NHS
Wolverhampton
Clinical Commissioning Group

**Meeting of the Public Primary Care Commissioning Committee**
**Tuesday 2nd July 2019 - 2.00 pm to 3.30 pm**

**PA125 Stephenson Room, 1st Floor, Technology Centre,**
**Wolverhampton Science Park WV10 9RU**

# A G E N D A

| | | | | |
|---|---|---|---|---|
| *1.* | *Welcome and Introductions* | | *Chair* | ***Verbal*** |
| *2.* | *Apologies* | | *Chair* | ***Verbal*** |
| *3.* | *Declarations of Interest* | | *Chair* | ***Verbal*** |
| *4.* | *Minutes of Previous Meeting 4th June 2019* | | *All* | ***Enc 4*** |
| *5.* | *Matters Arising From Previous Minutes* | | **Chair** | Verbal |
| *6.* | *Committee Action Points* | | **Chair** | Enc 6 |
| *7.* | *Primary Care Update Reports* | | | |
| ***7 a*** | ***Primary Care Quality Report*** | ***A*** | *Liz Corrigan* | ***Enc 7 a*** |
| ***7 b*** | ***Primary Care Operational Management Group Update*** | ***A*** | *Mike Hastings* | ***Enc 7 b*** |
| ***7 c*** | ***Primary Care Networks Update*** | ***A*** | *Sarah Southall* | ***Enc 7 c*** |
| ***7 d*** | ***Training Hub Proposal*** | | *Sarah Southall* | ***Enc 7d – to follow*** |
| ***7 e*** | ***Quality Assured Spirometry Business Case (Revised Costs)*** | ***D*** | *Claire Morrissey* | ***Enc 7 e*** |
| *8.* | **Any Other Business** | | | |

*Date of Next Meeting:* ***Tuesday 6th August 2019 at 2.00pm***

PA025 Marston Room, Ground Floor, Technology Centre, Wolverhampton Science Park WV10 9RU

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**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP**
**PRIMARY CARE COMMISSIONING COMMITTEE**

**Minutes of the Primary Care Commissioning Committee (PUBLIC)**
**Tuesday 4 June 2019 at 2.00pm**
**PA025 Marston Room, Technology Centre, Wolverhampton Science Park WV10 9RU**

**MEMBERS ~**

**Wolverhampton CCG ~**

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

**NHS England ~**

| | | |
|---|---|---|
| Bal Dhami | Senior Contracts Manager – Primary Care, NHSE | Yes |

**Non-Voting Observers ~**

| | | |
|---|---|---|
| Tracy Cresswell | Wolverhampton Healthwatch Representative | No |
| John Denley | Director of Public Health | No |
| Dr B Mehta | Wolverhampton LMC | No |
| Jeff Blankley | Chair of Wolverhampton LPC | No |

**In attendance ~**

| | | |
|---|---|---|
| Mike Hastings | Director of Operations (WCCG) | Yes |
| Peter McKenzie | Corporate Operations Manager (WCCG) | Yes |
| Sarah Southall | Head of Primary Care (WCCG) | Yes |
| Gill Shelley | Primary Care Contracts Manager (WCCG) | Yes |
| Dawn Bowden | Quality Assurance Co-ordinator (WCCG) | Yes |
| Diane North | Primary Care Commissioning Committee Administrator (WCCG) | Yes |

**Welcome and Introductions**

WPCC515 Mr Trigg (Vice Chair) welcomed attendees to the meeting and introduced Dawn Bowden who was presenting the Primary Care Quality Report on behalf of Liz Corrigan.

**Apologies**

WPCC516 Apologies were received from –

Sue McKie, Committee Chair
Helen Hibbs, WCCG Chief Officer
Tony Gallagher, WCCG Director of Finance
Liz Corrigan, Primary Care Quality Assurance Co-ordinator
John Denley, Director of Public Health, City of Wolverhampton Council
Jeff Blankley, Chair of Wolverhampton LPC
Dr B Mehta, Wolverhampton LMC
Dr M Kainth, Locality Chair/GP
Dr D Bush, Locality Chair/GP
Tracy Cresswell, Healthwatch Wolverhampton

**Declarations of Interest**

WPCC517 No declarations of interest were made.

**Minutes of the Meeting held on the 7th May 2019**

WPCC518 The minutes of the meeting held on 7th May 2019 were agreed as an accurate record.

**RESOLVED: That the above was noted.**

**Matters Arising from Previous Minutes**

WPCC519 There were no matters arising from the previous minutes.

**RESOLVED: That the above was noted.**

**Committee Action Points**

WPCC520 **Action 30 (Minute No: WPCC452) – Primary Care Strategy Update**
Delegated authority was granted 14th March by Governing Body for Primary Care Commissioning committee to approve the draft Primary Care Strategy. On the agenda for the meeting. Action closed.

**Action 31 (Minute No: WPCC468) – Primary Care Networks**
On the agenda for the meeting. Action closed.

**Action 35 (Minute No: WPCC499) – NHS Benchmarking Network- Primary Care 2018.**
On the agenda for the private meeting. Action closed.

**Primary Care Update Reports:**

**Primary Care Quality Report**

The following highlights from the report were given:-

WPCC521

- The serious incident referred to on page 2 had since been reviewed and closed and will be logged with NHS England Performers Information Gathering Group (PIGG).
- There were 4 incidents for the next PIGG meeting.
- The Friends and Family Test (FFT) had seen an increased uptake this year, which, it was felt, was due to the new texting system.
- A new action plan was in place for collaborative contracting visits.
- Work was on-going for the Practice nurse retention programme and there would be regular meetings across the STP about the Training Hubs.

**RESOLVED: That the report and highlights above were noted.**

**Primary Care Operational Management Group Update**

The following highlights from the report were given:-

WPCC522

- The closure of Tettenhall Medical Practice's branch site at Wood Road was currently in mid-patient consultation. Arden & GEM Commissioning Support Unit (AGCSU) had supported the consultation and patient feedback so far had been good.
- Estates & Technology Transformation (ETTF) funded building work at Newbridge surgery was fast approaching completion. Work at the East Park site had commenced and completion was expected to take 6 months. Comms would be going out in relation to this.
- Wolverhampton CCG was supporting NHS England with national Contract Variations. The City of Wolverhampton Contracting team were liaising with individual practices.
- The NHS England Policy Guidance Manual had been updated and shared across the CCG.
- A new system of bookable space within Primary care would be introduced by the Estates team to minimise some of the existing issues, in particular around non-GMS services running out of GP Practices and confusion between practices on claiming.

**RESOLVED: That the update was noted.**

**Primary Care Contracting Update**

WPCC523

- The report provided an update on the QOF Post Payment Verification for 17/18 concluding it had been a satisfactory process with no specific concerns or issues and was well supported by GP assessors. It will be repeated for QOF 18/19, reviewing different disease areas.

- Ms Shelley provided an update on the consultation of the closure of Tettenhall Wood Surgery and advised that the next drop-in session would be 3 July 2019, with a further 2 additional drop-in sessions proposed for patients and members of the public. There had been an extremely high response to the online survey and from earlier drop-in sessions and although patients were not particularly happy about the proposed closure of the surgery, they had provided much positive feedback about the surgery and the services they provided.

- There had been some queries raised at Audit and Governance committee around the contract management and review process, which is a rolling programme. The concern was that a number of practices had not yet been seen in the 3 years since it began. It was advised that this was a result of resources within the team and had since been addressed with the addition of two staff members to the process (one of which was Ms Shelley). It was confirmed that there were 11 practices still to see and that these would be completed by the end of July.

A query was raised about the media interest surrounding the closure of Wood Road Surgery and it was acknowledged that the Express & Star had run a piece in their newspaper when the letters first went out to patients. Following one of the drop in sessions, the Express and Star also wanted to know the reasons for the closure and had focused on Property Services and the increases in charges. A response to this had been provided by the CSU. There was a further piece in the Express and Star and on social media around councillors demanding answers. It was felt that Practices, like any other independent business, would need to make these sort of decisions faced with a fall in profits. Mr Marshall stated that he was due to attend a meeting with local councillors tomorrow, 5th June, which was more about the CCG's influence on these sort decisions and whether a new buyer could be found.

**RESOLVED: That the update was noted.**

**Primary Care GP Networks**

- The report provided the outcomes of decisions made in response to the Primary Care Network application process considered at CCG Panel on 16th May 2019. It defined the configuration of each of the networks including the name of the Clinical Director and which practices were within each network and provided assurance that signatures had been obtained from all practices.

WPCC524

- The network Direct Enhanced Service (DES) required that a number of items be submitted as part of the application process and the panel were able to approve four applications on 16th May. There were queries around the other two applications but these were subsequently resolved meaning the CCG was able to ensure at 21st May that there were six networks approved for Wolverhampton.
- Assurance was provided by NHS England on 21st May to confirm the outcome of panel decisions and a subsequent repeat submission had

occurred on 4 June confirming there were no subsequent changes since 21st May.

- Group Leads meet presently at monthly intervals and these meetings will change to clinical directors meetings from July, a draft terms of reference has been prepared in readiness and is awaiting sign off by the Executive Team. A series of assurance statements have been prepared, which clinical directors will be required to support the CCG in achieving. The assurance statements have been defined by NHS England and are a series of statements required to report on a quarterly basis on behalf of Wolverhampton but also as part of the wider STP and constitute the minimum expectations for Primary Care Networks. Locally there will be a task and finish group that forms part of the Primary Care Strategy governance and associated work programme.
- Network agreement and milestone dates were provided on page 3. Currently, the CCG was at the stage where a large number of practices were signing up to the DES via the national system and variations were being made to GMS, PMS and APMS contracts in conjunction with colleagues at NHS England.
- The practices within each of the networks were actively working together, with the clinical directors, to develop detailed network agreements. There were a number of schedules that formed the basis for the network agreement and were due to be submitted to the CCG later in June ahead of the national submission date to NHSE. This would enable the CCG to review the content to ensure it was pitched at the right level with priorities clearly defined. Networks would be required to publish their development plans in July.
- A number of new roles were being phased in, the first being Social Prescribing Link workers. An initial workshop took place in May. A further session was planned for June. A similar approach would be adopted for Clinical Pharmacists and other roles in conjunction with Clinical Directors.
- The maturity assessment within the paper complemented the network formation and provided an indication of where all the networks were on an aggregate basis for Wolverhampton and demonstrated progression made based on work done over 2 - 3 of years putting us in a very good place within the STP to achieve the required standards by next Summer.

A query was raised about why some of the assurance statements were listed in white such as the evaluation of high impact activity. It was confirmed that the evaluation had been prepared for consideration and was a piece of work taking place not only in Wolverhampton but across the STP and that the data analytics meeting was not due to take place until week commencing 10th June 2019. The preparatory work had been done and just needed to ensure the data provisions were in place for July when the networks would go live.

A question was asked regards the PCN Maturity Assessment, whether there were plans in place to deal with the items with exclamation marks. It was confirmed that these items would form the basis of the Primary Care Networks Development Plan and the CCGs Task and Finish Group and would be linked

to each of the network agreements being developed. The network agreements would indicate the areas of work for focus within the programme of work and it was hoped to be able to confirm these at the next committee in July.

The hard work involved was acknowledged by the committee and it was felt that the whole process had been really well managed from a CCG perspective.

It was highlighted that since the report the national guidance had been updated by NHS England and there were some slight amendments around practices joining networks across borders provided all parties were harmonious and agreeable. It was queried if this would open up the opportunity for challenge and potentially it could, however discussions that had taken place with neighbouring commissioners had concluded with a stance Staffordshire Practices would remain within their STP/ICS footprint.

**RESOLVED: That the update was noted.**

**Primary Care Strategy (Wolverhampton)**

With regard to the Wolverhampton Primary Care strategy, the first draft had been prepared on behalf of the CCG by the CSU and was a working draft that would be developed & strengthened further. Feedback from a public engagement event that took place on 23rd May 2019 would be incorporated. It was intended to have a wider debate at the forthcoming members meeting in order to ensure that the content, particularly the vision and priorities were mutually agreed with Clinical Directors and the document flowed accordingly. A further iteration, anticipated for the August committee, will be shared for final comment.

WPCC525

A query was raised about workstreams as the strategy listed separate workstreams for practices as providers and PCNs. It was felt that focusing on PCNs as providers would be the way forward however it was acknowledged that the two elements existed. The network task and finish group would support provision at scale, linking into the assurance statements, and the practices as providers workstream would focus on the activities taking place at practice level e.g. QOF activity, QOF+ with the assurances around GMS, PMS and AMPS contract provisions. Mr McKenzie felt there was potential for overlap, which was acknowledged as an area for review as the programme of work developed.

**RESOLVED: That the update was noted.**

**Primary Care Strategy (STP)**

WPCC526

- The committee had been granted delegated authority by the Governing Body to approve the Primary Care Strategy in principle. This was due to the time constraints placed on the STP to submit the strategy by 20 June 2019.

- The strategy was considered by the committee and recognition given to the fact it was a draft. Comments would be received up to14 June before the final draft version be submitted to NHS England on 20 June. The committee agreed the strategy in principle but confirmed their expectation to be kept appraised of developments and requested sight of the final draft version and any feedback and amendments.
- Clarity was sought on how the STP Strategy related to the CCG Strategy and whether the STP Strategy created limits within which the CCG Strategy should work. It was confirmed that NHS England had advocated, as part of the long-term plan, that the STP would have its own strategy and this would be prepared based on the template issued. The STP strategy aggregated the Black Country position and presented an overall position and direction of travel for the future. The local CCG strategy would include more detail on local place-based primary care services and the needs of the local population and the vision for primary care in Wolverhampton.

The STP strategy had been developed in a very short timescale. Originally, it was required for the Autumn of 2019 however at the end of April 2019, NHS England had issued a template requesting completion and submission by 20th June. Today's submission was by no means the final version and it was recognised there were areas that needed strengthening but the aim was to get the document out so that committees had sight of it, giving them chance to comment before the submission deadline. Due to the short timelines it was reiterated that comments would need to be submitted by next Friday 14th June so that they could be considered and incorporated into the final draft for 20th June. NHS England would then provide feedback and there would be a short window of opportunity for final amendments to be made before re-submission.

The Chair asked for clarification of who would do the actual sign-off of the final Strategy. It was defined that this committee needed to be comfortable with the content within the strategy and that similar conversations were taking place in each of the CCGs and STP Joint Commissioning Committee.

It was acknowledged that the template provided did not flow particularly well. Some priorities needed to be cross-referenced with the STP operating plan and clinical strategy to ensure a consistent message.

The Committee agreed to support the first draft of the document in principle. Feedback on progress would be submitted to committee before the next meeting and following submission to NHS England.

**RESOLVED: That the update was noted.**

**Quarterly Primary Care Assurance Report**

WPCC527 The Primary Care Assurance Pack was presented for committee assurance and had been considered at Milestone Review Board in April and accepted in principle. The Milestone Review Board had raised a number of queries as

detailed on the cover sheet of the report. It was acknowledged that some of the information in the report was now a bit outdated, in particular the Primary Care Networks map and the QOF+ document which had since been improved and finalised. The Milestone Review Board were able to accept the content and the assurance that was provided with the caveats around the queried items that would be worked up further.

**RESOLVED: That the update was noted.**

**Any Other Business**

WPCC528 There was no further business raised by Committee.

**Date of Next Meeting**

WPCC529 **Tuesday 2nd July at 2.00pm in PA125 Stephenson Room, 1st Floor, Technology Centre, University of Wolverhampton Science Park WV10 9RU**

Primary Care Commissioning Committee Actions Log (Public)

| Action No | Date of meeting | Minute Number | Item Title | Item | By When | By Whom | Action Update |
|---|---|---|---|---|---|---|---|
| 37 | 04 June 2019 | WPCC525 | Wolverhampton Primary Care Strategy update | The next iteration of the Wolverhampton Primary Care Strategy to be presented to the Aug 19 meeting | Aug-19 | Sarah Southall | 04/06/19: Next iteration to be presented to the Aug meeting |
| 38 | 04 June 2019 | WPCC526 | STP Primary Care Strategy update | Further update to be provided to committee members following submission deadline of 20th June and before next meeting 2nd July | Jul-19 | Sarah Southall | 04/06/19: Further update to committee due before Jul meeting and following 20th June NHS England deadline. |
| 39 | 05/03/2019 moved from private to public actions 04/06/19 | WPCC481 | Tettenhall Medical Practice - Wood Road Branch Closure | An Update to be provided at the conclusion of the consultation period | Sep-19 | Gill Shelley | 04/06/19 Action inherited from Private action Log. Update to be provided at conclusion of consultation. Consultation ends Aug, report to be presented to committee in Sept |

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# WOLVERHAMPTON CCG

## PRIMARY CARE COMMISSIONING COMMITTEE
## 2nd JULY 2019

| | |
|---|---|
| **TITLE OF REPORT:** | Primary Care Quality 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**<br>☒ **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 | |

## 1. BACKGROUND AND CURRENT SITUATION

**PRIMARY CARE QUALITY DASHBOARD**

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

| Issue | Comments | Highlights for May 2019 | Mitigation for June 2019 | Date of expected achievement of performance | RAG rating |
|---|---|---|---|---|---|
| **Serious Incidents** | All RCAs are reviewed at SISG and escalated to PPIGG if appropriate. | Near miss reported to PPIGG at NHSE – chair happy with response at practice and local level no further action required. RCA for serious incident currently being finalised for review at SISG and referral back to PPIGG | Serious incident escalated to PPIGG – closed no further actions as it had already been reviewed by PAG | No further actions at present | 1b |
| **Quality Matters** | All issues being addressed by appropriate teams at the CCG and trust that has raised the issue. For review at PPIGG as relevant | Currently up to date:<br>• 12 open<br>• 2 of these are new<br><br>Main themes are:<br>• IG breaches<br>• Prescribing issues<br>• Referral issues | Currently up to date<br>• 4 open<br>• 8 closed<br><br>**Four referred into PPIGG with four further pending** | On-going process as new Quality Matters are identified | 1a |
| **Escalation to NHSE** | Four incidents to be reviewed at PPIGG from Quality Matters | Four incidents have received a response from the relevant practice which will be reviewed at PPIGG | No issues at present | No further actions at present | 1b |
| **Infection Prevention** | Planning continues around training for practices in reduction of gram negative infection – collaboration with IP team, prescribing and continence teams. | Monitoring of IP audits continues, monitoring of practice sepsis leads continues. | Four incidents referred into PPIGG with four more pending review this month | Expected completion by end of July 2019 | 1a |

| | | | | | |
|---|---|---|---|---|---|
| | Some practices have still not identified a sepsis lead and this is being chased. | | | | |
| **MHRA** | No issues at present. | No further update | No further update | No further actions at present | 1a |
| **Complaints** | No issues at present – quarterly report due July 2019 | Awaiting Quarter 4 complaints report from NHSE | Quarter 4 complaints data not yet available | No further actions at present | 1a |
| **FFT** | Quarterly full report due in July 2019<br>Practices who were unable to submit via CQRS or who had submitted but data was not showing on NHSE return have had their data added manually | In April 2019<br>• 2 practices did not submit (3 practices attempted to submit via CQRS but were unable to – this data was entered into the spreadsheet manually)<br>• 2 practices submitted fewer than 5 responses<br>• Uptake was 2.4% compared to 0.9% regionally and 0.7% nationally | In May 2019<br>• 5 practices did not submit – there appeared to be an issue with CQRS in some sites and one has submitted late<br>• 1 practice submitted fewer than 5 responses<br>• Uptake was 1.8% compared to 0.8% regionally and 0.6% nationally | No further actions at present | 1a |
| **NICE Assurance** | No actions at present – next NICE meeting in August 2019 | Nothing new to report | New NICE guidance for primary care discussed in May 2019 – available to providers | No further actions at present | 1a |
| **Collaborative contracting visits** | 11 practice visits are outstanding, this will be completed by late summer in line with recent audit. | Visit schedule has been reviewed and an action plan is being devised to ensure that all practices receive their visit in a timely manner. | Visit schedule now available with all practices allocated a visit | Expected completion by end of September 2019 | 1b |
| **CQC** | No issues at present | CQC inspections continue, two practices have requires improvement rating – one has merged with another practice and one is being managed by RWT | One practice identified as being requires improvement – meeting arranged with practice and CCG to discuss action plan | Expected completion by end of September 2019 | 1b |

| | | | | | |
|---|---|---|---|---|---|
| **Workforce Activity** | Awaiting NHS Digital workforce data release. | Retention programme will be launched in line with the GPN strategy documents and deliverables identified at this time | Awaiting approval of GPN strategy in Dudley and Sandwell and then to arrange launch – funding to be agreed | September 2019 | 1a |
| **Workforce Numbers** | Awaiting NHS Digital workforce data release. | Still awaiting digital workforce data | Workforce figures are still pending due to changes in data collection | Awaiting further information | |
| **Training and Development** | None flagged at present | GPN strategy approved at STP CLG group and by all other CCGs apart from Sandwell (delay due to PCN work) – launch to be arranged for summer 2019<br>Work continues with WDC around diabetes training<br>Spirometry training dates agreed and expressions of interest gathered<br>Training offered by continence team for HCAs and GPNs. Discussions have commenced around launch of the GPN strategy. | • Training continues across the workforce for:<br>• GPs – retention work<br>• GPNs – strategy launch and retention work, flu training ,ARTP spirometry and diabetes training<br>• Other professions – pharmacy network meetings and PA Fellowships to commence<br>• Practice manager update sessions planned | September 2019 | 1a |
| **Training Hub Update** | To continue monitoring, risk remains open. | Discussions have commenced with Training Hubs in late May – potential hub and spoke model discussed. Development of primary care training academy planned model with a board in place to offer direction to the teams. | • Work to reconfigure the Training Hub provision continues.<br>• Primary Care Board due to meet in June 2019 to discuss the work plan for hubs and PCNs | This action is on-going and will be updated as new information is available. | 2 |

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# 2. PRIMARY CARE QUALITY REPORT

## 2.1. PATIENT SAFETY

| Measure | Trend | Assurance/Analysis |
|---|---|---|
| **Serious Incidents** | N/A – not enough data to display a graph/trend | **Incidents:**<br>• 1 Serious Incident referred to PPIGG – closed by chair as it had already been reviewed by PAG.<br>• All incidents are reviewed by serious incident scrutiny group<br>• Incidents are also reviewed by NHSE PPIGG group |
| **Quality Matters** | QM Themes 2019-20 (chart, June: IG Breach 0; Appointments 1; Referral issue 1; Prescribing 2; Interpreting issue 0; Clinical 0) | • There are currently 4 open Quality Matters (QM)<br>• 8 Quality Matters were closed in June<br>• **Four have been referred into PPIGG with four further pending pending.** |



| Monthly Variance | May | June | Percentage |
|---|---|---|---|
| New issues | 2 | 3 | 24% |
| Open issues | 9 | 4 | 60% |
| Overdue issues | 0 | 3 | 16% |
| Closed issues | 2 | 8 | 8% |

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| Escalation to NHS England | Chart: Escalation to NHSE | Assurance |
|---|---|---|
| **Escalation to NHS England** |  | • Four incidents reported to PPIGG in May:<br>○ Incorrect referral<br>○ Unsafe anticoagulation practice<br>○ Delayed referral<br>○ Delayed verification of death<br>• Four further incidents to be reported following Quality Matters review relating to:<br>○ Prescribing x 2<br>○ Treatment delay<br>• Issue with interpreters |



## 2.2. INFECTION PREVENTION

| Measure | Trend | Assurance/Analysis |
|---|---|---|
| **IP Audits** | No data at present – awaiting new audit cycle | • **IP Audit Ratings:** Gold 97-100%; Silver 91-96%; Bronze 85-90%; No rating ≤84%<br>• The cycle for 2019/2020 has yet to start, further update at next month's meeting.<br>• Work will continue with RWT IP team. |
| **MRSA Bacteraemia** | N/A | • No CCG cases noted<br>• No areas of concern to report. |
| **Influenza vaccination programme** | No data at present | • Flu planning group met in May 2019 – new action log commenced next meeting July 2nd.<br>• Training is booked from Black Country Training Hub in July 2019<br>• Flu vaccine ordering information requested from practices, some orders are low compared to cohort – to address via flu planning group, however vaccines are available across groups/PCNs<br>• Flu Fighters comics to be shared across the Black Country |
| **Sepsis** | No data at present | • Training for practice nurses is being planned for November 2019.<br>• Work has commenced around organising a deteriorating patient education session for nurses in the summer |

## 2.2. MHRA Alerts

| Measure | Trend | Assurance/Analysis |
|---|---|---|
| **MHRA Alerts** | (chart and table below) | No concerns to report at present |

MHRA Alerts

Field safety notice: 56%
Device alerts: 11%
Drug alerts: 33%

| | May | June | Total | Percentage |
|---|---|---|---|---|
| Field safety notice | 2 | 1 | 6 | 46% |
| Device alerts | 2 | 0 | 2 | 15% |
| Drug alerts | 1 | 1 | 5 | 38% |
| | | | 13 | |

## 2.3. PATIENT EXPERIENCE

| Measure | Trend | Assurance/Analysis |
|---|---|---|
| **Complaints** | | **Complaints Numbers and Themes:**<br>2018/2019 Data<br><br>Quarter 4 data not yet received from NHS England. |
| **Friends and Family Test** | (see table below) | • Uptake remains significantly higher than regional and national uptake.<br>• Total non-responders 5 practices (no data, zero data or supressed data) – lower than regional and national average. All practices have been contacted.<br>• Uptake is reviewed on a monthly basis by the Quality Team and Primary Care Contract Manager. |

| Percentage | March | April | West Midlands | England |
|---|---|---|---|---|
| Total number of practices | 40 | 40 | 2066 | 7001 |
| Practices responded | 92.5% | 85.0% | 64.8% | 63.4% |
| | 37 | 34 | | |
| No submission | 7.5% | 12.5% | 35.2% | 36.6% |
| | 3 | 5 | | |
| Zero submission (zero value submitted) | 0.0% | 0.0% | N/A | N/A |
| | 0 | 0 | | |
| Suppressed data (1-4 responses submitted) | 5.0% | 2.5% | 6.4% | 7.8% |
| | 2 | 1 | | |
| Total number with no data (no/zero submission and supressed data) | 12.5% | 15.0% | 41.6% | 44.4% |
| | 0 | 6 | | |
| Response rate | 2.4% | 1.8% | 0.8% | 0.6% |

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| Key (compared to WM) | |
|---|---|
| Lower performance | |
| Higher performance | |
| Same performance | |

## 2.4. CLINICAL EFFECTIVENESS

### NICE Assurance – Updated Quarterly (next due August 2019)

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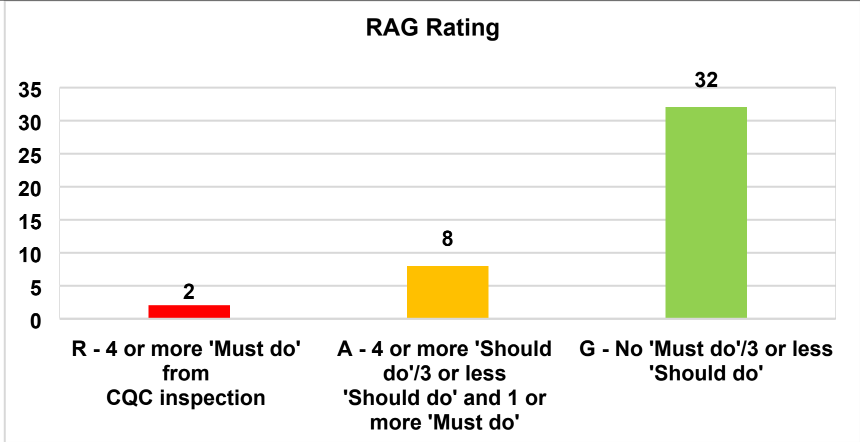
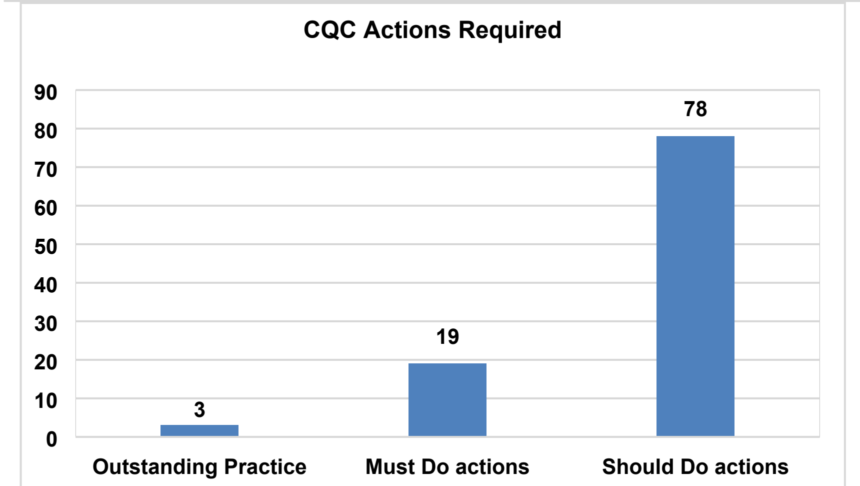
| Guideline | Ref | Published | Last Updated | Primary Care |
|---|---|---|---|---|
| Delirium: prevention, diagnosis and management | CG103 | Jul-10 | Mar-19 | x |
| The Debrisoft monofilament debridement pad for use in acute or chronic wounds | MTG17 | Mar-14 | Mar-19 | x |
| Ertugliflozin as monotherapy or with metformin for treating type 2 diabetes | TA572 | Mar-19 | Mar-19 | x |
| Lung cancer: diagnosis and management | NG122 | Mar-19 | Mar-19 | x |
| Lung cancer in adults | QS17 | Mar-12 | Mar-19 | x |
| Urinary incontinence and pelvic organ prolapse in women: management | NG123 | Apr-19 | Apr-19 | x |
| Caesarean section | CG132 | Nov-11 | Apr-19 | x |
| Surgical site infections: prevention and treatment | NG125 | Apr-19 | Apr-19 | x |
| Ectopic pregnancy and miscarriage: diagnosis and initial management | NG126 | Apr-19 | Apr-19 | x |
| Suspected neurological conditions: recognition and referral | NG127 | May-19 | May-19 | x |
| Stroke and transient ischaemic attack in over 16s: diagnosis and initial management | NG128 | May-19 | May-19 | x |
| Crohn's disease: management | NG129 | May-19 | May-19 | x |
| Ulcerative colitis: management | NG130 | May-19 | May-19 | x |

| | | | | |
|---|---|---|---|---|
| Lead-I ECG devices for detecting symptomatic atrial fibrillation using single time point testing in primary care | DG35 | May-19 | May-19 | x |
| Prostate cancer: diagnosis and management | NG131 | May-19 | May-19 | x |
| Prostate cancer | QS91 | Jun-15 | May-19 | x |

| Measure | Trend | Assurance/Analysis |
|---|---|---|
| **Collaborative Contracting visits** | Pie chart: 70% Practices visits completed; 5% Practices visits booked; 25% Outstanding visits | 10 practices are still outstanding and one practice is currently completing their action plan – visit schedule is now set up<br><br>Themes from visits identified are:<br>• Policies needing updating or amending e.g. version control, update date or author<br>• Missing policies.<br>• Mandatory training gaps – particularly safeguarding training.<br>• Missing certificates e.g. training and insurance – cover is available but the certificates are not. |

| CQC ratings | <br> | CQC continue to liaise with CCG to support the inspection process. One practice has recently had a requires improvement rating – four in total for Wolverhampton and a meeting has been arranged with the practice.<br><br>Outstanding actions are managed by inspectors via 3 monthly virtual or face to face review.<br><br>Inspections by year:<br>2015 – 3<br>2016 – 12<br>2017 – 14<br>2018 – 11<br>2019 – 4<br><br>Several practices are due an inspection due to changes in provider. |
|---|---|---|

| 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 |



## 2.5. WORKFORCE DEVELOPMENT

### 2.5.1. Workforce Activity

| Measure | Assurance/Analysis |
|---|---|
| **Recruitment and retention** | • STP lead is currently identifying and raising risks<br>• STP Primary Care Strategy is currently being finalised – draft to NHSE on 20th June and final version to NHSE on 28th June<br>• STP project manager to be recruited to support GP and GPN retention programme alongside other workforce work streams<br>• GP International recruitment is currently on hold.<br>• Overseas settlers programme still under development – continuing<br>• GP retention programme up and running with support for GPs in the first five years, retirement support and portfolio careers.<br>• The practice nurse retention programme now complete – for launch with GPN strategy and presentation of ideas for co-design.<br>• HCA apprenticeship programme has 3 staff who have commenced with further interest from another individual and one practice who is interested in larger scale HCA training and the employment of business and administration apprentices.<br>• NA apprenticeship programme details have been shared with practices with tentative interest from 3 so far – to finalise applications this month.<br>• Work experience pilot is due to commence on 1st July with a local school – placements include CCG, GP, pharmacy and public health<br>• A proposal has been made to create a GPN training and retention tracker across the STP – local information will be used to help populate this |

| | |
|---|---|
| **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 and at CLG – launch to be arranged once funding identified. This now forms part of STP Primary Care Strategy.<br>• Action 1: Work experience pilot placements now finalised students identified with placements set up between 1st and 5th July.<br>• Action 2, 4 and 10: Digital Clinical Supervision pilot, has now finished but the sessions are continuing in Wolverhampton face to face and via Skype.<br>• Action 4: GPN Strategy supports GPN involvement in PCN boards at strategic level.<br>• Action 3: there are currently 17 practices and the CCG itself offering student nurse placements with another one expressing an interest, but there is some movement of mentors due to job changes.<br>• Action 4: The GPN fast track programme continues with Wolverhampton nurses attending – nurses are also undertaking Fundamentals of General Practice Nursing<br>• Action 5: Further work is being developed to promote the Return to Practice programme via Futureproof.<br>• Action 7: Nurse Education forum continues on a monthly basis with plans to develop this further next year<br>• Action 9: The CCG will support 3 Nursing Associate apprenticeships with backfill in primary care, comms have been developed and circulated with 3 candidates interested.<br>• Action 9: HCA apprenticeships programme has commenced with two candidates started in April and 4 further candidates identified as part of a pipeline programme in one practice.<br>• Action 10: The Nurse Retention plan has now been collated with work streams being planned as part of the GPN Strategy – task and finish group under development |



### 2.5.2. Workforce Numbers

| Measure | Trend | Assurance/Analysis |
|---|---|---|
| **Workforce Numbers** | No data at present – awaiting figures from NHS Digital | Figures taken from NHS Digital data are for September 2018 with the next update due imminently. Local figures are monitored. |

### 2.5.3. Training and Development

| Measure | Assurance/Analysis |
|---|---|
| **GP** | • Overseas GP training will not go ahead<br>• 250 GP trainees within STP areas – work to commence to convert these to full time GP posts – approximately 75 due to complete this year to work with these individuals to identify them and what they will need to get them to stay<br>• TPDs identified to discuss retention of trainees<br>• GP retention programme to continue |
| **Nurse Training** | • Practice Makes Perfect continues. |

| | |
|---|---|
| | • MERIT diabetes course will be available from September 2019 funded by Novo Nordisk – this has been arranged in conjunction with Wolverhampton Diabetes Centre<br>• Flu training is booked for July 2019<br>• Apprenticeship programmes are up and running<br>• Spirometry training is arranged for September and December 2019<br>• One qualified nursing associate in post in VI practice, potentially 2-3 for recruitment for September as part of the nursing roles apprenticeship programme |
| **Other Professionals** | • HEE have JDs available for all new primary care roles<br>• There are varied models of employing new roles within PCNs being proposed from maintaining current provision and buying cover, to direct employment to a proposed social enterprise model<br>• Physicians Associates regulation is now imminent within the next 2 years including prescribing - internship recruited to 4 days in primary care and 1 day in mental health. Apprenticeship standard in development. PCNs will have funding to support 1st year of appointment of PAs. Work around preceptorship for new PAs across the STP being considered. To map PA placement sites across Wolverhampton.<br>• One paramedic employed in the city – to check his role<br>• Clinical pharmacist roles continue within practice groups – pharmacist network under development |
| **Non-clinical staff** | • Overseas GP training will not go ahead<br>• 250 GP trainees within STP areas – work to commence to convert these to full time GP posts – approximately 75 due to complete this year to work with these individuals to identify them and what they will need to get them to stay<br>• TPDs identified to discuss retention of trainees<br>• GP retention programme to continue |



### 2.5.4. Training Hub Update

| | **Exceptions and assurance** |
|---|---|
| **Black Country Training Hub** | • Training Hubs to work with PCNs to identify workforce and training needs<br>• Training Hubs are continuing with business as usual – training and updates booked in Dudley<br>• Nurse Facilitator is now chair of Black Country branch of RCN<br>• Digital Nurse Champion project being led by Nurse Facilitator<br>• HCAs and new to GPN being supported by Sandwell<br>• Evaluations due on Sandwell projects including admin into HCAs, NMPs |
| **LWAB.HEE** | • HEE health and wellbeing project undertaken – this is due for release and contains information about mental health and suicide prevention and wellbeing guardians being available at senior level and wellbeing check-in with students and new employees, financial implications and home life also a consideration<br>• Suicide framework has been developed |

| | |
|---|---|
| | • NHS People Plan is now available - costed plan will come out later this year, this includes sections on primary care and support for development<br>• NHSE and HEE are now both Midlands and East<br>• New regional director and deputy director, Russell Smith is new regional dean<br>• LWAB are agreeing direction – all funding out to trusts with some protected for primary care 25% of monies for system-wide work<br>• LWAB are doing scenario work looking at “what ifs” around workforce |
| **Higher/further Education** | • Fundamentals starting in January<br>• SP degree starting in September |

## 3. CLINICAL VIEW

N/A

## 4. PATIENT AND PUBLIC VIEW

N/A

## 5. KEY RISKS AND MITIGATIONS

All risks addressed through Quality and Safety, Primary Care and Workforce Risk registers.

## 6. IMPACT ASSESSMENT

### *6.1. Financial and Resource Implications*
N/A

### *6.2. Quality and Safety Implications*
Report is also delivered to Quality and Safety Committee – quality implications are addressed via this group.

### *6.3. Equality Implications*
N/A

### *6.4. Legal and Policy Implications*
N/A

### *6.5. Other Implications*
N/A

**Name**
**Job Title**
**Date:**

**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 Inclusion Service | **N/A** | |
| 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)** | **Yvonne Higgins** | |

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Wolverhampton
Clinical Commissioning Group

# WOLVERHAMPTON CCG
# PRIMARY CARE COMMISSIONING COMMITTEE
# 2nd July 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**<br>☒ **Assurance** |
| **PUBLIC OR PRIVATE:** | This report is intended for the public domain. |
| **KEY POINTS:** | • The CCG continues to support Tettenhall Medical Practice with their patient consultation regarding their intention to close their Wood Road branch to ensure the patient's voices are heard.<br>• Construction work is now complete at Newbridge Surgery.<br>• Primary Care Networks are established and the operational group are supporting in the set-up of contracts, IT, etc. |
| **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 financial envelope | Operational issues are managed to enable Primary Care Strategy delivery. |

## 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**
**Wednesday 12th June 2019 at 1.00pm**
**CCG Main Meeting Room, Wolverhampton Science Park, WV10 9RU**

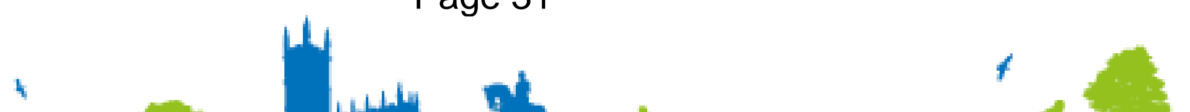
**Present**

| | | |
|---|---|---|
| Mike Hastings | (MH) | WCCG Director of Operations (Chair) |
| Peter McKenzie | (PMcK) | WCCG Corporate Operations Manager |
| Jo Reynolds | (JR) | WCCG Primary Care Transformation Manager |
| Mandy Sarai | (MS) | WCCG Business Support Officer |
| Gill Shelley | (GS) | WCCG Primary Care Contracting Manager |
| Ramsey Singh | (RS) | WCCG IM&T Infrastructure Project Manager |
| Sarah Southall | (SS) | Head of Primary Care (Wolverhampton CCG) & GPFV |
| Jane Worton | (JW) | WCCG Primary Care Liaison Manager |

| Item | | |
|---|---|---|
| 1. | **Welcome and Introductions** | |
| 2. | **Apologies**<br>Apologies for absence were received from: Bal Dhami; Yvette Delany; Dr Mehta; Peter McKenzie; Jo Reynolds. | |
| 3. | **Declarations of Interest**<br>There were no declarations of interest. | |
| 4.<br>4.1<br><br><br>4.2 | **Primary Care Operational Management Group Minutes**<br>Notes from Wednesday 17th May 2019<br>The minutes taken from the meeting on Wednesday 17th May 2019 were signed off and recorded as an accurate record.<br><br>Action Log<br>Items on the action log were discussed. | |
| 5.<br>5.1 | **Notes of the Clinical Reference Group Meeting**<br>Clinical Reference Notes<br>The Clinical Reference Group did not take place last month. | |
| 6.<br>6.1 | **Risk Profile**<br>Risk Register<br>All risks are within review periods.<br><br>Property Services<br>Risk has been reflected on the risk register. | |

| | | |
|---|---|---|
| | <u>Protected Learning Time</u><br>Risk will need to be put on the risk register.<br><br><u>PLT Risk</u><br>This risk has been updated and is going through the Workforce Task and Finish Group.<br><br><u>GMS APMS Contracts</u><br>This risk needs to be added for Vocare and GMS. | |
| **7.** | **Matters Arising**<br>There were no matters arising. | |
| **8.**<br><br>**8.1** | **Primary Care Updates**<br><br><u>Review of Primary Care Matrix</u><br>JW gave an update around the Wood Road consultation. The additional drop- in sessions had been set up for July. CCG executive members will attend to represent the CCG. It is anticipated that the drop in sessions will be well attended. The last drop in session had 157 attendees.<br><br>CSU have received survey responses as follows;<br>• online received 542<br>• hard copies surveys 200<br>• 10 letters received including emails and enquiries.<br><br>CSU will pull together some analysis at the end of the consultation period and a report will go to the Primary Care Commissioning Committee in September.<br><br>Public meetings have taken place regarding the practice. Letters have also been sent to patients. Information is available in the practice.<br><br>The Primary Care dashboard has been developed by BI to capture all the Primary Care data as well as Workforce. | |
| **8.2** | <u>Forward Plan for Practice System Migrations Mergers and Closures</u><br>RS reported that VI did not allow Health & Beyond to visit the practice until April. Due to this the ‘go-live’ had been pushed back. The original date to go-live was to take place in June with EMIS Web. There were issues with data extraction during the migration due to change of data format. EMIS and TPP are working closely to resolve; second attempt to extract and migrate the data has been scheduled. Slight slippage for go-live; for 25th July for Bilston Urban Village. This has affected Pennfields go-live date which will now be 15th August. Following on by this RS will complete the Practice Merger for Bilston Urban Village and Ettingshall.<br><br>Server failure took place at Dr Sharma’s practice on Tuesday 11th June 2019. Two servers on site had gone down. The server had to be rebuilt and should be back up and running soon. Work had continued throughout the day to rebuild the system. | |
| **8.3** | <u>Estates Update/LEF</u> | |





| | | |
|---|---|---|
| | TK gave an Estates Update; previously Dr Sharma's practice should have moved into the Dental Suite via ETTF. This has not taken place. The Better Care Fund is looking to use space at Bilston Health Centre for the South East locality. A follow up meeting to take place to look at the requirements in terms of the estates. The heads of terms are being held by the Council.<br><br>Newbridge site have now completed. A grand opening to take place. A selection of patients will be chosen to come and open the surgery.<br><br>East Park work is still being completed. Internal work has been finished. External work will be commencing shortly.<br><br>Bookable Space has been pushed back to the summer. This is being managed by the EDU.<br><br>Estates Strategy for Wolverhampton has been signed off at the last Primary Care Commissioning Committee.<br><br>Meeting with SH (Steve Howells) regarding the North East GPs for Oxley will take place. There is some movement around Accord, who will be serving notice to NHS PS on the land as they want to move to develop the Oxley hub. Dr Mittal is to be kept in the loop regarding this matter.<br><br>MD (Mike Daley) has met with GS regarding the Oxley Hub. MD is working on behalf of SH and would like to make contact with Ashfield Road surgery. MD has asked GS to arrange those meetings. | |
| **8.4** | Primary Care Networks (PCN)<br>**Action:** Vexatious complainants to be included in update of CCG Complaints Policy and process for Zero Tolerance to be prepared. The following to attend the meeting; Yvonne Higgins (H&S Lead), Sarah Fellows, Liz Corrigan, Sarah Southall, Matt Boyce, Helen Pidoux/Admin team. Mike to discuss with Sally Roberts in the first instance.<br><br>A number of changes will take place in the coming months. Network DES mobilisation and formalisation of the networks will take place from 1 July.<br>There will be opportunities for education and development across a number of programmes that will be available to PCNs. One in particular is being lead at STP level through the Clinical Leadership Group (Dartmouth Institute). A national prospectus is being finalised and should be with the CCG by the end of the month.<br>Group Leads meeting will change to Clinical Directors meeting from July, a new Terms of Reference are with Executive Team to agree.<br>Any changes within the networks would need to approved through the Primary Care Commissioning Committee ie movement of practice(s) or change of Clinical Director etc.<br>NHSE have prepared and shared a series of assurance statements for STPs to provide assurance on. This information will be shared within the STPs relevant forums also.<br>Contract assurance is being explored by Jane and Gill to confirm what PCN Assurance Visits May include. A proposal will be prepared confirming the learning | |

| | | |
|---|---|---|
| 8.5 | that has been observed from the first round of practice contract visits and proposals for the future including PCNs. The proposal will provide different options with how this can be delivered going forward.<br>Network Development plans will be discussed in a future meeting as these haven't yet been finalised.<br>Payments for the 4 networks cannot be executed through CQRS and Exeter hence the CCG will be required to do this. The PCN Guidance was re-issued last week confirming the role of CCGs in making those payments. A process is being prepared to between finance and contracting to ensure that all payments for networks can be made including the new roles reimbursement scheme.<br><br>Primary Care STP Update<br>Update as above. | |
| 9.<br>9.1<br><br><br><br><br>9.2<br><br><br>9.3 | **Primary Care Quality Update**<br>Primary Care Quality Report<br>LC gave a brief update. The serious incident received previously had now been resolved.<br>Workforce – no new figures received.<br><br>Collaborative Working Model: Practice Issues and Communication Log<br>No issues reported.<br><br>Ashfield Road Surgery –CQC<br>Ashfield Road Surgery has been rated as *Requires Improvement.* GS, LC and JW to meet to discuss this further. | |
| 10.<br>10.1<br><br><br>10.2 | **Primary Care Contracting**<br>Collaborative Contract Review Programme<br>No issues reported.<br><br>Primary Care Contracting Update<br>Two doctors from Health and Beyond will be joining Dr Suryani on his contract, with a view with Dr Suryani coming off as soon as possible | |
| 11.<br>11.1 | **Discussion Items**<br>Post Payment Verification of Enhanced Services 18/19<br>GS brought the PPV process for 18/19 to the committee to discuss with the group in detail. MJ (Marion Janavicius) will work with GS to compile the data. MJ will be invited to the next Primary Care Operational Management Group to look at the data sheets for last year's claims. Recommendation will be made at this committee. | |
| 12. | **Any other Business**<br>There were no items to discuss under Any other Business. | |
| 13. | **Date and time of Next Meeting – Wednesday 3rd July 2019 at 13:00-14:30 in the Main Meeting Room** | |

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: 20.6.19**

**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 Inclusion Service | N/A | |
| 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** | **20.6.19** |

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**WOLVERHAMPTON CCG**

**Primary Care Commissioning Committee**
**July 2019**

| | |
|---|---|
| **TITLE OF REPORT:** | Primary Care Networks Update |
| **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 in preparation of primary care networks mobilising in readiness of being formal entities from 1 July 2019. |
| **ACTION REQUIRED:** | ☐ **Decision**<br>☒ **Assurance** |
| **PUBLIC OR PRIVATE:** | This documentation is suitable for sharing in the public domain. |
| **KEY POINTS:** | • Network DES – Payments and role reimbursement are due to be made to networks in July 2019.<br>• Full Network Agreements<br>• Network Changes – Formal notification has been received from a network confirming a change in Clinical Director arrangements.<br>• PCN Development Programme(s) – National prospectus has been developed to compliment a range of other offers and locally the STP has designed a PCN Development Programme with RightCare and Dartmouth Institute.<br>• New Roles – Social Prescribing Link Workers are due to be recruited by Wolverhampton Voluntary Sector Council and seconded exclusively to each network.<br>• Clinical Directors Meetings – Meetings commence in July 2019.<br>• Data Analytics – National dashboard not yet available, this is expected later in July.<br>• Patients & Public Engagement - the role of practices and primary care networks in accordance with contractual obligations. |
| **RECOMMENDATION:** | The committee should consider the progress that has taken place and confirm if they have any queries or require clarification on working taking place and future reporting requirements.<br>The committee should also confirm their agreement to the change of Clinical Director for the VI Network. |
| **LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:** | 1 Improving the quality and safety of services we commission.<br>2 Reducing health inequalities in Wolverhampton.<br>3 System effectiveness delivered within our financial envelope. |

## 1. BACKGROUND AND CURRENT SITUATION

1.1. The committee have been kept appraised of the preparatory work that has been taking place through close liaison between the CCG and each Primary Care Network. As preparatory phase in concluding and formal implementation of the new way of working commences on 1 July 2019.

## 2.0 Network DES

Practices are required to sign up to the DES via CQRS by 30 June 2019 and payments pertaining to the Network DES will be made by the CCG thereafter. There are a range of payments to be made comprising of the following:-

| Type | Value | Payee |
|---|---|---|
| Core PCN Funding | £1.50 per patient | Payable to the Network |
| Clinical Director(s) | £0.51 per patient | Payable to the Network |
| Network Participation Payment | £1.76 per patient | Payable to Practices |
| Roles Reimbursement Scheme<br>i) Clinical Pharmacist(s)<br>ii) Social Prescribing Link Worker(s) | 70% 1 per Network*<br>100% 1 per network | Payable to the Network |
| Extended Hours DES | £1.09 per patient | Payment to the Network |

In order for payments to be made to the network and practices in line with the DES processes are being agreed between the CCGs Finance and Primary Care Teams to ensure payments are timely and in line with the requirements of the DES. Whilst this is being worked through the committee should note that workforce baselines for each network (submitted on 28 June) have been shared with NHS England for consideration, these will be used as the basis for reimbursements. Allocations and payments will commence in July.

### 2.1 *Network Agreement*

The Network DES requires all networks to have in place a full network agreement signed by all parties within the network by 30 June. A meeting has been scheduled with PCN Clinical Directors and Group Managers to identify areas of priority and issues faced by PCNs and explore what support will be required from the CCG.

### 2.2 *Network Changes*

A change in Clinical Director arrangements has been confirmed from Royal Wolverhampton Trust for the Vertical Integration Network. The change will take effect on 1 July due to retirement of a GP who had been included on the network application. A process was underway to identify a replacement but hadn't concluded at the point of submitting the network agreement.

The committee should confirm their agreement to the change in line with the Network DES – Dr John Burrell will assume the role of Clinical Director from 1 July and be the CCGs point of contact for the network.

***2.3 PCN Development Programmes***

There are a range of offers available to primary care networks that will encourage development and maturity in 2019/20 initially. A national prospectus issued to STPs at the end of June explores the needs of PCNs both from an education and organisational development perspective. The prospectus comprises of 8 modules for PCNs designed to meet local needs:-

1 PCN Set Up
2 Organisational development support
3 Change management quality and culture
4 Leadership development
5 Collaborative working (MDTs)
6 Asset based community development and social prescribing
7 Population health management
8 PCN Clinical Director development support

The development programme will enable PCNs to reach Step 3 of the maturity matrix over a period of time whilst they develop using a framework that can be shaped to meet their specific needs. The prospectus isn't intended to be a prescriptive list that must be complied with nor a framework that PCNs will be performance managed against rather a prospectus that has been co-designed by a PCN focus group lead by NHS England so that the programme is flexible and meets the needs of individual networks.

Priority will be given to two offers - development of Clinical Directors and PCN Start Up - these will commence implementation from July 2019. A self-assessment tool is due to be issued for PCNs to complete focussing on what they are already doing/done, how much time PCN leads need to commit to development work, PCN needs and meeting immediate needs and preferred learning methods. This will allow each network to prioritise and focus on what is important to them over the coming months. A copy of the assessment will be issued to Clinical Directors and discussed further with them in July.

Other offers including General Practice Improvement Leaders Programme continues to be available along with other Time for Care Programme Offers. This information has been shared with Clinical Directors for consideration/confirmation of expression of interest.

Locally, the STP Clinical Leadership Group have secured funding from RightCare for Primary Care Networks, an initial event is due to take place on Thursday 4 July, all Clinical Directors from across the STP have been invited to the first meeting of all Clinical Directors.

The workshop has been designed to focus on developing clinical transformation leadership within Primary Care Networks to drive innovation, develop person-centred models and create integrated teams. All Wolverhampton networks have confirmed they will be attending along with the Head of Primary Care.

***2.4 New Roles***

In addition to existing arrangements for Social Prescribing each network will benefit from a fully funded (employment costs) Social Prescribing Link Worker who will be aligned to their network. Two workshops have been held with Clinical Directors from each PCN and also Wolverhampton Voluntary Sector Council who are the commissioned provider of the CCGs Social Prescribing Service. The outcome of the workshop was that all Clinical Directors were in agreement that the existing service should be developed further, recruitment of additional Social Prescribing Link Worker(s) will be lead primarily by Wolverhampton Voluntary Sector Council, this approach is fully supported by each Network Clinical Director. Following appointment each network will be allocated a link worker, seconded to them exclusively via a Service Level Agreement. A separate report will be shared with the committee in August to provide more detailed assurance about the intended arrangements.

**2.5 Clinical Directors Meetings**

Monthly clinical directors meetings will commence in July 2019, a revised terms of reference has been shared and comments invited from members of the group, although this will not be a formal forum. The primary focus will be not only on network development and maturity but also to ensure all Clinical Directors are supported by the CCG and benefit from regular round table discussions and access to peer support.

**2.6 Data Analytics**

A review of analytics support has taken place to determine what and how data will flow to networks. The CCG has developed a primary care dashboard comprising a range of quality and resilience indicators that can be reviewed at regular intervals both at practice and network level. Data is intended to flow to networks at quarterly intervals, this is in addition to the National Primary Care Dashboard currently being finalised by NHS England. The Wolverhampton Dashboard is being developed further to include additional data and will be shared with networks as follows for their review:-

| Reporting Period | Issue to Networks | Data Categories & Developments |
|---|---|---|
| April to June 2019 | August 2019 | Practice, Acute, Community & Mental Health |
| July to September 2019 | November 2019 | As above plus Prescribing & additional Quality Indicators |
| October to December 2019 | February 2020 | As Above |
| January to March 2020 | May 2020 | As Above |

The dashboard will be used as the basis for networks to be better informed about population health needs and utilisation enabling them to review activity and expose

areas presenting challenge and/or variation from the Wolverhampton and national average.

The national dashboard when released is intended to compliment local data and is expected later in July.

**2.7 Patient & Public Engagement**

Patient engagement is a core responsibility of practices and networks under their primary medical services contracts. PCNs will be expected to reflect those requirements through engaging, liaising and communicating with their registered population in the most appropriate way, informing and/or involving them in developing new services and changes related to service delivery.

This includes engaging with sections of the community who are hard to engage with. PCNs will also be required to provide reasonable support and assistance to the CCG in the performance of its duties to also engage with patients in the provision of and/or reconfiguration of services where applicable to the registered population.

Clinical Directors have confirmed that following a recent engagement event lead by the CCG (STP Primary Care Strategy Development) that the questions and outputs from group discussions will be discussed at PCN and practice level Patient Participation Group Meetings and should not be responded to generically by the CCG.

## 3.0 CLINICAL VIEW

The Group Leads and Committee membership comprises extensively of GP and other clinical representation. Group Leads (Clinical Directors) are actively engaged in discussions with the CCG regarding all aspects of PCNs detailed in this report.

## 4.0 PATIENT AND PUBLIC VIEW

See 2.7 patient engagement detailed above.

## 5.0 KEY RISKS AND MITIGATIONS

The CCGs risk pertaining to the formation of primary care networks has been fully mitigated and therefore closed on the risk register.

## 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:** | July 2019 |

**SLS/PCC-PCNS/JUL19.V1**

NHS
Wolverhampton
Clinical Commissioning Group

# WOLVERHAMPTON CCG

## Primary Care Commissioning Committee
## 2 July 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 an updated business case for the provision of quality assured spirometry within primary care, for the committee to approve the recommendations. |
| **ACTION REQUIRED:** | ☒ **Decision**<br>☒ **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.<br>• 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<br>• 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 | Deliver new models of care that support care closer to home and improve management of Long Term Conditions |

| Wolverhampton | |
|---|---|
| 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 an updated 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, and Primary Care Commissioning Committee in May where further amendments to the business case were required with regards to the costing model. These amendments have been made, and will be represented at the Primary Care programme board in July 2019.

## 2. MAIN BODY OF REPORT

2.1. The main report regarding to Quality Assured Spirometry has previously been presented at the committee

2.2. The committee should refer to section 8 (Cost) of the attached business case, where within Option 2 (preferred option) the breakdown of costs has been amended to reflect comments from local Clinical Group Leads.

## 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.

## 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:** | **18/06/19** |

**ATTACHED:**

- **Primary Care Quality Assured Spirometry Business Case**

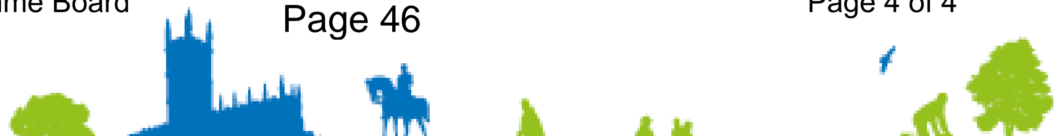
**RELEVANT BACKGROUND PAPERS**

**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**<br><br>**Revised business case emailed L Sawrey** | **25/04/19**<br><br>**29/05/19** |
| 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 | **Kelly Huckvale** | **22/05/19** |
| 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** | **18/06/19** |





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Wolverhampton
Clinical Commissioning Group

# BUSINESS CASE

| Project: | Primary Care Quality Assured Spirometry |
| --- | --- |
| Project Number: | |
| Date: | June 2019 |
| Project Lead: | C Morrissey |
| Project Sponsor: | |
| Version No: | 0.7 |

# 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/ Lesley Sawrey** | **Feb 2019**<br><br>**Apr 2019**<br><br>**May 2019** | **Amendments made to costs, due to 19/20 not being ratified, therefore based upon 18/19 costing template**<br><br>**Further amendments made to costs based upon revised (but not signed off) 19/20 costing template**<br><br>**Further amendments made to the timings within the costing template, and emailed through to L Sawrey for sign off** |
| 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** |
| Information Governance | **Kelly Huckvale** | **Apr 2019**<br><br>**May 2019** | **Initial DPIA submitted for comment**<br><br>**Approved DPIA received** |
| Legal/ Policy (Corporate Operations Manager) | | | **Not required for the purpose of the business case** |
| Primary Care | | **Feb 19**<br><br>**May 19** | **Presented at Primary Care Programme board Feb 19, with amended version being presented in May 19**<br><br>**Approved in principle at Primary Care Commissioning Committee – with a view that costing template may require further amendments** |
| 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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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**11 Quality Impact Assessment**

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# 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 March 19 = 1018

Referrals to service per month

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **RWT** | 50 | 84 | 78 | 66 | 63 | 40 | 181 | 94 | 72 | 108 | 103 | 79 |

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<br>• Additional demand for direct access spirometry at Acute Trust<br>• 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**<br>• **Opportunity for primary care networks to develop and provide services at scale for patients**<br>• **Support the commitment of developing local workforce within the GP5YFV**<br>• **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<br>• Opportunity for individual GP practices to provide services<br>• Support the commitment of developing local workforce within the GP5YFV<br>• 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 55 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 = £21.84 per 55 mins
- Additional indirect costs = £9.39 per appointment
- Total appointment cost = £31.22

| Group | No of Spirometry appointments required | Appointment Cost | FYE |
|---|---|---|---|
| **PCH1** | 908 | £31.22 | £28,347.76 |
| **PCH2** | 1076 | £31.22 | £33,592.72 |
| **Unity** | 1296 | £31.22 | £40,461.12 |
| **VI** | 772 | £31.22 | £24,101.84[3] |
| **Total** | 4052 | | **£126,503.44** |

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 for primary care would be **c£62,440** and c£126,503.44 thereafter.

If the total amount of projected activity were to be commissioned directly through RWT, it is anticipated this would cost **£194,496**

Costs for Option 2 (part year effect – costs included for Primary Care and RWT)

| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Direct Access (RWT) | 350 (£16,800) | 300 (£14,400) | 200 (£9,600) | 150 (£7,200) |
| Primary Care | 0 | 0 | 750 (£23,415) | 1250 (£39,025) |
| | | | | |
| Total | £16,800 | £14,400 | £33,015 | £46,225 |
| | | | | |
| Grand Total | | | | **£110,440** |

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

[3] It is important to note there is potential that VI practices will utilise Direct Access Spirometry through the Trust

secondary care will continue, with some practices opting to not undertake quality assured spirometry within primary care.

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 | July 2019 |
| Approval of business case | July 2019 |
| Primary Care to undertake training | Sept – Dec 2019 |
| Mobilisation/ implementation | Jan 2020 |
| 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

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# 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** | **claire.morrissey@nhs.net**<br>**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**<br>**RWT Respiratory Clinical Leads**<br>**Primary Care Group leads – consultation on costing and service specification** |

# Section A - Project Details

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

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

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

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

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

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

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

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

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

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

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

# Section B – Screening Analysis

| Equality Analysis Screening |
|---|
| It is vital that the CCG ensures that it demonstrates that it is meeting its legal duty, as the responsible manager you will need to identify whether a Full Equality Analysis is required.<br><br>A full EA will only not be required if none of the following aspects are identified and you are confident there is no impact.<br><br>*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?<br>*For example will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.* | Yes |
| If the CCG is enacting a decision taken by others, e.g. NHS England or Local Authority - does it have discretion to change, modify or mitigate the decision? | Yes |
| Is the board/committee being asked to make a decision on the basis that this proposal will have a consequential effect on any change? e.g. Financial changes | Yes |
| Will this decision impact on how a **provider** delivers its services to patients, directly or indirectly? | Yes |
| Will this decision impact on any third parties financial position (i.e. Provider, Local Authority, GP Practices)? *For example are you removing funding from theirs or any contract?* | Yes |
| If you have answered **NO** to **ALL** the above questions, please provide supporting narrative to explain why none of the above apply. | |

**Equality Analysis Form**

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

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

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

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

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

**Sign Off / Approval (Section A and B)**

| Title | Name | Date |
|---|---|---|
| **Project Lead** | Claire Morrissey | 16/04/19 |
| **Equality and Inclusion Officer** | David King | 16/4/19 |
| **Equality and Inclusion Comments** | As only staff who have been trained will be able to perform or interpret the assessments there is a potential for patient waiting times to be extended.<br><br>CCG should work with providers to mitigate.<br><br>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**<br>*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.<br><br>PCC-CIC, 2016. *Improving the quality of diagnostic spirometry in adults: the National Register of certified* |

Equality Analysis Form

| 1. Evidence used<br>*What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses* | |
|---|---|
| | *professionals and operators.* London: PCC-CIC.<br><br>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<br><br>Reducing health inequalities in Wolverhampton:<br>• Improve and develop primary care in Wolverhampton<br>• Deliver new models of care that support care closer to home and improve management of Long term conditions<br><br>System effectiveness delivered within our financial envelope<br>• Proactively drive our contribution to the Black Country STP<br>• Continue to meet our Statutory Duties and responsibilities<br>• 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<br>• Increase the number of patients with an agreed care plan<br>• increase the number of people who report feeling supported to manage their condition |

**Equality Analysis Form**

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

| **2. Impact of decision**<br>*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**<br>*Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.* |

## 2. Impact of decision

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

**YES**

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

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

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

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

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

Respiratory services 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. Impact of decision<br>*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.* |
|---|
| **2.4 Marriage and civil partnership**<br>*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**<br>*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**<br>*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,<br><br>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**<br>*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**<br>*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**<br>*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** |

| **2. Impact of decision**<br>*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 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**<br>*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**<br>*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.* | | | | |
| | | | | |

| **4. How will you measure how the proposal impacts health inequalities?**<br><br>**<u>The CCG has a legal duty to identify and reduce health inequalities.</u>**<br><br>*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<br>• Increase the number of patients with an agreed care plan<br>• increase the number of people who report feeling supported to manage their condition<br>• increase the number of patients living with respiratory conditions receiving flu/ pneumonia vaccines |

| 4. How will you measure how the proposal impacts health inequalities?<br><br>The CCG has a legal duty to identify and reduce health inequalities.<br><br>*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 the number of smokers with LTCs offered support and treatment |

| **5. Engagement/consultation**<br>What engagement is planned or has already been done to support this project? | | |
|---|---|---|
| **Engagement activity** | **With who?**<br>*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**<br>*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.<br><br>CCG should work with providers to mitigate.<br><br>The CCG will continue to commission direct access from RWT for patients in the interim whilst primary care undertake appropriate levels of accreditation. |

| **6. Mitigations and changes**<br>*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.* |
|---|
| |

| **7. Is further work required to complete this EA?**<br>*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**<br>*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. | |

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

| **10. Final Sign off**<br>The Completed EA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process.<br><br>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)<br><br>Name:<br>Date: | |
| Equality & Inclusion Review and Quality Assurance<br><br>Name:<br>Date: | |
| Executive Director Review:<br><br>Name:<br>Date: | |
| Name of **Approval Board** (*e.g. Commissioning Committee; Governing Body; Primary Care Commissioning Committee*) at which the EA was agreed at:<br><br>Approval Board:<br>Approval Board Ref Number:<br>Chair:<br>Date:<br>Comments:<br><br><br>Actions from the Approval Board to complete: | |
| Review date for action plan (section 7): | |

**BOARD ASSURANCE FRAMEWORK NOTES**

(Please **DELETE** before submission)

**Equality Analysis Form**

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<br>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.<br>b. Greater integration of health and social care services across Wolverhampton<br>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.'<br>c. Continue to meet our Statutory Duties and responsibilities<br>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<br>d. Deliver improvements in the infrastructure for health and care across Wolverhampton<br>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. |

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

**Section A**

| Field | Details |
|---|---|
| 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)<br><br>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<br>* the number of people who attend an appointment<br>* improve the recorded prevalence of respiratory registers across the City<br>* increase the number of patients who have a confirmed diagnosis<br>* increase the number of people who report feeling supported to manage their condition<br>* increase the number of patients living with respiratory conditions receiving flu/ pneumonia vaccines<br>* increase the number of smokers with LTCs offered support and treatment<br>* improve the number of patients completing pulmonary rehabilitation<br>* 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<br><br>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

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

**Section D**

GP / Clinical Review (Required)

| Field | Details |
|---|---|
| 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)

| Field | Details |
|---|---|
| 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

| Field | Details |
|---|---|
| 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 | | | |

1 Rare; 2 Unlikely; 3 Possible; 4 Likely; 5 Almost Certain
Descriptor
Rare Unlikely Possible Likely Almost certain

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

NHS
Wolverhampton
Clinical Commissioning Group

# Data Protection Impact Assessment (DPIA)

| **Section A - Key Information**<br><br>***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<br><br>01902 441774 |
| **Date completed** | 25/04/19 |
| **Information Asset Owner**<br><br>***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.<br><br>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.<br><br>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.<br><br>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:<br><br>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.<br><br>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**<br><br>**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?<br>**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, the use of biometrics or facial recognition. | YES or NO | YES or NO |
| 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?**<br><br>**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?**<br><br>**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?**<br><br>**(e.g. email, fax, post, courier, other – please specify all that will be used)** | |

| **C4. Consultation requirements**<br>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.<br>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**<br><br>**(to individuals, to the CCG or to wider compliance )** | **Proposed Risk solution (Mitigation )** | **Is the risk reduced, transferred or accepted? Please specify.** | **Consequence Score**<br><br>**1= Low**<br>**1= Medium**<br>**3= High** | **Likelihood Score**<br><br>**1=Low**<br>**2= Medium**<br>**3=High** | **Risk Score**<br><br>**(C x L)** | **Further detail if required** |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

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| **C6. Further information**<br>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**<br><br>**(delete as applicable)** | 1. No action is required by IG excepting the logging of the Screening Questions for recording purposes.<br><br>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.<br><br>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:** |

<table>
<tr><td colspan="3">Once the DPO has reviewed the DPIA (where applicable), this will be issued to the Project Lead and IG Lead for audit.<br><br>The Project lead will then present the completed DPIA to the relevant board for approval</td></tr>
<tr><td>Board</td><td colspan="2"></td></tr>
<tr><td>Board Chair</td><td></td><td>Date:</td></tr>
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