

**Meeting of the Primary Care Commissioning Committee (PUBLIC)**  
**Tuesday 4th September 2018**  
**2 pm**  
**Stephenson Room, 1st Floor, Technology Centre, Wolverhampton**

**A G E N D A**

- |    |  |                |         |
|----|--|----------------|---------|
| 1  | Welcome and Introductions                                    | Chair          |         |
| 2  | Apologies  | Chair          |         |
| 3  | Declarations of Interest                                     | Chair          |         |
| 4  | Minutes of the Meeting held on 7th August 2018               | All            | 1 - 8   |
| 5  | Matters Arising from the Minutes                             | Chair          |         |
| 6  | Committee Action Points                                      | All            | 9 - 10  |
| 7  | Pharmacy First Scheme or all Patients Progress Report        | Hemant Patel   | 11 - 18 |
| 8  | Primary Care Quality Report                                  | Liz Corrigan   | 19 - 36 |
| 9  | Update Report following the retirement of Dr Mudigonda       | Gill Shelly    | Verbal  |
| 10 | Primary Care Operational Management Group Update             | Mike Hastings  | 37 - 44 |
| 11 | Primary Care Counselling Service - EIA (for info)            | Sarah Southall | 45 - 60 |
| 12 | QOF+ Scheme - DPIA (for info)                                | Sarah Southall | 61 - 70 |
| 13 | Any Other Business   | All            |         |
|    | 13.1 Amended Delegation Agreement                            | Mike Hastings  | 71 - 80 |
| 14 | Date of Next Meeting: Tuesday 2 <sup>nd</sup> October at 2pm |                |         |

For further information on this agenda or about the meeting generally, or to submit apologies for absence, please contact on or email

<b>MEMBERSHIP</b>	
Wolverhampton CCG	Ms McKie (Chair) Dr D Bush Dr H Hibbs Mr S Marshall Dr Reehana Ms Roberts Mr Trigg
NHS England	Mr B Dhami
Patient Representatives	Sarah Gaytten
Invitees (Non-Voting)	Ms Cresswell (Health watch) Mr Denley (Health and Wellbeing Board)

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

**Minutes of the Primary Care Commissioning Committee (PUBLIC)  
Tuesday 7<sup>th</sup> August 2018 at 2.00pm  
Stephenson Room, Technology Centre, Wolverhampton Science Park**

**MEMBERS ~  
Wolverhampton CCG ~**

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

**NHS England ~**

Bal Dhami	Contract Manager	Yes
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**Independent Patient Representatives ~**

Sarah Gaytten	Independent Patient Representative	Yes
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**Non-Voting Observers ~**

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

**In attendance ~**

Mike Hastings	Director of Operations (WCCG)	Yes
Dr Helen Hibbs	Chief Officer (WCCG)	Yes
Tony Gallagher	Chief Finance Officer	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
John Denley	Director of Public Health (WCCG)	Yes
Liz Corrigan	Primary Care Quality Assurance Coordinator (WCCG)	Yes
Laura Russell	Primary Care PMO Administrator (WCCG – minutes)	Yes

## **Welcome and Introductions**

WPCC310 Ms McKie welcomed attendees to the meeting and Introductions took place.

## **Apologies**

WPCC311 Apologies were submitted on behalf of Dr Reehana and Sally Roberts.

## **Declarations of Interest**

WPCC312 Dr Bush, Dr Kainth and Dr Asghar declared that, as GPs they have a standing interest in all items relating to Primary Care.

Ms Gaytten declared that, in her role as employee of the University of Wolverhampton, she worked closely with practices to arrange placements for student nurses and therefore had a standing interest in items related to primary care.

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

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

## **Minutes of the Meeting held on the 3<sup>rd</sup> July 2018**

WPCC313 The minutes from the meeting held on the 3<sup>rd</sup> July 2018 were agreed as an accurate record.

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

## **Matters Arising from the Minutes**

WPCC314 Ms McKie noted that a last meeting under any other business the Committee were reminded of the importance of sending in reports on time to ensure people had enough time to read the papers prior to the meeting.

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

## **Committee Action Points**

WPCC315 **Minute Number PCC302a - Premises Charges (Rent Reimbursement)**  
The cost directives are still awaited. Mr Hastings reported he had picked up through the BMA that they may not be released until the premises review had been undertaken. It was agreed to close the action and Mr Hastings would bring to the Committee once the cost directives had been released.

**Minute Number WPCC117 - Provision of Services post Dr Mudigonda**

### **retirement from a partnership to a single hander**

The update is due in September 2018.

### **Minute Number WPCC186 - Pharmacy First Scheme for all patients**

The report had been deferred to the September Committee meeting.

### **Minute Number WPCC215 - QOF+ Scheme 2018/19**

The signed DPIA for QOF+ is to be shared with the Committee. It was highlighted this is still outstanding from the Governance Lead and it would be chased.

## **Quarterly Finance Report**

WPCC316 Mr Gallagher reported to the Committee the quarterly report on the CCGs financial position at Month 3. The delegated Primary Care Allocations for 2018/2019 as of month 3 are £36.267m. It was noted that although there was slippage on individual headings it is assumed we will achieve an overall breakeven position at this stage.

A full forecast review has been carried out in month 3, and an assessment of likely slippage of development areas will be undertaken at the end of month, and future updates will be provided within the next report.

It was noted that in terms of PMS premium reserves any developments within the PMS contracts on future savings are ring-fenced within the Primary Care delegated budget.

There were no questions raised by the Committee and they accepted the report as assurance of the CCGs Primary Care financial position.

**RESOLVED: That the above is noted**

*Mr Gallagher left the meeting*

## **Pharmacy First Scheme of all Patients Progress Report**

WPCC317 This item has been deferred to the September 2018 meeting.

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

## **Primary Care Quality Report**

WPCC318 Ms Corrigan provided to the Committee the monthly Primary Care Quality Report which provides an overview of activity in primary care. The following key points were raised:

- Infection prevention audits continued to take place during July 2018, with the majority are scoring a silver rating. The main issues that have been raised were around the need to update the decor issues. They are working with practices to resolve issues and re-audits are undertaken on a three month basis.
- A City wide flu vaccine group is now in place and vaccine uptake is

being monitored and the group are exploring ways to improve the uptake.

- There are no MHRA alerts reported within the month.
- The report states there is one serious incident, this has since been deescalated. There are currently no serious incidents to report.
- Quality Matters continues to be monitored and all Primary Care incidents have been forwarded to the relevant practices and to NHS England where appropriate.
- The CCG continues to be copied in on new complaints from NHS England as they were reported. There have been 25 new GP complaints received since the beginning of November 2017.
- The figures for Friends and Family Test have made a slight improvement on last month's submission. Overall responses remain positive (86% overall would recommend their practice, 4% would not).
- Work continues to refine the workforce development plan in line with STP and national drivers.

Mrs Southall asked in relation to 2.1 infection prevention, 84% have no rating, have they been supported and do they have action plans in place. Ms Corrigan noted these practices were visited last month and action plans are in place to support the practices.

Dr Hibbs queried the data for influenza vaccination programme for the over 65's take up as it states 13%. Ms Corrigan noted this was an error within the report and agreed to update with the correct figures.

**RESOLVED:**

- **The report was accepted by the Committee.**
- **Ms Corrigan to amend the influenza vaccination programme data.**

## **Domestic Violence Coding Update**

WPCC319 Ms Corrigan presented to the Committee the Domestic Violence Multi Agency Risk Assessment Conference (MARAC) Data reporting specification, QIA, EIA and DPIA.

The work will be funded by the Home Office to run this programme within Primary Care. This programme will ensure that practices can accurately track and identify any repeat domestic violence incidents. In order to do this patient records need updating with any incidents that have occurred within the last 12 months. This information has already been identified and now needs including on the patient record at the patients practice. Practices will receive a payment of £2.50 per update and records are to be updated within 4 weeks of signing up to the service.

It was noted a full EIA did not need to be undertaken, but concerns under the DPIA regarding data sharing agreement. Ms Corrigan stated the Domestic Violence Forum have an agreement in place which is overarching data sharing agreement which is covered by the safeguarding

adults and crime disorder act.

The committee asked if this is look back and review exercise how do we make sure we continue this going forward. It was noted that this would become business as usual; they have worked with IM&T to ensure the clinical systems are set up with the appropriate read codes. The practices have received training and have the programme set up, so awareness has been promoted and will continue to be promoted.

Discussions took place regarding data sharing and whether patients are aware their information is being shared amongst different stakeholders. It was noted if a patient raised an issue with domestic violence, then a risk assessment would be undertaken with the patient and part of the consent would be inform them of the data sharing. Mr Hastings noted consideration is needed for data sharing as patients may be happy to share this information with the GPs but not on a wide scale and it is how this is managed and handled sensitively. In terms of the system there is a list of exception codes that can be used, it was agreed that Mr Hastings and Ms Corrigan would meet to discuss.

#### **RESOLUTION:**

**Mr Hastings and Ms Corrigan would meet to discuss the exception coding and how this can be managed to protect patient's data.**

**The Committee accepted and agreed the report and the EIA,DPIA and QIA.**

*Ms Corrigan left the meeting*

### **Primary Care Assurance Report**

WPCC320 Mrs Southall stated the report format has changed into a reporting pack of quarter 1 (2018/2019) activity. Mrs Southall outlined the content of the report, which is based on the primary care strategy and GPFV programmes of work that was presented to the quarterly Milestone Review Board Meeting in July 2018. It also provides an overview of activity for enhanced services, commissioned services activity and practice referral data.

Mr Marshall stated in relation to the pre-enhanced services such as social prescribing, care navigation and primary care counselling there is a great deal of variability between the practices on the take up to these. Mr Marshall asked in terms of social prescribing the CCG have received funding from the Department of Health to employ X6 FTE support workers, what are we doing to ensure they are fully utilised according to the funding available. Mrs Southall noted in terms of social prescribing this will form part of the second phase of care navigation, there will also be an increase of support workers across the City. It has not been decided on where the support workers will be located. The practice groups will be scrutinising the referral rates of the services at their meetings.

Dr Bush asked in terms of the graph presentation could the rate be presented in per thousand as this will be easier to interpret in terms of practice list size. It was agreed this would be included within the next report.

Ms Mckie queried the care navigation activity as the data is quite varied across the practices and not all practices have been included. Ms Southall reported that initially there were a few problems with practices recoding the information as not appropriate coding on the clinical system had been identified. The team have been working with IM&T to resolve the issue and more training has been provided. A launch will be undertaken for the second phase of care navigation and will include a relaunch of phase one.

**RESOLUTION: The graphs in the report need to be amended to reflect/interpret by practice size.**

### **Primary Care Counselling Service**

WPCC321

Mrs Southall presented to the Committee on behalf of Mr R Khular an update report on the Primary Care Counselling Service. This includes work that has been undertaken to address issues that have been raised by the referring practices such as access to the service and waiting times.

There have been 975 referrals into the service since May, although the volume of referrals identifies a clear need for the service, there are concerns regarding capacity of the service with this level of demand. A number of patients had been referred to the service by the Healthy Minds service at BCPFT. The provider had questioned whether these referrals should be accepted, or whether BCPFT should refer the patient back to the GP. It has also been identified that local practitioners had reported that they do not understand the difference between Healthy Minds and the Primary Care Counselling Service. The referrals for May are broken down as follows:

- Referrals received - 975
- No contact from the patient - 264 (28%)
- Open - 481(49%)
- Completed -110 (12%)
- Unsuitable referral - 52 (5%)
- Client doesn't wish to access service at this time - 68 (6%)
- Total – 975 (100%)

An assurance visit was undertaken to the service by members of the Primary Care Team in July 2018. Mrs Southall outlined the findings from the report and noted that a case not audit is to take place mid-September by members of the Primary Care and Quality Team. A further report will be provided at the December Committee Meeting.

**RESOLUTION:**

**The Committee accepted the report and approved the DPIA and QIA, the EIA is to be shared at the next meeting.**



**Primary Care Counselling Service Update report to be provided at the December Committee Meeting.**

### **CCG Benchmarking Project**

**WPCC322** Mrs Southall provided the Committee with an update on work that has been undertaken with regards of the CCG Benchmarking project and presented an overview of how the work will be taken forward in the future.

Mrs Southall noted that the purpose of the Benchmarking concept is to allow the organisation to be measured against others with a view to recognise relative strengths and areas for improvement. The report proposes a series of actions on how the CCG can robustly monitor a number of indicators on key areas such as Patient Experience, provision of Enhanced services and the configuration of the Primary Care. This will enable the CCG to recognise areas for improvement and to develop actions to address these.

The Committee raised no questions and accepted the assurance provided.

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

### **Primary Care Operational Management Group Update**

**WPCC323** Mr Hastings gave the Committee an overview of the discussions that took place at the Primary Care Operational Group Meeting, which took place on the 4th July 2018. There were no issues raised by the committee.

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

### **Any Other Business**

**WPCC324** There was no other business noted at the meeting

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

### **Date of Next Meeting**

**WPCC325** Tuesday 7<sup>th</sup> August 2018 at 2.00pm in PC108, Creative Industries Building, Wolverhampton Science Park.

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## Primary Care Commissioning Committee Actions Log (public) Open Items

Action No	Date of meeting	Minute Number	Item	By When	By Whom	Action Update
10	05.09.17	WPCC117	<p><b>Provision of Services post Dr Mudigonda Retirement from a Partnership to single handed contract – Business Case</b></p> <p>Ms Shelley agreed to report back to the practice that the Committee request in line with the with the business case they meet the expectation of reporting back in 12 months' time that they have a partner on the contract and that they have aligned to a new model of care</p>	September 2018	Ms Shelley	<p>07.11.17 - Ms Shelley informed the Committee the report is not due back until 12 months' time. It was noted they are still awaiting confirmation as to what new model of care they are going to align to.</p> <p>05.12.17 – Report due September 2018 and confirmation received that the practice will align to primary Care Home 1.</p> <p>06.02.18 - Report due September 2018</p> <p>22.05.18 – Due in September 2018</p>
11	06.02.18	WPCC186	<p><b>Pharmacy First Scheme or all Patients</b></p> <p>Mr Patel to report on progress to the Committee in 6 months' time.</p>	September 2018	Hemant Patel	<p>22.05.18 – Due in August 2018.</p> <p>07.08.18 – The item has been deferred to the September meeting.</p>
14	22.05.18	WPCC215	<p><b>QOF+ Scheme 2018/19</b></p> <p>The DPIA to be shared with the Committee.</p>	September 2018	Sarah Southall	<p>03.07.18 - The signed of DPIA for QOF+ is to be shared with the Committee.</p> <p>07.08.18 - The signed DPIA for QOF+ is to be shared with the Committee. It was highlighted this is still outstanding from the Governance Lead and it would be chased.</p>
15	07.08.18	WPCC318	<p><b>Primary Care Quality Report</b></p> <p>Ms Corrigan to amend the influenza vaccination programme data.</p>	September 2018	Liz Corrigan	

16	07.08.18	WPCC318	<b>Domestic Violence Coding Update</b> Mr Hastings and Ms Corrigan would meet to discuss the exceptional coding and how this can be managed to protect patient's data.	September 2018	Liz Corrigan/Mike Hastings	
17	07.08.18	WPCC318	<b>Primary Care Assurance Report</b> The graphs in the report need to be amended to reflect/interpret by practice size.	September 2018	Sarah Southall	
18	07.08.18	WPCC318	<b>Primary Care Counselling Service</b> EIA is to be shared at the next meeting.	September 2018	Sarah Southall	

**WOLVERHAMPTON CCG**
**PRIMARY CARE COMMISSIONING COMMITTEE**  
**4<sup>th</sup> September 2018**

<b>TITLE OF REPORT:</b>	Pharmacy First Scheme for all patients
<b>AUTHOR(s) OF REPORT:</b>	Hemant Patel/Sarah Southall
<b>MANAGEMENT LEAD:</b>	Steven Marshall
<b>PURPOSE OF REPORT:</b>	To report on progress to the Committee
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain.
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>• The CCG agreed to continue the commissioning of the under 16's Pharmacy First (Minor ailment scheme) from NHSE. This was in addition to the over 16s pharmacy first scheme already commissioned.</li> <li>• Main purpose of the service is to reduce demand on GP practices, walk-in-centres and Accident and Emergency.</li> <li>• The service has been administered and managed by the Midlands and Lancs CSU on behalf of the CCG.</li> <li>• The amalgamated Pharmacy First Service went live on 1<sup>st</sup> June 2018.</li> <li>• To date 47 of the 66 pharmacies have expressed an interest in providing this service across Wolverhampton.</li> <li>• Latest data suggest only 29 pharmacies have provided this service/sent claims to date (data up to 31<sup>st</sup> July 2018).</li> <li>• Use is lower than in previous years – possibly due to contracts yet to be signed or misinformation regarding commissioning arrangements (information provided via prescribing advisors and Local Pharmaceutical Committee colleagues that represent all pharmacy contractors in Wolverhampton.)</li> </ul>
<b>RECOMMENDATION:</b>	Primary Care Commissioning Committee to note the progress made to date on the Pharmacy First Scheme.
<b>LINK TO BOARD</b>	[Outline how the report is relevant to the Strategic Aims and



<b>ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	objectives in the Board Assurance Framework – See Notes for Further information]
1. Improving the quality and safety of the services we commission	Continuation of existing service
2. Reducing Health Inequalities in Wolverhampton	Improve and develop primary care in Wolverhampton. Withdrawal of this service would put increased demand on GP practices
3. System effectiveness delivered within our financial envelope	The service makes best use of community pharmacist's skills and helps develop and maintain a modern up skilled workforce across Wolverhampton.

## 1. BACKGROUND AND CURRENT SITUATION

- 1.1. Reports suggest that 20% of GP consultations can be dealt with by self-care and support from community pharmacy.
- 1.2. In areas of high deprivation, Pharmacy First schemes that allow access to a limited range of NHS- funded over the counter medicines for low income and deprived families to support self-care have been shown to be cost-effective in reducing demand on GPs, walk-in-centres and Accident and Emergency.
- 1.3. Many pharmacies are now open 100 hours a week with a qualified pharmacist on hand to advice on minor illnesses, medication queries and other problems.
- 1.4. Community pharmacy can support self-care for long term conditions, coughs and colds and other complaints and support better health through provision of healthy lifestyle advice. Many Wolverhampton pharmacies are now designated as healthy living pharmacies.
- 1.5. Over the last 3 years local GP practices have worked closely with community pharmacies to encourage patients to self-treat ailments, rather than going to their general practitioner particularly when it comes to asking for antibiotics which will be ineffective for symptoms of viral infections.
- 1.6. Community pharmacy teams have resources in place to help them provide messages to patients on self-care about the normal self-limited duration of ailments and the red flags (warning symptoms) where patients are referred to their GP.
- 1.7. In 2013 the PCT transferred funds for the minor ailment service to NHSE in order to continue the service via the new commissioner. In 2017 the over 16s service was



decommissioned by NHSE and taken over by the CCG. In May 2018 NHSE decommissioned the under 16's service.

- 1.8. In response the CCG decided that a service covering all ages should be continued and commissioned locally.
- 1.9 The CCG accepted the Pharmacy First service offer from MLCSU, which is for MLCSU to facilitate the scheme on behalf of the CCG commissioners (collaborative between Dudley, SWB and Wolverhampton CCG). The service charge covers:-
  - Procurement, contract and implementation of PharmOutcomes® IT Software System
  - Service design, development and management
  - Payments Management function
  - Reporting Function
  - Helpdesk Function

Payments due to pharmacy contractors for this service will be generated by the CSU who will provide schedules with back up data for CCG budget holders to sign off. On receipt the CCG will make arrangements to pay pharmacy contractors via their normal payment process.

- 1.10 The CCG commissioned Pharmacy First Scheme went live on 1<sup>st</sup> June 2018 and to date 47 of the 66 pharmacies have expressed an interest in providing this service across Wolverhampton. Latest data suggest only 29 pharmacies have provided this service/sent claims to date (data up to 31st July 2018). Please find attached poster to promote the service, e-mail communication sent to community pharmacies and sign-up sheet for community pharmacy.
- 1.11 In previous years (prior to 2017/18) the average monthly consultations and spend were 550 and £4.3K respectively.

Over the past 12 months the average monthly consultations and spend were 291 and £2.2K respectively.

Current activity data between 1/6/18 and 31/7/18 shows that 351 consultations have taken place in Wolverhampton at a cost of 2.7K for 2 months.

The reduction in year may be due to the number of factors including the new contract sign up process, misinformation regarding on going commissioning of the service and level of communication regarding the service thus far.



## **2. FUTURE PLANS**

- 2.1. In March 2018 NHS Clinical Commissioners made recommendations to CCGs regarding conditions for which over the counter items should not routinely be prescribed in primary care. These recommendations were made following a national consultation. The recommendation would result in patients sourcing medicines via alternate routes including directly purchasing for the treatment of minor and short lived ailments. The recommendations do include several caveats which would permit the continued prescribing by GP practices such as, patients with long term conditions, significant social vulnerability, treating side effects of other NHS treatments etc.

The CCG have agreed to support these recommendations subject to appropriate engagement with patients (currently underway).

GP members have supported the continued commissioning of this service as a means to support practices to implement the national recommendations to CCGs. This is likely to have an impact on the Pharmacy First Scheme leading to increased awareness and utilisation.

- 2.2. The CCG intend to launch a communication campaign to raise awareness of the scheme with the communication and engagement team in the autumn via newsletter, the Primary Care Medicines Team and Care Navigation Team. As part of the campaign posters and leaflets will be sent to practices to raise awareness with patients.

## **3. CLINICAL VIEW**

- 3.1. This service has been supported by Dr Reehana & Dr Stone.

## **4. PATIENT AND PUBLIC VIEW**

This is a service the patients and public support.

## **5. KEY RISKS AND MITIGATIONS**

- 5.1. Financial risks – if the service proves to be very popular the financial implication could be higher than originally anticipated.

## **6. IMPACT ASSESSMENT**

### ***Financial and Resource Implications***



- 6.1. Current spend is lower than in previous years due to factors such as a new sign up process, misunderstanding of the commissioning of the scheme and level of communications.

### ***Quality and Safety Implications***

- 6.2. A Quality Impact Assessment (QIA) is not required at this stage. A QIA would be required if there were any material changes to the service or a review was undertaken.

### ***Equality Implications***

- 6.3. As this is a continuation of an existing service there is no benefit in carrying out an EA at this stage. The recommendations are for an Equality Assessment to be conducted at the point the service is reviewed.

### ***Legal and Policy Implications***

- 6.4. A Data Protection Impact Assessment (DPIA) is not required as there is a NHS Standard Contract in place which covers all relevant IG clauses. A DPIA should be completed if and when there are any proposed changes to the service (or process procedure or system).

### ***Other Implications***

- 6.5. None

**Name: Hemant Patel**

**Job Title: Head of Medicines Optimisation**

**Date: 28<sup>th</sup> August 2018**

### **ATTACHED:**

Attached items:

Communication e-mail sent to community pharmacies



STP MAS  
Communication.docx

Poster





MAS Poster Final  
Final.pdf

Information of community pharmacies signed-up to provide the service



Copy of STP MAS  
Sign Ups 060818.xlsx

### RELEVANT BACKGROUND PAPERS

(Including national/CCG policies and frameworks)

### 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.**

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	Dr Reehana/ Dr Stone	<b>23/08/18</b> <b>23/08/18</b>
Public/ Patient View	N/A	
Finance Implications discussed with Finance Team	Lesley Sawrey	<b>23/08/18</b>
Quality Implications discussed with Quality and Risk Team	Suhk dip Parvez	<b>23/08/18</b>
Equality Implications discussed with CSU Equality and Inclusion Service	David King	<b>28/08/18</b>
Information Governance implications discussed with IG Support Officer	Kelly Huckvale	<b>23/08/18</b>
Legal/ Policy implications discussed with Corporate Operations Manager	N/A	
Other Implications (Medicines management, estates, HR, IM&T etc.)	As per report	<b>28/08/18</b>
Any relevant data requirements discussed with CSU Business Intelligence	N/A	
<b>Signed off by Report Owner (Must be completed)</b>	Hemant Patel & Sarah Southall	<b>28/08/18</b>





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**WOLVERHAMPTON CCG**

**PRIMARY CARE COMMISSIONING COMMITTEE**  
**4<sup>th</sup> SEPTEMBER 2018**

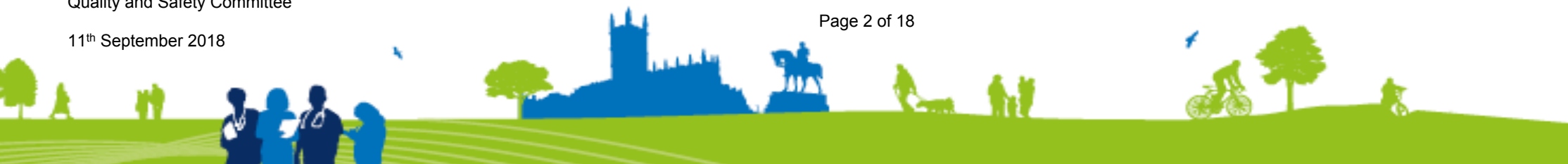
<b>TITLE OF REPORT:</b>	Primary Care Report
<b>AUTHOR(S) OF REPORT:</b>	Liz Corrigan
<b>MANAGEMENT LEAD:</b>	Content reviewed by Sally Roberts
<b>PURPOSE OF REPORT:</b>	To provide an overview of activity in primary care, and assurances around mitigation and actions taken where issues have arisen.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain OR This report is confidential for the following reasons
<b>KEY POINTS:</b>	Overview of Primary Care Activity
<b>RECOMMENDATION:</b>	Assurance only
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	
1. Improving the quality and safety of the services we commission	Providing information around activity in primary care and highlighting actions taken around management and mitigation of risks
2. Reducing Health Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	



**PRIMARY CARE QUALITY DASHBOARD**

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

Data for April 2018		
Issue	Concern	RAG rating
<a href="#">Infection Prevention</a>	No new IP audits in August due to annual leave – update on action plans requested. All practices have now reported on aTIV flu vaccine ordering.	1b
<a href="#">MHRA</a>	Since 1 <sup>st</sup> April 2018 <ul style="list-style-type: none"> <li>19 weekly field safety bulletins with all medical device information included.</li> <li>3 device alerts/recalls</li> <li>6 drug alerts/recalls</li> </ul>	1a
<a href="#">Serious Incidents</a>	None to report at present	1a
<a href="#">Quality Matters</a>	Currently up to date: 7 open 2 overdue 3 closed	1b
<a href="#">Escalation to NHSE</a>	On-going process	1a
<a href="#">Complaints</a>	Details of 30 complaints received since 1 <sup>st</sup> November 2017 27 now closed 3 still under investigation	1a
<a href="#">FFT</a>	In June 2018 <ul style="list-style-type: none"> <li>6 practice submitted no data</li> <li>2 zero submission</li> <li>2 submitted fewer than 5 responses (supressed data)</li> </ul>	1b
<a href="#">NICE Assurance</a>	NICE assurance to be linked to GP Peer Review system	1a
<a href="#">CQC</a>	2 Practices currently have a Requires Improvement rating and are being supported with their action plan.	1b
<a href="#">Workforce Activity</a>	Work around recruitment for GPs, and development of GPN 10 Point Action Plan continue.	1b
<a href="#">Training and Development</a>	A training business case is due to be presented to Workforce Task and Finish Group. Work continues on Practice Nurse Strategy and documents.	1a
<a href="#">Training Hub Update</a>	TBC	1a



## 1. BACKGROUND AND CURRENT SITUATION

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

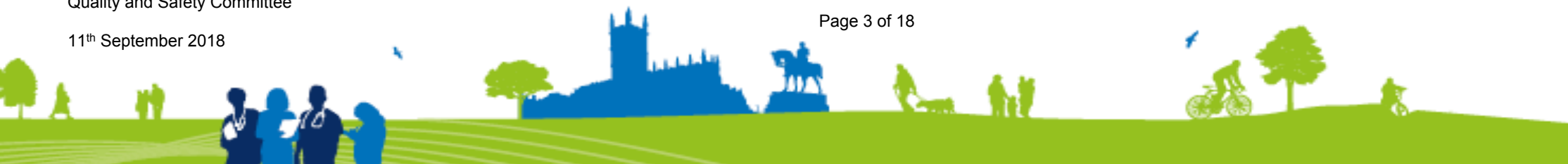
## 2. PATIENT SAFETY

### 2.1. Infection Prevention

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

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

Infection Prevention Audits 2018/19		
Rating	Number	Percentage
Gold	1	8.3%
Silver	7	58.3%
Bronze	2	16.7%
No rating	2	16.7%
<b>Issues identified within primary care:</b>		<b>Exceptions and assurance:</b>
<ul style="list-style-type: none"> <li>• Ensure audits are being undertaken</li> <li>• Cleaning schedules needed</li> <li>• Bins need replacing</li> <li>• Clinical wipe holders needed</li> <li>• Damage to plaster and décor</li> <li>• Sinks need replacing</li> <li>• Wipeable notice boards needed</li> <li>• Wipeable blinds needed</li> <li>• Couches must be moveable</li> <li>• Paper roll holder position</li> <li>• Ensure air vents are cleaned</li> </ul>		<p>A follow up regarding red rated practices has been requested from Mike Christie IP liaison for Primary Care. Support will be provided for practices where appropriate via liaison with IP and CCG Operations Team.</p> <p>Monitoring of IP audits is undertaken by the Primary Care Quality Assurance Coordinator in conjunction with the IP team and by the Primary Care Team, a new audit cycle has now commenced.</p>



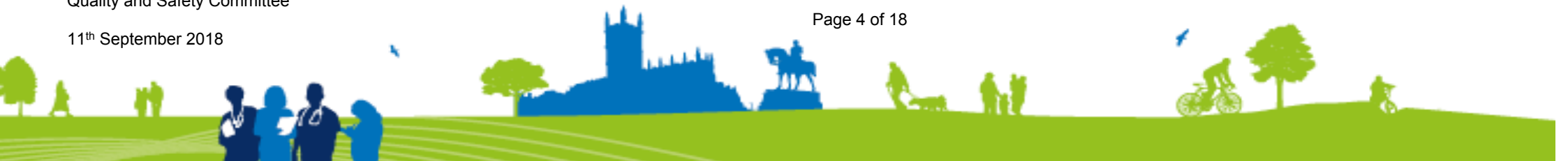
- Ensure soap dispensers are cleaned
- Legionella risk assessment needed

**MRSA Bacteraemia:**

None to report this month.

**Influenza vaccination programme:**

2017/18 Influenza Vaccine Programme activity		Exceptions and assurances:
Numbers of practices with sufficient orders of aTIV		
39/42 (93%)		Continued monitoring of flu vaccine ordering and uptake is being undertaken by Public Health and NHSE the primary care flu vaccine task group has met twice and is due to meet again on 7 <sup>th</sup> September and continues to explore ways to engage with traditionally hard to reach groups through working at scale. Flu training for primary care staff was held on 24 <sup>th</sup> July and 16 <sup>th</sup> August with 100 staff trained.
Final 2017/18 Flu Season Vaccine Uptake		
Under 65s uptake 45.5%	Under 65s declined 18%	

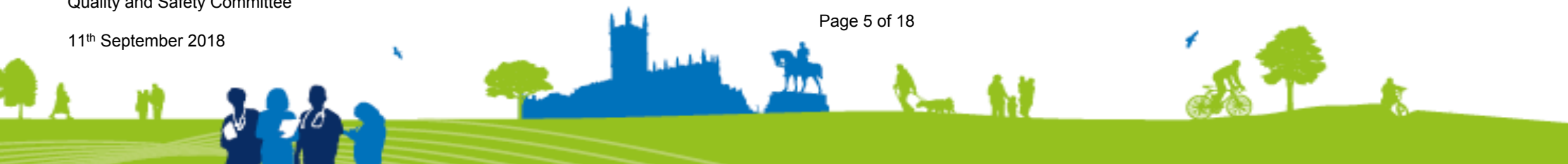


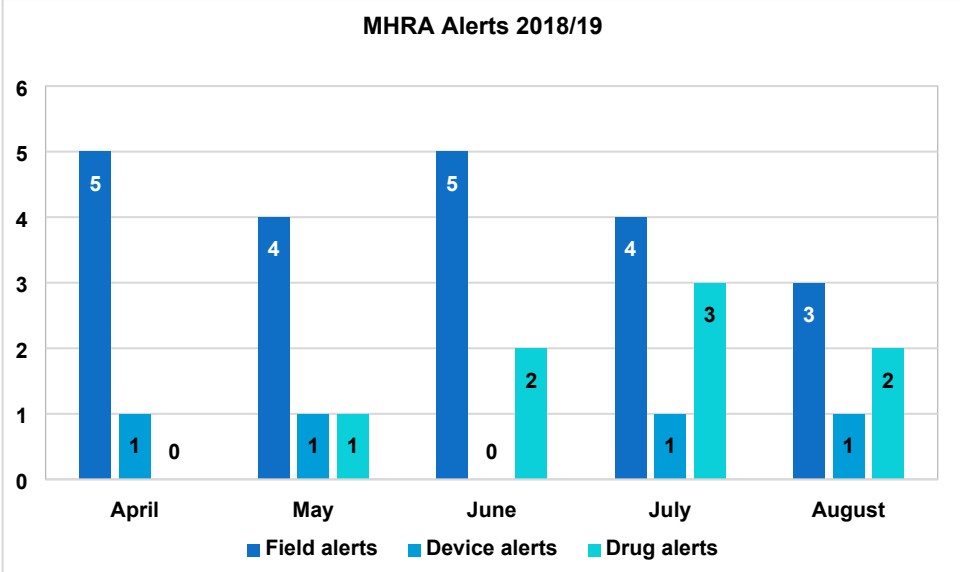


Over 65s uptake <b>68.5%</b>	Over 65s declined <b>15%</b>	
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## 2.2. MHRA Alerts

MHRA Alerts from April 1st 2018		Exceptions and assurances
Alert Type	Number	
Field Safety Bulletin	21	<p>There are currently no direct actions required by CCG.</p> <p>Healthcare professionals are informed about the alerts via a monthly newsletter (Tablet Bytes). In addition, ScriptSwitch messages and/or PMR searches are used to inform healthcare professionals where appropriate. The management of alerts is part of both the GP contract and a requirement under CQC registration. Practices are required to keep a record of alerts and actions taken for scrutiny. At present this is monitored by the CCG via collaborative contracting visits.</p> <p>Suspected adverse drug reactions should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) through the Yellow Card Scheme (<a href="http://www.mhra.gov.uk/yellowcard">www.mhra.gov.uk/yellowcard</a>).</p> <p>Drug, device and Field Safety Notices to date links are below – these are managed centrally by the government and forwarded directly to practices by NHS England: <a href="https://www.gov.uk/drug-device-alerts">https://www.gov.uk/drug-device-alerts</a></p>
Device alerts/recalls	4	
Drug alerts/recalls	8	





**2.3. Serious Incidents**

There are currently no serious incidents being investigated in primary care. All serious incidents are reviewed by internal serious incident scrutiny group and reported to NHS England PPIGG group for logging and appropriate escalation and feedback is provided to the CCG.

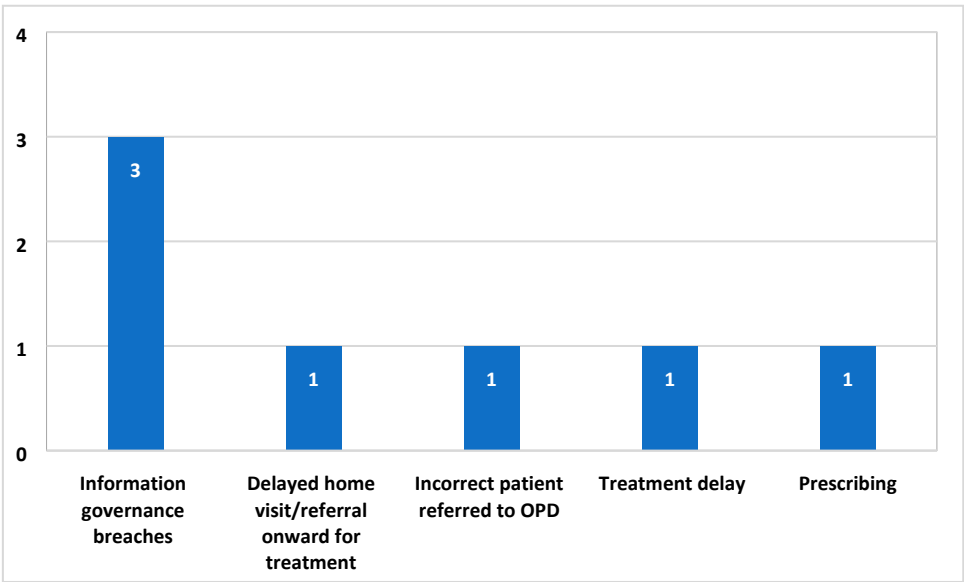
**2.3. Quality Matters**

Quality Matters Status 2018/19 and Variance		
Status in August 2018	Number	Exceptions and assurances:
Open	7	Overdue incidents are currently being chased with practices.



<b>Overdue</b>	2
<b>Closed</b>	3

**Quality Matters Themes:**



Page 25

- Information governance breaches – incorrect blood forms given to patients
- Delayed home visit/referral onward for treatment
- Incorrect patient referred to OPD (2 patients with same name)
- Treatment delay

Quality Matters continue to be monitored, and all Primary Care incidents have been forwarded to the relevant practices and to NHSE where appropriate. Practices are asked to provide evidence of investigation and learning from these incidents and this is provided to NHSE who will then escalate accordingly and feedback to the CCG or to the Serious Incident Scrutiny Group for further consideration. The Quality Team plan to share lessons learned from Quality Matters in primary care as part of an on-going programme.



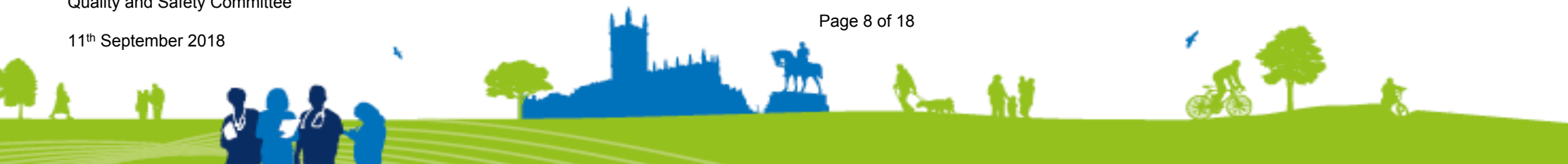
## 2.4. Escalation to NHS England

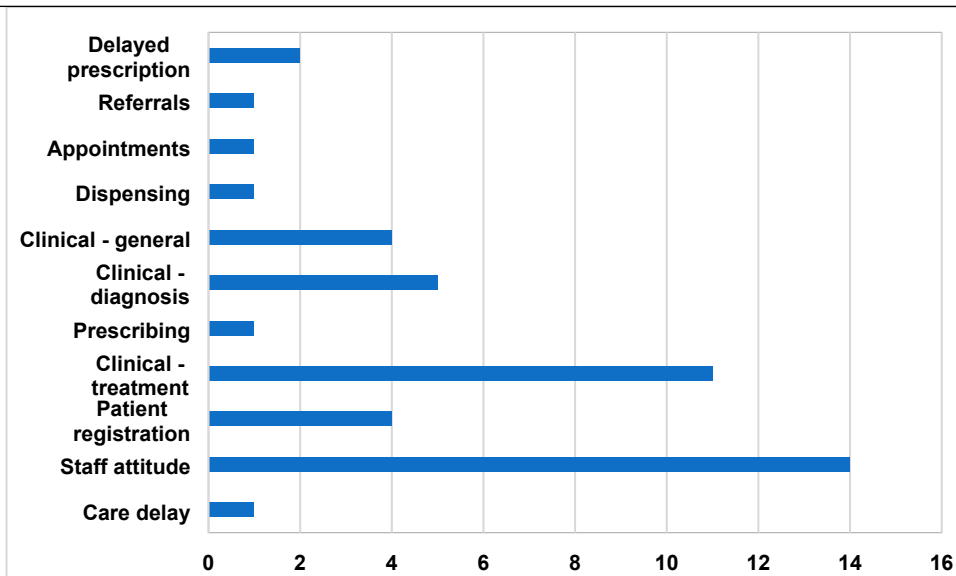
Incidents submitted for review August 2018
Three issues have been referred to PPIGG recently. Assurances around NHSE escalation are provided by bi-weekly feedback from action logs from PPIGG meetings and quarterly reports relating to complaints raised and their outcomes. Any action from escalation is shared via PPIGG and reports, however comprehensive information is not always available. PPIGG outcomes are shared with Primary Care Contract Manager and Primary Care Liaison Manager and practice visits set up if necessary. Data is triangulated with other information i.e. Quality Matters, FFT, IP audits and complaints.

## 3. PATIENT EXPERIENCE

### 3.1. Complaints

Complaints Data 2018/19						
	April	May	June	July	August	Exceptions and assurances:
<b>Number</b>	2	2	3	1	2	<ul style="list-style-type: none"> <li>• Actions and lessons learned identified are:</li> <li>• Reflection</li> <li>• Sharing of pathways and treatment plans – revision of current processes</li> <li>• Audit</li> <li>• Review of records</li> <li>• Discussion at practice meetings</li> <li>• Review of telephone calls and processes</li> </ul> <p>The CCG does not have oversight of GP complaints dealt with within the surgery. NHSE is now sharing complaints data and this can be triangulated with other data e.g. SIs and Quality Matters. All complaints reported to NHSE are logged via PPIGG for appropriate escalation; this includes local actions e.g. additional training or serious incident reporting. Practices must provide evidence of their complaints procedure and handling, including action plans and</p>
<p><b>Complaints Numbers and Themes:</b></p> <p>3 complaints have been received from NHSE since the new process began on 1<sup>st</sup> November 2018. Please note that each complaint may have more than one theme.</p>						

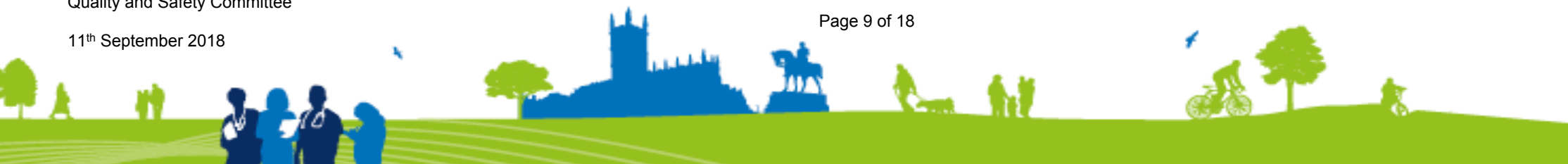




lessons learned for CQC and for the CCG Collaborative Contracting team.

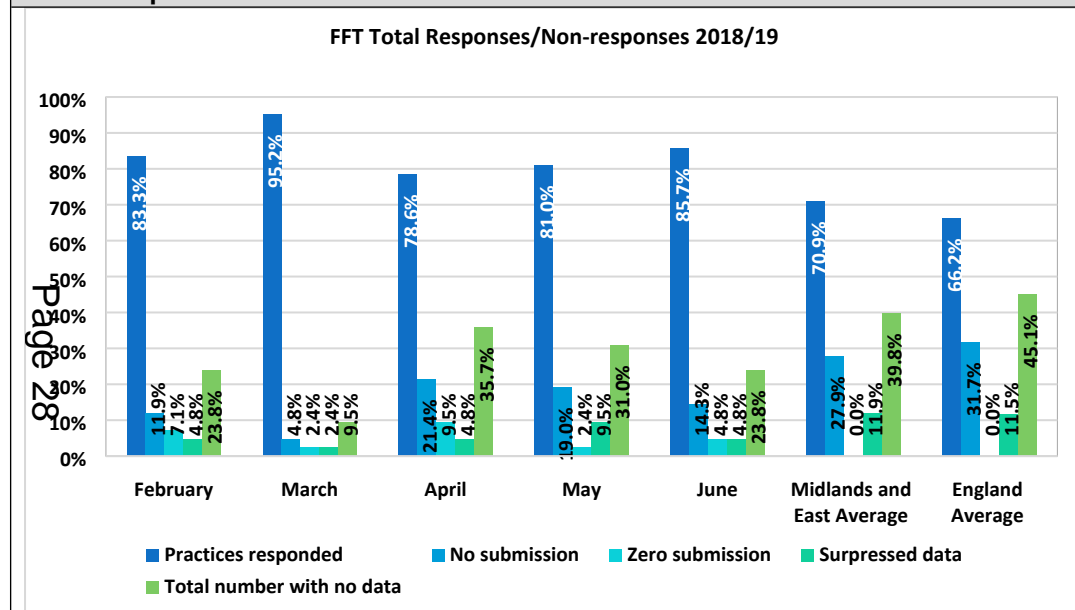
### 3.2. Friends and Family Test

Friends and Family Test Data Overview 2018/19						
Percentage	March	April	May	June	West Midlands	England
<b>Total number of practices</b>	42	42	42	42	2154	7222
<b>Practices responded</b>	95.2% ↑ 40/42	78.6% ↓ 33/42	81% ↑ 34/42	86% ↑ 36/42	70.9%	66.2%
<b>No submission</b>	4.8% ↓ 2/42	21.4% ↑ 9/42	19% ↓ 8/42	14.3% ↓ 6/42		
<b>Zero submission (zero value submitted)</b>	2.4% ↓ 1/42	9.5% ↑ 4/42	2.4% ↓ 1/42	4.8% ↑ 2/42	N/A	N/A
<b>Suppressed data (1-4 responses submitted)</b>	2.4% ↓	4.8% ↑	9.5% ↑	4.8%	11.9%	11.5%



	4/42	15/42	4/42	2/42		
<b>Total number with no data</b>	9.5% ↓	33.3% ↑	31% ↓	23.8%		
	4/42	15/42	13/42	10/42	39.8%	45.1%
<b>Response rate</b>	1.8% ↑	1.4% ↓	1.7% ↑	1.7% ↔	0.6%	0.5%

**Data Comparison** **Exceptions and assurances:**



There were improvements in none submissions again this, overall response rate remains at 1.7%, still significantly better than both the regional and national averages.

Submissions are now being monitored as per FFT Policy.

**Practice FFT Uptake in July 2018**

**No data, suppressed data and zero submissions**

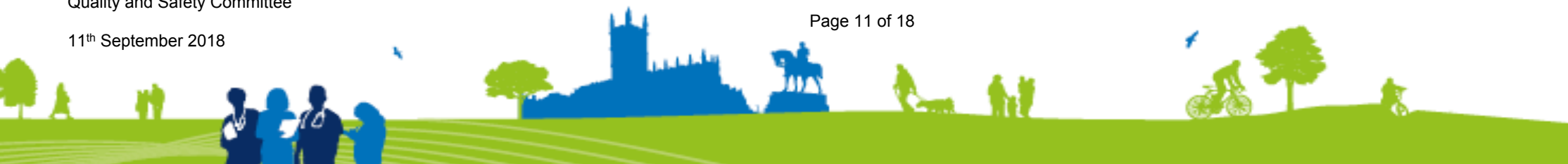
Ten practices submitted no data, or suppressed data (fewer than 5 responses). All practices submitting no data have been contacted directly by the Quality Team, Locality and Contract managers are aware of these practices and those with zero and suppressed data and have contacted them for further assurances around any issues within practices and increasing uptake as per FFT Policy.

**Above average uptake**



Nine practices had above average uptake. All practices have been contacted by Locality Managers to share their data.

FFT Ratings and Method of Response 2018/19																																																									
<p><b>Ratings Data Comparison</b></p> <p style="text-align: center;"><b>FFT Ratings 2018/19</b></p> <table border="1"> <caption>FFT Ratings 2018/19 Data</caption> <thead> <tr> <th>Month/Region</th> <th>Extremely Likely</th> <th>Likely</th> <th>Neither</th> <th>Unlikely</th> <th>Extremely Unlikely</th> <th>Don't Know</th> </tr> </thead> <tbody> <tr> <td>February</td> <td>54.5%</td> <td>27.0%</td> <td>5.4%</td> <td>1.6%</td> <td>3.3%</td> <td>8.1%</td> </tr> <tr> <td>March</td> <td>57.2%</td> <td>26.6%</td> <td>4.7%</td> <td>1.7%</td> <td>3.3%</td> <td>6.5%</td> </tr> <tr> <td>April</td> <td>58.6%</td> <td>26.8%</td> <td>4.2%</td> <td>1.7%</td> <td>2.6%</td> <td>6.1%</td> </tr> <tr> <td>May</td> <td>62.2%</td> <td>23.4%</td> <td>4.2%</td> <td>1.3%</td> <td>2.9%</td> <td>6.0%</td> </tr> <tr> <td>June</td> <td>58.9%</td> <td>24.6%</td> <td>5.4%</td> <td>1.8%</td> <td>2.7%</td> <td>6.7%</td> </tr> <tr> <td>West Midlands Average</td> <td>67.5%</td> <td>20.6%</td> <td>3.9%</td> <td>2.4%</td> <td>3.4%</td> <td>2.2%</td> </tr> <tr> <td>England Average</td> <td>70.2%</td> <td>19.0%</td> <td>3.7%</td> <td>2.4%</td> <td>3.6%</td> <td>1.2%</td> </tr> </tbody> </table> <p>A brief survey of practice activity around the collation qualitative data and how FFT data is used within practice has been undertaken. Responses have been low, and the general consensus:</p> <ul style="list-style-type: none"> <li>• “you said we did” exercises</li> <li>• Discussion at practice meetings</li> <li>• Inclusion of action plans within business plans</li> <li>• Data published on websites and within practice annual report</li> </ul> <p>GP survey data for patient experience shows:</p>	Month/Region	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know	February	54.5%	27.0%	5.4%	1.6%	3.3%	8.1%	March	57.2%	26.6%	4.7%	1.7%	3.3%	6.5%	April	58.6%	26.8%	4.2%	1.7%	2.6%	6.1%	May	62.2%	23.4%	4.2%	1.3%	2.9%	6.0%	June	58.9%	24.6%	5.4%	1.8%	2.7%	6.7%	West Midlands Average	67.5%	20.6%	3.9%	2.4%	3.4%	2.2%	England Average	70.2%	19.0%	3.7%	2.4%	3.6%	1.2%	<p><b>Exceptions and assurance:</b></p> <p>Overall 83% would recommend their practice, 4% would not with ratings slightly lower than last month, and lower than regional and national (87%/90% would recommend and 6% would not) averages. This month 12.1% gave either a “don’t know” or “neither” answer compared to 5.8% regionally and 4.9% nationally and this has increased slightly. There is still a strong correlation between these responses and submission via practice check in screens and SMS text as previously discussed.</p> <p>9 practices had higher than average not recommended ratings, and 6 practices lower than average would recommend ratings (with little correlation between the two) – these have been discussed with Locality Managers in relation to the recently released patient survey data.</p> <p>FFT activity continues to be monitored on a monthly basis by the Operational Management Group, and via the NHSE Primary Care Dashboard. Non responders, suppressed and zero data is monitored monthly, practices that do not submit are contacted by the Primary Care Contract Manager or locality managers and appropriate advice and support offered to facilitate compliance. Those that fail to submit on a regular basis may receive a contract breach notice, and a number of sites are being monitored closely. Wolverhampton LMC have offered to support the process to avoid the need for breach notices to be applied. Information from FFT is also triangulated with NHSE Dashboard and GP Patient Survey data when available and with Quality Matters, SIs and complaints.</p>
Month/Region	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know																																																			
February	54.5%	27.0%	5.4%	1.6%	3.3%	8.1%																																																			
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England Average	70.2%	19.0%	3.7%	2.4%	3.6%	1.2%																																																			



Overall 79% good and 8% poor compared to 84% good and 6% poor nationally.  
There is some correlation between practices with low FFT scores and this data, however there are differences and this may be due to the way in which questions are asked in the two different surveys, with the GP survey being more specific about:

- Phone service
- Online services
- Receptionists
- Appointments
- Care at last appointment
- Managing health conditions
- Out of hours provision

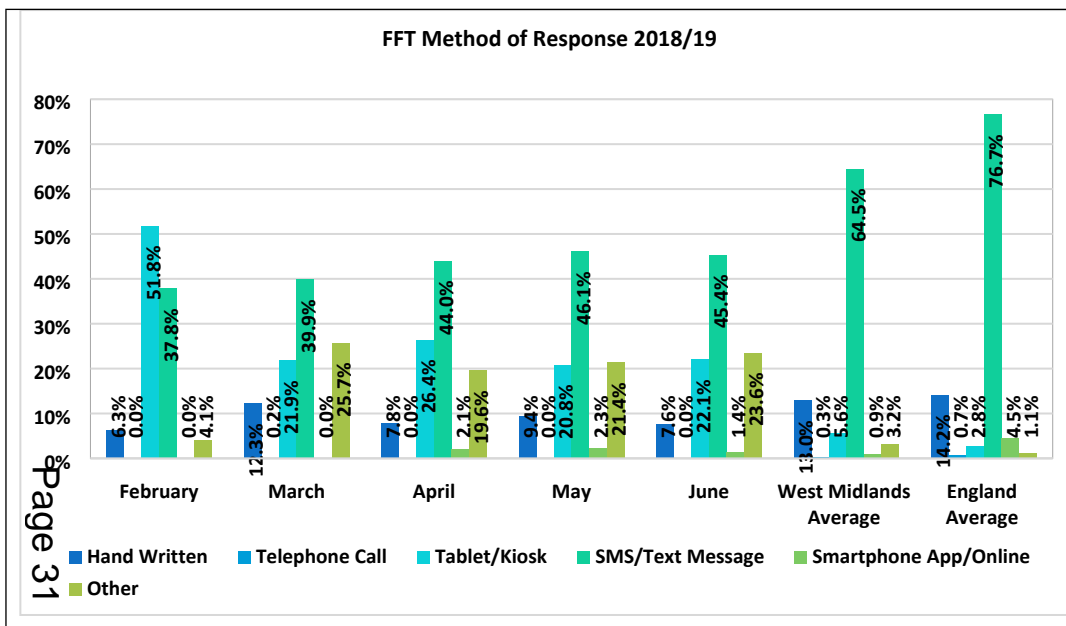
**Method of Response Data Comparison**

**Exceptions and assurance**

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This month the majority of responses have again come via electronic media, SMS text and Tablet/Kiosk, with an increase in use of website/app, this continues to increase while other methods e.g. handwritten continue to decrease. Please note that some practices do not appear to record the method of collection.

## 4. CLINICAL EFFECTIVENESS

### 4.1. NICE Assurance

Guideline	Date	Linked to Peer Review	Exceptions and assurances:
Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups (QS167)	May-18		The next NICE meeting is due to be held on 12 <sup>th</sup> September 2018. The assurance framework around NICE guidance will be applied in line with the peer review system for GPs, the following clinical areas are part of the peer review process
Epilepsies: diagnosis and management (CG137)	Apr-18		
Neuropathic pain in adults: pharmacological management in non-specialist settings (CG173)	Apr-18	Yes	



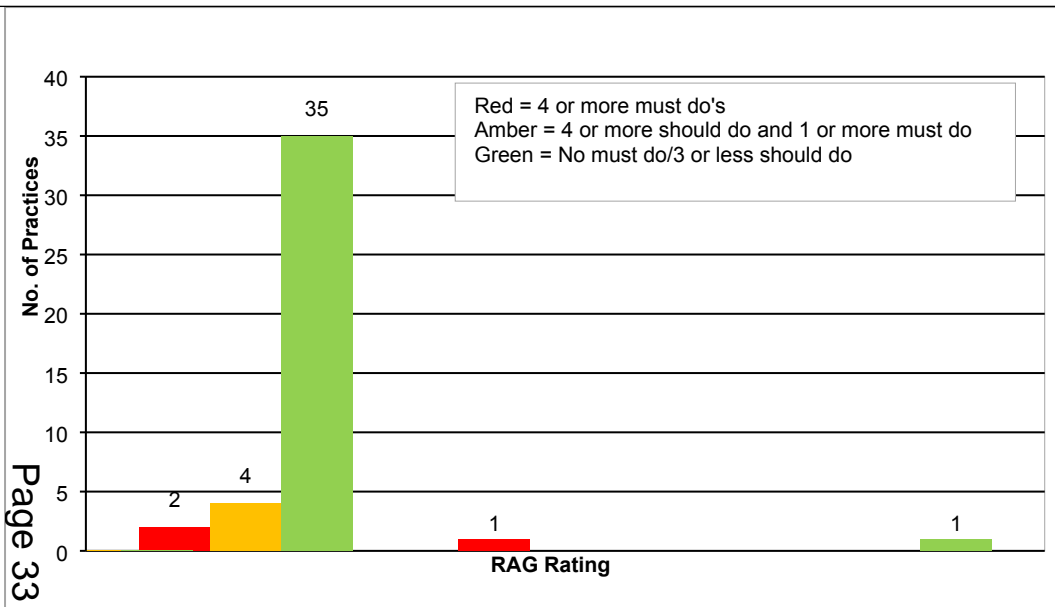
Bipolar disorder: assessment and management (CG185)	Apr-18		and relevant guidance will be discussed in line with these areas: <ul style="list-style-type: none"> <li>• Urology</li> <li>• Trauma &amp; Orthopaedics</li> <li>• ENT</li> <li>• Ophthalmology</li> <li>• Pain Management</li> <li>• Gastroenterology</li> <li>• Haematology</li> <li>• Cardiology</li> <li>• Dermatology</li> <li>• Rheumatology</li> <li>• Gynaecology</li> </ul>
Depression in adults: recognition and management (CG90)	Apr-18		
Lyme disease (NG95)	Apr-18		
Drug misuse prevention (QS165)	Mar-18		
Otitis media (acute): antimicrobial prescribing (NG91)	Mar-18	Yes	
Stop smoking interventions and services (NG92)	Mar-18		
Emergency and acute medical care in over 16s: service delivery and organisation (NG94)	Mar-18		
Physical activity and the environment (NG90)	Mar-18		
Heavy menstrual bleeding: assessment and management (NG88)	Mar-18	Yes	
Attention deficit hyperactivity disorder (QS39)	Mar-18		
Heavy menstrual bleeding (QS47)	Mar-18	Yes	

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**REGULATORY ACTIVITY**  
**CQC Inspections and Ratings**

CQC Inspections and Ratings to date 2018/19												
CQC Ratings by Domain	Overall	Safe	Effective	Caring	Responsive	Well-led	Families, children and young people	Older people	People experiencing poor mental health (including people with dementia)	People whose circumstances may make them vulnerable	People with long term conditions	Working age people (including those recently retired and students)
Outstanding	0	0	0	0	0	0	0	0	0	0	0	0
Good	33	31	34	35	35	33	33	33	33	33	33	33
Requires Improvement	3	5	2	1	1	2	3	3	3	3	3	3
Inadequate	0	0	0	0	0	1	0	0	0	0	0	0
<b>RAG Ratings – actions from CQC inspections:</b>							<b>Exceptions and assurances</b>					





There are currently two practices with a Requires Improvement rating (the third practice is now under different registration and has not yet been inspected) these are being monitored by the Primary Care and contracting team with input from the Quality Team, face to face support has been offered to both practice teams.

Collaborative contracting visits are carried out where appropriate and CQC actions plans reviewed.

Themes for improvement identified within the CQC reports are as follows:

- Ensuring safe recruitment of locums.
- Providing assurances around responses to safety alerts.
- Ensuring systems for good governance.
- Ensuring appropriate responses to best practice guidance.
- Engaging in service improvement audit.
- Improvement around communication with staff within the practice around performance.
- Ensuring equipment is safely managed.
- Performing health and safety audits and ensuring they are updated.
- Providing evidence of sepsis management as per NICE guidance.



## 6. WORKFORCE DEVELOPMENT

### 6.1. Workforce Activity

	Activity	Exceptions and assurance	
<b>Recruitment and retention</b>	<p>Work continues to promote CCT fellowships in Wolverhampton.</p> <p>Student nurses at University of Wolverhampton are now sharing CVs with the CCG and these are being forwarded to GP practices with consent.</p> <p>Work is due to commence on work experience pilot.</p> <p>Stronger links with apprenticeship providers are being developed through Training Hub.</p>	No exceptions noted.	
Page 34	<b>Workforce Numbers</b>	NB - Figures are taken from NHS Digital data – some practices have not agreed to share their information and there may be higher numbers of staff than shown here. Locality Managers are encouraging practices to tick the data sharing agreement to allow CCG to view data.	
	<b>Group</b>		<b>WTE</b>
	<b>Nurses (all levels)</b>		58.5
	<b>Health Care Assistants</b>		22.3
	<b>Junior doctors (inc registrars)</b>		25.1
	<b>Locum GPs</b>		2.1
	<b>Salaried GPs</b>		35.5
	<b>GP partners</b>		73.4
	<b>Administration/Receptionists</b>		244.3
	<b>Practice Managers</b>	42.2	
	<b>Apprentices</b>	8.7	
<b>GPN 10 Point Action Plan</b>	<p>Action 1 - Continuation of student nurse CVs being sent to CCG and forwarded to practices</p> <p>Action 2 – Continue to support leadership programmes.</p> <p>Action 3 - Work continues to ensure student mentors have updates in conjunction with university.</p> <p>Action 4 - Induction and preceptorship is now being incorporated into the Black Country GPN Strategy. Training Hub to develop pilot programme to support this.</p> <p>Action 5 – Continue to promote Return to Practice programmes.</p> <p>Action 6 - Work Experience pilot to be developed with school on Walsall/Wolverhampton border to include practices from both areas.</p> <p>Action 7 - Sponsored places funding now confirmed. Additional training around spirometry and diabetes proposed via business case to Workforce T&amp;F group.</p> <p>Action 8 –Advanced Clinical Practice funding decision now made, numbers low across</p>	Monthly returns are provided to NHSE on behalf of the Black Country, collated by Wolverhampton CCG.	



	<p>the Black Country. Action 9 - training programme for HCAs funding agreed by LWAB via Training Hub, this will be bolstered by additional sponsorship from pharma. Action 10 - to work with CCG re: practice resilience funding to identify opportunities to improve retention.</p>	
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## 6.2. Training and Development

	Activity	Exceptions and assurance
<p><b>Nurse</b></p> <p>Page 35</p>	<p>A business case is due to be presented to Workforce Task and Finish Group covering costs and logistics of training in:</p> <ul style="list-style-type: none"> <li>• Spirometry – to meet with requirements of ARTP guidelines/CQC requirements</li> <li>• Diabetes – to ensure knowledge base in order to fulfil requirements of QoF+</li> <li>• HCA training – to ensure equity of training/updates available to HCAs.</li> </ul> <p>Practice Makes Perfect continues as per agenda. Flu training is now complete – 100 places were available and all were taken. HCA LTC training continues provided by Education for Health – respiratory update to be provided in September with 15 places available.</p> <p>Wolverhampton CCG have been approached to take part in digital clinical supervision pilot for nurses, this is at an early stage and discussions are due to be held with IM&amp;T and senior leaders.</p>	<p>Business case to be reviewed by T&amp;F group and forwarded to relevant boards/committees for consideration.</p>
<p><b>Non-clinical staff</b></p>	<p>Training continues in the following areas:</p> <ul style="list-style-type: none"> <li>• Care navigation</li> <li>• Dementia friends</li> <li>• Practice Manager development programme</li> </ul>	



6.3. Training Hub update

		Exceptions and assurance
<b>Black Country Training Hub</b>	Awaiting update – to be provided verbally.	TBC

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**WOLVERHAMPTON CCG**  
**PRIMARY CARE COMMISSIONING COMMITTEE**  
**4<sup>th</sup> September 2018**

<b>TITLE OF REPORT:</b>	Primary Care Operational Management Group Update
<b>AUTHOR(s) OF REPORT:</b>	Mike Hastings, Director of Operations
<b>MANAGEMENT LEAD:</b>	Mike Hastings, Director of Operations
<b>PURPOSE OF REPORT:</b>	To provide the Committee with an update on the Primary Care Operational Management Group.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This report is intended for the public domain.
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>• Since November there had been 25 new GP complaints raised to NHSE. There is an equal split of those that are upheld and those which are not.</li> <li>• The technical issues relating to the Friends and Family Test (FFT) had been resolved. It is expected that the number of submissions will increase this month. Practices with a higher than average uptake have been shared with the locality Managers and will go to Group Leads to encourage good practice.</li> <li>• Improving access 100% sign up has been achieved for 30 minutes access per 1000 patients and this will be running in all Groups from September.</li> </ul>
<b>RECOMMENDATION:</b>	To provide the Committee with an update on the Primary Care Operational Management Group.
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	
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.

**Present:**

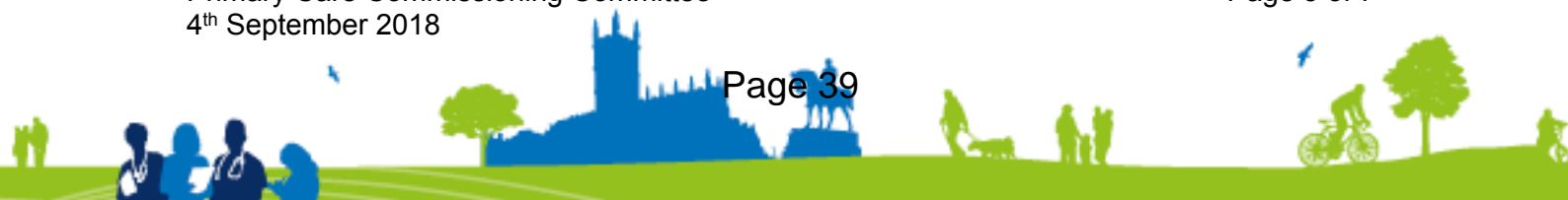
Mike Hastings	(MH)	WCCG Director of Operations
Peter McKenzie	(PMck)	WCCG Corporate Operations Manager
Jane Worton	(JW)	WCCG Primary Care Liaison Manager
Jo Reynolds	(JR)	WCCG Primary Care Development Manager
Ramsey Singh	(RS)	WCCG IM&T Infrastructure Project Manager
Liz Corrigan	(LC)	WCCG Primary Care Quality Assurance Co-ordinator
Charmaine Hurd	(CH)	Student Nurse
Ankush Mittal	(AM)	Consultant Public Health
Dr Bhavin Mehta	(BM)	Local Medical Committee Representative
Carol McNeil	(CM)	Assistant Contract Manager, NHS England
Jeff Blankley	(JB)	Local Pharmaceutical Chair

Item		Action
1.	<b><u>Declarations of Interest</u></b> BM declared his interest as a GP.	
2.	<b><u>Apologies</u></b> Sue McKie (SM) Hemant Patel (HP) WCCG Head of Medicines Optimisation Sarah Southall (SS) WCCG Head of Primary Care Tally Kallea (TK) WCCG Commissioning Operations Manager Yvette Delaney (YD) CQC Inspector for Primary Medical Services	
3.	<b><u>Welcome &amp; Introductions</u></b> MH welcomed everyone to the meeting.	
4.	<b><u>Notes and Action Log from the Last Meeting</u></b> The previous meeting notes were accepted and action log updated.	
5.	<b><u>Draft Notes of Clinical Reference Group Meeting</u></b> No comments were made.	
6.	<b><u>Matters Arising</u></b> There were no matters arising.	
7. 7.1	<b><u>Discussion Items/Assurance</u></b> <b><u>Review of Primary Care Matrix</u></b> JW provided the following update:  MGS Medical Centre - CCG continues to work closely with the Practice, having fortnightly Transition meetings with the Contract Holders.	





	APMS Re-procurement - Work continues in the re-procurement of the APMS contracts for Ettingshall Medical Centre, Bilston Urban Village and Pennfields Medical Centre.	
7.2	<b><u>Forward Plan for Practice System Migrations Mergers and Closures</u></b> RS noted that there had been no significant changes to the plan	
7.3	<b><u>Estates Update/LEF</u></b> The meeting was updated around estates developments in Wolverhampton.	
7.4	<b><u>Primary Care Quality Update</u></b> LC presented the quality report, highlighting the following updates: <ul style="list-style-type: none"> <li>• A number of Infection Prevention audits had been undertaken by Mike Christy. A number of issues had been identified and revisits were planned. LC reported that she would be attending an IP visit to gain better understanding.</li> <li>• CCG have returned data on flu vaccination ordering for all practices for NHSE.</li> <li>• SB had shared data for breast and bowel screening and was working with Primary Care to increase uptake.</li> <li>• Meeting of the Cancer Strategy Group was due to take place. This is a national issue including capacity. This was raised at the Trust Board Development meeting.</li> <li>• Quality Matters continue to be monitored; all Primary Care incidents have been forward to the relevant practices and NHSE where appropriate. QM incidents are reported to PPIGG.</li> <li>• Since November there had been 25 new GP complaints raised to NHSE. There is an equal split of those that are upheld and those which are not.</li> <li>• The technical issues relating to the Friends and Family Test (FFT) had been resolved. It is expected that the number of submissions will increase this month. Practices with a higher than average uptake have been shared with the locality Managers and will go to Group Leads to encourage good practice.</li> <li>• JW to check if the FFT policy was approved at Primary Care Commissioning Committee. (Post meeting note: this has been approved and has gone out to practices).</li> <li>• NICE assurance this month will be linked with the peer review process.</li> <li>• Two practices with a Requires Improvement rating are being monitored by the Primary Care and Contracting Team with input from the Quality Team.</li> <li>• The Workforce dashboard is now working and is being finalised to be taken to the August Workforce Task and Finish Group.</li> <li>• The Practice Nurse Education forum continues and will be further developed with additional training sessions.</li> </ul>	
7.5	<b><u>General Practice Forward View Update</u></b> JR provided the following update: <ul style="list-style-type: none"> <li>• The GP Forward View - there are 85 different projects, 23 more started in the last quarter. There are currently 46 open and 23 waiting to commence.</li> </ul>	



	<p>Working towards completion by next May ahead of target.</p> <ul style="list-style-type: none"> <li>• There has been full sign up by all practices to QOF+ scheme</li> <li>• Improving access 100% sign up has been achieved for 30 minutes access per 1000 patients and this will be running in all Groups from September.</li> <li>• Evening appointments are well utilised, as are those provided in the hubs at weekends</li> <li>• Next financial year the requirement will increase from 30 minutes per 1000 patients to 45 minutes per 1000 patients</li> <li>• Special access is out for expressions of interest. 1 provider has come forward.</li> <li>• Primary Care, Care Navigation Phase 2 – an event has been held and a number of services are being considered</li> <li>• Social prescribing has been awarded Department of Health funding.</li> <li>• Training for practice managers is ongoing and includes upskilling, mentoring and coaching. Practice managers are keen to work at Group level and have fed back that the training has been beneficial</li> <li>• A more robust contract monitoring process is being developed</li> <li>• Issues relating to the pathways between Relate and Healthy Minds are being reviewed</li> </ul>	
7.6	<p><b><u>Contract Visit Programme</u></b> An update was provided around the recent Collaborative Contract Review Visits that had been undertaken.</p>	
7.7	<p><b><u>Collaborative Working Model: Practice Issues and Communication Log</u></b> LC is continuing to chase and update the Log.</p>	
7.8	<p><b><u>Care Query Panel</u></b> Practices continue to submit queries into the email box although these have decreased over time. If queries are not upheld payment is not made. Monthly review meetings take place to decide whether or not RWT are in breach. If the query is with another provider then this is taken forward by one of the team.</p>	
7.9	<p><b><u>Risks</u></b> PM provided an overview of the risks on the Primary Care risk register, where a number of confidential risks were discussed in detail.</p>	
7.11	<p><b><u>Internal Audit Report 201/2018 - Draft (Primary Care Commissioning)</u></b> The Internal Audit report will go to the CCG's Audit and Governance Committee to give Committee assurance that reports are being considered.</p>	
8.	<p><b><u>CQC: Primary Care Update</u></b> Due to apologies received from CQC not update was given.</p>	
9.	<p><b><u>Primary Care Commissioning/Contracting Update</u></b> GS reported APMS procurement is currently underway.</p>	
10.	<p><b><u>Public Health: Primary Care</u></b> As noted at the last meeting Public Health is moving forward with this year's Flu</p>	



	Vaccination campaign.	
11.	<b><u>NHS England</u></b> NHS have requested that the CCG refreshes its Winter Planning Policy.	
12.	<b><u>LMC Update</u></b> There was no update from LMC.	
13.	<b><u>Pharmaceutical Involvement in Primary Care</u></b> There was no update from Pharmaceutical Involvement in Primary Care.	
14.	<b><u>AOB</u></b> There were not items raised to discuss under any other business	
15.	<b><u>Date and Time of Next Meeting</u></b> Friday 7 <sup>th</sup> September 2018 at 1.00pm-3.00pm Main Meeting Room, Wolverhampton Science Park, WV10 9RU	

## 2. CLINICAL VIEW

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

## 3. PATIENT AND PUBLIC VIEW

- 3.1. Patient and public views are sought as required.

## 4. KEY RISKS AND MITIGATIONS

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

## 5. IMPACT ASSESSMENT

### *Financial and Resource Implications*

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

### *Quality and Safety Implications*

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

### *Equality Implications*

- 5.3. Equality and Inclusion views are sought as required.

***Legal and Policy Implications***

5.4. Governance views are sought as required.

***Other Implications***

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

**Name: Mike Hastings**  
**Job Title: Director of Operations**  
**Date: 17.08.18**



**REPORT SIGN-OFF CHECKLIST**

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

	<b>Details/ Name</b>	<b>Date</b>
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	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Mike Hastings</b>	<b>02.08.19</b>



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## Equality Analysis Form

<b>Name of Project/Review</b>	<b>Primary Care Counselling Review</b>
<b>Project Reference number</b>	
<b>Project Lead Name</b>	<b>Ranjit Khular</b>
<b>Project Lead Title</b>	<b>Primary Care Transformation Manager</b>
<b>Project Lead Contact Number &amp; Email</b>	<a href="mailto:r.khular@nhs.net">r.khular@nhs.net</a> 01902 442462 07920 537528
<b>Date of Submission</b>	
<b>Version</b>	<b>1</b>
<b>Is the document:</b>	
<b>A proposal of new service or pathway</b>	[REDACTED]/NO
<b>A strategy, policy or project (or similar)</b>	[REDACTED]/NO
<b>A review of existing service, pathway or project</b>	YES [REDACTED]
<b>Who holds overall responsibility for the project/policy/ strategy/ service redesign etc</b>	
Sarah Southall, Head of Primary care	
<b>Who else has been involved in the development?</b>	
<p><b>Sarah Fellows, Mental Health Commissioning Manager</b>  <b>Vic Middlemiss, Head of Procurement</b>  <b>Primary Care Commissioning Committee Representatives</b>  <b>Dr Gill Pickavance</b></p>	

## Section A - Project Details

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

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

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

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

This service is commissioned in line with the national strategy '**No Health without Mental Health**' 2011

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

Patients have improved access to treatment, that is also suitable for their needs

GPs have improved access to treatment for their patients

Other local mental health programmes have a partnership with the provider so that referrals may be shared due to appropriateness of need

## Section B – Screening Analysis

### Equality Analysis Screening



## Equality Analysis Form

### Equality Analysis Screening

It is vital that the CCG ensures that it demonstrates that it is meeting its legal duty, as the responsible manager you will need to identify whether a Full Equality Analysis is required.

A full EA will only not be required if none of the following aspects are identified and you are confident there is no impact.

*E.g. 'This report is for information only' or 'The decision has not been made by the CCG' or 'The decision will not have any impact on patients or staff'. (Very few decisions affect all groups equally and this is not a rationale for not completing an EA.)*

Screening Questions	YES or NO
<p>Is the CCG making a decision where the outcome will affect patients or staff?</p> <p><i>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.</i></p>	Yes
<p>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?</p>	N/A
<p>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</p>	No
<p>Will this decision impact on how a <b>provider</b> delivers its services to patients, directly or indirectly?</p>	Yes
<p>Will this decision impact on any third parties financial position (i.e. Provider, Local Authority, GP Practices)? <i>For example are you removing funding from theirs or any contract?</i></p>	No
<p>If you have answered <b>NO</b> to <b>ALL</b> the above questions, please provide supporting narrative to explain why none of the above apply.</p> <p><i>(Advice and guidance can be sought from the equality team if required).</i></p>	

## Equality Analysis Form

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](mailto: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](mailto:David.king17@nhs.net) or [Equality@ardengemcsu.nhs.uk](mailto:Equality@ardengemcsu.nhs.uk)

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

Title	Name	Date
Project Lead		
Equality and Inclusion Officer		
Equality and Inclusion Comments		
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](mailto:David.king17@nhs.net) or [Equality@ardengemcsu.nhs.uk](mailto:Equality@ardengemcsu.nhs.uk)

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

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

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

## Section C - Full Equality Analysis Section

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

### 1. Evidence used

*What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses*

The evidence used in this analysis has been the demographics of the local population and the data on those that are suffering with mild to moderate levels of common mental health disorders, such as stress, depression and anxiety.

The numbers of referrals to the Healthy Minds service, and feedback from General practices about the waiting times to access this service has also been referred to.

### Corporate Assurance Impact

State overarching, strategy, policy, legislation this review or service change is compliant with

The GP 5 Year Forward View the national strategy 'No Health without Mental Health' 2011

**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*)

Yes

**What** is the intended benefit from this review or service change?

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

## Equality Analysis Form

### 1. Evidence used

*What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses*

	<p>supervised, setting.</p> <p>The intended outcome is to improve well-being, and speed the recovery of patients, which will also release general practitioner consultations for other patients.</p> <p>The Primary Care Counselling Service currently will provide a number of solution- focused quality counselling interventions to patients.</p>
<p><b>Who</b> is intended to benefit from the implementation of this review or service change?</p>	<p>The Primary Care Counselling Service currently will provide a number of solution- focused quality counselling interventions to patients. Specifically services include:</p> <ul style="list-style-type: none"> <li>• Counselling for Low Mood and Life Events,</li> <li>• Low level Cognitive Behavioural Therapy</li> <li>• Counselling interventions to support patients who have anger management issues / difficulties</li> <li>• Focused counseling for depression anxiety or life events</li> </ul>
<p><b>What</b> are the key outcomes/ benefits for the groups identified above?</p>	<p>The provider will administer the following diagnostic tests at the beginning of the intervention to establish a baseline of the service users mental wellbeing:</p> <p><b>PHQ9</b> which is a multipurpose instrument for diagnosing, monitoring and measuring the severity of depression</p> <p><b>GAD7</b> which is a self-administered patient questionnaire is used as a screening tool and severity measure for generalised anxiety disorder</p> <p><b>CORE 10</b> which is a generic, short, and easy-to-use assessment measure</p>

## Equality Analysis Form

1. Evidence used	
<i>What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses</i>	
	<p>for common presentations of psychological distress in UK primary care mental health settings.</p> <p>The provider will repeat the above tests at the end of the intervention as a means of measuring the progress made by the patient.</p>
<b>Will</b> the review or service change meet any statutory requirements, outcomes or targets?	

2. Impact of decision	
<i>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.</i>	
<b>2.1 Age</b>	<i>Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.</i>
<p><b>Capacity to interact with the service is taken into consideration by the service, for example age related illnesses such as dementia may affect patients ability to participate and benefit from the sessions</b></p> <p><b>The provider is required to ensure that patients with different communication needs and potentially reduced capacity are able to access the service where possible. This will be done through a review of the individuals circumstances and support need prior to any sessions.</b></p>	
<b>2.2 Disability</b>	<i>Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/learning disabilities, cognitive impairments.</i>
<p><b>Capacity to interact with the service is taken into consideration by the service, individuals ability to access the service and/ or participate in the sessions are taken into consideration by the service with reasonable adjustments made.</b></p> <p><b>The provider is required to ensure that patients with different communication needs and potentially reduced capacity are able to access the service where possible. This will be done through a review of the individuals circumstances and support need prior to any sessions.</b></p>	
<b>2.3 Gender reassignment (including transgender)</b>	<i>Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.</i>

## Equality Analysis Form

### 2. Impact of decision

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

**There is no evidence to suggest that people identifying with any gender group would be negatively affected or experience any barriers but there will be sensitivities around this area that will need to be taken into consideration by the provider.**

**If an individual undergoing gender reassignment wishes to access this service, it should be reviewed as to whether they should access this service or be referred to specialist counselling services related to the gender reassignment pathway.**

### 2.4 Marriage and civil partnership

*Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.*

**There is no evidence to suggest that marital status affects access to this service.**

### 2.5 Pregnancy and maternity

*Describe any impact and evidence in relation to Pregnancy and Maternity. This can include working arrangements, part time working and caring responsibilities.*

**There is no evidence to suggest that pregnancy and maternity affects access to this service. Postnatal depression would be delivered by local Maternity services.**

### 2.6 Race

*Describe race-related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures and language barriers.*

**There is no evidence to suggest that race affects access to this service.**

**There is access to interpreters available for any patient experiencing language barriers.**

**The service will pay due regard to cultural sensitivities.**

### 2.7 Religion or belief

*Describe any impact and evidence in relation to religion, belief or no belief on service delivery or patient experience. This can include dietary needs, consent and end of life issues.*

## Equality Analysis Form

### 2. Impact of decision

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

**There is no evidence to suggest that religion or belief affects access to this service. The service will pay due regard to cultural sensitivities.**

#### 2.8 Sex

*Describe any impact and evidence in relation to men and women. This could include access to services and employment.*

**There is no evidence to suggest that sex affects access to this service. The service employs both male and female counsellors.**

#### 2.9 Sexual orientation

*Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.*

**There is no evidence to suggest that this group would be negatively affected but there will be sensitivities around this area that will need to be taken into consideration by the provider.**

#### 2.10 Carers

*Describe any impact and evidence in relation to part-time working, shift-patterns, general caring responsibilities. (Not a legal requirement but a CCG priority and best practice)*

**Considerations have been made to try and mitigate any issues this group may have accessing the service, for example sessions are available in the evening and in various community based locations**

#### 2.11 Other disadvantaged groups

*Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the CCG in meeting its legal duties to identify and reduce health inequalities.*

## Equality Analysis Form

### 2. Impact of decision

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

**Patients will need to be registered with a Wolverhampton GP to access the Primary Care Counselling Service**

**This service is for low level, mild mental health support, and may not be suitable for patients in certain circumstances or need. Specialist services, for issues such as domestic violence and substance misuse, are available through other providers.**

### 3. Human rights

*The principles are Fairness, Respect, Equality, Dignity and Autonomy.*

<b>Will the proposal impact on human rights?</b>	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
--	-----	--------------------------	----	-------------------------------------

<b>Are any actions required to ensure patients' or staff human rights are protected?</b>	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
--	-----	--------------------------	----	-------------------------------------

**If so what actions are needed? Please explain below.**

The service is delivered in line with the NHS Constitution and under the terms of the NHS Standard Contract.. As a result the CCG ensures that the Human Rights of patients, their families and staff are protected/maintained. This is checked through Contract Management processes.

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

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

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



## Equality Analysis Form

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

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

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

One of the cohorts of patients targeted through this service is those who experience stress, anxiety or depression as a result of having a long term condition or disability.

As part of the monthly reporting requirements the provider is expected to report on the numbers of patients with a long term condition or disability that are referred to the service and are accessing the service.

### 5. Engagement/consultation

What engagement is planned or has already been done to support this project?

Engagement activity	With who? <i>e.g. protected characteristic/group/community</i>	Date
Patient case studies	The provider routinely completes patient case studies that detail a patients' experience of using the service, how the intervention has supported them, and what the impact of accessing the Primary Care Counselling service has been for them.	Ongoing
Patient Outcome measures	Patients accessing the service complete 3 outcome measures on each occasion that they access the service	Ongoing
GPs	Prior to the start of the service the CCG engaged extensively with GPs on the design and delivery of the service.	

*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...*

## Equality Analysis Form

### 5. Engagement/consultation

What engagement is planned or has already been done to support this project?

Engagement activity	With who? <i>e.g. protected characteristic/group/community</i>	Date
---------------------	---	------

*(If a supporting document is available, please provide it or a link to the document)*

Following the engagement with GPs on the design of the service, it was felt that GPs had represented the views of patients sufficiently for the service to commence. Feedback is now reviewed to ensure the service is fully meeting the needs of patients.

### 6. Mitigations and changes

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

### 7. Is further work required to complete this EA?

*Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)*

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

### 8. Development of the Equality Analysis

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

## Equality Analysis Form

Version	Change and Rationale	Version Date
<i>e.g. Version 0.1</i>	<i>The impact on wheelchair users identified additional blue badge spaces are required on site to improve access for this group.</i>	<i>26 September 2017</i>

### 9. Preparation for Sign off

	Please Tick
1) Send the completed Equality Analysis with your documentation to <a href="mailto:Equality@ardengemcsu.nhs.uk">Equality@ardengemcsu.nhs.uk</a> and <a href="mailto:David.king17@nhs.net">David.king17@nhs.net</a> for feedback prior to Executive Director (ED) sign-off.	
2) Make arrangements to have the EA put on the appropriate programme board agenda	
3) Use the Action / version section to record the changes you are intending to make to the document and the timescales for completion.	

### 10. Final Sign off

The Completed EA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process.

The completed form should also be sent to PMO so that the CCG can maintain an up to date log of all EAs.

**Version approved:**

#### Designated People

Project officer\* (Senior Officer responsible including action plan)

Name: R Khular

Date: 16/8/18

Equality & Inclusion Review and Quality Assurance

Name: David King

Date: 16/08/2018

Executive Director Review:

Name:

Date:

Name of **Approval Board** (e.g. Commissioning Committee; Governing Body; Primary

## Equality Analysis Form

Care Commissioning Committee) at which the EA was agreed at:

Approval Board:

Approval Board Ref Number:

Chair:

Date:

Comments:

Actions from the Approval Board to complete:

Review date for action plan (section 7):

## BOARD ASSURANCE FRAMEWORK NOTES

(Please **DELETE** before submission)

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

Strategic Aims	Strategic Objectives
1. Improving the quality and safety of the services we commission	a. <u>Ensure on-going safety and performance in the system</u> 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. <u>Improve and develop primary care in Wolverhampton</u> – Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this b. <u>Deliver new models of care that support care closer to home and improve management of Long Term Conditions</u> 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. <u>Proactively drive our contribution to the Black Country STP</u> Play a leading role in the development and delivery of the Black Country STP to support material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country footprint. b. <u>Greater integration of health and social care services across Wolverhampton</u> Work with partners across the City to support the development and delivery of the emerging vision for transformation; including exploring the potential for an ‘Accountable Care System.’ c. <u>Continue to meet our Statutory Duties and responsibilities</u> Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework

## Equality Analysis Form

	<p>d. <u>Deliver improvements in the infrastructure for health and care across Wolverhampton</u> The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.</p>
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**Data Protection Impact Assessment (DPIA)**

Key Information – please be as comprehensive as possible (Section A)	
<b>Name of Project</b>	QOF+ 2018/19
<b>Project Reference Number</b>	
<b>Project Lead Name</b>	Sarah Southall
<b>Project Lead Title</b>	Head of Primary Care
<b>Project Lead Contact Number &amp; Email</b>	<a href="mailto:Sarah.southall@nhs.net">Sarah.southall@nhs.net</a> (01902 441784 or 07880 584563)
<b>Date completed</b>	10 May 2018
<b>Information Asset Owner</b> <i>The senior person(s) responsible for the system/software/process</i>	CCG Director of Operations (includes respective teams within the CCG) and individual GP Practices participating in the scheme.
<b>Description of project:</b>	<p>In order to support the continued improvement and development of Primary Care the purpose of this scheme is to build on the benefits of the national Quality Outcomes Scheme (QOF).</p> <p>QOF awards practices funding in response to them managing chronic disease, public health concerns and goes some way to implementing preventative measures such as regular blood pressure checks. QOF+ seeks to take this work further with a greater emphasis on local priorities &amp; the importance of developing the prevention agenda further as follows:-</p> <ul style="list-style-type: none"> <li>• Diabetes (pre-diabetic)</li> <li>• Alcohol</li> <li>• Obesity</li> </ul> <p>The CCG is committed to continued investment in Primary Care as part of the implementation of the Primary Care Strategy (2016). The vision for practices as providers of healthcare in Wolverhampton is to provide 'cradle to grave prevention' ensuring patients have access to high quality care, proactively identifying those at risk of ill health.</p>

	A copy of the respective scheme is attached for reference.
<b>Will the project involve any data from which individuals could be identified (including pseudonymised data)?</b>	<u>Yes</u>

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

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

Email: [Kelly.Huckvale@ardengemcsu.nhs.uk](mailto:Kelly.Huckvale@ardengemcsu.nhs.uk)

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

**Sign Off / Approval (Section A only)**

Title	Name	Signature	Date
<b>Project Lead</b>			
<b>IG Officer</b>			
<b>IG Officer Comments</b>			
<b>Programme Board</b>			
<b>Programme Board Chair</b>			

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



**PLEASE CONTACT THE IG OFFICER TO COMPLETE SECTION B TOGETHER.**

**Section B**

Screening Questions	YES or NO
Will the project involve the collection of <b>new</b> information about individuals?	YES
Will the project compel individuals to provide information about themselves?	YES
Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	YES
Are you using information about individuals for a new purpose or in a new way that is different from any existing use?	YES
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.	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
Is the information to be used about individuals' health and/or social wellbeing?	YES
Will the project require you to contact individuals in ways which they may find intrusive?	NO

**If the answer to ALL the questions in section B is "NO", please return Section A and B to the IG Officer and do not complete Section C of the Data Protection Impact Assessment.**

**Sign Off / Approval (Section A & B only)**

Title	Name	Signature	Date
<b>Project Lead</b>			
<b>IG Officer</b>			
<b>IG Officer Comments</b>			
<b>Programme Board</b>			
<b>Programme Board Chair</b>			

If any of the screening questions in Section B have been answered “YES” then please continue with Section C of the Data Protection Impact Assessment.

### Section C

#### Key Contacts

Key Stakeholder Names & Roles:	Wolverhampton CCG GP Practices 42 (potentially)  Diabetes Prevention Programme Provider
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#### Use of personal information

<b>Description of data:</b>	<p><i>Information within existing clinical systems ie name, address, date of birth, NHS number, gender, Read Coded clinical data, ethnicity. Demographic data via NHAIS extracts</i></p> <p><i>Data Pseudonymised at source using the Nottingham Open Pseudonymiser. A common salt is applied in Wolverhampton</i></p> <p><i>The CCG will aggregate data via use of Graphnet (Andrew Woods). All data used will be Pseudonymised. GP Practices will have access to patient identifiers on outputs via role based and active directory.security.</i></p>
<b>What is the justification for the inclusion of identifiable data rather than using de-identified/anonymised data?</b>	For the provision of direct care.
<b>Will the information be new information as opposed to using existing information in different ways?</b>	Existing information used in different ways should patients be captured on the diabetes, alcohol or obesity register(s).

<p><b>What is the legal basis for the processing of identifiable data?</b></p> <p><b>If consent, when and how will this be obtained and recorded?</b></p>	<p>Provision of direct patient care at practice level.</p> <p>Extracts created by Graphnet. Graphnet is a Framework included company the CCG uses for data extraction and supply of an Integrated Patient Record solution (CareCentric). The CCG also uses the company for specific Business Intelligence work to support CCG wide initiatives linked to Direct Patient Care and service redesign.</p> <p>Graphnet automatically removes records based on expressed dissent for record sharing where recorded in the Patients primary care record.</p>
<p><b>Who will be able to access identifiable data?</b></p>	<p>Practice personnel who have access to the clinical system &amp; specialist providers whom the patient(s) may have been referred to.</p> <p>Access to extracted data is controlled via SQL Server security. Only approved Graphnet personnel have access at database level. Any generated reports that require patient identifiers will have had to go through the CCGs internal IG processes for approval before any development work to produce the reports is done.</p>
<p><b>Will the data be linked with any other data collections?</b></p>	<p>No</p>
<p><b>How will this linkage be achieved?</b></p>	<p>NA</p>
<p><b>Is there a legal basis for these linkages?</b></p>	<p>NA</p>

<p><b>What security measures will be used to transfer the data?</b></p>	<p>Smartcard Access at practice level to clinical systems.</p> <p>Smartcard access for TPP</p> <p>Files from EMIS systems transferred using SSL and AES encryption. sFTP protocols are applied and exist within NHS.Net.</p> <p>Any data made available to practices will be controlled within the CCGs network using Active Directory permissions</p>
<p><b>What confidentiality and security measures will be used to store the data?</b></p>	<p>N3 connection for clinical systems.</p> <p>Data stored on servers managed under SLA at Royal Wolverhampton (RWT) NHS Trust. Server access controlled by RWT IT staff with approval via Wolverhampton CCG ICT.</p>
<p><b>How long will the data be retained in identifiable form? And how will it be de-identified? Or destroyed?</b></p>	<p>Within the patients clinical record which will be retained in line with the NHS Records Management Code of Practice.</p>
<p><b>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?</b></p>	<p>User access controls within Clinical System at practice level, used in accordance with respective practice NHS IG Toolkit(s).</p> <p><i>Governance arrangements are detailed in the Contract the CCG has with Graphnet.</i></p> <p><i>Although Graphnet is a third party, data used resides solely within the secure IT networks of Wolverhampton. Outputs will be aggregate using pseudonymised datasets, where data is made available via secure web based portals the use of output will be governed by existing GP practice IG guidelines and requirements.</i></p>

<p><b>Are procedures in place to provide individuals access to records on request under the subject access provisions of the General Data Protection Regulations?</b></p> <p><b>Is there functionality to respect objections/ withdrawals of consent?</b></p>	<p>GP as Data Controller will manage requests for information in line with existing arrangements for patient clinical records.</p>
<p><b>Are there any plans to allow the information to be used elsewhere either in the CCG, wider NHS or by a third party?</b></p>	<p>No</p>

<p><b>Describe the information flows</b></p> <p>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.</p>	
<p><b>Does any data flow in identifiable form? If so, from where, and to where?</b></p>	<p>Demographics – NHAIS</p> <p>Primary Care - EMIS &amp; TPP System One</p> <p>All are daily data extracts, standard extracts provided by system suppliers</p>
<p><b>Media used for data flow?</b></p> <p><b>(e.g. email, fax, post, courier, other – please specify all that will be used)</b></p>	<p>Via encrypted text files within NHS Networks</p>

<p><b>Consultation requirements</b></p> <p>Part of any project is consultation with stakeholders and other parties.</p> <p>In addition to those indicated “Key information, above”, please list other groups or individuals</p>
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with whom consultation should take place in relation to the use of person identifiable information.

It is the project's responsibility to ensure consultations take place, but IG will advise and guide on any outcomes from such consultations.

Refer to QOF+ Framework

**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.

<b>Risk Description</b>  (to individuals, to the CCG or to wider compliance)	<b>Proposed Risk solution</b> (Mitigation)	<b>Is the risk reduced, transferred, or accepted? Please specify.</b>	<b>Further detail if required</b>


**Further information**

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

Once Section A, B and C has been completed, please send the 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.

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

Title	Name	Signature	Date
<b>Project Lead</b>	Sarah Southall	Sarah Southall	16/05/18
<b>IG Officer</b>	Kelly Huckvale	Kelly Huckvale	10/08/18
<b>IG decision</b>  <b>(delete as applicable)</b>	<p>1. No action is required by IG excepting the logging of the Screening Questions for recording purposes.</p> <p><b>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.</b></p> <p>3. The questionnaire shows significant use of personal information requiring IG involvement via a report and/or involvement in the project to ensure compliance.</p>		
<b>IG Officer Comments:</b>  Reviewed and discussed with CCG lead for Graphnet. DPIA may need to be revisited if any processes change, however satisfied in the meantime and this is approved by IG.			
<b>Programme Board</b>			
<b>Programme Board Chair</b>			



**WOLVERHAMPTON CCG**
**PRIMARY CARE COMMISSIONING COMMITTEE**  
**4 SEPTEMBER 2018**

<b>TITLE OF REPORT:</b>	Amended Delegation Agreement
<b>AUTHOR(s) OF REPORT:</b>	Peter McKenzie, Corporate Operations Manager
<b>MANAGEMENT LEAD:</b>	Peter McKenzie, Corporate Operations Manager
<b>PURPOSE OF REPORT:</b>	To advise the Committee that NHS England have sent the CCG a revised version of the Delegation Agreement between themselves and the CCG which has been updated to take account changes in Data Protection Legislation.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>• The discharge of the powers delegated to the CCG by NHS England in respect of Primary Medical Services is supported by a Delegation Agreement</li> <li>• The Delegation Agreement has been varied by NHS England to take into account changes in Data Protection Legislation including the Data Protection Act 2018 and the General Data Protection Regulation (GDPR)</li> <li>• NHS England have requested that the CCG return a signed copy of the agreement by 21 September 2018.</li> </ul>
<b>RECOMMENDATION:</b>	That the Committee notes the changes to the Delegation Agreement.
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	
3. System effectiveness delivered within our financial envelope	<u>Continue to meet our Statutory Duties and responsibilities</u> The Delegation agreement supports the lawful discharge of the powers delegated to the CCG by NHS England. The changes ensure that the agreement is compliant with Data Protection legislation.

## **1. BACKGROUND AND CURRENT SITUATION**

- 1.1. NHS England has delegated responsibilities to the CCG in respect of the commissioning of Primary Medical Services. This delegation is set out in a legal delegation agreement signed by both the CCG and NHS England.
- 1.2. Following Changes to UK Data Protection Legislation, NHS England have made a number of technical changes to the delegation agreement to ensure it remains compliant with the relevant legislation.

## **2. CHANGES TO DELEGATION AGREEMENT**

- 2.1. NHS England have written to the CCG to advise them that a national variation needs to be made to the Delegation agreement to reflect the changes to Data Protection legislation, most significantly the GDPR.
- 2.2. The changes to the agreement ensure that it references the correct legislation and uses the appropriate terminology from the GDPR and Data Protection Act 2018. A copy of the variation agreement, which details the specific changes, is appended to this report.
- 2.3. A signed copy of the agreement will be returned to NHS England by the 21 September 2018 deadline required.

## **3. CLINICAL VIEW**

- 3.1. Not applicable.

## **4. PATIENT AND PUBLIC VIEW**

- 4.1. Not applicable.

## **5. KEY RISKS AND MITIGATIONS**

- 5.1. There are no specific risks associated with this report.

## **6. IMPACT ASSESSMENT**

### ***Financial and Resource Implications***

- 6.1. There are no financial or resource implications arising from this report.

***Quality and Safety Implications***

6.2. There are no Quality and Safety Implications arising from this report.

***Equality Implications***

6.3. There are no legal implications arising from this report.

***Legal and Policy Implications***

6.4. The delegation agreement provides the legal framework for the CCG to exercise the powers delegated to it by NHS England. The proposed variation is line with the provisions for varying the agreement and ensures the agreement remains compliant with Data Protection Legislation.

***Other Implications***

6.5. There are no other implications arising from this report.

<b>Name</b>	Peter McKenzie
<b>Job Title</b>	Corporate Operations Manager
<b>Date:</b>	August 2018

**ATTACHED:**

Variation to Delegation Agreement

**RELEVANT BACKGROUND PAPERS**

Delegation Agreement between CCG and NHS England

### 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.**

	<b>Details/ Name</b>	<b>Date</b>
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	Report Author	28/08/18
Other Implications (Medicines management, estates, HR, IM&T etc.)	N/a	
Any relevant data requirements discussed with CSU Business Intelligence	N/a	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Peter McKenzie</b>	<b>28/08/18</b>

## BOARD ASSURANCE FRAMEWORK NOTES

(Please **DELETE** before submission)

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

Strategic Aims	Strategic Objectives
1. Improving the quality and safety of the services we commission	<p>a. <u>Ensure on-going safety and performance in the system</u> 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</p>
2. Reducing health inequalities in Wolverhampton	<p>a. <u>Improve and develop primary care in Wolverhampton</u> – 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</p> <p>b. <u>Deliver new models of care that support care closer to home and improve management of Long Term Conditions</u> 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</p>
3. System effectiveness delivered within our financial envelope	<p>a. <u>Proactively drive our contribution to the Black Country STP</u> 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.</p> <p>b. <u>Greater integration of health and social care services across Wolverhampton</u> 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.’</p> <p>c. <u>Continue to meet our Statutory Duties and responsibilities</u> Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework</p> <p>d. <u>Deliver improvements in the infrastructure for health and care across Wolverhampton</u> The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.</p>



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## Variation Agreement

**Variation Reference:** GDPR

**Proposed by:** NHS England

**Date of Proposal:** 21 August 2018

**Date of Variation Agreement:** 21 August 2018

Capitalised words and phrases in this Variation Agreement have the meanings given to them in the Agreement referred to above.

1. The Parties have agreed the [National] Variation summarised below:

- 10.2 replace 'govern' with 'describe'
- 10.3 add 'Schedule 4'
- Schedule 1: Definitions and interpretation:
- Replace references to the Data Protection Act (DPA) with GDPR (the General Data Protection Regulation).
  - Replace reference to the DPA, the EU Data Protection Directive 95/46/EC with reference to GDPR, the Data Protection Act 2018
  - Replace 'Sensitive Personal Data' with 'Special Category Personal Data'
- Schedule 4: Further Information Sharing Provisions
- 4.2
  - 6.2 Replace 'Sensitive Personal Data' with 'Special Category Personal Data'
  - 7.1 Replace DPA with GDPR
  - 7.1.2 Amend to: 'amendment of respective privacy notices and policies to reflect the processing of data carried out further to this agreement, including covering the requirements of articles 13 and 14 GDPR and providing these (or making them available to) Data Subjects;'
  - 7.2 Amend to: 'Each Party shall procure that its notification to the Information Commissioner's Office and record of processing maintained for the purposes of Article 30 GDPR reflects the flows of information under this Agreement.'
  - 8.1, 8.3, 9.2, 9.3, 9.4.2, 9.4.3, 9.5.2: Replace 'Sensitive Personal Data' with 'Special Category Personal Data'
  - 8.2 Replace 'DPA' with 'Data Protection Act 2018'
  - 9.3.2 Amend to: 'in respect of the Relevant Information it shall promptly (and within 48 hours) notify the other Party. The Parties shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Information Law.'
  - 9.4.1 Amend to: 'process the Personal Data (including Special Category Personal Data) only in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;
  - 9.4.4 Amend to: 'process the Personal Data in accordance with the requirements of Information Law and in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) GDPR.'
  - 9.5 – 9.9 Amend to:  
9.5 Each Party shall act generally in accordance with Information Law

requirements, and in particular shall implement, maintain and keep under review appropriate technical and organisational measures to ensure and to be able to demonstrate that the processing of Personal Data is undertaken in accordance with Information Law, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

9.5.1 Take account of the nature, scope, context and purposes of processing as well as the risks of varying likelihood and severity for the rights and freedoms of Data Subjects; and

9.5.2 Be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data (and Special Category Personal Data) and having regard to the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

9.6 In particular, each Party shall:

9.6.1 ensure that only Personnel authorised under this Agreement have access to the Personal Data (and Special Category Personal Data);

9.6.2 ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

9.6.3 obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;

9.6.4 permit the other Party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

9.6.5 if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

9.7 Specific requirements as to information security set out in the Personal Data Agreement(s).



9.8 Each Party shall use best endeavours to achieve and adhere to the requirements of the NHS Information Governance Toolkit, particularly in relation to Confidentiality and Data Protection Assurance, Information Security Assurance and Clinical Information Assurance.

9.9 The Parties' Single Points of Contact ("**SPoC**") set out in paragraph 14 (*Governance: Single Points of Contact*) below will be the persons who, in the first instance, will have oversight of third party security measures.

- 10.4 Add 'and held'
- 11.1 Add 'and to comply with the principles set out in Article 5(1)(c) and (d) GDPR.'
- 12.4 Replace 'the fifth Data Protection Principle' with 'requirements of 5 (1) (e) GDPR'
- 12.1 Add 'as well as any other purported exercise of a Data Subject's rights under Information Law or complaint to or investigation undertaken by the Information Commissioner.'
- Template Personal Data Agreement – changes to formatting, replace DPA Schedule 2 condition/s with 'GDPR Article 6 legitimising conditions' and replace 'DPA Schedule 3 condition/s' with GDPR Article 9 legitimising conditions'

2. The National Variation is reflected in the attached Schedule and the Parties agree that the Agreement is varied accordingly.

3. The Variation takes effect on 21 August 2018

**IN WITNESS OF WHICH the Parties have signed this Variation Agreement on the date(s) shown below**

**Signed by**

**NHS England**

**Paul Baumann for and on behalf of NHS England**



**Signed by**

**[**

**] Clinical Commissioning Group**

**[**

**] (for and on behalf of [**

**])**

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