NHS
Wolverhampton
Clinical Commissioning Group

Primary Care Commissioning Committee (PUBLIC)

Tuesday 7th May 2019 14:00-15:30
PA125 Stephenson Room, 1st Floor, Wolverhampton Science Park WV10 9RU

A G E N D A

Item No.	Item	Lead	Page Nos
1	**Welcome and Introductions**	Chair	Verbal
2	**Apologies**	Chair	Verbal
3	**Declarations of Interest**	Chair	Verbal
4	**Minutes of the meeting held on 2 April 2019**	All	1 - 8
5	**Matters Arising from previous Minutes**	Chair	Verbal
6	**Committee Action Points**	Chair	9 - 10
7	**Primary Care Update Reports**		
7a	Primary Care Quality Report	Liz Corrigan	11 - 32
7b	Primary Care Operational Management Group Update	Mike Hastings	33 - 40
7c	Primary Care Contracting Update	Gill Shelley	Verbal
7d	Primary Care Strategy Update	Steven Marshall	Verbal
8	**Discussion Items**		
8a	Primary Care GP Networks & DES (Map to be tabled)	Sarah Southall	41 - 110
8b	Spirometry Service - Business Case, Service Spec, Approved QIA,EIA (A-C) & DPIA	Sarah Southall	111 - 170
8c	Financial Position Q4 2018/19	Tony Gallagher	171 - 178
9	**Any Other Business**		
10	**Date of Next Meeting – Tuesday 4th June 2019 14:00** **PA025 Marston Room, University of Wolverhampton, WV10 9RU**		

This page is intentionally left blank

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 2 April 2019 at 2.00pm
PA025 Marston Room, Technology Centre, Wolverhampton Science Park WV10 9RU

MEMBERS ~

Wolverhampton CCG ~

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

NHS England ~

Bal Dhami	Contract Manager	No

Independent Patient Representatives ~

Sarah Gaytten	Independent Patient Representative	No

Non-Voting Observers ~

Tracy Cresswell	Wolverhampton Healthwatch Representative	No
John Denley	Director of Public Health	Yes
Jeff Blankley	Chair of Wolverhampton LPC	Yes

In attendance ~

Dr Helen Hibbs	Accountable Officer (WCCG)	Yes
Mike Hastings	Director of Operations (WCCG)	Yes
Liz Corrigan	Primary Care Quality Assurance Coordinator (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

Welcome and Introductions

WPCC485 Ms McKie welcomed attendees to the meeting.

Apologies

WPCC486 Apologies were submitted on behalf of Dr M Kainth, Dr B Mehta (LMC), Tracy Cresswell (Healthwatch) and Sarah Gaytten.

Declarations of Interest

WPCC487 Drs Bush and Reehana declared that as a GP they had a standing interest in all the items relating to primary care.

Ms McKie declared that in her role for Walsall and Wolverhampton on the Child Death Overview Panel, she has a standing interest in all items related to Primary Care.

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

Minutes of the Meeting held on the 5th March 2019

WPCC488 The minutes of the meeting held on 5 March 2019 were agreed as an accurate record.

RESOLVED: That the above was noted.

Matters Arising from the Minutes

WPCC489 There were no matters arising from the minutes.

RESOLVED: That the update was noted.

Committee Action Points

WPCC490 **Minute Number WPCC452 Primary Care Strategy Update.** A verbal update to be provided to today's meeting (WPCC494). Report to be submitted to the May meeting.

Minute Number WPCC468 Primary Care Networks. A report was presented to today's meeting (WPCC496)

Primary Care Quality Report

WPCC491 Ms Corrigan presented the report, providing an overview of activity in primary care. The following points were noted:-

- Further to a request from Quality & Safety Committee (QSC), next month's report will be presented in a dashboard format with more focus on data, highlighting trends and themes.
- A new practice infection prevention audit cycle was beginning, which would enable a comparison with 2018/19 ratings.
- Ron Daniels, Chief Executive of the Sepsis Trust had attended a well received session at Team W. A steering group involving relevant professionals had been established to improve sepsis diagnosis and

prevention work across primary care and care homes.

- It was noted that the team was monitoring one primary care serious incident. A Root Cause Analysis (RCA) was being undertaken prior to review at the Practice & Performer Intelligence Gathering Group (PPIGG).
- Quality matters was now up to date and issues viewing the Quality Matters (QM) inbox had been resolved
- Quarter 3 complaints data had been received from NHSE, showing that clinical issues and staff attitude were the most common themes, in line with previous data. Conflict resolution/customer care training for practice staff had been implemented in response.
- The uptake of Friends & Family Test for March 2019 was the best so far, partially due to the use of MJog text messaging. An anomaly was noted in the data this month which has been reviewed and correct figures will be circulated. A question was asked if it was possible to identify if responses were received from the same person more than once and it was confirmed this was not possible.
- Meetings in relation to developing a regional primary care training hub have been held with Kathrine King (Health Education England (HEE) Training Hub Lead). Funding is being provided at an STP level and a task and finish group is being established to develop a Training Academy.
- A successful GP Intensive Support Event had been held at the Molineux on 27th March. This highlighted work being done to retain GP trainees in the Black Country and offer alternative options for those wanting to retire or reduce their workload.
- A question was asked about what the numbers in the Workforce Numbers chart represented and it was confirmed these were full time equivalent posts in Primary Care.
- Reports from Public Health demonstrated that 66.9% of over 65 year olds had received the flu vaccination, which was slightly less than last year partially as a result of issues with the supply of vaccine. It was also noted that Wolverhampton had seen the highest increase in the rate of child flu uptake, which reflected the success of the marketing work undertaken.

RESOLVED:

1) **That the updated Friends and Family Test figures will be circulated.**
2) **That the update be noted.**

Primary Care Operational Management Group Update

WPCC492 Mr Hastings presented the Primary Care Operational Management Group Update from that group's March meeting. Points to note included:-

- The Rosevillas branch site closure had been completed. It was confirmed that the practice was not using the building for back office.
- The national NHS App is to go live on 17th June 2019. This shared app brings together multiple provision that patients can access.

- The Newbridge ETTF development will be completed in May and the planning issues at East Park are in the process of being resolved.
- Due to a change in funding arrangements, 100% rent reimbursements may be available in the future. Development of Alfred Squire practice is being considered.
- Primary Capital Horizons (PCH) are conducting an estates gap analysis following on from the six-facet survey which was conducted on Wolverhampton estate in 2014.
- The group had considered a proposal that the GP Forward View (GPFV) programme of work be aligned across the STP and recommended to the committee to progress on this basis.

RESOLVED:

1) **That the proposal to align the GP Forward View programme of work across the STP be approved by the committee.**
2) **That the update be noted.**

Primary Care Contracting Update

WPCC493 Ms Shelley provided an update on primary care contracting to the committee. The report highlighted a contract change at Woden Road Surgery where Dr Jones had come off the contract as a partner but remained as a salaried GP.

She also advised that the new APMS Contracts had been mobilised by the new providers on 1 April 2019. The transition from the old providers to the new providers appeared to have gone smoothly but a full update would be provided to the committee in May.

RESOLVED: That the update was noted.

Primary Care Strategy Update

WPCC494 Mr Marshall provided a verbal update.

A workshop had taken place to develop a vision of where Primary Care needed to be, based on the 10-year plan and 5-year forward view. The CSU have been commissioned to develop a draft strategy based on the outcome of this session by the end of May.

Following this there will be a period of engagement with GPs, public and patients after which a 2 year plan (on a rolling refresh) will be produced. This would feed into the development of the STP Primary Care strategy (completion expected by end June) for submission to NHS England in Autumn.

RESOLVED: That the update was noted

QOF+ 2019/20

WPCC495 Mrs Southall provided a verbal update, highlighting that the 2018/19 QOF had closed and work was taking place to reconcile activity to allow payments to be confirmed.
A Draft scheme for 2019/20 would be available by the end of April for the committee to consider in May 2019. Scheme value increases from £1.2m to £2.1m in 2019/20 and includes alcohol, diabetes & obesity being carried forward. Additions include hypothyroidism, COPD and asthma, as well as a group of quality indicators comprising of SMI & LD health checks, Dementia diagnosis rates & bowel cancer screening.

In response to a question about cervical screening, Mrs Southall confirmed this was now included in QOF. It was felt that some collaborative work could be done to improve the uptake of screening and earlier detection rather than patients presenting much later.

RESOLVED: That the update was noted

Primary Care Networks

WPCC496 Mrs Southall presented the report, which provided an update on the requirements for GP Practices to establish formal Primary Care Networks (PCN) giving timelines for the process that had been established at STP level. The process enables a consistent approach to be adopted across all 4 CCGs.

A Members Meeting was taking place on 4 April 2019 with the aim of confirming the outline geographies for each network and to discuss the DES in more detail. Following this, formal applications for the establishment of the networks would be made and considered by a panel comprising of the committee Chair, Executive Nurse, The Directors of Strategy and Transformation and Operations, Head of Primary Care, Corporate Operations Manager and a Local Medical Committee representatives. A further update will be provided at the next meeting.

The CCG needs to ensure that the whole CCG area is covered, which will be different to current GP area maps. Funding for roles in the PCNs will be based on patient headcount and there are slightly different arrangements for roles already employed in general practice and those commissioned elsewhere. It was noted that this particularly applied to social prescribing and there was an offer from Public Health to assist with developing this service with a workshop planned for May 2019. The current service in the City was partially funded by the Department of Health with CCG match funding.

RESOLVED: That the update was noted

Delegated Commissioning: Audit Report & Action Plan

WPCC497 Ms Shelley presented the action plan following the CCG's Internal Audit Report 2018/19 for Delegated Commissioning.

The audit rated us as low risk with a recommendation that practice patient list sizes are presented to Primary Care Operational Management Committee (PCOMG) on a quarterly basis. It was agreed figures would be presented on the Primary Care Dashboard.

There was also one implication/recommendation to regularly assess practices on quality, safety and performance.

A Primary Care dashboard, now in draft form, is to be developed to report both of the above to Primary Care Operational Management Group (PCOMG) and will assist in identifying practices to be targeted for visits alongside a random visiting plan approach.

RESOLVED: That the update was noted

Black Country GP Nursing Strategy

WPCC498 Mrs Corrigan presented the General Practice Nursing (GPN) Strategy Report and supporting documents. The aim being to provide a forward view for general practice/primary care nursing for the Black Country. Supporting documents included:-

- A career progression framework aligned to the HEE career and education framework for GPNs
- A competency framework based on the RCGP GPN framework
- An induction and preceptorship framework based on existing programmes e.g. Capital Nurse

The strategy had built on work undertaken in Walsall and received input from all CCGs, Nursing Staff and GP Practices. The frameworks include guidance on competency and induction for practice nurses as well as information on education and career development. As the frameworks are relatively lengthy documents, consideration is being given to the development of a website for ease of reference.

The frameworks were intended to be used by nurses across the lifespan of their career by standardising and defining nurse roles across primary care. The skills frameworks were based on the Royal College of General Practitioners (RCGP) toolkit with additional sections including learning disabilities, mental health, end of life and frailty.

The committee recognised the hard work undertaken by Mrs Corrigan to develop the strategy.

RESOLVED: That the committee endorse the General Practice Nursing Strategy.

Any Other Business

WPCC499 Mrs Southall advised that the NHS Benchmarking Network had produced a Primary Care 2018 report which would be presented to the May meeting of the committee.

Date of Next Meeting

WPCC450 **Tuesday 7th May at 2.00pm in PA125 Stephenson Room, 1st Floor, Technology Centre, University of Wolverhampton Science Park WV10 9RU**

This page is intentionally left blank

Primary Care Commissioning Committee Actions Log (Public)

Action No	Date of meeting	Minute Number	Item Title	Item	By When	By Whom	Action Update
30	05 February 2019	WPCC452	Primary Care Strategy Update	Primary Care Strategy Update to be presented to the committee Apr 19 for consideration.	May-19	Steven Marshall	02/04/19: A verbal update was provided 26/03/19: Verbal update to be provided at the April meeting. Final Strategy to be presented in May.
31	05 March 2019	WPCC468	Primary Care Networks	An Update on the development of the Primary Care Networks be shared when further guidance is available	Apr-19	Sarah Southall	02/04/19: A report was presented to committee 26/03/19: Primary Care Networks report included in within the April agenda.
32	02 April 2019	WPCC491	Primary Care Report	Revised Friends & Family Test figures to be circulated following today's meeting	Apr-19	Liz Corrigan/Diane North	08/04/19: Revised FFT data circulated to members via email
33	02 April 2019	WPCC496	Primary Care Networks	New geographical areas and DES to be discussed at Members meeting 03/04/19. Further update to be provided at next meeting	May-19	Sarah Southall	
34	02 April 2019	WPCC497	Audit Report & Action Plan	Practice patient list sizes to be presented quarterly on the Primary Care Dashboard	Quarterly	Gill Shelley	
35	02 April 2019	WPCC499	NHS Benchmarking Network – Primary Care 2018	Report on NHS Benchmarking Network to be provided to next committee	May-19	Sarah Southall	

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

PRIMARY CARE COMMISSIONING COMMITTEE
7th May 2019

TITLE OF REPORT:	Primary Care Report
AUTHOR(s) OF REPORT:	Liz Corrigan
MANAGEMENT LEAD:	Yvonne Higgins
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
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	
3. System effectiveness delivered within our financial envelope	

PRIMARY CARE QUALITY DASHBOARD

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

Date:				
Issue	**Highlights for March 2019**	**Highlights for April 2019**	**Areas of concern**	**RAG rating**
Infection Prevention	Four IP audit have been undertaken in late February early March– the overall average rating is silver. The flu vaccination programme is now complete for 2018/19, some flu outbreaks have been noted in care homes. Work continues to drive the improvement in the management of sepsis in primary care.	New IP audit cycle has not yet commenced; comparison with 2018/19 figures will be made this year. Flu planning group will meet to plan the 19/20 season and training is booked. Work on e-coli reduction continues with IP, meds optimisation and continence teams. Training planned for November.	Some practices have no identified sepsis lead – awareness raising via the e-coli group will continue.	1a
MHRA	Since 1st April 2018 • 51 weekly field safety bulletins with all medical device information included. • 5 device alerts/recalls • 16 drug alerts/recalls	Since 1st April 2019: • Field safety notices - 1 • Drug alerts – 3 • Device alerts - 0	None flagged at present	1a
Serious Incidents	One serious incident currently under investigation at the practice	One serious incident is currently being reviewed by scrutiny group. A second near miss has been identified.	Both incidents have been reviewed at practice level and will be reviewed by scrutiny group and PPIGG.	1b
Quality Matters	Currently up to date: • 10 open • 3 of these are overdue	Currently up to date: • 14 open • 4 of these are overdue	Overdue issues are being chased and have been escalated to Locality Managers. Main themes are: • IG breaches • Prescribing issues • Referral issues	1b

			These are being addressed by appropriate teams at the CCG and trust that has raised the issue.	
Practice Issues	Issues relating to DocMan, and maternity discharges are being managed.	DocMan issues are now closed. Awaiting a date for a meeting re: maternity discharges	To continue to work with practice to arrange a date.	1b
Escalation to NHSE	On-going process	Awaiting QM responses and scrutiny of RCA to refer cases into PPIGG	QM responses have been chased and escalated to Locality Managers	1b
Complaints	Six complaints received by NHSE in Quarter 3	Awaiting Quarter 4 complaints report from NHSE	No concerns flagged at present, awaiting Q4 data to gauge success of conflict resolution training commissioned following Q2 report.	1a
FFT	In February 2019 • 1 practice did not submit • 4 submitted fewer than 5 responses (supressed data)	In March 2019 • 3 practices did not submit • 3 practices submitted fewer than 5 responses • 1 practice submitted a zero response	Continue to monitor via the FFT policy with support from LMC. Trends around "would" and "would not recommend" will be discussed with the Locality Managers.	1a
NICE Assurance	NICE assurance is now linked to GP Peer Review system – next meeting due in May	NICE assurance meeting was held in March. 11 new guidelines were identified as relevant for primary care.	NICE guidance continues to be monitored via peer review.	1a
CQC	One practice currently have a Requires Improvement rating and is being supported with their action plan.	One practice currently has a Requires Improvement rating and is being supported.	To continue to monitor and work with CQC to support practices	1b
Workforce Activity	Work around recruitment and development for all staff groups including new roles continue	Retention programme information has been written up and work streams identified Apprenticeship programmes are up and running with HCAs in place and NAs expressing an interest Work has commenced around recruitment of overseas professionals currently resident in UK	None flagged at present	1a

Training and Development	Spirometry training, Nursing Associate and HCA apprenticeship programmes now up and running. Practice Nurse Strategy and documents for submission to Primary Care Commissioning Committee. Training for nurses and non-clinical staff continues as per GPFV	GPN strategy document approved awaiting STP wide approval at Clinical Leads Group Diabetes training being planned with input from WDC and Foot Health	None flagged at present	1a
Training Hub Update	Training Hub work continues across the Black Country. HEE have been reviewing the role and function of the Training Hubs in light of the re-procurement process. Risk identified and logged on register.	Training Hub meeting due to be held in late April to discuss role and function going forward.	To continue monitoring, risk remains open.	2

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.

1. PATIENT SAFETY

1.1. 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%

Figure 1: Infection Prevention Audits.

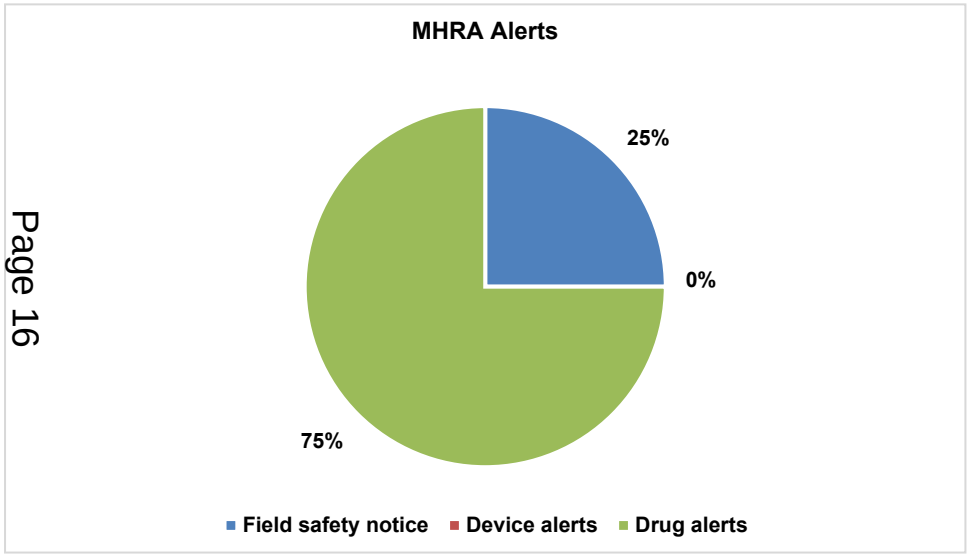
Ratings overview and issues identified within primary care:	Exceptions and assurance:
The cycle for 2019/2020 has yet to start, further update at next month's meeting	Work will continue with RWT IP team.

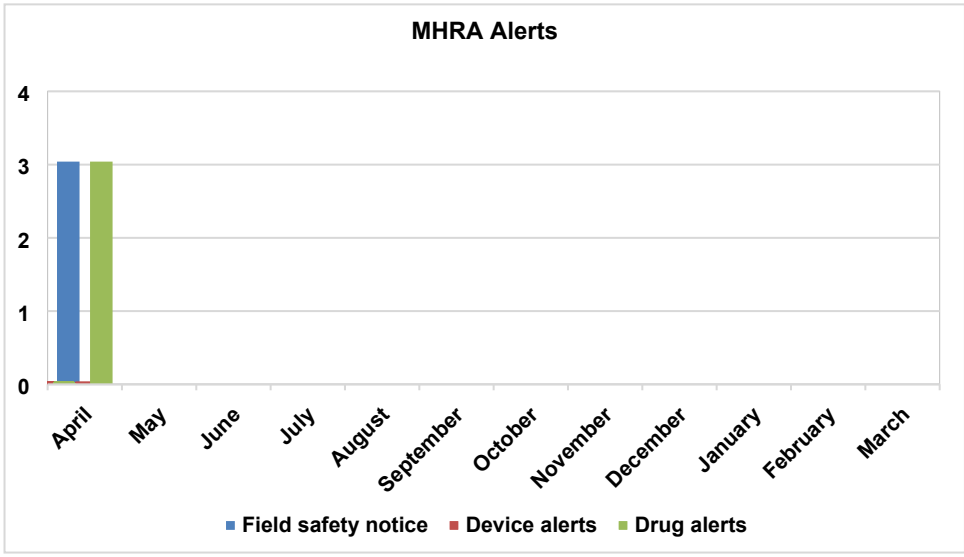
MRSA Bacteraemia No CCG cases noted up to February 2019	No areas of concern to report.
Influenza vaccination programme Flu planning group to re-convene in May 2019. Training is booked c/o Black Country Training Hub in July 2019 with further sessions across the region in August and September. Flu vaccine ordering information requested from practices, some orders are low compared to cohort – to address via flu planning group	To discuss vaccine ordering at flu planning group
Sepsis Additional work has been carried out to identify sepsis leads in primary care, and to ascertain if practices have access to pulse oximetry and what their safety netting and escalation processes are. Practice nurse and GP representation is now available in the e-coli steering group.	No areas of concern to report.

Training for practice nurses is being planned for November 2019.	

1.2. MHRA Alerts

Figure 2: MHRA Alerts from April 1st 2019





Areas for concern.

No areas of concern to report.

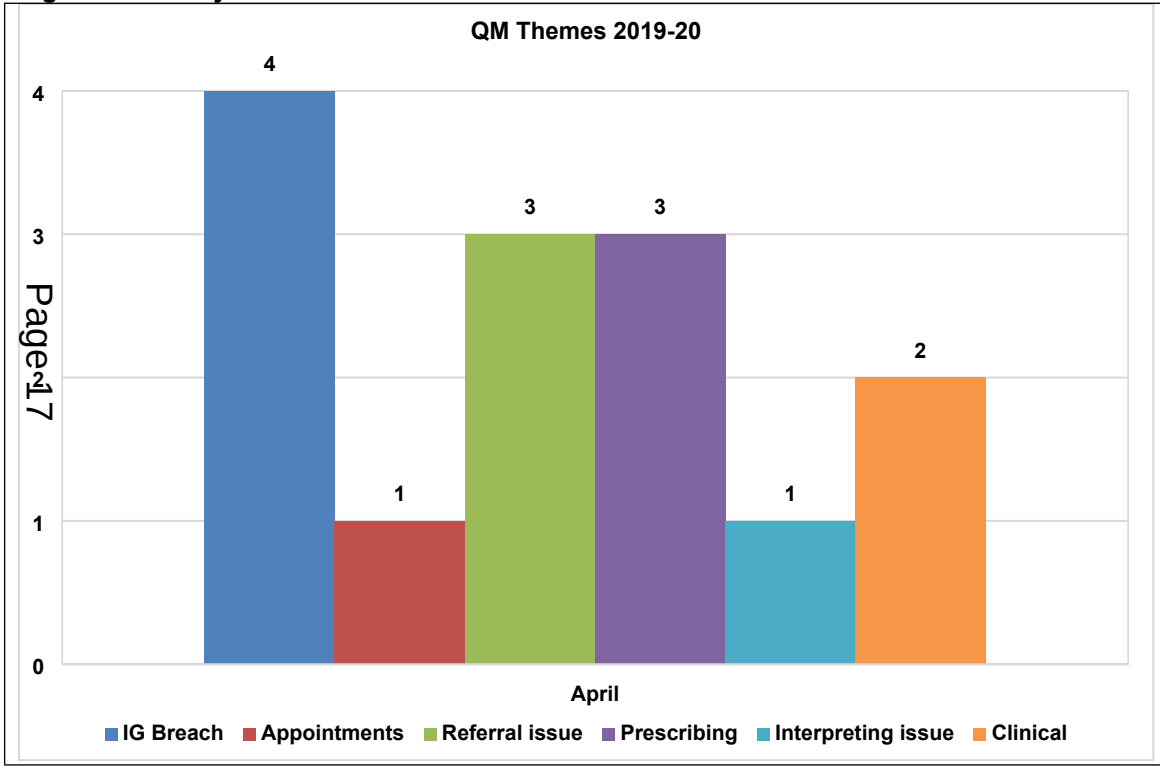
1.3. Serious Incidents

1 Serious Incident currently being reviewed in Primary Care, Final RCA submitted for scrutiny.

1 near miss identified, for review of significant event analysis undertaken by practice and referral to PPIGG.

1.4. Quality Matters

Figure 3: Quality Matters Status 2019/20 and Variance



Monthly Variance	April	Total	Percentage
New issues	4	4	29%
Open issues	6	6	43%
Overdue issues	4	4	29%
Closed issues	0	0	0%
	14	14	100%

1.5. Escalation to NHS England

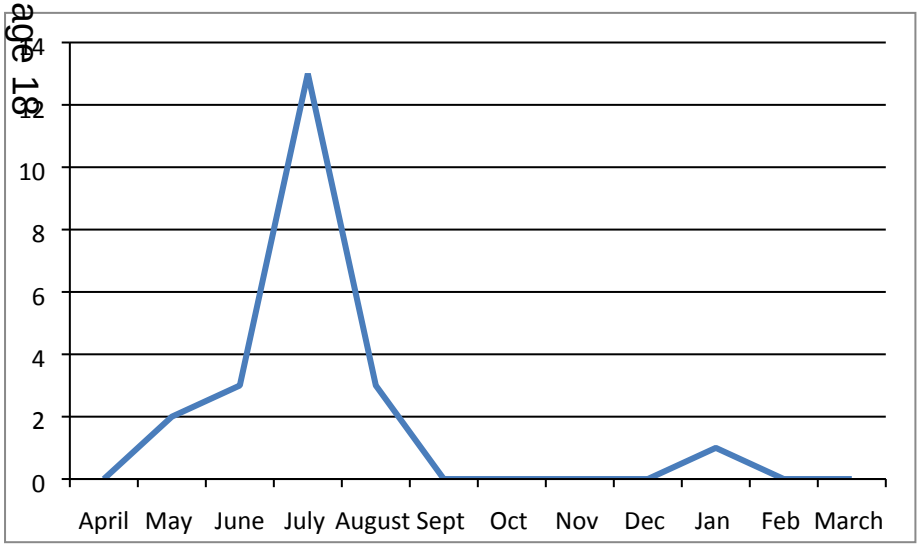
Escalation to Practice and Performance Information Gathering Group (PPIGG) NHSE

Incidents submitted for review April 2019	Outcome from PPIGG
No incidents reported for March	N/A
Exceptions and assurances:	
Nothing to report at present.	

2. PATIENT EXPERIENCE

2.1 Complaints

Figure 4: Complaints Data



Complaints Numbers and Themes:
An overview was provided in the January report. Quarter 3 Information shows:

Six complaints were logged with NHSE between October and December 2018.
Two were not upheld (33%)
Three were partially upheld (50%)
One was upheld (17%)

Themes were:

- Refusal to refer (8%)
- Communication between practice and patient/carer (15%)
- Clinical treatment (including errors) (31%)
- Appointment availability (15%)
- Staff attitude and behaviour (15%)
- Prescription issues (8%)
- Inappropriate treatment (8%)

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

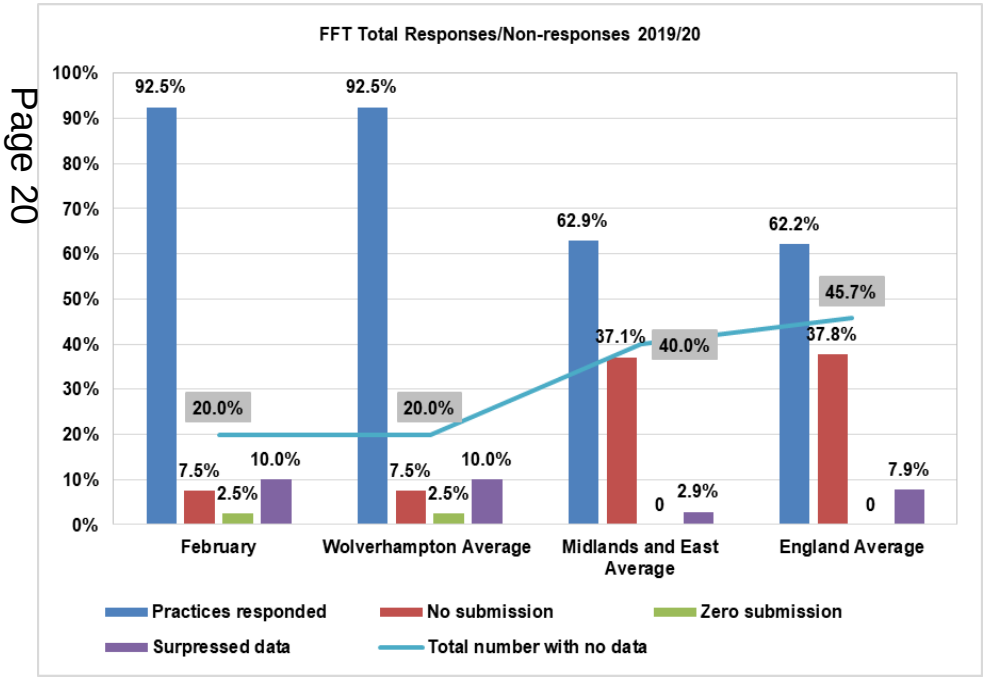
	Quality Matters.

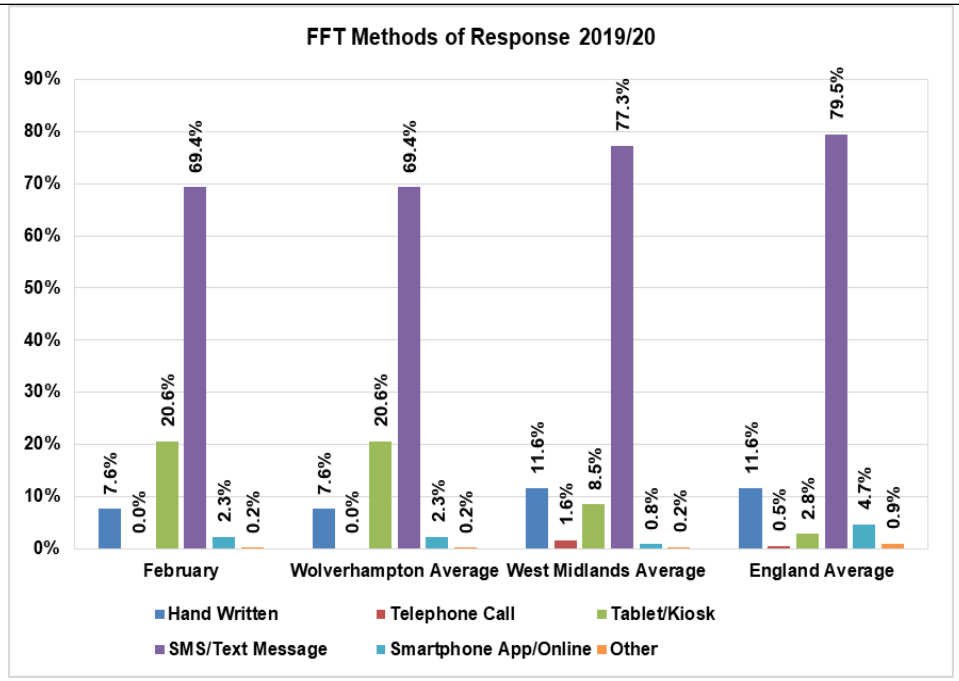
Areas for concern.

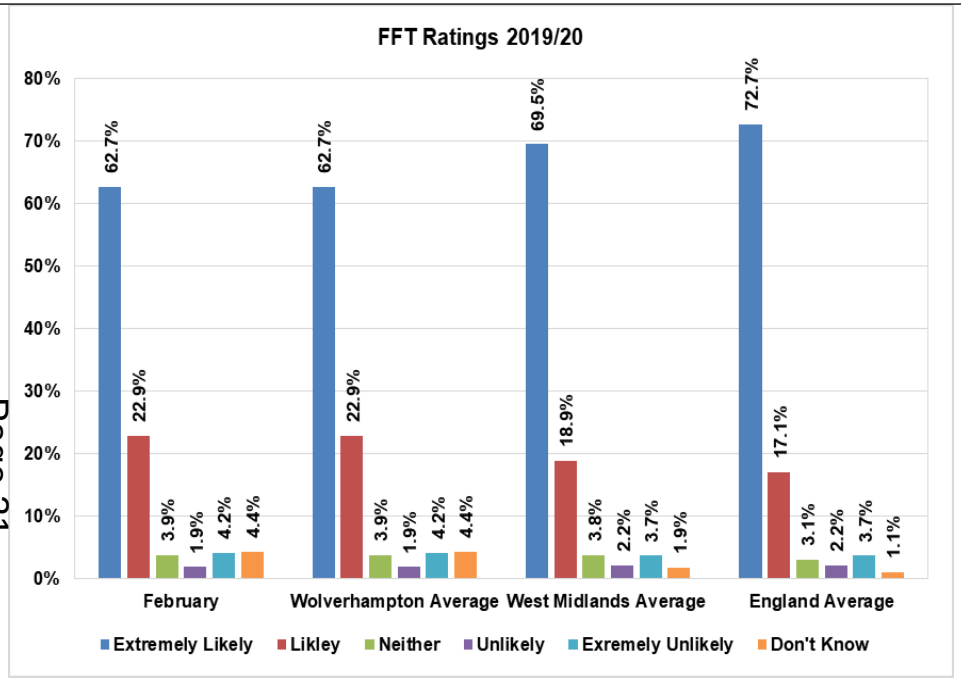
The most common themes identified this year are clinical treatment (29% of incidences) and staff attitude (28% of incidences). These incidents relate to Quarter 3 (October – December 2018), since this time the CCG has put in place Conflict Resolution and other front facing staff training following feedback from Q2 data, there is also ongoing work around peer review for high and low referrers, and work around cancer referrals. The full impact of this will most likely be seen in the Q1 data for 2019/20 which will be expected in September 2019.

2.2. Friends and Family Test

Friends and Family Test Data Overview 2018/19







Areas for concern:

Uptake is slightly lower overall this month at 1.8%, but is still consistently higher than regional and national uptake.
Total non-responders are stable at 7 practices with no data, zero data or supressed data.
Uptake is reviewed on a monthly basis by the Primary Care Contract Manager.
SMS text and tablet/check in screen remains the most common method of response – reflecting the use of new technology.
Ratings for those who are extremely likely to recommend their GP are slightly lower than regional and national averages, however as uptake is higher in the city it is likely that this is a more representative sample. 55% of practices have a higher than average "would recommend" rate; 27.5% have a higher than average "would not recommend" rating. There is correlation between practices with higher would recommend and lower would not recommend and vice versa – uptake is high enough in these practices to be confident that the results are not skewed and have been discussed with the locality managers.

3. CLINICAL EFFECTIVENESS

3.1. NICE Assurance – Updated Quarterly

New or amended guideline -	Ref	Linked to Peer Review
Intrapartum care for women with existing medical conditions or obstetric complications and their babies	NG121	No
Lung cancer: diagnosis and management	NG122	No
Cough (acute): antimicrobial prescribing	NG120	Yes
Renal and ureteric stones: assessment and management	NG118	Yes
Cerebral palsy in adults	NG119	No
Chronic obstructive pulmonary disease (acute exacerbation): antimicrobial prescribing	NG114	No
Chronic obstructive pulmonary disease in over 16s: diagnosis and management	NG115	No
Post-traumatic stress disorder	NG116	No
Bronchiectasis (non-cystic fibrosis), acute exacerbation: antimicrobial prescribing	NG117	No
Delirium: prevention, diagnosis and management	CG103	No
Antenatal care for uncomplicated pregnancies	CG62	No
Areas for concern		
None identified		

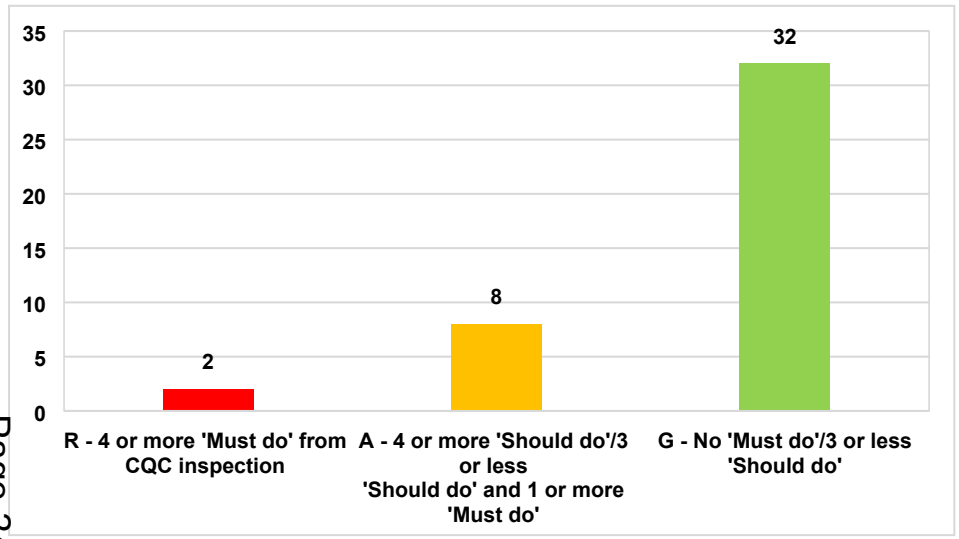
4. REGULATORY ACTIVITY

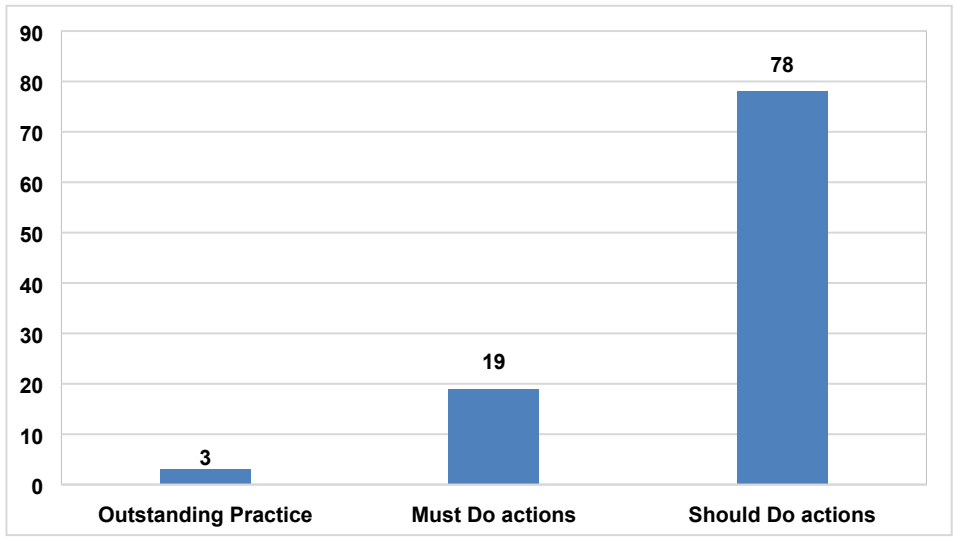
4.1. CQC Inspections and Ratings

Figure 6: CQC Inspections and Ratings to date 2019/20

CQC Ratings by Domain	Overall	Safe	Effective	Caring	Responsive	Well-led	People with long term conditions	Families, children and young people	Older people	Working age people (including those recently retired and students)	People experiencing poor mental health (including people with dementia)	People whose circumstances may make them vulnerable
Outstanding	0	0	0	0	0	0	0	0	0	0	0	0
Good	39	35	40	41	41	39	39	39	39	39	39	39
Requires Improvement	3	7	2	1	1	2	3	3	3	3	3	3
Inadequate	0	0	0	0	0	1	0	0	0	0	0	0
	42	42	42	42	42	42	42	42	42	42	42	42

CAG Ratings – actions from CQC inspections:	QCQ Actions required





Areas for concern

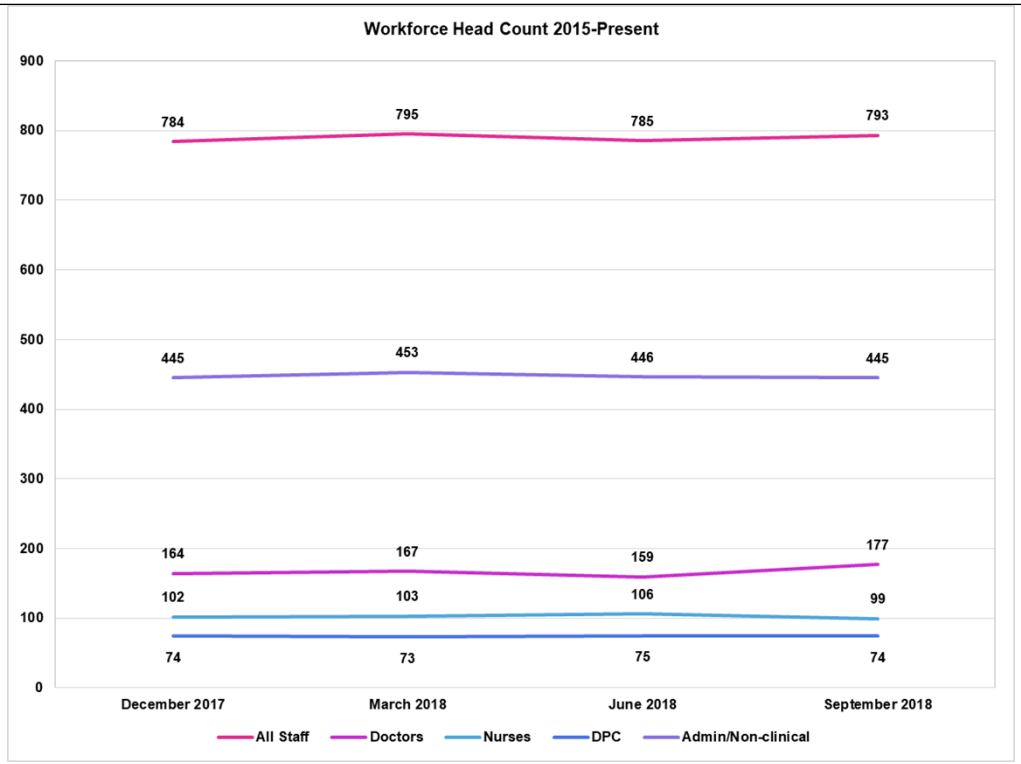
CQC continue to liaise with CCG to support the inspection process. No concerns have been reported back to CCG this month.
Outstanding actions are managed by inspectors via 3 monthly virtual or face to face review.

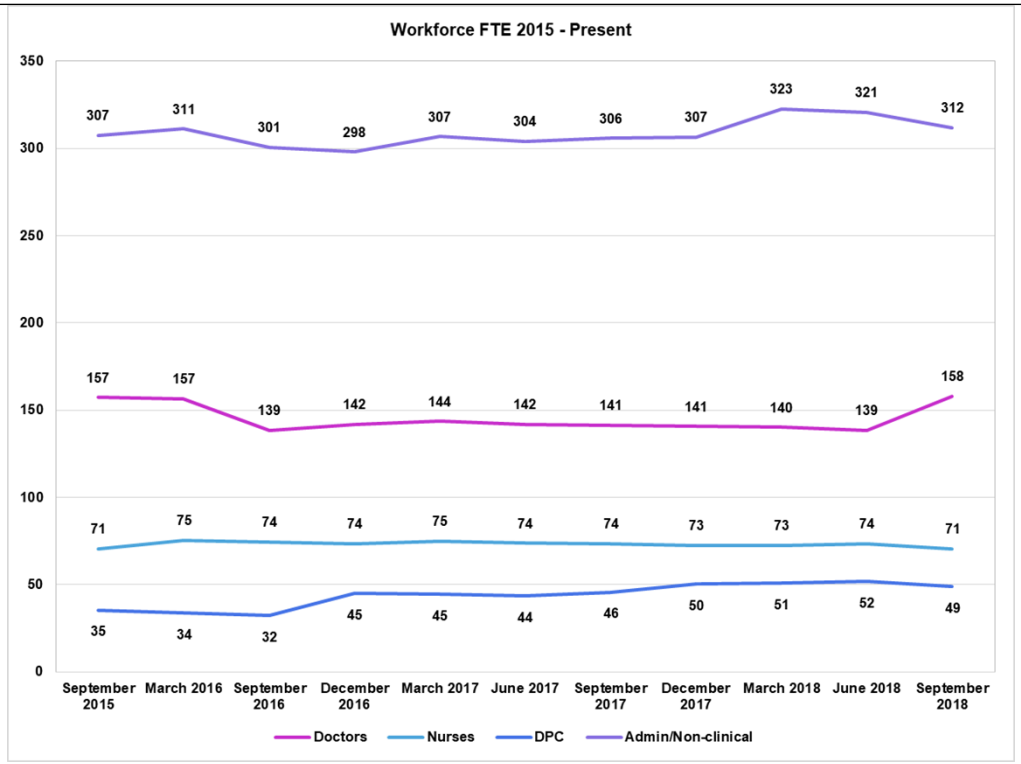
Inspections by year:
2015 – 3
2016 – 12
2017 – 14
2018 – 10
2019 – 3

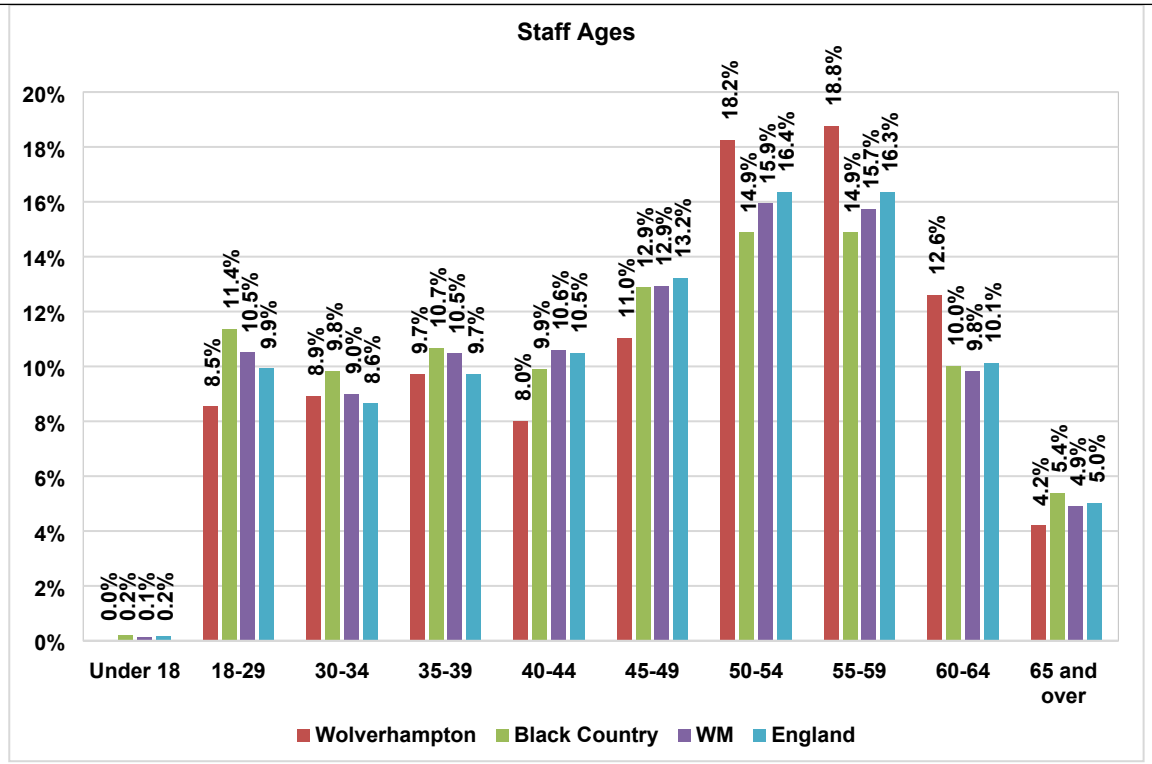
5. WORKFORCE DEVELOPMENT

5.1. Workforce Activity

	Activity	Exceptions and assurance
Recruitment and retention	• GP International recruitment is currently on hold awaiting further decisions from HEE. • A business case to support development of health care staff who are already resident in the Black Country but who are not working in this area is being worked up by STP GP Forward View Lead • GP retention programme is up and running with support for GPs in the first five years, retirement support and portfolio careers. • The practice nurse retention programme is being developed along the same lines as the GP programme with a focus on induction/preceptorship, portfolio careers, mentorship and retirement planning. • HCA apprenticeship programme has had a positive start with 2 staff who have commenced the programme, one who has expressed an interest and one practice who is interested in larger scale HCA training and the employment of business and administration apprentices. • NA apprenticeship programme details have been shared with practices with tentative interest from 3 so far. • CCG continue to work with University of Wolverhampton to increase all health care placements with a focus on nursing and Physicians Associates • Work experience pilot – a new GP placement site is needed for 1st – 5th July 2019 due to original placement being no longer available	**CCG have been approached by Nursing in Practice magazine for comments around our GPN recruitment and retention work.**

Workforce Numbers		Figures taken from NHS Digital data are for September 2018 with the next update due imminently. DPC = Direct Patient Care (i.e. Health Care Assistants)

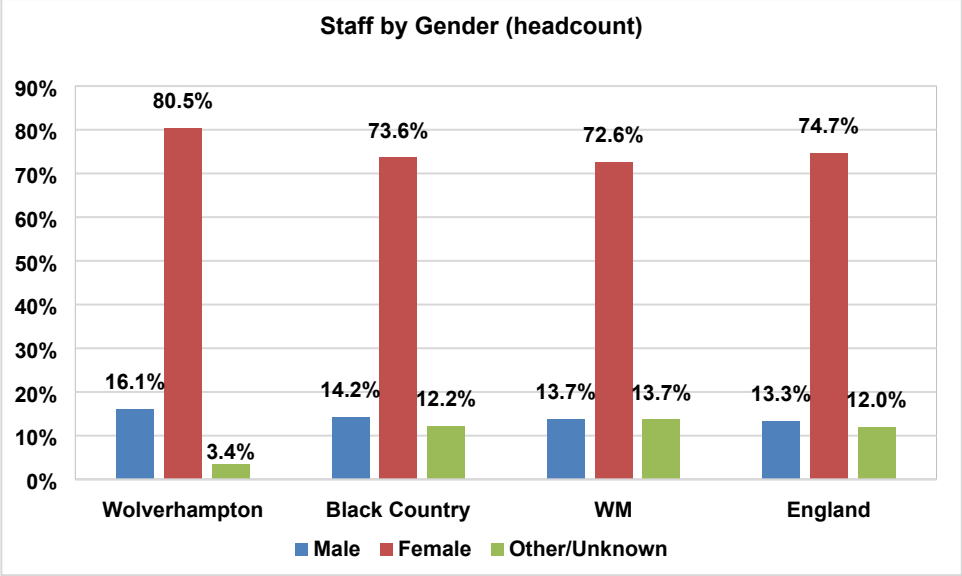

Workforce FTE 2015 - Present
350
300
250
200
150
100
50
0
307 311 301 298 307 304 306 307 323 321 312
157 157 139 142 144 142 141 141 140 139 158
71 75 74 74 75 74 74 73 73 74 71
35 34 32 45 45 44 46 50 51 52 49
September 2015
March 2016
September 2016
December 2016
March 2017
June 2017
September 2017
December 2017
March 2018
June 2018
September 2018
Doctors
Nurses
DPC
Admin/Non-clinical



There are high numbers of staff aged 50+ and this reflects the national picture.

The majority of staff working in primary care are female, again reflective of national picture.

Recruitment and retention of staff to address workforce trends is addressed above.



GPN 10 Point Action Plan	• Action 1, 2, 4, 5, 7, 8, 9 and 10: GPN strategy has been approved at CCG Primary Care Commissioning Committee for regional approval. • Action 1: Work experience pilot has been set up between a local secondary school, CCG, Public Health, Pharmacy and GP practices and to promote the role of the GPN through case studies. CCG staff attended the school and speak to Year 10 pupils about careers in primary care. • Action 2, 4 and 10: Digital Clinical Supervision pilot, has now finished but the sessions are continuing in Wolverhampton. • Action 3: there are currently 17 practices and the CCG itself offering student nurse placements with another one expressing an interest, there are plans by the university to further increase this with the changes to NMC mentorship standards. • Action 4: The GPN fast track programme is due to start with 4 Wolverhampton nurses attending, this is in conjunction with other CCGs and Training Hub this also forms part of the strategy.	No exceptions for Wolverhampton

	• Action 5: Further work is being developed to promote the Return to Practice programme. • Action 7: Nurse education forum continues on a monthly basis - 2019 programme has included sepsis, lymphoedema, CVD and wound care sessions so far. An International Nurse's Day event is being planned for the May session with CPD opportunities and LD health checks discussed. • Action 9: The CCG will support 3 Nursing Associate apprenticeships with backfill in primary care, comms have been developed and circulated. One NA has recently completed studies and is now registered with the NMC. • Action 9: HCA long term condition training sessions have been developed further in conjunction with the Training Hub. • Action 9: HCA apprenticeships programme has commenced to allow current non-clinical staff in practice to develop clinical skills as part of a development programme linked with the NAA programme has commenced with two candidates starting in April and 4 further candidates identified. • Action 10: The Nurse Retention plan has now been collated with workstreams being planned.	

5. Training and Development

	Activity	Exceptions and assurance
Nurse Training	• Practice Makes Perfect continues. • Diabetes training is currently being developed in conjunction with Wolverhampton Diabetes Centre and Foot Health • Flu training is booked for July 2019 • Apprenticeship programmes are up and running • Spirometry training is arranged for June and September 2019	No exceptions
Non-clinical staff	GPFV training continues around: Document management Practice manager support	No exceptions.

5.3. Training Hub update

		Exceptions and assurance

Black Country Training Hub	• Acknowledged as central to future workforce planning by HEE and NHSE.
	• £22M investment each year for three years, although it's not clear when this funding will be available.
	• There is to be one 'lead' Training Hub per STP, with locality Hubs sitting underneath this in some areas if required. The lead Hub must have representation from all locality Hubs, as well as other partners from across health and community care sitting on its board.
	• The structure will not be dictated by HEE but will need to be 'signed off' by them once agreed at STP/ICS level. Communication to STPs/ICSs re. Training Hubs will go out by the end of April.
	• Expectations of Training Hubs in year one:
	  ◦ staff infrastructure,
	  ◦ financial model,
	  ◦ leadership and culture,
	  ◦ stakeholder engagement,
	  ◦ quality assurance,
	  ◦ workforce planning,
	  ◦ GP network and system coverage.
	• Expectations in years two to three:
	  ◦ primary and community care remit,
	  ◦ place-based training and education,
	  ◦ workforce development,
	  ◦ management of GP training placements and other clinical placements, including possible rotations between primary and secondary care,
	  ◦ tariff management,
	  ◦ local inductions for clinicians new to the area.
	• Guidance will be issued re. staff infrastructure but it won't be prescriptive. It was suggested that there may be roughly one project manager, one administrator and one clinical educator per 300,000 of population.	

LWAB	• GP training places were oversubscribed in 2018 with 3,473 places taken up, and the pre-reg nursing placement target was exceeded nationally. • There have been 7 IGPR recruits in the West Midlands. <u>Update from Community of Practice for Nursing Associates: General Practice: 15/04/2019</u> • Cervical Screening Programme available to newly qualified NAs; awaiting clarity from PHE regarding the TDDI regulated list. • Trainee Nursing Associate standards have been approved; end point assessment units will be forthcoming. • Clinical Negligence Scheme for General Practice; includes students and trainees. The Scheme • Skills for Health have been commissioned to produce core competency framework for AGPN to be delivered next year; request to be made to expand for all nursing roles to include HCA, NA, GPN. • Wider discussions required by group to produce JDs for NAs. • Wolverhampton CCG to provide completed templates for HCA and NA Apprentices to ensure continuity in national profiles. (Completed)	

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
PRIMARY CARE COMMISSIONING COMMITTEE
7th May 2019

TITLE OF REPORT:	Primary Care Operational Management Group Update
AUTHOR(s) OF REPORT:	Mike Hastings, Director of Operations
MANAGEMENT LEAD:	Mike Hastings, Director of Operations
PURPOSE OF REPORT:	To provide the Committee with an update on the Primary Care Operational Management Group.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This report is intended for the public domain.
KEY POINTS:	• The AMPS mobilisation work with Health & Beyond is now completed. • Two ETTF funded building developments are in progress with works to be completed at Newbridge by June and at East Park by the end of the year. • A room booking system is to be introduced across primary care enabling practices to improve space utilisation and billing arrangements. • CQC are starting their Annual Regulatory Review via telephone interviews with practices. • Dentistry, Optoms and Pharmacy Primary Care Services are remaining with NHS England for 19/20.
RECOMMENDATION:	To provide the Committee with an update on the Primary Care Operational Management Group.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	The Primary Care Operational Management Group monitors the quality and safety of General Practice.
2. Reducing Health Inequalities in Wolverhampton	The Primary Care Operational Management Group work with clinical groups within Primary Care to transform delivery.
3. System effectiveness delivered within our	Operational issues are managed to enable Primary Care Strategy delivery.

financial envelope	

1. BACKGROUND AND CURRENT SITUATION

1.1. Notes from the last Primary Care Operational Management Group are set out below.

Primary Care Operational Management Group
Friday 12th April 2019 at 11am
CCG Main Meeting Room, Wolverhampton Science Park, WV10 9RU

Present		
Mike Hastings	(MH)	WCCG Director of Operations (Chair)
Tally Kalea	(TK)	WCCG Commissioning Operations Manager
Peter McKenzie	(PMcK)	WCCG Corporate Operations Manager
Jo Reynolds	(JR)	WCCG Primary Care Transformation Manager
Mandy Sarai	(MS)	WCCG Business Support Officer (minute taker)
Ramsey Singh	(RS)	WCCG IM&T Infrastructure Project Manager
Phil Strickland	(PS)	WCCG Governance & Risk Coordinator
Jane Worton	(JW)	WCCG Primary Care Liaison Manager
Bal Dhami	(BD)	NHS England Senior Contracts Manager
Yvette Delaney	(YD)	Inspector for Primary Medical Services Care Quality Commission (Central West)
Gill Shelley	(GS)	WCCG Primary Care Contracting Manager
Apologies		
Steve Barlow	(SB)	WCC Health Protection Lead Practitioner
Jeff Blankley	(JB)	Chair of the Wolverhampton Local Pharmacy Committee
Liz Corrigan	(LC)	WCCG Primary Care Quality Assurance Co-coordinator
Hemant Patel	(HP)	WCCG Head of Medicines Optimisation
Sarah Southall	(SS)	Head of Primary Care (Wolverhampton CCG) & GPFV
Dr S.Vij	(SV)	GP at Whitmore Reans Health Centre

Item		
1.	**Welcome and Introductions**	

2.	**Apologies** Apologies for absence were received from, Hemant Patel, Sarah Southall & Dr S. Vij, Steve Barlow, Jeff Blankley, Liz Corrigan.	
3.	**Declarations of Interest** There were no declarations of interest declared at this meeting.	
4. 4.1 4.2 4.3	**Primary Care Operational Management Group Minutes** Minutes from Wednesday 6th March 2019 The Minutes taken from the meeting on Wednesday 6th March 2019 were signed off and recorded as an accurate record. Apart from under Section 9.1 Serious Incident Should read '*Serious Incident is being investigated'.* Action Log Items on the action log were discussed.	
5. 5.1	**Notes of the Clinical Reference Group Meeting** Clinical Reference Notes –20th February 2019 The Clinical Reference Group notes were reviewed at for information purposes.	
6. 6.1	**Risk Profile** Risk Register There were no new risks submitted this month	
7.	**Matters Arising** There were no matters arising.	
8. 8.1 8.2 8.3	**Primary Care Updates** Review of Primary Care Matrix JW provided an update. The APMS Mobilisation process is now complete. This is in the transition phase and contracts have been signed. JW has met with Joanne Round and John Seymour to discuss. All actions and logs have been closed. An issue about the back log of work that had been left. Health and Beyond are completing a piece of work to analyse numbers. They will discuss this with RWT. This has been logged on the internal risk register for this project. Feedback at the next meeting to see what the improvements are. Details can also be put in the GP Bulletin. Forward Plan for Practice System Migrations Mergers and Closures Rosevilla's branch site has been closed. RS confirmed that the reimbursement for estates will come back into the central budget. RS informed the ODS team in Exeter to close the practice and delete from their system; however RS was notified the information needed to come via the practice. RS has notified the practice of this. Work will commence on Bilston Urban Village and Pennfields. Once they have gone live then the Bilston Urban Village and Ettingshall merge will commence. Estates Update/LEF The work on the Newbridge site is to be completed by June. East park have also	

	started building work which is due to be completed by the end of this financial year. NHS have confirmed that the funding for the other ETTF scheme has been signed off for Alfred Squire. JR to look into doing a press release for the Newbridge site. Void space – this is an ongoing issue. Any services that require a room within GP practices can be directed to a new room booking system. TK to meet with Andrew to discuss how this is carried out in Sandwell and Walsall. Training will also need to be sought to be able to use the new system. Design Bureau have completed an analysis over at the Bilston Health centre for Utilisation. Following on from this they will do a landscape model of whole of Wolverhampton. They will then create a mini dashboard of utilisation in Wolverhampton in terms of estate, condition etc. This will link with the Primary Care dashboard.	
8.4	<u>Primary Care Networks</u> Members meeting took place on Wednesday 3rd April, information around the handbook and guidance that has been received around the DES was disseminated and network formations discussed. Practices are required to submit initial network registration form by 15th May, commissioners to confirm and approve network areas by 30th May, each network needs to have all GP practices signed up to the DES via CQRS by 30th June, with the Network DES commencing 1st July. There are discussions being held between practices as to how the networks are formed, it is anticipated that there will be movement between the Practice groups due to the logistics of networks being geographically based. Currently, extended access will remain at practice group level. Plans are in place for delivery of 45 mins per 1000 patients extended access across all groups, with Unity working with VI to provide access to VI patients on behalf of the trust. Advertising is in place to promote extended access over the Easter weekend.	
8.5	<u>Primary Care STP Update</u> The Black Country GP Retention Intensive Support Site (GPRISS) Celebration Event was held on the 27th March, and provided a chance to share the initial outcomes of a number of successful workforce schemes that have been put in place to support GPs to stay in general practice. The programme of work has been recognised for the success it has achieved, and has been extended for a further year. Wave 2 of first fives will be launched during April, with further requests for portfolio careers being received.	
8.6	<u>Care Quality Commission Update</u> The Annual Regulatory Review has begun. This started off with Cannock Road and Ashmore Park. Provider information collection is an introductory call to the	

	GP practice. It is to inform the practice of the process and to collect information such as date, time and who will be present and how they want to receive the call. Information is collected at that time. This is not an inspection. All the information given and taken is only over the telephone. Once the information has been received, YD does the annual review. This then gets reviewed by the immediate manager and following on from this a decision is made regarding a visit to site. A letter will be sent out to the practices following on from this. Outcome of the PIC call is collecting intelligence from the practice themselves.	
8.7	Public Health Update There are some issues reported with TB in the Whitmore's area. These are ongoing and a big risk to Public Health at the moment.	
8.8	NHS England Update No updated provided.	
8.9	Wolverhampton Local Medical Committee Update No updated provided.	
8.10	Pharmaceutical Involvement in Primary Care No updated provided	
8.11	NHS England Update - DES Position for 19-20 It was reported that the GP Contracting Team within NHS England are in the process of updating the specifications in respect of the three nationally Directed Enhanced Services (DES) that are to be re-commissioned for the financial year 2019/2020 on behalf of West Midland CCG's. Currently, Practices can sign up to provide Minor Surgery, Learning Disability and Extended Hours DES services to their registered patients. The updated DES specifications will be shared with the respective CCG primary care leads for approval before circulation to Practices. It was noted that the extended hours DES is to be commissioned for a three month period from 1 April 2019 to end of June 2019, after which point it would be provided by the Primary Care Networks. GS informed the Group that her understanding was that the Minor Surgery DES was to be decommissioned nationally from April 2019 and the CCG had developed a locally commissioned minor surgery service. BD reconfirmed that the minor surgery DES was available for individual practices to participate in for 2019/2020. It was agreed to clarify the position and confirm if the MS DES is to be offered to Practices within the Wolverhampton CCG area. **Action: GS to confirm if the Minor Surgery DES is to be offered to Practices for 2019/2020 financial year.** MH asked if there were any plans to delegate any other NHS E commissioned Primary Care Services to the CCG. The services specifically referred to were Dentistry, Optoms and Pharmacy Primary Care Services. BD informed the Group that his understanding was that these primary care services were remaining with	

	NHS England for 19/20.	
9. **9.1**	**Primary Care Quality Update** Primary Care Quality Report No Update provided.	
10. **10.1** **10.2**	**Primary Care Contracting** Collaborative Contract Review Programme Dr Whitehouse visit was carried out. 16 actions were identified. 7 of which were related to Public Health. No major concerns raised. Thornley Street – visit to be carried out shortly. Following on from this will be Dr Sharma and Dr Mudigonda. Primary Care Contracting Update Updates as follows provided by GS; Letter from Dr Bilas who is giving his intention to subcontract from RWT from 3rd June. He has been asked to complete the assurance framework .This will go to the Primary Care Commissioning Committee in May for approval. Paperwork is currently being processed by NHS England to add Dr Sharma on to the contract for IH Medical Practice. APMS Mobilisation – Mobilisation has gone well. Working with Arden and Gem CSU around Patient Consultation around the closure of Wood road surgery closure this will commence on 7th May 2019.	
11. **11.1**	**Discussion Items** Improving the Interface between Primary & Secondary Care – Clinicians – Toolkit 2018 A workshop was held across the STP to see how we can work together. The care query process is around the interface between primary and acute care.	
12.	**Any other Business** No items were discussed under any other business.	
13.	**Date and time of Next Meeting –** Wednesday 1st May 2019 at 1.00-2.30pm in the Main Meeting Room	

2. CLINICAL VIEW

2.1. A clinical representative from LMC attends the meetings and gives views on all discussions.

3. PATIENT AND PUBLIC VIEW

3.1. Patient and public views are sought as required.

4. KEY RISKS AND MITIGATIONS

4.1. Project risks are reviewed as escalated from the programme.

5. IMPACT ASSESSMENT

Financial and Resource Implications

5.1. The group has no authority to make decisions regarding Finance.

Quality and Safety Implications

5.2. A quality representative is a member of the Group.

Equality Implications

5.3. Equality and Inclusion views are sought as required. ***Legal and Policy Implications***

5.4. Governance views are sought as required.

Other Implications

5.5. Medicines Management, Estates, HR and IM&T views are sought as required.

Name: Mike Hastings
Job Title: Director of Operations
Date: 18.4.19

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	N/A	
Public/ Patient View	N/A	
Finance Implications discussed with Finance Team	N/A	
Quality Implications discussed with Quality and Risk Team	N/A	
Equality Implications discussed with CSU Equality and	N/A	

Inclusion Service		
Information Governance implications discussed with IG Support Officer	N/A	
Legal/ Policy implications discussed with Corporate Operations Manager	N/A	
Other Implications (Medicines management, estates, HR, IM&T etc.)	N/A	
Any relevant data requirements discussed with CSU Business Intelligence	N/A	
Signed off by Report Owner (Must be completed)	**Mike Hastings**	**25.1.19**

NHS Wolverhampton Clinical Commissioning Group

WOLVERHAMPTON CCG

Primary Care Commissioning Committee
7 May 2019

TITLE OF REPORT:	Establishing Primary Care Networks
AUTHOR(s) OF REPORT:	Sarah Southall, Head of Primary Care
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	To ensure the committee are sighted on progress being made regarding the formation of Primary Care Networks.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This documentation is suitable for sharing in the public domain.
KEY POINTS:	• GPs & Practice Managers received an overview of the requirements for Primary Care Networks at the CCGs Members Meeting held on 3 April 2019 (see enclosure). • Primary Care Network Applications are due to be submitted to CCGs from member practices by 15 May 2019 a panel meeting has been convened for 16 May to consider/approve applications. • Practices have been liaising with Group Leads resulting in some of the outlier practices realigning with another group (see enclosure). • NHS England received an update regarding progress being made towards Primary Care Networks on 30 April, a further update is due on 21 May.
RECOMMENDATION:	The committee should consider the progress taking place as per the timeline for applications for Primary Care Networks. Note that discussions continue with practices to reduce overlap and maintain sensible geographies.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1 Improving the quality and safety of services we commission. 2 Reducing health inequalities in Wolverhampton. 3 System effectiveness delivered within our financial envelope.

1. BACKGROUND AND CURRENT SITUATION

1.1. The committee were alerted to the requirements attached to the formation of Primary Care Networks in April 2019. The report provides an update on the activities that have taken place through engaging with member practices to ensure the formation of networks is in line with national guidance.

2.0 Network DES

2.1 Members Meeting April 2019

In response to a plethora of national guidance published on 29 March 2019 practices were briefed on the requirements they should fulfil when forming primary care networks. The event was well attended enabling discussions to take place regarding the key documents:-

- Primary Care Networks Reference Guide
- The NHS Long Term Plan
- Investment & Evolution : GP Contract Reform
- Primary Care Network Handbook
- Network Contract Directed Enhanced Service (DES)

A copy of the slides can be found in appendix 1.

2.2 *Network DES*

The DES was published on 29 March and will be funded by the CCG at a cost of £1.50 per patient. Funding had been set aside as part of budget setting based on the assumption that all member practices will be part of a network.

The British Medical Association have published a handbook for general practice to guide them on what they need to do to be recognised as network and this includes the application process (by 15 May 2019). This useful resource provides examples of the approach to appointing a Clinical Director, internal governance and decision making, accountability, data sharing & employment models for new workforce allocations.

Each network will be required to confirm the practices who wish to work together, list size, name of clinical director, nominated practice to receive funds and also a map of the network area based on a sensible network boundary.

Practices are actively working towards completion of application forms with support from their respective Group Manager(s).

By 30 June each network will be required to submit a fully completed network agreement outlines ***decisions*** about how practices will ***work together***, which practice ***does what***, how ***funding*** will be ***allocated*** between practices, how the ***new workforce will be shared (including who employs them.*** The agreement will be subject to regular review and will therefore be amended over time ie new workforce/services as they become available.

The DES also confirms a maturity timeline that will form the basis of the performance requirements detailed in the Network Agreement.

2.3 Application Timeline

The timeline being worked to takes account of both national and local requirements to ensure that all requirements are met in a timely manner:-

Requirement	***Due Date***
PCN Participation in Network DES confirmed to NHS England	30 April 2019
Primary Networks submit registration information to CCG	By 15 May 2019
CCG Panel Meeting to consider/ approve applications	16 May 2019
CCGs confirm to Joint Commissioning Committee outcome of panel meetings	16 May 2019
Confirm outcome of Panel to STP Joint Commissioning Committee & Clinical Leadership Group	17 May 2019
NHS England Primary Care Networks (Commissioner Event)	17 May 2019
CCGs confirm network coverage to NHS England	21 May 2019
CCGs approve variations to GMS/PMS/ APMS contracts	By 31 May 2019
NHS England, CCGS & LMCs resolve any issues	Early June 2019
Network DES goes live	1 July 2019
National Entitlements start	July 2019

The committee will be kept appraised of progress and completion of the above timescales in subsequent meetings.

2.4 Workforce - New Roles

The new GP contract and BMA Handbook confirm a range of new roles that will be funded nationally for 5 years providing certainty to networks who will be allocated role as follows over a 3-4 year period:-

Year	***Role(s) & Numbers***
2019	1 Clinical Pharmacist & 1 Social Prescriber per network
2020	1 First Contact Physio(s) & 2 Physicians Associate(s) per network
2021	1 Community Paramedic per network
2022	All roles increasing by 2024 typical network will comprise of:- • 3 Social Prescribers* • 3 First Contact Practitioners • 2 Physicians Associates* • 1 Clinical Pharmacist* *Note: there will be some flexibility on numbers & professionals in networks*

The above roles will be part funded by NHS England in the sum of 70% however 100% funding will be available for Social Prescribing Link Workers. The DES introduces a principle of 'additionality'. Additionality will be measured on a 2018/19 baseline of staff supporting practices as taken at 31 March 2019 (NWRS). Practices will be required to participate in a survey to confirm this data very shortly in order to assist networks in claiming funding for new additional staff roles beyond the baseline.

In addition each network will receive a contribution towards the cost of employing a Clinical Director one day per week (0.25 funded by NHS England based on a 40k network population).

3.0 CLINICAL VIEW

The Group Leads and member practices have been actively engaged in information and discussions at group level in order to ensure the functionality of each network is in line with national guidance.

4.0 PATIENT AND PUBLIC VIEW

Patient engagement has been encourage at practice level and a presentation was shared at the Patient Participation Group Chairs Meeting held on 19 March.

5.0 KEY RISKS AND MITIGATIONS

There is a risk that one group will overlap significantly with other networks in the city and may result in the CCG being unable to approve their application. Ongoing discussions with Group Leads are taking place.

6.0 IMPACT ASSESSMENT(S)

Financial and Resource Implications

National funding allocations have been provisionally confirmed for Primary Care Networks comprising of Engagement Costs, Network DES, Workforce and New Roles. The CCG has set aside funds to cover the cost of the Network DES.

The committee will be kept informed regarding further funding allocations as they are confirmed over the coming months.

Quality and Safety Implications

The Chief Nurse has been actively engaged in discussions regarding the formation of Primary Care Networks in both Wolverhampton and the wider STP footprint.

Equality Implications

An equality impact assessment has not been undertaken.

Legal and Policy Implications

There are no legal implications identified at this stage.

Name: Sarah Southall
Job Title: Head of Primary Care
Date: May 2019

Enclosure(s): Enclosure 1 Members Meeting Presentation
Enclosure 2 Network DES
Enclosure 3 Primary Care Network Map (draft to be tabled)

Network Contract Directed Enhanced Service

Contract specification 2019/20

NHS England INFORMATION READER BOX		
Directorate		
Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	**Strategy & Innovation**
Finance		

Publishing Approval Reference:	**000363**
Document Purpose	Resources
Document Name	Network Contract Directed Enhanced Service Contract specification 2019/20
Author	NHS England
Publication Date	29 March 2019
Target Audience	NHS England Regional Directors, NHS England Directors of Commissioning Operations, GPs
Additional Circulation List	CCG Clinical Leaders, CCG Accountable Officers, Communications Leads
Description	The Network Contract DES Directions will begin on the 1 April 2019 and following sign-up to the DES, the requirements on GP practices (outlined in section 4 of the DES specification) will apply from 1 July 2019. It will remain in place, evolving annually until at least 31 March 2024. The first year of this DES covered by this document lasting until 31 March 2020 will be a development year, with the majority of service requirements being introduced from April 2020 onwards. The success of a PCN will depend on the strengths of its relationships, and in particular the bonds of affiliations between its members and the wider health and social care community who care for the population. Non-GP providers will be essential in supporting the delivery.
Cross Reference	NA
Superseded Docs (if applicable)	NA
Action Required	NA
Timing / Deadlines (if applicable)	**NA**
Contact Details for further information	NHS England GP Contracts Team Quarry House Quarry Hill Leeds LS2 7UE england.gpcontracts@nhs.net

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the website is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the website.

Network Contract Directed Enhanced Service

Contract Specification 2019/20

Version number: 1

First published: 29 March 2019

Prepared by: Primary Care Strategy and NHS Contracts Group

Classification: Official

Gateway publication reference: **000363**

Equalities and health inequalities statement

"Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities."

Contents

Please be aware that all aspects of this service specification outline the requirements for this programme. As such, commissioners and practices should ensure they have read and understood all sections of this document as part of the implementation of this programme.

Practices are advised that to ensure they receive payment, particular attention should be paid to the payment and validation terms. Practices will need to ensure they understand and use the designated clinical codes as required to ensure payment.

Other formats of this document are available on request. Please send your request to: england.gpcontracts@nhs.net

1. Introduction

1.1 The Network Contract DES Directions will begin on the 1 April 2019, and following sign-up to the Network Contract DES, the requirements on GP practices will apply from 1 July 2019. The Network Contract DES is intended to remain in place until at least 31 March 2024, with the Network Contract DES specification evolving over time, subject to annual review and development. The Network Contract DES forms part of a long-term, larger package of contract reform as set out in Investment and Evolution: A five-year framework for GP contract reform to implement the NHS Long Term Plan, which also sets out the key features of the Network Contract DES.

1.2 This Network Contract DES specification applies to the first year of the Network Contract DES, covering the period 1 April 2019 to 31 March 2020. It has been agreed between NHS England and the British Medical Association's (BMA) General Practitioners Committee England (GPC). The focus of the Network Contract DES in 2019/20 is to support the establishment of primary care networks (PCNs) and the recruitment of new workforce, with the bulk of service requirements coming in from April 2020 onwards.

2. Eligibility for and sign-up to the Network Contract DES

2.1 GP practices signing-up to the Network Contract DES must hold a registered patient list and be offering in-hours (essential services) primary medical services.

2.2 To participate in the Network Contract DES, commissioners and PCNs must comply with the requirements set out in this section.

2.3 At the earliest opportunity and in any event by the 15 May 2019, PCNs must complete and return the registration form set out at Annex A of this Network Contract DES specification. The registration form requires the following information:

a. the names and ODS codes[1] of the proposed member GP practices[2];

[1] https://digital.nhs.uk/services/organisation-data-service
[2] This may be a single super practice.

b. the PCN list size - sum of its proposed member GP practices' registered list as at 1 January 2019;
c. a map clearly marking the proposed geographical area covered by the PCN (Network Area);
d. the initial Network Agreement – this requires completion of the proposed GP member practices' details in the front end of the Network Agreement and in Schedule 1, details of the Network Area, the Clinical Director and nominated payee (PCNs may also provide in their initial Network Agreement additional information in Schedule 1 relating to PCN meetings and decision-making but it is recognised that this may not have been fully agreed by 15 May submission date);
e. the single practice or provider (who must hold a primary medical care contract)[3] account that will receive funding on behalf of the PCN; and
f. the named accountable Clinical Director.

2.4 Prior to 15 May 2019, commissioners must confirm to PCNs how completed registration forms must be submitted.

2.5 By 15 May 2019, PCNs must have submitted the initial completed registration form in the manner indicated by the commissioners (i.e. to whom it must be sent and in what format, paper or electronic).

2.6 During the period 16 May 2019 to 31 May 2019, commissioners will seek to confirm and approve all Network Areas (see section 3 for further details on Network Areas) in a single process that ensures that all patients in every GP practice are covered by a PCN and that there is 100 per cent geographical coverage.

2.7 By 31 May 2019, commissioners should have reached agreement with practices on any issues relating to the proposals in registration forms, such as PCN list size and the Network Area. Commissioners should also have agreed the workforce baseline with the PCN as set out in paragraph 4.5.3. Further information on the Network Area is provided in paragraphs 2.10, 2.11 and in section 3 of this Network Contract DES specification.

[3] Payment nomination would only apply where there is more than one primary medical care contractor in the PCN.

2.8 By 31 May 2019, it is expected that commissioners will confirm that registration requirements have been met, including discussing and agreeing the Network Areas across the CCG. Where this is not possible due to ongoing discussions about the information set out in the registration form, commissioners will aim to confirm to PCNs that registration requirements have been met as soon as possible after this date, but prior to 30 June 2019.

2.9 After commissioner confirmation has been received and prior to 30 June 2019, each GP practice in a PCN will sign-up to the Network Contract DES through the Calculating Quality Reporting Service (CQRS), when available,[4] and by recording the agreement in writing with the commissioner. Where 100 per cent population coverage has not been achieved within the initial registration timeframe (i.e. by 31 May 2019), this should be done by 30 June 2019.

2.10 Commissioners will work closely with Local Medical Committees (LMCs) during the registration period to resolve any issues in order to secure 100 per cent geographical coverage of PCNs. This will include ensuring any patients with a GP practice not participating in the Network Contract DES are covered by a PCN (for example through commissioning a local incentive scheme).

2.11 Where 100 per cent coverage is not achieved, commissioners and LMCs should, after all local options have been explored, seek discussion and agreement to Network Areas with NHS England Regional Teams and GPC England.

2.12 GP practices signing-up to the Network Contract DES specification accept that the associated funding is dependent on the PCN working together to deliver the requirements.

2.13 The GP practices within a PCN that are signed up to the Network Contract DES must ensure the full Network Agreement is completed and signed prior to 30 June 2019. GP practices must also ensure they have in place appropriate data sharing arrangements and, if required, data processor arrangements (both using the template to be provided), that are compliant with data

[4] Further guidance relating to CQRS will be provided by NHS Digital when services are updated. If CQRS is not available by 30 June 2019, GP practices must still ensure they have confirmed their sign-up in writing to the commissioner and agree to subsequently participate in the service through CQRS.

protection legislation to support the delivery of extended hours access services prior to 30 June 2019.

2.14 By 30 June 2019, PCNs must confirm to the commissioner that the fully completed Network Agreement has been signed by all PCN member GP practices and that the GP practices have entered into the appropriate data sharing (and, if relevant data processor arrangements) to support delivery of extended hours access services from 1 July 2019. A PCN will be considered to be established on the date this confirmation is provided to the commissioner.

2.15 If a PCN is unable to confirm the matters in paragraph 2.14 above by 30 June 2019, this means the PCN will not be established by 1 July 2019. The establishment of the PCN and the commencement within that PCN of the Network Contract DES will be delayed until such point as the confirmation is provided. Any delay in the commencement of the Network Contract DES will have an effect on payments that are linked to the Network Contract DES.

2.16 All GP practices signing-up to this Network Contract DES, confirming the matters outlined in paragraph 2.14 above by 30 June 2019 and committing to being active members of their PCN as it evolves over coming years will be eligible to claim the Network Participation Payment from July 2019 to support GP practice engagement. This payment is set out in the General Medical Services Statement of Financial Entitlements (SFE) and commissioners should ensure that arrangements are made for commensurate payments for primary medical service contractors described in paragraph 2.1 to whom the SFE does not apply. It is a payment of £1.761 per weighted patient per year (equating to £0.147weighted per patient per month).

2.17 A GP practice may sign-up to the Network Contract DES after 30 June 2019. To participate in the Network Contract DES after 30 June 2019 and be eligible to receive the Network Participation Payment, the relevant GP practice will need to provide the following information to the commissioner:

a. Confirmation that the GP practice is a member of a PCN and party to the Network Agreement;
b. Agreement that payments under the Network Contract DES are made to the nominated practice or provider;

c. Any changes to the information originally submitted by the PCN that results from the GP practice joining the Network Contract DES; and

d. Confirmation that the GP practice has put in place patient record sharing arrangements (as clinically required) and data sharing arrangements of the PCN (as referred to in this section 2), in line with data protection legislation and patient opt-out preferences[5], prior to the start of any service delivery under the Network Contract DES.

2.18 Any changes to the membership of the PCN (i.e. GP practices leaving or joining) and/or the Network Area will require discussion with and approval from the commissioner. The commissioner will not unreasonably withhold approval to changes to the membership of the PCN (i.e. GP practices leaving or joining) and will not unreasonably withhold approval on changes to the Network Area. PCNs will be required to give commissioners at least 28 days' notice, providing as much information as possible on the changes, including any information required by the commissioner. Where changes are approved, they will not take effect until the start of the next quarter after approval is given. In these circumstances, contract variations will need to be entered into and the PCN will need to ensure the Network Agreement is updated accordingly. See Annex B of this Network Contract DES specification for further requirements relating to changes within a PCN.

2.19 In the event a GP practice withdraws from the Network Contract DES and/or leaves a PCN, the commissioner will need to consider the effect on provision of the PCN related services to the GP practice's registered population. The commissioner will be expected to cease the Network Participation Payment to that GP practice and if applicable reclaim any overpayments (as set out in the SFE). See Annex B to this Network Contract DES specification for further requirements relating to changes as a result of a GP practice withdrawing from the Network Contract DES and consequential changes to the PCN.

[5] https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/how-we-look-after-your-health-and-care-information/your-information-choices/opting-out-of-sharing-your-confidential-patient-information

3. Description of Primary Care Network and Network Area

3.1 Commissioners and practices should agree Network Areas which are sustainable for the future, taking account of how services are delivered by wider members of the PCN beyond the practices and with a view to the evolution of PCNs as described in *Investment and Evolution* and the changes to the Additional Roles Reimbursement Scheme from year two. They should also seek to minimise disruption to any pre-existing Primary Care Networks that have already been locally agreed with their CCGs and wider partners if these also satisfy the Network Contract DES criteria.

3.2 A PCN is defined as GP practice(s) (and other providers[6]) serving an identified 'Network Area' with a minimum population of 30,000 people. In exceptional circumstances, commissioners may 'waive' the 30,000-minimum population requirement where a PCN serves a natural community which has a low population density across a large rural and remote area.

3.3 PCNs will typically serve populations between 30,000 to 50,000. When setting the Network Area, consideration must be given to the future footprint which would best support delivery of services to their patients in the context of the broader Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP) strategy. Commissioners will usually only approve registration of a PCN if the PCN list size is indicated to be between 30,000 and 50,000.

3.4 A PCN will not tend to exceed 50,000 people, but this is not a strict requirement and commissioners may agree to larger PCNs. In such circumstances, the PCN may be required to organise itself operationally into smaller neighbourhood teams that cover population sizes between 30,000 to 50,000.

3.5 Typically, a PCN will consist of more than one GP practice but a single GP practice could form the GP component of a PCN. In such circumstances it is

[6] Examples of non-GP providers - community (including community pharmacy, dentistry, optometry), voluntary, secondary care providers and social care.

expected that the practice will work with other practices and providers to achieve the optimal benefits of PCN working.

3.6 There is no requirement for the Network Agreement that is signed by 30 June 2019 to include collaboration between practices and other providers, but this will need to be developed over 2019/20 and to be well developed by the beginning of 2020/21 when the Network Agreement will need to be updated to reflect the new Network Contract DES specification. This will be worked towards in 2019/20 and demonstrated as a requirement from April 2020 if a single GP practice forms the PCN and remains signed-up to the Network Contract DES.

3.7 The Network Area must cover a boundary that makes sense to its: (a) constituent members (b) other community-based providers who configure their teams accordingly and (c) the local community, and would normally cover a geographically contiguous area. PCNs would not normally cross CCG, STP or ICS boundaries, but there may be exceptions to this such as where the practice boundary, or branch surgery, crosses the current CCG boundaries.

3.8 The Network Area will be agreed with commissioners through the registration process (see section 2), on behalf of the ICS or STP. Commissioners will not unreasonably reject the proposed Network Area.

4. Requirements[7]

4.1 The Network Contract DES Directions will begin on 1 April 2019 and following, sign-up to the Network Contract DES, the requirements on GP practices will apply from 1 July 2019. The Network Contract DES is intended to be updated annually until at least 31 March 2024. The content in this contract specification will apply from 1 April 2019 until 31 March 2020.

4.2 With agreement between the commissioner and the PCN, commissioners may develop and commission local Supplementary Network Services[8] as an agreed supplement to the Network Contract DES, supported by additional local resources. So as to not impact upon the national reporting and

[7] Commissioners and practices should ensure they have read an understood all sections of this document as part of the implementation of this programme and to ensure accurate payment.

[8] Supplementary Network Services would be services commissioned locally, under separate arrangements and with additional resource, building on the foundation of the Network Contract DES.

requirements set out in the Network Contract DES, these local supplements should be via a separate local incentive scheme (LIS) and, as would be expected, in discussions with the LMC. This will minimise additional reporting requirements for commissioners if varying the national specification. The Network Contract DES specification must not be varied locally and commissioners are not able to increase or reduce the basic requirements nor reduce the national funding pursuant to this Network Contract DES specification.

4.3 In this Network Contract DES specification and unless expressly stated otherwise, a requirement or obligations relating to a PCN is a requirement or obligation of each of the GP practices in a PCN that have signed up to the Network Contract DES.

4.4 Network infrastructure

4.4.1 The PCN will be required to:

a. Have a single practice or provider (who must hold a primary medical care contract) to receive payments on behalf of the PCN. The practice or provider nominated will be known as the 'nominated payee'.

b. Have in place an underlying Network Agreement signed by all PCNs members, using the mandatory[9] national template. The Network Agreement[10] template is available here.

c. Ensure that an accountable Clinical Director, who will work across the PCN, is in place at all times during the term of the Network Contract DES.

d. Have in place appropriate arrangements for patient record sharing in line with data protection legislation honouring patient opt-out preferences[11] (a template data controller/data processer agreement and a template data controller/data controller agreement will be published separately in due course, for use as required).

[9] Where PCNs decide to seek advice related to the Network Agreement, these costs will not be covered under the Network Contract DES nor by commissioners at a local level.
[10] The Network Agreement template has been agreed between NHS England and GPC.
[11] https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/how-we-look-after-your-health-and-care-information/your-information-choices/opting-out-of-sharing-your-confidential-patient-information

4.4.2 Network Clinical Director

a. The PCN will be required to appoint a named accountable Clinical Director. The Clinical Director is accountable to the PCN members and will provide leadership for the PCN's strategic plans, working with members to improve the quality and effectiveness of the network services.
b. The Clinical Director will be a practicing clinician from within the PCN member practices able to undertake the responsibilities of the role and represent the PCN's collective interests. It is most likely this role will be fulfilled by a GP but this is not an absolute requirement.
c. The Clinical Director will work collaboratively with Clinical Directors from other PCNs within the ICS/STP area, playing a critical role in shaping and supporting their ICS/STP, helping to ensure full engagement of primary care in developing and implementing local system plans.
d. The following sets out the key responsibilities[12] for the Clinical Director:
    i. They will provide strategic and clinical leadership to the PCN, developing and implementing strategic plans, leading and supporting quality improvement and performance across member practices (including professional leadership of the Quality and Outcomes Framework Quality Improvement activity across the network). The Clinical Director would not be solely responsible for the operational delivery of services; this will be a collective responsibility of the PCN.
    ii. They will provide strategic leadership for workforce development, through assessment of clinical skill-mix and development of a PCN workforce strategy.
    iii. They will support PCN implementation of agreed service changes and pathways and will work closely with member practices and the commissioner and other networks to develop, support and deliver local improvement programmes aligned to national priorities.

[12] This section sets out the high level minimum requirement of the role of the Clinical Director. The detailed requirements will vary according to the characteristics of the PCN, including its maturity and local context and should be set out in the PCN's Network Agreement.

iv. They will develop local initiatives that enable delivery of the PCN's agenda, working with commissioners and other networks to reflect local needs and ensuring initiatives are coordinated.

v. They will develop relationships and work closely with other Clinical Directors, clinical leaders of other primary care, health and social care providers, local commissioners and LMCs.

vi. They will facilitate participation by practices within the PCN in research studies and will act as a link between the PCN and local primary care research networks and research institutions.

vii. They will represent the PCN at CCG-level clinical meetings and the ICS/STP, contributing to the strategy and wider work of the ICS/STP.

e. PCNs will be responsible for managing any conflicts of interest. Clinical Directors will take a lead role in developing a PCN's conflict of interest arrangements, taking account of what is in the best interests of the PCN and their patients.

f. Each PCN will be required to appoint a Clinical Director. This should follow a selection process either via appointment, election or both (see Network Contract DES guidance for further information) and included in Schedule 1 of the Network Agreement.

4.4.3 Data and analytics

a. The PCN will be required to have in place appropriate data sharing and, if appropriate data processor arrangements between members of the PCN, which must be in place prior to the start of the activity to which they relate[13]. A national template will be published in due course.

b. The PCN will also be required to share non-clinical data between its members in certain circumstances. The data to be shared should be that required to support understanding and analysis of the population's needs, service delivery in line with local commissioner objectives and compliance with the minimum requirements of this Network Contract DES

[13] For extended hours access appointments this will be for 1 July 2019.

specification. PCNs will determine appropriate timeframes for sharing of this data.

c. Where the functionality is available, clinical data sharing for service delivery should use read/write access, so that a GP from any practice can refer, order tests and prescribe electronically and maintain a contemporaneous record for every patient. Appropriate data sharing and, if appropriate, data processor, arrangements must be in place prior to the start of network service delivery (which means for extended hours access by 30 June 2019).

d. In 2019/20, the PCN should also work towards the collection, sharing and aggregation of data[14] across the member practices to enable it to carry out the following actions envisaged to be requirements of the Network Contract DES in 2020/21:

   i. support benchmarking and identification of opportunities for improvement;

   ii. identify variation in access, service delivery or gaps in population groups with highest needs; and

   iii. review capacity and demand management across the PCN, including sharing appointment data for the PCN to action (this could be achieved through using the GP workload tool or other similar tools).

e. Commissioners and the wider system will support PCNs in the analysis of data.

4.4.4 Patient engagement

a. GP member practices within the PCN will have requirements relating to patient engagement under their primary medical services contracts. The PCN will therefore be expected to reflect those requirements by engaging, liaising and communicating with their collective registered population in the

[14] Data sources include workload data, population data, appointment data, cost data, outcome data and patient experience data (e.g. friends and family test, GPPS).

most appropriate way, informing and/or involving them in developing new services and changes related to service delivery. This includes engaging with a range of communities, including 'seldom heard' groups.

b. The PCN will be required to provide reasonable support and assistance to the commissioner in the performance of its duties[15] to engage patients in the provision of and/or reconfiguration of services where applicable to the registered population.

4.4.5 Sub-contracting arrangements

a. PCNs (and their member GP practices) considering sub-contracting arrangements related to the provision of services under the Network Contract DES must have due regard to the requirements set out in the statutory regulations or directions that underpin the member GP practices' primary medical services contracts in relation to sub-contracting, which will also apply to any arrangements to sub-contract services under the Network Contract DES.
b. The PCN member GP practices may be required under their primary medical services contract to notify the commissioner, in writing, of their intention to sub-contract as soon as reasonably practicable and before the date on which the sub-contracting arrangement is intended to begin.
c. The PCN (and their member GP practices) must make available on request from the commissioner any information relating to sub-contracting arrangements and reporting information relating to either the delivery of network services or the engagement of PCN staff, for which reimbursement is being claimed under the Network Contract DES.
d. Commissioners may withhold consent to sub-contracting arrangements in accordance with the statutory regulations or directions that underpin the GP member practices' primary medical services contracts that relate to withholding consent to sub-contracting services.

[15] Section 14Z2 of the 2006 NHS Act.

4.5 Primary Care Network workforce and requirements

4.5.1 The PCN will be able to access funding as part of the Network Contract DES and as further set out in section 5, to support the recruitment of new staff to deliver health services across the PCN, as agreed by members of the PCN and set out in the Network Agreement.

4.5.2 To provide clarity on what is meant by new additional staff, the Network Contract DES introduces a principle of 'additionality'. To receive the associated funding, a PCN needs to show that the staff delivering additional services for whom funding is requested comply with this principle of additionality. The additionality rule serves both to protect pre-existing local investment in primary care (e.g. by commissioners), as well as to expand capacity.

4.5.3 Additionality will be measured on a 2018/19 baseline of staff supporting GP practices as taken at 31 March 2019 against all five staff roles. The baseline will be determined by combining information from the National Workforce Reporting System (NWRS) as at 31 March 2019 and a survey of commissioners during April 2019 according to subsequent guidance. GP practices must ensure they return the relevant data via NWRS and co-operate with commissioners in supplying information for the survey in order to be eligible for the Network Contract DES. The survey will seek information from commissioners on numbers of staff within these five roles being funded via local schemes regardless of who employs the staff or what body provides that funding. It will not be possible for commissioners to stop funding these staff on the grounds that these could instead be funded through PCN reimbursement. Commissioners will be required to maintain existing funding for the baseline staff levels.

4.5.4 PCNs will be required to demonstrate that claims being made are for new additional staff roles beyond this baseline (including in future years, replacement as a result of staff turnover). Commissioners must be assured that claims meet the additionality principles above.

4.5.5 A failure to submit information or the provision of inaccurate workforce information is a breach of the Network Contract DES specification and may result in commissioners withholding reimbursement pending further enquires. Reimbursement claims will be subject to validation and any suspicion that

deliberate attempts have been made to subvert the additionality principles will result in a referral for investigation as potential fraud.

4.5.6 Staff employed within the five roles after 31 March 2019 (i.e. above the baseline set) will be eligible for reimbursement under the Network Contract DES, if those staff are employed or engaged to deliver services across the PCN and if the PCN meets the requirements set out in this Network Contract DES specification.

4.5.7 The only exception to this baseline, will be those clinical pharmacists employed via the national *Clinical Pharmacist in General Practice Scheme* or those pharmacists employed via the *Medicines Optimisation in Care Homes Scheme*[16]. For this exception to apply the employee must be in post prior to 31 March 2019. PCNs and member GP practices must transfer clinical pharmacists, employed prior to 31 March 2019, from the existing *Clinical Pharmacist in General Practice Scheme* and meet the requirements set out in this Network Contract DES specification by 31 September 2019, after which this exception will no longer apply. For those pharmacists employed under the *Medicines Optimisation in Care Homes Scheme* transfer will take place after the scheme ends in March 2020. Further information for this latter group will be available prior to this scheme coming to an end. Full details on the transfer arrangements are available in the Network Contract DES guidance.

4.5.8 Staff delivering the additional network services may be employed by a member of the PCN, or another body (e.g. GP Federation, voluntary sector provider, Local Authority or Trust). If the network chooses to commission the additional network services from another body, outside of the PCN, which therefore employs the staff, this does not change the general position that the PCN and its member practices are responsible for ensuring that the requirements of the Network Contract DES are delivered. The employer remains responsible for all costs (including taxes and where applicable VAT)

[16] This will include some pharmacy technicians currently funded by CCGs.

and liabilities relating to the employment of staff and PCNs should set out in the Network Agreement if and how any costs and liabilities will be shared.

4.5.9 Funding available via the Network Contract DES for workforce to deliver the additional network services will be made to the nominated payee. It will be a contribution of 100 per cent for social prescribing link workers and 70 per cent for clinical pharmacists[17] towards the aggregate of actual salary and 'on' costs (pension and national insurance contributions) of employing the staff member (up to the maximum amount for the relevant role - see table 1 in section 5) and paid following the start of the employment.

4.5.10 If the workforce delivering the additional network services is employed by a non-PCN body, the contribution will be the relevant percentage of the actual salary costs that have been appropriately apportioned to PCN-related activity.

4.5.11 The nominated payee will be required to submit a monthly claim (see section 5 for further details). Commissioners will need to carry out audit appropriately and PCNs will need to co-operate fully in providing the relevant information. Failure to provide the requested information may result in the commissioner withholding or reclaiming reimbursements.

4.5.12 To ensure satisfactory provision of additional network health services, the following requirements will apply to any workforce recruited through the Network Contract DES:

a. Individuals employed will be embedded within the PCN's member practices and be fully integrated within the multi-disciplinary team delivering healthcare services to patients. They will have access to other healthcare professionals, electronic 'live' and paper based record systems of the GP member practices, as well as access to admin/office support and training and development as appropriate.

b. Individuals will benefit from a review and appraisal process, as appropriate between the PCN's member practices and any employing

[17] In future years, the 70 per cent contribution will also apply to physician associates, physiotherapists and paramedics.

organisation. They will also have access to appropriate clinical supervision and administrative support.

c. As agreed in the Network Agreement, individuals will be deployed to deliver additional network health services as described by the relevant criteria in this Network Contract DES specification and the job description for each role which the PCN will develop and agree. The relevant criteria are set out below.

4.5.13 PCNs and commissioners will agree the process for PCNs to notify commissioners of any changes to workforce where this has an impact on the payments being claimed (for example changes in WTE, new starters).

4.5.14 PCNs will record information on workforce employed, whether by the PCN itself or by another body, via the Network Contract DES in NHS Digital's National Workforce Reporting System (NWRS) in line with the existing requirements for general practice staff.

4.5.15 Clinical pharmacist

a. Clinical pharmacists being employed through the Network Contract DES funding will either be enrolled in or have qualified from an accredited training pathway that equips the clinical pharmacists to be able to practice and prescribe safely and effectively in a primary care setting (currently the CPPE Clinical Pharmacist training pathways[18,19]), and in order to deliver the key responsibilities outlined below.

b. The following sets out the key responsibilities for clinical pharmacists in delivering the additional PCN health services to patients:

i. Clinical pharmacists will work as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas.

ii. They will be prescribers, or will be completing training to become prescribers, and will work with and alongside the general practice team. They will take responsibility for the care management of

[18] https://www.cppe.ac.uk/career/clinical-pharmacists-in-general-practice-education#navTop
[19] https://www.cppe.ac.uk/wizard/files/general-practice/clinical-pharmacists-in-general-practice-education-brochure.pdf

patients with chronic diseases and undertake clinical medication reviews to proactively manage people with complex polypharmacy, especially the elderly, people in care homes, those with multiple co-morbidities (in particular frailty, COPD and asthma) and people with learning disabilities or autism (through STOMP – Stop Over Medication Programme).

iii. They will provide specialist expertise in the use of medicines whilst helping to address both the public health and social care needs of patients at the PCN's practice(s)[20] and to help in tackling inequalities.

iv. Clinical pharmacists will provide leadership on person centred medicines optimisation (including ensuring prescribers in the practice conserve antibiotics in line with local antimicrobial stewardship guidance) and quality improvement, whilst contributing to the quality and outcomes framework and enhanced services. Through structured medication reviews, clinical pharmacists will support patients to take their medications to get the best from them, reduce waste and promote self-care.

v. Clinical pharmacists will have a leadership role in supporting further integration of general practice with the wider healthcare teams (including community and hospital pharmacy) to help improve patient outcomes, ensure better access to healthcare and help manage general practice workload. The role has the potential to significantly improve quality of care and safety for patients.

vi. They will develop relationships and work closely with other pharmacy professionals across PCNs and the wider health and social care system.

[20] 'Modernising Pharmacy Careers Programme: Review of pharmacist undergraduate education and pre-registration training and proposals for reform.' Report to the Medical Education England Board. April 2011 https://hee.nhs.uk/sites/default/files/documents/Pharmacist-pre-registration-training-proposals-for-reform.pdf

vii. Clinical pharmacists will take a central role in the clinical aspects of shared care protocols, clinical research with medicines, liaison with specialist pharmacists (including mental health and reduction of inappropriate antipsychotic use in people with learning difficulties), liaison with community pharmacists and anticoagulation.

c. All clinical pharmacists will be part of a professional clinical network and will have access to appropriate[21] clinical supervision as outlined in the Network Contract DES guidance. As the number of clinical pharmacists working within PCNs increases, this should be on a ratio of one senior clinical pharmacist to five junior clinical pharmacists, and in all cases appropriate peer support and supervision must be in place.

4.5.16 Social prescribing link workers

a. The following sets out the key responsibilities for social prescribing links workers in delivering the additional PCN health services to patients:

i. As members of the PCN team of health professionals, social prescribing link workers will in 2019/20 take referrals from the PCN's members, expanding from 2020/21 to take referrals from a wide range of agencies[22] in order to support the health and wellbeing of patients. PCNs which already have social prescribing link workers in place, or which have access to social prescribing services may take referrals from other agencies prior to 2020/21.

ii. Social prescribing link workers will:

- assess how far a patient's health and wellbeing needs can be met by services and other opportunities available in the community;

[21] Clinical supervision of junior clinical pharmacists must be by a senior clinical pharmacist. The senior clinical pharmacist does not need to be working within the PCN, but could be part of a wider local network, including from secondary care or another PCN.

[22] These agencies include but are not limited to: the PCN's members, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations.

- co-produce a simple personalised care and support plan to address the patient's health and wellbeing needs by introducing or reconnecting people to community groups and statutory services;
- evaluate how far the actions in the care and support plan are meeting the individual's health and wellbeing needs[23];
- provide personalised support to individuals, their families and carers to take control of their health and wellbeing, live independently and improve their health outcomes;
- develop trusting relationships by giving people time and focus on 'what matters to them'; and
- take a holistic approach, based on the person's priorities, and the wider determinants of health.

iii. The role will require social prescribing link workers to manage and prioritise their own caseload, in accordance with the health and wellbeing needs of their population. Where required and as appropriate, the social prescribing link workers will refer people back to other health professionals within the PCN.

b. The PCN's member GP practices will identify a first point of contact for general advice and support and (if different) a GP to provide supervision for the social prescribing link worker. This could be one or more named individuals within the PCN. In addition, the PCN will ensure the social prescribing link worker can discuss patient related concerns (e.g. abuse, domestic violence and support with mental health) with a relevant GP (for example the patient's named accountable GP).

c. Referrals to social prescribing link workers will be required to be recorded within GP clinical systems using the new national SNOMED codes (see section 6).

d. The following sets out the key wider responsibilities of social prescribing link workers:

[23] Including considering if the persons needs are met (for example, reasonable adjustments, interpreter etc).

i. Social prescribing link workers will draw on and increase the strengths and capacities of local communities, enabling local Voluntary, Community and Social Enterprise (VCSE) organisations and community groups to receive social prescribing referrals.

ii. Social prescribing link workers will work collaboratively with all local partners to contribute towards supporting the local VCSE organisations and community groups to become sustainable and that community assets are nurtured, through sharing intelligence regarding any gaps or problems identified in local provision with commissioners and local authorities.

iii. Social prescribing link workers will have a role in educating non-clinical and clinical staff within the PCN on what other services are available within the community and how and when patients can access them. This may include verbal or written advice and guidance.

e. PCNs should be satisfied that organisations and groups to whom their social prescribing link workers(s) direct their patients have basic safeguarding processes in place for vulnerable individuals and that the service is able to provide opportunities for the person to develop friendships and a sense of belonging, as well as to build knowledge, skills and confidence.

f. PCNs will ensure all staff working across the PCN are aware of who the named social prescribing link workers are and how to refer to them.

g. At a local level, PCNs will work in partnership with commissioners, social prescribing schemes, Local Authorities and voluntary sector leaders to create a shared plan for social prescribing. This will include how they will build on existing schemes and work collaboratively to recruit additional social prescribing link workers to embed one in every PCN and direct referrals to the voluntary sector.

4.6 Extended Hours Access

4.6.1 Provision of extended hours access appointments is a requirement of the Network Contract DES from 1 July 2019. This is separate from the CCG commissioned extended access services in 2019/20. Where a commissioner is not satisfied that a PCN is delivering extended hours access in accordance

with the requirements of this Network Contract DES specification then it may withhold payment[24] as set out in Annex B to this Network Contact DES specification.

4.6.2 PCNs will be required to provide:

a. additional clinical sessions[25] (routine appointments including emergency or same day appointments), outside of PCN member practices core[26] contracted hours, to all registered patients within the PCN;

b. extended hours access appointments in opening hours which are held at times that takes into account patient's expressed preferences, based on available data at practice or PCN level and evidenced by patient engagement;

c. an additional period of routine appointments that equate to a minimum of 30 minutes per 1,000 registered patients per week, calculated using the following formula:

additional minutes* = a network's aggregate CRP** ÷ 1000 × 30

*convert to hours and minutes and round, either up or down, to the nearest quarter hour
**contractor registered population (CRP) will be determined at 1 January 2019.

(for a PCN with 50,000 registered patients this equates to a minimum of 25 hours per week);

d. extended hours access appointments by the PCN's member practices, or subcontracted appropriately, in continuous periods of at least 30 minutes on a regular basis in full each week, including providing sickness and leave cover; and

e. a reasonable number of these appointments face-to-face, with the rest provided by telephone, video or online consultations or a mixture of these methods.

[24] Payment withheld in this context would be an appropriate proportion of the payments in relation to both extended hours access and Core PCN funding payments.
[25] All appointments provided under the DES must be demonstrably in addition to appointments commissioned under the improving access arrangements.
[26] For PMS and APMS contractors within the PCN, extended access hours do not apply to any hours covered by core hours set out in their contracts. PCNs will be required to take consideration of this when agreeing the extended hours access offer to their registered patients. For GMS practices core hours are from 08:00 to 18:30.

4.6.3 PCNs will determine how the extended hours access appointments will be delivered as part of the Network Agreement. All PCN member practices will be expected to actively engage in planning of the service. The exact number of extended hours access appointments delivered from each member GP practice premises will be for the PCN to determine subject to complying with the minimum additional minutes set out in paragraph 4.6.2 above. Not every individual clinician or practice will be required to deliver a particular share of these appointments.

4.6.4 Extended hours access appointments may be offered with any healthcare professional or others working under supervision in the PCN[27].

4.6.5 PCN member practices must ensure that patients are aware of the availability of extended hours access appointments, including any change to published availability, through promotion and publication of the days and times of these appointment through multiple routes. This may include the NHS Choices website, in the practice leaflet, the practice website, on a waiting room poster, by writing to patients and active offers by staff booking appointments. Any cancellation of extended hours access appointments, including arrangements for re-provision (e.g. bank holidays) should be re-offered within a two-week period around the original appointments and all patients within the PCN must be notified. Commissioners will also consider how best to communicate extended hours access to their local populations by publicising information to help patients to identify which practices are offering appointments at given times.

4.6.6 PCN member practices will be required to inform patients of any changes to the pattern of extended hours access appointments, providing reasonable notice to patients.

4.6.7 If any PCN member practice is providing out of hours services to their own registered patients, they must offer routine extended hours access appointments in addition to the out of hours service.

[27] With regard to sessions provided by healthcare assistants: “the arrangements must include the provision of a specified number of clinical sessions, provided by a registered health care professional or by another person employed or engaged by the contractor to assist that health care professional in the provision of primary medical services under the contract”.

4.6.8 Unless a GP practice has prior written approval from the commissioner, no PCN member GP practice will be closed for half a day on a weekly basis and all patients must be able to access essential services, which meet the reasonable needs of patients during core hours, from their own practice or from any sub-contractor. This means that unless a GP practice has prior written approval from the commissioner, all PCN GP member practices will not close for half a day on a weekly basis.

4.7 Further requirements

4.7.1 The PCN's member GP practices will have contractual responsibility and liability to fulfil the requirements of this Network Contract DES specification.

5. Network financial entitlements

5.1 The PCN's member practices signing-up to the Network Contract DES will be required to sign up via CQRS (when available), to have met the off-line registration requirements outlined in section 2 by no later than 30 June 2019 and been approved by the commissioner. Commissioners will need to ensure they are satisfied that PCNs (and their GP practice members) have met all the requirements outlined in section 2 prior to approval. References in this section 5 to payments calculated on a per registered patient basis or based on registered lists sizes, are references to the registered patients or registered list of GP practices that are members of a PCN and which have signed up to the Network Contract DES via CQRS (when available) and agreed the same in writing with the commissioner.

5.2 Payments under the Network Contract DES will be made into the bank account of the single nominated practice or provider (who holds a GMS, PMS or APMS contract). It is the responsibility of the PCN to inform the commissioner of the relevant details. The PCN will include in the Network Agreement the details of arrangements between the nominated practice or provider receiving the payments and may indicate the basis on which that nominated practice or provider receives the payments on behalf of the other practices, e.g. as an agent or trustee.

5.3 Payment to PCNs under the Network Contract DES reflects funding for:

5.3.1 Clinical Director - population based payment[28] calculated using a baseline equivalent of 0.25 WTE (1 WTE is £137,516 in 2019/20) per 50,000 registered population size as at 1 January 2019[29]. This is a payment of £0.514[30] per registered patient for the period 1 July 2019 to 31 March 2020 (which equates to £0.057 per patient per month), reflecting the fact that the Network Contract DES begins in July and this will be the point at which the Clinical Director takes up the post. The payment will start from July 2019 and is payable on a monthly basis by commissioners, no later than the last day of the month in which the payment applies and taking into account local payment arrangements.

5.3.2 Core PCN funding (for use by the PCN as required) - payment of £1.50 per registered patient as at 1 January[31] 2019 (equating to £0.125 per patient per month). This payment is to be made from CCG core allocations[32] as per the NHS Operational Planning and Contracting Guidance 2019/20. The first payment is to be made on or by the end of July 2019 and should be backdated[33] to 1 April 2019 and cover the period 1 April to July 2019). Thereafter payments will be payable on a monthly basis by commissioners, no later than the last day of the month in which the payment applies and taking into account local payment arrangements.

5.3.3 Workforce (through the Additional Roles Reimbursement Sum) - PCNs will be entitled to claim a percentage reimbursement of either 70 per cent or 100 per cent as set out in Table 1 and based on actual[34] salary (including employer on-costs[35]) up to the maximum amount as outlined in Table 1, for the delivery of additional network health services. The following conditions apply:

[28] This is a contribution to the role.
[29] https://digital.nhs.uk/services/organisation-data-service
[30] For example, a 40,000 PCN would receive £20,627 or a 50,000 PCN would receive £25,784. The additional 6 per cent employer's superannuation will be met centrally.
[31] https://digital.nhs.uk/services/organisation-data-service
[32] Rather than specific primary medical care allocations.
[33] Backdating of Core PCN funding will not apply post sign-up to the Network Contract DES in year.
[34] If relevant the percentage will be appropriately apportioned to PCN related activity.
[35] This does not include the additional 6 per cent employer contributions.

a. The payments will be payable on a monthly basis in arrears following the start of employment. Commissioners will make payments no later than the last day of the following month in which the payment applied and taking into account local payment arrangements (for example, July 2019 payment to be made on or by end August 2019).
b. For 2019/20 this funding will be available to support the relevant percentage reimbursement of one Whole Time Equivalent (WTE) clinical pharmacist and one WTE social prescribing link worker per PCN. PCNs beyond a population size of 100,000 will be able to claim the relevant percentage reimbursement for two WTE clinical pharmacists and two WTE social prescribing link workers, extending to one additional WTE of each of these roles per 50,000 population.
c. With agreement from the commissioner, PCNs will be able to substitute between clinical pharmacists and social prescribing link workers, within the parameters outlined in paragraphs 5.3.3.a and 5.3.3.b, providing the PCN:
    i. has made sufficient efforts, but is unable to recruit a clinical pharmacist or social prescribing link worker (due to limited workforce availability), OR
    ii. can demonstrate it already has access to a full complement[36] of clinical pharmacists or social prescribing link workers.
d. PCNs will be required to demonstrate that claims being made are for additional staff roles beyond the baseline (including in future years, replacement as a result of staff turnover) as set out in this Network Contract DES specification. Commissioners will be required to ensure the claims meet the 'additionality rules' set out in paragraphs 4.5.2 to 4.5.7. PCNs (and GP member practices) not fully participating in the process for setting the baseline data will not be eligible for workforce reimbursement under the DES and could

[36] Full complement is equivalent to 1 clinical pharmacist or 1 social prescribing link worker per 50,000 population.

be subject to the recovery of funds and referral for investigation of fraud as set out in paragraph 4.5.5.

e. Clinical pharmacists reimbursed under either the national *Clinical Pharmacists in General Practice Scheme* or *Medicines Optimisation in Care Homes Scheme* that have been transferred[37] to receive funding under the Network Contract DES must meet the terms set out in this Network Contract DES specification and the clinical pharmacist will need to be working across the PCN and carrying out the same duties described in paragraph 4.5.15 in the delivery of additional network health services.

f. PCNs should bear in mind that from 2020/21 reimbursement for workforce will be available up to a sum calculated on the basis of their weighted population, providing greater future flexibility. The guidance provides further details.

5.3.4 Extended hours access appointments - payment of £1.45 per registered patient as at 1 January[38] preceding the relevant year. For 2019/20 it is a payment of £1.099 per registered patient (equating to £0.122 per patient per month) under this DES for the period 1 July 2019 to 31 March 2020 reflecting the fact that the DES begins in July (and prior to this the stand-a-lone extended hours access DES covers the period 1 April 2019 to 30 June 2019). The payment will start from July 2019 and be payable on a monthly basis by commissioners, no later than the last day of the month in which the payment applies and taking into account local payment arrangements. Recurrent investment of £30 million has been included in global sum.

5.4 Payments due to a PCN being formed in-year after 30 June 2019, or where a GP practice signs-up and joins a PCN in-year, will be made on a pro-rata basis accordingly.

5.5 Commissioners will need to be satisfied prior to making the first payment that the PCN has met the requirements outlined in section 2 including that a data-

[37] Information regarding the transition arrangements is available in the Network Contract DES guidance (see link at footnote 24).
[38] https://digital.nhs.uk/services/organisation-data-service

sharing agreement is in place by 30 June 2019 to support extended hours access delivery.

5.6 Commissioners will be able to reclaim payments on a pro-rata basis if a PCN member GP practice, which signed up to the Network Contract DES, cease participation in the Network Contract DES during the financial year. Any reclaim of payments will be made at the end of a financial quarter.

Table 1: Percentage of actual salary costs claimable and maximum reimbursement amounts per role for 2019/20.

Role	AfC band	Percentage reimbursement (of actual salary inclusive of employer on-costs)	Maximum reimbursable amount[39] £
Clinical pharmacist	7-8a	70%	37,810
Social prescribing link worker	Up to 5	100%	34,113

5.7 PCNs will only be eligible for payment where all of the following requirements have been met:

a. As set out in paragraph 4.4.1.

b. For workforce related claims, the PCN has met the requirements as set out in paragraph 4.5 for the relevant roles against which payment is being claimed. Payments can be claimed upon the commencement of the individual's employment. Payment under the Network Contract DES, or any part thereof, will only be made if the PCN satisfies the following conditions:

i. The employing organisation (whether this be a PCN member or a third party) continues to employ the individual(s) for whom payments are being claimed and the PCN continues to have access to them;

[39] The maximum reimbursable amount is the sum of (a) the weighted average salary for the specified AfC band plus (b) associated employer on-costs. These amounts do not include any recruitment and reimbursement premiums that PCNs may choose to offer. If applicable, the on-costs will be revised to take account of any pending change in employer pension contributions. The maximum reimbursement amount in subsequent years will be confirmed in line with applicable AfC rates.

ii. The PCN makes available to commissioners any information under the Network Contract DES, which the commissioner needs and the PCN either has or can be reasonably expected to obtain in order to establish that the PCN has fulfilled the requirements of the Network Contract DES specification;

iii. The PCN makes any returns required of it and does so promptly and fully; and

iv. All information supplied pursuant to or in accordance with this paragraph must be accurate.

c. For extended hours access related claims, the PCN has met the requirements as set out in paragraph 4.6. Payment under the Network Contract DES, or any part thereof, will only be made if the PCN satisfies the following conditions:

i. The PCN makes available to commissioners any information under the Network Contract DES, which the commissioner needs and the PCN either has or can be reasonably expected to obtain in order to establish that the PCN has fulfilled the requirements of the Network Contract DES specification;

ii. The PCN makes any returns required of it in relation to the delivery of services as set out in the Network Contract DES and does so promptly and fully in keeping with reasonable requirements set by the commissioner; and

iii. All information supplied pursuant to or in accordance with this paragraph must be accurate.

5.8 Commissioners will be responsible for post payment verification. This may include auditing claims of the PCN (and its member practices) to ensure that they meet the requirements of the Network Contract DES. Where required, PCNs and/or their member GP practices will provide to the commissioner in a timely manner all relevant information and assistance to support assessment of compliance with the requirements of this service and expenditure against the Network Contract DES.

5.9 PCNs (and their member GP practices) will be required to adhere to current financial probity standards that are in place across the NHS, ensuring that the deployment of resources would stand up to wider scrutiny as an efficient and

effective use of NHS funding. PCNs unable to provide sufficient information to substantiate claims may result in payments being withheld or reclaimed. Any payment being withheld or reclaimed would be proportionate to the information the PCN is unable to provide.

5.10 Administrative provisions relating to payments under the Network Contract DES are set out in Annex B.

6. Monitoring

6.1 Commissioners will monitor services and calculate payments under the Network Contract DES using NHAIS or any subsequent replacement system.

6.2 Network member practices will be required to manually input data into CQRS, until General Practice Extraction Service (GPES) (or any subsequent replacement system) is available to conduct electronic data collections. The data input will be in relation to the management counts only. For information on how to manually enter data into CQRS, see NHS Digital.

6.3 Network member practices will be required to use the relevant SNOMED codes, as published in the supporting Business Rules on the NHS Digital website (http://www.hscic.gov.uk/qofesextractspecs) to record:

a. Social prescribing offered
b. Social prescribing declined
c. Referral to social prescribing service
d. Clinical pharmacists' consultations
e. Clinical pharmacists' medication reviews
f. Clinical pharmacists' care home visits

6.4 Details as to when and if automated collections are available to support this ES will be communicated via the HSCIC.

6.5 The Technical requirements for the 2019/20 GMS Contract document will list the SNOMED codes for this service when available. The codes will be used as the basis for the GPES data collection, which will allow CQRS to calculate aggregated numbers to support the management information counts. It is required that practices use the relevant codes within their clinical systems as only those included in this document and the supporting Business Rules will be acceptable to allow CQRS calculations. PCN member practices will therefore need to ensure that they use the relevant codes and if necessary, re-code patients.

Annex A: Network Contract DES registration form

Network Contract DES Registration Form

This registration form sets out the information required by the commissioner for any GP practices within primary care networks signing-up to the Network Contract Directed Enhanced Service.

The completed form is to be returned to [insert name] by [insert method of sending] to be received no later than 15 May 2019.

PCN members and ODS code

Network Member Practices	ODS code	Practice's registered list size (as at 1 January 2019)

PCN list size

[This is the sum of member practice's list sizes as at 1 January 2019]

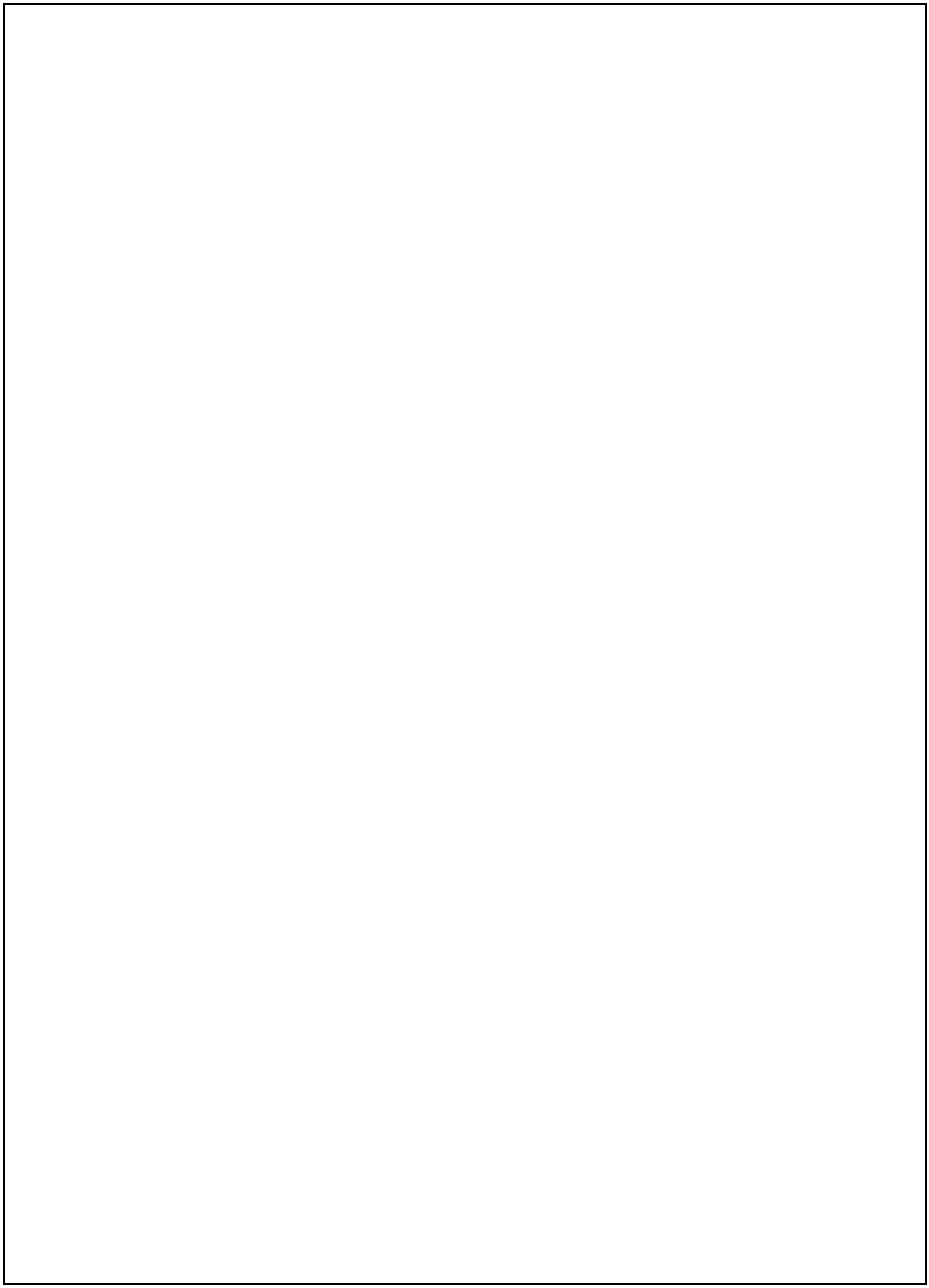
Name of Clinical Director

Name	Job Title	Practice/organisation	Contact Email Address

Details for PCN's nominated payee

Name of single nominated practice or provider ('nominated payee'):		
Name of bank account (if different to above)	Account number	Sort code

Map of Network Area



Appendix A: Initial Network Agreement

Annex B. Administrative provisions relating to payments under the Network Contract DES

B1. Provisions relating to the Network Contract DES payments

B1.1. Payments under the Network Contract DES are to be treated for accounting and superannuation purposes as gross income of the PCN member GP practice(s), in the financial year.

B1.2. The payments calculated under this Network Contract DES specification are set out in section 5.

B1.3. Payment under the Network Contract DES, or any part thereof, will be made only if the PCN satisfies the following conditions:

a. the PCN must make available to commissioners any information under the Network Contract DES, which the commissioner needs and the PCN either has or could be reasonably expected to obtain,

b. the PCN must make any returns required of it (whether computerised or otherwise) to the payment system or CQRS and do so promptly and fully; and,

c. all information supplied pursuant to or in accordance with this paragraph must be accurate.

B1.4. If the PCN or PCN member GP practice(s) do not satisfy any of the above conditions, commissioners may, in appropriate circumstances and acting reasonably, withhold payment of any, or any part of, an amount due under the Network Contract DES that is otherwise payable to the PCN.

B1.5. If a commissioner makes a payment to a PCN under the Network Contract DES and:

a. the PCN was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment or because the payment was calculated incorrectly (including where a payment on account overestimates the amount that is to fall due); or

b. the commissioner was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money has already been paid,

then the commissioner is entitled to repayment of all or part of the money paid. Commissioners may, in this circumstance, recover the money paid by

deducting an equivalent amount from any payment payable to the PCN or to each individual member practice of the PCN, and where no such deduction can be made, it is a condition of the payments made under the Network Contract DES that the PCN[40] must pay to the commissioner that equivalent amount.

B1.6. Where the commissioner is entitled under the Network Contract DES to withhold all or part of a payment because of a breach of a payment condition and the commissioner does so or recovers the money by deducting an equivalent amount from another payment in accordance with paragraphs B1.4 and B1.5 of this annex, it may, where it sees fit to do so, reimburse the PCN the amount withheld or recovered, if the breach is cured.

B2. Provisions relating to a situation where a PCN member GP practice's primary medical services contract expires or is terminated prior to 31 March 2020

B2.1. Where a PCN member GP practice has entered into the Network Contract DES but its primary medical services contract expires or terminates for any reason prior to 31 March 2020, then that GP practice's participation in the Network Contract DES will cease from the date of expiry/termination. In such circumstances, the following will apply:

a. The GP practices within the PCN must, as soon as they are aware of the possibility of a member GP practice no longer being a member of the PCN, notify the commissioner.

b. The commissioner will consider the matter, including holding discussions with all GP practices within the PCN.

c. The commissioner will consider the consequences of the GP practice no longer being a member of the PCN. This will include:

   i. the likely consequences for the registered patients of the GP practice when that GP practice is no longer a member of the PCN – i.e. whether a new primary medical services contract will be

[40] The PCN will be required to agree how they would deal with such a circumstance, so as not to disadvantage the nominated payee. Where required, commissioners may consider withholding the SFE payment.

entered into which takes over the former GP practice's existing patient list, whether registered patients of the previous GP practice are dispersed between existing GP practices in the area or any other likely consequences;

ii. the impact of any consequences on the PCN's Network Financial Entitlements. It is acknowledged that for payments based on registered list sizes, the consequence of a GP practice no longer being a member of a PCN could in certain circumstances result in a reduction in the level of payments made to a PCN; and

iii. any other relevant matters.

d. The commissioner will, depending on the likely consequences and following any discussion with the LMC, determine the outcome of such matters including any changes to the registration of the PCN such as changes to the Network Area and/or level of payments due to the PCN under this Network Contract DES specification. Where the remaining GP practices propose any changes to the PCN, the commissioner will not unreasonably withhold consent to those changes.

e. The commissioner may, depending on the likely consequences and at its discretion, determine that where there is a significant influx of new patients registering with a PCN member GP practice, it is appropriate for payments that are based on a registered list size to be based on registered list sizes as on a date that is more recent than 1 January 2019.

B2.2. From the date of the expiry or termination of the GP practice's primary medical services contract, the GP practice will no longer be a member of the PCN and the PCN will remove that GP practice from the Network Agreement.

B3. Provisions relating a situation where a PCN member GP practice withdraws from the Network Contract DES prior to 31 March 2020

B3.1. Where a PCN member GP practice has entered into the Network Contract DES but subsequently wishes to withdraw from the Network Contract DES prior to 31 March 2020, that GP practice must inform all other GP practices in the relevant PCN in accordance with any notification period set out in the

PCN's Network Agreement and ensure the commissioner is notified at least three months prior to the proposed withdrawal date.

B3.2. Where the commissioner receives a notification as set out in paragraph B3.1 above, it shall consider the consequences of the GP practice no longer participating in the Network Contract DES. It shall discuss matters with the GP practices in the relevant PCN. Its consideration will include:

a. whether that GP practice is intending to remain in the relevant PCN. As set out in paragraph 2.18 of the Network Contract DES specification, any changes to the membership of a PCN requires discussion with, and the approval of, the relevant commissioner, such approval not to be unreasonably withheld;

b. the likely consequences for the registered patients of the GP practice when that GP practice no longer participates in the Network Contract DES;

c. the impact of any consequences on the relevant PCN's Network Financial Entitlements. It is acknowledged that for payments based on registered list sizes, the consequence of a GP practice no longer participating in the Network Contract DES is likely to result in a reduction in the level of payments made to a PCN;

d. whether it is appropriate to commission a local incentive scheme as referred to in paragraph 2.10 of this Network Contract DES specification; and

e. any other relevant matters.

B3.3. The commissioner will, depending on the likely consequences and following any discussion with the LMC, determine the outcome of such matters including any changes to the registration of the PCN such as changes to the Network Area and/or level of payments due to the PCN under this Network Contract DES specification. Where the remaining GP practices in the PCN propose any changes to the PCN, the commissioner will not unreasonably withhold consent to those changes.

B4. Provisions relating to PCN member GP practices which leaves a PCN prior to 31 March 2020 (subject to Annexes B5 to B7)

B4.1. Where a PCN member GP practice that is signed up to and remains signed up to the Network Contract DES:

a. intends to voluntarily leave the PCN prior to 31 March 2020; or

b. may potentially be expelled from the PCN prior to 31 March 2020,

then, should any of these events occur, it will lead to a change to the membership of the PCN.

B4.2. As set out in paragraph 2.18 of the Network Contract DES specification, any changes to the membership of a PCN requires discussion with, and the approval of, the relevant commissioner, such approval not to be unreasonably withheld.

B4.3. The GP practices in a PCN must therefore notify the commissioner where any of the events set out in paragraph B4.1 above may occur and, in the event a GP practice intends to voluntarily leave, the commissioner should be notified as soon as the PCN is aware of the intention of that GP practice to leave.

B4.4. The commissioner will consider the matter, including holding discussions with all GP practices within the PCN.

B4.5. The commissioner will consider the consequences of the GP practice leaving the PCN. This will include:

a. the likely consequences for the registered patients of the GP practice when that GP practice leaves the PCN – i.e. whether that GP practice is looking to join another PCN;

b. the impact of any consequences on the Network Financial Entitlements of the PCN which the GP practice is leaving and that of the PCN the GP practice is joining. It is acknowledged that for payments based on registered list sizes, the consequence of a GP practice leaving a PCN is likely to be a reduction in the level of payments made to a PCN;

c. the viability of the PCN with reference to the aggregate minimum registered patient level for PCNs set out in the Network Contract DES specification and any request by the remaining practices in the PCN to

dissolve the PCN and for those GP practices to be allowed to cease participating in the Network Contract DES; and

d. any other relevant matters.

B4.6. The commissioner will, depending on the likely consequences and following any discussion with the LMC determine the outcome of such matters including any changes to the registration of any affected PCN including but not limited to changes to the Network Area and/or level of payments due to an affected PCN under this Network Contract DES specification. Where the remaining GP practices in the PCN propose any changes to the PCN, the commissioner will not unreasonably withhold consent to those changes.

B4.7. From the date the GP practice leaves a PCN, the PCN will remove that GP practice from the Network Agreement.

B5. Provisions relating to PCN member GP practices who merge or split, but remain within the same PCN (subject to Annex B7 below)

B5.1. It is acknowledged that the prior consent of the commissioner will be required where:

a. two or more PCN member GP practices merge and the resulting single GP practice remains within the same PCN; or

b. two or more GP practices are formed from the split of a single GP practice and the resulting GP practices remain within the same PCN.

B5.2. Where the commissioner agrees any of the events set out in paragraph B4.1 above, then for the purposes of the Network Contract DES, payments due under the Network Contract DES will continue to be made in accordance with this Network Contract DES specification.

B6. Provisions relating to PCN member GP practices who merge or split, but change PCNs (subject to Annex B7 below)

B6.1. It is acknowledged that the prior consent of the commissioner will be required where:

a. two or more PCN member GP practices merge and the resulting single GP practice does not remain within the same PCN; or

b. two or more GP practices are formed from the split of a single GP practice and the resulting GP practices do not remain within the same PCN.

B6.2. Such actions will result in changes to the membership of a PCN. As set out in paragraph 2.18 of the Network Contract DES specification, any changes to the membership of a PCN requires discussion with, and the approval of, the relevant commissioner, such approval not to be unreasonably withheld.

B6.3. The GP practices in a PCN must therefore request the commissioner's consent as soon as practicable where any of the events set out in paragraph B6.1 above are proposed.

B6.4. The commissioner will consider the requests in accordance with its policies relating to mergers and splits. Part of that consideration will include the consequences on the Network Contract DES. Where the commissioner considers the Network Contract DES element of the matter, it will discuss matters with the GP practices in the relevant PCNs. Such consideration will include:

a. the likely consequences for the registered patients of the GP practice(s);

b. the impact of any consequences on the Network Financial Entitlements of the relevant PCNs. It is acknowledged that for payments based on registered list sizes, the consequence of a GP practice leaving a PCN is likely to be a reduction in the level of payments made to a PCN;

c. the viability and/or appropriateness of the relevant PCNs with reference to the minimum and upper figure patient levels for PCNs set out in this Network Contract DES specification and any request by the remaining practices in a PCN to dissolve the PCN and for those GP practices to be allowed to cease participating in the Network Contract DES; and

d. any other relevant matters.

B6.5. The commissioner will, depending on the likely consequences and following any discussion with the LMC, determine the outcome of such matters including any changes to the registration of any affected PCN including but not limited to changes to the Network Area and/or level of payments due to

an affected PCN under this Network Contract DES specification. Where the remaining GP practices in the PCN propose any changes to the PCN, the commissioner will not unreasonably withhold consent to those changes.

B6.6. From the date the GP practice(s) leaves a PCN, the PCN will remove that GP practice(s) from the Network Agreement.

B7. Provisions relating to non-standard splits and mergers

B7.1. Where a PCN member GP practice participating in the Network Contract DES is subject to a split or a merger and:

a. the application of the provisions set out above in respect of splits or mergers would, in the reasonable opinion of the commissioner, lead to an inequitable result; or,

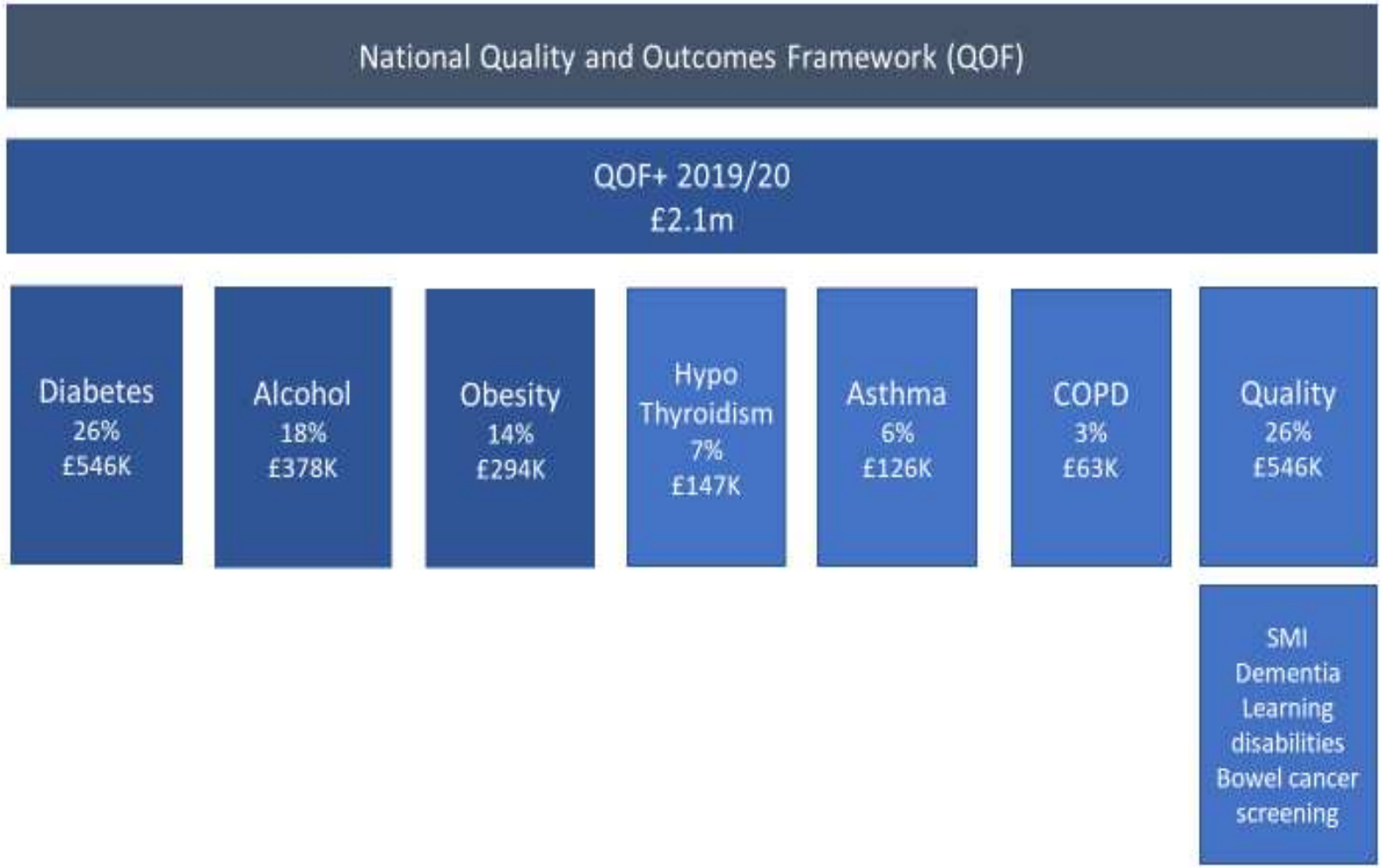
b. the circumstances of the split or merger are such that the provisions set out in this section cannot be applied,

the commissioner may, having regard to the views of the PCN member GP practice(s) concerned, agree to such payments as in the commissioner's opinion are reasonable in all circumstances.

QOF+ Update

- QOF+ Development Group December 2018 →
- FAQ Document
- Ongoing support from IM&T Facilitators
- 2018/19 Scheme & preparation for 2019/20

Month	2018/19	2019/20
March 2019	Close scheme	Draft revised scheme with additional content including new indicators
April 2019	Commence reconciliation process, including notification of payment	Finalise indicator wording Identify read codes & build searches (Insight) Final draft document shared for comment
May 2019	Address queries & arrange payment Scheme Value £1.2m	Approval at Primary Care Commissioning Committee Scheme Value £2.1m Commence implementation of new scheme – support pack


National Quality and Outcomes Framework (QOF)
QOF+ 2019/20
£2.1m
Diabetes
26%
£546K
Alcohol
18%
£378K
Obesity
14%
£294K
Hypo Thyroidism
7%
£147K
Asthma
6%
£126K
COPD
3%
£63K
Quality
26%
£546K
SMI
Dementia
Learning disabilities
Bowel cancer screening

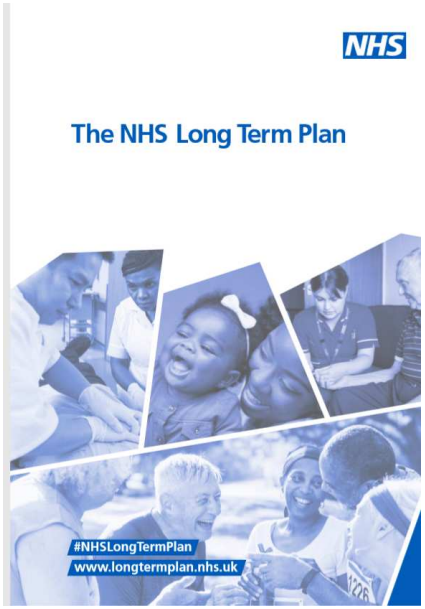
Primary Care Networks

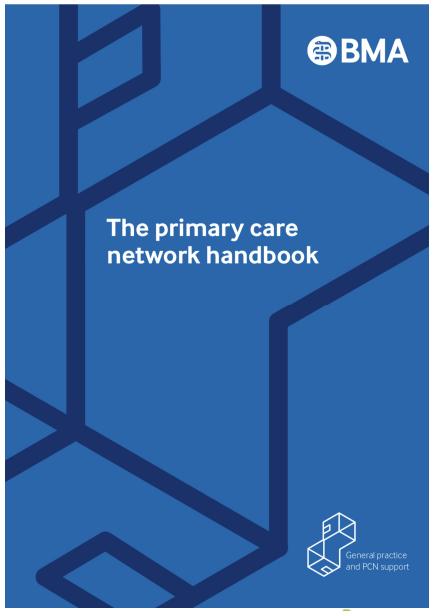
NHS England

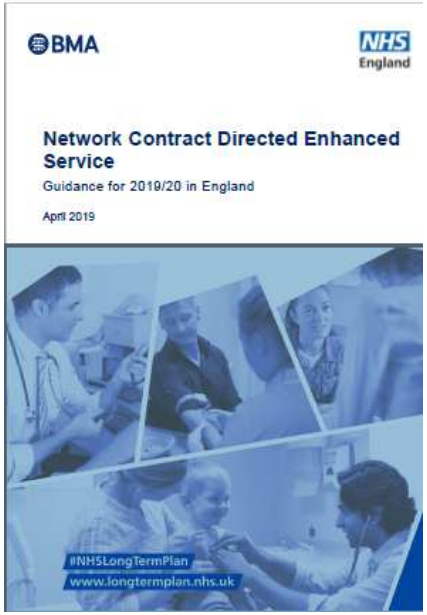
Primary care networks

Reference Guide

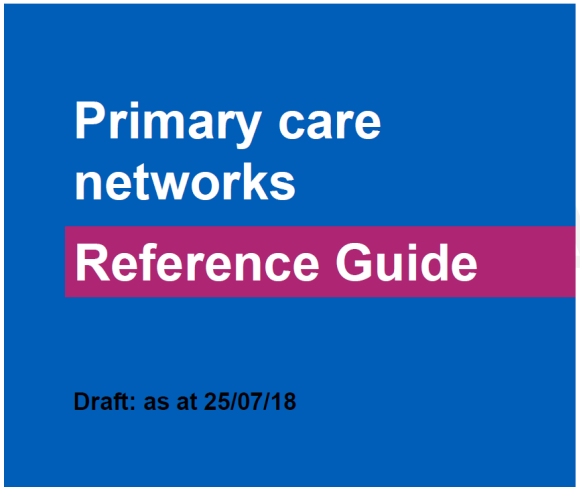
Draft: as at 25/07/18







Primary Care Networks



NHS England

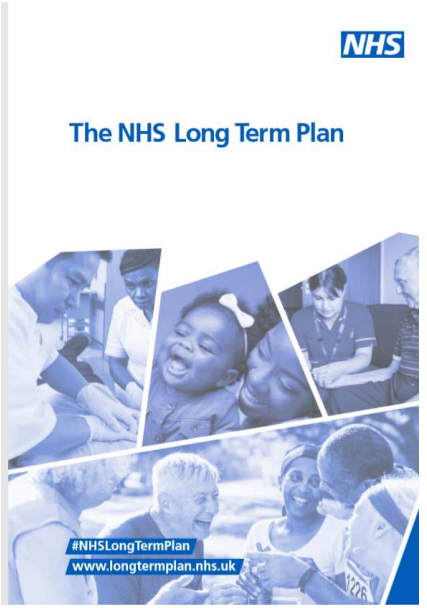
- *Practices working together and with other local health & care providers*
- *Providing care in different ways to match different people's need*
- *Focus on prevention, patient choice & self care*
- *Use of data & technology*
- *Making best use of collective resources across practices*

- Core Characteristics
  - Improved ways to deliver care
  - Practice Resilience
  - Collaboration & integration
  - Every practice → Network

- Enablers
  - Workforce
  - Patient & Public Engagement
  - Digital
  - Clinical Governance
  - Estates
  - Business Model
- Maturity Levels
  - Foundations for transformation
  - Steps 1→3

Primary Care Networks

- New ways of work for Primary Care - PCNs
- Changes to QOF
- International Recruitment*
- Support for Care Homes*
- Focus on Population Health
- Move to ICS – Primary Secondary Care Toolkit*
- Clinical Priorities
  - Smoking
  - Obesity*
  - Alcohol*
  - Air Pollution
  - Antimicrobial Resistance
- Engaging People



Primary Care Networks

NHS England's definition:-

- Primary care networks enable the provision of proactive, accessible, coordinated and more integrated primary and community care improving outcomes for patients.

- They are likely to be formed around natural communities based on GP registered lists, often serving populations of around 30-50,000 patients.

- Networks will be small enough to still provide the personal care valued by both patients and GPs but large enough to have impact through deeper collaboration between practices and others in the local health (community and primary care) and social care system. They will provide a platform for providers of care being sustainable into the longer term.

General Practice the Bedrock of the NHS – Survive & Thrive (BMA)

What great PCNs look like and how they will develop

	Foundations for transformation	*Step 1*	*Step 2*	*Step 3*
Right scale	**Plan:** There is a plan in place articulating a clear end state vision and steps to getting there, including actions required at team, network and system level	**Practices** identify partners for network-level working and develop shared plan for realisation.	**Practices** have defined future business model and have early components in place. Functioning **interoperability between practices,** including read/write access to records. Data sharing agreements in place.	**Network business model** fully operational. **Interoperable systems** Workforce shared across network. Rationalisation of estates.
Integrated working	**Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there.	**Integrated teams**, which may not yet include social care, are working in parts of the system.	**Integrated teams** in place throughout system and formalised to include social care, the voluntary sector and easy access to secondary care expertise in at least some sites.	**Fully functioning integrated teams** in place across whole system including general practice, access to secondary expertise, nursing, community services, social care and voluntary sector. Care plans and coordination in place for all high risk patients.
Targeting care	**Time:** Primary care, in particular general practice, has the headroom to make change.	**Analysis on variation** between practices is readily available and acted upon. **Basic population segmentation** is in place, with understanding of needs of key groups and their resource use. Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them. **Prototypes** in place for highest risk groups.	The system can **track data in real time,** including visibility of patient movement across the system and between segments, and information on variability. **New models of care** in place for most population segments, including both proactive and reactive models, with standardised protocols in use across the system.	**Systematic population segmentation including risk stratification**, with in depth under-standing of needs of each population segment. Routine peer review of metrics in and between networks. **New models of care in place to meet needs of all population segments**. Internal referral processes in place.
Managing resources	**Transformation resource:** There are people available with the right skills to make change happen.	Steps taken to ensure **operational efficiency** of primary care delivery.	**Networks have sight of resource use** for their patients, and can pilot new incentive schemes.	Primary care networks take **collective responsibility for available funding.** Data being used at individual clinical level to make best use of resources.
Empowered Primary Care		**Primary care** has a seat at the table for all system-level decision making.		**Primary care network** full decision making member of ICS leadership.

Primary Care Networks

Core of a PCN

- Build on current primary care
- Groups of practices working together
- Based on GP registered lists 30-50,000 combined list size
- Nominated Clinical Director
- Shared workforce, patient & public engagement, technology, clinical governance, technology enabled care, information systems,

What will they do

- Practices will be more resilient (patient & practice)
- Core values & strengths
- Majority of care will remain with practice – strong focus on prevention - population focus
- Services provided collectively if not viable for every practice to provide
- Offer more options for patients to access services tailored to their communities
- Greater voice in service redesign
- Share resources, receive funding

Primary Care Networks

Summary of agreement

- Addresses workload issues
- Brings a permanent solution to indemnity costs and coverage
- Improves the Quality and Outcomes Framework
- Introduces a new Network Contract DES
- Helps join-up urgent care services
- Enables practices and patients to benefit from digital technologies
- Delivers new services to achieve *NHS Long Term Plan* commitments
- Gives five-year funding clarity and certainty for practices
- Tests future contract changes prior to introduction

PCN Focus

- Funding
- New Workforce
- Requirements
- Network Agreement
- Extended Hours Access DES

Funding

Uplift in global sum 2019/20

£1.50 per patient funded by CCG (Network DES & additional ring fenced ££ (NHSE) for PCNs

70% NHSE/30% PCNs funding for new roles

BUT

100% funding for Social Prescribers (NHSE)

Clinical Director 1 day per week (based on 40k network population 0.25 funded by NHSE)

Extended Access DES → Network Contract

Workforce

2019 1 Clinical Pharmacist & 1 Social Prescriber per network

2020 1 First Contact Physio(s) & 2 Physicians Associate(s) per network

2021 1 Community Paramedic per network

2022 All roles increasing by 2024 typical network will comprise of:-

- 3 Social Prescribers*
- 3 First Contact Practitioners } *flexibility on numbers & professionals in networks*
- 2 Physicians Associates*
- 1 Clinical Pharmacist*

Requirements

Clinical priorities etc

Complete short submission to CCG (names, codes for each practice & network list size)

Map marking the network area & name/details of provider to receive funding

Name of Clinical Director

Initial Work Agreement signed by each practice

Network Agreement

outlines ***decisions*** about how they will ***work together***, which practice ***does what***, how ***funding*** will be ***allocated*** between practices, how the ***new workforce will be shared (including who employs them)***

……can be amended over time ie new workforce/services as they become available including funding

Extended Hours DES

Extended Hours Access DES – currently ***practice level*** sign up will move to ***network*** & will be responsible for equivalent coverage for 100% of network population in addition to services currently ***provided by hubs/PCNs*** – funding will continue at ***£6.00 pp*** delivered via the network

Note: DES Funding will flow to the Network

****STPs ensure PCNs are provided with data analytics for population segmentation & risk stratification****

Primary Care Networks

Working in Partnership with People & Communities

- Public participation including local people, service users & carers, as an integral part of PCN decision making
- Working in partnership with people & communities having an ongoing dialogue with the wider community as well
- Local people should be involved and able to influence decision making, contribute by sharing ideas and ambitions, supporting evaluation options & supporting continuous improvement

What the public said

- Services working better together across health & social care
- Those with complex needs, a single point of access for help & support
- Access to local organisations outside the nhs that can help them stay well
- Quicker access to a range of services out of hospital to manage urgent needs
- Technology to help self care, care navigation, book appointments, arrange prescriptions, access records online and patient consultations online

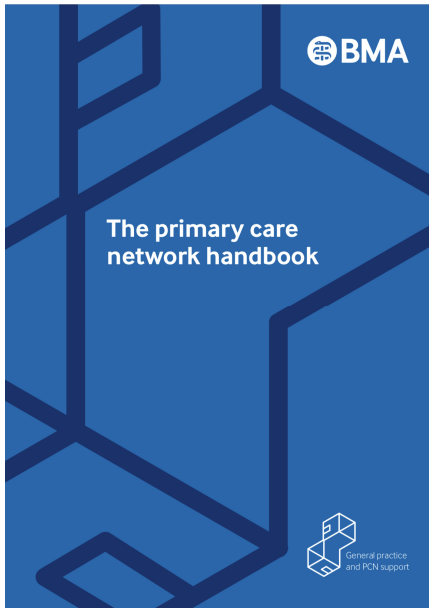
Patients should experience

- Joined up services
- Access to a wider range of professionals & diagnostics
- Different way of getting advice & treatment
- Shorter waiting times
- Greater involvement
- An increased focus on prevention & personalised care

Primary Care Networks

Creating PCNs

- Geography - *The only involvement of the CCG in this process should be when there are gaps in the total PCN coverage of their area*
- To be recognised as a PCN, individual GP practices will need to make a brief joint submission
- Appoint a clinical director
- First Steps, Early Stage, Mature Stage
- Internal Governance – Governing/representative body, decision making, accountability, data sharing, dispute resolution, finances, HR Policies etc
- PCN Structures & Employment Models – leadnominated employee, shared employment contracts



NOTE: Risk Assessment - no VAT nor CQC issues envisaged

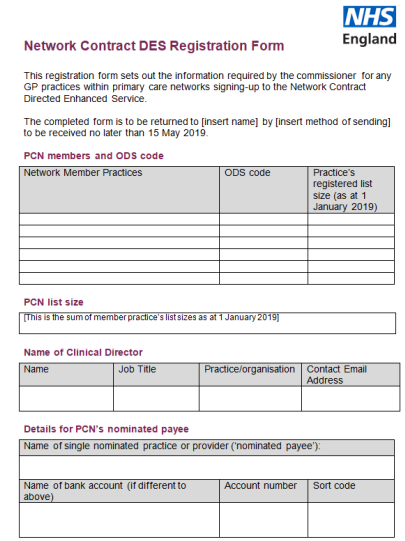
Primary Care Networks

- CCG Process – communicated to practices & prepared for sign off in May
- Work closely with LMC – CCG & Practices
- Full agreement(s) signed by 30 June*
- ££Network Participation Payment (practice)
- ££Network DES (network)
- Network Area – minimum 30k patients, neighbourhoods, delivery of services, network development, sensible network boundary
- Network infra-structure – nominated payee will be a contract holder of PMS, clinical director (at all times), patient record sharing (patient opt out preferences), data analytics, patient engagement, sub contracting
- Workforce requirements – recruitment of new staff, principle of additionality ie 18/19 baseline (NWRS), Clinical Pharmacists, Social Prescribing Link Workers
- Extended Hours DES – Network DES from 1 July (not CCG commissioned service), additional clinical sessions £1.09 pp,
- Financial Entitlements –
  - Core PCN Funding £1.50 pp (CCG ££)
  - Clinical Director Contribution £0.51 pp Jul-Mar 2020 (£0.57 pp Apr 2020)
  - Staff Reimbursements (70% & 100%)
  - Extended Hours Access DES
- Future Requirements – Collaboration with non GP Providers 2020/21, Network Service Spec's (medication reviews, EHCH, anticipatory care, cancer diagnosis, personalised care, CVD, neighbourhood inequalities
- Monitoring – Social Prescribing & Clinical Pharmacist activity


NHS England

Network Contract Directed Enhanced Service

Contract specification 2019/20


NHS England

Network Contract DES Registration Form

This registration form sets out the information required by the commissioner for any GP practices within primary care networks signing-up to the Network Contract Directed Enhanced Service.

The completed form is to be returned to [insert name] by [insert method of sending] to be received no later than 15 May 2019.

PCN members and ODS code

Network Member Practices	ODS code	Practice's registered list size (as at 1 January 2019)

PCN list size

[This is the sum of member practice's list sizes as at 1 January 2019]

Name of Clinical Director

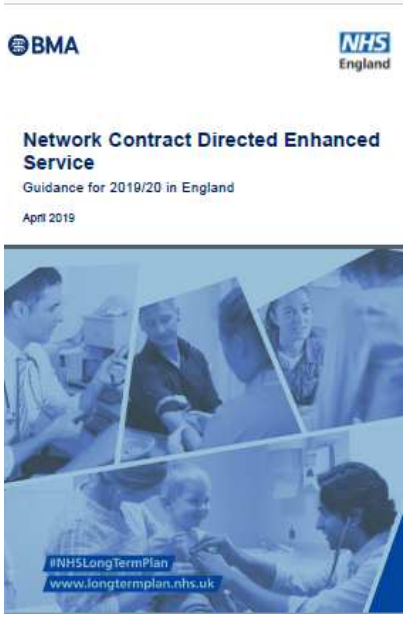
Name	Job Title	Practice/organisation	Contact Email Address

Details for PCN's nominated payee

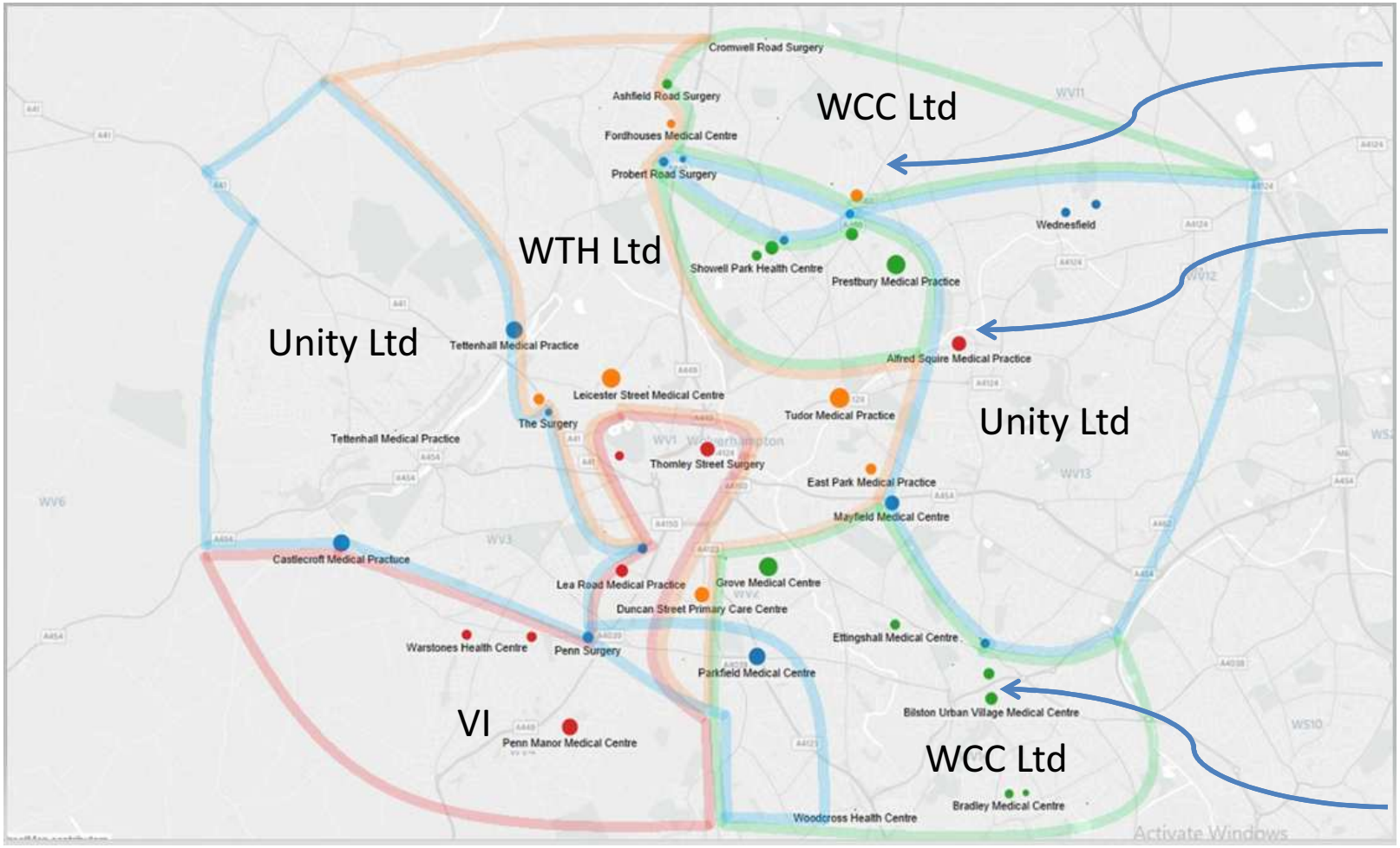
Name of single nominated practice or provider ('nominated payee'):		
Name of bank account (if different to above)	Account number	Sort code

Primary Care Networks

Date	CCG Action	STP Assurance
January – April 2019	PCNs prepare to meet the Network Contract DES registration requirements	Primary Care Leads confirm progress & raise queries/concerns via fortnightly meetings that in turn are clarified with SRO & Clinical Lead. CCGs are supporting practices & arranging approval panels for 16 & 17 May 2019.
By 27 March 2019	NHS England & GPC England jointly issue the Network Agreement and 2019/20 Network Contract DES	STP Assurance Process developed & agreed with SRO & Clinical Lead Reassurance to NHSE regarding preparedness.
By 15 May 2019	All Primary Care Networks submit registration information to their CCG	CCGs confirm receipt of applications from their membership in line with Network DES/Application Form. Number approved and/or any exceptions to PCN Guidance. CCGs should confirm 100% alignment of all member practices as per requirements of the guidance i.e. practices, map, CD etc in line with the contract. CCG Primary Care Leads confirm the outcome of their panel meetings to GPFV Programme Director by 20 May 2019 (including exceptions) Information will be shared with SRO & CLG
By 31 May 2019	CCGs confirm network coverage & approve variation to GMS/PMS/APMS Contracts	STP work with CCGs to resolve issues where 100% alignment has not been achieved. SRO & CLG review STP application status & agree next steps (*date to be confirmed but likely to be 23 May 2019*). Assurance that contract variations have been completed by 31 May 2019.
Early June 2019	NHS England and GPC England jointly work with the CCGs and LMCs to resolve any issues	STP receive regular updates on progress made where issues are being resolved (weekly) that will be shared with STP SRO & CLG until all member practices are suitably aligned & documented evidence is in place. Confirmation of CCG Governance arrangements with Clinical Directors & Clinical Chairs linked to STP Clinical Leadership Group.
1 July 2019	Network Contract DES goes live across 100% of the country	Rolled out via Primary Care Leads & standing item on monthly meetings. STP strategies ie Workforce, Primary Care etc updated to reflect CCG map(s) of PCNs and also confirm how networks will be engaged in the implementation of all relevant work programmes.
July 2019 – March 2020	National entitlements under the 2019/20 Network Contract start: • Year 1 of the additional workforce reimbursement scheme Ongoing support funding for the Clinical Director • Ongoing £1.50 per head from CCG Allocations	Linkage with CLG established & large scale STP wide event arranged at *quarterly intervals*.
April 2020 onwards	National Network Services start under the 2020/21 Network Contract DES	



Where any of us propose any change to the services we provide to patients at a Network level, we will discuss how to best to involve and/or inform patients of those proposed changes in line with our collective and individual patient engagement obligations.



- 6 Networks 36-54,000 population, maintaining integrity
- 3 Practice Outliers (North East & South East)
- Discussions continue at ‘network’ level regarding moves/changes
- CCG & STP Processes for approval
- PPG Meetings

Multi Disciplinary Team Meetings

All 3 MDT coordinators now in post – these posts deliver all of the administrative function of the MDT

Full range of professionals supporting MDT working

17 practices now live with 2 more going live this week

A mix of models - joint and single practice

Starting to collect feedback from professionals regarding their experience of MDT working – positive feedback to date

Case studies being collated to evidence outcomes for patients (available to all)

Community Services

- There is a need to ensure that Community services are wrapped around PCN's as detailed within the guidance
- Current Community Service specifications have a focus on working in geographical localities, NE/SE/SW to align with the BCF vision of Community Neighbourhood Teams
- 1st CNT developed in December 2018 – NE Health and Social Care Teams
- Commenced re writing Community Service Specifications to ensure alignment with PCN's. A DRAFT District Nursing specification is currently going through governance.

GP Home Visiting Service

Following a successful pilot across a small number od practices, an evaluation has taken place and there will be a recommendation going to CCG Boards to roll out this enhanced service across Primary Care

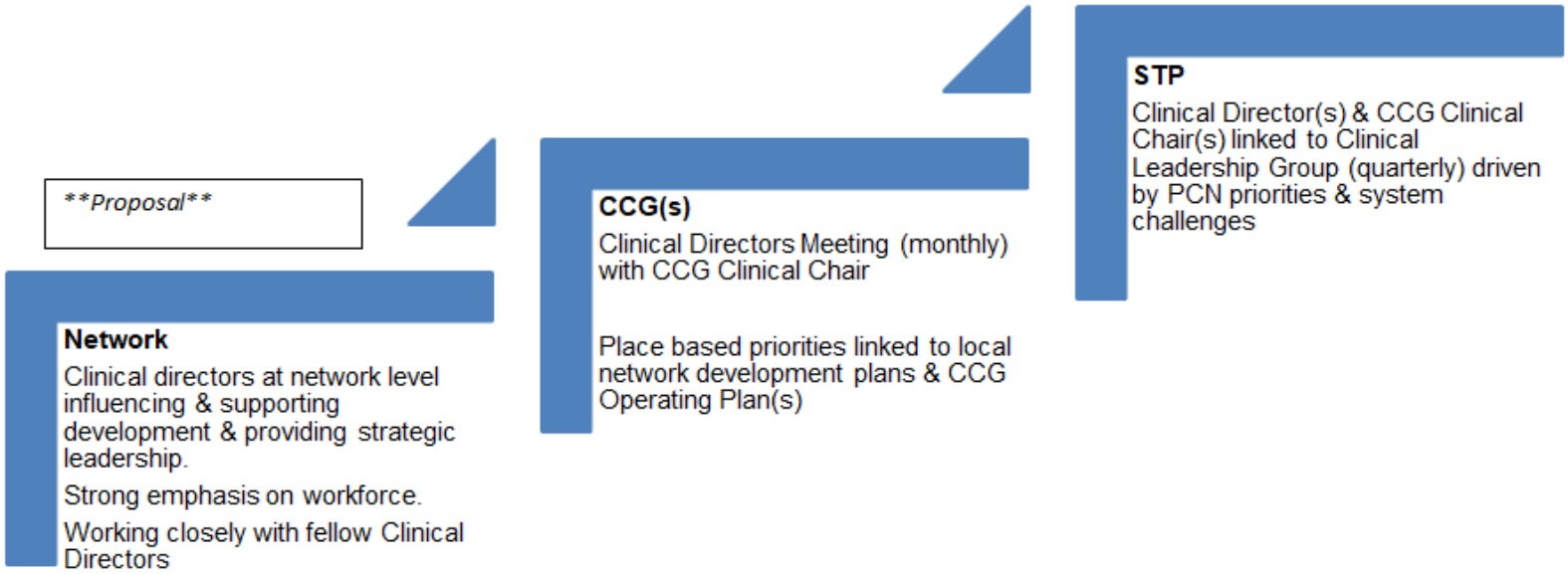
What worked well?

- Patients received a timely response and were able to be receive a visit on the same day (where clinically appropriate)
- Patient received a day time visit and were able to access medication on the same day if required.
- Patients benefited from a responsive, person centred, coordinated service
- If patients are not suitable for the service; patients are referred onto a more suitable service ensuring continuity of care
- Patients with complex needs benefit from a smooth seamless access/ escalation to the RIT whom are able to more appropriately meet their needs and prevent further deterioration and possible admission
- The Home Visiting Service is able to free up GP time to care, to enable GP's to focus on more complex patients or improve their work life balance
- There are no reported poor patient experience or quality issues

- Practices will be asked to sign up for the service as with other local enhanced services
- There will likely be a phased approach to roll out to manage demand and to manage recruitment to the team
- Look out for the notification

Primary Care Networks

Group Discussions……..



This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Primary Care Commissioning Committee
7 May 2019

TITLE OF REPORT:	Primary Care Quality Assured Spirometry
AUTHOR(s) OF REPORT:	Claire Morrissey
MANAGEMENT LEAD:	
PURPOSE OF REPORT:	To provide the Primary Care Commissioning Committee with a business case for the provision of quality assured spirometry within primary care, for the committee to approve the recommendations.
ACTION REQUIRED:	☒ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	Public
KEY POINTS:	• ARTP spirometry qualifications are the recognised competency assessment for all practitioners performing spirometry, with the ARTP being responsible for holding the national register of accredited spirometry practitioners. All personnel performing/ interpreting spirometry must undertake accredited training by 31 March 2021. • CQC expects practices to be able to demonstrate that all staff who perform/ interpret spirometry are competent, and are on the National Register.
RECOMMENDATION:	• The report should be noted, with the committee noting any further actions • Primary Care commissioning committee should agree that the CCG will commit financial resource to provide a primary care quality assured spirometry service within the primary care network
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Ensure on-going safety and performance in the system
2. Reducing Health Inequalities in Wolverhampton	Deliver new models of care that support care closer to home and improve management of Long Term Conditions

3. System effectiveness delivered within our financial envelope	Greater integration of health and social care services across Wolverhampton

1. BACKGROUND AND CURRENT SITUATION

1.1. The purpose of the report is to provide the Primary Care commissioning committee with a business case regarding the provision of quality assured spirometry within the primary care networks.

1.2. This report has previously been presented at the Primary Care Programme board where further amendments to the business case were required. These amendments have been made, and will be represented at the Primary Care programme board on 16th May 2019.

2. MAIN BODY OF REPORT

2.1. Spirometry is an essential investigation for diagnosis and severity assessment for people living with respiratory conditions such as COPD and Asthma. Nationally, most COPD cases are undetected, it is estimated there are approximately 2.2 million people living with COPD that do not have a confirmed diagnosis.

2.2. Regarding the diagnosis of Asthma; the British Thoracic Society (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, had adopted BTS/ SIGN guidelines, where it is recommended that Spirometry, with bronchodilator reversibility is the preferred investigating test for patients with **Intermediate** probability of asthma.

2.3. Locally, there are circa 5,200 patients currently on a primary care COPD register, and it is estimated on average there are approximately 500 new cases diagnosed per year. In addition, there are approximately 17,000 patients on a primary care Asthma register where again there are approximately 500 new cases diagnosed per year.

2.4. It is important to note, through primary care extracts, it is not possible to extract numbers of new Asthma diagnosis that were considered to be of intermediate probability, and therefore requiring spirometry with bronchodilator reversibility. Therefore the business case has been costed based upon the total number of new diagnosis on primary care registers per year.[1]

2.5. 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

[1] For the purposes of primary care registers, QOF also requires a prescription within 12 months of diagnosis.

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.

2.6. 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[2] 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.

2.7. 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

3. CLINICAL VIEW

3.1. Black Country STP Respiratory Clinical leaders group

4. PATIENT AND PUBLIC VIEW

4.1. N/A

5. KEY RISKS AND MITIGATIONS

5.1. There is a risk there will be low uptake within primary care to provide the service.

5.2. Primary Care practitioners may not be able to maintain competencies if provision of service is at practice level rather than network level.

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

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. Funding has been identified within the Primary Care budget for this service.

Quality and Safety Implications

6.2. Quality Impact Assessment has been agreed and signed off by CCG Quality team.

Equality Implications

6.3. Full Equality Impact Assessment currently being discussed by CSU Equality lead, with anticipation of being signed off with no further amendments

Legal and Policy Implications

6.4. As outlined within the above report, CQC requires practices to be able to demonstrate that all staff that perform/ interpret spirometry are competent, and are on the National Register.

Other Implications

6.5. N/A

Name	**Claire Morrissey**
Job Title	**Strategic Transformation Manager**
Date:	**25/04/19**

ATTACHED:

- **Primary Care Quality Assured Spirometry Business Case**
- **Primary Care Quality Assured Service Specification**
- **Quality Impact Assessment**
- **Equality Impact Assessment**
- **Data Quality Impact Assessment**

RELEVANT BACKGROUND PAPERS

NHS
Wolverhampton
Clinical Commissioning Group

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	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**Emailed business case S Chhokar**	**25/04/19**
Quality Implications discussed with Quality and Risk Team	**S Parvez**	**27/02/19**
Equality Implications discussed with CSU Equality and Inclusion Service	**D King**	**30/04/19**
Information Governance implications discussed with IG Support Officer	**DPIA submitted to Kelly Huckvale**	**25/04/19**
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)	**Claire Morrissey**	**25/04/19**

This page is intentionally left blank

BUSINESS CASE

Project:	**Primary Care Quality Assured Spirometry**
Project Number:	
Date:	**Apr 2019**
Project Lead:	**C Morrissey**
Project Sponsor:	
Version No:	**0.5**

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 Helen Ward/ Dr John Burrell/ Group leaders**	**Feb 19**	
Public/ Patient			**Not required for the purpose of the business case**
Finance	**S Chhokar**	**Feb 2019** **Apr 2019**	**Amendments made to costs, due to 19/20 not being ratified, therefore based upon 18/19 costing template** **Further amendments made to costs based upon revised (but not signed off) 19/20 costing template**
Quality	**S Parvez**	**Feb 2019**	**QIA signed off**
Performance			**Not required for the purpose of the business case**
PMO			**Not required for the purpose of the business case**
Contract & Performance			
Medicines Management			**Not required for the purpose of the business case**
Equality	**D King**	**Apr 2019**	**Full EQIA**

Date:

Information Governance	**Kelly Huckvale**	**Apr 2019**	**Initial DPIA submitted for comment**
Legal/ Policy (Corporate Operations Manager)			**Not required for the purpose of the business case**
Primary Care		**Feb 19**	**Presented at Primary Care Programme board Feb 19, with amended version being presented in May 19**
IMT / IT			**Not required for the purpose of the business case**
Business Intelligence			**Not required for the purpose of the business case**
Estates			**Not required for the purpose of the business case**

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

2 Table of Contents

Page

Business Case

3 Purpose

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.

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

4 Reasons

Around 1.2 million people in the UK are living with diagnosed COPD (British Lung Foundation, 2018) and numbers are increasing which indicates un-diagnosed cases are being identified more readily, and that record-keeping is better, as well as a possible increase in incidence. Previous research indicated that around 60% of cases remain undiagnosed, but more research is needed to ascertain if this is still the case. Currently in Wolverhampton there are approximately 5200 individuals with diagnosed COPD. In the last year around 500 new cases were diagnosed in the city which was 10.8% of the current register.

Spirometry is required to make a diagnosis in the clinical context of suspected COPD:

- Dyspnoea
- Chronic cough or sputum production
- And/or
- History of exposure to risk factors for the disease

Further information can be found in the most recent GOLD Report (2018, p. 23)

Spirometry is the most commonly performed lung function test. By performing maximal inspiratory and expiratory manoeuvres through a mouthpiece, it provides health care professionals with basic information about a patient's airways function and lung capacity.

Spirometry may be performed for a variety of reasons, including:

- To detect the presence or absence of lung disease
- To confirm the findings of other investigations
- To quantify the extent of lung impairment
- To investigate the effects of other diseases on lung function
- To monitor the effects of environmental exposures
- To determine the effects of medication interventions

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.

COPD register figures produced locally indicate there are c500 newly diagnosis of COPD per year.

Activity within the current direct access for diagnostic spirometry service provided by The Royal Wolverhampton NHS Trust is as follows:

- Total referrals to 2nd November 2018 = 537
- Projected total referrals before 31st March 2018 = 863 (537 to date plus 326 projected)

Referrals to service per month

	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
RWT	26	50	84	78	66	61	25	92

Spirometry will be provided for new diagnoses, and should be considered where a patient's condition has deteriorated to assess any changes in lung function only. Taking into account additional numbers for example those that would need to be screened and found not to have COPD; a total of 2028 appointments would need to be available (four times the number of new diagnoses based on activity from primary care and RWT) across the city this year, and it is expected that this would rise again next year. To be able to meet demand it is important that each practice group is offered the opportunity to provide services to their practice population.

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.

Therefore the below provides an indication at primary care hub level the number of new diagnosis for COPD and Asthma, with a prescription within the previous 12 months

Group	New COPD cases in 2017/18	New Asthma cases with prescriptions in 2017/18	Subtotal of new diagnosis	No of Spirometry appointments required
PCH1	108	119	227	908
PCH2	134	135	269	1076
Unity	149	175	324	1296
VI	116	77	193	772
Total	507	506	1013	4052

5 Options

The below table presents options to consider

Option	Implications
Option 1 – do nothing	• CCG has committed to a continuation of commissioning direct access spirometry for newly diagnosed • Additional demand for direct access spirometry at Acute Trust • Will not meet the CCGs commitment within the GP5YFV regarding workforce planning and developing staff to support delivery of services
Option 2 - preferred option	• **Development of quality assured spirometry skills is in line with both ARTP and CQC guidance** • **Opportunity for primary care networks to develop and provide services at scale for patients** • **Support the commitment of developing local workforce within the GP5YFV** • **Support one of the key clinical priorities for Respiratory conditions as part of the Black Country STP Respiratory Clinical leaders group**
Option 3 - other options	• Development of quality assured spirometry skills is in line with both ARTP and CQC guidance • Opportunity for individual GP practices to provide services • Support the commitment of developing local workforce within the GP5YFV • Support one of the key clinical priorities for Respiratory conditions as part of the Black Country STP Respiratory Clinical leaders group

6 Benefits Expected

- Improved offer of diagnostic quality assured spirometry within primary care, care closer to home
- Improved early diagnosis
- Improved reported prevalence
- Greater number of people living with respiratory conditions feeling supported and empowered to manage their own condition
- Reduction in acute based activity (ED presentations, unplanned admissions, avoidable outpatient appointments)
- Reduction in bed days
- Reduction in GP attendances

7 Risks

ID	Description of Risk	Likelihood	Impact	Action/Contingency	Owner	Status
1	May not be approved of appropriate programme board	2	2	Seek approval from primary care commissioning committee	Primary care Programme delivery board.	Open
2	Low uptake within primary care	3	3	Work collaboratively with locality managers to improve engagement with primary care networks	Primary Care programme delivery board	Open
3	Maintenance of competencies	3	3	Work collaboratively with primary care to ensure maintenance of competencies to deliver a quality assured service	Primary care programme board	open

8 Cost

Funding for the project has been identified through Primary Care budget.

The costs of the project are dependent upon the chosen option

Option 1 – There will be no change from the on-going situation. The CCG has previously commissioned Direct Access for diagnostic spirometry with the local Acute Trust at a cost of £48,000 for 1000 tests, and have committed to extending this arrangement for 19/20[2] with the Trust whilst primary care undertake training to provide at scale within the respective networks.

Costs for Option 1 - £48,000

Option 2 **(preferred option)** – approve the development of primary care quality assured spirometry within primary care networks. The breakdown of costs for this option uses the recent costing template and the following methodology:

- Each spirometry appointment would be 30 mins
- It is anticipated that a practice nurse (top band 6) or appropriately trained health care professional will undertake the test

[2] Cost for Direct Access Diagnostic Spirometry is £48,000 for 1000 tests

- Some administration time has been incorporated into the costs for letters regarding the outcome of the appointment are sent to the referring GP practice

Unit cost has been calculated as:

- Practice Nurse (top-point) band 6 = £15.88 per 40 mins
- Receptionist band 2 = £3.95 per 20 mins
- Additional indirect costs = £6.83 per appointment
- Total appointment cost = £26.66[3]

Group	No of Spirometry appointments required	Appointment Cost	FYE
PCH1	908	£26.66	£24,207.28
PCH2	1076	£26.66	£26,686.16
Unity	1296	£26.66	£34,551.36
VI	772	£26.66	£20,581.52[4]
Total	4052		**£106,026.32**

It is anticipated that the service within primary care would not commence until Q3 (practices to undertake training and submission of required portfolio) therefore for 19/20 it is estimated that costs would be **c£53,013.16** and c£106,026.32 thereafter

Costs for Option 2

	Q1	Q2	Q3	Q4
Direct Access (RWT)	350 (£16,800)	300 (£14,400)	200 (£9,600)	150 (£7,200)
Primary Care	0	0	750 (£19,995)	1250 (£33,325)
Total	£16,800	£14,400	£29,595	£40,525
Grand Total				**£101,320**

There is currently a gap of c1000 tests in projected activity levels. However further work is scheduled through the Black Country STP Respiratory clinical leaders group, and as part of NHSE Right Care Respiratory National Priorities Initiatives for 19/20, to develop further schemes regarding enhanced case finding to increase the prevalent population to reduce the gap from observed to estimated prevalence. During 20/21 there will need to be additional provision for an increase in activity.

Therefore this scheme is needed to ensure primary care are upskilled and competent to undertake increased diagnostic testing.

It is expected that secondary care activity will reduce as primary care are upskilled and start performing diagnostic testing. However it should be noted that a level of activity into secondary care will continue, with some practices opting to not undertake quality assured spirometry within primary care.

[3] Costs are based upon revised 19/20 costing template however this has yet to be ratified, and could be subject to change. Confirmed 19/20 costs will be applied when the template has been agreed.
[4] It is important to note there is potential that VI practices will utilise Direct Access Spirometry through the Trust

Regarding Diagnostic and follow up costs, if someone has a confirmed diagnosis made, then the patient will be added to the appropriate QOF disease register and will be managed/ followed up through the GMS contract and QOF+ framework.

Option 3 – approve the development of primary care quality assured spirometry within individual GP practices. The cost for this will be the same as option 2.

9 Timescales

Milestone	Deadline
Finalise business case	Apr 2019
Primary Care programme board submission	May 2019
Approval of business case	May 2019
Primary Care to undertake training	Jun – Oct 2019
Mobilisation/ implementation	Nov 2019
Monitoring	Jan – Feb 2020
Evaluation of service provision and performance monitoring	March 2020

10 Equality – Appraisal

Primary Care Quality Assured Spirometry E

11 Quality Impact Analysis (QIA)

QIA QA Spirometry Feb 19 v0.2.xlsx

12 Data Privacy Impact Assessment (DPIA)

Primary Care Quality Assured Spirometry D

This page is intentionally left blank

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	Primary Care Quality Assured Spirometry
Commissioner Lead	Claire Morrissey, Solutions & Development Manager
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Lung disease is the UKs third biggest 'killers', where over 12 million people have a diagnosis of a lung condition, with an estimated total cost to the UK of £11.1billion. Asthma costs the NHS c£3billion per annum, where COPD costs the NHS c£1.9billion per annum.

COPD is the only major cause of death that is on the increase in the UK. Within Respiratory illness, 29% of costs are associated with COPD.

The UK has one of the highest emergency admission and death rates for childhood Asthma in Europe.

Chronic obstructive pulmonary disease (COPD) describes lung damage that is gradual in onset and that results in progressive airflow limitation. This lung damage, when fully established, is irreversible and, if it is not identified and treated early, leads to disability and eventually death. The greatest cause of COPD is smoking. Other factors include workplace exposure, genetic make-up and general environmental pollution.

Around 1.2 million people in the UK are living with diagnosed COPD (British Lung Foundation, 2018) and numbers are increasing which indicates un-diagnosed cases are being identified more readily, and that record-keeping is better, as well as a possible increase in incidence. Previous research indicated that around 60% of cases remain undiagnosed, but more research is needed to ascertain if this is still the case.

The main symptoms of COPD are shortness of breath and reduced exercise ability, together with a cough and production of phlegm, which may get worse at certain times of the year.

COPD is a progressive illness, and the likelihood of people dying as a result of COPD increases with age. Most patients are not diagnosed until they are in their fifties. In the past, many people described as suffering from COPD were diagnosed as having chronic bronchitis, emphysema or chronic unremitting asthma. In some people, chronic bronchitis and emphysema affect different parts of the same lung, and so the two conditions can often occur together.

COPD causes more than 25,000 deaths a year in England and Wales, one person dies from the condition every 20 minutes. Data from the World Health Organization (WHO) shows that death rates from diseases of the respiratory system in the UK are higher than both the European average and

the European Union (EU) average with a marked difference for females where UK death rates from respiratory disease are three times higher than those in France and Italy.

Providing care and treatment for these people places a significant burden on the NHS. The profile of COPD means that it is an expensive disease for the NHS when it is not identified and treated early. It is the second most common cause of emergency admission to hospital and fifth largest cause of readmission. The direct cost of COPD to the UK healthcare system is estimated to be between £810 million and £930 million a year and, without change, this impact is set to grow.

Raising awareness of COPD is an important strand in securing better outcomes. Many people are not aware of COPD, its symptoms and its risk factors and are therefore unlikely to change behaviours that lead them to avoid the causes and exacerbating factors, such as cigarette smoke and workplace dusts and gasses. Lack of awareness also contributes to a tendency to ignore early symptoms of cough and breathlessness, only requiring treatment when the disease is fairly advanced, by which time a major opportunity to intervene has been missed.

COPD is not curable, but it is treatable. Its progress can be halted, and it can be managed to minimise the burden it imposes. There is a great deal of evidence to show that healthcare interventions do improve outcomes in COPD but late diagnosis, unwarranted variations in treatment, incorrect diagnoses and poor prescribing all contribute to a wide variation in outcomes and costs associated with treating the disease. For the majority of sufferers COPD is a preventable disease therefore education and encouragement of positive behaviours is a key element in all preventative and treatment strategies, making early diagnosis through quality assured spirometry important.

Quality assured 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.

Spirometry is required to make a diagnosis in the clinical context of suspected COPD:

- Dyspnoea
- Chronic cough or sputum production
- And/or
- History of exposure to risk factors for the disease

Further information can be found in the most recent GOLD Report (2018, p. 23)

Spirometry is the most commonly performed lung function test. By performing maximal inspiratory and expiratory manoeuvres through a mouthpiece, it provides health care professionals with basic information about a patient's airways function and lung capacity.

Spirometry may be performed for a variety of reasons, including:

- To detect the presence or absence of lung disease
- To confirm the findings of other investigations
- To quantify the extent of lung impairment
- To investigate the effects of other diseases on lung function
- To monitor the effects of environmental exposures
- To determine the effects of medication interventions

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.

1.2 Local Context

The CCG has identified COPD and Asthma as a priority area.

Currently in Wolverhampton there are approximately 5200 individuals with diagnosed COPD. In the last year around 500 new cases were diagnosed in the city which was 10.8% of the current register.

In December 2015, there were 17,263 patients on the Asthma QOF registers, approximately 6.5% of the total registered population. National average prevalence for Asthma in 13/14 was 5.9%, locally the prevalence is 6.1%.

Spirometry will be provided for new diagnoses, and should be considered where a patient's condition has deteriorated to assess any changes in lung function only. Taking into account additional numbers for example those that would need to be screened and found not to have COPD or Intermerdiate probability of Asthma, or where a patients condition has deteriorated and requires a repeat test activity has been projected as four times the amount of patients who have had a new diagnosis within 18/19.

As it is expected that this would rise again year on year through enhanced case finding schemes. To be able to meet demand it is important that each practice group is offered the opportunity to provide services to their practice population.

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.

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

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.

Therefore the below provides an indication at primary care hub level the number of new diagnosis for COPD and Asthma, with a prescription within the previous 12 months

Group	New COPD cases in 2017/18	New Asthma cases with prescriptions in 2017/18	Subtotal of new diagnosis	No of Spirometry appointments required
PCH1	108	119	227	908
PCH2	134	135	269	1076
Unity	149	175	324	1296
VI	116	77	193	772
Total	507	506	1013	4052

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

2.2.1 For patients:

- Early/ timely access for diagnostic spirometry and appropriate intervention
- High satisfaction with users of the service
- Improved clinical outcomes for patients
- Patients treated in the right place/ setting
- Reduced referrals into secondary care

2.2.2 For Clinicians

- An improved community offer for patients
- Provision of timely and accurate diagnostic assessment and appropriate intervention
- Improved knowledge and management of respiratory conditions amongst multi professionals, leading to improved referrals and overall proactive patient care
- Good working relationships and robust referral pathways within Wolverhampton City
- Robust clinical governance arrangements

2.2.3 For Commissioners

- Compliance with local and national recommendations to bring care closer to home
- Compliance with national guidelines relating to the competency assessment framework for Quality

Assured Spirometry

- Sustainable, cost effective service without a compromise on quality
- A reduction in secondary care activity and associated costs
- Strong relationships between commissioners and providers to ensure service improvement is a priority

3. Scope

3.1 Aims and objectives of service

Wolverhampton CCG wish to commission primary care based spirometry service to:

- Provide accurate and timely diagnostic quality assured Spirometric assessment of patients with respiratory symptoms that commonly fit with COPD or Intermediate probability of Asthma. To ensure the diagnosis is correct and the right treatment pathway is followed in line with current National and Local Guidelines
- Enable the responsible GP/Clinician to develop a personalised service for individuals
- Provide this assessment to enable the referring GP/Clinician to initiate the future management
- Provide this service in the community closer to home
- Enable early diagnosis leading to improved quality of life for people with specific respiratory conditions and their carers
- Enable Referrer's timely and appropriate access to the services for patients presenting with symptoms
- Proactively improve the service as appropriate to meet evolving local health needs and priorities
- Enables the GP/Clinicians to then enhance and support the service users to 'self-care'
- Represents best value in terms of quality and costs

The provider will perform the diagnostic Spirometric test upon appropriate request, to adults (over the age of 18 years old) living in Wolverhampton or registered with a Wolverhampton GP Practice in a community setting, where the provider is querying a diagnosis of COPD.

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

This is a standalone test to support the comprehensive and holistic assessment performed by the referring GP/Clinician. The Provider will interpret the test and suggest a likely diagnosis. The aim is to deliver care closer to home and helping patients to avoid unnecessary hospital outpatient appointments which prior to this, is the only alternative.

The service will be provided in primary care venues to be determined. The service will provide specialist advice on diagnostic spirometry.

The overall aim of the service provider is to provide Diagnostic Spirometry to those patients identified by their GP/Clinician who have symptoms suggestive of Asthma or chronic obstructive pulmonary disease (COPD), identified opportunistically or through case finding.

The aims of the service are:

- To provide prompt and accurate quality assured spirometry assessments and interpretations

- To accurately assess suspected asthmatic patients with Reversibility testing
- To increase the proportion of people diagnosed with COPD comparing recorded prevalence with predicted prevalence
- To increase the number of people accurately diagnosed at onset or an early stage of the disease
- To help the general population towards decreasing the number of people dying prematurely from COPD due to inaccurate or delayed diagnoses and aim to enhance the quality of life for people with COPD by an earlier diagnosis
- To ensure that all service users have a positive experience of care
- To ensure effective communication between relevant health professionals

The objectives of a primary care Service are:

- to treat all service users and their carers with dignity and respect
- to ensure that the service response will be appropriate, equitable, timely and is convenient and accessible to users, providing a range of clinic availability
- to work in partnership with other health care professionals and provide seamless service to patients and to ensure best outcomes for patients
- to provide direct patient care through a competent, capable and educated, multi-disciplinary workforce of professionals with appropriate ARTP accredited Spirometry training

3.3 Service description/care pathway

The provider will provide ARTP Standard diagnostic assessment and interpretation service to adults (over the age of 18 years old) living in Wolverhampton or registered with a Wolverhampton GP who present with symptoms of Intermediate probability of Asthma or COPD. This is not a service for Annual Reviews.

The service will provide:

- **Quality Assured Diagnostic Spirometry** performed in clinic for people presenting with symptoms of COPD. This will be in line with ARTP accreditation and approaches. (*Quality Assured Diagnostic Spirometry should be delivered in accordance with BTS/SIGN, NICE, ARTP and GOLD guidance)*
- **Working with patients and carers** providing accurate information, advice and education about the test appropriate to the needs of the patient
- **The service provision will enable correct diagnosis** by performing the test, for practices that do not have the scope or ability, thereby reducing health inequalities, in line with the 'missing millions' (BLF, 2009)
- **Communicating with GPs** and other health care professionals (as appropriate) with regards to clinical findings within agreed pathways and timescales

3.4 Service Model and Care Pathways

The service will be delivered in the best interest of the patient, reducing inequality and in accordance with the approved National and Local guidelines.

3.4.1 Manage referral and arrange assessment

The service provider, is responsible for raising awareness of the service and ensuring referrals are made to the service.

- The service shall ensure that all referred patients are offered an assessment if appropriate
- The service shall liaise with primary care practices within their hub in order to achieve integration

across the system and increase uptake of referrals. If the referral information is not complete, the Provider will reject the referral outlining the reasons for rejection of the referral

- The Provider shall accept or reject the referral to the Spirometry Service based on the information contained in the referral information. If the referral is rejected, the Provider shall record the reason and refer the patient onto GP-supported management

The service shall contact eligible patients and carers by telephone or letter within 2 weeks of receipt of referral. In either case, the communication will quote the GP's name as the referrer and will explain the service and invite the patient to attend a spirometry assessment (initial offer).

- The service shall send patients who cannot be contacted after 2 attempts within 4 weeks, an offer of an assessment date in writing. The Provider will use all reasonable efforts to contact eligible patients including contact by mobile phone, text message, and email as appropriate
- If the offer is not accepted, or the patient cannot be contacted within 2 attempts, **the patient shall be referred back to the GP** as a failed attempt
- The referrer shall ascertain whether the patient has had an acute exacerbation within the previous 4-6 weeks. Where there has been an acute exacerbation within the previous 4-6 weeks the patient will not be ready for an assessment, the Provider shall arrange for an assessment to take place no earlier than 4-6 weeks from the start of the acute exacerbation, or within a longer period as agreed to be appropriate in respect of chronic unstable patients. The Provider shall then contact the patient within 3 days prior to the assessment date to confirm that the patient is still willing and ready to attend the assessment, and has not had a further exacerbation. Where the patient is ready and willing, they shall be offered an assessment date that is within 6 weeks of successful contact

The Provider shall re-offer (second offer) an assessment date to patients who are not ready and/or not willing within a reasonable and mutually agreed timeframe of the initial offer.

3.4.2 Confirm COPD Spirometry and Assessment booking

A proposed assessment date should be accepted by the Patient/Carer, assuming the GP/Clinician has provided appropriate information, and the patient is fully aware of the preparation for the appointment. Information provided to the patient, should contain the following as a prerequisite for attendance:
The information shall ask the patient to:

- Avoid smoking for at least 24 hours before the test
- Avoid eating a large meal before the test
- Avoid exercise or exertional activity before the test – Avoid rushing to the appointment and give extra time to arrive
- Not to wear restrictive clothing that may affect ability to blow
- Not take bronchodilators prior to the test Reversibility patients should be asked to avoid short acting bronchodilators (SABA) – e.g. salbutamol, in the four hours before the test. Long acting (LABA) bronchodilators should not be taken in eight hours before test, and Long Acting Muscarinic Antagonists (LAMA) for 36 hours.

The GP shall advise the patient to take all prescribed inhalers to the appointment (in the event that the patient has been prescribed inhalers but has not undergone quality-assured diagnostic spirometry).
The Provider shall send confirmation of the date, time and all relevant information to the patient and/or carer regarding the assessment and encourage the patient to make every effort to attend the assessment.

3.4.3 Clinical Assessment and Diagnosis

It is the responsibility of the referrer to ensure the clinical assessment and differential diagnosis is done before referral into the service. The Provider will only be responsible for suggesting a most likely diagnosis and communicating this to the patient and referrer. It is the GP/Clinicians responsibility to make this diagnosis and commence relevant management.

3.4.3.1 Patients should be made aware of the risk of cancellation of the appointment if they are late by 15 minutes.

3.4.3.2 The Provider shall ensure that the patient has adhered to pre-visit requirements and confirm that there are no contraindications, by utilising a brief pre-assessment checklist of the patient to ensure it is safe to proceed.

3.4.3.3 The referring clinician shall ensure that an up-to-date smoking history is provided. The history shall include an assessment of pack years smoked (number of cigarettes smoked per day multiplied by the number of years smoked and divided by 20).

3.4.3.4 The Provider shall undertake a quality-assured diagnostic spirometry test ensuring that the test is undertaken in an appropriate setting.

3.4.3.5 The Provider shall, depending on the extent that any of the pre-test advice has been followed by the patient, use their discretion to decide whether or not to proceed with the test. If they decide not to proceed they will rebook the test if appropriate.

3.4.3.6 The Provider shall assess the patient for contraindications to spirometry in accordance with the guidelines.

3.4.3.7 The Provider shall explain and demonstrate to the patient what will happen during the tests and ensure that the patient understands what is required of them, and why it is important to perform each manoeuvre as best they can

3.4.4 Post-bronchodilator testing

As discussed above the Provider shall offer post-bronchodilator testing where appropriate.

The Provider shall record:

- the post-bronchodilator results using the largest post-bronchodilator FEV1 and the largest VC or FVC to determine the FEV1/VC ratio
- the flow/volume and time/volume graphs
- any technical comments on the spirometry as detailed in the Guide

3.4.5 Repeat Spirometry Testing

Where a patient has two exacerbations either requiring hospital admission or treated elsewhere and reported in any 12 month period and they have a large "step change" in deterioration they may require a repeat spirometry test.

3.4.5 Diagnosing COPD

The Provider shall suggest a diagnosis based on the findings of the physiological tests in accordance with the recommendations set out in the respective National Clinical Guidelines. As some symptoms are not unique to Asthma & COPD, other disorders may need to be considered. The GP has the responsibility to consider differential diagnosis and confirm with the patient as some patients may not have a respiratory condition.

The Provider shall grade severity of airflow obstruction in accordance with the NICE guidance which grades the disease by reference to airflow obstruction from Stage 1 to Stage 4 (NICE 2010).

3.4.6 Diagnosing Asthma

The Provider shall suggest a diagnosis based on the findings of the physiological tests in accordance with the recommendations set out in the respective National Clinical Guidelines. As some symptoms are not unique to Asthma & COPD, other disorders may need to be considered. The GP has the responsibility to consider differential diagnosis and confirm with the patient as some patients may not have a respiratory

condition.

The Provider shall grade severity in accordance with BTS/ SIGN Guidance 153 (Sept 2016)

3.4.7 Communicate the diagnosis

3.4.7.1 Communicating results to the Referring GP/Clinician
The Provider shall communicate the results of the spirometry to the patient's GP together with all appropriate information in respect of it including the test results. Where possible, the provider shall communicate the results electronically with the GP. A response letter will be sent alternately until communication between computer systems is overcome.

3.4.7.2 Data Collection
The Provider shall employ a system of data collection, storage, retrieval and transmission to capture the information set out below in respect of the COPD Spirometry and Assessment Service. Patient confidentiality and data protection should be considered at all times in this process. This includes appropriate records of the different sections of the spirometry test. Good practice suggests that all efforts should be stored graphically and as raw data with the selected best efforts indicated and an indication of the quality shown. Any technical problems or patient limitations or errors should also be recorded.

3.4.7.3 Patients with an uncertain diagnosis
Should a diagnosis be unclear for any reason, the Provider shall explain the basis of the recommendation and the on-going assessment is the responsibility of the GP/Clinician.

3.4.7.4 Communicate serious illness notification to GP
Where a certain diagnosis is suspected, the Provider shall communicate a 'serious illness notification' to the patient's general practitioner. This can take a format similar to that used for a diagnosis of cancer and communication should be by email or fax via nhs.mail.

3.4.7.5 Discharge Letter
The discharge letter summarising the main points of the tests results. For patients diagnosed with COPD or asthma it is the GP's responsibility to ensure that the patient is entered onto the relevant QoF register and that the correct read codes are added at the same time in the patients records to meet the correct standards for diagnosis and documentation (E.g post-bronchodilator Spirometry, negative or positive reversibility etc

3.4.8 **Review and Audit of the Service**
The Provider agrees to engage and support the commissioner in undertaking periodic review and audit of the service to assess overall results and its performance to ensure a high quality and safe service compliant with all national and local standards is being delivered to the local patient population.

The relevant NICE and ARTP guidelines are to be followed as they relate to equipment calibration, testing methodology and interpretation of results. Practices will accept referrals for spirometry from other GP Practices who are unable to undertake their spirometry in-house. Participation in a quarterly audit and annual audit is required with a maintained register of patients receiving this service.
Nurses and HCAs performing spirometry must hold the appropriate ARTP certificate and remain fully updated thereafter. All practices providing the Service are to provide an annual review which will include:

- Brief details as to the arrangements for testing
- Name and position of staff performing spirometry
- Name and position of staff interpreting spirometry
- Accreditation details of health care practitioners performing and interpreting spirometry
- Details of the standards of calibration and maintenance of Spirometers

3.4.9 **Equipment**
All equipment required by the staff is provided as part of this service by the provider. National guidelines

regarding medical equipment required to deliver the service will be adhered to at all times.

3.5 Population covered

The service will be provided to all Wolverhampton residents (over 18 years for query COPD, and over the age of 5 for query intermediate probability of asthma), registered with a Wolverhampton GP Practice, even if GP surgeries have patients residing outside Wolverhampton boundaries. Such patients need to be able to attend the set clinics.

The service provider will receive referrals from GPs surgeries within their respective primary care network

3.6 Any acceptance and exclusion criteria and thresholds

3.6.1 **Referral Criteria and Sources**
The service will be expected to meet the needs of adults who are deemed to be at risk and display the symptoms suggestive of Asthma or COPD, but **who have not already received a diagnosis** confirmed by quality-assured diagnostic spirometry.

The service will primarily accept referrals from General Practitioners Surgeries (GPs) within their respective primary care network, although there might be referrals received on occasions where a patient has recently commenced treatment on the Asthma or COPD pathway but does not have a diagnosis confirmed by quality assured diagnostic spirometry.

3.6.2 **Exclusion Criteria**
Any Patient already diagnosed with COPD or Asthma. Any patient who has had an acute episode within 4-6 weeks

3.6.3 Accessibility
The service will be accessible to all, regardless of disability, race, gender reassignment, religious/belief, sex, pregnancy and maternity or sexual orientation, income levels and deal sensitively with all service users and their family/friends and advocates

3.6.4 Response Time Detail and Prioritisation

- 2 weeks from receipt of referral

3.7 Interdependence with other services/providers

The service will work in conjunction with:

- General Practitioners
- Practice Nurses
- Allied Health Professionals
- Primary Care and CCG teams
- Respiratory Specialists
- Service users, carers and the public
- Nursing and Residential Homes

This list is not exhaustive and may include others at different stages of the patient pathway

3.8 Interdependencies

Effective delivery of the service is dependent upon a number of factors including:

- Promotion and knowledge of the service

- Staff base to accommodate referrals
- Equipment; including spirometry, computers, telephones and other for office based functions
- Estates (availability and accessibility of suitable premises to operate clinics from and rent costs incorporated into the costings)
- Referrals from GP Practices, to include all the clinical information and provide the relevant medication for reversibility

3.9 Days / Hours of Operation

The service should be accessible from Monday to Friday. Operating hours within these days is for the discretion of the provider, but must ensure the hours are appropriate to the needs of the service and patients and that over a weekly period, both morning and afternoon appointments are available. The provider may also wish to provide the service during extended hours.

3.10 Housebound patients

The term 'housebound' means an adult who is unable to leave their place of residence without the support of an ambulance or patient transport. For housebound patients requiring diagnostic spirometry the provider will arrange patient transport to attend the community clinic.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- (ARTP) Association for Respiratory Technology and Physiology: http://www.artp.org.uk/en/spirometry/
- (BTS/SIGN) British Thoracic and Scottish Intercollegiate Guidelines Network – 141 – British Guideline on the management of Asthma, 2014 www.brit-thoracic.org.uk
- (BTS/ SIGN) British and Thoracic and Scottish Intercollegiate Guidelines Network – 153 – British Guideline on the management of Asthma, 2016 www.brit-thoracic.org.uk
- Department of Health: COPD Commissioning Toolkit, 2012
- GOLD (Global initiative for Chronic Obstructive Lung Disease) COPD guidelines www.goldcopd.org
- GOLD Asthma (2015) www.ginasthma.org
- Interactive Health Atlas for Lung conditions in England, 2011
- NICE COPD (2010) www.nice/guidance/cg101.org.uk
- NICE Asthma (2013) www.nice/guidance/qs25.org.uk
- QOF (Quality and Outcomes Framework) www.nhsemployers.org
- Review of Respiratory Care across Sandwell, Birmingham and Solihull (2013), Respiratory Clinical Network.
- 'Why Asthma still Kills' Royal College of Physicians, (2014) www.rcplondon.ac.uk

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

The service will use as a resource to refer to the following organisations to source and share best practice:

- The British Thoracic Society (BTS)
- The Primary Care Respiratory Service (PCRS)
- The European Respiratory Society (ERS)

- The British Lung Foundation (BLF)
- NICE for COPD & Asthma
- GOLD International Guidelines
- Other community spirometry providers

4.3 Workforce

The service provider will:

- Determine the optimum skill-mix of appropriately qualified staff, ensuring annual leave, sickness and maternity/paternity leave entitlements do not affect the service availability
- Provide clinics with a range of appointments in a primary care setting to address inequality
- Ensure that the educational provision for clinical staff employed in providing the service is an integral component of the service
- Encourage and enable staff to undertake spirometry training as appropriate (i.e. as identified via PDR)
- Ensure staff are ARTP qualified and accredited with their respective professional body e.g. NMC, MRCP, HCPC and there are no concerns about clinical practice
- Ensure that all staff in contact with patients are Disclosure and Barring Service (DBS) checked and hold work permits if appropriate
- Be able to guarantee a safe service level at all times to meet the potential demand

4.4 Quality of Service

In order to demonstrate quality of the service, the provider should:

- Assess patients' satisfaction with the service through a monthly patient experience survey
- Be able to demonstrate a robust process for dealing with patient complaints and compliments and evidence that these have been acted upon to ensure continuous improvement
- Demonstrate management of capacity and demand for service delivery within the funding agreement. Additional activity will need additional funding.
- Provide evidence to demonstrate that the service takes in to account the different needs and inequalities for patients using the service, and how service responds to these
- Demonstrate integrated working with other healthcare providers and services to ensure seamless, joined up care for patients
- Conduct quality control checks in accordance with ARTP recommendations
- Maintain an equipment log in accordance with ARTP recommendations

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-C)

Local Quality	Threshold	Method of	Consequence of	Timing of application	Service

Requirement		Measurement	breach	of consequence	Spec No
Total number of spirometry tests	100% of contracted value	Review of monthly Service Quality Performance Report		Monthly	
Total number of housebound patients seen by the service	Based line required	Review of monthly Service Quality Performance Report		Monthly	
Percentage of routine appointment patients seen within 2 weeks	100%	Review of monthly Service Quality Performance Report		Monthly	
Number of patients DNA	<10%	Review of monthly Service Quality Performance Report		Monthly	
Number of appointments cancelled by the provider	<5%	Review of monthly Service Quality Performance Report		Monthly	
Percentage of users (patients and carers) satisfied with service	95%	Review of monthly Service Quality Performance Report		Monthly	

5.2 Applicable CQUIN goals (See Schedule 4 Part D)

6. Location of Provider Premises

The Provider's Premises are located at:

The service will be provided in primary care venues, providing clinics as required for the safe delivery of the service, in line with the care closer to home agenda. The provider will ensure that where services are delivered that the premises adhere to all External Assurance Standards.

7. Individual Service User Placement

This page is intentionally left blank

Section A

Quality Impact Assessment : QIPP Project (Quality, Innovation, Productivity and Prevention) 2018/19	
Project Name	Primary Care Quality Assured Spirometry
UI Number	<To Be Filled In>
Project Lead	Claire Morrissey
Quality Lead	Sukhdip Parvez
Programme Board	Primary Care Programme Board
Verifying Clinician	<To Be Filled In>
Project Overview	development of Quality Assured Spirometry in primary care for diagnosis of respiratory conditions (predominantly COPD and Asthma) 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.
Quality Indicators	* the number of people who are referred for diagnostic spirometry * the number of people who attend an appointment * improve the recorded prevalence of respiratory registers across the City * increase the number of patients who have a confirmed diagnosis * 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 * improve the number of patients completing pulmonary rehabilitation * reduction in respiratory clinical pathway variations to improve clinical outcomes
KPI Assurance (sources & reporting)	<To Be Filled In>

Section B

ASSESSMENT		
	Positive Impact of the Project on:	**Negative Impact of the Project on:**
Patient Safety	<To Be Filled In>	<To Be Filled In>
Patient Experience	improving health related qualys, patient experience, and improved patient information for those patients living with respiratory conditions Care closer to home	<To Be Filled In>
Clinical Effectiveness	improving clinical effectiveness through early diagnosis of respiratory condition	<To Be Filled In>
Mitigation	Direct Access for Diagnostic Spirometry has been commissioned through the Trust while primary care undertake accreditation and demonstrate competencies to provide the service	

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	*1*	*1*	*2*	**1 to 3: Low Risk**
Patient Experience	*1*	*1*	*2*	**1 to 3: Low Risk**
Clinical Effectiveness	*1*	*1*	*2*	**1 to 3: Low Risk**

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

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

	Likelihood				
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

Note: the above table can to be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Section D

GP / Clinical Review (Required)	
GP / Clinical Name	
Date	**21/02/2019**
Comments	***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.***

Section E

Quality Leads Comments (Required)	
Quality Lead Name	**Sukhdip Parvez**
Date	**26.02.2019**
Comments	***The quality team fully endorses this project because this project will help improve the clinical diagnosis and thus improve clinical outcomes for patients living with long term respiratory conditions in community. Agree with the risk grading for this project.***

Section F

APPROVAL - Business Case QIA		
Reviewer	**Signature**	**Date**
Project Lead	**<Must Be Completed>**	
Patient Rep	**<Must Be Completed>**	
Quality Lead	**<Must Be Completed>**	
Programme Board Review	**<Must Be Completed>**	
Approval Board Approval	**<Must Be Completed>**	

Section G

Post Implementation Review	
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			

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	**0.1**

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.

Primary Care colleagues
RWT Respiratory specialists
Patients – aim to improve early diagnosis within primary care for patients living with a respiratory condition

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

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. (*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 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:

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*	
	• 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 • 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

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*	
	• 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.

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

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.

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 are predominantly 'adult' services aged 18 and over.

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

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

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.*
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.
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? **<u>The CCG has a legal duty to identify and reduce health inequalities.</u>** *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
e.g. Version 0.1	*The impact on wheelchair users identified additional blue badge spaces are required on site to improve access for this group.*	*26 September 2017*
0.1	Initial EA	16/04/19
0.2	Full EA	17/04/19

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.	
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: Date:	
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.

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

Data Protection Impact Assessment (DPIA)

Section A - Key Information ***please be as comprehensive as possible***	
Name of Project	Primary Care Quality Assured Spirometry
Project Reference Number	
Project Lead Name	Claire Morrissey
Project Lead Title	Strategic Transformation Manager – LTCs, Frail Elderly
Project Lead Contact Number & Email	clairemorrissey@nhs.net 01902 441774
Date completed	25/04/19
Information Asset Owner ***The senior person(s) or organisation (e.g. Provider) responsible for the system/software/process***	Primary Care
Description of project:	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 Commission1 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.
Will the project involve any data from which individuals could be identified (including pseudonymised data)?	**Primary Care Providers will be in receipt of patient identifiable data** **CCG commissioning will not receive any patient identifiable data**

IF THE ANSWER TO THE ABOVE IS "NO" AND 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.

Please forward only Section A to the IG Officer for Arden & GEM CSU.

Email: Kelly.Huckvale@nhs.net

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.

IF THE ANSWER TO THE ABOVE IS "YES" PLEASE COMPLETE SECTION B.

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

Sign Off / Approval (Section A only)

Title	Name	Date
Project Lead		
IG Officer		
IG Officer Comments		

The Project lead will then present section A of the DPIA to the relevant board for approval		
Programme Board		Date:
Programme Board Chair		Date:

Section B – Screening Questions

Screening Questions	By CCG	By Provider
	YES or NO	**YES or NO**
Will the project involve the collection of **new** information about individuals?	YES or NO	YES or NO
Will the project compel individuals to provide new information about themselves?	YES or NO	YES or NO
Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	YES or NO	YES or NO
Will the project use information about individuals for a new purpose or in a new way that is different from any existing use? **NB You will need to consider whether identifiable information may be required to evaluate the project.**	YES or NO	YES or NO
Does the project involve you using new technology which might be perceived as being privacy intrusive? For example,	YES or NO	YES or NO

the use of biometrics or facial recognition.		
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 or NO	YES or NO
Is the information to be used about individuals' health and/or social wellbeing?	YES or NO	YES or NO
Will the project require you to contact individuals in ways which they may find intrusive?	YES or NO	YES or NO

If the answer to ALL of the CCG and the Provider screening questions in section B are both answered "NO", you do not need to complete Section C of the DPIA. Please return Section A and B to the IG Officer for sign off.

If the answer to ALL of the CCG screening questions is "NO" but one or more answer to any of the Provider screening questions is "YES", then please liaise with the Provider to ensure a DPIA is completed (by the Provider) and the provider's DPIA is evidenced to the CCG before commencement of the project/service.

Please return Section A and B to the IG Officer for Audit.

If the answer to any of the screening questions is "YES" for the CCG AND the Provider - a full DPIA will need to be completed.

Please liaise with the IG Officer for an initial discussion before completing Section C.

Sign Off / Approval (Section A & B only)

Title	Name	Date
Project Lead		
IG Officer		
IG Officer Comments		

The Project lead will then present Section A & B of the DPIA to the relevant board for approval

Programme Board		Date:
Programme Board Chair		Date:

Section C - Full DPIA

C1. Key Contacts	
Key Stakeholder Names & Roles:	

C2. Use of personal information	
Description of data:	
What is the justification for the inclusion of identifiable data rather than using de-identified/anonymised data?	

Will the information be new information as opposed to using existing information in different ways?	
Will the project involve new or inherently privacy-invasive technologies e.g. Biometrics, facial recognition, Smart Device/ Apps?	
What is the legal basis for the processing of identifiable data? **If consent, when and how will this be obtained and recorded?**	
Who will be able to access identifiable data?	
Will the data be linked with any other data collections? How will this linkage be achieved and what is the legal basis for these linkages?	
What security measures will be used to transfer the data?	
What confidentiality and security measures will be used to store the data?	
How long will the data be retained in identifiable form? And how will it be de-identified? Or destroyed?	

What governance measures are in place to oversee the confidentiality, security and appropriate use of the data and manage disclosures of data extracts to third parties to ensure identifiable data is not disclosed or is only disclosed with consent or another legal basis?	
Are procedures in place to provide individuals access to records on request under the subject access provisions of the Data Protection Act 2018 and General Data Protection Regulations? **Is there functionality to respect objections/ withdrawals of consent?**	
Are there any plans to allow the information to be used elsewhere either in the CCG, wider NHS or by a third party?	

C3. Describe the information flows - The collection, use and deletion of personal data should be described here and it may also be useful to refer to a flow diagram or another way of explaining data flows.	
Does any data flow in identifiable form? If so, from where, and to where?	
Media used for data flow? **(e.g. email, fax, post, courier, other – please specify all that will be used)**	

C4. Consultation requirements Part of any project is consultation with stakeholders and other parties.

In addition to those indicated “Key information, above”, please list other groups or individuals with whom consultation should take place in relation to the use of person identifiable information. It is the project’s responsibility to ensure consultations take place, but IG will advise and guide on any outcomes from such consultations.

C5. Privacy Risks

List any identified risks to privacy and personal information of which the project is currently aware. Risks should also be included on the project risk register.

Risk Description **(to individuals, to the CCG or to wider compliance)**	**Proposed Risk solution (Mitigation)**	**Is the risk reduced, transferred or accepted? Please specify.**	**Consequence Score** **1= Low 1= Medium 3= High**	**Likelihood Score** **1=Low 2= Medium 3=High**	**Risk Score** **(C x L)**	**Further detail if required**

C6. Further information

Please provide any further information that will help in determining privacy impact.

Once Section A, B and C has been completed, please send the completed DPIA to the Information Governance Officer who will review the impact and determine how the impact will be handled.

This will fall into three categories:

1. **No action is required by IG excepting the logging of the Screening Questions for recording purposes.**
2. **The questionnaire shows use of personal information but in ways that do not need direct IG involvement – IG may ask to be kept updated at key project milestones.**
3. **The questionnaire shows significant use of personal information requiring IG involvement via a report and/or involvement in the project to ensure compliance.**

It is the intention that IG will advise and guide those projects that require it, but at all time will endeavour to ensure that the project moves forward and that IG is not a barrier - unless significant risks come to light which cannot be addressed as part of

the project development.

IG Sign Off / Approval (Section A, B & C only)

Title	Name	Date
Project Lead		
IG Officer		
IG decision **(delete as applicable)**	1. No action is required by IG excepting the logging of the Screening Questions for recording purposes. 2. The questionnaire shows use of personal information but in ways that do not need direct IG involvement – IG may ask to be kept updated at key project milestones. 3. The questionnaire shows significant use of personal information requiring IG involvement via a report and/or involvement in the project to ensure compliance.	
IG Officer Comments:		

Once the IG lead has approved the DPIA, it may be sent to the Data Protection Officer to review and add any comments or provide advice (if required)	
DPO Advice (if required):	
DPO Name:	**Date:**

Once the DPO has reviewed the DPIA (where applicable), this will be issued to the Project

Lead and IG Lead for audit. **The Project lead will then present the completed DPIA to the relevant board for approval**		
Board		
Board Chair		**Date:**

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Public Primary Care Commissioning Committee
7th May 19

TITLE OF REPORT:	Financial Position as at Month 12, March 2019
AUTHOR(s) OF REPORT:	Sunita Chhokar-Senior Finance Manager
MANAGEMENT LEAD:	Tony Gallagher, Director of Finance
PURPOSE OF REPORT:	To report the CCG financial position at Month 12, March 2019
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• M12 assumed 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 of the 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

Delegated Primary Care allocations for 2018/19 as at M12 are £36.571m. The forecast outturn is £35.795m delivering a underspend position of £0.776m.

The CCG planning metrics for 2018/19 are as follows;

- Contingency delivered across all expenditure areas of 0.5%
- Non Recurrent Transformation Fund of 1%. The CCG is not required to deliver a surplus of 1% on their GP Services Allocations.

2. Allocations

- No additional allocation in quarter 4 2018/19

3. M12 Forecast position

	Annual Budget £'000	FOT £'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	22,309	22,133	(176)		(176)	0
General Practice PMS	1,916	1,507	(409)		(409)	0
Other List Based Services APMS incl	2,433	2,849	416		416	0
Premises	2,817	2,466	(351)		(351)	0
Premises Other	94	60	(34)		(34)	0
Enhanced services Delegated	887	776	(111)		(111)	0
QOF	3,802	3,727	(74)		(74)	0
Other GP Services	1,765	2,277	512		1,482	(970)
Delegated Contingency reserve	183	0	(183)		(183)	0
Delegated Primary Care 1% reserve	366	0	(366)		(366)	0
Total	**36,571**	**35,795**	**(776)**		**194**	**(970)**

Further to last Quarter's reported position of £0.970m underspend the CCG has identified potential provision relating to costs for List size adjustments for Showell Park practice and ongoing issue relating to PMS/GMS. This has reduced the forecast underspend to £776k.

- The 0.5% contingency and 1% reserves are showing an underspend year to date with expedniture being fully utilised on "other GP Services" line . In line with NHSE planning metrics no expenditure should be shown on the 0.5% contingency and 1% reserves

The Primary Care Team receive monthly updates by practice, for referrals, First Outpatients and conversion to treatment. All is provided by specialty. They utilise this data to identify potential

outliers and to share good practice.This data is available at CCG level, Practice grouping level, Practice level and also available at GP level if required. In addition a Primary Care dashboard is in development which will assist in their further in depth analaysis.

4. Primary Care Reserves

- The forecast outturn includes a 1% Non-Recurrent Transformation Fund (£366k) and a 0.5% contingency (£183k) in line with the 18/19 planning metrics.
- In line with national guidance the 1% Non-Recurrent Transformation Fund can be utilised in-year non-recurrently to help and support the delegated services. This is fully committed at Month 12 and will be utilised for QOF plus .
- The 0.5% contingency is fully committed at Month 12 and has be utilised for the Diabetes living well project (£80k) and to cover practice configuration (£103k).

5. PMS premium reserves

- The PMS premium will grow each year as a result of the transition taper of funding of PMS practices; as a CCG we need to ensure we have investment plans in place to recognise this increasing flexibility. Over the next four years the anicipated cumulative position of the PMS premium is shown in the table below and the actual resource flexibility will depend on how effective expenditure is controlled. The funds for 2018/19 are fully committed.

Year	£000
18/19	677,371
19/20	860,470
20/21	978,284
21/22	1,096,098

6. Other Primary Care

- Other Primary Care relates to schemes that the CCG commission locally. The CCG is reporting a breakeven position as at M12 18/19. Plans are in place to ensure the full budget is utilised and any re-investments are returned to CCG commissioned primary care. The CCG is assuming practices complete the activity and make the necessary payment claims. Some of the key schemes to note are Social Prescribing, Quick Start Resilience, HCA development and ASC meetings.

- In month 11 the CCG received the following allocation :

- £50k GPFV workforce retention

	Annual Budget £'000	FOT £'000	Variance £'000 o/(u)	In Month Movement Trend	In Month Movement £'000 o/(u)	Previous Month FOT Variance £'000 o/(u)
Other Primary Care	1,210	1,210	0		0	0
Total	**1,210**	**1,210**	**0**		**0**	**0**

7. GP FV

GPFV schemes are funded from national monies provided from NHSE to deliver schemes in line with GP Forward View and comprises:

- Access
- Admin & Clerical
- Online Consultation

As at M12, the position is reported as breakeven.

	Annual Budget £'000	FOT £'000	Variance £'000 o/(u)	In Month Movement Trend	In Month Movement £'000 o/(u)	Previous Month FOT Variance £'000 o/(u)
GP Forward View	1,399	1,399	0		0	0
Total	**1,399**	**1,399**	**0**		**0**	**0**

- Plans are in place to ensure the Online consultation payments are made by 31st May 19. Admin and Clerical payments have been made to the practices.
- Access Scheme is paid by the CCG directly to the practice's in line with the Service Specification

8. Extended Enhanced Service

- The following table details an overspend position for the basket services. Practices submit a monthly claim form and payments are made accordingly.The CCG is assuming a continuation of current level of claims in derving a FOT. A final reconcilation will be completed once March claims have been processed. These services relate to Minor Injury, High Risk Drugs, Simple and complex dressing, Testosterone, Denosumab, Ear Syringing, Suture Clip Removals etc.
- Variations in claims and between practices form part of the management of the Local Enhanced Services budget by the Primary Care team.

	Annual Budget £'000	FOT £'000	Variance £'000 o/(u)	In Month Movement Trend	In Month Movement £'000 o/(u)	Previous Month FOT Variance £'000 o/(u)
Local Enhanced Services	735	753	17		17	0
Total	**735**	**753**	**17**		**17**	**0**

9. Transformation Fund

- The transformation fund is funded by the CCG based on a two year scheme, the CCG is now in the second year of the scheme 18/19. The funds can be accessed by the practices as long as they achieve the 10 high impact actions. The CCG has made the first and the second payment with a balance of £1k due to a practice not aligned to a group
- For 17/18 a benefit of £57k has been released into the position as this relates to practices which were not aligned to any grouping and did not complete actvity.

10. Prescribing

The Prescribing FOT is currently reporting an underspend £453k (based on 10 months actual data), of which majority relates to NCSO (no cheaper stock obtainable) and Cat M (annual price increase with effect from 1st Aug 18). Such pressures are national issues and the CCG is seeking clarity from NHSE regarding whether these pressures are recurrent.

The table below provides, for information, the drug item volumes and cost for the 12 months of 2017/18 and months 1 to 10 of 2018/19:

Drugs Volume	April	May	June	July	August	September	October	November	December	January	February	March
2017/18	437,361	478,614	477,699	468,043	463,317	479,940	497,784	497,785	472,139	487,166	438,264	465,453
2018/19	451,918	475,010	467,442	467,170	483,542	457,804	501,543	495,214	462,510	489,723		
Volume % Change	3.33%	-0.75%	-2.15%	-0.19%	4.37%	-4.61%	0.76%	-0.52%	-2.04%	0.52%		

Drugs Value	April	May	June	July	August	September	October	November	December	January	February	March
2017/18	3,555,492	3,876,882	4,036,596	3,953,707	3,863,081	3,877,675	3,971,339	3,960,233	3,791,186	3,518,104	3,402,160	3,651,221
2018/19	3,459,512	3,701,390	3,648,409	3,628,971	3,832,570	3,519,622	3,773,340	3,636,772	3,538,689	3,855,940		
Value % Change	-2.70%	-4.53%	-9.62%	-8.21%	-0.79%	-9.23%	-4.99%	-8.17%	-6.66%	9.60%		

11. 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
- Diabetes prevention programme
- Special access service(zero tolerence)

The variance underspend of which £776k relates to 1819 activity which have not occurred . In 19/20 the CCG are proposing a non recurrent development pot of £1m for any new pilot shemes which will 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: 18/04/19

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**	**18/04/19**
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**	**24/04/19**

This page is intentionally left blank