NHS
Northumberland
Clinical Commissioning Group

Equality Strategy 2016 – 2020

Outlining our strategic direction to ensure compliance to Equality, Diversity and Human Rights (EDHR)

Author	Hannah Pearson, Senior Governance Officer,
Owner	
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1.0 Foreword

NHS Northumberland Clinical Commissioning Group (CCG) are committed to ensuring that equality and human rights are taken into account in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting or involving people in our work.

This strategy reflects the Equality Act 2010 which provides a legislative framework to:

- Protect the rights of individuals and advance equality of opportunity for all
- Update, simplify and strengthen the previous legislation; and
- Deliver a simple, modern and accessible framework of discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

The strategy describes a clear picture of the significant targets we have set in relation to equality and human rights. It is a long-term commitment driven by both equalities legislation and by the needs and wishes of our local people and staff. For that reason much of the work will be on-going over the next few years.

We look forward to the work ahead, facing the challenges, and meeting the targets we have set ourselves.

Vanessa Bainbridge
Chief Operating Officer

2.0 Introduction

The CCG was established in April 2013 and operates as a collaborative, open and transparent, caring and accountable organisation, which seeks to maximise the value added in clinician involvement with commissioning decisions.

As a public sector organisation, the CCG is required to publish its equality information to demonstrate compliance with the general equality duty, as specified in the Equality Act 2010, which states in summary:

'*Those (organisations) subject to the general equality duty must, in the exercise of their functions, have due regard to the need to:*

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

The Act brings together and replaces the previous anti-discrimination laws with a single Act, which aims to simplify and strengthen the law, removing inconsistencies and making it easier for people to understand and comply with it.

The Act covers the following protected characteristics:

For further information on the protected characteristics please see 'Appendix 1'.

Additionally, the CCG must:

- Prepare and publish one or more objectives they think they should achieve to do any of the things mentioned in the aims of the general equality duty, and at least every four years thereafter.
- Ensure that those objectives are specific and measurable.
- Publish those objectives in such a manner that they are accessible to the public.

For further information on the General and Specific Public Sector Equality Duties (PSED) please refer to 'Appendix 2'.

3.0 Meeting our Equality Duties

This strategy is the first step in outlining our strategic direction to ensure compliance with the Public Sector Equality Duty and, highlights the national and local drivers that will shape and influence our approach.

3.1 Our vision

Since its inception in 2013 the CCG's vision has been to:

'ensure that the highest quality integrated care is provided, in the most efficient and sustainable way, by the most appropriate provider to meet the longer term needs of the people in Northumberland'.

We have three strategic objectives that support the achievement of our vision:

- To assure the delivery of safety, quality and performance
- To create joined up pathways across organisations to deliver seamless care
- To deliver clinically led health services that are focussed on the patient and based on evidence

Our definition and vision of whole system integration is of patient-centred integrated care as described by the patients and service users themselves. We are creating a culture of integration around these people rather than the organisation or system. We believe that the most crucial aspect of integrated care is how care is better coordinated by providers around people's needs, and how professional groups work together in teams to ensure that this is delivered successfully.

3.2 Leadership and governance

Equality and Diversity is governed and reports into the Governance Group.

The Board ensures we are compliant with legislative, mandatory and regulatory requirements regarding equality and diversity.

It ensures we develop and deliver national and regional diversity-related initiatives within the CCG; provides a forum for sharing issues and opportunities; functions as a two-way conduit for information dissemination and escalation; monitors progress against the Equality Strategy; and supports us in the achievement of key equality and diversity objectives.

A quarterly Governance Assurance Report is submitted to the Governance Group outlining relevant updates in relation to Equality, Diversity and Human Rights (EDHR).

3.3 Our staff

The CCG directly employs less than 150 staff, which means we are not required by law to publish staff equality data. However, we are committed to attracting, retaining and developing a diverse and skilled workforce that is representative of our local population.

We actively work to remove any discriminatory practices in our work, eliminate all forms of harassment and promote equality of opportunity in our recruitment, training, performance

management and development practices. We have policies and processes in place to support this.

From 1 July 2016 we will be monitoring our staff data in relation to the Workforce Race Equality Standard (WRES) as set by NHS England.

We routinely provide equality, diversity and human rights training which is mandatory for all our staff and Governing Body members. Enhanced training is available, as appropriate to individual roles.

3.4 Our population and their health needs

The CCG covers the county of Northumberland and serves a population of approximately 316,000 people with 43 GP practices.

The health of people in Northumberland is varied compared with the England average. About 18% (9,300) of children live in low income families. Life expectancy for women is lower than the England average.

Life expectancy is 9.3 years lower for men and 7.3 years lower for women in the most deprived areas of Northumberland than in the least deprived areas.

19.8% of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 is worse than the average for England. Levels of breastfeeding initiation and smoking at time of delivery are worse than the England average.

The rate of alcohol-related harm and self-harm hospital stays is worse than the average for England. Estimated levels of adult excess weight are worse than the England average. The rate of smoking related deaths is also worse than the average for England.

Rates of sexually transmitted infections and TB are better than average. Rates of statutory homelessness, violent crime, excess winter deaths and early deaths from cardiovascular diseases are better than average.

Public Health England | Local Health

Local Health
Selection: E38000130 - NHS Northumberland
Source:

Indicators	Selection value	value England	England worst	Summary chart	England best	England 25th perc
Income Deprivation (%)	13.3	14.7	36.8		4.8	10.6
Low Birth Weight Births (%)	6.9	7.4	10.8		5.3	6.6
Child Poverty (%)	18.5	21.8	59		6.6	14.5
Child Development at age 5 (%)	67.6	63.5	51.2		77.5	60
GCSE Achievement (5A*-C inc. Eng & Maths) (%)	58.2	58.8	44.4		77.6	56.3
Unemployment (%)	4.3	3.8	3.5		1.4	2.6
Long Term Unemployment (Rate/1,000 working age population)	12.1	10.1	33.5		2.5	5.8
General Health - bad or very bad (%)	6.3	5.5	3.5		2.8	4.6
General Health - very bad (%)	1.4	1.2	2.2		0.6	1
Limiting long term illness or disability (%)	20.7	17.6	25.6		11.2	15.3
Households with central heating (%)	98.7	97.3	92.6		99.3	96.8
Overcrowding (%)	3.6	8.7	34.9		2.7	4.5
Provision of 1 hour or more unpaid care per week (%)	11.3	10.2	13		6.5	9.4
Provision of 50 hours or more unpaid care per week (%)	2.8	2.4	4		1.3	2
Pensioners living alone (%)	30.7	31.5	45.2		25.7	29.6
Older People in Deprivation (%)	16	18.1	56.4		7.2	13.9
Obese Children (Reception Year) (%)	9.8	9.4	13.5		5.9	8.2
Children with excess weight (Reception Year) (%)	23.2	22.5	28.7		16.4	21
Obese Children (Year 6) (%)	18.3	19.1	26.7		11.4	16.8
Children with excess weight (Year 6) (%)	32.9	33.5	42.3		24.4	30.8
Children's and young people's admissions for injury (Crude rate/100,000 aged 0-17)	1340.8	1180.9	1313.4		714	1005.1
Occasional smoker (modelled prevalence, age 11-15) (%)	1.7	1.5	2		0.4	1.4
Regular smoker (modelled prevalence, age 11-15) (%)	3.9	3.1	4.7		1.1	2.9
Occasional smoker (modelled prevalence, age 15) (%)	4.7	4	5.3		1.2	3.7
Regular smoker (modelled prevalence, age 15) (%)	10.7	8.7	12.7		3.2	8
Occasional smoker (modelled prevalence, age 16-17) (%)	6.9	5.9	7.8		1.8	5.5
Regular smoker (modelled prevalence, age 16-17) (%)	17.7	14.8	20.7		5.7	13.7
Deliveries to teenage mothers (%)	2.8	1.5	4.1		0.3	1.5
Admissions for injuries in under 5s (Crude rate per 10,000)	148.5	139.6	263.8		81.1	111.2
Emergency admissions in under 5s (Crude rate per 1000)	163.4	150	307.5		67	106.3
A&E attendances in under 5s (Crude rate per 1000)	541.3	503.5	1550.7		196.3	366.5
Obese adults (%)	27.3	24.1	30.9		14.5	22.7
Binge drinking adults (%)	23.8	20	37.3		7.5	17.2
Healthy eating adults (%)	24.2	28.7	19.4		46.5	24.9
Emergency hospital admissions for all causes (SAR)	117.5	100	163.6		66	86.7
Emergency hospital admissions for CHD (SAR)	124.9	100	318.3		61.3	84.9
Emergency hospital admissions for stroke (SAR)	112.9	100	155.2		72.9	91.1
Emergency hospital admissions for Myocardial Infarction (heart attack) (SAR)	134.8	100	228.4		54.8	83.8
Emergency hospital admissions for Chronic Obstructive Pulmonary Disease (COPI	127.9	100	286.3		42.3	73.4
Incidence of all cancer (SIR)	101.4	100	121		81.1	95.9
Incidence of breast cancer (SIR)	100.8	100	116.3		77.9	95.1
Incidence of colorectal cancer (SIR)	106.4	100	118.7		72.8	95
Incidence of lung cancer (SIR)	114.2	100	207.5		52.5	82.5
Incidence of prostate cancer (SIR)	92.9	100	154.4		64.9	87.5
Hospital stays for self harm (SAR)	125.5	100	241.4		30.1	71.6
Hospital stays for alcohol related harm (SAR)	116.9	100	172.2		51.9	86.3
Emergency hospital admissions for hip fracture in 65+ (SAR)	105.7	100	130.1		81.2	95.2
Elective hospital admissions for hip replacement (SAR)	118.4	100	145.5		43.3	86.6
Elective hospital admissions for knee replacement (SAR)	131.6	100	140.7		43.5	90.2
Life expectancy at birth for males (years)	78.8	78.9	72.6		82	77.5
Life expectancy at birth for females (years)	82.2	82.8	78.2		85.9	81.7
Deaths from all causes, all ages (SMR)	103	100	148.9		76.5	93
Deaths from all causes, under 65 years (SMR)	95.8	100	183.3		63.7	87.3
Deaths from all causes, under 75 years (SMR)	98.3	100	180.7		73.1	88.3
Deaths from all cancer, all ages (SMR)	102.3	100	134.8		78.1	93.2
Deaths from all cancer, under 75 years (SMR)	100.4	100	149.4		77.6	91.4
Deaths from circulatory disease, all ages (SMR)	98	100	154.3		75	94
Deaths from circulatory disease, under 75 years (SMR)	94.9	100	228.6		62.7	86.6
Deaths from coronary heart disease, all ages (SMR)	93.7	100	181.2		65.9	89.3
Deaths from coronary heart disease, under 75 years (SMR)	98.1	100	256.6		51.2	84.1
Deaths from stroke, all ages (SMR)	103.6	100	151.9		60	91.7
Deaths from respiratory diseases, all ages (SMR)	102.5	100	180.6		66.3	88.5

● significantly worse ● significantly better ● not significantly different from average

The 2016 Health Profiles outline the following areas of focus for the CCG:

- Community wellbeing and resilience
- Addressing the social determinants of health
- Promoting and facilitating a healthy lifestyle

Further information detailing the health profiles for the CCG can be found at:

www.healthprofiles.info.

3.5 Communications and engagement

The CCG has three lay members on its Governing Body and one of these is a champion for engagement and experience.

Patient and public engagement is critical to the success of developing the CCG, promoting GPs as the leaders of commissioning in the NHS and the authoritative source of information on local health services to help people make informed choices on health matters. In particular there needs to be a focus on working with community and voluntary organisations to increase engagement with easy to overlook communities.

The CCG has an approved Communication and Engagement Strategy. This strategy sets out the CCG's approach to how it intends to work towards its engagement vision, through effective communication and engagement with service users and the public, within the CCG and with healthcare partners.

The strategy looks at the way in which the CCG will communicate with, and involve all its constituent practices, and takes into account a range of responsibilities in relation to its role as a publicly accountable organisation.

Two of the key objectives of the strategy are:

- To ensure processes are in place for robust internal communications to facilitate a high level of engagement and awareness of the CCG and its vision and mission, leadership and governance arrangements with other internal audiences i.e. CCG staff, colleagues working in the commissioning support organisation, and other NHS partners
- To ensure processes are in place for robust external communications to facilitate a high level of engagement and awareness of the CCG and its vision and mission, leadership and governance arrangements with external audiences i.e. Northumberland County Council, the Health and Wellbeing Board, Healthwatch, community and voluntary sector, MPs and parliamentary questions

4.0 What we need to do

4.1 Equality Analysis

Essentially, equality analysis is about asking a simple question: Can everyone who needs to use the service, no matter who they are, no matter what their background? And when they do, have we done everything possible to make sure it's a positive experience for them? To be able to answer yes, we have to firstly do some thinking and research and secondly agree some actions. To ensure that our decision making is robust and does not discriminate we need to undertake an equality analysis.

Equality Analysis (EA) is a legal requirement under the Equality Act 2010 and the public sector equality duty and is a process of systematically analysing a new or existing policy or strategy to identify what effect or likely effect will follow as a result of its implementation for different groups within the community. It can also be used as a mechanism for analysing the impact of a whole service or one aspect of the service.

We have developed and implemented a tool and guidance for use by staff to help identify likely equality implications of any of our policies, projects or functions. Training has been provided to our staff and our Joint Locality Executive Board will consider the results of any analysis undertaken during the decision-making process. EA is published, either as part of

a policy document or separately on our website.

4.2 Equality Delivery System (EDS2)

The EDS is a tool that has been designed by the NHS to enable organisations to analyse equality performance with the assistance of local stakeholders, prepare equality objectives and embed equality into mainstream commissioning activities.

The CCG has adopted the Equality Delivery System (EDS) and we continue to use the EDS2 framework as an opportunity to raise equality in service commissioning and performance for the community, patients, carers and staff.

4.3 Workforce Race Equality Standard (WRES)

The WRES is a mandatory part of the 2016/17 NHS Standard Contract that requires CCG's to have "due regard" to the WRES in helping to improve workplace experiences and representation at all levels for their own BME staff.

The WRES has nine metrics, four specifically focusing on workforce data, four from the NHS Staff Survey, and one requiring organisations to ensure that their Boards are broadly representative of the communities they serve.

From 1 July 2016 onwards, CCGs will be expected to produce an annual WRES report, accompanied by an action plan.

The CCG will ensure that WRES data is compiled and reported in line with NHS England's requirements and those actions are identified to increase Workforce Race Equality across all nine indicators of the standard.

4.4 Accessible Information Standard

The Accessible Information Standard asks organisations to make sure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.

Commissioners of NHS and publicly-funded adult social care must have regard to this standard, in so much as they must ensure that they enable and support compliance through their relationships with provider bodies.

The CCG will ensure they are compliant with the standard by taking the following actions:

- Ensuring that their commissioning and procurement processes, including contracts, tariffs, frameworks and performance-management arrangements (including incentivisation and penalisation), with providers of health and / or adult social care reflect, enable and support implementation and compliance with this standard.
- Seeking assurance from provider organisations of their compliance with this standard, including evidence of identifying, recording, flagging, sharing and meeting of needs.

5.0 Conclusion

The CCG has developed detailed constitutional and governance arrangements to ensure the structures are in place to develop and maintain the organisation's capacity to deliver on all statutory duties and responsibilities.

Through this strategy, the CCG will endeavour to work with and gain the support of people with the right skills, competencies and capacity to ensure it can carry out all corporate and commissioning responsibilities, including the delivery of statutory functions including equality, diversity and protecting people's human rights.

The CCG will incorporate equality, diversity and human rights into all aspects of its business plans, such as its commissioning and organisational development plans, developing an organisational culture which is diverse in its makeup, uphold equality of opportunity and fairness for all.

Appendix 1- Protected Characteristics

This equality strategy outlines our commitment to take the following categories into account, which are the specific groups listed in the Equality Act 2010, and are referred to as the nine protected characteristics:

Age- Where this is referred to, it refers to a person belonging to a particular age.

Disability- A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

Gender reassignment - A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.

Transgender is an inclusive, umbrella term used to describe the diversity of gender identity and expression for all people who do not conform to common ideas of gender roles.

Marriage and Civil Partnership- In the Equality Act marriage and civil partnership means someone who is legally married or in a civil partnership. Marriage can either be between a man and a woman, or between partners of the same sex. Civil partnership is between partners of the same sex.

Pregnancy and maternity - Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Race - Refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.

Religion and belief - Religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Sex - A man or a woman.

Sexual orientation - Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

Appendix 2 - Equality Act 2010 Section 149 General / Specific Duties

Equality Act 2010 Section 149 General / Specific Duties (1-3)		
General Duties		**Due Regard**
1	Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010	Remove or minimise disadvantages connected with a relevant protected characteristic (e.g. address the problems that women have in accessing senior positions in the workplace) Take steps to meet the different needs of persons who share a relevant protected characteristic (e.g. ensure the particular needs of BME women fleeing domestic violence are met) Encourage persons who share a relevant protected characteristic to participate in public life or any other activity in which they are under- represented (e.g. take steps to encourage more disabled people to apply for senior posts).
2	Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it	Tackle prejudice (e.g. tackle hate crime for people with protected characteristics)
3	Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.	Promote understanding (e.g. promote an understanding of different faiths).
NB	Organisations that are not public authorities are also required to have due regard to the needs listed above whenever they carry out public functions. This could include, for example, a private company with a contract to provide certain public services.	
Specific Duties		
4	**Publication of information** Each public authority must publish information to show that it is complying with the s.149 duty by 31st January 2012 and at least on an annual basis after that. Authorities must include information about persons who share a protected characteristic who are its employees (if it has 150 or more employees) and its service users.	
5	**Equality objectives** Each public authority must prepare and publish one or more objectives it thinks it should achieve to have due regard to the need to eliminate discrimination and harassment, to advance equality of opportunity or to foster good relations. Any objective must be specific and measurable. Authorities must publish their first objectives no later than 6 April 2012 and at least every four years after that.	

6	**Health Inequalities** - The NHS Constitution states that the NHS has a duty to "…pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population". The Health and Social Care Act 2012 introduced the first legal duties on health inequalities, with specific duties on NHS England and CCGs. CCGs have duties to: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved; Exercise their functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where they consider that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved; Include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities; Include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities.