NHS Rotherham CCG Governing Body – February 2018

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.

RCCG Diabetes Assessment Rating

To complement the headline assessment of your CCG that was completed under the auspices of the Clinical Commissioning Group Improvement and Assessment Framework (CCG IAF) for 2016/17 and published in July, an additional assessment for diabetes has been undertaken by the independent panel for NHS England.

The assessment outcome in relation to diabetes for 2016/17 is **Good**. The letter is attached as appendix A.

Engagement Report (To discuss at OE whether COR or paper)

Attached (appendix Bi & Bii) is a generic update on engagement at an ACS level from the South Yorkshire and Bassetlaw Accountable Care System. Governing Body is asked to discuss and support the recommended approach to engagement at ACS level, especially in relation to the legal responsibilities. Also attached (appendix Biii) is and equality and diversity briefing paper from the ACS.

Action: Governing Body is asked to discuss and support the recommended approach to engagement at ACS level.

Collaborative Partnership Board

Following on from the Collaborative Partnership Board meeting on the 12th January 2018 I have been asked to share with you the minutes of the meeting of the 8th December 2017 (appendix C) and the ACS CEO report from Sir Andrew Cash (appendix D).

ACS Templates for Equality Impact Assessment & Engagement.

Helen Stevens, Associate Director Communications and Engagement | South Yorkshire and Bassetlaw Accountable Care System has written to all CCGs in the SYB ACS and requested we use the same systems, templates and processes to:

- Complete EIAs
- Monitor and assess projects in terms of engagement
- Record engagement activity, especially where this impacts on the protected characteristics

The forms have been developed in line with current best practice, and have been informed by the work of Dorset CCG, who are already in the process of a hospital services review. They are also in line with the template used by NHSE, and would ensure consistency across the footprint.

The E&D form has been reviewed by the Yorkshire and Humber STP equality and diversity reference group (made up of E&D leads from across the region), and their comments incorporated, therefore reflects current best practice.

Completing these templates, recording, assessing and planning activity is a key part of the process of any major service change.

These forms would replace those currently used by RCCG; and would be used from this point on, not retrospectively.

The templates are attached as appendix E

Action: GB is required to approve the use of these templates

Winter Update -

Nationally the NHS has been under significant pressure over the winter period. In Rotherham all partners worked together to produce our Rotherham system winter plan which is overseen by the Rotherham A&E delivery Board. To date the Rotherham system has experienced significant pressure but the plan has allowed Rotherham to perform well relative to other areas and the Rotherham Urgent and Emergency Care Centre has performed above the national average in both December and January.

Following national advice non urgent elective activity was scaled down in January. We expect to resume full elective activity from February onwards.

Communications Update

- There has been extensive media coverage of winter pressures within the NHS, with a focus on A&E. Hallam FM and Rotherham Advertiser have both covered stories on Rotherham, which included messages to patients on the most appropriate services to use when they are ill.

- The local media has covered the news that the Rotherham mental health social prescribing scheme has been recognised in the Government's 25-year environment plan 'A Green Future: Our 25-year Plan to Improve the Environment'.

- A refresh of the Right Care, First Time campaign has recently taken place with updated resources distributed through GP practices, hospital services and council information points. The campaign provides advice to local people on appropriate services available to them when they need them.

Publications gateway reference: 07564

10 January 2018

Dear CCG Accountable Officer and Clinical Lead,

2016/17 Diabetes Assessment

To complement the headline assessment of your CCG that was completed under the auspices of the Clinical Commissioning Group Improvement and Assessment Framework (CCG IAF) for 2016/17 and published in July, an additional assessment for diabetes has been undertaken by the independent panel. This draws on recently published National Diabetes Audit data for 2016/17.

Each CCG is provided with one of four ratings, described as: 'outstanding'; 'good'; 'requires improvement'; and, 'inadequate'. The assessment for your CCG in relation to diabetes for 2016/17 is **Good**.

The methodology used by the panel to derive the diabetes assessment can be found in the Annex**.**

The assessment is based on two key diabetes indicators and provides a snapshot of how one CCG's performance compares with other CCGs. It is not fully comprehensive, and other key elements in the diabetes treatment pathway include timely access to multidisciplinary foot-care teams and specialist diabetes inpatient teams.

The results for the individual indicators for your CCG are as follows:

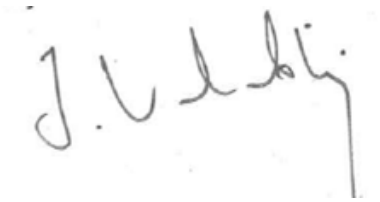
Indicator	**2016/17 score**
Achievement of NICE-recommended treatment targets	**38.5%** (4,985 of 12,960)
Attendance at structured education	**9.5%** (90 of 945)

The latest scores for these indicators will be included in the next issue of the dashboard, which is made available to CCGs through NHS England regional teams. Consideration of these results should help to identify where CCGs may be able to learn from each other and drive overall improvement. For further information on improvement support, please visit the clinical priority area pages on our website.

The 2016/17 diabetes rating for your CCG should not be released by the CCG until it is published on 18 January 2018 on the MyNHS section of the NHS Choices website.

A commentary on the 2016/17 ratings for diabetes has been prepared by Chris Askew, the chair of the diabetes independent panel. This will be published on the NHS England website at the same time as the assessment results are published on MyNHS.

Yours faithfully,



Professor Jonathan Valabhji
National Clinical Director for Obesity and Diabetes

Diabetes assessment methodology 2016/17

The 2016/17 rating for diabetes considers two indicators:

- Diabetes patients that have achieved all the NICE-recommended treatment targets (HbA1c, blood pressure and cholesterol for adults and HbA1c for children)
- People with diabetes diagnosed less than a year who attend a structured education course.

The two indicators have each been calculated using 2016-17 National Diabetes Audit (NDA) data.

Each diabetes indicator is assigned a band based on the thresholds shown in table 1. For the treatment targets indicator, the national median was used as the threshold for good performance. For the structured education indicator, the bands were derived based on deviation from the national average.

The approach for the treatment targets indicator has an important difference to that for the structured education indicator. Whereas we wish to drive the proportion of relevant patients who attend structured education to be as high as possible, we are mindful of the important clinical implications of driving blood glucose levels and blood pressure too low, given the associated respective risks of hypoglycaemia and postural hypotension, particularly in older individuals who are frail. As such, the metric incentivises achievement of the current median CCG proportion of patients achieving the NICE-recommended treatment targets whereas for attendance at structured education the metric incentivises the proportion attending to be significantly better than the mean, in other words, as high as possible.

Table 1 – Diabetes indicator banding method

Indicator (Time period used)	Indicator banding category thresholds (1 = best performing, 3 = poorest performing)	Benchmark
Treatment targets (2016-17)	- Indicator value upper confidence interval less than 37.9% = Band 3 - Indicator value upper confidence interval greater than or equal to 37.9% and less than 40.0% = Band 2 - Indicator value upper confidence interval greater than or equal to 40.0% = Band 1	National median (40.0%); and 25th percentile (37.9%)
Structured Education (2015 cohort)	Indicator value signficantly lower than national average = Band 3 Indicator value not significantly different to national average = Band 2 Indicator value significantly higher than national average = Band 1	National average (7.3%)

To note: The thresholds for the treatment targets rate and structured education indicator in table 1 have been rounded to 1 decimal place. The exact thresholds on which bandings are based for the treatment targets indicator are 39.97165% (upper) and 37.89140% (lower). The exact threshold on which banding is based for the Structured Education indicator is 7.29757%

The overall rating for diabetes is based on the CCG band for each of the diabetes indicators as illustrated in table 2:

Table 2 – Diabetes assessment rating

		Treatment targets		
		1 (Best performing)	**2**	**3 (Poorest performing)**
Structured education	**1 (Best performing)**	Outstanding	Good	Requires improvement
	2	Good	Requires improvement	Requires Improvement
	3 (Poorest performing)	Requires improvement	Requires improvement	Inadequate

Public and patient involvement update from the South Yorkshire and Bassetlaw Accountable Care System

XX October 2017

1. Purpose

South Yorkshire and Bassetlaw Accountable Care System has an agreed communications and engagement strategy and six month action plan. This paper considers the opportunities to embed public and patient involvement in the work of the partners within the ACS.

In particular, it sets out in more detail the proposed involvement approach and resource implications across the partnership.

2. Embedding public and patient involvement

2.1 Health and Care Working Together in South Yorkshire and Bassetlaw is committed to meeting the needs of future patients in a safe and sustainable way. As one of eight Accountable Care Systems (ACS) in the country, it is moving at pace in order to deliver the ambitions outlined in its Sustainability and Transformation Plan. As is clear within the Plan, there are some key areas where involvement and insight will be crucial and to deliver effective and meaningful engagement, the ACS will need to consider how this is resourced.

The ACS engagement agenda is at a crucial point. With the hospital services review in its early stages, workstreams starting to consider public and patient involvement and a SYB-wide campaign to raise awareness of the ACS about to get underway, consideration of how partners will continue to meet their statutory duties is timely.

There are a number of opportunities to ensure engagement and involvement is co-ordinated and meaningful across the Health and Care Working Together partners. This includes supporting the ACS to:

- Ensure health, care and support services are co-designed with local communities to achieve the best outcomes for the population.
- Ensure stakeholder involvement is at the heart of service improvement so citizens and communities can be more in control of their care.
- Build awareness of our ACS vision in South Yorkshire and Bassetlaw programme amongst local voluntary and community organisations so they can contribute positively.
- Provide regular communication on the progress and successes of the ACS programme in South Yorkshire and Bassetlaw so that communities have confidence in local services

2.2 Recommended approach to ACS engagement

As engagement and involvement across the ACS develops and evolves, there is a need to better co-ordinate and align activity and develop clarity around accountability.

If participation is to be delivered in a style which enables full involvement, consideration will need to be given to promoting and marketing opportunities for involvement and ensuring activities are arranged across the whole area and in accessible venues.

2.22 To strengthen accountability and assurance, we have already:

- Developed a Health and Care Working Together engagement framework with CCG engagement leads and the region's Healthwatches (see attached)
- Developed a consistent approach to engagement across SYB through the adoption of the SYB public and patient participation 14Z2 form. This will ensure that consideration is given to the level and type of participation required. Each of the engagement leads in the five CCGs in SYB support this approach.
- Recruited to the public and patient involvement manager role within the ACS (on a fixed term 18 month contract with national monies)
- Carried out a retrospective mapping of engagement and consultation activity across SYB ACS (see https://www.healthandcaretogethersyb.co.uk/get-involved) to:
    - understand the work that has already taken place or is underway and highlight any gaps in activity across South Yorkshire
    - understand and reference the views of the local population
    - ensure that a committed and sustained approach to involvement is delivered over the next three years
    - show how we are meeting our legal obligation to involve.

And we are in the process of

- Recruiting to a SYB Citizens' Panel to support the work of the ACS, workstreams and reviews (see attached)
- Developing an SYB Equalities Impact Assessment form, with the support and guidance of the Yorkshire and Humber Equality and Diversity Network
- Developing a database of public and patients who are interested in being involved
- Developing a quick guide to aid form completion and guidance relating to decisions

There are also ongoing actions to:

- Increase opportunities for involvement, especially with lesser heard groups and grassroots communities, following a stakeholder mapping exercise
- Develop work-stream engagement plans, complementing and strengthening the communications plans
- Support colleagues to ensure completion of the 14Z2 form

2.23 To support the ACS engagement approach across CCGs, the development of an ACS wide remuneration policy for public and patient involvement budget is recommended. This would include eg consistent mileage rates.

3. Recommendations

Barnsley/Bassetlaw/Doncaster/Rotherham/Sheffield CCG's Governing Body is asked to discuss and support the recommended approach to engagement at ACS level, especially in relation to the legal responsibilities.

It is asked to:

a) Approve the development of an ACS wide remuneration policy for public and patient involvement, to be discussed and agreed at the Joint Committee of Clinical Commissioning Group
b) Note and discuss the engagement framework and SYB public and patient participation 14Z2 form
c) Note and discuss the Citizens' Panel approach and recommended approach to public and patient involvement in workstreams

Paper prepared by Katy Hyde
On behalf of Helen Stevens

Date November 2017

Appendix A

Health and Care Working Together in South Yorkshire & Bassetlaw

Engagement Framework

1) Context & Background

NHS England requires each local care system in England to work together to create an ambitious local plan to meet the triple aim set out in the NHS Five Year Forward View. This local plan is called a 'Sustainability and Transformation Plan' (STP) and must set out over five years how each area will:

- Improve the health and wellbeing of their local population.
- Improve the quality of local health and care services.
- Deliver financial stability and balance throughout the local health and care system.

Why do we need an STP?

- Although there have been big improvements in healthcare in the last 15 years
- People with cancer and heart conditions are experiencing better care and living longer
- Waits are shorter and people more satisfied
- But the quality of care is variable
- Preventable illness is widespread
- Health inequalities are deep-rooted (people living in more deprived areas are less likely to live long, healthy lives).
- People's needs are changing, new treatment options are emerging and we face particular challenges in mental health, cancer and support for older people.
- Pressures on service are building and we need to work together to find the best solutions.

What is our function as a dedicated Accountable Care System (ACS)?

The head of NHS England in June 2017 pledged to end the "fractured" health and social care system that leaves too many patients "passed from pillar to post" by giving local leaders and communities more control over how they improve health and social care.

Simon Stevens said: "As the NHS approaches its 70th Birthday, we are now embarked on the biggest national move to integrating care of any major western country. For patients this means better joined up services in place of what has often been a fragmented system that passes people from pillar to post."

Eight 'accountable care systems' (ACSs) will bring together local NHS organisations, often in partnership with social care services and the voluntary sector. They build on the learning from and early results of NHS England's new care model 'vanguards', which are slowing emergency hospitalisations growth by up to two thirds compared with other less integrated parts of the country.

The first group of designated ACSs have agreed with national leaders to deliver fast track improvements set out in Next Steps on the Five Year Forward View, including taking the strain off A&E, investing in general

practice making it easier to get a GP appointment, and improving access to high quality cancer and mental health services.

These areas will also lead the way in taking more control over funding available to support transformation programmes – with the combined indicative potential to control around £450m of funding over the next four years – matched by accountability for improving the health and wellbeing of the populations they cover. NHS national bodies will provide these areas with more freedom to make decisions over how the health system in their area operates

2) Purpose & Objectives

The purpose of the communications and engagement framework is to support the vision and strategic aims of the Accountable Care System and support the local Transformation Board to deliver the priorities. We have to deliver new models of care which will be sustainable across our region to ensure our services can continue to deliver a high quality service.

Our plan is about working together and in new ways and we have identified eight key priorities:

- Healthy Lives, Living well and Prevention
- Primary and Community Care
- Mental Health and Learning Disabilities
- Urgent and Emergency Care.
- Elective and Diagnostic Services.
- Children and Maternity services
- Cancer.
- Spreading Best Practice and Collaborating on Support Services (this work includes shared support services and estates)

In addition, we have work areas looking at digital and IT, workforce, medicines optimisation and a review of acute hospital services.

3) Putting our plan into action:

To deliver these priorities we need to bring health and care services closer together to develop new ways of providing health and care across South Yorkshire and Bassetlaw. Our ambition is:

For everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and live longer.

- We will reduce inequalities for all and help you live well and stay well for longer.
- We will join up health and care services so they are responsive to your needs and accountable.
- We will invest in and grow primary and community care with general practice at the centre.
- We will treat and care for the whole person looking after their mental health and physical health
- We will standardise acute hospital and specialised care – improving access for everyone reducing inequalities and improving efficiencies.
- We will simplify urgent and emergency care, making it easier for people to access the right services closer to home.
- We will develop the right workforce in the right place with right skills for now and in the future.

- We will use the best technology to keep people well at home to support them to manage their own care and to connect our resources so they can provide joined up care
- We will create a financially sustainable health care system.

- And we will work with you to do this.

4) Developing our Framework

A long history of collaboration and working together to improve health and care for the people of South Yorkshire and Bassetlaw has given us a strong foundation to deliver our ACS. We have joined together very quickly, building on existing relationships and forming a credible guiding coalition of partners who recognise the opportunities and are motivated to deliver significant improvements.

During February and April 2017 a programme of local conversations with local communities was arranged to gather more information about individuals and groups perceptions and feelings towards the South Yorkshire and Bassetlaw Sustainability and Transformation plan. To ensure independence and impartiality the conversations were managed through our local Healthwatch organisations and Voluntary Action/CVS.

Any future engagement for the ACS must continue to build on the work which has already taken place and should consider the successes of the programme which was reflected in the independence and impartiality coupled with a more informal approach where the fluidity of conversations enabled people to feel relaxed, engaged and valued.

The 'Community Conversations about the South Yorkshire and Bassetlaw Sustainability and Transformation Plan', identified key themes in relation to people's understanding of Sustainability and Transformation:

- Communication and Engagement - lack of clarity of both the Sustainability and Transformation Plan and local Place Plans
- Funding – concerns about privatisation, lack of detail around how changes will be funded but a recognition that there is a finite resource and awareness of what can be done to meet the needs of the population with the resources available.
- Service Change – general agreement that the NHS and Social care services need to change and develop but that local services meet the needs of the local population, timescales and potential pace of change are a concern.

5) Putting our framework into action:

We want to take our population with us every step of the way and are committed to ensuring individuals and group's views and experiences influence our work streams. We need to ensure that a diverse range of people have the opportunity and the information they need to be involved in the decision making. We will consider a range of options for involvement and will address barriers which can prevent involvement, for example seeking venues which are accessible, for disabled people.

Our Principles:

- We will be clear about how the information we collect will be used.
- We will work hard to demonstrate to our population that any involvement is Not just a tick-box exercise!
- We will be clear how the findings will be fed back to those involved and the wider population.
- We will explain how we will monitor things after the activity has been completed.

Implementing the ACS – ensuring support for delivery

The main objective is to ensure that the local population are better informed and have opportunities to engage. Our local conversations highlighted that a general level of understanding and awareness of the Sustainability plan was low and in many cases the 'Community Conversations' were the first time participants had heard about the ideas and themes and many people struggled to grasp the concept behind the STP.

We will utilise the full set of channels open to us to communicate and *engage*, including all forms of media and advertising, to ensure we reach out and build a broad coalition of support for transforming health and care in South Yorkshire & Bassetlaw. Our communication and engagement plans will develop and adapt as the ACS takes shape and the detail is agreed by the main health and care organisations. The ACS will only be a success if we involve and take our main stakeholders with us every step of the way.

6) Public Engagement and Involvement

There has been a step change in what constitutes good engagement in recent years. 'Old style' engagement, where public bodies developed ideas behind closed doors and then shared them with the public for discussion is regarded as poor practice. Best practice means involving the public at every stage and using their input to co-design solutions.

We have engaged local people and stakeholders in developing our plans because it is the right thing to do and to ensure we met our statutory responsibilities. Strategic plans are improved by engaging the public in them as they take shape. This also makes their eventual implementation easier.

We recognise that the successful delivery of the level and scale of change needed will necessitate the need to address the issues identified in the community and staff conversations. Engaging with and involving our population is an essential element of our planned delivery. In order to affect change and support individuals to take greater control of their own health and care we understand the need to involve our population to achieve these changes. As our engagement takes shape our ambition in how we can work collaboratively is set out below, with six key drivers.

Working well together	Working with each other
1. We will understand what's worked in the past and consider how to apply it to the present and future.	1. Our relationships will be conducted with equality and respect.
2. We will have a shared goal and take joint responsibility for our work.	2. We will listen and proactively seek participation from communities who experience the greatest health inequalities & poorest health outcomes.

3. We will take time to plan well.	3. We will use the strengths and talents that people bring to the table
4. We will involve people as early as possible.	4. We will respect and encourage different beliefs and opinions.
5. We will give feedback on the results of people's participation	5. We will recognise record and reward people's contributions.
6. We will provide support so that we can work, learn and improve together	6. We will use plain language and openly share information

South Yorkshire and Bassetlaw ACS will ensure that all the engagement methods will be adopted appropriately and effectively to empower patients and the public to become active participants in service redesign and delivery to support the transformation needed. We will work hard to deliver 'fair and proportionate' engagement, adopting 'The Gunning Principles'.

- Takes place at a time when proposals are still at a formative stage. If involvement is to be meaningful, it should take place typically at an early stage. However, it is often permissible to consult on a preferred option or decision in principle, so long as there is a genuine opportunity for the public to influence the final decision.
- Gives the public sufficient information and reasons for any proposal to allow the public to consider and respond.
- Allows adequate time for the public to consider and respond before a final decision is made.

Furthermore when considering the breadth and depth of engagement we understand that 'One size doesn't fit all'. We understand the need to think innovatively and adapt our approaches so that we can ensure access to seldom heard and hard to reach communities and those individuals and groups with protected characteristics.

7) Key elements of our Framework

Place based plans that focus on:

- Prevention
- Healthy children
- Primary care at scale
- Risk Stratification
- End of Life.

Transformation programmes:

- Urgent and emergency care
- Elective care
- Cancer
- Children's and maternity
- Mental health and learning disabilities

Cross cutting themes:

- Workforce
- Digital and I.T.
- Support services and estates
- Medicines optimisation

We have produced a public-facing summary of the ACS for use with the general public and stakeholders.

There is on-going media interest in our ACS delivery and we have agreed who our spokespeople are for any interview requests.

We have a website, to enable our population to view our on-going delivery and to engage either virtually or at our proposed engagement events – www.healthandcaretogethersyb.co.uk

8) Planning for Involvement:

There are a range of areas in which future communications and engagement will be needed, at local and regional level, as changes are implemented. We are working with local Healthwatch organisations, CCGs and provider programme managers and the local authority to define these opportunities more clearly.

Our principle of talking to the public about proposed changes and involving them in developing and implementing change will continue.

Between 3 October 2016 and 14 February 2017, two public consultations were carried out on the future of hyper acute stroke and children's surgery and anaesthesia services across South and Mid Yorkshire, Bassetlaw and North Derbyshire. Carried out by Commissioners Working Together, a collaborative partnership of eight NHS clinical commissioning groups and NHS England, overall communications and engagement activity was pro-actively co-ordinated by the Commissioners Working Together communications team. Activity in each of the local areas was carried out by the CCG communications and engagement leads to ensure all activity was joined up, timely and appropriate. An external evaluation of the engagement was undertaken and the findings of this will help to inform future engagement.

We know that the following will be important to underpin any future work, including consultations:-

- One consistent message, and one central resource for materials
- Ensuring we work with partner organisations across the statutory and voluntary sectors
- Local flexibility where needed
- Iterative and reflective processes, developing as we work
- Building on existing groups, networks and relationships
- Working together across boundaries, targeting communities
- Using a variety of mechanisms effectively- from social media to one to one conversations; and deliberative events
- Making sure that all responses are valued and counted within our processes

9) Coordinating Involvement:

A **Communications and Engagement Strategic Group** has been established, comprising provider, local authority, CCG and programme leads for communications and engagement. This group will help to steer the communications and engagement approach overall, including provider and local authority staff and stakeholders.

We will continue to work on the basis that the programme team will devise communications and engagement materials and messaging centrally, for local use and adaptation by CCGs, providers and local authorities**.** Local leads will be asked to help shape the messaging through our strategic communication and engagement group. Engagement with the public at borough level will continue to be led by CCGs, with support from the central team.

A comprehensive report has been produced which provides an overview of patient and public involvement which has been undertaken over the last three years in relation to our eight priority areas. Accessing this information will ensure that we avoid duplication and will identify for us where there are gaps in our local knowledge so we can resource appropriately.

Each of our five CCG's has a 'Place Plan' which sets out local priorities and ambitions this incorporates an Engagement Strategy which will support this overarching strategy highlighting the ambitions for South Yorkshire and Bassetlaw in relation to the STP plan. Each place is represented on this strategic group through the local engagement lead to support co-ordinated engagement.

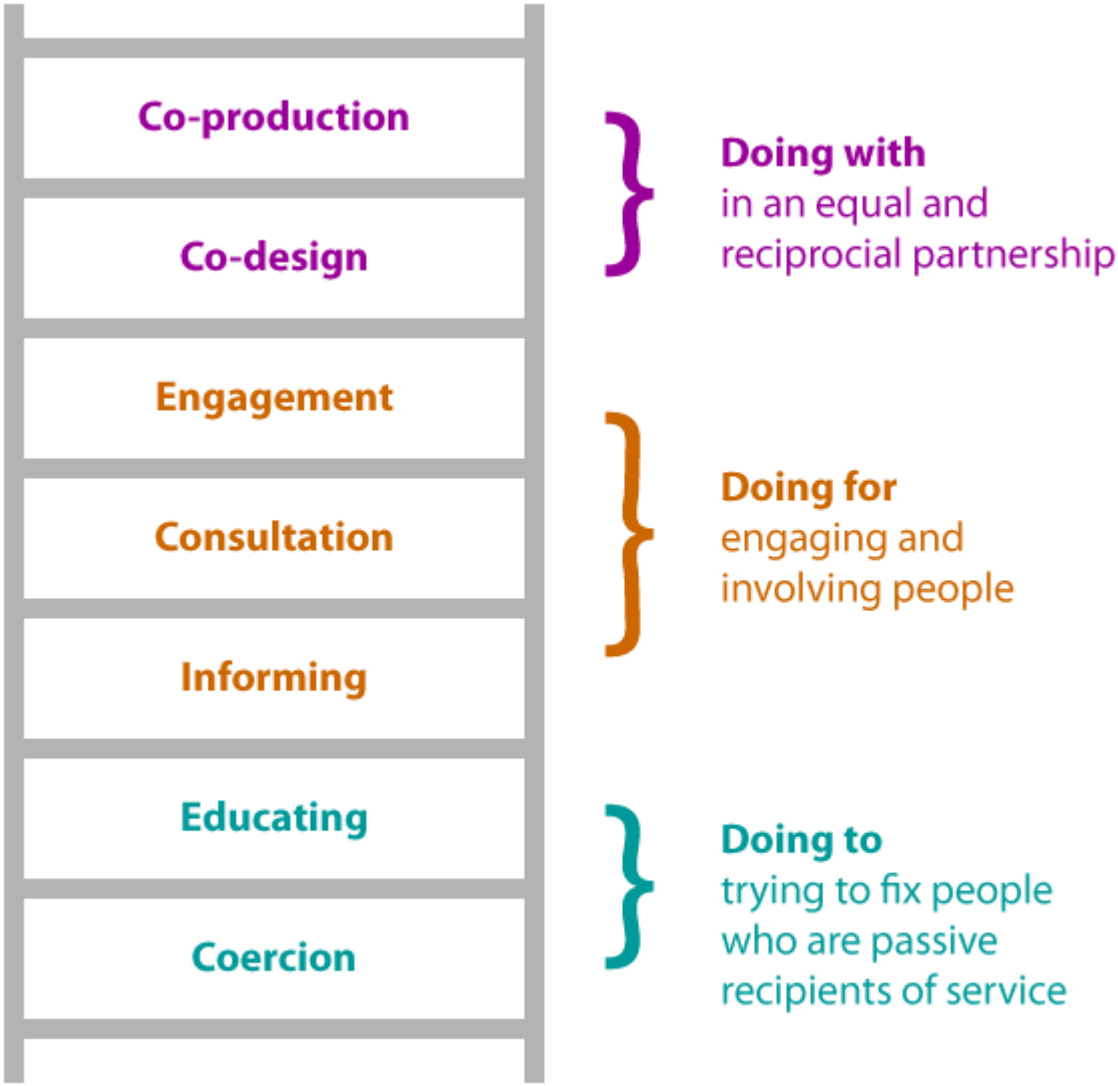
10) Involvement opportunities:

We know that the key to delivering our sustainability and transformation work-streams is through meaningful involvement in both the design and delivery of future services. We are committed to ensuring that any involvement is both fair and proportionate and understand that it has to be planned effectively and resourced appropriately. In order to deliver on our ambitions we have already begun to link with local groups to help to develop a set of principles which will inform the Hospital Services Review. Additionally each of our work-streams have recruited volunteers for strategic involvement and our recent out-patient and elective workshop was an excellent example of clinical and non-clinical stakeholders supporting each other to determine a case for change moving forwards.

The workshop highlighted the value of co-production and the ladder of co-production will help to shape the different approaches which will be needed to support our work.

Co-production builds upon a range of approaches such as consultation, engagement and co-design. We understand the need to adopt different, approaches if real co-production is to be put into practice.

Consultation, engagement and co-design encourage people to input by asking for their ideas, experience and opinions. Co-production is different because it also needs people's actions. This can happen through 1-2-1 relationships with professionals where people play an active role in shaping and implementing their own support, or in wider peer or community support between people and professionals. Co-production means that power is shared more equally between those who use services and those who provide them. Everyone's skills and personal resources are put to use.



11) The 10 Step Approach:

Staff:

We need to make sure our staff are involved and informed and are considering a number of options for how this may be taken forwards which may include a staff forum. Consideration is being given to our priorities and the need to directly engage with:

- GPs and other staff in primary care
- Hospital-based clinicians
- Allied health professionals (across health and social care)
- Social care professionals
- NHS staff in administrative and management roles

Patients and Public:

We have considered a number of options for how best to ensure that 'seldom heard' groups and those with protected characteristics are considered in each of our work streams. With this in mind we have developed a

document which clearly asks each work-stream lead to consider how opportunities can be provided for those groups. (See Appendix 1)

There is a need to consider:

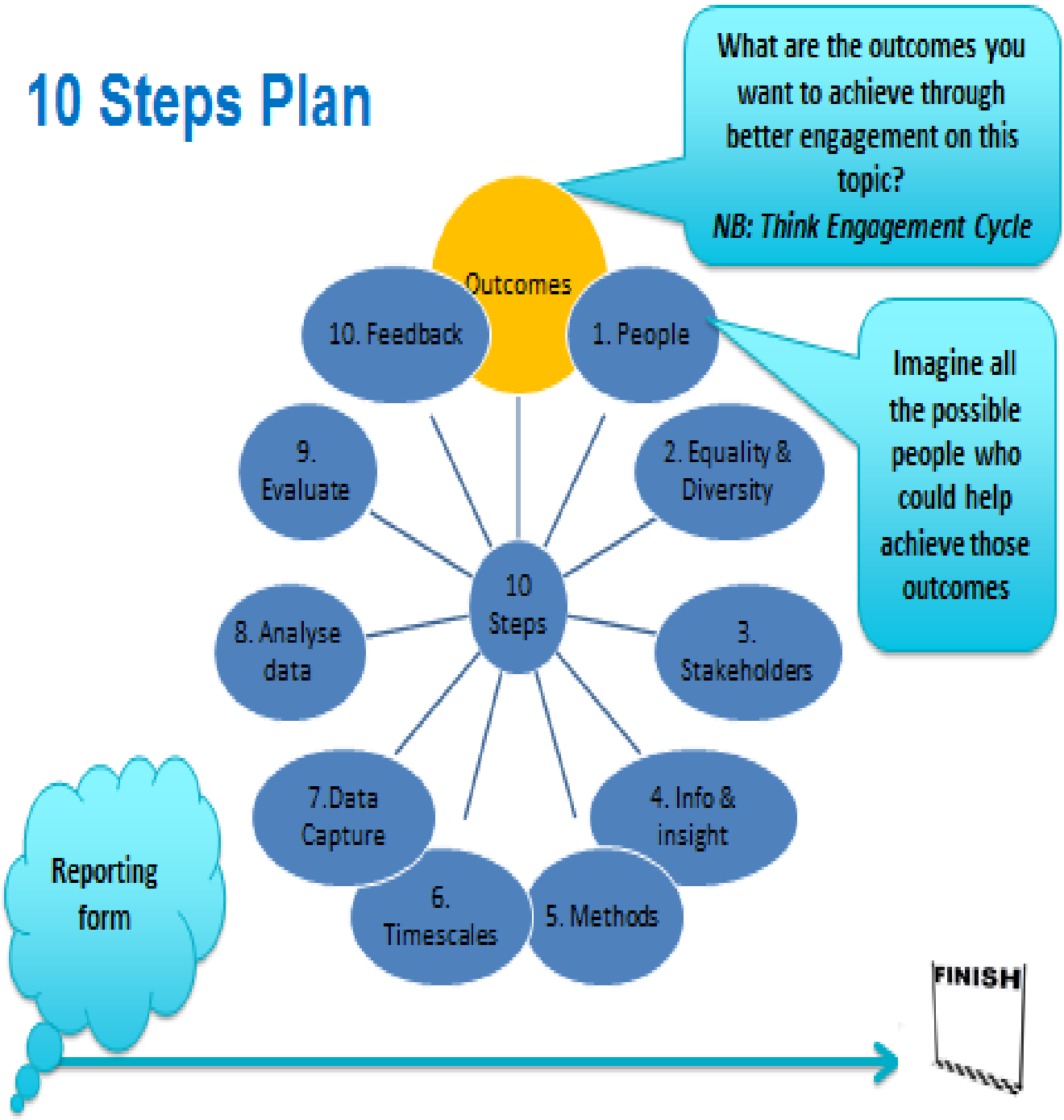
- Nine protected characteristics
- Seldom heard Groups
- Communities

What do we already know:

There is a wealth of information which is already available and to collate this information we have commissioned a mapping exercise to help us identify areas where we need to gather more information. Accessing this information will ensure that we avoid duplication and will identify for us where there are gaps in our local knowledge so we can identify any equalities gaps and resource appropriately.

We will consider the impact of the proposed activity on affected individuals. As a general rule, the greater the extent of change and number of people who will be affected, the greater the level of activity is likely to be necessary to achieve an appropriate level of public involvement. However, the nature and extent of public involvement required will always depend on the specific circumstances of an individual commissioning process.

We will ensure that we consider the '10 Steps plan' so that we are able to show that our engagement is planned, considers those groups who may be affected and that we always share and feed back to those whom have been involved.



12) Supporting best Practice:

This framework has a supporting document which has been developed to support engagement which meets our collaborative statutory requirements and shows our commitment to involving our population. The framework will enable us to evidence that we have correctly identified the need to involve patients and public in the activity and that our planned activity is both fair and proportionate. We are currently developing an Equality Impact Assessment Form and supporting Action Plan which will support future planning.

Partner organisations with the South Yorkshire and Bassetlaw ACS, have a variety of legal duties including to involve the public in the exercise of their statutory functions.

Appendix A(1)

Health and Care Working Together in South Yorkshire and Bassetlaw

Section 14Z2: Patient and Public Participation Form

Introduction

Clinical Commissioning Groups have a duty under Section 14Z2 of the NHS Act 2006 (as amended) to 'make arrangements' to involve the public in commissioning.

- This form is a tool to help commissioners identify whether there is a need for patient and public participation in their commissioning activity, and if required help them plan for a level of participation which is 'fair and proportionate' to the circumstances.
- The form must be completed at the start of the planning process for any commissioning activity and before operational commissioning decisions are taken which may impact on the range of commissioned services and/or the way in which they are provided.
- Completed forms may be used as evidence in the event of a legal challenge. Please retain a copy within your local system.

Step 1 – Title of the plan/proposal/project/commissioning activity and a brief description (including key objectives where appropriate). *Possible examples - procurement of a new service, proposals for service change, national policy development or an operational commissioning decision which affects services, e.g. closure of a GP practice.*

Location: *e.g. CCG, area*	
Title and Brief Description of Proposed Activity:	
Key Objectives of the Proposed Activity:	

Step 2 – Is there likely to be an impact on patients and the public? *To assess impact you should consider the overall population and groups/individuals within that population who are likely to be affected.*

If the plans, proposals or decisions are implemented, do you think there will be:

(a) An impact on how services are delivered?

☐ **Yes** ☐ **No**

Please explain your answer and provide further details:

(b) An impact on the range of health services available?

☐ Yes ☐ No

Please explain your answer and provide further details:

(c) Any other impact that you can envisage at this point in time? Please describe.

*If you have answered yes to (a), (b) or (c), it is highly likely that the Section 14Z2 duty applies. Note: the duty **always** applies to planning of commissioning arrangements (regardless of impact).*

Does the Section 14Z2 duty apply to the activity? ☐Yes ☐No

Please explain briefly why you have answered yes or no to the above:

Please note that if you have determined that Section 14Z2 does not apply to this particular activity it is good practice to retain a copy of the form should a challenge be made at a later date.

Step 3 – Describe any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight? *Examples could include patient and public views by patient and public voice (PPV) partners; surveys; intelligence on patient and public views from partners including other commissioners, Healthwatch and voluntary and community organisations.*

Please briefly complete each question below:

(a) What arrangements/mechanisms are already in place to involve the public which are relevant to this activity? (These may be local, regional, or national):

(b) How will the insight available to you help to inform your decision?

Please note that consideration of existing arrangement and patient and public insight will help inform any additional arrangements required under step 4.

Step 4 – Are additional arrangements for patient and public involvement required for this activity and in particular how will you ensure that 'seldom-heard' groups, those with 'protected characteristics' under the Equality Act, and those experiencing health inequalities are involved? (In due course, it may be appropriate to develop a full communications and engagement plan).

a) If yes, provide a brief outline of your approach and objectives for any additional patient and public participation:

b)

b) Have you considered the following:

Seldom-heard groups	☐ Yes ☐No
Nine Protected Characteristics	☐ Yes ☐ No
Health Inequalities	☐ Yes ☐ No

c) Briefly describe how your proposed participation will be 'fair and proportionate', in relation to your commissioning activity?

Step 5 - Planning for impact and feedback

(a) Provide a brief outline of how the information collected through patient and public participation will be used to influence the plan/activity.

(b) How will the outcomes of participation be reported back to those involved? *(refer to your communications and engagement plan, if appropriate)*:

(c) How will you assess the ongoing impact of the change on patients and the public after it has been completed?

Name of person completing the form:

Job Title:

E-mail address:

Team:

Date:

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of

8 December 2017

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Decision Summary

Minute reference	Item	Action
124/17	**CEO ACS Report** The Chair informed members that there is an ACS Development Day in London on Wednesday, 13th December 2017 and a report back will be given to members at the next Collaborative Partnership Board meeting or via e-mail. The priority focus areas together with a proposed management structure will be discussed at a workshop for CEO's in January and the proposed structure will be populated and implemented by April 2018.	The Chair W Cleary-Gray
125/17	**Integrated Operational Report** Richard Jenkins will be circulating information and requesting advice from the team regarding two issues one being the ownership of any breaches and the second being tariffs and the flow of money. The Chair requested the Cancer Alliance to report back to the Executive Steering Group or Collaborative Partnership Board with three or four sustainable proposals resulting from the scoping project.	R Jenkins L Smith
126/17	**Developing the ACS and Future Commissioning Arrangements** Will Cleary-Gray asked members to note that before becoming operational the ACS needs to complete an overarching strategy for 2018/19 in the next quarter. He added that the STP vision and strategy would also require refreshing.	W Cleary-Gray

127/17	**Workstream Priorities:** **Estates** Chris Edwards confirmed that the estates workstream needs to develop its strategy to enable it to deliver its priorities. He confirmed that the workstream would develop a strategy and priorities by the end of January 2018. **Digital/IT** Nicola Haywood-Alexander confirmed the workstream could move the priorities into actions in the next three months and it will populate the priorities with specifics by the beginning of 2018. **Medicines Optimisation** Idris Griffiths confirmed that the workstream would populate the priorities in time for discussion at the meeting in January 2018.	C Edwards N Haywood-Alexander I Griffiths
128/17	**Finance** The Chair requested Jeremy Cook to link in with Richard Jenkins (and others) regarding the analytical review as this linkage will provide information to enable him to highlight the four largest common opportunities across the system for 2018/19. The Chair highlighted that the top four large common opportunities identified from the analytical review will be discussed at the workshop in January 2018.	J Cook W Cleary-Gray
129/17	**Hospital Services Review** Alexandra Norrish informed members that there will be an interim report published on the website regarding the public engagement event held on the 6th December 2017.	A Norrish

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of

8 December 2017

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Name	Organisation	Designation	Present	Apologies	Deputy for
Sir Andrew Cash CHAIR	South Yorkshire and Bassetlaw ACS	ACS Lead/Chair, Sheffield Teaching Hospitals NHS FT, CEO	✓		
Adrian Berry	South West Yorkshire Partnership NHS FT	Deputy Chief Executive		✓	
Adrian England	Healthwatch Barnsley	Chair	✓		
Ainsley Macdonnell	Nottinghamshire County Council	Service Director		✓	Anthony May CEO
Alison Knowles	Locality Director North of England,	NHS England	✓		
Alan Davis	South West Yorkshire Partnership NHS FT	Director of Human Resources	✓		Adrian Berry
Alexandra Norrish	South Yorkshire and Bassetlaw ACS	Programme Director – Hospital Services Review	✓		
Andrew Hilton	Sheffield GP Federation	GP		✓	
Anthony May	Nottinghamshire County Council	Chief Executive		✓	
Ben Jackson	Academic Unit of Primary Medical Care, Sheffield University	Senior Clinical Teacher		✓	
Catherine Burn	Voluntary Action Representative	Director		✓	
Chris Edwards	NHS Rotherham Clinical Commissioning Group	Accountable Officer	✓		
Chris Holt	The Rotherham NHS FT	Deputy Chief Executive & Director of Strategy and Transformation		✓	
Des Breen	Working Together Partnership Vanguard	Medical Director	✓		
Diana Terris	Barnsley Metropolitan Borough Council	Chief Executive		✓	
Greg Fell	Sheffield City Council	Director of Public Health	✓		John Mothersole CEO
Frances Cunning	Yorkshire & the Humber PHE Centre	Deputy Director – Health & Wellbeing	✓		
Helen Stevens	South Yorkshire and Bassetlaw ACS	Associate Director of Communications & Engagement	✓		

Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Accountable Officer	✓		
Jackie Pederson	NHS Doncaster Clinical Commissioning Group	Accountable Officer	✓		
Jane Anthony	South Yorkshire and Bassetlaw ACS	Corporate Committee Administrator, Executive PA & Business Manager	✓		
Janette Watkins	Working Together Partnership Vanguard	Director	✓		
Janet Wheatley	Voluntary Action Rotherham	Chief Executive	✓		
Jeremy Cook	South Yorkshire and Bassetlaw ACS	Interim Director of Finance	✓		
John Mothersole	Sheffield City Council	Chief Executive		✓	
John Somers	Sheffield Children's Hospital NHS Foundation Trust	Chief Executive	✓		
Jo Miller	Doncaster Metropolitan Borough Council	Chief Executive		✓	
Julia Burrows	Barnsley Council	Director of Public Health	✓		
Julia Newton	NHS Sheffield CCG	Director of Finance		✓	
Kathryn Singh	Rotherham, Doncaster and South Humber NHS FT	Chief Executive		✓	
Kevan Taylor	Sheffield Health and Social Care NHS FT	Chief Executive		✓	
Lesley Smith	NHS Barnsley Clinical Commissioning Group	SYB ACS System Reform Lead, Chief Officer, NHS Barnsley CCG	✓		
Lisa Kell	South Yorkshire and Bassetlaw ACS	Director of Commissioning Reform	✓		
Louise Barnett	The Rotherham NHS Foundation Trust	Chief Executive		✓	
Maddy Ruff	NHS Sheffield Clinical Commissioning Group	Accountable Officer		✓	
Matthew Groom	NHS England Specialised Commissioning	Assistant Director	✓		
Matthew Sandford	Yorkshire Ambulance Service NHS Trust	Associate Director of Planning & Development	✓		Rod Barnes
Mike Curtis	Health Education England	Local Director	✓		
Neil Taylor	Bassetlaw District Council	Chief Executive		✓	
Nicola Haywood-Alexander	South Yorkshire and Bassetlaw ACS	Digital Programme Director	✓		
Paul Moffat	Doncaster Children's Services Trust	Director of Performance, Quality and Innovation		✓	
Paul Smeeton	Nottinghamshire Healthcare NHS Foundation Trust	Chief Operating Executive	✓		
Richard Henderson	East Midlands Ambulance Service NHS Trust	Chief Executive		✓	
Richard Jenkins	Barnsley Hospital NHS Foundation Trust	Chief Executive	✓		
Richard Parker	Doncaster and Bassetlaw Teaching Hospitals NHS FT	Chief Executive	✓		

Richard Stubbs	The Yorkshire and Humber Academic Health Science Network	Acting Chief Executive		✓	
Rob Webster	South West Yorkshire Partnership NHS FT	Chief Executive		✓	
Rod Barnes	Yorkshire Ambulance Service NHS Trust	Chief Executive		✓	
Roger Watson	East Midlands Ambulance Service NHS Trust	Consultant Paramedic Operations	✓		Richard Henderson
Rupert Suckling	Doncaster Metropolitan Borough Council	Director of Public Health	✓		
Ruth Hawkins	Nottinghamshire Healthcare NHS FT	Chief Executive		✓	
Sharon Kemp	Rotherham Metropolitan Borough Council	Chief Executive	✓		
Simon Morritt	Chesterfield Royal Hospital	Chief Executive	✓		
Steve Shore	Healthwatch Doncaster	Chair		✓	
Tim Moorhead	NHS Sheffield Clinical Commissioning Group	Clinical Chair		✓	
Victoria McGregor-Riley	NHS Bassetlaw CCG	Director of Primary Care		✓	
Will Cleary-Gray	South Yorkshire and Bassetlaw ACS	Sustainability & Transformation Director	✓		

Minute reference	Item	Action
120/17	**Welcome and introductions** The Chair welcomed members to the meeting	
121/17	**Apologies for absence** The Chair noted apologies for absence.	
122/17	**Minutes of the previous meeting held 10th November 2017** The minutes of the previous meeting were agreed as a true record.	
123/17	**Matters arising** **Workstream Priorities:** Primary Care At their last meeting the Collaborative Partnership Board did not approve the top 3 priorities for this workstream as presented. The workstream will be presenting their revised top 3 priorities to the Collaborative Partnership Board in January 2018. **Workforce** The top 3 priorities for this workstream were approved and Mike Curtis will be progressing the items identified i.e. the amendment of the strategy and drawing up the narrative required.	

	Finance Update: Jeremy Cook advised members that the Executive Steering Group approved the proposed allocation of the £3.2m uncommitted funds at their meeting on 21st November 2017. **Hospital Services Review** Alexandra Norrish said that she would talk to the communications team about the survey being circulated to the Joint Health Overview and Scrutiny Committee if it had not already been done. Post meeting update – The members of JHOSC had received communications on the review at its launch and been invited to share the survey link with their constituents. **To consider any other business** Dissemination of papers post CPB meetings. Will Cleary-Gray highlighted that the introduction of this system will help to ensure there is consistent communication across the ACS regarding the business going forward to Governing Bodies and Boards.	
124/17	**National Update** **CEO ACS Report** The Chair gave his Chief Executive Officer report to the meeting. This monthly report provides members with an update on: • The work on the ACS CEO over the last month. • A number of key priorities not covered elsewhere on the agenda. In addition to his report the Chair added the following updates: **Developing governance and resourcing to support the ACS strategic priorities** Ian Dalton, Chief Executive of NHS Improvement has said that NHSE/I need to give more clarity about governance and this is one of his key priorities to address. He also said there are semantics and differences in terminology used when referring to ACSs and this something that he will be addressing as the second wave of ACSs come on board in April 2018. The Chair highlighted that SYB STP had initially progressed work to develop itself into an ACS and is now exploring the development of its future governance arrangements. The Governance Group and Audit Chairs (one audit Chair from each place) had a workshop on 1st December 2017 to explore future governance arrangements, to ensure they are in place and that they will guarantee the ACS has consistent management,	

	cohesive policies, guidance, processes and decision-rights for a given area of responsibility, and proper oversight and accountability. The workshop was facilitated by Chris Ham, Chief Executive of the King's Fund. The Chair informed members that there is an ACS Development Day in London on Wednesday, 13th December 2017 and a report back will be given to members at the next Collaborative Partnership Board meeting or via e-mail. The Chair highlighted the priority focus areas for the SYB system working together in Phase 1, 2018/19 i.e. integrated ACS strategy and new regulation, workforce planning, financial strategy, SYAB ACS priorities, system transformation priorities, research, education and innovation, patient and public involvement, population health management. The priority focus areas together with a proposed management structure will be discussed at a workshop for CEO's in January and the proposed structure will be populated and implemented by April 2018. The Chair highlighted that the shadow phase (phase 1, 1st April 2018 to 31st March 2019) of the ACS could have two options regarding its management structure: • the creation of a senior structure of full time positions or, • the creation of a structure comprising of part time positions working at SYB ACS and the remainder of their week working in their substantive posts. The Chair stated that the ACS requires high-quality senior people to fill the positions in the proposed new management structure and it should also ensure there is good geographical representation across the five ACS areas. The Chair highlighted the following focus areas for the SYB ACS working together in phase 1: • building an integrated ACS strategy and new regulation - ensuring the structure is not another tier of management and that links the systems organisations and places through the ACS. • Workforce planning - having a senior HR leadership presence at a system level • Financial strategy - getting ready to deliver the control total from 1st April 2019 (not 2018). • System transformation priorities - the 45 priorities identified by our workstreams need to be focussed to 10-12 priorities for the ACS. This will be completed at the workshop in January 2018. • Research, education and innovation - there is £3.5bn in the recently launched UK Life Sciences Industrial Strategy that could be available to benefit the population of South Yorkshire and Bassetlaw. The ACS is keen to forge better links with industry to help in the creation of jobs in areas such as the advanced manufacturing, digital and in healthcare medical technology industry.	**The Chair** **W Cleary-Gray**

- Patient and public involvement - active public involvement to enable the ACS to evolve with public support and participation.
- Population Health Management – understanding the SYB population needs and inequalities to inform commissioning decisions and best use of funds to improve outcomes in areas such as childhood obesity, tobacco and alcohol cessation.

The Chair responded to a comment regarding the Autumn Budget and the requirement to reduce management costs by 15-20%. He said that the SYB ACS needs to change the way it delivers services to achieve savings and we need to work with NHSE/I, CCGs and hospitals to achieve this.

Will Cleary-Gray asked members to note that there are limits to the amount of transformational funding available for backfilling posts. The ACS will not be developing another tier of management in its structure therefore it needs to develop new ways of working. A management structure will be discussed and developed at the workshop in January.

Lisa Kell added that it is beneficial that Alison Knowles and her team from NHSE are linked with SYB ACS and can offer the ACS support regarding governance issues. The national team has also offered support to SYB ACS in creating a governance structure for the future ACS.

The Chair asked members to note that in the future governance of the ACS it is likely that the meeting arrangements will change as from April 2018. The Governance and the Audit Chairs groups are initially formulating the meeting structure required to proceed from 1st April 2018 and may engage with Ian Dalton in this work.

Autumn Budget 2017

The Chair highlighted that the Autumn Budget announced a further £2.8b of revenue funding for the NHS and added the maximum amount SYB would receive from the additional funding would be the fair share element which stands at 2.9%), which the following is a break-down by year.

2017/18 £9.7m

2018/19 £46.4m

2019/20 £25.1m

The Chair reminded members that it was the 70th anniversary of the National Health Service on 5th July 2018. The ACS should ensure that it is in a position to bid into any potential capital funding that may be made available in the 70th anniversary year.

	The Collaborative Partnership Board noted the update.	
125/17	**Integrated Operational Report** Alison Knowles referred to her paper (C) circulated with the agenda papers and highlighted that the report provides an interim view of performance across the ACS pending the development of the wider single assurance framework. She highlighted that South Yorkshire and Bassetlaw ACSs overall performance has improved with achievement of eight out of the ten national indicators (compared to seven in August). In a ninth area, (waiting time in A&E), the ACS achieved the expected in-year performance of at least 90% but did not deliver the national standard. The access to diagnostic tests within six weeks of referral remained below national standards. Richard Jenkins informed members that short term recommendations have been implemented for echocardiography and it is expected that these will result in positive traction towards the targets in 1-2 months. Extra capacity is being implemented to progress work required in echocardiography. He added that he will be circulating information and requesting advice from the team regarding two issues one being the ownership of any breaches and the second being tariffs and the flow of money. Lesley Smith added that the Cancer 62 day target has been achieved in September but October and November may not achieve the target. However, it should be noted that there are other sides to improvement that should be highlighted other than targets i.e. sharing learning and 'taking on' cancer from 1st April 2018. She added that the areas of traction are Upper GI, Head and Neck, Chemotherapy and Introducing a Faecal Immunochemistry Test in primary care for people with lower GI symptoms. The Cancer Alliance will be undertaking a scoping project and will be bringing back information relating to the above four areas of traction and their commissioning, provision and transformation. The Cancer Alliance will address what change is required in provision and commissioning going forward from 1st April 2018. The Chair requested the Cancer Alliance to report back to the Executive Steering Group or Collaborative Partnership Board with three or four sustainable proposals resulting from the scoping project. The Collaborative Partnership Board noted the current published performance against key national indicators for the South Yorkshire & Bassetlaw ACS.	**R Jenkins** **L Smith**

126/17	**Developing the ACS and Future Commissioning Arrangements** Will Cleary-Gray updated members regarding the development of the ACS and future commissioning arrangements. He asked members to note that before becoming operational the ACS needs to complete an overarching strategy for 2018/19 and then distill the information into the workstreams identified in the Memorandum of Understanding. He added that the STP vision and strategy would also require refreshing. The Hospital Services Review will report on its recommendations and the ACS need to be mindful that it meets the principles of the Hospital Services Review when drawing up its overarching strategy. He informed members that setting out the operational plan for 2018/19 and the development of an overarching strategy needs to be completed in the next quarter. The Chair highlighted that any financial implications of the Hospital Services Review recommendations should be affordable and sustainable. Sharon Kemp informed members that Local Authorities are keen to get involved in place based commissioning. She added that it is important for CEOs to be involved in place based commissioning as it feeds into local tariffs. The Chair thanked Will Cleary-Gray for his update.	**W Cleary-Gray**
127/17	**Workstream Priorities –** slides will be circulated to members after this meeting **Children's and Maternity** John Somers and Chris Edwards presented the Children's and Maternity workstream top 3 priorities for the Collaborative Partnership Boards approval as: • Improve quality and sustain access to surgery and anaesthesia care, network the provision. • Sustain children's acute care, through a network approach and new models of care. • Deliver Better Births in maternity care. John Somers spoke to the Children's element of the workstream priorities stating that the key drivers for the priorities were accessibility, shortage of paediatric nurses and a public consultation process.	

	He informed members that in relation to the first priority one to two children are involved in accessing the services on a monthly basis. The hospital sites involved are Pinderfield's General Hospital in Wakefield, Sheffield Children's Hospital NHS FT and Doncaster Royal Infirmary. As part of the project, peer reviews are currently being undertaken; these are challenging but are proving to be very useful. Three peer reviews have taken place and there are another three to be undertaken in January 2018. The children's surgery and anaesthesia services project has got traction for implementation to proceed in 2018/19. In relation to the second priority a managed clinical network has been established and this will be aligned with the Hospital Services Review (HSR) as their recommendations emerge (HSR recommendations will be published at the end of April 2018). New sustainable models of paediatric care are being investigated along with upskilling of community services to reduce the impact on secondary and specialist care. Chris Edwards spoke to the maternity element of the workstream priorities i.e. Better Births in maternity care. Maternity has been allocated £150k and there is a further £4m (of national monies) in the Memorandum of Understanding. The maternity plan has received good feedback from the national team. Maternity care consists of consultant led, midwife led and home birth services. Chris Edwards highlighted that there is a challenge to the workforce resulting from declining numbers of consultants and midwives in the maternity services. The Chair noted that a stock take is required at 'place'. This will enable the ACS to identify the areas that it should be involved in to make progress. Chris Edwards added that we require solutions to establish how we recruit and keep our workforce. Rupert Suckling highlighted that the key priorities identified for this workstream risked a disconnection from the vision of the children's and maternity workstream. We should be mindful that the vision of the workstream does not get left behind. The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented. **Estates** Chris Edwards presented the Estates workstreams top 3 priorities for the Collaborative Partnership Boards approval as: • Develop an ACS estates strategy. • Detailed delivery plan for estates priorities. • Optimisation of high quality estate.	

	Chris Edwards informed members that the priorities have been developed with the Interim Director of Finance and the ACS Estates Workstream Lead using specific criteria. He said that the Sir Robert Naylor Review was published in April 2017 and it sets out the new NHS estates strategy focused on delivering improved care. However, the review was not very beneficial to the estates workstream as it is London centric and so the workstream is waiting for the Estates National Strategy to be published in December 2017 which could have an impact on the workstream. He highlighted that the workstream requires skills and resources to be put in place. He informed members that sites have been identified that address all the national priorities and in doing so will therefore attract funding. Alison Knowles highlighted that NHS estates and technology transformation funding (ETTF) is a multi-million pound investment (revenue and capital funding) in general practice facilities and technology across England and we should ensure that the capital links back to the ACS strategy so that estates attract ETTF funding. The estates workstream should note the process to acquire ETTF funding and the ACS can utilise the funds on its projects. A discussion took place regarding the outcome of the Hospital Service Review (HSR) and the need for the workstream to be aware of any implications for them resulting from the HSR recommendations. Chris Edwards informed the meeting that he sits on the Sheffield City Region Joint Assets Board and in this capacity he is aware of current and future initiatives and opportunities in this sector. Chris Edwards confirmed that the estates workstream needs to develop its strategy to enable it to deliver its priorities. He confirmed that the workstream would develop a strategy and priorities by the end of January 2018. The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented. **Digital/IT** Nicola Haywood-Alexander presented the Digital workstreams top 3 priorities for the Collaborative Partnership Boards approval as: • The future ACS digital delivery framework. • Population health data and information requirements.	**C Edwards**

	• Interoperability – technical architecture and integrated care records. Nicola Haywood-Alexander gave a brief overview of the progress of the Digital/IT workstream. She added that the Digital/IT workstream would like to move to a more facilitative role regarding the sharing of data between NHS organisations. The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented. Nicola Haywood-Alexander confirmed the workstream could move the priorities into actions in the next three months and it will populate the priorities with specifics by the beginning of 2018. **Medicines Optimisation** Idris Griffiths presented the Medicines Optimisation workstreams top 3 priorities for the Collaborative Partnership Boards approval as: • Efficient prescribing • Universally adopting initiatives and innovations • Implementing results of national consultation Richard Jenkins raised the point that there is significant duplication in the analysis of new drugs by individual hospitals and this requires addressing, we need a system that will analyse all new drugs on behalf of everyone in the SYB ACS footprint and in doing so save resources across the system. The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented Idris Griffiths confirmed that the workstream would populate the priorities in time for discussion at the meeting in January 2018. The Chair thanked people for presenting their information at this meeting.	**N Haywood-Alexander** **I Griffiths**
128/17	**Finance Update** Jeremy Cook, Interim Director of Finance SYB ACS, presented his finance report to the meeting. The report informs members on a number of items e.g. Directors of Finance meetings and other general updates, the Autumn Budget and financial reporting. Jeremy Cook informed members that he will be discussing the opportunities of undertaking an analytical review across the ACS which covers operational productivity (providers), right care	

	(commissioners), getting it right first time (providers), medicines optimisation (commissioners) and menu of opportunities (commissioners). The Chair requested Jeremy Cook to link in with Richard Jenkins (and others) regarding the analytical review as this linkage will provide information to enable him to highlight the four largest common opportunities across the system for 2018/19. The opportunities should identify what should be done at an Accountable Care Partnership (ACP) level and what needs to be done at an ACS level to improve efficiency and effectiveness. The Chair highlighted that the top four large common opportunities identified from the analytical review will be discussed at the workshop in January 2018. The Collaborative Partnership Board noted the contents of the report. The Chair thanked Jeremy Cook for his report and for presenting the information contained therein.	**J Cook** **W Cleary-Gray**
129/17	**Hospital Services Review Update** Alexandra Norrish updated the group on progress on the Hospital Services Review (a copy of her presentation will be circulated to members). She said that the first cut and analysis will be produced in time to be discussed at the Hospital Services Steering Group meeting in January 2018. Alexandra Norrish informed members that there had been a very good and constructive public engagement event held on the 6th December 2017 and there will be an interim report published on the website regarding this event. Helen Stevens added that the public engagement element of the event had proved to be successful. The Chair thanked Alexandra Norrish for her presentation and attendance at this meeting.	**A Norrish**
130/17	**To consider any other business** There was no other business brought before the meeting.	
131/17	**Date and Time of Next Meeting** The next meeting will take place on 12th January 2018 at 9.30am to 11.30am in the Boardroom, NHS Sheffield CCG, 722 Prince of Wales Road, Sheffield, S9 4EU.	

ACS CEO Report

SOUTH YORKSHIRE AND BASSETLAW
ACCOUNTABLE CARE SYSTEM
COLLABORATIVE PARTNERSHIP BOARD

12 January 2018

Author(s)	**Sir Andrew Cash, ACS Lead and Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust**
Sponsor	

Is your report for Approval / Consideration / Noting

For noting and discussion

Links to the STP (please tick)

☑ **Reduce inequalities**	☑ **Join up health and care**	☑ **Invest and grow primary and community care**	☑ **Treat the whole person, mental and physical**
☑ **Standardise acute hospital care**	☑ **Simplify urgent and emergency care**	☑ **Develop our workforce**	☑ **Use the best technology**
☑ **Create financial sustainability**	☐ **Work with patients and the public to do this**		

Are there any resource implications (including Financial, Staffing etc)?

N/A

Summary of key issues

This monthly paper from the ACS CEO provides an:

- Update on the work of the ACS CEO over the last month
- Update on a number of key priorities not covered elsewhere on the agenda

Recommendations

The Collaborative Partnership Board is asked to note and discuss the update.

Accountable Care System CEO Report

SOUTH YORKSHIRE AND BASSETLAW
ACCOUNTABLE CARE SYSTEM

12 January 2018

1. Purpose

This monthly paper from the ACS CEO provides an:

- Update on the work of the ACS CEO over the last month
- Update on a number of key priorities not covered elsewhere on the agenda

2. Report – January 2018

2.1 STP leaders network meeting

STP leaders across England met in December to share learning and experiences from their areas. Topics covered included:

- The importance of co-ordinating national funding schemes
- National HR framework discussions
- Developments in place and system accountabilities

The next scheduled meeting is Friday 12 January. A workshop to explore governance models is also planned in January.

2.2 SYB ACS Workshop

The next ACS workshop is planned for Friday 2 February, at the New York Stadium in Rotherham. The focus for the session will be on two key areas:

- To agree the priorities for 18/19
- To understand the governance and management structure needs for 18/19 and 19/20

The session is with chief executives and chief officers, with some executive leads from their teams and will be facilitated by Chief Executive of the King's Fund, Chris Ham.

2.3 Visit from Director of Nursing for England, Hilary Garrett

Director of Nursing for England, Hilary Garrett, will visit South Yorkshire and Bassetlaw on Tuesday 13 February to support conversations about the Five Year Forward View/Accountable Care Partnership/Accountable Care System with nurses across the region.

Plans are currently being drawn up with chief nurses for Hilary to attend as many local sessions as possible with a Q&A session and marketplace for staff where they can learn more about what's happening in their organisation, place and across the region in relation to transformation and what it means for them.

2.4 Forward planning for discussions on the ACS

Since publishing the Sustainability and Transformation Plan for South Yorkshire and Bassetlaw in November 2016, we have gone from strength to strength as a partnership - from being announced as one of the first Accountable Care Systems in the country, to being rated as Outstanding in the first progress dashboard and now, preparing to operate in shadow form as an ACS from April onwards.

We've achieved a considerable amount in a short space of time which is testament to the existing strong partnership working and the commitment from everyone to progress and improve the health and wellbeing of South Yorkshire and Bassetlaw.

Quarter four is always a busy time - with operational and winter pressures, final quarter deadlines and preparations for the new financial year in a few months' time but together, we're in an excellent position, with national funding and support to help us over the coming year as we work towards transforming services in our region.

As we think about the year ahead, I also want to take the opportunity to ask you and your governing body or board to start to think about **forward planning** for discussions to help enable the ACS moving forward on business. These are likely to include, but are not exclusive, the **ACS integrated strategy** which will allow us to **re-fresh our plan** and **operational planning for 18/19** and beyond, **future governance arrangements** for our next phase, **finance (payment reform** and operating a **system control total**), **transformation** (including the **Hospital Services Review**) and how **commissioning reform** and **new models of care** can enable delivery.

We will shortly issue a forward plan, which sets out the timetable for the year ahead and which will include an indication of what is for private and what is for public discussion to help you in your planning.

2.5 Citizens' Panel

Our newly formed Citizens' Panel met in December for a session run by NHS England called, "10 steps to even better engagement." The workshop provided the Panel with a helpful opportunity to start thinking about their role in increasing public participation in our local areas, with the real-life examples of the five services within the hospital services review.

Further work is now taking place to widen the representation of the panel to our various populations.

2.6 Awards success

In December two of our partners won Health Business Awards held at a ceremony in London to celebrate the significant contributions made each year by organisations and individuals that work inside and alongside the NHS.

Congratulations to:

- NHS Barnsley Clinical Commissioning Group for winning the Clinical Commissioning category and;
- Yorkshire Ambulance Service for winning in the category for Transport and Logistics Staff Partnership.

3. Recommendations

The Collaborative Partnership Board is asked to note and discuss the update.

Date 12 January 2018

Equality and diversity briefing for the Executive Steering Group

SOUTH YORKSHIRE AND BASSETLAW
ACCOUNTABLE CARE SYSTEM
EXECUTIVE STEERING GROUP

20 February 2018

Author(s)	**Katy Hyde, Public and Patient Engagement Manager** **Helen Stevens, Associate Director Communications and Engagement**
Sponsor	**Will Cleary-Gray**

Is your report for Approval / Consideration / Noting

Noting and approval

Links to the STP (please tick)

☑ **Reduce inequalities**	☑ **Join up health and care**	☑ **Invest and grow primary and community care**	☑ **Treat the whole person, mental and physical**
☑ **Standardise acute hospital care**	☑ **Simplify urgent and emergency care**	☑ **Develop our workforce**	☑ **Use the best technology**
☑ **Create financial sustainability**	☑ **Work with patients and the public to do this**		

Are there any resource implications (including Financial, Staffing etc)?

The need to consider and work towards ensuring the ACS is meeting the legal requirements of its constituent organisations in relation to equality and diversity means that staff within the ACS who are leading transformation work will need to assign time and resource for the work.

Summary of key issues

- The paper outlines the challenges/risks and issues for South Yorkshire and Bassetlaw Accountable Care System in relation to undertaking effective and safe equality analysis in the light of legal precedents.
- It draws attention to the legal requirements within the Equality Act 2010, the Public Sector Equality Duty and also the need for due regard for decision makers.
- There are a number of ways in which work focusing on equality and diversity will support the ACS as it looks to improve the health and wellbeing of the population of South Yorkshire and Bassetlaw.
- There are some key risks that decision makers will want to be aware of.
- An approach which embeds equality and diversity into everyday business, is consistent across all workstreams and offers training for staff is recommended.

Recommendations

The Senior Management Team/Executive Steering Group is asked to:

- Note the contents of the paper regarding the current position in the South Yorkshire and Bassetlaw ACS especially in relation to its legal responsibilities.
- Approve the recommended approach and next steps, including the adoption of the template plan and form at an ACS level and also within the five CCGs.

Equality and diversity briefing for the Executive Steering Group

SOUTH YORKSHIRE AND BASSETLAW
ACCOUNTABLE CARE SYSTEM

20 February 2018

1. Purpose

To outline the challenges/risks and issues for South Yorkshire and Bassetlaw Accountable Care System in relation to undertaking effective and safe equality analysis in the light of legal precedents.

2. Background

2.1 Legal requirements: The Equality Act 2010 and the Public Sector Equality Duty

The Equality Act 2010 brought together all the previous and separate pieces of anti-discrimination legislation into one Act of Parliament. The Act covers the following “protected characteristics": age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

The Equality Act contains special provisions for public sector bodies known as the Public Sector Equality Duties (PSED). It is made up of the general duty which is the overarching requirement and ‘specific duties’ which are intended to help performance of the general duty.

The general duty has three aims and it applies to most public authorities, including CCGs who must, in the exercise of their functions, pay due regard to them. These are:

- Aim 1: eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- Aim 2: advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- Aim 3: foster good relations between people who share a protected characteristic and people who do not share it.

Equality impact assessment (EIA) is a way of systematically analysing a new or changing policy, strategy, process etc to identify what effect, or likely effect it could have on ‘protected groups’ to ensure appropriate decisions, which reduce health inequalities, address discriminatory consequences and maximise opportunities to promote equality, are made.

Equality impact assessment is an integral part of our commissioning processes. It involves looking at what steps could be taken to advance equality, eliminate discrimination and promote good relations. Case law has demonstrated that we need to ensure that we give full consideration to the impact our decisions have on protected groups to avoid both risks in terms of litigation and reputation. We also need to ensure that those we commission deliver on equality improvements.

As a group of public authorities we are subject to the general and specific public sector equality duties. Using an equality impact assessment is one way of demonstrating that we are compliant with the Equality Act 2010.

2.2 Due Regard: The Brown principles

There are six principles for paying 'due regard', which were set out in the case of R. (Brown) v. Secretary of State for Work and Pensions (2008).

They are:

- Decision makers must be made aware of their duty to have 'due regard' to the aims of the duty.
- Due regard involves a conscious approach. Attempts to justify a decision as being consistent with the exercise of duty when it was not considered before the decision are not enough to discharge the duty. General regard to the issue of equality is not enough to comply with the duty.
- The duty must be exercised in substance, with rigour and with an open mind in such a way as it influences the final decision.
- The duty has to be integrated – it is not just a question of ticking boxes.
- The duty cannot be delegated.
- It is good practice for those exercising public functions to keep accurate records showing that they have actually considered the general equality duty and pondered relevant questions. If records are not kept it may make it more difficult evidentially for a public authority to persuade a court that it has fulfilled its duty.

3. Supporting the work of South Yorkshire and Bassetlaw ACS

There are a number of ways in equality and diversity information can support the work of the ACS:

- Work on equality and diversity must start at the beginning of any process to demonstrate that 'due regard has been given' to the impact of any proposal. Demographic breakdown of the population is needed as this should influence any proposal should it go to formal consultation. We will undertake this work as soon as any potential change is foreseen.

- Section 149 of the Equality Act 2010 lists nine protected characteristics which need to be given full consideration in relation to possible impact of a proposed change. We can evidence our commitment to listening through delegating some of the targeted engagement to local community organisations with proven track records of reaching those groups.

- An initial equality analysis will identify what it is that we don't know, this will assist and strengthen any engagement work moving forward.

- Publishing equality impact assessments on the ACS website demonstrates a recognition of our legal requirements and our commitment to really understanding the views of our whole population. As each stage progresses the E.I.A should be refreshed and published.

- As critical friends, the members of the Citizens' Panel will provide additional confirmation that appropriate and proportionate consideration has been given to our duty.

4. Risks for the ACS

There are a number of risks in relation to equality and diversity that the Executive Steering Group will want to be aware of:

- There are disparities in current forms across ACS organisations available for undertaking the equality impact assessment and therefore process.
- That 'Due Regard Duty' is not fully recognised or understood, and that whilst the undertaking to engage can be delegated there needs to be an assurance that those to whom it is delegated are suitable qualified and trained.

- Due Regard is open to interpretation by public bodies and proving that 'due regard' has been given can be very costly for an organisation.
- Legal requirements to consult are built into legislation.
- Equality and diversity is not yet reported through governance structures.

4. Suggested approach

Evidence indicates that equality engagement is not yet fully embedded as a core part of the ACS's activity and there is insufficient assurance across the system of effective and safe equality analysis in the light of legal precedents. In part, this is due to confusion/lack of clarity around accountability.

4.1 Embedding

The completion of an EIA must become 'business as usual' for the system. Furthermore as work streams progress a refreshed EIA must be produced. Accurate records must be kept and maintained showing how the EIA and information drawn through it has been used to target and effectively engage with our population with particular emphasis on those for whom any decision will have an impact.

4.2 Consistent approach

A consistent approach is recommended, which would ensure that:

a) The EIA is completed at the start of any proposal or activity, using the same plan and form (see Appendix 1 and 2 for the EIA plan template and 14Z2 form).
b) The findings are used to develop and plan thorough and comprehensive engagement.
c) Targeted engagement is arranged when it is clear that the protected characteristic groups have not been given an opportunity to respond.
d) The form is refreshed at pertinent points during the process.
e) Findings are reported through the governance routes and formally documented.

4.3 Training

Training for appropriate personnel is recommended to ensure a full understanding of the process.

5. Next steps

- Raise the profile and importance of completing an Equality Impact Assessment for each step and process
- Provide training if needed to ensure there is a recognition relating to the rising numbers of legal challenges to consultation decisions on equality grounds.
- For the template and form to be adopted by the five CCGs in the ACS, to provide a consistent approach.

5. Recommendations

5.1 The Senior Management Team/Executive Steering Group is asked to:

- Note the contents of this paper regarding the current position in the South Yorkshire and Bassetlaw ACS especially in relation to its legal responsibilities
- Approve the recommended approach and next steps, including the adoption of the template plan and form at an ACS level and also within the five CCGs.

Paper prepared by Katy Hyde, Public and Patient Engagement Manager
On behalf of Helen Stevens, Associate Director Communications and Engagement

Date 4 January 2018

Appendix 1

Equality Analysis and Engagement Plan

A template for staff 2017

Engaging with patients and the public is a **statutory duty**. This planning template has been developed to support the process and to ensure that alongside our statutory duty we ensure that any planned activity is meaningful allowing for fair and proportionate involvement. We need to ensure that we can evidence that we have considered the impact our activities will/may have on patients and the public; and identifying changes we can make to reduce/remove any negative impacts is a **statutory duty.** The equality analysis in this plan forms the initial stage of the equality impact assessment process.

The purpose of an Equality Impact Assessment (EIA) is to improve the work of the Accountable Care System by making sure it does not discriminate and that, where possible, promotes equality. It is a way to make sure individuals and teams think carefully about the likely impact of their work on service users and take action to improve activities, where appropriate.

The Equality Impact Assessment (EIA) focuses on systematically assessing and recording the likely equality impact of an activity or policy. There is a focus on assessing the impact on people with protected characteristics. This involves anticipating the consequences of activities on these groups and making sure that, as far as possible, any negative consequences are eliminated or minimised and opportunities for promoting equality are maximised.

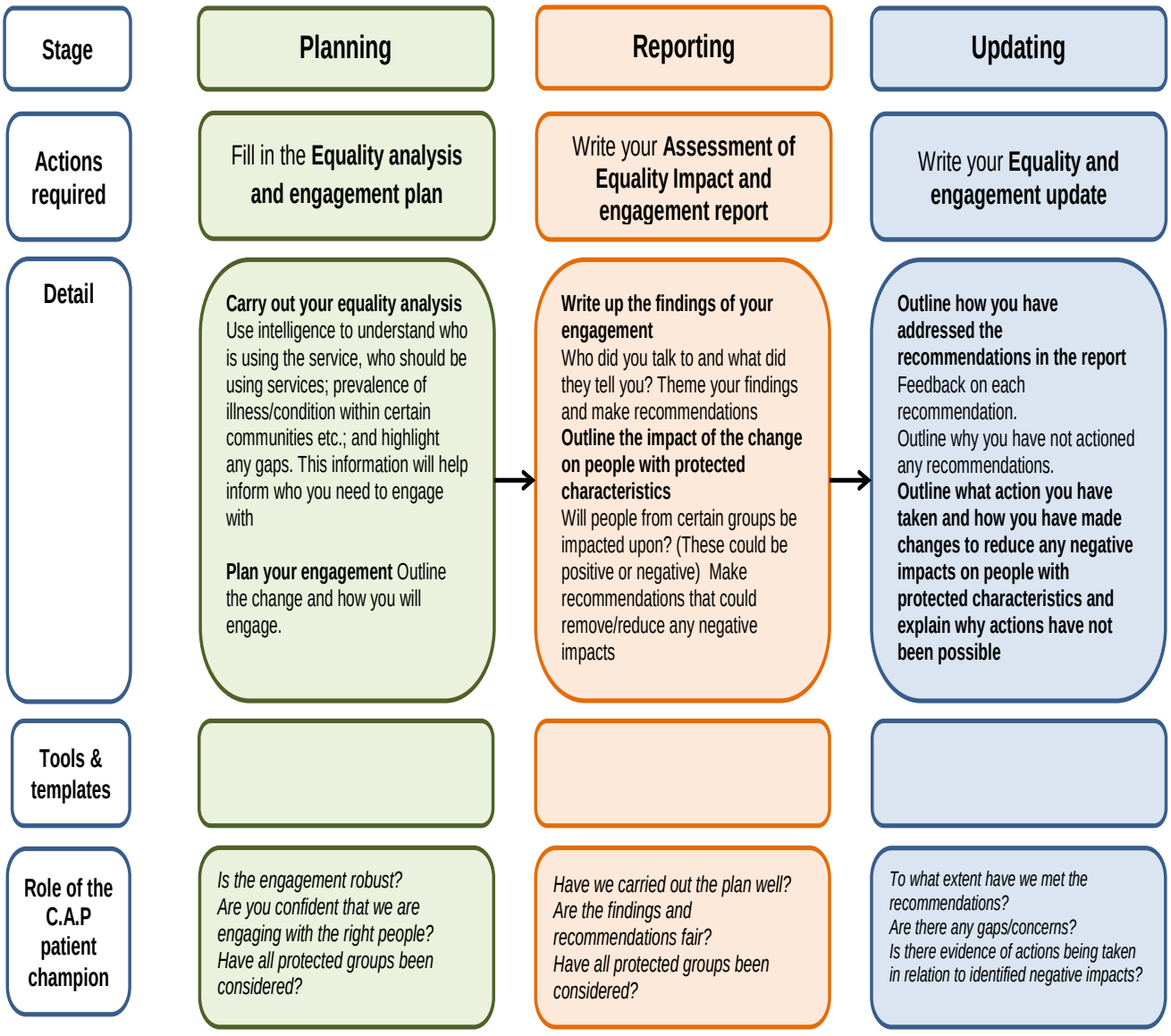
The EIA is carried out by completing a form, drawing on existing research, monitoring information, and consultation. Once this has been completed, action plan can be drawn up and any decisions to change the delivery of an activity or policy can be made.

The Citizen's Panel is a group of patients and organisational representatives who meet regularly to assure the board that we are engaging in the right ways and with the right people. It is made up of members of the public who are asked to represent the wider public at the meeting. An element of their role is to act as 'critical friend' and to challenge where necessary any decisions where they feel that any planned engagement may not hear the views of those individuals or groups with protected characteristic

There are three reasons an Equality Impact Assessment might be presented to the Citizens' Panel:

1. To give advance notice of a **significant** service change (a level 3 or 4 change)
2. To present the equality analysis and engagement plan
3. To provide a update on an engagement project that has previously been taken to CP

If you have any questions please speak to the communications team


Stage
Planning
Reporting
Updating
Actions required
Fill in the Equality analysis and engagement plan
Write your Assessment of Equality Impact and engagement report
Write your Equality and engagement update
Detail
Carry out your equality analysis
Use intelligence to understand who is using the service, who should be using services; prevalence of illness/condition within certain communities etc.; and highlight any gaps. This information will help inform who you need to engage with
Plan your engagement Outline the change and how you will engage.
Write up the findings of your engagement
Who did you talk to and what did they tell you? Theme your findings and make recommendations
Outline the impact of the change on people with protected characteristics
Will people from certain groups be impacted upon? (These could be positive or negative) Make recommendations that could remove/reduce any negative impacts
Outline how you have addressed the recommendations in the report
Feedback on each recommendation.
Outline why you have not actioned any recommendations.
Outline what action you have taken and how you have made changes to reduce any negative impacts on people with protected characteristics and explain why actions have not been possible
Tools & templates
Role of the C.A.P patient champion
Is the engagement robust?
Are you confident that we are engaging with the right people?
Have all protected groups been considered?
Have we carried out the plan well?
Are the findings and recommendations fair?
Have all protected groups been considered?
To what extent have we met the recommendations?
Are there any gaps/concerns?
Is there evidence of actions being taken in relation to identified negative impacts?

1. Project Title:

2. Project Lead: **Contact details:**

3. This activity/project is:

4. Describe your activity/project

a. Describe the activity/project (what are you planning, proposing, changing and why?)

b. Outline the aim of the engagement

c. Outline the objectives of the engagement

d. Outline expected outcomes from the engagement

e. How will you use patient involvement to influence the outcome?

- How does the project support the South Yorkshire and Bassetlaw ACS? (delete as appropriate)

- People will live longer and have healthier lives
- People will live full, active and independent lives
- People's quality of life will be improved by access to quality services
- People will be involved in decisions made about them
- People will live in healthy and sustainable communities

f. What is the level of service change? (see appendix A)

Level 1 ☐	**Level 2** ☐	**Level 3** ☐	**Level 4** ☐

If your project is classed as a 'significant variation' (level 3) or 'major change' (level 4) please contact england.yhclinicalstrategy@nhs.net for a preliminary discussion to support planning and agree whether the service change needs to follow the NHS England Service Change Assurance process.
The assurance process generally looks at the 'case for change' The key players in the process include overview and scrutiny teams, and the clinical senates.

You can also refer to the DH guidance: (please note that level 4 changes will require considerable long term planning and this DH guidance is mandatory for all level 4 changes)
http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/nhs_public_involvement_-hempsons_stp.pdf
DH 2013

5. Pre-activity/proposal/consultation information (Equality Analysis)
What do you already know about peoples' access, experience, health inequalities and health outcomes? Use **relevant** intelligence from existing local, regional or national research, data, deliberative events or engagements.

Example:
"Prevalence of mental health disorders in adult minority ethnic populations in England: a systematic review" Institute of Education January 2016

Identifying impact: please consider how the activity may impact on each of the identified protected characteristics outlined in Appendix B

- **Positive Impact:** will actively promote or improve equality of opportunity;
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures.

Gathering of Information
This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.

(Please complete each area)	What key impact have you identified?			Information Source	
	Positive Impact	Neutral impact	Negative impact		What action, if any, is needed to address these issues and what difference will this make? For example: At this point no action is required. Further EIA screenings will be developed in future once there are recommendations to assess.
Human rights	☐	☐	☐		
Age	☐	☐	☐		
Carers	☐	☐	☐		
Disability	☐	☐	☐		
Sex	☐	☐	☐		
Race	☐	☐	☐		
Religion or belief	☐	☐	☐		
Sexual orientation	☐	☐	☐		
Gender reassignment	☐	☐	☐		
Pregnancy and maternity	☐	☐	☐		

5. Pre-activity/proposal/consultation information (Equality Analysis)
What do you already know about peoples' access, experience, health inequalities and health outcomes? Use **relevant** intelligence from existing local, regional or national research, data, deliberative events or engagements.

Marriage and civil partnership (only eliminating discrimination)	☐	☐	☐		
Other relevant groups	☐	☐	☐		

If your analysis has highlighted any gaps please outline what action you will take in section 7.

6. What timescales are you working to?
Please share your equality analysis and engagement plan with the C.A.P at the earliest opportunity and allow time to make any necessary changes to your engagement.
(include planning implementation, evaluation and feedback)

Complete equality analysis and engagement plan	
Attend C.A.P to share your plan if deemed appropriate	
Follow process in section 4 (if level 3 or 4)	
Carry out engagement- either formal or informal	
Complete engagement report	
Commencement of service	
Feedback to stakeholders and the CAP	

7. Engaging with your stakeholders
(consider using a mapping tool to identify stakeholders)

a. Who is the change going to affect and how? (Taking into consideration the information/data research and equality analysis in section 5)

To engage with the following…			
Group (Which group of people? Providers, patients, public, carers etc)	**Inform/engage** (Are you engaging or informing?)	**How** (How will you engage with them? – Surveys, focus groups etc. This will need to be different for different groups)	**By who** (Who will carry out this work? Commissioners, engagement team, third sector, Engaging Voices)
Example: patients using the chronic pain service	Engaging	Asking patients in the waiting room to fill out a survey about their experience. Holding focus groups with chronic pain service users	CCG staff to carry out surveys in the waiting room. CCG staff will plan and deliver the focus groups
Underpinning principles to ensure that our engagement activities are accessible to all our diverse communities.	• All the above will have access to material and suggested text developed by CCG communications and engagement team • The bulk of the above activity will be done by email and on social media • Documentation in alternative formats will be available on request.		

8. What resources do you need for the engagement?

a. Do you need to make any of your resources accessible (i.e. for people with learning disabilities; sight impairments; or alternative languages?)

9. What are your engagement questions?

a. What do you want to find out?

b. What questions will you ask?
c. How will you test the questions to ensure they are suitable?
d. How many people do you need to speak to?
e. How will you demonstrate that you have engaged with a representative sample?

10. Results
a. How will you use the feedback – who does it need to be shared with?

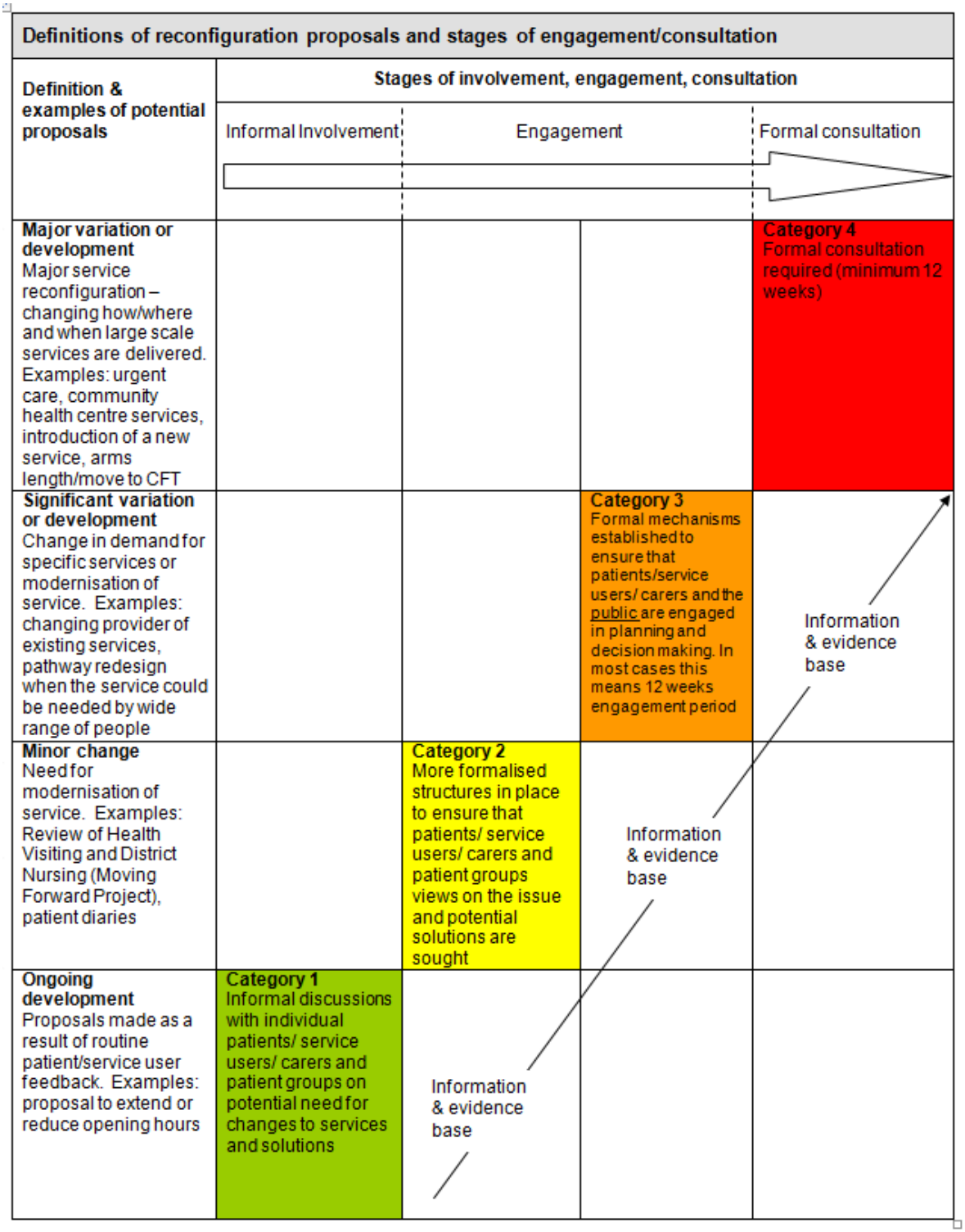
11. Feedback and Evaluation
a. How and when will you feedback to participants?

Action Plan Dates

	Action	Approx. Timescale (from start of project)	Lead	Deadline	Comments/ progress
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
C.A.P supports the equality analysis and engagement plan					
		Approx. timescale(from date of C.A.P			
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
Start engagement					
		Approx. timescales (from start of engagement)			
18.					
19.					
20.					
21.					
22.					
23.					
24.	partners identified in the plan				

	Action	Approx. Timescale (from start of project)	Lead	Deadline	Comments/ progress
Engagement ends					
		Approx. timescales (from end of engagement)			
25.					
26.					
27.					
28.					
29.					
30.					
31.					
32.					

Appendix A – Stages of engagement



Appendix B – Protected characteristics *(Equality and Human Rights Commission 2016)*

Thinking about equality impacts across protected characteristics

When considering the impact on polices, actions or services on different groups, you may find it useful to consider the following questions. This list is not exhaustive.

Protected characteristic	Some questions to ask when considering the equality impact
Age	• How have / will you engage with different age groups: what different process and communication methods can you use? • Do you have data to show if there is a higher need or any different usage of the service / project by different age groups? • Do you use inclusive imagery and language? • Is your service / project / policy accessible and inclusive to different age groups, including in terms of location and also time? • Does / will the workforce reflect the age profile of the area where the service / project will be delivered?
Disability	• How have / will you engage with disabled people: what different process and communication methods can you use? • Do you have data to show if there is a higher need or usage of the service / project by disabled people? • Are staff trained on disability awareness, including learning disability? • Is information and services accessible to people who have a range of different disabilities eg physical, sensory and learning disabilities? E.g. are pre visits available? • Does the service / project / policy give consideration to the Accessible Information Standard? • Do you communicate a zero tolerance approach to disability related harassment among staff, patients, carers and the local community? • Do you engage with disabled staff to make sure you have made reasonable adjustments in the workplace to support them in their role?
Gender reassignment	• Are staff aware of the legal requirements affecting the provision of confidential services to trans people? • Are records fully reflective of the gender identify of a trans patient / service user / employee and are staff empowered to communicate appropriately with trans people? • Do your services meet the needs of trans people and are they appropriate to the gender which they identify? • Do you communicate a zero tolerance approach to transphobia and trans related harassment among staff, patients, carers and the local community?
Marriage and civil partnership	• Do publicity and information, policies and procedures treat marriage and civil partnership equally?
Pregnancy and maternity	• How have / will you engage with pregnant women and parents of young children: what different process and communication methods can you use? • Do you have data to show if there is a higher need or any different usage

Protected characteristic	Some questions to ask when considering the equality impact
	of the service / project by pregnant women or families with young children? • Does your service/ project support breastfeeding mothers or parents with children? • Do you support pregnant women and parents with children in the workplace through flexible working and job-sharing? • Does your policies and procedures give equal maternity / paternity rights to staff adopting?
Religion or belief	• How have / will you engage with people with different religious beliefs: what different process and communication methods can you use? • Do you communicate a zero tolerance approach to Islamphobia among staff, patients, cares and the local community? • Is your service / project / policy sensitive to different religious requirements eg the times people may wish to access a service, religious days and festivals, dietary requirements, prayer space etc.
Race	• How have / will you engage with people from different ethnic backgrounds: what different process and communication methods can you use? • Do you have data to show if there is a higher need or any different usage of the service / project by different ethnic groups? • Do you build positive relationships with ethnic minority community organisations and community advocates to facilitate the involvement of different ethnic groups? • Do you communicate a zero tolerance approach to racism among staff, patients, cares and the local community; and challenge negative myths and stereotypes about different ethnic groups and new arrivals to the UK? • Is your workforce representative of the communities where you work in terms of race?
Sex	• Do you have data to show if there is a different need or usage of the service / project by men and women? • Does your service / project / policy consider that men and women may articulate different needs and aspirations? • Are your services accessible to men and women in terms of location but also time? • Do you consider gender equality in the workplace at all levels?
Sexual orientation	• How have / will you engage with lesbian, gay, bisexual (LGB) people: what different process and communication methods can you use? • Do you have data to show if there is a higher need or any different usage of the service / project by LGB people? • Does publicity and information, policies and procedures include reference to LGB and heterosexual people equally? • Do you communicate a zero tolerance approach to homophobia and biphobia among staff, patients, carers and the local community? • Do you build positive relationships with LGB community advocates and the LGB community?

Appendix 2

Section 14Z2: Patient and Public Participation Form

Introduction

Clinical Commissioning Groups have a duty under Section 14Z2 of the NHS Act 2006 (as amended) to 'make arrangements' to involve the public in commissioning.

- This form is a tool to help commissioners identify whether there is a need for patient and public participation in their commissioning activity, and if required help them plan for a level of participation which is 'fair and proportionate' to the circumstances.
- The form must be completed at the start of the planning process for any commissioning activity and before operational commissioning decisions are taken which may impact on the range of commissioned services and/or the way in which they are provided.
- Completed forms may be used as evidence in the event of a legal challenge. Please retain a copy within your local system.

Step 1 – Title of the plan/proposal/project/commissioning activity and a brief description (including key objectives where appropriate). *Possible examples - procurement of a new service, proposals for service change, national policy development or an operational commissioning decision which affects services, e.g. closure of a GP practice.*

Location: *e.g. CCG, area*	
Title and Brief Description of Proposed Activity:	
Key Objectives of the Proposed Activity:	

Step 2 – Is there likely to be an impact on patients and the public? *To assess impact you should consider the overall population and groups/individuals within that population who are likely to be affected.*

If the plans, proposals or decisions are implemented, do you think there will be:

(a) An impact on how services are delivered?
☐ **Yes** ☐ **No**

Please explain your answer and provide further details:

(b) An impact on the range of health services available?
☐ Yes ☐ No

Please explain your answer and provide further details:

(c) Any other impact that you can envisage at this point in time? Please describe.

*If you have answered yes to (a), (b) or (c), it is highly likely that the Section 14Z2 duty applies. Note: the duty **always** applies to planning of commissioning arrangements (regardless of impact).*

Does the Section 14Z2 duty apply to the activity? ☒ Ye ☐ No

Please explain briefly why you have answered yes or no to the above:

Please note that if you have determined that Section 14Z2 does not apply to this particular activity it is good practice to retain a copy of the form should a challenge be made at a later date.

Step 3 – Describe any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight?
Examples could include patient and public views by patient and public voice (PPV) partners; surveys; intelligence on patient and public views from partners including other commissioners, Healthwatch and voluntary and community organisations.

Please briefly complete each question below:

(a) What arrangements/mechanisms are already in place to involve the public which are relevant to this activity? (These may be local, regional, or national):

(b) How will the insight available to you help to inform your decision?

Please note that consideration of existing arrangement and patient and public insight will help inform any additional arrangements required under step 4.

Step 4 – Are additional arrangements for patient and public involvement required for this activity and in particular how will you ensure that 'seldom-heard' groups, those with 'protected characteristics' under the Equality Act, and those experiencing health inequalities are involved?
(In due course, it may be appropriate to develop a full communications and engagement plan).

a) If yes, provide a brief outline of your approach and objectives for any additional patient and public.participation:

b) Have you considered the following:

Seldom-heard groups ☐ Yes ☐No

Nine Protected Characteristics	☐ Yes ☐No
Health Inequalities	☐ Yes ☐No

c) Briefly describe how your proposed participation will be 'fair and proportionate', in relation to your commissioning activity?

Step 5 - Planning for impact and feedback

(a) Provide a brief outline of how the information collected through patient and public participation will be used to influence the plan/activity.

(b) How will the outcomes of participation be reported back to those involved? *(refer to your communications and engagement plan, if appropriate)*:

(c) How will you assess the ongoing impact of the change on patients and the public after it has been completed?

Name of person completing the form:
Job Title:
E-mail address:
Team:
Date:

Once this form is completed please retain a copy for your records.