NHS
Wolverhampton
Clinical Commissioning Group

Primary Care Commissioning Committee (PUBLIC)

Tuesday 7th May 2019 at 2.00 pm

A G E N D A

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NHS
Wolverhampton
Clinical Commissioning Group

Equality Analysis Form

Name of Project/Review	**Quality Assured Spirometry**
Project Reference number	**UI 169**
Project Lead Name	**Claire Morrissey**
Project Lead Title	**Strategic Transformation Manager – LTC/ Frail Elderly**
Project Lead Contact Number & Email	**clairemorrissey@nhs.net** **01902 441774**
Date of Submission	
Version	**0.3**

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**

Who holds overall responsibility for the project/policy/ strategy/ service redesign etc
Primary Care
Who else has been involved in the development?
Black Country STP Respiratory Leads **RWT Respiratory Clinical Leads** **Primary Care Group leads – consultation on costing and service specification**

Equality Analysis Form

Section A - Project Details

Preliminary Analysis – *copy the details used in the scoping report*

Chronic obstructive pulmonary disease, or COPD, is a group of lung conditions including bronchitis and emphysema. They make it difficult to empty air from the lungs because the airways have been narrowed, this results in a difficulty in taking in oxygen and getting rid of carbon dioxide. Treatment is available for COPD to alleviate symptoms, but the damage done by the condition is irreversible making early diagnosis through spirometry important.

Spirometry measures the total amount of air that an individual can breathe out from their lungs and how fast they can blow it out. It is important that this procedure is carried out correctly to ensure that patients are diagnosed properly.

The Association for Respiratory Technology and Physiology (ARTP) are the guardians of quality-assured diagnostic spirometry in the UK. Training is available to those who are novices to this measurement and a certification system is used to ensure that those who undertake diagnostic spirometry are performing and interpreting the results to internationally acceptable standards.

The All Party Parliamentary Group (APPG) Report on inquiry into Respiratory Deaths (2014) called for a system to assess and certify the competence of all healthcare professionals undertaking and interpreting diagnostic spirometry. This document, which is part of a suite of resources relating to quality assured diagnostic spirometry, sets out a framework for taking forward the APPG recommendations.

Key to this framework is the establishment of a National Register of certified healthcare professionals and operators. This Register will ensure that commissioners, employers, and patients can be assured that healthcare staff performing and/or interpreting diagnostic spirometry hold a valid, current certificate of competence. The Care Quality Commission[1] expects practices to be able to demonstrate:

- How they ensure spirometry equipment is cleaned and maintained according to the manufacturer's guidance (KLOE S3 – reliable systems, processes and practices).
- That all staff who perform spirometry tests or interpret results are competent (KLOE E3 - staff skills, knowledge and experience). They can demonstrate this if the staff are on the National Register.

The ARTP are also responsible for holding the national register of spirometry certified practitioners.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

[1] https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-83-spirometry-general-practice

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.
Primary Care colleagues RWT Respiratory specialists Patients – aim to improve early diagnosis within primary care for patients living with a respiratory condition

Section B – Screening Analysis

Equality Analysis Screening
It is vital that the CCG ensures that it demonstrates that it is meeting its legal duty, as the responsible manager you will need to identify whether a Full Equality Analysis is required. A full EA will only not be required if none of the following aspects are identified and you are confident there is no impact. *E.g. 'This report is for information only' or 'The decision has not been made by the CCG' or 'The decision will not have any impact on patients or staff'. (Very few decisions affect all groups equally and this is not a rationale for not completing an EA.)*

Screening Questions	YES or NO
Is the CCG making a decision where the outcome will affect patients or staff? *For example will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.*	Yes
If the CCG is enacting a decision taken by others, e.g. NHS England or Local Authority - does it have discretion to change, modify or mitigate the decision?	Yes
Is the board/committee being asked to make a decision on the basis that this proposal will have a consequential effect on any change? e.g. Financial changes	Yes
Will this decision impact on how a **provider** delivers its services to patients, directly or indirectly?	Yes
Will this decision impact on any third parties financial position (i.e. Provider, Local Authority, GP Practices)? *For example are you removing funding from theirs or any contract?*	Yes
If you have answered **NO** to **ALL** the above questions, please provide supporting narrative to explain why none of the above apply.	

Equality Analysis Form

(Advice and guidance can be sought from the equality team if required).

If the answer to ALL the questions in the screening questions is "NO", please complete the below section only and do not complete a full assessment.

Please forward the form with any supporting documentation to Blackcountry.Equality@ardengemcsu.nhs.uk

These initial assessments will be saved and retained as part of the CCG's audit trail. These will also be periodically audited as part of the CCG's Quality Assurance process and the findings reported to the Chief Nurse, PMO Lead and the CCG's Governance team.

Please ensure you are happy with the conclusion you have made, advice and guidance can be sought from: David.king17@nhs.net or Equality@ardengemcsu.nhs.uk

Sign Off / Approval (Section A and B)

Title	Name	Date
Project Lead	Claire Morrissey	16/04/19
Equality and Inclusion Officer	David King	16/4/19
Equality and Inclusion Comments	As only staff who have been trained will be able to perform or interpret the assessments there is a potential for patient waiting times to be extended. CCG should work with providers to mitigate. The CCG will continue to commission direct access from RWT for patients in the interim whilst primary care undertake appropriate levels of accreditation.	

Programme Board Review		
Programme Board Chair		

If any of the screening questions have been answered "YES" then please forward your initial assessment to David.king17@nhs.net or Equality@ardengemcsu.nhs.uk

And complete the next section of the Equality Form Assessment, once you are ready to request approval of the change from the appropriate approval board.

If you required any support to complete the FULL Equality form, please contact the Equality Manager.

The Completed EA will then require a final sign off as per section 10.

Section C - Full Equality Analysis Section

If at an initial stage further information is needed to complete a section this should be recorded and updated in subsequent versions of the EA. An Equality Analysis is a developing document, if you need further information for any section then this should be recorded in the relevant section in the form and dated.

1. Evidence used *What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses*	
On the 12th September 2016 there was the launch of a competency assessment framework "Quality Assured Spirometry" (2016), and this document sets the minimum competency standards for healthcare practitioners performing spirometry. The ARTP spirometry qualifications are now the recognised competency assessment qualifications for all practitioners performing spirometry. The ARTP are now also responsible for holding the national register of spirometry accredited practitioners at all levels. The framework will be phased in commencing 1st April 2017 with full implementation by 31st March 2021.	
Corporate Assurance Impact	
State overarching, strategy, policy, legislation this review or service change is compliant with	All Party Parliamentary Group on Respiratory Health, 2014. *Report on inquiry into respiratory deaths.* London: Crown. PCC-CIC, 2016. *Improving the quality of diagnostic spirometry in adults: the National Register of certified*

Equality Analysis Form

1. Evidence used *What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses*	
	professionals and operators. London: PCC-CIC. https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-83-spirometry-general-practice
Will this review or service change fit with the CCGs Boards Assurance Framework Aim and Objectives? If yes, please indicate which ones *(see notes page for guidance)*	Improving the quality and safety of the services we commission Reducing health inequalities in Wolverhampton: • Improve and develop primary care in Wolverhampton • Deliver new models of care that support care closer to home and improve management of Long term conditions System effectiveness delivered within our financial envelope • Proactively drive our contribution to the Black Country STP • Continue to meet our Statutory Duties and responsibilities • Deliver improvements in the infrastructure for health and care across Wolverhampton
What is the intended benefit from this review or service change?	Improve early diagnosis, and therefore proactive management of respiratory conditions
Who is intended to benefit from the implementation of this review or service change?	Patients, primary care
What are the key outcomes/ benefits for the groups identified above?	• Increase the number of patients who are on a primary care respiratory register • Increase the number of patients with an agreed care plan • increase the number of people who report feeling supported to manage their condition

Equality Analysis Form

1. Evidence used *What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses*	
	• increase the number of patients living with respiratory conditions receiving flu/ pneumonia vaccines • increase the number of smokers with LTCs offered support and treatment • Reduction in hospital ED attendances for non-acute respiratory conditions through improving patient knowledge of self-management • Reduction in readmission rate for long term respiratory conditions • improve the number of patients completing pulmonary rehabilitation • improve hospital capacity to manage acutely unwell or high risk respiratory patients • improved access to community respiratory services • reduction in respiratory clinical pathway variations to improve clinical outcomes • reduction in morbidity and mortality rate related to respiratory conditions
Will the review or service change meet any statutory requirements, outcomes or targets?	Yes – NICE, NHS Outcomes Framework Domains: • Enhancing quality of life for people with long term conditions • Ensuring people have a positive experience of care

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*
2.1 Age *Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.*

2. Impact of decision

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.

YES

Sub-National Population Projections show that Wolverhampton's population is changing. The older population (age 65 years and over) is predicted to increase over the next 10 years both locally and nationally. Projections estimate Wolverhampton's population in 2037 as 273,300 with growth being most rapid in the older populations. The estimates show:

- The number of people aged 65 years or older in Wolverhampton is projected to grow from 41,400 in 2012 to 59,900 in 2037: a gain of 18,500 (44.7% growth). The number aged 85 years or older is shown to grow by 6,200 (106.9% growth), from 5,800 in 2012 to 12,000 in 2037.

The Department of Health estimates that there will be a 30% increase in the number of people with three or more long term conditions between 2010 and 2020. The amount that we spend on health and social care for people with long term conditions is set to increase.

In Wolverhampton Information extracted from primary care clinical systems currently indicates there are approximately 82,000 adults aged 18 and over (approximately 31% of total population) that are currently registered on a chronic condition register which equate to nationally derived QOF cohort counts (including diabetes, asthma, heart disease, lung disease, dementia, stroke and arthritis) and an increasing number will develop these conditions as they grow older.

Figures published by the British Lung Foundation indicate that, particularly for COPD, people living with a diagnosis are mostly over the age of 40, with the proportion of people increases markedly with advancing age.

Respiratory services particularly for COPD are predominantly 'adult' services aged 18 and over.

Regarding diagnosis of Asthma; the BTS and NICE are due to release joint guidelines in the summer of 2019. Locally, Wolverhampton, upon clinical advice from Acute and Primary Care respiratory specialists, have adopted BTS guidelines, and will continue to do so until the aforementioned joint guidelines are released.

BTS/SIGN guidelines recommend that Spirometry, with bronchodilator reversibility is the preferred investigating test for patients with **Intermediate** probability of asthma. For the purposes of primary care registers, QOF also requires a prescription within 12 months of diagnosis.

Through primary care data extracts, it is not possible to extract numbers of new diagnosis that were considered to be of intermediate probability, and therefore requiring spirometry with bronchodilator reversibility.

Equality Analysis Form

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*
The provider will perform the diagnostic spirometric test upon appropriate request to children and younger people (where possible) from the age of 5+ living where the provider is querying **intermediate** probability of Asthma **Positive Impact** – improve quality of care for patients
2.2 Disability *Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/learning disabilities, cognitive impairments.*
It is unlikely that the programme will have an adverse impact on disability, Respiratory conditions are recognised as Long Term Conditions.
2.3 Gender reassignment (including transgender) *Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.*
It is unlikely that the programme will have an adverse impact on gender reassignment (including transgender)
2.4 Marriage and civil partnership *Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.*
It is unlikely that the programme will have an adverse impact on marriage and civil partnership
2.5 Pregnancy and maternity *Describe any impact and evidence in relation to Pregnancy and Maternity. This can include working arrangements, part time working and caring responsibilities.*
It is unlikely that the programme will have an adverse impact on pregnancy and maternity
2.6 Race *Describe race-related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures and language barriers.*
It is unlikely that the programme will have an adverse impact on race, however it is important to note that when we look at our patient demographics for those patients that are registered on a primary care COPD QOF register, we know from local data, that 78% of patients are white/ Caucasian.
2.7 Religion or belief *Describe any impact and evidence in relation to religion, belief or no belief on service delivery or patient experience. This can include dietary needs, consent and end of life issues.*

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*
It is unlikely that the programme will have an adverse impact on religion or belief
2.8 Sex *Describe any impact and evidence in relation to men and women. This could include access to services and employment.*
It is unlikely that the programme will have an adverse impact on sex
2.9 Sexual orientation *Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.*
It is unlikely that the programme will have an adverse impact on sexual orientation
2.10 Carers *Describe any impact and evidence in relation to part-time working, shift-patterns, general caring responsibilities. (Not a legal requirement but a CCG priority and best practice)*
It is unlikely that the programme will have an adverse impact on Carers
2.11 Other disadvantaged groups *Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the CCG in meeting its legal duties to identify and reduce health inequalities.*
It is unlikely that the programme will have an adverse impact on other disadvantaged groups

3. Human rights *The principles are Fairness, Respect, Equality, Dignity and Autonomy.*				
Will the proposal impact on human rights?	Yes	☐	No	☑
Are any actions required to ensure patients' or staff human rights are protected?	Yes	☐	No	☐
If so what actions are needed? *Please explain below.*				

3. Human rights
The principles are Fairness, Respect, Equality, Dignity and Autonomy.

4. How will you measure how the proposal impacts health inequalities?

The CCG has a legal duty to identify and reduce health inequalities.

e.g. patients with a learning disability were accessing cancer screening in substantially smaller numbers than other patients. By revising the pathway the CCG is able to show increased take up from this group, this a positive impact on this health inequality.

- Increase of the number of patients who are on a primary care respiratory register
- Increase the number of patients with an agreed care plan
- increase the number of people who report feeling supported to manage their condition
- increase the number of patients living with respiratory conditions receiving flu/ pneumonia vaccines
- increase the number of smokers with LTCs offered support and treatment

5. Engagement/consultation
What engagement is planned or has already been done to support this project?

Engagement activity	**With who?** *e.g. protected characteristic/group/community*	**Date**
Meetings	Group Leaders/ Clinical Reference Group	Jan – Mar 19

Please summarise below the key finding / feedback from your engagement activity and how this will shape the policy/service decisions e.g. patient told us, so we will… (If a supporting document is available, please provide it or a link to the document)

This is a national policy/ service changed as agreed with the All Party Parliamentary Group on Respiratory Health, who have recommended that Health Education England work with professional bodies such as the Primary Care Respiratory Society (PCRS) and the British Thoracic Society (BTS) and NHSE to ensure consistent standards of training and competency assessment for all healthcare professionals treating people with respiratory conditions.

6. Mitigations and changes
If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over the counter medication. It was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore an exception is provided for this group which has resolved the issue.

As only staff who have been trained will be able to perform or interpret the assessments there is a potential for patient waiting times to be extended, whilst primary care are able to deliver the service at scale.

CCG should work with providers to mitigate.

The CCG will continue to commission direct access from RWT for patients in the interim whilst primary care undertake appropriate levels of accreditation.

7. Is further work required to complete this EA?
Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)

Work needed	Section	When	Date completed
e.g. Further engagement with disabled service users to identify key concerns around using the service.	*2 - Disability*	*June to July'17*	*September 2017*

8. Development of the Equality Analysis
If the EA has been updated from a previous version please summarise the changes made and the rationale for the change, e.g. Additional information may have been received – examples can include consultation feedback, service Activity data

Version	Change and Rationale	Version Date
0.1	Initial EA	16/04/19
0.2	Full EA	17/04/19
0.3	Amended Full EQIA	30/04/19

9. Preparation for Sign off

	Please Tick
1) Send the completed Equality Analysis with your documentation to Equality@ardengemcsu.nhs.uk and David.king17@nhs.net for feedback prior to Executive Director (ED) sign-off.	

9. Preparation for Sign off	
2) Make arrangements to have the EA put on the appropriate programme board agenda	
3) Use the Action / version section to record the changes you are intending to make to the document and the timescales for completion.	

10. Final Sign off The Completed EA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process. The completed form should also be sent to PMO so that the CCG can maintain an up to date log of all EAs.	
Version approved:	

Designated People
Project officer* (Senior Officer responsible including action plan) Name: Date:
Equality & Inclusion Review and Quality Assurance Name: David King Date: 30/4/19
Executive Director Review: Name: Date:
Name of **Approval Board** (*e.g. Commissioning Committee; Governing Body; Primary Care Commissioning Committee*) at which the EA was agreed at: Approval Board: Approval Board Ref Number: Chair: Date: Comments: Actions from the Approval Board to complete:
Review date for action plan (section 7):

BOARD ASSURANCE FRAMEWORK NOTES

(Please **DELETE** before submission)

Following a review of the BAF, it will now be based on the risks associated with the CCG achieving its strategic aims and objectives as follows:-

Strategic Aims	Strategic Objectives
1. Improving the quality and safety of the services we commission	a. Ensure on-going safety and performance in the system 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	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
3. System effectiveness delivered within our financial envelope	a. Proactively drive our contribution to the Black Country STP Play a leading role in the development and delivery of the Black Country STP to support material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country footprint. b. Greater integration of health and social care services across Wolverhampton Work with partners across the City to support the development and delivery of the emerging vision for transformation; including exploring the potential for an 'Accountable Care System.' c. Continue to meet our Statutory Duties and responsibilities 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 d. Deliver improvements in the infrastructure for health and care across Wolverhampton 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.