NHS Rotherham CCG Governing Body – 5 April 2017

CHIEF OFFICER'S REPORT

Lead Director:	**Chris Edwards**	Lead Officer:	n/a
Job Title:	**CCG Chief Officer**	Job Title:	n/a

Purpose
This report informs the Governing Body about national/local developments in the past month.

System Risk Reserve

A letter has been received from Paul Baumann, the Chief Finance Officer at NHS England requesting that CCG's release this year's non-recurrent reserves. Members will recall this as the 1% surplus reported by the Chief Finance Officer as part of the CCG's financial obligations. The effect of this release is intended to increase the surplus of the whole of the commissioning sector by around £800m and help offset the provider deficit position to secure financial balance for the NHS overall. For Rotherham this is around £4m. ***(Appendix 1)***

NHS England Letter – Support to CCGs

This letter from Dr David Black offers support from NHS England to CCG's in updating policies or publishing new commissioning guidance that will involve managing or restricting access to elective services. Assistance is offered with communications and messaging so that patients, clinicians, the public, media and stakeholders best understand our plans, how they will work in practice and the rationale for the change. The CCG will be required to give notice of such changes to NHSE at least 4 weeks before updating policy or publishing guidance to ensure consistent messages are conveyed when making difficult decisions in trying to best manage resources for the benefit of all patients.
(Appendix 2)

NHS Protect Future Arrangements

This letter from Sue Frith, Managing Director of NHS Protect details changes in NHS Protect's functions from April 2017 and outlines their plans for security management work going forward. ***(Appendix 3)***

Information Governance Toolkit

On completion of the 2016/17 Information Governance action plan Rotherham CCG has attained an overall IG Toolkit score of 76%, maintaining the score achieved for 2015/16, and the status of "satisfactory", which reflects that a score of 2 or greater has been achieved across all of the toolkit controls. The IG Toolkit score was approved by Audit & Quality Assurance Committee on 17th March and has subsequently been submitted to NHS England.

Consultation analysis for Hyper Acute Stroke Services and Children's Surgery and Anaesthesia Services

For Children's Surgery and Anaesthesia Services, three options were developed and put forward for consideration, including a preferred option. For hyper acute stroke services, one option was developed and put forward for consideration.

The consultation, to get the views of patients, public and others with an interest in these issues, was launched on 3 October 2016 and ran until 14 February 2017. The original closing date for the consultation of 20 January 2017 was extended to take account of the Christmas period and to allow as many people as possible to take part in the consultation. The next item details the outcome for Children's Surgery Anaesthesia Services consultation. The CCG is awaiting confirmation of the outcome from the Hyper Acute Stroke Services consultation which will be reported once received.

Outcome from Consultation on Children's Surgery Anaesthesia Services

Members will recall previous updates on this work being undertaken as part of the Working Together Programme. The consultation has now concluded and over a thousand responses were received on the proposals to change children's surgery and anaesthesia services across South and Mid Yorkshire, Bassetlaw and North Derbyshire. These responses have now been independently analysed.

The responses received were of mixed sentiment depending on location and interest. Broadly, those who agreed with the proposal to change children's surgery and anaesthesia services did so because they felt the proposals offered a better quality of care for children with fairer and more equal access to services. There were also responses to say that people trusted in the NHS locally to make the best decisions on their behalf.

Those who disagreed did so because they felt the proposals would reduce access to care closer to home, the impact on patient outcomes and patient safety and some were sceptical about the reasons for change. A full analysis of all the findings and all issues are within the report which can be viewed along with the consultation at http://bit.ly/2nLclfC.

As with any public consultation, the responses received cannot be seen as representative of the population as a whole but instead representative of interested parties who were made aware of the consultation and were motivated to respond.

Using the feedback from all partners, public and patients, full business cases, which will include the independent analysis of the responses to the consultations, will be considered by the Joint Committee of Clinical Commissioning Groups (JC CCG) at its meeting on 24 May where partners are expected to make a decision about the future of the two services.

Public Sector Equality Duty Update

Each year we publish on our website the CCG's Public Sector Equality Duty (PSED) report. The attached annual report describes how we are meeting our equality objectives and other equality and diversity work undertaken within the CCG. Although not required as part of our Public Sector duties under the Equality Action 2010 it is a mark of best practice. (***Appendix 4***)

The Rotherham Foundation Trust CQC Report

On the 2nd March the CQC published the report of their follow up visit to TRFT from Sept/Oct 2016. The full report can be seen here http://www.cqc.org.uk/sites/default/files/new_reports/AAAF9040.pdf. I have invited the Chief Officer from Rotherham Hospital to our Governing Body in May to talk to us about the report.

NHS England Letter – Easter Preparedness & Responsiveness

A letter has been received from NHS England and NHS Improvement outlining the required reporting over the Easter holiday period. The letter is attached. (***Appendix 5***).

Rotherham CCG Annual General Meeting

The Rotherham CCG Annual General Meeting will be held on Wednesday 5th July 2017 at Carlton Park Hotel, Rotherham, S60 2BG. This year it will be precluded by the Rotherham Health & Wellbeing Board from 9-11am with the AGM expected to commence around 11.30am. This will be followed by Public Governing Body commencing at 2.00pm. The exact timings are still to be confirmed but Members are requested to hold the day in diaries.

Communications Update

- The Rotherham Advertiser has published coverage of Rotherham weight management services, including the CCG's approach, following the council's recent decision to decommission the Rotherham Institute for Obesity service.
- The Sunday Politics show aired a story in March on the implementation of clinical thresholds, based on obesity and smoking levels, by CCGs across Yorkshire and the Humber. Rotherham was mentioned in a graphic showing obesity levels in the Borough.
- During the first few months of 2017, the CCG has worked with the Rotherham Advertiser on a health and wellbeing feature, which includes topical health information and advice. The next edition will be published on Friday 14th April 2017.
- A number of senior officers and the safeguarding GP lead recently took part in media training. The training focused on radio interview techniques, key messages and mock interviews, using real life topical subjects.
- Communications activity is underway for the Easter bank holiday weekend. Messages are focused on directing people to the most appropriate service for their illness/condition and on what to do for primary care advice when GP practices are closed.

App 1

To: CCG Chief Financial Officers

CC: CCG Audit Chairs

Gateway Reference: 06572

15th March 2017

System Risk Reserve

During the pre-planning stage for 2016/17, NHS England, NHS Improvement and the Department of Health identified significant financial risk in the likely combined plans for the NHS for 2016/17, especially in the provider sector. Therefore we asked commissioners to set aside the 1% share of their allocations that would normally be spent non-recurrently to act as a system risk reserve. I am aware that this placed greater pressure on the financial position for many CCGs in 2016/17, which was reflected in the higher levels of efficiency savings included in plans.

As expected, provider financial position is such that we now require each commissioning organisation to release the full amount of the 1% non-recurrent reserve to its bottom line. The aggregate effect of this will be to increase the surplus across the whole of the commissioning sector by around £800m, which will help to offset the provider deficit position and help to secure a balanced position for the NHS overall.

This is an essential element of the risk management strategy agreed across the health sector for 2016/17, and it is vital that we secure the full expected benefit from the release of the risk reserve. Auditors are aware of the requirement to release the risk reserve in this way, so this should not result in adverse audit reports for any organisations.

Commissioners are asked to effect the release of the reserve at month 12, which we expect to be the only change between the forecast for month 11 and the actual outturn for the year. With this in mind, I have asked the regional finance directors to contact each CCG to confirm our expectations for the year-end position. CCGs are reminded that the 16/17 outturn before release of the risk reserve will be used for performance assessment purposes, including associated measures such as IAF and Quality Premium.

Guidance regarding cash management has been posted on Sharepoint, explaining that an amount equivalent to the 1% reserve has been removed from the Maximum Cash Drawdown, and therefore the cash will not be available for CCGs to deploy.

I would like to express my gratitude for your support in successfully executing this key element of the financial risk management strategy for 2016/17.

Yours Sincerely

Paul Baumann
Chief Financial Officer
NHS England

App 2

Our Ref: DB/KD/03/03/2017

Your Ref:
Email: david.black4@nhs.net
Direct Dial 0113 82 53368
Date: 15 March 2017

Yorkshire & the Humber
Oak House
Moorhead Way
Bramley
Rotherham
South Yorkshire
S66 1YY

Chris Edwards and Dr Julie Kitlowski
Rotherham CCG

Dear Chris and Julie,

Managing access to elective services – Severity criteria, pre-referral pathway requirements and lifestyle thresholds – Support to CCGs

The purpose of this letter is to ask that you inform NHS England at least 4 weeks in advance of updating policies or publishing new commissioning guidance to manage or restrict access to elective services by setting or changing; severity criteria, pre-referral pathway requirements or lifestyle thresholds.

This will enable NHS England to support and assure your work, brief regional and national colleagues in advance and ensure that the CCG communications are supported by NHS England and include consistent messages. We have significant experience in working with CCGs on these policies and our involvement is intended to assist you in making best use of the resources available to optimise outcomes for patients and the population that you serve. We can also assist you with communications and messaging so that patients, clinicians, the public, the media and stakeholders can best understand what you are planning to do, how it will work and why it needs to be done. We want to help you to be well prepared.

The context is of recent media interest in the introduction by CCGs of restrictions to elective services, criticism by some organisations such as the Royal College of Surgeons, political interest, a House of Commons debate and requests for information from the NHS England central communications team (who in many cases have not had prior notification, because we have not had prior notification). In a recent letter to DCOs and NHS England Medical Directors, Carol Stubley and Mike Prentice state that this 'puts us all on the back foot as opposed to working with CCGs proactively to understand their plans before they get into the public domain'.

We are very supportive of your work to best manage resources for the benefit of all patients and understand that this may mean that difficult decisions need to be made. NHS England can support you to ensure that any plans to change access to services have been appropriately developed; with sufficient clinical and patient/public involvement and that the messages released to the wider public are clear and consistent and take account of NHS England guidance.

We expect that many CCGs will be in the process of developing similar schemes and initiatives to deliver plans for 2017-19. This is something we would encourage, where

plans are well developed and clinically validated. All such proposals will need to be reviewed whether developed as part of your 2017/18 plans or as in year initiatives.

Would you please inform us when/if your CCG is planning to change access thresholds and we can then work with you to assure and review the work. This will include support from NHS England communications. Please inform us at least 4 weeks before the plans enter the public domain.

Attached to this communication is a CCG self-assessment checklist template for your use which outlines key questions and considerations and we would ask you to populate this as part of the policy / pathway development. This should assist you in your work and the template should also be returned to us prior to any papers being presented to your Governing Body in public. This should be 4 weeks in advance of publication.

We would encourage collaboration between CCGs and whole STP approaches where possible. This will deliver consistency across larger populations and facilitate understanding and implementation.

Should you have any questions or comments regarding this letter could I please ask you to contact Kate Gatherer in the first instance on kgatherer@nhs.net. Please return completed templates and plans to Kate Gatherer and copy to the locality team for your area. We would be pleased to receive one completed template for more than one CCG, where the work has been completed jointly and the responses are the same for all the CCGs named.

Yours sincerely

Dr DAVID BLACK, Medical Director (joint)
NHS England, Yorkshire & the Humber
& Deputy National Clinical Director,
Specialised Commissioning

Jointly with:

Alison Knowles, Locality Director – NHS England North, Yorkshire & the Humber

Julie Warren, Locality Director – NHS England North, Yorkshire & the Humber

Brian Hughes, Locality Director – NHS England North, Yorkshire & the Humber

CCG Clinical Thresholds for Elective Interventions

Rationale

This self assessment checklist and return will enable NHS England to support and assure your work, brief regional and national colleagues in advance, and ensure that the CCG communications are supported by NHS England and are consistent. We have significant experience in working with CCGs on these policies and our involvement is intended to assist you in making best use of the resources available to optimise outcomes for patients and the population that you serve. We can also assist you with communications and messaging so that patients, clinicians, the public, the media and stakeholders can best understand what you are planning to do, how it will work and why it needs to be done. We want to help you to be well prepared

Instructions for the CCG self assessment checklist exercise

1. Ensure the CCG name is included on the CCG Summary page.
2. All sections need to be completed.
3. Please attach relevant documentation to the form. Please also enter a brief summary in the 'comments' column.
4. Additional documentation to support this template may be submitted along via email.

Submission deadline

Ensure that the documentation is returned to NHS England at least 4 weeks in advance of their publication date to allow sufficient time for our review, to provide support and complete assurance of the work.

CCG Self-Assessment Summary

Region:	**North**
DCO:	**Yorkshire & Humber**
CCG:	
Sign off:	*(Please provide name and contact details)*

Please summarise your self-assessment for each of the areas outlined in subsequent tabs:

Area	Assessment Level	Summary of actions being taken if not fully confident

CCG Clinical Thresholds, pathway requirements and lifestyle requirements for Elective Interventions

Criteria for Assessment	
Examination/Analysis of clinical evidence base/guidance	**NICE Guidance and evidence based approaches to severity criteria and pathway requirements**
	Have you investigated and taken account of the latest NICE guidance relevant to the proposed clinical thresholds and criteria?
	Have national policies/guidance and best practice/experience from elsewhere informed this work?
	Have you reviewed the relevant NHS RightCare information to inform the case for change?
	Severity Criteria and pre-referral pathway requirements
	Are the clinical criteria clear and easy for clinicians and patients to understand?
	Will patients be advised to seek review by their GP or other appropriate health care professional should their condition change during the period for lifestyle changes? Is it clear how patients are advised?
	Have plans been put in place to ensure that patients' clinicians make clinically appropriate arrangements for any necessary review whilst patients are on the pathway for elective care.
	Is it clear that patients already on the waiting list, who have an expectation of treatment, will not be subject to retrospective application of the new policy or pathway approach?
	Exceptions
	Have clinical exceptions been considered and included as part of the policy or process?
	Do the exception criteria ensure that vulnerable patients are not disadvantaged? (Note that patients with mental illness, learning disability and cognitive impairment must be clinically assessed to ensure that where they may benefit from opportunities to improve their lifestyle, these are offered).
	Is there a process to consider requests for individual patients with exceptional clinical circumstances?
	Lifestyle Restrictions
	Are these consistent across all the interventions and clinical areas covered?
	Are the lifestyle requirements clearly laid out and understandable by clinicians and patients?
	Have you ensured that the criteria are clear regarding ascertainment and recording of smoking status and BMI (including application of waist circumference where patients maybe have a high BMI due to muscle bulk)?
	Is advice available to patients and clinicians on the support available for lifestyle changes on the CCG website and in a leaflet or other suitable format (this information should be clear where there is limited provision of state provided support)?
Clinical Involvement and governance	**Planning and Involvement**
	Has the Local Authority(ies) been informed of this work?
	Are the pre-referral pathway requirements available and access / referral routes clear?
	Have primary care and the relevant secondary care clinicians been involved in developing the policy?
	Have clinicians been advised how to provide ongoing input, for example to highlight changes that may be needed in the policy or pathway?
	Have the local LMC been informed?
	Have GPs and other referrers been clearly advised of start dates and the expectations placed upon them?
	Has an equality impact assessment been completed?
	Have the proposals been developed and approved through the CCGs governance processes and Council of Representatives consulted?
Patient and Public Involvement	How have patients and the wider public been involved in this development?
	How will the policy/process/ pathway be clearly communicated to patients and the wider public? What mechanisms are in place to monitor media/public interest?
	Is the extent of engagement and consultation needed proportionate to the changes proposed and consistent with legal requirements?
Implementation	Are there plans to monitor and evaluate intervention?
	Have contract monitoring processes been put in place?
	Have all providers received clear communication to understand that interventions must not be provided outside the requirements of the policy statement?
NHS England Involvement/ STPs / Media Messages	Has NHS England been informed at least 4 weeks prior to proposals entering the public domain?
	Has the CCG communications lead worked with NHS England communications to ensure the messages are clearly and consistently communicated and enquiries managed appropriately?
	Has a stakeholder communications plan been drafted that takes account of Health and Wellbeing Boards, local councillors, MPs, and patient groups.
	Has a senior clinical spokesperson been identified in anticipation of media and other stakeholder interest in the proposals.
	Has the STP and STP partners been briefed on the proposals?
	Have the proposals been included in STP plans?
Financial and service delivery benefits and impacts	Has the financial benefits / impact been assessed?
	Has the financial impact on providers been considered? Does the contract(s) need to be amended?
	Have the proposals been reflected in QIPP plans and operational plans, and any effect on RTT modelled?

Yes / No	CCG Commentary	Evidence to support statements (e.g. CCG documents attached)	Risks identified by the CCG	NHS England assessment, advice to the CCG and further information required	Timescales and other comments - NHS England to complete

App 3

NHS Protect

Correspondence by email only

4th Floor, Skipton House
80 London Road
London
SE1 6LH

Tel: 020 7895 4500, Fax: 020 7895 4600
generalenquiries@nhsprotect.gsi.gov.uk
www.nhsprotect.nhs.uk

To: All security management directors
NHS bodies in England

23 March 2017

Dear colleague

I am writing to you to thank you for the support and assistance you have given to the NHS security management and tackling violence agenda in your role as security management director. Your support for the work that NHS Protect and its predecessor organisation, the NHS Security Management Service, have pursued during the last 14 years has been invaluable.

Much has been achieved during this time; with your support, national initiatives have been successfully developed and progressed from the centre, and these initiatives have assisted NHS organisations locally in their security management work.

I also wanted to update you on plans for the creation of a new special health authority dedicated to counter fraud work. The new organisation will be called the NHS Counter Fraud Authority (NHSCFA). It will exist in shadow form from 1 April 2017 and on an interim basis I will be taking up the post of chief executive officer for the new authority. The transfer of staff and the creation of the NHSCFA will take place during the first quarter of 2017-18, with the new organisation being launched on 3 July 2017. At this point NHS Protect will cease to exist.

You will be aware that the services provided by NHS Protect's Local Support and Development and Training teams will cease on 31 March 2017. The remaining NHS Protect security management functions will also be decommissioned at this time as part of the transition leading to the establishment of the NHSCFA. Details of this are set out in the appendix to this letter.

As the NHSCFA comes into being with a focus on fraud, bribery and corruption, I am confident that the network of experienced and accredited NHS security management professionals we have established over the years will continue with their work to manage security and tackle violence at a local level.

I am sure you will continue to support your local specialist staff in this work.

If you require any further information please email us at transition@nhsprotect.gsi.gov.uk.

Yours sincerely,

Sue Frith
Managing Director

Appendix

Security management standards for providers and commissioners

The existing NHS security management standards for providers and commissioners will remain in place, as the standards are part of the requirements of the current NHS Standard Contract. Quality and Compliance work for security management functions will no longer be undertaken by NHS Protect beyond the current round of assessments and will not be part of the remit of the NHSCFA.

Security Incident Reporting System (SIRS)

Management of the central reporting of security incidents will not be part of the remit of the NHSCFA. The central collation and analysis function of reports made to SIRS will be decommissioned and the SIRS system will no longer accessible to users.

Security management manual and other security management guidance

Existing security management guidance and the NHS security management manual will temporarily remain on the NHS Protect extranet or the NHSBSA website. From April to 1 July 2017 we will arrange migration of this content to a public web archive so it is still accessible for reference in the future. The management, development and updating of security management guidance and the security management manual will not be part of the remit of the NHSCFA.

National security alerts

National security alerts will no longer be issued by NHS Protect. Existing alerts contain either contact details of the originating NHS body and LSMS or details of the police officer involved in the case. Enquiries or information relating to existing alerts should be directed to those identified as contacts and not NHS Protect, who will no longer have resources in place to circulate and manage the information. The issue of national and regional alerts for security management matters will not be part of the remit of the NHSCFA.

Security Management Director (SMD) and Local Security Management Specialist (LSMS) nominations

Organisations are no longer required to send nominations for the SMD and LSMS roles to NHS Protect. The collection of SMD and LSMS details will not be part of the remit of the NHSCFA. A further circular regarding private-sector training provision for LSMSs will be released shortly.

Please note that as the nominations process will now cease, no new ID cards will be issued to LSMSs by NHS Protect.

NHS
Rotherham
Clinical Commissioning Group

Equality & Diversity in NHS Rotherham CCG

1. Introduction

Equality does not mean treating everyone the same some people are disadvantaged through differences like disabilities. Ensuring that everyone has an equal opportunity may mean making different adaptations for different people – eg targeting communication campaigns into specific communities in appropriate formats. Equality is therefore not about treating everyone the same, but about treating people according to their needs so that we reduce disadvantage.

Diversity literally means "difference". There are many things that make us different such as our age, our education, our past experiences, our health status, our ethnicity, or any disabilities we have. Valuing diversity is about creating a working culture and working practices that recognise, respect, and harness differences for the benefit of those for whom we commission services, for our staff, for our partners and for our organisation.

Equality and Diversity is central to the work of NHS Rotherham Clinical Commissioning Group (CCG) to ensure that we commission equity of access to services and treatment. The promotion of equality, diversity and human rights is central to the NHS Constitution and other national drivers to reduce health inequalities and increase the health and well-being of the population. We are committed to embedding values of equality and diversity into our commissioning processes, policies and procedures that secure health and social care for our population and into our employment practices.

The Equality Act 2010 brought with it ***Public Sector Equality Duties***. Public bodies are required to declare their compliance with the duties on an annual basis.

Section 149 of the Equality Act outlines the ***general duties*** we have to have due regard in the exercising of our functions:

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

For the ***specific duties*** we are required to:

- Publish information to demonstrate compliance with the general duty, on the make-up of our workforce, and on those affected by our policies and procedures
- Publish one or more equality objectives covering a four year period

In the context of the Public Sector Equality Duty the ***protected characteristics*** are defined as:

- Age
- Disability
- Gender
- Race
- Religion & Belief
- Sexual orientation
- Pregnancy and maternity
- Gender reassignment
- Marriage and civil partnership

2. How we meet these duties: A Summary

Our Vision

Promoting equality and human rights is one of the cornerstones of all of Rotherham Clinical Commissioning Group's functions and activities, as an employer and commissioner. This will be applied by ensuring that Rotherham Clinical Commissioning Group has an ongoing programme of equality work, covering all our functions. This is quality assured by the Equality Steering Group and encompasses the following:

- All policies, strategies, service redesign and newly commissioned services undergo via Equality Impact Assessment (EIA) at the start of the development process, and we will implement the outcomes of these.

- Establishment of a rolling programme of EIAs covering all existing commissioned services.

- All staff receiving equality and human rights training through induction, staff briefings, face to face and e-learning.

- Embedding the principle of promoting equality and meeting individual's needs in all our policies and service developments.

- Ensuring effective and sensitive support mechanisms for staff and patient complaints systems for anyone experiencing discrimination.

- Monitoring workforce, service user and complaints data in accordance with our duties under the Equality Act 2010.

- Ensuring that engagement with Rotherham diverse communities informs our Annual Commissioning Plan.

Summary of our Equality Performance

In our Commissioning Role	***Commissioning:*** • Data to inform commissioning is gleaned from various sources including the *JSNA (Joint Strategic Needs Assessment),* Census data, ongoing consultations and engagement activities, patient feedback and targeted or specific health assessments. • When commissioning significant changes to services we undertake equality analysis of the potential impact of our plans to ensure that we meet our equality duties, and to benefit patients • *SC13 Equity of Access, Equality and Non-Discrimination* is a core standard embedded in the Standard NHS provider contract. This ensures that our providers meet the same equality standards as we do. • Our Procurement Strategy makes specific reference to the *Equality Act 2010.* All bidders are required to meet the requirements of the *Equality Act 2010* as a pre-qualification criterion; this is then tested during the procurement process and becomes a standard requirement in a resulting contract. ***Partnerships:*** • We are working closely with Rotherham Council to better understand and address health inequalities. We recognise that access to healthcare services can be variable for certain groups (e.g. less take-up of some services by some protected groups for a variety of reasons) • Our JSNA, produced collaboratively, details Rotherham's diverse communities, their needs, and the aspirations of all partners in addressing these ***Engagement:*** • We have a strong commitment to engagement and understand the need to reach out to communities and individuals whose voice may be otherwise unheard. Our engagement is targeted in two ways, against our commissioning priorities, and against the 9 protected characteristics in all the work we do. We have a robust process to record all our engagement activity, ensuring we identify and address priorities and gaps. Below are examples of some of our work:- • Age - We acknowledge that older people are more likely to use services, and have worked in partnership with Rotherham Older People's Forum, who has carried out surveys and consultations. We also worked with young people to design and produce information they told us they needed.

	Disability – Jointly with RMBC we have commissioned a user led accessibility audit of 1000 buildings and services in Rotherham, including health services. Our Social Prescribing Service links patients with voluntary organisations, it was developed from community discussions, and is valued by patients. • Gender - We have met with targeted groups for example women from South Asian backgrounds, to both deliver messages and to hear their specific concerns and issues. • Race – Where possible, we audit patient feedback (for example, Friends and Family Test data) by race, to identify any difference in experience. • Sexual Orientation - We have strong links with local LGBT groups, and aim to ensure people are involved in any consultation work we complete, as well as listening to this overlooked community. • Pregnancy and Maternity - We are working with a community organisation who are leading on developing a perinatal mental health support group, and a major consultation • Gender Reassignment – Our medicines management team are working proactively with a transgender group to look at medication in primary care and access to services.
In our role as a Corporate Body	• Our Equality and Diversity Steering Group reports directly to AQUA, and feeds into the formal Engagement and Communications Governing Body Sub-Committee and has responsibility for ensuring that due regard is paid to our public sector equality duties. • We have a GP lead championing Equality across the organisation, an Executive lead and an operational lead. • We have various corporate documents which capture our equality commitment including our Equality & Diversity Policy, our Equality Delivery System self-assessment, and publication of equality data annually by the end of January each year. • Our team members need knowledge of the public sector equality duties and the need to consider equality impact during commissioning decisions, which we are achieving through one-to-one support from Communication, Engagement, Experience & Equality team members, through mandatory e-learning, and through supplementary face-to-face training for Governing Body members as our key decision makers. • Everyone is different, and everyone's individual experience, knowledge and skills bring a unique contribution to our organisation, and we value all contributions equally. Our Equality and Diversity Policy is published on our website as our corporate commitment. Recruitment and selection processes are transparent and include consideration of

	equality. The breakdown of our organisation by protected group is broadly representative of the community which we serve. • We have committed to the Workforce Race Equality Scheme (WRES) which requires all NHS organisations to demonstrate how they are addressing race equality issues in a range of staffing areas. We have published our WRES Report for 2016/17 on our website.

Our Equality Delivery System (EDS) Self-Assessment

The main purpose of the ***Equality Delivery System 2 (EDS2)*** is to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

From April 2015, EDS2 implementation by NHS provider organisations was made mandatory in the NHS standard contract. EDS2 implementation is explicitly cited within the CCG Assurance Framework, and will continue to be a key requirement for all CCGs.

The Equality Delivery System comprises 18 outcomes grouped into four goals as detailed below.

- Better health outcomes
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership

Essentially, there is one factor for NHS organisations to focus on within the Equality Delivery System grading process: *How well do people from protected groups fare compared with people overall?* There are four grades – undeveloped, developing, achieving and excelling.

UNDEVELOPED	Undeveloped if there is no evidence one way or another for any protected group of how people fare, or evidence is not available. Undeveloped if evidence shows that the majority of people in only two or less protected groups fare well.
DEVELOPING	Developing if evidence shows that the majority of people in three to five protected groups fare well.
ACHIEVING	Achieving if evidence shows that the majority of people in six to eight protected groups fare well.
EXCELLING	Excelling if evidence shows that the majority of people in all nine protected groups fare well.

We have committed organisationally to using the principles of the Equality Delivery System (EDS) within NHS Rotherham CCG, and in 2016/17 we have refreshed our self-assessment against each of the 18 outcomes.

Summary EDS Self-Assessment

Goal	Ref	Description	Self-assessed score	Overall score per Goal	Organisation rating
			U D A E	U D A E	U D A E
Goal 1 Better health outcomes	**1.1**	Commissioning, procurement, design and delivery	**D**	**D**	**Developing / Achieving**
	1.2	Assessing health needs	**D**		
	1.3	Care pathway transitions	**D**		
	1.4	Patient safety	**A**		
	1.5	Health Promotion	**A**		
Goal 2 Improved patient access and experience	**2.1**	Access to services	**A**	**A**	
	2.2	Informing, supporting & involving patients in care decisions	**A**		
	2.3	Patient Experience of care	**D**		
	2.4	Complaints	**A**		
Goal 3 A representative and supported workforce	**3.1**	Recruitment and selection	**A**	**A**	
	3.2	Equal pay	**D**		
	3.3	Training & development	**E**		
	3.4	Staff safety	**A**		
	3.5	Flexible working	**A**		
	3.6	Staff experience	**E**		
Goal 4 Inclusive leadership	**4.1**	Board Leadership	**D**	**A**	
	4.2	Identification of equality impact	**A**		
	4.3	Line management	**E**		

Key: U Undeveloped | D Developing | A Achieving | E Excelling

3. Equality Objectives

Based on our self-assessment against the national Equality Delivery System, our main areas of focus must be where we have identified there is greatest potential for improvement i.e. outcomes one, two and three where we have assessed ourselves as “developing”. These outcomes focus on better health outcomes and improved patient access and experience respectively.

We believe that our original Equality Objectives remain relevant to these and useful success indicators to measure ourselves against on our journey to our overall equalities vision contained within our Strategy. They are:

- ***Objective 1:*** Make effective use of equality data within the commissioning cycle to prioritise commissioning of services and embed equality within Provider contracts.

- ***Objective 2:*** Ensure appropriate and accessible targeted communication with local communities to ensure commissioners are aware of issues/barriers that influence commissioning decisions.

- **Objective 3:** Develop consistency of equality approaches across the CCG in respect of equality leadership, staff environment and access to development opportunities.

- **Objective 4:** Demonstrate leadership in advancing the equality agenda internally and with partners and providers to ensure inequalities are addressed within a partnership approach to ensure equity of access and outcomes for patients.

January 2017

Appendix 1: Core Data and Information

Source	Brief description	Use within organisation
NHS Rotherham CCG Equality Information in the CCG Annual Report	A summary within the CCG Annual Report capturing summary equality activity within the preceding year.	Used to collate a summary of equality activity and identify any emerging themes.
Joint Strategic Needs Assessment (JSNA)	The Joint Strategic Needs Assessment (JSNA) is a process that identifies the current and future health and wellbeing needs of a local population.	Used to identify commissioning priorities and areas of health inequalities to target interventions.
Yorkshire & Humber Public Health Observatory	Yorkshire and Humber Public Health Observatory (YHPHO) produces information, data and intelligence on people's health and health care for practitioners, policy makers and the wider community.	Used to identify areas of health inequalities. http://www.yhpho.org.uk/
Census 2011	The Census has collected information about the population every 10 years since 1801 (except in 1941). The latest census in England and Wales took place on 27 March 2011.	The statistics collected from the Census are used to understand the similarities and differences in the populations' characteristics locally, regionally and nationally. 2011 Census - Office for National Statistics
Provider equality data	Data recorded by our Providers on activity by protected characteristics.	The data is recorded by protected characteristic and used to identify themes, support the commissioning process, and to monitor Provider activity.
Engagement activities and findings	Data on themes emerging from patient and public engagement activity.	Themes and trends are identified and reported to governing body in the monthly engagement report.
Workforce Data	Workforce Race Equality Standard published January	Monitoring of the workforce in terms of representativeness across the protected characteristics. Published within our quarterly Corporate Assurance Report.
Staff Survey	An annual national survey of our staff in terms of satisfaction.	Used to develop an action plan which supports making improvements in the workplace for staff moving forwards.

Source	Brief description	Use within organisation
Complaints	Data on complaints received by NHS Rotherham CCG relating to services that we commission. In addition, we hold issue logs on concerns around provider services. We also hold regular quality meetings with providers, which include an overview of complaints and issue they receive, and their actions	The data is recorded by protected characteristic and used to identify themes and support the commissioning process.
Equality Delivery System	A self-assessment of our activity against the national voluntary Equality Delivery System outcomes.	The summary results are included in this report and published in full on our website. The data is used for self-assessment across all standards, and for a deep dive into specific clinical areas.

To: A&E Delivery Board Chairs
CC: Acute Trust provider CEOs
CCG Accountable Officers
Ambulance Trust CEOs
Mental Health Trust CEOs
Community Trust CEOs

21 March 2017

Dear Colleague,

Easter 2017 preparedness and assurance

As we emerge from what has been an immensely challenging winter, can we firstly take this opportunity to place on record our personal thanks to all staff working across the entire health and care system for their continuing hard work, commitment and dedication over what has been a prolonged period of pressure.

Since our very helpful call with LDB Chairs on 14th February, we have noted a significant improvement in A&E performance across many systems in the North at a level not seen in other regions. Whilst there is still a long way to go, we know that much of this improvement is down to the leadership of LDB chairs working with their system partners and other local leaders.

To ensure that progress is sustained, our next challenge is to ensure that we are well prepared for the challenges of the forthcoming Easter bank holiday weekend and we know that LDBs have been actively working on local plans which include overseeing inter-agency collaboration and ensuring that all parts of the urgent and emergency care pathway, both in and out of hospital, are well prepared for this period.

To support local resilience planning, we have been asked to confirm national expectations around key areas which are set out below.

Primary care

- CCGs should ensure there is primary care access available on every day of the bank holiday weekend
- CCGs should be assured around commissioning additional primary care capacity (additional GP sessions) for the holiday period
- CCGs should ensure all OOH services in their area are fully staffed and well sign-posted
- Bank holiday primary care cover to be provided through hub and GP federation arrangements, or through other locally agreed mechanisms

NHS 111

- NHS 111 providers will be submitting plans showing hour by hour clinical/non-clinical call handler capacity, to meet forecast demand, throughout the bank holiday period.

- All plans will be assured (and challenged if appropriate) against modelling of predicted call volumes to ensure sufficient capacity is in place to respond to demand and challenged where insufficient capacity is identified.
- All NHS 111 providers will be required to submit refreshed data on Unify2 by 24 March

Out of hospital urgent care

- All systems that have urgent care centres co-located with their EDs are to have primary care streaming in place 8am-11pm 7 days per week by Easter
- CCGs will need to ensure all other MiUs, UCCs and walk-in centres have sufficient capacity in place to meet demand over the bank holiday period
- CCGs will need to ensure that local Directories of Services (DoS) are up to date and live to ensure all out of hospital urgent care services fully utilised as clinically appropriate, so that the ED is not used as a default

Bed capacity

- To ensure we have sufficient bed capacity to meet anticipated demand over the Easter bank holiday period, all acute trusts should aim to reduce G&A bed occupancy to 90% by the day before Good Friday (Thursday 13 April).

Easter SITREPs

To help identify and manage emerging pressures over Easter, we would be grateful if every acute trust with a Type 1 A&E department could provide a completed daily SITREP on the following days to take account of the Easter bank holiday weekend:

- Friday 14 April
- Saturday 15 April
- Sunday 16 April
- Monday 17 April

For clarity, this means every acute trust with a type 1 A+E department will need to submit a SITREP, signed off at a senior level within the organisation via the usual NHSI webform and to the same timescales that apply on working days (i.e. by 11am each morning to take account of the previous 24 hours and up to 8am that day).

Additional arrangements for the most challenged systems (Appendix 1)

For systems which have had particularly significant challenges around recovering ED performance, there is an expectation of some specific additional actions across the Easter period.

These are described in Appendix 1.

National and Regional Assurance

We would like to thank Local A&E Delivery Boards for completing the regional template covering metrics on out of hospital care. We are keen to understand the capacity that systems will have in place from Wednesday 12th April – Wednesday 19th April and we will discuss emerging issues with you and local DID and DCO teams in the next few days.

There is one item which we have been asked to provide additional national assurance on.

In relation to GP out of hours/unscheduled care services, you have already provided a RAG rating around provider confidence to fill clinical shifts.

However, can you please provide some additional information on the percentage of unfilled clinical shifts against the RAG:

R > 15% shifts unfilled
> 5-15% shifts unfilled
G < 5% shifts unfilled

We would be grateful if this figure could be emailed to england.northwinter@nhs.net by **close of play on Thursday 23 March.**

Finally, following the joint letter from Jim Mackey and Simon Stevens 'Action to get A&E performance back on track' (9 March 2017; Gateway ref: 06600), we can now confirm the NHSI/E RD responsibility arrangements for linking with individual LDBs through STPs around the UEC agenda.

These are set out overleaf (Appendix 2).

Please be assured that these new arrangements aren't intended to change the current role, responsibilities or accountabilities of NHSE DCO, NHSI DID teams and Local Delivery Boards around UEC and A&E delivery. The aim is to ensure that we are able to effectively manage delivery across complex care systems by developing a single delivery chain with clear lines of communication and leadership.

Thank you for your continuing help and support which is greatly appreciated. We look forward to seeing many of you at the regional A&E programme launch event on 31 March.

Yours faithfully,

Richard Barker

NHS England
Regional Director (North)

Lyn Simpson

NHS Improvement
Executive Regional Managing Director (North)

APPENDIX 1

Group of particularly challenged systems that are expected to incorporate specific arrangements (a) - (c) below into Easter plans:-

- Northern Lincolnshire And Goole - (a) and (b)
- Lancashire Teaching - (a) and (b)
- Wirral Acute - (a) and (b)
- East Lancashire - (a) and (b)
- York - (a) and (b)
- Pennine Acute - (a) and (b)
- Southport and Ormskirk - (a) and (b)
- Hull and East Yorkshire - (a) and (b)
- Morecambe Bay - (a) and (b)
- Mid Yorkshire - (a) and (b)
- East Cheshire - (a), (b) and (c)
- Stockport - (a), (b) and(c)

(a) a named Executive Director on the ground each day over the Easter weekend and Bank Holiday period

(b) weekend discharge teams in place with authority to facilitate rapid discharges over the entire Easter period

(c) the profile and volume of elective activity on and around the Easter period should be agreed with the NHSI DID and NHSE DCO regarding the impact it may have on ED performance

N.B. This is seen as best practice and other systems are encouraged to consider planning similar provisions

APPENDIX 2 North Non-specialist trusts with type 1 A&E split by RD

RD – LYN SIMPSON

STP	A&E delivery board	U&EC	Provider	% 4 hours or less December 2016 (all types)	
WNEC	West North & East Cumbria	NE & N Cumbria	North Cumbria University Hospitals NHS Trust	85.8%	RNL
GM	Bolton	GM	Bolton NHS Foundation Trust	79.2%	RMC
GM	Central Manchester & UH South Manchester	GM	Central Manchester University Hospitals NHS Foundation Trust	90.5%	RW3
GM	Pennine	GM	Pennine Acute Hospitals NHS Trust	77.8%	RW6
GM	Salford	GM	Salford Royal NHS Foundation Trust	83.7%	RM3
GM	Stockport	GM	Stockport NHS Foundation Trust	69.4%	RWJ
GM	Tameside & Glossop	GM	Tameside And Glossop Integrated Care NHS Foundation Trust	76.2%	RMP
GM	Central Manchester & UH South Manchester	GM	University Hospital Of South Manchester NHS Foundation Trust	83.7%	RM2
GM	Wrightington, Wigan and Leigh	GM	Wrightington, Wigan And Leigh NHS Foundation Trust	82.6%	RRF
NTW	Sunderland	NE & N Cumbria	City Hospitals Sunderland NHS Foundation Trust	91.3%	RLN
NTW	Gateshead & Newcastle	NE & N Cumbria	Gateshead Health NHS Foundation Trust	94.8%	RR7
NTW	North Tyneside & Northumberland	NE & N Cumbria	Northumbria Healthcare NHS Foundation Trust	87.0%	RTF
NTW	South Tyneside	NE & N Cumbria	South Tyneside NHS Foundation Trust	91.9%	RE9
NTW	Gateshead & Newcastle	NE & N Cumbria	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	91.4%	RTD
DDTHRW	County Durham & Darlington	NE & N Cumbria	County Durham And Darlington NHS Foundation Trust	89.5%	RXP
DDTHRW	North Tees	NE & N Cumbria	North Tees And Hartlepool NHS Foundation Trust	90.7%	RVW
DDTHRW	Hambleton, Richmond & Whitby & South Tees	NE & N Cumbria	South Tees Hospitals NHS Foundation Trust	93.8%	RTR
HCV	Hull and East Yorkshire	HCV	Hull And East Yorkshire Hospitals NHS Trust	87.3%	RWA
HCV	North Lincolnshire & North East Lincolnshire	HCV	Northern Lincolnshire And Goole NHS Foundation Trust	82.4%	RJL
HCV	York & Scarborough	HCV	York Teaching Hospital NHS Foundation Trust	81.1%	RCB

RD – RICHARD BARKER

STP	A&E delivery board	U&EC	Provider	% 4 hours or less December 2016 (all types)	
LSC	Fylde Coast	LSC	Blackpool Teaching Hospitals NHS Foundation Trust	83.3%	RXL
LSC	Pennine Lancashire	LSC	East Lancashire Hospitals NHS Trust	77.3%	RXR
LSC	Central Lancashire	LSC	Lancashire Teaching Hospitals NHS Foundation Trust	78.0%	RXN
LSC	Morecambe Bay	LSC	University Hospitals Of Morecambe Bay NHS Foundation Trust	81.0%	RTX
C&M	North Mersey and Southport	C&M	Aintree University Hospital NHS Foundation Trust	79.0%	REM
C&M	West Cheshire & Wirral	C&M	Countess Of Chester Hospital NHS Foundation Trust	82.4%	RJR
C&M	Eastern Cheshire	C&M	East Cheshire NHS Trust	79.8%	RJN
C&M	Mid Cheshire	C&M	Mid Cheshire Hospitals NHS Foundation Trust	89.3%	RBT
C&M	North Mersey and Southport	C&M	Royal Liverpool And Broadgreen University Hospitals NHS Trust	85.8%	RQ6
C&M	North Mersey and Southport	C&M	Southport And Ormskirk Hospital NHS Trust	90.9%	RVY
C&M	Mid Mersey, Warrington & Halton	C&M	St Helens And Knowsley Hospital Services NHS Trust	83.9%	RBN
C&M	Mid Mersey, Warrington & Halton	C&M	Warrington And Halton Hospitals NHS Foundation Trust	85.1%	RWW
C&M	West Cheshire & Wirral	C&M	Wirral University Teaching Hospital NHS Foundation Trust	82.1%	RBL
WY	Bradford & Airedale	WY	Airedale NHS Foundation Trust	87.0%	RCF
WY	Bradford & Airedale	WY	Bradford Teaching Hospitals NHS Foundation Trust	82.1%	RAE
WY	Calderdale & Huddersfield	WY	Calderdale And Huddersfield NHS Foundation Trust	92.5%	RWY
WY	Harrogate & Rural District	WY	Harrogate And District NHS Foundation Trust	92.5%	RCD
WY	Leeds	WY	Leeds Teaching Hospitals NHS Trust	78.1%	RR8
WY	Mid Yorkshire	WY	Mid Yorkshire Hospitals NHS Trust	77.0%	RXF
SYB	Barnsley	SYB	Barnsley Hospital NHS Foundation Trust	83.5%	RFF
SYB	Doncaster & Bassetlaw	SYB	Doncaster And Bassetlaw Hospitals NHS Foundation Trust	86.6%	RP5
SYB	Sheffield	SYB	Sheffield Teaching Hospitals NHS Foundation Trust	80.6%	RHQ
SYB	Rotherham	SYB	The Rotherham NHS Foundation Trust	79.2%	RFR