participate in. • If approved, the scheme would be offered to all Wolverhampton Member Practices in order to tackle 3 priority areas. • The purpose of the scheme is to prevent ill health and patients developing disease associated with alcohol & obesity & where reasonably possible are highly prevalent in Wolverhampton. • All supporting documents have been discussed and agreed with specialists in quality, equality & information governance/privacy.
RECOMMENDATION:	The committee are required to receive & consider the Business Case with a view to approval in order for the scheme to be launched with member practices in Wolverhampton.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1. Improving the quality and safety of the services we commission : Continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions. 2. Reducing Health Inequalities in Wolverhampton : Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this. 3. System effectiveness delivered within our financial envelope : The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.

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NHS
Wolverhampton
Clinical Commissioning Group

BUSINESS CASE

Project:	QOF+ Scheme 2018/19
Project Number:	
Date:	May 2018
Project Lead:	Sarah Southall, Head of Primary Care
Project Sponsor:	Steven Marshall, Director of Strategy & Transformation
Version No:	1.0 Draft

1 Business Case History

Template Revision History

Date of this revision: 01/04/2018

Revision date	Summary of Changes	Changes marked
08/2013	Preliminary Equality Analysis added	1.1
	First issue	
12/2014	Quality Impact Analysis added	1.2
18/06/15	Document Review	1.3
02/03/16	Addition of Task and Finish Section	1.4
17/03/2017	New CCG Logo and document formatting	2.0
01/04/2018	Task and Finish section, DPIA and front sheet	3.0

Task and Finish Group Views

Task and Finish Group Views - please confirm who has been identified as the lead for each of the following areas below, and their initial comments:

Area / Team	Lead Name	Date	Initial comments from the Leads review of the Scoping Report
Clinical	Dr Reehana	16.05.18	Comments included in the QIA
Public/ Patient	Sue McKie	11.05.18	No comments received
Finance	Tony Gallagher	11.05.18	No comments received
Quality	Sally Roberts	11.05.18	No comments received
Performance	Mike Hastings	11.05.18	Can I suggest that a very simple one page is included which explains (possibly with a worked example?) how and how much practices earn points -> £££ in year one. Including the part year effect and the sliding scale (i.e. all or nothing or graduated payments based upon % attainment). This is the main question for practices and a simple explanation would help.
PMO			
Contract & Performance	Vic Middlemiss	11.05.18	No comments received
Medicines Management	Hemant Patel	11.05.18	No comments received
Equality	David King	11.05.18	No comments received
Information Governance	Peter McKenzie	11.05.18	No comments received
Legal/ Policy (Corporate Operations Manager)			
Primary Care	Steven	11.05.18	No comments received

	Marshall		
IMT / IT	Mike Hastings	11.05.18	No comments received
Business Intelligence			
Estates			

All of the sections above must be completed before the report is submitted to the relevant board. If any of these leads are not applicable please indicate why, do not leave blank.

Report Distribution

This document/report has been distributed to:

Name	Title	Date of Issue	Version
Primary Care Commissioning Committee		11.5.18	V1.0

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Business Case

3 Purpose

In order to support the continued improvement and development of Primary Care the purpose of this scheme is to build on the benefits of the national Quality Outcomes Scheme (QOF).

QOF awards practices funding in response to them managing chronic disease, public health concerns and goes some way to implementing preventative measures such as regular blood pressure checks. QOF+ seeks to take this work further with a greater emphasis on local priorities & the importance of developing the prevention agenda further as follows:-

- Diabetes (pre-diabetic)
- Alcohol
- Obesity

The CCG is committed to continued investment in Primary Care as part of the implementation of the Primary Care Strategy (2016). The vision for practices as providers of healthcare in Wolverhampton is to provide 'cradle to grave prevention' ensuring patients have access to high quality care, proactively identifying those at risk of ill health.

4 Reasons

The CCG Integrated Assessment Framework (IAF) Assessment for *Diabetes* was rated as 'requires improvement' with reported prevalence higher than other comparable CCGs. Data indicates a much higher prevalence of diabetes in black and minority ethnic (BME) communities in Wolverhampton when compared with England. BME communities make up 32% of Wolverhampton CCG's population, compared with 15% BME communities in the population of England as a whole. Therefore, the scheme has been constructed with a combination of preventative and responsive indicators that seek to improve the CCGs performance in diabetes particularly in the IAF.

Alcohol mortality in Wolverhampton is worsening and remains above the England average. The number of emergency alcohol specific admissions to hospital has increased over the past decade from 493 in 2005 to 956 in 2015. A lifestyle audit commissioned by Public Health Wolverhampton in 2016 identified that alcohol increased with age, was higher in people who earned more and higher in those from a white ethnic background. The number of males being admitted to hospital for alcohol specific conditions in emergencies is more than double the number in females. This same age range of men account for most of alcohol service users whilst men aged 45 – 69 years account for the highest rate of alcohol related deaths.

The most recent JSNA identified *Obesity* as significant issue for Wolverhampton. In the region of 59% of males are either overweight or obese, compared to 52% females in Wolverhampton. Based on a lifestyle survey conducted by Public Health Wolverhampton respondents who had a black ethnic background had the highest proportion of individuals with excess weight (63%). Only half of Wolverhampton 49.9% of the population were estimated to be physically active, significantly lower compared to England 57% and the West Midlands 55%.

5 Options

The CCG are keen to introduce a focus on prevention in primary care rather than continuing to invest new money in reactive healthcare. This view has been expressed by member practices at initially in November when discussed continued with a range of General Practitioner colleagues that lead to shortlisting the areas of greater priority. There is potential to develop the scheme further beyond the 3 priorities currently included.

6 Benefits Expected

There are 19 indicators within the scheme that will be measured via GP clinical systems that will form the basis for reviewing the effectiveness of the scheme. The scheme seeks to achieve the improved outcomes (10 Investment Appraisal) but recognise that benefits of the improved outcomes may not be realised for some time and may not be evident until subsequent year of the scheme 2019 and beyond. Therefore, continued investment and development are also considered beneficial in achieving improved outcomes for the population of Wolverhampton.

7 Risks

Risks that are foreseen with deployment of the scheme are as follows:-

There is a risk of practices experiencing difficulty implementing the scheme if support isn't available from the CCG. Ongoing support will be available from the Primary Care & IM&T Team during the implementation and monitoring of this scheme.

Risk of practices not signing up to the scheme due to the amount of additional work attached to the scheme. Practice Groups will be encouraged to deliver components of the scheme at scale via their hubs where reasonably possible in order to keep costs down and avoid replication.

Risk of practices not achieving the thresholds defined in the scheme due to the numbers of patients they are required to work with. A preparatory scheme has been in place to enable practices to identify patients pertaining to each priority in readiness for commencing intervention(s).

Risk of practices reaching partial achievement if they have not undertaken the preparatory work funded in 2017/18. There are xx practices who have not participated fully in the preparatory work for the scheme.

Risk of variation if searches to identify at risk patients are not pre-defined in clinical systems. The IM&T Facilitators will have searches set up in clinical systems in readiness for practices commencing this work.
All risks will be factored into the communication to practices when launching the scheme and on an ongoing basis whilst monitoring activity & uptake.

8 Cost

The total annual investment for the scheme in year 1 is £1.2 million, funded from with Primary Care budgets and as part of the continued commitment to invest in Primary Care in Wolverhampton.

The scheme provides a breakdown confirming the value of the scheme to each of the CCGs 42 member practices, should they achieve all points attached to the thresholds for each of the 19 indicators.

There is potential for a combination of full and partial achievement, individual performance will be monitored at practice and group level at quarterly intervals.

9 Timescales

Member practices were engaged in discussions about what the priorities should be for this investment concluding with a shortlist of suggested areas. There was an overwhelming desire for more preventative work to take place in order to avert disease and effects on long term health.

An external review being commissioned by the CCG, this took place January/February 2018 and included scoping work coupled with a review of evidence at national level to determine the evidence base for interventions pertaining to the three priority areas.

In March the first draft of the scheme was shared for initial consideration with clinicians across primary care including Group Leads, Clinical Reference Group and LMC Following a period of development of the scheme with clinical engagement from a number of forums

10 Investment Appraisal

The return on invest for the priorities that have been identified is based on interventions identified in the evidence review. This draws on a range of data sources and has been applied to population estimates. In this section of the

business case the following indicative cost savings for each priority should be recognised:-

	Diabetes	**Alcohol**	**Obesity**
Outcome	Better glycaemic control at 12 months, assuming 10% the population with diabetes could lead to a 5% reduction in A&E Attendances and 6% reduction in hospital admissions & day cases reducing costs by £7,000 per year.	Assuming 20% of the population reduced their alcohol consumption would lead to a 14% reduction in alcohol related health conditions & a reduction in 10% of A&E attendances resulting in costs being reduced by £250,000 per year for secondary care.	Obesity identification, brief advice leading to weight loss leading to reduced demand on general practitioners. Assuming 10% of obese adults was estimated cost savings to primary & secondary care were £37,000 per year.
Saving	For every £1 spent on the intervention there would be a saving of £0.33.	For every £1 spend on the intervention there will be a saving of £2.83	For every £1 spend on the intervention there will be a £0.96

The outcomes for all 3 priorities identify effective & cost effective interventions that will benefit primary and secondary care settings. Some of the interventions within the scheme require primary care to work in partnership with a range of community & commercial providers. Providing brief advice and intervention is a theme that cuts across all 3 priorities therefore economies of scale at the point of delivery will be encouraged at practice group level in order to avoid replication of costs with set up and ongoing provision.

Investment has been apportioned based on practice list size, page 43 of scheme confirms the potential amount each practice may be paid for undertaking this activity in order for longer term savings and improved outcomes to be realised.

11 Equality – Appraisal

A full equality analysis has been undertaken and can be found in Appendix 1. This was approved in April by the respective lead. A number of components of the impact assessment will be a live document and forms the basis for ongoing monitoring of the scheme.

12 Quality Impact Analysis (QIA)

A quality impact analysis has been duly completed and approved by the relevant lead, this took place in April 2018 (Appendix 2).

13 Data Privacy Impact Assessment (DPIA)

A data privacy impact assessment has been undertaken and considered by the relevant lead, this took place in May 2018 (Appendix 3).

Enclosures: Appendix 1 Equality Analysis
Appendix 2 Quality Impact Assessment
Appendix 3 Data Privacy Impact Assessment
Appendix 4 QOF+ Scheme 2018/19
Appendix 5 Frequently Asked Questions

SLS/QOF+-BC/MAY18/V1.0

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Quality Impact Assessment :
QIPP Project (Quality, Innovation, Productivity and Prevention) 2018/19

Section A

Project Name	QOF+
UI Number	
Project Lead	Sarah Southall/ Ranjit Khular
Quality Lead	Liz Corrigan
Programme Board	Primary Care/ MMO Programme Board
Verifying Clinician	Dr S Reehana
Project Overview	The QOF+ scheme has been developed as a framework to be delivered by Primary Care within which there are arange of potential scheme ideas, with a broad focus on prevention. The scheme in 2018/19 will focus on Diabetes (primary and secondary prevention) Obesity and Alcohol. The scheme will will focus on practices: screening for hazardous and harmful drinking and providing brief intervention: Screening for T2DM and appropriate intervention. This intervention includes onward referral to the NDPP or altnerative equivalent provision if required. producing care plans for all patients with a known diagnosis of diabetes, customised to the level of patient need Offering BMI calculation for new patients and those with obesity-related conditions such as diabetes and cardiovascular disease and deliver or signpost patients to the most appropriate intervention. Some launch events will be held as par of the mobilisation process to ensure practitioners are clear about the expectations of them.
Quality Indicators	**Diabetes:** patients aged 18 or over that are new to list , who have had screening carried out using an Assessment Score. patients deemed **at 'moderate' overall risk** of developing diabetes, for whom 'brief intervention' has been offered patients deemed to have 'pre-diabetes' (**high overall risk),** who have a record of being referred to an intensive lifestyle intervention **patients with diabetes, on the register:** * for whom a care plan has been completed * who have a record of an albumin: creatinine ratio test * with a record of a foot examination and risk classification patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry onto the diabetes register **patients with diabetes, on the register** * in whom all eight care processes are complete in the preceding 12 months * in whom the last blood BP (measured in the preceding 12 months) is 140/80mmHg or less * whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less **Alcohol:** percentage of patients aged 16 or over who have been screened for hazardous, harmful or dependent levels of alcohol consumption using the AUDIT-C tool patients with any or any combination of at risk conditions who have been screened for hazardous, harmful or dependent levels of alcohol consumption using the AUDIT-C tool patients identified as having hazardous or harmful levels of alcohol consumption, who are recorded as having been offered 'brief advice' **Obesity** patients, with diabetes, for whom a BMI is recorded patients, with any or any combination of the following conditions: AF, CHD, heart disease, hypertension, peripheral arterial disease, stroke and TIA, for whom a BMI is recorded patients with BMI >=30 kg/m2 who are recorded as having been offered 'brief advice' .
KPI Assurance (sources & reporting)	

Section B

ASSESSMENT

	Positive Impact of the Project on:	Negative Impact of the Project on:
Patient Safety	Improved identification of patients at risk of developing diabetes, who are at risk of drinking at harmful levels and whose BMI presents risks to their health will be identified and appropriate intervetions delivered to prevent the onset of diabetes, alcohol related harm and conditions related to Obesity	
Patient Experience	Depending on their presentation patients will be given brief advice by the GP or be signposted or referred to other services (depending on severity or level of need)	Some patients may not engage with the interventions proposed or agree with the outcomes of the risk assessments
Clinical Effectiveness	The interventions that would be undertaken by the practices and those that patients would be signoisted towards are all preventative and if followed through would reduce the lokelihood of the patient becoming diabetic, obese or drinking at harmful levels. This will have positive impacts on the patients wellbeing in the longer term.	
Mitigation	GP staff delivering the service will advise the patients that the interventions being recommended are in line with best practice/ clinical guidelines and that these are based on evidence that they will result in a postive effect on their longer term health and wellbeing.	

Risk Scoring Guide:

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 to determine the likelihood score (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode.

If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score

3 Determine the consequence score (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

4 Calculate the risk score the risk multiplying the likelihood by the consequence: L (likelihood) x C (consequence) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level

Risk Quantification Matrix

Table 1 Likelihood score (L)

What is the likelihood of the consequence occurring?

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Section C

Risk Grading
(What is the Risk of the negative Impact occurring)

	Likelihood Score	Consequence Score	Overall Risk Score	
	1 Rare; 2 Unlikely; 3 Possible; 4 Likely; 5 Almost Certain	*1 Negligible; 2 Minor; 3 Moderate; 4 Major; 5 Catastrophic*	*Likelihood x Consequence (L x C) = R (Risk score)*	*Drop Down Selection*
Patient Safety				
Patient Experience	*2*	*2*	*4*	**4 to 6: Moderate Risk**
Clinical Effectiveness				

Risk System

Likelihood score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk scoring = consequence x likelihood (L x C)

1 to 3	Low Risk	8 to 12	High Risk
4 to 6	Moderate Risk	15 to 25	Extreme Risk

Section D

GP / Clinical Review (Required)

GP / Clinical Name	**Dr S Reehana**
Date	**16.05.18**
Comments	The CCG Chair has been involved in the development of this scheme from the outset, introduction of the discussion with member practices and the prioritisation of clinical areas that have been included. Her involvement has also provided oversight of the commissioned literature review and return on investment report and engagement with practices following availability of the first draft scheme. Since then ongoing discussions have taken place with GP representatives at a range of forums, engagement has been extensive.

Section E

Quality Leads Comments (Required)

Quality Lead Name	**Liz Corrigan**
Date	**03/04/18**
Comments	Will need to take into account the current issues with the NDPP provider capacity. Have training needs for staff been identified across the board or is this a work in progress? Are any problems anticipated in the light of reduced Public Health lifestyle provision? No, as the scheme does not require PH practitioners to deliver any of the interventions. the services that practitioners would refer patients to are still within the rationalised PH Commissioning portfolio e.g specialist alcohol services Has thought been given to alternatives if practices do not want to sign up? Could the Leicester diabetes risk score be added to the NHS Health Check template via discussions with Public Health?

Section F

APPROVAL - Business Case QIA

Reviewer	Signature	Date
Project Lead	**Sarah Southall and Ranjit Khular**	**01.04.18**
Patient Rep		
Quality Lead	**Liz Corrigan**	**03/04/18**
Programme Board Review	**Primary Care Programme Board**	**09.04.18**
Approval Board Approval	**Primary Care Commissioning Committee (Public)**	

Post Implementation Review

Section G

Benefits Realisation & Close Review	
Date of Project Implementation	
Date of Project Review	
Findings From Benefits Realisation Review	*include here feedback from patients, performance & activity information +/- and quality monitoring arrangements for the future.*
Concerns identified as a result of this scheme	
What change has occurred as a result of the project implementation	
Date of Closure	*insert date*
Summary of Achievements & Monitoring Arrangements	*insert bullet points providing a summary of achievements and how the project/ service will be monitored hereafter.*
Reason for Closure	*i.e. project achieved, abandoned, delivered or suspend.*
Final Risk Score	

APPROVAL			
Reviewer	**Signature**	**Date**	**Agreed Yes/No Including Comments**
Project Lead			
Patient Rep			
Quality Lead			
Head of Quality			
Programme Board Review			

FULL Equality Analysis Form

Step 1	Document Ownership

Name of Project/Review	QOF + scheme
Project Reference number	**TBC**
Project Lead Name	**Ranjit Khular**
Project Lead Title	**Primary Care Transformation Manager**
Project Lead Contact Number & Email	r.khular@nhs.net 01902 442462 07920 537528
Date of Submission	**27th March 2018**
Is the document:	
A proposal of new service or pathway	**NO**
A strategy, policy or project (or similar)	**NO**
A review of existing service, pathway or project	**YES**
Has a Preliminary Appraisal already been completed	**NO**
If the Preliminary Appraisal confirmed that a full EA was NOT required, please only complete step's one and two.	

Step 2	Establishing Relevance

Public Sector Equality Duties

To ensure compliance with the Equality Act 2010, all strategies or policies or projects, proposals for a new service or pathway, or changes to an existing service or pathway, should be assessed for their relevance to equality – for patients, the public, and for staff. The general equality duty requires that when exercising its functions that the NHS has due regard to the need to:

- Eliminate unlawful discrimination, harassment , victimisation and any other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristics and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

Protected Characteristics

You need to analyse the effect on equality for all protected characteristics – namely: Age, Disability, Sex, Race, Gender reassignment, Sexual Orientation, Religion and Belief; Pregnancy and Maternity, Marriage and Civil Partnership. Please also consider other groups who are currently outside the scope of the Act, but who may have a significant relationship with NHS services (for example Carers, homeless people, travelling communities, sex-workers and migrant groups).

With reference to the Public Sector Equality Duties and the Protected Characteristics is an Equality Analysis required? YES/NO

Please summarise your conclusion if an equality analysis is <u>not</u> required (please refer to the Preliminary EA for the reason why)

If a full EA is **not** required, please attach step's 1 &2 from the FULL EA; the Preliminary EA and the Business Case and email these to the Equality and Inclusion Business Partner for reference and audit Juliet.herbert1@nhs.net and equality@ardengemcsu.nhs.uk

If you have now concluded that the project/document **is relevant**, and a FULL EA is required please contact the Equality lead to complete the FULL equality analysis together.

Juliet Herbert - Equality and Inclusion Business Partner, Arden & Greater East Midlands CSU

Email: **juliet.herbert1@nhs.net**

Mobile: 07780 33 82 82

Or

equality@ardengemcsu.nhs.uk

Step 3	Responsibility, Development, Aims and Purpose

Who holds overall responsibility for the project/policy/ strategy/ service redesign etc	Sarah Southall, Head of Primary Care
Who else has been involved in the development?	Ranjit Khular, Primary Care Transformation Manager

Purpose and aims: (briefly describe the overall purpose and aims of the service – for a new service – describe the rationale and need for the proposal, referring to evidence sources. For a change in service or pathway – specify exactly what will change and the rationale/ evidence, including which CCG priority this will contribute to):

The QOF+ scheme has been developed as a framework to be delivered by Primary Care within which there are a range of potential scheme ideas, with a broad focus on prevention. The scheme in 2018/19 will focus on Diabetes (primary and secondary prevention) Obesity and Alcohol. The scheme will focus on practices:
screening for hazardous and harmful drinking and providing brief intervention
Screening for T2DM and appropriate intervention
producing care plans for all patients with a known diagnosis of diabetes, customised to the level of patient need

Offering BMI calculation for new patients and those with obesity-related conditions such as diabetes and cardiovascular disease and deliver or signpost patients to the most appropriate intervention

State overarching, strategy, policy, legislation this review is compliant with	This development is aligned with the CCG Primary Care Strategy and the local Prevention Strategy.
Does this fit with the CCGs Aims?	Yes
What is the intended benefit from this review?	The intended benefits are as follows: Identification of patients who are at risk of developing Type 2 diabetes who can then be referred to a programme to help reduce the likelihood of them going on to develop the condition. Identification of patients who are drinking at potentially harmful levels and referring them to services preventative services
Who is intended to benefit from the	Patients

implementation of this piece of work?	
What are the key outcomes/ benefits for the groups identified above?	The key benefits are identification of risk factors and interventions that are preventative and/or early intervention. If the interventions are followed through this will reduce the likelihood patients developing diabetes and other long term conditions attributable to obesity and excessive alcohol consumption.
Does it meet any statutory requirements, outcomes or targets?	No
Does it contribute to the Equality Delivery System Goals? (specify goals and related outcomes)*	1. Better health outcomes Yes 2. Improved patient access and experience Yes

*Equality Delivery System goals are fully explained in the Equality analysis guidance notes

Step 4	**Protected Characteristics – analysis of impact**
Please provide analysis of both the positive and negative impacts of the proposal against each of the protected characteristics providing details on the evidence (both qualitative and quantitive) used. If the work is targeted towards a particular group (s) – provide justification e.g. women only services. Any gaps in evidence should be accounted for and included in your Action Plan.	

Age **Impact and evidence:** Consider and detail impact and evidence across all age groups.	
Is this group affected by this Appraisal	**YES**
Positive Impact	Patients of all ages who are at risk of developing Type 2 diabetes, being obese or consuming hazardous levels of alcohol will be identified and offered brief intervention and onward referral to other services to prevent them developing Long term conditions.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Disability **Impact and evidence:** Consider and detail impact and evidence on disability (this includes physical, sensory, learning, long-term conditions and mental health) and if any **reasonable adjustments** may be required to avoid a disabled patient, or member of staff, from being disadvantaged by the proposal.	
Is this group affected by this Appraisal	**YES**
Positive Impact	Patients who may have any physical , sensory, learning, long term condition or mental health related disability at risk of developing Type 2 diabetes, being obese or consuming hazardous levels of alcohol will be identified and offered brief intervention and onward referral to other services to prevent them developing Long term conditions. For Patients with Learning Disabilities the interventions may be undertaken as part of the LD Healthcheck.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Sex **Impact and evidence:** Consider and detail impact and evidence on both males and females	
Is this group affected by this Appraisal	**YES**
Positive Impact	All patients, male or female at risk of developing Type 2 diabetes, being obese or consuming hazardous levels of alcohol will be identified and offered brief intervention and onward referral to other services to prevent them developing Long term conditions.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Race **Impact and evidence:** Consider and detail impact and evidence on ethnic groups	
Is this group affected by this Appraisal	**YES**
Positive Impact	All patients, from any ethnic group at risk of developing Type 2 diabetes, being obese or consuming hazardous levels of alcohol will be identified and offered brief intervention and onward referral to other services to prevent them developing Long term conditions.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Religion or Belief **Impact and evidence:** Consider and detail impact and evidence on people of different religions, beliefs (and those who may have no religion)	
Is this group affected by this Appraisal	**YES**
Positive Impact	All patients, of any belief, or non-belief at risk of developing Type 2 diabetes, being obese or consuming hazardous levels of alcohol will be identified and offered brief intervention and onward referral to other services to prevent them developing Long term conditions.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Sexual Orientation **Impact and evidence:** Consider and detail impact and evidence on people of different sexual orientations	
Is this group affected by this Appraisal	**YES**
Positive Impact	No specific impact for this group identified.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Gender Reassignment/ Transgender **Impact and evidence:** Consider and detail impact and evidence on transgender people	
Is this group affected by this Appraisal	**YES**
Positive Impact	All patients at risk of developing Type 2 diabetes, being obese or consuming hazardous levels of alcohol will be identified and offered brief intervention and onward referral to other services to prevent them developing Long term conditions. How the individual identifies themselves in terms of gender will not be a barrier to the patient accessing the service.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Pregnancy and Maternity **Impact and evidence:** Consider and detail impact and evidence on work arrangements, breastfeeding etc.	
Is this group affected by this Appraisal	**YES**
Positive Impact	All patients at risk of developing Type 2 diabetes, being obese or consuming hazardous levels of alcohol will be identified and offered brief intervention and onward referral to other services to prevent them developing Long term conditions. Access to brief intervention, whether this results in a referral or not will be available to all patients during and after pregnancy. For women who are pregnant the BMI calculations will take the pregnancy into account in determining whether brief intervention or onward referral is indicated.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Marriage and Civil Partnership **Impact and evidence:** Consider and detail impact and evidence on employees who are married or in a civil partnership	
Is this group affected by this Appraisal	**YES**
Positive Impact	All patients at risk of developing Type 2 diabetes, being obese or consuming hazardous levels of alcohol will be identified and offered brief intervention and onward referral to other services to prevent them developing Long term conditions. A patient's marital status will not be a barrier to the patient accessing the service.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Other Excluded Groups/ Multiple and social deprivation **Impact and evidence:** Consider and detail impact and evidence on groups that do not readily fall under the protected characteristics such as carers, transient communities, ex-offenders, asylum seekers, sex-workers, and homeless people.	
Is this group affected by this Appraisal	**YES**
Positive Impact	This service is only available where a patient is registered with a GP practice. This could be a barrier to accessing the service for a patient who is of no fixed abode / homeless. Practices have the option to temporarily register a patient to allow them to access this support. No further mitigation is possible for this particular service and patients ineligible would need to present at urgent care / walk in centre locations for support. Should any patient be in need of this support and unable to access it the CCG would expect the most appropriate practice (with an open list) to register the patient. All patients at risk of developing Type 2 diabetes, being obese or consuming hazardous levels of alcohol will be identified and offered brief intervention and onward referral to other services to prevent them developing Long term conditions.
Negative Impact	
Impact Rating **H = High** **M = Medium** **L = Low**	

Public Sector Equality Duty (PSED)	
Please provide details on how the proposal contributes to:	
Eliminating unlawful discrimination, harassment and victimisation;	• The referral process supports GPs to provide equitable access for all patients.
Advancing equality of opportunity between people who share a protected characteristic and those who do not;	
Fostering good relations between people who share a protected characteristic and those who do not.	

Provide detail of cumulative impact of this and other proposals: (Please consider whether this proposal, when combined with other decisions made by the CCG, might have a contributory positive or negative impact on the Public Sector Equality Duty.)
There are no implications for this development, or any other known developments that would have an impact on the Public Sector Equality Duty.

Step 5	**NHS Constitution and Human Rights**
Checklist – how does this proposal affect the rights of patients set out in the NHS Constitution or their Human Rights?	

	Constitutional Rights	**Yes/No**	**Please explain**
a.	Could this result in a person being treated in an inhuman or degrading way?	No	There are no provisions QOF + scheme that will result in any person using the service, or other person to be treated in an inhuman or degrading way.
b.	Does the proposal respect a patient's dignity, confidentiality, and the requirement for their consent?	No	There are no provisions within the QOF+ scheme that will result in any patient's dignity, confidentiality being compromised.
c.	Do patients have the opportunity to be involved in discussions and decisions about their own healthcare arising from this proposal?	Yes	Patients will be able to inform
d.	Do patients and their families have an opportunity to be involved (directly or through representatives) in decisions made about the **planning** of healthcare services arising from this proposal?	No	Patients will not be directly involved in this process. The planning of healthcare services is outside of the scope of the this process.
e.	Will the person's right to respect for private and family life be interfered with?	No	The service will not share any details of the individual with any third party without the informed consent of the patient.
f.	Will it affect a person's right to life?	No	The service will not compromise an individual's right to life

g.	Will this affect a person's right not to be discriminated against?	No	Having their potential referral discussed by the GP and secondary care Consultant within this process will not result in a patient being discriminated against.
h.	Will this affect a person's right to freedom of thought, conscience and religion?	No	Having their referral discussed by the GP and Secondary Care Consultant within this process not restrict a person's right to freedom of thought, conscience and religion

Step 6	**Engagement and Involvement (Duty to involve – s242 NHS Act 2006) Francis Recommendations 135**

a) How have you involved users, carers and community groups in developing this proposal? (Please give details of any research/consultation drawn on (desk reviews – including complaints, PALS, incidents, patient and community feedback, surveys etc)).

b) Also give details of any specific discussions or consultations you have carried out to develop this proposal – with users, carers, protected characteristic groups and/or their representatives, other communities of interest (e.g. user groups, forums, workshops, focus groups, open days etc.).

c) How have you used this information to inform the proposal?

There has not been any involvement with any users or carers; this has not been undertaken by the CCG.

This process is to review referral behaviours and practices of the GP, patients are not part of this process.

d) Have you involved any other partner agencies (such as Local Authorities, Health and Well-being boards, Health Scrutiny Committees, Local Healthwatch, Public Health, CSU or CCG)

Please give details of any involvement to date or planned:

No

Step 7	**Including people who need to know**

Please consider the way in which the proposal will be explained to a wider audience.

(Will translation or interpretation materials be required (audio, pictorial, Braille as well as alternative languages); are there any particular approaches required for different cultures using outreach or advocacy support**;** is some targeted marketing required?
Communications regarding the further development of the facility and some of it's newer features are being cascaded through the leads of the primary care groups.

Step 8	**Monitoring Arrangements**
Please identify the monitoring arrangements that will be introduced to ensure that the effect of the proposal does not result in a disproportionate impact on any protected group (e.g. by creating an unintended barrier); For example, including contractual requirements to provide equality monitoring data on those accessing the service or making complaints.
The process will be monitored and reported on a regular basis through the locality managers based in the Primary Care Team within the CCG. Member GPs have been consulted on the scheme through discussion at the Members Meeting and initial drafts of the specification have been presented and discussed at the Group Leads meeting and the Clinical Reference Group.

Which committee / Board / group will receive updates on the monitoring?	
Name:	**How often reports will be presented.**
Primary Care Strategy Committee	This Project is overseen by the Primary Care Strategy Committee who will receive regular updates on the implementation and outcomes of the review process.

Step 9	**Decision Making**
Taking the equality analysis and the engagement into consideration, and the duties around	

the Public Sector Equality Duty, you should now identify what your next step will be for the proposal	
Decision steps available	**Rationale for your decision**
Continue unchanged	There are no considerations within the above Equality Impact Analysis which require any changes to the original plan.
Adjust the proposal (please detail the changes you will make in the Action Plan at **Step 10**)	N/A
Fundamental review of / stop the proposal	N/A

Step 10	**Action Plan**
Please reference all actions identified above & any additional actions required to ensure that this proposal can be implemented in compliance with Equality legislation, NHS Constitution and Human Rights requirements.	

Action	**What will it achieve or address?**	**Lead Person**	**Timescale**
No Actions proposed	N/A	N/A	N/A

Step 11	**Preparation for sign off**	**Please tick**

1) Send the completed Equality Analysis with your documentation to Juliet.herbert1@nhs.net or equality@ardengemcsu.nhs.uk for feedback prior to Executive Director (ED) sign-off.	
2) Make arrangements to have the EA put on the appropriate programme board agenda	
3) Use the Action Plan to record the changes you are intending to make to the document and the timescales for completion. A review date for the action plan will be recorded by the programme board.	

Step 12 Sign off/ Approval

Designated People	Date
Project officer* (Senior Officer responsible including action plan) Name: Ranjit Khular / Sarah Southall Signature: 	15/02/2018
Equality & Inclusion Business Partner: Name: David King	4/4/2018
Executive Director: Name: Steven Marshall, Deputy AO and Director of Strategy and Transformation Signature: S Marshall	09.04.18
Name of Approval Board, at which the EIA was agreed at: Board: Chair:	
Review date for action plan:	

***as the Project Manager/Senior Responsible Officer you need to be assured that you have sufficient information about the likely effects of the policy in order to ensure proper consideration is given to the statutory equality duties.**

Once all the above Approvals have been completed, resend the completed form to the Equality Lead for reference and Audit

After Sign Off
1. Confirm with Equality & Inclusion Business Partner or CSU's Equality Team who will record the Executive Director decision and what meeting it will be recorded at. 2. Confirm with Equality & Inclusion Business Partner or Equality Team who will record the programme board decision and programme board title and date. 3. Arrange for publication of the Equality Analysis on the CCG's website.

Advice, information and support is available from the Equality and Diversity Team

Juliet Herbert - Equality and Inclusion Business Partner
Arden & Greater East Midlands CSU

Email: **juliet.herbert1@nhs.net**

Mobile: 07780 33 82 82

Or

equality@ardengemcsu.nhs.uk

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NHS
Wolverhampton
Clinical Commissioning Group

QOF + Scheme 2018/19
Frequently Asked Questions

Following a series of discussion with member practices spanning November 2017 to May 2018 the QOF+ Scheme has been developed with a focus on the areas of priority identified by GP colleagues. Early discussions identified the absence of a focus on prevention of longer term ill health and an overwhelming recognition of the areas that concerned GPs most ie diabetes, alcohol & obesity.

The scheme is built on those 3 pillars of priority and as a result of sharing the document with primary care colleagues a series of queries were captured and form the basis for a future source of reference for implementers of the scheme in the form of a 'frequently asked questions' format.

Questions Specific to Indicators	
QOFP01-4 Diabetes – what's the definition of each risk?	Details on Page 14 confirm a two stage approach to identifying people at risk & use of the Leicester Risk Score Tool.
QOFP08 Diabetes – referral to a structured education programme, what if the referral is declined?	Offer a read for code for accepted and another for offered but declined.
QOFP12-14 Alcohol – why all patients? The indicator reads as though all patients over 16 should be screened with the Audit-C Tool, is this new patients?	Detailed on Page 19 target groups are new patients, screening for other conditions, other chronic disease management appointments, medication reviews.
QOFP13 – Alcohol currently worded to cover all patients over 16 but this is a lot of patients?	This indicator applies to new patients registered since 1.4.18 only.
QOFP14 – Alcohol focuses on high risk subsets there is no definition of gastro intestinal disorders.	This will be defined and built into the search that will be available at practice level via the practice clinical system(s).
QOFP18 Obesity – we don't currently record BMI for arterial disease, stroke & TIA?	Opportunities for measurement are in line with recommendations made in NICE CG43, 2006/2015) ie routine health checks.
Questions Specific to Clinical System	
Leicester Risk Score doesn't include Blood Sugar?	Refer to page 14 two stage approach to identifying people at risk & when to use the Leicester Risk Score Tool.
Does Leicester Risk Score now need to be used for new patient health checks?	No, a request has been made to include the risk score in the NHS Health Check template.
Will searches be pre-set within GP Clinical Systems?	Yes all searches will be set up in advance & read codes will be confirmed during the launch.
Will read codes be available to code activity/interventions?	Yes the IM&T Team are actively working to define that codes that should be used for these activities. A list will be shared during the launch.
How often should risk be reassessed?	Detailed in table 1 on page 15 & also page 16.
What are the 8 care processes?	Detailed on Page 9

Other Generic Questions	
Can other health professionals undertake activities ie Practice Nurse, Clinical Pharmacist or HCA if competent?	Yes, where deemed clinically competent as per NICE Guidance.
What are the intentions beyond the first year?	The CCG is committed to investing in primary care and will be exploring what in year developments may be feasible and will build upon this document in future years.
What are points worth?	Where the threshold has been achieved the number of points constitute % of the overall financial allocation.
Current intensive lifestyle provider is not accepting new referrals?	Discussions are nearing a conclusion to identify an alternative method of providing this service. Further information will follow shortly.

NHS
Wolverhampton
Clinical Commissioning Group

QOF+ Framework

2018/19

Version 2.3 (Final Draft)

Contents

1 Background

1.1 Leadup to this work

Supporting the continued improvement and development of Primary Care is a key ambition for Wolverhampton CCG, reflected in the plans set out in our Primary Care Strategy. We have assumed fully delegated responsibility for commissioning primary care from April 2017 and undertaken significant work to support emerging clinical groupings to meet the needs of their patients, in line with the priorities set out in the *GP Forward View*.

Interventions for 2018/19 include:

- Retrospective GP peer review of referral behaviours, to manage demand for acute services;
- Risk stratification, to direct review of patients at highest risk of unplanned admission to hospital;
- Early diagnosis and enhanced review/care planning for people with COPD and asthma;
- Improving uptake of bowel cancer screening.

The 'QOF+' scheme builds on the benefits of the national Quality and Outcomes Framework (QOF) scheme. The purpose of the national QOF scheme is to reward and incentivise GP practices in England for the quality of care they provide to their patients and to help standardise improvements in the delivery of primary care.

QOF awards practices funding for:

- Managing some of the most common chronic diseases (such as asthma or diabetes);
- Managing public health concerns (such as smoking or obesity);
- Implementing preventative measures. (such as regular blood pressure checks).

Our QOF+ scheme has been developed in response to engagement with our member practices. Group discussions at a session with our Members in November 2017 identified a range of potential scheme ideas, with a broad focus on prevention. These were assessed for feasibility, potential impact and alignment with wider local priorities. They were subsequently refined by our Primary Care team into three main priority areas for further exploration:

- Diabetes
- Excessive alcohol consumption
- Obesity

We undertook a focused review of effective primary care interventions relating to these three priority areas in January and February 2018. This included scoping work, a review of the evidence and a return on investment exercise, to quantify potential impacts. The findings of this review have informed the components of the QOF+ scheme, detailed in the sections below.

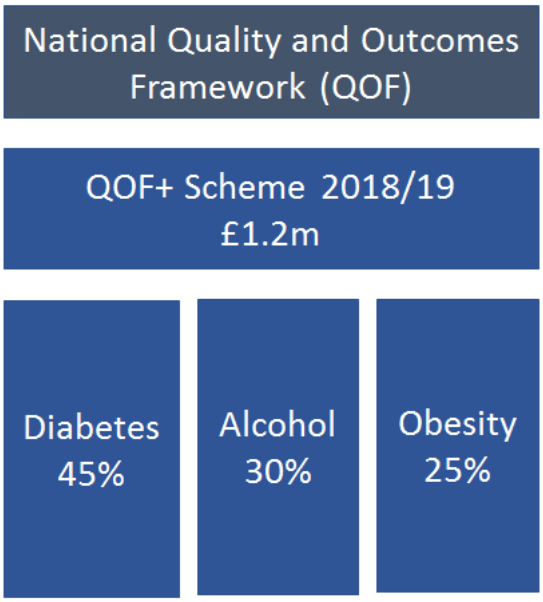


Figure 1 – Highlighting Wolverhampton CCG interventions in Primary Care for 2018/19

In February 2018, a preparatory scheme was launched with a focus on improving data quality for:

- Patients classified as 'pre-diabetic' (i.e. aged 18+ with HbA1c 42-47 mmol/mol or FPG 5.5-6.9 mmol/L);
- Patients with a body mass index (BMI) of 40+ kg/m^2;
- Patients with gestational diabetes;
- Patients with prognostic indicators of a respiratory condition.

This document sets out:

- National and local context for the priorities of the QOF+ scheme, including population need;
- The underlying evidence base and a description of proposed interventions;
- Intended outcomes and 'QOF+ indicators' to be measured;
- Payment mechanisms for the QOF + scheme.

1.2 National context

Diabetes

- **Public Health England (2015) estimates there are 3.8m people aged 16 years and over in England with diabetes (of which 940,000 are undiagnosed).** This is equivalent to 8.6% of the population in this age group.
- Based on population projections, **by 2035, diabetes prevalence is expected to increase to 4.9m (9.7%).**
- Prevalence is higher in men than in women (9.6% vs 7.6%), higher in people from South Asian and black ethnic groups compared with people from white, mixed or other ethnic groups (15.2% vs 8.0%) and increases with age.

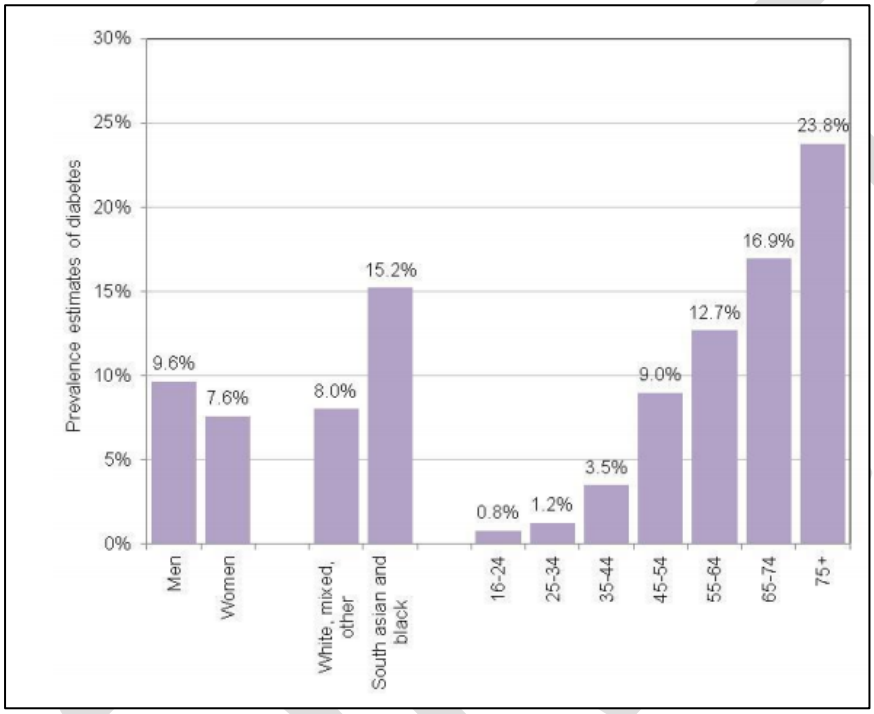


Figure 2 – Summary of expected diabetes prevalence for England in 2015 by age group, sex and ethnicity (Taken from Diabetes Prevalence Model, PHE 2015)

- **Obesity is the most potent risk factor for Type 2 Diabetes Mellitus (T2DM)**, accounting for ~80-85% of the overall risk.
- **Diabetes UK (2016) estimate people with diabetes in England and Wales are 34.4% more likely to die earlier than their peers** – in T2DM, the average reduced life expectancy for an individual diagnosed in their 50s is ~6 years.
- **It is estimated that £10bn is spent by the NHS on diabetes annually** – people with diabetes are twice as likely to be admitted to hospital and 45.1m prescriptions items were dispensed in primary care across England in 2013/14 (net ingredient cost of over £803m).
- In England and Wales, the National Diabetes Audit 2016-17 indicated **only 40.8% of all people with T2DM are achieving the treatment targets** recommended by NICE to reduce the risk of complications, **whilst only 47.6% of people with T2DM receive the recommended eight annual care processes.**

Alcohol

- **Public Health England (2016) reports 10.8m adults in England are drinking at levels that pose some risk to their health**, whilst 1.6m may have some level of alcohol dependence. Alcohol dependence is more common in men (6%) than in women (2%).
- **The cost of alcohol to society is estimated as £21bn per year**, made up of £11bn in alcohol-related crime, £7bn in lost productivity and £3.5bn in the cost to the NHS. In 2013/14, there were 333,014 admissions to hospital where the main reason was alcohol-related.

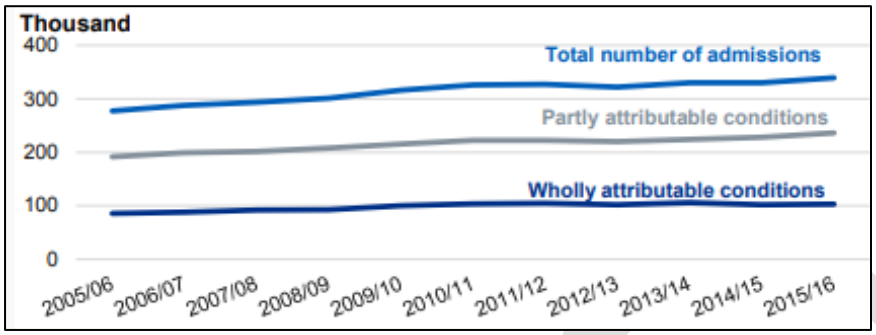


Figure 3 – Alcohol attributable deaths in England by condition (from Statistics on Alcohol, NHS Digital 2017)

- **Excessive alcohol consumption is a major cause of preventable premature death.** It accounts for 1.4% of all deaths registered in England and Wales in 2012. An analysis of 67 risk factors and risk factor clusters for death and disability found that **alcohol is the third leading risk factor for death and disability,** after smoking and obesity.

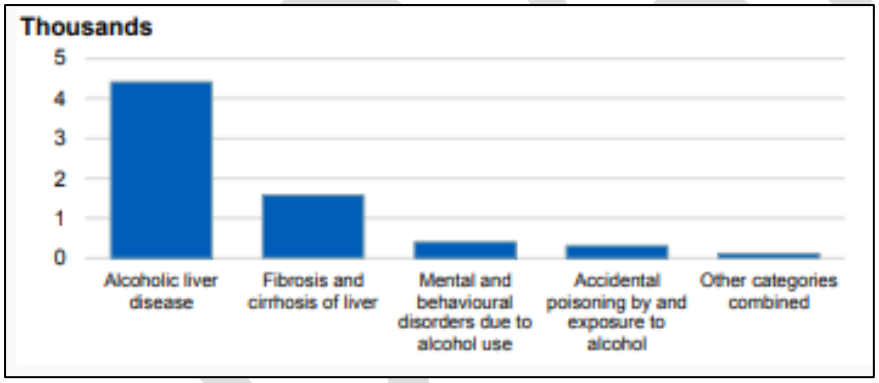


Figure 4 – Alcohol attributable deaths in England by condition (from Statistics on Alcohol, NHS Digital 2017)

- **Guidance from the Chief Medical Officer (2016) warns that drinking any amount of alcohol carries a health risk, including increasing risk of a range of cancers (such as mouth, bowel, stomach and breast).**
- **Alcohol misuse is associated with mental health problems.** There is a strong association between alcohol misuse and suicide.
- **The impact of harmful drinking and alcohol dependence is much greater for those in the lowest income bracket and those experiencing the highest levels of deprivation.**

Obesity

- **Public Health England (2017) reports nearly two-thirds (63%) of adults in England were classed as being overweight (BMI of over 25 kg/m^2) or obese (BMI over 30 kg/m^2) in 2015.** Prevalence of obesity is similar between men and women.
- **Prevalence of obesity in England has risen sharply, from 14.9% to 26.9% between 1993 and 2015**. Highest obesity levels are found in the 55-64 age group.

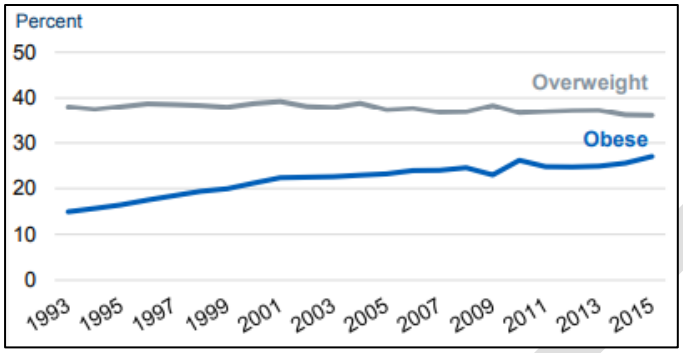


Figure 5 – Prevalence of obesity over time in England (from Statistics on Obesity, Physical Activity and Diet, NHS Digital 2017)

- **The cost of obesity to society is estimated at £27bn.** It is estimated the NHS spent £6.1bn on overweight and obesity-related ill health in 2014-15 – this is projected to reach £9.7bn by 2050.
- **Obesity is responsible for more than 30,000 deaths per year**, on average reducing lifespan by 9 years. It increases the risk of a range of diseases, including cancers, hypertension and T2DM.
- Figures from the Health Survey for England (2016) show that **only 67% of men and 55% of women aged 16 were classed as 'active'** (doing at least 150 minutes of moderate physical activity per week.) People from Asian, Black and Chinese ethnic groups were more likely to be inactive than those from White and Mixed Asian groups.

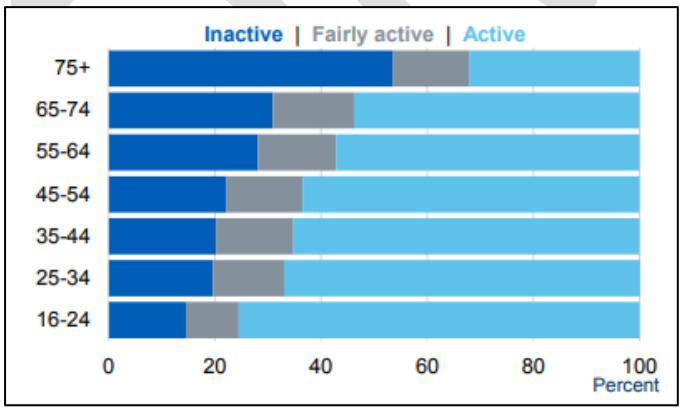


Figure 6 – Activity levels by age in England (from Statistics on Obesity, Physical Activity and Diet, NHS Digital 2017)

- **Only 26% of adults ate the recommended 5 portions of fruit and vegetables a day in 2015.** More than a quarter (27.1%) of adults and one fifth of children eat food from out-of-home food outlets at least once a week.

1.3 Local context and population needs

Diabetes

Analysis undertaken as part of the RightCare programme identified:

- **Wolverhampton has a reported diabetes prevalence of 8.17% of the adult population,** equating to 17,424 registered diabetic patients (2015/16).
- **Reported prevalence is higher than other comparable CCGS (apart from Walsall), and in addition, estimated prevalence is higher than all comparable CCGs.**
- **Wolverhampton has an estimated prevalence of 9.40%, equating to ~20,000 people with diabetes.**
- Data indicates a much higher prevalence of diabetes in Black and Minority Ethnic (BME) communities in Wolverhampton when compared to England. BME communities make up approximately 32% of the Wolverhampton CCG population, compared with the average of ~15% BME communities in the population of England as a whole.

The 2016-17 CCG Integrated Assessment Framework (IAF) assessment for diabetes was rated as 'Requires improvement'. Data from the **2016/17 National Diabetes Audit** identified:

- 38.9% of patients with all types of diabetes achieved all treatment targets.
- 2.7% of patients with diabetes diagnosed less than a year attended a structured education course.
- **For the eight recommended care processes for T2DM:**

Care process	Wolverhampton	National
HbA1c	95.2%	95.1%
Blood pressure	96.8%	96.2%
Cholesterol	93.8%	92.7%
Serum Creatinine	94.0%	95.0%
Urine albumin	58.2%	65.2%
Foot surveillance	84.7%	79.4%
BMI	81.0%	83.1%
Smoking	81.4%	85.5%
All eight care processes	44.0%	47.6%

- **For the treatment targets for people with T2DM:**

Care process	Wolverhampton	National
HbA1c <7.5%	65.8%	66.8%
Blood pressure <=140/80 mmHg	73.1%	74.2%
Cholesterol <5 mmol/L	75.1%	76%
All three treatment targets	40.2%	40.8%

Alcohol

The most recent Joint Strategic Needs Assessment (JSNA) for Wolverhampton identified:

- **Alcohol related mortality is worsening over time** and remains above the England average (17.4 DSR per 100,000[1] in Wolverhampton vs 11.6 per 100,000 in England for 2012/14).

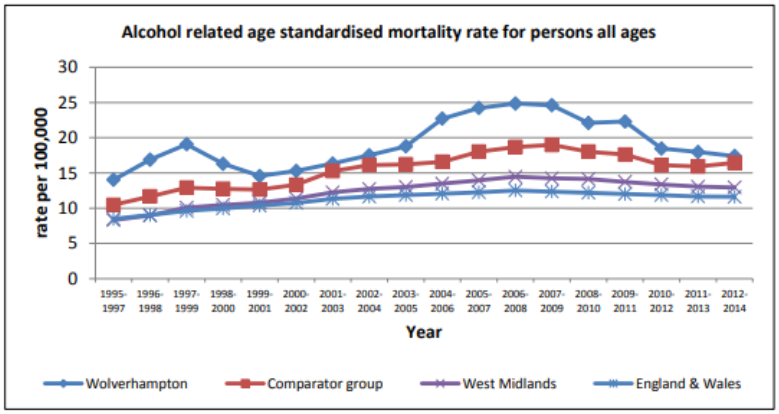


Figure 7 – Alcohol-related age-standardised mortality rate by age in Wolverhampton, 1995-2014 (from Causes of Early Death, JSNA Overview Report 2016)

- **The alcohol related mortality is worst in the most deprived areas of Wolverhampton** – DSR per 100,000 ranges from 4.5 in the least deprived areas, to 24.9 in the most deprived areas.

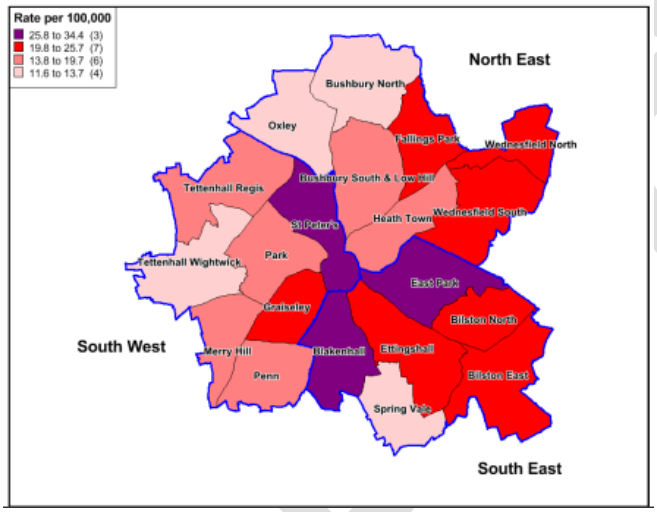
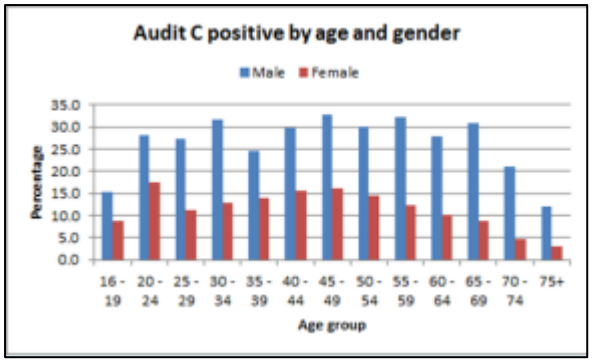
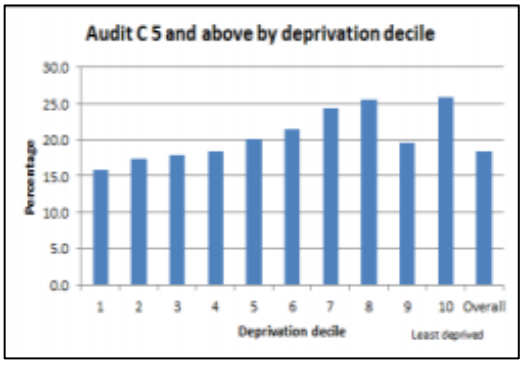


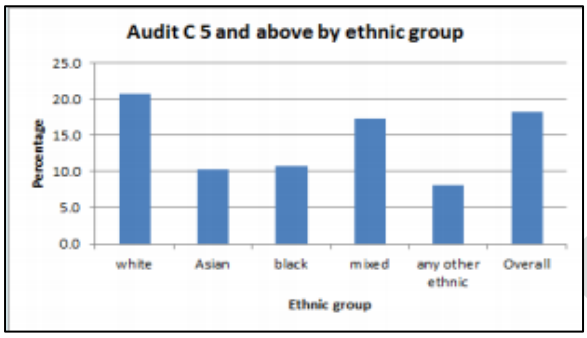
Figure 8 – Alcohol-related mortality by ward in Wolverhampton (from Causes of Early Death, JSNA Overview Report 2016)

Wolverhampton Public Health Team commissioned an adult lifestyle survey in 2016, including the short Audit-C questionnaire to identify the prevalence of alcohol misuse. **The use of alcohol increased with age, was higher in people who earned more (i.e. less deprived) and was higher in those from a white ethnic background.**

[1] The DSR for an area is the number of deaths, usually expressed per 100,000, that would occur in that area if it had the same age structure as the standard population and the local age-specific rates of the area applied. Directly standardised mortality rate is calculated by dividing the number of deaths by the actual local population in a particular age group, multiplied by the standard population for that particular age group and summing across the relevant age groups. The rate is usually expressed per 100,000.







Figures 9-11 – AUDIT-C positive individuals by age, gender, deprivation and ethnicity in Wolverhampton (from Live, Work and Stay Well, JSNA Overview Report 2016)

The number of emergency alcohol-specific admissions to hospital in Wolverhampton has increased over the past decade, from a low of 493 in the year prior to September 200,5 to a peak of 956 in the year prior to February 2015.

- The number of males being admitted into hospital for alcohol specific conditions in emergencies is more than double the number of females.
- Men age 35 to 54 years account for the highest rate of alcohol admissions – this same age range of men account for most of alcohol service users, whilst men aged 45 to 69 years account for the highest rate of alcohol-related deaths.
- Over three quarters of emergency alcohol specific hospital admissions are of individuals with a White ethnicity (77.9%).

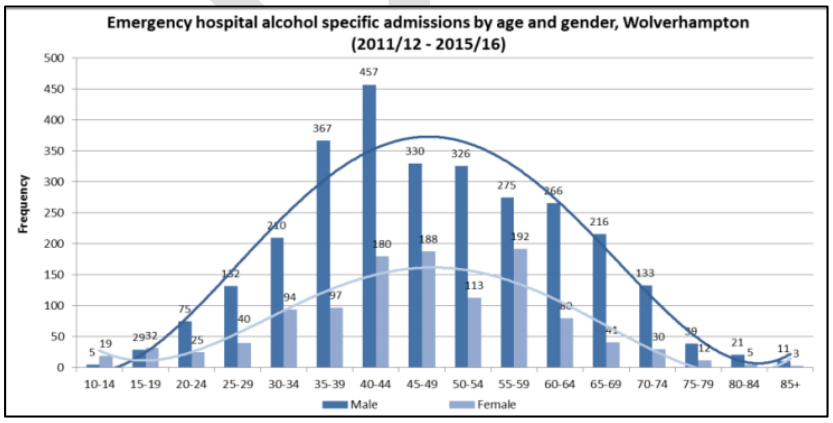


Figure 12 – Emergency alcohol-specific admissions to hospital by age and gender in Wolverhampton, 2011-16 (from Live, Work and Stay Well, JSNA Overview Report 2016)

Obesity

The most recent JSNA identified obesity as a significant issue for Wolverhampton:

- Almost two-thirds (59.6%) of males are either overweight or obese, compared to 52.1% females in Wolverhampton.

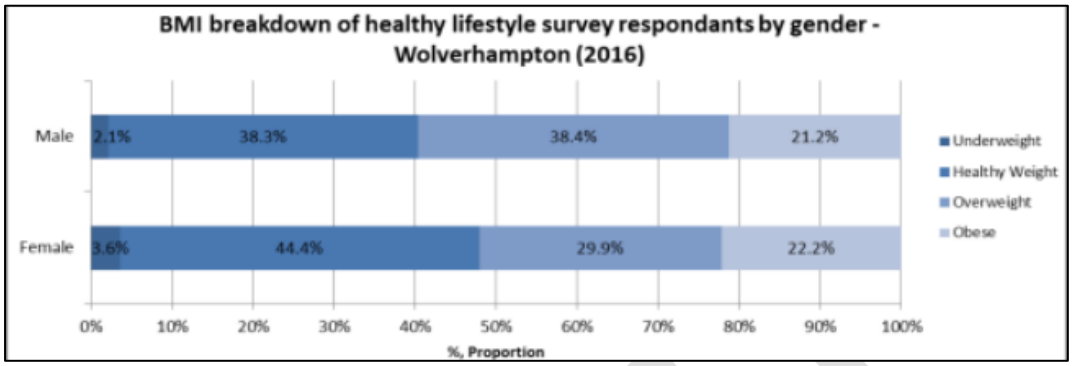


Figure 13 – BMI by gender in Wolverhampton (from Live, Work and Stay Well, JSNA Overview Report 2016)

- **Respondents who had a Black ethnic background had the highest proportion of individuals with excess weight** (63.6%). Individuals with an ethnic background other than those stated had the second highest proportion of individuals with excess weight (56.9%).

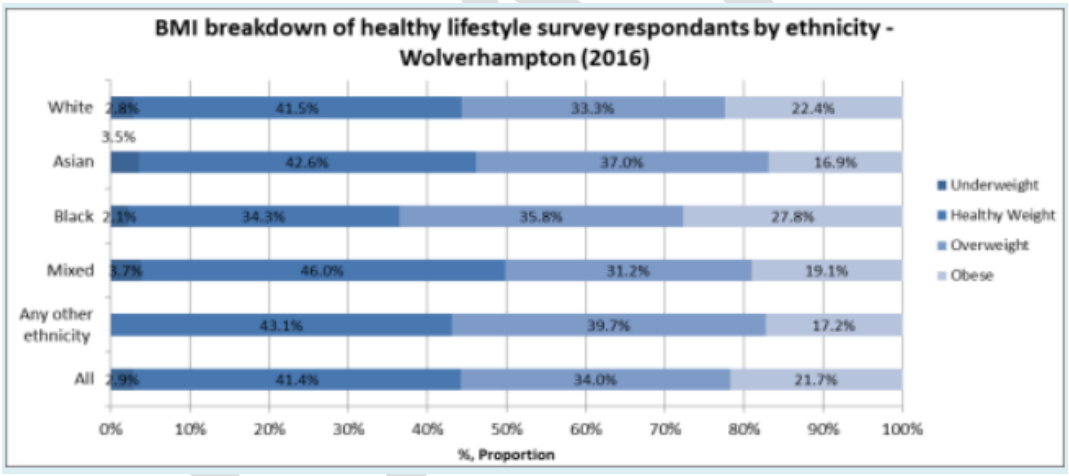


Figure 14 – BMI by ethnicity in Wolverhampton (from Live, Work and Stay Well, JSNA Overview Report 2016)

- **The proportions of individuals with excess weight are higher in the wards in the East of Wolverhampton,** compared to the wards in the West of the city.

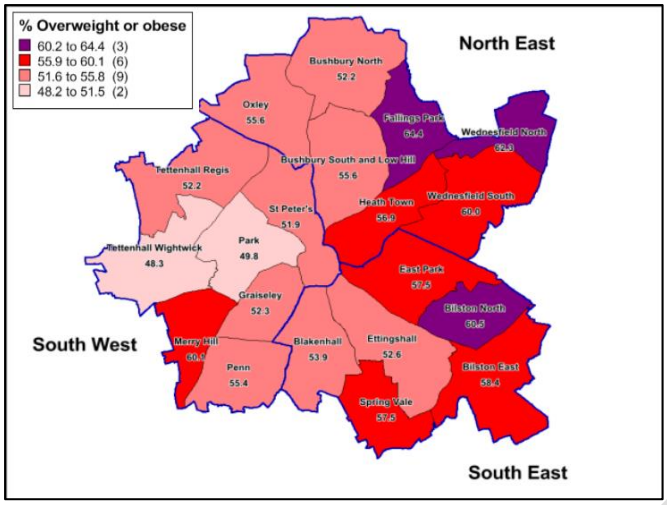


Figure 15 – % Overweight or obese by ward in Wolverhampton (from Live, Work and Stay Well, JSNA Overview Report 2016)

- **Only half of the Wolverhampton (49.9%) population were estimated to physically active,** which is significantly lower compared to England (57.0%) and the West Midlands (55.1%). The proportion of physically active adults has fallen slightly since 2012.

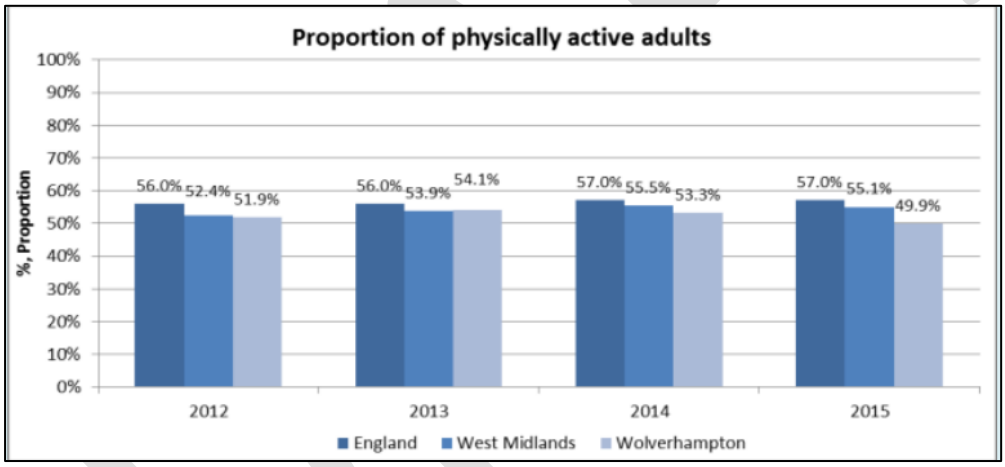


Figure 16 –Proportion of physically active adults in Wolverhampton, 2012-15 (from Live, Work and Stay Well, JSNA Overview Report 2016)

1.3 Evidence base for proposed interventions

Diabetes

Screening for T2DM

What is the intervention?

NICE recommends that a two-stage approach be taken in primary care for identifying people at high risk of developing T2DM (NICE PH38, 2012) or being in a pre-diabetic state (impaired fasting glycaemia or IFG):

1. Conduct a risk assessment, using either a computer-assisted tool or a self-assessment questionnaire;
2. With people identified as high risk, conduct either a glycated haemoglobin blood test (HbA1c) or fasting plasma glucose blood test (FPG).

Populations or risk factors considered to be particularly worth targeting for a risk assessment include:

- All eligible adults aged 40 and above, except pregnant women
- People aged 25–39 of South Asian, Chinese, African-Caribbean, black African and other high-risk black and minority ethnic groups, except pregnant women
- Adults with conditions that increase the risk of T2DM[2]
- NICE also recommend that people with a family history of T2DM take part in risk assessment tests. (NICE PH38, 2012)

A systematic review underpinning NICE PH38 (ScHARR Public Health Collaborating Centre, 2011a) considered evidence on the effectiveness of different risk assessment tools. The tools they considered with moderate to strong evidence of effectiveness included the **Leicester Risk Assessment Score (LRA)**, a 7-item questionnaire, designed to be used to identify either Impaired Glucose Regulation (IGR) or undiagnosed T2DM in a multi-ethnic population (Gray et al, 2010). It has been developed into the **Leicester Practice Database Score,** which can be used to interrogate electronic patient records, which is particularly useful where people have glucose or HbA1c data already collected. (Gray et al, 2012)

NICE recommends that individuals with a **fasting plasma glucose of 5.5–6.9 mmol/l or an HbA1c level of 42–47 mmol/mol [6.0–6.4%]** should be treated as high risk of developing T2DM and considered to be suffering from prediabetes.

Which staff should deliver the intervention?

The NICE cost-effectiveness modelling review (ScHaRR, 2011b) created a model that involved **admin staff** to administer the risk assessment and **HCAs or nurses** to conduct the blood tests.

What are the outcomes or benefits?

This strategy has been found effective and cost-effective for correctly identifying people at risk of diabetes. The outcomes for the identification are often discussed in conjunction with a preventative lifestyle intervention, as it is considered the first step in ensuring the success of that intervention in reducing rates of T2DM.

Prevention of T2DM

What is the intervention?

2 These include: cardiovascular disease, hypertension, obesity, stroke, polycystic ovary syndrome, a history of gestational diabetes and mental health problems. NICE also advises people with learning disabilities and those attending accident and emergency, emergency medical admissions units, vascular and renal surgery units and ophthalmology departments may be at high risk.(NICE PH38 2012)

Based on the outcomes of the risk assessment tests, different interventions are recommended by NICE, which correlate with different risk of diabetes (PH38, 2012).

Table 1 - Preventative interventions for different risk levels for T2DM

Risk level	Intervention	Follow-up/recall
Low **(Low or intermediate risk score)**	Brief advice (5 minutes)	Every 5 years
Moderate **(High risk score, with HbA1c <42mmol/L or FPG <5.5 mmol/L)**	Brief intervention	Every 3 years
High **(High risk score, with HbA1c 42-48 mmol/mol or FPG 5.5-6.9 mmol/L)**	Referral to intensive lifestyle intervention	Annually
Diabetic	Management processes	As appropriate

Adapted from: NHS Right Care Casebook (2015)

What is meant by 'brief advice'?

For people at low risk (with a low or intermediate risk score), primary care staff are advised by NICE (PH38, 2012) to inform the individual that they are currently at low risk, but that it may increase in the future.

They are advised to offer them brief advice of 5-15 minutes long, discussing the patient's risk factors, as well as lifestyle choices that may keep their risk low. (NHS Right Care Casebook, 2015) Encouragement and reassurance should be offered. (PH38, 2012)

Who should deliver 'brief advice'?

The NICE evidence review does not specify who should deliver brief advice. Based on who is delivering the risk assessment tool, **this could be a healthcare assistant or nurse.** Phillips (2013) recommends that nurses with diabetes or CVD expertise are best placed to provide this kind of communication with patients.

Health inequalities and population differences:

NICE advises offering verbal and written information about culturally appropriate local services and facilities that could help them change their lifestyle. Examples could include information or support to: improve their diet (including details of any local markets offering cheap fruit and vegetables); increase their physical activity and reduce the amount of time spent being sedentary (including details about walking or other local physical activity groups and low-cost recreation facilities). The information should be provided in a range of formats and languages. (PH38, 2012)

What is meant by 'brief intervention'?

For people with a moderate risk (a high-risk score, but with a fasting plasma glucose less than 5.5 mmol/l or HbA1c of less than 42 mmol/mol [6.0%]), NICE advises that staff inform the person of their moderate risk, the chance of that risk increasing but also the opportunity to prevent it.

Staff are advised to provide a longer conversation, a 'brief intervention' which aims to improve a person's diet and help them to be more physically active. Staff are advised to identify which of a patient's risk factors can be modified and discuss with them how they can achieve this by changing their lifestyle. Staff should be trained in evidence-based behaviour techniques and only signpost providers that use similar techniques (PH38, 2012). This could involve asking the patient whether they would like to join a structured personalised weight-loss programme, with tailored advice about diet, physical activity and behaviour change. A brief intervention may be delivered in groups or on a one-to-one basis. Diabetes UK provides resources to people directly who wish to reduce their risk of prediabetes, free of charge. This includes goal-setting action plans and food diaries to encourage people to monitor their diet.

How often should risk be reassessed?

The reassessment/ recall period for each of these preventative interventions is shown in Table 1. **NICE recommends that primary care practices keep an up-to-date register of people's level of risk of prediabetes or diabetes and introduce a recall system based on the same two-step strategy mentioned previously**.

Primary care staff are recommended to use clinical judgement on whether people may need more frequent monitoring of their health and risk factors (such as their BMI, relevant illnesses or conditions, ethnicity and age). An annual review is recommended for people who were found to have risk scores and blood test readings indicating prediabetes, to monitor their progress. (PH38, 2017)

Care planning for T2DM

The NHS Right Care Pathway for Diabetes (2017) highlights the importance of involving patients with diabetes in their own care planning, **which should include agreeing set goals and creating an action plan.** They refer to NICE guidance (NICE QS6, 2011) that this should be reviewed annually, but also note that the frequency of care planning should be based on an individual need, which can vary with condition.

There is systematic review evidence (Coulter et al., 2015) that personalisation in care planning leads to small positive outcomes for patients with long term conditions, particularly diabetes. Diabetes UK and Year of Care provide materials to support professionals to engage in collaborative care planning.

Which staff should deliver the intervention?

Collaborative care planning is a whole-system approach that can involve administrators, HCAs, nurses and GPs.

What are the benefits?

The systematic review by Coulter et al. (2015) found that involvement in personalised care led to better HbA1c levels in diabetic patients – there was a mean difference of -0.24% across nine studies, between those receiving personalised care planning and those who received 'usual care'.

Structured education for people with diabetes

What is the intervention?
NICE recommends that patients diagnosed with diabetes are enabled to access evidence based structured education programmes for people with diabetes in line with NICE Guidance (NICE NG17, 2015, updated 2016; NICE NG 28, 2009, updated 2015). NICE recommends that DAFNE is offered to people with Type 1 diabetes within 6-12 months diagnosis and that carbohydrate (CHO) counting training is an essential element of training (NICE NG17, 2016). For patients with T2DM, an immediate referral to structured education is recommended (such as DESMOND or XPERT). Patients who have missed structured education when first diagnosed should be referred at the earliest opportunity (NICE NG28, 2015).

Which staff should deliver the intervention?
These programmes are mainly delivered outside of primary care. DAFNE is delivered by specially trained educators (diabetes specialist nurses and diabetes specialist dietitians) to groups of 6–8 adults over 5 consecutive days. It is provided on an outpatient basis in any setting (secondary care or community). DESMOND and XPERT groups are run by trained health educators in community-based settings. Primary care staff therefore can refer their patients to local groups – XPERT provide classes in Wolverhampton (XPERT Health website).

What are the benefits?
Structured education has been found to improve glycaemic control – HbA1c levels decreased after three years in a follow up of a cluster randomised controlled trial of DESMOND. Khunti et al. (2012) found that compared with baseline at 12 months HbA1c levels decreased by 1.49% in the intervention group receiving DESMOND and a decrease was sustained after three years (Khunti et al., 2012). In a review of different studies of DAFNE it was found to decrease Hba1c levels and improve quality of life, although studies with long follow up found that these benefits may not be long-term (Owen and Woodward, 2012).

Care processes

NICE recommends all people with diabetes aged 12 years and over should receive each of the nine care processes annually and, when diagnosed, attend a structured education programme. (NG28, 2015).

Nine Annual Care Processes for all people with diabetes aged 12 and over	
Responsibility of Diabetes Care providers (included in the NDA 8 Care Processes)	
1. HbA1c (blood test for glucose control)	**5. Urine Albumin/Creatinine Ratio** (urine test for early kidney disease)
2. Blood Pressure (measurement for cardiovascular risk)	**6. Foot Risk Surveillance** (foot examination for foot ulcer risk)
3. Serum Cholesterol (blood test for cardiovascular risk)	**7. Body Mass Index** (measurement for diabetes management)
4. Serum Creatinine (blood test for kidney function)	**8. Smoking History** (question for cardiovascular risk)
Responsibility of NHS Diabetes Eye Screening (screening register drawn from practices)	
9. Digital Retinal Screening (photographic eye test for diabetic eye disease)	

Figure 17 – Nine annual care processes for people with diabetes (from National Diabetes Audit, 2016-17: Care Processes and Treatment Targets short report)

Treatment Targets

NICE recommends treatment targets for HbA1c (glucose control), blood pressure and serum cholesterol:

- Target HbA1c reduces the risk of all diabetic complications;
- Target blood pressure reduces the risk of cardiovascular complications and reduces the progression of eye disease and kidney disease;
- Target cholesterol reduces the risk of cardiovascular complications.

In addition, practices should ensure engagement with acute consultants to review complex patients, care planning requirements etc through regular MDTs with acute consultants (Minimum 2 per year).

In addition, the Diabetes Network are currently reviewing educational requirements of primary care workforce to review and training/ educational requirements to upskill workforce, to improve the management of patients within primary care. We will be looking to hold an 'XPERT in a Day' for nominated representatives from practices (ideally practice nurses) to improve the uptake of patient attendance.

Alcohol

Screening for hazardous and harmful drinking

What is the intervention?

NICE recommends that primary care professionals should carry out alcohol screening as "an integral part of their practice" (PH24, 2012). The Alcohol Use Disorders Identification Test (AUDIT) developed by the World Health Organisation (WHO) has been found to be both effective and cost-effective for identification (O'Donnell et al., 2014; Angus et al., 2014; NICE PH24, 2012). NICE found the evidence for the use of shorter tools including AUDIT-C (3 item) is variable in quality, **but they are recommended for use if time is tight**. (NICE PH24, 2012)

Which staff should deliver the intervention?

Staff that can undertake screening include GPs or nurses. Purshouse et al. (2012) highlights the cost-effectiveness of practice nurses delivering screening during patient registration appointments.

Who should be screened?

Purshouse et al. (2012) found that **universal screening was cost-effective,** whilst the AUDIT handbook emphasises the importance of a whole-population approach (WHO, 2001).

NICE guidance acknowledges that universal screening may not be feasible or practicable (NICE PH24, 2012). Where this is the case, primary care professionals are recommended to focus on groups at an increased risk of harm from alcohol and those with alcohol-related conditions. This includes people:

- With relevant physical conditions (such as hypertension and gastrointestinal or liver disorders);
- With relevant mental health problems (such as anxiety, depression or other mood disorders);
- Who have been assaulted;
- Who are at risk of self-harm;
- Who regularly experience accidents or minor traumas;
- Who regularly attend GUM clinics or repeatedly seek emergency contraception.

NICE guidance highlights key opportunities for screening:

- New patient registrations;
- Screening for other conditions;
- Other chronic disease management appointments;
- Carrying out medicine reviews.

Health inequalities and population differences:

NICE indicates that discussions about alcohol with patients should be sensitive to people's culture and faith and tailored to their needs. Clinicians should use professional judgement as to whether to revise the AUDIT scores downwards when screening:

- Women, including those who are, or are planning to become, pregnant;
- Younger people (under the age of 18);
- People aged 65 and over;
- People from some black and minority ethnic groups.

What outcomes/benefits might be expected?
The outcome of screening alone is identification of risky alcohol consumption. Purshouse modelled that screening only patients newly registering with a practice would identify up to 40% of all hazardous drinkers; screening all at their next visit, about 80%.

Brief advice

What is the intervention?
'Brief advice' is a structured education session, ideally offered to individuals immediately after completing AUDIT screening, if their score indicates they may be consuming alcohol in a hazardous or harmful way (NICE PH24, 2012). If this is not possible, NICE recommends the appointment to provide this advice take place as soon as possible.

The framework that continues to be the recommended basis of brief advice is FRAMES. (Bien et al., 1993) – 'feedback, responsibility, advice, menu, empathy, self-efficacy'. It is recommended that the session covers:

- The potential harm caused by their level of drinking and reasons for changing the behaviour, including the health and wellbeing benefits;
- The barriers to change;
- Outline practical strategies to help reduce alcohol consumption (to address the 'menu' component of FRAMES);
- Developing a set of goals.

Providers may choose the tool that is most appropriate for them. In the UK this includes a Structured Advice Tool from PHE Alcohol Learning Centre. NICE recommends that where there is an ongoing relationship with the patient or client, the **primary care professional should routinely monitor their progress** in reducing their alcohol consumption to a low-risk level. **Where required, offer an additional session of structured brief advice or, if there has been no response, offer an extended brief intervention** (which could include motivational interviewing or motivational-enhancement therapy).

Which staff should provide brief advice?
Platt et al. (2016) found a small effect that indicated **brief advice provided by nurses had the most effect** in reducing the quantity of alcohol consumed, but not the frequency.

What outcomes/benefits might be expected?
Screening tools are recommended to be used in conjunction with brief advice or brief interventions, when screening identifies that an individual is drinking in a hazardous or harmful way. Most of the evidence base considers the screening and brief advice or intervention together and found it to be **both effective and cost-effective in reducing alcohol consumption among hazardous or harmful drinkers**. (Platt et al., 2016; O'Donnell, 2014; Angus et al., 2014, Purshouse et al., 2013; NICE PH24, 2012). De-Xing (2017) found a consistent international evidence base for the effectiveness of screening and brief intervention.

NICE recommends that if an AUDIT score suggests that a person may be dependent on alcohol, they are referred onto a specialist alcohol team for further diagnostic tests and provision of specialist support (NICE PH24, 2012).

A summary of recommendations for intervention for different levels of alcohol use is provided in Table 2.

Table 2 - Intervention or referral pathways for different kinds of drinkers

Type of drinker	Notes	Intervention
Hazardous or harmful drinker	Full AUDIT score of 8 or more.	Brief advice delivered in primary care
Resistant harmful drinkers	Have not responded to brief advice	Referral to extended brief intervention
Dependent drinker	Further diagnostic tests required to confirm dependency	Referral to specialist alcohol services

Obesity

Measurement opportunities

What's the intervention?

NICE recommend that primary care staff use clinical judgement when deciding when to measure a person's height and weight to calculate BMI. (NICE CG189, 2014)

Opportunities for measurement highlighted by the guidance include:

- Registration with a general practice;
- Consultation for related conditions (such as type 2 diabetes and cardiovascular disease);
- Other routine health checks. (NICE CG43, 2006/2015)

Weight is acknowledged to be a sensitive subject, but a recent RCT found that patients are not as offended by a doctor discussing their weight as might be expected. Aveyard (2016) found that 81% (n=1530) patients felt that a GP brief intervention about their weight was appropriate and helpful. Only four patients out of 2728 felt the discussion was inappropriate or unhelpful.

The RCGP have designed brief guidance for health professional on raising the topic of weight. (RCGP 2013). NICE acknowledges that people may not be ready to change when suggestions are made about lifestyle changes – they recommend providing information and communicating with the patient that they can return another time. (NICE CG189, 2006/2015).

Brief advice

What's the intervention?

Obesity identification and brief advice has been highlighted by Public Health England as one of five key effective interventions to facilitate patients to better self-care and reduce demand on general practices[3].The intervention consists of giving brief advice and a booklet of self-help weight-management strategies to people who are obese. **There is evidence for the effectiveness of brief interventions in primary care in reducing weight outcomes.** Free online training resources are available from the RCGP and the World Obesity Federation (see references).

As part of a Brief Intervention for Weight Loss (BWeL) study, (Aveyard, 2016) GPs advised people who were obese about losing weight. They raised the topic of conversation at the end of a consultation about something else. The conversation was very brief (at 30 seconds long) and patients were either randomised to receive recommendations on weight loss and provided with written materials or referred to an NHS-funded 12 week commercially-run weight management programme, organised outside of primary care.

What are the benefits?

Although there was more weight loss among the BweL group that were randomised to receive the weight management group at 12 months, **weight loss was still recorded among those who only received advice.** The mean weight change was 1·04 kg in the advice only group, giving an adjusted difference of 1·43 kg (95% CI 0·89–1·97). 2·43 kg in the advice plus support group. The number needed to treat to achieve a 5% weight loss (about 5 kg) at 12 months was 8·8, which is very effective for a preventive intervention.

[3] Public Health England (2017) Five key interventions to facilitate patients to better self-care, improve their health and wellbeing and reduce demand on general practice if implemented systematically across primary care. Available at: https://www.swahsn.com/wp-content/uploads/2017/11/PHE-Report-2017-Five-Key-Interventions.pdf

2 Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

2.2 Locally defined outcomes

- A total of 100 'QOF+ points' are distributed between the three priority areas to incentivise continuous improvement.
- Points are distributed to reflect the number of indicators and anticipated workload associated with each priority area:

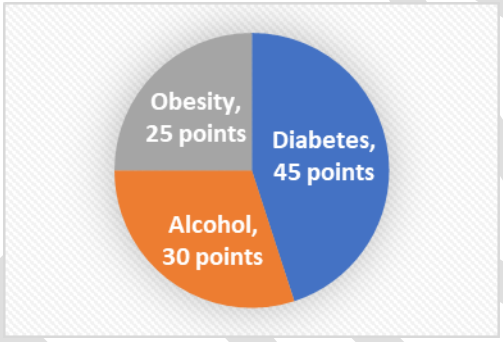


Figure 18 – Distribution of QOF+ points between priority areas 2018/19

- Where present, thresholds reflect the intention that this is a developmental piece of work. These are relatively low in Year 1 (without a sliding scale for achievement), with the intention of improving the baseline position and reducing unwarranted variation between practices. In subsequent years, these thresholds will be subject to change as improvements are realised.
- See 3.6 'Payment' and 3.7 'Implementation' for further details.

QOF+ Indicators 2018/19

Diabetes – primary prevention

Intended outcome	QOF+ indicator number	QOF+ indicator wording	18/19 threshold (%)	QOF+ points for achievement
Identify people in Wolverhampton at medium or high risk of developing T2DM	QOFP01	The contractor establishes and maintains a register of those at overall moderate risk and overall high risk of developing diabetes.	-	9
	QOFP02	The percentage of patients aged 18 or over that are new to list in the preceding 12 months, who have had screening carried out using the Leicester Risk Assessment Score.	50	4
Reduce the risk of people at medium or high risk of developing T2DM	QOFP03	The percentage of patients deemed at 'moderate' overall risk of developing diabetes, for whom 'brief intervention' has been offered in the preceding 12 months.	35	6
	QOFP04	The percentage of patients deemed to have 'pre-diabetes' (high overall risk), who have a record of being referred to an intensive lifestyle intervention in the preceding 12 months.	35	4

Diabetes – secondary prevention

Intended outcome	QOF+ indicator number	QOF+ indicator wording	18/19 threshold (%)	QOF+ points for achievement
Increase the proportion of people with diabetes who receive care planning annually	QOFP05	The percentage of patients with diabetes, on the register, for whom a care plan has been completed in the preceding 12 months.	40	3
Increase the proportion of people with receive each of the NICE recommended	QOFP06	The percentage of patients, with diabetes, on the register, who have a record of an albumin: creatinine ratio test in the preceding 12 months.	60	3

care processes annually				
	QOFP07	The percentage of patients with diabetes, on the register with a record of a foot examination and risk classification within the preceding 12 months. (DM012 Stretch Goal)	80	3
	QOFP08	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry onto the diabetes register. (DM014 Stretch Goal).	80	3
Increase the proportion of people with diabetes who receive all eight NICE-recommended care processes annually	QOFP09	The percentage of patients with diabetes, on the register, in whom all eight care processes are complete in the preceding 12 months.	50	4
Increase the proportion of people with diabetes who achieve NICE-recommended treatment targets	QOFP10	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80mmHg or less. (DM003 Stretch Goal)	80	3
	QOFP11	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less. (DM004 Stretch Goal)	80	3

Alcohol

Intended outcome	QOF+ indicator number	QOF+ indicator wording	18/19 threshold (%)	QOF+ points for achievement
Identify people in Wolverhampton who are consuming alcohol at hazardous or harmful levels	QOFP12	The contractor establishes and maintains a register of patients with hazardous, harmful or dependent levels of alcohol consumption.	-	3
	QOFP13	The percentage of patients aged 16 or over who have been screened for hazardous, harmful or dependent levels of alcohol consumption using the AUDIT-C tool.	40	9
	QOFP14	The percentage of patients with any or any combination of the following conditions: hypertension, anxiety/depression or other mood disorders, gastrointestinal disorders or liver disorders, who have been screened for hazardous, harmful or dependent levels of alcohol consumption using the AUDIT-C tool in the preceding 12 months.	50	9
Reduce alcohol consumption amongst people who are consuming at hazardous or harmful levels	QOFP15	The percentage of patients identified as having hazardous or harmful levels of alcohol consumption, who are recorded as having been offered 'brief advice' in the preceding 12 months.	40	9

Obesity

Intended outcome	QOF+ indicator number	QOF+ indicator wording	18/19 threshold (%)	QOF+ points for achievement
Identify people in Wolverhampton who are obese	QOFP16	The percentage of newly registered patients aged 16 or over who whom a BMI is recorded in the preceding 12 months.	50	3
	QOFP17	The percentage of patients, with diabetes, for whom a BMI is recorded in the preceding 12 months.	85	8
	QOFP18	The percentage of patients, with any or any combination of the following conditions: atrial fibrillation, coronary heart disease, heart disease, hypertension, peripheral arterial disease, stroke and TIA, for whom a BMI is recorded in the preceding 12 months	50	8
Reduce the weight of people who are classified as obese	QOFP19	The percentage of patients with BMI >=30 kg/m^2 who are recorded as having been offered 'brief advice' in the preceding 12 months.	40	6

3 Scope

3.1 Aims & objectives

See intended outcomes above.

3.2 Service description/care pathway

See section 1.3 'Evidence Review' for rationale and a more detailed description of interventions.

Diabetes – primary prevention

- GP practices will implement the Leicester Practice Database Score to assess the risk of their current practice population.
- They will undertake the Leicester Risk Assessment Score for all new patients registering with the practice.
- They will invite individuals with a 'high' risk score for blood tests (HbA1c or FPG).
- Following results of these blood tests, they will establish a register of patients deemed to be at 'moderate' overall risk or 'high' overall risk of developing Type 2 Diabetes Mellitus.
- Practices will undertake intervention and follow up/recall dependent on patient risk, as per the figure below:

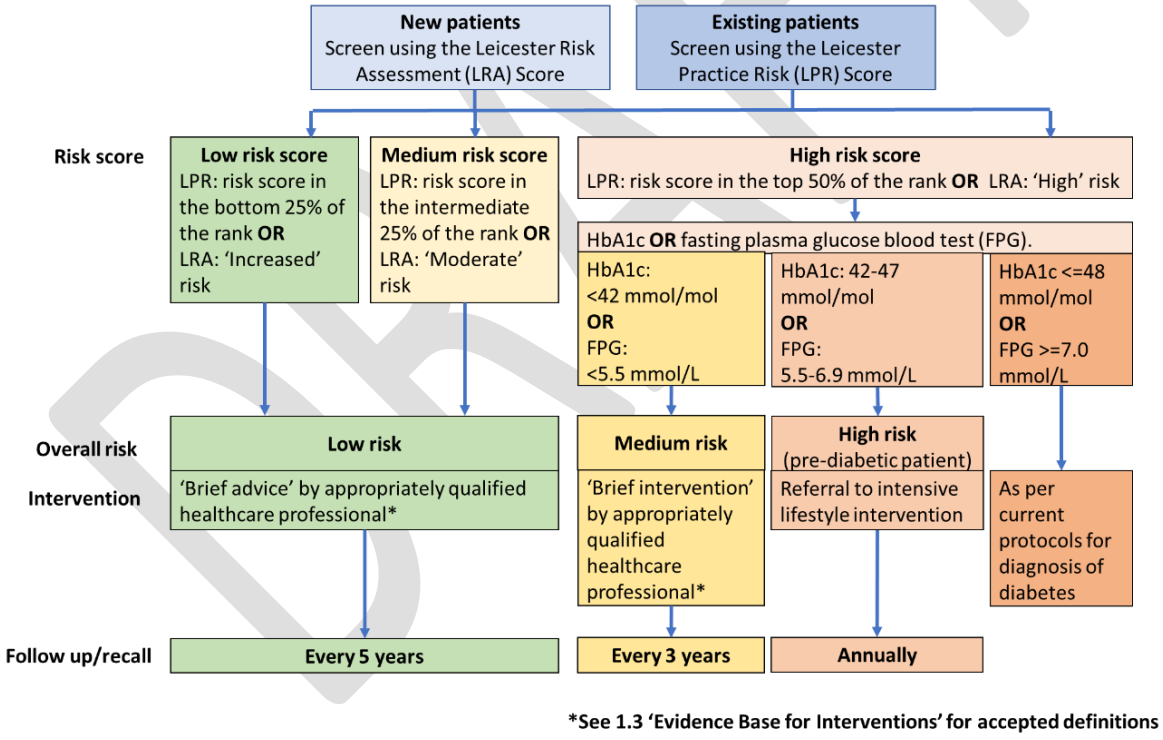


Figure 19 - Interventions and follow up/recall to be carried out by practices, based on patient risk of diabetes.

- Patients suspected to be suffering from diabetes will be managed in line with current practice.

Diabetes – secondary prevention

- GP practices will produce care plans for all patients with a known diagnosis of diabetes, customised to the level of patient need. As a minimum, this should include agreeing set goals and creating an action plan, based on the description in the evidence review above.

- GP practices will review care plans for people with diabetes based on individual need, but at least on an annual basis.
- GP practices will continue to refer patients newly diagnosed with diabetes to an approved structured education programme (such as DAFNE or X-PERT) and use appropriate coding on clinical systems to indicate whether patients have completed/partially completed/not attended the course.
- GP practices will continue current efforts to achieve recommended treatment targets for HbA1c (glucose control), blood pressure and serum cholesterol. They will aim to improve the proportions of individuals who achieve the targets for **blood pressure** and **serum cholesterol**.
- GP practices will continue current efforts to achieve the recommended eight individual care processes for patients with diabetes. They will aim to improve the proportions of individuals with diabetes who receive **each of these** care processes annually.
- They will focus efforts on achieving a higher proportion of individuals with diabetes who receive **all eight** NICE-recommended care processes annually.

Alcohol

- GP practices will undertake screening for 'hazardous' or 'harmful' or 'dependent' levels of alcohol consumption in their practice population aged over 16, using the 'AUDIT-C' tool.
- Patients with a positive AUDIT-C score will have the full AUDIT score carried out.
- Practices will initially focus screening on groups at an increased risk of harm from alcohol and those with alcohol-related conditions (see description in 2.2 'Locally defined outcomes')
- They will establish a register of patients deemed to be consuming alcohol at hazardous, harmful or dependent levels.
- **Practices will undertake intervention dependent on patient risk, as per the figure below:**

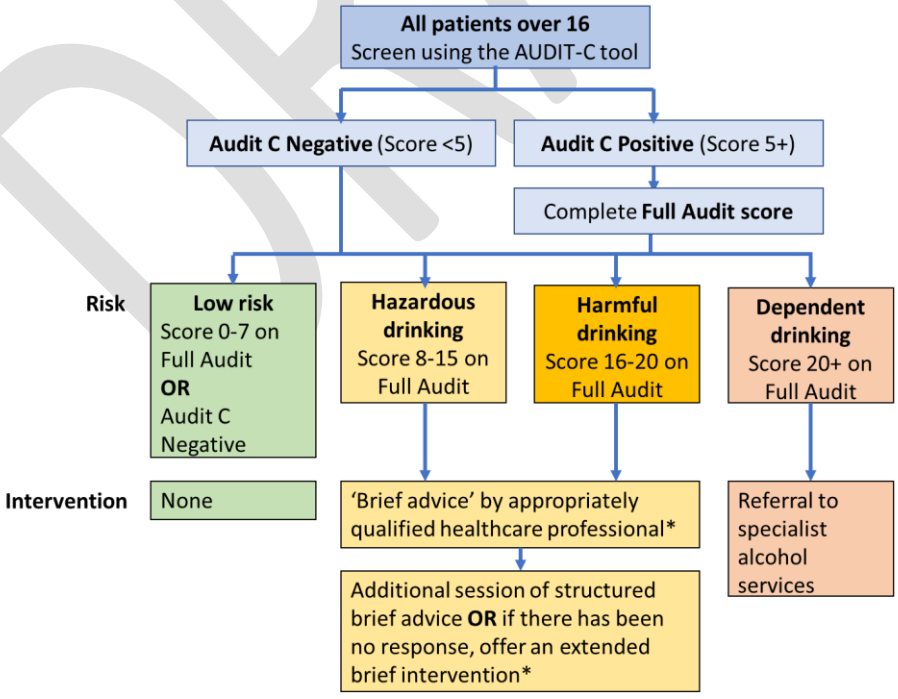


Figure 20 – Interventions to be carried out by practices, based on risk associated with alcohol consumption

- **Patients will have progress routinely monitored,** by an appropriate primary care professional, in reducing their alcohol consumption to a low-risk level.

Obesity

- GP practices will undertake screening for obesity through calculation of Body Mass Index (BMI) in their practice population.
- They will offer calculation of BMI for all new patients registering with the practice.
- They will offer calculation of BMI for patients with obesity-related conditions such as diabetes and cardiovascular disease (see description in 2.2 'Locally defined outcomes').
- **Practices will undertake intervention dependent on patient risk, as per the figure below:**

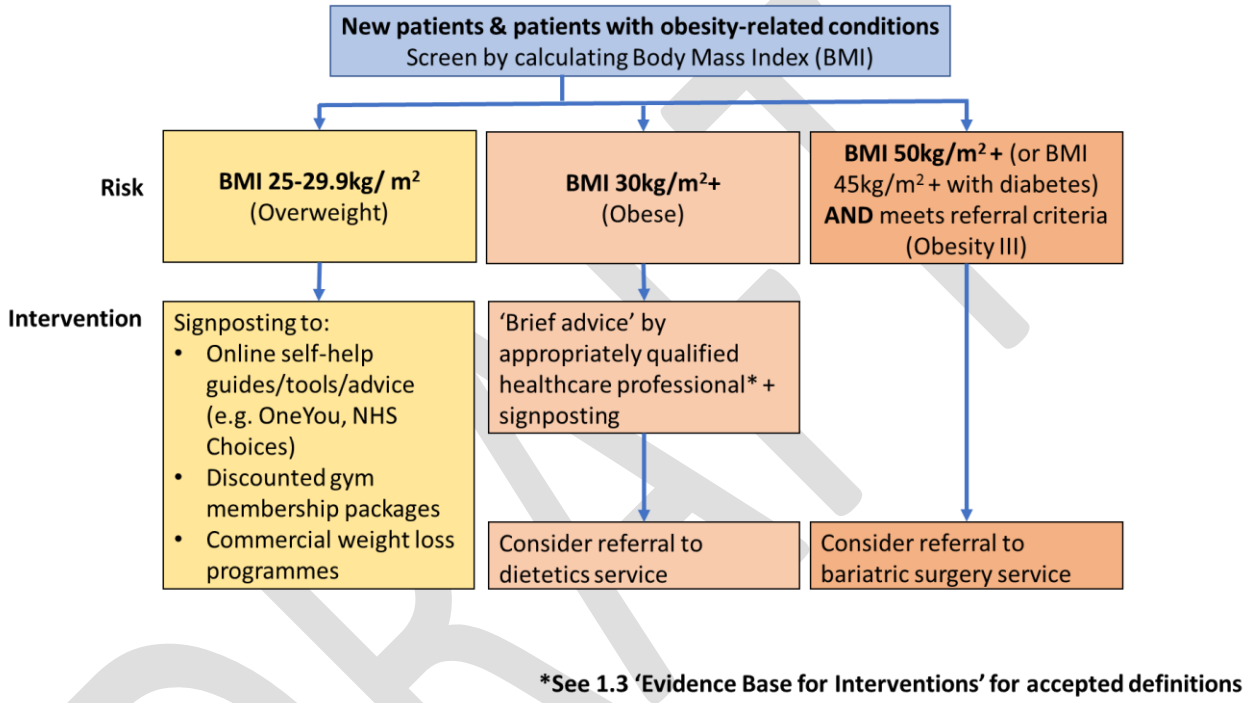


Figure 21 – Intervention to be carried out by practices, based on risk associated with obesity

- **Patients will have progress routinely monitored,** by an appropriate primary care professional, in reducing their weight to a low-risk level.

3.3 Population covered

- **Diabetes:** Any patient aged 18 or over registered with a Wolverhampton GP who is participating in this enhanced service.
- **Alcohol:** Any patient aged 16 or over registered with a Wolverhampton GP who is participating in this enhanced service.
- **Obesity**: Any patient aged 16 or over registered with a Wolverhampton GP who is participating in this enhanced service.

3.4 Any acceptance and exclusion criteria and thresholds

- **Acceptance criteria:** See 'Population covered'.
- **Exclusion criteria:** As in the national QOF scheme, 'exceptions' are patients who are on the disease register and who would ordinarily be included in the indicator denominator. However,

they are excepted from the indicator denominator because they meet at least one of the exception criteria (see Annex D of the Statement of Financial Entitlements for further details) (DHSC, 2017):

- Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the financial year to which the achievement payments relate.
- Patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances, for example, a patient who has a terminal illness or is extremely frail.
- Patients newly diagnosed or who have recently registered with the contractor who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels.
- Patients who are on maximum tolerated doses of medication, whose levels remain sub-optimal.
- Patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, contra-indication or have experienced an adverse reaction.
- Where a patient has not tolerated medication.
- Where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient.
- Where the patient has a supervening condition, which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease.
- Where an investigative service or secondary care service is unavailable.

Mechanisms for exception reporting will be confirmed during implementation.

3.5 Interdependence with other services/providers/programmes

The NHS Health Check programme

- **The NHS Health Check programme for the Wolverhampton area is commissioned by the Local Authority.**
- It provides a systematic mechanism for identifying and managing people with the common risk factors for cardiovascular disease, stroke, T2DM, kidney disease and dementia.
- **It has a focus on providing a structured approach to cardiovascular disease risk management, for those aged 40-74 who are not already on another disease register.**
- It offers personalised advice/treatment, an individually tailored management programme and behaviour change support, to help individuals manage their risk more effectively.
- **The NHS Health check programme aligns with both the national QOF scheme and our QOF+ scheme**, strongly supporting the achievement of several assessment and management indicators.
    - **Diabetes:** Collection of indicators needed for calculation of Leicester Risk Assessment/Leicester Practice Risk score (including ethnicity, BMI, waist circumference and opportunity to assess for potential hypertension)
    - **Alcohol:** Completion of AUDIT-C and opportunity to give brief advice.

- **Obesity:** Measurement of height/weight and calculation of BMI and opportunity to give brief advice.

The National Diabetes Prevention programme

- **The National Diabetes Prevention programme (NDPP) identifies those at the highest risk of developing T2DM and encourages referral to a structured educational programme.**
- The local provider of the programme is **Living Well Taking Control.**
- The core programme takes place over 7 weeks, with ongoing support for 12 months. Topics covered include eating a healthy diet, undertaking regular activity, achieving and maintaining a healthy weight, positive mental health and making healthy choices.
- The aims are to reduce the incidence of T2DM, reduce implications of complications associated with T2DM and reduce health inequalities in access/outcomes for those suffering from T2DM.
- **Referral criteria are** patients aged 18 and over **with** HbA1c 42 47 mmol/mol **OR** FPG 5.5-6.9 mmol/L ('pre-diabetes').
- **Patients currently access the programme in one of two ways:**
  - Opportunistic referral by GPs, in response to an eligible HbA1c/FPG blood test result;
  - GP practices searching clinical systems for eligible patients, then sending letters to patients asking them to contact the provider.
- The **QOF+ scheme aligns strongly with the NDPP**, incentivising referral of high risk patients with 'pre-diabetes' into intensive lifestyle interventions.
- **Access to the NDPP is currently supported by time-limited funding** – therefore local negotiations will inform future provision of this or equivalent services.

Local weight management services

- **Adult Weight Management Programmes have been decommissioned by the Local Authority from 31st December 2017.**
- Furthermore, the Healthy Lifestyles Team (providing access to health trainers) will be closing from 31st March 2018.
- **There are therefore no Tier 2 or Tier 3 weight management services for Wolverhampton from this point** – this is subject to ongoing discussion.
- Practices are advised to signpost individuals who are overweight/obese to self-help guides, tools and advice available online, such as through the One You website and NHS choices.
- Discounted gym/swimming membership packages are available from WV Active (owned by Wolverhampton City Council).
- Commercial weight loss programmes will need to be self-funded by individuals.
- **The Royal Wolverhampton NHS Trust dietetics service remains in place.**
  - Dietitians can work with patients to develop personalised eating plans, incorporating personal preferences and clinical conditions to optimise health and well- being.
  - Dietitians can also deliver group education and provide a cost-effective solution to optimising health for people with long term conditions e.g. diabetes, renal failure, coeliac disease.
  - Referral criteria are a BMI of >30kg/m^2 and a willingness to engage with services to make lifestyle changes.

- **The Tier 4 (bariatric surgery) service also remains** – commissioning policy/referral guidelines are unchanged.

Local alcohol services

TBC

3.6 Payment

Payment for participation in the scheme will be made as follows:

- **Level of payment made to practices will be dependent on the number of QOF+ points that they accrue, out of a total of 100 available points.** These are distributed between the QOF+ indicators, as detailed in '2.2 Locally defined outcomes'.
- **Award of points for each indicator will depend on achieving the threshold values.** Practices that achieve the threshold value for an indicator will be awarded the associated points.
- **Clinical facilitators will work with practices in-year, to set up the appropriate searches on clinical systems**, such that they can understand their level of achievement throughout the year and monitor/respond appropriately.
- **Measurement to determine final level of achievement will occur at the end of April 2019**, in line with the National QOF scheme. These end of year searches will be carried out remotely at the CCG, by means of the Graphnet system.
- As part of the reconciliation process, practices will have the opportunity to confirm reported figures that will inform payment.

3.7 Timescale and implementation

Following approval at Governing Body, practices will be given the opportunity to raise any queries and sign up for the scheme. Practices will be supported to implement the scheme effectively, including provision of relevant templates and protocols for clinical systems.

The sequence of events is summarised in the figure below:

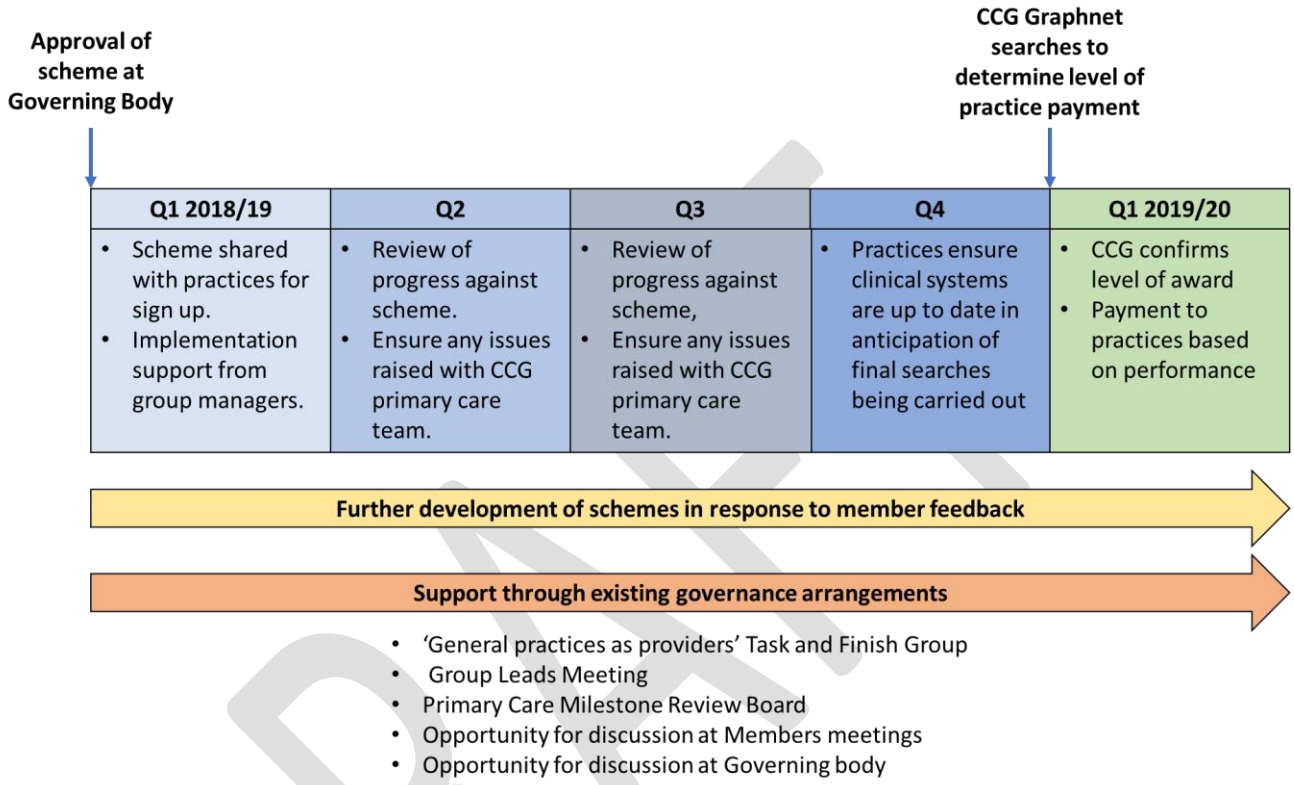


Figure 22 – Timescale of events for QOF+ scheme

4 Applicable service standards

4.1 Applicable national standards (e.g. NICE)

See reference list.

4.2 Applicable standards set out in guidance and/or issued by a competent body (e.g. Royal Colleges)

See reference list.

4.3 Applicable local standards

N/A

5 Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

See 3.6 'Payment'.

5.2 Applicable CQUIN goals

N/A

6 Location of provider premises

It is expected that the components of this scheme are likely to be provided at individual Wolverhampton GP member practices.

However, practices may wish to explore the feasibility of providing this service (or parts of it) at scale, through their own local agreement.

7 Individual service user placement

N/A

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Appendix 1 – Diabetes supporting materials

Read/SNOMED codes to be used

To be confirmed during implementation.

Supporting materials

The table below summarises the components of the Leicester Risk Assessment Score and the Leicester Practice Risk Score:

Table 3 Diabetes risk assessment methods, tools and questionnaires in scope

Name of assessment tool	Data collection method	Risk factors considered	Advantages	Disadvantages
Leicester Risk Assessment Score (LRA)	Self-assessment questionnaire.	■ Age ■ Ethnicity ■ Sex ■ Family history of diabetes ■ Treatment or history of hypertension. ■ Waist circumference ■ BMI	Designed for use with multi-ethnic UK population.	Self-assessment questionnaire requires patient presence for assessment
Leicester Practice Risk Score (LPRS)	Online software to enable automated calculation of risk scores using patient medical records.	■ Age ■ Ethnicity ■ Sex ■ Family history of diabetes ■ Treatment or history of hypertension. ■ BMI	Software provides spreadsheet to enable ranking of risk within practice (e.g. top 10%); does not consider waist measurement to enable use of existing information.	Information in patient records may be inaccurate.

The Leicester Risk self-assessment score is available from:

https://riskscore.diabetes.org.uk/start

The Leicester Practice Risk Score is available from:

https://www2.le.ac.uk/departments/health-sciences/research/biostats/downloads/risk-score-zip-file/view

Guidance for implementation of the Leicester Practice Risk Score is available from:

https://www2.le.ac.uk/departments/health-sciences/research/biostats/downloads/LPRSBackground.doc/view

An example output spreadsheet for the Leicester Practice Risk Score is available from:

https://www2.le.ac.uk/departments/health-sciences/research/biostats/downloads/SampleOutput.xls/view

Appendix 2 – Alcohol supporting materials

Read/SNOMED codes to be used

To be confirmed during implementation.

Supporting materials

The AUDIT-C and full AUDIT screening tool is available from:

https://www.alcohollearningcentre.org.uk/Topics/Latest/The-AUDIT-Alcohol-Consumption-Questions-AUDIT-C-An-Effective-Brief-Screening-Test-for-Problem-Drinking-/

Appendix 3 – Obesity supporting materials

Read/SNOMED codes to be used

To be confirmed during implementation.

Supporting materials

Training on delivering brief advice is available from:

- RCGP *Obesity and Malnutrition e-learning* Available at: http://www.rcgp.org.uk/learning/online-learning/ole/obesity-and-malnutrition.aspx
- World Obesity Federation *SCOPE Obesity e-learning* Available online at: https://www.worldobesity.org/scope/e-learning/