East Leicestershire and Rutland
Clinical Commissioning Group

EQUALITY DELIVERY SYSTEM 2 (EDS2)
(v11, 7 June 2016 - FINAL)

CONTENTS

1. Introduction to Equality Delivery System (EDS2)

The Equality Delivery System (EDS) framework has been designed by the NHS to support NHS commissioners and providers to meet their duties under the Equality Act 2010. The EDS has four goals that are supported by 18 outcomes, the four goals are as follows:

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

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

NHS East Leicestershire and Rutland Clinical Commissioning Group (CCG) has used the EDS2 as a toolkit to meet and document evidence to demonstrate compliance with the requirements of the Public Sector Equality Duty (under the Equality Act 2010); and in discussion with local partners (including local populations) to review and improve performance for people with characteristics protected by the Equality Act 2010. Furthermore, the CCG has also linked the EDS2 to the Articles of the Human Rights (see below).

Articles of the European Convention on Human Rights:

Article 2 | Right to life
Article 3 | Anti-torture and inhumane treatment
Article 4 | Anti-slavery
Article 5 | Right to liberty and security of the person
Article 6 | Right to a fair trial
Article 7 | Anti-retrospective conviction
Article 8 | Right to private and family life
Article 9 | Right to freedom of thought, conscience and religion
Article 10 | Right to freedom of expression
Article 11 | Right to freedom of assembly and association
Article 12 | Right to marriage
Article 13 | Right to an effective remedy
Article 14 | Anti-discrimination

Article 1 of the First Protocol: Protection of property
Article 2 of the First Protocol: Right to education
Article 3 of the First Protocol: Right to free elections

NHS East Leicestershire and Rutland CCG supports the NHS Accessible Information Standards and, therefore if you require a copy of this document in an alternative format, please contact the Corporate Affairs Team on **(0116) 295 7576**. We will do our best to support and develop equitable access to all policies and procedures.

2. Who are we and what do we do?

In 2015/16, ELR CCG was entrusted with an allocation (our budget) of £401,370,000 with which to plan and buy the health services needed by people living in East Leicestershire and Rutland. The services we are responsible for planning and buying include:

- hospital treatment
- rehabilitation services
- urgent and emergency care
- community health services
- continuing healthcare
- primary medical services
- mental health
- learning disability services

We do not provide these services ourselves; we pay organisations to deliver them for patients on our behalf. We ensure services are delivered to the standards that we expect for our patients. We work very closely with all of these provider organisations to thoroughly scrutinise the care patients are receiving, identify any concerns at an early stage and help providers to improve the situation where standards may have fallen.

We were proud to receive full delegation of primary medical care commissioning (hereafter referred to as primary care commissioning) from NHS England from 1 April 2015. This means we commission the day to day services that our patients receive from their GP practice. Primary care commissioning has meant exciting opportunities to develop community-based healthcare that delivers better outcomes for patients.

The aim of primary care commissioning is to focus on general practice to act as an enabler to facilitate the changes needed both for improved patient outcomes and new ways of working. This means there is a need to reconsider traditional ways of delivering health care and redevelop how the following services/people interact:

- Individual GPs or groups of GPs
- Specialists
- District Nursing / Intermediate Care Team
- Health and Social care coordinators / Social Care / Crisis Response teams
- Community / virtual beds
- Mental Health Services
- Voluntary sector.

The desired outcome is an integrated service for our patients, with shared planning and management by professionals who work together not just within their organisations, but with our patients ensuring care is organised and developed in partnership with our patients.

Our vision is to improve health by meeting our patients' needs with high quality and efficient services, led by clinicians and delivered closer to home.

Our strategic aims are:

- **Transform Services and enhance quality of life for people with long term conditions** - with a particular focus on COPD, diabetes, dementia, mental health and learning disabilities
- **Improve the quality of care** - focusing on clinical effectiveness, safety and patient experience, with specific goals to deliver excellent community health services, acute care, mental health care and improve the quality of primary care
- **Reduce inequalities in access to healthcare** - targeting areas and population groups with the greatest need
- **Improve integration of local services** - between health and social care and between acute and primary/community care
- **Listening to our patients and public** - our commitment is to listen, and to act on, what our patients and public tell us
- **Living within our means** - the effective use of public money**.**

Our aim and strategic priorities feed into the joint strategic plan for 2014-19 (the Leicester, Leicestershire and Rutland Five Year Strategy), which is implemented through the Better Care Together Programme. The Strategy sets out a shared vision to reform health and care services, providing suitable, affordable and sustainable solutions that will improve outcomes for the local people. For details on the Strategy, please see http://www.bettercareleicester.nhs.uk/the-bct-plan/

It is aligned to the three Joint Health and Wellbeing Strategies and Better Care Fund (BCF) plans across Leicester, Leicestershire and Rutland with an emphasis across the system on reducing health inequalities, reducing avoidable admission to hospital, redesign of alternative pathways and prevention of illness.

Our population:

- During 2015-16, ELR CCG served 317,922 patients across 32 GP Practices in Blaby, Lutterworth, Market Harborough, Rutland, Melton Mowbray, Oadby and Wigston;

- According to the National Census 2011, the CCG's population was predominantly made up of 30-59 years olds (40.4%); 21% of 0-17 year olds; 12.9% of 18-29 year olds and 25.6% of people aged between 60-90+. In addition,

- 49% of the CCG's population were male and 51% is female, which includes people who are gay, bisexual and of other sexual orientation;
- 53% were married and 0.2% in a same sex / civil partnership; 15.9% were divorced / widowed from a same sex relationship;
- People had varying long-term health problems / disabilities that predominantly affected those aged 35-84 and limited their daily activities;
- the majority of the population for East Leicestershire and Rutland was White (English/Welsh/Scottish/Irish/Northern Irish/British/Traveller) – 90.2%; followed by 7.2% Asian (Asian/Asian British), 0.7% Black (Black/African/Caribbean/Black British), 1.4% Mixed/multiple ethnic groups and 0.5% Other ethnic group;
- 60.7% of the CCG's population was Christian, followed by 32% who have no religion or preferred not to declare this. The remainder of the population is Hindu, Sikh, Muslim, Buddhist, Jewish or another religion.

- the average life expectancy in East Leicestershire and Rutland is 80.2 years for men, and 84.1 years for women, both of which are higher than the England average;

- the proportion of people aged 60 and over is higher than the England average (22.6%), and our older population is predicted to increase over the next 10 years, with an estimated 19,000 additional people aged 60 years and over. 3,715 of this population will be aged over 85 years;

- the health of our local population is generally better than the overall population of England. However, there is a significant number of people affected by ill health, including GP-diagnosed coronary heart disease (10,545 people), hypertension (48,454 people), and diabetes (16,926 people).

In ELR CCG, only a small proportion of people live in deprivation when compared to other parts of England. Within the CCG, there are areas that have poorer health outcomes. The main areas affected are in Oadby and Wigston. In one area of Wigston for example, residents have a significantly higher rate of mortality from all causes and mortality from respiratory diseases than the England average. Although not significantly higher, rates of mortality from stroke are higher than the England average.

Evidence suggests that the most effective way to reduce the gap in life expectancy in the short term is to improve the management of diseases (including cardiovascular disease (CVD) and chronic obstructive pulmonary disease (COPD)) and their risk factors, including smoking, alcohol, hypertension and diabetes that predominately affect the socially excluded.

There were 2,967 deaths per year, on average, of patients registered with one of our member practices; cancer, CVD and respiratory disease accounted for 69% of these deaths. Many of these deaths could have been avoided through earlier diagnosis and better treatment. This has directly influenced our clinical work in relation to diabetes, cardiovascular disease, COPD, dementia, access to primary care services and mental health.

The CCG is working with Public Health, particularly within Better Care Together and the Better Care Fund, to improve the levels of premature mortality in key areas including cancer, CVD, lung disease and liver disease; and prioritising improving the earlier detection of disease and management of these conditions.

Significant health inequalities exist for our patients from minority and seldom heard groups, including patients from our Black and Minority Ethic (BME); Lesbian Gay Bi and Trans (LGBT) community; travelling families; and young people suffering with mental health. During 2015/16 we reviewed our achievements against our equality objectives and refreshed the objectives to focus on specific groups of patients. More information about this can be found in the update on equalities section of our Annual Report and Accounts 2015/16 on our website www.eastleicestershireandrutlandccg.nhs.uk **.**

Positive action has been taken to support the implementation of our equalities objectives for 2013-15:

i) **Objective 1: Addressing needs of older people and access to services** – focusing on supporting the elderly to live independently at home, for example through the implementation of personal health budgets; review of reablement services to support living at home and access to services closer to home.

i) **Objective 2: Targeting provision and access to seldom heard groups – travelling families, BME, LGBT, rural deprivation** – for example in respect of travelling families maintained engagement and access to health visitor services; introduced pilot for 7-day services in Oadby and Wigston (Wigston being our most deprived area across East Leicestershire and Rutland).

ii) **Objective 3: Access to early intervention and prevention of Mental Health issues** – the Improved Access to Psychological Therapies service met the national standards for access to patients; we improved diagnosis of dementia which means that patients who need access to appropriate treatment and services are able to access them.

In our area there are an increasing number of children living longer with life-limiting and complex health conditions. There are also a significant number of children attending hospital services that could be cared for more appropriately in a community or home setting.

The consolidation of children's hospital services in Leicester provides an ideal opportunity to review all models of care and check appropriate integration is in place with community and primary care services.

Children, young people and carers have also told us they are worried about a range of issues that affect their mental health and wellbeing. These include academic pressure, peer pressure, family breakdown, sexual exploitation and cyber-bullying. They would like more support in school or through confidential help-lines and websites. In 2016/17, additional funding will be provided to CCGs

to implement a Transformational Plan designed to address these issues. In total, the three CCGs in our region will receive approximately £2million. This will be used alongside existing funds from local commissioners to implement the plan.

Across the country, it is predicted the number of births will increase each year which will put significant pressure on our maternity and neonatal services. Our aim is to continue to provide high quality, safe maternity and neonatal services based on best practice and which are easily accessible. These services will be supported by the appropriate infrastructure across both primary and secondary care. The proposals for the future of maternity services will form part of a public consultation under the Better Care Together programme.

As a CCG we strive to improve services to deliver better quality patient care and experience, whilst reducing clinical variation, eliminating waste and delivering better value for money. The feedback that patients provide is extremely valuable to us in being able to carry out this aspect of our role.

Partnership working

Partnership working is vital to East Leicestershire and Rutland Clinical Commissioning Group and it is the best way to bring about many of the changes we wish to see implemented.

In 2015/16 we actively engaged with partner organisations to build on existing relationships, and develop new and improved relations with clinicians, patients and carers, public members, staff, partner organisations, including local authorities, and other commissioning agencies.

We are an active partner in the Better Care Together (BCT) programme, working to transform the health and social care system in Leicester, Leicestershire and Rutland (LLR) by 2019. In addition to the key role we play in planning and delivering change under Better Care Together partnership, we work in collaboration with Leicestershire County Council and West Leicestershire CCG and with Rutland County Council to implement shared priorities for health and social care integration through two Better Care Funds.

This work is strengthening our joint commissioning and working arrangements to deliver integrated care for older people and supporting people with long-term conditions (LTCs). This is particularly crucial if our CCG is to meet its financial challenges through the transformation of care systems, and improve the quality of healthcare across all our providers.

The Better Care Fund has been a critical enabler to forward the integration agenda during 2015/16. In 2015/16 through our contribution to the Leicestershire Better Care Fund and Rutland Better Care Fund enabled £17.2m worth of care to be jointly commissioned locally on health and care to drive better integration of health services and improve outcomes for patients, service users and carers. The CCG, in conjunction with Leicestershire County Council and Rutland County Council, has used this as a catalyst towards our vision for a modern model of integrated care.

From the outset of Health and Wellbeing Boards across Leicestershire and Rutland we have been closely involved in designing and delivering the joint strategies to support the people of East Leicestershire and Rutland. The close working relationships between health, local authority and the third sector has meant that real progress has been made to enable sustainable integration that supports quality, cost effective services.

We recognise that the alignment between the CCG's one-year plan, the local health and social care economy (LLR) five-year plan and the Better Care Funds strengthens our capacity to deliver transformative change and will result in a sustainable high quality system for the population of East Leicestershire and Rutland.

Some examples of our achievement are detailed in the tables under each goal.

Goal 1: Better Health Outcomes

The NHS should achieve improvements in patient health, patient safety and public health for all, based on comprehensive evidence of needs and results

1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities

Evidence (What has actually been done / achieved?
NHS East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG or the CCG) has a diverse population made up of many different groups and communities. People have differing health needs which need tailored commissioning, communication and engagement. We believe that patients are at the centre of the way we design and commission our services. Our commissioning strategy is designed to respect and reflect the needs of all communities and groups in order to deliver first class health services to all. This is most apparent in our commitment to delivering equitable health services in line with equality legislation and policy. This is supported by our approach to tailoring our communication, engagement and consultation to meet the needs of our different communities. The demographics of the population, along with existing health equalities, are a key consideration when developing our annual commissioning intentions and strategic and operating commissioning plans. The commissioning of local NHS services involves the CCG working with public health, providers, partners and local communities, to identify and understand patients' needs and design services to meet those needs. This is done by working within a structured and planned process called the 'commissioning cycle'. This process is continuous to ensure that services are developed and improved based on provider performance, patient experience and current local need. The commissioners of services lead the process for deciding how best to provide services and for making this happen. Some examples to show how we commission, procure, design and deliver our services to meet the health needs of our local communities are detailed below. **Leicester, Leicestershire and Rutland 5 Year Strategy – Better Care Together Programme** The Better Care Together (BCT) Programme is a key determinant of contracted service changes aimed at improving clinical care, patient experience and increasing efficiency. The CCG's Commissioning Intentions and Operational Plan align with the Better Care Together 9 settings of care priorities at both an ELR CCG and Leicester, Leicestershire and Rutland level: • Maternity, neonates, children and young people • Planned Care with Cancer • Urgent Care • Mental Health • Learning Disabilities • Long Term Conditions

Evidence
(What has actually been done / achieved?

- Frail and Older People
- End of Life Care
- CHC and Personalisation

The Commissioning Intentions direct how services are commissioned from providers and contracts agreed. Local health priorities were reflected in the 2015/16 contracts at both CCG specific (and LLR) levels; and will also be reflected in contracts for 2016/17.

The Operational Plan is supported by public health to support the needs of the ELR CCG population. In addition, the plan has been developed using the Right Care Atlas of Variation data for each of the BCT Clinical priority areas, to ensure that focus is given to areas of health need for which ELR CCG are an outlier to support a focus for improving health outcomes.

Going forward in 2016/17, the Operational Plan will support the delivery of the 5 year system Sustainability and Transformation Plan (STP) at Unit of Planning level, defined as Leicester, Leicestershire & Rutland. The Plan is built to ensure delivery of the 9 'Must Do's':

- Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.

- Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the Right Care programme in every locality.

- Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.

- Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

- Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.

- Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following

Evidence
(What has actually been done / achieved?

an emergency admission.

- Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

- Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

- Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

The following documents are reviewed as part of this process to review our local priorities:

- Performance Reports for Constitutional Standards
- Contractual Performance against Key Performance Indicators
- Joint Strategic Needs Assessment
- Right Care Atlas of Variation
- National Guidance and Standards
- Quality Premium Targets
- The Annual Operational Plan

The Commissioning Intentions are developed jointly across the 3 CCGs and provide the strategic LLR focus as well as specific CCG requirements; this supports the alignment of clinical pathway development, the BCT Work streams, contractual negotiations, the operational plan and supports the Five Year Forward View.

As part of the process Equality Impact Assessments are undertaken to understand any impact against the protected groups, understanding what group may be affected, what the mitigating circumstances are, agree actions to address any negative impact and any potential barriers to access of services. Although equality assessments form a key part of the planning process (including the business cases reviewed as part of the QIPP process), going forward there will be a focus on outcomes and impact as part of the evaluation process.

Evidence
(What has actually been done / achieved?

Quality, Innovation, Productivity and Prevention (QIPP) Schemes – Quality / Equality Assessments

The 2015/16 QIPP Programme was aligned to the Better Care Together work streams and focused delivering on the following:

- Admission Avoidance
- Reductions in attendances at A&E
- Effectively and proactively addressing the Continuing Healthcare issues including ensuring that the Fast Track process it utilised appropriately and that eligibility criteria is adhered to and that reviews are undertaken
- Supporting the left shift of activity from Hospital settings into the community in line with bringing care closer to home
- Increasing access to Primary Care and supporting Long Term Conditions
- Developing a whole system approach through the Integrated Health and Social Care Pathway
- Reducing the number of Mental Health placements outside of the county

The financial target for 2015/16 was £8,367,000 and the final outturn was £7,887,814 which equates to 94% achievement of the schemes, with a strong focus on improving quality outcomes for patients.

The QIPP schemes for 2016/17 will focus on ensuring patients experience the right treatment in the right setting, including across protected characteristic groups in the following:

- increasing the level of services that are delivered in a Community Setting, rather than at an Acute Hospital
- by removing any duplications across pathways
- linking to the Better Care Together Strategy.

QIPP schemes will be developed across the following key work streams:

- long-term conditions
- planned care
- urgent care
- transformation of mental health and learning disability
- including specific QIPP from our BCF plans (e.g. prescribing; primary care transformation; running costs management).

A scrutiny group has been established in 2015/16 to review the quality and equality impact assessments providing a confirm and challenge where negative impact has been identified; and where further consideration needs to be given. The process will evolve in 2016/17 with a revised template to document the quality and equality impact assessment of each scheme.

Evidence (What has actually been done / achieved?
Mental health and learning disabilities In 2015/16, we continued to work closely with our mental health providers, clinicians and service users to improve our acute mental healthcare pathway, promoting independence and enabling individuals to be part of their communities. In times of crisis, and when patients require admission to inpatient care, we want to ensure they receive high quality care that promotes recovery in safe settings. As part of commissioning a new service or service redesign, we use the Atlas of Variation equalities data to ensure we are meeting the health needs of our patients. **Improving Access to Psychological Therapies (IAPT)** IAPT services are designed based on addressing the mental health prevalence of each practice and allocating sufficient resources in meeting patients' needs, treatment, and specific therapies to aid in the recovery of the patient. The choice of treatment is part of the assessment and the patient has a voice in which treatment is used through discussion at the outset of treatment. For instance, if a patient has more than one problem, they agree which to concentrate on first and how to go about it, recording the way forward. In order to ensure that we achieve parity of esteem across physical and mental health services, our plan outlines our ambition for how we want to work with our mental health providers, clinicians and service users to improve our acute mental health pathway taking step-up and step-down approach to system redesign. This is so that we can improve the care provided for mental health service users within the community setting; that promotes independence and enables individuals to be part of their communities. In times of crisis (and when patients require admission to an inpatient setting), we want to ensure that patients receive high quality care that promotes recovery within safe settings of care. During 2015/16, we implemented and maintained the waiting time standard for Improving Access to Psychological Therapies (IAPT), with recovery rates being higher than the national average. • % of people accessing the service (target 15%) – achieved 14.0% (outturn 2015/16) • % of people moving to recovery (target 50%) – achieved 55% (outturn 2015/16) • Waiting times 6 weeks from referral to treatment (target 75%) – achieved 71.7% Initially, the IAPT service was GP-led and following a series of consultations with stakeholders, service users, GPs, voluntary organisations, PCT membership, Healthwatch etc, it was noted that patients (particularly from BME groups, the LGB&T community and the male population) were not discussing anxiety and mental health related issues with their GPs as they were contacting the IAPT service direct. As a result, a 'self-referral' process was established; as well as the availability of telephone appointments as an alternative to face-to-face appointments. During 2015- 16, the following progress has been made: • **self-referral leaflets** - disseminated to a number of venues across the CCG (i.e. within community venues, libraries, GP practices, Arriva

Evidence (What has actually been done / achieved?
patient transport; article issued via Voluntary Action Leicestershire and Rutland to all of their membership, which included voluntary organisations and community groups). This has also supported the development of self-referral capabilities to ensure the service is accessible to all (including the LGBT community), but not limited via Trade. • **Development of Long term conditions pathways / referral routes** - worked with Age UK; and the Alzheimer's Society. The IAPT service also collates information in relation to age, gender, disability (learning / physical / mental / sensory etc), long term conditions, ethnicity, religion and sexual orientation. The next steps for the development of the IAPT service is to work alongside community health / social / public health teams to: • recognize anxiety and depression in their clients (e.g. carers) and aid in the referral into the service; • raise awareness (and increase the use of) of the service to the population through wider dissemination of the self-referral leaflets; • Waiting times standards - Increasing timely access to the service ensuring 75% of patients receive treatment within 6 weeks of referral and 95% of patients within 18 weeks. The service is acting on achieving these standards.
Help to Live at Home (HTLAH) East Leicestershire and Rutland CCG, in conjunction with West Leicestershire CCG and Leicestershire County Council carried out a detailed piece of work which commenced in 2014 and continued into 2015/16. The main aim of which was to jointly commission a new model of personal care at home for Leicestershire residents with effect from 2016/17. In conjunction with our Partners, we developed and assessed a range of options for commissioning the new service, and the work programme included: • Engaging in productive dialogue with service providers about the options and future needs for this service. • Understanding and analysing the detail of the activity currently being commissioned across Local Authority (LA) and NHS partners, and modelling future demands. • Reviewing the overall model of care, especially how personal care at home connects to other pathways within the health and care system such as hospital discharge. • Shedding light on operational and technical barriers and improvements that need to be addressed for this service to succeed. • Considering how personal care at home will connect to other preventative and wellbeing services in Leicestershire's communities. • Understanding citizen needs and expectations. The benefits that are expected from the new service are: • Improved outcomes for service users, in particular in delivering person-centred reablement

Evidence (What has actually been done / achieved?
• A more resilient market to meet the changing shape of health and care services/demands, given our local demography, and that more care will be delivered in the community in the future. An equality impact assessment was undertaken in the initial stages of the work programme when considering the options.
Dementia During 2014-15, the CCG worked with its local authority partners to support the development of local authority services for people with dementia and their carers, which included providing advice, information and support to help people with dementia (and their carers) to maintain their independence and to continue to live at home. In 2015/16 we implemented an enhanced service across primary care to improve timely diagnosis and treatment of people with dementia. This increased diagnosis of dementia (from 54% in April 2015 to 61% of the targeted age group at the end of March 2016 – the highest increase in our region) meant more of our patients benefitted from accessing support quickly. We also developed a bespoke dementia template that was implemented onto GP practice systems, which has brought together all the different elements of dementia reporting and care into one place meaning GPs can offer a more effective service to patients. We also implemented the dementia Shared Care Agreement in order to improve the capacity of the Memory Assessment Service. A shared care agreement outlines ways in which the responsibilities for managing the prescribing of a drug can be shared between the specialists in hospital and our GP practices. Further initiatives included: • commissioning services from the **Alzheimer's Society** to provide support for patients both whilst in hospital and in the community as well as for carers (e.g. attend activities, offer emotional support, information and guidance on living well with dementia both in group and one to one settings; • **Supporting the Dementia Friends campaign** to help people develop an understanding of dementia and turn it into action to help people in their community living with the disease; • Working in conjunction with neighbouring CCGs to support **Dementia Awareness Week (May 2015) with the theme "Life doesn't end when dementia begins";** • GPs working with patients to promote early diagnosis, and help people to plan ahead and make decisions about their care while still able to do so; monitoring data received from the **Dementia Quality Toolkit** and incorporated to **Practice Profiles and Dashboard**; • Launching our **Dementia Champions Award (September 2015)** • Developing a **Dementia Action Plan** to cover increasing diagnosis in practices; Care Planning; Post-Diagnostic Support; Dementia Educations for Primary Care Clinicians and practice staff; Video, web and social media support; Resources, bulletins and information packs. • Offered a programme of 'Memory Matters' days to local practices, based on a highly successful event designed and run by the

Evidence (What has actually been done / achieved?
Uppingham Surgery in Rutland. In October 2015, the National Dementia Lead facilitated a **Multi-Agency Dementia Care Planning workshop** which involved the NHS England East Midlands Dementia Lead; and representatives from the Alzheimer's Society, Age UK, Secondary Care service leads, and Local Authority and District Councils. The aim of this workshop was to o Develop a multi-agency recognised care plan template; o Map the impact on current services of increased dementia diagnosis; o Scope different service models; o Scope post diagnostic support. As a result of the work undertaken, this has benefited patients in the following ways: • Earlier diagnosis of dementia for patients, their carer(s) and families, offers referral to services that will enable them to plan their lives better, to provide treatment as appropriate and offers timely access to other forms of support and to enhance the quality of life (8% increase in early diagnosis for 295 patients) • Provide improved care and support for patients and families • Dementia care closer to home • Help decrease waiting times and increase capacity in the Memory Assessment Service by agreeing to repatriation of appropriate dementia patients by way of the Shared Care Agreement. In February 2016, the CCG held a **Practice Learning Time (PLT)** which provided dementia education for clinicians and practice staff. In addition, case studies were gathered through the 'Listening Booth,' and a Dementia Carer Case Study was presented to the CCG's Governing Body meeting in March 2016.
Winterbourne Review The CCG is committed to delivering against the Winterbourne View Concordat, which is also being driven by the 5 year LLR Better Care Together strategy within which Learning Disabilities has been identified as a key work stream. To support this work, a stakeholder reference group has been established, which includes families of children, young people and adults, commissioners and NHS providers. This group is used as a longer term stakeholder/advisory group for the Winterbourne View delivery plan (and additional members will be brought in as required). There will be a degree of overlap with other local authorities and CCGs in the LLR area, and particularly in relation to work with providers. The decision to collect and track data for people with learning disabilities and/or autism was agreed as part of the **Winterbourne Review Concordat: Programme of Action.** All CCGs are required to hold, manage and maintain a register of people with learning disabilities and/or

Evidence (What has actually been done / achieved?
autism who may have a mental health condition or behaviour that challenges and are in an in-patient setting. The CCG is mandated to input information from their local registers onto the **Assuring Transformation (AT) clinical audit platform,** which is collated by the Health and Social Care Information Centre (HSCIC) on behalf of NHS England (http://www.hscic.gov.uk/assuringtransformation). This requires the CCG to collect data on age, gender and ethnicity; and whether the person has a learning disability, autistic spectrum disorder (ASD), or both. As a Commissioner, the CCG needed to ensure its service providers were offering information to individuals and their families/carers about the data collation and their option to 'object' to their information being included. As a result, the LLR CCGs wrote to all providers who currently have patients on the WBV register and provided **an "easy read" document (Collecting information to improve the quality of care for people with learning disabilities and/or autism, NHS England**) to be talked through with relevant patients in a way they are able to understand, if they are unable to read it themselves. A process for handling the objections fairly has also been agreed. In October 2015, NHS England, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (ADASS) published 'Building the right support' and a new Service Model, which required Local Authorities, CCGs and NHSE Specialised Commissioners to come together to form Transforming Care Partnerships (TCPs) to build up community services and close unnecessary inpatient provisions over the next 3 years and by March 2019. The Better Care Together LD Steering Board became the Transforming Care Partnership (TCP) for LLR, which included representation from patients and Healthwatch. A comprehensive **LLR Transforming Care Plan (TCP)** has been developed, which will involve people with lived experience of inpatient services and their families/carers. This Plan includes demographic data which looks at future populations of people with learning disabilities; and outlines the development of community-based services to support people to remain safe within their home setting and prevent admissions to mental health hospitals. It also looks at how we support those people being discharged from an inpatient setting in order to prevent re-admissions.
Primary Care Practice Profiles The CCG has developed a Practice Profile for each of its GP Practices, which captures a range of data and information, which includes: • Practice Information (including age/sex of its population); • Quality and Outcomes framework (QOF) Prevalence and Additional Services – child immunisation, flu vaccination, adult pneumococcal; Local Authority Services (i.e. health checks; learning disability checks, cervical screening, breast feeding data); • Community Based Services (CBS) Quality Indicators – infection control, patient safety alerts, number of incidents/serious incidents/complaints, patient experience; • New Outpatients and Emergency Admissions – outpatient referrals; emergency admissions; Top 30 Specialities; • GP Support Investment and Framework - Palliative Care Register; Care plans for EoL; After Death Audits; Death In Place of Choice; Care Home Care Plans; Dementia Register; COPD Register; Diabetes Register; AF Register; • Patient Experience, Safeguarding, and Choose & Book - Patient Experience Survey; Reporting Poor Quality Care; Choose and Book

Evidence (What has actually been done / achieved?
data; Safeguarding training by Practice; • Prescribing – performance against the Prescribing QIPP scheme and budget. There are a number of QOF domains, which are currently in the GP SIP. Whilst the QOF data does not directly feed into the GP SIP, it supports the following QOF work areas, which allow GP Practice to implement appropriate care and care planning for our patients: • increasing their Palliative Care Registers; • Identifying Patients with Atrial Fibrillation (AF); • Identifying patient with Chronic Obstructive Pulmonary Disease (COPD); • Identifying patients with Dementia. During 2015-16, the Practice Profiles were provided to the Care Quality Commission (CQC) in support of Practice visits and inspections (and to GP Practices), upon request.
Support and Investment Plan (SIP) for General Practice 2014-16 The 2-year **Support and Investment Plan for General Practice** (hereby referred to as the 'GP SIP') has been designed to build on the high quality healthcare provided by General Practice and to fund the continued improvement in quality and outcomes for our patients. The CCG believes that working in collaboration with our providers, partner organisations and members will enable us to exceed the national expectations of high quality outcome focused health care for our patients. The GP SIP is one of the CCGs strategies for engaging and involving our member practices in the delivery of the key quality and outcomes priorities set out in our constitution and 2-Year Operational Plan to: • Support people to live independently for longer • Improve outcomes for people living with Long Term Conditions • Improve quality of life • Reduce Inequalities in access to healthcare • Reduce utilisation of the acute sector through integrated community services • Listen to Patients and the Public It is recognised that 2014/15 was a transitional year to support the transformational change in primary care. With the successes from last year (i.e. Long Term Conditions, Care Homes, Care Plans, End of Life care and Medicines Quality), and the CCG holding the entire commissioning budgets for primary, community and secondary care from April 2015, it meant the CCG could focus its **Investment Strategy** on those areas that would not only have the greatest impact on patients, but also support the recruitment and retention of general practice and community staff through premises development, funding for new models of care and reducing inequality. During 2015-16, the CCG invested a further £1m in

Evidence (What has actually been done / achieved?
General Practice, which was available to groups of practices working as Federations in order to develop and deliver new ways of providing health care to larger population groups. The clinical priorities for the 2015/16 GP SIP continued to focus on the key elements achieved in 2014-15, however, the refreshed GP SIP including the following new element: Long Term Conditions – Dementia. The long term plan is to redesign how services are provided by integrating health and social care with increased investment in a new community service model, with General Practice at the centre. This was crucial for 2015-16 as the role of the CCG changed with the delegated responsibility of co-commissioning of all GP contracts. The renewed focus was on general practice to act as an enabler to facilitate the changes needed for both improved patient outcomes and new ways of working. In reality, this means that there is a need to reconsider traditional ways of delivering health care and redevelop how the following services / people interact: 1. GPs or groups of GPs 2. Specialists 3. District Nursing / Intermediate Care Team 4. Health and Social care co-ordinators / Social Care / Crisis Response teams 5. Community / Virtual beds 6. Mental Health Services 7. Voluntary Sector During 2015-16, the CCG succeeded in the following elements of the GP SIP: • Care Planning / End of Life Care – palliative care registers have increased by 7.5% across the CCG; patient's death in their place of choice reported a 12.6% increase across the CCG; • Care Homes – care plans for care home patients have increased throughout the year by 14.7%; • Long Term Conditions: Dementia – dementia registers have increased by 8.7%; overall CCG dementia prevalence at March 2016 is 61% of the target age group. • **COPD -** COPD registers of those diagnosed have increased overall by 5.7%; Care plans for patients with stage 3 severe COPD have shown an increase of 22.8%; Patients referred to pulmonary rehab has increased throughout the year by 94%; • **Diabetes -** Diabetes registers of those diagnosed have increased overall by 5.3% supporting better patient management; Diabetic type 2 patient referrals to Desmond education programmed have increased throughout the year by 79%.
Community Services ELR CCG embarked upon significant change to commission future community and primary care services, which are clearly articulated in the following CCG's strategic documents:

Evidence (What has actually been done / achieved?
• Integrated Community Services Strategy • Primary Care Operating Framework: A GP Guide, November 2014 • Better Care Together Programme National policy, evidence and best practice states that innovation and creativity are required to progress beyond the structural changes that were made as part of the transforming community services programme, and towards the transformation element of the **Community Services Strategy**. Both locally and nationally, there is an ageing, frail population and an increasing prevalence of chronic disease. As demand for community services is rising, it is estimated that more people in ELR will be over 70 years of age by the year 2030; with a range of complex health issues which will require rehabilitation and reablement. In order to develop and scope a proposed draft model for the future of community services, the CCG engaged with local stakeholders including providers, Local Authority, voluntary sector and GP locality groups. The results of the engagement process enabled the CCG to understand the current issues and the potential to bring together community and primary care services; home based care, clinic and GP care plus rehabilitation and reablement services. It was the CCG's aim to set out potential ways in which each locality could have the right level (and range) of services to meet the needs of local patients. The purpose of the Community Services Strategy is to: • Agree and confirm what this transformation means locally, with our patients and stakeholders; • Ensure alignment of strategies and initiatives across partner organisations; • Ensure the CCG has a shared understanding of the direction of travel and how we will know when we have got there; • Make a contribution to achieving financial balance and toward delivery of the draft *Better Care Together: five-year strategic plan* • Provide a tool for engagement and communication. In September 2015, the CCG launched its engagement process for a proposed **Community Services Model** that had been developed as a potential model for making a difference to how care is commissioned and provided based on local need and a 'Home First ' approach. Engagement took place with a range of local stakeholders as part of developing this potential model, which was subject to further detailed clinically-led engagement at Governing Body level with stakeholders, patients and their families: • **Wider Stakeholder Meetings from January to March 2015** with Local Authority (Leicestershire County Council, Rutland County Council); ELR CCG / GP Representatives; Health Watch; Locality meetings in Blaby and Lutterworth; Oadby and Wigston; Melton Rutland and Harborough; • **Additional meetings also held with** Health Watch; Better Care Together Programme Leads and Information Lead; UHL; LPT; Individual GP Leads; GEMCSU information lead; and Nominated ELR CCG staff.

Evidence
(What has actually been done / achieved?

The LLR BCT work programme aims to achieve a position of financial balance and improve clinical outcomes for patients. Key to this, is the Leicester, Leicestershire and Rutland Alliance (a strategic Group) that currently comprises of:

- University Hospitals of Leicester NHS Trust;
- Leicestershire Partnership NHS Trust;
- Leicester, Leicestershire and Rutland Provider Company Ltd;
- East Leicestershire and Rutland Clinical Commissioning Group;
- West Leicestershire Clinical Commissioning Group.

In light of the above, the following number of areas were identified that needed to be addressed through the proposed model to ensure a solid foundation for community services:

- Change the current model of community services commissioning to give the CCG and its GPs more accountability to influence how services are delivered;
- Creation of joint GP/Provider posts to enhance accountability;
- Delivery of a rehabilitation and reablement model that moves services from a hospital to a home environment;
- Improving access to community services that are currently considered sub-optimal including physiotherapy;
- Expanding the times when care is available both at home and in health facilities;
- Establishing clinical support networks and services in acute and primary care to identify, enable and manage both complex care, frail elderly and sub-acute care locally;
- Making the most of the land and estate available to deliver local services avoiding unnecessary travel to acute hospitals;
- Minimising service barriers through simplified specifications and joint commissioning of primary, social and community services; and
- Changing the model of community services commissioning to focus on outcomes rather than inputs.

During October - December 2015, the CCG invited people to give their views on the proposed new system of care by launching an online, written; and an ‘easy to read’ questionnaire in order to obtain widespread engagement into the proposed model of care.

Urgent Care / MIU

Following review, public consultation and authorisation in 2014-15, ELR CCG’s Urgent Care Service commenced in April 2015, which provides walk-in urgent care services for Oadby and Wigston seven days a week, including evenings and a weekend service at Oakham, Melton and Market Harborough (provided by ELR Urgent Care Ltd (ELRUC)). The service provider supports the delivery of a full range of urgent care for the NHS; with patient-centred care at the core of its activities; using appropriate skill mix and modern systems. This service complements the minor injury service delivered within general practice.

Evidence
(What has actually been done / achieved?

Recognising the move from mobilisation to service delivery of the ELR UC service, full contract management arrangements have been in place since, with comprehensive quality and performance indicators under formal review. Revised community based services contracts have also been issued to all primary care services providers.

Recognising the need and commitment to deliver a significant, resourced marketing and communications strategy to communicate the new arrangements; a comprehensive approach has been taken to communicate with all stakeholders and the ELR population. Key activities have included:

- Development of key messages and creative, provided through every residence in ELR, allowing people to understand the choices and services on offer;
- Active media and social media campaign, going beyond the standard channels to exploit visual, audio and video formats;
- Poster campaign: within all practices, and other public locations supported by public and clinical volunteers from across ELR;
- Outreach with further seldom heard groups using the listening booth. **See 'We are listening' below.**

This promotional campaign has been recognised both locally and nationally and will be presented at a national NHS communications event in September 2015. To compliment this, an interactive **GPS mobile APP** has been developed to help all of our patients know what services are available from urgent care, GPs Pharmacies etc. It will also track where they are and direct them to the nearest appropriate open service. This APP also has the facility to verbally disseminate the information presented, which supports individuals with visual impairments. **See 'Design, Procurement and Delivery of New Website.'**

We used a variety of engagement methods, including surveys / engagement events to ask stakeholders, patients and members of the public what they thought of our plans and if they were clear.

Listening and Engagement Strategy

The updated clinically-led **Listening and Engagement Strategy – "Listening, Responding, Delivering'** continues the trajectory and builds on the foundations laid by our 2013-15 "Informing and Involving" strategy. It also responds to the clear and consistent message delivered through our 2015 NHS Ipsos Mori 360° stakeholder survey as well as views and opinions gleaned from our **2015 Summer of Listening** exercise and at our **2015 Annual General Meeting**. These showed:

- the fundamentals of our existing listening and engagement activity are sound and fit for purpose;
- there are areas of particular strength that are valued by our stakeholders and partners;
- we could improve some aspects of our activities to deliver real excellence; and
- a greater emphasis on demonstrating and communicating specific feedback and responses to what we had heard would be particularly welcome and valued.

Evidence (What has actually been done / achieved?
See Outcome 2.3 for further information.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Pregnancy and Maternity • Race (including nationality and ethnic origin) • Religion or Belief • Sex • Sexual Orientation	• Objective 1 • Objective 2 • Objective 3	• Article 2 | Right to life • Article 3 | Anti-torture and inhumane treatment • Article 8 | Right to private and family life • Article 10 | Right to freedom of expression • Article 11 | Right to freedom of assembly and association

1.2 Individual people's health needs are assessed and met in appropriate and effective ways

Evidence (What has actually been done / achieved?
Provider Performance / Quality Contract Management All provider **quality schedules,** as included within their contracts**,** are designed around the type of care the provider has been commissioned to provide. National and local indicators are built into the schedules to allow the CCG to monitor the service being provided and the provider organisation's ability to assess and meet all patients' needs. This is currently monitored through a variety of formats including patient experience/feedback, incident reporting, national and local benchmarking performance data and patient outcomes. See Outcome 1.4 for further details on the Quality Monitoring and Quality Schedule process.
Continuing Healthcare As part of the **CHC process**, the CHC team receive and review individual applications for CHC funding; and make recommendations to the CCG, in collaboration with specialist services and evidence based clinical input, to ensure a fit for purpose care package is in place to meet the needs of individual patients who are eligible for CHC on a case by case basis. This applies to both children and adults; males and females; identifying suitable placements (e.g. Domiciliary and/or Nursing Care services); and standard / bespoke equipment in support of their needs. The provision of CHC / PHB funding aims to increase the quality of life for all patients with long-term healthcare needs, their sense of wellbeing (and independence) as well as supporting them to stay out of hospital. For patients under the age of 18 (i.e. children), the CHC team will determine **Continuing Care (CC)** eligibility in accordance with the National Framework for Children and Young People's Continuing Care (25 March 2010). The majority of these cases are tri-funded, which also follow a robust multi-disciplinary team assessment; including Health, Social and Education services. For patients over the age of 18 (i.e. adults) who are eligible for CHC and require focused **domiciliary and/or nursing care services**, the CHC team will ensure the service providers deliver care in accordance with respect for the individual's capacity / capability and individuality / independence, and taking into consideration; • equality of opportunity; • rights and choice; • fulfilment; • privacy and dignity; • confidentiality and data protection; • service user engagement; person centred care; • cultural awareness; including individuals from Black and Minority Ethnic (BME) communities, where English is not the first language and

not widely spoken.

CHC / CC also include referrals for patients with complex care needs (e.g. specialist rehabilitation, individual funding requests, acquired and traumatic brain injury). All services are arranged and provided in ways that do not negatively discriminate against patients in terms of race, gender, disability, sexuality, culture, language, religion or age; and will ensure religious, cultural and spiritual needs of all patients are identified, respected and met, wherever possible.

From October 2015, patients with long-term healthcare needs (due to a serious illness or injury) who were eligible for 100% CHC funding were given the option to own a **Personal Health Budget (PHB)**. The purpose of a PHB is to give people greater choice, flexibility, control and ownership over their health and the support received by selecting services that are more convenient; closer to home; and chosen by themselves. For example, PHBs could be used to provide intensive help at home, equipment to improve quality of life or approved therapies. A healthcare professional works with the patient to prioritise the care needs that are important and appropriate for the patient; and create a care plan that reflects their personal health and social outcomes in line with the

The allocation of a PHB is agreed between the individual and their PHB team; and based on a detailed care and support plan, which identifies their health, wellbeing, and outcomes; and follows a **'7 steps for PHBs' process** (i.e. Getting started; Providing Information; Planning your care; Getting your plan agreed; Setting up your finances; Payments start; Clinical and Financial Reviews. In addition, a PHB can be managed in one of the following 3 ways:

1. Direct payment – given to the patient or an individual with responsibility for the patient;
2. Third party – given to organisations which help to agree and arrange the care that is needed for the patient; and hold the budget;
3. Notional sum – held by the patient's NHS team to spend in line with the patient's agreed wishes.

PHB's are an alternative mechanism of utilising NHS money for patients who want (and are clinically able) to take control of their care. For those who do not wish to take up a PHB, they can continue with their healthcare needs in line with routine NHS arrangements.

Supporting information:

- Outcome 1.1 for IAPT services.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Race (including nationality and ethnic origin)	• Objective 1	• Article 2 | Right to life • Article 3 | Anti-torture and inhumane treatment

• Sex		• Article 8 | Right to private and family life • Article 9 | Right to freedom of thought, conscience and religion • Article 10 | Right to freedom of expression • Article 13 | Right to an effective remedy • Article 14 | Anti-discrimination

1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed

Evidence (What has actually been done / achieved?
Help to Live at Home See section 1.1 above.
Mental Health / Learning Disabilities People can access mental health and learning disabilities via their GPs or Secondary Care. Carers are offered support if they care for someone with mental health or a learning disability. See Outcome 1.1 for further information.
GP Support and Investment Plan (SIP) 2015-16 Through the care planning process of the GP SIP (e.g. End of Life; Care Homes), discussions are held with patients, families and carers to decide the care plans, the needs and requirements of the patient. These are subsequently shared with Out of Hours, East Midlands Ambulance Service and NHS 111 services through 'special notes' and hard copies given to the patients to inform professionals involved in their care, the decisions they have made with their GP.
Community Services Model See Outcome 1.1 for further information.
Urgent Care / MIU See Outcome 1.1 for further information.
We are Listening (Listening Booth) (Fiona) 'We are listening' was a new initiative in launched February 2014 to pay due regard to the views of the wider community and designed to complement the data already available through patient surveys and other large scale feedback mechanisms and collate both positive and negative feedback from patients. The idea was to focus on how people feel and their attitudes and opinions by asking individuals: • If they have had a recent experience of the NHS or social care and to tell us about this; • what was positive; and • what could have been done differently.

The information gathered anonymously from this exercise was used to ensure that patient views remain at the heart of ELR CCG's quality monitoring and decision making; to develop patient stories, spot themes and trends about local services, and inform service improvements or to make changes to the services we provide. The patient stories have included people of varying ages, people with recognized mental health and learning disabilities, married couples and single people, parents of young children, representatives of both genders.

The listening booth has been used to promote service and pathway changes, such as Urgent Care and Community Health Services consultations.

During 2015-16, a total of 651 items of feedback have been recorded:

- 36 events (GP practices, local businesses, seldom heard groups, Libraries in Oadby, Wigston and Blaby, Melton Mencap, Lutterworth Parkinson Support Group, South Wigston Tesco, Harborough Leisure Centre, Supersonic Boom, ELR CCG AGM, Dementia Event, Leicester LGB&t Centre meeting, Oakham market, Wycliffe & Masharani Practices, Mother and Toddler Groups, Children's Centres / Family Centre Drop-in);
- Age range: Under 16's (3); 16-24 (19); 25-34 (83); 35-39 (32); 40-49 (75); 50-59 (109); 60-75 years (184); 76+ (121);
- Sex: Males (181) and females (407); Transgender (1);
- Disability declared: Physical disability (10); Diabetes (4); Loss of sight / hearing (2); mental health and their carer's (19); dementia and their carer's (41). Easy-to-read versions of Community Health Services disseminated to Mental Health Group, Market Harborough and the Forget-me-Knot Memory Café, Countesthrope (October 2015);

Events have been held in areas of social deprivation, such as South Wigston, and also areas suffering from geographical isolation, i.e. in the county of Rutland. The Listening Booth has also visited community groups where people attend who may have limited social networks. It is noted that data in relation to race, religion and belief and sexual orientation has not been captured, including other disadvantaged groups, which is under review for 2016-17.

Out of the 651 items of feedback received, 23 items related to continuity of care, which included comments from patients and family members in relation to support and advice received; examples of which are stated below:

- *"My husband had triple heart bypass surgery; the support from both the practice and hospital was marvellous."*
- *"Patient had NHS funded hip replacement at Fitzwilliam Hospital in Peterborough. The service was great, but felt that there was not enough follow up physiotherapy appointments."*

All feedback received has been fed back to service providers to inform improvements and share best practice.

Evidence:

- Scanned copies of feedback forms saved centrally and recorded on a database or reporting purposes;
- Dementia Healthcheck leaflets in Hindi held within the Team;

- Quarterly patient experience reports to ELR CCG Quality and Performance Committee (Apr and July 2015); F2SU report (Sept 15); patient stories to Governing Body (May, July, and Nov 15; Jan 2016).

See outcome 2.1 for:
- Design, Procurement and Delivery of new website
- Listening and Engagement Strategy

Medicines Optimisation Strategy

The Mandate for 2013-15 and the NHS Outcomes Framework 2012/13 identified 5 key areas that the NHS's strategic direction is required to pursue for one of its objectives. The Strategy highlighted four areas where medicines optimisation had an influence in ensure the key areas were met. One of these areas (Enhancing quality of life for people with long term conditions) required:
- smooth transitions between care settings, including primary and secondary care and health and social care;
- people feel supported to manage their condition;
- best treatments available for dementia;
- Unplanned admissions for asthma, diabetes and epilepsy under 19s, by optimising medicines use.

The CCG developed and implemented a **Medicines Optimisation Strategy for 2013-15,** which aimed to address the issues of improving safety, quality and medicines optimisation for patients, including those in hospitals, residential and nursing homes; and others receiving carer support in their own homes. The Strategy set the vision and the way forward for prescribing and managing medicines within the CCG during this time; and was extended for use in 2015-16, as it was being reviewed and updated in line with local and national priorities for 2016-17.

Supporting information:
- Outcome 2.1 for Design, Procurement and Delivery of new website; Listening and Engagement Strategy.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Marriage and Civil Partnership • Pregnancy and Maternity • Sex • Sexual Orientation	• Objective 1 • Objective 2 • Objective 3	• Article 2 | Right to life • Article 3 | Anti-torture and inhumane treatment • Article 8 | Right to private and family life • Article 10 | Right to freedom of expression

1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse

Evidence (What has actually been done / achieved?
Provider Performance / Quality Contract Management ELR CCG is committed to improving patient experience and fully recognises the importance of gathering and acting on patient experience data. The proactive capture, analysis and interpretation of information about the experience of patients and carers are used to inform all planning and commissioning decisions. All provider **quality schedules,** as included within their contracts**,** include indicators relating to Patient Safety, Safeguarding (Adults and Children) and Patient Experience; including a thorough review of medicines optimisation indicators. All providers are expected to report regularly on patient safety incidents and serious incidents, safeguarding compliance and the results and subsequent actions from patient experience surveys, with supporting evidence. The reports are submitted in line with the agreed timescales, reviewed/challenged/verified by the commissioner led quality contracting meetings and reported to the Quality Review Groups. **A summary from this Group is presented to the CCG's Quality and Clinical Governance Committee** (see summary report presented to the Governing Body - https://eastleicestershireandrutlandccg.nhs.uk/about-us/publications/governing-body-papers/). The 'Duty of Candour' has been included in all contracts with providers, and is monitored in conjunction with the Patient Safety and Contracts Teams. A system of undertaking Quality Visits has been developed; with visits to the main acute, mental health and community providers taking place more frequently. This also includes a desktop review with a range of stakeholders from across LLR CCGs of all available contract monitoring, patient safety and performance information. Patient experience in terms of the protected characteristics is collated by our provider organisations, and reviewed as part of ongoing contract monitoring processes. Indicators within the Quality Schedules are designed to ensure that, when applicable, providers are collecting and reviewing protected characteristics data and reporting any themes or trends. These are monitored through the lead Quality Review Groups to identify any wards or areas where there may be a risk to patient safety or quality, which forms part of the quality visit programme. The CCG will review the latest contractual requirements within the 2016/17 NHS Standard Contract for providers and ensure compliance with the following: • Workforce Race Equality Standard; • Accessible Information Standard.

In addition, the quality schedules will include indicators to ensure that providers report their progress to the CCG, including any actions required to ensure compliance. Where deficits are identified, the CCG will work with the provider to promote improvements.

Patient Safety: Serious Incidents

ELR CCG is committed to improving the safety and experience of our patients' and the healthcare we commission on their behalf. The CCG leads a hosted **Patient Safety Team** on behalf of the 3 CCG's within Leicester, Leicestershire and Rutland. The Team is responsible for managing incidents, including serious incidents and GP concerns, across our contracted provider organisations, secondary acute and non-acute organisations; and primary care.

During April – September 2015, NHS England introduced a new Serious Incident Reporting Framework, which acknowledged the amount of time required to investigate serious incidents, and to report incidents where the patient experienced severe harm or above as a result of the incident. A range of national reporting categories were also issued, which have been adopted for reporting incidents and GP concerns, such as abuse/alleged abuse of patients (i.e. adults and children by a member of staff or third party); accidents, information / data breaches; treatment delays; disruptive/aggressive/violent behaviour; self-inflicted harm; maternity (mother and/or baby); medical equipment; pressure ulcers; infection control; sub-optimal care etc. In addition to nationally reducing the overall number of serious incidents reported, this allowed a greater focus on learning from those that were actually serious incidents. The framework also allows for discretion to consider near miss incidents as a serious incident, where this is felt to be a significant opportunity for learning.

To support the framework, the Patient Safety Team reviewed the 'Policy and Procedure for Reporting, Investigating and Managing Incidents, Accidents, Near Misses and Dangerous Occurrences (Including Serious Incidents) 2012' and undertook a consultation process as part of the policy review. A **'Local Policy for the Reporting, Investigation and Learning from Serious Incidents (Relating to Commissioned Healthcare Services by LLR CCGs)'** was developed to ensure robust systems are in place to report, manage, learn from serious incidents and take appropriate action to prevent future harm from mistakes, mistreatment and abuse. The Policy, which was approved for implementation in February 2016, relates to the Equality Act 2010 (Section 146), the Health and Social Care Act 2012, and the following NHS England publications:

- Serious Incident Framework 2015,
- Never Events List 2015-16,
- Never Events Policy and Framework 2015-16

LLR CCGs have a responsibility to expect serious incidents to be reported in a timely manner, to be effectively and appropriately investigated, with robust action plans developed and implemented with learning shared as appropriate. In addition, the CCGs use serious incident intelligence to triangulate information from other monitoring systems such as Clinical Quality Review Groups (CQRGs) and Quality Surveillance Groups. LLR CCGs require its provider organisations to comply with the 7 key principles in the management of all serious incidents (NHSE SI Framework 2015, part 2),

1. Open and transparent

2. Preventative
3. Objective
4. Timely and responsive
5. Systems based
6. Proportionate
7. Collaborative

Each serious incident reported is monitored by the CCGs via the national reporting system: Strategic Executive Information System (StEIS), and the quality contract monitoring process; as well as being recorded on a local database (DatixWeb); and high level patient safety information is incorporated into the CCGs Quality dashboard.

LLR CCG – Reporting and Analysis
The hosted Patient Safety Team is responsible for producing monthly and quarterly reports on serious incidents to inform the governance processes within LLR CCGs, in conjunction with Quality Contract Leads so that emerging trends, risks and any concerning information can be shared to inform the quality contract monitoring processes. As part of this, patient and equality information is held in relation to each serious incident (i.e. age, gender, marital status / civil partnership, disability, race, religion / belief, sexual orientation, and level of English language spoken by the patient), which is in the process of being reviewed and will be implemented during Quarter 1 of 2016-17.

LLR Serious Incident Review Group
The hosted Patient Safety Team also manages the LLR Serious Incident Review Group, which provides assurance on the management, investigation and learning from serious incidents. This Group is also accountable to the 3 CCGs within LLR. As part of the **quarterly Patient Safety Reports**, a summary of the Group's work is provided to the Chief Nurses and the quality forums of each CCG; along with themes escalated, and a progress and assurance report. See summary reports of ELR CCG's Quality and Performance Committee that were presented to Governing Body (https://eastleicestershireandrutlandccg.nhs.uk/about-us/publications/governing-body-papers/)

Safeguarding
The Care Act 2014 introduces new safeguarding duties for local authorities including:

- leading a multi-agency local adult safeguarding system;
- making or causing enquiries to be made where there is a safeguarding concern;
- hosting safeguarding adults boards;
- carrying out safeguarding adults reviews;
- arranging for the provision of independent advocates.

Providers and commissioners ensure information about abuse or potential abuse is shared with Local Authority safeguarding teams; and liaise regularly with the local authority safeguarding lead(s) to ensure that there is a coherent multi-agency approach to investigating safeguarding concerns, which is agreed by relevant partners. The interface between the serious incident process and local safeguarding procedures are

identified in the local multi-agency safeguarding protocol and policies (adults and children:

- LLR Safeguarding Adults Board (http://www.llradultsafeguarding.co.uk/)
- Local Safeguarding Children's Board (child deaths, significant harm and serious sexual abuse reviews; including Unexpected and Expected (anticipated) death.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Marriage and Civil Partnership • Pregnancy and Maternity • Race (including nationality and ethnic origin) • Religion or Belief • Sex • Sexual Orientation	• Objective 1	• Article 2 | Right to life • Article 3 | Anti-torture and inhumane treatment • Article 8 | Right to private and family life • Article 10 | Right to freedom of expression • Article 13 | Rights to an effective remedy

1.5 Screening, vaccination and other health promotion services reach and benefit all local communities

Evidence (What has actually been done / achieved?
During 2015-16, ELR CCG supported the following health promotion campaigns for its local population: • ***Stay Well This Winter*** – staff and patients were reminded about common winter illnesses (e.g. colds, sore throats, asthma, norovirus, and the flu) via its website and in conjunction with NHS Choices - if feeling unwell to seek help straight away by visiting a pharmacy or calling NHS 111; to keep warm; and to eat well. Free vaccinations were offered by ELR CCG GP Practices to all patients who were 'at risk' (e.g. over 65s; vulnerable residents (including those with learning disabilities); pregnant women; those with long term conditions (and those that care for them); children between the ages of two and four; and older children with specific medical conditions, for example asthma or diabetes) in order to protect them against catching the flu, and developing serious complications. The CCG also offered free flu vaccinations to all members of staff, which were provided by its Occupational Health Department. In addition, the CCG also encouraged those that care for the elderly, ill or disabled to check with their GP if they too were eligible for a free flu vaccination in order to reduce the risk to their own health and the person they cared for. See https://eastleicestershireandrutlandccg.nhs.uk/stay-well/common-winter-illnesses/ for further details. • **Cervical Cancer Screening** – a campaign urging women aged between 25-49 years of age to attend regular screenings for cervical cancer every 3 years; and every 5 years thereafter until the age of 64. This campaign was supported during Cervical Cancer Prevention Week in January 2016.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Pregnancy and Maternity • Sex		• Article 2 | Right to life • Article 3 | Anti-torture and inhumane treatment • Article 8 | Right to private and family life

2. Improved patient access and experience

The NHS should improve accessibility and information, delivering the right services that are targeted, useful and useable in order to improve patient experience

2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds

Evidence (What has actually been done / achieved?
Help to Live at Home See section 1.1 above.
Community Services Model See Outcome 1.1 above.

Re-design of CCG website

During 2015, the CCG website was re-designed with the end-user in mind; with a particular focus on compatibility with all standard assistive software (e.g. nonvisual Desktop Access (NVDA), JAWS, Browsealoud); and feedback to consider the needs of those individuals with visual impairment, learning disability, inexperienced users of technology, non-English speakers, users behind strict firewalls. In line with the Equality Act, "reasonable adjustment" should be made to give the widest scope for access to the sites. The website was launched in August-September 2015, which included the following considerations:

- Full incorporation of Browesaloud;
- Full incorporation of language translation on all pages of the website via Google Translate (a multilingual statistical machine translation service to translate text, speech, images, or real-time video from one language into another). 2-way translation across more than 70 languages which results in comments added to the website can be instantly translated into more than 70 native languages;
- Use of embedded videos in the majority of news stories to support those with visual / sight difficulties – launch of the clinically-led engagement on Community Services Strategy;
- 'Responsive' website – easily used on a variety of media devices.

The website has drawn particular praise from the LLR Visually Impaired Forum (a group of people from various ages and abilities when it comes to technology), who said:

- *"We very much welcome any additional accessibility added to websites and want to record our thanks to the CCG."*
- *"We believe it would be really helpful to include some text on the page in addition to the icon which many users may not understand. Browsealoud is very helpful to a specific group of people and needs to be used in conjunction with some sight."*
- *"It does not, for example, indicate which elements are links which can be clicked on. It is not a substitute for a screen reader and the site should continue to be developed in accordance with WC3 accessibility guidelines for people using screen readers and magnification software."*
- *"Our testers using access technology found the website to be fully accessible, which is excellent."*
- *For people using apple devices – all of which come with speech and magnification built in, users will get a superior experience without Browsealoud."*

The comments and feedback will be reviewed and incorporated into future developments of the website.

Provider Performance / Quality Contract Management

All provider **quality schedules** include an indicator in relation Patient Experience (Improvement in self- reported experiences of patients accessing the service). **(For further details on the Quality Monitoring and Quality Schedule processes please see 1.4 Above)**

Listening and Engagement Strategy
With the increase use (and power) of mobile devices to improve how local people can access local services at the right time and in the right place, the CCG's new mobile App '**NHS Now'** allows users across EELR to get self-care advice or find their nearest, most appropriate and most convenient local health service currently open to them at any time of the day or night. It has been warmly welcomed by local Healthwatch and patient representatives, as well as staff working in our GP Practice membership. It can be downloaded free of charge by searching for "NHS Now" on the Apple App Store or Google Play.

IAPT Services
The services are primary care based, and open to all of the adult population who meet the threshold requirements of the service (and 'wrap around' services for those who do not). Patients receive the most appropriate treatment / intervention for their care, however, they can express patient choice for alternative NICE recommended treatment for anxiety and depression there are patient surveys carried out which reflect positive results in addition to established complaints systems.

Supporting information:
- Outcome 1.1 for Urgent Care / MIU
- Outcome 1.3 for 'We are Listening' (Listening Booth)

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Race (including nationality and ethnic origin) • Religion or Belief • Sex	• Objective 1 • Objective 2 • Objective 3	• Article 2 | Right to life • Article 3 | Anti-torture and inhumane treatment • Article 8 | Right to private and family life • Article 10 | Right to freedom of expression

2.2 People are informed and supported to be as involved as they wish to be in decisions about their care

Evidence (What has actually been done / achieved?
Help to Live at Home See section 1.1 above.
Mental Health / Learning Disabilities: People are informed and supported with their care via the Care Programme Approach (CPA), Advanced Statements, Advocacy, Patient and Carer Reference Group. The **Care Programme Approach** is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of complex needs. Anyone experiencing mental health problems is entitled to an assessment of their needs with a mental healthcare professional (e.g. nurse, social worker, occupational therapist), and to have a care plan in place that is regularly reviewed by that professional. The patient should be involved in the assessment of their needs; the development of the plan; and be informed of different choices for care and support services. In addition, a formal documented care plan should be provided that outlines any risks, including details in the event of an emergency / crisis. The mental health charity Rethink has produced a factsheet, which provides further information.
Provider Performance / Quality Contract Management The national **CQC Patient Survey** includes a question on whether patients feel they have been involved in decisions about their care. This is an annual survey, for which results are published on the CQC website (http://www.cqc.org.uk/content/surveys). For the main providers, this is monitored by the Quality Schedule and CQUIN schemes; and all other providers are expected to submit an action plan where improvements are necessary, monitored via the Quality Review meetings. All providers must abide by the duty of candour, which means that providers need to be open and honest where things have gone wrong, and the patient must be included in the investigation. This is monitored through the quality schedule.

Patient Participation Groups (PPGs)
PPG's are groups set up to allow patients to be involved in the decision making processes of the practice. Each PPG has its own purpose and personality as determined by individual practices. We are not involved in this process; however we do aim to influence good working relationships by sharing of best practice and PPG/PRG networking sessions.

Practices taking part in the previous Patient Representation Groups developed their PPG membership based on their list size demographics and submitted a report to the CCG at the end of the year detailing this. No equality information and data is collated by these groups.

See Outcome 2.3 in relation to positive experiences reported from these groups.

Supporting information:
- Outcome 2.1 for IAPT services.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Sex	• Objective 1 • Objective 2	• Article 2 | Right to life • Article 3 | Anti-torture and inhumane treatment • Article 8 | Right to private and family life • Article 10 | Right to freedom of expression • Article 11 | Right to freedom of assembly and association

2.3 People report positive experiences of the NHS

Evidence (What has actually been done / achieved?
Listening and Engagement Strategy The strategy seeks to increase both the reach and the impact of our engagement. In particular, achievement of the following four aims: 1. increase the number of people with whom we engage within those organisations with whom we are already engaged; 2. widen the range of organisations and individuals with whom we engage, in particular going beyond the normal NHS and social care 'family' to engage people in their wider lives and activities; 3. increase the quality of our engagement and the experience of those with whom we engage; and 4. increase the visibility of what we do with what we hear and improve the ways in which we provide specific feedback on specific topics. The CCG integrated the management and operation of the previously separate externally hosted databases underpinning its public membership scheme and stakeholder groups; and completed a thorough data-cleansing exercise as a pre-cursor to introducing a new facility via the 'myCCG' section on the website, which allows members to update their details online. Bringing these databases in-house has provided greater ability to track and understand the volume of individuals within each organisation with whom we engage**.** It also allows us to produce analyses of the characteristics of our public membership scheme, including age, gender, disability and ethnicity. The strategy also includes recent initiatives in relation to how we listen to our own staff, such as our **Freedom to Speak Up programme** and staff-led refresh of our organisational values. At the heart of our new strategy lies the concept of **Active Listening**. As a membership organisation, this includes listening to the views of our local GP Practices, as well as our own staff, our patients and local stakeholders. The CCG looked to deliver the concept of Active Listening in reality through the establishment of a series of Listening and Engagement Active Partnerships (LEAPs), in particular: • a review and refresh of our public membership scheme (brought in-house); • strengthening and deepening our ties and planned activities with local Healthwatch and the voluntary sector (including Voluntary Action Leicestershire and Voluntary Action Rutland); • strengthening our drive to engage seldom heard groups and ensuring that their voice is heard and acted upon; • reaching out beyond our immediate and familiar networks in health and social care to embrace and engage with organisations and individuals involved in complementary networks and interests (e.g. in environmental, sporting, cultural and educational spheres); and • our involvement in "Commissioning for better patient experience" (a national project with Macmillan Cancer and NHS England to develop commissioning tools and processes that support positive patient experiences of care). The CCG has developed 'Patient experience dashboards' for our main acute provider organisations as well as the local out of county providers where our residents may choose to access hospital services. Nine indicators have been developed, incorporating publicly available data and

data sourced by contracting teams. Indicators include a selection of patient safety and patient experience indicators to provide a high level overview of the quality of care being provided at each Trust. The dashboards are reported to the ELR CCG Quality and Performance Committee on a quarterly basis (See summary reports provided to the Governing Body - https://eastleicestershireandrutlandccg.nhs.uk/about-us/publications/governing-body-papers/).

We are Listening (Listening Booth)

In its first year, the Listening Booth travelled to over 25 locations, speaking to almost 200 people and allowing them to talk to us outside health locations, approaching them when they are feeling relaxed and have the time to talk about their experiences of healthcare. During 2015-16, the Listening Booth travelled to 36 locations and obtained 651 items of feedback in response to the following questions:

1. Have you had a recent experience of the NHS or social care? Tell us about it...
2. What was positive?
3. What could have been done differently?

The Listening Booth also forms an integral part of specific consultations and engagement programmes. By accessing a wide range of locations with the listening booth, representatives of seldom heard groups are able to participate in these consultations and engagements. All feedback received has been broken down into themes and trends, and provided to service provider. This information has been used to influence changes in the way we commission services, and also to influence improvements in the quality of care being provided, where patients have highlighted issues.

From the 651 items of feedback received, 393 items were positive, which equates to a 60% positive response rate in relation to services provided by NHS 111, Urgent Care Centres, GPs, University Hospitals of Leicester and the Leicestershire Partnership Trust. The majority of people who provided positive feedback also provided equalities data, which has been summarised as follows:

- Age range: 16-24 (9); 25-34 (42); 35-39 (22); 40-49 (32); 50-59 (59); 60-75 years (113); 76+ (86);
- Sex: Males (124) and females (232); Transgender (0);
- Ethnicity: White British (47); Asian Indian / British Asian (4); Black Caribbean (1); Mixed Other (0).

Patient stories have become an integral part of our public Governing Body meetings as these have been used to demonstrate meaningful changes and influence commissioning decisions through clinical discussions in these meetings; as these allow patients to tell us their real-life experiences in their own words. Some highlights include:

- Improvements to managing the risk of clostridium difficile infection;
- Input into the acute mental health pathway redesign;
- Focus on complex children's care system;
- the impact of fragmentation of pathways for patients who live on borders; and
- continuing challenges around the cancer diagnosis/ treatment pathway.

To further develop the impact and effectiveness of the Listening Booth, the CCG plans to:

- Incorporate the findings from Listening Booth feedback into our new ELR CCG MOOD Repository, increasing our ability to analyse and report on trends, themes and find examples of feedback to inform specific strategies;
- investigate how the can develop a virtual 'Listening Booth' available via our new website, so people can provide us with feedback even when we are not in their area;
- look to deploy the same Listening Booth question formats in paper form with our GP practices, providers and stakeholders;
- being more imaginative about the locations we choose to deploy our Listening Booth.

As part of the 'Listening and Engagement Strategy,' the CCG will also aim to significantly expand its capacity for capturing patient stories through video and film via a new service called 'ELR CCG TV,' being introduced.

See also Outcome 1.3 above.

Provider Performance / Quality Contract Management

All provider **quality schedules,** as included within their contracts**,** include indicators in relation to Patient Experience to ensure that providers collect data and information on patients experience from numerous different sources, such as:

- **Complaints**;

- **NHS Friends and Family Test (FFT)** – a tool for patients to provide feedback about the care and treatment received by using a simple question, which asks how likely (on a scale from 'extremely likely' to 'extremely unlikely'), the person is to recommend the service to a friend or family member. This was implemented nationally across all adult acute hospital inpatients; A&E departments; maternity services; community and mental health services; and GP Practices. Since April 2015, this has included dental; out-patient and ambulance services; as well as children and young people. All data received is published on a monthly basis (https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/);

- **Patient surveys** – CQC national surveys.

The data collated is reviewed to identify themes and trends of both positive and negative examples of patient's experience of NHS services and fed back to the CCG's through the Quality monitoring processes **(For further details on the Quality Monitoring and Quality Schedule processes please see 1.4 above).**

Patient Participation Group (PPG)

The aim of the Network is to provide a platform for engagement between ELR CCG and patients in commissioning intentions. It also aims to encourage locality working, and sharing of ideas and best practice. The CCG seeks the views of its patients through representatives of this

group and will feed information to its patients via the group representatives. No equality data or information is collated at these events.

Membership of the Network is at least one representative from each PPG/PRG in the ELR CCG area. Each PPG is part of one locality within the CCG. Practices through the National PRG DES were encouraged to develop PRG/PPGs that reflected the demographics of their patient list.

The Network meets four times a year (twice as Network events and twice as Locality meetings). The purpose of these events / meetings are as follows:

- **Network Events**
  - To engage ELRCCG patients in commissioning arrangements;
  - To update the membership group on current topics/issues influencing and affecting general practice. Opportunities are given for questions to enhance understanding of the issues;
  - Share and develop PPG Best Practice through networking opportunities and group based tasks;
  - Invite speakers to provide educative and informative presentations and discussions on current issues.
- **Locality meetings**
  - To provide an opportunity to update the group on the activities of individual PPGs/PRGs, sharing PPG Best Practice and supporting joint working;
  - To engage and update the membership group on current topics/issues influencing and affecting general practice - opportunities are given for questions to enhance understanding of the issues

Supporting information:

- Outcome 2.1 for IAPT services.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Sex	• Objective 2	• Article 8 | Right to private and family life • Article 10 | Right to freedom of expression • Article 11 | Right to freedom of assembly and association

2.4 People's complaints about services are handled respectfully and efficiently

Evidence (What has actually been done / achieved?
Complaints Policy / Procedure and Reporting The CCG has in place a complaints management policy and process, which is aligned to the national complaints regulations and sets out the principles to be applied in the review and investigation of complaints. In the main, the CCG is required to manage and handle complaints about: • providers that the CCG commissions services from (e.g. hospital trusts, mental health and community trusts etc); or • the commissioning decisions made by the CCG. The CCG aims to commission high quality services which provide a positive experience. Sometimes things go wrong, and when they do, we want patients / carers / the public to tell us about it. We recognise the value that complaints can provide in planning for the future and in improving services for the benefit of our patients and local community. Therefore, it is important that we have a Complaints Policy which outlines how we will manage complaints within the CCG and what our patients and the public can expect from the process and demonstrate how we convert patient experience and feedback into insights that influence our decision making. Integrating methods for seeking and acting on what our patients tell us about their experiences also forms an important part of our Involving and Informing Strategy. We also encourage positive feedback and compliments about our work or the quality of health services patients / carers / members of the public have received as a local resident. The key objectives of the CCG Complaints Management Policy are to: • ensure ease of access for patients and complainants; • have a fair, open and transparent process in the handling of complaints; • ensure complaints are dealt with in a timely manner; • ensure fairness for staff and complainants alike and ensure non-discrimination against staff or complainants, either those subject to a complaint or those that are making a complaint; • ensure lessons are identified and there is evidence of learning to improve services for patients and staff; • maintain confidentiality in accordance with the Data Protection Act 1998 and the NHS Code of Conduct • ensure that complaints involving more than one NHS organisation and joint complaints relating to health and social care are handled in a coordinated manner. The intentions as extracted from the Policy have been translated into actions, some of which are listed below: • **Complaints reporting through internal governance processes to ensure transparency and learning:** a quarterly and annual complaints report is presented to the CCG Quality and Performance Committee which has delegated authority from the Governing Body to ensure assurance and updates are reviewed in respect of patient experience, including complaints. See Complaints Reports to QPC in June and November 2015.

- **Equality monitoring form** was developed in conjunction with Equalities Lead at NHS Arden and GEM CSU to ensure all 9 protected characteristics were considered. This was designed to capture date of birth (age), sex / sexual orientation / gender reassignment, relationship status, long term conditions, ethnic group / background, religious identity and preferred language. This was rolled out in April 2015 and is sent to every complainant along with the initial letter of acknowledgement and consent form. The completed equalities forms are logged anonymously and protected characteristics reported on for further analysis and consideration. (S:\3. CORPORATE COMMITTEES\Quality & Performance Committee\2015\11. November – Paper D).

  Between April 2015 and March 2016, the CCG received a total of 10 equality monitoring forms, which provided the following information:
  - **Age range**: Under 16 (1); 16-24 (1); 35-59 (4); 60-75+ years (2);
  - **Sex**: Males (2) and females (8);
  - **Gender Reassignment**: No (10);
  - **Disability**: Mobility, Dexterity, Stamina; and Other;
  - **Married** / **Civil Partnership** (5); Single/In a relationship/Living with partner/Divorced (4)
  - **Race**: English/Welsh/Scottish/Northern Irish/British (8); Indian (1);
  - **Religion** / **Belief**: Christian (5); Sikh/Other (2); Prefer not to say (3);
  - **Sexual Orientation**: Heterosexual / Straight (8); Prefer not to say (2)
  - **Preferred Language**: English (9); Prefer not to say (1).

The CCG's website (https://eastleicestershireandrutlandccg.nhs.uk/compliments-and-complaints/) also allows individuals to submit a complaint in writing (including email), over the phone, face to face and via the CCG's online feedback form.

Provider Performance / Quality Contract Management

Providers submit regular reports on complaints data through the quality contracting meetings. **(For further details on the Quality Monitoring and Quality Schedule processes please see 1.4 Above)**

The national CQC Patient Survey includes a question on whether patients feel they have been treated with privacy and dignity. All providers must also report on the Friends and Family Test, which gives real time feedback of patient experience and is monitored by the Quality Schedule for the main provider contracts.

The privacy and dignity of patients is a key part of the assessment of quality in the commissioner led quality visits to providers, which is an annual survey. Providers are expected to submit an action plan where improvements are necessary, monitored via the Quality Review meetings.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Gender Re-assignment • Marriage and Civil Partnership • Race (including nationality and ethnic origin) • Religion or Belief • Sex • Sexual Orientation	• Objective 1 • Objective 2 • Objective 3	• Article 2 | Right to life • Article 3 | Anti-torture and inhumane treatment • Article 8 | Right to private and family life • Article 9 | Right to freedom of thought, conscience and religion • Article 10 | Right to freedom of expression • Article 14 | Anti-discrimination

3. A representative and supported workforce

The NHS should support the diversity of its workforce (whether paid or non-paid) to improve the quality of their working lives, enabling them to better respond to the needs of patients and local communities

3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

Evidence (What has actually been done / achieved?
The CCG has in place a **Recruitment and Selection Policy and Procedure** to ensure a fair process is in place, which reflects the requirements of the Equality Act 2010, and summarised below: • All vacancies within the CCG are advertised on NHS jobs, unless there are any individuals who are 'at risk' of redundancy via Management of Change; • Adverts state the CCG is an equal opportunities employer and all applications will be welcomed and considered regardless of a person's age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. The adverts also state the CCG are a 'Positive about Disabled People' employer - disabled applicants need only meet the essential criteria to be invited to interview; • All applications are made online and individuals are provided with an applicant number. The application forms are sent to recruiting manager (excluding personal details of the applicant) to shortlist based on the criteria within the person specification and which states evidenced and measured at application stage. Once shortlisted and an interview slot has been accepted, the personal details of the application are provided to the interview panel; • Questions at the interview are based on the person specification and applicants are scored according to the responses provided – the applicant with the highest score is provided with a conditional offer, subject to the completion of all pre-employment checks (e.g. identity checks, right to work in the UK, professional / qualification checks, employment history / references / training verification, criminal records / barring, work health assessments). The interview process does not permit questions in relation to the protected characteristics to be asked as part of the recruitment process; • Shortlisting and selection decisions are objective and are only made on the basis of how closely the candidates meet the person specification and interview assessment criteria. Once recruited, staff details are recorded on the Electronic Staff Record (ESR) system, from which reports are provided to the CCG on gender, disability and BME (quarterly) and age, sexual orientation and gender profile by branding (annually). People Services recruitment process is audited by Deloitte every six months, who take a selection of staff files (including new starters) and cross references to the requirements of People Services are being implemented and signed off as required. I.e. Contracts of employment only being issued when appropriate pre-employment checks have been completed.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Gender Re-assignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race (including nationality and ethnic origin) • Religion or Belief • Sex • Sexual Orientation	Not applicable.	• Article 4 | Anti-Slavery • Article 8 | Right to private and family life • Article 10 | Right to freedom of expression • Article 11 | Right to freedom of assembly and association • Article 13 | Rights to an effective remedy

3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations

Evidence (What has actually been done / achieved?
The national Agenda for Change pay system was introduced in October 2004 to ensure that pay in the NHS was consistent with the requirements of equal pay law. Posts within the CCG have been evaluated in line with Agenda for Change pay system; and Job Evaluation enables jobs to be matched to national job profiles to determine which Agenda for Change pay band a post should fall within. Job descriptions and person specifications are sent to an independent panel for review where the information is evaluated and scored against 16 factors. The final score results in the banding applied to the post. The process of evaluation is based solely on the job description and person specification and therefore does not discriminate against the protected characteristics. All job evaluation scores / outcomes are recorded and held by NHS Arden & Greater East Midlands Commissioning Support Unit (GEM CSU).

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Gender Re-assignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race (including nationality and ethnic origin) • Religion or Belief • Sex • Sexual Orientation	Not applicable.	• Article 4 | Anti-slavery • Article 14 | Anti-discrimination

3.3 Training and development opportunities are taken up and positively evaluated by all staff

Evidence (What has actually been done / achieved?
All CCG staff are required to complete an **appraisal on an annual basis** where individuals and managers will have the opportunity to discuss training and development needs. The appraisal will also provide an opportunity to discuss the effectiveness of previous training / development, which has been implemented. One to one meetings throughout the year are also in place which will also provide individuals with the opportunity to discuss training and development needs. The CCG also encourage staff to complete an **annual staff survey**, which provides individuals with the opportunity to feedback in relation to development, appraisals and support which has been provided. For 2015/16, the final CCGs response rate was 86.4% and the final average response rate of 70.2% (in comparison to the final response rate for 2014/15 at 94%). Although, the final response rate was lower than last year, the CCG noted this as excellent in comparison to other organisations. For 2016-17, the HR team is considering the development of a training action plan. The annual survey includes a range of questions in relation to appraisals / training for staff; and includes both positive and negative comments (the lower the score, the better they reflect performance). Where a training need is identified by staff and/or the Line Manager, appropriate action is taken to bridge the gap. The recent 'Improve your Report Writing in 2 Hours' was identified by Senior Managers due to the standard of reports submitted to the Executive Management Team (EMT) meetings. This training has been offered to all members of staff, with the first session to be delivered in March 2016. The outcome / results of the staff survey are communicated to the Executive Management Team and subsequently to all staff at all levels; and for these to be reviewed at Team / Directorate level, to identify areas for improvement and produce action plans.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Gender Re-assignment • Marriage and Civil Partnership	Not applicable.	• Article 4 | Anti-slavery • Article 10 | Right to freedom of expression • Article 11 | Right to freedom of assembly

• Pregnancy and Maternity • Race (including nationality and ethnic origin) • Religion or Belief • Sex • Sexual Orientation		and association • Article 2 of the First Protocol: Right to education

3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source

Evidence (What has actually been done / achieved?
The CCG has a **Dignity at Work – Bullying, Harassment and Victimisation Policy** which describes the arrangements that have been made as far as possible to eradicate bullying, harassment and inappropriate behaviour at work and it describes how the CCG will deal with claims of alleged bullying, harassment or victimisation. All managers have a responsibility for ensuring that staff in their areas are familiar with this policy and procedure, and have received the relevant support to be able to deal with issues that arise. Appropriate action will be taken against any employee who contravenes the Policy. Dependent on the circumstances this could be seen as gross misconduct, which may be subject to action under the Disciplinary Policy and Procedure and could result in dismissal. In February 2015, the Freedom to Speak Up report was published by Sir Robert Francis QC. The report outlines the findings of an independent review into creating open and honest reporting cultures in the NHS. Many of the recommendations of the Freedom to Speak Up review relate to the creation of an open, honest and transparent culture within NHS organisations, with a focus on ownership from staff across all levels. The Freedom to Speak up Review identifies vulnerable groups, locums and agency staff, students and trainees, BME groups and staff working in primary care. The CCG action plan reflects all of these recommendations. In response, the CCG formed the **Freedom to Speak Up Steering Group** and a **Staff Focus Group** to address the issues identified in the Freedom to Speak Up report. One of the first pieces of work for both groups was to determine the appetite of staff to refresh the ELR CCG values, to reflect these recommendations and ensure that the culture of the CCG is in line with this vision. As a result the CCG's organisational values have been refreshed to ensure that the CCG operates in an open, transparent and patient focussed way across all levels. These values of "one team", "Integrity", "patient centred", "ownership" and "excellence" will be embedded in our organisational culture through values based leadership, recruitment and appraisal. In addition, CCG corporate policies have been updated to encompass the recommendations, ensuring that all staff are able to speak up if they have concerns about bullying and harassment. The CCG is planning a series of training events to ensure that all staff are able to recognise and report incidences of bullying and harassment, and feel confident to do so.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Gender Re-assignment	Not applicable.	Article 3 | Anti-torture and inhumane treatment Article 8 | Right to private and family life

• Marriage and Civil Partnership • Pregnancy and Maternity • Race (including nationality and ethnic origin) • Religion or Belief • Sex • Sexual Orientation		Article 10 | Right to freedom of expression

3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives

Evidence (What has actually been done / achieved?		
The CCG **Managing the Balance between Work and Life Policy** complies with current Employment Legislation on flexible working and authorised time off. Its aim is to inform all employees of their entitlement to 'leave' and 'flexible working' and to ensure that those rights are understood. The types of leave available within the policy are: Special Leave; Parental Leave; Job Sharing; Working at Home; Part Time and Term Time Working; Annualised Hours; Short Term Reduction in Hours; and Flexible Retirement. The CCG recognises that, as a means of improving both staff recruitment and retention, and ensuring a balance between work and life, it needs a flexible approach to working patterns. The policy gives individuals the right to request a flexible pattern of work and places a duty on the CCG to consider these requests seriously. The CCG fully supports this approach to work, and expects managers to consider requests positively, and, wherever possible, accommodate flexible working patterns.		
Protected Characteristics that apply to above	**Equality Objectives that apply to above**	**Articles of Human Rights that apply to above**
• Age • Disability • Gender Re-assignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race (including nationality and ethnic origin) • Religion or Belief • Sex • Sexual Orientation	Not applicable.	Article 8 | Right to private and family life Article 10 | Right to freedom of expression

3.6 Staff report positive experiences of their membership of the workforce

Evidence (What has actually been done / achieved?
Annual Staff Survey The CCG completes an annual staff survey which provides individuals with the chance to provide comments in relation to their working lives. The feedback received supports the CCG to work with staff together to improve the place of work**.** See outcome 3.3 for details of survey results. **Positive (and lower/better than Trust average) responses** in relation to: • Individuals looking forward to attending work; • Good communication between senior management & staff; • Individuals recommending the CCG as a place to work; • Feel concerns of unsafe clinical practice would be addressed lower than Trust average. **Negative (and higher/worse than Trust average) responses** in relation to: • Individuals putting themselves under pressure to come to work despite not feeling well enough; • Individuals stating that they have not had an appraisal within the last 12 months. **CCG Site User Group** The CCG has a Site User Group which includes a representative from each Team / Directorate within the CCG. The Group meets on a monthly basis and individuals raise positive thoughts and experiences, as well as areas for improvement on behalf of their team. The Group is also used as a mechanism for cascading information to and from teams to ensure all members of staff are included. All matters raised are discussed by the Group and possible solutions identified from best practice and/or individual experiences. Members of the Group have stated during the meetings that they enjoy being part of the Group as they feel integrated and part of changes that have been made to aid the wellbeing of their colleagues. The Group has met regularly since August 2015 to incorporate areas of concern pre (and post) the office move in March 2016; and will continue to meet regularly throughout 2016-17, as required.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age	Not applicable.	• Article 10 | Right to freedom of expression

• Disability • Gender Re-assignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race (including nationality and ethnic origin) • Religion or Belief • Sex • Sexual Orientation		• Article 11 | Right to freedom of assembly and association

4. Inclusive leadership

NHS organisations should ensure that equality is everyone's business with everyone taking an active role

4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.

Evidence (What has actually been done / achieved?
The Governing Body had demonstrated its commitment to promoting equality within and beyond the CCG in the following ways: • approved the Equality and Diversity Policy in 2012 – 2015; • approved the equality objectives for 2013 – 2015 and the new objectives approved in March 2016. See Accountable Officer's report presented to the Governing Body (https://eastleicestershireandrutlandccg.nhs.uk/wp-content/uploads/2015/08/Combined-PUBLIC-Gov-Body-papers-15-March-2016-exc-I-and-N.pdf); • supported with the publication of the equalities information; • in 2016, it approved the new CCG values which supports behaviours of equity and fairness, including inclusion ensuring we work as one team; • the Better Care Together programme had a specific task and finish group dedicated to establishing the equality analysis and review process for implementation across the BCT work streams. For instance, **an equality analysis has been undertaken in respect of the consultation process for BCT.** • the CGG has established a group to review and challenge quality and equality impact assessments relating to proposed business cases providing assurance to the Strategy, Planning and Commissioning Committee in respect of the impact of protected characteristics of proposed schemes and actions to be taken to mitigate the risks identified.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human Rights that apply to above
• Age • Disability • Gender Re-assignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race (including nationality and ethnic origin) • Religion or Belief • Sex • Sexual Orientation	• Objective 1 • Objective 2 • Objective 3	• Article 2 | Right to life • Article 3 | Anti-torture and inhumane treatment • Article 4 | Anti-slavery • Article 8 | Right to private and family life • Article 10 | Right to freedom of expression • Article 11 | Right to freedom of assembly and association

4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed.

Evidence (What has actually been done / achieved?)		
The **corporate report template** requires authors to consider due regard to the 9 protected characteristics when compiling their report; and in relation to the project / programme being reported on. In addition, reports being presented to the Governing Body and the key corporate Committees are aligned to the **corporate risk register** as the report template requires authors to make reference to the appropriate risk within the **Board Assurance Framework**.		
Protected Characteristics that apply to above	**Equality Objectives that apply to above**	**Articles of Human Rights that apply to above**
• Age • Disability • Gender Re-assignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race (including nationality and ethnic origin) • Religion or Belief • Sex • Sexual Orientation	• Objective 1 • Objective 2 • Objective 3	• Article 2 | Right to life • Article 3 | Anti-torture and inhumane treatment • Article 4 | Anti-slavery • Article 8 | Right to private and family life • Article 10 | Right to freedom of expression • Article 11 | Right to freedom of assembly and association

4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.

Evidence (What has actually been done / achieved?)
The CCG believes that everyone has a right to be treated with consideration, dignity and respect; and is committed to providing a work environment where all employees feel supported and equipped to challenge harassment, bullying, stereotyping and discriminatory behaviour; where it is expected that all employees will treat each other fairly and with mutual respect. The CCG has a **Dignity at Work policy,** which applies to all staff, including line managers and middle managers. The policy informs individuals to support and promote respect and dignity in care; and not to undermine a person's self-respect regardless of any difference. The Policy refers to 'due regard' for advancing equality, which involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics; • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people; • Encouraging people from protected groups to participate in public life, or in other activities where their participation is disproportionately low. The Policy refers to harassment and explains that harassment relates to unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating, or offensive environment for that individual. In order to promote a positive working environment, managers should: • Conduct themselves in a way which does not intimidate or cause offence or embarrassment to others, and to be aware of behaviour which may cause offence, even if unintentional; • Promote attendance on relevant training programmes; • Promote awareness that bullying or harassment will not be tolerated; • Take all reasonable steps to ensure that bullying or harassment does not occur in the workplace for which they are responsible; • To take appropriate action if they become aware of or witness any acts of bullying or harassment; • Treat all complaints of bullying or harassment seriously, sensitively and confidentially and ensure complaints are dealt with promptly. The Policy supports individuals to work in an environment free from discrimination and ensures a process is in place to deal with such issues as they arise.

Protected Characteristics that apply to above	Equality Objectives that apply to above	Articles of Human rights that apply to the above
• Age • Disability • Gender Re-assignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race (including nationality and ethnic origin) • Religion or Belief • Sex • Sexual Orientation	Not applicable.	• Article 10 | Right to freedom of expression • Article 14 | Anti-discrimination