Members are reminded that they must declare all relevant pecuniary and non-pecuniary interests relating to any items of business to be discussed at this meeting

BIRMINGHAM CITY COUNCIL

HEALTH, WELLBEING AND THE ENVIRONMENT OVERVIEW AND SCRUTINY COMMITTEE

TUESDAY, 20 JUNE 2017 AT 10:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING/WEBCAST**

The Chairman to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's Internet site (www.birminghamnewsroom.com) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

2 **APPOINTMENT OF COMMITTEE AND CHAIR**

To note the resolution of the City Council appointing the Committee, Chair and Members to serve on the Committee for the period ending with the Annual Meeting of the City Council in 2018.

3 **ELECTION OF DEPUTY CHAIR**

To elect a Deputy Chair to substitute for the Chair if absent.

4 **APOLOGIES**

5 **ACTION NOTES/ISSUES ARISING**

5 - 8

To confirm the action notes of the meeting held on 25th April 2017.

6 **DECLARATIONS OF INTERESTS**

Members are reminded that they must declare all relevant pecuniary interests and non-pecuniary interests relating to any items of business to be discussed at this meeting. If a pecuniary interest is declared a Member must not speak or take part

in that agenda item. Any declarations will be recorded in the minutes of the meeting.

9 - 10

7 **TERMS OF REFERENCE**

To note the Committee's terms of reference, as set out in the attached schedule.

8 **JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEES - APPOINTMENTS**

The Committee is asked to agree appointments to the Joint Health Overview and Scrutiny Committees including Councillor John Cotton as Joint Chair:-

Birmingham and Sandwell Joint Health Overview and Scrutiny Committee
(5 Members)

Labour (3); Conservative (1); Liberal Democrat (1)

Birmingham and Solihull Joint Health Overview and Scrutiny Committee
(7 Members)

Labour (5); Conservative (2)

9 **DATES OF MEETINGS**

To approve a schedule of dates for meetings during 2017/18.

(A) The Chairperson proposes that meetings be held at 1000 hours on the following Tuesdays in the Council House:-

2017	2018
18 July	January (Tbc)
19 September	20 February
October (Tbc)	March (Tbc)
21 November	24 April
19 December	

(B) The Committee is also requested to approve Tuesdays at 1000 hours as a suitable day and time each week for any additional meetings required to consider 'requests for call in' which may be lodged in respect of Executive decisions.

Monthly dates have been reserved with a view to planning all work i.e. Committee meetings, inquiries etc to fit into the schedule.

11 - 80

10 **CLINICAL COMMISSIONING GROUP TRANSITION UPDATE**

Paul Sherriff, Director of Operations and Corporate Development, Birmingham CrossCity CCG; Rhod Mitchell, Chair, Birmingham and Solihull Health Commissioning Board; Dr Andrew Coward, Chair, Birmingham South Central CCG; Natalie Penrose, NHS England.

81 - 90

11 **MENTAL HEALTH RECOVERY AND EMPLOYMENT CONSULTATION**

Dario Silvestro, Commissioning Manager, Mental Health Joint Commissioning Team; Tom Howell, Senior Strategic Mental Health Commissioner, Joint Commissioning Team.

12 **REQUEST(S) FOR CALL IN/COUNCILLOR CALL FOR ACTION/PETITIONS RECEIVED (IF ANY)**

To consider any request for call in/Councillor call for action/petitions (if received).

13 **OTHER URGENT BUSINESS**

To consider any items of business by reason of special circumstances (to be specified) that in the opinion of the Chairman are matters of urgency.

14 **AUTHORITY TO CHAIRMAN AND OFFICERS**

Chairman to move:-

'In an urgent situation between meetings, the Chair jointly with the relevant Chief Officer has authority to act on behalf of the Committee'.

BIRMINGHAM CITY COUNCIL

HEALTH, WELLBEING AND THE ENVIRONMENT O&S COMMITTEE

1000 hours on 25th April 2017, Committee Room 3 & 4 – Actions

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Present:

Councillor John Cotton (Chair)

Councillors Uzma Ahmed, Sue Anderson, Mick Brown, Carole Griffiths, Andrew Hardie, Karen McCarthy and Robert Pocock

Also Present:

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care

Graeme Betts, Interim Corporate Director in Adult Social Care

Diane Reeves, Chief Accountable Officer, Birmingham South Central Clinical Commissioning Group

Jemima Shurvinton, My Healthcare Sustainability/Urgent Care Commissioning Manager

Rose Kiely, Overview & Scrutiny Manager, Scrutiny Office

Gail Sadler, Research & Policy Officer, Scrutiny Office

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1. NOTICE OF RECORDING

The Chairman advised that this meeting would be webcast for live or subsequent broadcast via the Council's Internet site (which could be accessed at "www.birminghamnewsroom.com") and members of the press/public may record and take photographs.

The whole of the meeting would be filmed except where there were confidential or exempt items.

2. APOLOGIES

Councillors Deirdre Alden, Mohammed Idrees and Kath Hartley.

3. ACTION NOTES/ISSUES ARISING

The action notes of the meetings held on 28th March 2017 were noted.

4. DECLARATIONS OF INTEREST

Members were reminded that they must declare all relevant interests relating to any items of business to be discussed at the meeting. Councillor Andrew Hardie declared an interest as a registered GP working as a locum in Birmingham.

5. REPORT OF THE CABINET MEMBER FOR HEALTH AND SOCIAL CARE

Councillor Paulette Hamilton (Cabinet Member for Health and Social Care) and Graeme Betts (Interim Corporate Director in Adult Social Care) presented a report which provided an overview of progress on delivering key priorities over the past year and set out priorities and challenges for 2017/18. They provided responses to questions from members around:-

- The Birmingham and Solihull Sustainability and Transformation Plan (STP).
- The situation regarding residents of West Birmingham who are currently under the Black Country STP.
- Plans for budget savings that do not impact upon the quality of care in the system.
- How the additional social care funding of £27.064m (2017/18) will be spent.

RESOLVED:-

- Members were told that a plan for how the additional social care funding would be spent needed to be in place by the end of May. Therefore, the plan should be available to be presented to Scrutiny by the beginning of July.

6. THE HILL URGENT CARE CENTRE SERVICES

Diane Reeves (Chief Accountable Officer, Birmingham South Central Clinical Commissioning Group) and Jemima Shurvinton (My Healthcare Sustainability/Urgent Care Commissioning Manager) updated the committee on the circumstances which had led to the decision by Birmingham South Central Clinical Commission Group not to re-procure urgent care services at The Hill.

RESOLVED:-

- The report was noted.

7. REPORT FROM THE WASTE STRATEGY TASK AND FINISH GROUP

Councillor Robert Pocock, Chair of the Task and Finish Group, presented a report which set out the remit of the group, the outcome of the meetings which had taken place and highlighted emerging issues which should be included in the 2017/18 work programme of the appropriate O&S committee.

RESOLVED:-

- The report was noted.

8. HEALTH, WELLBEING AND THE ENVIRONMENT OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2016-17

RESOLVED:-

That the work programme be noted.

9. REQUEST(S) FOR CALL IN/COUNCILLOR CALL FOR ACTION/PETITIONS

None

10. OTHER URGENT BUSINESS

None

11. AUTHORITY TO CHAIRMAN AND OFFICERS

RESOLVED:-

That in an urgent situation between meetings the Chair, jointly with the relevant Chief Officer, has authority to act on behalf of the Committee.

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The meeting ended at 1117 hours.

HEALTH, WELLBEING AND THE ENVIRONMENT OVERVIEW AND SCRUTINY COMMITTEE

To fulfil the functions of an Overview and Scrutiny Committee as they relate to any policies, services and activities relating to cleaner neighbourhoods, waste management, environment, Adult safeguarding, social care and public health and to discharge the relevant overview and scrutiny role set out in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012, including:

- The appointment of Joint Overview and Scrutiny Committees with neighbouring authorities; and
- The exercise of the power to make referrals of contested service reconfigurations to the Secretary of State as previously delegated to the Health and Social Care Overview and Scrutiny Committee by the Council.

All Councillors, except Cabinet Members (and the Lord Mayor) can be members of an Overview and Scrutiny Committee. Chairs of these committees are appointed by the Full Council and Deputy Chairs are elected by each committee at its first meeting, for the purpose of substitution for the Chair if absent.

Good Overview and Scrutiny adds value to councils in many ways, for example it:

- Provides “critical friend” challenge to executive policy-makers and decision-makers;
- Enables the voice and concerns of the public and its communities to be heard;
- Is carried out by ‘independent minded members’ who lead and own the scrutiny process;
- Drives improvement in public services.

7.1 General role

Overview and Scrutiny Committees will:

(a) make reports and/or recommendations to the full Council, the Executive and/or other organisations in connection with the discharge of the functions specified in their terms of reference;

(b) consider any matter covered in their terms of reference that may affect or be likely to have an effect on the citizens of Birmingham; and

i. is relevant to the Council’s strategic objectives; and/or

ii. is relevant to major issues faced by officers in managing a function of the Council; and

iii. is likely to make a contribution to moving the Council forward and achieving key performance targets.

(c) exercise the “request for call-in” and “call-in” any Executive decisions made but not yet implemented by the Executive.

Overview and Scrutiny Chairs should maintain regular engagement with Cabinet Members to enable flexibility to be built into the Overview and Scrutiny work programme, so as to respond to the council’s policy priorities in a timely way.

7.2 Specific functions

(a) Policy development and review

Overview and Scrutiny Committees may:

(i) assist the Council and/or the Executive in the development of its budget and Policy Framework by appropriate analysis of policy and budget issues;

(ii) conduct appropriate research, community and other consultation in the analysis of policy and budget issues and possible options;

(iii) consider and implement mechanisms to encourage and enhance community participation in the development of policy options;

(iv) question Members of the Executive and/or Chief Officers about their views on issues and proposals affecting their areas of responsibility; and

(v) liaise with other external organisations operating in the city, whether national, regional or local to ensure that the interests of local people are enhanced by collaborative working.

(b) Scrutiny

Overview and Scrutiny Committees may:

(i) review and scrutinise the Executive decisions made by and performance of the Executive and/or Chief Officers in relation to decisions taken by them or in relation to their areas of responsibility/department;

(ii) review and scrutinise the performance of the council in relation to its policy objectives, performance targets and/or particular service areas – including the areas of responsibility of the Regulatory and Non-Executive Committees, but not the actual decisions of the Regulatory and Non-Executive Committees;

(iii) make recommendations to the Executive, Chairmen of Committees, Chief Officers and/or Council arising from the outcome of the scrutiny process;

(iv) review and scrutinise the performance of other relevant public bodies in Birmingham (including Health Authorities) and to invite reports from them by requesting them to address the Overview and Scrutiny Committee and local people about their activities and performance;

(v) question and gather evidence from any person (with their consent);

(vi) establish short life working groups to carry out specific time limited enquiries as agreed with the five Overview and Scrutiny Committee Chairs and subject to available resources.

Birmingham and Solihull CCGs: transition update

Health Overview and Scrutiny Committees

Pre-consultation engagement briefing

Introduction

The NHS commissioning partners in the Birmingham and Solihull Sustainability and Transformation Partnership (STP) are:

- NHS Birmingham CrossCity Clinical Commissioning Group (CCG);
- NHS Birmingham South Central CCG; and
- NHS Solihull CCG.

During this presentation, we will outline the alternatives for future arrangements of the Birmingham and Solihull NHS commissioning organisations, how we plan to continue involving stakeholders.

We request your input.

Birmingham and Solihull STP

The Birmingham and Solihull STP sets out a number of key achievements. These are:

- Care is designed for the individual and their needs.
- Care is provided in the most appropriate place, with whoever is the best person or organisation leading it.
- Greater access to high quality community-based, rather than hospital-based, services where it's most appropriate for the individual.
- Easier access to a GP, who provides the individual with consistently high quality care.
- There is a greater focus on helping individuals to stay independent in their home, and in their community, for as long as is right for them.
- If individuals have a long-term condition, or a condition that can be managed at home, they feel supported and able to do that.
- If individuals are admitted to hospital in an emergency, their care is high quality and seamlessly coordinated so they are seen by the right people at the right time, receive the treatment they need and are able to return home quickly and safely, with the right support in place thereby ensuring that there is a greater focus on their health and wellbeing as a whole.

The above aspirations will be achieved in part through objective one of the STP; *Creating efficient organisations and infrastructures.*

Purpose

- To discuss the outline process and timeline for creating a single commissioning organisation.

- To test and refine our thinking on the possible alternatives, particularly the alternative we prefer at this stage.

- To engage, in an open and transparent way.

- To recognise the need for formal governance around the process and robust decision making. As well as ensuring the HOSC is consistently and meaningfully contributing to the process; with this insight being used to influence our decisions on which proposals to put to the public.

The case for change

- NHS commissioning functions have to efficiently serve the five-year objectives set out by the STP, in its published plan.

- Working at this scale, NHS commissioning will be stronger, more efficient, more consistent and more credible.

- Working at this scale also give us the best opportunity to improve experience and health outcomes for local people, reduce unacceptable health inequalities, and improve provider performance.

- The positive steps we have taken over the past 12 months do not address all available efficiencies.

- More efficient working means we can make best use of the £1.7bn we have to spend on healthcare for 1.2m people in Birmingham and Solihull.

Background

June 2016:

CCGs decide to align strategy and commissioning functions to deliver the STP plan.

September 2016:

CCGs considered a range of alternatives and decided to form a joint commissioning committee, the Birmingham and Solihull Health Commissioning Board (HCB).

Summer 2017:

The joint commissioning committee is creating a single staff team to support its functions.

Stable and permanent alternatives to the historic position will be considered and implemented.

The alternatives

Currently, the CCGs operate a joint health commissioning board.

Alternative 1: Return to three separate CCGs/historic arrangements;

Alternative 2: Form a federation; continue with three separate CCGs, but establish shared management team, governance and decision making;

Alternative 3: A single CCG for Birmingham and a single CCG for Solihull, establish joint working arrangements with Solihull CCG with single management teams, joint processes and committees; and

Alternative 4: Full functional organisational merger – one single Birmingham and Solihull commissioning approach and management team.

On balance, we prefer Alternative 4 at this stage.

Alternative 1

Return to three separate CCGs/historic arrangements.

Positive impact	Negative impact
Structures are familiar to external stakeholders	Undo progress made on achieving partnership ambitions
CCGs set objectives based on locally focussed priorities	Some significant disruption for staff
	Internal boundary anomalies are not addressed
	Three commissioning voices with three sets of commissioning priorities
	No economies of scale
	Three sets of relationships for providers and stakeholders
	Potential to lose some clinical leadership.
	Potential to lose some staff talent
	Does not address Birmingham co-terminosity issue in relation to West Birmingham

Alternative 2

Form a federation; continue with three separate CCGs, but establish shared management team, governance and decision making.

Positive impact	Negative impact
CCGs improve their collective voice	Planning limitations imposed by potential for any CCG to withdraw at any time
Arrangement aligns to Birmingham and Solihull partnership boundary	There is unrealised potential for economies of scale
CCGs can set objectives on locally focussed priorities	Change in governance structures required
Incorporates shared governance standards	Does not sufficiently address the financial challenge
There is little disruption for staff	Potential to lose some clinical leadership
Significant opportunity to improve consistency in stakeholder engagement	Potential to lose some staff talent
	Does not address Birmingham co-terminosity issue in relation to West Birmingham

Alternative 3

A single CCG for Birmingham and a single CCG for Solihull, establish joint working arrangements with Solihull CCG with single management teams, joint processes and committees.

Positive impact	Negative impact
Partially addressees the co-terminosity issue, West Birmingham aside, and aligns to existing local authority, scrutiny and health & wellbeing board arrangements	Planning limitations imposed by potential for either one of the two CCG to withdraw at any time
	There is unrealised potential for economies of scale
CCGs improve their collective voice	Resources and attention required to make formal application process for legal change to governance structure
Arrangement aligns to Birmingham and Solihull partnership boundary	
CCGs can set objectives on locally focussed priorities	Potential for reduced influence of local voice in system-wide decision making
Could be a good building block for future models of commissioning	Does not address the full scale of the financial challenge
Incorporates shared governance standards.	Danger of Solihull CCG becoming a junior partner
There is little disruption for staff	Potential to lose some clinical leadership.
Significant opportunity to improve consistency in stakeholder engagement	Does not sufficiently address the financial challenge
Shared governance and decision making	Potential to lose some staff talent
	Does not address boundary issues including West Birmingham

Alternative 4 *(our preference)*

Full functional organisational merger – one single Birmingham and Solihull commissioning approach and management team.

Positive impact	Negative impact
The arrangement is permanent and stable	Resources and attention required to make formal application process for legal change to governance structure
CCG has one voice	
Arrangement matches Birmingham Solihull partnership boundary	Potential for local voice to be lost in system-wide decision making
CCG can choose to have locally focussed priorities	Potential to lose some clinical leadership.
The most coherent and strongest option to create a commissioning organisation to deliver future-proofed commissioning.	Potential to lose some staff talent
One governance standard	Does not address Birmingham co-terminosity issue in relation to West Birmingham
There is little disruption for staff	
Significant opportunity to improve consistency in stakeholder engagement	
Potential for efficiencies and economies of scale fully realised	

Summary

In our assessment:

- **Alternative 1** offers significant disadvantages to our current arrangements.
- **Alternative 2** offers no significant advantage over our current arrangements.
- **Alternative 3** offers some advantages over our current arrangements.
- **Alternative 4** offers significant advantages over our current arrangements.

The issues

During pre-consultation engagement, stakeholders have raised issues which we are noting and addressing. The following two are prominent and recurrent:

The money issue

Birmingham CrossCity and Birmingham South Central both have cumulative surpluses of combined of £36.2million as at 31 March 2018 (assuming delivery of current plans).

Solihull CCG has a cumulative deficit rising to £8.3million by 31 March 2018 (assuming delivery of current plans).

The boundary issue

Part of Birmingham is not covered by the Birmingham and Solihull STP. Responsibility for commissioning NHS services for the people of West Birmingham lies with Sandwell and West Birmingham CCG and the Black Country STP.

Involving stakeholders

Our phased approach to involving stakeholders observes good engagement practice, general election purdah, and democratic expectation for a public consultation on significant changes:

- **Phase one – May/June 2017:** Engage strategic stakeholders
- **Phase two – June 2017:** Engage wider stakeholders
- **Phase three – July/August 2017:** Formal consultation
- **Phase four – August/September 2017:** Consultation data analysis and reporting. Scrutiny by NHS England and decision on whether to authorise proceeding with preferred option.

This outline process has been discussed, in principle, with the HOSCs and is subject to full scrutiny committee approval.

Public statement

"The Birmingham and Solihull CCGs have recently met with us to discuss the outline process and timeline for creating a single NHS commissioning organisation for Birmingham and Solihull; the three CCGs have been working with NHS England to develop plans on how their organisations move forward with this. The CCGs are seeking our views on this important matter, including discussing their draft plans for engaging and consulting with stakeholders."

"Engagement and consultation will take place over June and July; a decision on whether the CCGs will be authorised to proceed with the preferred option is not expected until the end of September".

Single commissioning voice - formal public consultation plan

1. Purpose of the document

This document sets out the approach for formal consultation and describes the communication and engagement tools that can help us deliver the stated objectives.

2. Background

There are three Clinical Commissioning Groups in Birmingham and Solihull:

- NHS Birmingham CrossCity CCG;
- NHS Birmingham South Central CCG; and
- NHS Solihull CCG.

In June 2016, the Birmingham and Solihull Clinical Commissioning Groups (CCGs) determined that an alignment of commissioning functions, and strategy, was required to support the delivery of the Birmingham and Solihull Sustainability and Transformation Plan (STP).

A number of options where considered by the CCGs' Chairs and Accountable Officers and there has been agreement, in line with the constitutional requirements of each CCG, to progress the ambition for a single commissioning voice for Birmingham and Solihull.

The original options considered were:

1. Do nothing;
2. Federation - continue with three separate CCGs, but establish some joint processes and committees in common;
3. Three governing bodies - supported by a single management team, joint processes and committees (as above);
4. A single CCG for Birmingham and a single CCG for Solihull, with single management teams, joint processes and committees; and
5. Full functional organisational merger – one single commissioning approach and management team.

3. Context for consultation

This formal public consultation is part of the CCGs' statutory duty to consult with the public about a major change and follows on from the pre-consultation engagement work that has already taken place.

The formal public consultation is a much more in-depth engagement exercise involving all stakeholders including the wider public and other interested parties. It is time-specific and the outcome from the public consultation will be taken into account by a number of decision making bodies.

Further to agreement from the Birmingham and Solihull Health Oversight and Scrutiny Committees, full public consultation will take place over six weeks, to enable consultation respondents sufficient time to duly consider the proposals and to respond to the consultation. A

high-level process timeline can be found in appendix one.

To support this process, an equalities analysis has been conducted in order to identify any potential disproportionately affected protected groups. Key strategic stakeholders will be mapped and are set out in appendix two.

4. Legal duty

Section 14Z2 of the Health and Social Care Act 2012, places a requirement on CCGs to ensure stakeholder involvement in commissioning processes and decisions. Independent legal advice has confirmed the requirement to formally consult.

5. Objectives

Based on the situation outlined above, and communications and engagement best practices, the top level communication and engagement priorities are:

- An external reputation for transformational change;
- Creating a momentum of transformational change, including a shared vision of the benefits of doing things differently;
- The ongoing management of significant partnerships with the public and other key stakeholders;
- Engaging local people to build a vision for the future, ensuring that they are involved in decision making; and
- Starting to promote the vision of a local health system that encourages whole-system behaviour change, focussing on prevention, early intervention and demand management.

6. Key messages

The guiding principle of our messaging will be straightforward dialogue, that isn't too simplistic, patronising or defensive; promoting respect and recognition to our audiences. Knowledge and insight gained from engagement with our identified audiences must be used to shape key messages and will include identifiable golden threads.

The overarching key messages in the consultation phase will be as follows:

- NHS Birmingham CrossCity, Birmingham South Central, and Solihull CCGs have stated a preferred option to create a single commissioning organisation by April 2018; this has been agreed as the strategic direction of travel with respective memberships and governing bodies of each organisation.

- The Birmingham and Solihull Sustainability and Transformation Partnership (STP) sets a clear direction for planning, and partnership working, for the next five years. To maximise the benefits of planning and partnership working at this scale, we need a strong, consistent and credible commissioning vision and voice.

- We are doing this to deliver the best possible outcomes for local people; tackling health inequalities and meeting the needs of a diverse population.

- This vision of working towards the creation of a single commissioning organisation, subject to consultation, is the next logical progression to the steps the CCGs have taken over the past 12 months.

- It will enable us to work more consistently, maximise our £1.7b budget and will fully realise the potential benefits of this for our 1.2m patients.

7. Overarching narrative on the preferred option

Our preferred option provides the most coherent and strongest option to create a commissioning organisation to deliver future-proofed commissioning, which is aligned to the Birmingham and Solihull STP footprint. It also aligns to existing local authority, scrutiny and health and wellbeing board arrangements. We acknowledge that creating a new commissioning organisation may cause some disruption and be distracting in the short-term; however it's longer term benefits ensure that services are consistent, equitable and high-quality for patients. Capacity would be increased and bureaucracy reduced, making the organisation more efficient and coherent.

8. Consultation materials and resources

A number of materials will be produced as part of the public consultation. These will include a consultation document, as well as supporting materials, which will raise awareness of the consultation and encourage people to take part.

9. Consultation document

A full consultation document will be produced, which will include:

- the case for change
- the options for the proposed changes
- what the proposals mean for patients and stakeholders
- how the proposals have been developed and who has been involved
- timescales for the proposed changes
- a questionnaire to obtain people's views on the proposals
- contact details

The consultation document and questionnaire will be written in plain English and will be tested by a readers' panel, made up of patients and members of the public, to ensure that they are easy to understand.

The consultation document will be available in different languages and alternative formats, on request.

10. Consultation document distribution

A range of consultation materials will be distributed to key NHS buildings across Birmingham and Solihull.

They will also be sent to key stakeholder organisations, for example, Healthwatch and voluntary and community organisations, for onward distribution.

A process will be in place to ensure a regular 'stock check' is undertaken with additional copies being distributed if needed throughout the consultation period.

11. Supporting materials

In addition to the consultation document as described above, materials will include:

- a stakeholder briefing
- a presentation for meetings and events
- frequently asked questions
- a media pack – traditional and social media

Other materials may be produced as a result of feedback during the consultation.
Partner organisations, for example NHS organisations, Healthwatch and voluntary sector organisations, will be asked to include information in their newsletters and on their websites and to support the distribution of consultation materials.

12. Engagement events and meetings

Public and stakeholders

A series of four public meetings will be arranged; two in Birmingham and two in Solihull where CCG staff will discuss the proposals and why things need to change. Attendees will then be given an opportunity to ask any questions they might have and to give their views.

GP membership

Two meetings will be arranged specifically for the general practice (GP) memberships; one in Birmingham and one in Solihull. CCG staff will discuss the proposals with GPs who are members of the Birmingham and Solihull CCGs, building on previous conversations about why things need to change. Attendees will then be given an opportunity to ask any questions they might have and to give their views.

Key stakeholders will be contacted before the consultation starts with an offer for a member of staff to attend a meeting, or event, they are holding during the consultation period.

Venues will be selected on the basis of location, accessibility, parking, size, facilities, as well as value-for-money.

The dates, times and venues of public engagement events organised by the project will be widely advertised in the media, online, via social media and via partner organisations.

Any feedback given at these meetings will be recorded and will form part of the final consultation report.

13. Digital and social media

As part of a public consultation, it is important to give people as many different ways to respond as possible. Some people may prefer to complete a paper questionnaire, whereas others may find an online survey easier. Both options will therefore be provided as part of this consultation.

Consultation pages will be developed on the CCGs' websites and will include:

- An overview of the project
- Key documents including the consultation document and posters
- FAQs

DRAFT

- Press releases in relation to the project
- Details about the public consultation meetings
- The consultation survey
- Information about FOI requests and complaints
- Contact details for further information

Key stakeholders will also be contacted at the start of the consultation, to ask them to add information about the consultation to their websites and to circulate the consultation web link to their contacts.

Facebook and Twitter will be used to raise awareness about the consultation amongst social media communities; this will include paid for targeted Facebook advertising.

14. Media

Proactive approaches will be made to key contacts in the local media to raise awareness of the proposals and the forthcoming consultation and a press release will be issued to launch the consultation and informing the public about the consultation survey and public events.

In the middle of the consultation, a second proactive press release will be issued reminding people of the consultation survey deadline and encouraging them to have their say.

Key spokespeople will be identified and will be put forward for interviews (press, radio and television), where appropriate, throughout the consultation phase as well as for presentations at relevant meetings and events. Support and training will be provided to ensure they are well briefed and can respond clearly and effectively to questions about the proposals.

Media enquiries will be dealt with in a professional and timely manner, throughout the life cycle of the project.

15. Analysis of consultation feedback

An independent organisation will be appointed to analyse all consultation responses and to produce a consultation report thereby ensuring maximum openness and transparency.

Stakeholders will be able to respond to the consultation in a variety of different ways including online or by completing a paper questionnaire. Feedback received from both online and paper questionnaires will be included in a consultation report along with feedback obtained by other methods, for example, from engagement meetings and events, letters, emails, petitions and so on. The feedback will be categorised based on demographic data provided by the respondents.

A telephone helpline will be set-up for people who require support in completing the consultation questionnaire, or have any questions about the process.

In addition, consideration will be given to how respondents whose first language is not English can be supported, for example, translation of the consultation questionnaire or interpretation through the use of a telephone-based interpretation facility. Feedback will be sought on this from participants in the pre-consultation engagement exercise.

16. Enquiries

The consultation may prompt some enquiries. A dedicated number, email address and freepost address will set up and will be available during the consultation phase. Telephone calls, emails

and letters will be responded to from Monday to Friday, during normal working hours. Each enquiry will be recorded on a database and responded to by the appropriate team member in a timely manner.

There are also likely to be a number of Freedom of Information (FOI) requests, which are required to be responded to within a certain timeframe. FOI requests will be managed by the normal CCG FOI procedures.

17. Budget

Every effort will be made to ensure value-for-money is achieved during this process. However, this desire will need to be balanced with the reality of time constraints, the breadth and depth of the communications and engagement activities required as well as the specialist skills needed to deliver them. There may be a need to commission some additional, specialist support from external parties.

18. Evaluation

Measurement of communications and engagement outcomes will take place throughout the process; to ensure that we remain aligned to the delivery to our goals. Evaluation allows us to: improves the effectiveness of our activities; adapt our approach as situations change; and allocate our resources appropriately.

Effectiveness of the communications and engagement activities will be measured by:

1. The number of stakeholders who engage in the events;
2. The overall number of survey responses;
3. The number of survey response aligned to the demographic profile of Birmingham and Solihull;
4. The number of third sector organisations reporting a good and/or better experience in relationships with the CCGs;
5. The number of questions and general enquiries received overall and from different stakeholder groups;
6. For digital communications and social media; user statistics, numbers of people participating in crowdsourcing, number of posts, number of retweets, comments, likes and shares; and
7. How feedback given by all stakeholders has meaningfully influenced the proposals; this will be demonstrated via regular ‘you said, we did’ communications to ensure that we are maintaining interest.

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Appendix one
High-level draft timeline

Key deliverable	Timescale
Production of equality impact assessment / analysis of existing insight and data	01 - 31 May 2017
Development of pre-consultation engagement plan and materials	April – May 2017
Initial dialogue with Birmingham and Solihull HOSC chairs	May 2017
Phase 1 pre- consultation engagement activity	May 2017
Commission external consultation data analysis and reporting support	May 2017
EIA completed	31 May 2017
BSol Health Commissioning Board sign-off pre-consultation proposal, draft consultation plan and equality analysis	14 June 2017
Clinical Chairs approve programme of GP membership engagement and consultation	June-August 2017
Phase 2 pre-consultation engagement activity, inc. two stakeholder events	June 2017 27 and 28 June 2017
Formal HOSC presentations (prior to consultation)	Solihull – 19 June 2017 B'ham – 20 June 2017
Production of consultation plan and materials	May – June 2017
Formal consultation starts	3 July 2017 (TBC - if four week period agreed)
Four public consultation meetings	July 2017
Two GP membership meetings	July 2017
Interim independent consultation report completed	Mid-July
BSol Health Commissioning Board sign-off pre-consultation proposal, 11 tests document, and receive interim consultation report for assurance	19 July 2017
Formal consultation ends	28 July (TBC - if four week period agreed)
Submit draft pre-consultation proposal to NHS England	By 31 July 2017
Full independent consultation report completed	Mid-August 2017
NHS E regional review panel considers draft pre-consultation proposal	August 2017
EIA updated	August 2017
Pre-consultation proposal updated to reflect consultation outcomes and EIA	August 2017
BSol Health Commissioning Board approval of preferred option	Early September 2017
GP membership receive outcome of consultation and approval of preferred option	Early September 2017
Formal HOSC presentations (post consultation)	Early September 2017
NHS E regional review panel review, including additional evidence from consultation	Early September 2017
NHS England Commissioning Committee	27 September 2017
Share consultation feedback and decision? with stakeholders	End September 2017

Note: key dates are highlighted.

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Appendix two

Identified stakeholders to be contacted

Stakeholder Groups
1) National/regional NHS and health-related organisations
NHS England
2) Local NHS and health-related organisations
Birmingham Local Medical Committee / Solihull Local Medical Committee
Birmingham Local Pharmaceutical Committee / Solihull Local Pharmaceutical Committee
Healthwatch Birmingham / Healthwatch Solihull
Birmingham Health and Wellbeing Board / Solihull Health and Wellbeing Board
3) NHS and health-related organisations in neighbouring counties
Healthwatch Warwickshire, Coventry, Staffordshire, Worcestershire, Walsall, Dudley
4) Birmingham and Solihull Clinical Commissioning Groups
CEO/Chair/Clinical Lead/Governing Body
GP member practices/GPs/Practice Managers
CCG staff
Communications teams (internal/CSU)

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CCGs' public and patient involvement groups: People's Health Panel Strategic Patient Partners Primary Care Engagement Forum Patient Participation Groups Local patient networks CCG membership scheme members
5) CCGs in neighbouring counties (South Warwickshire, Warwickshire North, Coventry and Rugby, South East Staffordshire and Seisdon Peninsular, Walsall, Dudley, Redditch and Bromsgrove)
6) Acute Hospital Trusts in Birmingham and Solihull (University Hospitals Birmingham NHS Foundation Trust/Heart of England NHS Foundation Trust/ Birmingham Children's Hospital NHS Foundation Trust/ Birmingham Women's NHS Foundation Trust)
CEO, Chair and Board
Comms team
7) Other NHS and private service providers (e.g. Birmingham Community Healthcare NHS Trust, Birmingham and Solihull Mental Health NHS Foundation Trust)
CEO, Chair, Board
Comms team
8) Birmingham City Council/Solihull Metropolitan Borough Council/West Midlands Combined Authority
Chief executive
Leader
Councillors (city, borough, parish)
Comms team
Joint HOSC

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Public health
9) MPs in Birmingham and Solihull.
10) MPs in neighbouring counties, as appropriate.
11) Media (including local, regional, national and health-specific publications)
12) Voluntary sector organisations BVSC Solihull Sustain
13) Seldom heard groups
Seldom heard group – black and minority ethnic people
Seldom heard group – children and young people
Seldom heard group – older people
Seldom heard group – people with a sensory impairment
Seldom heard group – people with a disability
Seldom heard group – socio-economically disadvantaged people
Seldom heard group – asylum seekers and refugees
Seldom heard group – gypsies, roma and travellers
Seldom heard group – carers
Seldom heard group – homeless people
Seldom heard group – LGBT people
14) Patient and public groups – with an interest in health services

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15) Religious groups and settings

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Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Alternatives 1 - 4 Single Commissioning Voice
Equality Analysis

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Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

NHS Birmingham CrossCity Clinical Commissioning Group
NHS Birmingham South Central Clinical Commissioning Group
NHS Solihull Clinical Commissioning Group

NHS Birmingham CrossCity Clinical Commissioning Group
NHS Birmingham South Central Clinical Commissioning Group
NHS Solihull Clinical Commissioning Group

1. Background

EA Title	Alternatives 1 – 4 Single Commissioning Voice Equality Analysis		
EA Author	Balvinder Everitt – Senior Manager Equality and Diversity	**Team**	Quality
Date Started	6 June 2017	**Date Completed**	8 June 2017
EA Version	V.02	**Reviewed by E&D**	David King – Manager for Equality and Human Rights

What are the intended outcomes of this work? Include outline of objectives and function aims

In June 2016, the BSol CCGs determined that an alignment of commissioning functions, and strategy, was required to support the delivery of the Birmingham and Solihull Sustainability and Transformation Plan (STP).

A number of alternatives where considered by the CCGs' Chairs and Accountable Officers. The original alternatives considered were:

1. Historic arrangements- return to three CCGs
2. Federation - three CCGs, but establish shared management team, governance and decision making;
3. A single CCG for Birmingham and a single CCG for Solihull, with single management team, joint processes and committees; and
4. Full functional organisational merger – one single BSol commissioning approach and management team.

This is a retrospective Equality Analysis and focuses on the potential equality impacts on the combined alternatives 1 and 2 (due to their similarity and minimal material differences) and alternative 3. A separate detailed EA has been completed on alternative 4 as the preferred alternative.

As part of pre-consultation engagement, the CCG Chairs and Accountable Officers supported a preferred alternative for a single merged CCG (alternative 4) and a paper was received by the CCG Governing Bodies confirming the direction of travel in June and July 2016. A separate detailed EA has been completed on alternative 4 as the preferred alternative.

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

Combined Alternatives 1 and 2

The impacts of the proposal will be considered for staff, patients, GP members, providers (large providers and third sector), and partner organisations across Birmingham and Solihull.

The demographic profile of each CCG's (Birmingham CrossCity CCG, Birmingham South Central CCG, and Solihull) population will be utilised along with staff profile information, in the assessment of impacts for each protected characteristic, disadvantaged and vulnerable groups as well as socio-economic factors.

Alternative 3
The impacts of the proposal will be considered for staff, patients, GP members, providers (large providers and third sector), and partner organisation across Birmingham.

The demographic profile of Birmingham CrossCity CCG and Birmingham South Central CCG will be utilised along with staff profile information, in the assessment of impacts for each protected characteristic, disadvantaged and vulnerable groups as well as socio economic factors.

Alternative 4
See Single Commissioning Organisation Equality Analysis.

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
Demographic Information Census 2011	BSOL Transition Group	
JSNAs, CCG Annual Equality Reports		
PHE: Migrant Health in the West Midlands 2017		
BSOL Single Commissioning Organisation Outline Consultation document		
Organisational Staff Profile Information (BCC, BSC, Sol)		
NHS Employers Equity in Implementing Organisational Change Guidance		

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative)

3. Impact and Evidence:

within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:

Demographic Age Profile Information for Birmingham and Solihull

- Birmingham has a relatively young population compared to other cities in England, with a larger proportion of children and young people, and a smaller proportion of people in older age groups. However, Birmingham's population is far from stable and the rate of growth for various age groups varies widely. 46% of the Birmingham population is under 30. 13% is over 65 years. There is also a sizeable 20-24 years population due to the large student population.
- The Solihull population is relatively stable with the older population; with the greatest increase in the 65+ population. 19% of the population are over 65 years, compared to 13% in Birmingham. The number of children and young people (aged 15 and below) in Solihull is, at 19%, in-line with the England average, although it is notable the borough has a relatively low proportion of pre-school age children; those aged 0-4 years represent 29% of all children in Solihull compared to 34% nationally.

Staff Age Profile Information for the 3 CCGs

Age Profile of staff across the CCGs						
CCG	Age Bands					
	Under 20	20 -29	30-44	45-59	60-64	Over 65+
BCC CCG 31 Jan 2017 data (168 staff)	0%	9%	39.5%	48%	2.5%	0%
South Central CCG 31 March 2017 data (82 staff)	1%	6%	29%	57%	6%	0%
Solihull CCG 31 March 2017 (69 staff)	1%	2%	29.5%	58.5%	9%	0%

Impacts:

Combined Alternatives 1 to 2

- There would be no or minimal impacts of these alternatives on age, as they relate to staff and to patients. Place based commissioning would need to ensure an effective response to the age profiles and variations within and across Birmingham and Solihull. There may be the potential loss of some possible benefits that would arise from a merger (as indicated in Alternative 3 and Alternative 4).

Alternative 3

- There would be no impacts on age for Solihull patients or staff as the status quo would be retained
- BSC CCG is the lead commissioner for children's services, and already works very closely with BCC CCG when making commissioning decisions. There are no known adverse impacts on age for Birmingham patients or staff employed by BCC CCG and BSC CCG. Any commissioning decisions would need to take account of the age variations within the diverse localities across Birmingham.

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3. Impact and Evidence:

- Any resulting workforce activities are assessed for their impact on age.

Alternative 4

- See Single Commissioning Organisation Equality Analysis.

Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:

Demographic Disability Profile Information for Birmingham and Solihull

- According to census data across Birmingham as a whole 9.1% of the population either have a disability that limits their day to day activities a lot, compared to 8.2% for Solihull and 8.3% for England. When you look at activities limited a little, the figure for Birmingham is the same as England at 9.3%, though the figures for Solihull are higher at 9.7%.
- There are high rates for people with LD or autism receiving specialist inpatient care (across the STP – 65 per million population)
- Across the STP the proportion of people with a learning disability on the GP register receiving an annual health check is the lowest across all STP's (28.6%). NHSE has set a target of 75% by 2020.

Staff Disability Profile Information for the 3 CCGs

- BCC CCG cannot publish staff disability information due to the small numbers involved. 28% of staff has a 'disability unknown'.
- No BSC CCG staff have declared a disability. 32% have chosen not to declare whether they have a disability.
- Solihull CCG 26% have chosen not to declare their whether or not they are disabled and 10% data is unknown.

Impacts:

Combined Alternatives 1 and 2

- There would be no or minimal impacts of these alternatives on disability, as they relate to staff and to patients. Place based commissioning would need to ensure an effective response to the disability profiles and variations within and across Birmingham and Solihull. There may be the potential loss of some possible benefits that would arise from a merger (as indicated in Alternative 3 and Alternative 4).

Alternative 3

- There would be no impacts on disability for Solihull patients or staff as the status quo would be retained.
- Disability workstreams such as Transforming Care would need to be aligned if

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3. Impact and Evidence:

this alternative was preferred.

- Some disabled patients and disability groups may fear that their voices will not be heard by a larger commissioning organisation and as a result their needs will not be met. In order to mitigate this, the relationships and trust built across BCC CCG and BSC CCG with their respective disabled communities will need to be maintained and built upon by the new BSOL organisation.
- The single commissioning approach would need to ensure it is able to respond to the disability issues across the City.
- Workforce activities resulting from any resulting management of change would require further equality analysis and reasonable adjustments put in place for disabled staff.

Alternative 4

- See Single Commissioning Organisation Equality Analysis.

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

Demographic Gender Reassignment Profile Information for Birmingham and Solihull

- There is a lack of good quality statistical data regarding trans people in the UK. Current estimates indicate that some 650,000 people are "likely to be gender incongruent to some degree"
- There is research evidence which indicates that trans people experience fear and discrimination when accessing health services.

Staff Gender Reassignment Profile Information for the 3 CCGs

- All three CCG's do not collect gender identity equality information on staff, as it is not currently available to record on ESR.

Impacts:

Combined Alternatives 1 and 2

- There would be no or minimal impacts of these alternatives on gender identity, as they relate to staff and to patients. Place based commissioning would need to ensure an effective response to gender identity within and across Birmingham and Solihull. There may be the potential loss of some possible benefits that would arise from a merger (as indicated in Alternative 3 and Alternative 4).

Alternative 3

- There would be no impacts on gender identity for Solihull patients or staff as the

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3. Impact and Evidence:

status quo would be retained

- There are no known adverse impacts for gender identity for staff or patients of BCC CCG and BSC CCG. Any commissioning decisions and management of change decision affecting staff would need to ensure equality, inclusion, and fairness for this protected group, and resulting workforce activities are assessed for their impact on gender identity.
- The CCGs will work to ensure that this group is given the opportunity to raise any concerns and that where possible reasonable adjustments / mitigations are put in place to support them."

Alternative 4

- See Single Commissioning Organisation Equality Analysis.

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

There are no known impacts of any of the alternatives 1-4 on marriage and civil partnership.

Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:

Staff Pregnancy and Maternity Profile Information for the 3 CCGs

- BCC CCG monitors the number of women returning from periods of maternity leave
- BSC CCG and Solihull CCG do not currently collect this data due to the small size of the organisations

Impacts:

Combined Alternatives 1 and 2

- There would be no or minimal impacts of these alternatives on pregnancy and maternity, as they relate to staff. Place based commissioning would need to ensure an effective response to maternity services within and across Birmingham and Solihull. There may be the potential loss of some possible benefits that would arise from a merger (as indicated in Alternative 3 and Alternative 4).

Alternative 3

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3. Impact and Evidence:

- There would be no impacts on pregnancy and maternity for Solihull staff as the status quo would be retained
- There are no known adverse impacts for pregnancy and maternity for staff of BCC CCG and BSC CCG. Any decisions impacting staff would need to ensure any men or women on a period of maternity leave or shared parental leave are included as part of any management of change processes, and resulting workforce activities are assessed for their impact on pregnancy and maternity.
- The CCGs will work to ensure that this group is given the opportunity to raise any concerns and that where possible reasonable adjustments / mitigations are put in place to support them."
- Place based commissioning would need to ensure an effective response to maternity services within and across Birmingham

Alternative 4

- See Single Commissioning Organisation Equality Analysis.

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

Demographic Ethnic Profile Information for the 3 CCGs

- Ethnicity and the associated cultural and religious differences is a big factor in Birmingham, the most ethnically diverse city in the United Kingdom. 58% of Birmingham's population is White British, but the White British share varies widely with age. 42% are from a Black and Minority Ethnic background (BAME). BAME groups are very unevenly distributed within Birmingham. The heart of the city has the majority of the 'non-white' ethnic groups. Over half of the 'non-white' population (51%) live in these areas with only 18% in south Birmingham. Birmingham is a growing city linked in part to migration (9.9% increase since 2004)

- Solihull is less ethnically diverse than Birmingham with over 89% of the population being white. There are 70 known Gypsy Travellers residing within Solihull according to the 2011 census.

- Solihull's BAME population has more than doubled since the 2001 Census and now represents nearly 11% of the total population. Generally the greatest proportion of BAME residents live in the Urban West of the borough and in the 3 North regeneration wards. Nationally, the Afiya Trust suggests that "many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities". (Afiya Trust 2010)

- The Birmingham South Central catchment area covers a population of 286 000

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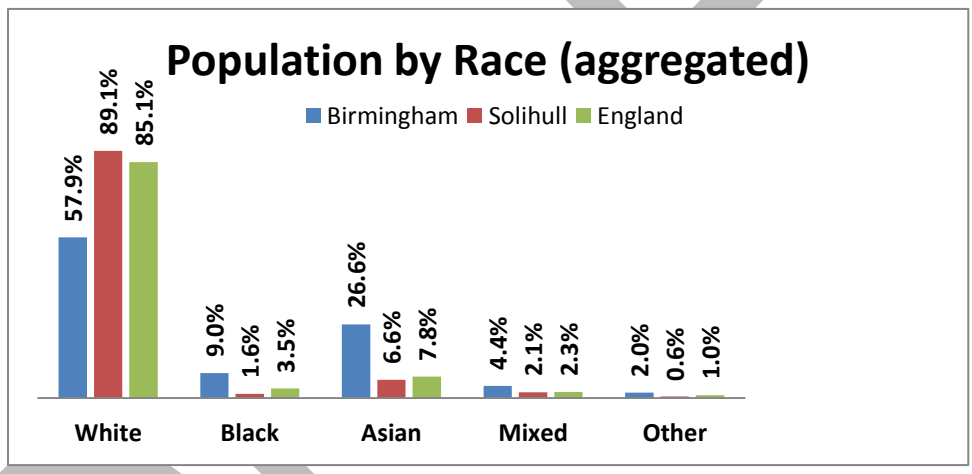
3. Impact and Evidence:

and is characterised by two distinct geographical corridors with different population characteristics. The population within the northern area of the catchment includes Sparkbrook, Springfield, Edgbaston, and Ladywood and is ethnically diverse, with high levels of deprivation and unemployment. It also has a younger population of 28% under the age of 18 years compared to Birmingham average of 25%. The southern area of BSC predominately covers the wards of Bournville, Northfield, Kings Norton, Weoley, and Brandwood. The percentage of ethnic minority residents for these wards is below the city average. The unemployment rates are also below the city average, but there are pockets of high Worklessness rates

- The following chart shows the populations of Birmingham, Solihull and England by aggregated race data; Solihull has the largest White population with 89.1% whilst Birmingham has a significantly larger Black and Asian population than both Solihull and England.



- Some ethnic minority communities may feel their voices will not be heard by a larger commissioning organisation, resulting in less localised commissioning. In order to mitigate this, the relationships and trust built across each CCG with their respective communities will need to be maintained and built upon by the new BSOL organisation.

Migrant Population Information in Birmingham

- The Birmingham population grew by 12% since 2001 with 65+ growth at 13%.
- 22% of Birmingham's population are born overseas (non UK born).
- PHE Migrant Health in WM Report 2017 states that in 2011 Migrants to Birmingham were from the following parts of the world:
  - *55% Middle East and Asia*
  - *15% Africa*
  - *15% EU*
  - *10% Americas and Caribbean*

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3. Impact and Evidence:

- *4% rest of Europe*
- *1% Australasia*

- 10% of the 0-15 years population in Birmingham were migrants largely from EU followed by the Middle East and Asia.

Migrant Population Information in Solihull

- In Solihull the overall population has grown by 5% with the 65+ growth at 21%. 7% of the Solihull population are born overseas (non UK born). Of these, two thirds have been resident in the UK for ten years or more making migration a less significant feature of Solihull's demography.
- PHE Migrant Health in WM Report 2017 states that in 2011 Migrants to Solihull were from the following parts of the world:
  - *35% Middle East and Asia*
  - *15% Africa*
  - *15% EU*
  - *18% Ireland*
  - *2% Rest of Europe*
  - *8% Americas and Caribbean*
  - *2% Australasia*
- 3% of the 0-15 years population in Solihull were migrants largely from Europe followed by the Middle East and Asia.

Language information

- The top five languages after English spoken in Birmingham are Urdu, Panjabi, Bengali, Pakistani, Polish.
- Around 3% of the Solihull population do not have English as their main language.

Staff Ethnic Profile Information for the 3 CCGs

- In 2017, BCC CCG has a BAME staff profile of 31%, which has remained fairly stable over the last three years.
- In March 2017, BSC CCG has a BAME staff profile of 26%
- In March 2017 Solihull CCG had a BAME staff profile of 12%.
- Research and evidence produced by NHS Employers maintains that organisational change brings a difficult period for many NHS staff, and some staff from minority or disadvantaged groups may feel even more vulnerable at this time.

Impacts:

Combined Alternatives 1 and 2

- There would be no or minimal impacts of these alternatives on race, as they relate to staff and patients. Place based commissioning would need to ensure an effective response to the ethnicity profiles and variations within and across

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3. Impact and Evidence:

Birmingham and Solihull. There may be the potential loss of some possible benefits that would arise from a merger (as indicated in Alternative 3 and Alternative 4).

Alternative 3

- There would be no impacts on race for Solihull staff as the status quo would be retained
- There are no known adverse impacts for race for staff of BCC CCG and BSC CCG. Any decisions impacting staff would need to ensure all ethnic groups included as part of any management of change processes, and resulting workforce activities are assessed for their impact on race.
- The CCGs will work to ensure that this group is given the opportunity to raise any concerns and that where possible reasonable adjustments / mitigations are put in place to support them."
- There would need to be an effective and seamless response to the NHS Workforce Race Equality Standard for the two CCGs.
- Commissioning decisions would need to be place based and responsive to the ethnic diversity and variation across the City. BCC CCG and BSC CCG would need to ensure that it continues to build and maintain the relationships and trust with its third sector and ethnic minority communities and patient groups ensuring they are fully engaged throughout any change process.

Alternative 4

- See Single Commissioning Organisation Equality Analysis.

Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:

Demographic Religion or Belief Profile Information for the 3 CCGs

- Christianity is the largest religion in Birmingham however at 46.1% this is lower than that of England as a whole which is 59.4%. Birmingham has more Muslims (21.8%), Sikhs (3%) and Hindus (2.1%) than England (5%, 0.8% and 1.5% respectively).
- The majority of Solihull residents describe themselves as Christian (65.6%), with no religion the 2nd largest group (21.4%). There are significantly more Muslims (+3,610, 221%), Sikhs (+1,938, 124%) and Hindus (+1,834, 99%) than in 2001. The majority of Solihull Muslims and Hindus live in the Urban West of the Borough and therefore are local to the Solihull site. Sikh communities are more dispersed across the Borough.

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3. Impact and Evidence:

Staff Religion or Belief Profile Information for the 3 CCGs

- BCC CCG collects religion and belief information on its staff but this data is too small to publish. 39% of staff ascribe to a religion. 36% do not wish to disclose their religion or belief information.
- BSC CCG has 23% Christian and 70% not specified their religion
- Solihull CCG 20% staff identified as Christian, 58% chosen not to declare their religion or belief

Impacts:

Combined Alternatives 1 and 2

- There would be no or minimal impacts of these alternatives on religion or belief, as they relate to staff and patients. Place based commissioning would need to ensure an effective response to the religious profiles and variations within and across Birmingham and Solihull. There may be the potential loss of some possible benefits that would arise from a merger (as indicated in Alternative 3 and Alternative 4).

Alternative 3

- There would be no impacts on religion or belief for Solihull staff as the status quo would be retained
- There are no known adverse impacts for religion or belief for staff of BCC CCG and BSC CCG. Any decisions impacting staff would need to ensure all groups are included as part of any management of change processes, and resulting workforce activities are assessed for their impact on race.
- Commissioning decisions would need to be sensitive and respectful of the diversity of religion and belief across the City.
- The CCGs will work to ensure that this group is given the opportunity to raise any concerns and that where possible reasonable adjustments / mitigations are put in place to support them."

Alternative 4

- See Single Commissioning Organisation Equality Analysis.

Sex: Describe any impact and evidence on men and women. This could include access to services and employment:

Demographic Gender Profile Profile Information for the 3 CCGs

- Birmingham has a slightly higher number of women 545,239 (50.8%) than men 527,806 (49.2%) this reflects the picture for England as a whole. Life expectancy for men is 77.6 years compared to a national average of 79.4

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3. Impact and Evidence:

years, for women it is 82.2 years compared to a national average of 83.1 years. Birmingham has a gap in life expectancy between the most deprived and least deprived areas of 7.4 years for men and 4.9 years for women.

- In Solihull it is slightly different, where again women are in the majority but by a higher figure than for that of Birmingham and England (51.4%). Life expectancy in Solihull is higher than the national average; however the gap ranges by up to nearly 10 years between the best and worst wards. Life expectancy is 80.3 years for men and 84.8 years for women.

Staff Gender Profile Information for the 3 CCGs

- BCC CCG has a staff profile of 71% female and 29% male
- BSC CCG has a staff profile of 63% female and 37% male
- Solihull CCG has a staff profile of 74% female and 26% male.

Impacts:

Combined Alternatives 1 and 2

- There would be no or minimal impacts of these alternatives on gender, as they relate to staff and patients. Place based commissioning would need to ensure an effective response to the life expectancy variations across and within Birmingham and Solihull, when commissioning decisions are made for men and women. There may be the potential loss of some possible benefits that would arise from a merger (as indicated in Alternative 3 and Alternative 4).

Alternative 3

- There would be no impacts on gender for Solihull staff as the status quo would be retained
- There are no known adverse impacts for gender for staff of BCC CCG and BSC CCG. Any decisions impacting staff would need to ensure men and women are included as part of any management of change processes, and resulting workforce activities are assessed for their impact on gender.
- Commissioning decisions would need to ensure an effective response to the life expectancy variations across the City of Birmingham when commissioning decisions are made for men and women.

Alternative 4

- See Single Commissioning Organisation Equality Analysis.

Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:

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3. Impact and Evidence:

Demographic Sexual Orientation Profile Information for the 3 CCGs

- According to ONS, in 2015, 1.7% of the UK population identified themselves as lesbian, gay or bisexual (LGB). More males (2.0%) than females (1.5%) identified themselves as LGB in 2015. Of the population aged 16 to 24, there were 3.3% identifying themselves as LGB, the largest percentage within any age group in 2015.

- In the last five years alone, 24 per cent of patient-facing staff have heard colleagues make negative remarks about lesbian, gay and bisexual people, and one in five have heard negative comments made about trans people. Lesbian, gay and bisexual staff echoed this, with a quarter revealing they had personally experienced bullying from colleagues over the last five years. One in ten health and social care staff across Britain have witnessed colleagues express the dangerous belief that someone can be 'cured' of being lesbian, gay or bisexual. (Stonewall Unhealthy Attitudes Report)

Staff Gender Profile Information for the 3 CCGs

- All three CCGs collect sexual orientation information on staff. This data is too small to be published.

Impacts:

Combined Alternatives 1 and 2

- There would be no or minimal impacts of these alternatives on sexual orientation, as they relate to staff and patients. Place based commissioning would need to ensure an effective response to sexual orientation across and within Birmingham and Solihull, when commissioning decisions are made for Lesbian, Gay, Bi-sexual (LGB) people and communities. There may be the potential loss of some possible benefits that would arise from a merger (as indicated in Alternative 3 and Alternative 4).

Alternative 3

- There would be no impacts on sexual orientation for Solihull staff as the status quo would be retained
- There are no known adverse impacts for sexual orientation for staff of BCC CCG and BSC CCG. Any decisions impacting staff would need to ensure LGB staff are included as part of any management of change processes, and resulting workforce activities are assessed for their impact on sexual orientation.

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3. Impact and Evidence:

- The CCGs will work to ensure that this group is given the opportunity to raise any concerns and that where possible reasonable adjustments / mitigations are put in place to support them."
- Place based commissioning would need to ensure an effective response to sexual orientation across and within Birmingham when commissioning decisions are made for Lesbian, Gay, Bi-sexual (LGB) people and communities.

Alternative 4

- See Single Commissioning Organisation Equality Analysis.

Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:

Demographic Carers Profile Information for the 3 CCGs

- The 2011 Census indicated that 107,380 people in Birmingham provide unpaid care (10% of usual resident population). Of those who provided unpaid care over 26% provided 50 or more hours a week.
- There are nearly 21,000 carers in Solihull equating to 10.5% of the total population, higher than the national average of 9.9%. This correlates with the larger 65+years population in Solihull
- Unpaid Carers - data shows that a higher proportion of the CCG's population are undertaking care for family / relatives than the England average, this can be linked to the diverse communities identified within the population and must be considered when Commissioning decisions are made.

Staff Carers Profile Information

- Carers information is not collected for staff by any of the three CCG's
- It is noted that as with other vulnerable groups, those with caring responsibilities may feel more vulnerable during a period of organisational change. The CCGs will work to ensure that this group is given the opportunity to raise any concerns and that where possible reasonable adjustments / mitigations are put in place to support them.

Impacts:

Combined Alternatives 1 and 2

- There would be no or minimal impacts of these alternatives on carers, as they relate to staff and patients. Place based commissioning would need to ensure

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3. Impact and Evidence:

an effective response to carers across and within Birmingham and Solihull, when commissioning decisions are made. There may be the potential loss of some possible benefits that would arise from a merger (as indicated in Alternative 3 and Alternative 4).

Alternative 3

- There would be no impacts on carers for Solihull staff as the status quo would be retained
- Any decisions impacting BCC CCG and BSC CCG staff would need to ensure staff who are also carers are included as part of any management of change processes, and resulting workforce activities are assessed for their impact on carers.
- The CCGs will work to ensure that this group is given the opportunity to raise any concerns and that where possible reasonable adjustments / mitigations are put in place to support them."
- Place based commissioning would need to ensure an effective response to carers across Birmingham, when commissioning decisions are made, and relationships and trust built with carer groups and organisations maintained during any change.

Alternative 4

- See Single Commissioning Organisation Equality Analysis.

Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)

Demographic Information

- **HOMELESSNESS**: Birmingham accounts for almost half of all homelessness acceptances in the West Midlands and 9 per cent of the national total. In comparison with neighbouring authorities and core cities, rates of homelessness are disproportionately high. The main reasons for homelessness amongst priority homeless households are parents, relatives or friends no longer willing to accommodate (31 per cent of acceptances). Domestic violence is the single highest reason for households making homeless applications. Understanding the issues around homelessness is important in terms of access to healthcare, GP registration issues and discharge from hospital.

- **ASYLUM SEEKERS AND REFUGEES:** The 2011 Census shows that the majority (77.8%) of Birmingham residents were born in the UK. The highest

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3. Impact and Evidence:

concentration of new migrants were found in Ladywood (26.7%), Nechells (23%) and Soho (19.9%), longer established migrants were more likely to live in Lozells and East Handsworth, Sparkbrook and Handsworth Wood wards, and Washwood Heath.

- More established migrants were twice as likely to live in Sutton Coldfield, compared with new migrants. In Birmingham, Pakistan, India and Republic of Ireland were the most frequently recorded countries of birth outside of the UK in 2011. Birmingham has also been part of the Syrian re-settlement programme.
- There is evidence that many migrants are relatively healthy upon arrival with the native population but good health can deteriorate in the receiving country. A range of factors that impact the health of migrants include depression, isolation, dispersal into society, and poverty. These factors are important in terms of planning health services. Other factors for consideration include communicable diseases such as TB, cultural factors including female genital mutilation, and pregnancy with migrant women presenting much later for their first screening checks.
- In 2015 Birmingham had the highest number of migrant GP registrations in the West Midlands. However there is a discrepancy between GP registration data and flag 4 data (the numbers of migrants in the region registering for NI numbers) indicating that a significant proportion of migrants are not registered with a GP. Other migrant health issues in Birmingham also include; maternal and child health, lifestyle issues including tobacco use, alcohol consumption and substance use; sexual health and sexual violence, modern day slavery and human trafficking.
- Some migrants may also be impacted by the Government Health Care Charging Regulations 2017.

- **DEPRIVATION:** The wards of Sparkbrook, Springfield, Nechells and Ladywood have a high Black and Minority Ethnic (BAME) population compared to the Birmingham average of 30% (80%, 66%, 57% and 40% respectively). For these wards there is a high percentage of the population that live in the most deprived quintile (defined through IMD) in the country (e.g. 78% of Nechells and 72% of Ladywood). These areas are also associated with high unemployment, worklessness, and crime compared with Birmingham and England. Local intelligence suggests that there are also pockets of high deprivation in the Edgbaston and Springfield wards.

- In Solihull at a Local Authority level the population weighted Index of Multiple Deprivation rank shows that as a Borough Solihull is ranked 216th out of 326 LAs in England (66th percentile). Solihull is therefore among the least deprived 35% Local Authorities in the country on this measure. However, Solihull is a relatively polarised borough. This is reflected in the fact that compared with

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3. Impact and Evidence:

other Local Authorities in England a relatively high proportion of Local Super Output Areas(LSOA) are in the most deprived 10% in the country (ranked 77th out of 326, 24th percentile).

- Among the individual domains Solihull has the highest number of LSOAs in the bottom 20% nationally in the crime domain (36), followed by employment (26), income and education, training & skills (both 24). The borough has at least 10 LSOAs in the most deprived 5% of neighbourhoods in England in each of the crime, employment and income domains. All of the LSOAs in the bottom 10% nationally for overall deprivation in 2015 are in the North Solihull regeneration area (Chelmsley Wood, Kingshurst & Fordbridge, Smith's Wood wards and north Bickenhill), the most deprived being The Birds South (Smith's Wood), Chelmsley Wood Town Centre and Bennett's Well which are all in the bottom 3% nationally. In total 20 out of the 29 LSOAs in the wider North Solihull area are in the most deprived 20% in the country. Green Hill (Shirley East ward) and Hobs Moat North (Lyndon) are the only LSOAs outside of the regeneration area in the bottom 20% nationally, with Olton South, Ulverley East (Lyndon) and Solihull Lodge (Shirley West) also in the most deprived 30% in the country.

Other Staff Profile Information

Fixed term employees

Care should also be taken to make sure that staff on temporary or fixed- term contracts are treated equitably, as required by the Fixed Term Employees (Prevention of Less Favourable Treatment) Regulations 2002. The Regulations transpose the EC Directive on Fixed Term Work into UK legislation. The Regulations prevent fixed term employees being treated less favourably than similar permanent employees, and limit the use of successive fixed term contracts. In general, employees on fixed-term contracts have the right not to be treated less favourably than comparable permanent employees. There can be many types of temporary or fixed-term contracts and many reasons for the existence of such a contract, so the entitlement of such a contract holder will be dependent on individual circumstances, e.g. length of service. Therefore legal advice should be sought as appropriate.

Commissioning Support Unit (CSU) Staff

Whilst CSU staff are not directly employed by any CCG, the usage of CSU staff and support functions vary across the CCG's. Birmingham South Central and Solihull CCGs make extensive use of embedded CSU staff (as part of their operating model) across many teams and functions. Care should be taken to ensure CSU staff and management are engaged in any decisions that may impact upon them. The impacts on CSU staff will need to be fully considered as part of any management of change processes as these take place. Legal advice should be sought as appropriate.

4. Health Inequalities	Yes/No	Evidence

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Could health inequalities be created or persist by the proposals?	Alternative 1-2: No Alternative 3: No Alternative 4: *See Single Commissioning Organisation Equality Analysis.*	
Is there any impact for groups or communities living in particular geographical areas?	Alternative 1-2: No Alternative 3: No Alternative 4: *See Single Commissioning Organisation Equality Analysis.*	
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	Alternative 1-2:No Alternative 3: No Alternative 4: *See Single Commissioning Organisation Equality Analysis.*	

How will you ensure the proposals reduce health inequalities?

Deprivation and health inequalities data has been considered in the above section 'Other Disadvantaged groups'.

Alternatives 1 and 2

Alternatives 1 and 2 will result in either no impacts or closer working across the three CCG's, however this will be limited as it is not a full merger. This will work towards ensuring commissioning decisions are made equitably across the geographies in how patients access health services and what health services they access according to needs. All three CCGs are working towards reducing health inequalities under the requirements of the Health and Social Care Act.

Alternative 3

It is envisaged that a single commissioning voice in Birmingham will help to better align health services and health outcomes and reduce variation to accessing health services for Birmingham patients, avoiding a 'one size fits all' approach thereby reducing health inequalities.

Alternative 4

See Single Commissioning Organisation Equality Analysis

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	Patients will be afforded the same access to services
Respect – right to have private and family life	How will the person's right to respect for private and family life, confidentiality and	All services will continue to be delivered ensuring

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5. FREDA Principles/ Human Rights	Question	Response
respected	consent be upheld?	respect for private and family life
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	All three CCGs are statutorily committed to meeting their equality obligations.
	How will this affect a person's right to freedom of thought, conscience and religion?	No impact
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	All services will continue to be delivered ensuring dignity for patients is upheld.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	Patients will continue to have the opportunity to be involved in discussions and decisions about their own healthcare.
Right to **Life**	Will or could it affect someone's right to life? How?	No impact
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	No impact

6. Social Value	
Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.	
Marmot Policy Objective	**What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?**
Enable all people to have control over their lives and maximise their capabilities	N/A
Create fair employment and good work for all	N/A
Create and develop health and sustainable places and communities	N/A
Strengthen the role and impact of ill-health prevention	N/A

7. Engagement, Involvement and Consultation		
If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:		
Engagement Activity	**Protected Characteristic/ Group/ Community**	**Date**

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7. Engagement, Involvement and Consultation

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

As part of pre-consultation engagement, the CCG Chairs and Accountable Officers supported a preferred alternative for a single merged CCG (alternative 4) and a paper was received by the CCG Governing Bodies confirming the direction of travel in June and July 2016.
A separate detailed EA has been completed on alternative 4 as the preferred alternative. This details proposals to undertake a robust consultation and engagement exercise with staff, patients and stakeholders.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

Alternatives 1 and 2

- As the status quo would be maintained there would be no or minimal impacts on protected and vulnerable groups, as they relate to staff and patients. Place based commissioning would need to be fostered to ensure an effective response to protected and vulnerable groups across and within Birmingham and Solihull, when commissioning decisions are made.
- Alternatives 1 and 2 will result in either no impacts or closer working across the three CCG's in reducing health inequalities. However this will be limited as it is not a full merger. Greater joined-up and collaborative working will help ensure commissioning decisions are made equitably across the geographies in how patients access health services and what health services they access according to needs. All three CCGs are working towards reducing health inequalities under the requirements of the Health and Social Care Act.

Alternative 3

- It is envisaged that a single commissioning voice in Birmingham will help to better align health services and health outcomes and reduce any variation to accessing health services for Birmingham patients, thereby reducing health inequalities.
- There would be no impacts on protected and vulnerable groups within Solihull staff as the status quo would be retained.
- There are no known adverse impacts for protected and vulnerable staff groups within BCC CCG and BSC CCG. Any decisions impacting staff would need to ensure staff groups (including CSU staff) are included as part of any management of change processes, and resulting workforce activities are assessed for their impact on protected and vulnerable groups.
- Place based commissioning would need to ensure an effective response to

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diversity across and within Birmingham avoiding a 'one size fits all' approach when commissioning decisions are made.

Alternative 4
See Single Commissioning Organisation Equality Analysis

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

There are no mitigations or changes required at this stage for Alternatives 1 and 2.

A range of recommendations have been set out with regard to Alternative 4 - See Single Commissioning Organisation Equality Analysis.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

There are no monitoring requirements for Alternatives 1 – 4

Monitoring requirements are set out for Alternative 4 - See Single Commissioning Organisation Equality Analysis

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):

N/A

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages.

The results of the EA will be published on the three CCG's webpages.

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13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality and Diversity, Senior Manager for Assurance and Compliance or Equality and Human Rights Manager **and** signed-off by a delegated committee

	Name	Date
Quality Assured By:	Michelle Dunne – Senior Manager Quality and Assurance *M K Dunne* David King – Equality and Human Rights Manager	08/06/2017
Which Committee will be considering the findings and signing off the EA?	Health Commissioning Board	14 June 2017
Minute number (to be inserted following presentation to committee)		

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Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Birmingham and Solihull Single Commissioning Voice Organisation (alternative 4):

Outline preferred alternative

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Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

1. Background

EA Title	Birmingham and Solihull Single Commissioning Organisation: outline consultation process		
EA Author	Balvinder Everitt – Senior Manager Equality & Diversity	**Team**	Quality
Date Started	25 April 2017	**Date Completed**	8 June 2017
EA Version	V.03	**Reviewed by E&D**	David King – Equality and Human Rights Manager Arden and Gem CSU

What are the intended outcomes of this work? Include outline of objectives and function aims

To assess the potential equality, human rights, social value, and health inequality impacts of the proposals to progress the ambition for a single commissioning voice for Birmingham and Solihull. A number of alternatives were originally considered by the CCGs' Chairs and Accountable Officers. These are:

1. Historic arrangements- return to three CCGs
2. Federation - three CCGs, but establish shared management team, governance and decision making;
3. A single CCG for Birmingham and a single CCG for Solihull, with single management team, joint processes and committees; and
4. Full functional organisational merger – one single BSol commissioning approach and management team.

A separate Equality Analysis has been completed on alternatives 1 – 3.

As part of a pre-consultation engagement, the CCG Chairs and Accountable Officers supported a preferred alternative for a single merged CCG; a full functional organisational merger – one single commissioning approach and management team.

The preferred alternative to merge is part of a key programme of commissioning reform within the Sustainability and Transformation Plan and development of place based commissioning. This Equality Analysis assesses alternative 4 for its impacts on protected and vulnerable groups.

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

The impacts of the proposal will be for staff (including embedded CSU staff indirectly), patients, GP members, providers (large providers and third sector), and partner organisations.

The demographic profile of each CCG's population will be utilised for Birmingham and Solihull (BSOL) along with staff profile information, in the assessment of impacts for each protected characteristic, disadvantaged and vulnerable groups as well as socio-economic factors.

A review of the relevant stakeholders and community groups representing protected and vulnerable groups and communities across the BSOL footprint will be undertaken, to ensure there is a breadth and range of communities involved throughout the consultation and at each stage.

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.		
Research/Publications	**Working Groups**	**Clinical Experts**
Demographic Information Census 2011	BSOL Transition Group	
JSNAs, CCG Annual Equality Reports		
PHE: Migrant Health in the West Midlands 2017		
BSOL Single Commissioning Organisation Outline Consultation document		
Organisational Staff Profile Information (BCC, BSC, Sol)		
NHS Employers Equity in Implementing Organisational Change Guidance		

3. Impact and Evidence:

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

Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:

Patients:

- Birmingham has a relatively young population compared to other cities in England, with a larger proportion of children and young people, and a smaller proportion of people in older age groups. However, Birmingham's population is far from stable and the rate of growth for various age groups varies widely. 46% of the Birmingham population is under 30. 13% is over 65 years. There is also a sizeable 20-24 years population due to the large student population.
- The Solihull population is relatively stable with the older population; with the greatest increase in the 65+ population. 19% of the population are over 65 years, compared to 13% in Birmingham. The number of children and young people (aged 15 and below) in Solihull is, at 19%, in-line with the England average, although it is notable the borough has a relatively low proportion of pre-school age children; those aged 0-4 years represent 29% of all children in Solihull compared to 34% nationally.

The single commissioning approach will need to ensure it is able to make considerations of its two separate geographies (Birmingham and Solihull) and balance the age variations across them, when commissioning decisions are made (place based approach); with Birmingham having a young population, and Solihull with a relatively older population.

The consultation process will need to ensure it is inclusive of older people and younger people, and make use of a range of engagement tools and mechanisms to reach a range of ages.

3. Impact and Evidence:

There are no known adverse impacts on age, for patients.

Staff:

The staff profile of the three CCG's (FTE head count). Does not include CSU staff.

Age Profile of staff across the CCGs						
CCG	Age Bands					
	Under 20	20 -29	30-44	45-59	60-64	Over 65+
BCC CCG 31 Jan 2017 data (168 staff)	0%	9%	39.5%	48%	2.5%	0%
South Central CCG 31 March 2017 data (82 staff)	1%	6%	29%	57%	6%	0%
Solihull CCG 31 March 2017 (69 staff)	1%	2%	29.5%	58.5%	9%	0%

- All three CCG's have a large proportion of its workforce within the 30-44 and 45-59 age brackets, with no representation for those aged under 20 years and limited representation of those aged over 65 years..

Because the age make-up of all three CCG's is very similar there will not be a significant difference to the BSOL age makeup. There are no known adverse impacts on age, for staff.

Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:

Patients:

- According to census data across Birmingham as a whole 9.1% of the population either have a disability that limits their day to day activities a lot, compared to 8.2% for Solihull and 8.3% for England. When you look at activities limited a little, the figure for Birmingham is the same as England at 9.3%, though the figures for Solihull are higher at 9.7%.
- Prevalence in Birmingham of depression and neurotic disorders is similar to the national average although is higher in deprived populations. Serious mental illness (schizophrenia, bipolar disorder and other psychoses) though much less common in absolute terms in Birmingham, exhibit prevalence rates similar to the national average.
- The most common mental health problems in Solihull are neurotic disorders and depression. Large numbers of people in Solihull, over 24,000, are estimated to be suffering from these conditions - this represents 1 in 6 of the population aged 15-74. These conditions are more common in women and affect all age groups.
- 45.5% of Birmingham population has very good health compared to 47% of Solihull population.
- There are high rates for people with LD or autism receiving specialist inpatient care (across the STP – 65 per million population)
- Across the STP the proportion of people with a learning disability on the GP register receiving an annual health check is the lowest across all STP's (28.6%). NHSE has set a target of 75% by 2020.
- Some disabled patients and disability groups may fear that their voices will not be

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3. Impact and Evidence:

heard by a larger commissioning organisation and as a result their needs will not be met. In order to mitigate this, the relationships and trust built across each CCG with their respective communities will need to be maintained and built upon by the new BSOL organisation.

The single commissioning approach will need to ensure it is able to respond to the variations across and within its two geographies (Birmingham and Solihull) (place based commissioning) when commissioning decisions are made for disabled people. Specific disability work streams such as Transforming Care will need to be fully aligned across Birmingham and Solihull.
BSOL will need to maintain and build on the relationships and trust built with its third sector and disabled communities and patient groups, ensuring they are fully engaged throughout the change process.
The consultation process will need to ensure it is inclusive of disabled people ensuring engagement and consultation methods are accessible and inclusive, E.g. easy read alternatives are available.

Staff:

- BCC CCG cannot publish staff disability information due to the small numbers involved. 28% of staff has a 'disability unknown'.
- No BSC CCG staff have declared a disability. 32% have chosen not to declare whether they have a disability.
- Solihull CCG 26% have chosen not to declare their whether or not they are disabled and 10% data is unknown.
- Research and evidence produced by NHS Employers maintains that organisational change brings a difficult period for many NHS staff, and some staff from minority or disadvantaged groups may feel even more vulnerable at this time. Disabled staff are more likely to have a negative experience of organisational change. These impacts will need to be mitigated by ensuring effective support mechanisms are in place throughout the organisational change process, including an ability for staff to raise any equality issues or concerns.

The new BSOL organisation will need to ensure;

- **Effective support mechanisms enabling staff to raise any equality issues along with proactive activities that support mental health and wellbeing, throughout the organisational change process.**
- **Workforce activities resulting from the merger (such as recruitment, redundancy, job matching, job evaluation and grading, relocation etc) are assessed for their impact on disabled people and reasonable adjustments are put in place.**

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

Patients:

- There is a lack of good quality statistical data regarding trans people in the UK. Current estimates indicate that some 650,000 people are "likely to be gender incongruent to

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3. Impact and Evidence:

some degree”

- There is research evidence which indicates that trans people experience fear and discrimination when accessing health services.

There are no known adverse impacts of the proposals on gender reassignment, for patients.

Staff:

- All three CCG’s do not collect gender identity equality information on staff.
- As with other vulnerable groups, transgender staff may feel more vulnerable during a period of organisational change. The CCGs will work to ensure that this group is given the opportunity to raise any concerns and that where possible reasonable adjustments / mitigations are put in place to support them.

There are no known adverse impacts for gender reassignment, for staff.

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

There are no known impacts for marriage and civil partnership for patients and staff.

Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:

- BCC CCG monitors the number of women returning from periods of maternity leave
- BSC CCG and Solihull CCG do not currently collect this data due to the small size of the organisations

The new BSOL organisation will need to ensure that any workforce activities resulting from the merger (such as recruitment, redundancy, job matching, job evaluation, grading, and relocation etc) are assessed for their impact on women and men who are on a period of maternity or shared parental leave, and are included as part of any consultation and decision making which may impact on their employment.

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

Patients:

- Ethnicity and the associated cultural and religious differences is a big factor in Birmingham, the most ethnically diverse city in the United Kingdom. 58% of Birmingham’s population is White British, but the White British share varies widely with

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3. Impact and Evidence:

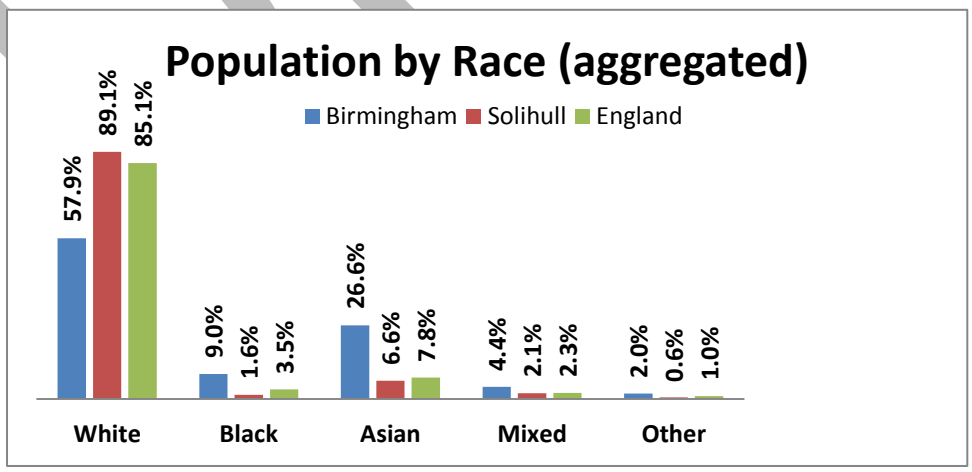
age. 42% are from a Black and Minority Ethnic background (BAME). BAME groups are very unevenly distributed within Birmingham. The heart of the city has the majority of the 'non-white' ethnic groups. Over half of the 'non-white' population (51%) live in these areas with only 18% in south Birmingham. Birmingham is a growing city linked in part to migration (9.9% increase since 2004)

- Solihull is less ethnically diverse than Birmingham with over 89% of the population being white. There are 70 known Gypsy Travellers residing within Solihull according to the 2011 census.

- Solihull's BAME population has more than doubled since the 2001 Census and now represents nearly 11% of the total population. Generally the greatest proportion of BAME residents live in the Urban West of the borough and in the 3 North regeneration wards. Nationally, the Afiya Trust suggests that "many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities". (Afiya Trust 2010)

- The Birmingham South Central catchment area covers a population of 286 000 and is characterised by two distinct geographical corridors with different population characteristics. The population within the northern area of the catchment includes Sparkbrook, Springfield, Edgbaston, and Ladywood and is ethnically diverse, with high levels of deprivation and unemployment. It also has a younger population of 28% under the age of 18 years compared to Birmingham average of 25%. The southern area of BSC predominately covers the wards of Bournville, Northfield, Kings Norton, Weoley, and Brandwood. The percentage of ethnic minority residents for these wards is below the city average. The unemployment rates are also below the city average, but there are pockets of high Worklessness rates

- The following chart shows the populations of Birmingham, Solihull and England by aggregated race data; Solihull has the largest White population with 89.1% whilst Birmingham has a significantly larger Black and Asian population than both Solihull and England.



- Some ethnic minority communities may feel their voices will not be heard by a larger

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3. Impact and Evidence:

commissioning organisation, resulting in less localised commissioning. In order to mitigate this, the relationships and trust built across each CCG with their respective communities will need to be maintained and built upon by the new BSOL organisation.

Migrant Population Information in Birmingham

- The Birmingham population grew by 12% since 2001 with 65+ growth at 13%.
- 22% of Birmingham's population are born overseas (non UK born).
- PHE Migrant Health in WM Report 2017 states that in 2011 Migrants to Birmingham were from the following parts of the world:
  55% Middle East and Asia
  15% Africa
  15% EU
  10% Americas and Caribbean
  4% rest of Europe
  1% Australasia
- 10% of the 0-15 years population in Birmingham were migrants largely from EU followed by the Middle East and Asia.

Migrant Population Information in Solihull

- In Solihull the overall population has grown by 5% with the 65+ growth at 21%. 7% of the Solihull population are born overseas (non UK born). Of these, two thirds have been resident in the UK for ten years or more making migration a less significant feature of Solihull's demography.
- PHE Migrant Health in WM Report 2017 states that in 2011 Migrants to Solihull were from the following parts of the world:
  35% Middle East and Asia
  15% Africa
  15% EU
  18% Ireland
  2% Rest of Europe
  8% Americas and Caribbean
  2% Australasia
- 3% of the 0-15 years population in Solihull were migrants largely from Europe followed by the Middle East and Asia.

Language information

- The top five languages after English spoken in Birmingham are Urdu, Panjabi, Bengali, Pakistani, Polish.
- Around 3% of the Solihull population do not have English as their main language.

The single commissioning approach will need to ensure it is able to respond to the variations across and within its two geographies (Birmingham and Solihull) when commissioning decisions are made for the ethnic diversity of patient populations.
The consultation process will need to ensure it is inclusive and broadly representative of the diverse communities of Birmingham and Solihull ensuring engagement and consultation methods are accessible and inclusive (including accessibility by language).
The new BSOL organisation will need to maintain and build on the relationships and trust built with its third sector and ethnic minority communities and patient groups ensuring they are fully engaged throughout the change process.

Staff:

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3. Impact and Evidence:

- In 2017, BCC CCG has a BAME staff profile of 31%, which has remained fairly stable over the last three years.
- In March 2017, BSC CCG has a BAME staff profile of 26%
- In march 2017 Solihull CCG had a BAME staff profile of 12%.
- Research and evidence produced by NHS Employers maintains that organisational change brings a difficult period for many NHS staff, and some staff from minority or disadvantaged groups may feel even more vulnerable at this time. This will need to be mitigated by ensuring effective support mechanisms are available to staff including an ability for staff to raise any equality issues or concerns.
- Equality monitoring of the organisational change programme will be required.

There will need to be an effective and seamless response to the NHS Workforce Race Equality Standard.
The new BSOL organisation will need to ensure that any workforce activities resulting from the merger (such as recruitment, redundancy, job matching, job evaluation, grading and relocation etc) are assessed for their impact on BAME staff.

Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:

Patients:

- Christianity is the largest religion in Birmingham however at 46.1% this is lower than that of England as a whole which is 59.4%. Birmingham has more Muslims (21.8%), Sikhs (3%) and Hindus (2.1%) than England (5%, 0.8% and 1.5% respectively).
- The majority of Solihull residents describe themselves as Christian (65.6%), with no religion the 2nd largest group (21.4%). There are significantly more Muslims (+3,610, 221%), Sikhs (+1,938, 124%) and Hindus (+1,834, 99%) than in 2001. The majority of Solihull Muslims and Hindus live in the Urban West of the Borough and therefore are local to the Solihull site. Sikh communities are more dispersed across the Borough.

There are no known adverse impacts for different religions and beliefs across Birmingham and Solihull. The single commissioning approach will need to be sensitive and respectful of the diversity of religion and belief across and within its two geographies when making commissioning decisions on behalf of its patients.

Staff:

- BCC CCG collects religion and belief information on its staff but this data is too small to publish. 39% of staff ascribe to a religion. 36% do not wish to disclose their religion or belief information.
- BSC CCG has 23% Christian and 70% not specified their religion
- Solihull 20% staff identified as Christian, 58% chosen not to declare their religion or belief

There are no known adverse impacts for religion and belief for staff.

Sex: Describe any impact and evidence on men and women. This could include

3. Impact and Evidence:

access to services and employment:

Patients:

- Birmingham has a slightly higher number of women 545,239 (50.8%) than men 527,806 (49.2%) this reflects the picture for England as a whole. Life expectancy for men is 77.6 years compared to a national average of 79.4 years, for women it is 82.2 years compared to a national average of 83.1 years. Birmingham has a gap in life expectancy between the most deprived and least deprived areas of 7.4 years for men and 4.9 years for women.

- In Solihull it is slightly different, where again women are in the majority but by a higher figure than for that of Birmingham and England (51.4%). Life expectancy in Solihull is higher than the national average; however the gap ranges by up to nearly 10 years between the best and worst wards. Life expectancy is 80.3 years for men and 84.8 years for women.

The single commissioning approach will need to ensure it is able to respond to the life expectancy variations across and within its two geographies (Birmingham and Solihull) when commissioning decisions are made for men and women.

Staff:

- BCC CCG has a staff profile of 71% female and 29% male
- BSC CCG has a staff profile of 63% female and 37% male
- Solihull has a staff profile of 74% female and 26% male.

The gender profile of the new BSOL single commissioning organisation is not likely to be significantly impacted due to the current similar gender profiles within the CCGs.

The new BSOL organisation will need to ensure that any workforce activities resulting from the merger (such as recruitment, redundancy, job matching, job evaluation, grading, and relocation etc) are assessed for their impact on sex.

Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:

- According to ONS, in 2015, 1.7% of the UK population identified themselves as lesbian, gay or bisexual (LGB). More males (2.0%) than females (1.5%) identified themselves as LGB in 2015. Of the population aged 16 to 24, there were 3.3% identifying themselves as LGB, the largest percentage within any age group in 2015.

- In the last five years alone, 24 per cent of patient-facing staff have heard colleagues make negative remarks about lesbian, gay and bisexual people, and one in five have heard negative comments made about trans people. Lesbian, gay and bisexual staff echoed this, with a quarter revealing they had personally experienced bullying from colleagues over the last five years. One in ten health and social care staff across Britain have witnessed colleagues express the dangerous belief that someone can be 'cured' of being lesbian, gay or bisexual. (Stonewall Unhealthy Attitudes Report)

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3. Impact and Evidence:

The single commissioning approach will need to ensure it is able to challenge discriminatory attitudes towards LGB people when commissioning decisions are made.

Staff:

- All three CCGs collect sexual orientation information on staff. This data is too small to be published.
- As with other vulnerable groups, LGB staff may feel more vulnerable during a period of organisational change. The CCGs will work to ensure that this group is given the opportunity to raise any concerns and that where possible reasonable adjustments / mitigations are put in place to support them.

The new BSOL organisation will need to ensure that any workforce activities resulting from the merger (such as recruitment, redundancy, job matching, job evaluation, grading, and relocation etc) are assessed for their impact on sexual orientation.

Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:

Patients:

- The 2011 Census indicated that 107380 people in Birmingham provide unpaid care (10% of usual resident population). Of those who provided unpaid care over 26% provided 50 or more hours a week.
- There are nearly 21,000 carers in Solihull equating to 10.5% of the total population, higher than the national average of 9.9%. This correlates with the larger 65+years population in Solihull
- Unpaid Carers - data shows that a higher proportion of the CCG's population are undertaking care for family / relatives than the England average, this can be linked to the diverse communities identified within the population and must be considered in Commissioning decisions.
- Carers information is not collected for staff.

It is noted that as with other vulnerable groups, those with caring responsibilities may feel more vulnerable during a period of organisational change. The CCGs will work to ensure that this group is given the opportunity to raise any concerns and that where possible reasonable adjustments / mitigations are put in place to support them.
The consultation process will need to ensure it is inclusive of carers across Birmingham and Solihull ensuring engagement and consultation methods are accessible and inclusive (including accessibility by language).
The new BSOL organisation will need to maintain and build on the relationships and trust built with its third sector and carer groups ensuring they are fully engaged throughout the change process.

Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include

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3. Impact and Evidence:

lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)

Birmingham

- **HOMELESSNESS**: Birmingham accounts for almost half of all homelessness acceptances in the West Midlands and 9 per cent of the national total. In comparison with neighbouring authorities and core cities, rates of homelessness are disproportionately high. The main reasons for homelessness amongst priority homeless households are parents, relatives or friends no longer willing to accommodate (31 per cent of acceptances). Domestic violence is the single highest reason for households making homeless applications. Understanding the issues around homelessness is important in terms of access to healthcare, GP registration issues and discharge from hospital.

- **ASYLUM SEEKERS AND REFUGEES:** The 2011 Census shows that the majority (77.8%) of Birmingham residents were born in the UK. The highest concentration of new migrants were found in Ladywood (26.7%), Nechells (23%) and Soho (19.9%), longer established migrants were more likely to live in Lozells and East Handsworth, Sparkbrook and Handsworth Wood wards, and Washwood Heath.
- More established migrants were twice as likely to live in Sutton Coldfield, compared with new migrants. In Birmingham, Pakistan, India and Republic of Ireland were the most frequently recorded countries of birth outside of the UK in 2011. Birmingham has also been part of the Syrian re-settlement programme.
- There is evidence that many migrants are relatively healthy upon arrival with the native population but good health can deteriorate in the receiving country. A range of factors that impact the health of migrants include depression, isolation, dispersal into society, and poverty. These factors are important in terms of planning health services. Other factors for consideration include communicable diseases such as TB, cultural factors including female genital mutilation, and pregnancy with migrant women presenting much later for their first screening checks.
- In 2015 Birmingham had the highest number of migrant GP registrations in the West Midlands. However there is a discrepancy between GP registration data and flag 4 data (the numbers of migrants in the region registering for NI numbers) indicating that a significant proportion of migrants are not registered with a GP. Other migrant health issues in Birmingham also include; maternal and child health, lifestyle issues including tobacco use, alcohol consumption and substance use; sexual health and sexual violence, modern day slavery and human trafficking.
- Some migrants may also be impacted by the Government Health Care Charging Regulations 2017.

- **DEPRIVATION:** The wards of Sparkbrook, Springfield, Nechells and Ladywood have a high Black and Minority Ethnic (BAME) population compared to the Birmingham average of 30% (80%, 66%, 57% and 40% respectively). For these wards there is a high percentage of the population that live in the most deprived quintile (defined through IMD) in the country (e.g. 78% of Nechells and 72% of Ladywood). These areas are also associated with high unemployment, worklessness, and crime compared with Birmingham and England. Local intelligence suggests that there are also pockets of high deprivation in the Edgbaston and Springfield wards.

Solihull

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3. Impact and Evidence:

- **DEPRIVATION**

At a Local Authority level the population weighted Index of Multiple Deprivation rank shows that as a Borough Solihull is ranked 216th out of 326 LAs in England (66th percentile). Solihull is therefore among the least deprived 35% Local Authorities in the country on this measure. However, Solihull is a relatively polarised borough. This is reflected in the fact that compared with other Local Authorities in England a relatively high proportion of Local Super Output Areas(LSOA) are in the most deprived 10% in the country (ranked 77th out of 326, 24th percentile).
Among the individual domains Solihull has the highest number of LSOAs in the bottom 20% nationally in the crime domain (36), followed by employment (26), income and education, training & skills (both 24). The borough has at least 10 LSOAs in the most deprived 5% of neighbourhoods in England in each of the crime, employment and income domains.
All of the LSOAs in the bottom 10% nationally for overall deprivation in 2015 are in the North Solihull regeneration area (Chelmsley Wood, Kingshurst & Fordbridge, Smith's Wood wards and north Bickenhill), the most deprived being The Birds South (Smith's Wood), Chelmsley Wood Town Centre and Bennett's Well which are all in the bottom 3% nationally. In total 20 out of the 29 LSOAs in the wider North Solihull area are in the most deprived 20% in the country.
Green Hill (Shirley East ward) and Hobs Moat North (Lyndon) are the only LSOAs outside of the regeneration area in the bottom 20% nationally, with Olton South, Ulverley East (Lyndon) and Solihull Lodge (Shirley West) also in the most deprived 30% in the country.

STAFF

Fixed term employees
Care should also be taken to make sure that staff on temporary or fixed- term contracts are treated equitably, as required by the Fixed Term Employees (Prevention of Less Favourable Treatment) Regulations 2002. The Regulations transpose the EC Directive on Fixed Term Work into UK legislation. The Regulations prevent fixed term employees being treated less favourably than similar permanent employees, and limit the use of successive fixed term contracts. In general, employees on fixed-term contracts have the right not to be treated less favourably than comparable permanent employees. There can be many types of temporary or fixed-term contracts and many reasons for the existence of such a contract, so the entitlement of such a contract holder will be dependent on individual circumstances, e.g. length of service. Therefore legal advice should be sought as appropriate.

CSU Staff
Whilst CSU staff are not directly employed by any CCG, the usage of CSU staff and support functions varies across the CCG's. Birmingham South Central and Solihull CCGs make extensive use of embedded CSU staff (as part of their operating model) across many teams and functions. Care should be taken to ensure CSU staff are engaged in any decisions that may impact upon them. The impacts on CSU staff will be fully considered as part of the management of change processes as these take place. Legal advice should be sought as appropriate.

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	

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Is there any impact for groups or communities living in particular geographical areas?	No	
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	

How will you ensure the proposals reduce health inequalities?

It is envisaged that a single commissioning voice will help to better align health services and health outcomes and reduce in variation to accessing health services across the BSOL geographies, thereby reducing health inequalities.

The single commissioning voice will commission its services in a manner that takes account and responds to the health needs and priorities of its diverse communities and geographical areas, and commission according to population needs.

During the period of transition towards becoming a single commissioning organisation there may be resulting financial impacts that would be absorbed by the new BSOL organisation. We will ensure that the outcomes will be to deliver the best possible outcomes for local people; tackling health inequalities and meeting the needs of a diverse population, as well as improved performance.

The new BSOL commissioning organisation will need to ensure an effective strategic response to its duty under the Health and Social Care Act 2012 to reduce health inequalities.

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	Patients will be afforded the same access to services
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	All services will continue to be delivered ensuring respect for private and family life
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	All three CCGs are statutorily committed to meeting their equality obligations. The CCG's are working together to align the equalities agenda for a BSOL equalities agenda and will be completing its EDS2 Grading Review during 2017 with a view to publishing joint equality objectives for the merged BSOL organisation in March 2018.
	How will this affect a person's right to freedom of thought, conscience and religion?	No impact
Dignity – the right not to be treated in a degrading	How will you ensure that individuals are not being	All services will continue to be delivered ensuring dignity

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way	treated in an inhuman or degrading way?	for patients is upheld.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	Patients will continue to have the opportunity to be involved in discussions and decisions about their own healthcare.
Right to **Life**	Will or could it affect someone's right to life? How?	No impact
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	No impact

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	**What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?**
Enable all people to have control over their lives and maximise their capabilities	N/A
Create fair employment and good work for all	N/A
Create and develop health and sustainable places and communities	N/A
Strengthen the role and impact of ill-health prevention	N/A

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	**Protected Characteristic/ Group/ Community**	**Date**

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

Engagement activity should include the following patient groups and their representatives across Birmingham and Solihull:

- Disabled people
- Carers

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- Black Minority Ethnic communities
- Lesbian Gay and Bi-sexual people
- Asylum Seekers and Refugee people
- Faith communities
- Patients representing across the geographies of Birmingham and Solihull (including those from deprived areas)
- GP membership and patient participation groups
- The consultation process will need to ensure it is inclusive of older people and younger people, and make use of a range of engagement tools and mechanisms to reach a range of ages.

Engagement activity should include the following staff groups:

- All staff and volunteers employed by the three CCGs (and conducted across both Birmingham and Solihull sites)
- Staff on leave (including maternity leave, shared parental leave, and sick leave as appropriate)
- Commissioning Support Unit Staff
- BCC CCG Staff Council
- BCC CCG Equality and Diversity Implementation Group
- Solihull CCG Staff Group
- BSC CCG HR Working Group
- Unions and Staff Representatives
- Annual Staff Equality (WRES) Survey Results for each CCG

Following the engagement activity the Equality Analysis will be reviewed and a second iteration produced incorporating the stakeholder engagement results.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

Summary of impacts on patients and communities in Birmingham and Solihull:

The preferred alternative to merge the CCGs is part of a key programme of commissioning reform within the Sustainability and Transformation Plan and development of place based commissioning. A single commissioning voice approach will need to ensure it remains responsive to local health needs and recognises and responds to the diversity of its geographies and patient populations across Birmingham and Solihull.

No significant adverse impacts have been identified for protected or vulnerable groups. A number of areas have been identified to ensure the approach towards merging and developing a single commissioning voice are inclusive and responsive to the diversity of patient populations across the BSOL footprint.

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Some communities may find it a barrier to engage with a larger commissioning body, than three smaller ones. The engagement process will establish whether this is an issue.

Summary of impacts on staff:

Research and evidence highlights that organisational change brings a difficult period for many NHS staff, and some staff from minority or disadvantaged groups may feel even more vulnerable at this time. These impacts will need to be mitigated by ensuring effective support mechanisms are in place throughout the organisational change process, including an ability for staff to raise any equality issues or concerns.

The preferred alternative to merge is likely to have an impact on the BSOL staff equality profile; as it moves towards becoming a larger organisation with staff from a range of backgrounds and expertise.

Effective staff engagement throughout the change process will be necessary including those staff groups who are on leave such as sick leave, maternity leave or shared parental leave. Staff who are on fixed term contracts and CSU staff will also need to fully included.

Workforce activities resulting from the merger (such as recruitment, redundancy, job matching, job evaluation, grading and relocation etc) will be subject to the Public Sector Equality Duty and will need to be assessed for their impacts on protected groups.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

Equality Analysis Recommendations for the emerging BSOL organisation:

1. **The three CCG's will need to ensure they respond to their organisational statutory responsibilities as individual CCG's but also work to align their equalities agenda's and can deliver an effective response to the Equality Act 2010 (regulations 2017), Public Sector Equality Duty, Health and Social Care Act, and NHS standards and implementation of NHS Equality Delivery System 2. Alignment of the three CCG's equalities agendas will help ensure the**

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authorisation of the merger.

2. **The consultation process will need to ensure it is inclusive and broadly representative of the diverse communities of Birmingham and Solihull ensuring engagement and consultation methods are accessible and inclusive (including accessibility by language) (See section 7 for groups to be included in the consultation).**
3. **The emerging BSOL organisation will need to maintain and build on the relationships and trust built with its GP membership and third sector; disabled communities, ethnic minority communities and patient groups ensuring they are fully engaged throughout the change process.**
4. **Any application to administer the preferred alternative to merge should include an equality statement committing to all significant decisions around the preferred alternative to merge being subject to an Equality Analysis.**

<u>Recommendations for the emerging single commissioning approach:</u>

5. **The single commissioning approach will need to ensure it is able to challenge discriminatory attitudes consistently when commissioning decisions are made, by ensuring an alignment of its equalities agendas across the three CCGs.**
6. **The single commissioning approach will need to ensure it is able to make considerations of its two separate geographies (Birmingham and Solihull) and balance the age variations across them when commissioning decisions are made; with Birmingham having a young population, and Solihull with a relatively older population.**
7. **The single commissioning approach will need to ensure it is able to respond to the life expectancy variations across and within its two geographies (Birmingham and Solihull) when commissioning decisions are made for men and women.**
8. **The single commissioning approach will need to ensure it is able to respond to the variations across and within its two geographies (Birmingham and Solihull) when commissioning decisions are made for the ethnic diversity of patient populations.**
9. **During the period of transition towards becoming a single commissioning organisation there may be resulting financial impacts that would be absorbed by the new BSOL organisation. We will ensure that the outcomes will be to deliver the best possible outcomes for local people; tackling health inequalities and meeting the needs of a diverse population, as well as improved performance.**

<u>Recommendations for Staff:</u>

The emerging BSOL organisation will need to ensure;

10. **Effective support mechanisms enabling staff to raise any equality issues throughout the organisational change process and access to wellbeing support (such as HR Drop-in Surgeries, access to E&D leads, access to Staff council representatives, access to counselling)**
11. **Workforce activities resulting from the merger (such as recruitment, redundancy, job matching, job evaluation, grading, relocation etc) are assessed for their impact on protected characteristics (including those staff on fixed term contracts and CSU staff) and reasonable adjustments and accommodations are put in place to ensure inclusive, fair and transparent processes.**

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12. **The emerging BSOL organisation will need to ensure that it engages with its staff on significant decisions regarding the merger including those staff who are on a period of maternity or shared maternity leave, sick leave, fixed term staff, and CSU staff, to avoid any adverse impacts occurring**

13. **Develop a BSOL preferred alternative to merger Equality Action Plan incorporating the above recommendations which will be overseen and monitored by the Joint BSOL Quality and Safety Committee.**

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

The emerging BSOL organisation will need to oversee the successful implementation of the change programme from an equality perspective, through good quality monitoring information and analysis.

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):

N/A

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages.

The results of the EA will be published on the three CCG's webpages.

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality and Diversity, Senior Manager for Assurance and Compliance or Equality and Human Rights Manager **and** signed-off by a delegated committee

Name	Date

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Quality Assured By:	Michelle Dunne – Senior Manager Quality and Assurance & David King – Equalities and Human Rights Manager	30 May 2017
Which Committee will be considering the findings and signing off the EA?	BSOL Transition Group	6 June 2017
Minute number (to be inserted following presentation to committee)	Health Commissioning Board	14 June 2017

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Excellence in Commissioning
Through Excellent Primary Care

NHS
Birmingham CrossCity
Clinical Commissioning Group

Recovery & Employment Consultation

Tom Howell Senior Strategic Mental Health Commissioner

Dario Silvestro Joint Commissioning Manager
Mental Health Joint Commissioning Team

Overview Of The Proposed Changes: To Mental Health Recovery and employment services

1. Establish 4 Recovery Centres
2. Establish Individual Placement Support Service (IPS)
3. Single provider or consortium model
4. Introduce Personal Health Budget (PHB) offer
5. Introduce outcome based payment

The Consultation Process

- An online survey completed by 116 people
- 2 public meetings (85 attendees)
- 11 facilitated sessions with users of existing services (200 attendees)
- Focus group for 18-25 year olds
- Formal market engagement exercise

Change 1: Establishing 4 New Recovery Centres Across The City

Feedback

- 67% strongly or somewhat agreed with proposal
- Recovery concept has been received positively
- Accessibility was an issue
- Name of Recovery Colleges and Recovery Hubs need amending to avoid confusion
- The ability to self-refer is considered important
- Also an be a element of signposting and network guiding by centres is considered crucial
- Consider needs of younger adults (18-25 years)

Response

- Specify development of satellite provision
- Involvement process to agree name
- Enable self-referral but retain access criteria
- Test inclusiveness of provider model through tender

Change 2: Establishing An Individual Placement Support Service

Feedback

- 75% strongly or somewhat agreed
- Agreed that employment can aid recovery
- Concern that people would be pressurised to move to employment
- The ability to access trained skilled Employment Advisors was welcomed
- Need to focus on skill development and training, not only employment
- There was concern that suitable placements are sought
- Retention staff could be available out of hours to ensure individuals sustain employment.
- Benefit advisors would also be advantageous

Response

- Employment targets to be revised
- Include benefit advisor role in model
- Include work retention role in model
- Seek service user feedback on experience
- Workers to focus on resilience and coping skills

Change 3: Recovery And Employment Services Are Provided By One Organisation (Or A Partnership)

Feedback

- 85% strongly or somewhat agreed
- Would increase quality
- Offer wider range of services, better expertise
- Improve communication
- Allow innovation
- But could also reduce choice.

Response

- Proceed as planned
- Retain and emphasise focus on personalisation

Change 4: Service Users To Be Offered Personal Health Budget

Feedback

- 69% strongly or somewhat agreed
- Could provide more flexibility and choice
- Would empower individuals
- PHB are confusing concept to understand – individuals would need support and advice
- There were apprehensions about fairness of access- who will be eligible?
- A menu of PHB options would be helpful

Response

- Provider will work closely with individuals to co-design approach to PHB
- Commissioners review process and approach at least annually

Change 5: Some payments to organisations providing services are based on their success

Feedback

- 55% strongly or somewhat agreed
- Payments by results could improve service as focuses IPS workers
- Anxiety that person centred approach would give way to outcome approach
- Risk that incentivising employment would lead to individuals being coerced or inappropriately placed
- PbR could focus on other recovery outcomes surrounding employment.

Response

- Retain PbR as marginal element of payment mechanism (7%)
- Revise employment targets
- Retain focus on recovery outcomes (not incentivised)

Moving forward…

After presenting at the Health, Wellbeing and the Environment Overview and Scrutiny Committee:

- Gain Governance approval to proceed with procurement - June 2017
- Commence Procurement - July 2017
- Recovery and Employment Service to begin in April 2018

Any Questions?